NHS
North East London
Integrated Care Board

NHS North East London ICB board

29 May 2024, 1.30pm – 4.10pm; Barking Town Hall

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0 1.1. 1.2. 1.3. 1.4.	**Welcome, introductions and apologies** Declaration of conflicts of interest Minutes of the meeting held on 27 March 2024 Matters arising Actions log	1.30	Chair	 Attached Attached Verbal Attached	Note Note Approve Note Note
2.0	**Resident story**	1.40		Verbal	Discuss/ note
3.0 3.1. 3.2.	**Chair and chief executive reports** Chair's report Chief executive officer's report	 2.00 2.05	 Chair ZE	 Attached Attached	 Note Note
4.0 4.1. 4.2. 4.3.	**Quality** Community Health Services in north east London A focus on women's health and gynaecology waiting lists Annual complaints report	 2.10 2.30 2.45	 PC DJ CPo	 Attached Attached Attached	 Note Note Note
5.0 5.1. 5.2.	**Strategy** Resident determined success measures, the Integrated Care Strategy and the development of a single outcomes framework The Integrated Care System strategic priorities and progress reporting	 2.55 3.05	 CPo JM	 Attached Attached	 Approve Approve
6.0 6.1. 6.2.	**Finance and performance** Financial overview Performance report	 3.15 3.25	 HB HB	 Attached Attached	 Note Note
7.0 7.1. 7.2. 7.3.	**Governance** Governance update Board Assurance Framework Committee exception reports for information: • Executive Committee • Audit and Risk Committee • Remuneration Committee • Quality, Safety and Improvement Committee	 3.35 3.40 3.50	 CPo CPo Chair	 Attached Attached Attached	 Approve Note Note

	Item	Time	Lead	Attached/ verbal	Action required
	• Finance, Performance and Investment Committee • Population Health and Integration Committee				
8.0	**Board forward plan**	3.55	Chair	Attached	Note
9.0	**Questions from the public**	4.00	Chair	Verbal	Note
10.0	**Any other business and close**	4.10	Chair	Verbal	Note

ICB Board members and attendees

Member	Role
Marie Gabriel	Chair, NHS North East London and North East London Health & Care Partnership
Zina Etheridge	Chief executive officer, NHS North East London
Diane Herbert	Non-executive member
Imelda Redmond	Non-executive member
Cha Patel	Non-executive member
Kash Pandya	Non-executive member
Fiona Smith	Non-executive member
Paul Calaminus	NHS trust partner member
Shane DeGaris	NHS trust partner member
Cllr Maureen Worby	Local authority partner member
Cllr Christopher Kennedy	Local authority partner member
Dr Mark Rickets	Primary care partner member
Dr Jagan John	Primary care partner member
Caroline Rouse	VCSE partner member
Paul Gilluley	Chief medical officer
Diane Jones	Chief nursing officer
Henry Black	Chief finance and performance officer

Participant	Role
Andrew Blake-Herbert	Local authority executive participant
Abi Gbago	Local authority executive participant
Jenny Hadgraft	Healthwatch representative
Charlotte Pomery	Chief participation and place officer

Johanna Moss	Chief strategy and transformation officer
Anne-Marie Keliris	Head of governance
Pauline Goffin	System Programme Director for Community Health Services/ Babies Children and Young People/Community Collaborative

North East London
Integrated Care Board

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

NHS North East London

- Declared Interests as at 07/05/2024

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 Remuneration Committee ICS People & Culture 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 Collaborative sub-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 ICS People & Culture 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

NHS North East London

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		
Fiona Smith	Non-Executive Member	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Remuneration Committee	Non-Financial Professional Interest	First Community Health and Care	Non Executive Director at First Community Health and Care CIC, in Surrey	2019-11-03		
			Non-Financial Professional Interest	East Surrey Place Based Partnership (NHS Surrey Heartlands ICB)	Member of East Surrey Place Based Partnership Board Chair of East Surrey Place Based Partnership Quality Committee	2022-07-03		
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 Primary care contracts 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 ICB Remuneration Committee	Non-Financial Professional Interest	Health Devolution Commission	Co Chair	2023-01-07		
			Non-Financial Professional Interest	Age Uk East London	Chair of Trustees	2024-02-18		
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	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
Kash Pandya	Non Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICB Remuneration Committee	Financial Interest	Southend-on-Sea Borough Council	Independent Audit Committee Member	2016-01-01		Declarations to be made at the beginning of meetings
			Financial Interest	Essex Police, Fire and Crime Commissioner's Audit Committee	Independent Audit Committee Member	2021-01-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Inverts Uk Ltd	Son is a Senior Procurement Consultant	2023-02-01		Declarations to be made at the beginning of meetings
			Indirect Interest	Accenture	Son is a Legal Director	2017-01-01		Declarations to be made at the beginning of meetings
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB 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 organisations to support their work to tackle racial and ethnic health inequalities.	2020-07-23		Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Member of the labour party	Member of the labour party	2020-04-01		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee Associated with my Chair role with the RHO	2020-07-23		Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Reviewer	2021-12-16		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UK Health Security Agency	Associate NED, (paid), UKHSA works with health and care organisations 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 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 07/05/2024

Name	Position/Relationship with ICB	Committees	Declared Interest
Francesca Okosi	Chief People and Culture Officer	ICB Board ICB Remuneration Committee ICS People & Culture 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.
Abi Gbago	Local Authority Member of Committee	ICB Board Newham Health and Care Partnership	Indicated No Conflicts To Declare.

NHS
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Minutes of the NHS North East London ICB board

27 March 2024, 1.30pm – 4.30pm, Unex Tower

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
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 Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
Attendees:	
Charlotte Pomery (CPo)	Chief participation and place officer, NHS North East London
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Jenny Hadgraft (JH)	Healthwatch participant
Andrew Blake-Herbert (ABH)	Local authority executive participant
Archna Mathur (AM)	Director of specialised services and cancer, NHS North East London and NEL Acute Provider Collaborative
Sara	Resident *for items 2.0 and 3.0 only*
Dr Myuri Moorthy (MM)	Clinical lead for diabetes and metabolism, Barts Health NHS Trust *for items 2.0 and 3.0 only*
Kath Evans (KE)	Babies, Children and Young People (BCYP) clinical lead, North East London ICS *for items 2.0 and 3.0 only*
Pauline Goffin (PGo)	System programme director for community health services/ BCYP/ community collaborative, North East London ICS *for items 2.0 and 3.0 only*
Christopher John (CJ)	Interim programme delivery lead for BCYP, NHS North East London *for items 2.0 and 3.0 only*
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance lead, NHS North East London
Apologies:	
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Abi Gbago (AG)	Local authority executive participant

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1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe. The Chair advised 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. Imelda Redmond declared a new interest as Chair of Age UK East London which will be added to the register of interests. 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 31 January 2024 were agreed as a correct record, subject to some corrections received by Archna Mathur for accuracy in relation to the specialised services item.
1.3	Matters arising
1.3.1	Joint Working Agreement with NHS England London for Specialised Services for 2024/2025
	AM presented the report and explained the following points: • 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 (NHSE) for the 59 services that are appropriate for more integrated commissioning, specifically where delegation is delayed until April 2025. • The joint working model, via the agreement will continue to be implemented through 2024/25 whilst the delegation conditions are worked through. The Joint Working Agreement is adapted from the national document, ensuring consistency across London ICBs. • 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. • In London it was also decided that a number of principles needed to be adopted. These included that 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. 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. Members discussed the report and points included the following:

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	• In response to a query regarding risk management, it was explained that the risks associated with the delegation of specialised services will be monitored by the Quality, Safety and Improvement Committee. **ACTION:** IR and DJ to ensure risks regarding the delegation of specialised services are monitored at the Quality, Safety and Improvement Committee. The ICB Board **approved** the Joint Working Agreement for the commissioning of specialised services in 2024/2025 and authorised the ICB Chief Executive to sign the Joint Working Agreement on behalf of North East London ICB.
1.4	Actions log
	4.1 Chair's report – the Chair requested a date is provided for when the disability equity workshop will take place. 6.2 Performance report – the Chair requested for the diagnostics deep dive to be scheduled earlier and to be linked to the regular performance report. The ICB board noted the actions taken since the last meeting.
2.0	**Resident story**
	Dr Myuri Moorthy introduced the resident's story by detailing a diabetes pilot project for young adults, aged 16-25 years, that is being led by Barts Health NHS Trust and that Sara has been a part of. The pilot focusses on both Type 1 and Type 2 diabetes in young adults, who have a higher risk of making inappropriate healthcare decisions as they are still developing physiologically and are the age group most disassociated from healthcare. Sara shared her experiences of living with diabetes since being diagnosed, aged 9, and key points included the following: • As a teenager, Sara was admitted to an Intensive Care Unit (ICU) for a number of weeks due to not effectively managing her diabetes. Sara explained how she felt pressure when making decisions as to what to eat or drink as she wanted to fit in with her peers and felt denial about having a life-long diagnosis. • Since being a part of the pilot, Sara detailed how the support available has helped with managing her diabetes as a young adult which included access to a psychologist to help with her mental health, as well as having the opportunity to complete a course on Dose Adjustment For Normal Eating (DAFNE) which is a structured education to assist with counting carbohydrates. Sara described the importance of the care and empathy that was shown to her by her nurse and how the programme has also enabled Sara to meet other diabetics and become part of a community that understands each other's experiences. • Sara detailed the importance of going to where young people are to engage with the young diabetic community as teenagers and young people are less likely to reach out to services and offer their views on how to improve. • When attending university, Sara attended a hospital outside of north east London for her treatment and explained this care was of lower quality than the care she received at Barts Health. Sara highlighted the importance of supporting mental health as this becomes particularly significant when transitioning from children's to adult's services. Members discussed Sara's story and points included the following:

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	• It is important to recognise the impact that a long term diagnosis can have on the person's wider family; it could mean there is a need for parents to be educated in the condition and perhaps a change in lifestyle and diet. • Continuity of care is very important in order for residents to build relationships and trust with their healthcare team; particularly for those living with long-term conditions. • It will be important to consider how we can achieve equity of provision across all north east London boroughs. • Social prescribing can have a greater impact on younger people, including their families and their need to adapt to their children's diagnoses. • Multidisciplinary team (MDT) meetings for high risk young adults with diabetes are held which include general practice and social workers, however this is not available for those who regularly attend appointments are deemed lower risk. It is important that trusting relationships are built with primary care services for residents who do not have MDT meetings. • Learning can be taken from this approach for other long-term conditions, including the more holistic methodology. This may require an initial investment but would save money in the longer term. • It is positive to note that youth workers were involved in Sara's story; however, a high turnaround of staff in this area may not be beneficial to residents. • It is important to note that Sara's school also had a positive part to play in her outcomes; their safeguarding officer was in regular contact with the healthcare team which enabled extra educational support to be provided. • At a senior nursing leadership forum a fortnight ago, leaders highlighted that one of the key areas they wanted to influence is for all nurses to work with their diabetic community; this includes hospital and social care nurses. The ICB board thanked Sara for sharing her story and noted the key points arising from the resident story. *At this point, the order of agenda items was changed to allow for the Growing Well report to be discussed in line with the resident's story.*
3.0	**Quality**
3.1	Growing Well priorities in north east London
	• KE, PGo and CJ presented the report and highlighted the following key points: • North east London is a young and diverse population and babies, children, and young people (BCYP) make up more than 25% of this and are our future adult population, underlining why they are a strategic priority for the North East London (NEL) Integrated Care System (ICS). 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 (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. • Poverty and cost of living pressures are likely to exacerbate issues given the relationship between deprivation and poor health, education and social outcomes. There are significant unmet health and care needs for the BCYP in our communities that are not being identified or effectively met by current

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	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. o Three overarching priorities for the BCYP portfolio have been developed at the request of the Population Health and Integration Committee which are: ▪ Increasing capacity for community-based care ▪ Responding to Special Educational Needs and Disabilities (SEND) demand ▪ Supporting the most vulnerable children. • A range of initiatives are underway to address the priorities, and a shared system of support and responsibility will be required to make this effective. We will need to be creative in order to move financial resource downstream as there are no extra monies available in the system. Members welcomed the report and thanked colleagues for their work. Key points of discussion included the following: • In order to maintain consistency as a system, consideration should be given to renaming the programme to 'Growing Well, Starting Well', which is used by all local authorities. • Issues should be tackled at scale at a north east London-level in order to ensure equity of provision as well as being more financially efficient. • It would be beneficial to have further collaboration with Public Health colleagues, specifically in relation to children's oral health which is a particular issue in north east London. Local authorities should also be able to assist with estate and colocation of services if required. • Poverty is a real issue for our population. At a pop up event in Barking and Dagenham, we fed 600 children who had not eaten that day. A joined up approach across all services would be welcomed to improve the lives of our children and their families. • There are some staffing vacancies at the ICB which include some roles pertaining to the BCYP programme; once these have been recruited to, we will be able to progress work at a faster pace as the team will have expanded. • In response to a query regarding how we listen to the voices of our children and young people, it was explained that this is an area that can be strengthened but that there is good work happening; particularly in local authorities and provider organisations with fora such as the Children in Care Councils, where we can hear from our most vulnerable residents. We also have parent and carer fora for our children with SEND which is essential for driving this work forward. There is a real opportunity for us to bring all these voices together across the north east London footprint. • Consideration should be given as to how we can better engage with parents. Some parents show disinterest with engaging with school events, such as concerts and plays; therefore, it may be even more difficult to involve them in health and care. • At a Place-level there is good engagement with Place Directors and local authorities, however this could be improved with Primary Care Networks in regard to the Fuller Programme. It may be beneficial to have paediatricians at Place to advocate for BCYP and to have a real multi-disciplinary approach. • The plan for 2024/25 is very ambitious, so consideration should be given to prioritising a smaller number of initiatives in order to ensure that we do not struggle to deliver the plan, particularly in the context of our resource challenges.

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	• The Chair advised that she will discuss with colleagues how we can have a forum that supports the ICB in its decision making that includes hearing from our residents. There are models that achieve this in other parts of the country that we could learn from. **ACTION:** Chair to discuss with colleagues how we can have a forum that supports the ICB in its decision making that includes hearing from children and young people. The ICB board noted the report.
4.0	**Chair and chief executive reports**
4.1	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: • This month we received our 2023/4 staff survey results, and whilst in some areas we have comparatively scored a little better from last year, the Chair apologised as the results were not acceptable and the Board committed to ensuring action to improve overall. The staff survey results will be discussed by the Workforce and Remuneration Committee and the resulting action plan will be reported to the Board in July. • The Chief Executive's report includes the values developed by the Integrated Care Board staff. At the February Board development session, members considered how this Board itself reflects those values and agreed that, in addition to reflecting these in individual contributions, that we should consider how our Board agendas, reports and wider governance arrangements also reflect these. • Progress on developing the success measures arising from the Big Conversation is being made. In discussion at the last meeting of the Integrated Care Partnership (ICP), it was agreed that the success measures derived 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. The next steps will be to socialise the approach and a smaller set of outcomes that reflect what our local populations tell us contributes to good care and to good outcomes in terms of health and wellbeing. A reporting process will be stood up to help monitor progress and hold us to account on health and care improvements for our local population, as set out in our shared strategy. • The Chair and Chief Executive Officer are undergoing their appraisals and partners will be asked to contribute to stakeholder assessments of individual performances. There is a detailed questionnaire that has been designed by NHS England which we will modify to make more user friendly and will also include the delivery of individual objectives. Members discussed the report and points included the following: • The ICP steering group reflected on the need for an honest discussion regarding how the ICB can evidence the impact of the ICP, illustrating how it has influenced and challenged. It will require a level of maturity to have this honest discussion and debate. The Chair advised that the last ICP steering group meeting had discussed a publication from NHS Confederation on what makes a good ICP. The steering group's conversation went above and beyond what is in the publication and members highlighted the importance of evidence of impact. The ICP is evolving as more partners are shaping the agenda and presenting items at its committee meetings. The ICP is also to

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<tr><td></td><td>hold a development day, before the summer, to discuss how it might further improve.

The ICB board noted the report.</td></tr>
<tr><td>4.2</td><td>Chief executive officer’s report</td></tr>
<tr><td></td><td>ZE presented the report and explained the following key points:
• The 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. There have been several improvements in performance which include the 4-hour Accident and Emergency (A&E) standard and in ambulance handover times. The programme is hosting a workshop encompassing a winter review of 2023/24 which will encompass industrial action, and joint planning for the 2024/25 priorities, with clinical and non-clinical system partners, place and collaboratives leaders.
• Following the ICB Board development session and staff engagement during February, we are preparing to launch our new organisational values in the next month, internally and beyond, making sure we’re clear they apply to all our work. We will wrap our values into our existing narrative and corporate pillars, including our ambition and the Integrated Care System (ICS) priorities. We will need to embed them in a range of different ways, in policy, process and practice, and ensure they are led and modelled consistently and clearly by our leaders. An important next step will be to develop a behaviour framework that gives specific examples of what our values look like in practice.
• Annually, all NHS funded organisations are asked to provide a self-assessed assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The ICB was rated as ‘substantially compliant’ which is an improved position from last year where we were rated as ‘partially compliant’.
• 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 is positive to see innovation starting in north east London being showcased nationally and is a reminder of some of the assets we have locally.
• Further progress on our corporate objectives will be included in our annual report which will be presented to the Board in June 2024.

Members discussed the report and key points included the following:
• It would be beneficial to outline the deliverables and timescales of the corporate objectives, which link to the four ICS aims. Success measures could be developed that triangulate with those identified as part of the Big Conversation to demonstrate that they are evidence-based, and can then inform decision-making.
• In response to a query raised regarding the Artificial Intelligence (AI) work happening at University College London Partners (UCLP), it was explained that this is a specific piece of work, however the infrastructure strategy that is being developed will contain how north east London can use and develop AI in the health and care environment.

The ICB board:
• Noted the report
• Noted the Emergency Preparedness, Resilience and Response assurance update.</td></tr>
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	• **Approved** the refreshed objectives for 2024-25 • Noted the final version of the ICB values.
5.0	**Strategy**
5.1	Joint Forward Plan refresh 2024/25
	JM presented the refreshed Joint Forward Plan (JFP) and explained the following points: • The 2024/25 JFP is north east London's second five-year plan since the establishment of NHS North East London. 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. • 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. We have been working with our colleagues across the ICS to ensure the document includes the latest and most relevant data and insight about our challenges as well as our opportunities and assets. • 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. • A correction is required in the paper which should read that Barking and Dagenham Committees in Common was engaged with, opposed to the Health and Wellbeing Board. Members discussed the refreshed JFP and points included the following: • In response to a query raised regarding socialising with Places, it was confirmed that all north east London boroughs had been involved in discussing the refreshed plan. • Members were pleased with the formatting of the plan which highlights the key information effectively. • It would be beneficial to have further reference to system partners and provider collaboratives within the plan as there is a risk that it becomes too clinical and health focussed. This includes social care and the Voluntary, Community and Social Enterprise (VCSE) partners. • It would be helpful to include plans for children's oral health in the appropriate section and it could be beneficial for the Board to receive a deep dive on dentistry at a future meeting. • Some residents have expressed disappointment that they have not yet received feedback on their contributions to the Big Conversation, therefore it is important that we remember to close the feedback cycle. • It would be valuable to have an executive summary of the plan which would help us to identify any gaps, but also allow for us to share with government representatives if the situation arose. • The section which highlights areas of disproportionate deprivation in north east London is beneficial and it would be helpful to enhance this further by stipulating the need for additional facilities and infrastructure in Barking and Dagenham. **ACTION:** Dentistry deep dive to be added to the forward plan. **ACTION:** Residents that contributed to the Big Conversation to receive feedback from the ICB to demonstrate the changes they have influenced.

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	The ICB board reviewed the changes to the Joint Forward Plan 2024/25 and **approved** it for final submission.
5.2	Overview of clinical and care professional leadership across north east London
	PG presented the report and highlighted the following key points: • 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 and it formally reports into the Executive Committee. This is attended by all senior clinical and care professional leaders across the ICS and meets virtually on a fortnightly basis. • Clinical leaders often work within clinical networks across north east London (NEL). Within the NEL Acute Provider Collaborative there are approximately 18 clinical networks which in the main are vertical networks across provider organisations with the 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 also clinical networks that work in a more horizontal way which are end-to-end pathway networks and involve clinical leaders form tertiary, secondary and primary care. These networks are being reviewed and their work plans refreshed. Their work will feed back into the Acute Provider Collaborative and then into CAG. • The NEL model of clinical and care leadership in social care 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. • We are starting to develop a training programme for clinical leadership which will focus on system leadership. This 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 operational 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. Members discussed the report and points included the following: • It could be beneficial to use this to develop leadership as a whole, as there are risks involved when separating leadership and clinical leadership; all should be working together to lead, including resident leadership. For example, with immediate system pressures, you can end up operationally dealing with the symptoms opposed to understanding the wider context. • It is important that we have a definition for clinical care and professional leadership, in the way we do for coproduction. • Clinical and care leadership at Board and collaborative levels should be included to ensure we are looking at all levels of the ICS; when decisions are being taken it is important that we hear the clinical voice. Decisions should be resident driven, clinically and care professionally led, and management enabled. • There are opportunities with the Leadership Academy to include succession planning as this cohort will be our future leaders.

DRAFT

	• There is a risk that the review to make 30% financial savings could lead to inequalities at Place, where some may have a designated clinical lead for a particular workstream, and others do not. It will be important to consider doing some of this at scale in order to mitigate the risk. • It is important to remember that the clinical leadership roles are part time and that individuals are required to do this alongside their primary employment. This should be factored in when planning to avoid capacity issues. • We want to see diversity in clinical and care leadership as it is mainly led by medical professionals, but this is something that will be developed to make others feel empowered to take on leadership roles. • The importance of recognising, clinical, care and professional leaders within the voluntary sector. • The Board requested an update report for later in the year. **ACTION:** Update on Clinical Care and Professional Leadership to be scheduled on the forward plan for later in 2024. The ICB board noted the report.
5.3	Update on the delivery plan for recovering access to primary care
	JM presented the report and explained the following points: • We have been making good progress against the requirements of the national plan. NHS England 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. • 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. • The Community Pharmacy Consultation Service commenced in March 2022 and there have been over 120,000 referrals from north east London (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. In NEL, 1% of referrals made to pharmacies are returned back to back to GP surgeries compared with a national average of 10%. • 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. The Clinical Advisory Group (CAG) is working to improve the primary-secondary care interface and will work with the acute and community collaboratives to enable this. • 91 practices have a signed contracts for a new digital telephone system, including all practices on old analogue systems. Another 70 practices already had digital systems but without the full functionality required by NHS England and upgrades are expected to take place from March. Members discussed the update report and key points included the following: • It will be important to communicate effectively with residents to enable them to understand the initiatives and services that are on offer; terms such as 'Pharmacy First' could mean different things to different people, therefore it

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	could be beneficial to have a Public Health colleague advise on communications. It is also important to note that our refugee and asylum seeker population will require a targeted approach. • Although the Pharmacy First initiative only uses 1% of GPs' time, it is important to recognise that there is still 99% of activity that can be improved. Costs of services is also something that should be taken into context as a digital telephony system is more expensive to run than an analogue system, and there is no additional funding support for practices. The British Medical Association is currently undertaking a vote from its members as to whether GPs should take part in industrial action in respect of the new national contract for primary care. • It could be beneficial for the provider collaboratives to do a piece of joint work to understand the cumulative impact from a resident's perspective which we could review to improve. An example would be blood tests • It will be important to have a sustainable infrastructure in place as part of a longer-term strategy to support the digital transformation taking place. We should also be mindful that digital exclusion is a real risk and could inadvertently create inequalities. • A key point to recognise is that this a mandated set of national requirements, which may involve some tension with our local plans for residents. • Data suggests that access has improved as more appointments are being offered, however this does not necessarily reflect residents' experience. The ICB board noted the report.
6.0	**Finance and performance**
6.1	Financial overview
	HB presented the financial overview and highlighted the following points: • The financial performance for the ICB and Integrated Care System (ICS) shows a year-to-date 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 reported forecast deficit at month 11 is £36.9m. This is made up of the H2 (second half of the financial year) system deficit of £25m plus the impact of industrial action costs over and above the allocation received, resulting in a pressure of £11.9m. • The Board is also being asked to approve two variations to Section 75 Agreements in relation to an adult social care technology fund award in Barking and Dagenham and Redbridge, and also for increasing awareness and uptake of immunisations in Newham. Members discussed the report and points included the following: • Consistent messaging regarding the impacts of industrial action is required in order to effectively manage expectations. • It was unlikely that the delivery efficiencies in continuing healthcare would be achieved in 2023/24, therefore it will be important to be more practical in the next planning round and represent our residents' health needs. • In response to a query regarding the next planning round it was explained that the national planning round for 2024/25 is underway and the ICB made its second submission to NHS England last week. We are not currently at a breakeven forecast but are in a median position in the wider London context.

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	• Achieving breakeven next year will be extraordinarily challenging and may require some difficult decisions regarding service provision, but these will be carefully thought through with resident and staff input. The ICB board: • Noted the contents of the report and the risks to the financial position. • **Approved** the variation to the Better Care Fund agreements for Barking and Dagenham, Redbridge and Newham places.
6.2	Performance report
	HB presented the performance report and explained the following points: • 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 slightly in month and remains above trajectory. Nationally, delivery of the year end ambition remains a key priority and focus. • Industrial action (IA) continues to have an ongoing impact on planned care capacity, the long waiting position and overarching momentum of elective recovery. • Delivery of 76% against the 4-hour Emergency Department (ED) standard is a high priority at ICB, regional and national level for achievement to year-end. Daily meetings between NHS England /NHS London with system Urgent and Emergency Care (UEC) directors have been established. • Additional support for diagnostics is being procured due to the challenged position. Members discussed the report and points included the following: • Severe mental health illness physical health checks have been challenging across 2023/24 due to a 10% target increase, however the position is expected to have improved when the quarter four (Q4) data is validated. • The Chief Nursing Officer advised that waits for gynaecology have increased and confirmed that a focussed report on women's health will be presented to the Board at its meeting in May. **ACTION:** Focus report on women's health to be presented to the Board in May. The ICB board noted the report.
7.0	**Governance**
7.1	Governance update
	CPo presented the report and highlighted the following points: • 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. The outcome of this review proposes the disestablishment of the current Workforce and Remuneration Committee and to establish separate committees of the Board as an ICS People and Workforce Committee and a Remuneration Committee. Revised terms of reference will be presented to the Board at its meeting in May for endorsement.

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The annual audit plan details each of the proposed reviews that our internal auditors 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.
NHS England has issued online training on managing conflicts of interest, specially designed for ICBs and the expectation is that this is 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. A link to the training will be circulated to Board members by the ICB governance team.
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.

Members discussed the report and points included the following:

In response to a query raised, it was confirmed that the proposed new committees would not replace the existing People Board which will continue to meet as usual.
The terms of reference for the Remuneration Committee and People and Workforce Committee will be presented at the Board meeting in May for endorsement, but delegation for approval is required so that meetings can take place prior to the next Board meeting.
Audit outcomes should be presented to the appropriate committees going forward for them to oversee assurance against recommendations.

ACTION: Link to conflicts of interest training to be circulated to Board members.
The ICB board:

Approved the disestablishment of the workforce and remuneration committee
Approved the establishment of the remuneration committee
Approved the establishment people and workforce committee
Delegated authority to approve the terms of references for the aforementioned committees to the Chair and Chair of the existing Workforce and Remuneration Committee
Endorsed the annual audit plan 2024/25
Noted the updated the conflicts of interest training for all ICB board and committee members
Noted the update to future board and committee templates
Approved the updated Governance Handbook.

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<td>Board Assurance Framework</td>
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CPo presented the Board Assurance Framework (BAF) and explained the following points:

At its development session on 28 February, Board members noted the complexities involved in determining the risk appetite and is therefore difficult to describe as a single point or number on a scale. It was 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 underway to develop this and will be shared at a future meeting.

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	The ICB board noted the report.
7.3	Committee exception reports for information
	The chairs/ vice-chairs of the committees of the Board each presented an exception report which highlighted the work undertaken by its members since the last meeting. The reports included updates from: • 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 two questions have been received from members of the public. The first question was from Terilla Bernard, Chair of the Patient Participation Group at Aldersbrook Medical Centre. Question Q1(a) is what was raised during the meeting and question Q1(b) is what had been submitted in writing. The answer provided is applicable to both questions. Since the date of the meeting, NHS North East London ICB has published a joint statement in relation to Aldersbrook Medical Centre which can be read here https://northeastlondon.icb.nhs.uk/news/joint-statement-on-aldersbrook-medical-centre/. **Q1(a):** A meeting was held on Monday morning that gave the Aldersbrook Medical Centre Patient Participation Group (PPG) hope that the discussions between providers and commissioners is continuing in relation to the Alternative Provider Medical Services (APMS) contract, as there had previously been little to no communication with the PPG to understand this. The PPG was heartened to listen to presentations at the meeting which demonstrated how our current providers are delivering the things that the story teller was saying in terms of understanding our patients' needs and recognising that some residents are digitally illiterate. It seems to be that money that is driving the decisions around commissioning of GP services, rather than quality and quantity of equitable services, so it is a shame that this seems to not be taken into consideration when looking at caretaking arrangements. **Q1(b):** Is the board aware that the ICB states that to provide stability for Aldersbrook Medical Centre (AMC) patients, they are moving away from APMS contracts; if this is the case why is there currently a programme across NEL to agree six new APMS contracts and a Barking and Dagenham practice has had its five-year extension recently agreed? Are we at AMC to assume that we are being singled out, because this does not appear to be equitable. **A1:** Services at Aldersbrook Medical Centre (AMC) are provided under a time-limited APMS contract. Following the five year review point, the current provider has decided not to extend the contract for a further five years.

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	The London Directive is to equalise APMS contracts so that the terms of these contracts fall in line with General Medical Services (GMS) and Personal Medical Services (PMS) contracts which are the national GP contracts. The ICB has been equalising all APMS contracts when these contracts reach their review point and all new APMS contracts are procured on an equalised basis, including the recent six practice procurement that has just concluded. The current provider did not agree to the ICB proposal for transitioning their APMS contract to equalisation with GMS / PMS contracts. AMC has a small list (4,700). The average list in Redbridge is about 8,740; the national average is 9,369. Therefore, there is a high risk that a procurement would not be successful. As AMC is too small to procure as a practice and the ICB has assessed that a GP practice should continue at Aldersbrook, with the financial and list size restraints, the move for AMC becoming part of an existing GMS / PMS practice under a dual site arrangement, appears to be the most suitable option. This would give longevity and stability to the practice and its patients. The Provider Selection Regime, which was only introduced in January 2024, gives commissioners greater flexibility in the range of options available to securing patient care, that didn't exist when the previous APMS procurement was undertaken. The Chair explained that the second question is a follow up from the last meeting and 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. **Q2:** What steps will the ICB take to work with data controllers and others to ensure that robust processes are in place across the ICS for the proper collection and processing of patient data, including that this is done with the full knowledge of patients? **A2:** The ICB takes the security of patient data very seriously and takes steps to ensure that providers who hold personal data both do so in a way that is secure, and that they communicate effectively with the individuals in question. For assurance, a Data Access Group has been established which is system-wide ICB-led forum where partners are required to submit requests in order to access data. We have a Strategic Information Governance Network (SIGN) which is another forum where system partners come together and collaborate on information governance issues. However, the ICB cannot take responsibility for the data that provider organisations hold as it does not have the legal authority to do so; this is the responsibility of each individual partner organisation. The Information Commission also has a legal duty to oversee and regulate data protection.
10.0	**Any other business and close**
	There was no other business to note.
	Date of next meeting – 29 May 2024

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North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
1.4 Actions log	27.09.23	Board to receive an update on the Integrated Care System (ICS) after action review of the industrial action at a future meeting.	PG	Jul 24	Agenda item scheduled for July 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.	JM	During 2024	Verbal update on plans to be provided at the meeting.
6.2 Performance report	31.01.24	Deep dive on diagnostics to be scheduled as a future agenda item.	HB	July 24	A diagnostics deep dive is being presented to the Finance, Performance and Investment Committee in June and further information will be included in the performance report to the Board in July.
1.3.1 Specialised services 2024/25	27.03.24	Imelda Redmond and Diane Jones to ensure risks regarding the delegation of specialised services are monitored at the Quality, Safety and Improvement Committee.	IR/ DJ	Sep 24	Item scheduled on the committee's forward plan for September 2024. The risk is included on the ICB's corporate risk register.
3.1 Growing Well priorities	27.03.24	Chair to discuss with colleagues how we can have a forum that supports the ICB in its decision making that includes hearing from children and young people.	Chair	July 24	Proposals are in development.
5.1 Joint Forward Plan refresh (1)	27.03.24	Dentistry deep dive to be added to the Board forward plan.	JM	Jan 25	Item scheduled on forward plan for January 2025.
5.1 Joint Forward Plan refresh (2)	27.03.24	Residents that contributed to the Big Conversation to receive feedback from the ICB to demonstrate the changes they have influenced.	CPo	May 24	Item scheduled on the May agenda in regard to resident

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
					determined success measures and next steps.
5.2 Clinical and care professional leadership	27.03.24	Update on clinical care and professional leadership to be scheduled on the forward plan for later in 2024.	PG	Sep 24	Item scheduled on forward plan for September 2024.
6.2 Performance report	27.03.24	Focus report on women's health to be presented to the Board in May.	DJ	May 24	Complete. Item scheduled on May agenda.
7.1 Governance update	27.03.24	Link to conflicts of interest training to be circulated to Board members.	CPo	Apr 24	Complete. Link circulated on 19 April by the Head of Governance.

CLOSED 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 scheduled for 21 May 2024.
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

North East London
Integrated Care Board

NHS North East London ICB board

29 May 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 outcomes of Integrated Care Partnership (ICP) discussions to inform Board decision making, it also considers Integrated Care Board (ICB) regulation, international and regional best practice and the outcome of the Board development session to further support ICB effectiveness. Recommendations: • That the Board receive and note the report • That the Board consider that recommendations of the Integrated Care Partnership as part of its decision making.
Action required	For noting
Previous reporting	None
Next steps/ onward reporting	The outcome of Board discussions will be reported back to the ICP
Conflicts of interest	None identified
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	Enabling an effective ICP that can evidence how we embed the views of local people and a range of stakeholders into our decision making, will strengthen our impact and enable sustainability.
Impact on finance, performance and quality	Ensuring financial sustainability, effective performance and improving quality within national frameworks and regulation will enable the ICB to further evidence its progress
Risks	Effectively preparing for regulation, learning from international, national and regional best practice and being shaped by the views of stakeholders, will assist in mitigating delivery and reputation risks.

1.0 Introduction

1.1 I am pleased to welcome two new Non-Executive Members (NEMs) to the Board, who are already known to many of you. Fiona Smith will be our lead NEM for quality and

Kash Pandya, who will be our lead NEM for strategic finance, each will chair one of our Board committees. I am grateful to Kash and Fiona for their willingness to join the Board for a year and I know they will provide additional insights, including as long standing non-executive members in north east London. I take this opportunity to thank Noah Curthoys, who has been an Associate Non-Executive since the inception of the ICB and prior to this a Lay Member of North East London Clinical Commissioning Group (CCG) and borough-based CCGs. Noah remains a friend of the ICB and has generously offered to support executives with policy responses. I also thank Sue Evans who has agreed to continue to chair our Primary Care Contracts Sub-committee, until an independent clinical chair is appointed.

1.2 Zina will provide more information in her Chief Executive report, but I wish to assure the Board that we have maintained a strong focus in improving ICB staff experiences. This was a key focus at the first Remuneration Committee, with an approach that includes improved processes, leadership and management skill development, and an organisational development strategy that emphasises an improved culture in line with our values. I am pleased to have spent a morning understanding how our staff have continued to shine as I considered our staff award nominations. I was also pleased to hear of our success in becoming the first ICB to be London Living Wage accredited, my thanks to all involved.

1.3 The remainder of this report includes the outcomes and recommendations arising from the recent Integrated Care Partnership (ICP) meeting, sets out developments in national and regional regulation and highlights best practice.

2.0 Integrated Care Partnership

2.1 The April meeting of the Integrated Care Partnership (ICP) considered the developing resident success measures and the emerging outcomes framework for the Integrated Care System. The outcomes framework was the subject of much discussion and in summary the ICP concluded the following:

- The outcomes framework should include non-NHS outcomes so that it better reflected system outcomes.
- A review of language within the framework was required so that it is inclusive of social care.
- Community insights need to be part of understanding Good Care.
- Assurance was sought that Provider Collaboratives were or are involved in the development of the outcomes framework.
- An important area that was missing in the framework was information technology and artificial intelligence, with the need to acknowledge digital exclusion.
- Timescales needed to be attributed to the outcomes framework and it should be underpinned by an engagement strategy.
- The framework needs to understand the wider determinants of health and consider outcomes external to the NHS relating to areas such as air quality and families in social housing or temporary accommodation. The local authority members agreed to discuss and consider whether there could be a collective housing outcome.
- The outcomes need to come back to what residents have asked for and should therefore clearly tie to the resident success measures and the purpose of the ICB.

- We need to create a “you said, together we did” report to feedback to residents and communities which could underpin continuous engagement.
- We should consider the voice of people in care homes for future engagements.

2.2 In conclusion, the ICP agreed that the resident success measures should be shared with our communities and those who participated in the Big Conversation as part of our ongoing dialogue, noting that further refinements would be made consequently. Members also supported further development of the outcomes framework, in consultation with partners, alongside an improved segmentation.

2.3 The ICP also considered how we can better work together as a system to reduce health inequalities by improving access to welfare rights, a challenge that I have previously highlighted. During the discussion it became clear that advice is provided by a range of organisations and as part of the delivery related core services. It was therefore agreed, as a first step, that a mapping exercise should take place to better understand gaps.

2.4 In addition, the ICP received updates from independent Care Providers Voice, (CPV) and the Voluntary Sector Collaborative (VSC). CPV outlined the work they do for their members, (who comprise of both residential and domiciliary care providers), which includes support, training, development, and collective voice. The VSC provide dan update on their development and advised that they were currently advertising for a co-ordinator role, funded by the ICB, to support their collective action.

3.0 Chair and Non-Executive Activities

3.1 There has been an emphasis on regulation during my conversations over the last couple of months, with further guidance from NHS England, (NHSE), an update from the Care Quality Commission (CQC) and consultations started or pending.

3.1.1 NHSE Guidance: NHSE has requested that all Boards, including Integrated Care Boards, undertake a self-assessment to understand where they are on their journey to implement the NHS improvement framework, ‘Improving Patient Care Together’ (IMPACT). The self-assessment tool is a maturity matrix against five framework components: building a shared purpose and vision; investing in people and culture; developing leadership behaviours; building improvement capability and capacity; and embedding improvement into management systems and processes. The result of the self-assessment is not to be submitted to NHSE, rather this is an exercise that is intended to support honest self-reflection. The Board is aware we have already started this conversation in North East London, with additional expertise being provided by East London NHS Foundation Trust, (ELFT), who are recognised international leaders in quality improvement and aligned population health management approaches. I was very pleased to be invited to ELFT’s 10-year anniversary evening, which rightly celebrated the service user and staff driven and systematic approach they have embedded.

3.1.2 Oversight: As part of their 2004/5 business plan, NHSE committed to updating the NHS Oversight Framework and how it will work with ICBs, providers and wider system partners to ensure oversight and performance management arrangements are proportionate and streamlined. We are expecting a public consultation to begin before the next Board, and we will ensure we work closely with partners in submitting a

response. I have already raised with both NHSE and the CQC, (who I spoke to recently as I presented at their staff induction), the need to ensure that NHSE and CQC regulation enriches and does not duplicate. The CQC approach to regulating ICBs is being developed further, with a government requested emphasis on ICBs, before returning to the Government for their required approval.

NHSE London region is working with London based ICBs and Trusts to develop its approach to supporting us with improving our productivity. Their approach has a focus on three areas, workforce, the standardisation of clinical processes and a non-pay strategy. This was discussed at a recent North East London Chairs meeting, which agreed that what was proposed is a sensible approach, although ranking of Trusts with different contexts may not be as helpful in understanding challenges. The Chairs' agenda also resulted in a discussion on the need to be realistic about demand as we develop clinical pathways, and about the complexity of transformation with the need to resolve underpinning issues such as estates. In addition, the meeting also asked that the ICB considers the wider impact of industrial action on staff relationships and on the discretionary effort staff previously provided before cover arrangements for industrial action began. Importantly, the Chairs' meeting highlighted the increase in violence and aggression that front line staff were experiencing, with examples of the work underway in Homerton to address this.

3.1.3 NHS Constitution, 10-year review: The NHS Constitution sets out the principles, values, rights, and pledges underpinning the NHS as a comprehensive health service, free at the point of use, for all who need it. The Government, led by the Department of Health and Social Care, is currently undertaking a 10-year review of the NHS Constitution, as legislated for in the 2009 Health Act. Views are sought from those who use its services, its staff and providers, by 11.59pm, on 25 June, details can be found at: https://consultations.dhsc.gov.uk/en/660d21db9ecc4223dd0174bf

3.2 Learning: I attended three meetings last month that encouraged learning from others, internationally, locally and across the region.

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3.2.1 I attended the Institute for Healthcare Improvement's International Conference which was held at Excel in Newham, and which sought to harness young voices, given the youth of our area, by reaching out to trainees, students and early career staff and had a focus on enhancing the health of populations given the challenges the surrounding communities face. I was privileged to partner with West Ham Community Foundation as a keynote speaker at the opening of the conference, to highlight our work with our local community in tackling health inequalities and wider determinants.

3.2.2 Closer to home, our Board development event, deepened my understanding of how the different elements of our system are working together, alongside their individual progress. The meeting had some resulting asks of us as an ICB, which included: whether we should develop some key elements, such as resident co-production and clinical leadership, that we ask provider collaboratives and places to embed in their ways of working; to ensure we continue to have difficult conversations by identifying where the key tensions lie and ensuring that these feature on our Board and committee agendas; the need for us to clarify leadership and decision making responsibilities further as we continue to develop; the need to consider our accessible integrated care initiatives, such as the Barking and Dagenham pop-up events, so that we better understand what they are evidencing for us; and finally the need to align

success measures and terms so that we have an agreed definition of what success looks like.

3.3 I am sure that the Board will be aware of the results of the London Mayoral election and will join me in offering Sadiq Kahn our congratulations, confirming our commitment to working with the Mayor to improve Londoners' health and care. The Mayor's manifesto set out his commitment to help Londoners to live in good health by championing and building the NHS and working with the London Health Board to drive improvements in the health and care system. The manifesto specifically mentioned his ambition to support the mental health needs of young people; to use the London Health Inequalities Strategy to continue to tackle inequalities; to support the placing of publicly accessible defibrillators in train stations; to encourage healthier eating, especially near school zones; and to address substance misuse through both treatment and recovery plans and through enforcement action for those providing drugs illegally. Entering a third term is an opportunity for the Mayor to reflect on the London Health Board, which I am currently a member of, and I understand he is discussing with stakeholders how he can best ensure it supports collaborative action to meet our joint ambitions.

4.0 Recommendation:

4.1 To receive and note the report.

4.2 That the Board consider that recommendations of the Integrated Care Partnership as part of its decision making.

Marie Gabriel – Chair: 06/05/24

NHS
North East London
Integrated Care Board

NHS North East London ICB board

29 May 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.
Previous reporting	N/A
Next steps/ onward reporting	N/A
Conflicts of interest	No conflicts of interest 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 March board meeting. There has been a focus on our operational planning for the year ahead whilst also working to more clearly define our longer term approach to population health, commissioning and resource allocation. On the former, we are close to signing off our system operating plan which gives us certainty about our delivery as a system this year and how we will address our challenges and ensure we deliver services effectively for the local population. It is clear from the scale of financial challenge that we face as a system, and the wider NHS, that we need to create both financial stability in the short term and financial sustainability over the longer term. We are working to create a longer term financial sustainability governance and plan.

To support our financial sustainability and importantly to better fulfil our strategic objectives around tackling health inequalities and planning our future services we have been focussing on a longer term strategic approach to planning and commissioning.

More broadly we have been focussed on our longer term strategic approach to planning. We continue to make the case for a fairer, more sustainable funding settlement for north east London.

2.0 Strategic commissioning

At a range of recent system meetings including the Population Health and Integration Committee we have discussed our approach to strategic commissioning. Having a clear population health framework is an important enabler for all of this work. Our insights and intelligence team have been working up a population health segmentation model to help enable services to be better targeted at need and enable better prevention. Alongside this we are developing a population health framework to ensure that we have a shared system understanding of what it means and can work collectively using all our shared data to better support the population.

This is a substantial piece of work and will be important to engage with the whole system as well as our residents. It will be a long term change that will take several years to effect and over the coming months we need to work through how we test and learn to build the most effective approach.

