North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024, 1.30pm – 4.30pm; Redbridge Town Hall

Agenda

	Item	Time	Lead	Attached/ verbal	Action required
1.0	**Welcome, introductions and apologies**	1.30	Chair		Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meetings held on 29 May and 21 June 2024			Attached	Approve
1.3.	Matters arising			Verbal	Note
1.4.	Actions log			Attached	Note
2.0	**Resident story**	1.40		Verbal	Discuss/ note
3.0	**Chair and chief executive reports**				
3.1.	Chair's report	2.00	Chair	Attached	Approve
3.2.	Chief executive officer's report	2.05	ZE	Attached	Note
4.0	**Quality**				
4.1.	Digital deep dive	2.10	PG	Attached	Note
4.2.	Industrial action – a review of 2023/24	2.30	PG	Attached	Note
5.0	**Strategy**				
5.1.	The ICS strategic priorities and progress reporting	2.45	JM	Attached	Note
6.0	**Finance and performance**				
6.1.	Financial overview	2.55	HB	Attached	Note
6.2.	Performance report	3.05	HB	Attached	Note
7.0	**Governance**				
7.1.	Governance update	3.20	CPo	Attached	Approve
7.2.	Board Assurance Framework	3.30	CPo	Attached	Note
7.3.	Committee exception reports for information: • Executive Committee • Audit and Risk Committee • Finance, Performance and Investment Committee • Population Health and Integration Committee • Quality, Safety and Improvement Committee • Remuneration Committee	3.40	Chair	Attached	Note
8.0	**Board forward plan**	3.50	Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
9.0	**Questions from the public**	3.55	Chair	Verbal	Note
10.0	**Any other business and close**	4.05	Chair	Verbal	Note
Date of next meeting: 25 September 2024					

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
Michelle Hodgkinson	Interim Chief People and Culture Officer
Anne-Marie Keliris	Head of governance
Pranoti Shah	Head of digital programmes
Niall Canavan	Chief information officer
Nicholas Wright	Deputy director of programmes

Purpose, priorities, aims and our decision-making principles

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

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

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

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

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

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

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

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

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

The four aims of our integrated care system

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

Our decision-making principles

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

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

North East London Integrated Care Board Register of Interests

- Declared Interests as at 09/07/2024

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 ICB Quality, Safety & Improvement Committee	Financial Interest	Eastlight Homes	Member of Board; Chair of Audit and Risk; member of Finance and Performance Committee	2022-12-12		
			Financial Interest	Igloo Consultants Limited	Director of family owned consultancy business	2022-12-12		
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 Community Health Collaborative sub-committee 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
			Financial Interest	Faircross Medical Centre	GP partner , and family member (brother) is also a partner	2024-04-01		
Dr Mark Rickets	ICB Primary Care Partner Member	ICB Board ICB Finance, Performance & Investment Committee ICB Workforce & Remuneration Committee ICS People & Culture Committee NEM Remuneration Committee Primary Care Collaborative sub-committee	Financial Interest	Nightingale Practice (NEL member practice)	Salaried GP	2022-02-02		Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GP Confederation	Nightingale Practice is a member	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	2022-02-02		Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	2022-02-02		Declarations to be made at the beginning of meetings
			Indirect Interest	Point of Care Foundation	My wife is an Associate with the Point of Care Foundation whose work includes being a mentor for NEL ICS Schwartz Rounds	2022-03-01		Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Paul Francis Gilluley	Chief Medical Officer	Clinical Advisory Group 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 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		
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Primary Care Collaborative sub-committee 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	Acute Provider Collaborative Joint Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Primary Care Collaborative sub-committee	Non-Financial Professional Interest	UCL Global Business School for Health	Health Executive in Residence	2022-09-01		
Kash Pandya	Non Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICB Remuneration Committee	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

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Marie Gabriel	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB 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
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 Waltham Forest Health and Care Partnership Board Waltham Forest ICB Subcommittee	Indirect interest		Wife is civil servant in Department of Health	2001-10-01		
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 09/07/2024

Name	Position/Relationship with ICB	Committees	Declared Interest
Francesca Okosi	Chief People and Culture Officer	ICB Board 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.
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
North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

29 May 2024, 1.30pm – 4.30pm, Barking Town Hall

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Diane Herbert (DH)	Non-executive member, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London (online)
Kash Pandya (KP)	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
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
Pauline Goffin (PGo)	System programme director for community health services/ BCYP/ community collaborative, North East London ICS *for items 2.0 and 4.1 only*
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Keeley Chaplin (KC)	Governance systems lead, NHS North East London
Apologies:	
Shane DeGaris (SD)	NHS trust partner member
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Fiona Smith (FS)	Non-executive member, NHS North East London
Andrew Blake-Herbert (ABH)	Local authority executive participant
Abi Gbago (AG)	Local authority executive participant

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe. Kash Pandya and Fiona Smith are new members of the board. The Chair advised people of housekeeping matters before proceeding.

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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 Integrated Care Board (ICB). No additional conflicts were declared. Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's website.
1.2	Minutes of the last meeting
	The minutes of the meeting held on 27 March 2024 were agreed as a correct record.
1.3	Matters arising
	There were no matters arising.
1.4	Actions log
	4.1 Chair's report – the system workshop on disability equity is being scheduled for Autumn 2024 and will be led by residents. The ICB board noted the actions taken since the last meeting.
2.0	**Resident story**
	Pauline Goffin introduced the resident's story and read out the experience of a local person that found themselves homeless and in need of several services across health and social care. • A 41 year old man suffered with multiple issues that included domestic abuse, alcohol and drug dependency and had lost contact with his family due to this. • This contributed to poor mental and physical health and he suffered with depression and weight loss. • He was placed in temporary accommodation in Waltham Forest. • He was assigned a GP under the Special Allocation Scheme but this was out of their local area. • He was given a full health assessment with the local homeless nursing service and was sadly diagnosed with cancer. The service was able to provide the links for him to maintain his care but due to the complexities of his health he progressed to end of life care. • He had a history of not engaging with health services and stopped attending his medical appointments including radiotherapy. • When the team visited him in his temporary accommodation, they deemed it not suitable and witnessed a lot of continued self-neglect. The team allocated him onto the FastTrack continuing health care service for end of life care. They were able to place him in more suitable accommodation and made contact with his family. • He remained in contact with his family as was his wish until he passed away. The mortality rate for homeless people is in the low 40s. Accessing community services can be complicated for someone that is homeless, especially with additional and complicated needs so it is important they receive continuity of care. The importance of continuity of care to build up trust with someone who can

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	link with a variety of health and social care teams across different geographical areas, whilst also maintaining the residents wishes, is crucial. Members discussed the story and points included the following: • It was felt that building trust is the most important aspect to put in place to increase engagement with services. • In Homerton Healthcare they have a dedicated team that includes a specialist nurse and doctor and social workers that help with step down accommodation, and this is a good practice model that should be shared across north east London (NEL) if not in place already. • The story highlighted the importance of sharing information between providers • The provider collaboratives may be the ideal fora to look at this in more detail and ensure best practice models are shared across NEL. The ICB board thanked Pauline for sharing the story and noted the key points arising from the resident story.
3.0	**Chair and chief executive reports**
3.1	Chair's report
	MG presented the report which provided an update on the most significant activities undertaken by the chair and non-executives since the last ICB board meeting. The following key areas were highlighted: • Changes to the ICB's non-executive roles have been made. The board noted its thanks to Noah Curthoys for his service and contribution as an associate non-executive member since the inception of the ICB, as his tenure has now ended. • NEL ICB has become the first ICB in the country to become London Living Wage accredited. • The Integrated Care Partnership (ICP) recently considered the emerging outcomes framework for the integrated care system requesting it reflect wider determinants such as community insights and technology. • The ICP also discussed improving access to welfare rights and challenges associated and it was good to hear examples of ways this is already done. A mapping exercise will be undertaken to identify gaps and aiming to reduce health inequalities. • NHSE has requested that all boards, including ICBs, undertake a self-assessment to understand where they are on their journey to implement the NHS improvement framework. This will be undertaken in a future development session of the board. Members discussed the report and points included the following: • Board reports have limited reference to technology and innovation and it was agreed that future reports should include more of this within them. There is a digital strategy in place and there has been a lot of work progressing the digital agenda across the system such as Barking and Dagenham, Havering and Redbridge Hospitals Trust's (BHRUT) introduction of an electronic patient record (EPR). • Public sector organisations are currently in a pre-election period for the July General Election. This means that they need to act impartially and not be seen to influence the election and its outcomes. The governance team have reviewed the forward planner for the board and committees to ensure there are no items being presented that will be affected by pre-election guidance. **ACTIONS:** A board development session will focus on the self-assessment against the NHS improvement framework

