North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024, 1.30pm – 4.30pm; Unex Tower, 5 Station Street, London E15 1DA

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair	Verbal	Note
1.1.	Declaration of conflicts of interest		Chair	Attached	Note
1.2.	Minutes of the meeting held on 31 January 2024		Chair	Attached	Approve
1.3.	Matters arising • Joint Working Agreement with NHSE London for Specialised Services for 2024/2025		AM	Attached	Approve
1.4.	Actions log		Chair	Attached	Note
2.0	**Resident story**	1.50		Verbal	Discuss/ note
3.0	**Chair and chief executive reports**				
3.1.	Chair's report	2.10	Chair	Attached	Note
3.2.	Chief executive officer's report	2.15	ZE	Attached	Approve
4.0	**Quality**				
4.1.	Growing Well priorities in north east London	2.20	KE/ PGo/ CJ	Attached	Note
5.0	**Strategy**				
5.1.	Joint Forward Plan refresh 2024/25	2.40	JM	Attached	Approve
5.2.	Overview of clinical and care professional leadership across north east London	2.50	PG	Attached	Note
5.3.	Update on the delivery plan for recovering access to primary care	3.00	JM	Attached	Note
6.0	**Finance and performance**				
6.1.	Financial overview	3.10	HB	Attached	Approve
6.2.	Performance report	3.20	HB	Attached	Note
7.0	**Governance**				
7.1.	Governance update	3.30	CPo	Attached	Approve
7.2.	Board Assurance Framework	3.40	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	3.50	Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
	• Population Health and Integration committee				
8.0	**Board forward plan**	4.00	Chair	Attached	Note
9.0	**Questions from the public**	4.05	Chair	Verbal	Note
10.0	**Any other business and close**	4.15	Chair	Verbal	Note
Date of next meeting: 29 May 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.

North East London Integrated Care Board Register of Interests

- Declared Interests as at 26/01/2024

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) Member of VCSE Collective	ICB Board ICP Committee	Financial Interest	Compost London CIC	As part of the VCSE Collective we may receive funds to promote and carry out activities as part of the VCSE Collective	2023-12-01	2023-12-30	
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	0022-12-12		
			Financial Interest	Igloo Consultants Limited	Director of family owned consultancy business	0022-12-12		
Christopher Kennedy	Councillor	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICP Committee	Non-Financial Professional Interest	London Borough of Hackney	Cabinet Member for Health, Adult Social Care, Voluntary Sector and Leisure in London Borough of Hackney	2020-07-09		
			Non-Financial Personal Interest	Lee Valley Regional Park Authority	Member of Lee Valley Regional Park Authority	2020-07-09		
			Non-Financial Personal Interest	Hackney Empire	Member of Hackney Empire	2020-07-09		
			Non-Financial Personal Interest	Hackney Parochial Charity	Member of Hackney Parochial Charity	2020-07-09		
			Non-Financial Personal Interest	Labour Party	Member of the Labour Party	2020-07-09		
			Non-Financial Personal Interest	Local GP practice	Registered patient with a local GP practice	2020-07-09		
			Non-Financial Personal Interest	Hackney Joint Estate Charities	sit in the board as trustee	2014-04-07		
			Non-Financial Personal Interest	CREATE London	LBH appointed rep	2023-04-05		
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 Nursing Officer	Clinical Advisory Group ICB Board 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
			Non-Financial Personal Interest	Sign Health	I am a Trustee of the charity	2023-05-01		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 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 Region	Personalised Care Clinical Director	2017-05-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	2011-08-01		Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is a shareholder	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
			Non-Financial Professional Interest	New West PCN	Co lead for health inequalities	2023-04-01		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	My 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	Trustee on the Board	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	GSTT NHS Trust	Daughter employed as a graduate trainee	2023-09-01		
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		
Johanna Moss	Chief strategy and transformation officer	Community Health Collaborative sub-committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee Primary care contracts sub- committee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Workforce & Remuneration Committee ICP Committee NEM Remuneration Committee	Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	2020-04-01		Declarations to be made at the beginning of meetings
			Financial 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 organizations 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 Clinical Advisory Group 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
			Non-Financial Professional Interest	UCL Partners	Member of the Board of UCLP on behalf of NHS NEL and by extension a Director	2023-09-18		

- Nil Interests Declared as of 26/01/2024

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 Community Health Collaborative sub-committee Havering ICB Sub-committee Havering Partnership Board ICB Audit and Risk Committee 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 Patient Choice Panel Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-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.
Paul Calaminus	Board member. Sub-Committee member.	Community Health Collaborative sub-committee ICB Board ICB Population, Health & Integration Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee NEM Remuneration Committee	Indicated No Conflicts To Declare.
Maureen Worby	Member of Committee	Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Jenny Hadgraft	Partnership working	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board ICB Board ICP Committee	Indicated No Conflicts To Declare.

NHS
North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

31 January 2024, 1.30pm – 4.00pm, East Ham Town Hall

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
Diane Herbert (DH)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, 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
Paul Calaminus (PC)	NHS trust partner member *via MS Teams*
Shane DeGaris (SD)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Cllr Christopher Kennedy (CK)	Local authority partner member
Caroline Rouse (CR)	VCSE 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
Jenny Hadgraft (JH)	Healthwatch participant
Abi Gbago (AG)	Local authority executive participant
Archna Mathur (AM)	Director of Specialised Services and Cancer, NHS North East London and NEL Acute Provider Collaborative
Claire Hogg (CH)	Director of Planned Care, North East London Acute Provider Collaborative and NEL ICS
Thangadorai Amalesh (TA)	Clinical co-lead for elective recovery, Barking, Havering and Redbridge University Hospital Trusts
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance lead, NHS North East London
Apologies:	
Dr Jagan John (JJ)	Primary care partner member
Andrew Blake-Herbert (ABH)	Local authority executive 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 introduced and welcomed Councillor Christopher Kennedy as the new local authority partner member of the ICB 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. No additional conflicts were declared. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
1.2	Minutes of the last meeting
	The minutes of the meeting held on 29 November 2023 were agreed as a correct record.
1.3	Matters arising
	Following the discussion at the last meeting regarding the Board forward plan, the Chair advised that no suggestions of further agenda items had been received from members. The Chair suggested that the appropriate members discuss the forward plan with their respective Provider Collaboratives.
1.4	Actions log
	4.2 Financial strategy – HB explained that a session for system chief executives regarding the medium-term financial strategy has been scheduled for 8 February and that a wider workshop is being arranged. 4.3 Freedom to speak up (FTSU) services – further discussions on freedom to speak up services will be held by the Quality, Safety and Improvement Committee. The ICB board noted the actions taken since the last meeting.
2.0	**Resident story**
	The Chair explained that unfortunately our resident, Amarjit, was unable to attend the meeting in person for personal reasons, but that AM would read out story on his behalf. Amarjit is Sikh resident of north east London and a user of renal services at Royal London Hospital. AM presented Amarjit's story and key points included: • Amarjit was diagnosed with early-stage renal failure and attended hospital for a catheter insertion to facilitate continuous ambulatory peritoneal dialysis (CAPD). One area of learning is the challenge of storing a 30 day supply of CAPD bags, it took a whole room. He was fortunate enough to receive a kidney transplant and was able to return to a full life and active life until things began to deteriorate 25 years later and he commenced haemodialysis three time times a week at the Royal London Hospital. • He has experienced Home Dialysis but this requires significant usage of electricity and special plumbing arrangements in the home, although he has received support from Waltham Forest Local Authority who have paid a percentage contribution towards his electricity and water bills. Demands on space at home, and caring responsibilities mean that home dialysis is no longer suitable for Amarjit so he is attending Royal London Hospital currently.

	• He has been referred to a self-care programme run by the Royal London, that will allow him to manage his own haemodialysis in another setting enabling him to "plug" into a dialysis machine on his own, without the need for staff and even interpret his own results. This will give him independence, does not generate additional electricity costs at home and is more efficient in terms of reducing bed utilisation at the Royal London and enable a more cost-effective service as the staff requirement is minimal. There is currently an unconfirmed opening date for this Independent Treatment Centre at Mile End so capacity is constrained. • Amarjit is now back on the transplant list and feels that renal services provided by the Royal London have given him a fantastic life. He is healthy and fit and takes good care of himself through diet and exercise, and now also supports other dialysis patients through their experience. • Amarjit is very mindful of the current obesity crisis, the strain of a growing population and the importance of a healthy lifestyle, particularly within his own Sikh community, where he feels pressure on renal services could grow and the need to expand these lifesaving services. As a keen sportsman he also wanted to specifically request that North East London hosts The British Transplant Games. He has been awarded a lifetime achievement award for Tennis and squash and would like north east London to be the place to showcase other achievements of transplant patients. Members discussed Amarjit's story which included the following points: • Further work will be required to enhance early interventions and prevention as Amarjit experience of returning to dialysis illustrates that transplantation is not the most appropriate or long term solution. • The capacity issues with renal services, particularly dialysis, means that forecasting demand and capacity will be extremely important to ensure that residents receive high quality services and care. • It would be beneficial to involve faith groups in the selfcare facilities in order to ensure that they are suitable for all of our communities. The ICB board thanked Amarjit for sharing his story 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 thanked all our staff who worked over the seasonal break, providing care and support to our residents, and explained her new year's resolution to have a focus on workforce, improving the experience of those we employ and further enabling residents to gain work with us, and secondly, to increase focus on the delivery of our ambition, deepening our partnerships as we further integrate and improve care and tackle health inequalities. • The Integrated Care Partnership (ICP) met on 10 January and considered an update on our approach to success measures, the need for action on community cohesion, the refresh of the Joint Forward Plan and received the report on Equity and Sustainability in North East London presented to our last Board. The meeting was refreshing in that a greater number of partner members were presenting items and speaking up. • The Partnership received the equity and sustainability presentation shared with the Board at its last meeting. The Partnership agreed that it was a great

	example of how the system can and is working together for the benefit of residents and partners. They asked that more information be added from a local government and voluntary sector perspective and that the addition of patient stories would bring it to life for readers. • In relation to the Joint Forward Plan prioritisation, the Partnership highlighted the importance of demonstrating that waiting lists are about access to all services, not just acute services, and that the wording should be amended so that all schemes must reduce health inequalities. In addition, the Partnership asked that we consider how the success measures, as set out by our residents through the Big Conversation, informed this prioritisation and highlighted the need for a resident led prioritisation criterion for capital expenditure. The ICB board noted the report.
3.2	Chief executive officer's report
	ZE presented the report and explained the following key points: • NHS England (NHSE) had introduced a new urgent and emergency care tiering system for systems, with criteria focussed on ambulance handovers and waiting times. North east London was placed in tier 1 (the lowest) performance but has improved considerably, which means that local people are getting the care they need faster. We have been notified that the system is now assessed as tier 2. North east London is the only system in the country to have seen this level of improvement in this timescale, work to further improve continues. • The mental health system has remained under pressure. The number of service users waiting in emergency departments over 4 hours has stabilised but the number of over 12 hour waits for a mental health bed continues to increase. Following the rollout of new 'Right Care, Right Person' guidelines by the Metropolitan Police, partners have worked closely to support this implementation and ensure it is rolled out as smoothly as possible. There has been little impact on mental health services and the needs of service users have been met. Numbers of calls and response rates continue to be monitored and discussed between partners. • Across north east London there are now more than 350 virtual ward beds supporting patients to receive care in their own homes rather than in a hospital setting. These beds are being delivered in each Place and by each of the acute providers as well as North East London Foundation Trust NELFT (NELFT) and East London NHS Foundation Trust (ELFT) working through the community provider collaborative. This emerging programme will seek to bring together pathways across same day emergency care, urgent community response, single point of access, primary care and ambulance services to provide better outcomes and experiences for our patients. • In December partners from across north east London came together to discuss our commitment to addressing violence against women and girls (VAWG), and to debate and agree what we, as a system, must do to make this commitment a reality. A task and finish group is being set up to monitor what steps we are taking to end VAWG across north east London and it is estimated that the cost to the NHS each year of VAWG is £1.9-2.3billion. • We were joined by senior leaders from NHS England who wanted to visit north east London to understand more about our integration work. As part of this we met with ELFT teams delivering integrated neighbourhood mental health support to talk about the successes and had an honest conversation

	about the challenges. They have subsequently sent us a letter which included very positive feedback. Members discussed the CEO's report, with key points including: • Considering a recent article published by the HSJ, it could be beneficial to review the costings of virtual wards as it had been suggested that they could cost up to twice as more. It was noted that the article was specific to the north west of England and that the level of occupancy will also be a factor in costings. It was highlighted that a discussion on virtual wards would be coming to the Board in May where this can be discussed further. • It was highlighted that Greenhouse Surgery has also received recognition by winning a national award for their work on outreach to homeless people. • Some voluntary organisations have recognised a correlation between the increasing prevalence of VAWG and the cost of living crisis, which could be due to increasing stress and tensions. It was also noted that violence and fear of violence for young people is a prevalent concern which also has an impact on their families and communities, which is being worked through with Place teams. It is important to also consider violence against our workforce and how we tackle violence, as a whole, in our partnerships. The ICB board noted the report.
4.0	**Quality**
4.1	A focus on specialised services ahead of delegation in April 2025
	AM presented the focus report and highlighted the following points: • Specialised services are a diverse portfolio of c150 services generally accessed by people living with rare or complex conditions. They are a catalyst for innovation and supporting pioneering clinical practice. Currently specialist services are planned nationally and regionally and delivered by hospitals with specialist clinical teams with expert training. • Responsibility for commissioning specialised services is being transferred to ICBs. In December 2023 the NHS England Board approved plans to continue to jointly commission appropriate specialised services with ICBs in London for a further year. This will help support a smooth transition of commissioning responsibility (Delegation) by April 2025. Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value. The Joint Working Agreement with NHSE and the ICB will be presented to the ICB Board for approval in March 2024. • Collectively the specialised services portfolio delivers care to large numbers of people. Nationally this equates to roughly 15% of the overall NHS commissioning budget, and for NEL ICB, specialised services equate to about 20% of the NEL Commissioning budget. From the total £587m which is to be delegated to the ICBs, £377m will go to NEL ICB (64%), £80m to other London ICBs (14%) and £96m will go to East of England (16%). This is important in understanding our flow of patients accessing specialist care in NEL from other ICBs, and how we work together to plan and commission services, across and outside London, ensuring sustainability of provision and income within NEL. • To support delegated commissioning, allocations have changed from a host regional commissioner basis in 2022/23 to a population basis from 2023/24 and will move to ICB level from 2024/25. Services not suitable for delegation will remain on a host regional commissioner basis. Over time, from 2024/25, allocations will gradually move to a needs-weighted

	population methodology which should help to address health inequalities. Through population-based allocations and ICBs being party to contracts that serve their populations, local commissioners will have much greater line of sight and influence over the services that their patients may be receiving out of area, making it easier to join up their local services with those specialist elements of pathways.
	• London region has stipulated four conditions to delegation:
	  o the development of a Legacy Risk Log,
	  o the development of a clinical risk-based strategic framework,
	  o Agreement of the future operating model with the regional specialised commissioning support team, and
	  o Agree a model for multi-ICB decision making.
	
	The ICB Board discussed the report and points included the following:
	• A specialised services quality dashboard had been developed and we are working with clinical networks and the provider collaboratives as part of a quality improvement approach.
	• The ICB Chief Medical Officer will be co-chairing a group reviewing the ICB legacy risk logs based on provider level risks and issues that are consistent across London.
	• It would be beneficial to provide further detail in the report coming to the Board in March on the numbers of residents who use specialised services as the presented report has a greater focus on the financial implications.
	• There are opportunities to design a strategic link with the wider partnership including links to Place and it will be important to include Directors of Public Health and local authority support in the work around early prevention.
	• It would be important to understand both primary prevention, (wider determinants) and secondary care prevention (clinical).
	• It is also important to understand the needs of different populations, for example for those who are homeless and who have undetermined status.
	• In response to a concern raised regarding the timeframe required to move to a needs-based allocation, it was explained that we have been working on the transition for one year already but that this extra year provides us with the opportunity to refine the details given the complexities involved.
	• Given our population growth we needed to ensure that allocation for specialised commissioned services is aligned.
	• Despite the associated risks, the delegation of specialised services provides us with real opportunities for our population.
	
	ACTION: Further report on specialised services to be presented at the next ICB Board meeting.
	
	The ICB Board noted the report.

5.0	**Strategy**
5.1	NEL ICS people and culture strategy
	FO presented the ICS people and culture strategy and highlighted the following points: • The strategy has been co-created following extensive engagement with system stakeholders and with consideration of our Interim Integrated Care Strategy, Joint Forward Plan, and national directives and plans. • Partners are clear that we need a radical new approach to how we work as an integrated care system to tackle what we are facing today and secure

	our sustainability for the future and this strategy will sit alongside individual partners' existing strategies. • The strategy outlines our challenges and how we plan to overcome them, recognising our role as an Anchor Institution in tackling issues relating to employment, health and wellbeing and diversity. It also acknowledges that we must be flexible to respond to emerging demands and population health needs. • It identifies four core people and culture pillars, focusing on how we attract, retain, innovate and lead our people. The focus also aligns to wider national people directives and plans, such as the NHS People Plan. • The strategy will be underpinned by a detailed delivery plan, which will be developed with partners, whereby the priorities for the next five years will be considered and agreed upon. • The strategy is ambitious and will be incumbent on the system partners working collaboratively and embracing the concept of establishing one workforce to create meaningful work opportunities and employment for people in north east London. • Further work is required regarding the social care workforce aspect, and we are awaiting a white paper from the government which will determine how we can take this forward. The ICB Board discussed the strategy and points included the following: • The need to work with children and young people to engage interest in health and care careers. • It could be beneficial to revisit initiatives such as key worker housing now that we are working as collaboratives and part of an integrated system. • There are opportunities to further develop integrated training which would be a quick win and will demonstrate that we are changing our ways of working and having an impact. • It will be important to develop and agree how we measure change. University College of London are looking at secure livelihoods in east London and have five parameters they use when interviewing and surveying residents, which could be something we learn from. In response to this, it was noted that the People Board will be responsible for working through the appropriate metrics required. • It is important to recognise that the delivery of the strategy will primarily happen at Place as this is where the most integration takes place and where culture will be embedded. • There is a need to incorporate social care nursing into the delivery plan as there tends to be a focus on hospital nursing. The sharing of training and backfilling of staff is being looked at by system Chief Nursing Officers. • The ambition to achieve parity for social care as well as outer London was welcomed, but recognition given to the complexities that will be involved in delivering this. This will need to tackled as a London-wide piece. The ICB Board **approved** the strategy and endorsed the next steps.
6.0	**Finance and performance**
6.1	Financial overview
	HB presented the report and explained the following points: • The ICS submitted an updated forecast position to NHS England (NHSE) as part of the H2 submission. This moved the ICS from a forecast breakeven position to a forecast month 12 deficit of £25m.

- The reported forecast deficit at month 9 is £42.4m. This is made up of the agreed system deficit of £25m deficit plus the impact of the additional cost of industrial action in December and January (£17.3m).
- The ICS has developed a formal finance recovery plan (FRP) to bring the current run rate of expenditure closer to plan.
- Better Care Fund (BCF) plans were presented to the Finance, Performance and Investment Committee in month 8, who recommended that the Board formally approves the 2023/25 BCF Section 75 arrangements.
- The contracting round is currently underway for 2024/25. NHSE has provided some guidance on the approach to contracting and it appears the approach will not differ significantly from 2023/24. NHS provider contracts are awarded under Direct Award Process A of the new Provider Selection Regime. The contracting round runs in parallel to the Operational Planning process and needs to reflect the targets and financial allocations agreed as part of that process. To ensure contracts are signed in a timely manner the ICB Board is recommended to delegate authority under the Scheme of Reservation and Delegation for the signature of contracts to the Chief Finance Officer and one other Chief Officer.

Members discussed the update and points included the following:

- We are aiming to improve the position through identifying and eliminating waste, thereby increasing productivity and the value of our spending, opposed to reducing services for residents. Quality impact assessments are undertaken at all Trusts and within the ICB which will identify and address any associated risks.
- There is an underspend in dental services which is due to the national shortage of dentists, but our system is one of the lowest in London.
- Local authorities will be experiencing a difficult financial position over the next few years; therefore, it will be important to consider whether there could be any unintentional impacts and work together as a system to address issues. It will also be important to consider the wider impacts on the voluntary, community and social enterprise sector too.
- The NHS does not have the duty to consult on budgets as local authorities do, therefore transparency and good communication will be key to working well as a system and to account to our population.
- It is important to note that, in regard to the Better Care Fund (BCF), Newham does not receive a higher allocation, but decide to categorise more of its overall spend under the BCF which is why the figures are higher for that borough.
- The NHS contracts are worth a significant amount of money; therefore, a meeting is taking place on 8 February with Trusts to discuss how we can take a different approach to allocate the contracting process for 2024/25. This will include how growth monies can be invested in a more targeted way in line with Integrated Care System aims and the Finance, Performance and Investment Committee will be sighted on the resulting contracts.

The ICB Board:

- Noted the contents of the report and the risks to the financial position
- **Approved** the signing of variations to the existing Section 75 agreements to add the BCF plans for 2023/25 with:
    - The City of London Corporation
    - The London Borough of Hackney
    - The London Borough of Newham

	○ The London Borough of Tower Hamlets ○ The London Boroughs of Barking and Dagenham, Havering, and Redbridge (joint Section 75 Agreement) ○ The London Borough of Waltham Forest • **Agreed** to delegate authority under the Scheme of Reservation and Delegation (SORD) for signature of NHS contracts and contract variations to the Chief Finance Officer and one other Chief Officer in order that contract documentation is signed in a timely manner.
6.2	Performance report
	HB introduced the item by thanking the performance team for their work to date and explained that the system is facing continued challenges on the constitutional standards. The Board received a verbal presentation from CH and TA regarding elective care which highlighted the following points: • The total waiting list in planned care has fallen for the third consecutive month following sustained growth from February 2023. However, the total waiting list remains above trajectory due to the impacts of the industrial action. North east London is the only system in London to have seen a reduction in the number of patients waiting 76 weeks over the last year. • Clinicians are being engaged through the provider collaboratives and understand the changes needed to improve the position. • A musculoskeletal (MSK) transformation programme is being launched which will explore how more patients can be treated in the community; thereby improving access and experience. • The women's health hubs have proven to be a great success with residents and demonstrate the improved collaborative working between primary and secondary care providers. • Work is underway to improve the number of surgeries cancelled on the day. There are many complexities involved in this piece which could have a significant impact on performance. • A culture shift has needed to happen in Trusts as they had previously been competing for services and finances but are now working in collaboration with each other. • There is a need to take a population health approach to our work and create a centre of excellence for our residents. PG provided the Board with a verbal update on urgent and emergency care activity which included the following points: • A significant amount of work has taken place over the last year to keep people well at home and safely out of hospital. • There has been substantial improvement in ambulance handovers at King George Hospital as well as improved performance at PELC urgent treatment centres. • In recognition of the progress made and a sustained performance improvement, we have received formal confirmation from the National Director of Integrated Urgent and Emergency Care that the system has now been moved from Tier 1 (requiring the highest of level of intervention and support) to Tier 2. North east London is the only system to have been moved from Tier 1 to Tier 2 nationally. Members discussed the performance updates and points included the following:

	• Diagnostics and community care remain an issue in north east London, which means that there are patients waiting anxiously at home. It would be beneficial to have a deep dive on diagnostics at a future meeting. **ACTION:** Deep dive on diagnostics to be scheduled as a future agenda item. The ICB Board noted the performance updates.
7.0	**Governance**
7.1	Governance update
	CPo presented the report and explained the following points: • A review of primary care governance arrangements has been undertaken and a revised primary care contracts subcommittee terms of reference and primary care scheme of reservation and delegation is presented which details the functions of the delegation agreement and who is responsible for the exercise of these. • Following the development of the people and culture strategy, a review of workforce and remuneration governance is underway, in recognition of the system approach to the people and culture strategy and implementation and of the need for a space to focus on decisions affecting the ICB workforce alone. An update on any proposed changes will be presented to the next meeting of the board. • The purpose of the Non-NHS Provider Accreditation Policy is to provide a transparent and clear governance process, for the accreditation of non-NHS providers expressing an interest in providing applicable NHS funded services to north east London residents. The ICB has established a Patient Choice Panel to consider applications from non-NHS providers onto the accreditation scheme and recommendations will require approval by the ICB Executive Management Team; the outcome of these decisions will be issued within five working days and the scheme of reservation and delegation will be updated to reflect this. Members discussed the report and comments included the following: • The inclusion of an independent clinical Chair on the Primary Care Contracts Subcommittee was welcomed, and it was noted that there may be a need for a specialist in certain circumstances. The role will be advertised in due course and in line with ICB policies. • All Primary Care Contracts Subcommittee meetings will be held in public to ensure transparency of decision making. • It could be beneficial to include detail in the scheme of reservation and delegation how business as usual and collaborative work can be approved. The ICB Board: • **Approved** the revised primary care contracts subcommittee terms of reference and primary care scheme of reservation and delegation • Noted the continued development of workforce and remuneration governance following the development of the people and culture strategy • **Approved** the changes to the scheme of reservation and delegation • **Approved** the updated Governance Handbook.
7.2	Board Assurance Framework
	CPo presented the Board Assurance Framework (BAF) and highlighted the following points:

	• A new risk has been added to the BAF regarding population growth related to specialist services. This risk will be owned by the Chief Medical Officer and mitigations include working together across the system to invest in prevention with each part of the system needing to identify how to move more resources into investment in prevention. • A focused session on a system risk register is scheduled on 2 February which will include ICB and provider governance leads. This meeting will be used to develop principles for a system risk register and for considering how we as a system operate an end to end risk management system. We are keen to articulate and apply a more dynamic link between the risks at Trust and at system level, including those on the BAF. • There is a discussion planned at the next development session of the ICB Board in February regarding risk appetite. Members discussed the framework and points included the following: • It will be important for the Board to consider the wider determinants of health risk to identify further mitigations and ensure there is an appropriate risk appetite in place. • Prevention will be a key component for the new specialist services risk. The ICB Board noted the updated Board Assurance Framework.
7.3	Committee exception reports for information
	The chairs/ vice-chairs of the committees of the Board each presented an exception report which highlighted the work undertaken by its members since the last meeting. The reports included updates from: • 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.
8.0	**Board forward plan**
	The Chair reminded members to consider items for inclusion on the Board forward plan.
9.0	**Questions from the public**
	The Chair advised that one question has been received from a member of the public and read the question on their behalf. Due to length of the question, a shortened version is included in the minute below, however the full version can be found on the ICB website. HB provided the answer below. **Q:** Given that NHS North East London is an integrated system, do members of the ICB agree that it should take responsibility for establishing comprehensive, patient-centred guidance for all organisations across the ICS to ensure that the data generated across the system (and that the ICB relies on) has been collected appropriately, including with the full knowledge of patients? **A:** The NHS uses data every day to manage patient care and plan services. Better use of existing data brings benefits for patients by ensuring more joined up care, improving health outcomes and ultimately helping to save lives. We take data

	privacy incredibly seriously. The ICB supports providers by investing in appropriate clinical systems which the ICB, where appropriate, supports moving providers to common systems, such as a number of shared or consistent systems being used across Barts Health, BHRUT and the Homerton. While the ICB has an overarching convening role in the management of the NEL healthcare system, the legal responsibility for keeping data safe rests with each individual NHS organisation (which includes hospital trusts and GP Practices). All independent organisations have responsibilities as controllers for that data under UK GDPR and UK Data Protection Act (2018). This legislation specifically identifies responsibility for collection and data integrity upon the controller for those records. This is an important principle as each organisation records information about treatment of patients as they go about the work of provision of healthcare services, so as processors they need to be directly accountable by law for how that data is stored and managed. In turn, the ICB seeks assurance from each provider Trust to ensure that data is recorded appropriately stored and managed safely and only used for appropriate and legal purposes. The ICB also conducts automated de-identified reviews of commissioning data sets, where we are legitimately involved in the data flow. This includes data quality and data completeness queries, with the results shared with partners. All NHS organisations are also required to complete an annual mandated NHS England Data Security and Protection Toolkit that assesses data quality and integrity processes, which when these are published provide the ICB with appropriate assurances. In addition to this, the UK data protection legislation provides a route of complaint and escalation where a data subject (a living person or patient in this context) feels that issues like data collection and / or integrity and other data matters are not being implemented in line with UK data protection legislation and that is via the role of the Information Commissioners Office (ICO) which overseas implementation of the UK data protection legislation in the UK. Furthermore, UK data protection legislation implements a number of data rights for data subjects which include having incorrect data corrected (data integrity) and transparency (publication of privacy notices by data controllers) and any challenge or complaints about how organisations (controllers) implement or uphold those rights should again be made to the ICO and not the ICB. Each organisation will use their data in different ways and therefore will publish their own privacy notices. Patients will be aware of which organisations are providing their care. The ICB carries out work with its ICS partners to promote and publicise how the NHS works across North East London and the ICB engages with patients at ICB and Place (borough) level. We are currently working through the North East London Citizens' Panel to test how easy the existing guidance on use of patient level data is to understand for local people. We are collating existing guidance with a view to promoting plain English guidance. NHS England has provided all providers with guidance here.
10.0	**Any other business and close**
	There was no other business to note.
	Date of next meeting – 27 March 2024

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Joint Working Agreement with NHSE London for Specialised Services for 2024/2025
Author	Archna Mathur, Director of Specialised Services and Cancer
Presented by	Archna Mathur, Director of Specialised Services and Cancer
Contact for further information	Archnamathur@nhs.net
Executive summary	NHS England currently commission all specialised services; however, in December 2023 the NHS England Board approved plans to: • Fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the North West regions of England from April 2024. • Continue to jointly commission appropriate specialised services with ICBs in the South West, South East, London and the North East and Yorkshire regions of England for a further year. • This will help support a smooth transition of commissioning responsibility (Delegation) in London by April 25. These arrangements are part of a careful and considered approach to delegating full commissioning responsibility across England for appropriate services by April 2025: • Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities and ensuring best value. • These plans, which were first set out in the *Roadmap for Integrating Specialised Services within Integrated Care Systems*, have been developed in close collaboration with NHS England's regional teams, ICBs and specialised service providers. They represent the outcome of a thorough assessment of ICB system readiness, and a comprehensive analysis of services to determine their suitability and readiness for more integrated commissioning. • NHS England (NHSE) regional and national teams will continue to work with London Region and London ICBs who are continuing with joint commissioning arrangements as we work towards full delegation from April 2025;

	Following discussion between ICB Chief Executives and NHS England London through the existing London Joint Committee for Specialised Service Delegation and London Regional Executive Team, it was agreed that London will continue formal joint working arrangements with ICBs allowing for a further shadow or transition year (2024/25) to work jointly on ensuring the four delegation conditions below are met: • the development of a Legacy Risk Log, • the development of a clinical risk-based strategic framework, • agree a future operating model for the commissioning hub, and • agree a model for multi-ICB decision making The Joint Working Agreement (JWA) formalises the arrangements for joint working with NHSE from 1 April 2024 to 31 March 2025, with a revised Terms of Reference for the London Joint Committee. The JWA has been shared with London ICBs and reviewed and approved at the NEL Specialised Services Programme Board.
Action required	The Board is asked to approve the Joint Working Agreement for the commissioning of specialised services in 2024/2025 and authorise the ICB Chief Executive to sign the Joint Working Agreement on behalf of North East London ICB
Previous reporting	ICB Chief Executives via the Executive Leadership Team, NHSE London through the existing Joint committee and ICB Specialised Service Programme Board. A "Focus on Specialised Services" was presented to the ICB Board in January 2024 supported by a patient story, providing broader context on the rationale, benefits and risks of delegation acting as a pre-curser to the request for approval of this Joint Working Agreement.
Next steps/ onward reporting	ICB Chief Executive to sign the Joint Working Agreement on behalf of the ICB.
Conflicts of interest	There are no conflicts of interest arising in this report.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population • n 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	Specialised services are a diverse portfolio of c150 services generally accessed by people living with rare or complex conditions. These include services for people with physical

	health needs, such as cancer, neurological, and genetic conditions and some mental health services too. Within NEL, the APC (Acute Provider Collaborative) will deliver the specialised service programme in partnership with the ICB, optimising the expertise of specialist clinicians and teams to drive economies of scale across NEL, improve care for local populations and working in a matrix on end to end pathway redesign with "place" to improve LTC management and prevention, aiming to reduce the future financial risk and demand on specialised services. The Joint Working Agreement is a stepping stone to full delegation that ensures the ICB and Trusts are closer to designing and shaping specialised services, bringing together clinicians, operational teams and clinical networks to redesign services to meet local population needs. The clinical priority areas of focus for 24/25 in NEL are Renal care, Haemoglobinopathies (sickle cell), neurosciences, HIV, liver and HEP C, and complex urogynaecology services. These priority areas are based on population need and requirement to reduce existing clinical inequality in our population.
Impact on finance, performance and quality	Funding for specialised services will shift from historic population-based allocation towards needs-based allocation, CFOs across London are proactively working with regional and national colleagues to clarify how the change in practice will work and obtaining a clearer understanding of the impact of a needs based formula. The delegated budget from April 25 is c£600m and this is set to increase year on year as NHSE deems more services suitable for delegation. Additionally, our population is set to grow by 364k over the next 20 years, which puts pressure on specialised services in terms of unfunded growth in activity, but also non-specialised services which patients may step down into e.g. level 1 specialised neuro-rehabilitation patients may eventually access community rehabilitation programmes as part of their longer-term treatment plan
Risks	• Implications of shift to needs based allocation. • Implications of a mixed economy with London in transition for a further year, and East of England as a neighbouring ICB with significant patient flows into north East London, taking on full delegation from April 24. • Implications of unfunded activity and population growth on specialised services

1. Background

NHS England currently commission all specialised services; however, in December 2023 the NHS England Board approved plans to:

- Fully delegate the commissioning of appropriate specialised services to Integrated Care Boards (ICBs) in the East of England, Midlands and the North West regions of England from April 2024.
- **Continue to jointly commission** appropriate specialised services with ICBs in the South West, South East**, London** and the North East and Yorkshire regions of England for a further year.
- This will help support a smooth transition of commissioning responsibility (Delegation) in London by **April 25.**

NHS England London Region and NEL ICB will continue to jointly commission a number of specialised services deemed suitable for delegation ensuring the delivery of more joined-up care for patients, improving their experiences and outcomes from treatment.

This integrated commissioning supports a focus on local and London wide population health management across whole pathways of care, ultimately aimed at improving the quality of services, tackling health inequalities and ensuring best value aligned to the Integrated Care Strategy of the ICB,

Commissioning responsibility for all other specialised services will be retained by NHS England - for some services, this will be on a permanent basis and for others this will be temporarily until they are considered ready for delegation.

These plans, which were first set out in the *Roadmap for Integrating Specialised Services within Integrated Care Systems*, have been developed in close collaboration with NHS England's regional teams, ICBs and specialised service providers. They represent the outcome of a thorough assessment of ICB system readiness, and a comprehensive analysis of services to determine their suitability and readiness for more integrated commissioning.

The arrangements in 2024/2025 represent a stepping-stone to delegating full commissioning responsibility for suitable services from April 2025. This will be subject to further Board consideration and decision.

2. The Joint Working Agreement

The Joint Working Agreement has been developed to legally underpin the joint working model in 2024/2025 for statutory joint committees between multi-ICBs and NHS England for the 59 services that are appropriate for more integrated commissioning, specifically where delegation is delayed until April 25. These arrangements will be implemented using NHS England's powers under section 65Z5 of the NHS Act 2006.

This model will support the transition to fully delegated commissioning arrangements for appropriate services from April 25.
The joint working model, via the agreement will continue to be implemented through 24/25 whilst the delegation conditions are worked through. The Joint Working Agreement ensures:

a) Joint decision-making between NHS England and ICBs for specialised services that are suitable and ready for greater ICB involvement.

b) Revised Terms of Reference for the London Joint Committee of NHS England and ICBs to facilitate collaboration and decision-making in relation to the services with a clear focus on delegation conditions and clearer mechanisms for escalation to the London Regional Executive Team.
c) Commitment towards full delegation, from April 25 although full accountability will remain with NHS England, albeit overseen by the joint committee.
d) The future operating model for the London region specialised services commissioning team will be jointly determined.
e) Decision-making safeguards for NHS England, recognising that this is a transitional year and liability remains with NHS England.
f) The London Joint Committee will be consulted on specialised services that are being retained by NHS England, although they will not have any decision-making powers relating to these services. In accordance with the NHS England Scheme of Delegation, the decisions to introduce arrangements under section 65Z5 and 65Z6 of the NHS Act 2006 are matters reserved to the NHS England Board.

The Joint Working Agreement is adapted from the national document, ensuring consistency across London ICBs.

3. The London Joint Committee for Specialised Delegation

Following discussion between ICB Chief Executives and NHSE London it was agreed that London will continue to convene a single joint committee; this will allow for co-ordinated decision making between ICBs and NHSE during this final transitional year with a clear focus on ensuring joint delivery against the delegation conditions.

The Joint Committee is co-chaired by the London Regional Director of Commissioning and an ICB Chief Executive Officer (CEO)**.**

The South London and North London ICBs will continue to meet as South/ North London Programme Boards, reporting into the Joint Committee; this will establish an appropriate geographic footprint for planning multi-ICB services (i.e., paediatrics, neurosurgery, cardiac, specialist respiratory etc), particularly taking account of significant patient flows from other regions.

A more detailed roadmap to delegation is appended to the Joint Working Agreement.

The London Joint Committee creates a decision-making forum for:

- London wide clinical risks and issues e.g., cancer, service resilience.
- Pan ICB quality issues, should they arise.
- The impacts of and any changes to patient flows from other regions.
- Developing a regional approach to nationally retained services and services identified as suitable but not yet ready for delegation to ICBs

4. Ways of working

In London it was also decided that a number of principles in terms of ‘ways of working’ needed to be adopted. Specifically:

1. NHSE and ICBs will work in a transparent collaborative way as co-commissioners of specialised services. The Joint Committee will not be used

as a forum to performance manage ICBs, as this would confuse NHSE's regulatory role with that of its commissioner function.

2. Where there are breaches of the agreement by either NHSE or the ICBs, Partners can raise their concerns either individually or collectively through the Joint Committee.

5. Recommendation

To ensure the agreements are in place for 1st April 2024, ICB Boards are being asked to authorise ICB Chief Executives to sign the Joint Working Agreements with NHSE.

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	Apr 24	A session has been proposed for 16 April 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	May 24	Item scheduled for the Board meeting in May 2024.
4.1 Chair's report	29.11.23	System workshop on disability equity to be arranged during 2024 and be led by disabled residents.	PG	During 2024	In progress.
4.1 Specialised services	31.01.24	Further report on specialised services to be presented at the next ICB Board meeting.	AM	March 24	Complete. Item scheduled on March agenda
6.2 Performance report	31.01.24	Deep dive on diagnostics to be scheduled as a future agenda item.	HB	Jan 25	Item scheduled on Board forward plan for January 2025

CLOSED ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
7.2 Board Assurance Framework	29.11.23	Risk appetites to be discussed at a future Board development session.	CP	Jun 24	Discussed at the Board development session on 28 February 2024.

North East London
Integrated Care Board

NHS North East London ICB board

27 March 2024

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 ICB effectiveness, national announcements along with local alignment and discussions being held at London meetings that the Chair attends. Recommendations: • That the Board receive and note the report
Action required	For Noting
Previous reporting	None
Next steps/ onward reporting	The staff survey results will be discussed by the Workforce and Remuneration Committee and the resulting action plan will be reported to the Board. The Board appraisal outcomes will be reported to the Board, with an improvement plan and the outcome of Chair and Chief Executive appraisals will be reported to the appropriate Board committees. The resulting objectives of the Chair will be shared with the Integrated Care Partnership and both the Chair and the Chief Executive's objectives will be shared with this Board.
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 continued emphasis on success measures shaped by local people will ensure that how we define and account for our impact is most relevant to them. Reviewing our Board effectiveness will enable us to ensure an ongoing focus on outcomes for our residents and sustainably. Considering how we can work more effectively with primary care in an integrated way will maximise benefits for local people.
Impact on finance, performance and quality	Improving the experience of our staff will better enable them to produce better outcomes for our residents. The focus on productivity will enable us to ensure the best value for residents from our resources.

Risks	Ensuring preparation for national plans and participating in strategic national and regional discussions enables our views to inform national policy and regional priorities, identifying and mitigating risks.

1.0 Introduction

1.1 This month we received our 2023/4 staff survey results, and more details feature in the Chief Executive's report. Whilst I welcome the areas where we have comparatively done a little better, I am overall disappointed with the result, and I apologise unreservedly to all staff who are having a less than positive experience as an employee of the Integrated Care Board (ICB). I take personal responsibility as Chair and will work with the Board and the executive team, alongside our staff, to focus on clear and rapid action to address our challenges and build on what we do well. There is an opportunity to learn from partners within the system, who continue to have improved and above average results and for us to undertake action across North East London in areas where we are all challenged.

1.2 The main part of my introduction focuses on the Board building its effectiveness and capacity in four ways. Firstly, the Board will recall that it agreed, at its September 2023 meeting, to appoint two further Non-Executive Members to add to our independent insight and also to reduce the overall Associate Non-Executive numbers. The advert for these two posts, one providing clinical and care professional insight and the other strategic financial and performance insight, is now live and can be found at https://hunter-healthcare.com/opportunities/non-executive-members-x2-nhs-north-east-london-integrated-care-board/. Secondly, Board members and wider partners have already been contacted by our governance team for their feedback on Board, Integrated Care Partnership and Board Committee effectiveness. Subsequently, NHS England has written to advise us of that they too are beginning their annual review of our effectiveness and will be reaching out to system partners directly for their input. I thank you in advance for your feedback and recognise that there is some similarity in the asks, so we are seeking to work with NHS England to align the two processes for next year. Thirdly, as Chair and Chief Executive, Zina and I are undergoing our appraisal and partners will be asked to contribute to stakeholder assessments of our individual performances. There is a rather detailed questionnaire that has been designed by NHS England that we will seek to make more user friendly, and we will also include the delivery of our individual objectives. I once again thank you for your insights.

1.3 Lasty, but very importantly, on effectiveness and related to my opening statement. The Chief Executive's report includes the values developed by the Integrated Care Board staff. At the February Board development session, we considered how this Board itself reflects those values and agreed that, in addition to reflecting these in our individual contributions, that we should consider how our Board agendas and reports and wider governance arrangements do so too. Zina and I will take the latter forward with the governance team and resulting changes to the reporting pack will be made.

1.4 The remainder of this report provides an update on developing success measures from the Big Conversation and shares key updates on national plans and key points from regional and local meetings.

2.0 Integrated Care Partnership

2.1 Whilst the Integrated Care Partnership, (ICP), is not meeting until April, progress on developing the success measures arising from the Big Conversation is being made. In discussion at the last meeting of the ICP, it was agreed that the success measures pulled out from the Big Conversation need to be triangulated with the work on what matters to local communities which has already been carried out through Places, Trusts and Collaboratives. Work is therefore underway to bring together the different initiatives across the Integrated Care System (ICS) that focus on outcomes and success measures, including the outcomes of the Big Conversation and work through each of the Place Partnerships and through each of the Collaboratives on what matters and what should therefore be prioritised. Each of these elements has in various ways included the voice of local people and those who draw on services, as well as community partners and wider stakeholders. This consolidation work – bringing together a long list of outcomes and things that matter to local people, covering a range of settings across north east London, will give us an ICS-wide outcomes framework and set of success measures that is comprehensive and efficient to report on, and that will support our population health approach as part of determining the impact of our implementation of the Integrated Care Strategy. The next steps are to socialise the approach and reduce the long list of outcomes to a smaller set which reflect what our local populations tell us contributes to good care and to good outcomes in terms of health and wellbeing. When agreed, a reporting process will be stood up to help monitor progress and keep us to account on health and care improvements for our local population, as set out in our shared strategy.

2.2 The ICP Steering Group did meet this month and considered the joint report from the NHS Confederation and Local Government Association, "Integrated Care Partnerships: Driving the Future Vision for Health and Care." The report sets out the essential characteristics of an effective ICP and makes some recommendations for national Government. The report is available online: https://www.local.gov.uk/publications/integrated-care-partnerships-driving-future-vision-health-and-care. The Steering Group agreed to recommend to the April ICP meeting that a development day be held to reflect on learning from the report and the feedback from colleagues as part of the current Board and Committee effectiveness survey. The Steering Group also reflected on the need for the ICP to be able to evidence its impact on the discussions and decisions of the Integrated Care Board and I will work with Charlotte and the ICP to ensure that this is clarified.

3.0 Chair and Non-Executive Activities

3.1 National I was pleased to present at a national Kings Fund conference on the work of North East London in tackling the inequalities experienced by babies, children, and young people, which features later on the agenda. My thanks to Kath Evans, the Director of Nursing, (Babies, Children and Young People), at Barts Health who has taken a leading role in our work and who was referred to in all the sessions I participated in. There are two themes arising from national conversations I would like to highlight as areas where we are also having local conversations. The first is primary care and the second is productivity.

3.1.1 Primary Care: There have been three national announcements regarding primary care, encompassing dentistry, pharmacy, and general practice. On 7 February 2024 the Sectary of State set out the Government's plan for dentistry. The aim

is to make dental services faster by establishing a new patient premium to support dentists to take on new patients and a new marketing campaign; simpler by streamlining and tackling bureaucracy, along with workforce reforms to maximise skills across the entire dental clinical team; and fairer by introducing new dental vans, offering incentives to encourage dentists to work in under-served areas and supporting practices with the lowest rates of payment for their work. There is also a Smile for Life Programme to tackle poor dental health particularly in young children. The goal is to fund 1.5 million additional treatments or 2.5 million appointments, noting a course of treatment can take more than one appointment for some patients. The application of the Government Plan locally is being worked through but will build on our work to improve access and to focus on tackling poor dental health in children.

3.1.2 Following the NHS England (NHS) announcement, in November 2023, of the Pharmacy First programme, the resulting programme, Pharmacy First Advance Service launched on 31 January. This service will enable community pharmacists to complete episodes of care for patients with seven common conditions, following specific clinical pathways, without the need for the patient to visit their general practice. The aim is, alongside expansions to the pharmacy blood pressure checking and contraception services, to save up to ten million general practice team appointments a year, helping patients to access quicker and more convenient care. Integrated Care Boards are being asked to support collaboration between general practice and community pharmacy to enable delivery of the service and to assure the safety and quality of service provision. This builds on our earlier Board commitment to enabling our residents to access services from their local community pharmacists through the North East London Selfcare Advice Service. This service will improve access for socially vulnerable residents to clinical advice regarding their minor ailments, supporting health promotion and providing links to other services. It also includes access to medication for the most vulnerable residents where the current rising cost of living may impact on their ability to purchase medicines.