3.0 Barking, Havering and Redbridge University Hospitals Trust (BHRUT) recovery

I am really pleased to confirm that BHRUT has now exited the NHS Oversight Framework segment 3 and the NHS England (NHSE) recovery support programme. This is a fantastic achievement and testament to all the hard work of Matthew Trainer and his team and the wider system support focussed on improving the quality of care for patients and making progress across financial, Urgent and Emergency Care (UEC) and quality challenges. NHSE particularly noted the stable leadership in place and the substantial improvement in urgent and emergency care performance. Really well done to everyone involved.

4.0 NHS England meetings

4.1 ICB executive meeting with Amanda Pritchard

At the end of April I met with Amanda Pritchard, NHSE Chief Executive, along with members of the ICB executive team for an informal discussion. We used this as an opportunity to outline the work we are doing across population health, demand and capacity, primary care and place as well as make the case for change with our population growth and capital funding. It was a very productive conversation and a great opportunity to showcase the work of the ICB and achievements so far.

4.2 National primary care meeting

In April, national primary care colleagues visited north east London to hear about our work on primary care. We described the brilliant work happening in north east London as well as our case for more appropriate funding levels. The team were really impressed with the work and we also had a national meeting with NHSE on our primary care work where we again talked about our population growth, deprivation, funding for primary care and were able to outline the impact of some of the funding formulas as well as showcase innovations across the system. It was a really positive meeting.

5.0 System working

5.1 System wide finance workshop

Following a board discussion earlier in the year, we had a system wide workshop on finance with chief executives and chief finance officers from the NHS and local authorities, as well as Board members, directors of adult services, children services and public health. We talked about our shared financial challenges, and where we can start to make progress by tackling these together, as well as how a strategic commissioning approach can support this.

5.2 Sign Live rolled out in Tower Hamlets

The board will remember that at our very first board meeting in July 2022 we heard from a service user and her husband who were deaf, about their experience of using health and care services in north east London. We then undertook some mapping work and developed a short/medium term plan for improvement. I am therefore really pleased to hear about one example of how we are addressing this in Tower Hamlets where they have rolled out Sign Live – an on demand British sign language interpreting service for GPs and Community Health Services.

This service enables immediate access to GP practices and other primary care providers via an on line service. Sign live is more responsive to deaf patients as it is accessible to all appointment types, including scheduled, walking into services and when calling for urgent or emergency care. This new approach is a marked improvement on the previous system, where deaf patients typically wait several days to book a British Sign Language (BSL) interpreter. It will be important to see how this service works and how our other place-based partnerships can learn from it.

6.0 System and national visits and events

6.1 Newham vision event

In my role, it is always encouraging to witness the extent of collaboration, partnership and integration underway across north east London. And as we mature as an integrated care system, there is a growing understanding of the constant development and persistent commitment to partnership and system working we all need to demonstrate to achieve the health and well-being improvement outcomes we are all seeking. So I was pleased to be invited by the mayor of Newham to the Newham vision event at the end of April. This was an opportunity for key strategic partners to come together to contribute to a resetting of partnership working in Newham, following a Local Government Association (LGA) peer review which enabled partners to step back and reflect on joint working going forward. The vision event took place in the intimate setting of a flat in a newly built development with amazing views across Newham and far beyond - a timely metaphor for the range of the scale on which we operate, with our partners.

6.2 Royal London Hospital maternity visit

Diane Jones (Chief Nursing Officer) and I visited the Royal London Hospital (RLH) maternity department in March. We met with the senior clinical team and staff working on the ground. It was good to get an insight in to the various pathway's pregnant people (or women) experience through their 40weeks journey. What struck me was the level of acuity and medical issues such as women with significantly high blood pressure, heart disease and obesity. However, it was assuring to speak with staff that demonstrated compassionate safe care.

7.0 ICB staff awards

In May we held our first ICB staff awards which was a fantastic opportunity to celebrate the range of great work that has taken place across the organisation. I really enjoyed reading the nominations, which set out both the level of fantastic work going on in the organisation, and also the care and support that many colleagues extend towards each other as well as the many examples of people acting in line with the values we have codified. We also congratulated a number of staff on their long service of 30+ years. Congratulations to everyone who was nominated, highly commended and a winner.

8.0 Partner news

8.1 Congratulations to Lorraine Sunduza OBE who has been confirmed as the substantive chief executive for East London NHS Foundation Trust (ELFT). Lorraine has been an asset to the system for many years and has made significant contributions during her time as interim chief executive officer so I am delighted to continue working with her on a permanent basis, it is a fantastic appointment for ELFT and the wider system.

Zina Etheridge
May 2024

North East London
Integrated Care Board

NHS North East London ICB board

29 May 2024

<table>
<tr><td>Title of report</td><td>Community Health Services in North East London</td></tr>
<tr><td>Author</td><td>Pauline Goffin – System Programme Director Community Services/Babies Children and Young People
Lianne Jebson – Assistant Programme Director, Community Health Services Place lead</td></tr>
<tr><td>Presented by</td><td>Paul Calaminus - Chief Executive Officer NELFT and Senior Responsible Officer for the Community Collaborative
Pauline Goffin - As above</td></tr>
<tr><td>Contact for further information</td><td>Pauline.goffin@nelft.nhs.uk</td></tr>
<tr><td>Executive summary</td><td>This paper:
• Highlights the opportunities, challenges and priorities the Community Health Services (CHS) Provider Collaborative is leading in partnership with Places
• Summarises the opportunity to learn from colleagues in North Central London regarding a strategic case for change to strengthen community services.
• Highlights the benefits integrated care can bring for our residents.
• Encourages the opportunity for all system partners to collaborate to redesign our core offers.
• Gives national and local examples of how community services are and could be an increased key enabler to wider system resilience.</td></tr>
<tr><td>Action / recommendation</td><td>The Board is asked to:
• discuss and comment on the paper.
• support the recommendations made.</td></tr>
<tr><td>Previous reporting</td><td>This paper is aligned to the:
• Report to the Finance, Performance and Investment Committee on Community Waiting lists in March 2024.
• Paper to the ICB Board regarding Babies, Children and Young People in March 2024.
• Paper to Urgent and Emergency Care Programme Board regarding the Virtual Care Strategy 9 May 2024.</td></tr>
<tr><td>Next steps/ onward reporting</td><td>N/A</td></tr>
<tr><td>Conflicts of interest</td><td>None known.</td></tr>
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Strategic fit	Given our residents and families have a range of needs, this report aligns the ICS priorities relating to Babies Children and Young People, and people with a Long-Term Condition, and /or Mental Health needs. Equally it aligns with: • Improving outcomes in population health and healthcare • Tackling inequalities in outcomes, experience, and access • Enhancing productivity and value for money • Supporting broader social and economic development
Impact on local people, health inequalities and sustainability	• Increasing access and capacity of community health services enables people to remain at home, giving them the best chance of recovery/managing their long-term condition in a familiar environment. • Ensuring there is sufficient capacity across primary and community health services supports wider system pressures affecting Urgent and Emergency Care, London Ambulance Services and Social Care. • Working together across primary care, the third sector, local authorities, and acute and community provider trusts to redesign our community offers, will provide better and equal outcomes for our residents.
Impact on finance, performance and quality	• There are increasing cost pressures across all programmes, providers, and Places relating to significant growth in population, acuity, and complexity. • Community Services have significant performance challenges in terms of the number of people on waiting lists, and particularly those waiting over 52 weeks. Current resource does not meet current and growing capacity and demand challenges. • A number of services are at risk of investment ceasing due to reliance on non-recurrent funding streams that will be challenged in the current financial climate which will significantly impact on performance and quality of provision. • There are a number of additional cost pressures where providers have been meeting increasing demand and no recurrent funding streams have yet been identified, impacting further on already pressured waiting lists.
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, will lead to continued inequality of care for both adults and Babies, Children and Young People across NEL. Equally continuing with the historical ways of resourcing and delivering services across organisations does not future proof NEL in terms of system resilience.

1. Introduction

1.1. North East London (NEL) has a broad range of community health services for adults and children. Most services are provided from four NHS provider Trusts (North East London Foundation Trust, East London Foundation Trust, Homerton Healthcare and Barts Health) plus over 65 smaller providers. Local authorities provide a range of community-based services to many of the same populations, either directly or commissioned via the voluntary, charitable and private sector.

1.2. Unlike acute or mental health services, there is no national definition of what constitutes a community health service. Neither is there a specific national funding stream to support increased demand, growing waiting lists, or development and parity with other services post Covid-19, as per elective recovery or the Mental Health Investment Standard.

1.3. NEL spend for community health provision alone is in the range of £465m. The service offers and models vary considerably due to historical legacy commissioning arrangements. The contracts are out of date and do not reflect current provision, the best models of care and therefore we cannot be assured they offer best value. In addition to this spend there is a variety of primary care and local authority provision in the community that is funded differently such as reablement, home care support, personal budgets, respite, residential care, and wider voluntary/charitable sector support. All of these budgets are under considerable pressure.

1.4. The NEL workforce across different sectors, will include some similar roles and skills, such as occupational therapists, and assistants working with nursing, social care, and therapy teams. Our residents have multiple needs, and it is highly likely our workforce is supporting many of the same people, often at the same time.

1.5. The outcomes of the NEL Big Conversation highlight the need for care that is accessible, person-centred, and involves health and social care working together holistically (see attachment 1). There are huge opportunities to think differently around the best way to support our residents, to stay at home, using the totality of our resources and skills. This will require a fundamental change in how we think about "resident first" rather than the historical stance of care provision aligned to organisational funding flows and particular service models.

1.6. The Integrated Neighbourhood Team Framework (highlighted in a report to the Population Health and Integration Committee in April) should be seen as the fundamental vehicle for Places to reduce duplication and work across health, social care and the third sector to build care around local residents.

1.7. These strategic whole system shifts will require pragmatic decisions from senior system leaders around processes, digital interoperability, ways of working and real shifts regarding funding flows that are directed to primary, community and local authority services, to support future sustainability, whilst recognising all organisations are significantly challenged.

1.8. The Community Health Services (CHS) Provider Collaborative is an enabler bringing together the user and carer voice, local and national best practice, and all seven Places (health, social care and third sector providers). To support the opportunity, System Stakeholder support across other collaboratives and sectors within the Integrated Care System, is essential including Mental Health, Learning Disabilities

and Autism, Babies, Children and Young People (BCYP), Long Term Conditions, Fuller Programme, Acute Provider Collaborative and Primary care Collaborative.

2. NEL Community Health Services

2.1. Adult community health services include musculoskeletal (MSK) services, dietetics, podiatry, continence services, wheelchair services, community nursing and our rapid response services, plus more specialist services such as wound care.

2.2. Community nursing offers vary across community health providers, and in the way Primary Care Networks utilise our nursing workforce. We have a number of specialist services to support long term conditions such as diabetes and asthma, across our providers and places outside of our core nursing offer. These services are highly skilled, but small in staffing numbers and fragile from a workforce perspective. There will be ways to extend the breadth and scale of their reach either by hosting arrangements and pooling provision, or by integrating skills, advice and expertise consistently into our core community nursing offer.

2.3. NEL childrens' community services are largely related to community nursing, community paediatrics and therapy services such as Speech and Language Therapy (SALT). There are interrelations with mental health and learning disability services such as Children and Adolescent Mental Health Services (CAMHS) and services for children with neurodiverse needs such as autism and/ or attention deficit hyperactivity disorder (ADHD). Simplistically, services for younger children are provided by our four main community providers through community paediatric provision in community contracts. As with adult services, we have no consistent core offer for community paediatrics with differences in the support to adoption, child protection and health based clinical expertise. Similar variance can be found in our BCYP therapy offers across health and education such as SALT.

2.4. Health visitors also have a crucial role, but they are employed within local authorities, just as some therapists will also be employed via education. There are opportunities to do things differently across our NEL workforce, harmonising approaches, skills and resources across health, social care and education, particularly given many families will access a range of this support.

3. The strategic case for change

3.1. Strategically, community services are key to supporting people at home, which is not only better for residents and their families but is a significant enabler to system resilience. Community services are crucial to reducing urgent and emergency care attendances and admissions, supporting swifter discharges, and reducing pressure on ambulance services and long term social care provision. There is strong national evidence to support the size of the opportunity and the economic case for change, but this can only be fully realised with a significant resource shift to support increased primary and community capacity.

3.2. More locally, a case study from North Central London (NCL) and Carnall Farrar (Driving NHS productivity through a clear community offer - CF (carnallfarrar.com) which was also published as a case study by the NHS Confederation - Deep Dive into Community Services Providers (Sept '23) Unlocking the power of health beyond the hospital | NHS Confederation) summarises how they:

a) Defined a core community services offer.
b) Reduced the legacy inequality and variance of provision, outcomes, and access across its population.
c) Succeeded in moving resource from acute provision to community provision.
d) Highlighted an average of £26m cost reduction opportunity in acute care in an average Integrated Care System (ICS) by investing in upstream, preventative care.

More detail and the advice to all Integrated Care Boards (ICBs) can be found in attachment 2.

3.3. Across north east London, we believe there are real opportunities to adopt a more strategic approach as part of achieving long term financial sustainability and improved health and wellbeing outcomes for our local population. Learning from other systems, as well as understanding better the pattern of provision and spend locally, we believe there are a range of benefits from a refreshed and longer term model which invests in earlier intervention and supports people to stay in their homes and communities wherever possible.

3.4. In terms of adult social care needs and collaborative opportunities across NEL, there is growing appetite for thinking together about opportunities and real examples of where this is working well. For example, the ICB and Director of Adult Social Services (DASS) NEL group has agreed an approach for fairer funding and distribution of the ICB portion of the adult social care discharge fund, adopting a new formula that accounts for evolving demographics and unmet needs not currently addressed by the national formula. This innovative approach, bringing together the ICB and multiple councils to work together and establish a new agreement based on current requirements rather than an obsolete formula, has the potential to establish a framework for consistent offers and a population health perspective across our seven Places in relation to community provision in the future for example. Likewise, the work on virtual wards spanning as it does acute, community, primary and social care activity is a good example of collaborative working, and further opportunities for joint working.

4. The NEL population and supporting system resilience

Integrated Neighbourhood Teams

4.1 There is an opportunity for community health services to engage more fully in the development of Integrated Neighbourhood Teams (INTs), which are teams of multidisciplinary professionals working together across organisational boundaries from health, care and the wider community. NEL has a clear INT framework, developed with Places and wider stakeholders, and shaped with population health improvement and quality improvement as guiding principles. INTs will develop new skills and capabilities including trusted decision making, shared goals and resident engagement in care delivery. INTs will be key to delivering improved and integrated primary and community care services, which also respond to need earlier in their local population and are able to join up with other local services.

Long term conditions

4.2 Long-term conditions account for half of GP appointments, 64 percent of all outpatient appointments, and over 70 percent of all inpatient bed days with a cost of around £7 in every £10 of total health and social care expenditure. In the most deprived areas,

people acquire three or more conditions when they are 7 years younger, compared with the least deprived. Social determinants of health have an impact on 80% of health outcomes from chronic disorders. Across NEL we have areas of significant deprivation linked with increased prevalence of long-term health conditions and lower life expectancy. These include:

- One in four (over 600,000 people) have at least one long-term condition, with significant variation between our places – for example, 33% of people in Havering compared with 23% in Newham and Tower Hamlets).
- 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 are most common.
- 159,117 people are on the diabetes register (6.47% of list size) an increase of 8,696 in 6 months. Tower Hamlets (314,122) and Redbridge (276, 365) have the highest number of people with diabetes.
- People of South Asian origin have heightened risk factors regarding Cardio Vascular Disease (CVD) and stroke: with studies showing underdiagnosed hypertension and likely the real impact in NEL is double the reported number.
- 79% of the population of those with sickle cell in NEL are of black ethnic origin, with 63.5% of people of African ethnicities particularly affecting Barking and Dagenham, City and Hackney and Newham.

Urgent and Emergency Care (UEC) Attendances

4.3 National research shows that around 14% of the population could be better supported at home to prevent an UEC attendance or admission (accounting for more than 20,000 admissions or 117,000 bed days annually).

4.3.1 In NEL the very young and very old attend UEC settings the most frequently. 0-4 years old are the highest attenders with the highest rates of attendance. This suggests we could do much more in terms of our seven days a week community nursing model, hospital at home and admission avoidance initiatives for babies and children and we are aware we could move to a more integrated pathway across acute and community provision. This is a core priority in the CHS collaboratives' transformation programme and a focus for 24/25 regarding "Improving Community Capacity".

4.3.2 Other than the very young, UEC attendance increases from the age of 64 significantly. People from a white or black origin are the oldest attendees whilst Asian attendees are relatively younger in comparison. Three quarters of UEC attendees in NEL were of white or Asian background, with similar rates for male and females. 41% of attendees are white. but whilst our white and Asian populations largely drive UEC demand, people of black and mixed-race origin attend at a higher volume.

4.3.3 There is a significant correlation between the most deprived areas and UEC attendances with Newham, City and Hackney and Tower Hamlets having the highest rates and Havering the lowest. Black people in City and Hackney and Tower Hamlets are 1.5 times more likely to attend UEC than white people.

4.3.4 Our UEC attendance data suggests that there is more we could do to strengthen community support tailoring it specifically to our populations. An initial look at variance

in spend, workforce, service models, access and outcomes helps us identify where to target support and resource. Equally, we should challenge ourselves as to whether our current initiatives are having the intended impact, such as our preventive approaches around health checks, and self-help (i.e. for those with diabetes or asthma) which are often national programmes but may not be designed and delivered in the right ways for our populations.

Integrating pathways

4.4 There is an appetite across the Urgent and Emergency Care and Community Programmes to look at opportunities to consolidate and integrate pathways across acute and community services (i.e. from virtual ward to rapid response, community and intermediate care beds and reablement).

4.4.1 For example, virtual wards continue to be a core initiative across NEL. Most virtual ward services are currently provided by acute trusts with some services also provided by NELFT. They have evolved differently across Places and are supported through a variety of technical solutions, focusing on specific patient pathways e.g. frailty and acute respiratory illness, whilst others have adopted in-person models. Virtual wards have supported patient flow and expedited discharge across different clinical pathways and complex clinical cases. Some services for example in Waltham Forest have also focused on admission avoidance pathways and the step-up care approach.

4.4.2 Further questions could be posed in relation to people requiring End of Life Care, those with a Universal Care Plan, and how this aligns or not to the numbers of people presenting at urgent and emergency care requiring end of life care. Our End of life strategy needs to encompass not just specialist support but the importance of a consistent community nursing offer and wider social care support, as these workforces provide a significant amount of end-of-life care.

4.4.3 There are further opportunities to utilise the expertise in the voluntary, charitable, and private sector – an example comes from work led by the NEL DASS Group through developing consistent domiciliary care offers whereby, for example, home care staff are recognised core members of multi-disciplinary teams, spotting early warning signs or using training organisations to better support carers at home and staff in residential homes avoiding hospital attendances.

5 Waiting Times

5.1. Community health service waiting times, demand and acuity have continued to grow since the covid pandemic but unlike the planned care performance targets there is no national funding stream to support community recovery. NEL is the tenth worst ICB in terms of community waiting lists out of the 42 ICBs nationally. Babies, children and young people make up 25% of our population (more in some Places) and are disproportionately affected compared to adults, by longer waiting times for community services.

5.2 The length of time waiting for first appointment can have varying levels of impact and risk, depending on the type of service you are waiting for and circumstances around family, day to day living, mental health and overall life outcomes. Equally residents and families may find themselves waiting for a variety of different appointments to access different services given multiple needs.

5.3 NEL has a mixed picture of resources and provision, due to legacy commissioning decisions, and therefore inequities around access, spend and resources, pathways, and outcomes across our populations. For example, for adults awaiting MSK assessments, wait times vary from six weeks in Hackney, to eight weeks in Waltham Forest, 23 weeks In Redbridge, 26 weeks in Barking and Dagenham and Havering, and 30 weeks In Tower Hamlets.

5.4 Of particular concern and national focus in the 24/25 NHS England (NHSE) Operating Plan are people waiting over 52 weeks. For BCYP we have 631 children waiting over 52 weeks for an appointment with the Community Paediatric team in ELFT, but in other areas, whilst there are huge waits for those waiting 18-52 weeks, we do not have families in other areas waiting as long.

5.5 In terms of linking the waiting list pressures to the financial pressures, the CHS Collaborative has identified a total of £21.3m ongoing commitments across all four core community health providers (the full year effect of previously agreed business cases).

5.6 There are significant additional pressures generated because of demand increases across all four CHS collaborative providers which total £15.8m.

6 NEL Community Collaborative – Our Aspiration, Opportunity, and Priorities

6.1. NEL ICS's aspiration should be to adopt a strategic and wide ranging view across the system to ensure community health services are understood, positioned to deliver maximum impact and aligned with other services and offers to meet local need. This means taking a broader approach across the system per se, designing our core offer with residents, carers and staff across social care, community and acute trusts, primary care and the voluntary, community and social enterprise sector.

6.2. The CHS collaborative will lead this redesigning of community health services by way of a two-year transformation programme, bringing together resident and subject matter experts across Places and partnering organisations. We will get into the granular detail of spend, variation in models, workforce, and patient outcomes.

6.2.1 To support with this, the CHS Collaborative held its fourth joint planning session in April, bringing together key stakeholders and system partners to further refine our priority areas and begin the development on a two-year transformational change strategy. The session was attended by over 40 participants, covering all four main community health providers and commissioners, seven Places and key stakeholder groups including clinical staff, operational and service leads.

6.2.2 The outputs of the workshop reinforced our initial priority areas for 24/25, whilst also highlighting the need to further explore the following opportunities areas. These will support with reducing variation and duplication, enhancing productivity, improving patient outcomes, whilst working towards refining our core offer for CHS as part of a two-year transformational change plan:

- **Single Point of Access Development:** Enhancing key access points across services to maximise same-day access and urgent care responsiveness, streamlining processes for improved patient experience and satisfaction.

- **Children's Nursing**: Developing a consistent seven days a week, community nursing model, utilising staff skill mix and supporting our specialist nurses and more fragile services.
- **Community Paediatrics**: Developing a consistent model of care to improve paediatric service delivery, aligning and utilising staff skill mix to meet evolving needs, whilst addressing variation in care to ensure consistency and quality.
- **Adults Community Nursing**: Developing an improved community nursing workforce and care model, utilising skill mix and exploring digital solutions to enhance efficiency, release time to care and improve patient experience.
- **Integrated Care Pathways**: Incorporating urgent care response (rapid response) and community bed pathways into a virtual care strategy, ensuring seamless alignment between services and developing an integrated strategy to help achieve this.
- **Integrated Neighbourhood Teams (INTs):** Better alignment with primary care transformation initiatives to support and foster INT development. This should include utilising proactive care plans and leveraging tools such as Eclipse, Universal Care Plans, Patient Knows Best and workforce modelling to the fullest, working with Places to ensure alignment with the wider partnership offer to neighbourhoods.
- **Cease variation in service provision:** Reduce variation in service provision by aligning system pathways and contracts, reaching a consistent, equitable core offer using population health approaches, data and analytics and improvement networks to build cases for change and to reduce variance where it exists
- **Infrastructure:** Align system wide infrastructure elements, including product costs, delivery mechanisms, and monitoring systems, whilst utilising resources to support service delivery. E.g. Equipment, Technology, Continence Products/ Patient Appliances

6.2.3 For 24/25, the following financial assumptions will underpin service provision across the CHS collaborative, informing the development of our transformation plans as they are established.

- At the end of March 23/24 all partners in the ICS (providers and ICB) posted £40m deficit.
- For 24/25, as a system a £50m deficit will be submitted.
- For community services there are no mechanism for growth built into current contracts.
- A significant number of additional pressures due to demand increases across all four CHS collaborative providers remain.

6.2.4 We will use Improvement Networks as the enabler for our two-year transformation programme. Place engagement with the Improvement Networks is key, to ensure that improvements have residents, carers, local authority colleagues, voluntary and community sector stakeholders and clinicians and care professionals involved from the beginning. They will embrace quality improvement tools and techniques, grounded in IHI methodology and aligned with the NHS Change model and are dedicated to fostering a culture of collaborative and innovation aimed at improving patient care, outcomes and experiences.

6.2.5 To support, we have an open dialogue with colleagues in North Central London (NCL) and Mid-South Essex to draw on some of their learning to date, particularly the NCL core offer and where it is beneficial to work together across our systems. We are also in discussions as a group of three system stakeholders with NHSE strategy and community teams jointly influencing a clearer national directive from NHSE to ICBs regarding real financial shifts to support the strategic case for change, considering the potential for a national CHS model, benefits realisation, taxonomy, and a defined set of outcomes.

6.2.6 Our Improvement Networks are developing and will fully mobilise throughout 24/25 to support these priorities, whilst closely monitoring the impact and benefits of their change initiatives throughout implementation.

7 Risks and mitigations

7.1 Taking into consideration some of the key discussion points presented within this paper, the following risks and mitigations have been identified:

7.1.1 Risk: System resilience and funding

- The legacy of differences in areas such as access, resources, and variation in outcomes, coupled with the inability to fund the substantial increases in demand for services across all seven places, poses a significant risk of increasing health disparities in care for both adults and Babies, Children, and Young People.

7.1.2 Mitigations

- Development of CHS Collaborative transformation plans that utilise innovative approaches enabling services to adapt and evolve to needs and demands. E.g. new technologies, care delivery models, and workforce development initiatives.
- Utilise data and analytics to identify areas of inequality and track progress in addressing these through the establishment of our Improvement Networks and delivery of change ideas.

7.1.3 Risk: System resilience and capacity

- Continuing with historical ways of resourcing and delivering services across organisations without adapting our approach to align with healthcare needs and increasing demand poses a considerable risk to the resilience of the system. Failure to future-proof the system may result in its inability to effectively respond to challenges, leading to potential disruptions in service delivery and compromised patient outcomes.

7.1.4 Mitigations

- Continue to foster collaborative working through the CHS collaborative, developing shared transformation plans and mobilising our Improvement Networks to explore key areas such as resource utilisation, mutual aid and share best practices.
- Establish mechanisms for continuous evaluation and improvement to monitor the effectiveness of our change initiatives and identify areas for refinement.

8 Conclusion and recommendations

8.1 This report is a follow-up to the report on CHS waiting times received by the Finance, Performance and Investment Committee in March 2024 and recommends that the Board support:

i. the development of a NEL strategic plan, building on work carried out elsewhere including NCL as per attachment 2

ii. the principles of working together on creating our community services offer and opportunities to use our resources differently across their totality, using integration as an overarching principle.

iii. the CHS Collaborative's approach to developing a two-year CHS transformation plan that is aligned to the existing programme structure and further enhances the opportunities to reduce variation, enhance productivity, improve patient outcomes, whilst working towards refining a core offer

iv. work with and across all seven Places and organisations with health, social care and the third sector, to reduce variance, through improvement networks, designing a core and consistent offer and sharing best practice both within and outside of NEL, approaching this jointly as an integrated care system.

v. the overarching principle of supporting people to live well at home, including through shifting resources from acute care settings to expand the capacity of community health services, creating additional capacity for key services that enable preventive care, chronic disease management, and supporting the management of care in the community.

6.0 Attachments

Attachment 1 – Big Conversation
Attachment 2 – NCL/Carnall Farrar Case for Change
Attachment 3 – CHS Waiting Times
Attachment 4 – Population Health Data
Attachment 5 – Place examples of Integrated practice

Attachment 1 – Big Conversation

The good care framework

What does good care look like?

The good care framework has been developed based directly on what local people have told us.

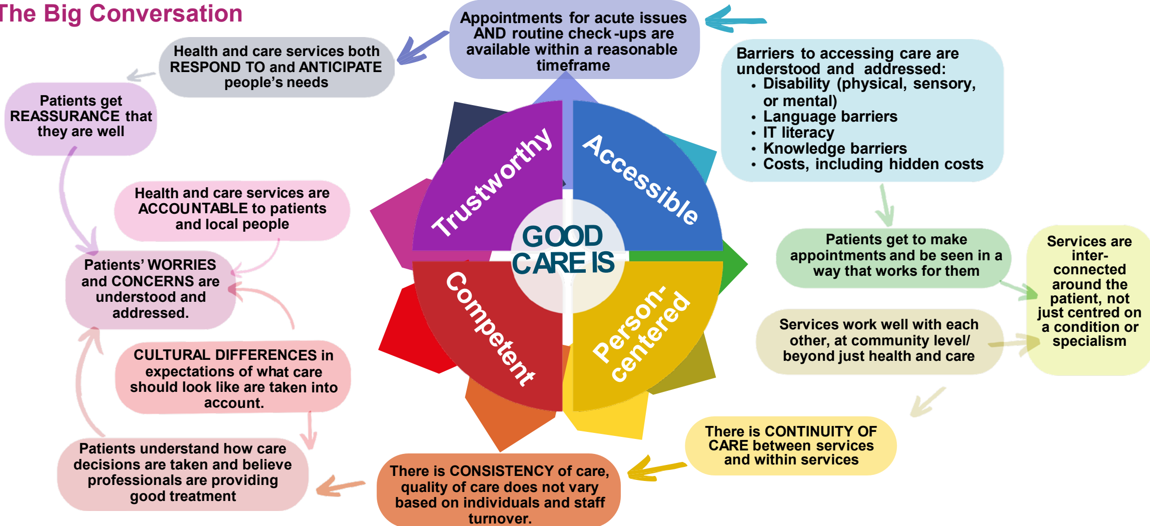
We asked local people open-ended questions about what good health and care means to them. At community events and in focus groups we helped local people to draw out what their own vision of good care would look like, using Liberating Structures and Participative Appraisal tools.

We took what they told us and and started to use qualitative data coding to identify themes, these themes eventually developed into the good care framework and our four pillars of good care, or four aspects of what makes the difference between good care and inadequate care. We also looked at the wider issues that impact good care at a society level.

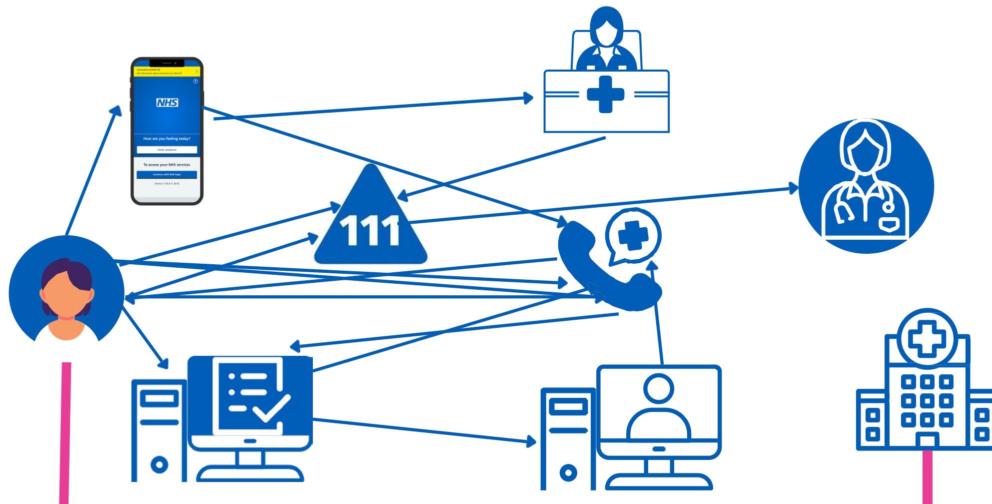
The resulting framework, informed by what local people said, can be used by stakeholders to develop their own success measures and evaluation tools. We have used it to examine in depth four priorities, chosen by local people in previous consultations.

What does good care look like?

The Big Conversation



This resonates with feedback we have heard directly from patients Accessible care means NOT being passed around between services



Local people came up with solutions for making primary care more accessible

Routine check-ups- akin to a health MOT- for various groups such as young children or people with long-term conditions

Better access to GPs and healthcare facilities, walk in hubs that people can access which run 24/7 so less pressure on A&E and less serious illnesses can be seen/sorted quicker. This will of course require more staff who need to be paid fair wages

Urgent primary care available on a non-appointment basis, for example in urgent care centres, walk-in centres or even an online live chat facility.

I was called for a routine mammogram and this was carried out fine but I feel the opportunity could have been used for basic checking of weight and blood pressure etc., same when I visited my doctor for smear test I had the test no problem but why weren't basic health checks carried out.

Closer links between GP surgeries and community services; community health advocates, co-located advice services, care navigators or social prescribers could potentially respond to this need.

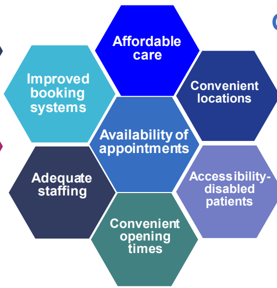
They should explain everything that I need to know, and offer support if I don't know how to do certain things - such as filling out forms. A lot of people are illiterate and can't do that - the system should help you proactively As it is, people have to pay private services or ask friends and family for help with that.

Out of hours service is good but even they don't always have appointments. Appointments do need to be available in the evening to and we need to get referrals.

What does good care look like?

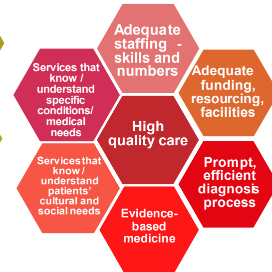
Good care is: trustworthy

Good care is: accessible



Good care is: person-centred

Good care is: competent



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Attachment 2 –NCL /CF advice to all ICBS

How local ICSs can seize the opportunity to achieve greater efficiency

1. Review current community healthcare across the local system

This includes reviewing how community healthcare services are currently commissioned and funded, what service specifications are in place, what the level of need is within each service, and what the healthcare needs of the local population are. This work will highlight disparities across the local area.

2. Review current community healthcare funding

The level of local need versus current funding for community healthcare services could be assessed at this point. Does the funding match need? If not, what level of investment would provide a consistent level of resource relative to need? In all likelihood, this could result in an overall increase in funding for community healthcare, although our research shows there is a strong business case for this through an associated reduction in acute spend.

3. Define a consistent offer for the local population, with packages of care and clear eligibility criteria

A consistent local offer, created in consultation with decision makers, frontline staff and residents, will align everyone under a common vision and make it easier to assess impact and return on investment over time. The offer could promote integration between acute, community and mental health care, and include clear referral criteria, benchmark activity rates for each service, as well as KPIs around health outcomes, patient experience and the reduction of health inequalities.

A model for the expected impact and return on investment should be developed alongside this offer. This would allow each local system to understand the benefits of the approach and where savings should fall. Showcasing this intended impact will help create buy in from stakeholders across the system. It also provides a basis to monitor against once implemented.

4. Tackle productivity

To realise gains, it's likely that improvements to capabilities may be required. This might include standardising staffing levels and ways of working across community services, so that the offer and care is more aligned and consistent. Initiatives can be identified that release capacity and resource within community providers to reallocate resource against gaps in service delivery. Facilitating collaboration between providers so that these initiatives are shared, and the methodology for quantifying how resources are released are co-agreed, can enable community resources to go further.

5. Collect and analyse data, measure, and refine

There is also a need to ensure that service and performance data is captured systematically, and is fully complete when it is captured, to benchmark productivity and drive improvements over time. Given that we know that community care can reduce the need for hospital care, it's important to measure what impact the new offer is having on occupied bed days in hospitals. Improvements to community data would support this – see our article How improved community data can support NHS efficiency for our view on how this can be achieved.

NCL variance across their 5 PLACES, due to legacy commissioning issues included:

- Enfield had over twice the prevalence of diabetes as Camden, but half the number of staff supporting people with diabetes.
- Children in Barnet wait 20 more weeks than children in Camden for initial speech and language therapy assessments.
- In Haringey, £98 per head was spent on community health services vs £192 per head in Islington.

NCL worked closely with stakeholders to design their core offer, drawing on case studies and national guidance, alongside local experience and examples of best practice. The result was a bespoke core offer that described the community services that should be universally available to all NCL residents, with clear descriptions of Response times, Criteria for people to access services, Requirements for services to meet national quality guidelines and workforce capabilities.

They also assessed the benefits and impacts for residents, as well as the financial impacts to the system. This was presented to system colleagues, encouraging buy in to the new strategic direction and an implementation plan was drawn up .

NCL secured a number of financial agreements at system level to support this, as per Attachment 2

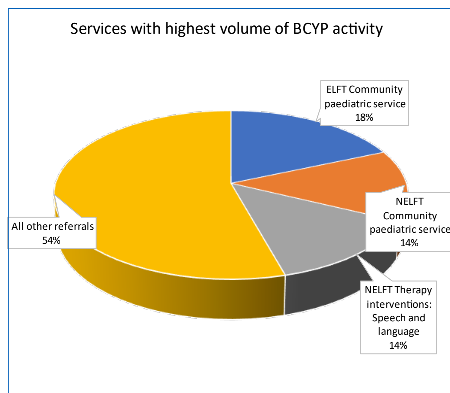
- £5.4m investment in virtual wards, expected to avoid 13,000 bed days annually.
- £1.95m in Enfield Year 1 interventions, expected to avoid more than 2,000 bed days annually.
- £1.45m in Haringey Year 1 interventions, expected to avoid more than 500 bed days annually.
- £0.5m in Haringey Year 2 interventions, expected to avoid more than 1500 bed days annually.
- £0.8m in Barnet Year 2 interventions, expected to avoid more than 6700 bed days annually.
- £0.4m in NCL-wide Year 2 interventions, expected to avoid more than 2700 bed days annually.

Attachment 3- CHS waiting times

BCYP Summary November data

- For child referrals NEL ICB remains at 10th position but referrals decreased by 2% to 8,390 above the average of 5,556.
- There were 6 referrals waiting over 104 weeks, a 40% decrease compared to last month.
- There were 924 referrals waiting between 52 -104 weeks a 7% increase compared to October.
- There were 2,343 child referrals waiting between 18 -52 weeks a 10% decrease compared to October.

Areas of Concern: ELFT & NELFT community paediatric service make up 32% of all BCYP referrals.

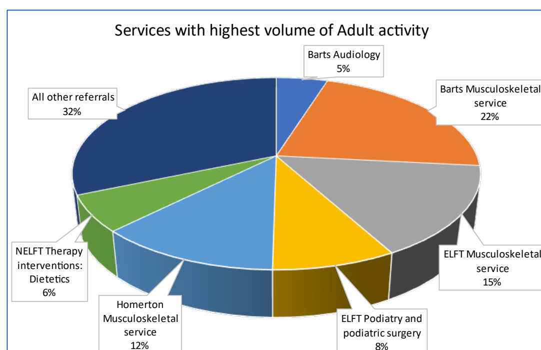


BCYP	Service	Number of Referrals
Services with highest volume of activity	ELFT Community paediatric service	1554
	NELFT Community paediatric service	1145
	NELFT Therapy interventions: Speech and language	1135
Number of referrals >104 weeks	ELFT Community paediatric service	5
	NELFT Therapy interventions: Occupational therapy	1
Number of referrals >52-104 weeks	Barts Therapy interventions: Speech and language	2
	ELFT Community paediatric service	617
	ELFT Looked after children teams	9
	ELFT Therapy interventions: Speech and language	1
	ELFT Therapy interventions: Occupational therapy	2
	Homerton Vision screening	2
	NELFT Community paediatric service	28
	NELFT Therapy interventions: Physiotherapy	1
	NELFT Therapy interventions: Speech and language	29
	NELFT Therapy interventions: Occupational therapy	91
	NELFT Therapy interventions: Dietetics	142
Number of referrals >18-52 weeks	ELFT Community paediatric service	591
	ELFT Therapy interventions: Speech and language	130
	Homerton Community paediatric service	274
	NELFT Community paediatric service	345
	NELFT Therapy interventions: Speech and language	204
	NELFT Therapy interventions: Occupational therapy	304
	NELFT Therapy interventions: Dietetics	228

Adults Summary November data

- For adult referrals NEL ICB is 10 th out of 42 ICBs, a slight improvement from 9 th position. Adult referrals decreased by 7% to 23,343 above the average of 17,407.
- For November there were 119 adult referrals waiting between 52 -104 weeks, this is a 14% increase from last month.
- There were 2,211 adult referrals waiting between 18 -52 weeks a 5% decrease compared to October.
- There are zero referrals waiting over 104 weeks.

Areas of concern: MSK services across providers and especially Barts MSK service.



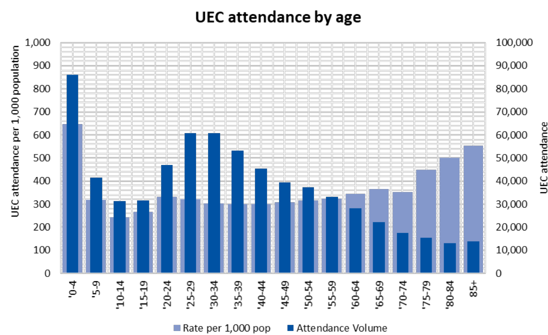
Adults	Service	Number of Referrals
Services with highest volume of activity	Barts Audiology	1,132
	Barts Musculoskeletal service	5,086
	ELFT Musculoskeletal service	3,584
	ELFT Podiatry and podiatric surgery	1,926
	Homerton Musculoskeletal service	2,859
	NELFT Therapy interventions: Dietetics	1,420
Number of referrals >52-104 weeks	Barts Audiology	8
	Barts Nursing and Therapy support for LTCs: Respiratory/COPD	8
	ELFT Musculoskeletal service	7
	ELFT Podiatry and podiatric surgery	6
	NELFT Therapy interventions: Speech and language	3
	NELFT Therapy interventions: Dietetics	87
Services with the highest number of referrals >18-52	Barts Nursing and Therapy support for LTCs: Respiratory/COPD	445
	ELFT Podiatry and podiatric surgery	561
	NELFT Therapy interventions: Dietetics	383

Attachment 4 – Population Health Data

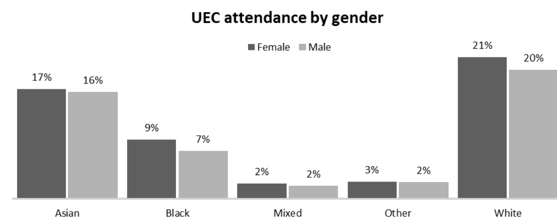
Data Sources – Secondary Users Services (SUS) data

Population and Person Insights PPI NHS **January 2024**

The young and old were the highest UEC attendees



There were no significant differences between the proportion of males and females with UEC attendances in NEL. However, female attendees were on average 2 years older than male attendees (35 v 33 years).



It is evident age plays a role in the demand for UEC services. The youngest often drove the highest demand for UEC services, with those 0-4 having both the highest attendance and the highest rates of attendance.

We can see when looked through a weighted lens, the rate of UEC attendance remains relatively stable for those in the working age group, generally between ages 20 and 64. Yet that rate increases for older patients.

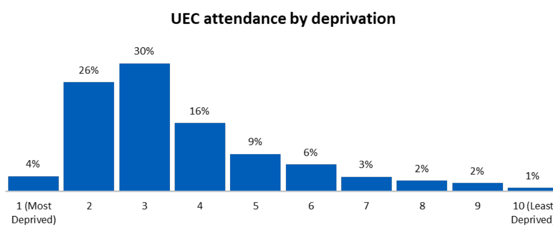
Ethnicity also plays a role with White and Black attendees often being the oldest, whilst Asian attendees being younger. Those attendees of Mixed ethnicity were significantly younger than other ethnic groups.

Demand for UEC services were largely driven by White and Asian patients, with three quarters of UEC attendees being either White or Asian; White attendees accounted for **41%** of all attendees. Male and female attendees were similar in terms of attendance across all ethnicities.

Despite White and Asian patients attending UEC having the highest volumes; Black and Mixed patients attended UEC at the highest rates, with Black individuals most likely to attend UEC.

Source: Secondary Uses Service

Three quarters of UEC attendees were from the four most deprived deciles



76% of UEC attendees are from the 4 most deprived deciles in NEL. **29%** of these were White patients, with **25%** being Asian patients and **14%** Black patients.

Of the **76%** of attendees from the 4 most deprived areas, **10%** were aged 0-4 years old.

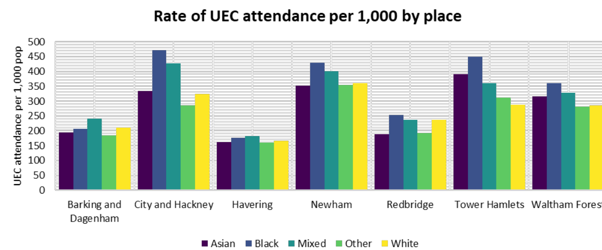
Most (**9 in 10**) of the patients who attended UEC and provided accommodation details were housed. That proportion was lower in the most deprived areas.