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	A discussion on the digital work across the system will be held at a future board meeting. The ICB board noted the report.
3.2	Chief executive officer's report
	ZE presented the report and explained the following key points: • Following the results of the staff survey, three areas of focus were identified which are: to develop the ICBs culture; leadership and management; and better basics. • A ballot of primary care GPs is being held on whether they will take strike action later in the year and the BMA's junior doctors committee has announced further strike dates which will take place in the run up to the General Election. Discussions are being held to ensure all learning from previous periods of industrial action have been picked up. • Population health has been a key focus at all committees across NEL looking at the development of a population health framework to ensure that we have a shared system understanding of what it means and are able to work collectively using all shared data to better support the population. • BHRUT has now exited the NHS Oversight Framework and the NHS England (NHSE) recovery support programme which is an immense achievement and reflects sustainable improvement in quality of care. They have also attained the London living wage accreditation with three out of five trusts in NEL in this position. All NEL local authorities, except one, have also received this accreditation. • Following the resident story held at the board meeting in April 2022 a lot of work has since taken place to develop a plan for improving health and care services for deaf people. A new accessible service has been rolled out in Tower Hamlets that enables immediate access to GP practices via an online service. Members discussed the report and key points included the following: • Providing support to women before they become pregnant should be an important element of the population health strategy as there are many pregnant women that have complex issues due to other health conditions. A demand and capacity exercise in maternity services is being undertaken to gain an understanding of the high levels of pregnant women with complex health needs. • Assurances were sought that pressures on primary care funding do not have a detrimental impact on secondary care. ZE clarified that there is a lot of work in this area including the primary and secondary care interface programme which is being led at place. The clinical advisory group (CAG) and the acute provider collaborative (APC) also ensure there is alignment of work programmes. • The importance of all our Trusts becoming London Living Wage employers was raised by Chris K and I believe someone advised that they are in the process. • The chair advised that the ICP discussed the various strategies across the organisation and how they interlink and that it would be useful to have a strategy map. This could also be shared with board members. **ACTION:** JM to provide a strategy map for ICP and board members' information. The ICB board noted the report.
4.0	**Quality**
4.1	Community Health Services (CHS) in north east London
	PC and PG presented the report and highlighted the following key points:

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	• There is no national definition of what constitutes a community health service. Neither is there a specific national funding stream to support increased demand. • Due to legacy arrangements, there is a variety of offers and models across NEL creating uneven waiting times and outcomes. Therefore, there is a need to define a core consistent offer, adapting to local needs. • NEL has a clear Integrated Neighbourhood Teams (INT) framework, developed with places and wider stakeholders. This creates an opportunity for community health services to engage more fully in the development of the INTs. • Nationally, around 14% of the population could be better supported at home to prevent an Urgent and Emergency Care (UEC) attendance or admission. • 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. It has set an approach and will agree priority areas and explore opportunities for the next two years. Members discussed the report and points included the following: • The Finance and Performance Investment Committee (FPIC) received the report and supported the recommendations. • It was important to identify some quick wins within the plan • As an ICB we need to be clear on our commissioning intentions in relation to community health services. • The voluntary sector is mentioned within the report but members felt they should have more involvement as they can offer knowledge and support, particularly where there are gaps. Patient and carer groups should also be included to ensure they have input. Involving areas further upstream such as public health would also support long term resilience. • We need to consider what more we can do upstream working with Directors of Public Health on this and also consider how this work relates to our long term conditions programme. • The Board noted the intersection between the work of the community collaborative and places. • It also noted the importance of work between primary and community care at place, quite often the same team of people are working together to integrated care at place. • An improvement network involving residents, carers and third sector is due to have its first meeting noting there is a need to work with UEC, primary care and local authorities. • The two year plan will include short and medium term actions. Recommendations made to the board are: i. the development of a NEL strategic plan, building on work carried out elsewhere. 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.

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	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, The ICB board **noted** the report and **supported** the recommendations made and to bring a report back to board with clarity on investment to deliver the plan in the first year.
4.1	A focus on women's health and gynaecology waiting lists
	DN presented the board with a report, that forms part of the ongoing strategy to raise awareness of Women's Health in NEL, noting the following key points: • The national Women's Health Strategy was published in August 2022. The strategy has priorities set for two years and is now in its second year. • There are two successful women's health hubs in NEL with plans to open a health hub in each of NEL's Places. • Support for women to become pregnant is part of the programme of care for maternity and a report will be presented to a future board meeting. • A large focus of the report is on the waiting list size for gynaecology which has the longest waiting times of any speciality in north east London. This has been exacerbated by industrial action. • An improvement and action plan are being developed, led by the gynaecology clinical steering group, to understand factors that are influencing demand and capacity for gynaecology and growth in the waiting list. Members raised the following points: • This required an integrated approach including the voluntary sector and with communities to tackle health inequalities. • That as this was the beginning of a programme of work, publicity is needed. • The APC could consider if additional clinics to reduce the backlog could be put on. • As well as the backlog the systemic factors should be tackled, for example waiting list discrepancies between ethnic groups. • Work with communities could be done to ensure women are more informed on their own health. There are gaps and discrepancies in areas of deprivation. • A review of patients treated for menopause is being completed. • There are women's health champions that are involved with the hubs who could help to identify communities that are not engaging with the services. • Healthwatch are looking at women's health such as access in Barking and Dagenham and the experience of Somali women in Redbridge. The ICB board noted the report and 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.
4.1	Annual complaints report
	CP presented the first annual complaints report to the board highlighting the following key points: • There has been a large increase in the number of complaints received since primary care complaints were delegated to the ICB on 1 July 2023. • Prior to delegation it was agreed by all London ICBs to standardise the response time to 40 working days for completion. • Based on three years of data complaints received by NHSE relating to primary care delivery the ICB has received 50% more in just nine months. This

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	increase is likely due to a public awareness raising campaign on how to make a complaint. • This has caused major challenges for the team due to the unexpected volume increase and an action plan has been produced to reduce the backlog this has caused. • Two complaints were referred to the Parliamentary and Health Service Ombudsman but only one was relevant to NEL. • Patient incidents are monitored and reported to the Quality, Safety and Improvement Committee by the Patient Safety Team. • Compliments are also received by the team and there is a plan to develop a response to recognise those that are acknowledged. • The key area of focus for the team is recovery from the backlog position and learning from complaints as it will provide good insight. Members of the board discussed the issues and comments included: • A more balanced report with details of compliments received will provide a view of what is going well in the organisation. However, a number of compliments are provided verbally and a process to capture these is being considered. • Trends and learning, particularly around primary care systems, should be included and shared with places. • It would be useful to triangulate complaints information with the results of other public surveys. • Concerns were raised that only 20% of complaints were completed within the 40-day deadline. This could create an organisational reputational risk. • Themes, learning, triangulation with partner providers will be considered and discussed with the executive team. The ICB board noted the report.
5.0	**Strategy**
5.1	Resident determined success measures, the Integrated Care Strategy, and the development of a single outcome's framework
	CP updated the board on developing success measures for the Integrated Care Strategy and the progress on developing a single outcomes framework which has arisen from the Big Conversation on what local people view as success. Key points of note were: • Residents wanted the basis for developing success measures to have: o trustworthy, accessible, competent and person-centred care from health and care staff o agencies/organisations working well together o more ways to support people's wellbeing o people to find navigating ways into health and care jobs made simpler o access made straightforward, especially to primary care • Measures of the outcomes and statements have been drafted and these will be tested back with system partners and local people before final agreement. • Discussions on adding more references to technology and digital continue. Members discussed the report and noted the following: • It should be resident led but there is little reference to evidence base and there may be a case for prioritisation. • There is a need for all partners to be collectively responsible for measuring success. • There is a social isolation baseline that can be used.

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	• It will be useful to provide timescales to report back to local residents and communities and for these to be tracked overtime. • The final success measures will be presented to the ICP for approval. The board agreed that: a) The draft success measures and draft indicators will be reflected back and tested with local people in a number of ways including through the use of online tools, the People's 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.
5.2	The Integrated Care System strategic priorities and progress reporting
	JM outlined the proposed approach to board reporting on implementation of the Integrated Care Partnership (ICP) strategy, focusing on the four flagship priorities – babies, children and young people; long term conditions; mental health; and workforce and employment. A yearly schedule is established which will provide 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; and an annual deep dive into the four strategic priority areas. **ACTION:** JM to consider if specific areas of transformation should be shared with related committees such as workforce and employment could be reported at the People and Culture Committee. The ICB board noted the draft progress report and approved the proposed approach to board reporting on the implementation of the ICP strategy.
6.0	**Finance and performance**
6.1	Financial overview
	HB presented the financial overview and highlighted the following points: • The unaudited reported position at year-end is an Integrated Care System (ICS) deficit of £48m. • This is £23m higher than the expected second half year forecast of £25m and is mainly as a result of pressures relating to the costs of industrial action and movements to the provider positions at year-end. • At year-end, the ICB reported a surplus of £14.4m, delivering £110m efficiencies and other financial recovery plan savings. • Continuing healthcare and prescribing were both overspent at year end. • Nationally there is a large gap on finances and work is ongoing by NHSE to finalise these.

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	Members discussed the report and points included the following: • The cost of leases is complex. They have changed the way they have done this to correct it and it is recognised that this adjustment will have a big impact to some in year one. • Work is being completed on the financial sustainability programme. • For the Dental Optometry and Pharmacy (DOPs) contracts. If there are capacity issues that generates an underspend. The issue is on supply rather than activity. Additional sessions were commissioned from practitioners willing to target areas of need. It is not expected to continue in 2024/25 but we commission all work we have the budget for. We need to put in place recovery plans. Primary care activity overspend is mainly on prescribing and a huge amount of work has been done at place to adjust this. • Population growth increases prescribing, and shortages of some medications has led to the prescribing of more expensive branded medications. • A request that future reports include a focus on productivity The ICB board **noted** the contents of the report and the final year-end outturn position. The board thanked all involved in this work.
6.2	Performance report
	HB presented the performance report and explained the following points: • The cancer faster diagnosis standard was achieved for the month at all three NEL acute trusts. • NEL was one of the lowest performing ICBs and this has been turned around. • The number of GP appointments delivered for the month (March 2024) was above plan. • Overall waiting lists have increased despite huge efforts across the system and the elective recovery fund. The APC has continued focus on this. • Mental health is making progress with severe illness and physical health checks improved. Members discussed the report and points included the following: • Improvements in the acute trusts' performance is welcome but there are concerns that demand shifts to primary care and community settings. When taking demand out of hospital there is a need to ensure there is no adverse effect on other areas in the system. When looking at the prevention approach the strategy should consider this. The ICB board **noted** the report.
7.0	**Governance**
7.1	Governance update
	CPo presented the report and noted that 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, following changes to the ICB constitution and the addition of two non-executive members to the board. • A review and update of the community health collaborative terms of reference. The ICB board: • **Noted** the approved terms of reference for the ICB remuneration committee and ICS people and culture committee

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	• **Approved** 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
	• **Approved** the updated Governance Handbook.