3.1.3 At the end of February NHS England shared arrangements for the 2023/25 GP contract, advising that the contract seeks to address requests from general practice for a simpler and more flexible arrangements, by helping practices free up time and improve patient access and experience This includes, cutting bureaucracy for practices; helping with cash flow and increasing financial flexibilities; giving Primary Care Networks (PCNs) more staffing flexibility; supporting practices and PCNs to improve outcomes through simplified directed enhanced service requirements; and improving patient experience of access by better understanding demand on practices ahead of winter. The response from the British Medical Association (BMA) was to caution that the contract and aligned increase in overall investment would not be enough to bring the stability needed. More locally, my conversations with primary care have asked that we remain focused on our joint ambition to shift care closer to home and remain mindful of any unintended impacts on primary care as we seek to balance our ICB budget, including the timing of changes to contracts. They also highlighted the need for better integration between primary, acute care, local authority, Voluntary, Community and Social Enterprise (VCSE) and stronger collaboration within primary care in its broadest sense and with Partnership bodies is critical. Another area requested by our general practice colleagues is the consistent and early engagement of primary care in our plans

and relevant decision making. This includes early involvement in the development of GP federation options and the need to work with wider general practice to plan and ensure capacity for the implementation of an effective neighbourhood model and within this gaining clarity on the role of PCNs. There has also been a call to understand the impacts on practices of delays in payments and the need to work with them on the national contract changes.

3.1.4 Productivity There has been an increased national focus on how productive the NHS is in meeting its quality and operational standards and in considering its efforts to achieve financial balance. It is expected that productivity will feature as part of the Annual Planning guidance and will consider areas such as establishment control including the use of agency and bank staff and ways to improve standard operating procedures. We expect there to be further regional governance arrangements, data and information sharing and support to assist us in improving productivity. This national focus is in line with the work already underway within North East London as we seek to achieve the best value for every pound of resident money we spend. In addition, to considering how we can work across the NHS, we are considering the challenges across the public and voluntary sector and how best we can work together to integrate care, increase value and not make decisions that adversely impact on one another's finances. Finally, in all that we do, we need to ensure that productivity measures include our ambition and statutory requirements to improve population health and tackle inequalities, including the wider determinants of health.

3.2 London Meetings: The March London Health Board had a focus on suicide reduction and an update on the progress of the London Health Inequality Strategy. The Mayor reminded all Board members to undertake the free online suicide prevention course, provided through Thrive London. I encourage our Board members to do the same: https://thriveldn.co.uk/communications/campaign/zerosuicideldn/. This was the last London Health Board before the London Mayoral elections and we have received election guidance from NHS England that is applicable to us as ICB members. I am sure that most colleagues will be aware of the requirements but thought it would be helpful to provide a link to the guidance, particularly as I am sure that it will remain relevant for the national elections that are expected this year. https://www.england.nhs.uk/long-read/pre-election-guidance-for-nhs-organisations-spring-2024. The London People Board also met this month and reflected on its priorities and how we could ensure alignment across London. There was a report from nationally funded retention exemplars in London, which I will share with the Workforce and Remuneration Committee. This programme is focused on Trusts and two of our Trusts, Barking, Havering and Redbridge University Hospital Trust and East London NHS Foundation Trust are participating so we will be able to benefit from their learning. I have asked that ICBs are considered if there is to be a next round of funding. Finally, on London we continue to work with ICS colleagues on how best we can work together, once across London to maximise benefits for Londoners. A verbal update on our late March meeting will be provided at the Board meeting.

4.0 Recommendation:

4.1 To receive and note the report.

Marie Gabriel – Chair: 03/03/24

North East London
Integrated Care Board

NHS North East London ICB board

27 March 2024

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 items in the report. • Note the Emergency Preparedness, Resilience and Response assurance update. • Discuss and approve the refreshed objectives for 2024-25 • Note the final version of the ICB values.
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	No conflicts have been identified.
Strategic fit	The report aligns to our strategic purpose, priorities and objectives of the ICB and ICS: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The ICB will enable us to have greater impact as we are enabled to work in a more integrated way across health and care organisations in north east London.
Impact on finance, performance and quality	N/A
Risks	N/A

1.0 Introduction

1.1 The following report provides an update on my activity and priorities since the January board meeting. I have ensured there is a concerted focus on continuing our work on financial sustainability and looking at our medium to longer term strategy, bringing together system leaders to discuss this. Internally we have been reflecting on our staff survey results and working to embed our organisational values. I have

also been visiting services and teams across the Integrated Care System (ICS) and continuing to represent North East London (NEL) at a regional and national level too.

2.0 System resilience

2.1 Industrial action

The board is asked to note that we were due to bring an update to this meeting on lessons learnt from the industrial action that has taken place over the last 18 months. However a system wide workshop is taking place in April where detailed discussions will take place looking at what we can learn from the impact of the strikes, how this impact was managed and what we can learn from this going forward. A detailed report will be produced and will therefore follow at the next board meeting with this detail.

2.2 Urgent and emergency care

The NEL Urgent and Emergency Care (UEC) programme continues to focus with system partners on the delivery of national priorities in addition to a focus on local population needs. Targeted work on same day access, NHS 111 procurement, ambulance care transformation and virtual wards continue to develop as part of the transformation programme.

Improvements for our population between 23/24 and 24/25 is as follows:

- The NEL 4-hour performance for January 2024, NEL Accident and Emergency (A&E) 4-hour performance (all types) was 71.50% against a trajectory of 72.89% with all trusts showing an improvement in performance since December 2024, provisional performance to 25 February 2024 was 69.37% against a trajectory of 75.49%.

- Across the system between April 23 to January 24 (23/24) 68.95% of patients attending A&E were seen within four hours which is an increase of 24,043 patients compared to the same period in the previous year.

- There has been a significant improvement in ambulance handovers compared to the same period in 22/23, with 24,409 more ambulances being offloaded into hospital emergency department within 60 minutes (an improvement from 51,985 to 76,394), releasing critical ambulance hours back to the community.

- In March 2024 there is a national focus on the requirement to deliver the national constitutional standard of 76% and sustaining of beds funded through the region and system for 23/24. Acute and system partners supported by the system coordination centre and UEC transformation team have developed detailed plans to support delivery with performance position at 13 March of 74.3% all types of activity with the system having invested additional support to Bart's through fixed term funding and project support.

- The programme is hosting a workshop encompassing a winter review for 23/24 encompassing Industrial Action, and joint planning for the 24/25 priorities, with clinical and non-clinical system partners, place and collaboratives leaders.

3.0 ICB business

3.1 **ICB staff survey**

Our latest staff survey results have been published in line with the national process. Overall I acknowledge these are not a positive set of results and I am really sorry to staff for the experience they have had. The survey was completed at the heart of our ongoing restructure, but we also know we have work to build on from previous years too. There are a number of key themes from the survey which I am working with senior leaders across the organisation to address. I am saddened to see the experiences many staff have outlined and am fully committed to making meaningful improvements for our organisation.

There are some positive results in the survey – in general we have heard that staff are broadly happy with our approach to flexible working, feel trusted to do their work, enjoy working with colleagues and feel valued by immediate managers. We want to build on these and our commitment now is to continue to collectively improve our organisational culture, embed our new set of values and work through the key areas of focus for us. These are:

- Embedding the new organisational structure, filling vacancies where we can and supporting people to do their jobs
- Ensuring we have a culture where people feel listened to and safe to speak up
- A clear approach to working practices
- A clear set of better basics in place to enable people to do their jobs – Information Technology (IT), decision making, finance, procurement, induction, people management, appraisal, learning and development, Human Resources (HR) policies
- Developing our leaders and managers
- A clear set of Equality, Diversity and Inclusion (EDI) objectives and a renewed focus on ensuring an equitable experience for all our staff.

Next steps are underway focused on individual department analysis and discussion, identifying staff champions and there is also an accompanying programme of work which will address many of the areas highlighted in the survey.

3.2 **ICB values**

It was great to explore our proposed organisational values with the Board at the last board development session and in line with feedback on the strength of the co-design process, I now share our final values following further input and steer from staff during February.

Feedback was given through drop-in sessions, a survey, team meetings and by specific subject matter leads (for example quality and patient safety), as well as from some of our staff networks. The values were also reviewed to ensure they align with system work, for example the ICS learning system principles that have been embedded into the updated Joint Forward Plan.

The overall structure hasn't changed but we have included changes in some wording and additions where people feel it is really important to set clear expectations. We will now prepare to launch our new values in the next month, internally and beyond, making sure we're clear they apply to all of our work, whether system or internally facing, across our departments, functions and levels of seniority. We will wrap our values into our existing narrative and corporate pillars, including our ambition and the ICS priorities.

The launch of our new values is a key part of the journey we are on to develop our ways of working to best deliver our ambitions as well as improve the experience people have working for our organisation. We will need to embed them in a range of different ways, in policy, process and practice, over a period of time and ensure they are led and modelled consistently and clearly by our leaders in particular. An important next step will be to develop a behaviour framework that gives specific examples of what our values look like in practice, and conversely what the types of behaviours that would not be in line with our values.

I hope the Board joins me in recognising this step we make in developing the ICB through the agreement and launch of our new organisational values.

3.2 **Emergency Preparedness, Resilience and Response Assurance Return**
Annually, all NHS funded organisations are asked to provide a self-assessed assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. NHS England London EPRR team, in partnership with the EPRR Lead from the ICB, conducts individual reviews with each organisation across London to discuss and agree levels of compliance with the core standards. This report details the outcomes of the review process.

In accordance with the requirements laid out in the EPRR 2023-24 Assurance Process Letter (1 August 2022), the overall level of compliance for all NHS organisations is based on the total percentage of amber and red ratings against green compliant ratings.

NHS NEL Integrated Care Board were assessed as substantially compliant with the following ratings.

Main Assurance		
Red ratings	**Amber ratings**	**Green ratings**
1	4	42
Total number of red / amber ratings	5	
Agreed overall level of compliance	Substantially Compliant	

This is an improvement on the ICB's position which was partially compliant in 2022/23.

The red rating referred to the assessment of the business continuity resilience of critical and essential suppliers. This is a large piece of work which is contingent on a number of areas which are still in development across the Integrated Care System. Amber ratings referred to the areas of training, whereby the EPRR training programme required the finalisation of the consultation process to achieve a fully compliant position.

NHS England recognised the hard work that the organisation had put into their EPRR and business continuity arrangements, especially in light of the challenges within the NHS in the last twelve months. NHS England highlighted the ICB's EPRR policy as an example of best practice.

4.0 System working

4.1 System leadership - medium term financial strategy

In February Henry Black (our Chief Finance and Performance Officer) and I convened a session with NHS Chief Executive Officers (CEOs) to discuss our medium term financial strategy and next steps. This was an important opportunity to come together and reflect on our strategy around financial sustainability including how we approach resource allocation and the principles we need in place to support this. It was a really helpful conversation and excellent demonstration of system working in action. More broadly we have also continued our focus on bringing system leaders together as a collective leadership team too and will continue to facilitate these kinds of discussions which are essential in ensuring we are all working together in the right way for our local populations.

4.2 Safeguarding chairs

This month Diane Jones (Chief Nursing Officer) and I brought together the independent safeguarding Chairs across the system. We have agreed with them to do this on a twice-yearly basis, subject to future changes arising from the new Working Together changes, and it is a really helpful way of system working and sharing insights on the key themes and issues arising across north east London. We covered topics including maternity and partnership working as well as sharing key themes in adult and children safeguarding over north east London from the last year.

4.3 Joint place based leaders

In February I convened our regular meeting with the joint place-based leaders. This is an opportunity to come together as place leaders and discuss key themes and topics, understand pressures and have high level strategic discussions too. At this meeting we had a really constructive discussion about the development of resource allocation and shaping a commissioning model in light of our aspiration to work on a population health basis.

4.4 Borough Commander discussions

We held another of our bi-monthly conversation with senior police colleagues across north east London this month. We started meeting to work through the implications of the move to ‘Right Care, Right Person’, the Metropolitan Police’s approach to ensuring that those experiencing or appearing to experience mental health crisis, or requiring welfare checks, get support from the right people rather than a police response by default. The implementation of the programme has gone relatively smoothly in north east London and the partnership work that has been put in place has contributed to that. Given that, we moved on to talk about a wider range of issues including serious youth violence and the strategic and public health approach to high risk in our population of young people of violence and exploitation. In conversation we recognised the roles we have as health organisations to this agenda, but also our roles as employers of large numbers of parents of young people, many of whom are anxious on a daily basis about their children.

5.0 System and national visits and events

5.1 Redbridge Primary Care Network

I met with the Redbridge Primary Care Network (PCN) team recently. Dr Anil Mehta, the clinical lead, and Tracy Rubery, the place director took me to see a brilliant inclusion health project. The project is led by a nurse who had set it up around eight years ago to provide health services to the homeless population of Redbridge,

through the Welcome Centre – a homeless day centre led by some other brilliant people – and also through an outreach van. The level of compassion and determination to ensure that this particularly vulnerable client group were able to access the services they needed, including mental health support, was really inspirational. I really enjoyed talking to some of the Healthy Living partnership's services users, and some of those using the day centre, about their stories and what the services mean to them. At the heart of their reflections on the services were a really personalised approach to people who sometimes, in their own words, feel that they are viewed as below everyone else in society. It was sobering to hear about the numbers of people requiring services, including those whose asylum applications are positively decided on and find themselves very quickly turned out of the hotels they have been housed in once they have leave to remain, with very little support to turn to. It was also lovely to go back to Dr Mehta's surgery which I first visited not long after I started to see the improvements they have made with a new triage system – I know that they are planning on sharing some of their learning.

5.2 **City and Hackney Primary Care Network**

I spent a fantastic day in Hackney last week, visiting GP practices in the morning. I started at the Spring Hill practice in Stamford Hill, where the practice is spread across a portacabin and two former flats (not adjacent) in a neighbouring block. All the staff I met were very much looking forward to moving into a newly refurbished building in a few months' time. I met Together Better – an organisation supported by volunteers and staff from Hackney PCNs that provide a wide range of wellbeing services for patients including social activities, men's exercise, yoga and art sessions. They are clearly highly valued by patients who report lots of beneficial effects on their health and wellbeing, particularly associated with the social contact and support. From Spring Hill we went to Lower Clapton and met a fantastic and really innovative and dynamic PCN Additional Roles Reimbursement Scheme team – including a first contact physio, pharmacist and vocational occupational therapist. The impact they were having for patients was really impressive – particularly in earlier help and prevention and keeping people in employment. It's a really innovative model and just the sort of good practice we should be sharing across north east London.

5.3 **Electronic Patient Record**

In order to understand more about the digital underpinnings of our system, and the infrastructure that supports some of the really exciting future opportunities to use data to better improve population health I went to visit the Barts Health's Chief Information Officer and IT teams in February to see what an electronic patient record system looks like in practice, and to talk to clinicians about how they use it and the potential it brings for collaboration. Listening to colleagues talking about what is possible, and how they are navigating and sorting the Artificial Intelligence (AI) and machine learning tools that have huge potential from those that are of limited real world value was really helpful. And hearing about how much of a target our systems are for hackers and how robust cyber security needs to be was a really timely reminder that we need to keep focussed on that element of digital systems too.

5.4 **Doctors in distress**

Last month I attended an event at 11 Downing Street along with Dr Paul Gilluley (Chief Medical Officer), to raise awareness of the level of severe mental distress in the clinical workforce, and specifically of the charity Doctors in Distress, set up by a family member of a clinician who sadly died by suicide. The event raised issues

around some of the structural and systemic issues at the heart of our workforce challenges and the importance of ensuring we do all that we can to address these.

5.5 **University College London Partners**

I also attended the University College London Partners (UCLP) board meeting recently – UCLP are the academic health science network that north east London is part of and we are doing some really interesting work with them including on how AI can help in the analysis of big data sets to identify those who are just getting to the point of potentially becoming more unwell and higher intensity users of services, coupled with an intervention from a nurse to prevent that escalation. It's really important that we shape the work in ways which reduce rather than increase health inequalities and it's a really good opportunity to explore ways of doing this.

6.0 Showcasing our work

The Health Service Journal (HSJ) award winning City and Hackney Tree of Life project was recently presented at a national peer learning event and NHS England are now looking at ways to share it more widely, and to assess whether it is widely scalable. It's great to see innovation starting in north east London being showcased nationally – a great reminder of some of the assets we have locally.

7.0 Partner news

7.1 Congratulations to Bas Sadiq who has been appointed as the new Chief Executive of Homerton Healthcare following a successful recruitment process. Bas is currently the Deputy Chief Executive of the Trust and has been a fantastic system partner, so we are delighted to welcome her to her new role when Louise Ashley retires in May.

Zina Etheridge
March 2024

Corporate objectives for the NHS North East London ICB 2024-2025

When the Integrated Care Board (ICB) was formally established on 1 July 2023 a set of transitional objectives were agreed by the Board. These focused on ensuring the ICB delivered the purpose and priorities of Integrated Care Systems (ICSs): improving quality and outcomes, securing greater equity, creating value and deepening collaboration.

Building on the transitional objectives for 2023-24 and a continued commitment to delivering the core purpose of ICSs, a set of formal objectives for the board for the next financial year were approved in May 2023 with **progress as follows:**

Objective	Progress to date
Making progress on the implementation of the Integrated Care Partnership (ICP) strategy through working with collaboratives and places to put programmes in place against the four core priorities in the strategy, with an overarching programme for each which sets out clear timescales and milestones and clarity on what action will happen at place and collaborative level.	We now have clear programmes established in Long Term Conditions (LTCs), Mental Health, Learning Disability and Autism (MHLDA) and Babies, Children and Young People (BCYP) with agreed leadership and a resourcing model to deliver the work. We have developed through extensive co-production and collaboration with system partners a workforce strategy which can now be translated into a programme of work. We have held a 'Big Conversation' with residents to inform our success measures for our strategy. Our places have developed further and led many innovative pieces of work such as the development of a holistic model of integrated neighbourhoods in City and Hackney and pop-up integrated health and wellbeing events in Barking and Dagenham which have supported thousands of people.
Deliver the NHS operational planning requirements – through this plan we will ensure the elective recovery, mental health standards trajectories set in the NEL operating plan are delivered alongside the financial plans, and that there is a joined-up approach to demand, especially urgent and emergency care, ensuing residents get the care they need. .	Performance across the ICB improved considerably in a number of areas – in particular there has been progress on long waits for planned care and significant improvement in the speed with which the residents of outer north east London in particular are able to access urgent and emergency care. For instance, by the end of this financial year there should be no patients who have been waiting for planned care for 104 weeks. However, progress on elective care has been challenged by ongoing industrial action which has also created further financial pressure, alongside the ongoing impacts from high inflation and challenges in demand.
Develop a system wide workforce strategy underlined with an action plan,	This was formally signed off by the board in January 2024 following extensive system

putting in place the foundations for a shared strategic plan for a workforce across north east London that meets capacity gaps, ensures we have the new skills we need for the future and provides great employment opportunities for our residents.	engagement and input. Further progress has been made on the London Living Wage with the ICB likely to achieve accreditation at the start of the new financial year, and [Homerton Healthcare having done so this year]
Work towards our commitment to being an anti-racist ICS. Further to the London wide commitment to a strategic anti-racism approach in London's Health and Care System, North East London ICB will develop a robust action plan to include anti-racism training and establish key networks to deliver on this commitment.	Substantial work has been done in some of north East London's places on anti-racism. An anti-racist ICS workshop was held in autumn 2023 bringing together system partners to discuss our commitment to being an anti-racist system to discuss, debate and agree what we, as a system, must do to make this commitment a reality. The next step is to follow up and create a clear strategy for the system. Overall less progress has been made at system level than we would have liked to see.
To further tackle health inequalities by supporting our place-based partnerships to develop and implement three-year plans aligned to our ICP strategy and national best practice frameworks. This will include the launch of a new NEL Health Equity Academy to improve shared learning and joint understanding of improved data and a focus on poverty, ethnicity and specific populations.	Sustainable funding across three years is in place for health inequalities and work is underway in each place to ensure that the priorities selected are right for each place partnership. The NEL Health Equity Academy, launched in November 2023. So far, achievements by the academy have included: • developing a webspace for the sharing of learning • supporting a health inequalities community of practice for those leading the place health inequalities funded projects • launching a network for Primary Care Netwok Health Inequality Leads • delivering, in collaboration with the London Leadership Academy, Influencing without Formal Authority training to around 90 people across the system • holding a Creating Health Equity in NEL event which was attended by people from all parts of the system working to reduce health inequalities. For 23/24 we are in the process of commissioning three programmes which will launch in April. These include Pride in Practice, a programme delivered by the LGBT Foundation to improve the

	experience of and access to primary care health services for the LGBT community, a bespoke for NEL health equity curriculum for primary care staff and an evaluation of the health inequalities funding to understand the impact funded programmes have had on reducing health inequalities in NEL. We are currently recruiting to our primary care Population Health and Health Equity fellowships and plan to create a similar programme for those working in Voluntary, Community and Social Enterprise (VCSE). There will also be the opportunity for some specific training and support focused on underserved groups within NEL. This will be assessed based on evidence of need and effectiveness in improving health equity.
Working as a system - having spent this year putting in place the key enablers for the ICS, there will now be a focus on putting in place the organisational development and culture of system working, ensuring it is systematically worked through and embedded.	Regular forums are in place led by the Chair and Chief Executive as well as other system leaders to bring together system partners are all levels to ensure effective ways of working and overall delivery of the ICP strategy. Each of our places has taken forward development work to grow the local partnership. The Acute Provider Collaborative has commissioned specific development support work, and the MHLDA has also focussed on development of ways of working. At system level we have been taking forward a piece of work to develop a system way development road map.

Proposed corporate objectives for 2024/25

Building on the previous year and in line with current priorities we are proposing a refreshed set of objectives as follows

1. **Working together as a system at all levels to deliver meaningful improvements in health, wellbeing and equity for our local population through:**
    - A continued focus on strengthening community based care, and greater integration through effective primary care and effective place-based working.
    - Achieving against our resident success measures.
    - Strong and effective clinical and care professional leadership and wider system development.

2. **Make further improvements in addressing health inequalities for our local populations across North East London by:**
    - Developing a whole system framework for and approach to population health management
    - Implementing the programmes within our health equity academy.
    - Using data and digital tools effectively to support prevention and identify and tackle health inequalities.

3. **Further develop and embed an approach to being an anti-racist ICS by**:
    - Building on our system work in 2023 finalise and implement a robust action plan to include anti-racism training and establishing key networks to deliver on this. commitment. To help close the health equity gaps across North East London and normalise race equality into being part of how our health and care system operates.

4. **Develop and enhance our workforce across north east London and create meaningful work opportunities and employment for people in NEL now and in the future through:**
    - Implementation of the system wide people and culture strategy. Following the development and sign off on the overall strategy in early 2024 the next stage is to put in place a robust action plan with a clear set of outcomes for this year, ensuring we begin the process of delivering the strategy across our system.
    - Embedding the right culture for our workforce in NHS North East London - ensuring staff have a positive experience and are supported and able to deliver meaningful improvements in health and wellbeing for our local population.

5. **Financial sustainability – deliver better health and wellbeing to our population in a financially sustainable way through:**
    - Ensuring that we spend our resources in way that focuses them in the areas which keep our population healthier for longer.
    - Tackling underlying system deficits and moving towards balanced budgets
    - A system wide programme of work to improve productivity
    - Making a case for more investment overall in NEL

Final NHS North East London ICB organisational values – March 2024

- **Ambitious – we strive for the best and make a difference by being innovative, courageous and bold**
  - We believe change is possible, are proactive and work together to take on challenges
  - We are committed and accountable, making decisions using a range of evidence and always knowing how our work contributes to our ambition and priorities
  - We foster an environment of learning and improvement, making space for new and creative ideas and empowering everyone to challenge the status quo
- **Collaborative – we work together with local people and each other to find the best solutions**
  - We actively make and respond to opportunities to work together across our organisation and system to find the best solutions to shared goals
  - We build strong and meaningful connections, share knowledge and recognise that working in a system is complex, continually adapting to meet this challenge
  - We create environments where diverse ideas and perspectives are valued and contribute to solutions
- **Inclusive – we are resolute in our pursuit of equity and equality, with mutual respect for all in everything we do**
  - We harness the power of our diversity and ensure that equity is meaningfully and visibly embedded in all that we do
  - We treat everyone with dignity, respect and fairness, speaking up and acting if this is not the case
  - We are open to change and encourage learning and meaningful conversation that helps achieve inclusion
- **Kind – we are open, honest and kind to each other in all our work**
  - We develop trust by being open, honest, authentic and acting with integrity
  - We contribute to positive environments that support our health and wellbeing and take time to listen, understand, empathise and support one another
  - We appreciate each other and celebrate achievements across our system

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Growing Well priorities in north east London
Author	Kath Evans – Clinical Lead, Babies Children and Young People (BCYP) Pauline Goffin – System Programme Director Community Services/Babies Children and Young People Chris John – Interim Programme Lead, Babies Children and Young People
Presented by	As above
Contact for further information	Pauline.goffin@nelft.nhs.uk
Executive summary	This paper offers a summary of the Place, Collaborative and system initiatives that support Growing Well, one of the four North East London (NEL)Integrated Care System's strategic priorities and describes three key overarching priorities for our younger north east London population and their families and the evidence base behind them.
Action / recommendation	The Board is asked to discuss and comment on the paper and identify any further actions in response.
Previous reporting	This paper is a follow-up to the report 'Growing Well in north east London' presented to the Population Health and Integration Committee in February 2024
Next steps/ onward reporting	N/A
Conflicts of interest	None known.
Strategic fit	This report aligns with all four ICS aims as how we enable babies, children and young people to grow well in north east London is a critical building block in our strategic approach: • 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	• Increasing access to prevention and self-management for children and young people with long term conditions (LTCs) and those with learning disabilities and autism supports all children better through the transition to adulthood, including as appropriate to adult services. • Opportunities to build on the work of integrated care child health pilots aligning with our Fuller Programme, and Integrated Neighbourhood teams, providing improved integrated mental, emotional and physical care locally for Babies, Children and Young People (BCYP) including care leavers • The programme priorities align with the NHS England Green Plan objectives.

Impact on finance, performance and quality	There are increasing cost pressures across all programmes, providers, Places and provider collaboratives relating to significant growth in population, in acuity and in complexity across all BCYP services, in an environment of sharp inequalities in poverty and opportunity. The resource gap is significant across health, social care and education and requires a radical and strategic shift in system planning and redistribution of funding to meet the needs of NEL's current BCYP populations, who will in turn become NEL adult residents. In each of our Places, there is a particular focus on ensuring adequate and effective funding for children and young people (CYP) with special educational needs and or disabilities (SEND) given increasing levels of complexity and demand, mandatory requirements and the need to work differently across the system to address this.
Risks	The legacy of difference in access, offers and resources as well as the inability to fund the significant increases in demand for services felt in all Places and across all parts of the system, will lead to continued inequality of care for BCYP in NEL.

1. Introduction

1.1 We are a young and diverse population in north east London – babies, children and young people (BCYP) make up 25% of our population and are our future adult population, underlining why they are a strategic priority for the North East London (NEL) Integrated Care System. The BCYP portfolio touches every part of the NEL system and is complex and far reaching, with a range of interrelated programmes across seven Places and each of the Collaboratives. Multiple health and social care providers, the police, education settings, community assets, and the voluntary, community and social enterprise sector (the VCSE) all contribute and the leadership of local authority partners is key in this space, with both their statutory functions and Place making responsibilities shaping the outlook for babies, children and young people growing up in north east London.

1.2 The BCYP priorities (see attachment 1) are aligned with the national NHS Core20Plus5 Strategy that supports Integrated Care Systems (ICSs) to drive targeted action for the most deprived 20% of the population. The emphasis on Growing Well is linked to how we better support BCYP with Long Term conditions, to improve their overall life chances and more universally how we ensure north east London is a great place to grow and develop into adulthood.

2. Context

2.1 The NEL population can be characterised as young, poor, diverse and growing, with the 0-19-year age group comprising between 21% of the total population in Tower Hamlets and 32% in Barking and Dagenham and an average of 25% (see attachment 2). Child Health profiles from the Office for Health Improvement and

Disparities in March 2023 noted that child health and wellbeing is significantly worse than the England average across a range of indicators[1] - the main findings are:

- Overall, comparing local indicators with England averages, the health and wellbeing of children in all NEL places except Havering is mixed. In Havering, it is better.
- In all NEL places except Havering, the percentage of school children from minority ethnic groups is higher than the London and England averages.
- In Barking and Dagenham, City and Hackney and Newham the proportion of children living in poverty is higher than the London and England averages.
- All NEL places except Waltham Forest have a higher proportion of term babies born with a low birth weight than the England average.
- All NEL places do not meet the recommended coverage of Measles, Mumps and Rubella (MMR) immunisations.
- In Barking and Dagenham, Newham, Redbridge and Tower Hamlets dental health is worse than the England average with a higher percentage of five-year olds having experience of dental decay.
- In Barking and Dagenham, City and Hackney, Newham and Redbridge, levels of childhood obesity are worse than England at reception and in year six. The level of obesity in Tower Hamlets in year six is worse than the England average but is better at reception age. Waltham Forest's level of obesity at reception age is similar to the England average but worse in year six.
- In Barking and Dagenham, Redbridge and Waltham Forest, the percentage of children achieving an expected level of development at 2 to 2½ years is lower than the England average, and higher in City and Hackney and Tower Hamlets. The percentage in Newham is similar to the England average. Data is not available for Havering.
- In all NEL places except Tower Hamlets the rate of child inpatient admissions for mental health conditions is lower than the England average. In all NEL places the rate of child inpatient admissions as a result of self-harm (10-24 years) is lower than the England average.
- In all places except Newham, the rate of hospital admissions for asthma (under 19 years) is above the England average.
- In Newham and Tower Hamlets, Accident and Emergency (A&E) attendances (0-4 years) are above the England average.
- All NEL places except Barking and Dagenham and Tower Hamlets are below the England average for children in care immunisations coverage. Redbridge has the lowest children in care immunisations coverage in England. Only City and Hackney has a higher proportion of children in care than the England average.

2.2 Poverty and cost of living pressures are likely to exacerbate matters given the relationship between deprivation and poor health, education and social outcomes. Furthermore, there are significant unmet health and care needs for the BCYP in our communities that are not being identified or effectively met by current services, leading to worsening health and poorer health outcomes for these individuals. Unmet need is not equally distributed, and contributes to health inequalities within the population. Support for BCYP health inequalities quality improvement work is being enhanced. An enhanced population health approach to gain a more accurate picture of future demand will help us all to make a difference.

[1] Available at: https://fingertips.phe.org.uk/profile/child-health-profiles/area-search-results/E12000007?place_name=London&search_type=list-child-areas

2.3 Our planned care programme is working to improve waiting times for elective surgery and outpatients in paediatrics. The primary areas of focus are paediatric audiology, dermatology, gastroenterology, rheumatology and allergy. There is also work led by the Acute Provider Collaborative BCYP Clinical Board on families who do not attend appointments with their child at acute hospital settings, known as the "Was not Brought" cohort.

2.4 A peer review of paediatric emergency departments (EDs) and Urgent Treatment Centres in NEL is planned for 24/25 to support improving safety and the quality of care for BCYP. The Royal College of Paediatrics and Child Health reports that Children and Young People (CYP) account for 25% of ED attendances - they are the most likely age group to attend EDs when they could be managed more effectively by integrated services in primary care or community settings. Despite the efforts of the primary care and community health services workforce, it has been increasingly challenging for CYP and families to access community-based services, which can leave families unsure what to do and drive up demand, particularly for urgent and emergency care services. CYP and families value home based care over disruption and expense of hospital services.

2.5 Across NEL there are an estimated 64,540 (13%) children aged 0-18 with Special Educational Needs and/or Disabilities (SEND). Within this number 21,348 (4.3%) will have an Education Health and Care Plan (EHCP) – this is a statutory document with mandatory requirements including 6 weeks for health assessment completion. There are high levels of indicated need for the health assessment e.g. speech and language therapy. Failure to deliver interventions can result in a tribunal.

2.6 Safeguarding BCYP must be a priority for all partners across NEL. Early identification and intervention protects the child in the short term and reduces the likelihood of poor outcomes in later life.

2.7 Outcomes for looked after children such as educational attainment and mental and physical health tend to be poorer than those of children in the general population. Across London in 2020, 53% of children in care were placed outside of their local authority (DfE 2020), a proportion that is likely to be similar amongst young people who have left care. Each borough has a care leaver offer, but these are individual to each authority and do not provide a consistent and shared offer in addition to issues of equity and accessibility.

3 BCYP Overarching Priorities

Following discussions across Places, Programmes and Collaboratives, we are working to ensure the complementary portfolio of activities across this complex picture are better aligned to improve outcomes for BCYP. We have rescoped three overarching BCYP priorities, which we believe we are best placed to deliver added value, join-up activities, improve access to services, ensure health inequalities are tackled and reduce unwarranted variation in the care of BCYP in north east London:

1. Increasing capacity for community-based care;
2. Responding to Special Educational Needs and Disabilities demand;
3. Supporting vulnerable children.

3.1 Increasing capacity for babies, children and young people's community-based care

3.1.1 The National Child Health Information System (CHIS) and GP registration data estimates that there are 12,000 unregistered children with primary care in NEL. Prioritising registration and access to services will ensure timely community-based care, reducing the pressure on urgent and emergency care services. This will require strong partnerships with our Primary Care Collaborative. Home-based, integrated community care is less disruptive for families. There is an opportunity to build on the Integrated BCYP pilots at Place (see attachment 3), via the Fuller Programme and the roll out of Integrated Neighbourhood Teams more widely, to support BCYP and families. The Community Health Services Collaborative, can develop a consistent community nursing offer, for example, to provide potential hub and spoke models for some of our specialist, fragile nursing services.

3.1.2 We are working closely with local authorities as the family hub programme is rolled out, part funded in some Places by central government. In Newham, for example, one family hub is now live with the second going live in February 2024, and two more later in the year. Funding is also supporting integrated programmes and services including early language development and infant feeding support.

3.1.3 Building on the success of Tower Hamlets Spotlight, at Place, we are working with our primary care and wider partners to develop Youth-Friendly Primary Care. Being open and accessible, catering for young people's unique needs and preferences, helps create a positive healthcare experience, leading to better health outcomes and engagement. Integrated mental health/sexual health services supported by youth work/social prescribing are highly valued.

3.1.4 Linking with the Urgent and Emergency Care Programme and the Community collaborative, we aim to ensure Hospital at Home and Children's Community Nursing seven days a week 8am-6pm are embedded across NEL (now being aligned with the Virtual Care approach) and to sustain the Frequent Attenders Project in Waltham Forest as other important initiatives as part of a more preventative and admissions avoidance model.

3.1.5 Integrated care and an increased focus in primary care will help better manage these issues effectively and improve the quality of life for BCYP with chronic health conditions, aiding transition to adult services. BCYP integrated community-based services join-up teams to support LTCs and can also have a preventive focus. Places take a leading role in ensuring a strong focus on prevention including increasing childhood immunisation rates, reducing childhood obesity and working on violence reduction.

3.1.6 Core20Plus5 for children and young people, is a national NHS England approach to support the reduction of health inequalities at a system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement:

3.1.7 **Asthma:** There have been over 10 asthma child deaths in NEL since 2017. One area is subject to regulation 28 notice to prevent future deaths. Deprivation, poor parental understanding, poor air quality and psychological/emotional issues place a child at high risk of death from asthma. The NEL asthma network with the asthma pilot practitioners have:

- rolled out Asthma-friendly schools across NEL;

- produced accessible information for asthma for families and practitioners;
- streamlined patient pathways to ensure high risk and severe/difficult asthma patients are escalated appropriately.

There is unwarranted variation across NEL in the percentage of CYP with physiologically confirmed diagnosis of asthma. Improving access to spirometry and addressing over reliance on reliever medication and decreasing the number of asthma attacks need to be a continued focus for 24/25 in order to make a difference for CYP from all backgrounds.

3.1.8 **Diabetes:** The incidence of type 2 (T2) diabetes in young people is increasing as a result of increasing childhood obesity and is particularly marked in Black and Minority Ethnic (BME) communities. There are also increasing numbers of young people diagnosed with type 1 (T1), as a result of Covid-19, placing increasing demand on both specialist paediatric and adult services. For example, Bart's Health, who provides both T1 and T2 services for Inner NEL has seen caseloads increase by 167 additional children over five years. Barking, Havering and Redbridge University Hospitals Trust (BHRUT), who provides services in Outer NEL has seen increases from 40 to 60 new cases of T1 in a year, whilst presentations for T2 have doubled in the past 2 years. Outer North East London Places have the highest concentrations of T2 in children in England.

3.1.9 Evidence shows that children's outcomes begin declining at transition into adulthood. The Royal London Hospital and Newham University Hospital are currently piloting Young Adults Transition schemes including youth work and social prescribing which has had some encouraging outcomes. However, there are long waits for transition services and consequently many young people/young adults are presenting at A&E with deteriorating health. Currently in Barking, Havering and Redbridge services run a sub-optimal transition and no young adult service compared to other neighbouring Trusts within North East London and nationally which disadvantages patients as they learn to manage their disease going into adulthood, leading to poor glycaemic control, increased incidence of acute attendance to hospital and increased risk of serious complications such as end stage renal failure leading to long term dialysis.

3.1.10 The large increase in demand for diabetes services and variation in access mean that actions for 24/25 will need to include increasing access to hybrid closed loop insulin pump technology in the most deprived quintiles and from ethnic minority backgrounds living with type 1 diabetes and increasing the proportion of CYP with type 2 diabetes receiving annual checks. This will improve diabetic control and reduce the risk of serious complications.

3.1.11 **Epilepsy:** The North Thames Paediatric Network (NTPN) is commissioned by NHSE to support work across London to improve and support models of care. We are working with NTPN to implement an epilepsy specialist nurse role from April 24 to improve access to services and support for epilepsy, particularly for young people with co-morbidities such as complex autism and epilepsy.

3.1.12 **Oral Health:** Strategies to improve oral health and reduce health inequalities are being led at place. These include: expanding the number of oral health promotion activities available to children and young people (CYP); increasing the uptake of the fluoride varnish and supervised tooth brushing programmes, and specialist services for vulnerable children; strengthening the role GPs can play in supporting good oral

health among their patients and addressing the backlog of tooth extractions in hospital for under tens.

3.1.13 **Mental Health:** There are various Improvement Networks developing, bringing together expertise across all seven Places and system providers. The Mental Health, Learning Disabilities and Autism Collaborative is leading work on improving access and consistent offers for CYP with mental health and/or neurodiversity needs. Work is progressing to support to schools around self-harm, and providing earlier and better support and resources to families and schools for children who may have neurodiverse needs.

3.2 Meeting the needs of children and young people with Special Educational Needs and Disabilities (SEND)

3.2.1 There is a consistent emphasis on ensuring CYP with SEND have healthy, happy and fulfilling lives which mirror the experience of all CYP wherever possible, and are therefore able to enter adulthood equipped with the support and tools to develop further, however complex their needs. From a services perspective, this should lead to reducing demand for adult social care and health services over time. The growing population, however, is placing huge demand on services right now and we are working on a model for funding the recognises both the growing demand and different ways of responding effectively.

3.2.2 There are significant pressures in community services for CYP with SEND. NEL has some of longest community waits in England for CYP – including paediatric therapy services (Speech and Language and Occupational Therapies - see attachment 4). There are challenges including the community wait target of 18 weeks Referral To Treatment (RTT) for therapies. For places loss of maintenance of existing investment is likely to exacerbate these pressures and worsen outcomes for BCYP. Other challenges include the statutory target of six weeks for health assessments for EHCPs - there is increasing demand for new assessments across all places. There are also long waits to commence the autism diagnostic pathway. If we develop and deliver pre and post diagnostic support offer this would help alleviate the long but equitable NEL wide waits. There is thus a mandatory financial pressure around provision for SEND which needs addressing as part of our 24/25 planning; the year-end forecast is circa £10million. Delayed Autism Spectrum Disorder (ASD) diagnostic waiting times are associated with increased financial costs, caused by, for example, failing to address the link between ASD and associated mental health conditions.

3.3 Supporting vulnerable babies, children and young people

3.3.1 We link up with the NEL Safeguarding Children Team and Safeguarding Children Partnerships in each place to focus on supporting vulnerable children and through intelligence sharing, identify safeguarding risks. Our vulnerable children, including those with long term conditions, SEND and mental health disorders, as well as looked after children, are likely to have had deteriorations in their health and wellbeing from the pandemic and cost of living crisis. We will explicitly support these groups across NEL (0-24 years); approaches will address inequalities and service issues faced by those young people transitioning to adult services.

3.3.2 The London Care Leavers Compact was established in early 2022 to deliver a consistent and high-quality offer for care leavers across the capital. Its health theme

includes work on: free prescriptions, priority/bespoke mental health offer and free leisure passes. Newham is an exemplar in Mental Health support, providing a specialist nurse for care experienced young people, it is an approach we would like to see in each place. NEL places have also supported partners coming together, under the leadership of the local authority, to support care leavers and those who are care experienced. We recognise the multiple and complex needs, across social, emotional, mental and physical health, of young people in this cohort and the many opportunities we have to prioritise a response to these needs. Work is progressing with NEL Local Authority Care leaving teams to provide free prescriptions (e.g. for those prescribed medication for ASD), strengthen mental health support and implement the London Care Leavers Compact as a priority.

3.3.3 The NEL Child Sexual Abuse Hub (The Hub) delivers support to CYP of all ages across all seven boroughs in NEL, who have experienced sexual abuse - including those with SEND and children in care. The Hub model is a one stop shop for medical, advocacy and early emotional support for children and their families, as well as offering advice and liaison to police and children's social care services. It is a known and respected NEL service and strengthening integration and improving access will further support this cohort of vulnerable CYP. The TIGER Harmful Sexual Behaviours Service is a therapeutic service for children who display harmful sexual behaviours across three boroughs in NEL (Barking and Dagenham, Havering and Redbridge). Its aim is to reduce and prevent harmful sexual behaviour. Provision of a similar service across the rest of NEL is needed to deliver equity of provision for our CYP.

4. Risks and mitigations

4.1 The legacy of difference in access, offers and resources as well as the inability to fund the significant increases in demand for services felt in all Places and across all parts of the system, will lead to continued inequality of care for BCYP in NEL. This in turn means poorer health outcomes over many years for families who already live in some of the most deprived neighbourhoods in the country – essentially added pressure on our urgent and emergency care and mental health systems. This has a domino effect for a child's educational outcomes, potential need for wider social care support, and impact in later life in relation to employment opportunities, longer term health outcomes, and overall life chances. All of this has a significant system economic impact as children grow into NEL's adult population. All places in NEL have identified SEND as an area of financial pressure, an area of high risk and high priority.

4.2 The fragile nature of the BCYP health and care workforce is reported by Places and providers with the risk of impacting on service provision and delivery. Collating and analysing workforce data so that it can be correlated to current provision is a necessary first mitigating step.

5. Conclusion

5.1 This report is a follow-up to its earlier version 'Growing Well in North East London' that was taken to the Population Health and Integration Committee (PHIC) in February 2024 where there was a full, strategic discussion on opportunities in relation to prevention and early intervention – not just for BCYP, but also for future adults who may otherwise develop mental or physical health needs. It makes recommendations for three overarching priorities for focused improvement.

5.2 Sustained action from all partners within the Integrated Care System (ICS) is critical to making a tangible difference for our BCYP population in order to improve their health outcomes which are amongst the worst in London and in some cases, England (see section 2.1). It is important that we increasingly adopt a population health approach. BCYP should be thought of as a population cohort and not just a priority or a programme – this will ensure that babies, children, young people and families are reflected in all that we do.

In conclusion, the Board is asked to agree the three BCYP overarching priorities for improvement. We would also like to ask the Board how it will work with us to support:

1. Creating a system-wide vision for BCYP as a priority population in north east London, that mobilises action to: reduce unwarranted variation, improve physical and mental health and wellbeing outcomes and reduces health inequalities;
2. A population health approach for BCYP with a genuine focus on prevention and early intervention;
3. A fair allocation of resources for BCYP as a priority population and addressing the legacy in variation of resources across the system (including variation between: population cohorts, places, programmes and collaboratives).
4. Developing and maintaining a resilient, sustainable and highly skilled child health and care workforce that meets the needs of BCYP.

6.0 Attachments - List appendices as:

Attachment 1 – DRAFT NEL BCYP Plans 24/25
Attachment 2 – NEL's 0-19 Population – Rapid Profile
Attachment 3 – BCYP at PLACE
Attachment 4 – BCYP Community waiting lists

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Joint Forward Plan refresh 2024/25
Author	Anna Carratt
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	a.carratt@nhs.net
Executive summary	This paper presents the ICB Board with the final draft of the North East London (NEL) Joint Forward Plan (JFP) for 2024/25 (for full document, see appendix A). The 24/25 JFP is north east London's second five-year plan since the establishment of NHS NEL. In this plan, we build upon the first, refreshing and updating the challenges that we face as a system in meeting the health and care needs of our local people, but also the assets we hold within our partnership. We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population. To address those needs, our transformation portfolio leads have been working with their group of partners to outline the changes planned in their areas as well as the impact it will have for our local people and the system. In addition, we have been working with our colleagues across the ICB to ensure the document includes the latest and most relevant data and insight about our challenges as well as our opportunities and assets. We have also engaged with all our health and well-being boards, the Place-based Partnerships, our Provider Collaboratives (see appendix B for full list of groups) as well as wider partners to seek their feedback and support of our JFP as our system delivery plan. The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services, the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities, and how we are developing key enablers such as our estate and digital infrastructure as well as financial sustainability. Our Joint Forward Plan will be refreshed yearly to reflect that, as a partnership, we have continual work to do to develop a cohesive and complete action plan for meeting all the challenges we face together. We will work with local people, partners and stakeholders to update and improve the

	plan yearly as we develop our partnership, to ensure it stays relevant and useful to partners across the system. Local Health and Wellbeing Boards are working with our Place-based Partnerships to ensure key aspects of locally developed Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategies (JLHWSs) are considered when developing our plans. Throughout March, the JFP has been taken to the ICB Executive Management Team (EMT), the Executive Committee and the Clinical Advisory Group for final comments, and we bring it to the ICB Board for final sign off. In parallel, a short version of the JFP will be produced and will be published alongside the full JFP on the North East London Health and Care Partnership website. The full JFP will also be submitted to NHS England by 31 March 2024.
Action / recommendation	The ICB Board is asked to review and comment on the changes to the JFP 24/25 and sign off for final submission.
Previous reporting	The Joint Forward Plan refresh: ▪ Clinical Advisory Group – 6 December 2023 ▪ Havering Health and Wellbeing Board – 20 December 2023 ▪ Outer NEL Joint Overview and Scrutiny Committee – 9 January 2024 ▪ Acute Provider Collaborative Executive – 9 January 2024 ▪ Integrated Care Partnership Committee – 10 January 2024 ▪ Primary Care Collaborative sub-committee – 10 January 2024 ▪ Havering Place-based Partnership Board - 10 January ▪ Executive Committee - 11 January ▪ Community Health Collaborative sub-committee - 15 January ▪ Barking and Dagenham Health and Wellbeing Board - 16 January ▪ Newham Health and Wellbeing Board - 17 January ▪ Hackney Health and Wellbeing Board - 25 January ▪ Voluntary, Community and Social Enterprise Collaborative - 26 January ▪ Mental Health, Learning Disability and Autism (MHLDA) Collaborative sub-committee - 31 January ▪ City of London Health and Wellbeing Board - 2 February ▪ Tower Hamlets Health and Wellbeing Board - 6 February ▪ Redbridge Place-based Partnership Board – 16 February ▪ Redbridge Health and Wellbeing Board - 26 February

	▪ Inner NEL Joint Overview and Scrutiny Committee – item deferred but shared with the group ▪ Directors of Adult Social Services – meeting cancelled but JFP shared with the group ▪ Executive Management Team – 7 March ▪ Clinical Advisory Group – 13 March ▪ Executive Committee – 14 March 2024
Next steps/ onward reporting	The Joint Forward Plan refresh: ▪ ICB Board (sign-off) – 27 March 2024
Conflicts of interest	No conflicts of interest have been identified
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 yearly refresh of the NEL Joint Forward Plan support the maturity of our system in being able to deliver our four core priorities and cross cutting themes, as well as our Place and Collaborative plans, which in turn are linked to reducing health inequalities.
Impact on finance, performance and quality	The JFP includes plans that will have impact on our finances, performance and quality, and where funding is required, standard ICB process will be followed for individual programmes and projects.
Risks	We have a requirement to develop and submit our JFP to the NHS England by 31 March 2024. Any delays in achieving sign off will have a negative impact on our reputation with NHSE and our partners that have contributed to the plan.