Of those recorded, **30%** of attendees to UEC did not have English as a main language. **20%** of those who did not have English as a main language needed an interpreter

Newham, City and Hackney and Tower Hamlets had the highest rate of UEC attendances in NEL. Havering had significantly lower rates than other places in NEL.

The highest UEC attendance rate were from Black patients in City and Hackney followed by Black patients in Tower Hamlets; in both, Black patients were at least **1.5 times more likely** to attend UEC compared to White patients.

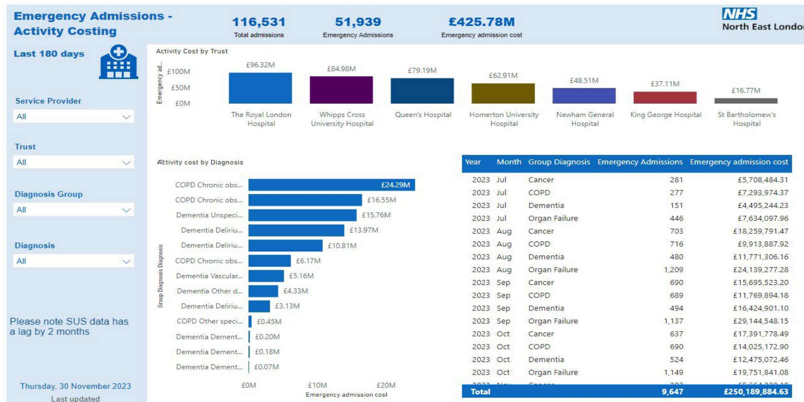
White and Asian patients attended UEC at similar rates in NEL except for Tower Hamlets were Asian patients were **1.4 times more likely**.



Source: Secondary Uses Service

NEL Admissions Costs Data

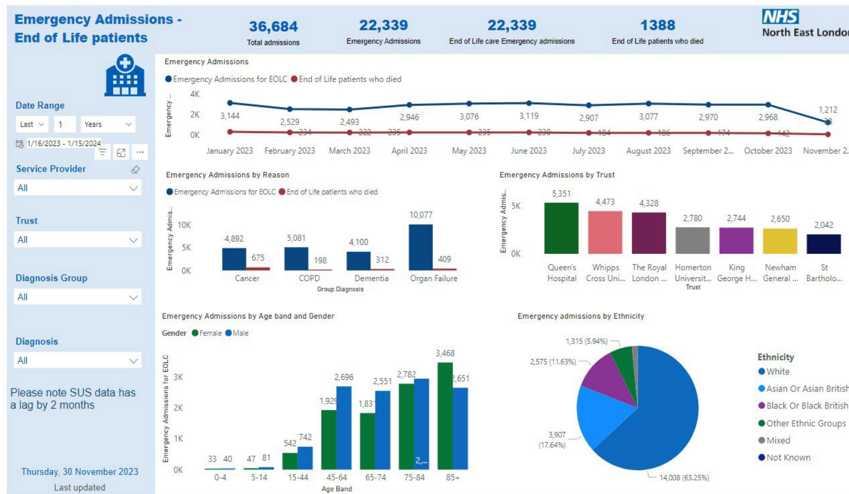
Taken from SUS Codes live data last 180 days November 2023 Data Pull



Year	Month	Group Diagnosis	Emergency Admissions	Emergency admission cost
2023	Jul	Cancer	281	£5,708,484.31
2023	Jul	COPD	277	£7,293,974.37
2023	Jul	Dementia	151	£4,495,244.23
2023	Jul	Organ Failure	446	£7,634,097.96
2023	Aug	Cancer	703	£18,259,791.47
2023	Aug	COPD	716	£9,913,887.92
2023	Aug	Dementia	480	£11,771,306.16
2023	Aug	Organ Failure	1,209	£24,139,277.28
2023	Sep	Cancer	690	£15,695,523.20
2023	Sep	COPD	689	£11,769,894.18
2023	Sep	Dementia	494	£16,424,901.10
2023	Sep	Organ Failure	1,137	£29,144,548.15
2023	Oct	Cancer	637	£17,391,778.49
2023	Oct	COPD	690	£14,025,172.90
2023	Oct	Dementia	524	£12,475,072.46
2023	Oct	Organ Failure	1,149	£19,751,841.08
Total			9,647	£250,189,884.63

NEL Admissions End of Life

Taken from SUS Codes live data last 180 days November 2023 Data Pull



NEL Population Health Data

Taken from Population and Person Insights PPI NHSE

NEL population and services utilisation (December 2023 data)- OOH Services Low Utilisation

What's my population?	Total Population	Under 18	65 and over	BAME	Core 20	Care Home
	2.4M	21.6%	9.3%	36.5%	24.5%	0.3%
		+8.2%	-47.6%	+184.7%	+19.0%	-62.3%

How is their health? *Prevalence by segment*	Healthy / Well	LTC	Disability	Incurable Cancer	Organ Failure	Frailty / Dementia
	74.9%	22.2%	1.0%	0.1%	0.9%	0.9%
	+6.8pp	-5.4pp	-0.4pp	-0.1pp	-0.4pp	-0.6pp

What services are they using? *Activity rate per 1000 people by PoD*	A&E Attendance	Non-Elective Adm.	Outpatient First Att.	Outpatient Follow-up Att.	Elective Admissions	Total Admissions
	249.6	82.7	413.1	909.2	85.1	167.8
	-3.9%	-29.1%	-16.7%	-14.0%	-34.0%	-31.7%

Activity Rate per 1000

A&E →	Non Elective →	Outpatient First Att. →	Outpatient Follow-up Att. →	Elective →	Total Admissions →
250	83	413	909	85	168
▼ 10 vs England	▼ 34 vs England	▼ 82 vs England	▼ 147 vs England	▼ 44 vs England	▼ 78 vs England

Cost per 1000

A&E →	Non Elective →	Outpatient First Att. →	Outpatient Follow-up Att. →	Elective →	Total Cost →
£50K	£305K	£77K	£128K	£149K	£709K
▲ £5,034 vs England	▼ £48,702 vs England	▼ £9,639 vs England	▼ £13,750 vs England	▼ £34,181 vs England	▼ £101,237 vs England

Attachment 5 – NEL PLACE Examples of Integrated practice

Redbridge – Ward Enablement

Based on a successful model at Colchester hospital, ward enablement starts the Reablement intervention ie carers encouraging and supporting people on their recovery journey post a hospital episode to regain as much independence as possible. The model was being piloted in Havering and Redbridge during 23/24 and Redbridge is continuing in 2024/25. The Redbridge scheme delivered by the NELFT Reablement team has a co-ordinator/assessor on wards and care worker providing intervention to patients on wards. The Redbridge pilot showed a reduced ALOS of 3.5 days and 2 weeks in the community reablement service (using 4 weeks as the baseline). At KGH this was also combined with a ward based exercise programme run by the acute PT team and was also successful in increasing mobility, confidence and better mental well- being.

Redbridge is extending and increasing numbers in 2024/25 to over 400 discharges through this route, with a view to this approach in the future being a potential default or key pathway.

Barking and Dagenham – Speech Education and Therapy in Schools Partnership (STEPS)

- NELFT and LBBD local authority jointly funded Two SLT specialists and one Education Specialist
- They met with SENcos in 39/48 primary schools, identifying strengths, areas of development, offering bespoke training and support where needed

STEPS Lead- School Lead Professional for Speech and Language

- Whole School to SCLNS (School Lead professionals) training delivered to teachers in 27 schools to date with a focus on the link with literacy and behaviour.
- Liaison/discussion with Literacy Leads with a focus on vocabulary
- Whole school SLCN training delivered to TAs in 20 schools
- Guide for Inclusive Practice for SLCN updated and disseminated to all primary schools and headteachers- supported and reviewed by SALT
- SLCN assessments disseminated to SENCos for early identification
- Detailed SLCN training for SENCos delivered- SALT input.
- Close liaison with SALT to identify priorities for training
- Joint training with SALT delivered in Summer term 2023
- Additional SLCN specific training in 3 schools
- Regular meetings with SALT to discuss priorities and issues
- Close liaison with Hunters Hall to re-establish training base

Speech and Language Therapy

- Two therapists to support universal training package in schools- schools have a direct contact for support and advice
- SENCos have termly inclusion meetings with link SALT

- All schools have an allocated link SALT
- Individual caseloads are being been assessed and reviewed (children with and without EHCP's)
- ARP support (for those who are commissioned by NELFT NHS SLT)
- Online training packages produced for schools in specific areas of SLCN

Plans/Aims for the Second year of the STEPS project
SALT- Speech & Language Therapy

- Training offer for the academic year – both online and face to face- SALT/ Lead Professional for SLCN
- Audit of impact of whole school teacher training – Lead Professional for for SLCN
- Follow up visits in schools - Lead Professional for SLCN
- A focus on training for TAs/Midday staff/parents- Lead Professional for SLCN
- Guidance for Inclusive Practice for Secondary schools to be written and disseminated- Joint working
- Whole school awareness training for secondary schools- joint working
- Ideas/Resources pack for primary schools- Lead Professional for SLCN
- Communication Friendly Environment certificate to be devised for schools- Joint working
- Ensuring all children have access to SALT- assessments and reviews
- All schools have an allocated Speech and Language therapy assistant (SLTA), who will be modelling interventions to staff in schools
- Supporting schools in ascertaining the link between SLCN and SEMH

This joint initiative was a response to Speech and language therapy being the highest need in all primary schools, and the number of children in LBBD being affected more than other PLACES . In LBBD up to 60% of primary school children have delayed language and 80% of reception year children have very low vocabulary knowledge. In the context of SALT referrals increasing, 50% of schools were investing in private speech and language therapists.

Waltham Forest Integrated Community Model

Waltham Forest system partners agreed that to be successful, the implementation of the new model of care required a 'collective movement'. That is, everyone working together proactively and in new ways to deliver 'different care, done differently in a different place'. The ambition and opportunity is to achieve fundamental, lasting change – 'challenging the status quo and doing a different kind of thing' as opposed to superficial change which often just leads to 'doing the wrong things, but righter'.

There are three key components to the Waltham Forest Integrated Care transformation programme:

- **Home First** - Targeted services for those that have acute/urgent health or care needs for a short period of time.
- **Care Closer to Home** - Care planning and support closer to home for those living and ageing with health and care needs.
- **Centre of Excellence** - Specialist services for those that need help with complex health needs.

National guidance generally reinforces the Home First, Care Closer to Home and the Centre of Excellence models of care we are seeking to implement through the transformation programme.

Funding of £6.8 million was released to deliver the new model of care and bring an additional 72.6 WTE staff over a five-year period between financial years 2022/23 and 2026/27. This would deliver gross savings of £2.8m in Year 1, reaching £13.1m in Year 5 against growth with a net impact of £328k in Year 1, reaching £5.57m in Year 5.

Workstream	Progress	Activity 22/23	Impact 22/23	Savings
Home First	Expansion of Rapid Response service which includes a community alarm falls response service.	10,955 referrals 96% urgent referrals responded to within 2 hours	29% reduction in non-elective admissions 2482 acute bed days saved 7 beds saved	£1,526,000
Care Closer to Home	Care Home Multi-agency response	95% care homes held monthly MDT	50% reduction in admissions. 371 acute bed days saved.	£163,000
Total				**£1,689,000**

Workstream	Priorities	Next Steps
Home First	**Discharge** Phase 1 implementation of new Discharge Model, followed by full implementation.	Home First Executive decision to implement a new discharge model.
	Admission Avoidance Phase 1 implementation of coordinated assessment function, followed by full implementation.	Home First Executive decision to implement coordinated assessment function.

	Virtual Ward Scale up Frailty Ward to 29 beds. Implementation of Respiratory Virtual Ward	Decision on remote monitoring solution Design of Respiratory Virtual Ward
	Rehabilitation, Reablement & Recovery Bring Bridging Service and Reablement together – implement new NELFT model. Transition reablement from current providers to Home Based support providers. Phase 1 Implementation of Single Therapy Team, followed by full implementation. Recruit Principal Therapist. Implement NHSE intermediate Care Framework for Hospital Discharge and NHSE New Community Rehabilitation and Reablement Model	Home First Executive decision to implement new NELFT model. Liaise with LBWF Legal service to transition reablement to home based support providers. Home First Executive decision to implement single therapy team and recruit Principal Therapist Assess the impact of implementation of NHSE new framework and community model on current processes. Subject to decision, implement Phase 1 to create community neuro-rehab team.
	Stroke and Neuro-rehab community model Submit business case for Phase 1 investment to NEL Investment Review Group	Subject to Home First Executive decisions, create and take forward enabling workstreams.
Care Closer to Home	**Care Home MDT** Complete roll out to all 15 Adult Care nursing homes MDTs. Finalise and approve Care Home revised MDT SOP.	Roll out last Care Home MDT (St Catherine's Rest Home). Engage with all Care Home and multidisciplinary teams to implement revised SOP. Identify skill gaps to support Care Home MDTs and transition Care Home MDTs to business as usual.

	PCN MDTs Implement PCN MDTs. Approved risk stratification dashboard in place. Completion of data sharing agreement.	PCN's recruitment of MDT Care Coordinators. Scale up and roll out MDTs to all PCN's. Roll out risk stratification dashboard to PCNs. Sign off funding for additional Community Diabetes resource.
	Complex LTC Management Complete review of the 3 WF top prevalent conditions and agree priority areas of focus for Hypertension, AF and Stroke. Patient engagement exercise to improve patient experience.	Incorporate outcomes into PCN MDT discussions. Confirm funding if needed to enhance existing services. Incorporate Primary Care led MH into PCN MDT discussions.
	Primary Care-led MH Map low level MH conditions and identify common primary care presentations.	Training and development programme roll out and comms with Providers.
	Enhanced Domiciliary Care Support Training matrix development with key providers. Conduct service evaluation	Identification of named contacts within each PCN to flag concerns.
Centre of Excellence	**Digital Hub:** Scale up Digital Hub remote monitoring service provision to include all key cohorts including virtual ward, post-hospital discharge and residents with long term conditions.	Confirm availability of funding to support scale up plans. Engage LBWF with regards to telecare procurement

	Incorporate telecare ambitions to remote monitoring model in order to deliver holistic service as set out in the business case. Secure long term operational service delivery team and device procurement and the associated funding required to achieve this. Conduct service evaluation	progress. Embed remote monitoring within operational team at NELFT (or other partner as deemed appropriate) Prepare service evaluation processes and documents.
	Complexity Hub: • Scale up fully the Complexity Hub service, ensuring involvement of all required specialist roles and enabling all PCNs to refer residents. • Facilitate the hosting of a Complexity Hub MDT each week, which will need to include funding to support clinical and professional roles to deliver service. • Prepare to convert service from virtual delivery to face-to-face delivery. • Conduct service evaluation.	Agree what, if any, funding is required for PCNs to release ARRS-funded roles to deliver service. Embed specialist secondary care input within service, to participate in delivery of MDT and also to take on clinical and developmental leadership role within service. Link in with Locality Hub programme to ensure estates requirements to host MDTs are captured and actioned. Prepare service evaluation processes and documents. Review of current NEL Training Hub and ACHA priorities against Centre of Excellence business case priorities.
	Leadership, Innovation & Training Hub: • System partners to agree delivery model, ensuring that it is in synergy with NEL Training Hub and Academic Centre for Healthy Ageing (ACHA)	Produce draft plan for delivery of this element.

	priorities respectively. • All partner organisations to support relevant operational staff in delivery of this hub, namely to form a task & finish group and actively participate in delivery of programme activities.	Meeting of Centre of Excellence Executive Group to develop proposal to be made to WF Health & Care Partnership Board with regards to direction of travel for this element. As above.
	• **Wellbeing Lounge:** • System partners to agree whether there remains a requirement for a Wellbeing Lounge in view of delivery of Promoting Wellbeing priorities and locality hubs.	Meeting between respective locality hub and Centre of Excellence programme clinical leads and SROs to
	Long Term Conditions Hub: System partners to agree whether there remains a requirement for a Long-Term Conditions Hub in view of delivery of PCN MDTs and Complexity Hub MDTs.	agree a joint plan moving forwards with regards to physical site delivery of Centre of Excellence and Locality Hubs.
	Estates: • System partners to agree whether there remains a requirement to develop a physical Centre of Excellence site on the 'F' Site at Whipps Cross Hospital, and whether it is still the intention to host all components as described above.	

North East London
Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	A focus on women's health and gynaecology waiting lists
Author	Claire Hogg, women's health champion, Director of Planned Care Diane Jones, women's health champion, Chief Nursing Officer
Presented by	Diane Jones
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Executive summary	This report forms part of our ongoing strategy to raise the awareness of Women's Health in North East London (NEL). The report specifically draws attention to the number of women on a gynaecology waiting list in NEL, the factors that are influencing this position across NEL and the actions being taken to address this. Gynaecology is a service used only by women. It has the single biggest waiting list in NEL. There are around 22,000 women on a gynaecology waiting list with our NHS acute providers in NEL. Health inequalities analysis of the gynaecology waiting list illustrates that women from deprived backgrounds wait longer; women of black and Asian heritage are over-represented on the waiting list compared to the general population; older women tend to wait longer and there are more women in comorbidities (other long term conditions) on the waiting list than in the general population. Contributing factors affecting capacity to meet demand include: the impact of industrial action, balancing medical workforce across maternity and gynaecology services, increase urgent and emergency care demand for gynaecology; availability of outpatient, diagnostic and theatre capacity. Actions and mitigations are being taken to address the demand and capacity mismatch that is driving increases in the gynaecology waiting list within organisations and at a system level through the development of women's health hubs.
Action / recommendation	The Board is asked to: • Raise the profile of women's health and wellbeing across North East London.

	• The Board is asked to note the status of gynaecology waiting list across NEL and the actions and mitigations being taken to address the demand and capacity mismatch that is driving increases in the gynaecology waiting list. • As a system we must take collective leadership action to raise the profile of women's health across NEL and the impact this has on healthy years of life and life expectancy for the female population. It is recommended that boards across the integrated care system identify champions for women's health issues. • Members of our integrated care system are asked to ensure attendance at our inaugural women's health and wellbeing conference on 26 June 2024. This event aims to raise the profile of women's health and wellbeing in NEL, how we are addressing the recommendations of the national women's health strategy and identify what additional actions we need to take to support improve health and wellbeing outcomes for women.
Previous reporting	NEL Gynaecology Clinical Leadership Group 13 March 2024 Acute Provider Collaborative Surgery Board 18 March 2024 Planned Care Board 9 May 2024 ICB Executive Committee 9 May 2024
Future reporting	NEL Women's Health Conference 26 June 2024
Next steps/ onward reporting	Work with Gynaecology Clinical Leadership Group and Planned Care Board to improve gynaecology waiting list position and create sustainable models of care. Local safeguarding partnerships.
Conflicts of interest	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
Impact on local people, health inequalities and sustainability	Reducing the waiting list will increase better outcomes for women and reduce the impact on them, their families, workforce, and communities.
Has an Equalities Impact Assessment been carried out?	This report does not require an Equalities Impact Assessment (EQIA). Actions taken to address the challenges will have EQIAs at the point of care.
Impact on finance, performance and quality	Financial implication: The Department of Health and Social Care (DHSC) has allocated ringfenced funding to ICBs for the development of women's health hubs. Performance implications: gynaecology waiting lists have been increasing. Provider organisations have identified actions and mitigations to address the imbalance of capacity and demand.

Risks	There is a risk that women on a gynaecology waiting list are at increasing risk of harm and unintended consequences on their health and wellbeing as a consequence of limited access care and support in comparison to the general population.

1.0 Context, Background and Purpose of the Report

1.1 This report forms part of our ongoing strategy to raise the awareness of Women's Health in North East London (NEL). The report specifically draws attention to the number of women on a gynaecology waiting list, the factors that are influencing this position across NEL and the actions being taken to address this. The report also includes recommendations for additional leadership actions across our Integrated Care System (ICS) to ensure we collectively improve women's health across NEL.

1.2 The national Women's Health Strategy was published in August 2022. It recognised that women, 51% of the population, face obstacles to accessing the care that they need.

1.3 Although, on average, women in the UK live longer than men, women spend a great proportion of their lives in ill health and disability compared to men. There has been insufficient focus on women specific issues and historically the health and care system has been designed by men for men. The 'male as default' approach has been seen in research and clinical trials; education and training for healthcare professionals and the design of healthcare policies and services. This means not enough is known about conditions that only affect women (such as miscarriage and menopause), or how conditions that affect both men and women impact them in different ways (such as cardiovascular disease).

Healthy life expectancy (HLE) provides an estimate of lifetime spent in 'very good' or 'good' health, based on how individuals perceive their general health. HLE has not changed significantly in London since 2011-13. However, for the first since 2011-13, female HLE is slightly lower than men. Between 2022-22, HLE at birth for both males and females in London was higher than for England at 63.9 years and 63.7 years respectively.

1.4 This is the first national Women's Health Strategy for England. It is a 10-year strategy that sets out a range of commitments to improve the health of women and girls. It aims to address inequities, barriers and challenges faced by women in accessing the support, care, and services that they need. It takes a life course approach recognising the changing health and care needs of women and girls across their lives.

1.5 The national strategy has been shaped by a public 'call for evidence' undertaken during 2021. It is based on almost 100,000 responses received from women and over 400 written responses from organisations and experts in healthcare.

1.6 Respondents to the ‘call for evidence’ identified gynaecological conditions as their top priority topic (63%) to be covered by the Women’s Health Strategy. This was followed by fertility, pregnancy loss and postnatal support (55%); the menopause (48%); menstrual health (47%) and mental health (39%).

1.7 Access to information was identified as a key issue for women. Only 8% of respondents said they had access to enough information on gynaecological conditions, such as endometriosis and fibroids. Only 9% had enough information on menopause, with 17% reporting they had access to information on menstrual wellbeing.

1.8 The focus of this report is on the waiting list size for gynaecology across North East London. This is the speciality with the single biggest waiting list in North East London by 50% and it is the only speciality that affects one gender, women.

1.9 To help us understand the issues impacting the gynaecology waiting list, the NEL Planned Care Team have been working with the Gynaecology Clinical Leadership Group, the Acute Provider Collaborative (APC), Surgery Clinical Board and operational and clinical leads for gynaecology at all of our hospital sites. We have used Key Lines of Enquiry (KLOE) to understand drivers of demand and availability of capacity and identify the actions being taken by hospital sites to reduce the waiting list size and waiting time.

1.10 The Board is asked to:

- Support and continue to raise the Raise the profile of women’s health and wellbeing across North East London.
- Note the status of gynaecology waiting list across NEL and the actions and mitigations being taken to address the demand and capacity mismatch that is driving increases in the gynaecology waiting list.
- Take collective leadership action to raise the profile of women’s health across NEL and the impact this has on healthy years of life and life expectancy for the female population.
- Prioritise attendance at our inaugural women’s health and wellbeing conference on 26 June 2024.

2. Key messages

2.1 Gynaecology is a service used only by women. It has the single biggest waiting list in NEL. There are around 22,000 women on a gynaecology waiting list with our NHS acute providers in NEL. Around 19,000 women are on non-admitted lists waiting for an outpatient appointment or diagnostic with around 3,000 waiting on an admitted list for day surgery or inpatient procedure.

2.2 The gynaecology waiting list is around 50% higher than the second and third largest speciality lists in NEL with both orthopaedics and earn, nose and throat (ENT) having around 14,000 people waiting.

2.3 The NEL Planned Care Team have worked with the Gynaecology Clinical Leadership Group and operational and clinical leads from each hospital site using key lines of enquiry (KLOEs) to factors that are influencing demand and capacity for gynaecology and growth in the waiting list. The impact of industrial action, balancing the medical workforce across maternity and gynaecology services, increase urgent and emergency care demand for gynaecology; availability of outpatient, diagnostic and theatre capacity are all contributing to the mismatch between demand and capacity.

2.4 Health inequalities analysis of the gynaecology waiting list illustrates that women from deprived backgrounds wait longer; women of black and Asian heritage are over-represented on the waiting list compared to the general population; older women tend to wait longer and there are more women in comorbidities on the waiting list than in the general population.

2.5 Actions and mitigations are being taken to address the demand and capacity mismatch that is driving increases in the gynaecology waiting list within organisations and at a system level through the development of women's health hubs.

2.6 As a system we must take collective leadership action to raise the profile of women's health across NEL and the impact this has on healthy years of life and life expectancy for the female population. It is recommended that boards across the integrated care system identify champions for women's health issues.

3. Gynaecology Waiting List in NEL: Demand, Capacity and Action

3.1 Although women in the UK on average live longer than men* (* see 1.3), women spend a significantly greater proportion of their lives in ill health and disability when compared with men.

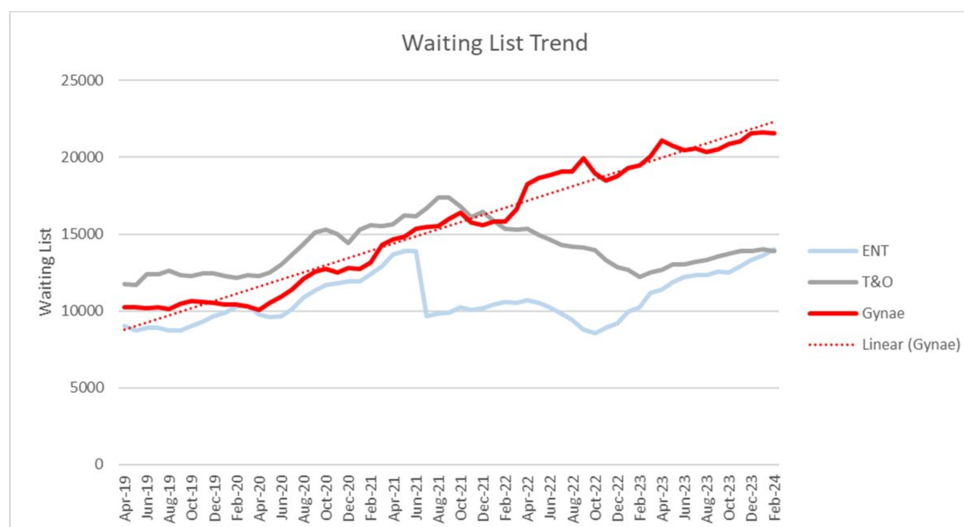
3.2 In NEL, we have around 220,000 people on a 'referral to treatment' waiting list for NHS acute hospital care. 56% of these people are women. This is higher than the proportion of women in the general population, which is around 50%.

3.3 The largest single speciality waiting list in NEL is gynaecology, a speciality which deals with the functions and disease specific to women and girls, especially those affecting the reproductive system.

3.4 There are around 22,000 women on a gynaecology waiting list in NEL (appendix 1). This is around 10% of the total waiting list. The gynaecology waiting list is 50% higher than the waiting list for orthopaedic and ENT, which are the second and third largest waiting list in NEL at around 14,000.

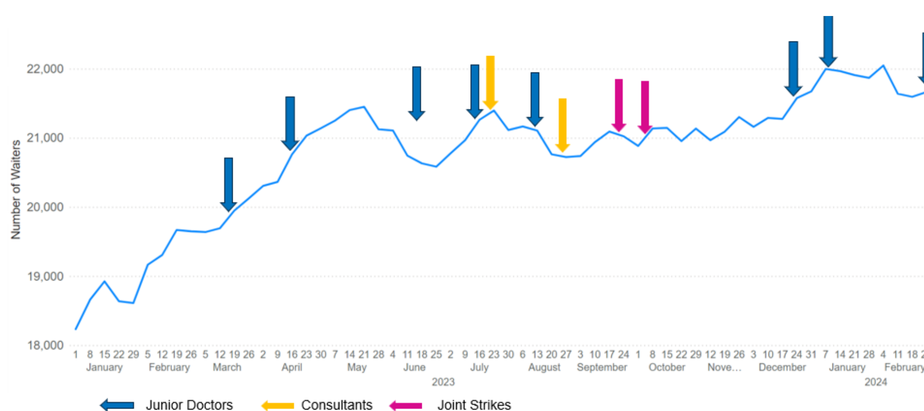
3.5 Chart 1 illustrates the rise in the size of the gynaecology waiting list since 2019 in comparison to orthopaedics and ENT.

Chart 1: Waiting List Trends in Gynaecology, Orthopaedics and ENT



3.6 We know that industrial action by medical staff has impacted on growth in the gynaecology waiting list during 2023 as illustrated by chart 2. Whilst industrial action has impacted waiting list growth in most surgical specialities, gynaecology is particularly impacted because of its association with obstetrics. During periods of industrial action, cover for obstetrics must be prioritised and gynaecology elective activity is stood down. Medical staff vacancies in obstetrics and gynaecology also compound hospitals' ability to cover activities during period of industrial action.

Chart 2: Impact of industrial action on gynaecology waiting lists



3.7 In addition, to industrial action, we know that raising awareness of perimenopause and menopause is also impacting on demand for gynaecology services. Although, this is not universal across all demographic groups in NEL.

3.8 The NEL Planned Care Team have worked with the Gynaecology Clinical Leadership Group and operational and clinical leads from each hospital site using key lines of enquiry (KLOEs) to understand other factors that are influencing demand and capacity for gynaecology and growth in the waiting list.

3.9 There are a number of factors that are creating a demand and capacity mismatch in gynaecology. In summary, these are:

- Balancing medical workforce to meet the demands for maternity and gynaecology services including providing out of hours cover, on-call rotas and covering vacancies and sickness absence.

- Demand for gynaecology services from routes other than GP referral is increasing. Hospital sites report increasing demand via consultant to consultant (C2C) referrals; the emergency department (ED) and same day emergency admission (SDEC) and the emergency gynaecology unit (EGU). This requires sites to review and re-prioritise capacity for emergency and urgent demand rather than routine capacity.

- Sites also report an increase in demand via the two week wait cancer pathway, which has also impacted on the availability of capacity for routine GP referrals.

- Demand for diagnostic tests including non-obstetric ultrasound and colposcopy has increased and is not yet matched by available capacity. This impacts on the speed at which women receive diagnosis and treatment.

- Availability of community-based gynaecology services or specialist primary care services is also impacting on the demand for secondary care gynaecology. This means women are being referred into hospital services due to lack of alternative provision.

- The complexity of some gynaecology conditions requires joint theatre lists to be organised with other specialities such as urology and colorectal surgery. This creates added complexity to theatre allocation and scheduling.

- Cancellations and re-scheduling gynaecology activity due to industrial action is creating inefficiencies in scheduling. Delays in access to diagnostic tests are reports are also impacting on cancellations.

- Sites also report high levels of ‘do not attends’ (DNAs), which appear to be associated with the length of wait, administrative processes, and in some cases demographics.

- Administrative process, such as waiting list validation, have been identified by some sites as leading to data quality issues e.g. duplicate entries or women remaining on the waiting list when they have been seen or treated. This leads to an inaccurate picture of demand and whilst it is not a significant driver of the position, it does need to be corrected so that capacity can be matched appropriately.

4. Gynaecology Waiting Lists: Health Inequalities Analysis

4.1 In addition, to the gender inequality that the size of the gynaecology waiting list illustrates, analysis of the NEL health inequalities dashboard has illustrated further inequalities and inequity within the gynaecology waiting list. Appendix 2 provides further details on this analysis. In summary:

- **Average weeks waiting** – On average gynaecology tend to have longer wait times when compared to average waiting times for the whole NEL waiting list (24

weeks compared to 20-week average). Noting that average waits masks very long speciality waits in excess of 78 weeks.

- **Waiting list size and waiting time by ethnicity** – Black/Black British and Asian/Asian British women are over-represented on the gynaecology waiting list compared to the general population of NEL (+5% & +13% respectively). 3% of the gynaecology waiting list has an “unknown” ethnicity compared to 15% of the NEL population, so this may account for some (but not all) of this discrepancy. Groups classified as other and mixed heritage tend to wait less time than other groups (between 1.6 – 2.4 weeks less respectively). The Black/Black British; White and Asian/Asian British groups have similar waiting times of around 24 weeks.

- **Waiting list and waiting time by age -** 30–49years women account for the majority of the gynaecology waiting list (56%) compared to 35% of NEL population. Younger women tend to have shorter waits than older women. Women in the group 20-39 years age groups wait circa 21-22 weeks compared to an average of 25 weeks for those over the age of 40years. The 70+years cohort has the longest average waiting time.

- **Waits by deprivation** – more deprived patients (cohort 1 and 2) tend to wait marginally less than other groups, it is unclear if this is statistically significant or not and requires further analysis.

- **Comorbidities on the gynaecology waiting list** – 25% of women on the gynaecology waiting list have a single comorbidity, with a further 20% having complex comorbidities, this is higher than the wider population (9% and 7% respectively). This is a trend seen in several specialities and reflects the nature of secondary care hospital provision.

4.2 In addition to the analysis from the health inequalities dashboard, the NEL Insights Team have undertaken some detailed analysis to get a better understanding of service utilisation relating to women’s health in NEL and how this may differ by age, ethnicity, and deprivation as well as by geography. This has specifically focused on menopause and hormone replacement therapy (HRT); incontinence and prolapse and long-acting reversible contraception (LARC).

4.3 In particular, this analysis has indicated that women of white ethnic groups have higher rates of HRT in NEL and that there is a strong inverse association between deprivation and HRT prescription, which women from the least deprived neighbourhoods being 126% more likely to receive HRT than those from the most deprived neighbourhoods.

4.4 The Insights Team analysis across all areas has indicated that we need to consider how we engage with all women across NEL to raise awareness of women’s health issues. We need to ensure our work with women is culturally and religiously sensitive. We need to listen to all of our women’s voices and work with them to identify what is helpful and how women can support their health and wellbeing.

5. Improvement Actions

5.1 The output of the key lines of enquiry with hospital sites has illustrated there are a range of factors influencing demand and capacity in gynaecology. Addressing these

issues is not simple and a wide range of actions across the referral to treatment pathway are required to create sustainable improvement. There are a range of actions being undertaken both at site and system level to address these factors.

5.2 Hospital site improvement actions include:

- Development and implementation of 'one-stop shop' and 'straight to test' pathways to support rapid diagnosis and treatment plans for women.

- Increasing outpatient delivered activity such as outpatient hysteroscopy and other outpatient-based procedures thereby reducing demand for theatre time. This is, however, dependent on the availability of outpatient procedure rooms, equipment, and trained staff.

- Using advice and guidance (A&G) to enable GPs to support women in primary care where appropriate.

- Using patient-initiated follow-up (PIFU) to support women to self-manage conditions and gain access to secondary care advice when required.

- Improvements in waiting list validation and consistent application of access policy principles across NEL. This includes ensuring consistency in application across common conditions and pathways such as the uterine fibroid pathway.

- Workforce recruitment and development plan to address challenges in balancing the medical workforce across maternity and gynaecology services.

- Short term capacity creating initiatives such as weekend lists, blitz clinics, insourcing and outsourcing to get on top of elective backlogs in outpatient and surgery.

5.3 System level improvement actions include:

- The development and implementation of Women's Health Hubs across NEL to address the inequity of access to gynaecology and reproductive health services in the community. We are building on successful models developed in City and Hackney and Tower Hamlets, which are providing women with quicker access to support, information, and treatment for gynaecology and reproductive health. Plans are developing and being implemented to improve access in Barking and Dagenham, Havering, Redbridge, Waltham Forest and Newham.

- We need work with local women's groups to raise the profile of women's health issues and access to services and advise. We need to understand cultural and religious influences and values and listen to women to support their needs and choices.

- Clinical harm review to be undertaken to consider of women's age, ethnicity and comorbidity.

- We are developing ways to communicate with women 'waiting well'. This includes promoting access to our Wait well, stay well website and adding further content to support women's health.

- We need to consider an approach to support women to speak out/ disclose harm in the absence of attending for a gynaecology procedure.

6. Risks and mitigations

6.1 There is a risk that women on a gynaecology waiting list are at increasing risk of harm and unintended consequences on their health and wellbeing as a consequence of access care and support in comparison to the general population.

6.2 An unintended consequence of long waiting times for gynaecology may mean women do not have an opportunity to raise or disclose safeguarding concerns when attending a gynaecological appointment.

6.3 Acute providers have identified the factors that are influencing the mismatch between demand and capacity that is impacting on waiting list size and waiting times. Actions and mitigations have been identified and are being implemented at acute providers.

6.4 At a system level, we are developing and implementing the women's health hub model across NEL to provide access to information, support, advice, and treatment in primary and community care settings.

6.5 We are at risk of creating inequalities of access to information, advice and services if we do not work with our local communities to raise awareness of women's health and listen to women's voices to respond to their needs.

6.6 Collectively we need to take leadership action across our integrated care system to raise the profile of women's health in NEL. This needs to be an action for all partners in our health and social care system from public health to providers of services for women and as employers of women.

7. Conclusion / Recommendations

7.1 We must raise the profile of women's health and wellbeing across North East London.

7.2 The Board is asked to note the status of gynaecology waiting list across NEL and the actions and mitigations being taken to address the demand and capacity mismatch that is driving increases in the gynaecology waiting list.

7.3 As a system we must take collective leadership action to raise the profile of women's health across NEL and the impact this has on healthy years of life and life expectancy for the female population. It is recommended that boards across the integrated care system identify champions for women's health issues.

7.4 Members of our integrated care system are asked to ensure attendance at our inaugural women's health and wellbeing conference on 26 June 2024. This event aims to raise the profile of women's health and wellbeing in NEL, how we are addressing the recommendations of the national women's health strategy and identify what additional actions we need to take to support improve health and wellbeing outcomes for women.

8. Attachments

Appendix 1 – Gynaecology waiting list analysis.
Appendix 2 – Health inequalities analysis

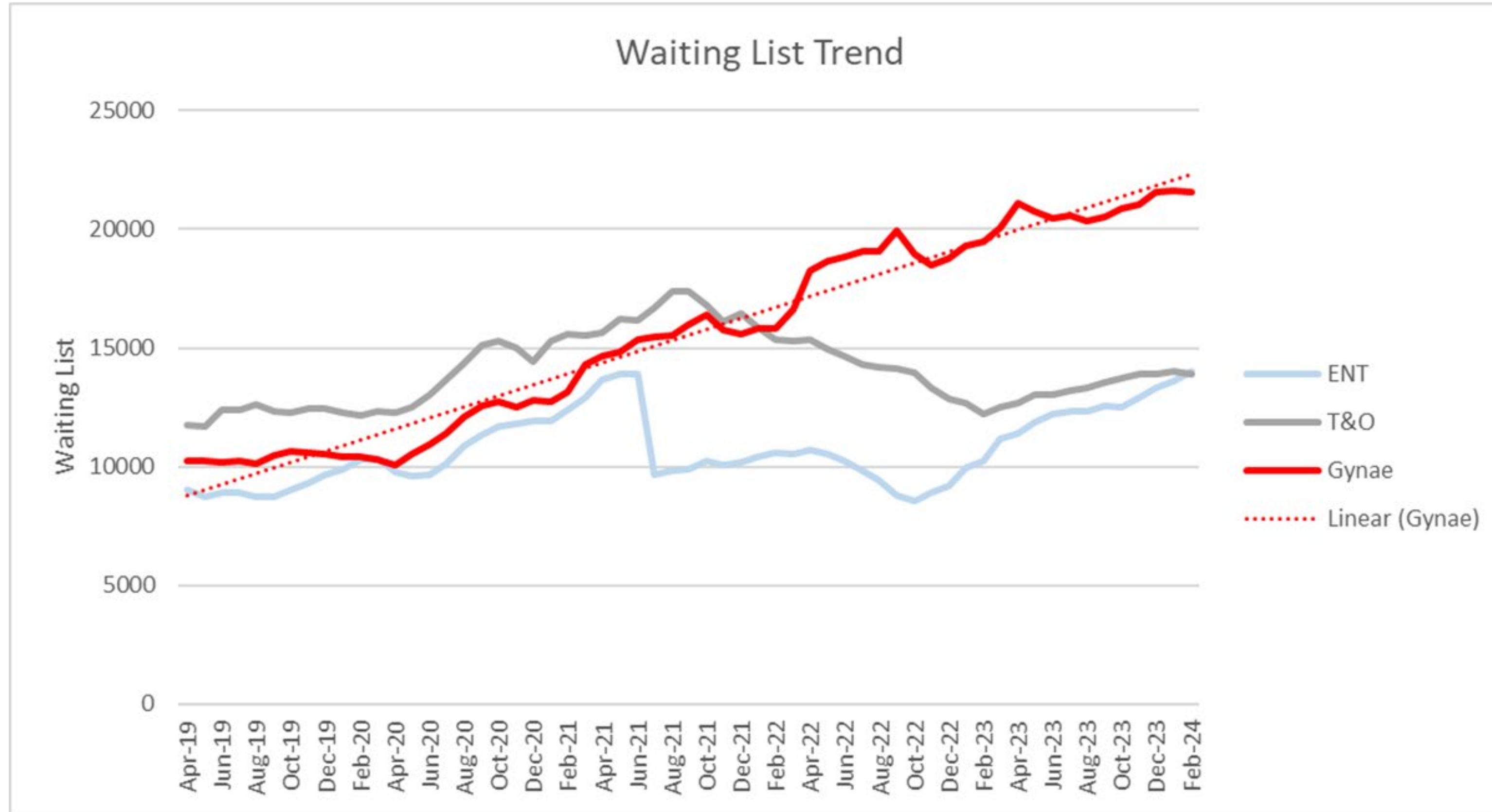
Claire Hogg, Director Planned Care
Diane Jones, Chief Nursing Officer
Women's Health Champions for NEL
3 May 2024