7.2	Board Assurance Framework
	CPo presented the updated Board Assurance Framework (BAF) and explained the report outlines progress to date and captures the highest risks to meeting the integrated care system (ICS) aims, purpose and priorities, and mitigations in place. 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 • Remuneration committee • Quality, safety, and improvement committee • Finance, performance and investment committee • Population health and integration committee. **ACTION:** PG to provide more information on the work of the Clinical Advisory Group at a future meeting. 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. An annual work plan is be developed for each committee which will ensure all agendas are aligned.
9.0	**Questions from the public**
	The Chair advised that two questions have been received from members of the public. A further two were received that were not relating to items of business on the agenda and they will receive responses directly. The first question was received from Shirley Islam, a City of London resident, relating to the Big Conversation engagement events held with local people and communities during 2023: **Q1:** During the summer of 2023, there was a series of 'Big Conversation' events across the eight boroughs. Unfortunately, a year later eg the NELHCP website states updates will be coming getinvolved/what-is-the-big-conversation/. How can we find out what happened as a result? In particular interested in the actual views and data captured from the residents in the City of London. In future may I suggest feedback within a few months, especially to those who took part for the first time, to increase and not decrease engagement going forward.

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	A1: Thank you for your question and your interest in the Big Conversation. As we heard during the board meeting, there has been work underway since last summer to ensure that we build on the Big Conversation in each Place. Working with the local HealthWatch in each area, we are in the last stages of the process of bringing a summary paper through each Place Partnership with detail of responses from local people and communities as well as the more thematic views which were expressed. In the next period, we are also going to test out with local people the draft success measures of the Integrated Care Strategy which were shaped through the Big Conversation, as set out in the board paper. As the board paper also states, we want to test the draft success measures back with local people as part of the process of adopting them to make sure that we have appropriately interpreted what is of most important to local people. I do apologise that it has taken several months to collate all the responses and to ensure that we correctly pick up the most important points. I do agree that feedback sooner would have been advantageous and I apologise that we haven't been able to update you before now. Taking forward ongoing dialogue in each Place remains a priority for us as we continue to engage with local people and to build and embed co-production. The second question was raised by Jan Savage on behalf of North East London's Save our NHS (NELSON) group regarding **Q2:** NEL ICB says it wants to know what its local communities think about their local NHS and care services. Yet its website's links to information on how residents in the different boroughs might become involved do not work. Among these links is one about how to ask a question at NHS North East London Board meetings. While this looks like a technical problem, we suggest there is an underlying and more substantial issue of democratic deficiency. Members of the public can attend NEL board meetings but these (previously once a month) are now only open the public every other month. In addition, questions from the public are edited, with the risk that the board's responses avoid key points or make little sense. To make matters worse its usually hard for those attending meetings virtually to see all board members present, and sound quality is poor. And although board members may be asked by the Chair to introduce themselves when they speak, they rarely do, and nothing is said to clarify their role. To address these issues, will the board ensure: • Questions from the public can be of varying length but those under a specified word limit (a limit allowing sufficient words to explain context) will not be edited • All broken website links will be fixed within 24hrs of being reported • All board discussions will be fully available to the public (apart from those that fall under genuine and legally valid exclusion criteria) • Names, roles and responsibilities of all those contributing to board meetings will be easily available to all in attendance. **A2:** The ICB engages with its north east London communities in a variety of ways, including the Big Conversation, holding meetings in public, and through the People's Panel which is made up of more than 2,200 residents living in north east London and was created as a way to listen to our diverse communities. Details on how local people can get involved can be found on our dedicated webpage https://northeastlondon.icb.nhs.uk/get-involved/opportunities-to-get-involved/. We encourage people to contact us if they notice any technical errors on our website and we aim to rectify any issues as soon as possible. Thank you for bringing the broken website link to our attention as this has enabled us to rectify the issue.

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	Since the ICB was established in July 2022 our ICB Board has met on a bi-monthly basis and each of these meetings have been held in public. The meetings are also recorded and can be viewed on our website https://northeastlondon.icb.nhs.uk/our-organisation/our-board/board-meetings-and-papers/. Due to the length of some questions received from the public there may be occasions where these are shortened for the meeting's minutes, however the minutes are transparent and stipulate when the question has been shortened and they include a link to our questions log which has all questions and answers written in full https://northeastlondon.icb.nhs.uk/our-organisation/our-board/questions-from-members-of-the-public/. We rotate venues for each ICB Board meeting to a different north east London borough, in order to provide local people with the opportunity to attend a Board meeting in person. The venues we attend have varying layouts and technology, which we appreciate can have a varying sound quality for those viewing online. We will continue to work with partner colleagues to source meeting venues appropriate for streaming online, recognising the priority of a physical presence for the Board in venues across north east London. Board members are asked by the Chair to introduce themselves when speaking and we have nameplates on desks to illustrate who each member is. We appreciate that this may be difficult to read for those viewing the meeting online, so going forward we will include an attendance list at the start of each pack of papers. We also have a page on our website that highlights who our members are https://northeastlondon.icb.nhs.uk/our-organisation/our-board/.
10.0	**Any other business and close**
	There was no other business to note.
Date of next meeting – 24 June 2024	

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NHS
North East London
Integrated Care Board

Minutes of the NHS North East London ICB board

24 June 2024, 12.00pm – 12.30pm, MS Teams

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Cha Patel (CPa)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London
Kash Pandya (KP)	Non-executive member, NHS North East London
Fiona Smith (FS)	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
Paul Calaminus (PC)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Cllr Christopher Kennedy (CK)	Local authority 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
Anne-Marie Keliris (AMK)	Head of governance, NHS North East London
Katie McDonald (KMc)	Governance lead, NHS North East London
Apologies:	
Diane Herbert (DH)	Non-executive member, NHS North East London
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Shane DeGaris (SD)	NHS trust partner member
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
Caroline Rouse (CR)	VCSE partner member
Francesca Okosi (FO)	Chief people and culture officer, NHS North East London
Andrew Blake-Herbert (ABH)	Local authority executive participant
Abi Gbago (AG)	Local authority executive participant
Jenny Hadgraft (JH)	Healthwatch participant

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe. The Chair advised 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 Integrated Care Board (ICB).

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	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.
2.0	**Annual report and accounts 2023/24**
	CPo presented the ICB annual report and highlighted: • NHS North East London ICB is required to submit an annual report and signed final audited year end accounts for the period 1 April 2023 to 31 March 2024 to NHS England by 28 June 2024. Despite a challenging timeline, colleagues have met the requirements to date and are on track, subject to agreement at this meeting, to submit the final version as required by 28 June 2024 having been signed off by the ICB's Chief Executive Officer. • The report provides an overview of the ICB's current and future focus, the work we are doing for our population, and how we have performed against targets and constitutional standards. • The report was considered by the Audit and Risk Committee on 22 April and 20 June 2024 and were updated following feedback from the committee, the recent external audit and NHS England. • CPo thanked all those involved in producing the reports, noting the significant collaborative effort that was undertaken. HB presented the ICB annual accounts and explained: • The annual accounts are in relation to the ICB as a statutory organisation. Provider organisations in the north east London system will be publishing their own annual accounts separately. • The ICB met its statutory financial duty to both breakeven and to contain management costs within their running cost allowances. The ICB delivered its surplus as agreed by NHS England. • On 20 June 2024 the Audit and Risk Committee ratified the annual accounts and have recommended them for approval by the ICB board. At the committee, internal and external auditors provided positive feedback and all points raised have been addressed and deemed satisfactory by internal and external audit. • The ISA 260 letter from external auditors, KPMG, provided a full unqualified opinion with no weakness in the controls environment. • HB thanked colleagues and auditors for their support in developing the annual accounts. CPa, as Chair of the Audit and Risk Committee, made the following comments: • The Audit and Risk Committee has been reviewing the annual report and accounts for several months and has provided the recommendation that the ICB Board approves the 2023/24 annual report and accounts. • Auditors were complimentary of the report and expressed their gratitude to the ICB for getting the report ready in a timely manner and in a good standard. CPa thanked auditors for their support. • Auditors provided some feedback which has since been actioned and they are satisfied with the reports. • Internal audit provided a positive endorsement and have offered some suggestions for inclusion in the 2024/25 report, which include the ICB

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	workforce following the restructure and to have increased impetus on closing management actions following audits. • It is pleasing to have a set of good year-end accounts, particularly in the difficult financial climate. ICB board members discussed the annual reports and accounts with key points including: • It would be helpful for a small number of minor amendments to be made in the annual report to provide clarification to members of the public, such as explaining instances where members joined committees partway through the year. The Chair agreed to send the suggested changes to the Head of Governance. • Members thanked all staff and stakeholders involved in creating the annual report and accounts. **ACTION:** Chair to send suggested amendments to the annual report to the Head of Governance. The ICB Board: • **Approved** the annual reports and annual accounts • **Agreed** to delegate authority to the Chief Executive Officer, Chief Finance and Performance Officer and the Audit and Risk Committee chair to resolve any issues should they arise before the final submission deadline on 28 June 2024.
3.0	**Questions from the public**
	There were no questions received from the public.
4.0	**Any other business and close**
	There was no other business to note.
Date of next meeting – 31 July 2024	

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NHS
North East London
Integrated Care Board

ICB board – action log

OPEN ACTIONS					
Agenda item	**Meeting date**	**Action required**	**Lead**	**Required by**	**Status**
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	The system workshop is being scheduled for autumn 2024 and will be led by residents.
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	Update provided in the Chair's report.
3.1 Chair's report	29.05.24	A board development session will focus on the self-assessment against the NHS improvement framework	CPo	June 24	Update provided in the Chair's report.
3.1 Chair's report	29.05.24	A discussion on the digital work across the system will be held at a future board meeting	PG	July 24	Digital deep dive item scheduled on this meeting's agenda.
3.2 CEO's report	29.05.24	Johanna Moss to provide a strategy map for ICP and board members' information.	JM	July 24	A strategy map has been developed and is attached overleaf.
5.2 ICS strategic priorities	29.05.24	Johanna Moss to consider if specific areas of transformation should be shared with related committees, such as workforce and employment could be reported at the People and Culture Committee.	JM	July 24	This has been reviewed with the Chief Participation and Place Officer and reporting will be aligned accordingly.
7.3 Committee exception reports	29.05.24	Paul Gilluley to provide more information on the work of the Clinical Advisory Group at a future meeting.	PG	Sep 24	Item scheduled on the forward plan.
2.0 Annual report and accounts	24.06.24	Chair to send suggested amendments to the annual report to the Head of Governance.	Chair	June 24	Complete.