End

Anna Carratt, 27th February 2024

Appendix A – Full Joint Forward Plan (final draft)

North East London Health & Care Partnership

North East London (NEL) Joint Forward Plan - Refresh

March 2024

1. Introduction

Introduction

- This Joint Forward Plan builds on our initial plan published in 2023/24, refreshing and updating the challenges that we face as a system as well as the assets of our partnership in meeting the health and care needs of our local people.
- We know that the current model of health and care provision in north east London needs to adapt and improve to meet the needs of our growing and changing population. In this plan we describe the substantial portfolio of transformation programmes through which we will deliver these changes, alongside the work of our seven Place-based Partnerships aligning around our six strategic cross-cutting themes.
- The plan sets out the range of actions we are taking as a system to address the urgent pressures currently facing our services; the work we are undertaking collaboratively to improve the health and care of our population and reduce inequalities; and our work to strengthen key enablers including our estate and digital infrastructure as well as financial sustainability.
- Our Joint Forward Plan will be refreshed annually to reflect that, as a partnership, we will need to adapt our plans in response to our collective learning and the evolving nature of the challenges we face together. We will work with local people, partners and stakeholders to update and improve the plan to ensure it stays relevant and useful to partners across the system. Local Health and Wellbeing Boards are working with our Place-based Partnerships to ensure key aspects of locally developed JSNAs and JLHWSs are considered when developing our plans.

Highlighting the distinct challenges we face as we seek to create a sustainable health and care system serving the people of north east London

In submitting our Joint Forward Plan, we are asking for greater recognition of three key strategic challenges that are beyond our direct control. The impact of these challenges is increasingly affecting our ability to improve population health and inequalities, and to sustain core services and our system over the coming years.

- **Poverty and deprivation** – which is more severe and widely spread compared with other parts of London and England, and further exacerbated by the pandemic and cost of living crisis which have disproportionately impacted communities in north east London
- **Population growth** – significantly greater compared with London and England and concentrated in some of our most deprived and ‘underserved’ areas, alongside a rapidly changing demographic profile in several of our places
- **Inadequate investment** available for the growth needed in both clinical and care capacity and for innovation as well as capital development to meet the needs of our growing population

In January 2023, our integrated care partnership published our first strategy, setting the overall direction for our Joint Forward Plan

Partners in NEL agreed a collective ambition underpinned by a set of design principles for improving health, wellbeing and equity.

To achieve our ambition, partners are clear that a radical new approach to how we work as a system is needed. Through broad engagement, including with our health and wellbeing boards, place-based partnerships and provider collaboratives we have identified six cross-cutting themes which will be key to developing innovative and sustainable services with a greater focus upstream on population health and tackling inequalities.

We know that our people are key to delivering these new ways of working and the success of all aspects of this strategy. This is why supporting, developing and retaining our workforce, as well as increasing local employment opportunities, is one of our four system priorities identified for this strategy.

Stakeholders across the partnership agreed to focus together on four priorities as a system. There are a range of other areas that we will continue to collaborate on, but we will ensure there is a particular focus on our system priorities. We have been working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

We recognise that a well-functioning system that is able to meet the challenges of today and future years is built on strong foundations. Our strategy sets out our ambition to transform our enabling infrastructure to support better outcomes and secure a more sustainable system. This includes our new financial strategy which will be fundamental to the delivery of greater value as well as a shift in focus 'upstream'.

Critically we are committed to a relentless focus on equity as a system, embedding it in all that we do.

Both our strategy and this Joint Forward Plan build upon the principles agreed by London ICBs with the Mayor of London.

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."

Improve quality and outcomes	Deepen collaboration	Create value	Secure greater equity

6 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 research and innovation

4 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**

The delivery of our Integrated Care Strategy and Joint Forward Plan is the responsibility of a partnership of health and care organisations working collaboratively to serve the people of north east London

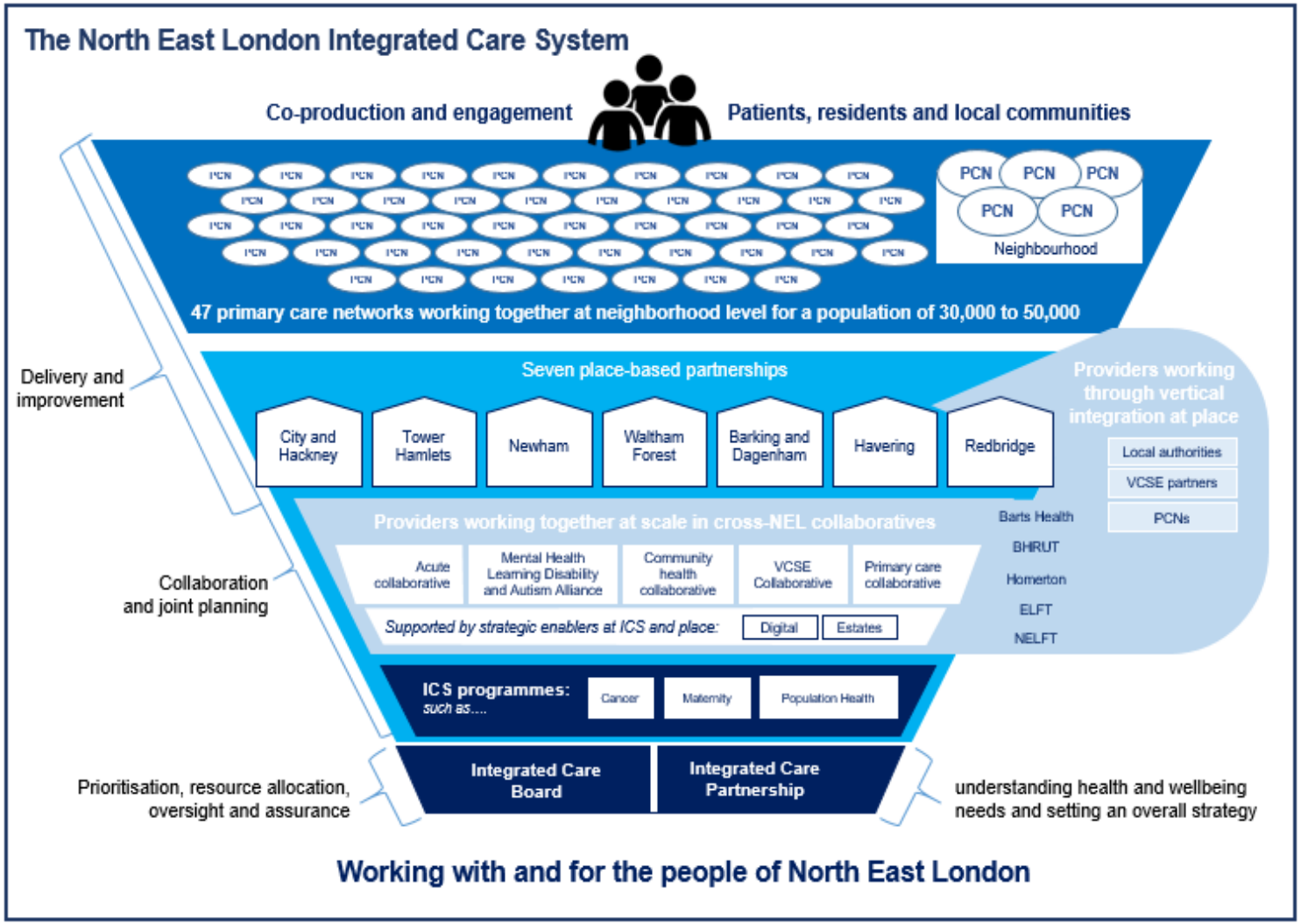
We are a broad partnership, brought together by a single purpose: **to improve health and wellbeing outcomes for the people of north east London**.

Each of our partners have positive impacts on the people of north east London – some providing care, others involved in planning services and others impacting on wider determinants of health and care such as housing and education. As we deepen our collaboration and strengthen integrated ways of working, we will seek to deliver greater impact for our population.

Our partnership between local people and communities, the NHS, local authorities and the voluntary and community sector, is uniquely positioned to improve all aspects of health and care including the wider determinants.

With hundreds of health and care organisations serving more than two million local people, we want to build on the strengths of individual partners and promote integration, ensuring that decisions are made at the most appropriate level.

Groups of partners coming together within both place-based partnerships and provider collaboratives are crucial building blocks for how we will deliver. We will reflect on the London Region review of provider collaboratives and incorporate any learning into the development of our NEL collaboratives.



2. Our unique population

Understanding our unique population is key to addressing our challenges and capitalising on opportunities

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. It is rich in history, culture and deep-rooted connections with huge community assets, resilience and strengths. Despite this, local people experience significant health inequalities. An understanding of our population is a key part of addressing this.

Rich diversity

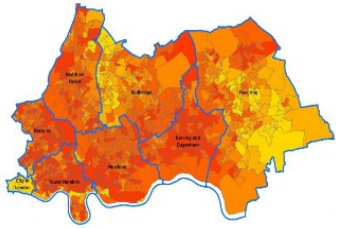
NEL is made up of many different communities and cultures. Just over half (53%) of our population are from global majority backgrounds.

Our diversity means a 'one size fits all' approach will not work for local people and communities, but there is a huge opportunity to draw on a diverse range of community assets and strengths.

Young, densely populated and growing rapidly

There are currently just over two million residents in NEL and an additional 206,226 will be living here by 2041 (ONS).

We currently have a large working age population, with high rates of unemployment and self-employment. A third of our population has a long term condition. Growth projections suggest our population is changing, with large increases in older people over the coming decades.



Poverty, deprivation and the wider determinants of health

Nearly a quarter of NEL people live in one of the most deprived 20% of areas in England. Many children in NEL are growing up in low income households (up to a quarter in several of our places).

Poverty and deprivation are key determinants of health and the current cost of living pressures are increasing the urgency of the challenge.

Stark health inequalities

There are significant inequalities within and between our communities in NEL. 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, including poverty and ethnicity.

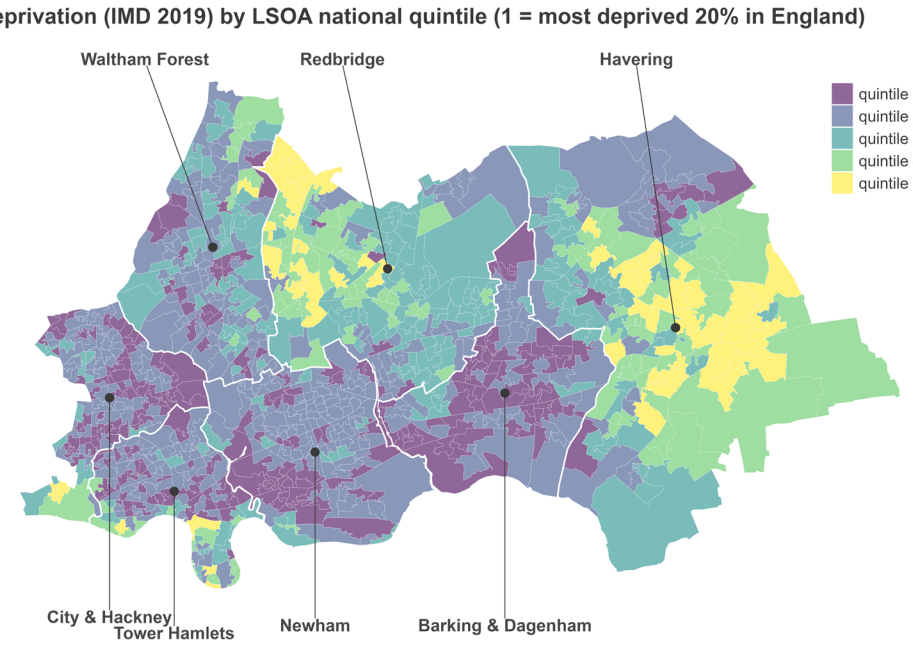
Our population has been disproportionately impacted by the pandemic and recent cost of living increase.

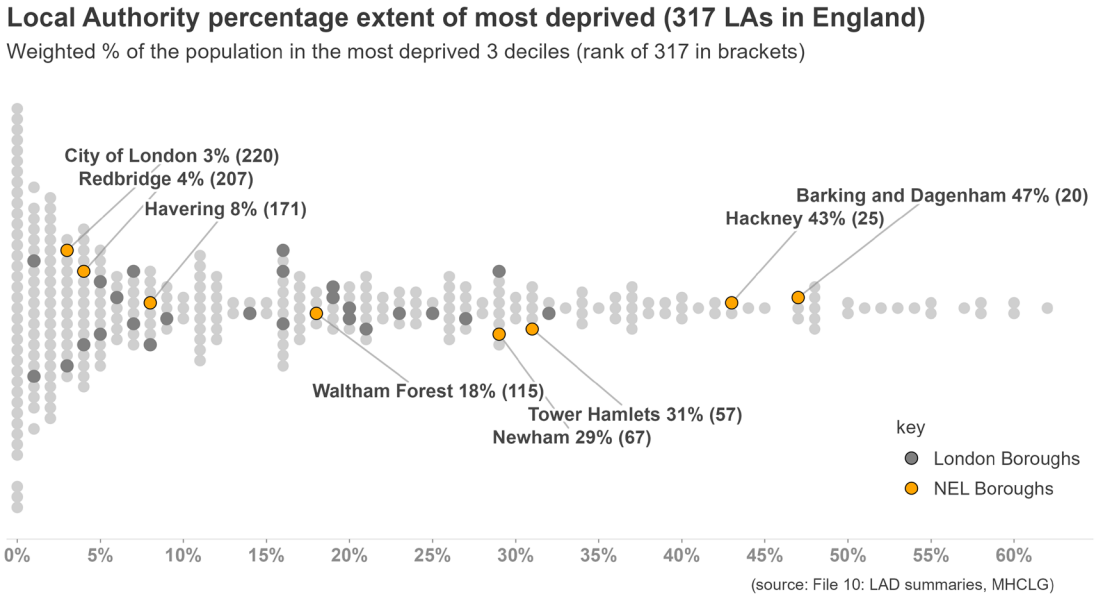
Poverty, deprivation and ethnicity are key factors affecting the health of our population and driving inequalities

Large proportions of our population live in some of the most deprived areas nationally. Deprivation is typically measured at small-neighbourhood level (LSOA). By this measure, NEL has four of the top six most deprived Borough populations in London, and some of the highest in the country (chart below).

By deprivation quintile, Barking and Dagenham (54%), City and Hackney (40%), Newham (25%) and Tower Hamlets (29%), have between a quarter and more than half of their population living in the most deprived 20% of areas in England (map and chart right).

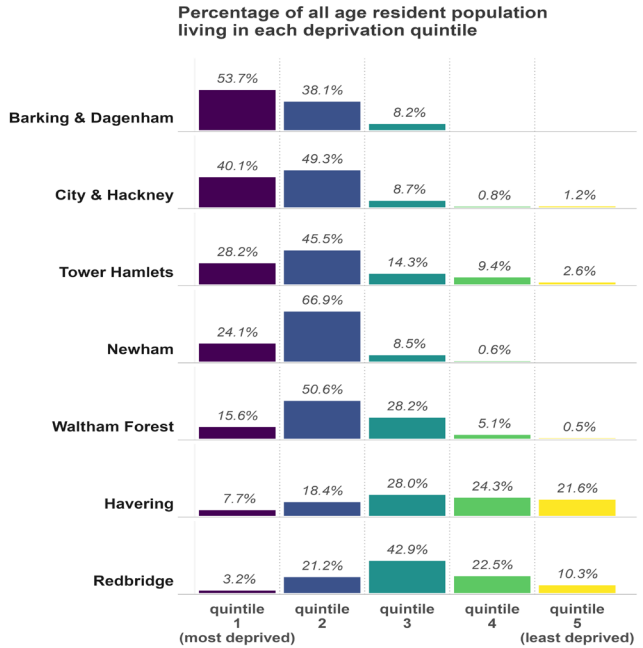
But even these small-area measures conceal severe hidden inequality. Recent research shows that NEL, and particularly Tower Hamlets, has a very high level of inequality within these small-neighbourhood areas. Affluent populations of one ethnic group live alongside very deprived populations of another ethnic group. This may pull up the 'average' deprivation metrics, but this masks large numbers of people who are still affected by severe poverty and deprivation.





People living in deprived neighbourhoods, and from certain ethnic backgrounds, are more likely to have a long term condition and to suffer more severe symptoms. For example:

- the poorest people in our communities have a 60% higher prevalence of long term conditions than the wealthiest along with 30% higher severity of disease
- people of South Asian ethnic origin are at greater risk of developing Type 2 Diabetes and cardiovascular disease, and
- people with an African or Caribbean family background are at greater risk of sickle cell disease.



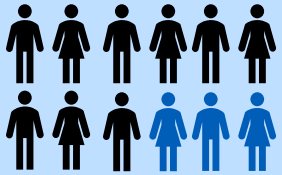
To meet the needs of our population we need a much greater focus on prevention, addressing unmet need and tackling health inequalities

Poverty

Five NEL boroughs have the highest proportion of children living in low income families in London and since 2014 the proportion of children living in low income families is increasing faster in NEL than the England average.

Homelessness and vulnerable housing

NEL has higher numbers if vulnerably housed and homeless people, including refugees and asylum seekers, compared to both London and England.



7 out of 10 of recent* deaths of people under 75 were found to be **avoidable.** This equates to on average **3,231 deaths per year** being avoidable in NEL.

NEL has high rates of avoidable mortality compared to London and England.
Barking & Dagenham has the **highest avoidable mortality** rate and **lowest healthy life expectancy** in all of London**.**

Cancer and cardiovascular disease accounted for **50%** of all avoidable deaths.
Lung cancer was the main contributor to avoidable deaths by cancer.
Ischaemic heart disease was the main contributor to avoidable deaths from cardiovascular disease.

There is a **strong relationship between higher levels of deprivation and higher rates of avoidable mortality in under 75s**. This is most stark for cardiovascular disease.

Obesity

1 in 10 children in reception and **1 in 3 children in year 6** had obesity in 2022/2023. This is higher than the London and England average.

Around 1 in 10 adults in NEL have obesity, which is higher than the London average. **Barking and Dagenham has the highest adult obesity rate in London.**

Low vaccination uptake

The NEL average rate of uptake for all infant and early years vaccinations in lower than both the London and the England rates.

There is indication of unmet need across our communities

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 services.

Tobacco

Smoking is a leading cause of health inequalities. **1 in 20 women in NEL smokes at time of delivery**, and adult smoking prevalence in most NEL boroughs is higher than the England average.

***Avoidable death definition:** under 75 deaths that are preventable through public health intervention, or treatable via effective healthcare. Data related to deaths over 5 years 2018 to 2022, including COVID-19 deaths. Source: ONS mortality data (NEL residents)

Population growth in NEL is set to continue which will increase the demand for local health and care services

North east London had the fastest growing population in the country over the last 20 years (2001 – 2021) and this rapid population growth for NEL is forecast to continue, driven by population demographics and local 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. 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.

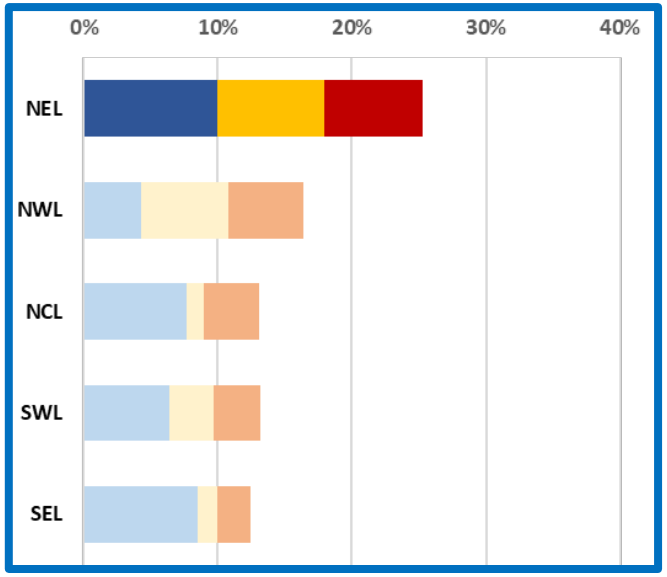
The GLA has produced planning scenarios indicating significantly increased growth in NEL:

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

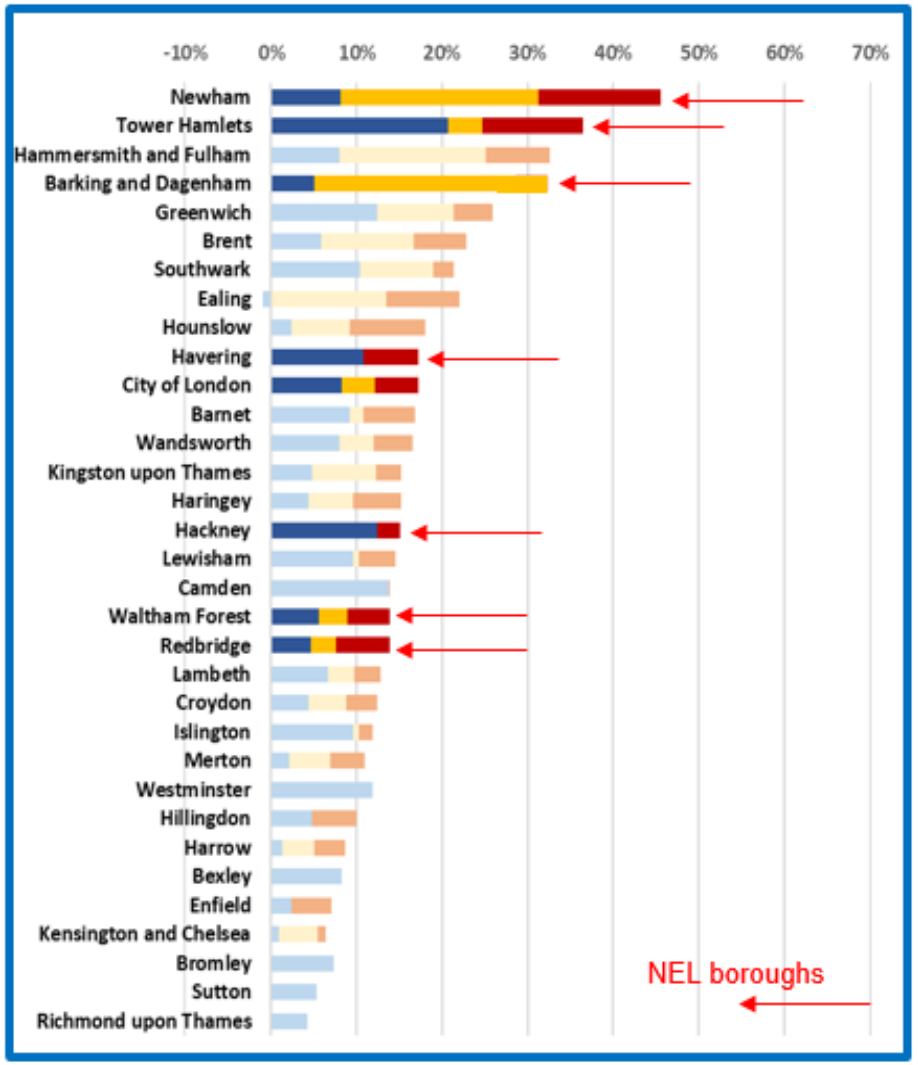
Identified Capacity Scenario:
Housing growth in line with identified development sites
Projecting a population increase of **331,432** by 2041

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

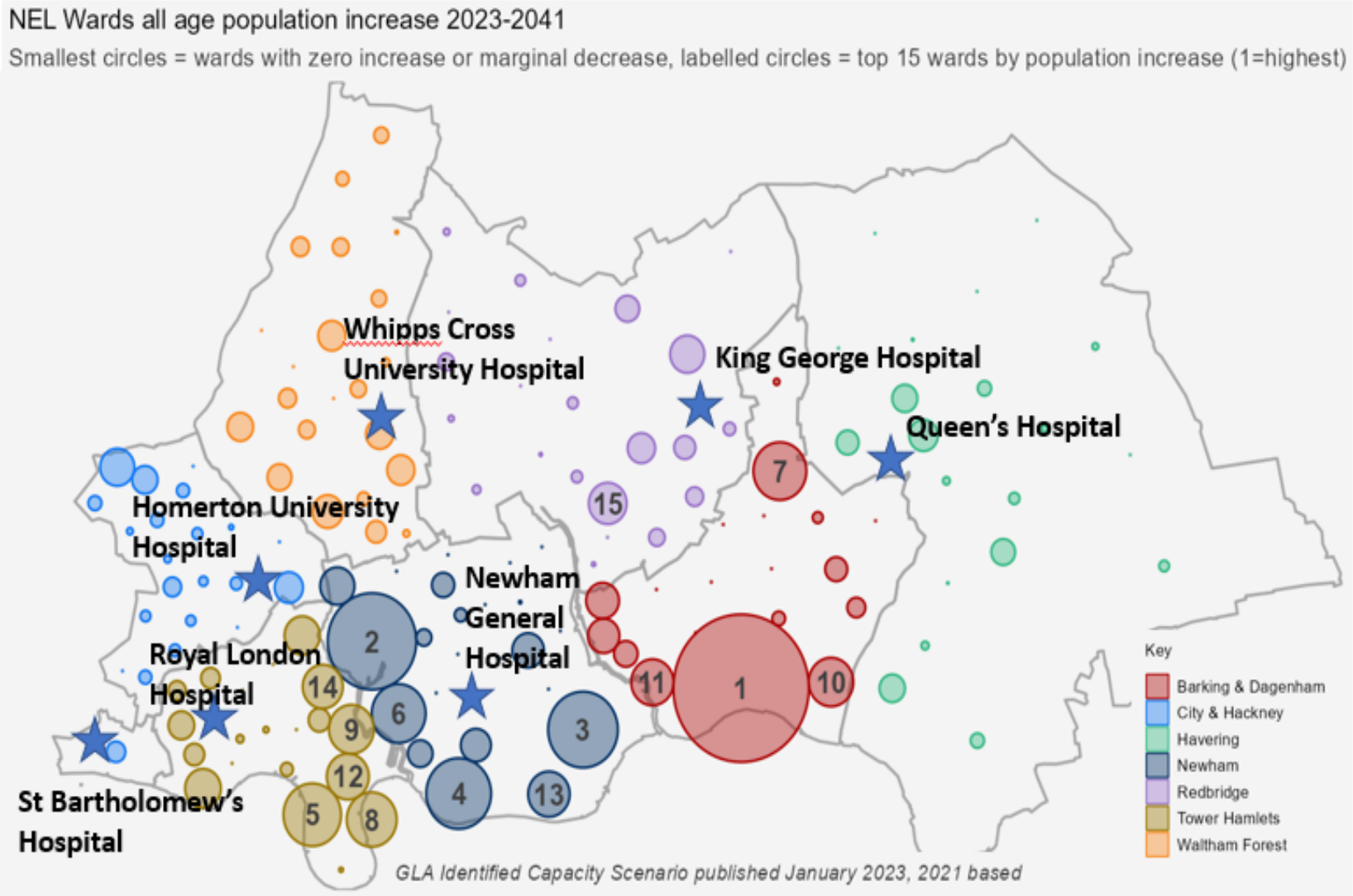
GLA housing-led population projections by ICS 2021-2041



GLA housing-led population projections by LA 2021-2041



Forecasted growth will be unevenly distributed across NEL, particularly across our most deprived and currently underserved places



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.**

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. This will mean service provision will likely need to adapt to new demand as uneven dispersed growth occurs.

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.

3. Our assets

We have significant assets to draw on

North east London is a vibrant, diverse and distinctive area of London, steeped in history and culture. The 2012 Olympics were a catalyst for regeneration across Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally, the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel. There are also plans for the Whipps Cross Hospital redevelopment and for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

Our assets

- **The people of north east London** – bring vibrancy and diversity, form the bedrock of our partnership, participating in our decisions and co-producing our work. They are also our workforce, provide many of hours of care and support to each other and know best how to deliver services in ways which work for them.

- **Research and innovation** – continuously improving, learning from international best practice and undertaking our own research and pilots, working with higher education and academic partners to evidence what works for our diverse communities/groups. We want to build on this work to provide world-class services that will enhance our communities for the future.

- **Leadership** – our system benefits from a diverse and talented group of clinical and professional leaders who ensure we learn from and implement the best examples of how to do things as well as innovating, using data and evidence to continually improve. Strong clinical leadership is essential to lead professional communities, support and inform difficult resourcing decisions as well as help set system priorities. Our ICS will benefit from integrated and diverse leadership including senior leaders, front line staff, the community and voluntary sector, local people and those with lived experience.

- **Financial resources** – we spend over £4bn on health services in NEL. Across our public sector partners including local authorities, schools and the police an additional £3bn is invested. We want to work together to ensure our collective use of resources are delivering best value for our population, improving outcomes and reducing inequalities in a sustainable way.

- **Primary care** - is the bedrock of our health system. We will support primary care partners to create a multi-disciplinary workforce, able to be both responsive and proactive in meeting the needs of their local population and focused on improving access, quality and outcomes for local people in an integrated way.

- **Collaboration** – we have historical collaborations between organisations that can be built on as our system matures further. For example, long established cooperation and collaboration has existed within the Barking & Dagenham, Havering and Redbridge (BHR) footprint as well as in City & Hackney which has adopted a collaborative commissioning approach. An interim NEL ICS Procurement Collaborative has been established across multiple providers working on clinical consumables, data & systems and transactional processing. Linked to this is a Social Value workstream that supports embedding social value into procurement.

Our health and care workforce is a great asset to us

Our ICS People and Culture Strategy sets out our vision for a joined up ‘One Workforce for NEL Health and Social Care’ which will work across organisational boundaries, collaborating and learning from each other to deliver consistent best practice. We will increase support for our current and potential workforce through the implementation of inclusive retention and health and well-being strategies, and creating innovative, flexible and redesigned heath and care careers.

We want to contribute to the social and economic development of our local population through upskilling and employing under-represented groups from our local people; creating innovative new roles; values-based recruitment; and locally-tailored, inclusive supply and attraction strategies in collaboration with education providers.

Our workforce is critical to transforming and delivering the new models of care we will need to meet the needs of our growing population. We will ensure that our staff have access to the right support to develop the skills needed to deliver the health and care services of the future and adapt to new ways of working. AI and digitalisation will play a major role in determining our workforce needs over the next ten years. Aligned to the Long Term Workforce Plan, we are working with our Higher Education institutes and health and care providers to increase trainees and placements for students to ensure that we have pipeline and pathway from education to employment in NEL. We will utilise apprenticeships to promote inclusion and provide opportunities for our population develop health and care careers in NEL.

The newly established NEL Health Equity Academy has an ambition to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people. One of the main ways in which we will do this is by delivering and coordinating education and training to increase understanding of and develop the skills needed to tackle health inequalities. This includes providing access to training on a range of topics including leadership for health equity, and skills-related training such as evaluation. We are developing a locally focused health equity curriculum for primary care, and developing fellowship offers for different sectors.

We will work together to describe our system values and behaviours which will support greater integration and collaboration across teams, organisations and sectors.

There are almost one hundred thousand people working in health and care in NEL, and our employed workforce is growing every year.

Our workforce includes:

- Over 5,600 people working in general practice (Aug 23)
- 47,638 people working in our Trusts (Aug 23)
- 46,000 people working in adult social care including the independent sector (22/23)
- These are supported by a voluntary sector workforce roughly estimated at over 30,000

We will provide better outcomes for our local people by working together across the voluntary and community sector, social care and health

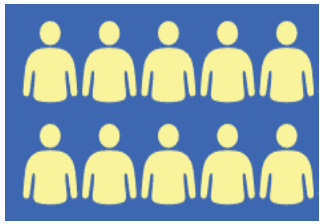
Voluntary, Community, and Social Enterprise (VCSE) organisations are essential to the planning of care and to supporting a greater shift towards prevention and self-care. They work closely with local communities and are our strategic partners in system transformation, innovation and integration. In NEL we benefit from an active VCSE Collaborative which aims to create the enabling infrastructure, support sustainability of our rich and diverse VCSE in NEL and ensure the contribution of the VCSE is valued equally. Our VCSE partners also play a key role within our Place-based Partnerships in finding solutions to local people's health and care needs, especially in its focus on wider determinants of health.

Social care plays a crucial role in improving the overall health and well-being of local people including those who are service users and patients in north east London. Social care promotes people's wellbeing and supports them to live independently, staying well and safe. It includes the provision of support to individuals who have difficulty carrying out their day-to-day activities due to physical, mental, or social limitations. Through this, social care services help to prevent hospital admissions and reduce the length of hospital stays. This is particularly important for elderly patients and those with chronic conditions who may require long-term social care support to maintain their independence and quality of life.

In north east London, we have a high percentage (75%) of elective patients discharged to a care home that have a length of stay that is over 20 days, which is considered a long stay in hospital. This compares to 33% for the median London ICS. We want to work with system partners in social care, health and the voluntary and community sector to learn from other ICSs and identify ways to shorten length of stay and improving quality of life for those affected.

The **work of local authorities more broadly, including their public health teams,** as well as education, housing and economic development, work to address the wider determinants of health such as poverty, social isolation and poor housing conditions. As described above, these are significant challenges in north east London, critical to addressing health and wellbeing outcomes and inequalities.

In our strategy engagement we heard of the desire to accelerate integration across all parts of our system to support better access, experience and outcomes for local people. We heard about the opportunities to support greater multidisciplinary working and training, the practical arrangements that need to be in place to support greater integration, including access to shared data, and the importance of creating a high trust and value-based environment which encourages and supports collaboration and integration.



There are **5,470 registered charities operating across north east London**, many either directly involved in health and care or in areas we know have a significant impact on the health and wellbeing of our local people. This includes organisations committed to reducing social isolation and loneliness, which is particularly important for people who are vulnerable and/or elderly.

Thousands of informal carers play a pivotal role in our communities across NEL, supporting family and friends in their care, including enabling them to live independently.

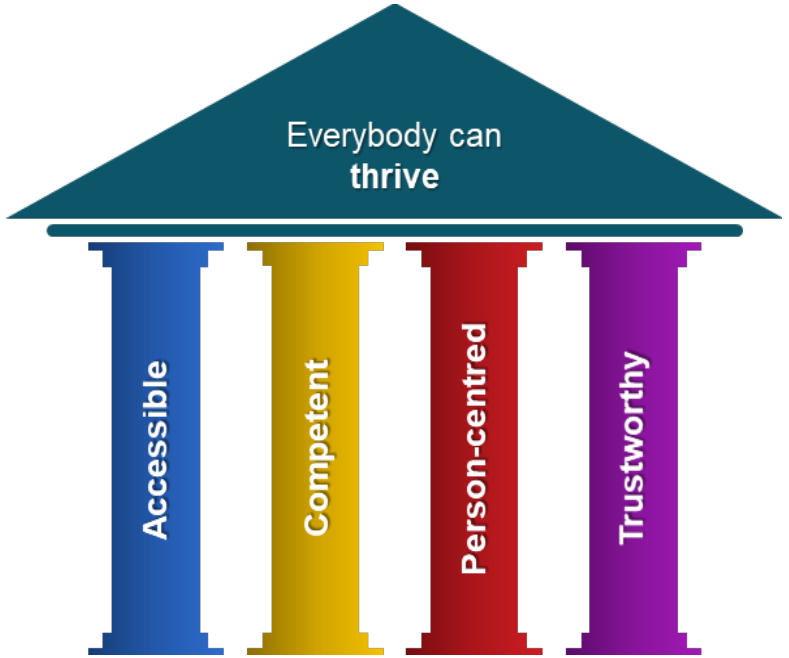
Listening and engaging with our residents across NEL about their health, care and wellbeing is essential to improving our services

We are committed to our '*Working with people and communities*' strategy, working with local people and those who use our services to identify priorities and the criteria against which we will monitor and evaluate our impact.

Over summer 2023 we engaged with around 2000 people in our 'Big Conversation' through an online survey, face to face community events and targeted focus groups including Turkish mothers in Hackney, South Asian men in Newham and Tower Hamlets, Black African and Caribbean men in Hackney, older people in the City of London, patients with Long Covid in Hackney, men in Barking and Dagenham, Deaf BSL users in Redbridge, young people in Barking and Dagenham and Pakistani women in Waltham Forest.

What we've heard people would like to see more of and what they believe makes a difference can be summarised as: **Good care.**

What does good care look like?



We will use these pillars to help us to understand whether we are making a difference to health and wellbeing outcomes.

What does good care mean?

Good Care is **Trustworthy:** • Listening to patients, honest and empathetic care • Follow-on, ongoing appointments • Reassurance, supported self-care • No gatekeeping • Anticipative, not just reactive care • Communication • Accountable care	Good Care is **Accessible:** • Availability of appointments • Affordable care • Improved booking systems • Adequate staffing • Convenient opening times • Accessibility – disabled patients • Convenient locations
Good Care is **Person-centered:** • Patient involvement in treatment options • Patients having a choice about where/how they access care • Shared medical records, consistency of care • Holistic approach to care • Continuity of care • Health and care services working with each other • Collaboration beyond health and care	Good Care is **Competent:** • High quality of care • Adequate staffing – skills and numbers • Services that know/understand specific conditions /medical needs • Services that know/understand patients' cultural and social needs • Evidence-based medicine • Prompt, efficient diagnosis process • Adequate funding, resourcing, facilities

We will continue to shape and design our programmes of work based on the insight from the big conversation and other engagement with our local people.

4. Our challenges and opportunities

The key challenges facing our health and care services

Partners in NEL are clear that we need a **radical new approach to how we work as an integrated care system** to tackle the challenges we face today as well as securing our sustainability for the future. Our Integrated Care Strategy highlights that a shift in focus upstream will be critical for improving the health of our population and tackling inequalities. The health of our population is at risk of worsening over time without more effective **prevention** and **closer working with partners** who directly or indirectly have a significant impact on healthcare and the health and wellbeing of local people, such as local authority partners and VCSE organisations.

Two of the most pressing and visible challenges our system faces today are the long waits for accessing **same day urgent care;** and a large backlog of patients waiting for **planned care**. Provision of urgent care in NEL is more resource intensive and expensive than it needs to be and the backlog for planned care, which grew substantially during Covid, is not yet coming down, as productivity levels are only just returning to pre-pandemic levels. Both challenges reflect pressures in other parts of the system and, in turn, impact other services.

The wider determinants of health are also a key issue, in particular rising levels of unemployment which during the pandemic rose to a peak of 79,600 before falling to 65,900. Currently 22% or 321,000 of our 16-64 population is classed as economically inactive. We have established work well programmes in partnership with all boroughs and across government departments to support people in to work.

We currently have a **blend of health and care provision for our population that is unaffordable**, with a significant underlying deficit across health and care providers. If we simply do more of the same, as our population grows, our financial position will worsen further and we will not be able to invest in the prevention we need to support the sustainability of our system.

To address these challenges and enable a greater focus upstream, it is necessary to focus on **improving primary and community care services**, as these are the first points of contact for patients and can help to prevent hospital admissions and reduce the burden on acute care services. This means investing in resources and infrastructure to support primary care providers, including better technology, training and development for healthcare professionals, and better integration of primary care with community services. In addition, there is a need for better management and **support for those with long-term conditions** (almost a third of our population in NEL). People with LTCs are often high users of healthcare services and may require complex and ongoing care. This can include initiatives such as care coordination, case management, and self-management support, which can help to improve the quality of care, prevent acute exacerbation of a condition and reduce costs.

Achieving this will require us to recruit and retain our workforce. This is a key challenge, with high numbers of vacancies across health and care roles in NEL, and an ageing population and high turnover of staff, and increasing numbers of staff reporting burnout, particularly since the Covid-19 pandemic.

The following slides describe these core challenges and potential opportunities in more detail. Where possible we have taken a population health approach, considering how our population uses the many different parts of our health and care system and why. More work is required to build this fuller picture (including through a linked dataset), as well as develop our population health outcomes-based approach to planning, commissioning and resource allocation, which forms part of our development work as a system.

We have high demand for people requiring urgent and emergency care

Key Challenges	*Detail*
Nationally demand for urgent and emergency care continues to grow post Covid-19. Across NEL we have planned for a 2% growth in UEC demand	• Patients are presenting with more complex conditions. • Since the pandemic the increase in complexity and acuity is having knock-on impacts across the urgent and emergency care pathway, this includes ambulance call-outs, ambulance handovers, A&E 4 hour performance and length of stays
Longer term trends point to an increasing need for health and care	Outside of the immediate challenges presented post pandemic we are facing a growth in demand due to: • population growth, • an ageing population, and; • greater numbers of people living with long term conditions.
Occupancy levels for our general and acute hospitals continues to be a challenge – especially during the winter	• High bed occupancy is a key driver for increased pressure across urgent and emergency care services. When our hospitals have high occupancy levels it is harder to identify beds for patients that need to be admitted. • Higher occupancy coupled with longer lengths of stay also results in challenges in discharging patients back into their own homes or their communities. Across NEL there is also the challenge in reducing the amount of hospital beds that are occupied at any one time by patients that are medically fit for discharge.
Increasing demand and length of stay on emergency mental health services	• Long waits for people with mental health needs in A&E are increasing. There continues to be significant demand from mental health attendances in A&E, with hospitals seeing an increase in the complexity and acuity of patients which leads to increased wait times and length of stay. Initiatives continue to be implemented to reduce these waits through delivery of mental health inpatient and community services

We have a large backlog of people waiting for planned care

Key Challenges	*Detail*
Demand for elective care continues to grow, adding to the significant existing backlog	• Demand for planned care is expected to continue growing between 2024/25 and 2027/28. • Referral demand (all sources) in 23/24 has been higher than the prior year, although this growth is not equitably split across NEL • As at January 2024, there are around 215,000 people waiting for elective care
Activity levels have continued to vary week on week. We have seen some improvement in our waiting list position in the latter part of the year, but this remains higher than last year	• Activity levels vary throughout the year, with industrial action a key factor in 2023/24. • Our waiting list position increased from 205k to 215k (April 23 to Jan 24) with the majority of this growth occurring between April to August. Since then the waiting list has been on a reducing trajectory
There are other factors impacting the delivery of elective care	• Recent and potentially further industrial (strike) action has meant that many appointments and treatment pathways have been impacted. Nationally this has led to reductions in the national elective recovery activity target.
Tackling the elective backlog is a long-term goal and will require continuous improvements to be made	• Reducing the elective backlog will require a joint effort across all our partner organisations in order to tackle the challenge. As we evolve as a system partnership we will be able to explore new ways of working between providers that will better utilise our collective elective care capacity.
There may be opportunities for improvements in elective care, particularly around LOS	• A benchmarking analysis of NEL against other London ICSs and England, indicated we have higher median LOS for elective admissions. Understanding these differences and adopting best practice from other ICSs may contribute to improvements.

We need to expand and improve primary care, including improving the way care is coordinated

- Over the year to September 2023, booked general practice appointments across NEL increased by about a third to over 11 million appointments (two thirds face to face and 77% within a week). NEL is 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.

- 47% of appointments were delivered by other professionals such as nurses and 44% of all appointments were seen on the same day as they were booked*. This figure includes both planned and reactive care. 57% of appointments were patient-initiated contacts, booked and seen on the same day.***

- There is wide variation in the number of delivered appointments or average clinical care encounters per week in NEL. For 2022/23 this ranged from 93.56 per 1000 (weighted registered) patients in Tower Hamlets, to 68.01 per 1000 (weighted registered) patients in Havering. The NEL average is 77.78 per 1000 (weighted registered) patients.**

- We are developing processes and technology to streamline patient access to the most appropriate type of appointment and advice, with clear signposting, for health care professionals and local people to ensure they are directed to the full range of services available at Practice and Place, in and out of general practice hours.

- Without substantial increases in primary care staffing the GP to patient ratio will worsen as demand for primary care increases in line with projected population growth. There are pockets of workforce shortages with significant variation in approaches to training, education and recruitment. We are focusing upon initiatives to keep our staff, such as mentoring and portfolio careers, having developed SPIN (specialised Portfolio innovation) which is the basis for the national fellowship programme which we are offering to GPs and other professional groups.

- There are opportunities to build on our best practice to further develop integrated neighbourhood teams, based on MDTs, social prescribing and use of community pharmacy consultation services, which will strengthen both our continuity of care of long term conditions and our ability to work preventatively.

Primary Care Networks (PCNs)

- Primary networks bring together GPs and other primary care professionals in small local areas to work together. They will work with new Integrated Neighbourhood Teams (INTs) to deliver joined up care based on individual and local needs.

- PCNs will be used to improve access, focus on preventative interventions, support personalised care, health education and harness wider community services through collaboration and navigation.

- PCNs will involve practices and federations, social care, community health services, mental health survives, pharmacy, care homes and links to hospitals and voluntary/community organisations.

Source(s):
*GPAD , **Discovery, ***Edenbridge APEX

Develop and build upon our community care resources

- Community has had no additional national funding to support post covid-19 and since the pandemic demand has increased creating further challenge. In NEL, the community health spend is over £465m across a variety of services spanning primary care, four core provider trusts and over 66 other providers

- Our Community offers and models vary due to legacy commissioning and differing resource allocation, resulting in some fragmentation and inequity of provision. NEL ICS is doing work to better understand the impact this has on patient outcomes and variability of access across our 7 PLACEs; exploring opportunities to tackle these issues and make changes. An example of this variance can be seen in pulmonary rehab services where we know there is difference in service inclusion criteria and staffing models. Waiting times also range between 35 and 172 days, with completion rates between 36% and 72% across our boroughs and services.

- Babies Children and Young people make up over 25% of our population and if we do not invest in their health and care it will significantly impact their life outcomes. This will also place further pressure across health, social care, education and criminal justice services. Our children and young people community service waiting lists are extremely pressured and the list is higher when compared to other systems. There are also a number of young people who are waiting in excess of 52 weeks for a first appointment with a community paediatrician.

- Our adult waiting lists have particular challenges including significant demands upon MSK pathways, SALT, podiatry and dietetics.

- Community services are the key to supporting and enabling people to remain at home. They are also a key system enabler, supporting resilience and reducing pressures across UEC, ambulance services and social care but this opportunity can only be realised with a significant system resource shift from crisis and acute pathways to preventative, primary care and community pathways..