Appendix 1

Gynaecology – Waiting List Analysis

NEL Gynae Waiting List Change & Trend

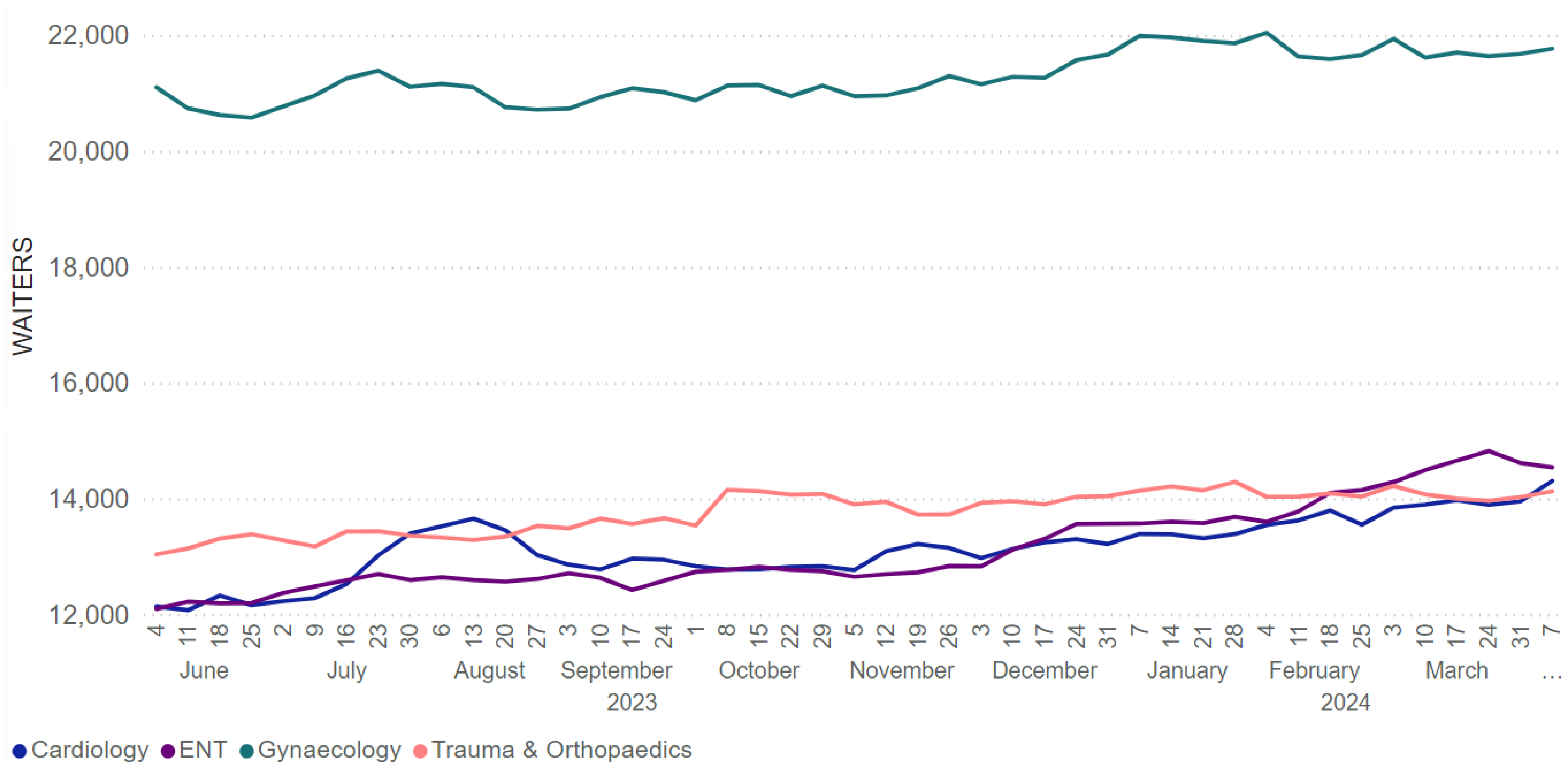
NHS
North East London



Data Source: RTT Published

Largest WL – Gynae compared to other specialities

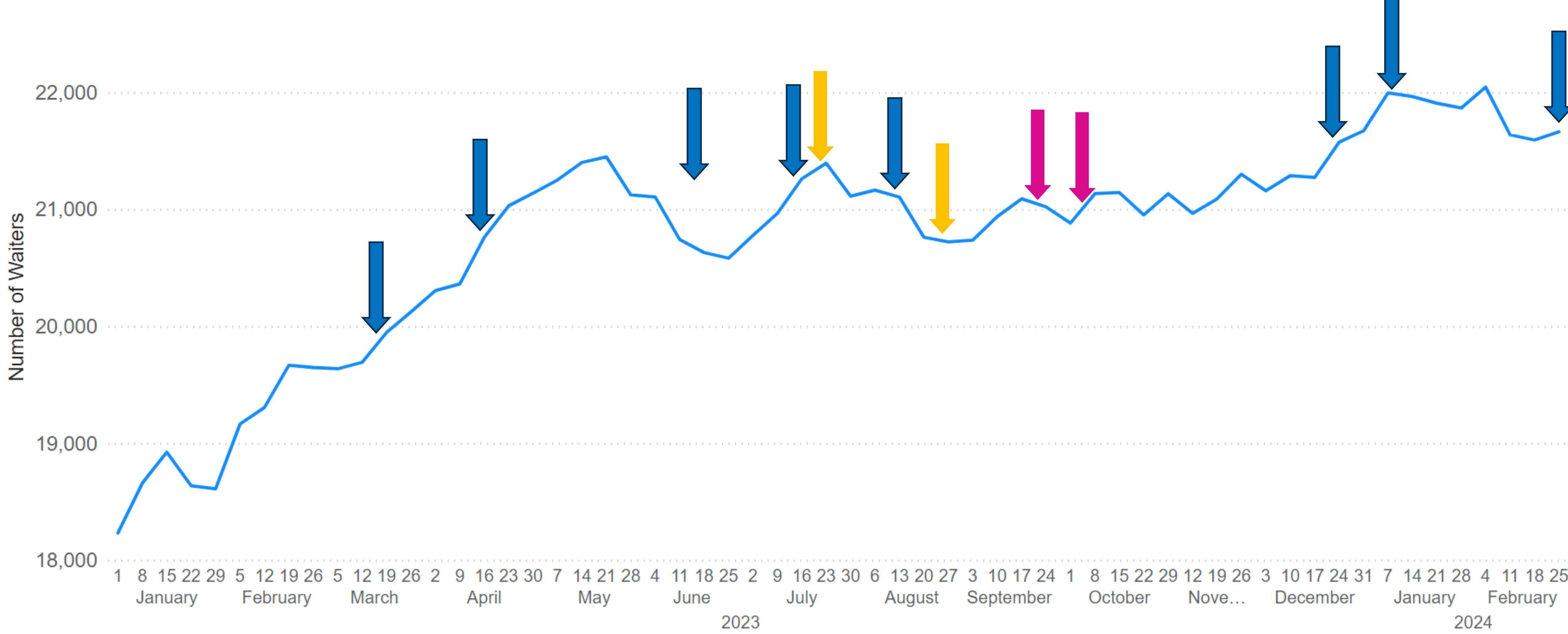
North East London



Data Source: WLMDS

Effect of IA on Gynaecology WL

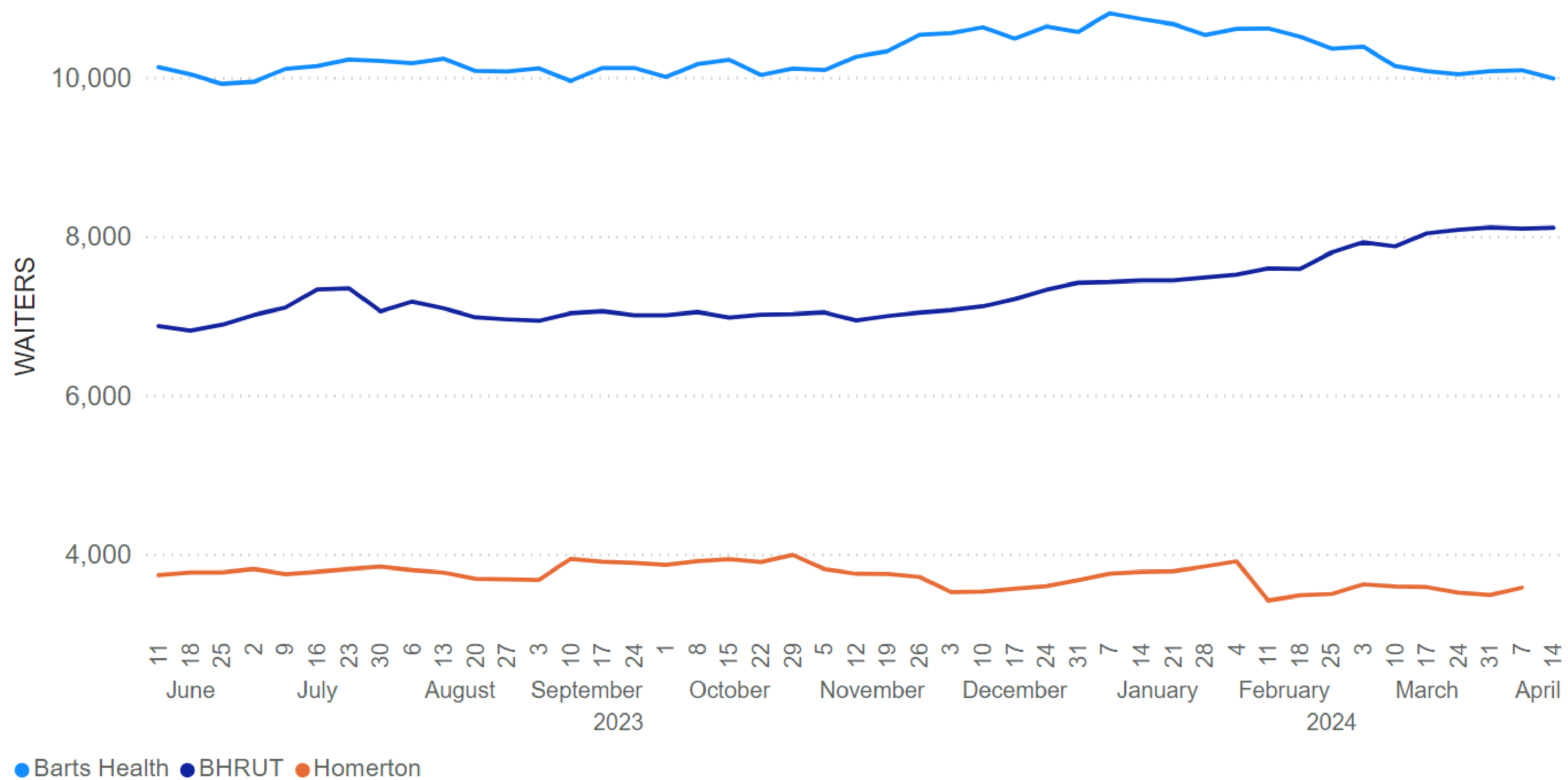
NHS North East London



Data Source: WLMDS

Trend in Gynae wait list by NEL Trust

NHS North East London



Data Source: WLMDS

Appendix 2

Health Inequalities Analysis

Inequalities – waiting times

- **Average weeks waiting** – On average Gynaecology patients tend to wait longer than patients on the wider list (24 vs 20 weeks)

- **Waiting time by ethnicity** – The "Other" and "Mixed" ethnic groups tend to wait less time on the PTL than other groups (between 1.6 – 2.4 weeks less respectively). The "Black/Black British", "White" & "Asian/Asian British" groups have similar waits (24.4-23.9)

- **Waits by age** – Overall younger patients tend to have shorter waits than older patients. Patients in the group 10-39 years age groups wait circa 21-22 weeks. Patients over 40 wait over 25 weeks on average, with the +70 cohort waiting the longest.

- **Waits by deprivation** – more deprived patients (cohort 1& 2) tend to wait marginally less than other groups, it is unclear if this is statistically significant or not.

Inequalities – Comparison of the Gynaecology wait list to the NEL population

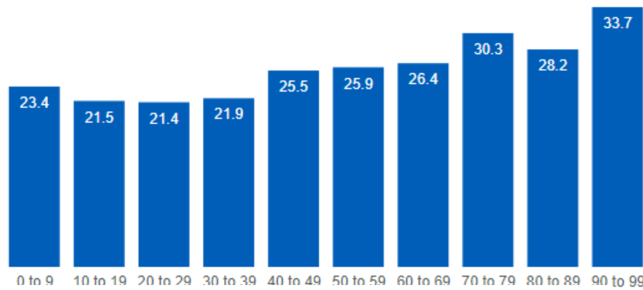
- **Ethnicity compared to NEL**– "Black/Black British" & "Asian/Asian British" patients make up a greater proportion of the Gynaecology PTL than would be expected based on the NEL population demographics (+5% & +13% respectively). Only 3% of the Gynaecology PTL is listed as having an "unknown" ethnicity compared to 15% of the NEL population, so this may account for some (but not all) of this discrepancy.

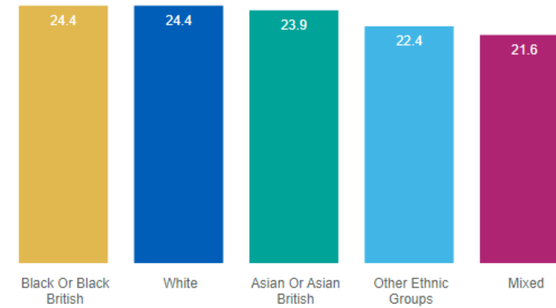
- **Comorbidities compared to NEL** – 25% of the Gynaecology PTL are listed as having a single comorbidity, with a further 20% having complex comorbidities, this is higher than the wider population (9% & 7% respectively). This is a trend seen in several specialities.

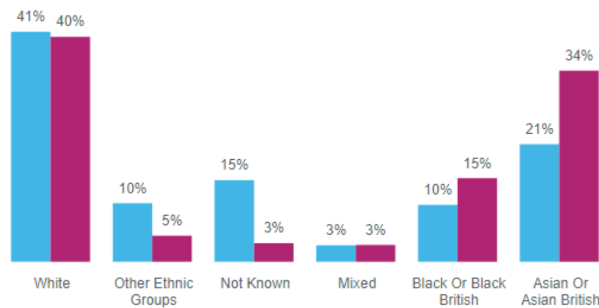
- **Age compared to NEL** – 30–49 year-olds account for the majority of the PTL (56%), but account for 35% of the wider population

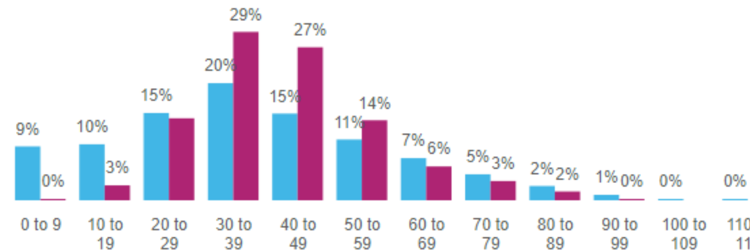
NHS North East London

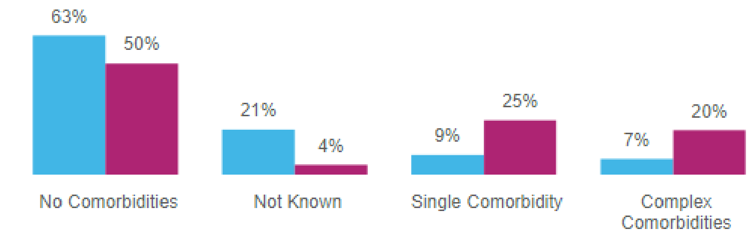
Health Inequalities Graphs











Note on charts from left to right

1. Illustrates average week wait by age band for women on gynaecology waiting list
2. Average week wait by ethnicity
3. Ethnicity on the gynaecology wait list compared to NEL population
4. Age on gynaecology wait list compared to NEL population
5. Comorbidties on gynae waiting list compared to NEL population

North East London Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	Annual Complaints Report
Author	Pam Dobson, Deputy Director of Corporate Support
Presented by	Charlotte Pomery, Chief Participation and Place Officer,
Contact for further information	Pam Dobson, Deputy Director of Corporate Support
Executive summary	The purpose of this report is to inform the Board of the following: • Complaints handling for the 12-month period to 31 March 2024, including the volume and the types of complaints received, broken down by function and by Place. • Performance against the agreed Key Performance Indicators (KPIs), and themes and trends breakdown by department and function. • How it is proposed to learn from this intelligence for service and quality improvements, to improve the experience for patients and residents.
Action / recommendation	The Board is asked to note this report
Previous reporting	Executive Management Team Executive Committee
Next steps/ onward reporting	As required; the intention is for the paper to be presented to the System Quality Group and Quality Safety and Improvement Committee
Conflicts of interest	There are no conflicts of interest arising from this report
Strategic fit	The contents of this report have the potential to align with each of the strategic aims of the Integrated Care System: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To improve value for money and efficiency • To support broader social and economic development
Impact on local people, health inequalities and sustainability	Improving our response to complaints and ensuring we hear directly from local people about their experience of drawing on our services is critical to improving both services and outcomes.
Has an Equalities Impact Assessment been carried out?	An equalities impact assessment is not required for this report.
Impact on finance, performance and quality	There are no direct impacts resulting from this paper.
Risks	There is a potential reputational risk due to longer response times for dealing with complaints. Also, a continued risk to

	delivery to ensure adequate capacity to meet the agreed KPIs in the wake of the continued increase in volume of complaints and the capacity to complete investigations within the required timescales

1.0 Introduction

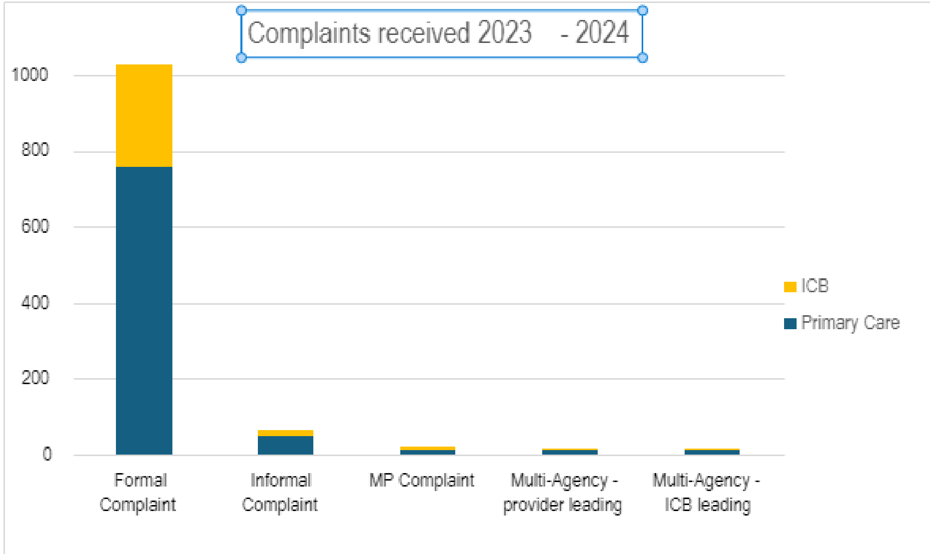
1.1 The purpose of this report is to provide the first annual report to the Integrated Care Board (the Board) about the number of complaints received by the organisation, the main categories and services where our patients and residents are raising issues to us through complaints and how it is proposed the organisation can utilise the intelligence gained to learn from complaints and ensure they are routinely used in service and quality improvement. The report further notes that the focus here is on complaints routed through the Integrated Care Board (ICB) rather than across the system.

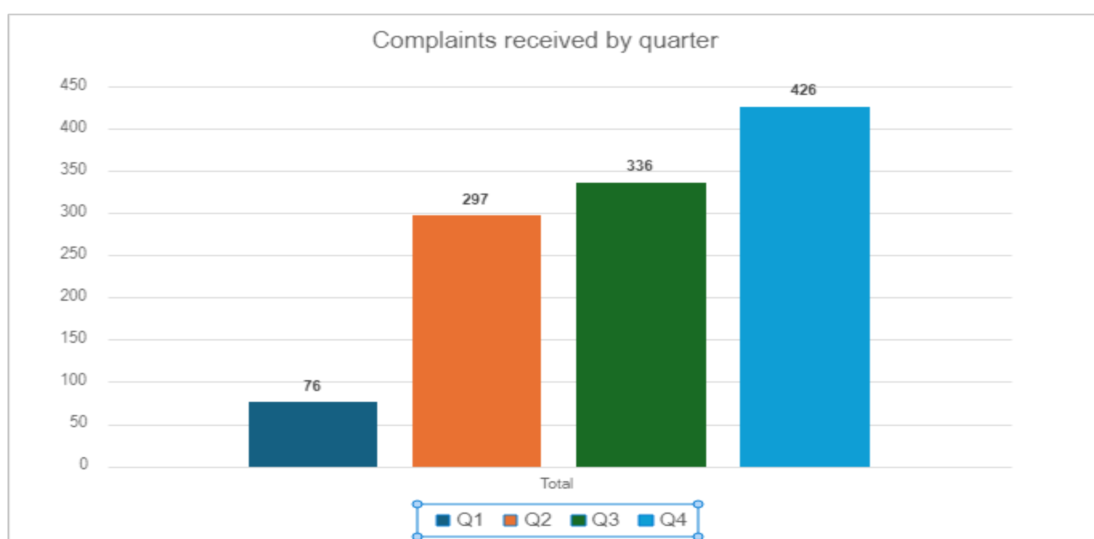
1.2 The organisation's complaints handling policies and processes follow the Local Authority Social Services and National Health Service Complaints (England) Regulations of 2009. In developing our policies and procedures, the best practice principles put forward by the Parliamentary and Health Services Ombudsman (PHSO) have been utilised.

1.3 The Board is asked to note this report and the accompanying appendix containing the more detailed performance report and agree the actions for implementing the learning from complaints.

2.0 Number of Complaints Received

2.1 In the financial year April 2023 to March 2024, the organisation received 1135 complaints. For the purposes of this report, complaints include informal and formal complaints as well Member of Parliament (MP) and councillor enquiries containing complaints. Integrated Care Board (ICB) related complaints totalled 300 compared to 253 in the year 2022/23. The organisation received 833 complaints about primary care, following the delegation of primary care complaints from NHS England (NHSE) on 1 July 2023.





Types of Complaints 23/24	Q1	Q2	Q3	Q4	Grand Total
Formal Complaint	70	271	293	393	1027
Informal Complaint	3	11	24	27	65
MP Complaint	3	9	7	1	20
Multi-Agency - provider leading		3	5	4	12
Multi-Agency - ICB leading		3	7	1	11
Grand Total	**76**	**297**	**336**	**426**	**1135**

2.2 Based on three years of data (running December 2019 to November 2022) the average number of complaints received by NHSE about primary care delivery in north east London, prior to delegation to the ICB, was 456. Over the last nine months of the financial year, the ICB has received 835 primary care complaints, an increase of more than 50%. Anecdotally it is thought the increase in the number of complaints received is as a result of the communication campaign and publication of the change of responsibility for the management of primary care complaints from NHSE to the ICB, raising awareness about where and how to raise a complaint. Whilst this is positive, it has contributed to a backlog of cases which is the subject of an action plan, approved by the Executive Management Team (EMT) in February 2024 and is now being implemented.

3.0 Performance Against Key Performance Indicators (KPI)

3.1 Prior to 1 July 2023 the ICB was working to a standard response time of 25 working days to fully investigate and respond to complaints. It was recognised that performance against this KPI was not always compliant as, over time, the number of complex and multi-organisational complaints had increased, and more than 25 working days was continually required to complete the investigation.

3.2 Immediately prior to the delegation of primary care complaints to the five ICBs in London, the issue of creating standard response times for all complaints (whether related to primary care or wider services) across London was discussed as part of

the delegation process. It was agreed across the ICBs that 40 working days for completion of all complaints would become standard and in place from 1 July 2023.

Performance against KPI is as follows: -

Standard Response Times	Number of complaints	% compliance	Key Performance Indicators
Complaint acknowledgement within 3 working days	**708***	**87%**	95% of cases pursued, acknowledged within 3 working days
Standard complaint responses within 40 working days for complaints pursued	**73 cases**	**20%**	85% of cases pursued dealt with to resolution within 40 working days.

*Cases excluded where not applicable or signposted to other organisations

This data now forms the baseline for regular performance reporting moving forward.

4.0 Complaint Outcomes

4.1 The organisation received 835 primary care complaints and 300 ICB complaints. Of these 1135 complaints, 496 cases were closed. Of these approximately 296 were not pursued for the following reasons: -

- Signposted to correct ICB /organisation.
- Referred to another organisation / Practice/provider to respond directly.
- Not applicable to the ICB.
- Consent not received.
- Request for further information not received.
- Case withdrawn.
- Dealt with by relevant ICB function – not a complaint.

However, approximately 103 cases were informally resolved and did not require a formal investigation.

4.1 The Appendix provides further details, broken down by type of complaint and by Place.

5.0 Complaint Service Areas/Categories

5.1 In the past financial year the service areas receiving the highest number of complaints are as follows:

Subject Area	Total
General Practice/GP out of hours	740
Secondary Care / Providers	127
Dental	90
Mental health	31
NHS 111	24
Planned Care	21
Community services	14

London Ambulance Service	9
Pharmacy	8

The top four areas in the table above (excluding Dental) remain consistent when compared to financial years 2021/ 22 and 2022/23. GP and secondary care are continuing to be the two highest areas for complaints received. When drilling down and looking at the sub-subject areas there are consistent themes across the five highest areas of complaints, detailed in the table below:

Sub subject area	Numbers received
Standard of care	193
Practice/services	128
Appointments	114
Attitude/behaviour/communication	101
Treatment	44
Removal from practice	41
Referrals	36
Decisions/Outcome	36
Delivery of Services	35
Appointment Access	31
Prescription - delay	24
Assessment - Decisions	20
Communication	16
Access to a GP practice	13
Missing Medical Records	12

6.0 Complaints referred to the Parliamentary and Health Services Ombudsman

6.1 The ICB was contacted by the Parliamentary and Health Services Ombudsman (PHSO) regarding two complaints during the year. In fact, only one of the cases was relevant for our ICB and the PHSO was provided with the contact details for the other. In comparison with previous years the organisation has received an average of two cases per financial year.

Details of complaint	Category	Sub category	Outcome
PHSO contact in relation to a complaint regarding a mental health concern.	Mental health	Treatment	Complaint not upheld
Local Government and Social Care Ombudsman (LGO) contact regarding assessment of patient and who paid the doctor that carried out assessment	Secondary Care Trust/Hospital	Assessment - Decisions	Patient not registered in the area at the time of the assessment. Details provided for correct ICB

7.0 Incidents

7.1 Patient incidents are monitored and reported to the Quality, Safety and Improvement Committee by the Patient Safety Team. The management of patient incidents is

governed through the recently introduced Patient Safety Incident Response Framework (PSIRF) which replaced the Serious Incidents Framework

7.2. Between April 2023 and April 2024, a total of 302 Serious Incidents and 115 Patient Safety Incident Investigations (PSIIs) were reported across north east London. Providers transitioned to PSIRF at different times, therefore numbers of PSIIs are not comparable yet, but will be moving forward.

Provider	SIs	PSIIs	Total
Barts	127	16	143
BHRUT	46	48	94
ELFT	47	16	63
Homerton	56	4	60
NHS 111	0	2	2
NEL ICB (Care Home / Primary Care)	6	0	6
NELFT	5	29	34
PELC	11	0	11
Spire	1	0	1
Tower Hamlets Care Group	3	0	3
Total	302	115	417

7.3. Due to reporting changes under PSIRF, incidents are no longer categorised at the reporting stage by overarching themes as they were under the Serious Incident Framework, as each provider has different learning priorities based on their Patient Safety Incident Response Plan (PSIRP). National changes to reporting and the ongoing impact have been escalated to, and are being monitored by, the Quality Safety and Improvement Committee.

7.4. Work is underway within the Quality directorate to establish methods to report on overarching themes, however this work has been delayed due to the ongoing staff consultation. The team hopes to begin reporting themes at the end of quarter two.

7.5. Triangulation of incident themes would be best undertaken alongside provider complaint themes, rather than ICB complaint themes.

8.0 Compliments

8.1 For the recording of compliments, there is currently no central logging process across the organisation. In primary care they are usually responded to thanking the sender for their email/letter and passed onto the practice/person mentioned. These are then filed away within the practice folder but are not usually shared or passed onto the complaints team. Compliments that are received by the patient experience team are formally acknowledged and shared with the relevant teams. In the last financial year, the team logged two compliments.

Details of the compliment	Category for reporting	Sub category
The patient has sent compliments for the care they received from staff at the Royal London Hospital.	Secondary Care Trust/Hospital	Standard of care

Compliment given regarding the exceptional care provided for a patient by the providers and care home.	Continuing Healthcare	Standard of care

9.0 Learning and next steps

9.1 Responding to individual complainants is of critical importance to those individuals and the care that they receive, often in real time. There is also often wider learning for services and for organisations in understanding the experience of those who draw on our services, in responding in a person-centred way and in learning so that this experience is less likely to be repeated for others. Whilst progress is being made to improve individual experiences, there remains work to do to embed the learning from complaints across service and quality improvement and to ensure that complaints are routinely considered in making changes to services and delivery. This will be a key area of focus in the year ahead so that themes from complaints are part of the information used to improve and understand services and resident experience.

9.2 This report focuses on complaints routed through the Integrated Care Board – and whilst this provides a partial view of the system through complaints which touch a number of organisations, it does not provide a systemic overview across north east London of areas of complaint and poor or positive experience. Whilst recognising that responding to complaints is a matter for individual organisations, it would be useful to understand – especially as we develop more integrated teams across our geography – the benefits of adopting a helicopter view across north east London to support learning and further service development.

9.3 Finally, work will continue to improve performance, that is in responding to complainants in a timely fashion, to a high-quality standard which includes follow up actions, that are carried out as agreed, are shown to be completed and relevant processes, pathways and service polices are reviewed and revised. Building a pipeline of staff within the organisation able to act as independent investigators, critical for complex complaints and to assure the complainant of objectivity, is a key area of focus and being taken forward through a staff development lens, providing opportunities for staff with a course offered as part of our organisational development programme.

10.0 Risks and mitigations

10.1 It is recognised that there is a potential reputational risk arising from the current backlog of cases and the subsequent longer response times for complaints. Also, a continued risk to delivery to ensure adequate capacity to meet the agreed KPIs in the wake of the continued increase in volume of complaints and the capacity to complete investigations within the required timescales. The mitigations to reduce the risks consist of the continued implementation of the agreed action to reduce the backlog which sets out new ways of working for the team and wider organisation.

11.0 Conclusion

11.1 As part of our wider commitment to listening to the voice and experience of local people as part of our everyday approach, complaints form a significant element of understanding how we as a system are responding to local needs. It is important to hold in our minds both the individual stories represented by complaints as well as thematic responses for quality and service improvement.

11.2 This first annual report for the Integrated Care Board on complaints, incorporating primary care complaints as well as those for the organisation directly, provides a

helpful baseline for complaints moving forward. It is recognised that there is more work to do to develop ourselves as a learning organisation and learning system in the sphere of complaints.

Pam Dobson
Deputy director corporate services
22 April 2024

NHS
North East London

Complaints Performance Report April 2023 - March 2023

Reporting cycle

A rolling year reporting cycle has been agreed for presentation to EMT on a bi-monthly basis. Reporting to date has been February 2024, May 2024. The agreed data template for reporting will include the information detailed below.

- Number of complaints (covering, concerns, informal and formal complaints, MP and Councillor complaints)

  1. Number and types of correspondence received overall
  2. Per financial year compared to the previous financial year.
  3. By quarters compared to previous quarters
  4. By Place and comparison with the previous year and quarters against the Place population
  5. Highest numbers by subject areas – themes and trends and relevant actions
  6. Highest numbers by sub subject areas - themes and trends and relevant actions
  7. Length of time to acknowledgement and resolution, against agreed key performance indicators
  8. Numbers upheld, partially upheld, not upheld
  9. Number resulting in recourse to the Ombudsman – investigated, not investigated, upheld or not upheld
  10. Demographic trend analysis of complainants where known.

Overview: April 2023 – March 2024

The following slides provide an overview and show performance against the agreed key performance indicators for complaints management for the financial year 2023 - 2024.

- For the purposes of this report, when referring to complaints, this covers the following types:
  - Formal complaints
  - Informal complaints
  - MP complaints
  - Councillor complaints

Received	23/24	22/23
Total correspondence	1816	486
- Total correspondence - ICB	774	
- Total correspondence – primary care	1042	
Total complaints	1135	253
- Total complaints – ICB	300	
- Total complaints – primary care	835	

Over the past 12 months the patient experience team received correspondence totalling 1816

This total is made up of 774 commissioner cases and 1042 primary care cases.

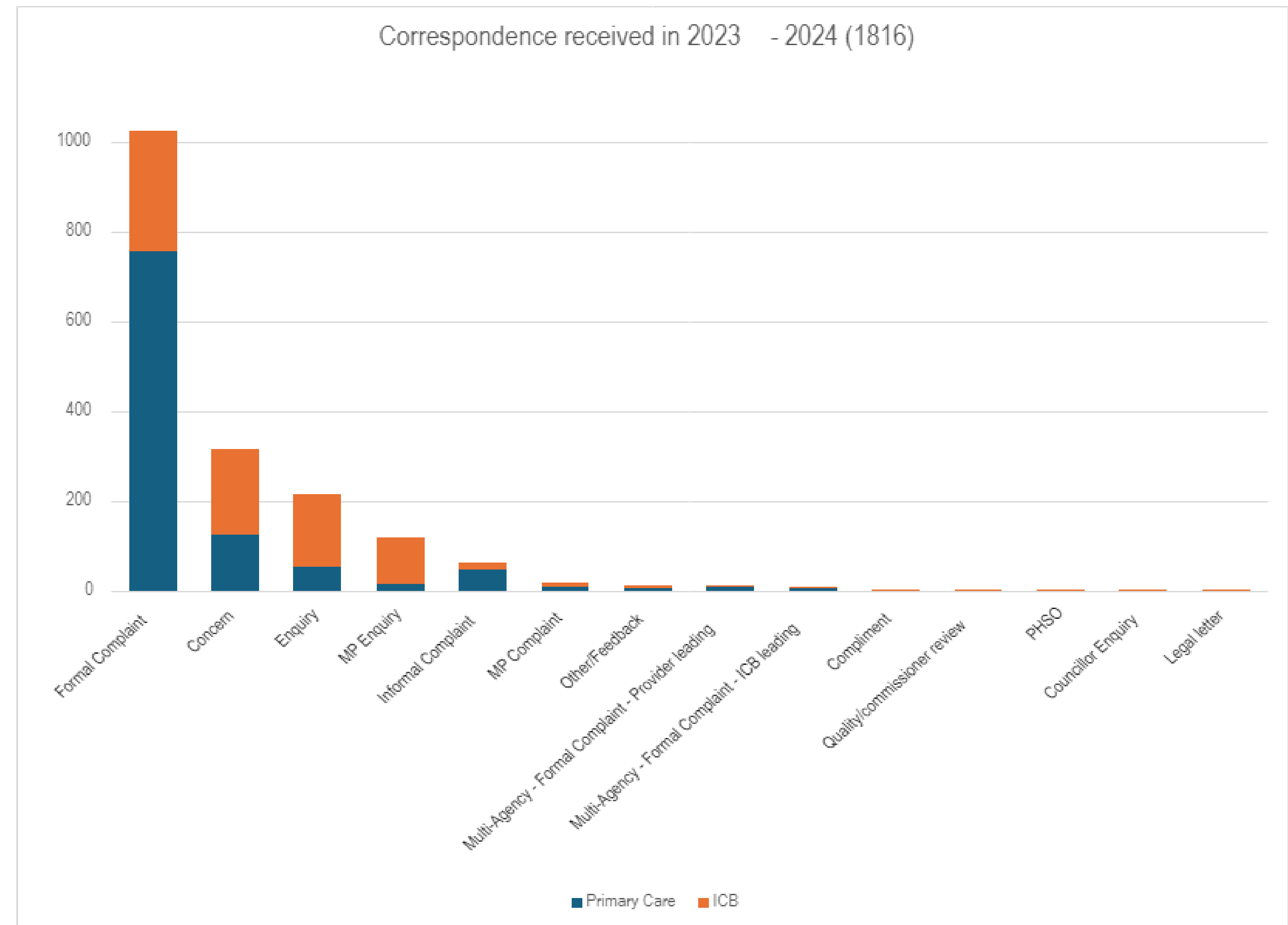
The ICB has received more than double the number of complaints received in the previous financial year. With the delegation of primary care complaints on 1 July 2023 from NHS England, their data for the previous two years showed an average of 456 complaints per year.

*Based on data as at 31 March 2024

Correspondence received in the 12 months to March 2024

In 12 months, 1 April – 31 March 2024 the complaints team received the following types of correspondence:-

Type of Correspondence	Primary Care	ICB	Grand Total
Formal Complaint	755	270	1025
Concern	127	190	317
Enquiry	54	163	217
MP Enquiry	16	103	119
Informal Complaint	48	17	65
MP Complaint	11	9	20
Other/Feedback	8	7	15
Multi-Agency - Formal Complaint	19	4	23
Compliment	2	2	4
Quality/commissioner review		3	3
PHSO	1	2	3
Councillor Enquiry	1	2	3
Legal letter		2	2
Grand Total	**1042**	**774**	**1816**

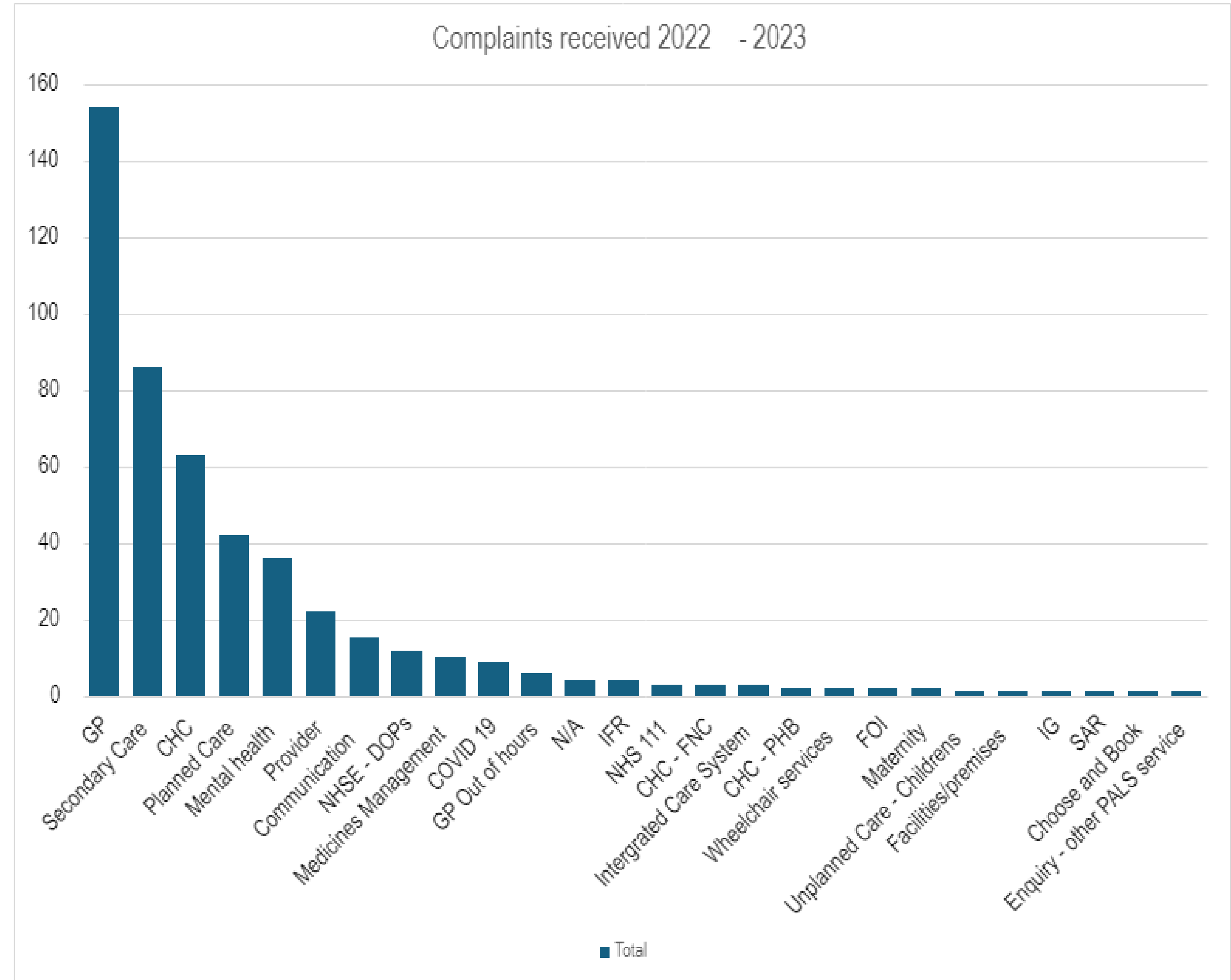


*Based on data as at 31 March 2024

Data taken from the complaints log database only and not the enquiries mailbox.

Correspondence received in 12 months for 22 - 23

Type of Correspondence	Primary Care	ICB	Grand Total
Formal Complaint	2	197	199
Enquiry		105	105
MP Enquiry		96	96
Informal Complaint		43	43
Other/Feedback		14	14
Quality/commissioner review		8	8
MP Complaint		8	8
Councillor Enquiry		6	6
Councillor Complaint		3	3
Compliment		2	2
PHSO		2	2
Grand Total	**2**	**484**	**486**

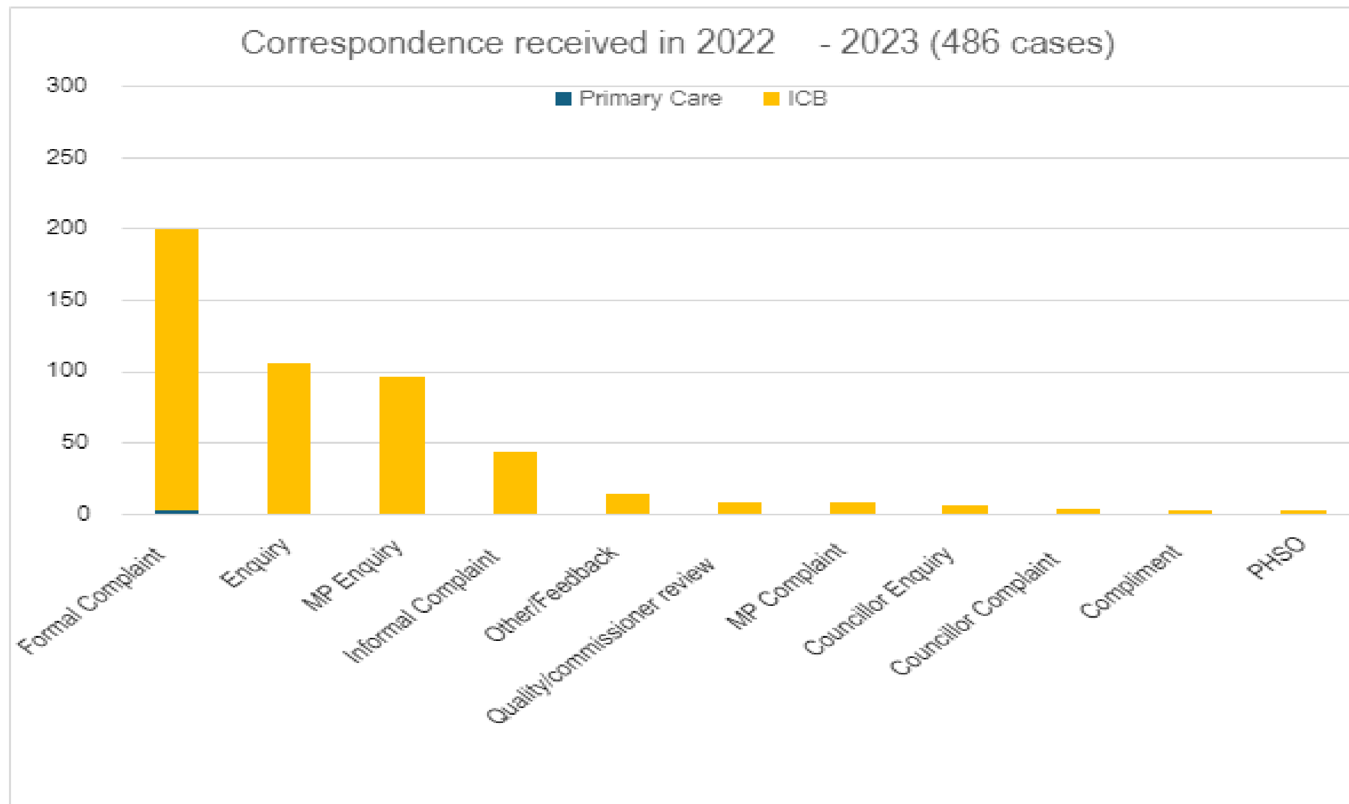


Data for 2022 – 2023 shows: -
The ICB received total correspondence of 486.
For 2023/24 for ICB related cases an increase of 288 more cases than the previous year – 774 in total
That equates to 253 complaints received in 22/23 and 300 received in 23/24.

*Based on data as at 24 January 2024

Data taken from the complaints log database only and not the enquiries mailbox.

Correspondence received 2022 - 2023



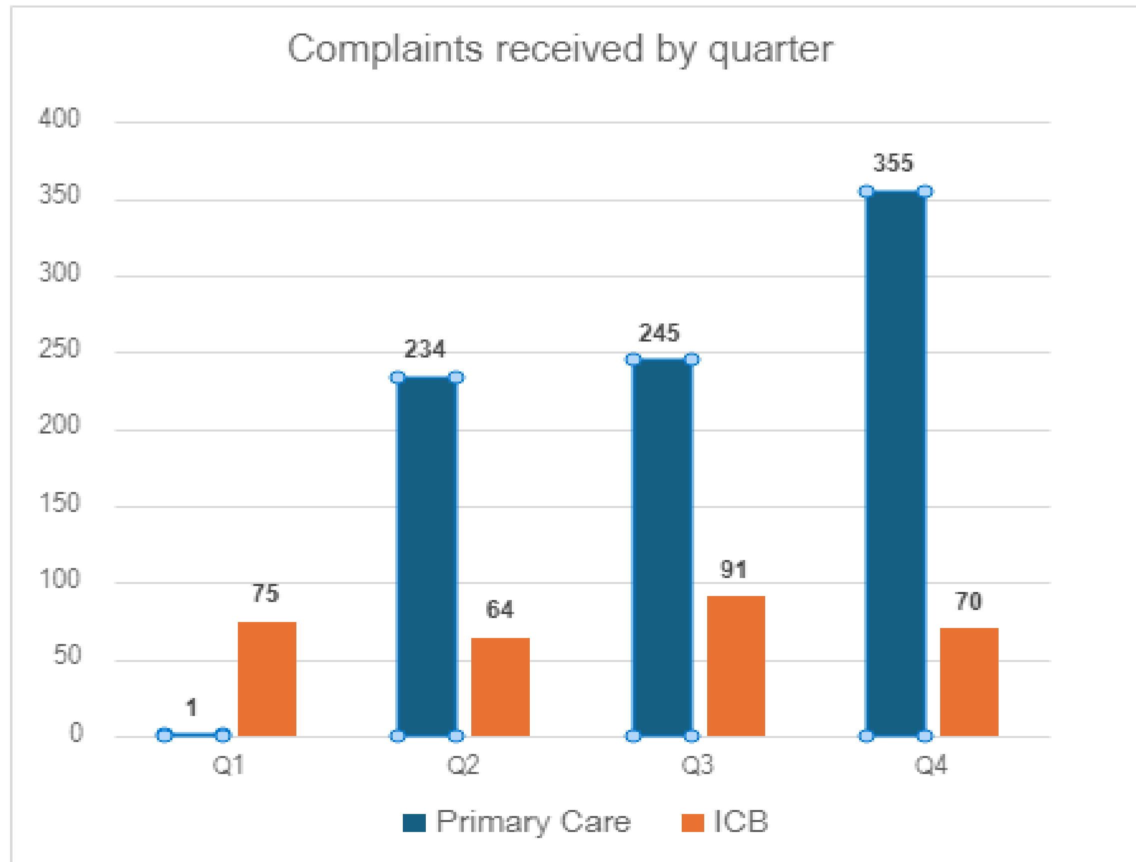
The ICB received total correspondence of 486 in 22/23, prior to the delegation of primary care complaints to ICBs, and in the following year the ICB received 288 more complaints - 774 in total.
That equates to 253 complaints received in 22/23 and 300 received in 23/24.