CLOSED 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.
6.2 Performance report	31.01.24	Deep dive on diagnostics to be scheduled as a future agenda item.	HB	July 24	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.
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 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.

NEL ICS strategy map

Ambition

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

How

We will deliver our ambition:

- Through our seven **Place-based Partnerships**, by working together to address the needs of the population, and delivering services in an integrated way in our neighbourhoods

- Through our five **Provider Collaboratives**, by working together to address unwarranted variation for our local people in access, experience and outcomes

- Through establishing **system wide transformation portfolios**, that addresses need that cuts across our places and provider collaboratives, and require innovative system change

We are changing the way we work, by collaborating across places, within places, and with our providers to enable the best possible outcomes for our local people in north east London.

What

What we are doing together as an Integrated Care System

NEL integration care strategy

What we focus on

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

How we work

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

Enabling strategies

- Infrastructure strategy – physical and digital
- People and culture strategy
- Medium term financial strategy

NEL Joint Forward Plan
5-year delivery plan for the ICS strategy

Transformation portfolios

Places	Acute Provider Collaborative				MHLDA Collaborative	CHS Collaborative	Primary Care Collaborative	ICB			
Place x 7	Planned Care	Cancer Alliance	Critical Care	Specialised services	MHLDA	CHS	Primary care / Fuller	UEC	LTC	BCYP	Maternity

Foundation to support the system working

What the ICB is focusing on, as part of the ICS

ICB corporate objectives
- Our organisational priorities for 2024/25

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

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

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

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

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

Informed by

- Co-designed by the whole partnership and informed by the voice of local people
- Informed by Joint Strategic Needs Assessments from our Local Authorities
- Is as longer-term strategy, outlining the key areas we as a partnership want to make a difference in

- Underlying system strategies providing the aims of our enabling functions, developed with partners

- Co-designed by the whole partnership and informed by the voice of local people
- The transformation portfolios outlines the priorities of the places, collaboratives and system portfolios for the next 3-5 years, to support the delivery of our ICS strategy

- Outlines the immediate corporate priorities for the ICB for the coming year 2024/25
- Essential to enable the system to meet its aims of the ISC strategy

North East London
Integrated Care Board

NHS North East London ICB board

31 July 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, and London developments. Recommendations: • That the Board receives and notes the report • That the Board considers the discussions and recommendations of the Integrated Care Partnership as part of its decision making and specifically agrees the recommendations to adopt housing as a key system issue and to reflect on its own diversity, including developing a system wide inclusive talent management approach.
Action required	The ICB Board is asked to note the report and agree the recommendations to adopt housing as a key system issue and to reflect on its own diversity, including developing a system wide inclusive talent management approach.
Previous reporting	None
Next steps/ onward reporting	The outcome of Board discussions will be reported back to the ICP.
Conflicts of interest	There are no known conflicts in relation to this report.
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	A focus on housing will assist in addressing a key inequality for families and people experiencing insecure housing. Enabling an effective ICP and strengthening its relationship with the ICB will embed the views of local people and a range of stakeholders into our decision making, strengthening our impact and enabling 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 and contributing to the progress of London will assist in mitigating delivery and reputation risks. Ensuring an effective partnership will reduce risks associated with system delivery.

1.0 Introduction

1.1 I am pleased to welcome Michelle Hodgkinson to her first Board meeting. Michelle is providing interim cover for our Chief People and Culture Officer. My thanks to Francesca Okosi for her contribution over the last two years, particularly on producing our system workforce plan and, on behalf of the Board, wish her well in her future endeavours. This is also the last day for our non-executive colleague Sue Evans, who has contributed to the NHS in north east London, as an associate non-executive member for the ICB and as a Lay Member of North East London Clinical Commissioning Group (CCG) and borough placed CCGs. My thanks to Sue for her continued support of and contribution to our residents, communities and staff.

1.2 Board members will recall that in March I agreed to work with officers to consider how we could ensure a children and young people voice at our Board meetings. We have identified best practice developed in other parts of the NHS, that enables the appointment of a Future Generation Associate Non-Executive Member who participates in Board and Committee meetings, with support from the ICB and a mandate from a wider group of children and young people. I am working with the governance team to further understand the benefits and will make a recommendation to the Non-Executive Remuneration Committee, following Board support today.

1.3 The remainder of this report includes the outcomes and recommendations arising from the recent Integrated Care Partnership (ICP) meeting, a summary of the NHS England (NHSE) oversight framework as agreed at our Board development event and sets out national and regional developments.

2.0 Integrated Care Partnership

2.1 The July meeting of the Integrated Care Partnership, (ICP), considered housing, health and care, how to further build on our community and resident participation and reflected on its own effectiveness including the relationship with this Board. The key points raised during its discussions are set out in the following paragraphs.

2.2 <u>Housing, Health and Care</u>

- The meeting received presentations from local government colleagues and discussed the impact of insecure housing on the health of families, babies children and young people. This included a recognition that there is not enough housing supply, leading to long waiting lists. The connection between health, care and housing includes poor health due to condition of housing stock, including temporary accommodation, for example damp and mould with associated additional demand and costs to the health service. The pressures on families of living in insecure housing and hostels, including impact on family relationships and

individual wellbeing, inability to access an internet connection and impact on educational attainment and access to services, the additional vulnerability of young people who spend more time outside of crowded homes and evidence that insecure housing is one of the main reasons for referral to social care and also has a relationship to infant mortality. Insecure housing also leads to challenges with the delivery of health and care services that are best provided in the home and also delays discharge. In addition, the meeting also noted the specific challenges experienced by street homelessness and insecurity for asylum seekers.

- The meeting also heard of good practice within and outside of North East London (NEL). This includes pioneering registration requirements for private landlords, an early help housing model, environmental health referrals which began locally and now are being adopted nationally, dedicated advice in hostels, training for residents who can also become community champions and a one key visitor model being developed by another ICB.
- The ICP meeting recommends that the Integrated Board adopt housing as a key issue so that it is embedded across our joint programmes of work, from neighbourhood, through place, to collaborative and systems. With this adoption to commit to supporting the sharing of best practice, enabling a deep understanding through mapping, training, and informing our communities, stimulating community support for neighbours

2.3 Resident and community participation

- In its discussion of how we could best to build on our community and resident participation and co-production work, the partnership began with the importance of quickly confirming and using the resident success measures as soon as possible. The Partnership then explored the suggestion that we should adopt a system-wide definition of co-production, harnessing the best practice already underway by partner members. Whilst it may be more difficult to gain one definition, the meeting discussed a range of principles that underpinned a system approach to co-production.
- These principles included the need to be more representative of our communities, including who sits around the ICP and ICB tables and to better ensure the mandated representation of residents and communities at those tables. Although on the latter it was noted that elected members, Healthwatch and the voluntary sector reflected community voice.
- The principles should also seek to have an integrated approach, so we were not asking similar questions to the same people, and we should be imaginative in the different ways we engage but be purposeful with the clarity of the language we use.
- We noted that to achieve quality co-production requires co-ordination; financial and time resources; a recognition of partner capacity, particularly within smaller voluntary and community organisations; and a consistent co-production payment policy across the system, (which is underway). It was therefore necessary to be honest about the parameters and principles of co-production exercises.
- The meeting noted that there was best practice already within NEL places and organisations and that we needed to ensure that our co-production approach built trust. In conclusion, the ICP requested that the principles provide a framework for honest, evidence driven, diverse yet focused co-production.

2.4 Developing ICP effectiveness:

- The Partnership used the NHS Confederation's 'Characteristics of a Successful Integrated Care Partnership' and our ICB effectiveness review to identify ways in

which we can improve. An action plan will be developed as a result, but key points included:

- The need to consider the capacity of smaller organisations so shorter reports, less acronyms, and knowledge support would help the partnership feel more equal.
- Improved partner conversations through presenters summarising key messages and being clear of the ask of the ICP, enabling us to hold each other to account for the delivery of the integrated care strategy. This along with post-meeting chair briefings would help partners to communicate with constituents and encourage conversations with place.
- The need to be clear on the impact of the Partnership, both on ICB decisions and its programmes of work. It was noted that this became apparent, for example, through the initiation of success measures and cost of living work, however it could be better identified. We could also be focused on the impact we wish to achieve through the forward agenda plan and holding more development sessions.
- There was a strong call for a more diverse partnership, representative of NEL, with a recommendation to the ICB that they consider how to diversity its Board and that we have a system approach to inclusive talent management.
- The partnership confirmed the current chairing arrangements and highlighted that the importance of the chair having an inclusive approach and agreed to consider a voluntary or community sector co-chair and, in the future, an independent chair.