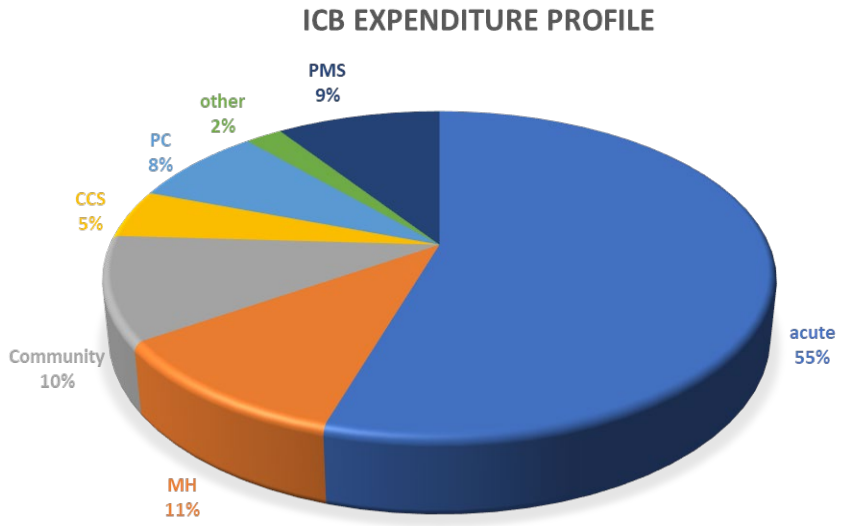
- There are opportunities to join up a range of initiatives across UEC, CHS and Place under our approach to virtual care, admission avoidance and supporting discharge (including virtual wards, rapid response, community beds, proactive care). This will involve looking at further integration and harmonising our core offer across a range of providers.

- Ensuring alignment of our emerging Integrated Neighbourhood teams and community offers for adults and babies, children and young people is a key element in supporting collaboration in relation to community nursing and social care

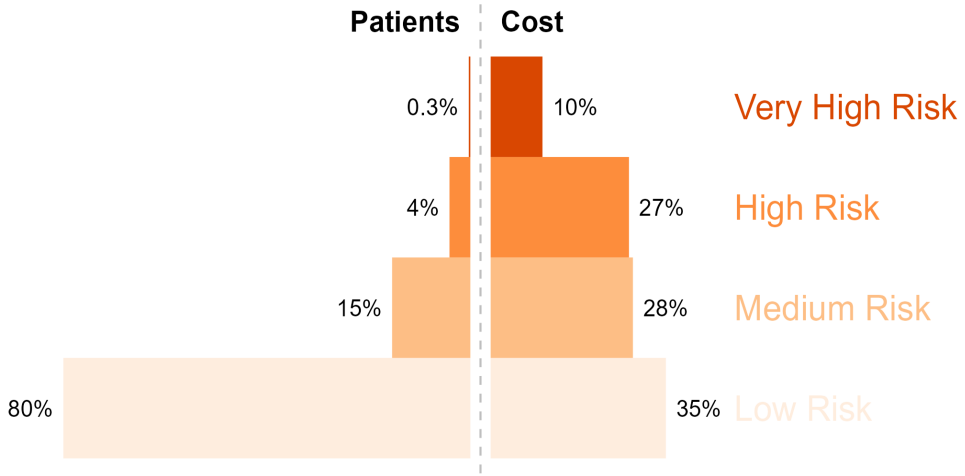
- The community collaborative are establishing numerous Improvement Networks using a partnership approach involving residents, carers and our clinicians to bring together best practice, drive change and implement innovation. This approach will ensure equitable and consistent pathways are delivered which are tailored to meet local population needs in a sustainable way.

We need to move away from the current blend of care provision which is unaffordable

- The NEL system has a significant underlying financial deficit, held within the Trusts and the ICB, estimated to be in excess of £200m. This is driven by a variety of factors including unfunded cost pressures.
- Current plans to improve the financial position, such as productivity/cost improvement programmes within the Trusts, are expected to close some of this financial gap and we know there are opportunities for reducing unnecessary costs, such as agency spend. The system is also looking at a range of further measures designed to improve the underlying run rate.
- In addition to a financial gap for the system overall, there are discrepancies between how much is spent (taking into account a needs-weighted population) across our Places, in particular with regard to the proportion spent on out of hospital care.
- The system received a capital budget of £95m in 2023/24, significantly less than other London ICSs (which receive between £130m-£233m) and comparable to systems with populations half the size of NEL*. This puts significant pressure on the system and its ability to transform services, as well as maintain quality estate. In 24/25 the estimated capital budget is circa £80m.
- There is huge variation in the public health grant received by each of NEL's local authorities from central government. The variation is at odds with the government's intended formula (which is based on SMR<75) and is the result of grants largely being based on historical public health spend. This impacts on our ability to invest upstream in preventative services.
- As a system the majority of our spend is on more acute care and we know that this is driven by particular populations (0.3% of the population account for 10% of costs associated with emergency admissions; just under 20% account for 65%).
- We now have an opportunity as a system to improve the outcomes of our local people by concentrating on population health needs, and therefore focusing more of our investments on prevention and securing greater equity for our residents. We intend to do this by focusing on what improvements in outcomes that are needed and allocating resources towards those outcomes.



Risk stratified cost of emergency admissions



Percentage of emergency admission cost and patients attributable to risk bands for expected risk of admission for patients registered with a NEL GP in February 2023. Combined Predictive Model run on NEL SUS data estimates risk of admission. Cost of all emergency admissions to patients in each risk band in FY22/23 to January 2023 extracted from SUS. Patients with no risk score have been excluded from the analysis but follow a similar pattern to the low risk group. Data from NEL data warehouse

* Capital figures are based on 2022/23. Norfolk and Waveney ICB received £98.5m capital in 22/23 and has a population of 1.1m people

We are further developing opportunities for research and innovation

We are actively growing our research and innovation architecture to ensure we can deliver better outcomes for our growing population as well as enabling greater value for money and sustainability as a system.

Our emerging research and innovation strategy will support our learning system ethos and align with the plans developed for research by our Place and Provider Collaborative teams. We will build on the existing research infrastructure and expertise across NEL and expand the opportunities for local people and health and care professionals to be involved in research. We have three emerging objectives of the strategy:

A. Supporting relevant, local research activity
B. Setting the direction and attracting relevant local research and innovation
C. Developing a system and the partnerships that enable evidence-informed decision making and quality improvement

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

A local and national asset it will bring infrastructure and researchers to work alongside businesses and entrepreneurs. Aiming to be world leading in prevention, prediction & precision.

- 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 economic impact

Innovation is also 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 life science developments in Whitechapel and a partnership with the national Dementia Research Institute to support our centre of excellence for older people at East Ham.

5. How we are transforming the way we work

Across the system we are transforming how we work, enhancing productivity and shifting to a greater focus on prevention and earlier intervention

- The previous section set out the challenges that the north east London health and care system needs to address to succeed in its mission to create meaningful improvements in health and wellbeing for all local people.
- This next section summarises our portfolio of transformation programmes, which have evolved organically over many years: rooted in the legacy CCGs and sub-systems, then across the system through the North East London Commissioning Alliance and the single CCG, and now supplemented by programmes being led by our place partnerships, provider collaboratives and NHS NEL.
- These transformation programmes have not previously been shaped or managed as a single portfolio. In aligning them to a single system integrated care strategy we hope to being greater clarity and coherence, as well as create opportunites for connecting and accelerating our work.
- This section sets out how partners across north east London are responding to the challenges described in the previous section. It describes how they are contributing to our system priorities by considering five categories of improvement outlined below.

1. Our core objectives of high-quality care and a sustainable system

2. Our NEL strategic priorities

3. Our supporting infrastructure

4. Place based Partnerships priorities x7

5. Our cross-cutting programmes

Urgent and emergency care

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:

- Develop a consistent community services offer across NEL
- Improving population health and outcomes, working closely with residents
- Supporting neighbourhoods and PLACEs to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Supporting wider system pressures by maximising CHS opportunities (i.e LAS call outs, UEC attendances, unplanned care, LA residential care pressures)

Key stakeholders:

Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission

The work within the portfolio is mapped against our strategy goals and four outcomes. **1) strengthening provision and access to alternative pathways, 2) optimising flow through hospitals, 3) using population health management to keep people well in the community and 4) setting up governance and pathways to form system wide sustainable plans**.

There are a range of projects to deliver on these outcomes that have been divided into directly managed by UEC portfolio and those sitting in other portfolios.

UEC directly managed – 111 procurement and development, hospital flow, ambulance flow, system co-ordination centre, urgent treatment centres, virtual wards and winter planning.

Other delivery areas such as same day access, urgent community response, mental health pathways and planned care sit in other portfolios but will be monitored and reported to the UEC Board.

Additionally establishing the NEL UEC PMO and governance will provide infrastructure to deliver a measurable impact.

Details of engagement with places, collaboratives and other ICB portfolios

One to ones throughout the summer to understand local strategies and plans to build up the NEL UEC portfolio. Work underway to propose new ways of working and governance structures. Collaboration will be at the heart of the portfolio.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:

- System co-ordination centre set up in line with specification - April 2026
- Reduction in delayed discharges and improvements to A&E performance
- Elimination of ambulance handover waits over 45 minutes - April 2027
- 111 provider working to a new specification following procurement process
- Expansion and coordination of virtual wards beds

Engagement with the public:

Engagement activities have taken plan at Place and Trust level which has informed plans and communications – to date there have been NEL UEC patient engagement activities

Community Health Services

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:

- Develop a consistent community services offer across NEL (new core offer and nursing model)
- Supporting neighbourhoods and PLACEs to enable people to stay well and independent, for as long as possible, wherever they call home
- Creating wider system value by unlocking system productivity gains i.e. reduction of hospital admissions
- Using evidence to understand the totality of services, outcomes and resources across NEL, identifying opportunities for improved outcomes
- Create and facilitate collaborative partnerships with system partners including local authorities, primary care, health providers, and the independent voluntary and charitable sector
- Improve resource allocations for residents ensuring taxpayers get better value for money
- Supporting wider system pressures by maximising Community Health Services (CHS) opportunities (i.e. LAS call outs, UEC attendances, unplanned care, LA residential care pressures)
- Continuous Improvement of population health and care outcomes working closely with stakeholders and residents

Key programmes of work that will deliver the vision and mission

- Leading a joint approach to Planning for the first time across NEL and continuing to promote and embed the process of joint working
- Developing and evolving Improvement Networks, bringing together subject matter experts with clinical leads and residents creating a conducive environment to design best practice pathways and consistent offers across NEL. For example NEL are establishing Improvement networks for MSK, Babies, children & young people (BCYP) with neuro diverse needs, BCYP SALT and Rapid Response.
- Improvement Networks will also support our broader community nursing offer for adults and BCYP
- Working with PLACES to ensure Integrated Neighbourhood teams maximise opportunities for integration (e.g. building on the work of Child health hubs)
- Increasing capacity and support to UEC pressures by bringing together pathways and opportunities across virtual wards, rapid response teams, community beds and proactive care
- Redesigning priority and pressured pathways with residents and stakeholders, for example within MSK and SALT.
- Implementing digital transformation across large and smaller CHS to improve service provision i.e. management of UCR 111 calls
- Leading the approach to contractual best value jointly with PLACE colleagues, maximising productivity, best value and consistent CHS offers that are reflected in revised contracts
- Focused work on understanding current and future population needs across NEL and at PLACE, including demand, capacity, productivity, user and carer experience and outcomes.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Consistent pathways and models for CHS in development minimising variances in outcomes and experience
- Maximising opportunities to integrate and avoid duplication
- Improved outcomes for residents including better access to quality services in the community / close to home or at home

Key stakeholders:

- Residents
- 7 PLACEs / Boroughs
- ELFT
- NELFT
- Homerton
- Barts
- 65+ bespoke providers/ Provider Network
- Clinicians

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- Joint planning sessions since Nov 2023 (45+ people across PLACEs and providers)
- Regular engagement with PLACE directors and Provider operational leads
- Joint working across collaboratives and programmes such as UEC , LTC, BCYP, MHLDA , Planned care (i.e the approach to Virtual care, joint MSK approach with Planned care)

Engagement with the public:

- Patient engagement at an early stage but conversations with Patient experience leads occurred in 2023 to utilise existing forums
- Additional programme/collaborative capacity April 24 will enable a focused approach to engagement across all Improvement networks as they develop

Primary care

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:
Our vision is for north east London to be a place where you can access consistent high-quality primary care, from a dedicated, motivated and multi-skilled workforce enabling local people to live their healthiest lives.
The aim of our portfolio is to deliver on ambitious plans to transform primary care, offering patients with diverse needs a wider choice of personalised, digital-first health services through collaboration with partners across the health and social care and communities. National and local plans place a focus on improving access, prevention, personalisation, tackling inequalities and building trusting environments.
Our local challenges include population growth, deprivation, exacerbating poor physical and mental health and workforce retention and development and a financial challenge urging cost effectiveness and efficiency.

Key stakeholders:
Place, PCNs, practices, pharmacy, Acute, Community and mental health collaboratives and Urgent and emergency care services. Healthwatch and patient groups.

Key programmes of work that will deliver the vision and mission

- There are a range of programme that make up the primary care portfolio to ensure the delivery of our goals.
- Empowering patients - supporting patients to manage own health, stay healthy and access services. Improving access - providing a range of services and assistance to respond to patient needs in a timely manner. Modernising primary care - developing new and digital tools to support highly responsive quality care. Building the workforce - staff recruitment, retainment and develop plans in place to improve job satisfaction and flexibility. Working smarter - reduced workload across primary/secondary services and improvements to sustainable and efficient ways of working. Optimising enablers - estate, workforce and communication plans to support the implementation of our goals.
- Integrated Neighbourhood Teams (INT) are pivotal to transforming Primary Care and will be delivered through work responding to the Fuller recommendations. **A framework** will offer a streamlined approach for the delivery by integrating Primary Care, including Pharmacy, Optometry and Dentistry, alongside wider health care, social care and voluntary sector organisations. INTs will facilitate care, through 'teams of teams' approach enabling **continuity of care**. These teams will also be instrumental in broadening the availability of care, providing **extended in and out-of-hours services,** including urgent care. A **single point of contact through advanced cloud-based telephony systems** will streamline access to care, while **improved signage and navigation** will guide patients to the right services.
- The Fuller initiatives are accompanied by other enabling programmes. **People**, will bolster the **capacity of the ARRS roles**, **establish training and development opportunities**, and **determine the ideal workforce** for INTs. Infrastructure, including, Estates and Data will align current plans to INT requirements, as well as **Digital First** which aims to improve digital access (including remote consultation), NHS App usage, improving practice efficiency and increasing competence to use digital tools.
- Wider programmes which are fully or partly delivered through primary care providers, include, **Pharmacy,** enhancing the role of the community pharmacy to improve access and patient self-management, **Long Term Conditions (LTCs),** including a range of interventions such as case-finding, annual or post-exacerbation reviews for targeted patients, as well as programmes that sit in other collaboratives such as **Personalisation** and **Vaccinations**. Other transformational projects to improve dental and optometry services will be developed in the future as their provider groups mature.

Details of engagement undertaken with places, collaboratives and other ICB portfolios
A number on workshops with collaboratives, places and the UEC/ LTC / digital / workforce programmes.
The portfolio is overseen by a lead for UEC portfolio to strengthen interplay. Working in conjunction with other portfolios is a key improvement area following the deep dive in October
Webinars held for PCNs to promote digital tools.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

April 2025:
•Same day handling of all calls to practices
•All practices transferred to cloud based telephony
•Improvements to NHS app and practices websites and e-Hubs
•All practices offering core and enhanced care for people with LTCs
•Additional services from community pharmacies
•All Places have INTs established for at least one patient cohort

April 2026:
•All practices will be CQC rated as GOOD or have action plans to achieve this further equalisation of enhanced services.

April 2028:
•Streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact

Engagement with the public:
Enhanced access engagement exercise with practices in 2022.
London wide digital tools engagement involved NEL residents. Fuller programme plans to engage on the SDA vision

Planned care

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:

- The aim of the programme is 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
- This will be delivered through an integrated system approach to improving equity of access to planned care for the people of North East London by focusing on 3 primary drivers – managing demand, optimising capacity & creating new capacity.
- The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing out of hospital services, outpatients, diagnostics and surgery.
- The planned care portfolio consists of three significant programmes of work – outpatient & out of hospital transformation; diagnostic recovery & transformation and surgical optimisation. The activities and interventions undertaken with these programmes are designed to improve the management of demand, optimise existing capacity and support and enable the creation of new capacity

Key stakeholders:

- Trusts
- APC
- ICB
- Place Based Partnerships
- Primary Care Collaborative including PCNs
- Community Care Collaborative
- Independent Sector Providers – acute and community
- Clinical and operational teams across all acute Trusts

Key programmes of work that will deliver the vision and mission

The portfolio of planned care recovery & transformation work spans the elective care pathway from pre-referral to treatment encompassing;

- **Outpatients and out of hospital services** - 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
- **Diagnostics -** 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, pathways
- **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.

Details of engagement undertaken with places, collaboratives and other ICB portfolios

The planned care recovery & transformation programme is an integrated system programme with system wide engagement at its heart. Priorities, governance and delivery structures have been created over the last 2 years with primary care, the ICB, PBP and acute providers.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

In NEL, this will mean delivering reduction in waiting times and reducing the variation in access that exists. Key benefits include;

- Reduce variation in service provision and improve equity of access
- Improve referral pathways. Enable patients to get the right service at the right time
- Improve patient accessibility to diagnostics, in order to; reduce pressures on primary and unplanned care, reduce waiting times, reduce steps in patient pathway, reduce follow-up activity; reduce non-admitted PTL, improved utilisation of imaging capacity
- Increase surgical activity at all sites, avoid wasted capacity, enable patients to be offered surgery at sites with shortest wait

Engagement with the public:

The national elective recovery plan has been developed with widespread public engagement. Our programme reflects these priorities, which are adapted to meet the needs of our local population.

Cancer

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:
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 that everyone has equal access to better cancer services so that we can help to: - Prevent cancer, Spot cancer sooner, Provide the right treatment at the right time, Support people and families affected by cancer
Drivers:
Our work enables the ICB to achieve its objectives, as set out in the 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

Key stakeholders:
- Patient and Carers
- Providers, Partners, PLACE
- Cancer board
- APC Board and National / Regional Cancer Board

Key programmes of work that will deliver the vision and mission
- The programme consists of projects to improve diagnosis, treatment and personalised care.
- Key milestones to be delivered by March 2025 and 2026 include:
    - Deliver BPTP milestones in suspected prostate, lower GI, skin and breast cancer pathways:
    - Delivering the operational plan agreed for 28d FDS, combined 31d treatment and 62d cancer standards.
    - Deliver 100% population coverage for Non-Specific Symptoms (NSS) pathways.
    - Ensure sustainable commissioning arrangements for NSS pathways are in place for 2024/25
    - TLHCs provided in 3 boroughs with an agreed plan for expansion for all boroughs by 2025.
    - Develop and deliver coproduced quality improvement action plans to improve experience of care.
    - Support the extension of the GRAIL interim implementation pilot into NEL.
    - Ensure all patients are offered the personalised care package with equal access to psychological support, pre-habilitation and rehabilitation services.
    - Personalised stratified pathways can reduce outpatient attendance and allow patients to be monitored remotely reducing the need to attend clinics.
    - Improve the quality of life and support patients need to live beyond cancer.

Details of engagement undertaken with places, collaboratives and other ICB portfolios
- WWeekly APG Operational delivery meeting
- Tumour specific Experts Reference Group (ERG)
- Project Delivery Groups (PDG)
- Cancer board – internal assurance
- Programme Executive Board – NEL operational delivery
- APC Board, CAB and National / Regional Cancer Board

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

2025/26:
- Access to Targeted Lung Health Check service for 40% of the eligible population
- Invitation for up to 45,000 people into the GRAIL pilot
- Continued mainstreaming as part of the Lynch Syndrome pathway
- Improved quality of life and experience of care.

2027/28
- Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
- Improved uptake of cancer screening
- Every person in NEL receives personalised care and support from cancer diagnosis

Engagement with the public:
- Patient Reference groups
- Campaign workshops

Maternity

1. Our core objectives of high-quality care and a sustainable system

Portfolio vision, mission and key drivers:
The 3 year delivery plan for maternity and neonatal services: 2023-2026. This has consolidated the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. The expectations on Local Maternity and Neonatal Systems are that they focus on the following areas;

- Listening to, and working with, women and families with compassion
- Growing, retaining, and supporting our workforce
- Developing a Culture of safety, learning and support
- Standards and structures that underpin safer, more personalised and more equitable care

Key stakeholders:
All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Key programmes of work that will deliver the vision and mission

- Pelvic Health Service: All women experiencing urinary incontinence to be able to access postnatal physiotherapy up to 1 year post delivery
- Increased breastfeeding rates, especially amongst babies born to women from black and minority ethnic groups or those living in the most deprived areas.
- Midwifery Continuity Care, prioritising the provision to women from Black and minority ethnic (BAME) groups who will benefit from enhanced models of care.
- Perinatal Optimisation Programme:
- Develop pathways to manage abnormally invasive placenta across NEL
- Demand and capacity review across the whole of NEL
- Workforce and Development Projects

Details of engagement with places, collaboratives and other ICB portfolios
All LMNS and APC board Stakeholders (PBC, LA, Trusts, MNVPs- service users, Third sector organisations) Regional Maternity Transformation Team, Chief Midwife Office, ICB BCYP, Public Health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- By reducing stillbirth, maternal mortality, neonatal mortality, and serious brain injury in women and babies from BAME groups and women from deprived areas. National ambition to reduce by 50% by 2025
- By closely aligning maternity and neonatal care to deliver the best outcomes for women and their babies who need specialised care by achieving <27 weeks IUT.
- By improving personalised care for women with heightened risk of pre-term birth, including for younger mothers and those from BAME groups and deprived backgrounds
- By ensuring that all providers have full baby-friendly accreditation and that support is available to those who are from BAME groups and/or living in deprived areas who wish to breastfeed their babies
- Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Engagement with the public:
EMNVPs, Third Sector organisations and communities identified in the E&E LMNS report.

Babies, children and young people

2. Our NEL strategic priorities

Portfolio vision, mission and key drivers:
Vision: To provide the best start in life for the babies, children and young people of North East London.
Mission: The BCYP Programme aims to reduce unwarranted variation and inequality in health and care outcomes, increase access to services and improve the experience of babies, children, young people, families and carers and strengthen system resilience.
Through strong working relationships across health and social care partners, we will increase collaboration, enhance partnership working and innovation, share best clinical and professional practices with each other and deliver high quality services.
Drivers: NEL Integrated Care Strategy, NHS Priorities and Operational Planning Guidance, NHS Long Term Plan, Ongoing impact of COVID-19 pandemic, Royal College of Paediatrics and Child Health – State of Child Health, Academy of Medical Royal Colleges – Prevention is better than cure and NHS England (London Region) Children and Young People's mandated requirements.

Key stakeholders:
ICB Executive, BCYP SRO,
Place Directors; Collaborative/ Programme Directors; Provider Directors; GP CYP Clinical Leads;
Directors of Children's Social Care; Designated Clinical/Medical Officers; NHSE (London) CYP Team; North Thames Paediatric Network; Safeguarding Team; Parent Forums

Key programmes of work that will deliver the vision and mission
Acute care - priorities are CYP elective care recovery, diabetes, allergy and addressing urgent and emergency care priorities for BCYP.
Community-based care -priorities are local integrated care child health pilots, increasing capacity (including 7 day access to children's community nursing and hospital@home), improving children's community service waiting times;
National/regional mandated priorities including long term conditions;
Primary care – priorities are BCYP unregistered with a GP, YP access to integrated health hubs; 'You're Welcome standards and Child Health training curriculum;
Special Education Needs and Disabilities (SEND) - SEND Inspection Readiness Group to ensure Places and ICB are prepared for new Ofsted Inspection framework and are meeting NHSE requirements. Focus Areas – Autism and Diagnostic pathways and Pre and Post offers of support for families.
Special cohorts including Child Sexual Abuse (CSA) hub, looked after children and care experienced young people.

Details of engagement with places, collaboratives and other ICB portfolios
Acute, community, mental health/learning disabilities and autism and primary care collaboratives. LTC and UEC Programmes.
Places via NEL BCYP Delivery Group

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Care is delivered closer to home as our children, young people, their families and carers have requested;
- Enhanced quality of care for BCYP with asthma, diabetes and epilepsy;
- Improved access to primary and integrated care for BCYP via integrated health hubs;
- CYP with SEND will receive integrated support across education, health and care and reduced waiting times for SLT and autism;
- Prescription poverty for our care leavers will be tackled.
- Reduce the impact of child sexual abuse through improved prevention and better response.

Engagement with the public:
Via Providers.
SEND Parent's Forum
National Voices

Long Term Conditions

2. Our NEL strategic priorities

Portfolio vision, mission and key drivers:
Our vision - 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, and support communities to prevent LTC onset or progression
Mission - Listening to communities to understand how we can support patients in managing their own conditions

- Reduce working in silos and embed a holistic approach to LTCs
- Reduce unwarranted variation and inequality in health and care outcomes
- Increase access to services and improve the experience
- Working partners to prevent residents from developing more than one LTC through early identification of risk factors
- To ensure there are appropriate interventions and services that support a patient in preventing or managing an exacerbation of their condition
- Keep hospital stay short and only when needed
- To ensure we effectively plan and provide services that are value for money

Key drivers – Long-term conditions have a national and regional focus as a core component of the Long Term Plan, with attention on Cardiovascular disease, stroke, diabetes, and respiratory. LTCs are entwined with us to address inequalities, and we support projects such as Core25Plus and Innovation for Healthcare Inequalities Programme. Furthermore: Long-term conditions (LTCs) is 1 of NEL's 4 System Priorities for improving quality and outcomes and tackling health inequalities. This is reflected in Place-based priorities which all have identified one or more LTCs. Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places (in Havering, the figure is 33%, vs 23% in Newham and Tower Hamlets). NEL is the highest performing ICB in England for many outcomes related to CVD, stroke, and renal, but local social demographics put the system at risk of continued growth in demand. Nationally, long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days. The most deprived areas, people acquired three or more conditions (complex multimorbidity) when they were 7 years younger, compared with the least deprived.

Key programmes of work that will deliver the vision and mission
Primary LTC prevention & Early identification: Social determinants of health (SDOH) impact 80% of health outcomes from chronic disorders and across NEL we have areas of significant deprivation which is linked with increased prevalence of long-term health conditions and lower life expectancy. We want to work with our local population to empowering and enabling people to manage their own health and engage in healthy behaviours across their lives, so they don't develop a LTC.
Secondary prevention and avoiding complication: DH data has demonstrated that 9 out of 10 strokes could be prevented and up to 80% of premature CVD deaths are preventable, if risk factors could be controlled. Working with social communities, and ensuring we provided person focused early identification, secondary care and avoiding complication enables us to improve outcome and reduce exacerbation of an LTC
Co-ordinated care and equability of service: Across NEL, one in four (over 600 thousand people) have at least one long-term condition, with significant variation between our places. The feedback from the Big Conversation reflects the need to join-up care and move forwards person focused approach. Working with colleagues at place we aim to continue to review current provision and reduce unwarranted variation in care across the pathway, with an aim of improving health outcomes
Enabling people to live well with a LTC and tertiary prevention: The effective support and management of LTC will increasingly require the management of complexity, and moving away from a single condition approach. In NEL 3 in 5 patients with a diagnosed long term condition have only one condition, the other 2 in 5 have multiple co-morbidities, of which diabetes and hypertension were most common

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
Work toward national targets including: Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation. Improve detection of undiagnosed hypertension and ensure those with hypertension are controlled to target – by 2029 80% of expected numbers with hypertension are detected and 80% of people with high blood pressure are treated to target. Improve access to and uptake of Cardiac Rehabilitation (CR) – by 2029 85% of eligible patients are accessing CR. Reduction of type 2 diagnoses / delayed onset in residents developing Type 2 (T2) diabetes delivered through an increase the number of people referred and starting the National Diabetes Prevention Programme (DPP) 45% of eligible populations). Symptoms of Transient Ischaemic Attack will have access 7 days a week to stroke professionals who can provide specialist assessment and treatment within 24 hours of symptom onset thus preventing long term disability

Key stakeholders:
Residents and communities, Place based teams, Regional and National colleagues, Organisation Delivery Networks, Voluntary organisations, Specialised Services, Pharmacy and Medicine Optimisation, Primary care, Babies, Children and Young People, Communities services, Community collaborative, Planned care, Acute Provider Collaborative, Mental health programme and collaborative, Urgent Care programme, BI and insights, Communication and engagement, Contracting and finance

Details of engagement undertaken with places, collaboratives and other ICB portfolios
Places – working with Heads of Live well across the 7 places who are responsible for LTCs
Clinical/improvement Networks – wider engagement with trusts, community providers, pharmacy, primary care and place
Organisation Delivery Networks (renal and CVD/cardiology)
Other programme directors including specialised service, community, mental health, BYCP.

Engagement with the public:
The big conversation which consists of 56 focus groups, 430 attendees of key community events and local survey focused on LTCs and the outputs are incorporated into priorisation for 24/25.
Furthermore, we have incorporated feedback at service level such PR and diabetes

Mental Health, Learning Disabilities and Autism

2. Our NEL strategic priorities

Portfolio vision, mission and key drivers:
The aim of the Mental Health, Learning Disability and Autism Collaborative is to work together to improve outcomes, quality, value and equity for people with, or at risk of, mental health problems and/or learning disability and autism in North East London. We do this by putting what matters to service users and their families front and centre of everything we do.

The service user and carer priorities that represent our key drivers include:
- Improving peoples' experience of accessing mental health services, including their first contact with services, and ensuring equity of access
- Children and young people can access different support from different people, including those with lived experience, when and where they need it
- People with a learning disability have the support they need and a good experience of care, no matter where they live

Key stakeholders:
NHS North East London, East London NHS Foundation Trust, North East London NHS Foundation Trust, local authorities, primary care, voluntary, community and social enterprise sector organisations, service users, carers & residents

Key programmes of work that will deliver the vision and mission
- Investing in and developing lived experience leadership across the MHLDA Collaborative so that experts by experience are active and equal partners in leading improvement and innovation across mental health, learning disability and neuro-developmental services
- Continuing the work led by our children and young peoples' mental health improvement network to reduce unwarranted variation across boroughs, and to do more of what works to reduce self-harm and improve outcomes for young people
- Accelerate the work of our talking therapies improvement network to improve access, and continue to transform and improve community mental health services, with a particular focus on improving equity of access for minoritised groups and people with neurodevelopmental needs
- Continue our focus on improving mental health crisis services and alternatives to admission - while also working to ensure that quality inpatient services are available for those who need them - making sure that people get the right support, at the right time, and in the right place
- Working to develop core standards for community learning disability services, with a view to reducing unwarranted variation between boroughs, and sharing good practice to support our specialist workforce better

Details of engagement with places, collaboratives and other ICB portfolios
Place based priorities for mental health are the cornerstone of our plans. We also connect closely with the Acute Provider Collaborative on mental health support in emergency departments and form part of their programme governance on UEC. We also have strong links into the BCYP programme and community health.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Improved access, outcomes and experience of NHS Talking Therapies for minoritised communities and other under-served populations
- Improved system-wide response to children and young people presenting with self-harm through the introduction of new evidence-based interventions, including better support to teachers, GPs and parents
- Improved offer of pre-diagnostic, diagnostic and post-diagnostic support for people with neurodevelopmental support needs
- Greater equity in the community learning disability support offer across boroughs
- Improved inpatient services with lower lengths of stay, and better options of high-quality supported housing / residential care for those who need it
- Widespread adoption of personalised and person-centred care planning processes with an emphasis on continuity of care and biopsychosocial assessment

Engagement with the public:
Our Lived Experience Leadership arrangements ensure we are continually engaging with children and young people, adults with mental health needs and people with learning disabilities and their families, and coproducing our work with service users

Employment and Workforce

2. Our NEL strategic priorities

Portfolio vision, mission and key drivers:

- Our vision is to create a transformational and flexible “One Workforce for NEL Health and Social Care” that reflects the diverse NEL communities and meets our system priorities.
- The mission focuses on developing a sustainable and motivated workforce, equipped with the right skills, competencies, and values, to improve the overall socio-economic outcomes of our NEL populations.
- The key drivers are responding to population growth and increasing demand, and developing meaningful and rewarding careers within health and social care services for local residents.

Key stakeholders:

- Provider CPOs
- People Board
- Place Directors
- Staff
- Local Authorities
- Care Sector

Key programmes of work that will deliver the vision and mission

- **System Workforce Productivity:** Continuing to address NEL’s difficult financial position through urgent investigation of workforce productivity drivers and implementation of productivity improvement initiatives.
- **System Strategic Workforce Planning:** Development of a strategic workforce planning function with the capacity, capability and digital enablers to provide the enable evidence-based decisions to ensure the long-term sustainability of the NEL Health and Social Care workforce. With the ultimate aim of developing of a system-wide health and social care workforce database and an integrated workforce planning system.
- **System Anti Racist Programme:** Embedding inclusive, anti-racist and empowering cultures across the system.
- **System wide scaling up and corporate services:** Identification of corporate services with scope for rationalisation. Streamlining operations, improving efficiency, standardising approach and reducing costs.
- **NEL Health Hub Project Programme:** Connecting local health and social care employers with colleges for employment opportunities. . Healthcare part is in partnership with Newham College and London Ambulance service and funded by GLA until March 2024. Social Care part is led by Care Provider Voice, aiming for 150 job outcomes, and funded until March 2025.
- These programmes are subject to approval by the People Board, Exec Committee, CPOS, Place, and collaboratives, aligning with the goal of enhancing socio-economic status in NEL through workforce development.

Details of engagement with places, collaboratives and other ICB portfolios

- Engaged with a broad spectrum of Health and Social Care partners through workshops and sessions.
- Involved Local Authorities, Voluntary and independent Care Sectors, Primary Care, NHS Trusts, Provider collaboratives, and Education Providers.
- More engagement is

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- **Integrated Health and Social Care Services:** Enhanced workforce development will lead to more integrated and effective health and social care services, improving overall care delivery.
- **Workforce Expansion and Skilling:** Initiatives like the NEL Health Hub and Social Care Hub are set to expand the healthcare workforce, providing training and development opportunities, leading to better staffed and skilled services.
- **Healthcare System Sustainability:** Focus on financial stewardship and innovation will contribute to a more sustainable healthcare system, ensuring long-term service delivery and effectiveness.
- **Equity in Healthcare Employment:** Targeted employment opportunities for under-represented groups in health and social care sectors will enhance workforce diversity, contributing to more inclusive and equitable healthcare services.
- **Enhanced Health and Well-being Services:** Programs like the Keeping Well Nel programme, funded until June 2024, will enhance health and well-being services, directly benefiting the ICS, workforce, and indirectly impacting local population health.

Engagement with the public:

- Actively engaged ICS staff via hackathons and NEL residents through community events and job fairs.
- Utilized feedback from the Big Conversation for inclusive strategy development.
- More engagement

Specialist commissioning

3. Our supporting infrastructure

Portfolio vision, mission and key drivers:
Our Vision: To ensure that the population of north east London have good access to high quality specialist care that wraps around the individual, and ensures the best possible outcomes
Our mission and drivers:
- We are responsible for planning and commissioning of delegated specialised health services across north east London. We are responsible for specialised spend, performance and outcomes, and ensuring all parts of the local health system work effectively together to deliver exemplary specialist care.
- We are responsible for integrating pathways of care from early intervention and prevention of LTC through to specialist provision, ensuring end to end pathways to improve outcomes and manage future demand of costly specialist care.
- We set priorities for specialised services and work with our local ICS, multi ICB partners and London regional partners to deliver world class specialised services to benefit patients within north east London, North London or London ensuring access to the right level of care.
- We will do this by working together with health partners, specialist providers, local authorities and the voluntary community and social enterprise (VCSE) sector, with residents, patients and service users to improve how we plan and deliver specialised services.

Key stakeholders:
NHS London Region and London ICB partners, NEL Provider Trusts, North London ICB Programme Board partners (NCL/NWL), ODNs, mandatory and local clinical networks, EoE Region, Local authorities, VCSE

Key programmes of work that will deliver the vision and mission
From 2024/25, ICBs will have budget allocated to them on a population basis, and from April 25 this will be allocated on a needs based allocation basis. The specialised allocation will follow a similar formula to that of other nonspecialised services that ICBs hold, and so can be considered and contracted for alongside the rest of the pathways we commission. Delegation of specialised services and transformation of specialised services allows us to consider the totality of resources for our population, making it easier to ensure investment in the most optimal way to improve quality and outcomes, reduce health inequalities and improve value.
The key programmes of work are to:
1. Ensure safe delegation of specialised services working alongside the NHSE regional team
2. Joint work with NHSE, London ICBS and locally in NEL focussed on specialised transformation: sickle cell disease (Haemoglobinopathies), HIV and Hepatitis (including liver disease), Renal disease, Neurosciences, Cardiology, complex urogynaecology and specialist paediatrics
3. Working alongside other portfolios will deliver this mission, mainly LTC to ensure a whole pathway approach routed in place, cancer, planned care, critical care, BCYP and mental health

Details of engagement with places, collaboratives and other ICB portfolios
- APC Executive, APC Joint Committee, NEL Executive leads,
- Close working with other ICB portfolios: LTC, Cancer, Planned Care, Critical Care, CYP, mental health

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
HIV: People living with HIV will have improved follow up care with investment in a community led peer programme with an aim to reduce by 70% the number of eligible patients that are lost to care/failed by care. This follow up care will include regular testing, counselling, mentoring, group support, assurance and information and advice.
Renal: Working towards maximise patient dialysing at home - 496 patients on home therapies by 31/32 (target of 28% of patients on home therapies by 2032). Working towards maximise patients being transplanted - 280 transplant operations completed in 31/32
Sickle Cell: Local people with sickle cell will receive appropriate analgesia and other pain management measures (ideally within 30 minutes) when attending any acute A&E in NEL . Residents will have timely access to multi-disciplinary team to support delivery of trauma-informed care based on the principles of safety, trust, choice, collaboration, empowerment and cultural competence.
Hepatitis and HIV: To achieve micro elimination of HCV across NEL (2025). Improved access to diagnostics and increase local prevention programmes by aligning with the British Liver Trust optimal pathway. This will support the reduction in the growth rate of liver disease (currently 20%).
Neurosciences:10% of eligible stroke admissions will have consistent 24/7 access to mechanical thrombectomy to reduce the impact of stroke. Improve detection of atrial fibrillation and ensure appropriate stroke risk reduction through anticoagulation - by 2029 85% of expected numbers with AF are detected, and 90% of patients with AF and high risk of a stroke on anticoagulation.
Cardiology: Shorter waiting times and reduced elective and non-elective. HF 30 day readmission rates have recently risen to more than 20%. We aim to reduce this to reduce this <15% with roll out of dedicated HF pharmacist to review and titrate patients post discharge

Engagement with the public:
- Engagement via regional and local clinical networks including Renal service users to inform dialysis provision
- Cardiac ODN: women, family
- HIV work with charities

Digital

3. Our supporting infrastructure

Portfolio vision, mission and key drivers: There are four key elements to the ICS digital strategy; patient access, population health, shared record access and provision of core infrastructure:

- **Patient Access** gives residents the ability to view their records and interact digitally with health and care providers. This is and will be provided through expanding use of the NHSApp, Online and Video consultation tools, online registration and the patient held record system, Patients Know Best
- **Population Health** utilises a variety of data sources to build a picture of care needs at various levels, primarily identifying specific cohorts of patients requiring intervention but also providing overviews at population level, allowing providers to alter service provision
- **Shared Records** is the mechanism for ensuring that clinicians and other care professionals have as full a picture as possible to allow them to provide the most appropriate care to individual patients / residents. This was pioneered in NEL and is now used across London and beyond
- **Core infrastructure** is the fundamental basis for all digital activity; the foundational work done at each provider that allows them to operate effectively and puts them on a sure footing to be able to contribute to and receive data from systems external to themselves

Key stakeholders:
All ICS health and care providers including NHS trusts, local authorities, GPs, community pharmacists, care home providers, third sector health and care providers, NHS England

Key programmes of work that will deliver the vision and mission
The largest investment currently taking place is the replacement of the core electronic patient record (EPR) system in BHRUT. This is being replaced by extending the existing Oracle Millennium system in use at Barts Health. Planning is underway, with the system expected to be live by March 2025. Other significant investments in Trusts include:

- The expansion of the functionality available via the NHSApp to include the ability to manage hospital and community appointments, and the ability for patients and clinicians to interact digitally where appropriate, thus improving the experience for digitally enabled patients and freeing up resource to support those wishing to use traditional methods. This is enabled by the PHR programme
- Use of artificial intelligence and robotic process automation to support diagnostics and faster completion of administrative tasks such as clinic management within trusts, thus improving patient experience and reducing the administrative burden on trusts
- All acute trusts using the same imaging platform to store and view x-rays, scans, etc., reducing the requirement for repeat diagnostic procedures and making them available to any clinician that needs access. ICS-wide cyber security plans are in place with funding having been secured
- Introduction of remote monitoring equipment to support expansion of virtual wards

Details of engagement undertaken with places, collaboratives and other ICB portfolios

- System-wide infrastructure strategy under development and centralised capital pipeline
- Members of the digital team attend portfolio and collaboratives' meetings. A meeting has taken place with place directors but further meetings are needed.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Residents can choose to interact with health and care professionals via the use of the NHSApp, Patient Held Record, online consultation and video consultation tools, which will smooth their interaction with the NHS and free up capacity to deal with people choosing to use other routes
- Patient level and aggregated information is provided to clinicians, managers and researchers, subject to a strict approval process. This helps change the planning and delivery of healthcare provision
- NEL hosted data is used across London and neighbouring ICS's, breaking down barriers by facilitating the sharing of information and good practice
- Information is provided to individual clinicians and other professionals from within their main system, giving access to information held by most London Trusts, which enables them to provide
- Key strategic programmes are co-ordinated by the ICS team, including Community Diagnostic Centres, Frontline Digitisation, Virtual wards, Care Sector, secondary care Appointment Systems and Primary Care Digital First, working with health, social care and third sector partners

Engagement with the public:
The One London programme has held various consultation meetings with patients across London, the results of which inform the strategies of each of the ICS' across London. Further engagement has been requested through further 'Big Conversations' planned in NEL

Physical infrastructure

3. Our supporting infrastructure

Portfolio vision, mission and key drivers:
North east london is already home to many state-of-the-art facilities, however, too much of our estate is not fit for purpose, whether that is inaccessible primary care facilities, or safety and compliance in some of our acute settings. Our system has been hampered by undercapitalisation which means that investment is swallowed up by maintaining current estate rather than enabling investment in new innovations that would create better value. Inadequate investment also weakens our resilience to the growing threats of climate change. Our vision is to drive and support the provision of fit for purpose estate, acting as an enabler to deliver transformed services for the local population. This is driven through robust system wide infrastructure planning aligned to clinical strategies, which is providing the overarching vision of a fit for purpose, sustainable and affordable estate.

Our emerging NEL Infrastructure Strategy contains 5 draft priorities:
1. Align infrastructure investment to system priorities
2. Improve infrastructure quality
3. Enable increased productivity
4. Integrate services and across community assets
5. Accelerate innovation

Key stakeholders:
All ICS health and care providers, local authorities (planning, regeneration and property), third sector organisations and London Estates Delivery Unit

Key programmes of work that will deliver the vision and mission
To support achieving the benefits we want to see for our population, our challenge in NEL is twofold: to take a forensic approach to sorting out the basics that will create the foundation for high quality services and health creating communities; while also accelerating innovation towards better outcomes and value for a population that is growing in both size and complexity. Across NEL ICS organisations exist a multitude of estates projects in the pipeline, scheduled to be delivered over the next 5 /10 years, these include:
- The redevelopment of Whipps Cross hospital and a new centre on the site of St George's, Hornchurch
- Formal opening of a new St George Health and Wellbeing Hub – Spring 2024
- Acute reconfiguration, that encompasses the estimated total value for Whipps Cross Redevelopment
- Mental Health & Primary and Community Care infrastructure developments
- IT systems and connectivity, aligned with the NEL Strategic digital investment framework
- Medical Devices replacement
- Backlog Maintenance works
- Routine Maintenance including PFI

Details of engagement undertaken with Places, collaboratives and other ICB portfolios
- System-wide infrastructure strategy under development and centralised capital pipeline
- Capital overseen by Finance, Performance and Investment Committee of NHS NEL.
- Local Infrastructure Forums meeting regularly in the seven places

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Additional facilities and access to services in the community (primary care, community diagnostics, integrated care, theatre capacity)
- Better patient experience whereby improvements and maintenance to existing sites is being undertaken

Engagement with the public:
Digital placemaking scoping project undertaken to determine public expectations of NEL buildings

Finance

3. Our supporting infrastructure

Portfolio vision, mission and key drivers:
Our aim is to achieve financial stability over the short to medium term – recognising the significant challenges the system faces this year and next – while also ensuring that we have a sustainable model over the medium to long term, by beginning the transformation of services now so that services are not overwhelmed by future demographic growth.

Key drivers:
- Incentivising transformation and innovation in clinical practice and the delivery of services to improve the outcomes of local people
- Supporting delivery of care closer to patients' homes, including investing in programmes that take place outside the hospital environment
- Refocus how the money is spent to focus on population health, including proactive measures that keep people healthier and to level up investment to address historical anomalies of funding
- Increasing investment in prevention, primary care, earlier intervention and the wider determinants of health, including environmental sustainability
- Ensuring that all partners are able to understand and influence the total amount of ICB resources being invested in the care of local people

Key stakeholders:
- Reporting to the ICB Board and Place Partnership Boards
- Finance, Performance and Investment Committee
- Audit and Risk Committee
- CFO lead monitoring of monthly and forecast performance

Key programmes of work that will deliver the vision and mission
- Supporting our providers to reduce transactional costs, improve efficiency and reduce waste and duplication
- Support the financial stability of our system providers and underpinning a medium to long term trajectory to financial balance for all partners
- Ensuring we do not create unnecessary additional financial risk, especially in the acute sector
- ICS investment pool to fund programs designed to reduce acute demand
- Finance development programme to agree overall budgets and develop place based budgets and budgetary delegation to place
- Effective integration of specialised commissioning, community pharmacy, dental and primary care ophthalmology services
- Supporting the integration of health and social care for people living with long term conditions who currently receive care from multiple agencies

Details of engagement undertaken with places, collaboratives and other ICB portfolios
Finance leads from our system partners, for example Hospital Trust Chief Finance Officers, are part of the ICB finance committees and networks, and will contribute toward how the finance structures and models are developed as we evolve as a system.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Improving quality and outcomes for local people of north east London
- Securing greater equity for our residents
- Maximising value for money
- Deepening collaboration between partners

Engagement with the public:
Insight from engagement with the public, such as the big conversation, feeds into the design of the way we are operating.