Subject Areas	Totals
GP	154
Secondary Care Trust/Hospital	86
CHC	63
Planned Care	42
Mental health	36
Provider	22
Communication	15
NHSE - DOPs	12
Medicines Management	10
COVID 19	9
GP Out of hours	6
N/A	4
IFR	4
NHS 111	3
Funded Nursing care (FNC)	3
Integrated Care System	3
CHC - PHB	2
Wheelchair services	2
FOI	2
Maternity	2
Choose and Book	1
Facilities/premises	1
Unplanned Care - Childrens	1
Enquiry - other PALS service	1
SAR	1
IG	1
Grand Total	**486**

*Based on data as at 24 January 2024

Data taken from the complaints log database only and not the enquiries mailbox.

Complaints received by quarter 2023/24



This graph shows the number of complaints received split by ICB and primary care. This clearly shows the increasing number of primary care complaints received per quarter.

For ICB complaints, showing an increasing and decreasing number of complaints received over the quarters.

Compliance against KPIs

Agreed KPIs: -

95% of cases pursued, acknowledged within 3 working days

85% of cases pursued dealt with to resolution within 40 working days

90% of MP enquiry cases dealt with to resolution within 20 working days

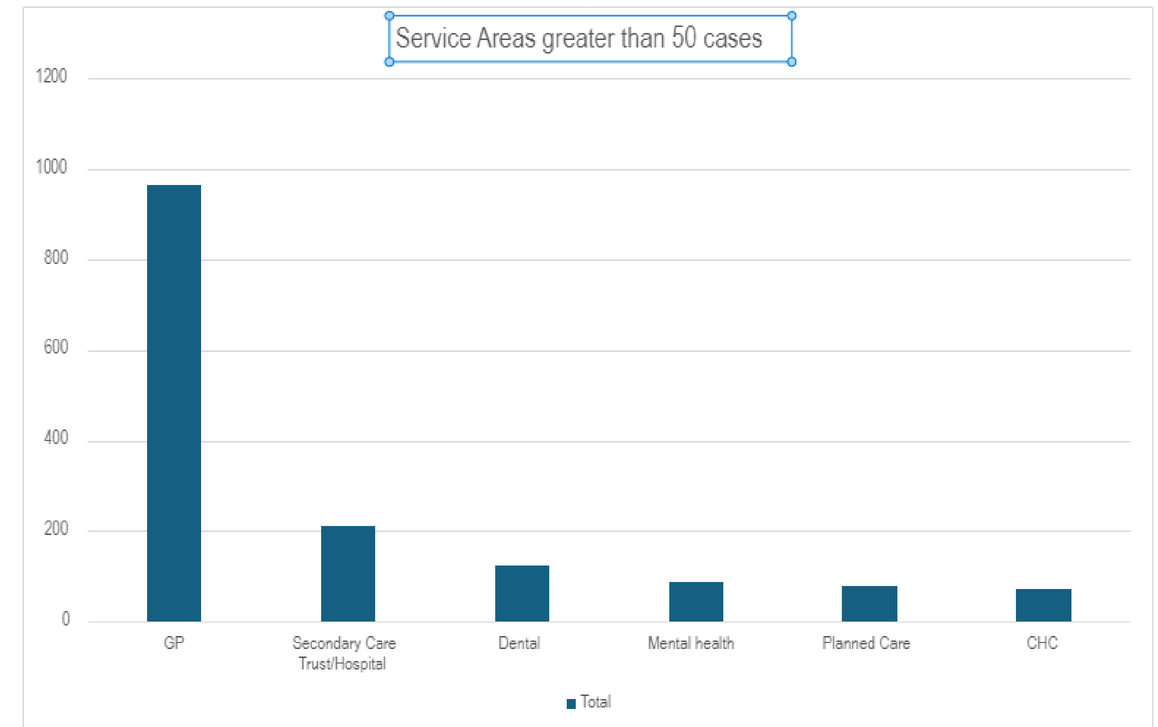
Of the total number of complaints pursued: -

- 87 % of cases acknowledged within 3 working days (formal acknowledgement)
- 20% of cases dealt with in 40 working days or less (73 cases)

Service Areas 1 April 2023 – March 2024

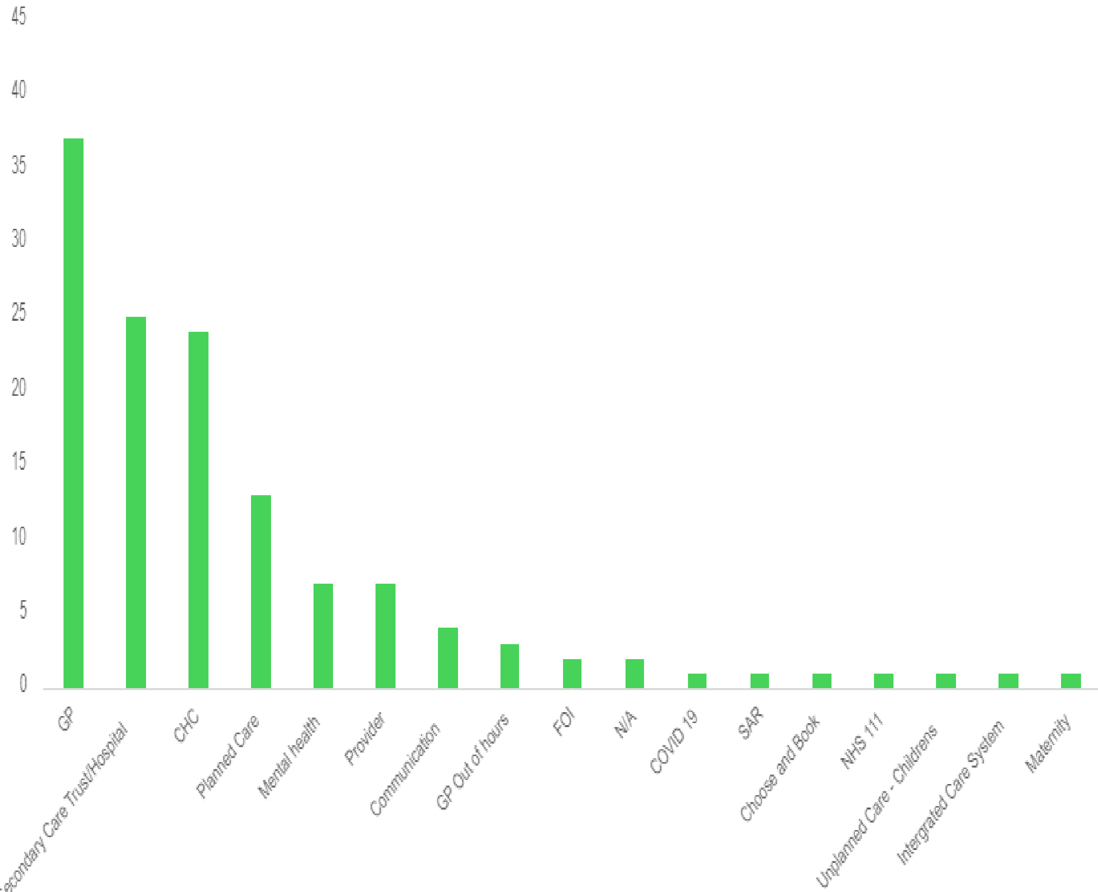
Subject Areas	Total
GP	964
Secondary Care Trust/Hospital	209
Dental	122
Mental health	86
Planned Care	77
CHC – FNC/PHB	86
NHS 111	35
Community services	26
Provider	24
COVID 19	22
LAS - London Ambulance service	16
Pharmacy	14
Medicines Management	11
Communication	10
Vaccination programme - Adults	9
Integrated Care System	9
IFR	9
N/A	7
Maternity	6
SAR	6
GP Out of hours	6
Wheelchair services	5
FOI	5
Ophthalmology	4
District Nursing	4

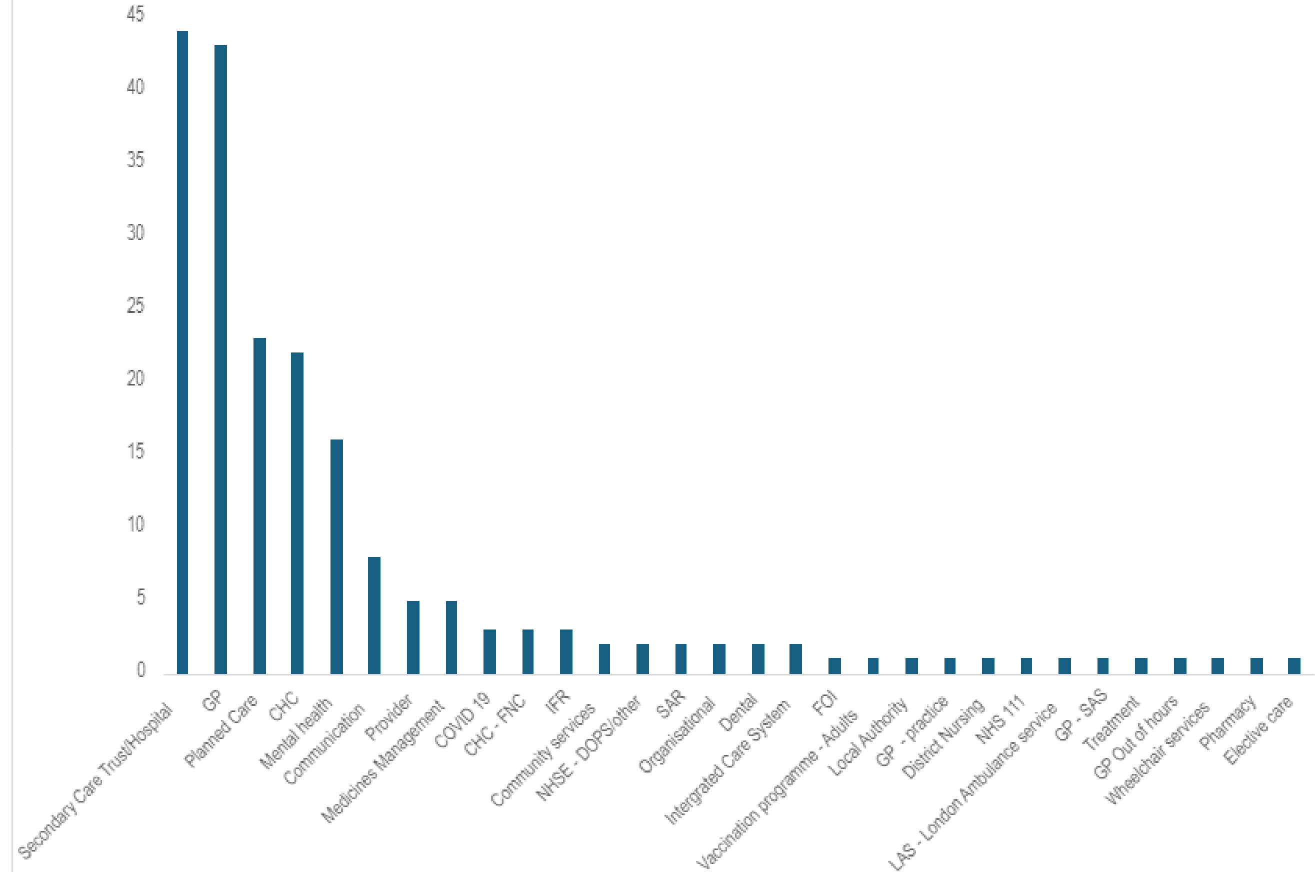
Subject Areas	Total
Attitude/behaviour/communication	4
Diagnostics	3
Elective care	3
CHC - Childrens	3
Local Authority	3
Organisational	3
Enquiry - other PALS service	2
IG	2
Learning Disability - Children	2
GP - practice	2
GP - SAS	2
Vaccination programme - Children	2
Data protection	2
NHSE - DOPs	2
Treatment	1
Appointment Access	1
(blank)	1
Facilities/premises	1
Health Visiting	1
Choose and Book	1
Nursing Home	1
Appointment delays	1
No suitable category	1
Grand Total	**1816**



- The tables show the total number of service areas and number of correspondence received.
- The graph above shows the 6 service areas receiving the highest number of complaints, that is
- GPs
- Secondary care
- Dental
- Mental Health
- Planned Care
- CHC

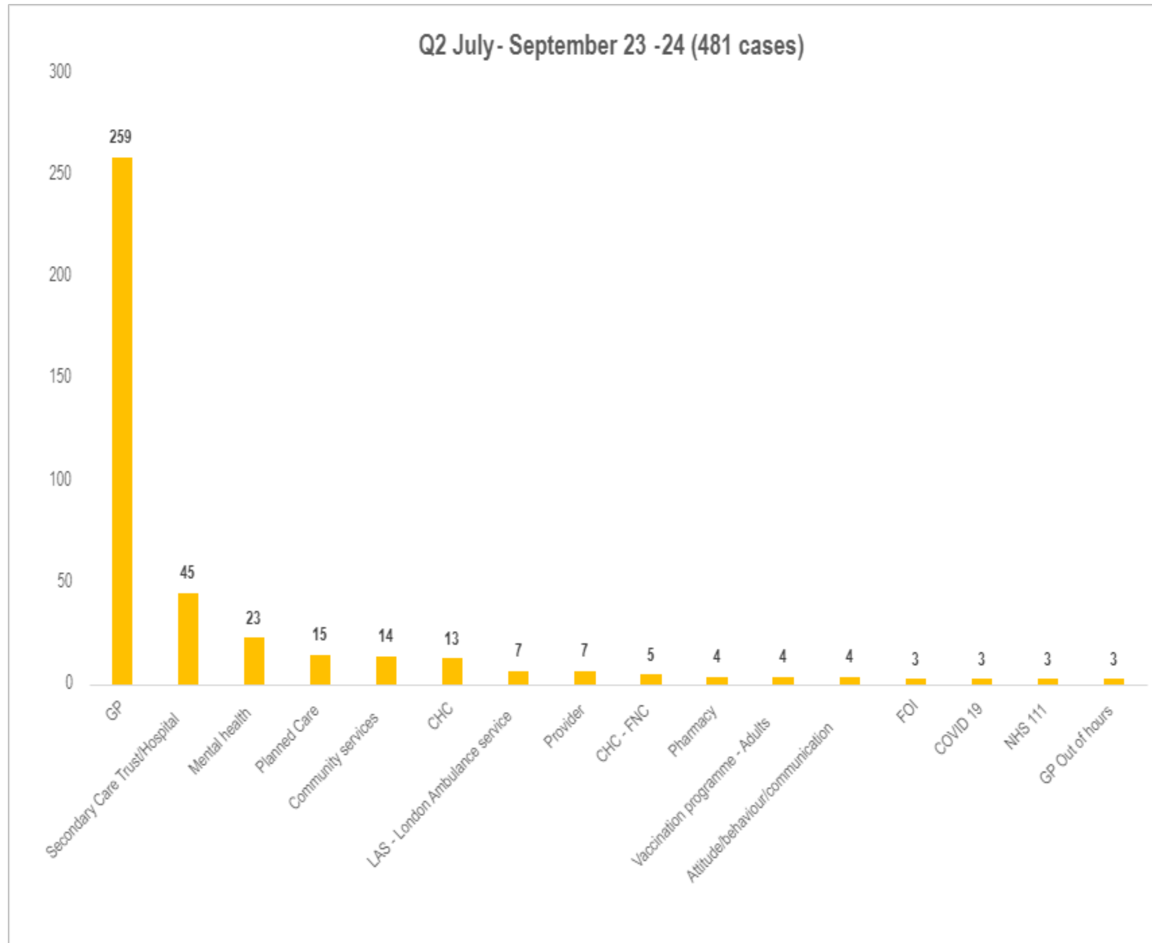
Comparison by quarter 4 22/23 and quarter 1 23/24

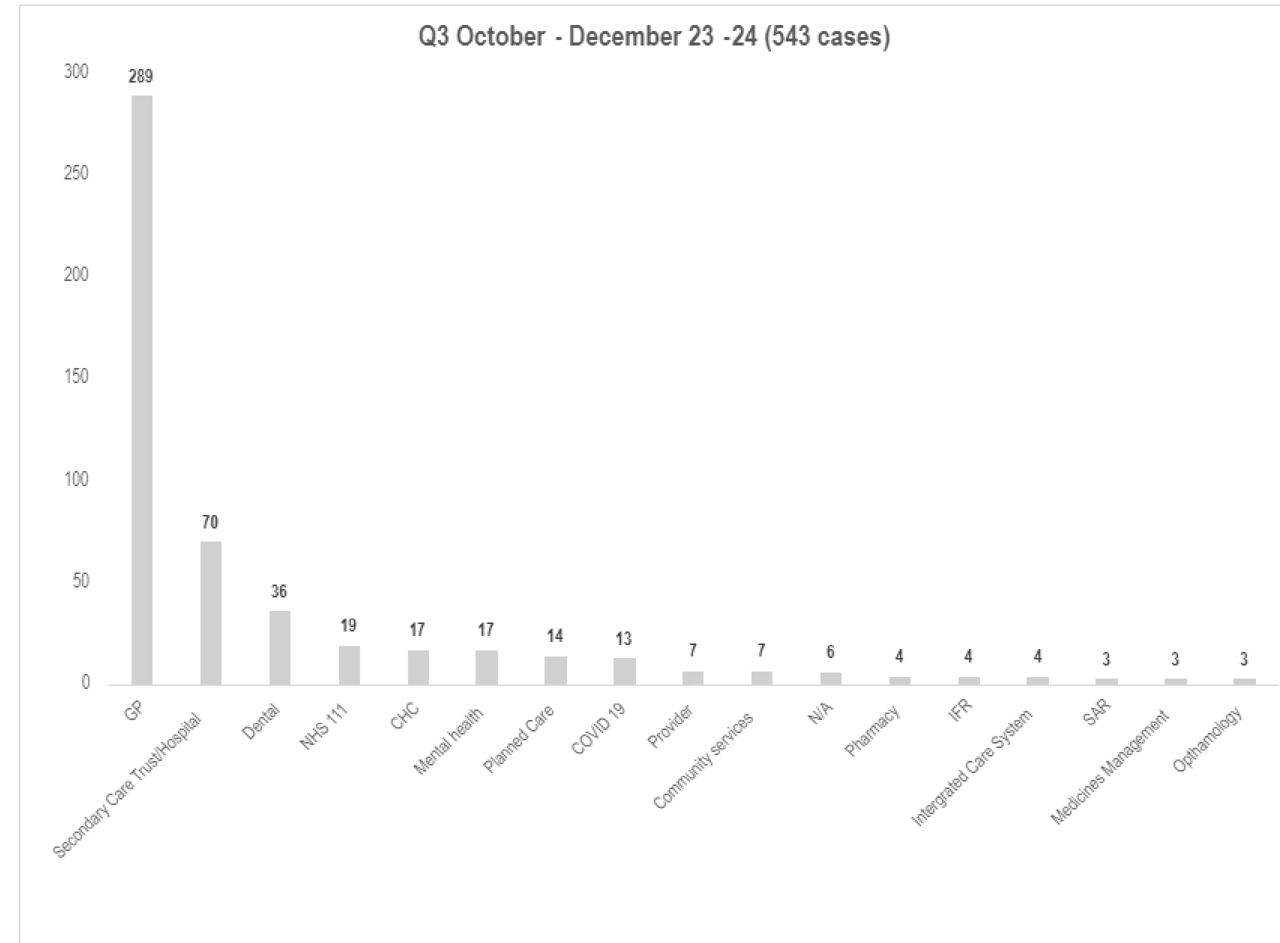




Q1 23/24 saw an increase of 69 cases compared to Q4 22/23. Complaints about GPs, secondary care, CHC, planned care and providers remain the highest and cases increased in Q1. Double the number of mental health complaints were received in Q2. In both quarters CHC cases remained high but stable. The number reduced slightly in Q2 23/24 but increased again in Q3.

Comparison of quarters 2 and 3 23/24

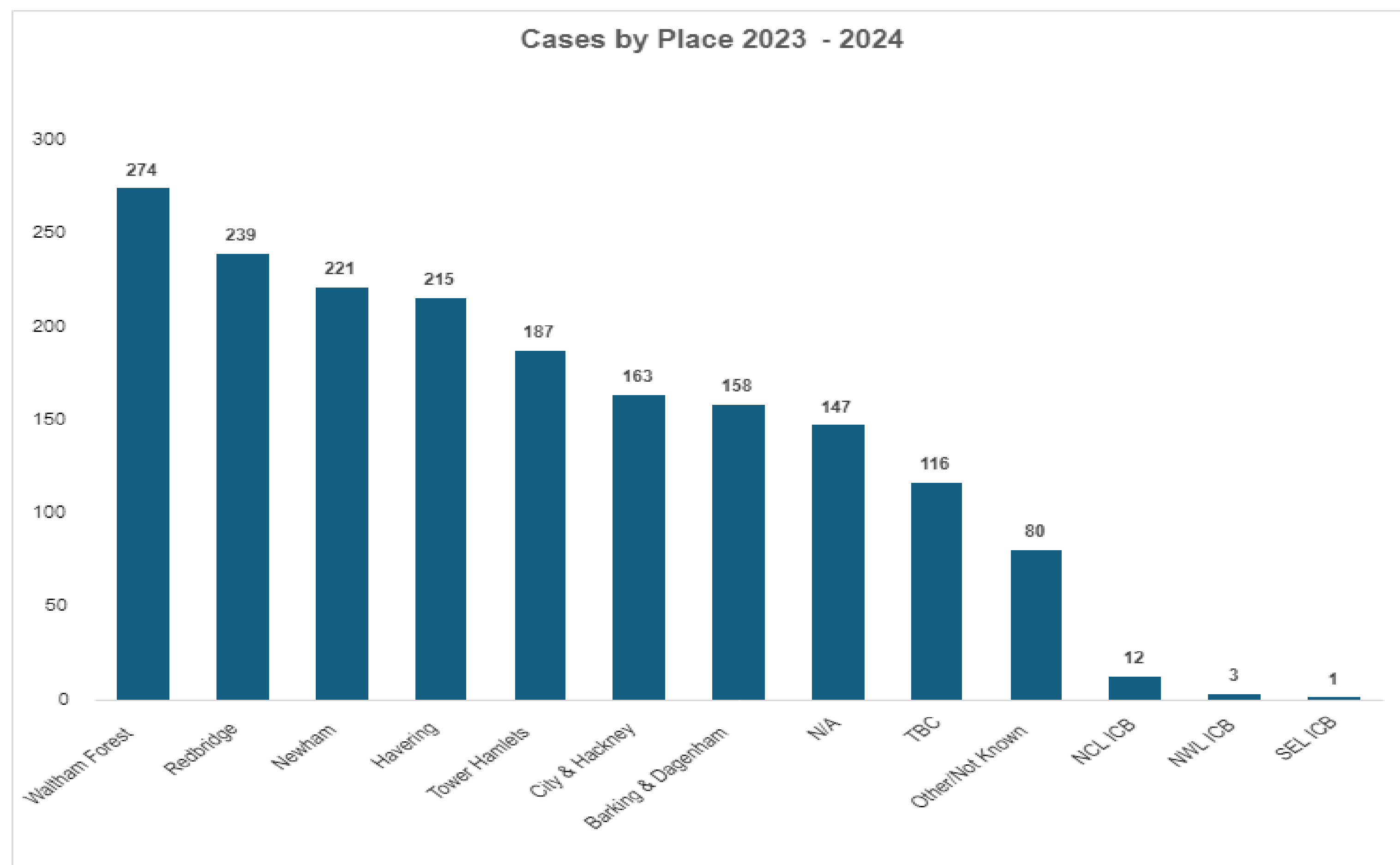




Q2 and Q3 2023/2024 shows the increased number of primary care cases since the 1 July 2023 delegation of primary care complaints. GP referrals have slightly increased in Q3, as have CHC cases with dental cases reduced. There is a marked increase in secondary care cases, which are mostly signed posted to the relevant organisation.

Correspondence by Place 2023 - 2024

Place	Total
Waltham Forest	274
Redbridge	239
Newham	221
Havering	215
Tower Hamlets	187
City and Hackney	163
Barking and Dagenham	158
Not pursued	359
Total	1816



The not pursued cases are those that are:-

- Signposted and closed to relevant providers, or other ICBs/organisations
- No consent received to progress cases
- No further contact received from the complainant after initial e-mail or ‘phone call and after follow up.

Themes and Trend Analysis

The analysis shows the following are the top areas for complaints received (table 1.) across the ICB. Across these 9 areas the most common themes (table 2) are listed below.

Table 1 9 Top Subject/Service Areas	Total
General Practice/GP out of hours	740
Secondary Care / Providers	127
Dental	90
Mental health	31
NHS 111	24
Planned Care	21
Community services	14
London Ambulance Service	9
Pharmacy	8

Most of the complaints received about secondary care issues are signposted back to the relevant organisation to handle.

Table 2 Sub subject area/service areas	Numbers received
Standard of care	193
Practice/services	128
Appointments	114
Attitude/behaviour/communication	101
Treatment	44
Removal from practice	41
Referrals	36
Decisions/outcome	36
Delivery of services	35
Appointment access	31
Prescription - delay	24
Assessment - decisions	20
Communication	16
Access to a GP practice	13
Missing medical records	12

Themes and Trend Analysis

When looking more closely into the top 4 sub subject/service areas we see the following.

Standards of care

- Lack of care and treatment;
- Breach of duty of care – lack or and missed diagnoses
- Inadequate end of life care
- Medication errors
- Mental health support

Practices/services

- Dental appointments; charges; cannot find NHS dentist; not able to register
- GP appointments; quality of care/service; lack of communication; discrimination

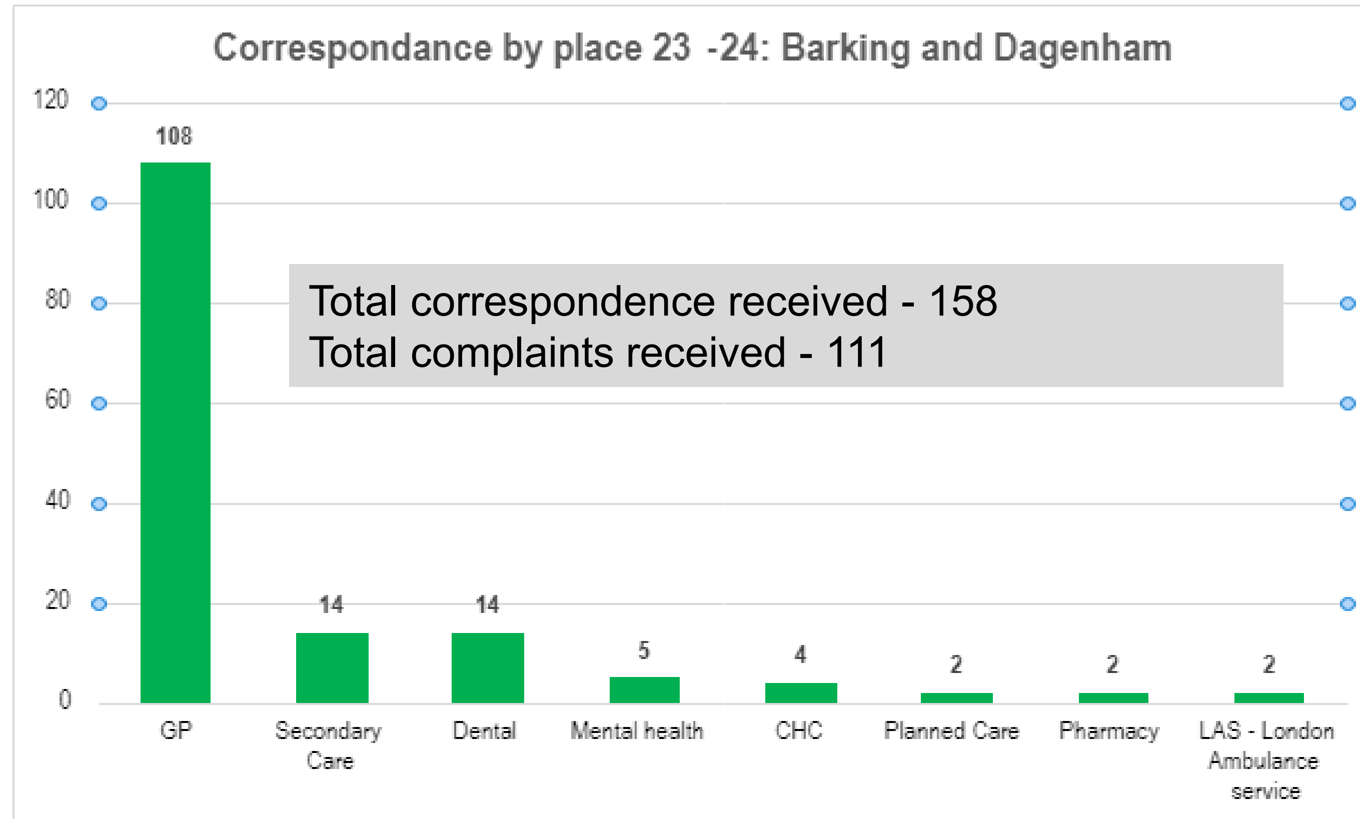
Appointments

- Lack of appointments – not able to obtain, difficulty booking, booking system delays, late cancellations and no notification, issues wanting in person appointments

Attitude/behaviour/ communication

- Conduct of GP - being dismissive and abrupt, also for nurses and locum GP
- Reception staff; rude, arrogant; aggressive, dismissive, unprofessional
- Poor communication

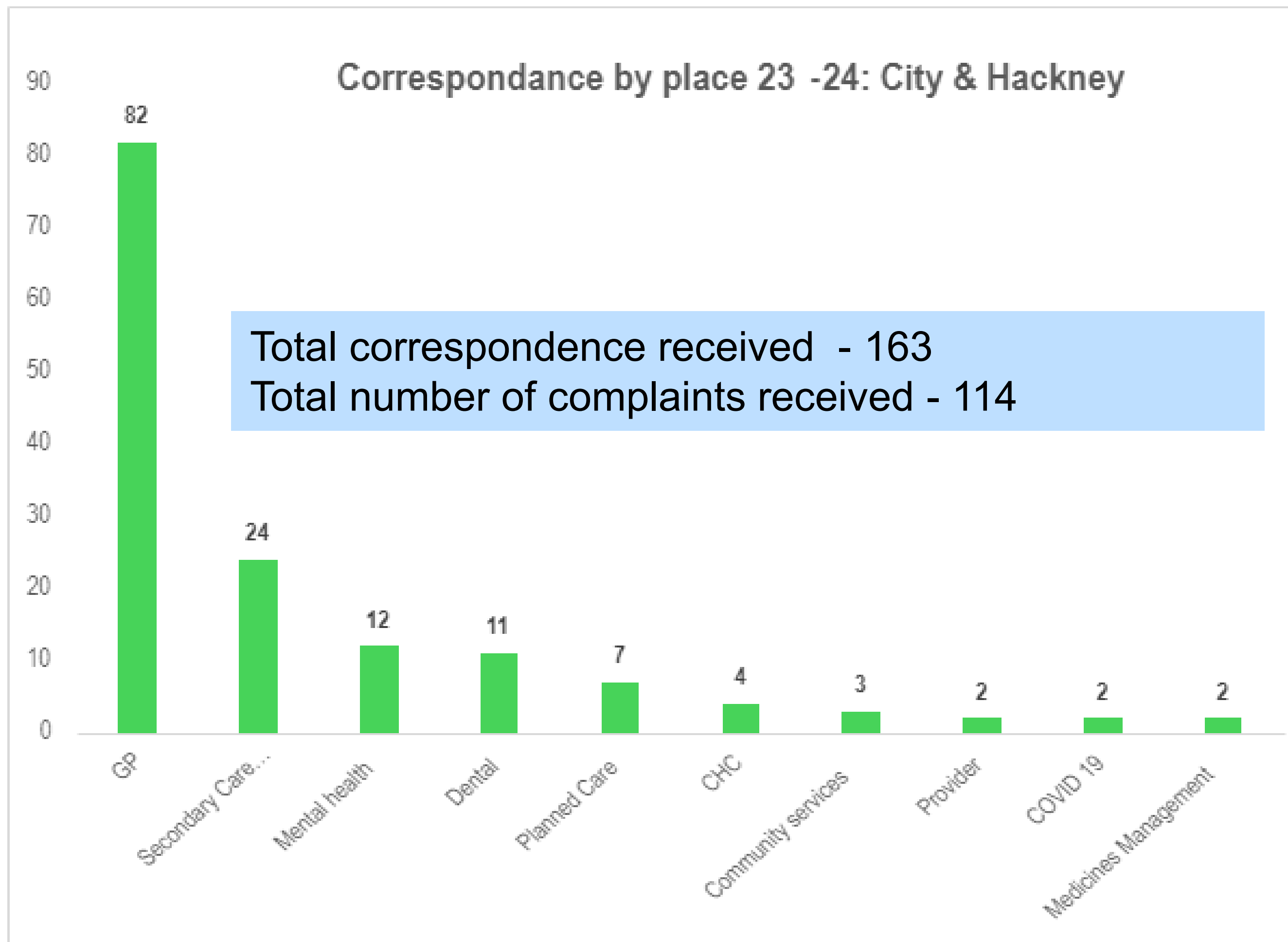
Cases by Place 2023 – 2024 – Barking And Dagenham



Complaints for GPs is more than 7 times greater than for other services. The issues being:-

Appointments	22
Practice/services	18
Standard of care	17
Attitude/behaviour/communication	9
Referrals	5
Removal from practice	5
Decisions/Outcome	4
Delivery of Services	4
Access to a GP practice	3
Missing Medical Records	3
Treatment	3
Delayed test results	2

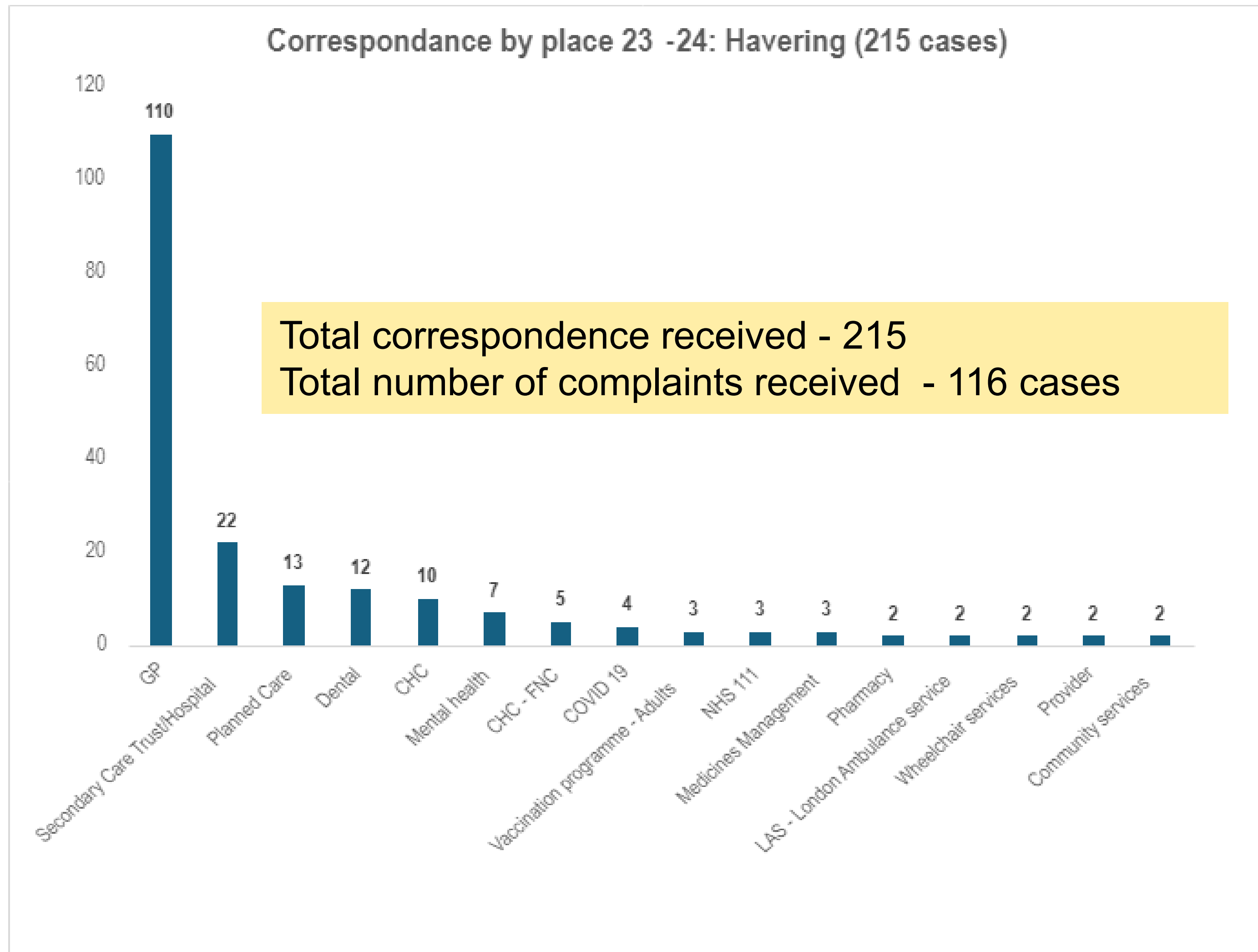
Cases by Place 2023 – 2024 – City and Hackney



Complaints for GPs is 6 times greater than for other services. The biggest issues being :

Practice/services	16
Standard of care	10
Attitude/behaviour/communication	9
Decisions/Outcome	7
Appointments	6
Referrals	5
Missing Medical Records	3
Treatment	3
Tests/Vaccine delays	2
Prescription - delay	3
Appointment Access	2
Removal from practice	2
Delivery of Services	2

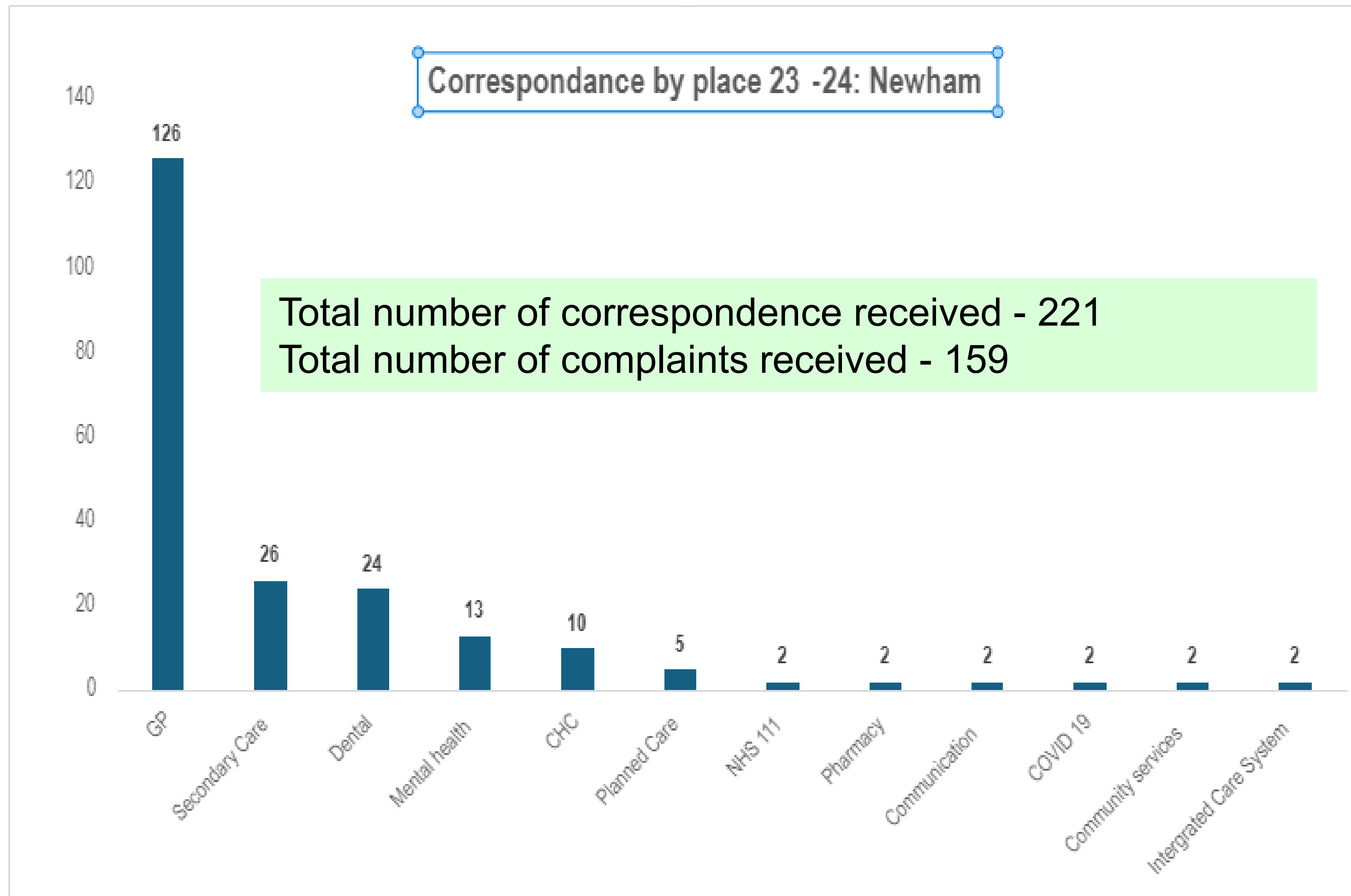
Cases by Place 2023 – 2024 - Havering



Complaints for GPs is 5 times greater than for other services. The biggest issues being: -

Issue	Count
Practice/services	16
Standard of care	16
Appointments	13
Attitude/behaviour/communication	13
Referrals	9
Decisions/Outcome	7
Appointment Access	5
Access to a GP practice	5
Treatment	3
Communication	3

Cases by Place 2023 – 2024 - Newham

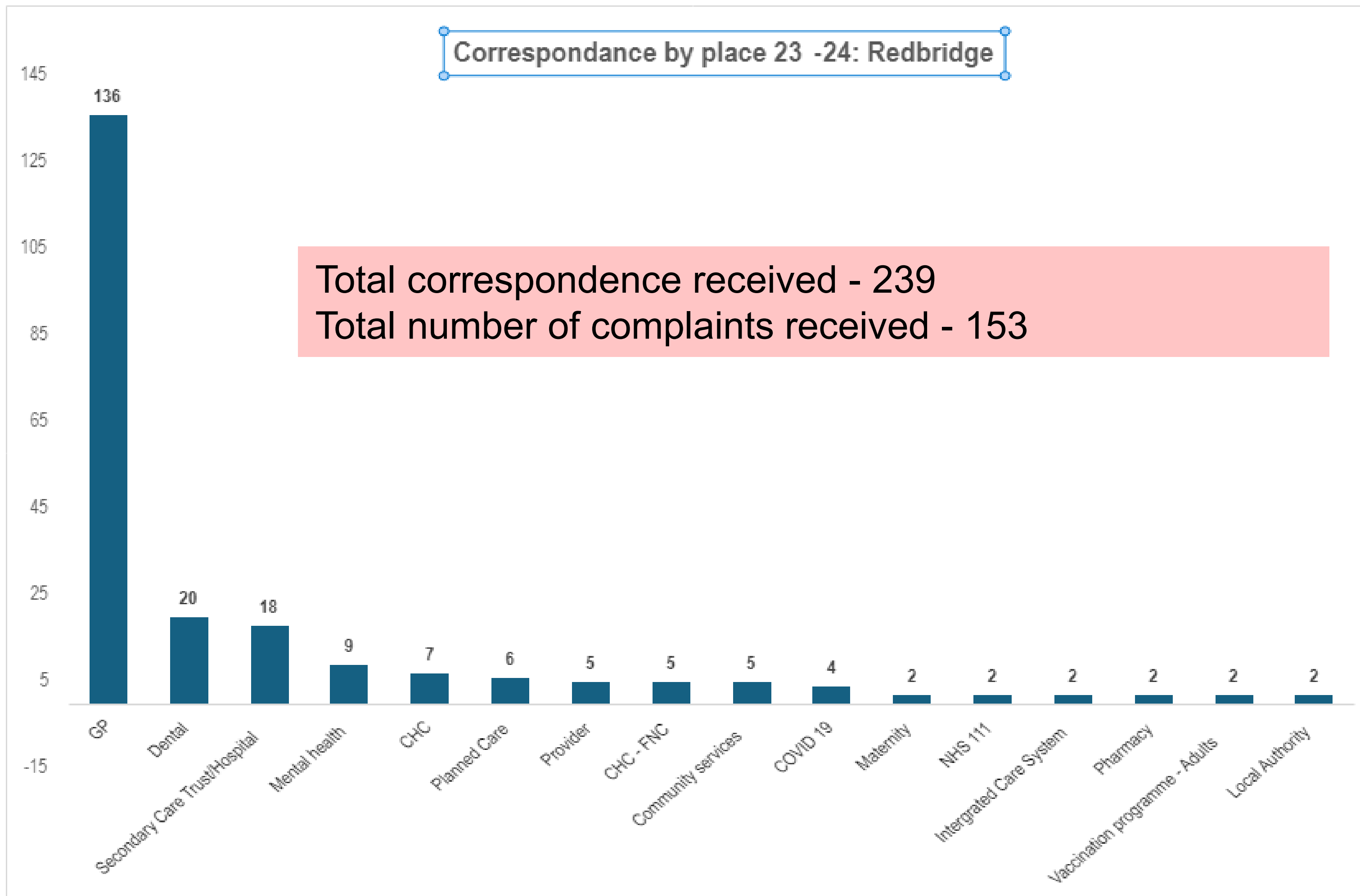


Total number of correspondence received - 221
Total number of complaints received - 159