3.0 General Election

3.1 As a result of the General Election on July 4, there have been changes both to our Members of Parliament (MPs) and to our Chair arrangements. A list of north east London MPs is set out in the table below along with the names and portfolios of the health and care and housing, communities and local government ministerial teams. I am sure you will join me in congratulating our local MPs; Wes Streeting, MP for Ilford North in Redbridge who has been appointed Secretary of State for Health and Social Care, and Stephen Timms, MP for East Ham in Newham, who has been appointed as a Minister of State in the Department for Work and Pensions, and Rushanara Ali, MP for Bethnal Greem and Stepney in Tower Hamlets, who has been appointed as Parliamentary Under-Secretary of State in the Department of Housing, Communities and Local Government. Our congratulations too, to Jacqui Smith, who has stepped down from her role as the Chair-in-common for Barts Health and Barking, Havering, Redbridge University Hospitals Trust (BHRUT) after being appointed as the Minister for Skills, Further and Higher Education. The resulting interim arrangements are, that her two Vice Chairs, Mehboob Khan, (BHRUT) and Adam Sharples (Barts Health) are acting chairs in an interim capacity.

Constituency	MP	Party	Newly elected
Barking	Nesil Caliskan	Labour	New -
Bethnal Green and Stepney	Rushanara Ali	Labour	Existing
Chingford and Woodford Green	Sir Iain Duncan Smith	Conservative	Existing
Cities of London and Westminster	Rachel Blake	Labour	New -
Dagenham and Rainham	Margaret Mullane	Labour	New -
East Ham	Stephen Timms	Labour	Existing

Hackney North and Stoke Newington	Diane Abbott	Labour	Existing
Hackney South and Shoreditch	Dame Meg Hillier	Labour	Existing
Hornchurch and Upminster	Julia Lopez	Conservative	Existing
Ilford North	Wes Streeting	Labour	Existing -
Ilford South	Jas Athwal	Labour	New -
Leyton and Wanstead	Calvin Bailey	Labour	New -
Poplar and Limehouse	Apsana Begum	Labour	Existing
Romford	Andrew Rosindell	Conservative	Existing
Stratford and Bow (New Constituency)	Uma Kumaran	Labour	New -
Walthamstow	Stella Creasy	Labour	Existing
West Ham and Beckton (New Constituency)	James Edward Asser	Labour	New -

(The following MPs stood down, Nickie Aiken: Conservative, Cities of London and Westminster; Lyn Brown, Labour, West Ham; Jon Cruddas, Labour, Dagenham and Rainham; John Cryer, Labour, Leyton and Wanstead; Dame Margaret Hodge: Labour, Barking; and Sam Tarry, Labour, Ilford South)

Health and Care Ministerial Team
Wes Streeting, Secretary of State (NEL MP)
Stephen Kinnock - Minister of State, with responsibility for Care
Karin Smyth - Minster of State, (role may cover NHS reform)
Andrew Gwynne – Parliamentary Under Secretary of State for Public Health and Prevention
Baroness Merron – Parliamentary Undersecretary of State, Patient Safety and Life Sciences
Housing, Communities and Local Government Ministerial Team
Angela Rayner, Secretary of State, (also the Deputy Prime Minister.)
Jim McMahon - Minister of State, (may take up the local government brief)
Matthew Pennycook - Minister of State for Housing
Alex Norris - Parliamentary Under-Secretary of State
Rushanara Ali - Parliamentary Under-Secretary of State (NEL MP)
Baroness Taylor - Parliamentary Under-Secretary of State, (also a Government Whip)
Lord Khan of Burnley - Parliamentary Under-Secretary of State

4.0 Chair and Non-Executive Activities

4.1 London Developments: Since our last Board meeting, I have attended London meetings focused on how best we can work together, once for London, to improve recruitment, development and retention of our health and care staff and how Integrated Care Boards, (ICBs), can collaborate to progress digital innovation. I also presented at a London ICB Chairs and Trust Chairs meeting on Chair Leadership in north east London, my thanks to Sir John Gieve and Sue Lees who were my co-presenters. On digital, the London drive is to use technology to improve prevention and prediction, better manage long term conditions, enable better access to care, transform pathways and improve our administration of services. The development work underway in

London is seeking to progress joint work to improve access to services through a digital front door. Interestingly, the London People Board conversation also had a focus on ensuring the London's health and care workforce are supported and enabled to benefit from and minimise the risks associated with the potential of digital technology.

4.2 All partnerships will have tensions and the most effective partnerships, surface and proactively seek to hold and to actively address points of potential friction. At the June ICB Board Development event we identified our core tensions, including the tension between collaboration and the need to hold each other to account for delivery; between leading collectively to achieve our ICB ambition to managing the impact of pressures on our individual organisations; between embracing the diversity of places with achieving standardisation across north east London; and between the immediate needs of organisational financial stability with the need for system sustainability. Our conclusions included a recommitment to our ambition as a driver of decisions and to create vehicles outside of statutory mechanisms in order to avoid protectionism, to increased openness and transparency which will enable us to feel comfortable in making unpalatable decisions, and a commitment to consider issues from different angles and to enact fundamental change.

4.3 At the Board development event I also agreed to provide a summary of the NHS England (NHSE) Oversight Framework, The Framework, which covers both ICBs and NHS providers, was open to consultation until last month and will be amended based on feedback and implemented later this year. Within this report I am focused on the impact for ICBs. NHS England has a statutory responsibility to conduct a performance assessment of ICBs annually, they do not have the same duty for NHS providers but do work with the Care Quality Commission (CQC) to undertake their oversight and assessments. Within the framework, oversight is the ongoing monitoring of performance and quality of services being delivered by the NHS. Assessment is the process by which NHSE judges an organisation's capability and governance. The aim is for a robust framework that enables a shared understanding of the accountabilities and roles between each member of the NHS system, clarifies how performance is monitored and outlines how support or intervention needs are identified and addressed. More details can be found at NHS England » NHS Oversight Framework

4.4 Oversight and assessment of ICBs

NHSE will focus on how well the ICB has discharged its functions and include, but will not be limited to, how effectively it has discharged its specific statutory duties. These are a duty to improve the quality of services; reduce inequality of access and outcome; obtain appropriate advice; promote and use research; have regard to the effect of decisions (the 'triple aim'); arrange to involve patients, carers and the public in commissioning plans and decisions that affect them; deliver ICB's financial duties; and to have regard to certain wider local needs assessments and strategies. The result of that consideration will lead to an annual delivery score within a segment of 1-4 and a capability assessment, which includes looking at how the ICB has performed its functions during the year.

4.5 The annual delivery score rating is the same one used for NHS Providers:

1 = Consistently high-performing across domains, delivering against plans and operating in a high-functioning NHS system.

2 = Developing with confidence in the ability to improve further and operate in a high-functioning NHS system.

3 = ICB or provider and/or wider system are significantly off-track in a range of areas. NHSE lack confidence in the capability to respond to challenges without support.
4 = There have been multiple serious failures of patient safety, quality, finance, leadership, or governance or the ICB or provider and NHS system face serious, long-standing and complex issues requiring an intensive co-ordinated response.

4.6 The capability assessment will be based on six core functional areas: strategy and planning; leadership of the NHS and partnership working; arranging for the provision of care services (commissioning); assuring performance, quality and delivery; securing transformation and learning; and effective governance and people. The consultation documentation outlined four capability gradings that would be given after an ICB assessment, as set out in the below table.

Excelling	The ICB can demonstrate it fully delivers/excels against all key lines of enquiry outlined under each activity	No specific support or intervention needs are identified. Expected to offer peer support to others or support the development of best practice tools.
Achieving	The ICB can demonstrate it fully delivers against most of the key lines of enquiry under each activity (with partial delivery against some)	Limited support or intervention is required. Support on specific issues may be provided where appropriate.
Progressing	The ICB can demonstrate partial delivery of all key lines of enquiry under each activity or full delivery of a small number	NHSE will work in partnership with the ICB to oversee the providers in the ICS. Bespoke regional support may be provided to develop capability.
Insufficient progress	The ICB has not demonstrated, or cannot currently demonstrate, delivery against the key lines of enquiry / can only demonstrate partial delivery of some key lines of enquiry under the activities	NHSE will work in partnership with the ICB to oversee the providers in the ICS. NHSE may consider entry of the ICB into the Recovery Support Programme if they are sufficiently concerned and if approved at the relevant NHS England governance group.

4.7 <u>ICB Role in the oversight of NHS provider organisations</u>
The draft framework recognises the need to work with and through ICBs in the oversight of providers. It outlines how NHS provider oversight will be led by an ICB that is assessed as 'Excelling' or 'Achieving' and oversight of NHS providers will be led in a partnership with NHSE if an ICB is assessed as 'Progressing' or 'Insufficient progress'. Where an ICB is leading, NHSE will have direct contact with the provider in agreed circumstances and it is the ICB that oversees performance, quality, financial and delivery against system plans through robust governance arrangements and open and mature discussions. Here the ICB proactively manages the system and provider risks, finding local resolution and acting as a liaison for the provider with NHSE escalating issues in a timely and transparent way. An ICB partnering with NHSE would jointly oversee the provider, NHSE may provide direct oversight and support to providers with the awareness of the ICB and will actively support the ICB in managing risks and finding resolutions to issues and challenges. NHSE will decide the structure of support

or intervention for the provider, having regard for the ICB's advice, and will work with the ICB to agree an improvement plan.