Barking & Dagenham

4. NEL Place based Partnership

Portfolio vision, mission and key drivers:

Vision

By 2028, residents in Barking and Dagenham will have improved physical and mental health and wellbeing, with a reduction in the gap in health inequalities between Barking and Dagenham resident and people living elsewhere. Our strategic aims are to:

- Enable babies, children and young people to get the best start in life
- Ensure that residents live well and when they need help they can access the right support at the right time in a way that works for them
- Enable residents to live healthier for longer and be able to manage their health, have increased opportunities to have an early diagnosis of health conditions and be provided with appropriate care to manage a condition before it becomes more serious

Interdependent ICB programmes

- Babies, Children and Young People; Maternity programme; Fuller programme; Population Health programme; Long Term Conditions programme; Urgent & Emergency Care programme; Estates

Interdependent Collaborative programmes

- Acute; Community Health; Mental Health, Learning Disability and Autism; Primary Care; VCSE

Key programmes of work that will deliver the vision and mission

- **Improving outcomes for CYP with SEND** with a focus on therapy support, ASD diagnosis and pre-and post-diagnostic support, mental health in schools
- **Tackling childhood obesity** leveraging the opportunities through family and community hubs for prevention
- **Development of Integrated Locality Health and Social Care Teams** (physical and mental health)
- **Developing a proactive and prevention approach to delivery of services** with targeted prevention approaches for falls prevention, dementia diagnosis and early support; long-term conditions identification and support and health outcomes for people who are homeless
- **Optimising outcomes and experience for pathways - d**eveloping a 24/7 Community End of Life Care Model; integrated Rehab and Reablement services; high Intensity User Services; demand and capacity management of high risk pathways (waiting list management)
- **Improving the physical health of people with SMI**

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- BCYP get the best start, are healthy, happy and achieve, thrive in inclusive communities, are safe and secure and grow up to be successful young adults
- Providing accessible services and support for residents to prevent the development of health conditions wrapped around local communities
- Improving physical and mental health and wellbeing for residents, particularly those with long term conditions
- Reduced reliance on acute and crisis services
- Improved physical health outcomes for those with a serious mental illness

Key stakeholders:

- NELFT
- Primary care/PCNS
- BHRUT/ Barts
- VCSE
- Healthwatch
- Local Authority- childrens and adults services; public health
- Estates and housing teas

Engagement with the public:

Best Chance Strategy for CYP and families; Just Say Parent Forum, engagement in Adults and Community strategy (ongoing)

Havering

4. NEL Place based Partnership

Havering Place based Partnership vision, mission and key drivers:
A Healthier Havering where everyone is supported to thrive; The vision of the Havering Partnership is to pool our collective resources to create person centred, seamless care and support designed around the needs of local people throughout their life course, with a strong focus on prevention, addressing inequalities and the wider determinants of health. This compliments Havering Council's vision for the 'Havering that you want to be a part of', with a strong focus on people, place and resources. We will do this by; Tackling inequalities and deprivation to reduce the impact that this has to access to services, and outcomes; Improving Mental and Emotional Support, Tackling Havering's biggest killers; Improving earlier care and support; coordinating and joining up care; working with people to build resilient communities and supporting them to live independent, healthy lives.

Interdependent ICB programmes
- Mental Health
- Long Term Conditions
- Urgent and Emergency Care
- Workforce and other enablers such as digital
- Planned Care
- Carers work and other cross place programmes

Interdependent Collaborative programmes
- Acute Provider Collaborative
- Community Provider Collaborative
- VCSE Provider Collaborative
- Mental Health Provider Collaborative
- Primary Care Collaborative
- North East London Cancer Alliance

Key programmes of work that will deliver the vision and mission
- **Start Well**; Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives
- **Live Well**; People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities. They can access care and information when needed.
- **Age Well**; People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks
- **Die Well**; People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people
- **Building community resilience programme and other key enablers**; including improvements to Primary Care and delivery of the recommendations in the Fuller review, roll out of the Joy App as our single database of services and referral mechanism for social prescribing, making better use of our estate and delivery of new models of care such as the St Georges project, improvements to urgent and emergency care, imbedding a prevention approach, addressing our key workforce challenges by working together, creating the enabling framework for place including information sharing agreements between partners to enable decisions and service improvement to be driven by joined up data.
- Built on a foundation of a **joint health and care team**, bringing together the Havering Place NHS team with the Local Authority Joint Commissioning Unit to deliver improved outcomes for local people and better value for money in our commissioned services

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
Under the programmes Start Well, Live Well, Age Well and Die Well Havering PbP aims to deliver by 2025 and 2027:
- A reduction in the number of children and their families attending emergency departments for non-emergency care
- Reduce the number of children who are physically inactive and/or obese
- Increase the number of social prescribing referrals to support people to access wider wellbeing support
- Increase the number of cancers being diagnosed at an earlier stage
- Increase the number of older people with a personalised care and support plan
- Reduce the number of frail older people living in cold, damp or moldy homes
- Reduce the percentage of older people who die within 7 days of an emergency hospital admission
- Increase the access to bereavement support in Havering

** Full details of the programme ambitions are captured in the Havering Place based Partnership interim strategy*

Key stakeholders:
- Local People
- Staff
- VCSE
- London Borough of Havering and their staff, who are coming together with the NHS Place team to form a joint team
- NELFT
- BHRUT
- Healthwatch
- Care Providers Voice (including Home Care and Care Home providers)
- PELC
- Primary Care including the GP Federation and PCNs
- NHS North East London partners
- Police and other community partners
- Wider NHS partners
- Wider Community partners and groups

Local People are at the heart of all of the work of the Place based Partnership

Engagement with the public:
A significant engagement programme has been underway with local people, VCSE groups, and stakeholders since the inception of the partnership. We are building an ongoing relationship with local people, and developing case studies to embed their experiences to drive improvements locally

4. NEL Place based Partnership

VISION, KEY PRIORITIES and KEY DRIVERS:
VISION: The Redbridge Place Based Partnership (RpBP) will relentlessly focus on improving the outcomes for the people of Redbridge and seek always to make a positive difference to people's lives. Together, we will build on what we have already achieved and use our combined resources to create person-centred, responsive care to build services around the needs of our communities within Redbridge. We will have a strong focus on prevention, addressing inequalities and the wider determinants of health.
KEY PRIORITIES: START WELL: Improve Access to Universal and Community Services, Deliver the Special Education Needs and Disability (SEND) Agenda, Improve Holistic and Early Years' Service Provision, Improve support for Emotional Wellbeing and Mental Health (MH) for Children and Young People (CYP). **LIVE WELL:** Improve Diagnosis and outcomes for Long Term Conditions through Targeted Community Engagement, Develop a Cardiology and Respiratory Plan, Improve Learning Disabilities and Autism (LDA) Health Check Rates. **URGENT and EMERGENCY CARE (UEC):** Develop a Programme to Improve Self-Care to reduce inappropriate use of UEC services, Develop Resources that support staff and Public to Access Services, Facilitate a Safe, Swift and Supported Discharge post Hospitilisation. **AGEING WELL:** Supporting People to know what services are available and how to access them, , Keeping People Well in a Place they Call Home, Making Redbridge a Great Place to Grow Old and fostering inclusion and a sense of community. **PRIMARY CARE**: Improve Childhood Immunisation Rates, Support the 'Fuller Stocktake Report' Programme, Development of Same Day Access Model, Improve Recruitment and Retention of Primary Care Staff, Support Development of Ilford Exchange, Support the Development of new models of Care including Neighbourhood Teams, Strengthening Multi-Disciplinary Teams (MDTs). **KEY DRIVERS FOR SUCCESS:** Good governance and accountability, a focus on the voice of those with lived experience, a focus on Organisational Development, a commitment to working in partnership and beyond organisational boundaries

Interdependent Integrated Care Board (ICB) Portfolios
Long Term Conditions (LTC), Learning Disabilities (LD), Autism and Mental Health (MH), Planned Care (PC), Health Inequalities (HI), Primary Care, Babies children & young people, urgent & emergency care, older people and cancer

Interdependent Provider Collaboratives
Community Collaborative, Acute Provider Collaborative, Cancer Collaborative, Primary Care Collaborative, Mental health collaborative and Voluntary community sector collaborative.

KEY PROGRAMMES OF WORK THAT WILL DELIVER THE VISION AND KEY PRIORITIES (Some Programmes of Work will be existing Projects while other areas are still in Development)
START WELL: Develop and Deliver a Paediatric Integrated Nursing Service (PINs), Learning Disability Key workers, Develop Integrated child health hubs in Primary Care using a Multi-Disciplinary Team (MDT) Approach, A programme to Improve links between Maternity and Early Years Provision, Deliver the Special Education Needs & Disability (SEND) programme, **LIVE WELL**: Review of the Cardiology and Respiratory Workstreams, Projects to address Long Term Conditions (LTC) undiagnosed patients, A review of areas where partners are aligned or overlap with Services, Develop a Population Health Approach to how we use information, Review of the Mental Health (MH) Liaison Service at King George Hospital (KGH), A programme to promote awareness and training for Learning Disabilities (LD) and Autism. **URGENT and EMERGENCY CARE (UEC):** Develop a Redbridge focussed UEC Plan. Review key services to identify overlaps including reviewing Substance Misuse pathways and increasing Community Treatment Team (CTT) capacity in 2024/25. Deliver a programme to reduce inappropriate use of ED and UTC services including: developing a Redbridge Communications and Engagement Plan which takes into account local communication preferences, support to self-care and a programme to support those unregistered to register with a GP practice.
AGEING WELL: Collate and update information on Dementia, End of Life and falls services for patients, Develop a local pro-active approach to care with system partners across Falls, Carers support, End of Life and Fitness and Nutrition, Develop and deliver a programme to tackle Isolation, Support and encourage older people to access Talking Therapies, Develop and pilot a range of Intermediate Care discharge models in bed-based units. **PRIMARY CARE: S**upport implementation of the Fuller workstreams, access recovery plan including PCN capacity and access plans, transitional funding, implementation of cloud based telephony and other primary care digital projects, like the NHS App. The continued development of the same day access model including the same day access hubs.
HEALTH INEQUALITIES: A range of projects undertaken by local partners across the health, care and voluntary sectors will seek to address differing health inequalities experienced by local communities. The projects are wide ranging and work with people who face a variety of complex interrelated issues but all seek to take a person centred and holistic approach. This is underpinned by the NHS Core20Plus5 approach. **ILFORD EXCHANGE HEALTH CENTRE:** To develop and deliver a new health centre in Ilford town centre following an extensive public consultation in September 2022.

SUMMARY OF BENEFITS/IMPACTS REDBRIDGE PEOPLE WILL EXPERIENCE by APRIL 2025:
By April 2025 the Redbridge Place Based Partnership will Deliver:
- A reduction in undiagnosed Long Term Conditions and improved diagnosis rates
- Improved End of Life Care services for People in Redbridge
- Improved services for Children and Young People with mental health issues
- Improved uptake of childhood immunisations
- Improvements against the Accessibility Information Standards
- Significantly reduce health inequalities underpin by the Core20+

Key stakeholders:
- London Borough of Redbridge (LBR)
- Community Action Redbridge (CAR)
- Healthwatch
- Healthbridge (GP Federation),
- The Primary Care Networks (PCNs) in Redbridge
- North East London NHS Foundation Trust (NELFT),
- NHS NEL Integrated Care Board (ICB)
- Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust (specifically Whipps Cross)

Engagement with the public:
A significant engagement programme has been underway with local people, VCSE groups, and stakeholders since the inception of the partnership. We are building an ongoing relationship with local people, and developing case studies to embed their experiences to drive improvements locally

Tower Hamlets

4. NEL Place based Partnership

Portfolio vision, mission and key drivers:

- Tower Hamlets residents, whatever their backgrounds and needs, are supported to self-care, thrive and achieve their health and life goals
- Health and social care services in Tower Hamlets are accessible, high quality, good value and designed around people's needs, across physical and mental health and throughout primary, secondary and social care
- Service users, carers and residents and children are active and equal partners in health and care and equipped to work collaboratively with THT partners to plan, deliver and strengthen local services
- All residents - no matter their ethnicity, religion, gender, age, sexuality, disability or health needs - experience equitable access to and experience of services, and are supported to achieve positive health outcomes

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB urgent care review
- Access to data & insights

Interdependent Collaborative programmes

- Community collaborative model for health and care
- Primary care collaborative
- Supporting out of borough NEL discharges
- Mental Health collaborative
- Planned Care workstream

Key programmes of work that will deliver the vision and mission

- Improving access to primary and urgent care
- Building resilience and self-care to prevent and manage long term conditions
- Implementing a localities and neighbourhoods model
- Facilitating a smooth and rapid process for hospital discharge into community care
- Being an anti-racist and equity driven health and care system
- Ensuring that Babies, Children and Young People are supported to get the best start in life
- Providing integrated Mental Health services and interventions

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Ensuring residents can equally access high quality primary and urgent care services when and where they need them
- Better prevention of long term conditions and management of existing conditions
- Ensuring that every resident can access the health and care services they need to support their continued health and wellbeing within their local area or neighbourhood, including GP, pharmacy, dental and leisure facilities
- A smooth and rapid process for discharging residents from hospital to suitable community-based care settings when they are ready for this transition
- Ensuring our health and care system and services are achieving equitable outcomes for all residents and addressing inequalities that exist, e.g. access, experience, representation and outcomes
- Ensuring babies, children and young people (and their families) are supported to get the best start in life, especially where they have additional needs
- Providing integrated services and interventions to promote and improve the mental wellbeing of our residents

Key stakeholders

- LBTH
- NEL ICB
- Barts Health Trust
- TH GP Care group
- ELFT
- Healthwatch
- TH CVS
- Tower Hamlets residents and service

Engagement with the public:

The workstreams and the THT Board include VCS and resident stakeholders who input into the design of the programme

Newham

4. NEL Place based Partnership

Portfolio vision, mission and key drivers:
Working with our diverse communities of all ages to maximise their health, wellbeing and independence. Supported by a health and care system that enables easy access to quality services, in your neighbourhood, delivered by people who are proud to work for Newham.

Interdependent ICB programmes
- Babies, Children and Young People
- Fuller
- Long Term Conditions
- Maternity
- Population Health
- Urgent & Emergency Care

Interdependent Collaborative programmes
- Acute
- Community Health
- Mental Health, Learning Disability and Autism
- Planned Care
- Primary Care
- VCSE

Key stakeholders:
- ELFT
- Healthwatch
- LBN
- NEL ICB
- NUH
- Primary Care
- Residents
- VCFS

Key programmes of work that will deliver the vision and mission
- Joint Planning Groups (JPGs) for Babies, Children and Young People; Mental Health; Learning Disabilities and Autism; Ageing Well; Primary Care; Long Term Conditions and Urgent Care
- Local Authority-led programmes across Health Equity, Homelessness, Carers and Well Newham (prevention)
- Population growth programme – implementing our model of care based on needs of our population and capacity in the system.
- Designing an outcomes framework in partnership with residents to measure benefits and achievements

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Increase early identification of LTCs and reduce the impact of long-term conditions on residents' lives.
- Support people to stay well in their own homes by proactively working together in their care & support.
- Improve the mental wellbeing of residents and ensure people have access to mental health support when and how they need it.
- Involve, engage and co-produce all our plans with residents.
- Ensure people stay in hospital for the optimum time and are supported to rehabilitate and recover.
- Ensure when people need urgent help they can access it quickly and as close to home as possible.
- Develop and integrate children's services to ensure children have the best start in life.
- Prepare for significant population growth in Newham and North East London and strengthen prevention initiatives.

Engagement with the public:

Residents and People & Participation Leads attend Partnership Board, JPGs and project groups

Waltham Forest

4. NEL Place based Partnership

Portfolio vision, mission and key drivers:
Our aim is for the population of **Waltham Forest** to have healthier lives by enabling them to **start well, live well, stay well and age well**, supporting each individual through to the end of their lives. We will do this by working together, as partner organisations and with our residents, **to improve health outcomes and reduce health inequalities.**

- We will engage and involve our residents to coproduce our interventions and services
- We will focus on supporting all residents to stay well and thrive throughout their lives
- We will use population health management approaches to understand the needs of our residents and target our resources to improve equity
- We will ensure when people need help, they can access high quality, good value services quickly and easily and are enabled to stay in their homes or return home as soon as possible.

Interdependent ICB programmes

- ICB anti-racism workstream
- ICB UEC workstream
- ICB CYP workstream
- ICB long term conditions workstream
- ICB MH workstream
- Primary Care Access
- ICB Fuller workstream
- ICB Digital workstream

Interdependent Collaborative programmes

- Whipps Cross redevelopment programme
- MH Collaborative
- Community Collaborative
- Primary care Collaborative
- Planned care workstream

Key programmes of work that will deliver the vision and mission

- Delivery of a programme of locality **prevention, wellbeing and self-care** to intervene earlier with residents to improve health outcomes dentification for intervention and support for residents with **LTCs.**
- Delivery of proactive anticipatory care through delivery of **Care Closer to Home** transformation programme and establishing **Integrated Neighbourhood teams and hubs.**
- Deliver alternative to unplanned attendances and admissions to acute hospital for adults and children and improve discharge pathways through the delivery of the **Home First programme** of transformation and improving **same day access to primary care** for all residents**.**
- To deliver priorities in our **children's health strategy** , including improving access to **therapies** and access to support for children with additional needs.
- To transform **EOL** services in Waltham Forest to ensure residents have the support to die in their choice of place.
- Improving access to **Mental Health and** support in community for all ages and promoting positive well-being for all.
- Reduce inequalities experienced by **autistic people** and those that have a Learning Disability, ensuring that we have the right accommodation and support in place to maximise independence and ensure good health outcomes.

Summary of the benefits/impact that north-east London local people will experience by April 2025 and April 2027:
1 Reduce the variation in undiagnosed Long Term Conditions, 2. Improve the uptake of immunisation, 3. Improved access for resident to health and care services to support health and wellbeing in their local areas, 4. Enable people to stay well in their own homes by proactively organising and managing their care & support, 5. Reduce the need to attend / stay in hospital for residents with complex needs, 6. Ensure residents in hospital for the optimum time and are supported to rehabilitate and recover, 7. Enable people to stay well in their own homes by proactively organising and managing their care & support, 8. Improved access to community palliative care support for resident at the end of life, 9. Improve access to support and services for babies, children and young people, especially those with additional needs, 10. Improved access to MH and LDA services

Key stakeholders
This plan has been developed by the WF health and Care Partnership Board, in collaboration with the Health and Well Being Board. It reflects discussion and engagement at Board and sub board multi agency and stakeholder forums and planning events held in 2023

Engagement with the public:
Comprehensive programme of engagement with local residents during 2023. 400 + residents and 50 + community groups involved. Insight informed the development 4 pillars of good care to be embedded into all our work programmes:
•Trustworthy
•Accessible
•Person- centred
•Competent

City & Hackney

4. NEL Place based Partnership

Portfolio vision, mission and key drivers:
Working together with our residents to improve health and care and make City and Hackney (C&H) thrive. We want to improve health outcomes and reduce health inequalities, focusing on 3 key areas:

1. Giving every child the best start in life (often by recognising the role of families)
2. Improving mental health and preventing mental ill-health
3. Preventing ill-health, and improving outcomes for people with long-term health and care needs

The C&H Neighbourhoods programme is about fostering community connections, at a hyper local level, and our aim is to improve quality of care, access and waiting times for all our residents particularly those experiencing Health inequalities. We apply the principles of right time, right place, right support. We acknowledge that the solution requires collaboration with wider system partners including local authorities, public health and our voluntary sector partners and residents. **Key drivers:** - National regional policy frameworks, local needs - we will target areas in C&H where we have poor outcomes and evidence of inequalities (as evidenced in JSNAs, Population Health data, etc.) We continue our work to become an anti-racist, systemic, and trauma informed partnership

Interdependent ICB programmes
Start Well – Immunisations; Maternity, hospital and community care, continuing care, SEND, Looked After Children and other vulnerable groups; LTCs; primary care. **Live Well** – Long term conditions (LTC) and Specialised Commissioning; Planned Care; Urgent and Emergency Care; Personalised Care. **Age Well** - Palliative & End of Life Care; NEL Care Home / Care Provider Forum / Network; Continuing Healthcare; NEL Carers Network. **Mental Health** (MH) - Children; Unplanned / Crisis Care; Community Care; NEL MH Delivery Group

Interdependent Collaborative programmes
Babies, Children and Young People (CYP) working with our NEL Collaboratives and the Local Maternity system (NLLMS). **Live Well –** Acute and Community Collaborative. **Age Well -** Mental Health Alliance; Primary Care Collaboratives. **Mental Health -** Mental Health Integration Committee (MHIC); Children's Emotional Health and Wellbeing Partnership; Psychological Therapies and Wellbeing Alliance (PTWA); CAMHS Alliance; Dementia Alliance; Primary Care Alliance; Hackney special interest group (SIG)

Key programmes of work that will deliver the vision and mission
Start Well – 0-25s commissioning across the ICB and Public Health; system wide approach to improving immunisations coverage with community leads as valued partners; SEND (separate City and Hackney SEND systems and governance); Systemic, Trauma and ant-racist informed transformation such as Improving Outcomes for Black CYP, upskilling the workforce in relation to Adverse Childhood Events; embedding real co-production e.g. across Preparing for Adulthood; focus on prevention and early identification of needs (improve outcomes and mitigate impact of waiting times) through system approach such as the SEND Graduated Approach. **Live Well** - Better Care Fund Partnership; Primary / Secondary Care Interface; Long Term Conditions Management. **Age Well** - Discharge Improvement Programme; Integrated Urgent Care - NEL Same Day Access Programme, Enhanced Community Response (robust provision of integrated urgent care – including primary care through Duty Doctor, urgent community response and emerging virtual wards); Robust utilisation of proactive care planning approach -1.3% of C&H Registered patients have a Universal Care Plan in place (compared with average of 0.5% for NEL and London-wide) and 99% of patients on Anticipatory Palliative Care Registers have a Universal Care Plan in place (and all have been offered). **Mental Health** - ADHD / ASD Assessment and Aftercare (All ages) – Backlog and Waiting times; Adult Talking Therapies – Integrated Pathways. Quality Improvement. Demand / Capacity and Waiting Times; Community Transformation / Continued Improvement with Neighbourhoods offer – aligning existing provision; Neurodevelopmental Pathways Review (CYP); Crisis / T3.5 Pathways Review (Including ICCS, Surge and IST); Whole System Approach (iThrive) – CYP Emotional Health and Wellbeing. **The City and Hackney Neighbourhoods Programme** - Supporting the workforce aligned to 8 Neighbourhoods and fostering community connections through: Working Together, Resident Voice at the Centre, Knowing your neighbourhood, Proactive care. Colocation and estates strategy. Personalisation Framework. Evaluation of impact. Developing local leadership.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
All our work is aimed at improving the health and wellbeing of our local residents and reducing inequalities.
Start Well: - Parents/carers, families, children and young people will know how to access advice, care and support when it is needed. Improved workforce communications with residents in a systemic, trauma informed anti -racist way. Reduced risks of preventable disease outbreak due to immunisation uptake promotion. Families and Children & Young People will know how to access support and will not be dependent on a diagnosis to access help / information / support. **Live Well and Age Well: - Improved** support with any care needs following a hospital admission. Patients will know about services available and be supported to access the care they need. Patients will have increased care provided outside hospital, closer to their home, where appropriate. **Mental Health: -** Residents will experience Improved waiting times and better overall quality of care, with a focus on faster neurodevelopmental assessment; Psychological therapies intervention; improving 117 Aftercare; Wellbeing in School and Youth Hubs; Crisis Care including Crisis prevention and wellbeing. We will better meet the needs of residents who experience greater health inequalities e.g. social deprivation and serious mental illness.

Key stakeholders:
- Residents / Carers
- Local Authorities
- VCSE
- Homerton Hospital
- Barts Health
- Adult Social Care
- Childrens Social Care
- Hackney /CoL Education
- ELFT – CAMHS / Adults
- HUH CAMHS / Adults / Acute / Paeds
- Primary Care / GP Confed
- VSO Partners / SIG

Engagement with the public:
- Healthwatch
- Service-user reps
- Engagement with the public
- Advocacy Project (MHIC)
- Alliance coproduction and Participation
- Separate City of London and Hackney SEND Parent Carer Forums

Health Inequalities

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:
Health inequalities exist between NEL and the rest of the country – for example we have particularly high rates of children with excess weight and poor vaccination and screening uptake – but they also exist between our places and communities. These inequalities are avoidable and unfair and drive poorer outcomes for our population. We want to improve equity in access, experience and outcomes across NEL. To do this we have made reducing health inequalities a cross-cutting theme that is embedded within all of our programmes and services within places and across NEL – everyone has a role to play. In light of NHS England's Statement on the Information on Health Inequalities, the ICB is collating and analysing a range of indicators across key health domains including the Core20Plus5, to better understand, measure and act upon the inequalities that exist in healthcare access, experience and outcomes within NEL. Over the coming months and years, the intention is for this data to inform and drive further action across ICS partners.

Key programmes of work that will deliver the vision and mission

- Dedicated health inequalities funding has been provided to each place-based partnership to lead locally determined programmes to reduce health inequalities within their local communities. These projects will be evaluated and the learning shared and showcased.
- Development of a NEL Health Equity Academy to support all people and organisations working in health and care in NEL to be equipped with the knowledge, skills and confidence to reduce health inequalities for the benefit of local people
- Implementation of a community pharmacy scheme to provide targeted pharmacist advice and free over the counter medicines for people on low incomes and experiencing social vulnerability across NEL, to support our communities in the context of cost of living pressures.
- Taking a Population Health Management (PHM) approach, led by places and neighbourhoods, will support frontline teams to identify high risk groups and identify unmet need. A PHM Roadmap has been developed for NEL and is being implemented.
- Embedding the NEL Anchor Charter, working with system partners to ensure we are measuring and creating the opportunities that being an anchor institution affords are leveraged for our local population, to address structural inequalities such as ensuring the NHS in NEL is a London Living Wage accredited employer, embedding social value in procurement process and better utilising our infrastructure to support community activation and supporting a greener, healthier future.
- Delivering our ICS Green Plan including developing an Air Quality Programme, ICS wide net zero training programme, and embedding net zero into our procurement processes to support our aim of reducing our collective carbon footprint by 80% by 2028 and to net zero by 2040.
- Improving access to primary care for health inclusion groups (homeless and refugee and asylum seekers) through safe surgery programme, supported discharge for homeless through the out of hospital care programme, supporting families in temp accommodation to access support out of borough, commissioning a NEL wide initial health assessment for those seeking sanctuary housed in contingency accommodation, and commissioning a needs assessment for health inclusion in NEL to identify needs for other underserved groups that require focus.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Reduced differences in health care access, experience and outcomes between communities within NEL, particularly for people from global majority communities, people with learning disabilities and autism, people who are homeless, people living in poverty, and for carers.
- Improved health life expectancy for all communities across NEL, irrespective of who you are or where you live.
- Our population receives more inclusive, culturally competent and trusted services, underpinned by robust equity data.

Key stakeholders:
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts
NHS E and TPHC
ICB

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS.
- Significant engagement across the system on what is useful from a Health Equity Academy
- Engagement from across the system on Anchors, Net-zero and health inclusion around homelessness and refugee and asylum seeker programmes

Engagement with the public: Engagement on specific topics, and in depth at place level.

Prevention

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:
We want to increase our focus as a system on prevention of ill-health and earlier intervention. This means increasing our focus and resources 'upstream', to prevent illness in the first place. Preventive health offers need to be appropriate for all in our diverse communities, and will only be effective when working across organisations and local authorities to address the wider determinants of health. In NEL we face significant challenges around preventable ill health, for example more than 40% children are overweight or obese and nearly all of our places have worse screening rates for breast, bowel and cervical cancer than England. This has an impact on health outcomes, demand for care and health inequalities, so these are key drivers for enhanced action.

Key programmes of work that will deliver the vision and mission

- Mobilising tobacco dependence treatment services across all of our trusts so that they are available in all inpatient, maternity and community services, and making these services sustainable for the long term.
- Alcohol care teams (ACTs) have been established at the Royal London Hospital and Homerton Hospital, and we will continue to make these services sustainable moving forwards and make the case to expand coverage to other hospitals in NEL.
- Population Health Management (PHM) is a key methodology that can be utilised as an approach using population health data as a means of targeting cohorts of our population that will benefit from focused approaches that include preventative interventions where appropriate. NEL ICB has recently employed a dedicated PHM lead who will be supporting places to deliver prevention intervention across NEL through improved population cohort analysis, intervention design and evaluation of intervention outcomes.
- Delivering equitable vaccination programmes in NEL builds on our experience during the Covid-19 pandemic and will continue to deliver according to national programmes and local need. We will work as a system to work with and target communities with low vaccination rates
- Cancer prevention, awareness and screening is a focus of the work of the NEL Cancer Alliance, who are strongly involved with active awareness campaigns targeting our local NEL population. These campaigns cover different cancers and aim to raise awareness and prevent cancer and support early diagnosis. For example, prostate, lung, breast, cervical and endometrial cancer awareness campaigns have been developed targeting population cohorts.
- Anchor Institutes are evolving across our system with all of our NHS Trusts and Local Authority Chief Executives having signed up to the NEL Anchor Charter. These are a set of principles that support using our institutions and the organisations as assets to better support out local communities. These aim to help tackle and reduce the wider determinants of health supporting prevention of ill health alongside health inequalities.
- We will deliver Long Term Condition programme collaboratively (for example cardiovascular, stroke, respiratory and diabetic related diseases) ensuring they are aligned with the national and regional programmes that focuses on entire pathways from LTCs prevention to escalations of LTC management within acute care. The NEL LTCs teams are linking in with systemwide colleagues with several key activities focused on LTC prevention and early identification.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Increased smoking quits, leading to a wide range of improved health outcomes and lives saved, particularly in more deprived communities.
- ACTs support patients experiencing harm as a result of alcohol use disorders, and will lead to a reduction of alcohol-related conditions such as CVD, cancers and liver disease, as well as harm from accidents, violence and self-harm.
- There is a commitment over time to increase the proportion of our budget that is dedicated to prevention and earlier interventions, this would be done concurrently to shifting the system partners have a greater focus on prevention.
- Our anchor institutions will also begin to play more of a role in tackling poverty and promoting social and economic development.
- A maturing infrastructure including population health management awareness and digital population data availability will help impact the NEL system in supporting prevention by helping to identify those population cohorts that will greatly benefit from prevention and earlier intervention services and engagement.
- NEL ICB has developed a draft Immunisation Strategy with system partners to build on the legacy of the covid vaccination programme. This will be refined in line with the National Immunisation Strategy. The ambition is to build on the digital advancements for service delivery, develop the workforce to support access for local people and embed engagement with all communities to support uptake of vaccinations across the whole life course, thereby preventing ill health.

Key stakeholders:
Public health teams
Local authority departments
Voluntary and community sector
Primary care
NHS trusts

Details of engagement undertaken with Places, collaboratives and other ICB portfolios:
Key prevention engagement related to specific programmes are well documented by each of the organisations and programmes leading on each area of work.
Central NEL ICB oversight of all prevention related engagement across all programmes and services is a challenge and therefore an alternative approach is to ensure that the system (via Places, Collaboratives and workstreams) is able to identify, scale and spread those areas of Prevention engagement which has proven successful

Engagement with the public:
Key public engagement is occurring within our workstreams that encompass a preventative element. For example as mentioned Cancer and Long term conditions

Personalised Care

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:
Personalised care involves changes in the culture of how health and care is delivered. It means holistically focussing on what matters to people, considering their individual strengths and their individual needs. This approach is particularly important to the diverse and deprived populations of NEL, where health inequalities have been exacerbated by the pandemic and further compounded by the cost of living increase. Embedding personalised care approaches into clinical practice and care, which take into account the whole person and address all their needs holistically will ensure our most vulnerable communities are supported in the years ahead. We have built a strong foundation for personalised care over the last three years as a system, with an early focus on social prescribing and personal health budgets. Aligned to the 'Comprehensive model of Personalised Care', our vision is to lead and enable the delivery of the six components of personalised care and embed these in local population health approaches.

Key programmes of work that will deliver the vision and mission

- Ensuring all social prescribing link workers can capture the NEL social prescribing minimum dataset via a digital template and analyse the data in a PowerBI dashboard
- Expanding the implementation of Joy platform across NEL to provide a directory of service platform in alignment with Fuller actions relating to same day access
- Developing personalised care workforce plans with primary care and training hubs to support the Fuller actions relating to integrated neighbourhood teams
- Support equity of offer and quality assurance of personal health budgets across NEL for the Right to Have cohorts
- Piloting new approaches to deliver personal health budgets for rough sleepers and discharge from hospital to support underserved groups and address winter planning pressures
- Developing a strategy to embed creative health in services across the system with specific focus on addressing health inequalities
- Promote supported self-management and digital enablement through Patients Know Best
- Standardise personalised care and support planning including increasing use of digital tools e.g. Patients Know Best and Universal Care Plan
- Invest in social prescribing 'community chests' to increase resources in the community and voluntary sector locally, targeted at addressing local inequalities and providing social value to our communities where it is needed most.
- Promote patient choice and shared decision making across the ICS to increase the involvement of each patient in decisions about prevention, diagnosis and their care or treatment.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Local people are asked what matters to them in setting their treatment or care goals and can access a wide range of non-medical support in the community.
- Particularly vulnerable people and underserved groups are identified and given additional support to access services ensuring their experience and outcomes of care are equitable.

Key stakeholders:
Primary care
Place-based directors
Local authority
Public health teams
VCSFE
NHSE and TPHC
Acute teams e.g. social prescribing & discharge

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

- NEL Population Health and Inequalities Steering Group is made up of representatives from places and collaboratives, and leads from across the ICS
- Engagement with place at the CPPO SMG

Engagement with the public:

- Engagement on specific topics, and in depth at place level

Co-Production

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:
People and communities have the right to participate in all aspects of our work. From the design of services to setting of budgets, from the development of strategy to being active participants in the delivery of services, and from holding us to account to shaping the measures by which our success will be defined.
We believe participation is a right because it is a right within the NHS Constitution, it is public money and therefore health and care services belong to our local people and are directly linked to their health and wellbeing. We know that by working alongside residents and communities in partnership we will together be better able to address inequalities, improve access, experience and outcomes, and that our best services are those that have been co-designed with the people who use them. Our NEL Working with People and Communities (WPC) strategy sets out our commitment to co-production and resident involvement.
Communities themselves often have the best understanding of the issues affecting them and the solutions that are needed to deliver change. As well as the benefits to the NHS, our wider partnership and our population in north east London, coproduction and resident involvement has the potential to deliver real benefits for individuals as they develop an increased understanding of services, new skills, improved confidence and a sense of being able to shape their surroundings and their own health and wellbeing.

Key stakeholders:
Local people
Healthwatch and other patient representatives
Voluntary and Community sector
Place Directors and clinical leads
Complaints and patient experience
Programme teams
NHS Trusts and local authorities

Key programmes of work that will deliver the vision and mission
- Delivery of the key commitments set out in the Working with People and Communities Strategy to provide local people with meaningful opportunities to be involved in the work of the ICS including how we spend our available funding
- Engagement and coproduction planning to support work across a specific topic or programme of work e.g. end of life care, with children and young people, maternity and women's health
- Development of partnership coproduction frameworks across all seven Place Based Partnerships
- Embed the insight provided through the Community Insight System into transformation programme, service development and improvement across NEL.
- Work with the VCSE Collaborative to build capacity within the voluntary and community sector at both a place and NEL level
- Implement the ICB Reward and Recognition policy to invest in consistent and quality engagement activity at Place and across NEL, and work towards a consistent framework with all ICS partners

Details of engagement undertaken with Places, collaboratives and other ICB portfolios
Building on WPC strategy - engagement and coproduction activity including the Big Conversation, targeted engagement, and insight gathered by partners through the CIS.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:
- Local people experience improved access to services and quality of care as their experiences have helped to shape the services they receive.
- Residents and their carers or representatives feel empowered by meaningful opportunities to service improvements or transformation
- Improved health outcomes as residents build their confidence and ability to positively manage their own health and wellbeing
- Improved efficiency - listening to people's experiences of services could help maximise our limited resources
- Great transparency and confidence in the ICS and its decision on service improvement and transformation

Engagement with the public:
Big Conversation (summer 2023), CIS reports and specific engagement and coproduction activity

Learning System

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:

The transition to an Integrated Care System has provided an opportunity to work differently in relation to how we plan, deliver, integrate and improve our services across north east London. In developing and embedding our new system operating model, our aim is to embed research, innovation, continuous learning and quality improvement in all that we do.

As we move towards a continuous learning approach and culture, the following principles will be key for our system:

- We are well-informed – before we act, we fully consider the impact of our decisions on individual, community and system outcomes and equity drawing on both data and insights; research and evidence.
- We are responsive – we are effectively monitoring our interventions, learning and taking action in a timely manner.
- We reciprocate – we work together sharing knowledge openly and without blame; valuing collaboration over competition.

We will ensure that a learning system approach and culture is threaded through the new system operating model for the ICS to support closer working and integration between partners supported by greater sharing of data and information; and through improvement in how we learn from each other and spread new and innovative ways of working.

Key programmes of work that will deliver the vision and mission

- Develop and deliver a learning system approach, that enables us to access learning and our local evidence base to support transformation. This will include establishing a knowledge system, developing an evaluation framework and a common methodology for learning and improvement, providing training and support to embed a learning culture.
- Design and deliver our population health approach to inform future commissioning and planning. This will include developing population health management (PHM) tools, embed learning from early pilots, developing culture, behaviour and skills around PHM and related training, and by design of an incentives model.
- Develop and deliver our research strategy to ensure that we are attracting more research in our system, that research is addressing the most important questions for our population, and that more local people can participate in research.

Summary of the benefits/impact that north east London local people will experience by April 2027:

- Development of a localised evidence-base, helping us to make decisions most suitable to our context and populations.
- We use data, evidence and insights to build our understanding of our population and to drive our priorities.
- All staff consider quality improvement a key part of their role and are continually striving to improve services and outcomes for local people.

Key stakeholders:

Place-based directors
Collaborative directors
Portfolio directors
Quality and safety
Complaints
Strategy
Programme Management Office

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

First discussion meeting yet to take place and so as yet no engagement has taken place

Engagement with the public:

Engagement on specific topics, and in depth at place level

High Trust Environment

5. Our Cross Cutting Themes

Portfolio vision, mission and key drivers:

Our health and care partnership inherits a legacy of competitive and sometimes adversarial relationships between organisations, which often do not serve local people well. This is based in part on an old financial and contractual regime that encouraged the defence of organisational interests rather than a shared view of how all partners best work together to drive improvements to health, wellbeing, and equity. NEL partners have already come together to agree on our collective ambition for improving health, wellbeing and equity as well as four design principles for our system - improving quality and outcomes; deepening collaboration; creating value and securing greater equity.

We have the opportunity to ensure that our new ways of working reflect this commitment across our whole system spanning local authorities, the community, voluntary faith and social enterprise sector and health. This includes defining how place partnerships, provider collaboratives, and NHS NEL each contribute to delivering local ambitions with all parts of the system coming together as equal partners. It also means defining the interfaces between these key building blocks of our system, and the handoffs between the types of care that they are responsible for, which our experience tells us is critical to effective delivery.

Alongside this, we need to build the environment of high trust that enables seamless delivery across pathways spanning social care, primary and community care and secondary care regardless of organisational or sector boundaries. Only building this truly collaborative and high-trust culture will enable our new partnership to work for local people and within and across local partners; without it, our new structures will have limited impact on the people of north east London.

Key programmes of work that will deliver the vision and mission

- Building on the work to develop a mutual accountability framework, we will continue to develop our system operating model towards greater integration as a system. This will provide increasing clarity for the system on our respective roles and responsibilities as well as developing collective agreement on how place partnerships, provider collaboratives, and NHS NEL will work together to deliver better outcomes for local people. This work will be informed by the NHSE London review of provider collaboratives that is currently underway as well as the strategic reset of the APC to incorporate areas of collaboration previously being taken forward on a Barts Health / BHRUT footprint.
- In addition, this work includes developing our population health outcomes approach to planning, commissioning and resource allocation.
- Alongside this we will continue to design and deliver the cultural and behavioural development programme which began in 23/24 with the support of an external system development partner.

Summary of the benefits/impact that north east London local people will experience by April 2025 and April 2027:

- Local people trust our services and advice because they feel that their voices are heard and our delivery is culturally competent.
- Partners feel actively engaged in and know how best to contribute to our partnership work. We are working towards our collective ambition and can demonstrate how our agreed design principles are shaping our approach.
- Our partnership work is undertaken in a spirit of constructive engagement and shared risk, guided by the aspirations and needs of local people, with issues tackled together without blame.
- All partners adopt an open-book approach to aspirations, challenges, risks, and finances.

Key stakeholders:

Place-based Partnerships Collaboratives, including the VCSE
Local Authority

Details of engagement undertaken with Places, collaboratives and other ICB portfolios

- Early engagement started with Place and collaborative leads
- Full engagement plan to be developed to include in-depth conversation with all system partners

Engagement with the public:

- This is a system specific programme.
- Specific interventions will be tested and engaged with local people as required

6. Implications and next steps

How will we know we have succeeded - NEL Outcomes Framework

- The interim North East London Integrated Care Strategy was published and adopted by the Integrated Care Board in January 2023.
- The strategy highlights our four system priorities for improving quality and outcomes and addressing health inequalities as well as our six crosscutting themes which are part of the new approach for working together across NEL.
- The strategy was developed in conjunction with system partners, along with a set of success measures, which aimed to measure delivery against the priorities and crosscutting themes.

What do we mean by an outcomes framework?

- An outcomes framework is a way for us to measure the effectiveness of our ICS strategy by focusing on the outcomes that are achieved, rather than just the activities that are carried out. That way we can assess whether our strategy is making a positive difference in people's lives.

In order to support the development of the outcomes framework, the below principles have been drafted to shape the design and implementation:

- **Assess delivery against ICS strategic themes and objectives**
- **Demonstrate current delivery on priority areas**
- **Develop outcome measures in conjunction with transformation leads, provider collaboratives, and ICS partner organisations**
- **Avoid developing an outcomes framework in the model of a performance framework**
- **Importance of recognising that outcomes are often long-term goals**
- **Assess wider population health measures rather than focus on statutory or mandated performance targets**
- **Make the system responsible for delivering metrics**

We will use the insight gathered through the Big Conversation, in paritcular what our residents told us is important to them about their experience and access to services, to develop our Outcomes Framework and a set of quality ambitions.

Next steps for our transformation programmes

- As the early analysis shows, all programmes within the portfolio can demonstrate alignment with elements of the integrated care strategy and operating plan requirements. The extent to which the portfolio responds to the more specific challenges described in the first half of this plan is more variable.
- Our shared task now is to prioritise (and therefore deprioritise) work within the current portfolio according to alignment with the integrated care strategy, operating plan requirements, and additional specific local challenges.
- This task is especially urgent in light of the highly constrained financial environment that the system faces, along with the upcoming significant reduction in the workforce within NHS North East London available to deliver transformation.
- The work required to achieve this is two-fold – part technical and part engagement – and will be carried out in parallel, with the technical work providing a progressively richer basis for engagement across all system partners and with local people

Technical work

Tightening descriptions of the current programmes of work as the basis to inform prioritisation, especially:

- the **quantifiable beneficial impact** on local people, beyond the broad increases or decreases in certain measures currently signalled;
- the definition of **firm milestones** on the way to delivering these benefits;
- the **financial investment** in each programme and the anticipated returns on this investment; and
- quantifying the **staff resource** going into all programmes, and from all system partners.

Engagement

There is an important cross-system conversation needed, that enables us to create a portfolio calibrated to the competing pressures on it. Principle pressures to explore through engagement include:

- achieving early results that relieve current system pressures ***and*** creating the resources to focus on achieving longevity of impact from transformation around prevention;
- implementing transformation with a wide range of benefits across access, experience, and outcomes ***and*** ensuring, in the current financial climate, that we achieve the necessary short-term financial benefits;
- focussing on north east London's own local priorities ***and*** being open to additional regional or national opportunities, especially where new funding is attached;
- focussing on fewer large-impact transformation programmes ***and*** achieving a breadth that reflects the diversity of need and plurality of ambition across north east London; and
- ensuring that benefits are realised from transformation work already in train ***and*** pivoting to implementing programmes explicitly in line with current priorities.

We will continue to evolve as a system

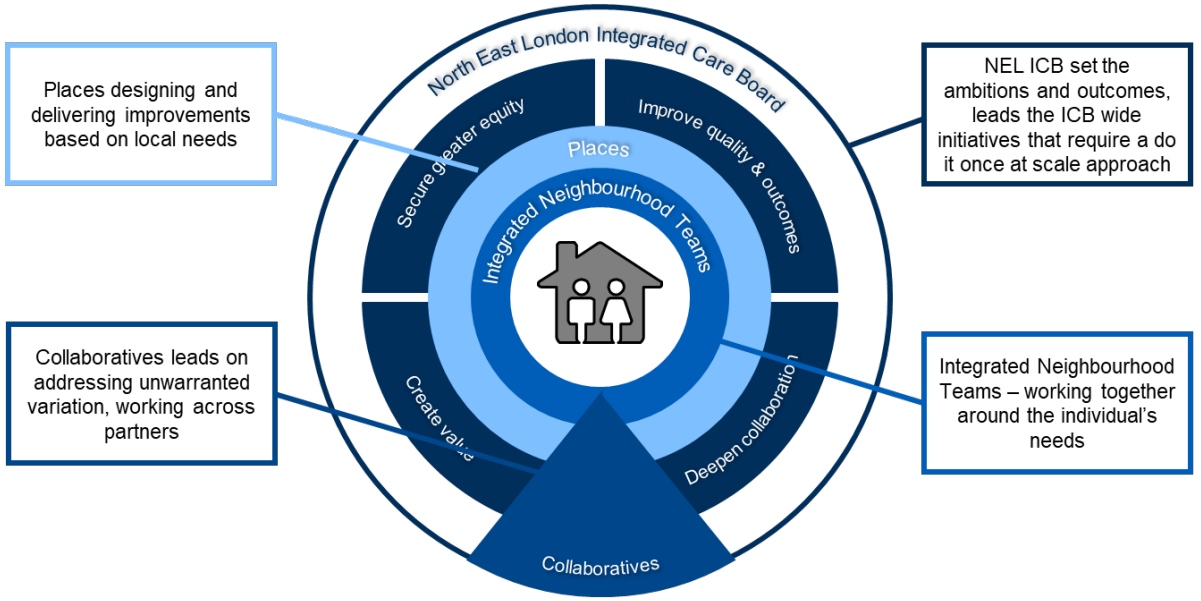
Our system has been changing rapidly over recent years, including the inception of provider collaboratives, the launch of seven place based partnerships, the merger of seven CCGs followed by the creation of the statutory integrated care board and integrated care partnership in July 2022.

Since becoming an ICS we have designed our way of working around teams operating:

- At **Place** delivering integrated services and improvements for Neighbourhoods and Place;
- In **Provider Collaboratives** reducing unwarranted variation, driving efficiency and building greater equity;
- For **NEL,** convening and sharing best practice, supporting greater alignment and tackling variation, providing programmatic support and oversight, and delivering enabling functions to our organisation and ICS through a business partner model.

Coordination between our Places, Collaboratives and NEL wide programmes is critical so that we:

- 'Pull together' in the same direction towards measurable and meaningful impact for our local population.
- Ensure that activity, transformation and engagement happens at the most appropriate level, duplication is reduced and tensions are identified and resolved
- Deliver value for money
- Deliver beneficial and sustained impact for the health and wellbeing of local people.



During 23/24 we appointed a learning partner to work with us to accelerate system development with a specific focus on providing greater clarity on roles and responsibilities, exposing the tensions and barriers holding back our progress and focusing on how we develop the behaviours to support greater integration and collaboration. We will continue this work over the coming months and years underpinned by our ambition to create a **High Trust Environment** that supports integration and collaboration and to operate as a **Learning System** driven by research and innovation.

Designing together *how* we want to work is as critical as agreeing *what* we want to deliver.