Complaints for GPs is 5 times greater than for other services. The biggest issues being :

Standard of care	29
Practice/services	21
Appointments	14
Attitude/behaviour/communication	10
Removal from practice	7
Appointment Access	7
Prescription - delay	5
Referrals	4
(blank)	3
Treatment	3
Access to a GP practice	3
Prescriptions -missing items	2
Decisions/Outcome	2
Missing Medical Records	2

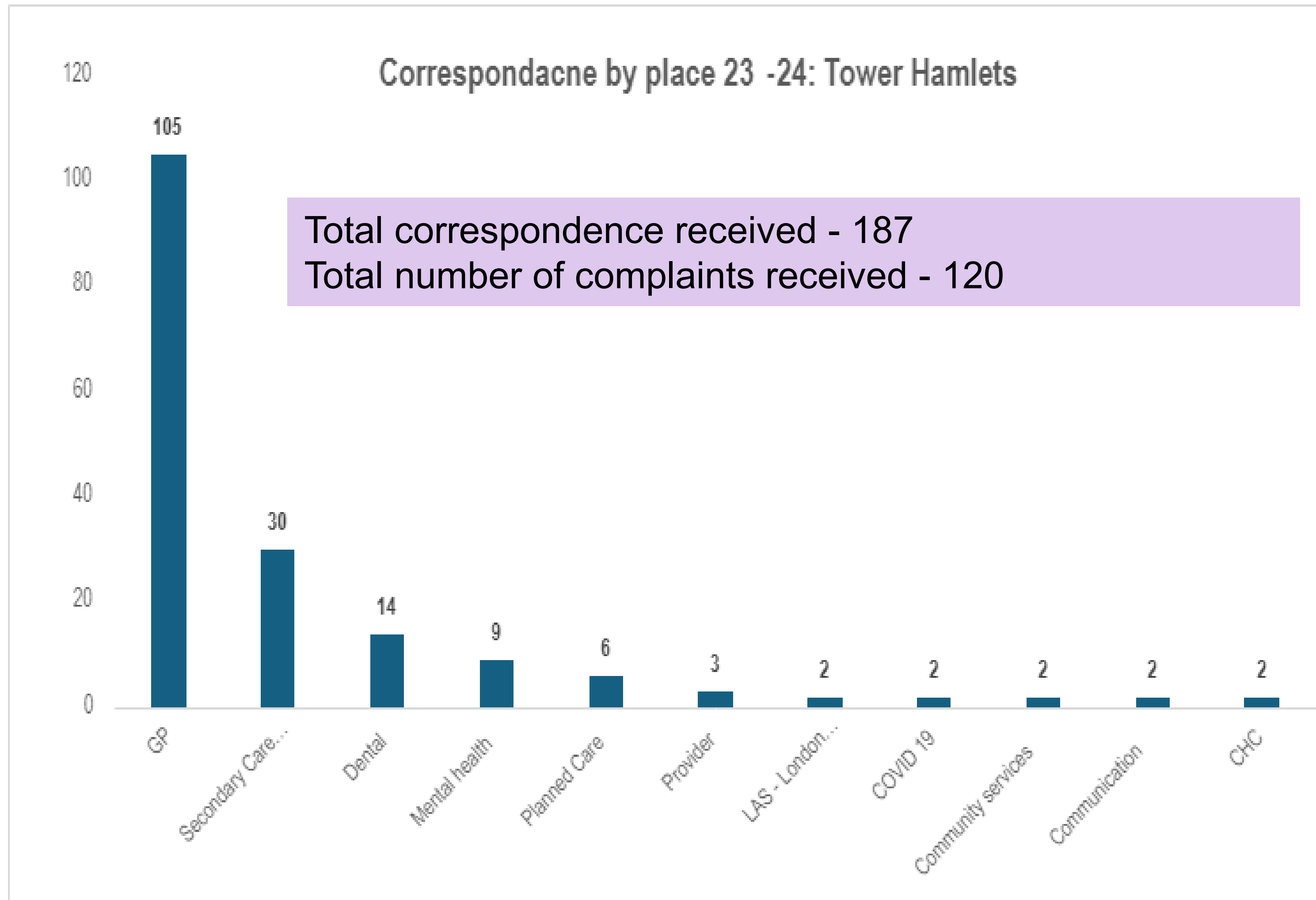
Cases by Place 2023 – 2024 - Redbridge



Complaints for GPs is 7 times greater than for other services. The biggest issues being: -

Standard of care	25
Practice/services	21
Appointments	14
Attitude/behaviour/communication	12
Referrals	8
Delivery of Services	7
Treatment	6
Removal from practice	6
Prescription - delay	6
Appointment access	5
Access to a GP practice	5

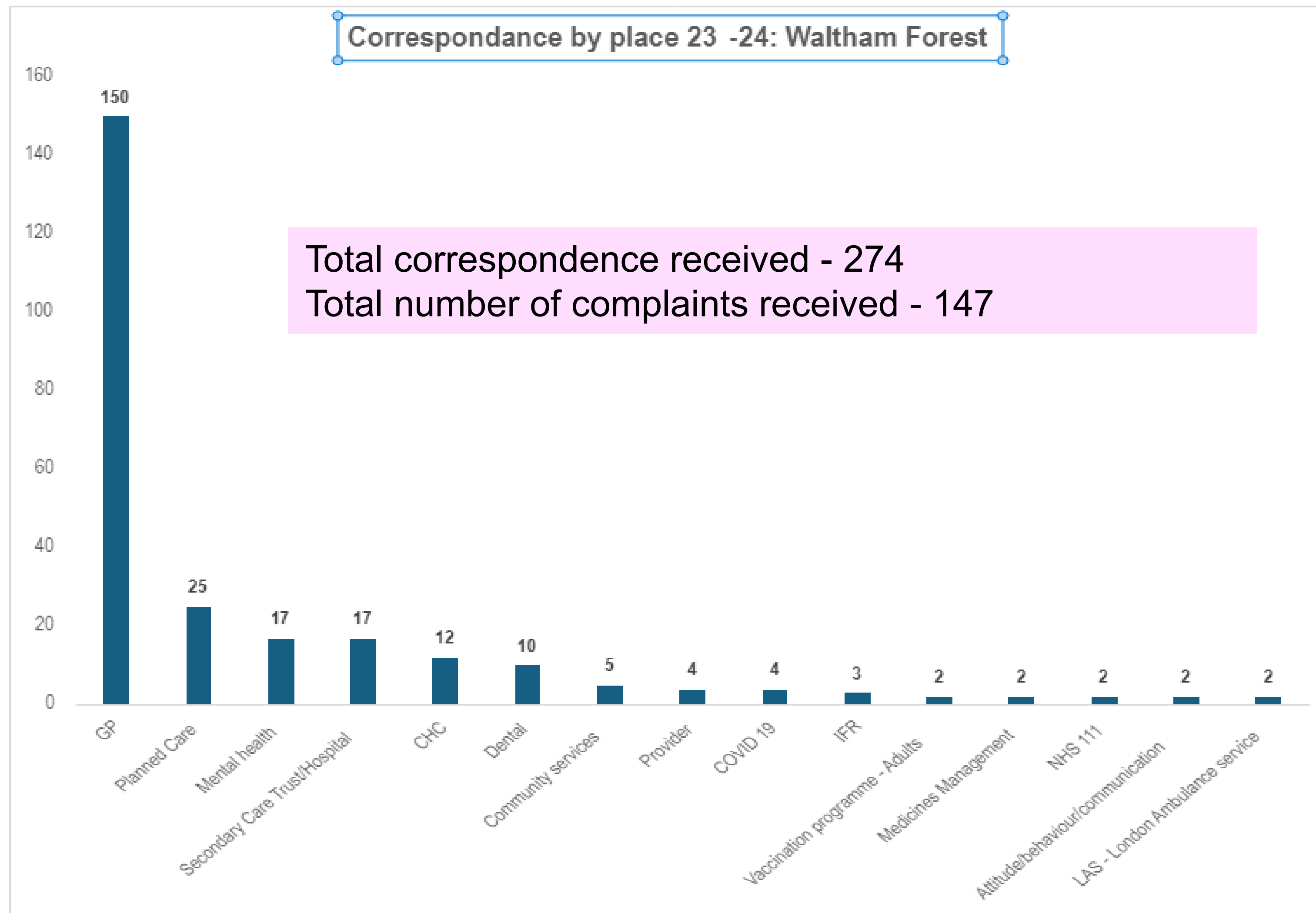
Cases by Place 2023 – 2024 – Tower Hamlets



Complaints for GPs is 6 times greater than for other services. The biggest issues being :

Practice/services	25
Standard of care	15
Appointments	13
Appointment Access	9
Attitude/behaviour/communication	7
Prescription - delay	6
Delivery of Services	5
Removal from practice	4
Decisions/Outcome	3
Referrals	3
Treatment	3
Access to a GP practice	3

Cases by Place 2023 – 2024 – Waltham Forest



Complaints for GPs is 11 times greater than for other services. The biggest issues being:

	Standard of care	22
	Practice/services	14
-	Appointments	13
	Removal from practice	8
	Attitude/behaviour/communication	8
	Appointment Access	6
	Prescription - delay	5
	Access to a GP practice	4
	Delivery of Services	4
	Referrals	3
	Decisions/Outcome	3
	Treatment	3
	Missing Medical Records	3
	N/A	2
	Assessment - Decisions	2
	Patient Safety	1
	Appointment delays	1
	Data protection	1
	Delayed Test results	1
	No Choice	1
	Prescriptions -missing items	1
	Records	1

NHS North East London Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	Resident determined success measures, the Integrated Care Strategy and the development of a single outcomes framework.
Author	Charlotte Pomery, Chief Participation and Place Officer
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	Charlotte.pomery@nhs.net
Executive summary	This paper follows through on the Integrated Care System's (ICS) commitment to ensure local people shape the success measures of the Integrated Care Strategy through the Big Conversation whilst aligning with other strands of resident informed work on outcomes, to position the success measures for the Integrated Care Strategy in a wider context. Under the aegis of the Integrated Care Partnership, all partners have for some time been committed to ensuring that the Big Conversation shapes the success measures for the Integrated Care Strategy – whilst at the same time recognising the range of outcomes and priorities already developed in Collaboratives, in programmes and in Place partnerships with the active engagement of local people including those who draw on services and their carers. This paper acts as an update to the Board on developing success measures for the Integrated Care Strategy and sets out the progress on developing a single outcomes framework which has also arisen from the Big Conversation's on what local people view as success.
Action / recommendation	The Board is asked to agree that: a. The draft success measures and draft indicators will be reflected back to and tested with local people in a number of ways including through the use of online tools, the Citizens' Panel, face to face meetings in Places and potentially a single event for north east London, the logistics of which are being explored. This testing will include consideration of whether the indicators are broad enough to include the whole system and also whether they reflect the reality of, say, the role of digital in population health. b. These draft success measures and draft indicators will also include an opportunity to consider how the indicators are brought to life and delivered in Places and in Collaboratives through active engagement with local people building a rapport based on constructive responses to what people see as most important.

	c. The development of a single outcomes framework, which has arisen from both the Big Conversation and work on population health improvement, continues, working with a range of stakeholders to build understanding and alignment.
Previous reporting	Integrated Care Partnership
Next steps/ onward reporting	Place Partnerships; Collaboratives; Local Communities; Integrated Care Partnership
Conflicts of interest	No conflicts 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 improve value for money and efficiency • To support broader social and economic development
Impact on local people, health inequalities and sustainability	As set out in the paper, focusing on outcomes rather than services or outputs will strengthen our focus on making a difference and responding to what local people feel is most important, as reflected in the Big Conversation discussions. Aligning our system around a single outcomes framework, incorporating our Integrated Care Strategy Success Measures, will contribute to ensuring we have a shared, sustained and positive impact on the health and wellbeing of our local population.
Has an Equalities Impact Assessment been carried out?	No.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report at this stage.
Risks	We need a clear outcomes framework for our work as an integrated care system, to ensure that we focus together on delivering our core purpose and aims as an ICS. There are financial, reputational, delivery and quality risks of failing to cohere around an agreed set of high level outcomes.

1. Introduction

1.1 The ‘Big Conversation’ is the result of the commitment that was made in our ‘w*orking with people and communities’* strategy to work with local people to identify priorities and the criteria against which we will evaluate the impact of our approach and work as a system. This has been followed through to the Integrated Care Partnership’s Interim Integrated Care Strategy, where the Partnership agreed that the success measures would be initiated and shaped by local people through a big conversation approach.

1.2 This paper summarises work on developing success measures through the Big Conversation and identifies how it aligns with other work underway to deliver the

integrated care strategy. It is brought here – following a number of in-depth conversations at the Integrated Care Partnership which has developed the work and thinking thus far – to update the Board and to invite comment, recognising the work already reflects a wide range of perspectives and threads back to what is most important to local people as articulated through the Big Conversation.

1.3 This paper also sets out how the work on the Big Conversation has shaped our thinking on developing a single outcomes framework for north east London and the importance of this reflecting what local people think makes most difference in the improving population health and wellbeing.

1.4 In order to maintain dialogue, we will test the draft success measures and indicators with a range of stakeholders including through Collaboratives and Place Partnerships and directly with local people over the coming months.

2. Background

2.1 North east London is a vibrant, diverse and fast-growing sub-region with a population of over two million, rich diversity and huge inequalities. Our health and care landscape is complex and constantly evolving to meet emerging needs and demand – and we know that local wellbeing is affected not only by the services we commission and deliver but also by our community infrastructure, by poverty and by wider determinants of health such as employment, housing and education. Through our Integrated Care Strategy we aimed to set out our key priorities and to highlight our intended ways of working – and through the Big Conversation we further aimed to understand how we would know we are being successful in addressing those areas which are of most importance to our local population.

2.2 Over the summer and autumn of 2023 we heard from around 2000 local people about what good care looks like and what matters most to them via:

- face to face events in each of our eight areas
- focus groups with under-represented groups in our community run by our local Healthwatch organisations
- online survey
- dedicated engagement with existing community groups tackling inequalities

2.3 The Big Conversation focused on the four priorities for improving quality and outcomes and tackling health inequalities set out in our interim Strategy and on the six cross-cutting themes underpinning our ways of working as an ICS. We have always recognised that the Big Conversation is an approach to an ongoing dialogue rather than a one-off event or series of events. We recognise the significant involvement of local people through Place Partnerships, Collaboratives and individual Trusts and GP Practices. We also recognise that it is not scale of response but rather depth of conversation which has been demonstrated through this particular phase of the process and that continuing to engage broad segments of our population in conversations, at different times and in different places, is part of our ongoing system development. We continue to work to ensure that this is a reality – and are actively following up with community conversations in individual places.

2.4 In analysing the rich conversations and dialogue captured through the Big Conversation, we are aware that the findings can and should be used in a variety of ways. First, the subject of this paper, to inform the success measures for our Integrated

Care Strategy. Second, to inform our emerging commissioning model and to provide service specific feedback at both Place and Collaborative on what matters most to local people and specifically to develop a conversation on how good care – care which is trustworthy, competent, accessible and person-centred – is enabled and delivered. Third, to inform ways of working at Place and Collaborative which ensure that the voice of local people is reflected in all that we do, a voice which not only provides feedback and responses but initiates conversations and focus. Fourth, to build co-production as a model for us going forward not as a one-off but as the way that we build for the future. And fifth, to ensure that our approach to quality improvement, safety and risk is aligned to the priorities for local people – there is a specific opportunity to align our big conversation outcomes with the eight pillars of quality in our quality framework for example. There may be other uses to which the findings can be applied and we will continue to ensure that we iterate and grow the findings as we develop as an integrated care system.

3. Findings

3.1 Analysis of the data from all the conversations enabled the findings to be clustered as set out below, as the basis for developing success measures:

- People like to see trustworthy, accessible, competent and person-centred care from health and care staff
- People like to see agencies/organisations working well together and to know where they can go to get help/answers
- People would like to see more ways to support people's wellbeing - to be physically and mentally well - in their local communities
- People find navigating ways into health and care jobs complicated – people are not sure where to start/being put off
- People like it when access is made straightforward, especially to primary care

3.2 The Integrated Care Partnership has considered, over the course of three meetings, how these statements translate into success measures through which we can track the implementation and impact of the Integrated Care Strategy. In developing the success measures for the Integrated Care Strategy, partners have been keen to ensure that they reflect the richness of the lives of people with health and care needs – not for example thinking solely in terms of the services they access and or need but in terms of what makes a difference to them and how much of a difference we can make to their health and wellbeing.

3.3 There was also agreement that the Big Conversation statements first be triangulated with the work on what matters to local communities which has already been carried out through those settings such as Place Partnerships and Collaboratives. It is 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 – which is now reflected in the ongoing development of a draft ICS wide single outcomes framework and set of detailed indicators that will also support our population health improvement approach. The approach we are adopting is to propose that the success measures for the Integrated Care Strategy also sit in the single outcomes framework as those which ultimately affect the whole population, as determined by local people.

4. Alignment with population health improvement approach

4.1 Informed by The Big Conversation and co-production work with local people, by our existing outcomes at Place, programme, Collaborative and by national work in this area, the development of a single outcomes framework is therefore now underway, We have started to bring all the various (at least ten in north east London) outcomes frameworks into a single list. This includes desired outcomes emerging from:

- The Big Conversation
- Four strategic priority programmes (Enabling Babies, Children, Young People and Families to Thrive, Enabling Improved Mental Health and Wellbeing, Living Well with Long Term Conditions, and Employment and Workforce)
- Places, Collaboratives and Trusts
- Other strategic programmes
- Published outcomes frameworks including outcomes held in local authority led outcomes frameworks

4.4.1 The approach is to identify outcomes and indicator measures which affect the whole population as well as individual segments of our population, thus bringing together the Big Conversation and more targeted work. The aim is not to create a hierarchy but an interconnected framework which enables the system to share work and focus on outcomes and improving overall health. The encouraging news is that all outcomes to date have slotted into this single framework.

5 Draft success measures

5.1 We are making significant progress on identifying how measures of these outcomes and statements could look – having actively taken into account all the outcomes, measures and indicators we are currently aware of in the system. They are in draft, here below, but need further engagement with system partners through Place Partnerships and the Collaboratives and with the public to ensure that they fully capture and reflect what is important to people, effectively enable a set of outcomes with complex drivers and contexts to be measured through clear indicators and also constitute the best set available to us. We recognise there may not always be a perfect match but we need to recognise the process of developing a single outcomes framework will require some flexibility as we strive to achieve consistency and strategic coherence across north east London. The draft success measures and indicators are set out below:

a. We want to receive trustworthy, accessible, competent and person-centred care from health and care staff

- Increase in people experiencing good care: across the dimensions of trustworthy, competent, accessible and person-centred

b. We want to see agencies/organisations working well together and to know where they can go to get help/answers

- People living longer and healthier lives
- Improved health equity amongst all communities in north east London

c. We want more ways to support people's wellbeing - to be physically and mentally well - in their local communities

- Reduction in people reporting that they are socially isolated
- Reduced rates of childhood obesity in each of the Places across north east London
- Reduction in the rate of increase in long term conditions across north east London

d. We want it to be easier to find work within the north east London health and care system

- Reduction in numbers of local people in employment in health and care who experience in work poverty. These are most likely to be disabled people and households with children
- % increase in numbers of people who enter and remain employed (on a paid or voluntary basis) in health and social care locally who also live in north east London

e. We want straight forward access to care, especially to primary care

- People living longer and healthier lives
- Improved health equity amongst all communities in north east London

5.2 There is a recognition that the draft success measures need to be tested back with system partners, including statutory and non-statutory partners and local people and communities, before being agreed as the final set. The Partnership is clear that the indicators are for the whole system, not for NHS partners alone, and so, for example, there is work underway to consider whether any of the detailed indicators could explicitly reference wider determinants such as housing and air quality, for example. Some of this conversation will take place as local partnerships respond to the specific findings from their local populations and as the draft success measures are more widely shared through Place Partnerships. The Big Conversation findings will form part of their approach to engagement, co-production and quality improvement. In each Place the work is being embedded within their framework approaches to co-production to ensure we have the appropriate reach and depth of engagement needed.

6 Conclusion and next steps

6.1 The Big Conversation has always been considered an ongoing dialogue rather than a one off event and therefore a way of continuously underlining the centrality of local people in improving their health and wellbeing. It is positive that the ambition of local system partners for the success measures of the Integrated Care Strategy in north east London to be shaped by local people is being realised and is also leading to work to develop a single outcomes framework, framed by those same success measures. These developments will help to cement further joint and integrated working and mobilise actions around a shared set of outcomes, whilst continuing to embed the voice of local people in the work we do together as a system.

6.2 The Board is asked to agree that:

i. The draft success measures and draft indicators will be reflected back to and tested with local people in a number of ways including through the use of online tools, the Citizens' Panel, face to face meetings in Places and potentially a single event for north east London, the logistics of which are being explored. This testing will include consideration of whether the indicators are broad enough to include the whole system and also whether they reflect the reality of, say, the role of digital in population health.

ii. These draft success measures and draft indicators will also include an opportunity to consider how the indicators are brought to life and delivered in Places and in Collaboratives through active engagement with local people building a rapport based on constructive responses to what people see as most important.

iii. The development of a single outcomes framework which has grown through the Big Conversation and work on population health improvement continues, working with a range of stakeholders to build understanding and alignment.

Charlotte Pomery
May 2024

North East London
Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	The Integrated Care System strategic priorities and progress reporting
Author	Anna Carratt, Deputy Director of Strategic Development
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	a.carratt@nhs.net
Executive summary	This paper outlines a proposed approach to board reporting on implementation of the Integrated Care Partnership (ICP) strategy, focused on the four flagship priorities – babies, children and young people; long term conditions; mental health; and workforce and employment. It is proposed that a yearly schedule is established which provides the board with: • An overview of successes and lessons learnt from the previous year • A summary of agreed plans for the year ahead including Key Performance Indicators (KPIs) as set out in the Joint Forward Plan (JFP) • Regular updates on progress against the plans as well as key KPIs to demonstrate impact • An annual deep dive into the four strategic priority areas It is proposed that other system portfolios and the six cross-cutting themes (as set out in the JFP) report on progress to the ICS Executive Committee, which will provider oversight. The ICB Quality, Safety and Improvement Committee will provide scrutiny and assurance to the ICB Board on the delivery of all system transformation programmes. This process does not cover reporting on outcomes, which will be addressed through the development of a single outcomes framework for our shared work on population health improvement.
Action / recommendation	The ICB board is asked to: • Approve the proposed approach to board reporting on the implementation of the ICP strategy • Comment on the draft progress report and identify any additional information required for future reports
Previous reporting	Executive Management Team. The ICS strategy and JFP have been reported through all our place-based partnerships and provider collaboratives as well as our Clinical Advisory Group, the Executive Committee and the ICP committee.

Next steps/ onward reporting	Commence bi-monthly reporting on the four strategic priorities to the ICB Board.
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 improve value for money and efficiency • To support broader social and economic development
Impact on local people, health inequalities and sustainability	As set out in the paper, this paper outlines a process to enable the ICB board to monitor progress of our strategy implementation. The ICS strategy and our related joint forward plan sets out in detail how we are addressing health inequalities and the way we work with local people.
Has an Equalities Impact Assessment been carried out?	No, each strategic programme will carry those out as needed.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report.
Risks	We need a regular reporting on our strategic priorities to enable the ICB Board to be assured of progress and impact.

1. Introduction

1.1 This paper responds to a request from the Chair to provide regular Board reporting on the implementation of the Integrated Care Partnership (ICP) strategy, focused on the four flagship priorities – babies, children and young people; long term conditions; mental health; and workforce and employment (for further details, please see appendix A).

1.2 It is proposed that a yearly schedule is established which provides the board with:

- An overview of successes and lessons learnt from the previous year
- A summary of agreed plans for the year ahead including Key Performance Indicators (KPIs) as set out in the Joint Forward Plan (JFP)
- Regular updates on progress against the plans as well as key KPIs to demonstrate impact
- An annual deep dive into the four strategic priority areas

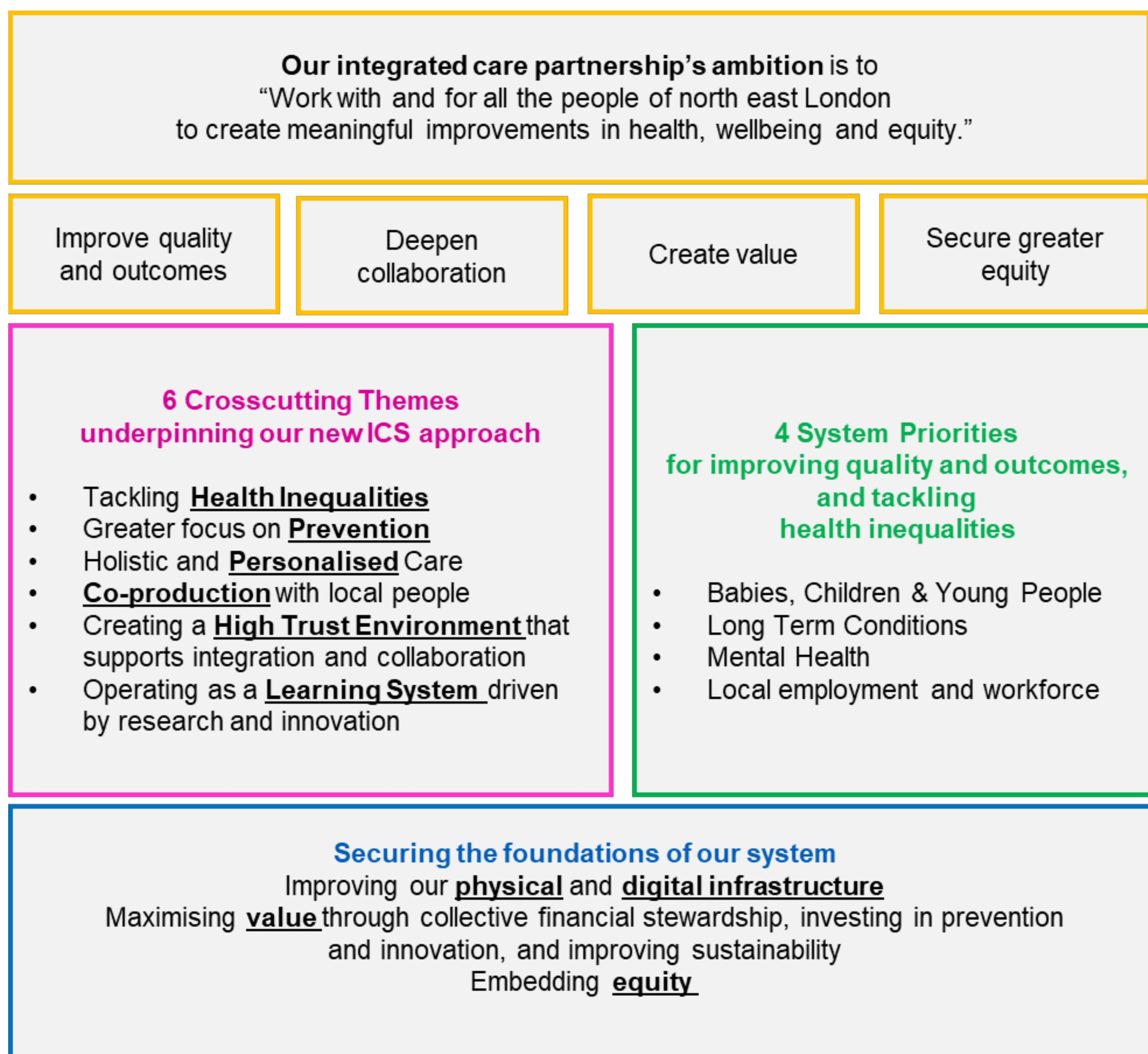
1.3 It is proposed that other system portfolios and the six cross-cutting themes (as set out in the JFP) report on progress to the Integrated Care System (ICS) Executive Committee, which will provide oversight.

1.4 The ICB Quality, Safety and Improvement Committee will provide scrutiny and assurance to the ICB Board on the delivery of all system transformation programmes.

1.5 This process does not cover reporting on outcomes, which will be addressed through the development of a single outcomes framework for our shared work on population health improvement.

2. Context

2.1 In January 2023, the North East London (NEL) Integrated Care Partnership (ICP) published its strategy, setting out a collective ambition for improving health, wellbeing and equity.



2.2 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.

2.3 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

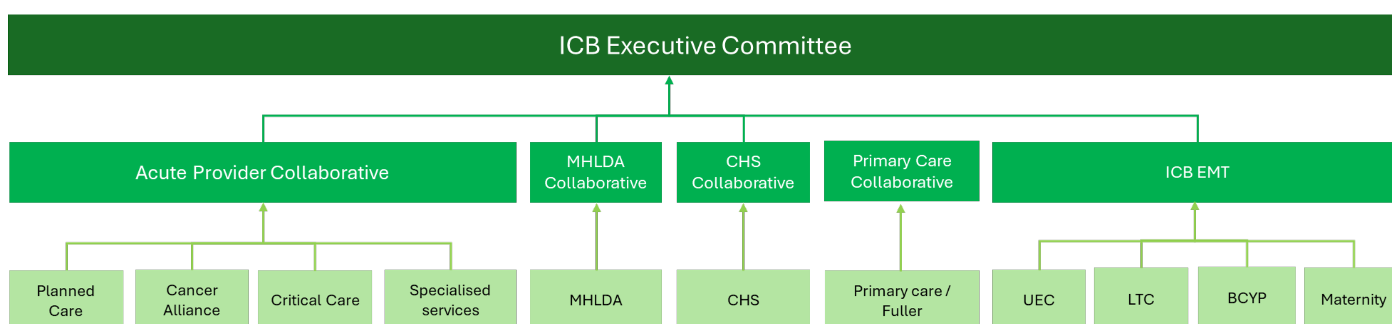
working with partners to consider how all parts of our system can support improvements in quality and outcomes and reduce health inequalities in these areas.

2.4 We know that the current model of health and care provision in NEL needs to adapt and improve to meet the needs of our growing and changing population. In June 2023, the ICB published its first Joint Forward Plan (JFP). This described the substantial portfolio of transformation programmes through which we will deliver the changes we need to make.

2.5 Many of the transformation programmes have been in place for several years but the JFP provided an opportunity to test alignment with the ICP strategy and opportunity for joint working between programmes.

3. Our programmes: scope and governance

3.1 There are currently eleven system transformation portfolios, which vary in scale and scope. Each system transformation portfolio has a nominated Senior Responsible Officer (SRO) and programme director. The governance for some portfolios is hosted by one of the NEL Provider Collaboratives and others are hosted by the ICB:



3.2 There are consistent principles which apply to all system transformation portfolios, regardless of governance;

- We will consider the whole life course, from Babies, Children and Young People (BCYP) to end of life care
- We will consider end to end pathways, from primary prevention to specialised services
- We will work with all Place-based Partnerships and Provider Collaboratives in shaping and delivering our work
- We will adopt a system mindset, seeking to deliver best value for NEL residents

4. Reporting schedule

4.1 This reporting schedule outlines how the four strategic priorities will be monitored and assured by the ICB board including a mid-year assessment on progress of the six cross-cutting themes.

4.2 For future years, it is proposed that the May board focuses on successes from the last financial year, as well as the plans for the new year.

5. Regular board reporting

5.1 It is proposed that regular reporting to the ICB board covers:

5.1.1 Progress reporting on activities:

- progress to date including any successes or new initiatives that have gone live since the last report
- key milestones for the next reporting period
- key issues and risks
- interdependencies with other system portfolios, Place-based Partnership and Provider Collaborative programmes

5.1.2 Impact reporting:

- focusing on three to four KPIs for each flagship priority presented to show delivery against the planned trajectory
- any relevant financial reporting presented to show delivery against the planned trajectory

Reporting template- progress report

[Name of strategic priority]

Portfolio vision: *[from JFP]*	**Reporting date:** *[month year]* **Portfolio board:**
Progress since last report *[Update against previous milestones]*	**Successes or new initiatives that have gone live since last report**
Key milestones for the next reporting period *[SMART milestone for next period]*	**Key issues for the Board to be aware of**
Interdependencies/interfaces to other portfolios (including Places and Collaboratives)	

End: Anna Carratt, 8 May 2024

Appendix A: Overview of the strategic priorities - what we have set out in the Integrated Care Strategy and our Joint Forward Plan (JFP) for 2024/25

North East London

The ICS strategic priorities and progress reporting

ICB board strategic priorities, progress reporting process and template

May 2024

Summary

- This paper outlines a proposed approach to board reporting on implementation of the ICP strategy, focused on the four flagship priorities – babies, children & young people; long term conditions; mental health; and workforce & employment.

- It is proposed that a yearly schedule is established which provides the board with:
  - An overview of successes and lessons learnt from the previous year
  - A summary of agreed plans for the year ahead including KPIs (as set out in the Joint Forward Plan)
  - Regular updates on progress against the plans as well as key KPIs to demonstrate impact
  - An annual deep dive into the four strategic priority areas

- It is proposed that other system portfolios and the six cross-cutting themes (as set out in the JFP) report on progress to the ICS Executive Committee, which will provider oversight.

- The ICB Quality, Safety and Improvement Committee will provide scrutiny and assurance to the ICB Board on the delivery of all system transformation programmes.

- This process does not cover reporting on outcomes, which will be addressed through the development of a single outcomes framework for our shared work on population health improvement.

Recommendations

The ICB board is asked to

- approve the proposed approach to board reporting on the implementation of the ICP strategy
- comment on the draft progress report and identify any additional information required for future reports

Context

In January 2023, the North East London (NEL) Integrated Care Partnership (ICP) published its strategy, setting out a collective ambition 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.

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 know that the current model of health and care provision in NEL needs to adapt and improve to meet the needs of our growing and changing population. In June 2023, the NEL Integrated Care Board (ICB) published its first Joint Forward Plan (JFP). This described the substantial portfolio of transformation programmes through which we will deliver the changes we need to make.

Many of the transformation programmes have been in place for several years but the JFP provided an opportunity to test alignment with the ICP strategy and opportunity for joint working between programmes.

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**

Our programmes: scope and governance

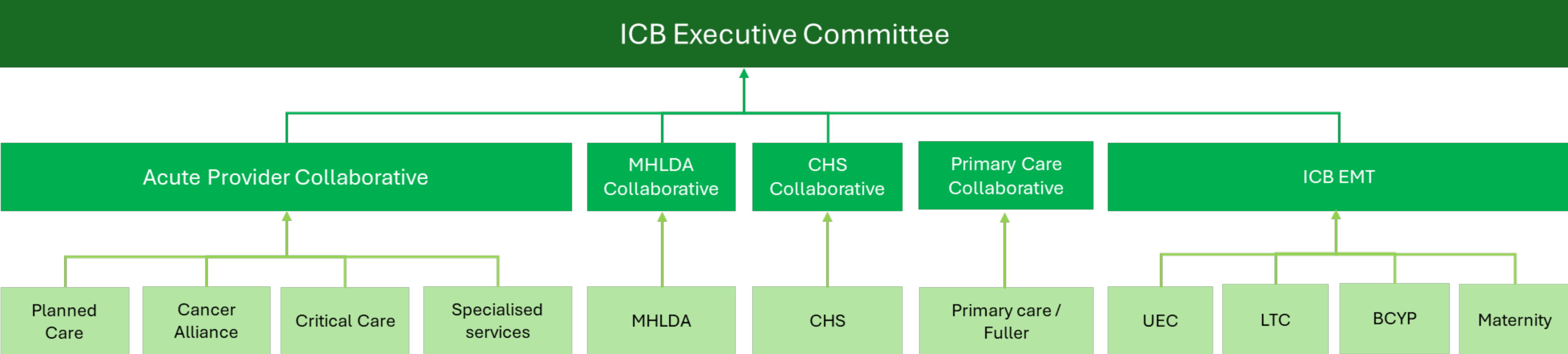
There are currently eleven system transformation portfolios, which vary in scale and scope. These are;

- Babies, children and young people (BCYP)
- Long term conditions (LTC)
- Mental health, learning disabilities and autism (MHLDA)
- Cancer
- Community health services (CHS)
- Maternity
- Critical care
- Planned care
- Primary care
- Specialised services
- Urgent and emergency care (UEC)

Each system transformation portfolio has a nominated Senior Responsible Officer (SRO) and programme director. The governance for some portfolios is hosted by one of the NEL Provider Collaboratives and others are hosted by the ICB.

There are consistent principles which apply to all system transformation portfolios, regardless of governance;

- We will consider the whole life course, from BCYP to end of life care
- We will consider end to end pathways, from primary prevention to specialised services
- We will work with all Place Based Partnerships and Provider Collaboratives in shaping and delivering our work
- We will adopt a system mindset, seeking to deliver best value for NEL residents



Regular board reporting

It is proposed that regular reporting to the ICB board covers

1. Progress reporting on activities:
    - progress to date including any successes or new initiatives that have gone live since the last report
    - key milestones for the next reporting period
    - key issues and risks
    - interdependencies with other system portfolios, Place Based Partnership and Provider Collaborative programmes
2. Impact reporting:
    - focusing on 3-4 KPIs for each flagship priority presented to show delivery against the planned trajectory
    - any relevant financial reporting presented to show delivery against the planned trajectory

Reporting template – progress report

BCYP exemplar

BCYP

Portfolio vision:
To provide the best start in life for the babies, children and young people of North East London.

Reporting date: May 2024 year

Portfolio board: BCYP

Progress since last report

- Finalising metrics for BCYP community-based care outcome measures
- SEND inspection readiness –submitted EOI for partnership for inclusion in neurodiversity (PINS)
- All Place's mobilised pre-paid prescriptions offer to care leavers, consultation with care experienced young people and leaving care coaches on health care compact .
- NEL Asthma nurses strengthening delivery of asthma bundle - 283 GPs able to undertake risk stratification searches, air quality resources developed and rolled out

Successes or new initiatives that have gone live since last report

- Mobilisation of mental health champions in all acute provider trusts
- Recruitment of Epilepsy specialist nurses by NTPN
- Child health and integrated youth health hubs mobilised

Key milestones for the next reporting period

- NEL SEND outcome measures agreed with parent/ carer forum members for inclusion in SEND dashboard
- 40 primary schools across NEL have completed self assessment for PINS project.
- Parent /carer forums across NEL engaged and supporting delivery of project in schools
- SPOT QI leads recruited in each Hospital Trust
- Youth worker pilot and integrated primary care pilot plan developed
- BCYP programme plan and priorities finalised.

Key issues for the Board to be aware of

- Delays in agreeing SDF allocation for BCYP will impact delivery of new and on ongoing pilots.
- Risk of poor Special Educational Needs and Disabilities (SEND) OFSTED rating and increasing capacity gaps around community/SEND health provision.
- Activity in secondary/tertiary care outstripping demand - Acute priority areas - diabetes, allergies respiratory and immunology
- Lack of priority, resources and infrastructure to deliver engagement with children, young people, their families and carers

Interdependencies/interfaces to other portfolios (including Places and Collaboratives)

Acute Provider Collaborative, Community Health Collaborative, Mental Health/LDA Collaborative, Place-Based Partnership Boards, Primary Care Collaborative, Urgent and Emergency Care programme

North East London

Appendix A: Overview of the strategic priorities

What we have set out in the Integrated Care Strategy and our Joint Forward Plan (JFP) for 2024/25

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

Our context and case for change

Babies, children and young people comprise one quarter of our population and the GLA birth rate projections predict a significant annual increase in births in Newham and Barking and Dagenham. The population of babies born in NEL is also hugely diverse. More than one third of the population aged 0-18 is of Asian ethnicity, 14% of black and 6% of mixed ethnic backgrounds.

In all our places except Hackney and Havering we have a higher proportion of babies born with a low birth weight than the England average. Babies born to Black and Asian women in NEL are nearly twice as likely to have a low birth weight than those born to White women. Low birth weight increases the risk of childhood mortality and developmental problems for the child and is associated with poorer health in later life.

In all our places except Havering, we have a higher percentage of children living in poverty than the England average (15.6%). There is a strong link between childhood poverty and poorer health outcomes including premature mortality. There is also evidence to show that children who live in poverty are exposed to a range of risks that can have a serious impact on their mental health.

Assessments indicate that 38,000 pupils in NEL need special educational support. 13,600 of these pupils have Educational, Health and Care Plans which outline the support they receive and these numbers are increasing.

In all places in NEL, overweight and obesity in children is higher than the England average (35%). Barking and Dagenham and Newham respectively have the highest and fifth highest rates in England. Dental decay in 5-year olds is also higher in all our places compared to England.

We saw physical and mental health outcomes deteriorate during the Covid-19 pandemic, particularly for vulnerable children and those with long term conditions within disadvantaged communities. In NEL at least 18,099 children and young people have asthma, 1,370 have epilepsy and 925 have type 1 diabetes.

We are currently seeing substantial pressures on child health urgent care services which is likely to be connected to the recent pandemic and cost of living pressures.

Currently there are 3,343 babies, children and young people in NEL with life limiting conditions requiring palliative and end of life care, and this number is gradually increasing. In years 2018 to 2020, there were around 100 infant deaths per year across NEL.

Key messages we heard through our engagement

Support for young people feels unequal and varies depending on stage of life.

I want to be involved in decisions about my care, and I don't always feel that my needs are understood. The care I receive feels rushed and impersonal and has varied in quality across services and at different stages of my life.

What we need to do differently as a system

Create the conditions for our staff to do their best possible work including creating a safe multi-disciplinary learning environment spanning teams across NEL, provider collaboratives and place-based partnerships with a focus on co-production, quality improvement and trauma-informed care.

Focus on tackling health inequalities by working with our place-based partnerships to increase support for our most vulnerable children and their families particularly those with learning disabilities and autism, young carers, those living in poverty and insecure housing and those from a black and ethnic minority background, developing an enabling programme of work which addresses workforce challenges, supports data capture and benchmarking, and promotes better communication.

Develop clearly defined prevention priorities supporting place-based partnerships to focus on the most deprived 20% of the population and other underserved groups, as well as a focus across NEL on prevention priorities including obesity and oral health.

Develop community-based holistic care, including supporting the development of family hubs building community capacity and strengthening adolescent healthcare. Through social prescribing and multi-disciplinary teams we will enable links to community assets including the community and voluntary sector and put health inequalities at the heart of our work

Improve the experience and support available for children as they transition to adult services ensuring they receive consistent services which are designed with young people to meet their specific needs with an aspiration that young people will transition at a point that suits them and their development, rather than a rigid service threshold.

Prioritise our children and young people's mental health, recognising the importance of support, and timely access to information, advice and care. We will harness the potential of the digital offer and work with children and young people to design and deliver high quality, accessible services in a range of settings.

Improve quality and outcomes for vulnerable babies, children and young people, including those with long term conditions, special educational needs and disabilities. Helping our babies, children and young people with asthma, diabetes and epilepsy, focussing on personalisation of care, and prevention. Supporting our children and families with special educational needs and disabilities through strengthening safeguarding, addressing workforce challenges and supporting data capture. Extending our services for autistic children and young people including the introduction of a new keyworker scheme.