5.0 Recommendations

5.1 To receive and note the report.
5.2 That the Board consider the discussions and recommendations of the Integrated Care Partnership as part of its decision making and specifically agrees its recommendations to adopt housing as a key system issue and to reflect on its own diversity including developing a system wide inclusive talent management approach.

Marie Gabriel – Chair: 18/07/24

North East London
Integrated Care Board

NHS North East London ICB board

31 July 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.
Has an Equalities Impact Assessment been carried out?	An Equalities Impact Assessment is not required for this report.
Impact on finance, performance and quality	N/A
Risks	N/A

1.0 Introduction

1.1 Since the last board we have had a General Election and a new Government is now in place. I would like to extend my congratulations to our newly elected local Members of Parliament (MPs) and those who have been appointed to Ministerial positions. Now that the dust is settling post-election we are ensuring we keep a focus on the priorities of the new government and what this means for North East London (NEL).

We are now two years in to being an Integrated Care Board (ICB) and it is a good time to reflect on what we have achieved together. We have needed to spend a lot of

time on operational issues, including industrial action but nonetheless across the system have achieved a significant amount – for instance work in the mental health, learning disability and autism collaborative on unwarranted variation, we brought in more investment including an extra £20m on capital last year, made progress with the Barking, Havering and Redbridge University Hospitals Trust (BHRUT) electronic patient record which builds capacity to join up patient pathways more effectively which is an important enabler for integration. There has been lots of work on health integration through pop-up clinics and money hubs, and ensuring our health inequalities funding is place-led, targeting the areas that need it most. We also made great progress in urgent and emergency care ensuring people are getting the care they need, built on the existing progress on women's health hubs in City and Hackney to start two others, ensured quality improvement is embedded through our work and we now have a million primary care appointments per month across our system.

We have also built many of the foundations to take system work to the next level though our collective work on building relationships, governance and teams to work in different ways. The work we have taken through many of our system fora, including the population health and integration committee, on a population health framework is a key plank to enable us to start focusing our resources in ways which better meet population health needs, and on prevention. Similarly, our segmentation approach will start to provide the more granular basis on which to do this. At place, the introduction of shadow place budgets, to be shared later in the summer, will start to enable a much clearer focus on how to reallocate resources better into community based and preventative work. The work that has been done in Newham to look at how services need to change to support the substantial population growth already underway will provide a map for our other places, and we are rolling this out in Barking and Dagenham too.

The following report provides some examples of our strategic focus as well as overview of my activities over the last two months.

2.0 Strategic focus

2.1 <u>Population growth – an innovative approach in Newham</u>

Population growth in NEL is a key challenge and there is an innovative programme of work underway in Newham looking at how best to manage the fact that over the next ten years Newham is predicted to have the highest level of growth across all London boroughs. This will likely impact on demand for services. The work found that an integrated neighbourhood model has the potential to address some of the key challenges, with benefits at all levels of the system. It outlines that integrated care is best delivered through a blend of services and proposes a range of targeted interventions for long term conditions, mental health and learning disabilities, frailty and dementia and urgent care. Underpinning all of this will be key enablers at place and neighbourhood level such as a vision, digital, data, workforce, leadership and estates. The next steps are for the place-based partnership to agree a vision and common purpose and agree a model for delivery. It's also really key that we take the learnings from this work and look at how we can implement it across other parts of the system. We have started sharing the Newham work across the system as the toolkit developed during the work can be used more widely, and a similar piece of work is underway in Barking and Dagenham.

2.2 <u>Shadow place budgets</u>

We have introduced shadow place budgets as part of a more strategic approach to planning services, enabling places to look in the round at the spend and activity for their local population. Providing this information will support place teams to shift resources to a focus on prevention to improve the long-term health and wellbeing of local people and address health inequalities. It also enables local authority resources to be shared in the same spirit and is designed to ensure there is a key set of criteria with which to make the most difference with resources.

2.3 Population segmentation

As seen through the recent paper at our population health and integration committee, we are putting building blocks in place to improve our population health management approach. This includes work on segmenting the needs of our population so we can more easily move towards a population health improvement approach.

Integration framework

This identifies the range of mechanisms we have in place for integration ensuring the focus is on delivering outcomes and the core purpose of an ICB. We continue to engage with partners on the ongoing development of our integration framework and will bring back a more detailed update to the board in due course.

3.0 ICB business

3.1 Staff survey action plan and next steps

Following the staff survey results earlier this year a corporate action plan was established focusing on developing our culture, leadership and management, better basics and a review of our restructure. There has been a renewed focus on staff experience, building on a body of evidence gathered via a range of channels including staff away days, drop in sessions, department briefings, written feedback and discussions with staff. At a corporate level we have delivered staff away days, refreshed our approach to staff reward and recognition with a recent staff awards and long service recognition, ensured a focus on Equality, Diversity and Inclusion (EDI) and a renewed focus on leadership and management as well as development sessions with senior leaders and improvements to some of our corporate infrastructure.

There has been a significant focus on working with staff as locally as possible through departmental and team led work and each department has a detailed action plan in place. The local focus has ensured staff feel part of the process, listened to and engaged with and some of our core organisational channels have been reviewed to ensure a regular flow of information (revised rhythm of corporate communications, introduction of a managers cascade, reinvigorated staff networks and a staff engagement panel. We have put in place an organisational programme to focus organisation wide work on the three core themes of culture, values and leadership, better basics and further developing our operating model. We will shortly be undertaking a pulse survey to understand where progress has been made, and where the gaps are. Looking forward we will be undertaking more regular pulse surveys as well as the next staff survey in the autumn.

3.2 Maternity and neonatal demand and capacity work

Earlier in the year we started a piece of work on a demand and capacity review has been undertaken of maternity and neonatal services in NEL to look at how services needed to change and develop to meet population need. This month we are

launching communications and engagement with our residents, staff (including Trusts and Local Authorities) and stakeholders on the findings of the review to raise awareness and understanding of the need for future changes, and gain their feedback on what the review found and the opportunities identified. You can find full details including how to take part on our website here: Have your say on the future of maternity and neonatal care - NHS North East London (icb.nhs.uk)

3.3 Joint Forward Plan refresh

Our Joint Forward Plan has been refreshed and uploaded to our website. This plan outlines how health and care organisations across north east London will work together to ensure residents get the care that they need. Included in this slightly amended version is the feedback from the ICB Board in March, and the specific request around health inequalities from the 2024/25 operational planning guidance. You can read it here.

4.0 NHS England meetings

4.1 ICB executive meeting with Amanda Pritchard

At the start of June, I met with NHS England's senior leadership along with Henry Black, our Chief Finance and Performance Officer, and our Trust Chief Executive Officers (CEOs) to talk through our operating plan for the year. We discussed the context of our financial position – particularly the growth in our population, the extent of deprivation and our underfunded capital position as well as our clarity about the assets we have alongside this challenge, and increasingly about our future strategy.

5.0 System working

5.1 Financial sustainability

As we continue to manage our financial pressures we are ensuring a continued focus on financial sustainability both internally across the ICB but also more widely across the system. You can see full detail of our financial position in the board paper but I would like to reassure the board that we are working closely with system partners and NHS England to manage ongoing pressures.

5.2 Meeting with system borough commanders

We are continuing our regular meetings with our three borough commanders and local health and care leaders to discuss issues relating to policing and mental health. This started out as a focus on Right Care, Right Person, but it has proved to be a really useful partnership forum and we are building a forward planner of topics to focus on including children and young people and serious violence.

5.3 Launch of the Artificial Intelligence (AI) in urgent and emergency care pilot

This scheme, with £13.5m funding over three years from NHS England, is focused primarily on NEL, though is also collecting data from North Central London. It is based on evidence showing that a good proportion of those using urgent and emergency care at the greatest level in any given year can be predicted and can be supported instead by a nurse-led intervention focused on intense telephone coaching on how to improve their health. The cohort is identified using machine learning at scale. It is a really innovative pilot and great to see NEL leading the way.

6.0 System and national visits and events

6.1 Maternity

Diane Jones, Chief Nursing Officer, and I are working our way through visits of all of north east London's maternity units. Maternity is an area of high focus for the ICB. Hearing from leads at both Queen's and Homerton hospitals about their challenges, as well as the work they are doing on improvement was really helpful – and it was useful to have a discussion about how we get more upstream and focus on supporting women to have healthy pregnancies and healthy babies from as soon after, and better still before, conception as possible. There is clearly a lot of cross-north east London work and mutual support and collaboration going on which is a great base for us to continue to build on.

6.2 Urgent and emergency care at Queen's hospital

I also spent time recently visiting the urgent and emergency care pathway at Queen's hospital – the experience for many patients has been substantially improved over the last few months with the urgent treatment centre moved out of the atrium, and performance significantly improved. Whilst there is still clearly work to do, in particular to remove corridor care, the Trust has a clear set of plans for further improvement. The wider support of the system has been key in getting to the improvement delivered so far and colleagues in the emergency department were keen to praise the contribution from ICB colleagues. At both Trusts the need for capital investment to support further improvement for patient care was raised.

7.0 Partner news

7.1 Congratulations to our CEOs included in the Health Service Journal (HSJ) list of top chief executives, particularly Matthew Trainer who came in at number one. Testament to the success BHRUT had at coming out of special measures a few months ago – a lot of hard work and commitment has gone into this so it is great to see Matthew's leadership recognised.