This work is helping us gain greater clarity on the responsibilities of different parts of the system, and critically how we want each part of the system to interact with another to enable integration and continuous improvement.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Overview of Clinical and Care Professional Leadership (CCPL) across North East London
Author	Dr Paul Gilluley, Chief Medical Officer Diane Jones, Chief Nursing Officer
Presented by	Dr Paul Gilluley, Chief Medical Officer
Contact for further information	Dr Paul Gilluley, Chief Medical Officer
Executive summary	• The purpose of this report is to show how clinical leadership has been developed at all levels through the Integrated Care System (ICS). The aim is to ensure that all decisions made within the organisation are clinically influenced. The paper will give the background to the development of the framework for clinical and care professional leadership, where we have reached at the present time, and the plans for future development as we move forwards • In summer 2022 the seven clinical directors at place were appointed. The clinical directors worked with the Chief Medical Officer to work on a framework of clinical and care professional leaders at both place and at NEL level. Posts were then advertised and recruited to be spring 2023. • In 2023 ICB were told they had to make a 30% reduction in their running costs which included the Clinical and Care Professional Leadership (CCPL) budget. Over the autumn the clinical directors at place worked with colleagues to rescope the framework to make the appropriate savings. • Clinical and care professional leadership is much wider in the ICS. The Chief Medical Officers (CMOs) and Chief Nursing Officers (CNOs) from the ICB and provider organisations meet virtually on a fortnightly basis. There is a forum for clinical and care professional leaders to meet fortnightly at the Clinical Advisory Group (CAG). There is also an established Allied Health Professionals (AHP) faculty and council. • Across the ICS there are also clinical leadership posts which are funded in Cancer Alliance, Long Term Conditions (LTC), Maternity and Neonatal and Digital. Work is underway on how these leaderships posts interface with clinicians who lead the clinical networks across both the acute and mental health collaboratives.

	Work needs to be done not only vertically engaging clinical leaders across provider organisations but also end-to-end clinical leadership across pathways. • Within Primary Care Networks there is resource for clinical leadership. Further development at place is required to fully develop this leadership • There are plans underway within the ICB to further develop our clinical and care professional workforce.
Action / recommendation	ICB Board is requested to note content of the report and discuss the plans outline.
Next steps/ onward reporting	Work is ongoing to develop links between clinical leads within provider organisations and place, to prevent duplication, and improve interface work. All places have this interface work underway and this is being monitored on a six-weekly basis through the Clinical Advisory Group, which is a sub-committee of the Executive Committee.
Conflicts of interest	No conflicts of interest have been identified.
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	This ensure there is a strong clinical voice in all decisions that are made across the ICS. We have developed a leadership culture where all things are viewed through and equity lens
Impact on finance, performance and quality	Financial investment will be required to develop our leadership workforce. A strong clinical and care professional leadership framework should ensure high performance and high-quality services.
Risks	• Clinical leadership is key to delivering transformation which in turn, is key to ensuring our systems are efficient and effective, and having insufficient clinical leadership will be a false economy. • We are increasingly seeing closer working with trusts and local authorities, and these organisations taking on system leadership roles on a range of agendas. This brings opportunities for more provider-based clinical and practitioner leaders to take on wider system roles. This will also release efficiencies on the overall clinical leadership budget. Given more time, identifying these opportunities with partner organisations could be a collaborative process that supports partnership working,

	so we would ask that places are given more time to fully realise these opportunities. • The CCPL will require further development which will require financial investment.

1. Background

Developing Integrated Care System (ICS) clinical and care professional leadership (CCPL) was identified as one of the key workstreams for the ICS transition programme. This paper sets out to review the framework for clinical and care professional leadership across the North East London ICS and at all levels.

The term clinical and care professional leadership is intended to be fully inclusive, reflecting the broad range of professions who need to work together through the Integrated Care Board (ICB), the Integrated Care Partnership (ICP) and across place-based partnerships, provider collaboratives and partners in primary care networks (including general practice and other primary care and community service partners). This includes allied health professionals (AHPs), pharmacists, doctors, nurses, social workers/practitioners, psychologists, healthcare scientists, physician associates, midwives, dentists, optometrists, orthoptists and public health professionals, among others. *ICS implementation guidance on effective clinical and care professional leadership (2021).*

A Clinical Steering Group was established with a reporting line to the North East London (NEL) Clinical Advisory Group (CAG) in Summer 2022. Steering Group membership included clinical leads from a wide range of backgrounds including a medical director, trust chief nurse, GPs, public health director and clinical scientist.

A period of engagement helped shape the priorities for developing clinical and care professional leadership across NEL. Engagement was undertaken with a broad range of groups and professional networks including the pharmacy network, the AHP Council, public health directors, and directors of adults and children's social care. A number of meetings and workshops were also held within the place-based partnerships and the following priorities emerged:

I. The need to develop a new clinical and care professional leadership model for the ICS focused on integrated place-based working aligned to the development of provider collaboratives and the system, and supporting the following principles:

   - Greater diversity of professions in system leadership roles
   - Greater inclusion within ICS clinical and care professional leadership
   - Strengthened accountability (as well as improved processes for recruitment and record keeping)
   - Greater focus on population health and co-production with local people

II. Investment in our talent pipeline in support of the above ambitions particularly in relation to diversity and inclusion

III. Development of opportunities for multi-disciplinary training and development in recognition of the value of cross-fertilisation across professions and the benefits for integration. Whilst we were undertaking our initial engagement, national guidance was published for ICSs and this guidance supported and reinforced the local ambitions as set out above.

2. Designing the new ICS CCPL model in NEL

Development of a new integrated place-based leadership model for the ICS was agreed as the immediate priority for our work on clinical and care professional leadership. A clear steer from the Executive Leadership Team (ELT) was given that ICB should not be seeking to transition the Clinical Commissioning Group CCPL model into the new ICB.

It was recognised that the development of the leadership model for the ICS would be a staged process with the first step being to move to place-based working and integration with emerging provider collaboratives, taking steps to increase diversity and inclusion and equalising the funding for clinical leadership across the seven places in NEL. It was recognised that the model would need to continue to develop over time, particularly as provider collaboratives matured and as investment in our talent pipeline built more diverse leadership capacity. Through further engagement, a set of principles to underpin the model design was finalised.

Place-based partnerships undertook extensive local engagement to develop their improvement and transformation priorities, and determine their preferred leadership models based on the agreed system-wide principles within the agreed funding envelope. Place-based partnerships were asked to submit early drafts which were then reviewed to improve consistency where appropriate and minimise duplication. A series of workshops and meetings took place bringing place-based partnership leads together with provider collaborative leads to align plans in key areas such as planned care, cancer, and mental health ahead of the final model being signed off by the ICB Executive Management Team (EMT).

A review of the present clinical and care professional leadership is underway. This review will aim to make 30% savings whilst maintaining a strong clinical and care professional voice within the system. The review is due to be completed by March 2024.

Work is ongoing to develop links between clinical leads within provider organisations and place, to prevent duplication, and improve interface work. All places have this interface work underway and this is being monitored on a six weekly basis through CAG.

3. Senior Clinical Leadership

The Chief Medical Officer (CMO) of the ICS meets virtually with provider CMOs on a fortnightly basis to discuss clinical issues. The Chief Nursing Officer (CNO) has similar meetings with the provider CNOs. The Director of Allied Health Professional (DAHP) has recently been appointed but will lead the AHP Forum.

The Clinical Advisory Group (CAG) was set up in November 2019. The purpose of the CAG is to provide clinical advice to the executives of the ICB. This is attended by all senior clinical and care professional leaders across the ICS. This meets virtually on a fortnightly basis. The meeting is chaired by the ICB CMO/CNO. The agenda is influenced by issues that are being decided by the ICB Executive team.

There is an established Local Maternity and Neonatal System (LMNS)

4. Clinical Networks

Clinical leaders often work within Clinical Networks across NEL. Within the NEL Acute Provider Collaborative there is around 18 clinical networks. These in the main are vertical networks across provider organisations which aim to reduce variation in clinical care and engage in quality improvement of clinical services. These involved clinical leads from provider organisations across the patch and provide multidisciplinary clinical leadership.

There are several networks across NEL which are end-to-end pathway networks and involve clinical leaders form tertiary, secondary and primary care. There are Maternal Medicine, Fetal Medicine and Neonatal networks. All these networks are being reviewed and their work plans refreshed. Their work will feedback into the Acute Provider Collaborative and then into CAG.

The Cancer Alliance is led by a Medical Director who develops and has oversight of national cancer programmes taking place within the ICS. The work of the Cancer Alliance feeds into the Acute Provider Collaborative. The Medical Director is supported by several clinical leaders. These posts are funded from ring-fenced national funding.

The Long-Term Conditions workstream has proposed a clinical leadership model which will be funded from ring-fenced funds. This is to ensure there is consistency of quality in our approach to long term conditions across the ICS.

5. Primary Care

Primary Care Networks (PCNs) are groups of GP practices that cover a population of 30,000 to 50,000 local residents. They are often referred to as “neighbourhoods” and are aimed at responding to the health needs of a local population. Each PCN is led by a Clinical Director and there is also provision for a clinical lead in Health Equality. Other clinical roles vary depending on the size of the PCN. Work is ongoing at place and with the ICB Primary Healthcare team to consider how we harness this clinical leadership provision and further develop this.

6. Social Care

The NEL model of clinical and care leadership is less well defined, which is acknowledged as an area to be developed further.

There is a regular fortnightly forum with Directors of Public Health and or Public Health consultants. Directors of Adults Social Services (DASSs) and Directors of Children’s Services (DCSs) also meet on a regular basis.

7. Future Development.

Clinical and Care Professional Leaders form a rich tapestry across the NEL ICS. Building relationships with these leaders will form a stronger system and ICB with a strong clinical and care professional voice at every level.

We will prioritise embedding the social care leadership with the clinical approach outlined in this paper particularly in strengthening our population health and health inequalities model.

Now we have identified our clinical leaders across the ICS we are now starting to develop a training programme for them in System Leadership. This will be based in NEL and will focus on the needs of our local population and how we can work across the system to meet those needs. The outcome will be a Leadership Academy which will skill our clinical and care

professional leaders to lead the system to meet the needs of our local residents. The aim is to have the Leadership Academy up and running by Autumn 2024.

North East London is already home to clinical and care professional leaders who have local, London-wide, national and international reputations. It is planned to invite these leaders to form a NEL Leadership Faculty which will advise on training of our leaderships and help support in that training.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Update on the delivery plan for recovering access to primary care
Author	Alison Goodlad, Deputy Director Primary Care
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	Sarah See, Managing Director for Primary Care (sarahsee@nhs.net)
Executive summary	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. A two-year programme is in place to address the requirements of the plan, incorporating four key areas: implementing modern general practice access, empowering patients to manage their own health, building capacity and cutting bureaucracy. A paper was presented to the Board in November 2023 which gave an overview of the national requirements of the plan and how we are working to implement the programme across North East London and the ICB gave assurance on our plans to deliver this. This update focusses on progress in three key areas: Expanding the role of community pharmacy, reducing bureaucracy at the interface between primary and secondary care and maximising use of digital telephony to enable practices to deliver modern general practice, along with a summary of progress against the delivery checklist for ICBs, risks and mitigations.
Action / recommendation	The ICB Board is asked to note the report.
Previous reporting	A paper giving an overview of the delivery plan for recovering access to primary care was presented to the Board in November 2023 and an update provided to the Executive Committee on 14 March 2024.
Conflicts of interest	No conflicts of interest have been identified.
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	North East London Integrated Care System (ICS) has an ambition of working with and for the local people to create meaningful improvements in health, wellbeing and equity to the local population. Improvements to general practice in terms of access, experience and outcomes for local residents are central to this ambition. Our plan has been informed by resident insight and experience. An Equalities and Health Impact Assessment has been completed for delivery of this plan
Impact on finance, performance and quality	The paper provides an update on how work will be undertaken to implement the national delivery plan for recovering access to primary care. This plan will deliver a vision for improving access to primary care and enhancing quality and patient experience for local residents. 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. In 2023/24, we have received £1.6 million for transitional funding for practices to move towards the modern general practice and £2.5 million for cloud-based telephony.
Risks	• Risk of insufficient capacity to deliver a wide-ranging complex programme. Projects and actions are broken down into blocks with different leadership and ownership across the system, working to a timeline. This is being assessed as a part of the primary care portfolio review. • Individual risks and mitigations against each project are outlined in Appendix A. There are wider risks to the sustainability of primary care services which may impact on delivery at a practice level, caused by factors such as variations in funding, patient access, quality, performance, challenges in the recruitment and retention of staff, increasing rent and service charges, together with poor quality estate.

1.0 Background

1.1 The Delivery Plan for Recovering Access to Primary Care was published by NHS England (NHSE) on 9 May 2023. This 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.

1.2 A paper was presented to the ICB Board in November 2023 which gave an overview of the national requirements of the plan and how we are working to implement the programme across north east London.

1.2 This report gives an update on progress in line with the requirement from NHSE for Integrated Care Boards (ICBs) to provide updates to their Boards in March 2024 on recovering access to primary care.

2.0 Introduction

2.1 Overall, we have been making good progress against the requirements of the plan. NHSE has developed a checklist of actions to enable ICBs to assess progress against the four plan commitments. Each action in the checklist has an owner and is attributed to a specific programme with leadership and progress captured within a programme report. The latest self-assessment for North East London (NEL) ICB can be found in appendix A.

2.2 Particular areas of current focus that will enable a step change in access for patients include expanding pharmacy services, maximising use of digital telephony and moving to a modern general practice model and the freeing up of clinical capacity by reducing bureaucracy at the interface with secondary care. Plans and progress in these particular areas are covered in more detail in the sections below.

3.0 Expansion of Community Pharmacy Service

3.1 The new Pharmacy First scheme aims to make it easier for patients to access the care they need. Pharmacy First is an advanced service that will include seven new clinical pathways and will replace the Community Pharmacist Consultation Service (CPCS). The full service will consist of three elements:

Pharmacy First (Clinical pathways)	Pharmacy First (urgent repeat medicine supply)	Pharmacy First (NHS referrals for minor illness
Uncomplicated Urinary Tract Infection Sinusitus Shingles Impetigo Infected insect bites Sore Throat Acute Otitis Media	previously commissioned as the CPCS	previously commissioned as the CPCS

3.2 Contractors will need to be able to provide all three elements (the only exception is Distance Selling Pharmacies who will not be required to do the otitis media pathway due to the need to use otoscopes). Remote consultations for six of the seven clinical pathways are permissible via high quality video and if clinically appropriate speed of access to medicines can be facilitated.

3.3 The existing referral routes for the CPCS will apply to the new clinical pathways' element, but patients will also be able to self-refer to a pharmacy for the seven clinical pathways (subject to the patient passing a clinically established gateway point in the relevant clinical pathway). A diagram illustrating the pathway for community pharmacy services is in appendix B.

3.4 The Community Pharmacy Consultation Service commenced in March 2022. There have been over 120,000 referrals from NEL GP surgeries for this service, which is the highest referral rate in England. This has been enabled by referrals from practices being made using Egton Medical Information Systems (EMIS) clinical

system integration. The Local Pharmacy Committee (LPC) were commissioned to train staff in practices and support the pharmacies to ensure delivery. In NEL 1% of referrals made to pharmacies are returned back to back to GP surgeries compared with a national average of 10%.

3.5 Under the Delivery Plan for Recovering Access to Primary Care it is a requirement of community pharmacy that blood pressure monitoring and oral contraception is available from community pharmacies from 1 December 2023. NEL has a Hypertension Case Finding service through which GPs can refer for blood pressure checks and advanced monitoring. NEL has onboarded over 100 pharmacies which now provide improved access to contraceptive services.

3.6 NEL has commissioned the LPC to deliver training and support implementation for pharmacies and practices funded from the Service Development Fund (SDF) investment. There is no data available as yet on additional activity. NEL ICB is also piloting a self-care scheme for eligible patients to get 'over the counter' products meaning they don't need to be referred back to the surgery for a prescription.

4.0 Roll out of digital telephony to support modern general practice access

4.1 Practice telephone systems play an important role in improving the experience of accessing general practice. NHSE has required all practices to have in place a digital telephone system that can perform certain key functions. This has the advantage of supporting practices to be able to provide patients with more holistic and personalised care with features such as automated booking, call recording and clinical systems integration. Modern digital systems allow for a much richer data collection regarding patient demand and the number of calls received to enable better management of the delivery of clinical services. Patients benefit from the option of receiving a call back, rather than waiting on hold.

4.2 Across NEL, 161 (61%) practices qualified for a funded upgrade, ranging from many requiring a complete change from an analogue system to a digital system, through to those being upgraded to a digital system with greater functionality. NEL practices are benefitting from a total investment of £2.5 million from NHSE for this purpose.

4.3 At present, 91 practices have a signed contract for a new digital telephone system, including all practices on old analogue systems. Implementation has been completed by some practices already, although most are awaiting implementation dates. Another 70 practices already had digital systems but without the full functionality required. Upgrades are expected to take place from March onwards. There is a requirement from NHSE to support practices once they have moved systems and the current proposal is to use the existing training hub digital facilitators to provide training to ensure that practices and their patients get maximum benefit from the new systems.

4.4 In order to facilitate working at scale NHS NEL has been encouraging all practices in a Primary Care Network (PCN) to use the same telephone system. Currently there are 20 PCNs where all practices either have or plan to have the same system, nine PCNs where it is possible that all practices will have the same system. The remaining PCNs have either not yet made a final decision or will continue to have a range of telephone systems across their practices. Although having a range of systems wont impact patient services in the short term, the PCN development programme will be aimed at helping practices to understand the longer-term benefits of moving onto one

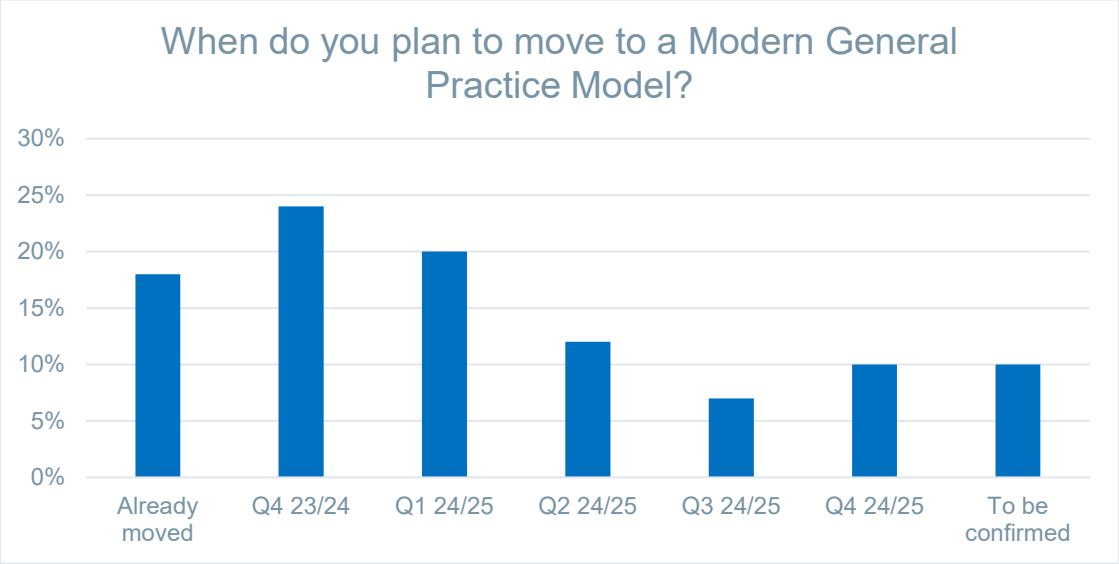
system to support collaboration and at scale working. Once practices do realise this benefit they can choose to change systems in 2027 at the latest.

5.0 Moving to a modern general practice model of access

5.1 The modern general practice model moves away from the 8am phone call queue and 'first come, first served' process for allocating appointments. Instead, the model requires consistent structured information to be collected at the point of contact – to let the practice know about symptoms, ask a question, make a request or follow up about something – with patients either providing this information via an online form or to reception staff who capture the information about their needs. Patients' needs can then be consistently assessed and triaged, allowing practices to provide patients with the most appropriate care or other response, from the right member of the practice team, including signposting or referring patients to other appropriate services.

5.2 To support implementation of the modern general practice aspirations as set out in the access recovery plan, GP practices are entitled to receive funding to create capacity for change management and quality improvement within their teams**.** NEL ICB has been allocated £3.2 million for this, split equally between 23/24 and 24/25. All practices have submitted plans for how they will spend this funding and 95% of these plans have currently been approved with the expectation that all will be approved by the end of March. Further detail can be found in the checklist in Appendix A.

5.3 As part of the application process, all practices were required to indicate when they planned to move to a modern general practice model. The chart below shows planned progress by practices towards this model over the next year. By 1 April 24, 44% of practices will have implemented this model. We anticipate that all practices will have moved to this model by April 2025.



6.0 Reducing bureaucracy at the interface with secondary care.

6.1 Reducing bureaucracy gives practices more time to focus on their patients' clinical needs. This workstream focusses on improving the interface between primary and

secondary care, in order to enhance the experience for patients and staff as well as increasing efficiencies across all providers.

6.2 The ICS's Clinical Advisory Group (CAG) provides strategic oversight of NEL's work to improve the primary-secondary care interface and will work with the acute and community collaboratives to enable this. Local interface groups have been established to ensure delivery at Place. CAG will identify and solve current and upcoming system interface challenges between primary and secondary care, strengthening relations, improving communication, developing new integrated pathways and ensuring interface processes meet the needs of all.

6.3 ICBs have been tasked with actions in four key areas: onward referrals; complete care (eFit notes and discharge/clinic letters); call and recall; and clear points of contact.

6.4 Most of the interface groups in NEL have completed a self-assessment tool in order to assess progress against the four areas, except for the Barking and Dagenham, Havering and Redbridge (BHR) Group who are not yet in a position to report. (see Appendix C).

6.5 Place-based partnerships have indicated that this is a resource intensive area of work, and Board recognition of this as a system priority would aid local discussions.

7.0 Key areas of focus going forwards into 24/25

7.1 As well as working to further develop the areas outlined above, we will be focussing on making further progress in the following areas:

- Working to increase the proportion of NEL practices with all four key functions of the NHS App enabled. This is currently 70% compared to the England average of 76%.
- Further progressing our GP registration campaign, encouraging continued use of our NEL online registration tool by local residents. There have been over 300,000 completed registrations since its launch with 90% of users reporting that it is easy/very easy to use.
- Working with the remaining 9% of practices to get 100% of NEL practices offering prospective records access.

7.2 All Primary Care Networks will be required to submit final reports demonstrating delivery against their capacity and access improvement plans in April 24 and these will be assessed to inform payments based on performance against their plans. This information will present an opportunity to assess progress in improving patient experience, demand management and accuracy of recording in appointment books.

7.3 It is expected that patients will report improved experience through national tools such as the friends and family test and annual GP-patient survey. We will also seek to understand progress through engagement with residents and voluntary sector partners such as Healthwatch. In addition, GP appointment data, primary care workforce data and data relevant to the uptake and use of digital tools will be used to assess progress.

Attachments

- A - Delivery Plan for Recovering Access to Primary Care – Progress against ICB Checklist
- B - Pharmacy First Pathway Overview
- C - Self-assessment against the four areas keys areas of improvement at the interface between primary and secondary care

Alison Goodlad
21 February 2024

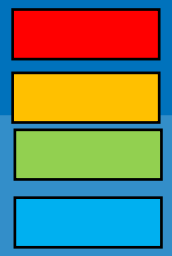
NHS
North East London

Appendix A

Delivery Plan for Recovering Access to Primary Care

Progress against ICB Actions checklist as at March 24

Key



Off track – At risk
Some slippage but expected to deliver
On track – no major concerns
Action closed/completed

ICB Progress against key milestones – Empowering Patients (1/2) February 2024

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	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 activity reporting which will improve on our reporting position. • 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. Phase 2 is at risk due to reduced transformation/contracting capacity within ICB	

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

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risk/Mitigations	RAG
Prospective records access	Apply system changes or manually update patient settings to provide prospective record access to all patients	31 Oct 2023	91% of practices live with prospective records access (95% London average). The remaining practices have requested to take 'opt in' approach. These practices have been informed that it is against their contractual obligation. They are being ask to re-submit a plan and measures are being put in place to ensure bulk enablement for these practices.	Risk that those remaining practices requesting bulk enablement won't agree to comply with the requirements of the contract. Support being provided to assist them. Remedial notices to be issued if absolutely necessary.	
Community Pharmacy	Support the expansion of community Pharmacy services (including oral contraceptive and blood pressure services)	Ongoing	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 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. 97% (359) pharmacies are signed up to deliver Pharmacy First - The highest percentage in London. NEL has commissioned the LPC to deliver training and facilitation of implementation for pharmacies and practices	ICB have been putting preparation in place in good time, so that we are ready to have local services in place once the national negotiations have been concluded and new services are launched. In order to ensure effective and appropriate use of the service, national and local communications are being put in place to raise public awareness.	

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

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risk/mitigations	AG
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	91 practices have signed contracts for digital systems including all practices on analogue systems and implementation is being rolled out. 70 practices requiring improved functionality will be upgraded from March onwards. Of the 7 accredited suppliers, the vast majority of practices (73) have chosen to use Xon	Risk that not all practices will move on time. £2.5 million provided by NHSE for this purpose.. Plans incorporated in PCN CAP Plans. Support provided by Digital Facilitators, although risk that the SDF funding for these posts won't continue. PCN Digital Transformation Leads may be able to provide some support if necessary	
Training	Nominate PCNs / practices for national intensive and intermediate transformation support through the GP Improvement Programme	2023/24 rolling programme	National Prog: 20 practices signed up so far for the 16 and 32 week programmes, spread across different places in NEL. Local Demand and Capacity training: 48 practices have undertaken this. .	Reluctance of practices to sign up to national programmes due to time commitment required and capacity issues. Practices that would benefit most being targeted. Backfill support has been offered through transitional funding. Local training offers have been made available and flexing around practice availability,.	
Training	Use the Support Level Framework (SLF) during 23/24 to understand need.	2023/24 rolling programme	12 practices currently actively undertaking the national programmes have had Support Level Framework discussions. All 8 practices in Havering Crest PCN have gone through the SLF process via a national pilot. 6 further PCNs have expressed an interest in going through an SLF process.	Lack of local capacity or funding to facilitate SLF discussions at practice level. Taking advantage of opportunity for national team to support with PCN focused SLFs.	

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

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risk/mitigations	RAG
Practice websites	ICBs to put in place a strategy for auditing usability and accessibility of all general practice websites using the GP website benchmark and improve tool. All GP websites to be audited in 23/24 and an improvement plan agreed	March 24	• Practices in NEL have been given the access for a 2nd website audit tool where it audited their website digital scoring, accessibility, information-sharing, areas of improvement and technical suggestion on how to improve. Status "Completed" • The second workstream is to establish "Gold Standard" pilot website which involve 3 practices and 3 PCNs across NEL. Status "In-Progress. Target of Completion in March 2024" • Once the "Gold Standard" pilot is completed, the next plan is to encourage all practices and PCNs in NEL to use the same website benchmark and promote standardisation between the practices and PCNs using the Gold Standard benchmark. Status "Future Plan"	• Lack of funding to promote and implementing the Gold Standard website to all practices and PCNs in NEL. • Risk of not having sufficient funding to continue to support future website reviews and audits • As a mitigation, Healthwatch could be approached to support a future website audit	

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

North East London Health & Care

Initiative	Description	Target	Update	Risk/mitigations	RAG
Local Training and support	Fund or provide local hands-on support to . We would expect the level of support to be similar to the national GPIP intermediate offer, and offered alongside wider and/or ongoing support for practices and PCNs where required to implement Modern General Practice,	March 24	Equip Team provide QI support and training to practices. Equip Team and have a lot of highly specific subject matter expertise around areas like primary care access, triage, data/measurement and team culture and have invested a lot of time in building relationships and tailoring support offers to the specific needs of local practices. A range of support is also available from other teams in NEL Digital Facilitators – General software systems support (including telephony) GP IT Facilitators – Independent EMIS Support Clinical Effectiveness Group (CEG) - Support on coding	Reliance on non-recurrent SDF funding. Unconfirmed SDF funding for 24/25 creates a risk for longer-term investment in Digital/IT Facilitators. 38 practices are using some of their transitional funding for QI coaching and training support from the Equip team.	
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	

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

North East London Health & Care

Initiative	Description	Target	Update	Risk/mitigations	RAG
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 were asked to submit plans by 31 Dec 23. Plans have been assessed and 50% will be paid in 22/23 on approval. The remaining 50% to be paid in 23/24 on completion. Practices can use the funding to clear backlog of appointments before moving to a new model, for organisational development support around aspects such as making best use of cloud based telephony or care navigation processes in the practice and for participation in local and national training programmes. Most practices have opted to use the funding for a range of different initiatives. 50% of practices are using some of the funding to clear appointment backlogs 75% of practices are using some funding for change management 52% of practices re using some funding for national and local training programmes. (38 of these practices are using it for contracting the local EQUIP QI team to support the practice in undertaking QI related initiatives)	We receive 1.6 mill funding in 22/23 and a further 1.6 mill 23/24 and it has to be spent in-year, therefore funding was allocated to practices on a 50/50 split in both years to ensure full spend achieved. All plans have been reviewed and approved to ensure appropriate use of funds and practices have been asked to resubmit where not compliant with the policy. Around 95% of practice submissions have been approved so far and the remaining practices are being followed up to ensure that they make a compliant submission.	

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

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risks and mitigations	RAG
Capacity and Access Plans	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. PCNs are producing action plans to improve pt experience and will need to undertake a pt survey to measure progress against one of the GP survey questions. PCNs to put plans in place for transition of all practices to a compliant telephony system and increased use of online-consultation. PCNs to have plans for ensuring accurate recording in appt books and at year end and to provide self-certification re: categorisation of appts. 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 throughout the year 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 collated and analysed at place level. Local discussions have taken place around support needs .	Completion of toolkit has been linked to access to transitional funding to ensure all toolkits returned	

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

North East London Health & Care Partnership

Initiative	Description	Target	Update	Risks and mitigations	RAG
Digital Tools	Select digital tools from the Digital Care Services Framework (DCSF). These are : EMIS Web clinical system; TPP SystmOne; Eclipse prescribing s/w AccuRx (Floreys, SMS plus, batch SMS) Online / video consultation; AccuBook	(National Framework was due January 2024 but has been delayed)	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. Select digital tools are still being procured by the legacy framework	The national Digital Care Services Framework was due to be in place in April 23 and was due to be released later in 23/24 but has been further delayed. Current criteria for spending this funding is too restrictive. We would like to see Edenbridge Apex, SMS fragments and EMIS Clinical Services on an expanded framework. OCVC funding being reimbursed before DCSF is live by liaising with procurement hub Working to ensure maximum utilisation of digital offers once framework released	
111 Diversion	Set up process for practices to inform of diversion to 111 and monitor exceptional use when over capacity	Ongoing	Practices should not be diverting to 111 during core hours. Should practices need to do so in exceptional circumstances, they are required to report this their primary care place teams.	Risk of inappropriate use of 111. Regular monitoring of 111 activity by practice across NEL	

ICB Progress against key milestones

North East London Health & Care Partnership

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 is being provided through workforce and place teams. The ICB has been 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 access improvement.	Ensure close monitoring of spend and year-end forecasting. Monthly group has been established to triangulate information between teams, with place teams working with PCNs on their recruitment intentions and progress and the central NEL team analysing claims data.	

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. All acute trust partnerships have completed a self-assessment outlining progress against the four key areas for improvement (onward referrals, fit notes, call recall, clear points of contact).	There are a large number of interface issues that need addressing across NEL and the Place Based Partnerships have indicated that this is a resource intensive piece of work. Need to ensure that his is prioritized and sufficient capacity in place to oversee this work over the next two years.	

North East London Health & Care Partnership

Reducing bureaucracy

Initiative	Description	Target	Update	Risks and mitigations	RAG
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. 81% of NEL practices use this service. There were 4,672 completed registrations in NEL in Dec 23 and 305,122 since its launch. This is expected to increase with the local GP registration campaign and is monitored monthly. 90% of people using the service report that it is easy/very easy to use.	Ensure practices use the service and advertise to new patients on their websites. We have started to run an online campaign to encourage registration focussed on low registration areas (based on A&E data). This has led to 750 views per day on the GP pages of the ICB website, directing people to register online via the portal.	

ICB Progress against key milestones

Enablers

Initiative	Description	Target	Update	Risks and mitigations	RAG Cor
Comms	Co-ordinate system comms to support patient understanding of the new ways of working in general practice including digital access, multidisciplinary teams and wider care available	Ongoing	Resident insight has informed our 'Right Care' campaign, aimed at supporting local people to access care appropriately. This runs for 12 months from Nov 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 vulnerable to preventable hospital admissions. Activity consists of a mix of targeted digital advertising, outdoor advertising, press, social media, and partner communications. From 20 Nov -12 Jan, our campaign pages have been viewed over 18K times	Risk that patients do not understand new ways of working in general practice - 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 Risk that comms will not be effective or reach the people most likely to benefit – Regular monitoring of advertising performance using data on engagement with web-based and social media materials.	
Directory of Service (DOS)	Maintain an up-to-date DoS and deliver training to all practices/PCNs on DoS	Ongoing	All ICBs in London fund a regional team which maintains an accurate DoS, allowing health professionals to access up to date information about available services across London. Places also shared info with practices/social prescribers on local services. e.g Find Support Services in Hackney which helps residents to access support from the voluntary and community sector.	Londonwide team maintaining Dos linked to 111 Places also shared info with practices/social prescribers on local services. from the voluntary and community sector.	

Practice/PCN Progress against key milestones (not already covered in the ICB actions section)

North East London Health & Care Partnership

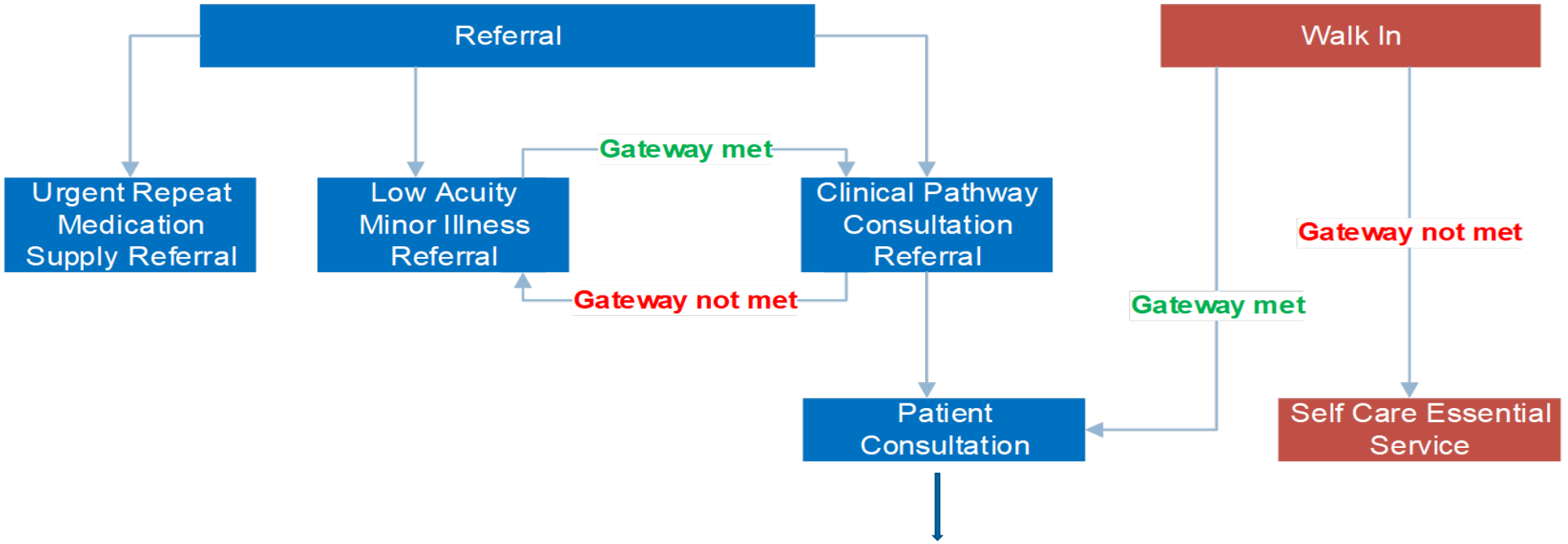
Empowering patients

Initiative	Description	Target	Update	Risks and mitigations	RAG
NHS App/Direct booking	PCNs / practices have enabled NHS App functions: Ensure directly bookable appointments are available online following bookable online appointment guidance Encourage patients to order repeat medications via app supported by comms toolkit Offer secure NHS App messaging to patients where practices have the technology to do so in place	Ongoing	94% of NEL practices offer patients the ability to book and cancel appointments on line (compared to 92.3% in London and 95.1% in England 41.8% of patients are enabled to book/cancel appointments online (compared to 45.6% in London and 45.3% in England 100% of NEL practices offer patients the ability to book repeat prescriptions online. (compared to 99.6% in London and 99.8% in England 44.9% of patients enabled to order repeat prescriptions online (compared to 50.6% in London and 50.4% in England). NEL practices with all four key functions enabled (70%), compared to the England Average of 76%.	Targeted work with practices to ensure that all functions are enabled. Practice level and ICB-level Communications to raise awareness of use of digital tools and the NHS app The number of appointments available via the App may be only a small proportion of the total appointments provided by a practice as there is also a significant focus on triage of requests prior to booking patients into an appointment.	

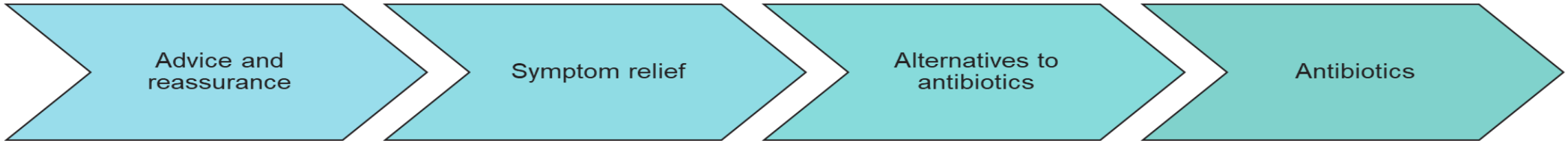
Appendix B

Pharmacy First Pathway Overview

North East London Health & Care Partnership



The existing referral routes for the CPCS will apply to the new clinical pathway's element, but patients will also be able to self-refer to a pharmacy for the clinical pathways (subject to the patient passing a clinically established gateway point in the relevant clinical pathway).



Appendix C
Self-Assessment against the four areas keys areas of improvement at the interface between primary and secondary care

Note: BHR are not included at this stage as they are not yet in a position to report.

Onward referrals

If a patient has been referred into secondary care and they need another referral, for an immediate or a related need (including diagnostic needs and community referrals, both in and out of area), the secondary care provider should make this for them, rather than sending them back to general practice.

Interface group	Self-assessment Rating *	Progress	Challenges
City and Hackney Place Based Partnership	2	Consultant to consultant referral pathway implemented in an increasingly consistent way across Homerton Healthcare.	Referral pathway refreshed in Q2-Q3 of 23/24 year and communications completed across both secondary and primary care
Tower Hamlets Together	1.5	Not consistently applied.	Contractual issues Lack of Data Lack of awareness
Newham	1.5	Not consistently applied	Lack of data IT is the main barrier as Barts Trust do not have Electronic Referral System (ERS) Increase awareness
Whipps Cross/Waltham Forest/Redbridge	1	Consultant-to-Consultant are possible across Whipps Cross (WX) departments but no common and agreed understanding of what is appropriate – creating doubt and unwillingness to refer.	Uncertainly due to frequent change in guidance. Local Interface Service Group WXH (IS-WXH) has asked specialities to report-back issues/concerns by end March to assist simplifying guidance.

Level 0
- No ability to make onward referral

Level 1
- Ability to refer for immediate needs e.g. two weeks referral

Level 2
- Level 1 + ability to refer for need related to the condition for which they had been originally referred (*non urgent)

Complete care (fit notes and discharge letters):

To help ensure the most seamless experience for patients, trusts should ensure that on discharge, or after an outpatient appointment, patients receive everything they need.

Interface Group	Self-assessment Rating *	Progress	Challenges
City and Hackney Place Based Partnership	0 for fit note 1 for discharge summary/outpatient letters	Currently paper fit note provided to the patient Level 1 implemented very consistently. Big improvements to the format and clarity of letters.	Without a digital platform to aid this through EPR it will be difficult to progress this. This would be suitable for a NEL wide solution. Further work needed to clarify timeframes and communicating this across both Trust and primary care
Tower Hamlets Together	0.5 0.5	eMED3's are issued on some sites of the Trust (Newham) and not others (RLH) No standard outpatient letter templates – with actions for GPs. No consistency across services. Electronic discharge summaries have a clear section for GP actions	Some lack of understanding for need for a formal, DWP fit note.
Newham	1 0.5	Use of FIT note varies by department to department . Outpatient and discharge letters – action points vary by department. The Trust is working on formulating a standard discharge letter template	No IT system to generate electronic FIT notes. Some lack of understanding for need for a fit note. Challenging to create a template that all Departments can use
Whipps Cross/Waltham Forest/Redbridge	0	Currently, Whipps Cross do not offer electronic fit notes.	Electronic fit note implementation approach and risks not

		Initially paper notes will be provided, while feasibility of electronical fit notes is investigated.	yet known (to be scoped).
	1	GP Actions are routinely specified by most specialities. Whipps Cross are currently assessing the consistency and content to address gaps and ensure quality.	GP clinical leads and Local Medical Committee are engaged to help build consistency across Waltham Forest and Redbridge.

Fit notes*
Level 0 - Only handwritten fit notes are issued both for outpatient and inpatient
Level 1 - Electronic Fit notes are not routinely issued on discharge
Level 2 - eMED3s are routinely issued on discharge
Discharge summary/outpatient letters
Level 0 - No 'GP Actions' section on discharge letters.GP Actions' not clearly listed on outpatient letters
Level 1 - 'GP Actions' section discharge letters. 'GP Actions' clearly listed on outpatient letters with details of meds
Level 2 - All departments have developed consensus guidance with GPs on what can be reasonably requested and within what timeframe, including clear pathways for urgent requests required on discharge and a minimum acceptable

Call and Recall

For patients under their care, NHS trusts should establish their own call/recall systems for patients for follow-up tests or appointments.

Interface group	Self-assessment Rating *	Progress	Challenges
City and Hackney Place Based Partnership	1	Implementation of 'Patient Knows Best' across Homerton healthcare will aid the move from Level 1 to Level 2 and work has already started on this. Over the coming months expected to move to Level 2	

Tower Hamlets Together	0.5	Works will in Endoscopy but this is not mirrored across the Trust or other departments.	Lack of admin support Clinical system Issues of clinical responsibility following pt discharge Historic process to pass to GP for re-booking. Need IT /system support
Newham		Variable across the hospital and clinician and scenario dependent.	Lack of capacity and systems in place to implement a robust system across the board
Whipps Cross/Waltham Forest/Redbridge	2	Text and connectivity to NHS App (and "Patient Knows Best" app) are used to inform of patients about appointments and offer letters etc. Some known gaps due connectivity issues – these are being reviewed for systematic management.	This is an area to accelerate and ensure consistent implementation and full coverage. Strategies are needed to mitigate risks around digital exclusion

* Level 0
- No call or recall mechanism in the trust for follow up tests or appointments

Level 1
- Manual process in place for checking appointment dates and times e.g. patient calls to check details and book follow-up tests

Level 2
- Digital process for checking the appointment and for booking follow-up tests electronically

Clear Points of Contact

ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: e.g. a single outpatient department mailbox or phone number for GP practices or primary care liaison officers in secondary care.

Interface Group	Self-assessment Rating *	Comments	Challenges

City and Hackney (C&H) Place Based Partnership	1	Working to ensure practices can make contact with the most appropriate person who can support with the query on the first contact and this is working well across C&H with Homerton Healthcare.	Work to do around communications with some clear timeframes when people can expect to receive a response and then how to escalate the query if a response has not been achieved in that timeline.
Tower Hamlets Together	0.5	Limited and not well publicised systems in place Need to map the gaps to see where there is already provision and where there is none.	Needs senior Trust support and will take new resource. Need robust procedures in place to ensure emails will be actioned, or redirected if sent to the wrong inbox.
Newham	0	The trust does not have single outpatient department emails.	Needs senior Trust support and will take new resource. Need robust procedures in place to ensure emails will be actioned, or redirected if sent to the wrong inbox.
Whipps Cross/Waltham Forest/Redbridge	0	No current single-point-of-access system in Whipps Cross. Process/system in place in Barts Health called AIRS (Access, Issues and Resolution Service, similar to PALS) being investigated for suitability for Whipps Cross for dealing with GP queries for results/appointments etc. as well as patient concerns.	

*Level 0

- No single outpatient department email or phone number for GP practices or no primary care liaison officers in secondary care

Level 1

- Dedicated email address or phone number for GP liaison which is available to all GP practices, with emails promptly responded to, or a primary care liaison officer in secondary care

Level 2

- A dedicated, overall named lead for resolving issues and improving the interface with primary care

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Financial overview (Month 11 2023-24)
Author	Ahmet Koray
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	henryblack@nhs.net
Executive summary	**Key Items** • The paper outlines the financial performance for the Integrated Care Board (ICB) and Integrated Care System (ICS), showing a year-to-date to February 2024 position with an adverse variance to plan of £8.3m for the ICB as part of a £52.7m adverse variance for the ICS. • The ICS submitted an updated forecast position to NHS England (NHSE) as part of the H2 submission. This moved the ICS from a forecast breakeven position to a forecast month 12 deficit of £25m. • The reported forecast deficit at month 11 is £36.9m. This is made up of the H2 system deficit of £25m deficit plus the impact industrial action costs over and above the allocation received (resulting in a pressure of £11.9m). • The ICB Board is asked to note the month 11 financial position and the variation from the H2 forecast deficit. • The ICB Board is asked to note the level of risk in delivering the year-end financial position if the FRP and actions outlined in the H2 submission aren't delivered. • An update is given on the proposed variation to the Better Care Fund (BCF) for Barking and Dagenham, Redbridge and Newham places.
Action required	• Note the contents of the report and the risks to the financial position. • The Board is recommended to approve the variation to the BCF agreements for Barking and Dagenham, Redbridge and Newham places.
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 have been identified.
Strategic fit	North East London (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 risk to the reported position is the delivery of the finance recovery plan. Furthermore, there is a risk that any additional industrial action will realise increased costs. The ICB risk rating is 20.

1. Purpose of the Report

The purpose of the report is to update the ICB Board on the month 11 financial position and the risks associated with delivery of the Integrated Care System (ICS) and Integrated Care Board (ICB) financial plan.

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

2. Month 11 Finance Overview

The month 11 year-to-date position across the North East London (NEL) system is a overspend variance to plan of £52.7m. This is made up of a provider overspend variance of £44.4m with an ICB overspend variance of £8.3m.

The H2 submission to NHS England (NHSE) moved the system forecast from breakeven to a £25m deficit. Month 9 was the first month of reporting against the revised plan.

At month 11 the ICS forecast was £36.9m which is £11.9m higher than the expected H2 (second half of the financial year) forecast. The H2 forecast included the costs of industrial action for H1 (first half of the financial year) only. Since then there have been strike days in December, January and February. An allocation was received in month 11 to cover the cost of strike days but the allocation received was less than the expected cost of the strikes, resulting in a shortfall in funding of £11.9m. At month 11 providers are unable to mitigate the excess costs and have reported a worsening forecast position.