What success will look like for local people

- *I have the same experiences and range of support for my development, health and wellbeing, no matter where I grow up in north east London*
- *I have the opportunity to access healthcare, education and care in ways that suit me and my goals*
- *I receive high quality and timely personalised care at a place of my choice*
- *I am treated with kindness, compassion, respect, information and communication is accessible and understandable*
- *I have opportunities to share my experience and insight, and seen change that I have influenced*
- *I have people who treat and look after me care as I move through the different stages of my life*
- *I am involved in decisions about my care*

What success will look like as outcomes for our population

- Reduce proportion of babies born with low birth weight in our population.
- Identify children living in poverty within our communities and ensure they are receiving the support they need to live a healthy life including equitable access to and outcomes from our health and care services
- Strengthen our focus on prevention, reducing levels of childhood obesity and dental decay, and increasing uptake of childhood immunisation
- Strengthen our support for children living with long term conditions and address health inequalities by reducing the number of asthma attacks, increasing access to prevention and self-management for children and young people with diabetes (particularly those living in poverty or deprivation and those from black and ethnic minority backgrounds), increasing access to specialist epilepsy support for children, including those with learning disabilities and autism and supporting all children better through the transition to adult services
- Improve access to children and young people's mental health services, and support young people better through the transition to adult mental health services
- Reduce the number of young people reporting that they feel lonely and isolated
- Collaborate between education, health and social care to ensure school readiness for all children and to meet the needs of children with special educational needs and disability

Babies, children and young people

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

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

Our context and case for change

31% of local people have a long term condition (which is an illness that cannot be cured) such as diabetes or COPD. Living with a long term condition can impact on many aspects of a person's life, including their family and friends and their work. People with a long term condition are more likely to suffer from further conditions or complications over time, including poor mental health.

Long terms conditions account for half of GP appointments, 70% of inpatient bed days and 70% of the acute care budget. Currently the majority of national spend on long term conditions is in acute or hospital based treatment or care with less spent in the community or in primary care e.g. for diabetes £1bn is spent annually in primary care nationally versus £8bn in acute care.

Long term conditions cannot be cured but when identified early and managed effectively, the impact the condition has on a person and their life can often be alleviated or delayed. Some long term conditions can also be prevented completely through healthier behaviours. In the context of a growing and ageing population in NEL, we must drive a shift towards prevention and earlier intervention and ensure the sustainability of services.

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 per cent higher prevalence of long term conditions than the wealthiest and 30 per cent 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.

Our population has a higher prevalence of type 2 diabetes, and several other conditions including hypertension and chronic kidney disease as well as a higher mortality rate for cardiovascular disease in the under 75s. One in five local people in NEL has respiratory disease. Further, there are likely to be high levels of unmet need – highest in our 'underserved' communities - that are not showing in the data but require proactive identification and better management.

Two-thirds of people with at least one long term condition have more than one mental health problem, including depression and/or anxiety, and there is a growing connection between living with a long term condition, social isolation and low self-esteem.

Key messages we heard through our engagement

Care for people with long term conditions feels uncoordinated and fragmented.

I am not always clear who I can turn to with a problem, where I can access non-medical support in my local community or support with my emotional and psychological wellbeing.

I do not want to be asked to repeat my story to different professionals and I want my transition from service to service to be much better co-ordinated and supported.

What we need to do differently as a system

Better coordination of care, including between mental and physical health and health and social care. Also better transitions between different services, such as between child to adult services, supported by information sharing which we will strive to make a practical reality for staff in their work.

More consistent communication with people living with long term conditions and their carers, including in relation to their end of life care. Ensuring that people are at the heart of every conversation and that we focus on their holistic needs and strengths (not just their care).

Empower and resource local communities and voluntary organisations to assist with case finding and linking people through to appropriate care, to increase available support for prevention and self-management, to support de-medicalising and destigmatising day to day support through social prescribing, and to increase access to emotional and psychological support and widen peer support.

Support health creation within local communities increasing opportunities and support for making healthier choices, including starting health and well-being conversations in early years and working together to reduce the number of people in NEL living with risk factors such as obesity or smoking.

More intelligent identification of those with long term conditions or risk factors using population health management data and tools to support primary prevention which includes enabling earlier and more proactive action particularly among 'underserved' communities where there are high levels of unmet need and greater (proportional) investment in primary care in order to lead to short-term decreases in overall health system costs.

Focusing on improving end to end pathways including improving quality of care and secondary prevention by detecting LTCs as soon as possible to halt or slow progress, encouraging personal strategies, and implementing programmes to improve health outcomes and prevent additional long-term problems.

Support people with long term conditions who may be adversely affected by poverty, particularly with the cost of prescriptions or equipment which our evidence and engagement has shown to be key issues during the cost of living crisis.

Lead by example as organisations that collectively employ a large number of people. Through our priority on workforce and local employment we will identify what more we can do as employers to encourage healthy behaviours and to support colleagues with long term conditions. We will also do more to value and support informal carers in recognition of the significant contribution they make to the health, wellbeing and independence of local people.

What success will look like for local people

- *I receive the support I need to make healthier life choices, increasing my chances of a long and healthy life*
- *If I develop a long term condition, it will be identified early and I will be supported through diagnosis; with my individual needs taken into account*
- *I feel confident to manage my own condition, and there is no decision about me without me*
- *I am able to access timely care and support from the right people in the right place*
- *I feel my quality of life is better because of the care and support I received*
- *I am able to care for my loved one, my contribution is recognised and valued and help is there for me when I need it*

What success will look like as outcomes for our population

- Reduce prevalence of obesity and we will be smokefree by 2030
- Increase earlier diagnosis including reducing the number of people with long term conditions diagnosed in an urgent care setting and increase early diagnosis of cancer
- Increase uptake of vaccines for people with chronic respiratory conditions to prevent more emergency hospital admissions
- Increase hypertension case finding in primary care to minimise the risk of heart attack and stroke within our population
- Increase the proportion of local people who say that they are able to manage their condition well
- Increase the proportion of local people who are able to work and carry out day-to-day activities whilst living with a long term condition
- Narrow the gap in outcomes for vulnerable or underserved groups e.g. people with learning disabilities and people who are homeless
- Improve the mental health and wellbeing of people with long term conditions and their carers

Long Term Conditions

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 prioritisation for 24/25.
Furthermore, we have incorporated feedback at service level such PR and diabetes

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

Our context and case for change

Mental health affects how we think, feel and act, and has a profound impact on our day-to-day lives. It is strongly linked with wider health outcomes and therefore improvements here impact our overall ambition to improve the lives of people living in north east London.

It is estimated that at least a fifth of local people in NEL have a common mental health problem like depression or anxiety, which is higher than the England average. We are also seeing an increasing need for mental health services to support people with severe and enduring mental health problems, with some of the biggest demand pressures in children and young peoples' mental health and eating disorder services. Equally we know that people with serious mental health problems endure worse physical health outcomes.

We have made great progress over the last several years in improving our services, with thousands more residents able to access evidence-based talking therapies, children and young peoples' mental health services (including in schools), specialist mental health care during and after pregnancy, and crisis and community mental health services that are far more integrated with primary care.

Yet, the Covid-19 pandemic and cost of living pressures have brought new challenges and have exacerbated the inequalities that were already present in our population. We must be mindful of the need to support those with long-standing needs who may be hit hardest, while also working proactively and preventatively to mitigate the risks of ever-greater numbers of people developing mental health conditions.

We still have further to go to ensure that people of all ages with mental and physical health conditions, including carers and people with dementia, get support in the areas that matter most to them, as early as possible. However, through honest and open conversations about equity, leadership, and representation with a diverse group of partners, we are beginning to think in a profoundly different way about how we can improve the quality of life of people with mental health needs in NEL.

Key messages we heard through our engagement

What matters to me is having the same experience and range of support regardless of where I live or go to school

What matters to me is challenging stigma about mental health
What matters to me is personal development and growth

What matters to me is using my lived experience to support and help others

What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late

What we need to do differently as a system

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

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

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

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

What success will look like for local people

Our draft success factors, developed with service users and carers, include the following (more detailed statements are being finalised with children and young people and adults):

- What matters to me is having the same experience and range of support regardless of where I live or go to school
- What matters to me is challenging stigma about mental health
- What matters to me is personal development and growth
- What matters to me is using my lived experience to support and help others
- What matters to me is accessing support in different ways that suits me and my goals, not just what is available and not when it is too late.

What success will look like as outcomes for our population

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

Mental Health, Learning Disabilities and Autism

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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

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

Our context and case for change

North east London has almost one hundred thousand staff working in health and care, with over 4,000 in general practice, 46,000 in social care, and around 49,000 within our trusts. Our workforce is the heart of our system and plays a central role in improving population health and care. Equally we have a growing population with a high proportion of working age people - we know that work is good for health and there is an opportunity for us to improve health in our local population and contribute to the local economy by upskilling and employing more local people into health and care roles within our system.

Alongside our paid workforce, our thousands of informal carers play a pivotal role in supporting family and friends in their care, including enabling them to live independently. Analysis undertaken by Healthwatch shows inequalities of experiences for carers who have poor experiences in accessing long term conditions (51%) and mental health services (70%), between 61% and 73% did not feel involved and supported.

Our employed workforce has grown by 1,840 people in the last year. Investment in primary care workforce has seen numbers grow by 3.7% in the last year, as well as a growth in training places for GPs. Retention and growth are a key part of all our workforce plans but we still have a number of challenges to overcome. We have an annual staff turnover rate of 23% and a high number of vacancies which places an additional burden on exiting staff as well as potentially impacting access to services. We have also heard from staff that burnout has been a growing problem, particularly since the COVID-19 pandemic. The interplay of increased workload and stress due to the pandemic is still having an effect. Sickness rates for north east London were higher than the national average of 4%, at 4.9%. Although we have the second lowest sickness rate in London, we know that mental health issues are the second highest reason for sickness, behind musculoskeletal problems.

To achieve our ambitions as an integrated care system we need to ensure that our workforce has access to the right support to develop the skills they need to deliver health and care services today as well as the skills to adapt to new ways of working, and potentially new roles in the future. Our workforce is critical to transforming and delivering the new models of care we will need to meet rising demand from a population that is growing rapidly with ever more complex health and care needs.

Underpinning this we will work to strengthen the behaviours and values that support greater integration, collaboration, and trust across teams, services, organisations and sectors.

Key messages we heard through our engagement

I value flexibility and work life balance over traditional rewards such as pensions

I want career development and career growth opportunities available to me locally

I felt over-worked before the pandemic and now it's really affecting my ability to work

I'm a local person with transferable skills but I don't feel local health and care jobs are accessible to me

I want the informal care I provide valued and supported

What we need to do differently as a system

Work together to employ more local people contributing to the local economy by upskilling and employing local people particularly those who are unemployed or at risk of unemployment which a range of routes into jobs including apprenticeships. Also invest in growing our own workforce from within, creating a consistent pipeline in partnership with our education institutions, and utilising system-wide approaches for all sectors.

Ensure we have efficient, streamlined, and accessible recruitment processes, promoting diversity and ensuring that under-represented groups have the opportunity to be employed in our services.

Work collaboratively to develop one workforce across health and care in NEL. We will work together to develop a deal that all employers will offer that enables career pathways across sectors with a focus on flexible career development and improved access to a consistent wellbeing and training offer shared across providers.

We commit to becoming a Living Wage system adopting the London Living Wage across NEL.

Prioritise retention of our current workforce, and create the opportunities for development across organisations to ensure that we have a stable and high performing workforce in all services. We will develop system approaches to career pathways, leadership and development.

Support the health and wellbeing of our staff, with a consistent offer of support for staff which recognises the challenges brought by the Covid-19 pandemic and current cost of living crisis.

Implement and continue to develop our new ICS clinical and care professional leadership model which will increase diversity and inclusion, and support development of current and future leaders for the system working hand in hand with local people.

Develop, recognise and celebrate our social care and voluntary workforce, prioritising specific retention programmes, ensuring that they have support when needed and feel valued equally for the contribution they make.

Value the contribution of carers and provide more and better support to them so that they are able to provide better support for others as well as improve their own health and wellbeing.

What success will look like for our people

- *Working in health and care in north east London, I feel valued and respected*
- *I have meaningful work and am able to support myself and my family financially*
- *I have access to training and career development opportunities whichever part of the local health and care system I am currently working within*
- *I feel I have local employment and volunteering opportunities across a range of health and care settings, regardless of my background*
- *I am able to care for my loved one, my contribution is recognised and valued, and help is there for me when I need it*

What success will look like as outcomes for our people

- Increase the number of local people working in health and social care, ensuring that our workforce is representative of the community it serves at all levels.
- Increase diversity and range of professional backgrounds reflected in our clinical and care professional leadership at all levels.
- Our carers feel supported, valued and provided with the skills to deliver personalised care to meet the needs of our residents.
- Staff will be able to transfer easily between employers in health and care.
- All staff in all sectors will have access to a consistent health and well-being offer.
- As part of our employment deal, a consistent offer of development, flexibility and mobility that all organisations in north east London sign up to, including recognition of skills across sectors and professions.
- We are increasing the ethnic diversity of board level and senior leadership to reflect the make-up of the population in NEL.

Employment and Workforce

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

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

NHS North East London Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	Financial Overview (Month 12 2023-24)
Author	Ahmet Koray, Interim Director of Finance
Presented by	Henry Black, Chief Finance and Performance Officer
Contact for further information	henryblack@nhs.net
Executive summary	**Key Items** • The unaudited reported position at year-end is an Integrated Care System (ICS) deficit of £48m. Within this the Integrated Care Board (ICB) delivered a surplus of £14.4m and North East London (NEL) providers reported a deficit of £62.4m. • The ICS submitted an updated forecast position to NHS England (NHSE) as part of the H2 (second half of the financial year) submission which expected the ICS to deliver a system deficit of £25m. Month 12 outturn shows a £23m variation to the expected H2 position. • £11.9m of the variance relates to provider industrial action costs over and above the allocation received (as reported in month 11). There was a circa £14.5m worsening position in month 12 with Barts Health, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT)'s positions all deteriorating due to unavoidable additional costs. This was partly offset with Homerton Healthcare improving their position by £3.4m, leaving the system with a net month 12 movement of circa £11.1m. • The ICB Board is asked to note the contents of this report and to note the final year-end outturn.
Action required	The ICB Board is asked to note the contents of the report.
Previous reporting	ICB Finance, Performance and Investment Committee, ICB Audit and Risk Committee, ICS Executive 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, Executive Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest have been identified.

Strategic fit	NEL-wide plans are set on the financial resources available. The report provides an update of the 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.
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 ICB risk rating is 20.

1. Purpose of the Report

The purpose of the report is to update the ICB Board on the month 12 financial position. The financial values reported align to the draft year-end position submitted to the auditors. There may be final changes post audit review.

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

2. Month 12 Finance Overview

The year-end Integrated Care System (ICS) deficit is £48m. This is made up of a provider deficit of £62.4m and an Integrated Care Board (ICB) surplus of £14.4m.

The H2 (second half of the financial year) submission to NHS England (NHSE) moved the system forecast from breakeven to a £25m deficit. At month 12 the ICS year-end position was £23m higher than the expected H2 position.

£11.9m of the variance occurred in month 11 and relates to provider industrial action costs over and above the allocation received.

In month 12, there was a net movement of circa £11.1m movement. This relates to a deterioration in the overall provider position of £14.5m, with Barts Health (Barts) (£1.6m), East London NHS Foundation Trust (ELFT) (£10m) and North East London NHS Foundation Trust (NELFT) (£2.9m) all deteriorating due to unavoidable additional costs. The movement in Barts is as a result of the Same Day Emergency Care (SDEC) service which requires a national funding solution. ELFT has incurred additional costs in relation to increased private bed usage (£0.5m) and also an accelerated depreciation pressure (£9.5m). NELFT's movement is as a result of ongoing pressures relating to private bed usage and prescribing. The system managed to partly offset this with Homerton Healthcare receiving additional income and improving their position by £3.4m. This left the system with a net year-end deterioration of £11.1m.

The ICB delivered the expected H2 surplus of £14.4m. This was achieved by delivering significant levels of non-recurrent mitigations and actions. The underlying position into 24/25 remains a significant deficit position.

2.1.1 ICS Month 12 Position

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

Organisations	Month 12 Outturn		
	Plan £m	Actual £m	Variance £m
BHRUT	(0.2)	(15.8)	(15.6)
Barts Health	(27.8)	(43.9)	(16.1)
East London NHSFT	5.4	(5.8)	(11.2)
Homerton	0.2	0.0	(0.2)
NELFT	7.0	3.0	(4.0)
Total NEL Providers	**(15.3)**	**(62.4)**	**(47.1)**
NEL ICB	15.4	14.4	(1.0)
NEL System Total	**0.0**	**(48.0)**	**(48.0)**

The pressures reported throughout the financial year remained at year-end.

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 incurred pressures in relation to pay awards and as a result of agency usage above the agency cap. Final agency outturn reported by providers was £179.1m (£38.5m above the agency cap).
- **Impact of Industrial action** – funding received was £11.9m lower than the costs incurred.
- **Efficiency and cost improvement plans** – final reported efficiencies were £261.8m against a target of £277.8m. Underperformance of £16.1m was reported. Providers reported improved delivery at year-end and were £0.8m below target. ICB performance was in line with prior reporting periods and showed under performance of £15.3m.
- **Financial Recovery Plan (FRP)** – For the purposes of reporting to NHSE the ICB recategorized efficiencies in line with the system approach to efficiencies. To hit the expected year-end surplus the ICB had a challenging FRP stretch target and delivered non-recurrent, non-cash releasing savings in excess of the planned savings target.

2.1.2 ICB Year-to-date and forecast position

At year-end, the ICB reported a surplus of £14.4m (in line with the H2 plan which was a £1m variance to the original operating plan target).

The key headlines in the ICB financial position are as follows:

i. The ICB delivered circa £110m efficiencies and other FRP savings to deliver the year-end position.
ii. Continuing Healthcare (CHC) and prescribing were both overspent at year-end. The overspend relates to undelivered savings plans, volume growth and price increases.

iii. Mental health and learning disabilities saw continued pressures to year-end in relation to high-cost adult placements, section 117 and female Psychiatric Intensive Care Unit (PICU) placements.
iv. Other programme services delivered a non-recurrent mitigation from the FRP, including balance sheet releases.
v. Corporate costs were overspent at year-end as a result of pay and non-pay variances due to undelivered savings plans as a result of delays to the organisational restructure.

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

	Month 12 Variance £m
Current Variance to Plan	(1.0)
Acute	15.2
Mental Health	(7.3)
Community Health	3.1
Continuing Care	(14.6)
Primary Care - Co Commissioning	(0.3)
Primary Care - DOPs	10.8
Primary Care - Other	(44.1)
Running Costs	0.0
Programme Wide Admin (Programme Corporate)	(22.4)
Other	58.6
Total Variance to Plan	**(1.0)**
Planned Surplus	15.4
(Deficit) / Surplus	**14.4**

3. Summary Month 12 Financial Position

The ICS has reported year-to-date variance to plan of £48m at year-end. This is £23m higher than the expected H2 forecast of £25m and is as a result of pressures relating to the costs of industrial action and movements to the provider position at year-end.

The ICB Board is asked to note the month 12 financial position.

North East London
Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	Performance Report
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 February 2024. For Urgent and Emergency Care (UEC) March 2024 data is available. The detailed description and analysis for each of the domains is included in these slides. • The total waiting list in planned care increased in February 2024 for the third consecutive month, following previous reduction. The number of long waiting patients, more than 78 weeks and more than 65 weeks, decreased in February 2024. • The number of patients waiting more than 62 days for cancer treatment was below trajectory for the month at a North East London (NEL) level. The cancer faster diagnosis standard was achieved for the month at all three NEL acute Trusts. • The number of patients waiting six weeks or more for a diagnostic test decreased in February 2024 at all three NEL acute Trusts. • The March 2024 published position against the 4-hour Emergency Department (ED) standard was improved across all three NEL acute Trusts. Both Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and Homerton Healthcare met trajectory for the month. • The number of GP appointments delivered for the month (March 2024) was above plan. • NEL continues to have good discharge performance in comparison to other London systems. • Virtual ward occupancy in the final month of 2023/24 was 70.3% with 11 classified wards set up. • There was improvement against all mental health metrics in the month, with the exception of Children and Young People (CYP) eating disorder urgent referrals (performance remains positive against trajectory and the national ask) and talking therapies access (performance remains positive against trajectory). There has been significant improvement in

	Severe Mental Illness (SMI) physical health check performance in Q4.
Action / recommendation	The Board is asked to note the report. Further queries may be raised with the 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 the Executive Management Team (EMT), Finance, Performance and Investment Committee (FPIC), Quality, Safety and Improvement Committee (QSIC) and 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.
Has an Equalities Impact Assessment been carried out?	An assessment is not required for this report.
Impact on finance, performance and quality	Industrial action (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 Introduction/ Context/ Background/ 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 with regards to the effective

monitoring of performance, identification of risks to delivery and the mitigating actions put in place.

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

1.3 The Board is asked to note the report and provide feedback on content and presentation.

1.4 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 Formal 2024/25 Operating Plan Guidance was published on 31 March 2024. Updates from the interim guidance included an increase in 4-hour Accident and Emergency (A&E) performance (from 77% to 78%), addition of a new outpatient metric to focus on maximising clock-stops (outpatient firsts and follow-ups with a procedure), as well as clarification across metrics within cancer, diagnostics, mental health, and community workstreams. The final 2024/25 North East London (NEL) submission was made to NHS England (NHSE) in line with the 2 May 2024 deadline:

2.1.1 All three NEL acute Trusts submitted compliant trajectories for delivery of 0 >65ww elective waits by September 2024, however this is with risk and is predicated on no further Industrial Action (IA) (a core national planning assumption) and ongoing movement of activity via the NEL Collaborative Capacity programme.

2.1.2 Diagnostics performance of 95% remains a significant challenge, with activity in some modalities showing a lower forecast outturn in 24/25 compared to 23/24.

2.1.3 All Trusts are forecasting compliant trajectories that meet the national ambition to deliver 78% 4-hour A&E performance (all types) by March 2025.

2.1.4 The combined NEL submitted position for Cancer 28-day faster diagnosis standard (FDS) and the 62-day standard aligns with NHSE requirements by March 2025.

2.1.5 NEL is aiming to have zero over 52 week waits for adults and Babies, Children and Young People (BCYP) on community waiting lists, with the exception of BCYP at East London NHS Foundation Trust (ELFT) by Quarter 4 2024/25.

2.1.6 NEL will work to sustain the 23/24 virtual ward position in 24/25 and improve existing capacity.

2.1.7 Reporting against 24/25 Operating Plan asks and trajectories will commence when April 2024 (M1) data is published in June 2024.

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

2.3 From April 2024 onwards the Referral to Treatment (RTT) Open Pathways Waiting List Minimum Data Set (WLMDS) will be published alongside the national validated RTT data. The WLMDS has been in use since 2021 but has not previously been published. This is not expected to alter the criteria for measuring waits but will provide weekly data.

2.4 The elective care long waiting position (over 78 week and 65 week waits) is reported against revised trajectories developed in response to the November 2023 planning ask. Delivery of the year end (March 2024) >78-week ambition remains a key priority and focus at national and regional level.

2.5 Following feedback from the Finance, Performance and Investment Committee (FPIC) additional context and benchmarking is included in the performance report for outpatient transformation metrics (Advice and Guidance (A&G) and Patient Initiated Follow Up (PIFU)).

2.6 Cancer performance from October 2023 is reported against the three combined national cancer standards below (shadow reporting against the former Cancer Waiting Time Standards also continues):

- 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)

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

2.8 The 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.

2.9 A deep dive on diagnostics is due to be presented to the June meeting of the Finance, Investment and Performance Committee and the July meeting of the ICB Board.

3.0 Performance in February and March 2024

3.1 The total waiting list in planned care increased in February 2024 (+3,031 pathways) for the third consecutive month, following previous reduction from July 2023 and now exceeds the July 2023 position by circa 0.4%, (+800 pathways). The overall increase from July is driven by the admitted waiting list at all three NEL acute Trusts and the non-admitted waiting list at Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and Homerton Healthcare. The total waiting list is approximately 19% above the trajectory level.

3.2 The number of patients waiting more than 78 weeks decreased in February 2024 (-97 pathways), to a total of 378 patients awaiting treatment (329 pathways at Barts Health, 49 pathways at BHRUT). It is however important to note, the number of patients waiting greater than 78 weeks has more than halved since December 2022 (significant progress has been made at Barts Health based on size and scale vs. the rest of London).

3.3 The number of patients waiting greater than 65 weeks decreased in February 2024 (-272 pathways), to a total of 2,392 pathways. An improved position at Barts Health (admitted and non-admitted pathways) in month.>65ww volumes at BHRUT increased and Homerton Healthcare (marginally) in-month. Overall, the volume of pathways >65ww in NEL has reduced by circa -4% (-97 pathways) in the last six months (in the context of IA), driven by reduction at Barts Health. Homerton Healthcare and BHRUT continue to provide collaborative capacity to Barts Health to support the long waiting position.

3.4 The number of patients waiting more than 62 days for cancer treatment increased in February 2024 (+29 Pathways), but below aggregate NEL-level trajectory for the month. Performance against the 62-day combined standard for the month was 65.73% against the 85% standard, 28 Day FDS was 77.76% against the 75% standard and 31 day combined standard was 96.45% against the 96% standard.

3.5 NEL delivered diagnostic activity levels above trajectory in all seven modalities in February 2024. The number of patients waiting six weeks or more for a diagnostic test decreased in February 2024 at all three NEL acute Trusts. Diagnostic performance for the month was 82.76%, against the 95% ask for March 2025. Diagnostics Waiting Times and Activity (DM01) performance was achieved against trajectory in February 2024 in Non-Obstetric Ultrasound Scan (NOUS) and Echocardiogram at NEL-level. Echocardiogram was also the only modality to achieve >95% (March 2025 ambition).

3.6 The published position against the 4-hour Emergency Department (ED) standard, was 75.86% in March 2024, with improvement across all three NEL acute Trusts. Both BHRUT and Homerton met trajectory for the month.

3.7 In February 2024, the number of appointments delivered in General Practice was circa 33,140 appointments above trajectory for the month.

3.8 NEL continues to have good discharge performance in comparison to other London systems.

3.9 Virtual ward occupancy in the final month of 2023/24 was 70.3% with 11 classified wards set up.

3.10 The NEL mental health position compared with other London systems is mostly positive. For services such as community access, Severe Mental Illness (SMI) physical health checks, perinatal and talking therapies access, NEL is the highest in London. There has also been significant improvement in SMI physical health check performance in Q4. Dementia diagnosis however continues to be the most challenged in London with performance of 60.38% in February 2024.

4.0 Risks and mitigations

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

5.0 Conclusion / Recommendations

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 ICB Performance Team

6.0 Attachments

6.1 Attached is the standard set of PowerPoint slides covering 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 – February 2024

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published February-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	✗	181,054	214,946	▲	
	Waiting List >104 Weeks (volume)			12	▲	
	Waiting List >78 Weeks (volume)	✗	75	378	▼	
	Waiting List >65 Weeks (volume)	✗	2,243	2,392	▼	
	Inpatient Elective Activity (% 19/20 BAU)	✓	95.62%	101.71%	▲	
	Consultant Led Outpatient Attendances (% 19/20 BAU)		97.99%	102.28%	▼	
	Consultant Led First Outpatient Attendances (% 19/20 BAU)		102.93%	101.13%	▼	
	Consultant Led Follow Up Outpatient Attendances without procedure (% 19/20 BAU)		104.65%	97.10%	▼	

KEY

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

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

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 Feb-24 for the 3rd month (following an overall downward trend from Jul-23) to 214,946 pathways the highest volume YTD, exceeding the previous peak position in Jul-23 by circa, 0.4%, + 800 pathways. The overall increase from July is driven by the admitted waiting list at all three NEL Trusts. In month between Jan and Feb the waiting list has increased by circa 3,000 pathways, driven by the non-admitted waiting list at NEL level (increase at all three Trusts), the admitted waiting list remained static in month (driven by small reduction at BHRUT and Homerton, offset by an increase at Barts Health) .
- There were 12 pathways >104ww (8 pathways awaiting inpatient treatment and 4 pathways awaiting outpatients) reported in Feb-24 (+7 pathways compared to Jan-24, which was the lowest position YTD). 10 pathways >104ww were at Barts Health and 2 pathways >104ww were at BHRUT (1x pathway treated in March and 1x pathway remains to be treated due to complexity).
- The total number of patients waiting 18 months or more (>78 weeks) decreased in Feb-24 (-97 pathways) to a total of 378 pathways, 329 pathways at Barts Health and 49 pathways at BHRUT. While the volume of pathways >78ww has grown overall in 23/24 YTD (+83 pathways), there are circa 580 fewer patients waiting >78ww than there was in Dec-22.
- There were 2,392 pathways >65ww in NEL in Feb-24 (-272 pathways from Jan-24), an improved position at Barts Health (admitted and non-admitted pathways) in month. >65ww volumes at BHRUT increased and Homerton (marginally) in month. Homerton and BHRUT continue to provide collaborative capacity to Barts Health to support the long waiting position.
- Consultant led activity in Feb-24 was 102% of 2019/20 levels (all outpatient appointments consultant and non-consultant led were 111%). Consultant led follow up appointments without a procedure were 97% of 2019/20 levels (Barts Health 100%; BHRUT 98% and Homerton 84%).
- Total inpatient admitted activity undertaken at the three NEL Trusts in Feb-24 was 102% of 2019/20 levels (104% day-case admissions and 89% ordinary admissions).

Workstream Issues and Risks

- Overall waiting list size – now showing growth following previous reduction.
- The number of patients continuing to wait >104 weeks (Barts Health) and >78 weeks (at Barts Health, BHRUT and ISPs).
- Volume of patients currently waiting >65ww (at 14/04 2,012 pathways).
- Volume of pathways in the >65ww 'risk' cohort and run rate required to deliver 0 >65ww by Sep-24 in line with the 24/25 planning ask (this equates to pathways waiting 41 weeks in mid-April, which in NEL is circa 23,600 pathways).
- Impact of further IA on the long waiting position and delivery of 24/25 ambitions / planning asks, as well as to overarching programme momentum.
- Impact of the requirement to deliver financial balance on delivery of elective activity, diagnostic capacity, waiting list initiatives / long waits and pathway transformation.
- 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 and resource, ongoing delivery of elective priorities and potential further IA. National decision making regarding the 2nd PIDMAS cohort remains awaited.
- Delivery of 24/25 Operating Plan asks and trajectories (National Guidance released in late March including long waits, activity and outpatient first and procedures), predicated on no further IA (a core national planning assumption), ongoing movement of activity via the NEL Collaborative Capacity programme, and maximisation of NEL TIF (Targeted Investment Fund) theatres as system assets - final Operating Plan submission due 2nd May

Mitigating Actions and Next Steps

- Weekly Tier 1 national arrangements with Barts Health. Daily >78ww calls with Barts sites continue, supported by the ICB performance team, to ensure progression and tracking of actions to support delivery of the >78ww plan to end March and into the new financial year.
- Homerton and BHRUT (from mid-Oct) continue to provide collaborative capacity to Barts Health. Use of London capacity also continues to support procedures with specific challenges (e.g. Barts Health Oral Surgery, TMJ procedures).
- Continued close working between Trusts and the ICB to mitigate and manage risks associated with delivery of financial balance vs. delivery of elective priorities.
- NEL wide D&Q, PTL management and validation peer review process continues – focus on NEL wide access principles and application of RTT rules. Awaiting release of the National Access Policy expected in early 24/25.
- Ongoing Trust and site theatre productivity and utilisation programmes, overseen via the NEL Surgical Optimisation Group.
- Ongoing engagement with and feedback to the national 'PIDMAS' programme, to help shape and inform national decision making.
- Barts Health continue work to lift circa 130 referral restrictions, supported by ongoing development and DQ improvement of referral data sets and the NEL referral tool to monitor impact.
- Deep dives underway in referral demand and gynae (due to size and scale of the gynae waiting list from a health inequalities perspective and to support/inform the NEL Women's Health strategy).
- Detailed analysis at speciality level to support the development of the NEL TIF theatre proposal.
- Dynamic >65ww demand and capacity modelling to determine risk specialties and additional actions for delivery of 0 waits in Sep-24
- 24/25 Collaborative capacity agreed in a number of specialties equating to movement of 150 patients per week across NEL. Discussions re Collaborative capacity in additional specialities including Dermatology, Rheumatology, Gastro, ENT, Respiratory and vascular.

Outpatient Transformation – February 2024

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published February-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	A&G/Specialist Advice (volume)	✓	21,881	32,168	▲	
	A&G/Specialist Advice (% OPFA)			39.68%	▲	
	A&G/Specialist Advice diversion rate (volume diverted)	✓	5,134	6,330	▲	
	Specialist Advice Diversion rate (%)		23.46%	19.68%	▲	
	Moved or Discharged to PIFU (volume)	✓	3,251	4,442	▼	
	Moved or Discharged to PIFU (% OPA)	✓	1.48%	1.91%	▼	

KEY

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

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

Key Headlines

- In Feb-24, 32,168 specialist advice requests were raised by NEL GPs (above planned levels), equating to 39.7% of all first outpatient attendances and 19.7% diversion rate (requests returned with advice and no onward booking). This continues to compares favourably to London performance of 31.6% of all first outpatient appointments and 18.3% diversion rate in Feb-24. NEL is ranked 8th out of 42 ICBs nationally based on the volume of requests and the volume of diverted requests in February.
- In Feb-24, 4,442 patients were moved or discharged to PIFU, equating to 1.9% of all outpatient attendances (Barts Health 1.2%; BHRUT 1.7%; Homerton 5.7%). While PIFU remains more challenged, NEL is not a regional outlier. Across London, 1.8% of outpatient appointments were moved or discharged to PIFU in Feb-24, with only NWL achieving a higher rate at 2.6%.

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment (starting to show some growth but remains circa -1% down on YTD peak in Jul-23)
- Difficulty in delivering meaningful and sustained reduction in outpatient follow-up appointments, including ability to measure impact of initiatives due to number of variables and complex nature of and interplay with the waiting list., as well as the risk of perverse / unintended outcomes (across RTT and non-RTT pathways)
- System functionality and interoperability to support and expedite key initiatives and interventions e.g. PIFU
- Resource implications and job planning to support and expedite key initiatives and interventions e.g. GIRFT and A&G/R
- Elective Recovery Fund (ERF), incentivisation and funding structure for 23/24 (follow-up activity above 75% of 19/20 levels is not be funded in 23/24 and no national incentivisation for A&G/R)
- Impact of the requirement to deliver financial balance on delivery of elective activity, diagnostic capacity, waiting list initiatives / long waits and outpatient transformation - 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
- Impact of further IA on the long waiting position and delivery of 24/25 ambitions / planning asks, as well as to 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.
- Delivery of 24/25 Operating Plan asks and trajectories (National Guidance released in late March including long waits, activity and outpatient procedures), predicated on no further IA (a core national planning assumption) and ongoing movement of outpatient activity via the NEL Collaborative Capacity programme – final Operating Plan submission due 2nd May

Mitigating Actions and Next Steps

- Continued review, development and use of the NEL outpatient transformation programme and governance to ensure ongoing alignment, sharing of best practice and collaboration.
- Use of the NEL 'sharing best practice group' to share learning.
- Proposal to strengthen Barts Health outpatient transformation governance currently going through internal governance processes.
- 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.
- External review of A&G/R impact and outcomes (quantitative and qualitative) incl. Primary and Secondary Care being scoped and commissioned.
- Continued participation in national GIRFT and 'Further Faster' programmes.
- Continued progress in work streams for MSK, Women's Health (gynae), ENT, Ophthalmology and Dermatology to develop alternate pathways and maximise community capacity incl., Dermatology work programme agreed and split into 2 phases to run concurrently; MSK priorities identified - next steps to agree timelines and pilots; Ophthalmology MECS specification review likely to result in re-procurement incl. SPA for Optoms; single NEL wide ENT CHS SPA due to go live in Jun-23; BHRUT Women's Health Hub in development informed by THH model.
- Extension of BHRUT T&O/MSK referral tool pilot (Rego) for further 1-year – T&F established to work with Primary Care and complete full evaluation
- 24/25 Trust Outpatient Transformation priorities presented to the NEL Outpatient Steering Group in March – agreed and aligned. Key priorities incl. DNAs (NEL DNA masterclass held in April) and PIFU

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 – February 2024

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 February-2024									
		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)	✗	91.13%	87.16%	▲		✓	107.09%	122.55%	▲	
	Computed Tomography (CT)	✗	96.40%	84.74%	▲		✓	124.00%	139.12%	▼	
	Non-obstetric Ultrasound (NOUS)	✓	85.52%	85.90%	▲		✓	113.02%	116.28%	▲	
	Colonoscopy	✗	99.88%	87.88%	▲		✓	103.94%	116.39%	▲	
	Flexi Sigmoidoscopy	✗	99.62%	64.61%	▼		✓	60.44%	77.08%	▲	
	Gastroscopy	✗	99.28%	72.89%	▲		✓	109.08%	133.12%	▲	
	Echocardiography	✓	96.67%	97.37%	▲		✓	104.73%	122.13%	▲	

Diagnostics – February 2024

SRO:	Claire Hogg	RAG	AMBER

Key Headlines

- The overall NEL diagnostics waiting list increased in Feb-24 to 58,467 (+996 Pathways compared to the previous month) driven by increases across all three NEL Acute Providers.
- The number of pathways waiting >6weeks (backlog) for a diagnostic test saw a reduction in Feb-24 to 10,081 pathways (-2,672 pathways compared to Jan-24), driven by decreases across all three NEL Providers.
- NEL Diagnostic performance for the month was 82.76%, up from the Jan-24 NEL position. BHRUT (96.38%), Barts (76.48%) and Homerton (89.95%) and the national requirement is for delivery of 95% by Mar-25.
- NEL delivered activity levels above trajectory in MRI (all three NEL Trusts), CT (all three NEL Trusts), NOUS (Barts Health), Colonoscopy (BHRUT and Homerton), Flexi-Sig (BHRUT and Homerton), Gastroscopy (all three NEL Trusts) and Echo (Barts and Homerton) in Feb-24.
- Industrial Action (IA) impacted the diagnostic waiting list and backlog position across NEL and other London ICB's.

Workstream Issues and Risks

- The volume of patients on the overall NEL Diagnostics Waiting List and those waiting >6 Weeks (backlog) for a diagnostics test
- The residual Paeds Audiology backlog at Barts Health needing to be cleared by Communitas anticipated at the end of Q2 2024/25
- The impact of any further Industrial Action (IA) on waiting list, backlog position, activity and delivery of the overarching diagnostics programme.
- 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 remains challenged but in the main attributed to Barts Health and a recovery action plan has been devised.
- NHSE requested quantum of surveillance patients to be added to DM01 and for a validation exercise and clinical harm review to be conducted across NEL Providers. Material impact on DM01 and RTT performance anticipated.
- 2024/25 planning round challenges given ongoing IA, receipt of interim draft planning assumptions alongside tight national deadlines for Operating Plan submission
- Delivery of 2024/25 Op Plan trajectories will be difficult given the NEL System's financial position

Mitigating Actions and Next Steps

- 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.
- Cemented funding for the CDCs and acquisition of a new MRI scanner
- 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.
- Improvement plans, additional capacity and activity are planned across Acute and Community sites to address this backlog during 2024/25.
- NEL also remains committed to the delivery of no more than 5% of patients waiting greater than 6 weeks by 2024/25.
- Restoration of diagnostic activity across NEL remains on track with the imaging modalities delivering above the 2023/24 Operational Plan where all Trusts are required to recover activity to 120% of the 2019/20 level of activity.
- 2024/25 Demand and Capacity planning looking at workforce and equipment is undeway
- 2024/25 Operating Planning underway via the APC task & finish group based on interim draft planning assumptions and template
- Secured around £31m of revenue to fund our CDCs in 2024/25 which will be positive news for our patients and residents of NEL.
- Barts Health recovery action plan (RAP) remains in place for the imaging modalities (MRI, Cardiac CT, NOUS) as well as Audiology
- Barts Health's Paeds Audiology backlog clearance with Communitas commenced mid-feb-24 and aim to clear the backlog within six months with oversight from NEL ICB Performance colleagues.
- Reinvigoration of the NEL Diagnostics programme to ensure issues are being mitigated locally and jointly ongoing alignment, sharing of best practice and collaboration.
- Monthly discussions continue at the Diagnostics Programme Board and Networks with escalations to Planned Care Board, as necessary.

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 – February 2024

SRO:	Femi Odewale	RAG	AMBER

Cancer	Metric	Latest Published February-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	Waiting List >62 Days (volume)	✓	505	503	▲ (red)	
	Faster Diagnosis Standard (%)	✗	78.16%	77.76%	▲ (green)	

KEY

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✓ ON × OFF track vs. trajectory.

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

Key Headlines

- **Faster Diagnosis Standards:** NEL closely approached the National 28-day faster diagnosis standard with a commendable 77.76% in February 2024, reflecting a slight deviation from the target of 78.16%.
- **31-Day Performance:** Successfully met the 31-day standard with a 96.45% achievement rate, surpassing the 96% benchmark. All providers demonstrated compliance, with Barts and BHRUT at 96.38%, and Homerton leading with 97.78%.
- **62-Day Standard:** The 62-day standard performance was 65.73%, indicating an area for ongoing improvement towards the 85% target. Efforts are being intensified across NEL to address the shortfall in performance.
- **Shadow Reporting:** NEL excelled in shadow reporting, achieving 94.23% against the 2-week wait standard, significantly outperforming the London average and setting a benchmark Pan London.
- **Patient Backlog:** The number of patients waiting over 62 days was marginally below the target, with a reduction to 472 pathways by mid-April, marking a notable improvement and the lowest backlog amongst the London ICBs.
- **Diagnostic Challenges:** While histopathology turnaround times presents a challenge, proactive measures are being implemented across the three NEL acute providers to enhance performance.
- **Operational Improvement:** Barts Health's exit from the Tier 2 support process in December 2023 is a testament to the substantial progress made.

Workstream Issues and Risks

- **Industrial Action:** The potential for industrial action remains an unpredictable risk, affecting the timely delivery of cancer treatments.
- **Diagnostic Delays:** Challenges with histopathology and imaging, particularly CT PET scans, are causing treatment delays across various tumour sites including lung, gynaecology, head and neck, and gastroenterology.
- **Performance and Funding:** Barts Health continues to address performance issues, utilising a £430K funding from NHS England primarily for additional sessions to reduce the 62-day treatment backlog.
- **Collaborative Solutions:** Workforce challenges at the RDC Clinic have been resolved through effective collaboration between the Trust and the Cancer Alliance, with all vacant positions now filled following a quality review.
- **Backlog Management:** Barts Health has exited the Tiering stratification, reflecting a reduced backlog. The focus remains on maintaining this position and achieving the 'DriveTo5' goal to further decrease the 62-day Patient Treatment List (PTL) backlog to 5%.
- **Ongoing Efforts:** The Providers and the Network are actively engaged in weekly efforts to mitigate the aforementioned risks.

Mitigating Actions and Next Steps

- **Collaborative Pathway Enhancement:** The NEL Cancer Alliance is proactively working with providers to refine best practice timed pathways, focusing on key areas such as urology, head and neck, lower gastrointestinal, and dermatology.
- **Operational Oversight:** NEL Operational Managers are ensuring the implementation of these pathways, particularly aiding providers below the England Faster Diagnosis standard.
- **Strategic Support:** A senior programme manager, funded by the Alliance, is aiding trusts in resolving backlog issues and has introduced an operational training package for MDT Coordinators.
- **Demand Management:** The launch of CDCs in NEL is anticipated to streamline demand, relieve pressure on acute trusts, and significantly decrease Radiology delays.
- **Innovative Pathways:** BHRUT is implementing a new Oral Lesion pathway using medical photography to hasten patient discharge, aiming for a 30% early-stage discharge rate.
- **Transformation Programmes:** The Alliance is initiating transformation programmes and AI-driven initiatives to enhance Histopathology delivery, reduce delays, and expand capacity.
- **Performance Goals:** The first draft of the 2024/25 Operating Plans for Cancer aims to elevate performance against the 28-day Faster Diagnosis Standard to 77% by March 2025, with a long-term goal of 80% by March 2026, and to achieve a 70% compliance with the 62-day standard by March 2025.