Zina Etheridge
July 2024

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Digital Deep Dive
Author	Pranoti Shah, Head of Digital Programmes
Presented by	Dr Paul Gilluley, Chief Medical Officer
Contact for further information	Pranoti Shah, Head of Digital Programmes, pranotishah@nhs.net
Executive summary	The attached slide deck provides a focus around some of the digital tools that are enabling a better experience for our local people as they interact with our clinical services. The key elements focussed on are the patient held record which provides information to patients that support them in being more actively involved in their own care, the upcoming ability to manage appointments in acute hospitals and the ability for patients to experience hospital level care in their own homes via virtual wards. The final element is the digitisation of social care records within adult social care providers to ensure that those providing care have access to the wider shared care record, enabling them to make fully informed decisions.
Action / recommendation	The Board is asked to note the progress to date
Previous reporting	This specific paper has not been to any other formal meeting, although all elements within it are delivered by properly constituted ICB programmes.
Next steps/ onward reporting	None
Conflicts of interest	None
Strategic fit	The items within this report align 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
Impact on local people, health inequalities and sustainability	The work described in this report will provide local people with better access to their own health information, the ability to interact more easily with clinicians in certain circumstances, have more control over appointments in acute hospitals, be able to spend a shorter period in hospital if part of their treatment can be via virtual wards and receive better informed care should they need to be looked after in an adult social care setting. Implementing digital tools frees up clinical and administrative time to allow patients unable to make use

	of digital technology to interact using more traditional forms of communication.
Has an Equalities Impact Assessment been carried out?	Not applicable to this report. Each programme mentioned has already undertaken its own EIA.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report. The cost of the digital programmes mentioned in the report has been met from within existing resources.
Risks	Each programme maintains its own risk register, of which high risks are escalated through the ICB's governance.

NHS
North East London

Digital Deep Dive

NHS North East London ICB board
31.7.2024

NHS
North East London

Digital in infrastructure and impact on our local residents

Digital in infrastructure

- Our Integrated Care Partnership (ICP) strategy has set a clear direction for our system towards improving quality and outcomes, deepening collaboration, creating value and securing greater equity. It has also described new cross cutting ways of working that will be key to achieving our aims – a greater focus on coproduction, prevention, personalisation and tackling health inequalities as we move towards working as a learning system driven by research and innovation and building greater trust and collaboration.

- Infrastructure, which we are defining as data systems, digital technology, buildings and equipment, is a key enabler for achieving the aims of our Integrated Care System (ICS) – our buildings and digital infrastructure must create the foundations for delivery of high-quality care and greater adoption of innovation; they must enable more preventative, personalised and integrated care, and help us to create healthier and more equitable communities. To support this, we need our infrastructure to be financially sustainable and resilient to increasing threats including cyberattacks, rising energy costs and climate change.

- We know that the pace of technology is accelerating globally and the best systems in the world are harnessing developments in Artificial Intelligence (AI), precision medicine, genomics, machine learning etc to create better value and more personalised care. Keeping pace with these developments is critical for North East London (NEL), not least because of the need to manage demand from our rapidly growing and increasingly complex population through a greater focus on prevention, and locally delivered proactive and integrated care.

- NEL is already home to both state of the art facilities e.g. Bart's Heart Centre, St George's and great examples of digitally enabled care. Equally there are world-class assets to build on including life sciences developments and big data platforms.

- However, too much of our estate is not fit for purpose, whether that is inaccessible primary care facilities, or safety and compliance in some of our acute settings. Equally the digital infrastructure and data systems that enable integration are not all in place e.g. we are only just moving towards electronic care records in all acute providers, and still working to develop shared records with local authorities.

- Our system has been hampered by undercapitalisation which means that investment is swallowed up by maintaining current estate rather than enabling investment in new innovations that would create better value. Inadequate investment also weakens our resilience to the growing threats of climate change and cyber security

- To support achieving the benefits we want to see for our population, our challenge in NEL is twofold: to take a forensic approach to sorting out the basics that will create the foundation for high quality services and health creating communities; while also accelerating innovation towards better outcomes and value for a population that is growing in both size and complexity.

- Ultimately, our success will hinge on our ability to drive the cultural change that is needed for our people to adopt new ways of working, empowered and enabled by a physical and digital infrastructure that is fit for the future of health and care in NEL.

- To do this our ICS Infrastructure Strategy sets out five priorities:

- Improve infrastructure safety and quality (including progress towards net zero)

- Enable increased productivity

- Integrate services within our communities to support health and wellbeing

- Develop new additional capacity

- Accelerate innovation

NHS
North East London

ICS Digital Strategy

Strategic Digital Infrastructure Framework in NEL

NEL Health and Care Partnership (NELHCP) continues to focus on the themes of connecting systems together, minimising the number of different systems in use and utilising the huge amount of data available to improve care for patients / residents and at population level.

This diagram shows how residents and their health and care professionals benefit from investment in each level

	Level 0 Infrastructure / Core systems	Level 1 Shared Records	Level 2 Population Health / Advanced Analytics	Level 3 Patient Access
	Robust foundations and digital maturity	**Single patient record**	**Realtime information for proactive care** **Using population information**	**Patient empowerment**
Patient	• My data is kept secure • I can be monitored at home • I can get a repeat prescription without going to see a doctor	• I don't have to repeat my story when I see different professionals involved in my care	• My data is used by the NHS and local authorities to plan better care • I can be contacted about specific issues by the right professional who has all the information they need	• I can review my health and care information • I can see my care plan and contribute to it • I can view and change upcoming appointments
Professional	• I can view and add to a comprehensive detailed record which is available when and where needed	• I can see important information collected by colleagues that enables me to make the best decision possible	• I can use information to focus my resources on residents most in need and so start to prevent issues • I can better organise the way my team operates	• I can support patients remotely and only when needed; not at fixed points • I can encourage my patients and provide better care

NHS
North East London

ICS digital strategy on one slide

NEL HCP Digital Strategy

Level 3 - Patient Access – gives residents the ability to view their records and interact digitally with health and care providers. This is and will be provided through expanding use of the NHSApp, Online and Video consultation tools, online registration and the patient held record system, Patients Know Best

Residents can choose to interact with health and care professionals via the use of the NHSApp, Patient Held Record, online consultation and video consultation tools

Level 2 - Population Health / Advance Analytics – utilises a variety of data sources to build a picture of care needs at various levels, primarily identifying specific cohorts of patients requiring intervention but also providing overviews at population level, allowing providers to alter service provision. This is primarily provided via the Discovery Data Service but also through additional data sets and capacity planning systems such as Edenbridge Apex

Patient level and aggregated information is provided via the Discovery Data Service (and other sources) to clinicians, managers and researchers, subject to a strict approval process. This helps change pathways as well as the planning and delivery of healthcare provision across NEL, North West London and South East London. This will move to the London Data Service in 2025

Level 1 - Shared Records – is the mechanism for ensuring that clinicians and other care professionals (in Social Care departments, Trusts, General Practice, Care Homes, Hospices, Community Pharmacists and other care settings) have as full a picture as possible to allow them to provide the most appropriate care to individual patients / residents. This is primarily provided through the east London Patient Record (eLPR) and the related London Care Record

Digital works across all organisations within the NEL Integrated Care System, across London and neighbouring ICS's, breaking down barriers by facilitating the sharing of information and good practice

Information is provided to individual clinicians and other professionals from within their main system, about specific patients via the east London Patient Record (circa 450k views per month), which now connects into the London Care Record, giving access to information held by most London Trusts

Level 0 - Infrastructure / Core systems - is the fundamental basis for all digital activity; the foundational work done at each provider that allows them to operate effectively and puts them on a sure footing to be able to contribute to and receive data from systems external to themselves. These systems include end user devices, electronic patient record systems, network capacity, cyber security, etc., in all care settings, including community diagnostic centres and care sector

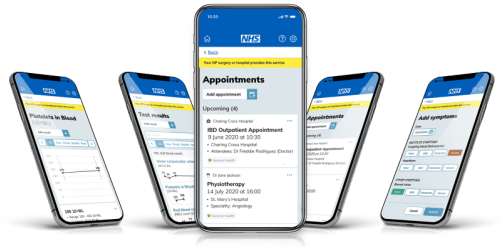
Key strategic programmes are co-ordinated by the ICS team, including Community Diagnostic Centres, Frontline Digitisation, Virtual wards, Care Sector, secondary care Appointment Systems and Primary Care Digital First, working with health, social care and third sector partners

NEL employs digital champions focussed on helping improve patient engagement. Staff training and facilitation is provided by several teams, depending on specific need; these include a team of facilitators in the NEL training hub focussing on the use of IT systems, Clinical Effectiveness Group facilitators focussing on the use of data and IT facilitators focussing on ensuring practice systems are usable. Trusts provide their own training for staff.

NHS
North East London

Patient Held Record (PHR) Programme

Patient Held Record



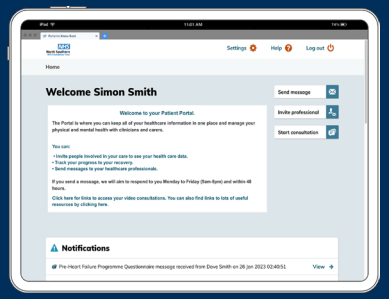
Background

- In August 2021 NEL Clinical Commissioning Group (CCG) Finance and Performance committee approved a three-year programme to implement a Patient Held Record system. The goal of a patient portal system is twofold: to give greater freedom of personal data access and recording to the patient, and to provide a way for clinicians and their patients to interact. A full procurement exercise took place involving four London ICBs, led by North West London. The Patients Know Best (PKB) product was selected.
- NHS England expected every Trust to have a Patient Engagement Portal which allowed patients to view their medical record and interact with those involved in providing their care, and to take the burden of said access away from staff, freeing them to work on other tasks. PKB met a significant part of this requirement.