Moving into month 12 the system is reporting ongoing run rate and other financial risks that may impact the delivery of the year-end position. Ongoing delivery of the Financial Recovery

Plan (FRP) and other cost improvement programmes remain critical to the ICS and its ability to deliver the year-end position.

2.1.1 ICS Month 11 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			Industrial Action (IA)	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	IA costs less Allocation Received £m	Adjusted Forecast £m
BHRUT	(2.9)	(24.3)	(21.3)	(0.2)	(15.8)	(15.6)	1.7	(14.1)
Barts Health	(25.3)	(40.2)	(15.0)	(27.8)	(42.2)	(14.4)	5.8	(36.4)
East London NHSFT	4.4	0.7	(3.7)	5.4	4.2	(1.2)	1.2	5.4
Homerton	0.2	(1.9)	(2.0)	0.2	(3.4)	(3.5)	2.1	(1.3)
NELFT	6.3	3.9	(2.4)	7.0	5.9	(1.1)	1.1	7.0
Total NEL Providers	**(17.3)**	**(61.7)**	**(44.4)**	**(15.3)**	**(51.3)**	**(35.9)**	**11.9**	**(39.4)**
NEL ICB	14.1	5.8	(8.3)	15.4	14.4	(1.0)	0.0	14.4
NEL System Total	**(3.2)**	**(55.9)**	**(52.7)**	**0.0**	**(36.9)**	**(36.9)**	**11.9**	**(25.0)**

All providers and the ICB are reporting year-to-date pressures at month 11, with Barts Health, Barking, Havering and Redbridge University Hospitals Trust (BHRUT) 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 £140.6m. Reported year-to-date spend across providers is reported as £168.6m. The year-end submitted forecast on agency spend is £184m (£43.4m above the cap).
- **Impact of Industrial action** – Funding of £15.7m was received in month 11 to cover the costs of industrial action for the period December 23 to February 24. However, reported costs were £27.6m resulting in a shortfall in funding of £11.9m. This has been reported in the forecast over and above the position agreed for H2.
- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 11 is £251m. Of this £230.5m has been delivered, leaving a year-to-date under delivery against plan of £20.5m (£9.3m providers and £11.2m ICB). The year-end forecast of efficiencies is an under delivery across the system of £23.9m.
- **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 £109.5m 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 £9.2m. 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 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 £8.3m. In line with the H2 submission the forecast surplus at year end is £14.4m (a £1m variance to the original operating plan target).

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 Unit (PICU), section 117 and adult placements). In contrast, there is a year-to-date £8.3m underspend in ring-fenced dental, ophthalmology, and pharmacy (DOPs) spend.

The ICB is reporting that it will hit its revised forecast position, a surplus of £14.4m. To hit this target the following assumptions are included in the forecast;

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 System Development Funding (SDF) and other programme budgets can be used non-recurrently to support wider system and ICB financial performance.
iii. Efficiencies and FRP stretch assumptions are assumed to be in line with the total savings target identified and will be required to deliver fully to hit the revised forecast position.

At month 11 the ICB is expecting to hit the revised financial target. However, continued price and activity increases in areas such as prescribing means that the ICB has reported a run rate risk to NHSE at month 11. This means that any variation to the assumptions built into the forecast position, or a further increase in run rate pressures remains a risk to the ICBs year-end position.

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

	YTD Variance £m	FOT Variance £m
Current Variance to Plan	(8.3)	(1.0)
Acute	(2.5)	2.3
Mental Health	(4.3)	(5.4)
Community Health	1.7	2.2
Continuing Care	(13.5)	(12.8)
Primary Care - Co Commissioning	(0.0)	(0.1)
Primary Care - DOPs	8.3	10.3
Primary Care - Other	(35.6)	(37.6)
Running Costs	0.0	(0.0)
Programme Wide Admin (Programme Corporate)	(6.6)	(7.3)
Other	44.3	47.4
Total Variance to Plan	**(8.3)**	**(1.0)**
Planned Surplus	14.1	15.4
(Deficit) / Surplus	**5.8**	**14.4**

3. Summary Month 11 Financial Position

The ICS has reported year-to-date variance to plan of £52.7m at month 11. In line with the H2 revised forecast and pressures as a result of industrial action the ICS has reported a forecast deficit of £36.9m at year-end.

Continued delivery of the FRP and management of the risks to the reported position is critical to achieving the reported year-end position.

The ICB Board is asked to note the month 11 financial position.

4. System Risks

Outstanding risks that are expected to be managed in-year include further slippage on cost improvement programmes, grip and control measures and a worsening of run rate pressures across the system. At month 11 it is expected that these risks will continue to be managed but a further deterioration at month 12 may impact the year-end position.

Risks moving forward into 24/25 include the non-recurrent mitigations used to deliver the financial position in 23/24. The cost improvement programme reported to NHSE includes £97.3m of non-recurrent schemes (the ICB share of this is £49.4m, providers £48m). The underlying position across the whole ICS impacts the planning round in 24/25 and links into the financial recovery process.

5. Better Care Fund (BCF) – variation to the Section 75 (s75) Agreement

Adult Social Care Technology Fund Award

Barking and Dagenham Place and Redbridge Place have been awarded two years funding as part of the Department of Health and Social Care programme to digitise social care.

The funding will flow through the ICB to the Local Authority as the lead provider utilising a variation to the Section 75 Better Care Fund 2019.

The flow of the funding will be from the Department of Health and Social Care to NHS England to NEL ICB to London Borough of Barking and Dagenham or London Borough of Redbridge, as the named lead provider organisation.

Funding allocated:
Barking and Dagenham - The funding allocated in 2023/24 is £517,606 and in 2024/25 is £569,830. There is no match funding or financial obligations to NEL ICB.
Redbridge - The funding allocated in 2023/24 is £407,150 and in 2024/25 is 585,571. There is no match funding or financial obligations to NEL ICB.

BCF variation:
An additional variation letter will be issued at each place awarded funding related back to the 2023-25 BCF section 75 variation letter and the original section 75 for Barking and Dagenham, Havering and Redbridge (BHR) places signed in 2019.

The Board is asked to agree the flow of funding to the respective local authority (via invoice) and the issuing of an additional variation letter as set out above.

Increasing awareness and uptake of immunisations

Immunisations protect our population against a range of communicable diseases. In north east London, coverage rates for Measles, Mumps and Rubella (MMR) have fallen below the World Health Organisation targets of 95% and there remains a risk of outbreaks in our communities. Immunisation is an effective way to prevent spread of this disease which can be fatal. We are also continuing our efforts to ensure high levels of vaccination against Covid, particularly amongst our most vulnerable residents.

NHSE has allocated funding to NEL ICB to support raising awareness and increasing uptake, with a focus on these two areas. We are working closely with partners across the system through Place Partnerships to ensure we can reach as wide a population as possible and are transferring funding through different mechanisms. In order to ensure this critical work can continue in Newham, we are proposing a variation to the s. 75 with Newham Council to enable funding to be deployed and work to be mobilised.

The ICB Board is recommended to formally approve the signing of a variation to the existing Section 75 agreement between the ICB and Newham Council to include funding of £144,000 to improve awareness and increase take up of immunisations in Newham.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Performance report – December 2023 / UEC January 2024
Author	NEL ICB Performance Team
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	Helen Pace, Head of Performance; helen.pace@nhs.net Olu Omotayo, Head of Performance; o.omotayo@nhs.net
Executive summary	• The attached set of slides describes the performance of the overall system across seven domains of performance in December 2023. For Urgent and Emergency Care (UEC) January 2024 data is available. • The total waiting list in planned care increased in December 2023, following month on month reduction in the previous four months. While the total waiting list remains above trajectory, overall there has been a circa -2% reduction from the July 2023 position (last six months), driven by reduction in the non-admitted waiting list. • The number of very long waiting patients waiting more than 78 weeks increased in month and remains above trajectory. Nationally, delivery of the year end (March 2024) >78-week ambition remains a key priority and focus. • The number of patients waiting greater than 65 weeks increased overall in month but remains below trajectory, due to a positive position against trajectory at Barking, Havering and Redbridge University Hospitals Trust (BHRUT). • Industrial action (IA) continues to have an ongoing impact on planned care capacity, the long waiting position and overarching momentum of elective recovery. • The number of patients waiting more than 62 days for cancer treatment decreased in December 2023 and remains below the trajectory level at both Barts Health and BHRUT. • The number of patients waiting six weeks or more for a diagnostic test increased in December 2023 at all three North East London (NEL) acute Trusts. • The verified position against the 4-hour Emergency Department (ED) standard, was improved from the December 2023 position in January 2024 across all three NEL acute Trusts. Despite an improved position, performance at Barts Health was below the operating plan trajectory for the month. • Delivery of 76% against the 4-hour ED standard is high priority at ICB, regional and national level for achievement to year-end. Daily meetings between NHS England /NHS London with system UEC directors have been established. • A deep dive on the community waiting list is due to be presented to the March meeting of the Finance, Investment and Performance Committee (FPIC) and ICB Board in May. • There has been sustained improvement in Children and Young People (CYP) access to mental health services (which continues

	to achieve against target). Severe Mental Illness (SMI) physical health check performance has been challenged across 2023/24. Dementia diagnosis also remains challenged.
Action required	The Board is asked to note the report. Further queries may be raised with the NEL ICB performance team if required.
Previous reporting	Each of the performance domains has associated improvement activity and this is managed through system-wide Boards or Collaboratives, for example, the Planned Care Board, Acute Provider Collaborative, and the UEC Programme Board.
Next steps / onward reporting	The NEL ICB Performance report interfaces Executive Management Team (EMT), Finance, Performance and Investment Committee (FPIC), Quality, Safety and Improvement Committee (QSIC) and the ICB Board.
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 local residents, as well improve performance, quality, equity of access and reduction of health inequalities for the NEL population as a whole.
Impact on finance, performance and quality	IA continues to impact patients, finance and performance. To fund the increased costs of IA nationally, the NHS was asked to undertake an urgent planning exercise in November 2023, reviewing the end-of-year performance trajectories and financial position. Amendments to planned care trajectories for patients waiting 65 and 78 weeks were made as part of this exercise and are included in this report.
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 Board. The aim is to provide assurance to the Board regarding 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 feedback on content and presentation.

1.3 The system's performance against the agreed activity volumes and standards has an impact on all four of the Integrated Care System (ICS)'s 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 Industrial action (IA) continues to have an ongoing impact on patients and waits for elective care, due to loss of planned care capacity and impact on the overarching momentum of elective recovery.

2.2 Barts Health remains in Tier 1 for elective recovery (with effect of November 2023), with additional Regional and National NHS England (NHSE) support.

2.3 Delivery of the year-end (March 2024) >78-week ambition remains a key priority and focus at national and regional level.

2.4 The elective care long waiting position (>78 week and >65 week waits) is reported against revised trajectories developed in response to the November 2023 planning ask.

2.5 Cancer performance from October 2023 is reported against the three combined national cancer standards:

- 28 day Faster Diagnosis Standard (FDS) (75% standard)
- One headline 62 day referral to treatment standard (85% standard)
- One headline 31 day decision to treat to treatment standard (96% standard)

Shadow reporting against the former Cancer Waiting Time Standards also continues.

2.6 Barts Health was moved out of the Tier 2 support process for cancer in December 2023.

2.7 The North East London (NEL) system was moved out of the Tier 1 support process for Urgent and Emergency Care (UEC) services to Tier 2 in January 2024. As a Tier 2 system, NEL continues to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan.

2.8 Delivery of 76% against the 4 hour Emergency Department (ED) standard is high priority at ICB, regional and national level for achievement to year-end. Daily meetings between NHSE/NHS London with system UEC directors have been established. Both Barts Health and Barking, Havering and Redbridge University Hospitals Trust (BHRUT) have developed detailed plans to deliver 76%, with Homerton Healthcare already above 76% but with additional ambition over the March period. NEL ICB are providing support to Bart's Health with senior project support to the Royal London Hospital Urgent Treatment Centre (UTC) to deliver the type 3 improvement plan and short-term investment for March by the system to UTC providers. The System Transformation Director for UTC and Place colleagues are supporting Royal London flow areas, including plans for 'perfect weeks', focus on criteria to reside and medically optimised patients. Additional hospital focus is on length of stay and discharge processes. Leadership to support plans has also been established including senior support in departments, linking with Mental Health and Ambulance services to optimise flow and reduce breaches.

2.9 A deep dive on the community waiting list is due to be presented to the March meeting of the Finance, Investment and Performance Committee (FPIC) and ICB Board in May.

3.0 Performance in December 2023 and January 2024

3.1 The attached set of slides describes the performance of the overall system across seven domains of performance in Dec 2023. For Urgent and Emergency Care (UEC) January 2024 data is available. The detailed description and analysis for each of the domains is included in these slides.

3.2 The total waiting list in planned care increased in December 2023 (+1,128 pathways), following month on month reduction in the previous four months. Overall there has been a circa -2% reduction from the July 2023 position (last six months), driven by reduction in the non-admitted waiting list across all three NEL acute Trusts. The total waiting list however, remains approximately 14% above the trajectory level.

3.3 The number of patients waiting greater than 78 weeks for planned care has more than halved by since December 2022 (significant progress has been made at Barts Health in the context of the size and scale of the Barts Health December 2022 position versus the rest of London). However, the number of patients waiting more than 78 weeks increased for the fourth month in December 2023 (+91 pathways), to a total of 421 patients awaiting treatment at Barts Health, BHRUT and Homerton Healthcare (379 of these pathways at Barts Health). This is above trajectory. Based on a mid-February unvalidated position, all London ICBs have circa 400 – 500 >78 week wait pathways, with the exception of South West London.

3.4 The number of patients waiting greater than 65 weeks for planned care also increased in December 2023 from the November 2023 position (+114 pathways), to a total of 2,875 pathways. This is below trajectory, due to a positive position against trajectory at BHRUT.

3.5 The number of patients waiting more than 62 days for cancer treatment decreased in December 2023 and remains below the trajectory level at both Barts Health and BHRUT (by approximately -6%, equating to circa 34 pathways overall). Performance against the 62-day combined standard for the month was 68.2% against the 85% standard.

3.6 NEL delivered diagnostic activity levels above trajectory in MRI, CT and Echocardiography in December 2023. The number of patients waiting six weeks or more for a diagnostic test however, increased in December 2023 at all three NEL acute Trusts. Diagnostic performance for the month was 78.8%, against the 95% ask for March 2025.

3.7 The validated position against the 4-hour ED standard was further improved in January 2024, with 71.5% of all patients seen within 4-hours of arrival. This is in the context of increased attendances. Despite the improved position, performance at Barts Health was below the operating plan trajectory for the month.

3.8 At NEL level the Urgent Community Response (UCR) 2-hour standard was achieved for Q3, 89% against the 70% national requirement. Discharge performance remains relatively positive against the London position.

3.9 There has been sustained improvement in Children and Young People (CYP) access to mental health services (which continues to achieve against target). Severe Mental Illness (SMI) physical health check performance, however, has been challenged across 2023/24 against the revised 70% ask for the year. Dementia diagnosis also continues to be challenged.

4.0 Risks and mitigations

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

5.0 Conclusion

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

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 NEL ICB Performance Team. Each of the performance domains is reported by the subject expert.

Planned Care Recovery & Transformation – December 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published December-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	✗	184,866	210,489	▲	
	Waiting List >104 Weeks (volume)			12	▲	
	Waiting List >78 Weeks (volume)	✗	200	421	▲	
	Waiting List >65 Weeks (volume)	✓	3,173	2,875	▲	
	Inpatient Elective Activity (% 19/20 BAU)	✗	98.74%	95.20%	▼	
	Consultant Led Outpatient Attendances (% 19/20 BAU)		99.34%	93.28%	▼	
	Consultant Led First Outpatient Attendances (% 19/20 BAU)		100.63%	91.99%	▼	
	Consultant Led Follow Up Outpatient Attendances without procedure (% 19/20 BAU)		104.07%	90.33%	▼	

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

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

Key Headlines

- The overall NEL RTT waiting list increased in Dec-23 (following reduction across the previous 4-months) to 210,489 pathways (+1,128 pathways from the previous month), driven by BHRUT (across the admitted and non-admitted waiting list) and Barts Health (across the admitted waiting list). The waiting list at Homerton fell for the 2nd consecutive month, driven by the non-admitted waiting list. All three Trusts above submitted operating plan trajectory for the month.
- There were 12 pathways waiting 2 or more years (>104ww) at Barts Health in Dec-23 (+3 pathways from the November position, 6 pathways awaiting inpatient treatment and 6 pathways awaiting outpatients). This is due to a combination of pathways progressing up the PTL, owing to complexity, choice and IA, as well some elements of DQ.
- The total number of patients waiting 18 months or more (>78 weeks) increased in Dec-23 to 421 pathways (+91 pathways from the previous month), a total of 379 pathways at Barts Health. BHRUT had 42 pathways >78weeks for the month and Homerton 0 pathways. Homerton and BHRUT continue to provide collaborative capacity to Barts Health to support the long waiting position.
- There were 2,875 pathways >65ww in NEL in Dec-23 (+ 114 pathways from Nov-23), driven by an increase at Barts Health across the admitted waiting list. The number of pathways >65ww decreased marginally at BHRUT Homerton in month.
- Consultant led activity in Dec-23 (noting IA at the end of the month combined with the Christmas period) was 93.3% of 2019/20 levels (all outpatient appointments consultant and non-consultant led were 102%). Consultant led follow up appointments without a procedure were 90.3% of 2019/20 levels (Barts Health 95%; BHRUT 87% and Homerton 79%).
- Total inpatient admitted activity completed at the three NEL Trusts in Dec-23 (noting IA at the end of the month combined with the Christmas period) was 95.2% of 2019/20 levels (98% day case admissions and 84% ordinary admissions).

Workstream Issues and Risks

- Overall waiting list size (noting circa -1.7% reduction overall in total waiting list in last 6-months).
- The number of patients continuing to wait >104 weeks and >78 weeks at Barts Health. Nationally, delivery of >78ww at year end (Mar-24) is a key focus and priority.
- Volume of patients currently waiting >65ww and in the >65ww risk cohort (all patients at risk of breaching >65ww by Mar-24 and beyond).
- Risk to delivery of revised trajectories >78ww and >65ww submitted as part of the H2 November planning process. Submitted trajectories did not account for further IA (incl. IA in Dec and Jan and recently announced for end Feb) which will continue to impact.
- Impact of further IA on the long waiting position incl. the 2023/24 exit position (as above), activity and overarching programme momentum.
- Impact of the requirement to deliver financial balance (as set out in the 'Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take') on elective activity, waiting list initiatives and long wait reduction in the remainder of 23/24 and for 24/25.
- 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 the continuation of the 'Patient Initiated Mutual Aid' (PIDMAS) programme at Trust and ICB level within current financial context, alongside elective recovery priorities and further IA. National decision making regarding the 2nd PIDMAS cohort remains awaited.
- Ability to robustly plan for 2024/25 in context of ongoing IA, receipt of interim draft planning assumptions only (not yet agreed with government and subject to change), alongside tight national deadlines for Operating Plan submissions.

Mitigating Actions and Next Steps

- Weekly Tier 1 national arrangements with Barts Health. Daily >78ww calls with Barts sites are now also in place, supported by the ICB performance team, to ensure progression and tracking of actions to support delivery of the >78ww plan to end March.
- Continued close working between Trusts and the ICB to mitigate and manage risks associated with delivery of financial balance vs. delivery of elective priorities.
- Additional waiting list initiatives in place in the most challenged specialties at Barts Health (Dermatology, Oral Surgery and Vascular) to mitigate the March >78ww position.
- Homerton and BHRUT (from mid-Oct) continue to provide collaborative capacity to Barts Health. London capacity is also being explored with regional escalation where required to support procedures with specific challenges (e.g. Barts Health Oral Surgery, TMJ procedures).
- NEL wide D&Q, PTL management and validation peer review process continues – focus on NEL wide access principles and application of RTT rules
- Ongoing Trust and site theatre productivity and utilisation programmes, overseen via the NEL Surgical Optimisation Group. Detailed procedure level analysis underway to identify variation across the system to inform the surgical optimisation strategy
- Ongoing engagement with and feedback to the national 'PIDMAS' programme, to help shape and inform national decision making
- Referral restrictions lifted at BHRUT. Referral restrictions remain in place for 4 specialties at Homerton. Barts Health continue work to lift circa 130 restrictions
- 2024/25 Operating Planning underway via the APC task & finish group based on interim draft planning assumptions and templates
- Detailed analysis based on NHSE data to identify additional specialties for focus (over and above where significant NEL programmes are already in place e.g. gynae, MSK, Dermatology, ENT) underway

Outpatient Transformation – December 2023

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published December-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	A&G/Specialist Advice (volume)	✓	19,210	24,938	▼	
	A&G/Specialist Advice (% OPFA)			35.59%	▲	
	A&G/Specialist Advice diversion rate (volume diverted)	✓	4,444	5,114	▼	
	Specialist Advice Diversion rate (%)		23.14%	20.51%	▼	
	Moved or Discharged to PIFU (volume)	✓	3,071	3,847	▼	
	Moved or Discharged to PIFU (% OPA)	✓	1.50%	1.92%	▼	

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 Dec-23, 24,938 specialist advice requests were raised by NEL GPs (above planned levels), equating to 35.6% of all first outpatient attendances and 20.5% diversion rate (requests returned with advice and no onward booking).
- In Dec-23, 3,847 patients were moved or discharged to PIFU, equating to 1.9% of all outpatient attendances (Barts Health 1.2%; BHRUT 1.6%; Homerton 5.8%).

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment (noting circa -3 % reduction in the non-admitted waiting list across last 6 months)
- 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)
- Unplanned IA (incl. IA in Dec and Jan and recently announced for end Feb) which will continue to impact overarching programme momentum
- 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
- Impact of the requirement to deliver financial balance (as set out in the 'Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take') - 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
- Ability to robustly plan for 2024/25 in context of ongoing IA, receipt of interim draft planning assumptions only (not yet agreed with government and subject to change), alongside tight national deadlines for Operating Plan submissions.

Mitigating Actions and Next Steps

- Reinvigoration of the NEL outpatient transformation programme to ensure ongoing alignment, sharing of best practice and collaboration.
- Revised T&O Trust and NEL level action plans in line with above ambition.
- 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
- A&G/R impact analysis completed with recommendations for further work at Trust level
- Trust review and learning from NEL insights DNA inequalities analysis
- Continued effort to roll-out national GIRFT specialty outpatient guidance and 'Further Faster' recommendations by individual Trust outpatient transformation programmes, supported at NEL level
- Use of the NEL 'sharing best practice group' to share learning and identify areas of focus
- Continued progress in work streams for MSK, Women's Health (gynae), ENT, Ophthalmology and Dermatology to develop alternate pathways and maximise community capacity. Dermatology proposal due to be discussion with Trust COOs and the Planned Care Board
- Tower Hamlets Women's Health Hub went live as a SPA for all TH routine gynaecology referrals on 1st Dec
- The TH community dermatology continues to support RLH backlog clearance by taking direct referrals from RLH PTL
- First & second NEL Referral Optimisation Workshop held with clear priorities agreed
- 2024/25 Operating Planning underway via the APC task & finish group based on interim draft planning assumptions and template

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

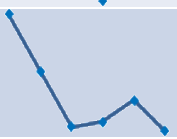
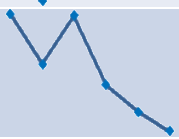
Diagnostics – December 2023

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 December-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)	⊗	89.62%	82.21%	▼		✓	107.12%	110.61%	▼	
	Computed Tomography (CT)	⊗	96.39%	82.62%	▼		✓	127.27%	132.57%	▼	
	Non-obstetric Ultrasound (NOUS)	⊗	84.47%	82.66%	▼		⊗	110.96%	105.44%	▼	
	Colonoscopy	⊗	97.11%	85.01%	▼		⊗	110.90%	84.36%	▼	
	Flexi Sigmoidoscopy	⊗	98.08%	68.58%	▼		⊗	59.09%	58.36%	▲	
	Gastroscopy	⊗	99.29%	69.08%	▼		⊗	105.66%	93.30%	▼	
	Echocardiography	⊗	98.59%	88.60%	▼		✓	97.23%	100.82%	▼	

Diagnostics – December 2023

SRO:	Claire Hogg	RAG	AMBER

Key Headlines

- The overall NEL diagnostics waiting list decreased in Dec-23 to 55,022 (-3,604 Pathways compared to the previous month) driven by decreases across all three NEL Trusts.
- The number of pathways waiting >6weeks (backlog) for a diagnostic test however increased in December to 11,667 pathways (+1, 860 pathways compared to Nov-23), with an increase across all three Trusts. At modality level, the number of pathways waiting >6-weeks increased across imaging modalities - MRI, CT and non-obstetric ultrasound (NOUS).
- Diagnostic performance for the month was 78.8%, down from the Nov-23 NEL position (across all three Trusts) of 83%. The national requirement is for delivery of 95% by Mar-25.
- Diagnostic activity however, was above trajectory in Dec-23 at NEL level in MRI (at all three NEL Trusts), CT (at BHRUT and Homerton) and Echo (at Barts Health and Homerton). Activity in Non-obstetric ultrasound (NOUS), Colonoscopy, Flexi Sig and Gastroscopy fell below trajectory at NEL level for the month.
- Ongoing Industrial Action (IA) continues to impact the diagnostic waiting list. NEL continues to report the highest volume of patients waiting an imaging investigation in London.

Workstream Issues and Risks

- The volume of patients waiting >6 Weeks (backlog) remains significantly high across NEL and the imaging backlog accounts for circa ~38% of all of London's backlog.
- Impact of further Industrial Action (IA) on waiting list, backlog position, activity and delivery of the overarching diagnostics programme. Risk to delivery of 23/24 trajectories which did not accounting for further IA which will continue to impact.
- Significant delays with the clearance of Barts Paeds Audiology residual backlog due to contractual delays with Communitas
- The constrained funding envelope accessible to the NEL system poses a risk as the benefits of schemes to increase capacity and improve productivity will not be 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.
- Endoscopy backlog position across NEL worsening in recent months attributed to Barts Health and a recovery action plan has been devised.
- Ability to robustly plan for 2024/25 in context of ongoing IA, receipt of interim draft planning assumptions only (not yet agreed with government and subject to change), alongside tight national deadlines for Operating Plan submissions.

Mitigating Actions and Next Steps

- At Barts Health recovery action plan remains in place for MRI, Cardiac CT, NOUS as well as Audiology
- Barts Health's Paeds Audiology backlog clearance with Communitas expected to commence mid-feb-24 and aim to clear the backlog within six months with oversight from NEL ICB Performance colleagues.
- Recruitment of four clinical Network leads – (x2 Imaging, Physiological Measurements and Endoscopy), provision of 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.
- Collaborative banking trial starting with Barts Health - Royal London workforce (Nurses, admin staff and radiographers) albeit challenges with getting the parity with pay identified.
- Implementation of 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.
- Other Diagnostics (DM01) issues are being mitigated locally jointly by NEL Acute Providers and ICB Colleagues.
- Cemented funding for the CDCs and a new MRI scanner, but the total amount of external funding is not what was anticipated.

Governance

- NEL diagnostics performance risks, delivery and recovery are discussed at the monthly Diagnostics Programme Board attended by NEL ICB Colleagues, Acute Provider Colleagues and Community Diagnostics Hub Colleagues.
- NEL Imaging, Endoscopy and Echo Networks are well established with regular meetings held on a weekly basis. Physiological Measurements network now also set up.
- NEL Planned Care Board and Acute Provider Collaborative (APC) Governance.

Cancer – December 2023

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published December-2023				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	Waiting List >62 Days (volume)	✓	558	524	▼	
	Faster Diagnosis Standard (%)	✗	78.10%	75.58%	▲	

KEY

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

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

Workstream Issues and Risks

- The industrial strikes had a significant impact on Barts' overarching performance. The trust received funding of 430K from NHSE, with the majority of it allocated towards providing extra sessions to address and clear the 62-day backlog.
- The issue at RDC Clinic has been successfully managed through collaboration between the Trust and Cancer Alliance, particularly concerning workforce-related challenges. A retrospective quality review has been conducted, and recruitment to fill vacant posts has now been completed.
- Barts Health has successfully exited Tiering stratification, indicating that the organisation no longer has a backlog above their fair share requirement. However, the sustainability of the backlog position remains a risk for the overall health system.
- Barts Health targeted work to reduce its 62d PTL backlog position down to 5% is ongoing (DriveTo5)
- The Providers and the Network are diligently addressing risk areas concerning histopathology turnaround times, workforce vacancies, imaging reporting, and any cancellations resulting from IA and CWT upload changes.

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 achieved the national 28 day faster diagnosis standard (75.4%) in Dec-23. However, performance was below planned trajectory at BHRUT (marginal).
- Performance against the 31-day combined standard for the month was 95.72%, against the 96% target. Barts Health 96.06% and BHRUT achieving 96.02% respectively. Homerton performance was 89.74%.
- Performance against the 62-day combined standard for the month was 68.2% against the 85% target. All three Trusts falling below 85% (Barts Health 74.0%; BHRUT 61.4%; Homerton 66.7%).
- Shadow reporting against the former 9 cancer waiting time standards continues to be monitored. NEL achieved 91.5% against the previous 93% 2ww standard in Dec-23, the strongest performance Pan London and significantly above the London aggregate position of 79.5%.
- The number of patients waiting >62 days fell in December to 524 pathways below the operating plan target of 558 pathways, Barts Health and BHRUT achieving against trajectory. NEL continues to make significant progress in reducing the number of patients waiting > 62-days. As at 4th Feb-24, NEL had a total of 475 pathways >62 days, equating to 6.5% of the total PTL. This is compared to that of the average for London ICB's and below London average (7.5%) and England average of (9.4%)
- Challenges in the diagnostic phase (histopathology) of cancer pathways remain a key risk to delivery across NEL, but remedial plans ongoing across the three NEL Acute Providers.
- As of Dec 2023, due to improvement made, Barts Health was moved out of the Tier 2 support process for cancer.

Mitigating Actions and Next Steps

- The NEL Cancer Alliance remains committed to collaborating with providers to focus on key pathways in urology (improving access to MRI and TP biopsy), head and neck (enhancing outpatient capacity and utilizing the ENT calculator), lower gastrointestinal (ensuring timely escalation of pathology turnaround times and optimising endoscopy capacity), and dermatology (implementing tele-dermatology services for efficient triage and one-stop excision procedures).
- The NEL Cancer Alliance is actively collaborating with providers to establish and enhance best practice timed pathways. The NEL Operational Managers have been appointed to oversee the implementation of Best Practice Timed Pathways (BPTPs) across NEL, with a specific emphasis on supporting providers that are currently falling below the England Faster Diagnosis standard.
- The NSS RDC tool is being utilized to effectively manage patient demand for those with a FIT level of less than 10, in alignment with the national guidelines endorsed by the London Clinical Advisory Group (CAG).
- Currently, two out of three providers in NEL are conducting pilot programs for tele-dermatology models aimed at managing 2ww referrals. The primary objective for the upcoming year 23/24 is to further develop, assess, and maintain these pathways throughout the entire system.
- The NEL Cancer Alliance is currently funding a senior programme manager to provide support to the trust and networks in identifying solutions to the backlog issues within the acute care system. Additionally, the programme manager is in the process of developing an operational training package for MDT Coordinators and collaborating with provider Trusts to establish a consolidated NEL Access Policy.
- 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 (St. Georges) 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 – January 2024

SRO:	Paul Gilluley	RAG	RED

	Metric	Latest Published January-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Ambulance Handovers ≥ 60 Min (volume)	⊗	National Req. ZERO	174	▼	
	12-hour Trolley waits (volume)	⊗	National Req. ZERO	1,287	▼	
	Total A&E Attendances (volume)	⊗	78,774	81,924	▲	
	A&E 4-Hour Performance All Type (%)	⊗	72.89%	71.50%	▲	
	A&E 4-Hour Performance Type 1 (%)	⊗	60.90%	59.78%	▲	
	Total A&E Admissions (volume)	N/A	N/A	14,515	▼	
	Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	⊗	10.58%	11.00%	▲	

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

- In January 2024 NEL became the only UEC system in the country which has moved out of the Tier 1 setting of the national regulatory process. In Jan-24, 71.50% of all patients were seen within 4-hours of arrival at ED, which did not deliver the 2023-24 Operating Plan trajectory set at 72.89% for the month. However, this position was another improvement from the previous month, circa 1.7% up. At Trust level compared to the previous month all three Trusts drove the further improvement; up circa 4% at Homerton, 2% at BHRUT and 0.8% at Barts Health. Whilst improved positions in January at Trust level delivered on trajectories at Homerton and BHRUT, Barts Health's position of 66.57% was circa 6% below trajectory (72.41%). In January at each Trust there were circa 400 fewer patients breaching 4 hours compared with December. The volume of A&E attendances has grown 10% since April and continued to grow a further 1% in January (from December) which was above the planned level for the month.
- The LAS reported monthly data (unpublished) identifies that 174 ambulance arrivals at NEL emergency departments (EDs) took more than 1-hour to be transferred from London Ambulance Service care in January. 98% of LAS handovers took place within 60 min (Bart's 97%, BHRUT 98%, Homerton circa 100%), similar to the previous month. The percentage handed over within 30 mins and 15 mins were also similar to the previous month across all thee Trusts.
- 12 Hour trolley waits (from decision to admit to admission) reduced in January to 1,287 (down from 1,311 December) the improvement was driven by BHRUT and Barts Health.
- Our system winter plan remains in place with a plan to undertake a review in March 2024, including impact of Industrial Action during the winter period. Additional capacity (beds and SDECs) were implemented in line with plan at the end of December.
- Our H2 plan including delivery of trajectories in March remain our targeted priorities which in additional to quality and safety gives access to potential capital investment in 2024/25.

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 & Flow and Type 3 Urgent Treatment Centre
- Cat 2 offloading for patients remain challenging despite hospital improvement despite the offload improvement at trust level the system continues to work with LAS to support where there are internal issues including LAS staffing.
- Occupancy linked with hospital flow is overall at 93.5% and 12 hour waits in ED have increased which has both a quality and potential patient outcome impact. 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. In addition optimised use of SDECs including , patients streamed directly to SDEC, discharges from SDEC and reduction on short length of stay overall.
- Mental health in ED waiting 12 hours or more was 15.8% in December (improved from 17% in the previous month) and bed occupancy in MH is 97-99%- this programme is a key area of focus lead by the MH collaborative aligned to the NEL UEC programme

Mitigating Actions and Next Steps

- W45 Handover review now mobilised to business as usual., 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
- Additional focus on Acute and MH flow in relation to discharge ready (no criteria to reside)
- Trusts have developed plans for the reduction of breaches and delivery of 76% by March.

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: Q3 ; Monthly: Dec-23 & Jan-24

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 - Dec-23**	⊗	**889,464**	**861,120**	▼
		E.T.3 - The number of people discharged by location and discharge pathway per month (Total) - Jan-24	⊗	**8,883**	**8,061**	▼
		E.T.3a - Hospital discharge pathway activity - pathway 0 - Domestic home or Other place - Jan-24	⊗	7,323	6,631	▼
		E.T.3b - Hospital discharge pathway activity - pathway 1 - Domestic home or Other place or Hotel (as temp place of residence) - Jan-24	⊗	1,088	1,052	▼
		E.T.3c - Hospital discharge pathway activity - pathway 2 - Care home, Designated setting, Hospice, Community rehab setting - Jan-24	⊗	145	124	▼
		E.T.3d - Hospital discharge pathway activity - pathway 3 – Care Home, Designated setting - Jan-24	⊗	327	254	▼
		E.T.5 - The number of patients on the virtual ward - Jan-24	⊗	**490**	**218**	▲
		The number of patients that the virtual ward is able to simultaneously manage - Jan-24	⊗	612	326	▼
		Virtual ward occupancy - Jan-24	⊗	80.07%	66.87%	▲
	Quarterly reported	**Learning disability registers and annual health checks delivered by GPs - Q3 23/24**	✓	**15.05%**	**21.97%**	▼
		2-hour Urgent Community Response (UCR) care contacts - Count of 2-hour UCR first care contacts delivered within reporting quarter - Q3 23/24	✓	**2,445**	**3,535**	▲
		Percentage of 2-hour standard UCR referrals achieved at the end of the reporting period (National Req. 70%) - Q3 23/24			**88.97%**	▲
		Community services waiting list-Number of patients waiting at a point in time aggregated for a) in scope CYP and b) in scope Adult services - Q3 23/24	⊗	**19,449**	**32,385**	▼
		Number of CYP (0-17 years) on community waiting lists - Q3 23/24	⊗	7,131	9,476	▲
		Number of Adults (18+ years) on community waiting lists - Q3 23/24	⊗	12,318	22,909	▼

Key Headlines

Primary Care

- December data shows 861,120 appointments in General Practice, below the trajectory for the month by circa 28,000 appointments. The operating plan trajectory is for 1 million appointments by March 2024, this is a 3% increase in 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.
- Work continues to implement The Primary Care Recovery Plan. 60 practices are to 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.
- Practices are also putting plans in place to use Access Recovery Plan Transitional Funding to support implementation of 'modern general practice' enabling them to provide a smooth, equitable experience of access to patients across phone, online and walk-in routes. These plans have now been approved and payments will be made by March 2024.
- Plans to implement integrated same day access, under the Fuller Programme are in place.

Hospital Discharge

- Overall, we continue to see relatively good discharge performance in comparison to other systems in London.

Virtual Wards

- The occupancy for VW is 67% with 11 classified wards set up through the foundry programme.
- There is a targeted plan through development of model linked to:
- Step up pathways in addition to Step down care
- Tech enablement including monitoring ,and pathways linked to admissions avoidance working with the community collaborative in relation to urgent care response
- Building on already established pathways in frailty and acute respiratory care
- A plan in 24/25 on a virtual care is in development to build on the progress so far in the virtual ward plan

Learning disability

- Learning disability registers and health checks delivered by GPs achieved against trajectory for Q3.
- 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
- 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

- At NEL Level the UCR 2 hours standard was achieved for Q3, 89% against the 70% national requirement.
- NEL is working towards an improvement network for UCR to look address variation of outcomes for residents, volume across the system

Community Waiting List

- The number of adults on CHS waiting lists decreased in Q3 to 22,909, but is above trajectory by circa 47% (10,591 pathways)
- The number of Children and Young People on CHS waiting lists increased in Q3 to 9,476, above trajectory by circa 37% (2,345 pathways)
- A deep dive on Community Waiting list is due to be presented to the March meeting of the Finance, Investment and Performance Committee (FPIC) and ICB Board

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

- Pressure remains in the system due to industrial action (IA) and seasonal pressures

Virtual Wards

- Providers and places continuing to roll-out services including tech enabled pilots, however workforce continues to be a risk to overall service delivery and achievement of planned trajectory.
- Uptake of services requires ramping up across the system to increase referrals from multiple sources. Currently VW referrals are predominantly coming from acute pathways, with very little step-up referrals being made.
- Providers continue to site uncertainty of re-current funding as an issue impacting service delivery

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

- There are potential opportunities to reduce variation and increase volume into UCR services
- Digitising UCR referrals long term continues to be an area of concern as this could drive up referrals into UCR automatedly but there is an issue with pass back between LAS and UCR providers via Adastra (digital caseload management tool) however it is being done in regions nationally
- Falls prevention continues to be a focus area for Enhanced health and care homes delivery and is being picked up alongside a review of NEL's UCR delivery. Care Homes can now access MIDoS services finder tool which should contribute to more ED admissions being avoided into ED from care homes.
- Urgent Care Plan now rolled out across NEL to prevent unnecessary admissions for those who have a care plan is being looked at as a complementary tool in UCR services to ensure we avoid unnecessary admissions at place.

Community Waiting List

- Waiting list size and volume of long waiting pathways
- Reasons preventing reductions in backlogs for providers include lack of clear service pathway and workforce availability.
- The data in the CHS report is from SitREps and this must be heavily caveated as it is at provider level and not patient level, therefore if a provider serves more than one ICB this will not be shown, the provider will only be mapped to one ICB. NHSE London have acknowledged this issue with ICBs.
- NEL continues to work with providers on data quality into CSDS but also ensuring deadlines for submissions are no longer missed to avoid missing data not being reconciled against out trajectory for the FY.

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 is working to deliver 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

- Task and finish groups being established through the VW steering group to tackle key issues on; Performance and reporting, Capacity and occupancy, Technology, Service evaluation and commissioning next steps
- Closer collaboration between UEC programme and community collaborative to maximise opportunities on broader referral pathways

Learning disability

- NEL are pleased to have achieved the national target for learning disability annual health checks. Work continues to focus on improving the quality of AHCs and piloting the new annual health check for autistic people in City & Hackney.

2 hour UCR

- NEL is doing some deep dive to help explore potential opportunities to reduce variation and increase volume of referrals into UCR
- UCR plan for winter with LAS started in December.
- Long term UCR teams hope to be able to pull relevant referrals into their services directly. Data and qualitative information collected during this drive will support long term improvement discussions alongside the deep dive
- Dashboard with MIDos usage data in Care Homes to be shared with UEC and Community Programmes / reporting

Community Waiting List

- Community Collaborative is working with providers to improve data quality. London has set out key data focus areas and outliers the community collaborative should focus on
- A deep dive on Community Waiting list is due to be presented to the March meeting of the Finance, Investment and Performance Committee (FPIC) and ICB Board

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

- ICB support to the discharge within Place based teams.
- New process for escalation of delays has been established which has simplified and streamlined the process.

Virtual Wards

- Programme reports 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 Collaborative Delivery Board (Delivery and System Assurance), Community Collaborative Executive (Oversight) and Community Collaborative.

Community Waiting List

- NEL Community Collaborative Delivery Board (Delivery and System Assurance), Community Collaborative Executive (Oversight) and Community Collaborative, NEL BCYP Programme Board (CYP)

Mental Health – December 2023

SRO:	Lorraine Sunduza	RAG	AMBER

	Metric	Latest Published					
		Dec-23	*Trajectory*	*National Target*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	IAPT Access (Rate)	✗	*27.10%*		*21.17%*	▼	
	Dementia Diagnosis (Rate)	✗	*66.70%*	*66.70%*	*60.36%*	▲	
	SMI Physical Health Checks (Performance)	✗	*70.00%*	*70.00%*	*58.99%*	▲	
	Perinatal (Rate)	✗	*8.46%*	*10.00%*	*8.25%*	▼	
	CYP Access (Volume)	✓	*24,098*		*24,790*	▲	
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*60.00%*	*77.14%*	▲	
	CYP Eating Disorders Urgent Referral (Performance)	✓	*95.00%*	*95.00%*	*100.00%*	⇔	
	CYP Eating Disorders Routine Referral (Performance)	✓	*95.00%*	*95.00%*	*97.00%*	⇔	
	Community Metal Health Access (Volume)	✓	*21,638*		*25,065*	▲	

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**

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.

Key Headlines

- There has been a continued improvement in CYP access rates (which is achieving its target) and Perinatal (which is just below target), but a volatile trend in Dementia access rates where there remains a significant gap to target.
- Despite excellent performance in 2022/23, performance in SMI Physical Healthchecks has dipped in recent quarters. This combined with an updated target of 70% from NHSE has meant that the target was missed for the first 3 quarters of 2023/24.
- Due to the issues with PC-MIS that affected NELFT Talking Therapies services, data for October for Barking and Dagenham, Havering, Redbridge, and Waltham Forest between 6th and 21st October was not recorded. As a workaround, the average position of September and November has been used as a proxy figure, to allow a proxy figure at ICB level. Performance for Talking Therapies access has seen a significant drop in December.
- The NEL position compared with other London systems is mixed. Dementia continues to be the lowest within London.

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, TT access, and SMI Physical Health checks 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.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

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: • Workforce and remuneration governance • Annual audit plan • Updated conflicts of interest training Further details on each of these developments are contained within the report below.
Action required	The ICB Board is asked to: • Approve the disestablishment of the workforce and remuneration committee • Approve the establishment of the remuneration committee • Approve the establishment people and workforce committee • Approve the annual audit plan 2024/25 • Note the updated the conflicts of interest training for all ICB board and committee members • Note the update to future board and committee template • Approve the updated Governance Handbook here.
Previous reporting	ICB Board and its 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 inclusive governance is designed to support the 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 Workforce and Remuneration governance

2.1 From 1 July 2022 the Board of the NHS North East London Integrated Care Board established the Workforce and Remuneration committee to agree the remuneration and terms of service for ICB board and executives and people oversight for ICB staff and wider oversight of workforce priority for ICS.

2.2 Following the development of the people and culture strategy, a review of workforce and remuneration governance has taken place, in recognition of the system approach to the people and culture strategy and implementation and of the need for a space to focus on decisions affecting the ICB workforce alone.

2.3 The outcome of this review proposes the disestablishment of the current workforce and remuneration committee and to establish separate committees of the Board with the following responsibilities:

Remuneration committee

- Seek assurance in relation to ICB statutory duties in relation to people, such as compliance with employment legislation, including Fit and Proper Person Regulation (FPPR) and Freedom to Speak Up (FTSU).
- Determine ICB pay policy and oversee contractual arrangements for all staff;

- Determine all aspects of remuneration and contractual arrangements for VSM and Executive Directors including agenda for change band 9;
- Approve changes to organisational structures and changes in the establishment which may increase funding requirements or reductions in cost or which may result in redundancies;
- Approve any proposed redundancy, severance or settlement costs and payments, where necessary providing this in advance of any authorisation needed from NHS England and the Treasury;
- Board succession planning;

ICS People and Workforce committee

- Responsibility for the workforce priority on behalf of the ICS including the delivery of the Long Term Workforce Plan. This will include creating meaningful employment for the local population across North East London. Creating a 'One NEL' workforce across Health and Social Care which contributes to creating a healthy community across NEL and creates a set of working environments in which a diverse and inclusive workforce can work and develop their careers;
- Oversee the delivery of the NEL System people and culture strategy;
- Establish a people board to deliver the NEL system strategy.

2.4 The remuneration committee and ICS workforce and people committee will meet before the next meeting of the ICB board and revised terms of reference will be presented to the board at its meeting in May for approval.

3.0 Annual audit plan 2024/25

3.1 The attached annual audit plan details each of the reviews that it is proposed internal audit undertake as part of the internal audit plan for 2024/25 based on our understanding of the areas where audit would be useful, and which are priorities for the organisation. In addition, mandatory core assurance work, which will also be carried out during the year, consists of reviews on:

- Risk Management
- Data security and protection toolkit
- Follow up and management time

3.2 The Board is asked to approve the plan which has already been discussed at the Executive Management Team meeting, Audit and Risk Committee and the recent Board development session. The version being presented today reflects initial views from those settings, which include the need to have a focus on our statutory compliance, systems, processes and people, as well as allowing space in the plan for audits to take place should any urgent reviews be required in-year.

4.0 Updated training for ICB board and staff

4.1 NHS England has issued online training on managing conflicts of interest, specially designed for ICBs and should be completed by all ICB staff, board members and sub-committee members. This includes those individuals appointed to sub-committees, who are temporary appointments or deputies.

4.2 The training explains how NHS-wide conflicts of interest rules should be applied within ICBs and will guide and support staff, board and committee members in identifying and managing real and perceived conflicts of interest. The link to the training can be found here: Managing-conflicts-of-interest-online-training-for-ICBs

5.0 Updated Board and Committee template

5.1 All future board and committee reports will include a section on equality impact assessments to ensure that any impact on equality is considered as part of all decision making.