Governance

- **Strategic Meetings:** The NEL ICB Cancer Alliance and Performance team conduct in-depth reviews and fortnightly meetings with NEL Acute Providers to discuss recovery action plans, with a focus on areas requiring attention.
- **Cancer Escalation Management:** Escalations within the cancer services are managed by the NEL Cancer Board, under the governance of the APC Board, which in turn reports to the ICB.
- **Performance Reviews:** The NEL Performance team holds regular discussions with Acute Providers to monitor performance against constitutional standards and progress in line with the Operational Plan Trajectories.

Urgent and Emergency Care – March 2024

SRO:	Paul Gilluley	RAG	AMBER

	Metric	Latest Published March-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Ambulance Handovers ≥ 60 Min (volume)	✗	National Req. ZERO	172	▲	
	12-hour Trolley waits (volume)	✗	National Req. ZERO	2,224	▲	
	Total A&E Attendances (volume)	✗	86,076	86,093	▲	
	A&E 4-Hour Performance All Type (%)	✗	77.05%	75.86%	▲	
	A&E 4-Hour Performance Type 1 (%)	✗	67.05%	62.09%	▲	
	Total A&E Admissions (volume)	N/A	N/A	14,901	▲	
	Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	✓	10.84%	10.56%	▲	

KEY

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

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▼/▲ deterioration ▼/▲ improvement

Key Headlines

- In Mar-24, 75.86% of all type patients were seen within 4-hours of arrival at ED against the national ask of all systems to meet 76% in March. NEL performance improved significantly from 70.54% in February as a result of focus and actions across all acute providers on improving A&E performance. Performance improved throughout Mar-24 against a background of slightly more A&E attendances than expected (86,093 against a trajectory of 86,076). At Trust level compared to the previous month, A&E performance improved across all NEL acute trusts: 8.27% at Barts Health, 1.33% at Homerton and 2.49% at BHRUT. Homerton and BHRUT met their trajectory in March 2024.
- Our ambulance data across the system shows that 98.12% of ambulance handovers in NEL took place within 60 minutes (Barts Health 97.35%, BHRUT 98.50%, Homerton 99.92%), however there were 172 ambulance arrivals at NEL EDs which waited over 1-hour to be transferred from LAS care in Mar-24. Similar to previous months, LAS reported category 2 response time in February-24 as an average of 39 minutes against the 27 minutes plan (March data is not yet available at the time of reporting).
- The number of adult G&A beds occupied with patients who no longer meet the criteria to reside remains at a similar level to previous months (10.56% in Mar-24 compared to 10.47% in Feb-24) and in line with the planned March-24 trajectory.
- The system saw a significant increase in patients waiting over 12 hours from decision to admit to admission with 2,224 in Mar-24 (from 1,301 in Feb-24), which is 2.6% of total A&E attendances. This was raised at the NEL UEC Board as a key area of focus for acute providers to ensure patient safety across all sites.

Workstream Issues and Risks

- Hospital flow and MH in ED- Increase in patients waiting for 12 hours including medical and physical health perspective. This will be one of the areas of focus in hospital flow
- Hospital flow- Sustaining the improvements seen in March 2024 including type 3 performance

Mitigating Actions and Next Steps

- The programme continues to work with place, providers on programmes in the development and delivery of the year 2 of the National Urgent and Emergency Care programme which will also align with national pathway priorities including SDEC, admission avoidance and frailty care.
- Following a system wide workshop on the 18 April 2024. The five transformation pillars: Integrated Care Pathways across primary, community and UEC, Ambulance Conveyances and System Clinical Coordination, Hospital Flow, Mental Health in ED and Mental Health Flow, and Winter Planning are being prioritised to align with national and NEL population need.
- Lessons learnt from winter and industrial action in 23/24 were discussed at the UEC workshop on 18 April 2024 to inform future resilience and transformation planning across the system.
- Trusts have been asked to undertake a lessons learned approach on the March approach, and sustaining best practice learned during the period to help support patient flow and performance.
- Additional focus on acute and mental health flow in relation to discharge ready (no criteria to reside) patients including discharges by 11am, optimised use of SDECs and reduction on short length of stay.
- The NEL Ambulance Optimisation Group to enable NEL and LAS to work collaboratively on improving ambulance handovers, category 2 response times, review of STEPS processes, optimisation of flow into hospitals and development of a clinical assessment model/ single point of access system wide
- Close working with Place Leads to examine progress of Virtual Ward capacity along with Community Beds and Domiciliary Care availability vs demand for discharges ready patients remains a focus including support for out of area patients and flow from the system coordination centre.

Governance

- NEL UEC Board reports into the NEL ICB Executive Committee

Health Services in the Community – Quarterly: Q3 ; Monthly: Feb-24 & Mar-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 ▼/▲ (red) deterioration ▼/▲ (green) improvement

		Metric	Latest Published: Achievement	Latest Published: Trajectory	Latest Published: Actual	Latest Published: Change from prev. period
Health Services in the Community	Monthly reported	**Appointments in General Practice - Feb-24**	✓	**980,442**	**1,013,582**	▼ (red)
		E.T.3 - The number of people discharged by location and discharge pathway per month (Total) - Mar-24	×	**8,855**	**8,225**	▲ (green)
		E.T.3a - Hospital discharge pathway activity - pathway 0 - Domestic home or Other place - Mar-24	×	7,322	6,908	▲ (green)
		E.T.3b - Hospital discharge pathway activity - pathway 1 - Domestic home or Other place or Hotel (as temp place of residence) - Mar-24	×	1,060	956	▲ (green)
		E.T.3c - Hospital discharge pathway activity - pathway 2 - Care home, Designated setting, Hospice, Community rehab setting - Mar-24	✓	145	183	▲ (green)
		E.T.3d - Hospital discharge pathway activity - pathway 3 – Care Home, Designated setting - Mar-24	×	328	178	▲ (green)
		E.T.5 - The number of patients on the virtual ward - Mar-24	×	**588**	**306**	▲ (green)
		The number of patients that the virtual ward is able to simultaneously manage - Mar-24	×	735	435	▲ (green)
		Virtual ward occupancy - Mar-24	×	80.00%	70.34%	▲ (green)
	Quarterly reported	**Learning disability registers and annual health checks delivered by GPs - Q3 23/24**	✓	**15.05%**	**21.97%**	▼ (red)
		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**	**3,520**	▲ (green)
		Percentage of 2-hour standard UCR referrals achieved at the end of the reporting period (National Req. 70%) - Q3 23/24			**89.77%**	▲ (green)
		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**	▼ (green)
		Number of CYP (0-17 years) on community waiting lists - Q3 23/24	×	7,131	9,476	▲ (red)
		Number of Adults (18+ years) on community waiting lists - Q3 23/24	×	12,318	22,909	▼ (green)

Key Headlines

Primary Care (Feb-24)

- Feb data shows 1,013,582 appointments in General Practice, above the trajectory for the month by circa 33,000 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 transferred 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 and all practices that were on non-compliant digital telephony systems will move over to systems with greater functionality.
- Capacity and Access 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 made.
- Plans to implement integrated same day access, under the Fuller Programme are in place.

Hospital Discharge (Mar-24)

- Overall, we continue to see relatively good discharge performance in comparison to other systems in London. Discharge volumes across all pathways are up in Mar compared to the previous month.
- Places and providers placed a particular focus on reviewing and discharging patients who no longer met the criteria to reside (discharge ready patients) to support the ambition to deliver 76% A&E performance in March.
- Places, UEC portfolio and mental health LDA collaborative are working collaboratively to design mental health discharge processes to support improve hospital flow.

Virtual Wards (Mar-24)

- Mar-24 occupancy is 70.3% with 11 classified wards set up and reporting through the foundry platform.
- Extensive engagement across NEL, including workshops in December and February which demonstrated broad support for the programme and provided valuable insights into virtual ward delivery. These engagements provided a deeper understanding of the workforce skill mix among providers and the utilisation of technology across various care pathways.
- The virtual ward pilots launched across the ICS with a combination of in-person and technology-enabled care models. The objective is to leverage the insights gained from last year's implementation to enhance delivery strategies in 2024/25.
- Expanding upon existing pathways in frailty and acute respiratory care.
- In 24/25, we're developing a virtual care plan to build on the progress made with the virtual ward initiative.

Learning Disability (Q3)

- Learning disability registers and health checks delivered by GPs achieved 75% NHSE target, delivering 84% of annual health checks for learning disability population aged 14+.
- 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 (Q3)

- NEL is now at 90% meeting current national target 2nd month in row (70% national target)
- National have formally set a per 100k population target which we are mapping.

Community Waiting List (Q3)

- NEL community collaborative has set up data quality improvement group.
- As of end of last quarter data (Dec) for adult services there are 105, 52+week waits with 65% (68) of this cohort belonging to NELFT dietetics service. For BCYP services there are 1,112, 52+ week waits 57% (633) of this cohort belonging to EFLT community paediatric service.
- National community data plan published to bring community on par with acute data. We will be required to ensure NEL is compliant, and we work to improve overall CHS data quality, reporting and monitoring.

Workstream Issues and Risks

Primary Care (Feb-24)

- The general practice appointments (GPAD) data had 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 (Mar-24)

- Pressure remains in the system due to industrial action (IA) and seasonal pressures
- This is a complex pillar to the portfolio, and will require optimised team infrastructure, and continued partnership working across health and social care.

Virtual Wards (Mar-24)

- Providers and places continuing to roll-out services including tech enabled wards, 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 few step-up referrals being made.
- Provider concerns about the uncertainty surrounding recurrent funding, which is affecting service delivery and sustainability.

Learning Disability (Q3)

- Delivering 9% above target suggests no workstream issues or risks in learning disabilities annual health checks. Delivery on this target will continue to be monitored and any issues can be raised by place leads.

2-hour UCR (Q3)

- Consistency in reporting and target are areas the collaborative will continue to focus on.
- Work continues pushing more cases into UCR service with LAS. There is a risk whilst we are meeting the 2 hr target volumes position at place as well as system can be improved.

Community Waiting List (Q3)

- Population growth is causing an increase in demand for services and impacting long waits, workforce issues are across all providers are also having an impact on services. As services cannot keep up with demand, the service specifications need to be reviewed in line with the current demand and profile of service users as services are running on models that are not fit for purpose.
- The 52-week waits being tackled does not mean the wait times overall will go down as a result of the above reason.

Mitigating Actions and Next Steps

Primary Care (Feb-24)

- 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' exercise has been 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 (Mar-24)

- Each Place is working to improve discharge. 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
    - Utilise SCC for focussing on out of area patients where system to system support is required.
    - 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.
    - Development of mental health discharge processes

Virtual Wards (Mar-24)

- 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
- Agreeing planned capacity and occupancy trajectories for the new financial year with Places and Providers.
- Consolidate the services we know to be making a difference and ensure patients have access to VW care across the ICS where appropriate
- Explore new pathways of care that are appropriate for virtual ward models; e.g. heart failure, children's services, end of life care and ambulance to virtual ward opportunity.
- Evaluate the current VW provision and patient experience to build confidence in the services and ensure delivery of a high quality of care, patient safety, improved outcomes, and value for money

Learning Disability (Q3)

- 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.
- PLACE leads to continue working with primary care networks and practices supporting any training needs.

2-hour UCR (Q3)

- Ongoing monitoring bi-monthly of UCR target
- Work on single point of access and improving visibility of UCR in shrewd. There is also discussion on the better use of the Universal Care Plans to initiate referral into UCR to support better at home management and overall conditioning in community (proactive care management)

Community Waiting List (Q3)

- High CYP wait times is being tackled via the CYP Improvement networks for SALT
- High MSK wat times are going to be tackled via MSK procurement process that has recently kicked off.
- CHS overall data quality reporting and monitoring is on the radar. NEL has set up an improvement group made up of BI leads. Community BI lead is identified to support improvement and future data planning.

Governance

Primary Care (Feb-24)

- 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 (Mar-24)

- 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.
- Hospital Flow has been identified as one of the five priorities within the NEL UEC portfolio for 24/25. Hospital discharge will be a key part of this work and will be reported through the NEL UEC Delivery Group and ultimately to the NEL UEC Board.

Virtual Wards (Mar-24)

- VW programme reports to the NEL Urgent and Emergency Care (UEC) Board which provides the governance for delivery and monitoring.
- NEL VW Steering group set up to manage operational and clinical delivery and expectations.
- The Community Collaborative which previously provided governance for the VW continues to monitor delivery/progress via regular reporting and engagement

Learning Disability (Q3)

- 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 (Q3)

- Community Collaborative
- UEC Programme Board

Community Waiting List (Q3)

- Community Collaborative

Mental Health – February 2024

SRO:	Lorraine Sunduza	RAG	AMBER

	Metric	Latest Published				
		Feb-24	*Trajectory*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	IAPT Access (Rate)	✓	*27.89%*	*28.66%*	▼	
	Dementia Diagnosis (Rate)	✗	*66.70%*	*60.38%*	▲	
	SMI Physical Health Checks (Performance)	✗	*70.00%*	*58.99%*	▲	
	Perinatal (Rate)	✗	*8.67%*	*8.45%*	▲	
	CYP Access (Volume)	✓	*24,580*	*25,280*	▲	
	Early Intervention in Psychosis (EIP)	✓	*60.00%*	*78.13%*	▲	
	CYP Eating Disorders Urgent Referral (Performance)	✓	*95.00%*	*100.00%*	⇔	
	CYP Eating Disorders Routine Referral (Performance)	✓	*95.00%*	*98.00%*	▲	
	Community Metal Health Access (Volume)	✓	*21,825*	*25,970*	▲	

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 (although a slight levelling off in February) in CYP access rates (which is achieving its target) and Perinatal (which is just below target), but a volatile trend in Dementia diagnosis rates where there remains a significant gap to target.
- While the SMI PHC target of 70% has been difficult to achieve during the first 3 quarters of 2023/24, local data indicated that the target has been achieved in Q4 at 71.2%.
- While access to Talking Therapies services has dipped slightly in February, the general trend is upward, and access is exceeding the trajectory and is on target to achieve the 28% by the end of the year.
- EIP, CYP Eating Disorders and Community Mental Health access remain good, all achieving their trajectories and on trend to achieve year end compliance.
- The NEL position compared with other London systems is mostly positive. For services such as Community MH access, SMI Physical Healthchecks, Perinatal and TT access, NEL is the highest in London. Dementia diagnosis however continues to be the lowest within London.

Workstream Issues and Risks

- SMI PHC SDF investment is currently paused pending a financial review.
- Perinatal access and Dementia diagnosis are 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.

NHS
North East London
Integrated Care Board

NHS North East London ICB Board

29 May 2024

<table>
<tr><td>Title of report</td><td>Governance update</td></tr>
<tr><td>Author</td><td>Anne-Marie Keliris, Head of Governance</td></tr>
<tr><td>Presented by</td><td>Charlotte Pomery, Chief Participation and Place Officer</td></tr>
<tr><td>Contact for further information</td><td>annemarie.keliris@nhs.net</td></tr>
<tr><td>Executive summary</td><td>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.

Since the meeting there have been several updates to the governance handbook including:
• Approved terms of reference for the ICB remuneration committee and Integrated Care System (ICS) people and culture committee.
• A review and update of all committee terms of reference
• A review and update of the community health collaborative terms of reference

Further details on each of these developments are contained within the report below.</td></tr>
<tr><td>Action required</td><td>The ICB Board is asked to:
• Note the approved terms of reference for the ICB remuneration committee and ICS people and culture committee.
• Approve the updated committee terms of reference following a review with each committee Chair.
• Approve the updated Governance Handbook here.</td></tr>
<tr><td>Previous reporting</td><td>ICB Board and its sub-committees.</td></tr>
<tr><td>Next steps/onward reporting</td><td>The Governance Handbook will be further reviewed on an annual basis.</td></tr>
<tr><td>Conflicts of interest</td><td>No conflicts of interest have been identified in relation to this report.</td></tr>
</table>

Strategic fit	Links to overall design and governance of the ICB and integrated care system 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.
Has an Equalities Impact Assessment been carried out?	An Equalities Impact Assessment is not required for this report.
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 At its last meeting, the Board approved the disestablishment of the workforce and remuneration committee and established two committees of the Board, the ICB remuneration committee and the Integrated Care System (ICS) people and culture committee. The Board delegated responsibility to approve the terms of reference of these committees to the ICB Chair and Non-Executive Member for remuneration.

2.2 The terms of reference were approved on 23 April 2024 and the first meeting of the remuneration committee was held on the same day and an exception report from the committee is included in the board papers.

2.4 The ICS people and culture committee will be meeting during the summer and an update on this first meeting will be shared at a future board meeting.

3.0 Committee terms of reference

3.1 Following changes to the ICB constitution and the appointment of two further Non-Executive Members to the Board, a review of all committee terms of reference has been undertaken with Committee Chairs. The terms of reference have been updated to reflect this review. The review included the following committees:

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

3.2 The Community Health Collaborative terms of reference have also been reviewed with the sub-committee Chair due to issues around sufficient representation from each NHS provider partner and proposed changes are included in the terms of reference to address this.

4.0 Recommendations

4.1 The ICB Board is asked to:

- Note the approved terms of reference for the ICB remuneration committee and ICS people and culture committee.
- Approve the changes to the ICB committee terms of reference including:
  - Finance, Performance and Investment Committee
  - Quality, Safety and Improvement Committee
  - Population Health and Integration Committee
  - Audit and Risk Committee
  - Community Health Collaborative Sub Committee
- Approve the updated Governance Handbook here.

NHS North East London Integrated Care Board

NHS North East London ICB Board

29 May 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.
Action required	To consider and note the report.
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 July. • Board to receive updated BAF in July 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.
Has an Equalities Impact Assessment been carried out	An Equality Impact Assessment is not required for this report.
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 North East London (NEL) wide.

1.0 Background

1.1 As both a statutory NHS organisation and the integrated care system (ICS) convener, the Integrated Care Board (ICB)'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 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, 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.

2.2 A review of the ICB risk management policy and strategy is underway and will include the proposals detailed above.

2.3 The revised policy and strategy will be presented to the ICB audit and risk committee on 20 June 2024.

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 22 April which included the BAF, the following comments were noted:

- Welcomed the work of the ICB risk champions to support the development of the risk management process.
- Noted the discussions with provider governance leads about the development of principles for a 'system' risk and the group is reviewing links between the ICB's Board Assurance Framework (BAF) and the provider BAFs.
- Noted that the ICB Executive Management Team (EMT) reviewed risk on a monthly cycle.
- The Chair fed back on her recent attendance at a meeting of the Homerton Healthcare Foundation Trust's Audit and Risk Committee and shared that they are pleased to be working together looking at a system-wide risk process.

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 will be presented to the audit and risk committee.

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 May 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	Apr/ May			
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	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	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	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	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	12	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	6

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	Apr/ May			
To enhance productivity and value for money	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London, 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.	Henry Black	Finance, Performance and Investment Committee	**20**	**20**	**20**	**20**	**20**	**20**	**20**	**6**	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	**1**
	There is a risk that 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**	**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**	**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**	**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**	**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	Paul Gilluley	Population Health and Integration Committee	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**6**	**Cautious:** We have limited tolerance of risk with a	**3**

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	Apr/ May			
	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.											focus on safe delivery	

Board Assurance Framework – May 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)	March 2025	Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	20 (4x5)	May 2024	Work is continuing across the system to address the financial risk held by both local authorities and the ICB across north east London. 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 and continuing

Efficiency programmes are being led by individual organisations, with some cross organisational transformation programmes.	31.03.24 and continuing
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
The establishment of the System Development Funding (SDF) group with a specific focus on current year fund management and reporting.	31.03.24 and continuing
A savings programme across the ICB with particular emphasis on those two greatest areas of cost pressure in 2023/24, i.e. prescribing and CHC.	31.03.24 and continuing

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

Chart: y-axis 0–18; x-axis May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Mar-25; legend: Rating, Target

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	March 2025	Significant work has been planned to ensure there is full engagement with a wide variety of stakeholders and partners reducing the likelihood.
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
12 (4x3)	May 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

<table>
<tr><td>ICS Aim</td><td colspan="4">To support broader social and economic development</td><td colspan="2">Risk applies to ICB
✓</td><td colspan="2">Risk applies to ICS
✓</td><td>Risk reference</td><td>CSTO009</td></tr>
<tr><td rowspan="2">ICS priority</td><td colspan="2">Children and young people</td><td colspan="2">Mental health</td><td colspan="2">Employment and workforce</td><td colspan="2">Long term conditions</td><td>Risk owner</td><td>Paul Gilluley</td></tr>
<tr><td colspan="2">✓</td><td colspan="2">✓</td><td colspan="2">✓</td><td colspan="2">✓</td><td>Responsible committee</td><td>Population Health and Integration Committee</td></tr>
<tr><td rowspan="2">Boroughs impacted</td><td>B&D</td><td>C&H</td><td>Havering</td><td>Newham</td><td>Redbridge</td><td>Tower Hamlets</td><td colspan="2">Waltham Forest</td><td rowspan="2">Risk appetite level (1-5)</td><td rowspan="2">2: Cautious</td></tr>
<tr><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td colspan="2">✓</td></tr>
<tr><td>Risk description</td><td colspan="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.</td></tr>
</table>

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 2025	An ambitious target to contribute towards the reduction in air pollution locally as a system hence reducing the likelihood and thereby reducing the harm it causes to individuals and the impact on NHS as a whole.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	May 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
18, 16, 14, 12, 10, 8, 6, 4, 2, 0 Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Mar-25 Rating Target	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 2025	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	16 (4x4)	May 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 2025	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)	May 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
14, 12, 10, 8, 6, 4, 2, 0; Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Mar-25; Rating, Target	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 2025	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also, to ensure pathways and processes are in place to support and encourage local people into health and care employment.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	12 (3x4)	May 2024	The strategy document has been signed off by the ICB Board. 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 2025	Significant programmes of work are planned or underway that will enable greater oversight across the System
Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
20 (5x4)	May 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
Chart: y-axis 0, 2, 4, 6, 8, 10, 12; x-axis May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Sep-24; legend: Rating, Target	**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 2025	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)	May 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
16, 14, 12, 10, 8, 6, 4, 2, 0 May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Mar-25 Rating, Target	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)	March 2025	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)	May 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
A UEC Delivery Group has been established to track, mitigate, and escalate key risks relating to UEC performance. UEC reporting is currently under review with initial focus on reporting to the UEC board.

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 has been 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
Reinvigoration of the NEL Diagnostics programme to ensure issues are mitigated locally and jointly, together with ongoing alignment, sharing of best practice and collaboration. CDC delivery continues which will be positive for patients and residents of NEL.	Ongoing

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
18, 16, 14, 12, 10, 8, 6, 4, 2, 0; Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Sep-24; Rating, Target	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)	May 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

25
20
15
10
5
0
Jan-24 Feb-24 Mar-24 Apr-24 May-24 Apr-26
Rating Target

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)	May 2024	The Joint Working Agreement with NHS England regarding the delegation of specialised services was agreed by 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	(red)
High	(orange)
Medium	(yellow)
Low	(green)

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	2	3	4	5
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

29 May 2024

NHS North East London Integrated Care Board

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 meeting of the Executive Committee held on 9 May 2024. The key items detailed in the report include: • Urgent and Emergency Care (UEC) update • Updates from the Clinical Advisory Group • A focus on women's health and gynaecology waits • Annual report on complaints in NHS North East London • Resident determined success measures and the development of a single outcomes framework
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the meeting held in May 2024.
Next steps/ onward reporting	The committee meets again on 9 July 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.
Has an Equalities Impact Assessment been carried out?	An equalities impact assessment is not required for this report.
Impact on finance, performance and quality	The committee is established to provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory. Provide executive oversight of system finance and associated risks. Ensure opportunities for bidding for transformational funding are maximised and provide oversight of

	bids. Approve matters in line with the scheme of reservation and delegation.
Risks	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

Purpose of the report

1.1 This report provides a summary of the key items from the meeting of the Executive Committee held on 9 May 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In May the committee received updates to the Urgent and Emergency Care (UEC) programme. The report outlined the progress to date since the establishment of the UEC portfolio in autumn 2023/24, such as the significantly improved performance in Accident and Emergency (A&E) departments from 70.54% in February 2024 to 75.86% in March 2024, despite March being a particularly busy period with more attendances and a higher acuity of patients. The report also highlighted that the UEC operating plan trajectories and associated narrative have been updated in line with the national operating plan guidance and will be signed off through the NEL ICB governance and presented to the NEL UEC Board in May 2024. There is ongoing engagement with system partners to learn lessons from 2023/24 and develop holistic and collaborative plans for 2024/25 that align with the national deliverables outlined in the NHS England Planning Guidance.

2.2 Members discussed an exception report from the Clinical Advisory Group which outlined the work being undertaken to improve interfacing between primary and secondary care providers and how we are aiming to expand this work to include mental and community health services. One topic of significance to the interfacing work is the provision of sick notes, and how secondary care colleagues could ease pressure on general practice by being able to provide these to residents. The Committee were informed that a recently reported measles outbreak has been confined to north west London, but that we will accelerate our immunisations programme in north east London to mitigate the potential associated risks.

2.3 The committee noted and approved the recommendations of the following reports which are being presented at this ICB Board meeting:

- A focus on women's health and gynaecology waits
- Annual report on complaints in NHS North East London
- Resident determined success measures and the development of a single outcomes framework
- Month 12 financial position

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.

NHS
North East London
Integrated Care Board

NHS North East London ICB board

29 May 2024

Title of report	Audit and Risk ommittee 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 22 April 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in March 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 22 April 2024.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 A first draft of the Integrated Care Board (ICB)'s annual report for 2023/24 was presented and comments were noted. Members were advised that the draft would be

updated following the comments received. A final draft will be presented to the committee prior to final sign off by the ICB board in June.

2.2 A first draft of the year-end accounts for 2023/24 were robustly reviewed. The final draft will be presented to the committee prior to final sign off by the ICB board in June.

2.3 Committee members noted updates from our External Auditor, Internal Auditor and our Local Counter Fraud Specialist. As part of the Internal Audit discussion, concerns were raised about the number of outstanding management actions. Committee members received assurance that this has been escalated and the appropriate action has been taken. However, the Head of Internal Audit Opinion will note the significant number of overdue management actions with little or no progress made.

2.4 An update on the planning process for 2024/25 was received and committee members were encouraged to hear how system partners are working closely together. The committee noted that there is still a lot of work to be done and the difficult financial position of our local authority colleagues was recognised.

2.5 Committee members noted an update on risk management, and the Board Assurance Framework along with the digital risk register were reviewed discussed. The impact and associated risks of Artificial Intelligence (AI) was discussed and helpful Government guidance on AI was shared with the committee after the meeting. The committee were encouraged by work being undertaken to produce a system wide risk register.

3.0 Risks

3.1 The annual report and year-end accounts are not submitted in time to meet national timelines.

3.2 The public facing Value for Money Risk Assessment has not yet been seen by the committee but will need to be signed off with other year-end submissions.

3.3 Planning for 2024/25 has identified a significant deficit position requiring action to meet an acceptable system position.

3.4 Further efforts are needed to achieve 100% Purchase Order compliance prior to the introduction of the new finance system.

April 2024

NHS North East London Integrated Care Board

NHS North East London ICB board

29 May 2024

Title of report	Remuneration Committee exception report
Author	Anna McDonald, Governance Manager
Presented by	Diane Herbert, Non-executive member
Contact for further information	anna.mcdonald@nhs.net
Executive summary	Following the decision made at the ICB board meeting on 27 March 2024 to; approve the disestablishment of the Workforce and Remuneration committee; approve the establishment of the Remuneration Committee; approve the establishment of the People and Culture Committee, this report provides an overview of the final actions of the Workforce and Remuneration Committee in March 2024 and the discussion at the first meeting of the new ICB Remuneration Committee held on 23 April 2024.
Action required	The board is asked to note the report.
Previous reporting	N/A
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.
Has an Equalities Impact Assessment been carried out?	An Equalities Impact Assessment is not required for this report.
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 final actions of the Workforce and Remuneration Committee in March 2024 and the discussion at the first meeting of the new Integrated Care Board (ICB) Remuneration Committee held on 23 April 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The final meeting of the Workforce and Remuneration Committee took place on 15 March 2024. During the meeting, the committee approved three additional voluntary redundancy applications and a small number of exit payments on the grounds of compulsory redundancy. An update on the Equality Impact Assessment (EQIA) was also noted. Following the final meeting of the committee on 15 March, members received an additional application for compulsory redundancy for virtual approval which was agreed.

2.2 The first meeting of the new ICB Remuneration Committee took place on 23 April.

2.3 The committee received a further update on the voluntary and compulsory redundancy applications and noted an update on the organisational structure and the EQIA. Committee members discussed each item in turn and requested further qualitative data on themes and patterns relating to each item.

2.4 In response to the results of the 2023 national staff survey, the committee received a summary report which included the key areas of focus for improvement at a corporate level and the plan to take the improvements forward. The committee recognised that a level of cultural change is needed and that this will take time. Members discussed the clear link between the objectives of the organisation and the individual objectives of staff and requested an update report for the next meeting.

2.5 The committee welcomed the good news that NHS North East London will be receiving the London Living Wage accreditation and agreed that it demonstrates the organisation's commitment to being an Anchor Organisation.

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the ICB'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.

30 April 2024.

North East London
Integrated Care Board

NHS North East London ICB Board

29 May 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 10 April 2024. The key items detailed in the report included: • Quality exception assurance Items • System quality report • Strategic risks update • Patient Safety Incident Review Framework progress update • Improvement programme update • Community anti-coagulation service • Safeguarding ○ Child Death Overview Panel Annual Report ○ Children Social Care Reforms and Working Together 2023 update ○ Policies for approval
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 12 June 2024 and a regular exception report will be presented to the Board.
Conflicts of interest	There are no 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.

Has an Equalities Impact Assessment been carried out?	No
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report.
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.

1.0 Purpose of the report

1.1 This report provides the Board with an overview of the items discussed at the Quality, Safety and Improvement (QSI) Committee held on 10 April 2024. This exception report outlines the key messages and actions taken by its member 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 Quality Exception Assurance report. As requested by the Committee, the report now incorporates the performance through a quality lens paper. Key highlights included:

- East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) declared internal critical incidences in terms of flow of and workforce issues. Both organisations initiated business continuity plans and have since been resolved.
- Whipps Cross declared an internal incident regarding flow into the Emergency Department (ED). A partnership quality summit is taking place in May to look at what can be done to avoid occurring.
- Homerton Healthcare has had their licence to provide fertility treatments suspended due to potential safety risks after receiving notification of three incidents reported about the service. The Trust is taking necessary actions to manage the patient pathway for women and have written to all current and potentially affected patients.
- National benchmarking suggests North East London (NEL) is an outlier for rates of ED attendances for Long Term Care, disability, incurable cancer, organ failure, and frailty/dementia. It was commented that those with incurable cancer and organ failure should not be attending ED due to risk and should have access to a comprehensive End of Life Programme. It was suggested that a deep dive into End of Life Care should be conducted to see what services are available across NEL and the quality of care available.
- It was suggested that a future Urgent and Emergency Care (UEC) Programme update should include whether the care patients are receiving is clinically appropriate when they are moved to another area before breaching.

2.2 The System Quality Report presented to the Committee is the most comprehensive report to date with further metrics relating to patient safety and patient experience added to the dashboard and the inclusion of the 2023 NHS Staff Survey results.
The Patient Safety Team now have access to monthly data downloads from the Learning from Patient Safety Event (LFPSE) service and are continuing to work with providers and the national LFPSE team to iron out issues.
NHS England National Patient Safety Team have launched a consultation to explore whether the existing Never Events Framework remains an effective mechanism to drive patient safety improvement. This is following findings of recent reports suggesting that several types and sub-types of Never Events, the barriers are not strong enough to totally prevent an incident from occurring and tracking these may not present a fair representation of an organisation's safety system.

2.3 The progress made in developing the strategic risks and controls and mitigations in place were discussed. It is expected that by June 2024 the work will be near completion and will become a live document that will be presented on a quarterly basis to the QSI Committee and will triangulate across other risk registers.

2.4 All large providers (Trusts and independents) will be working to Patient Safety Incident Investigation Response Framework (PSIRF) from 1 April 2024. All NHS organisations are expected to recruit Patient Safety Partners, whose role it is to champion the role of patients, families, and carers in the improvement of patient safety within our systems. Patient Safety Partners are now well embedded within our Trusts. The patient safety team has been working with the organisational development team to embed the principles of a patient safety culture into the organisational values and behaviours and working with the strategy, system development and inclusion directorate on the further development of the Learning System and the inclusion of our patient safety work within it.

2.5 An improvement programmes update report was shared with the Committee and provided an overview of the NEL ICB system portfolios and how these have been developed to support the improvement of the system. Once the final structure is confirmed, updated reports will be presented to both the Committee and the ICB Board. There are currently ten system transformation portfolios, which vary in scale and scope. Each system transformation portfolio has a nominated Senior Responsible Officer (SRO) and programme director. The governance for some portfolios is hosted by one of the NEL Provider Collaboratives and other are hosted by the ICB. Early analysis has shown that all programmes can demonstrate alignment with some elements of the Integrated Care Partnership (ICP) strategy. The ICB has asked to receive a summary update on each of the four flagship priorities (of which three are system transformation programmes) with reporting due to commence in May 2024. In addition, each system transformation programme will attend the ICB Board on an annual basis to present a 'deep dive' on its work.

2.6 The Child Death Overview Panel (CDOP) annual report for 2022-23 was presented to the Committee. The report demonstrated how the ICB's responsibilities in relation to child death statutory processes across the ICS have been discharged.

2.7 The Committee was briefed on the Children Social Care (CSC) reforms and Working Together 2023 update. Key elements of the work implementing the reform's improvements have been presented to the ICB Executive Management Team (EMT). Dashboards will be shared at future QSI Committee meetings.

2.8 The Committee was asked to approve a suite of legacy policies which included Managing Safeguarding Allegations 2022-25, Prevent Strategy 2022-25, and Training Strategy 2022-25. The Committee recommended that policies requiring approval are scrutinised at expert groups before being submitted to the Committee for final ratification.

3.0 Risks and mitigations

3.1 The Committee is highlighting the risk regarding Community Anticoagulation Services to the Board. An initial review indicated that there are deficiencies in clinical governance, oversight and regulatory compliance which need urgent remedial action and these deficiencies may have contributed to several recent patient safety incidents.

A risk assessment has been completed by the Pharmacy and Medicines Optimisation Team and will now undergo review with the ICB governance team to agree the risk score.

The Committee was asked to approve the recommendations as set out in the paper, it was agreed that as the approval requires clinical oversight this paper should be approved via the System Prescribing and Medicines Optimisation Board. The Committee acknowledged the quality issues raised for concern and endorsed the improvement plan.

Author: Keely Horton, Governance Officer
22 April 2024

NHS North East London Integrated Care Board

NHS North East London ICB Board

29 May 2024

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Governance Manager
Presented by	Kash Pandya, Non-Executive Member / Chair of the Finance, Performance and Investment Committee Henry Black, Chief Finance and Performance Officer
Contact for further information	matthew.knell@nhs.net
Executive position summary	The Finance, Performance and Investment Committee (FPIC) has met on Monday 25 March and Monday 29 April 2024. The meetings discussed the following business: • Months 11 and 12, 2023-24 finance reports, including updates from the Financial Recovery Director • Months 9 and 10, 2023-24 performance reports • Updates on the 2024/25 North East London (NEL) operating planning process and the ICB's budgets for 2024/25 • The Chief Finance and Performance Officer's (CFPO) risk register • A deep dive on Community Health Services • Updates from Committee sub groups • Seven business case approvals and procurement awards across the two meetings
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the March and April 2024 Committee meetings.
Next steps/ onward reporting	The Committee next meets on Monday 24 June 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	The ICS aims this report aligns with are: • To enhance productivity and value for money • To support broader social and economic development
Impact on local people, health inequalities and sustainability	One of the Committee's responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.

Impact on finance, performance and quality	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will provide assurance to the ICB on operational performance as it relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate. The Committee's current key priorities are recovery, sustainability and transformation.
Risks	The duties of the Committee will be driven by the Integrated Care System and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

1.0 Introduction

1.1 The last two meetings of the Finance, Performance and Investment Committee (FPIC) took place on Monday 25 March and Monday 29 April 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 meetings.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 The Committee received the Month 11 (February) and Month 12 (March) finance reports, discussing the latest financial positions and progress against the Financial Recovery Plan (FRP). Committee members acknowledged that the Integrated Care System (ICS) year-end deficit position had slipped over the course of the final two months of the year due to a difference in allocation released by NHS England (NHSE) to address the costs of industrial action encountered through the year and the planning that had assumed all costs would be covered. Additionally, a last minute issue in Same Day Emergency Care (SDEC) funding had been encountered at Barts Health NHS Trust, although this had been mostly mitigated through an improvement in the Homerton Healthcare NHS Foundation Trust (HHFT) position. Pressures at year end otherwise remained the same as discussed in previous months and included spend on agency and bank staffing, continuing healthcare and medicines.

2.2 FPIC members received, discussed and endorsed the proposal to vary the Better Care Fund (BCF) agreements for Barking and Dagenham and Redbridge places in March 2024 and recommended them for ICB Board approval, which were subsequently approved at its meeting on 27 March.

2.3 The Financial Recovery Director kept FPIC updated members on work underway against the Financial Recovery Plan (FRP) and the need to involve local authority and clinical colleagues in this work. Members noted how important a clear, communicated and understood decision making framework would be in this work, that covered the role of Collaboratives and how any possible decommissioning would be undertaken. The Committee expressed concern around the resourcing and structure of this work across the ICS, recognising that there did not appear to be a

‘Plan B’ available and the significant risk present around this work, flagging that delivery may be off track in 2024/25 in the first month of the year, but that reporting and assurance processes were not yet clear. Any changes in recovery structure needed to be swiftly clarified and adopted to ensure that delivery of the kinds of savings proposed within 2024/25 were possible and effectively supported.

2.4 The FPIC was kept updated on the production of the 2024/25 Operating Plan and Integrated Care Board (ICB) budgets, with the April meeting being informed that the draft plan was indicating a £98.3m deficit position, a £16.2m improvement compared to the previous submission in March 2024. Members recognised that this may further shift in the coming weeks before a final version was agreed and that within the plan, the ICB was stating a breakeven position, although this contained a high level of risk and assumed an efficiency plan delivery in excess of £68.5m. Additionally, the plan recognised ICS risk of £237m and an efficiency requirement of £289m. The FPIC endorsed the outline ICB budgets circulated to the April 2024 meeting, recognising that further detailed information would become available in the coming weeks.

2.5 The Committee received the Month 10 (January) and Month 11 (February) performance reports, discussing the latest metrics across North East London (NEL), including that in April 2024, waiting list performance was starting to trend upwards, with over 65 weeks reducing and significant improvements in over 104 week waits. Additionally, cancer performance across NEL was seeing positive movements across most services. Physical health checks for patients with serious mental illness had also seen significant improvements, driven by place-based improvement networks. The FPIC discussed the drivers behind increasing waiting lists, including that diagnostics performance would be explored in detail in a future meeting and that there was a mismatch between demand and system capacity currently, with notable increases in referrals from primary care.

2.6 The Committee recognised that the risk register presented to members remained a work in progress, with work underway to undertake a comprehensive refresh of the risk reporting process. Members raised questions around the status of risks related to widening health inequalities and whether this was best monitored by the FPIC, or Population Health and Integration Committee, along with risks around continuing healthcare and community health services. Work would be needed to explore and document the risks present in the 2024/25 operating plan and cover these in the risk register as the financial year gets underway.

2.7 The March 2024 FPIC approved the outcomes of three procurement processes to award contracts and one business case, following the ICB’s procurement processes, while the April 2024 meeting approved two business cases and the majority of the Local Incentive Schemes brought forward for extension into 2024/25. Members asked for further information and potential revisions to be made to the Home Visiting Service in order to provide clear information on the funding source and the growth element covered in the proposal.

2.8 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.

3.0 Risks and mitigations

3.1 The Committee received the latest finance and performance department risk registers at both meetings, containing risks rated at 12 and above and recognised that this remained work in progress.

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

Author: Matthew Knell, Governance Manager
Date: 14/05/2024

North East London
Integrated Care Board

NHS North East London ICB board

29 May 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 24 April 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in March 2024.
Next steps/ onward reporting	The committee meets again on 19 June 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.
Has an Equalities Impact Assessment been carried out?	An equalities impact assessment is not required for this report.
Impact on finance, performance and quality	There are no direct impacts resulting from this paper.
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 24 April 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 report which provided an update on our approach to strategic commissioning and explained how we will be using 2024/25 as a transition year between how we currently commission services to moving to a population health outcomes-based approach. The population health challenge in north east London has been defined by using a three-pronged analytical approach which include a

needs assessment, service assessment and community feedback. The benefits of this approach will develop over a ten-year horizon and this model aims to promote high-quality care that is efficient, person-centred, and geared towards long-term health improvements.

As highlighted in the Chief Executive's report, members had a rich discussion about the approach and recommended that it would be helpful for a roadmap to be developed which outlines what is coming through the pipeline in terms of commissioning, which will enable us to have shorter milestones within the longer-term piece. There was also discussion as to how we should define 'population health' and it was agreed that our definition would have a focus on population health improvement rather than population health management.

2.2 Members endorsed a report, with recommended changes, which explained that, as part of the Fuller programme, integrated neighbourhood teams (INTs) are being developed and one of the programme's priorities is to develop a framework to help Places and primary care teams to develop and implement INTs locally. The framework has three components that can be used as tools for local discussions and should be seen as support for local work rather than instructions on how to design and deliver INTs. The three components are a strategic framework that outlines our vision and goals, guidance for formation which is designed to aid the establishment of INTs, and a development framework which will work as a roadmap to guide INTs through the evolution of the capabilities.

The Committee recognised that this is a very challenging piece of work and is at the heart of what an Integrated Care Board should do and should be the key thing that we deliver. The approach to delivery will first require us to take a step back to identify the barriers and to determine what level of change is needed, and whether we have the capacity to action that change. It was also noted that there are complexities involved in terms of determining what a neighbourhood is and will require further discussion between our local government and Primary Care Network colleagues. A further update on the development of integrated neighbourhood teams will be presented at a future committee meeting.

2.3 The Committee highlighted the importance of alignment of with Places, Provider Collaboratives and system including strategic commissioning to strengthen our collaboration and integration as a partnership. The report highlighted that a range of collaboration and integration is happening which includes alignment of strategic priorities, pooled budgets and the appetite to develop greater integration of data and information sharing. It also demonstrated the need for a range of enablers to be in place to support integration which include alignment of processes, the ability to take opportunities when they arise and having 'brilliant basics', such as good information about workforce, budget and spend.

Members discussed how having conversations with our residents and workforce may help us to draw out examples of how we can improve integration. These conversations will also enable us to identify examples of wastage and duplication in the system. The Equity Academy is working to develop a library of resources which will include examples of initiatives taking place which will help us to learn from each other and take good practice forward.

2.4 The Committee received a proposal to establish a Health and Regeneration Group which would report to the Population Health and Integration Committee. The Group's overall purpose would be to lead a coordinated health and care approach to planning and regeneration policy and practice for the benefit of north east London residents. The membership would include representation from NHS system partners and local

authority subject matter experts (public health, planning, housing, regeneration and property).

Members noted that we are the fastest growing ICB in England, therefore it is important we have a strategic forum to pull together the plans across north east London that is wider than understanding the impacts locally. It was recommended that local authorities are involved in a consideration of which work is strategic and needed, and what should be conducted at Place. Once this reflective piece of work has taken place, the Group's terms of reference will be updated and brought back to the Committee for approval.

3.0 Risks and mitigations

3.1 The Committee received its first in a series of regular reports for members to conduct a deep dive into one of the key risks it holds responsibility for. The risk reviewed at the meeting in April is also included on the Board Assurance Framework: *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.*

Members discussed the mitigations that are in place and emphasised the need to do work on the ground to actually enact change and mitigate the risk effectively. It was suggested that we could take learning from Cormac Russell, a leader in asset-based community development, and that it would be beneficial to review our Working with People and Communities Strategy. Lived experience leadership is an example of how we can utilise wider community assets and will enable the power to shift to our residents. As we are not currently measured by regulators on having an asset-based approach, we will need to empower and encourage our clinicians to deliver our longer-term aims. Members reflected on how the meeting had an overarching theme of collaboration and integration, which in itself could be classed as an example of assurance and a mitigation.

Author: Katie McDonald, Governance Lead
Date: 10.05.2024

Integrated Care Board Forward Plan

North East London
Integrated Care Board

	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		Urgent and Emergency Care	Long term conditions	End of Life care	Dentistry
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)							
Update on Clinical and Care Professional Leadership							
Operating plan							
Infrastructure strategy							
Access Recovery Plans	Primary care						
Supporting equity and sustainability (population growth)							
Industrial Action review							
ICB staff survey report							
Big Conversation success measures							
ICS strategy progress report							
Green Plan review							