6.0 Recommendations

6.1 The ICB Board is asked to:

- Approve the disestablishment of the workforce and remuneration committee
- Approve the establishment of the remuneration committee
- Approve the establishment ICS people and workforce committee
- Approve the annual audit plan 2024/25
- Note the updated the conflicts of interest training for all ICB board and committee members
- Note the update to the board and committee template.
- Approve the updated Governance Handbook here.

INTRODUCTION

The annual audit cycle is designed to support the organisation and system to make improvements to access, experience and outcomes for local people - with an overall focus on tackling health inequalities.

The draft plan has been discussed with a number of stakeholders to ensure views from across the ICB are included. Discussions have taken place at the Executive Management Team, the Audit and Risk Committee and Board development session in February and the version being presented today reflects the views from those settings.

The ICB's approach to developing the internal audit plan is based on analysing organisational objectives, risk profile and assurance framework as well as other factors affecting North East London ICB in the year ahead, including changes within the sector.

The focus of the plan for this coming year is primarily on the controls and assurances within the ICB, however each audit will also consider the impact on and from the ICS.

The ICB is committed to learning from the internal audits and the outcomes will be reviewed by the relevant Non Executive Member Committee Chair and findings discussed at the relevant ICB committee.

Regular reviews of audit actions will be overseen by the Executive Management Team.

INTERNAL AUDIT PROCESS

In advance of each audit discussions with the responsible chief officer will take place to confirm the scope six weeks before the agreed audit start date.

Following the audit, a debrief meeting will be held with chief officer/audit sponsor at the end of fieldwork or within a reasonable time frame. Draft reports will be issued within 10 working days of the debrief meeting and will be issued by internal audit.

ICB responses to the draft report will be submitted to internal audit and within three working days of receipt of responses the final report will be issued.

INTERNAL AUDIT REPORTING

The final internal audit report will contain an action plan agreed with the ICB to address any weaknesses identified by internal audit.

The internal audit service will issue progress reports to the Audit and Risk Committee and management summarising outcomes of audit activities, including follow up reviews.

Regular updates will be presented to the Executive Management Team.

INTERNAL AUDIT STRATEGY 2024-2027

The 2024/25 annual audit plan is part of a three-year cycle of internal audit plans which focuses on ICB priorities and also ensures that the plan includes statutory requirements in a timely manner. The table below shows an overview of the audit coverage to be provided through delivery of the internal audit strategy, and the areas covered in the prior two years.

Audit Area	2022/23*	2023/24	2024/25	2025/26	2026/27
Data Security and Protection Toolkit	✓	✓	✓	✓	✓
Procurement / Contract Register	✓	✓	✓	✓	✓

Audit Area	2022/23*	2023/24	2024/25	2025/26	2026/27
Continuing Healthcare	✓	✓	✓	✓	✓
IT Controls					
• **IT Assets**					
• **Cyber Security**					
• **IT Governance and Risk Management**					
• **IT Assets**		✓	✓	✓	✓
• **GP IT Services**					
• **IT Projects**					
• **GDPR / Data Protection**					
• **IT Strategy and Digitalisation**					
• **IT Assets and Equipment**					
HR Processes					
• IR35 Arrangements					
• **Temporary Staffing (incl. pre-employment checks)**					
• Retention					
• Appraisals					
• **Recruitment**	✓	✓	✓		
• Equality, Diversity, and Inclusion					
• Sickness Absence					
• Rostering					
• Staff Engagement and Wellbeing					
• HR Governance					
• **Workforce Strategy / People Plan**					

Audit Area	2022/23*	2023/24	2024/25	2025/26	2026/27
Transformation Programmes / Projects					✓
Conflicts of Interest	✓	✓		✓	
Risk Management	✓	✓	✓	✓	✓
Primary Care Commissioning / PCNs / Delegated Duties	✓	✓		✓	✓
Population health Management / Health Inequalities		✓		✓	
Key Financial Controls / **Financial Ledger / Transfer of Balances**	✓	✓	✓		
Financial Planning, Management and Financial Recovery and Cost Improvement Programmes		✓	✓	✓	✓
Borough Performance Management and Governance	✓			✓	
Waltham Forest GP Federated Network / Arrangements with Local Federations **- Finance and Governance and Primary Care Services**		✓	✓		
Resilience / Emergency Response and Recovery Plan / Business Continuity		✓			
Medicines Optimisation	✓				
Infection Prevention and Control					✓
Estates and Capital Programmes					✓
Complaints			✓		
Safeguarding					✓
Whistleblowing				✓	

Audit Area	2022/23*	2023/24	2024/25	2025/26	2026/27
Green Plan and Sustainability					✓
Assurance Mapping		✓	✓		
Action Tracking and Follow Up	✓	✓	✓	✓	✓
Management	✓	✓	✓	✓	✓

*ICB coverage only. Other reviews in 22/23 were undertaken for the CCG which covered DSPT, Due Diligence and Risk Management, and Estates Management.

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North East London
Integrated Care Board

INTERNAL AUDIT PLAN 2024/25

The table below shows each of the reviews that the ICB propose to undertake as part of the internal audit plan for 2024/25. The table details the strategic risks which have focused the internal audit coverage.

Area and Strategic Risk	Audit approach	Proposed timing	Proposed Audit Committee Reporting
AIM 1: To improve outcomes in population health and healthcare			
Financial controls Following the 23/24 deep dive into transfers of funding to third parties, internal audit will consider the learnings from this review and how these are applied across other arrangements in NEL to develop a consistent and robustly governed set of financial controls that are efficient, effective, and delivering value for money and outcomes. The review will focus on the financial arrangements and on the ICB controls and governance with particular focus on how decisions are made and taken to hold ICB monies within other entities, specifically federations and primary care networks. This review will also look at how the ICB obtains assurance that the service quality is being delivered and value for money achieved. Management Concern	Assurance	April 2024	August 2024
AIM 2: To tackle inequalities in outcomes, experience, and access			
Continuing Healthcare - progress on harmonisation Following the 21/22 review, there will continue to be follow up on management actions, including the harmonisation of processes. The follow up will focus on the projects currently undertaken by the ICB to bring the legacy CCG systems into one NEL ICB system and focus on the project delivery against timescales and how any slippage is being mitigated. Management Concern	Assurance	June 2024	October 2024
HR Processes – Temporary Staffing Internal audit will undertake a review on areas of HR on a cyclical basis year on year. In this year there will be a focus on the control environment around temporary (agency, fixed term, interim) staffing including the approval of using temporary staff for vacant positions, the undertaking of pre-employment checks and assurance mechanism in place with external providers that this is being undertaken appropriately and the accurate recording of individual's status in the organisation.	Assurance	May 2024	August 2024

Area and Strategic Risk	Audit approach	Proposed timing	Proposed Audit Committee Reporting
This work will involve joint working with LCFS and HR advisors where required. Management Concern			
Fit and Proper Persons In 2019, NHS England (NHSE) established the Fit and Proper Person Test (FPPT) Framework following the recommendations raised from the 2019 Tom Kark KC review of the FPPT which highlighted the need for stronger background checks, greater measurement consistency and clearly defined requirements. The strengthened NHSE FPPT Framework aims to ensure a consistent approach to assessing the suitability of individuals to hold positions and helps to define the required skills for Board members. The review will focus on the establishment of policies and procedures including alignment to the NHSE Fit and Proper Person Test (FPPT) Framework. Management Concern	Assurance	November 2024	February 2025
Complaints Internal audit will review the arrangements in place to investigate complaints including serious incident investigations. The review will include how the organisation uses the learning as well as exploring what training and education is available for staff to aid their understanding. The review will assess how the organisation listens and collaborates with providers and resident-led groups who speak on behalf of residents, it will also review how the organisation shares feedback and lets people know they have been listened to. Management Concern	Assurance	April 2024	August 2024
AIM 3: To enhance productivity and value for money			
IT Controls / IT Equipment The review will focus on key aspects of IT usage and control throughout the systems in place within the ICB. The exact area of focus will be agreed with management but will include processes for recording and tracking the deployment and return of IT devices and equipment. The internal audit Technology Risk Assurance specialists will support the internal audit team. Management Concern	Assurance	May 2024	August 2024

Area and Strategic Risk	Audit approach	Proposed timing	Proposed Audit Committee Reporting
Financial Management and Recovery, Financial Controls and ISFE 2 Transition Financial Management and Recovery Dependent on the outcome of the review in 2023/24, internal audit may undertake a financial management and recovery review, whose scope will be determined and shaped by the assessment of the ICB's delivery against financial plan and will focus solely on the financial management arrangements. Financial Controls and ISFE 2 Transition As the ICB will be migrating to a new ledger, in line with all other ICBs nationally, internal audit will provide advice and support over a sample of the core finance systems and processes in operation. It will also consider the requirements of External Audit around the transfer of balances to establish how we can perform early work to support. Internal audit will undertake this review jointly with LCFS. Board Concern	Assurance	July 2024	October 2024
Contract Register and Data Quality The ICB is in the process of moving all contracts to a new contract management tool. This review will focus on the migration to the new system, including a data quality assessment, and how it is being used effectively to record and monitor those contracts held. As part of the review, internal audit will review how the new Provider Selection Regime which came into force on 1st January 2024 has been implemented and will consider the fraud and bribery risks of the new regime, including potential for lack of separation of duties, and the impact on the new ledger. Internal audit will undertake this review jointly with LCFS. Board Concern	Assurance	April 2024	August 2024
AIM 4: To support broader social and economic development			
Risk Management and System Working Internal audit will undertake a review of the risk management embedding process within the ICB. This will include review of relevant borough and committee meetings to assess the level of challenge and consideration of risks. This work informs the Head of Internal Audit Opinion.	Assurance	January 2025	April 2025

Area and Strategic Risk	Audit approach	Proposed timing	Proposed Audit Committee Reporting
Separately, internal audit will also consider the arrangements for ICB assurance over system risks, and how the ICB works with ICS partners to receive assurance over a sample of risk areas. Board Concern			
Core Assurance			
Data Security and Protection Toolkit – 2023/24 submission The review will consider: • Action plans in place to improve performance. • The Governance arrangements in place for the delivery, completion and sign off of the DSP Toolkit return and wider requirements. • Compliance reviews by the information centre and their impact on compliance with DSP Toolkit requirements. • The validity of the toolkit return based upon a review of a sample of toolkit requirements. This review will be undertaken in line with NHS Digital requirements by our Technology Risk Assurance specialists.	Assurance	April 2024	June 2024
Other Internal Audit Activity			
Action tracking and detailed follow up: Regular status reporting to executives on the implementation of actions. Progress on actions will feed into the ICB Head of Internal Audit Opinion. Internal audit will conduct additional detailed follow up testing on a sample of actions raised from a partial assurance reports issued in 23/24, and management actions that are still long outstanding, such as those relating to IR35 and Medicines Optimisation.	Follow up	For each Audit Committee	
Contingency: To allow additional reviews to be undertaken in agreement with the audit committee or management based in changes in risk profile or assurance needs as they arise during the year.	N/A	N/A	N/A
Assurance Mapping: Internal audit developed an assurance map in 23/24 which outlined the ICB's assurances for key risks and areas using a three lines of defence model. The exercise helped to identify gaps in assurances and inform planning for future years, across the Organisation, the System and at Place level.	N/A	Throughout the year	

Area and Strategic Risk	Audit approach	Proposed timing	Proposed Audit Committee Reporting
Internal audit will provide support to management to ensure the assurance map remains accurate, relevant, and reflective of system assurances as they develop.			
Management: This includes annual planning; preparation for and attendance at audit committee; regular liaison and progress updates; liaison with external audit and other assurance providers; and preparation of the annual opinion.	N/A	Throughout the year	

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

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 • Being outward looking • Population growth – specialist services The last Audit and Risk Committee also considered the BAF and an initial assurance map.
Action required	To consider, note and agree 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 May. • Board to receive updated BAF in May 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 At its development session on 28 February, Board members discussed the proposed risk appetite for each service area, such as quality, finance, place-based partnerships, workforce, etc. Members highlighted the importance of reviewing the risk appetite on an annual basis to ensure that the risk appetite does not exceed the ICB's capacity to effectively manage its risks and the ICB's ability to meet its financial control total.

2.2 The Board noted the complexities involved in determining the risk appetite which it is therefore difficult to describe as a single point or number on a scale. There was a

recognition of the importance of considering and mitigating risks as a system, understanding the consequences of mitigations on other partners. The Board talked through the wider approach to risk, the risk universe in which we are operating and the importance of exploring the tensions and dissonance in our approach to risk. The Board suggested that a framework is developed to enable a more effective way of describing and deciding what the appetite for each service area should be. The Board agreed the need to work more strategically on setting out a formulation of risk (which might include tensions and dissonance as well as alignment) as part of developing the framework. Work is getting underway and will be shared at a future meeting.

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 committees' 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 21 February which included the BAF and a draft assurance map, the following comments were noted:

- Consideration needs to be given in regard to how we reflect sustainability in primary care
- The committee welcomed the draft assurance map which provides an overall picture of the whole organisation and will help to inform the discussions on risk.

4.3 A meeting of risk champions was held in February to support the development of the risk management process and revise the risk management strategy and policy.

4.4 A meeting with provider governance leads was held in February and discussed the development of principles for a system risk register and considered how we as a system we operate an end to end risk management system. We are keen to articulate and apply a more dynamic link between the risks at Trust and at system level, including those on the BAF. The group are reviewing links between ICB BAF and BAF of our providers – an update on this will be provided at the next NEL audit chairs meeting in April 2024.

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, against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.

- There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower

range of local peoples' needs and risk not bringing into account wider community assets.

- 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. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of intervention from regulators such as the Care Quality Commission (CQC).

- There is a risk that the lack of 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 Integrated Care Partnership (ICP) Strategy to improve equitably the health and wellbeing of people across north east London, to reduce inequalities and to invest in prevention and were we to fail 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 without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer-term sustainability.

- There is a risk that the failure to share mutual accountability for the delivery of current and future operating plans and constitutional standards, could result in clinical variation and have a negative impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.

- There is a risk that without a collaborative and innovative plan to address the significant growth in population across north east London over the coming years, there will be 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 existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.

- 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, if the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms.

6.0 Next steps

6.1 The review of the ICB risk management strategy and policy is a rolling programme of work involving risk champions across the ICB.

6.2 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

North East London
Integrated Care Board

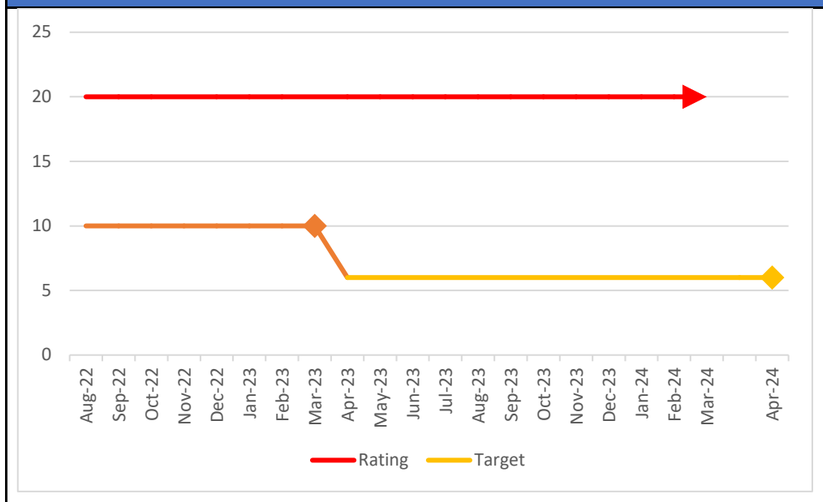
Board Assurance Framework March 2024 – Dashboard

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score						Target	Risk Appetite	Order in BAF
				Apr/ May	Jun/Jul	Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/Mar			
To improve outcomes in population health and healthcare	There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower range of local peoples' needs and risk not bringing into account wider community assets.	Charlotte Pomery	Population Health and Integration Committee	12	12	12	12	12	12	8	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**2**
	There is a risk that, if the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms.	Paul Gilluley	Population Health and Integration					**20 NEW RISK TO BAF**	20	20	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**11**
To tackle inequalities in outcomes, experience and access	There is a risk that existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.	Diane Jones	Quality, Safety and Improvement Committee	20	20	20	15	15	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. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of intervention from regulators such as the CQC.	Diane Jones	Quality, Safety and Improvement Committee	20	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 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	12	12	12	12	12	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**6**
	There is a risk that the financial challenges we face as a system mean we are unable to	Henry Black	Finance, Performance and	20	20	20	20	20	20	6	**Cautious:** We have	**1**

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score						Target	Risk Appetite	Order in BAF
				Apr/ May	Jun/Jul	Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/Mar			
To enhance productivity and value for money	achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London, to reduce inequalities and to invest in prevention and were we to fail 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.		Investment Committee								limited tolerance of risk with a focus on safe delivery	
	There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer-term sustainability.	Johanna Moss	Finance, Performance and Investment Committee	**10 NEW RISK TO BAF**	**10** ↔	**10** ↔	**10** ↔	**10** ↔	**10** ↔	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**8**
	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.	Henry Black	Finance, Performance and Investment Committee	**15 NEW RISK TO BAF**	**15** ↔	**15** ↔	**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.	Johanna Moss	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 against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.	Charlotte Pomery	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	**10**
	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** ↔	**16** ↔	**16** ↔	**16** ↔	**16** ↔	**16** ↔	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**3**

Board Assurance Framework – March 2024

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, to reduce inequalities and to invest in prevention and were we to fail 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)	March 2024	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. 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

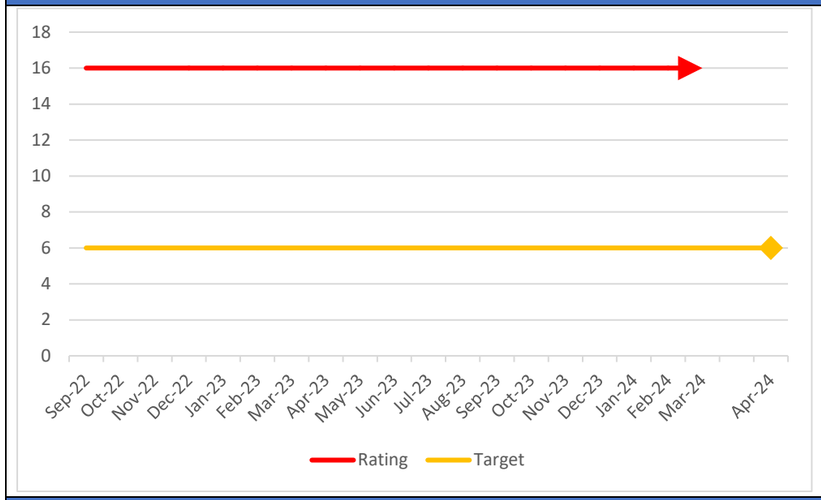
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO15 (previously CSTO01)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Charlotte Pomery
	✓		✓		✓		✓			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 ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower range of local peoples' needs and risk not bringing into account wider community assets.**										

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)	March 2024	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 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

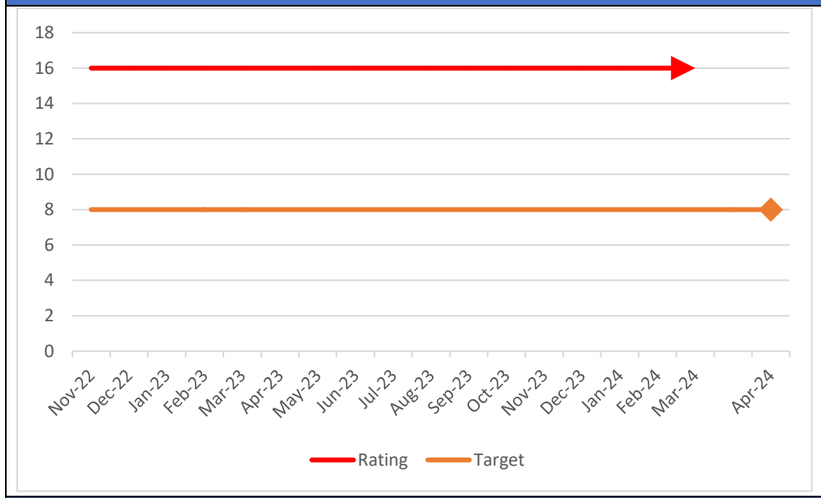
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO009
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	Population 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	April 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)	March 2024	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	April 2024
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. They have worked with the Net Zero Lead and BCYP team to develop a case study for an Air Quality Programme to be discussed with the Chief Transformation and Strategy Officer (CTSO) and Chief Medical Officer (CMO) in May.	Complete

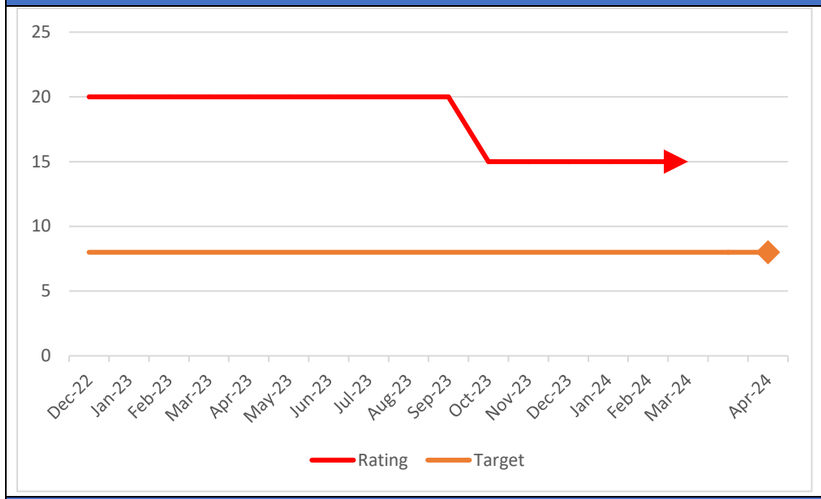
ICS Aim	To support broader social and economic development							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO012 (previously CPPO11)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			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 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)	March 2024	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	CNO02
									✓		
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 existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.**										

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)	March 2024	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
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.
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
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

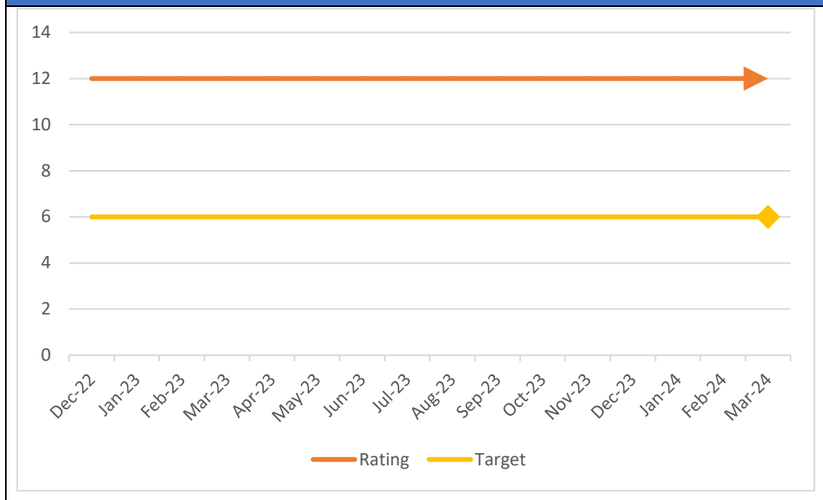
	Complete
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 **complete and planned for Feb 24 meeting**
BHR UEC Place Programme Board around BHR UEC Improvement Plan and Strategy, avoidable admissions, discharge funding programmes	26/04/23 & 31/05/23 & 28/06/23 **Complete**
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

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 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.

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)	March 2024	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	CNO01
								✓	✓		
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. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of 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)	March 2024	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 without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer term sustainability.**										

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)	September 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)	March 2024	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.	Spring 2024
Development of long-term Strategic Infrastructure Approach.	Spring 2024
Options and priority areas for investment reviewed to enable better future planning of investment and spend.	Spring 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.	Spring 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)	March 2024	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.

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	Complete
Revised planning assumptions for H2 2023/24 issued, with assurance process for Trusts and ICB, including Quality Impact Assessment	22 Nov 2023

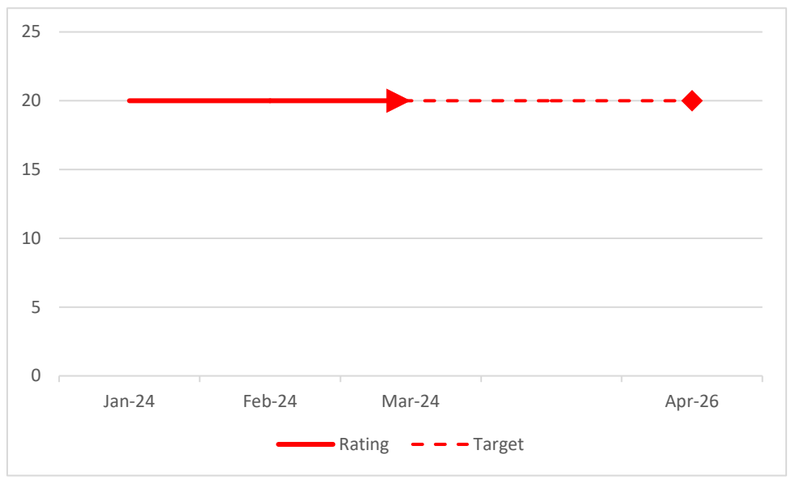
ICS Aim	To support broader social and economic development							Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO13
								✓	✓		
ICS priority	Children and young people		Mental health			Employment and workforce		Long term conditions		Risk owner	Charlotte Pomery
	✓		✓			✓		✓		Responsible committee	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 against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.**										

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)	March 2024	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 improve outcomes in population health and healthcare							Risk reference	CMO001
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions				Risk owner	Paul Gilluley
	✓	✓	✓	✓				Responsible committee	Population Health and Integration
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 the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms.**								

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (4x5)**	January 2024	The risk has been identified owing to a specific challenge in NEL related to renal dialysis capacity, a specialised service, currently commissioned by NHSE, and due for delegation in April 25. The capacity challenge has arisen due to unfunded growth in demand which is marked in NEL owing to the aetiology of the population. Risks in unfunded growth for other specialised services are therefore likely to arise where funded capacity is likely to be insufficient to meet rising demand for complex specialist care as the population needs increase in response to new drugs, technology and advances in specialist provision. Quality and safety impacts of reduced capacity and access to certain specialist treatments can be extremely detrimental to patient outcomes in addition to the financial pressures on the NHS more broadly.
	Target rating (LxS)	**Target date**	**Rationale**
	20 (4x5)	April 2026	The risk remains as red with a target for April 26 as this will be one-year post delegation of specialised service commissioning to ICBs. The risk is likely to remain at a high score as preventative interventions to manage specialist demand will take time to demonstrate impact. Simultaneously, the volume of specialised services to be delegated will increased over time, potentially leading to a greater imbalance in demand and capacity owing to increasing population demands based on complexity and multiple pathology
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (4x5)	March 2024	The Joint Working Agreement with NHS England regarding the delegation of specialised services is being presented to the ICB Board at it's meeting on 27 March 2024.

Controls and assurances
Maintenance of the Delegation Risk Log
Service portfolio analysis for specialist services to be delegated and clarity on impacts of needs-based funding formula.
Speciality deep dives to assess compliance with national service specs and early identification of demand and capacity imbalance
Reports and updates provided to: • NEL Specialised Services Programme Board • NEL Specialised Services Transformation sub group • NEL Specialised Services Contracts and Finance Committee • North London Programme Board for specialised services • London Joint Committee for Specialised Service Delegation • Acute Provider Collaborative Executive Committee • Acute Provider Collaborative Joint Committee • ICS Executive Leadership Team/ Executive Management Team

Mitigations/ actions to address the risk	Target date
Development of a legacy risk log identifying current provider, specialised service level risks	Completed
Open dialogue with current NHSE regional commissioning and finance teams to manage challenges whilst commissioning still led by NHSE	Completed

Internal approach integrating specialised commissioning with the LTC agenda, ensuring prevention initiatives and whole pathway transformation for the priority specialised service pathways for longer term impact	Completed
Work with the NEL insights team to forecast demand for certain specialised services	Ongoing
Working together across the system to invest in prevention with each part of the system needing to identify how to move more resources into investment in prevention.	Ongoing

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 ICB board

27 March 2024

Title of report	Executive Committee exception report
Author	Katie McDonald, Governance Lead
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Katie McDonald, Governance Lead katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the virtual meeting of the Executive Committee held in March 2024. The key items detailed in the report include: • Urgent and Emergency Care (UEC) priorities • Emergency preparedness, resilience and response annual report • Growing well in north east London • Joint forward plan refresh • Clinical care and professional leadership across north east London • Recovering access to primary care • Joint working agreement with NHS England
Action required	Note
Previous reporting	None – this is an exception report from the meeting held in March 2024.
Next steps/ onward reporting	The committee meets again on 9 May 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 virtual meeting of the Executive Committee held in March 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In March the committee received its second report of a new standing agenda item regarding updates to the Urgent and Emergency Care (UEC) programme. The report outlined the improvements that have been made in urgent and emergency care (UEC) recovery and transformation in 2023/24, and the plans that are being developed with system partners to improve quality, safety, access and availability of UEC services in North East London (NEL) in 24/25. The Committee were advised on the updates to the UEC governance, current performance, plans to deliver the 76% A&E performance ambition and further developments to the NEL UEC priorities that were endorsed by the NEL UEC Board and ICB Executive Committee in January 2024. Detailed planning is being undertaken jointly with system partners to develop and refine these priorities to support NEL to deliver on its UEC vision for NEL residents, services and staff.

2.2 Members received a high-level overview of North East London ICB's emergency preparedness, emergency planning, resilience and response (EPRR) activities as a Category 1 responder. From 2023 NHS England (NHSE) has required ICBs to stand up a Local Health Resilience Partnership (LHRP) to discuss health resilience matters across north east London. Whilst each organisation and their Boards are responsible for their own EPRR governance, the LHRF is intended to be influential in developing an ICS-wide EPRR programme, risk register and mitigations which can be assessed, agreed and shared between partners. With the required endorsement, the LHRF will begin meeting in Spring 2024.

The ICB's EPRR work programme was audited in 2023 by RSM UK with a rating of 'reasonably assured'. Future requirements included improvements across the ICB's lessons learned process, increase in EPRR resource and committee reporting. Areas of best practice include health data utilisation within emergency planning and noted multi-agency collaboration.

Members received the scores from the self-assessed assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards which is submitted to NHSE. The ICB was assessed as 'substantially compliant', which is an improved position to last year where we were assessed as 'partially compliant'. Further detail on this has been outlined in the Chief Executive Officer's report.

2.3 The committee noted and endorsed the following reports which are being presented at this ICB Board meeting:

- Growing well in north east London

- Joint forward plan refresh
- Clinical Care and Professional Leadership (CCPL) overview
- Recovering access to primary care
- Joint working agreement with NHS England

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

27 March 2024

Title of report	Audit and Risk committee exception report
Author	Cha Patel, Audit and Risk Committee Chair
Presented by	Cha Patel, Audit and 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 21 February 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in January 2024.
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	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 21 February 2024.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 The committee received and discussed the regular update report from the Procurement Group and received a helpful presentation on the new Provider

Selection Regime (PSR).

2.2 Committee members received an update on risk including digital risk and members were presented with a helpful assurance map which informed the discussion.

2.3 Updates from our External Auditor, Internal Auditor and our Local Counter Fraud Specialist were received. As part of the Internal Audit discussion, four internal audit final reports were noted and discussed.

2.4 A financial overview was presented which included a high-level summary of the level of debt currently outstanding for the ICB. An update on progress in regard to the ICB's implementation of 100% purchase order compliance by 1 April 2024 was given and members were assured that progress is expected to accelerate in light of the new ways of working under the Provider Selection Regime.

3.0 Risks

3.1 An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

12 March 2024

North East London
Integrated Care Board

NHS North East London ICB board

27 March 2024

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 meeting held on 7 February 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in January 2024.
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 meeting held on 7 February 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The committee received a verbal update on the Equality Impact Assessment (EqIA) on the final outcome of Phase 2 of the ICB's restructure and the responsible chief officer advised that the final document would be provided to the committee members after the meeting.

2.2 A further update on the ICB's voluntary redundancy scheme was considered and members supported a further number of voluntary redundancy applications that were recommended for approval by the Voluntary Redundancy Panel.

2.3 The proposed re-structure of the Chief Nursing Officer's department was presented and an in-depth discussion took place. Key areas of the department's re-structure had been paused during Phase 2 of the consultation process in order to ensure that the new operating model would meet its statutory responsibilities and enable the ICB to exercise its responsibilities for oversight of the quality of patient care across the integrated care system in north east London. The committee approved the proposed changes.

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.

28 February 2024.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

Title of report	Quality, Safety and Improvement (QSI) Committee exception report
Author	Keely Horton, Governance Officer
Presented by	Imelda Redmond, Non-Executive Member
Contact for further information	Keely.horton1@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 14 February 2024. The key items detailed in the report included: • PELC Improvement update • Quality strategic risk update • System Quality Report • Quality Exception Assurance Items • UEC Programme Board update • Performance report through a quality lens • Paediatric Audiology Report • Safeguarding: SUDI update • NEL LMNS Maternity Incentive Scheme Year 5 Submission report
Action / recommendation	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 10 April 2024 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	The Committee has adopted a new approach to its review of strategic risks. It proposes to review NEL ICB strategic risks but from a Quality perspective. A risk register to that effect will be presented at its future meetings. The Committee however has an awareness of the following risks: • those related to tackling inequalities in outcomes, experience and access. • the Continuing Healthcare (CHC) Digital Systems procurement process has been paused.

Quality, Safety and Improvement Committee Exception Report

1.0 Purpose of the report

1.1 This report provides the Board with an overview of the items discussed at the QSI Committee held on 14 February 2024. 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 Committee received a PELC Improvement report which provided an update on the enhanced surveillance to support PELC following the inspection undertaken in November 2022 where PELC was rated inadequate by the CQC at all four sites.
There has been a strong partnership approach to implement the necessary actions to make rapid improvements in response to the Enforcement Notices and other deficiencies noted in the inspection.
Following the CQCs reinspection in August 2023 there was a noted improvement and PELC were moved from inadequate to requires improvement.
The Committee acknowledged the amount of work that has been undertaken to make the required improvements and the professional response. It is evident that changes have been embedded and are sustainable to continue improvement. The Committee agreed to transition PELC from monthly ICB Enhanced Surveillance assurance meetings to monthly contract meetings and there will remain the ability for the ICB to escalate PELC to enhanced surveillance should there be significant quality concerns.

2.2 The Committee were briefed on the refreshed risk register following previous discussions which have taken place at the Committee. A list of high-level risks were presented to QSI for discussion and agreement.
The Committee provided feedback on the circulated risks and fedback that the risks need to include a health inequalities element and Mental Health, Learning Disabilities and Autism.
Phase 2 will be discussed at the April 2024 Committee and will include discussions around understanding the mitigations to the agreed quality risks and where does responsibility for mitigation sit and how does QSI obtain assurance.

2.3 The System Quality Report was presented to the Committee. The report aligns with the Quality Assurance, Improvement and Control quadrants of the NEL Quality Management System. The report and dashboard will evolve over time as appropriate metrics and measures are identified and system priorities flex.
Reporting data on the scale and nature of harm caused to patients within NHS care continues to be an issue while the system works to move over to the Patient Safety Incident Response Framework and the use of the Learning from Patient Safety Events service. Work is ongoing with providers while they are waiting to be connected to LFPSE.
The number of reports to Freedom to Speak Up services across NHS Trusts has increased across North East London services, with 522 reports in 2021/22 and 715 reports in 2022/23. Data shows that for 2023/24, with 516 reports in the first two quarters. The National Sexual Safety Collaborative (SSC) was commissioned as part of NHS England's Mental Health Safety Improvement Programme (MHSIP). Both East London NHS Foundation Trust and North East London NHS Foundation Trust took part in the collaborative and have undertaken work to support those working in their organisation to achieve the SSC standards. A Deep Dive into this piece of work is being considered.
The Quality, Safety and Improvement Committee support this form of reporting and endorse the approach of system collaboration to support cross-team and multi-partner working, acknowledging that the wider system and NEL system are not set up to fully undertake system quality reporting and stating when data is not readily available.
The Committee support the release of funding for the Quality Development Team to be able to access QI Macros and for relevant staff to access training related to Measurement for Improvement and related software.

2.4 The Committee received a Quality Exception Assurance report, key highlights included:

- Whipps Cross Colposcopy Service – Investment Review Group recommended to go through NEL cancer alliance for funding. Barts Health have secured mutual aid from NEL as a way to mitigate by clearing the back log.
- Richard House – progressing with enhanced surveillance process.
- Cygnet Newham – individual residents have now secured placements resulting in no more patients left on the ward.
- Medicines Management update on Valproate prescribing. An overarching valproate improvement group has been established to monitor and facilitate the implementation of this alert across NEL ICS. The Committee agreed that wider discussions are needed at Place on what action is needed for valproate prescribing and further communication needs to be shared with primary care.

2.5 A paper outlining the progress that has been made since autumn 2023 with the establishment of the NEL UEC portfolio and the programmes of work was shared with the Committee. Programmes are being delivered across the system at place, provider, collaborative and ICS levels to improve quality, safety, access and availability of UEC services in NEL.
The specific proposed workstreams that will focus on delivering the programmes aims are winter planning; mental health in ED and flow; hospital flow; integrated care pathways across primary, community and UEC; ambulance conveyances / system clinical coordination.
Five UEC transformation priorities have been defined for further development in 24/25 as part of the 24/25 planning processes, aligned with the ICS Joint Forward Plan and NHSE Operating Plan Guidance.

North East London has exited the regulatory framework of Tier 1 into Tier 2 for UEC performance. This is as a result of improvement in performance and evidence on the leadership focussed on UEC pathways and care. NEL are the only system nationally to have exited Tier 1.
Healthwatch have noted concerns such as high number of people that shouldn't be at A&E and who could potentially be linked to other services to help ease the capacity issues. The Committee discussed educating local residents to navigate through health care systems. The RightCare Campaign aims to support health and care systems to improve care quality, population health and system sustainability.

2.6 Performance Report through a Quality Lens was provided to the Committee. The Committee welcomed the level of reporting and the assurance the report will provide to ensure that the right quality conversations are taking place in acute provider collaboratives and programme boards. The proposal is to bring a full Performance Quality Insight and Assurance Report to alternative QSIC meetings, as it will enable the quality team to influence actions to mitigate quality and safety risks identified through this quality governance approach, and provide system partners enough time to undertake necessary actions to improve outcomes for residents.

2.7 The Committee received an update report on paediatric audiology. The only benchmarked data published nationally relating to paediatric audiology waiting times is DMO1 (Diagnostics Waiting Times and Activity) which covers both adults and children. Barts Health report on DMO1 but NELFT do not. Barts has the biggest audiology waiting list in London and the highest percentage of 6 week+ and 13 week+ waiters in London. Looking at all hospitals currently reporting in England, Barts ranks fifth in England for the percentage of 6 week+ waiters.
Barts Health's Paediatric Audiology backlog clearance with Communitas is being progressed and aims to clear the backlog within six months with oversight from NEL ICB Performance colleagues.
Assurance has been provided to NHSE Region as the ICB regulator and feedback has been provided. Further details will be reported at the next Committee.
The Committee were concerned that the high waitlist was not alerted sooner and the potential of harm caused. The Committee have asked that communication is to be provided to all GP providers on planned action for clearing the backlog of waiting lists and expected timeframe.

2.8 A progress report on the quality improvement activity being coordinated on the Sudden Unexpected Deaths in Infant (SUDI) was presented to the Committee. NEL ICB are leading on a piece of work across the seven boroughs to oversee provision of SUDI training and a NEL wide SUDI steering group has been established to deliver the Quality improvement and preventative work. Children Centres are being linked in and part of the conversations to improve outcomes.

2.9 The Committee were briefed on the Local Maternity & Neonatal System (LMNS) Maternity Incentive Scheme, year 5 submission. BHRUT have met all 10 safety actions, Barts Health and Homerton have not met all safety actions. Areas where the providers were not compliant have an action plan to work through and is monitored by the LMNS.

North East London
Integrated Care Board

NHS North East London ICB Board

27 March 2024

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) most recently met on Monday 26 February 2024. The meeting discussed the following business: • Month 10, 2023-24 Finance Report, including updates from the Financial Recovery Director • Month 9, 2023-24 Performance Overviews • Updates on the 2024/25 North East London (NEL) allocation and operating planning process • The Chief Finance and Performance Officer's (CFPO) Risk Register • Updates from Committee sub groups • Three procurement awards
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the February 2024 Committee meetings.
Next steps/ onward reporting	The Committee next meets on Monday 25 March 2024 and a regular exception report will be presented to the Board along with any approved minutes.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Which of the ICS aims does this report align with? • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will provide assurance to the ICB on operational performance as it

	relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate. The Committee's current key priorities are recovery, sustainability and transformation.
Risks	The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction / Context / Background / Purpose of the report

1.1 The last meeting of the Finance, Performance and Investment Committee (FPIC) took place on Monday 26 February 2024. This exception report outlines the key messages, recommendations, decisions and actions taken by FPIC members in accordance with its terms of reference across both meeting.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee received the Month 10 (January) Finance Report, discussing the latest financial positions and progress against the Financial Recovery Plan (FRP). Committee members acknowledged that issues encountered in continuing healthcare (CHC) and medicines management were also being encountered across the country, to the extend that NHS England (NHSE) were making additional allocations available in 2024/25 to address these two specific areas.

2.2 The FPIC acknowledged that 70% of the 2023/24 savings that were contributing to the year end position had been secured through the use of non-recurrent funds, which would not be available in 2024/25.

2.3 The Committee was updated on the latest information around the 2024/25 allocation and the route towards production of an operating plan for the upcoming financial year. This included the schedule of returns to NHSE required in the coming weeks towards the production of a final 2024/25 operating plan by the end of May 2024. Members highlighted that the system needed to be upfront and transparent about the upcoming challenges, and that if partners were clear that they needed to declare deficit positions, the system should be open about this. Productivity would need to be major focus of efforts through the upcoming year, with a shared and consistent approach to workforce planning vital for the system as whole.

2.4 The Committee was briefed on month 9, 2023-24 clinical performance across NEL providers in February 2024. The discussions included that while the planned care waiting list had continued to fall for the fourth consecutive month, it remained above trajectory, with the number of very long waiting patients (more than 78 weeks) increasing. The impacts of industrial action on the waiting list was explored and risks around a potential secondary waiting lists held in consultant led follow ups flagged. Members recognised the efforts underway to develop a process to measure any potential impacts of financial savings on local performance metrics.

2.5 The February 2024 FPIC approved the outcomes of three procurement processes to award contracts, following the ICB's procurement processes.

2.6 Updates from Committee sub groups were received from the Primary Care Contracts Sub-Committee, Financial Recovery Board (FRB) and Investment Review Group and noted by the FPIC.

2.7 FPIC members agreed the award of a contract for ICB external audit services for 3 years, with the option of a 2 year extension.

3.0 Risks and mitigations

3.1 The Committee received the latest Finance and Performance Directorate Risk Registers at both meetings, containing red risks rated at 12 and above and recognised that this remained work in progress.

3.2 Members asked that potential risks be explored around the overarching achievement of the system wide savings programme to document whether progress was on track and the likelihood – and consequences of missing goals in the upcoming year.

3.3 There may need to be a risk escalated to the NEL ICB Board Assurance Framework (BAF) around the 2024/25 allocation, impacts of the operating plan and savings requirements across the NEL system.

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

Author: Matthew Knell, Senior Governance Manager
Date: 18/03/2024

North East London
Integrated Care Board

NHS North East London ICB board

27 March 2024

Title of report	Population Health and Integration committee exception report
Author	Katie McDonald, Governance Lead
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 7 February 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in January 2024.
Next steps/ onward reporting	The committee meets again on 24 April 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 7 February 2024 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 Committee received a paper which summarised some of the early outcomes and learning from the evaluations of the year 1 (2022/23) health inequalities funding, completed by Places. Key themes around what works for health equity have been identified, including cross-sector collaboration and partnership working, engagement and co-production with communities, improving accessibility of healthcare communications, and action on the wider determinants of health including the cost of living. Some of the main challenges experienced by projects and places include staff capacity, funding, and recruitment delays, measuring impact and data quality. Members noted that there are similar projects happening across Places and

discussed the importance of learning from each other and the need to determine how we can scale up those that are successful to enhance value for money. It was also highlighted that there should be a structured evaluation process in place, similar to the quality improvement approach, as impact measures can be subjective.

2.2 Members welcomed a report regarding the Growing Well programme in north east London, which is being presented to the Board at this meeting. The report offered a summary of the Place, Collaborative and system initiatives that support Growing Well, which is one of our four Integrated Care System (ICS) strategic priorities and described some of the key opportunities for our younger north east London population and their families. The paper highlighted the work linked to the Core20Plus offer, as well as on the importance of a more universal approach based on prevention and early intervention to improve the life chances for all babies, children and young people in north east London.

Members had a rich discussion on work that is happening as well as how we can improve the programme. It was highlighted that the wider determinants of health are a primary concern for our young population, such as childhood obesity and access to dentistry. Violence and fear of violence is also a concern for our young people and their families, so this could be another area we explore as a partnership. It will be important that we develop the long-term strategy and pinpoint how we will deliver our vision to make north east London the best place to grow up, through early support when it is needed and the delivery of accessible and responsive services.

2.3 The Committee discussed a proposed process for developing population health management which highlighted that work is underway to design an operating model for the ICS, having an improvement approach, and reviewing the prevalence of diseases in our population. A learning partner has been commissioned who will help us identify and strengthen behaviours, but we will need to pull this work together into a cohesive commissioning strategy that links with our integrated care strategy. Members discussed how it will be important to allocate our resources in a different way to benefit the needs of the population whilst being financially sustainable. Good quality data will enable us to target the most appropriate areas and achieve the longer-term aspiration of preventing illness and disease.

3.0 Risks and mitigations

3.1 The Committee discussed the Board Assurance Framework (BAF) risks which it is responsible for and highlighted that our mitigations need to be short term in order to achieve the longer term aims. It was also recognised that babies, children and young people, as well as health inequalities, should be reflected in all risks on the BAF.

Author: Katie McDonald, Governance Lead
Date: 14.03.2024

Integrated Care Board Forward Plan

	27-Mar-24	29-May-24	21-Jun-24	31-Jul-24	25-Sep-24	27-Nov-24	29-Jan-25
Resident story							
Resident story to be themed in line with the scheduled deep dive							
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							
Approval of Corporate Objectives							
Organisational values and behaviours							
Annual audit plan							
Specialised services Joint Working Agreement							
Finance and Performance							
Overview report							
Assurance							
Board Assurance Framework							
Quality							
Deep dives	Babies, children and young people	NHS community services and virtual wards		Urgent and Emergency Care	Long term conditions	End of Life care	Diagnostics
Quality report							
Annual complaints report *to include complaints, incidents, compliments and what this tells us about the system*							
Strategy							
Joint forward plan (5 year plan)							
Clinical Care Leadership							
Operating plan							
Infrastructure strategy							
Access Recovery Plans	Primary care						
Supporting equity and sustainability (population growth)							
Industrial Action review							
Staff survey report							
Big Conversation success measures							