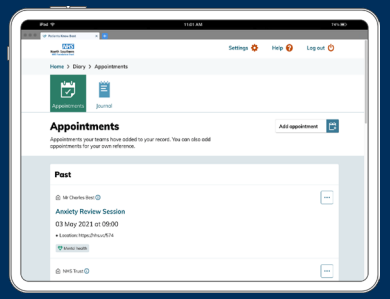
Patients Know Best

- Patients Know Best (PKB) is a secure digital platform accessed through the NHSApp, that allows patients to view their health record and add their own information, leading to better health outcomes.
    - PKB promotes personalised care, self-care, and healthy lifestyles.

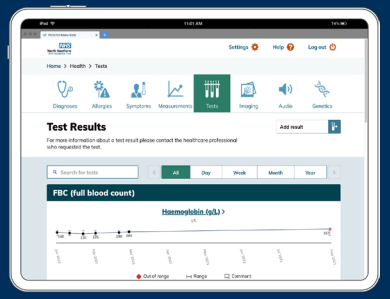
PKB Snapshot



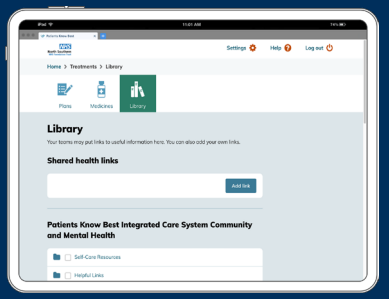
View Your Record



View Appointments



View Test Results



Access Clinical Documents, Resources & Care Plans

Digitally Empowering Patients

All trusts within NEL (3 Acute and 2 Community & Mental Health Trusts) are using PKB for their patients. With PKB, patients can view:

- Appointments, Care Plans, Test Results, and Documents (Appointment letters, Discharge Summaries)

Ongoing Enhancements

Trusts are currently adding new information to PKB, including:

- Integrating Radiology appointment data and results. Creating Document Libraries. Using Advanced Questionnaire Functionalities.

Statistical Snapshot

Total Records Created: 1,585,651

Total Registered Patients: 255,129

Weekly Registrations: 1,500 – 2,000

Data as of 30/06/2024

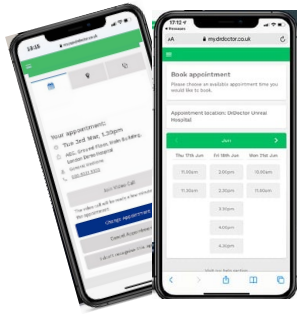
Goals of PKB

We aim to provide an online patient health record that empowers patients by allowing them to:

- **Access Records Anytime:** View all their appointments, medical correspondence, test results, medication lists, and care plans in one place.
- **Communicate with Their Team:** Securely message their healthcare team to reduce unnecessary visits and phone calls.
- **Access Resources:** Find information and advice from their healthcare team online.
- **Add Their Data:** Include their past medical history and clinical documents in one place.
- **Track Their Health:** Keep a health journal, monitor symptoms, and record measurements.

NHS Wayfinder is a service from NHS Digital that lets patients in England securely view their upcoming hospital appointments with acute trusts through the NHS App and website. This service is now connected with the three NEL acute trusts, pulling information from PKB and allowing patients to view their hospital appointments easily in the NHS App.

Digitally Engaging Patients



Background

- All acute organisations with Portals are also expected to develop a minimum level of functionality to support elective recovery and to work with the NHS England Wayfinder team to surface their Portal through the NHS App. A key aspect of this patient portal is the ability for patients to manage their own appointments, including cancelling and rebooking. Supporting waiting list management was also a key requirement.
- As PKB did not provide this functionality and had no plan to develop this, DrDoctor, a patient engagement platform, was procured to provide this functionality.

DrDoctor Functionality

Patients will be able to:

- Book, cancel or change their outpatient appointments through the Portal
- Receive relevant messaging for appointments to ensure the individual wishes to take up their appointment at 12 / 18 / 26 and 52 weeks

Trusts will be able to:

- Send a waiting list validation questionnaire to patients through the Portal
- Send other relevant questionnaires to patients to support perioperative pathways
- Effectively manage their resource against improved and more timely responses from patients
- Focus on condition pathways that account for the longest outpatient waits, the highest number of missed appointments (DNAs and cancellations) and the greatest evidenced potential for reducing follow-up appointments

NHS Wayfinder Integration

Once integrations are complete, and the DrDoctor Portal is live, including NHS app functionality. Patients can access appointments, guidance, and rescheduling options in one place, reducing DNAs, postal costs, and administrative work.

NHS
North East London

Digitising Social Care Records

Digital Offer to NEL Adult Social Care (ASC) Providers - background

Digital transformation of health and social care is a top priority for NEL. NEL ICB have taken the national and local decisions on digital that will put the health and social care system in a position to deliver the four goals of reform identified by the Secretary of State. The system will be equipped to:

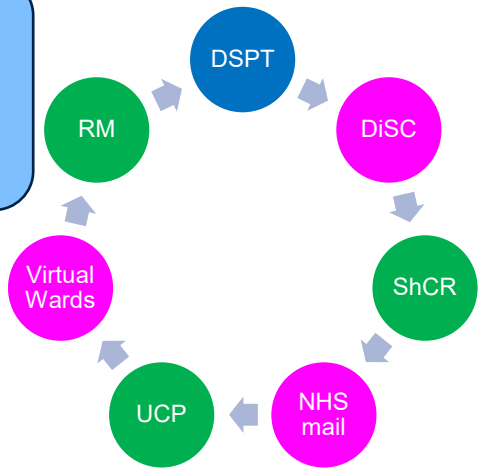
- Prevent people's health and social care needs from escalating
- Personalise health and social care and reduce health disparities
- Improve the experience and impact of people providing services
- Transform performance

- Digitising health and social care records and supporting the adoption of shared care records (ShCRs). We know that digitally mature providers operate with approximately 10% improved efficiency compared with their less digitally mature peers.

- The goal is for all NEL ASC provider organisations to have all the attributes of digital maturity, including electronic records and other critical systems, by March 2025. This will allow carers to spend less time on administrative tasks and more time with the people they care for.

- The team undertook a digital maturity exercise in 2022 and again in 2024 for all ASC service providers to determine a targeted approach that helped identify the local cohorts of care providers who are likely to require support, to implement digital systems.

- Across NEL we offer, 121 support for any ASC CQC registered provider to become compliant by completing the Digital Security Protection Toolkit (DSPT). This is the gateway to allow ASC providers to access the following workstreams: Digitalisation of Social Care Records (DiSC) Funding, Shared care records (ShCR), GP connect, NHS Mail, Remote Monitoring, Universal Care plan (UCP), Virtual Wards



Digital Security Protection Toolkit (DSPT)

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables healthcare organisations to measure their performance against the data security and information governance requirements mandated by the Department of Health and Social Care (DHSC), notably the 10 data security standards set out by the National Data Guardian.

The picture to date indicates that NEL have 98.35% compliance rate and 5% above the London average (NHSE data).

Count of Site type						
	NHS North Central London CCG	**NHS North East London CCG**	NHS North West London CCG	NHS South East London CCG	NHS South West London CCG	Grand Total
Approaching Standards	0.47%	**0.00%**	1.56%	0.87%	0.00%	0.54%
Parent is compliant but site isn't	0.00%	**0.00%**	0.00%	0.44%	0.58%	0.23%
Registered (via parent organisation)	0.47%	**0.00%**	0.78%	1.31%	0.58%	0.62%
Registered (via site)	1.40%	**0.41%**	5.08%	2.62%	4.08%	2.88%
Registered but compliance expired	0.00%	**0.00%**	0.39%	0.00%	0.00%	0.08%
Standards Met	93.46%	**98.35%**	89.45%	91.27%	93.29%	93.15%
Unregistered	4.21%	**1.23%**	2.73%	3.49%	1.46%	2.49%
Grand Tota	100.00%	**100.00%**	100.00%	100.00%	100.00%	100.00%

Digitalisation of Social Care Records (DiSC)

This project is to support the implementation of an Electronic Planning Record (EPR) System (also known as a Care planning System) for any paper-based ASC CQC registered provider within NEL.

Year one/two of the project (2022/23 & 2023/24) supported the digital maturity work and funded 100 ASC CQC care providers enabling NEL ICB to reach the NHSE target of 70% of Care Providers using Digital Care Records by 2024.

The national target for 2024/25 is for 80% of CQC registered providers are to have a Digital care planning system in place enabling 80% of people who receive care to have a Digital Social Care Record in place by March 2025.

For the final year of the project 2024/25, NEL have been allocated Funding as follows:

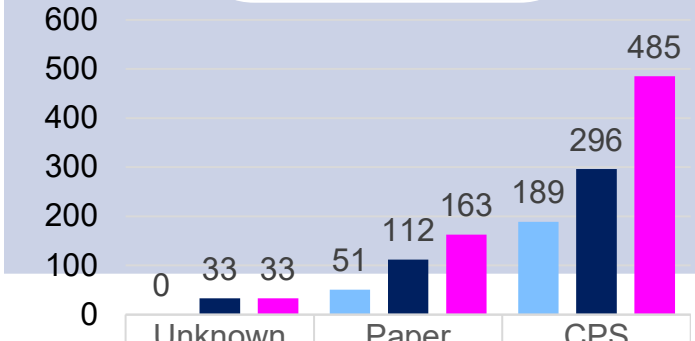
Digital Transformation Fund- £798,750

Implementation Support Fund - £137,620

NEL ICB's target is to reach a further 85 CQC registered Care providers by the end of March 2025 (Based on NHSE data) Total number of CQC registered providers (excluding dormant locations and providers who have registered within the last 12months) – 684. The 80% NHSE target equates to 547 CQC care providers having an EPR/DSCR system in place by March 2025.

To date the team have received 66 expressions of interest for this funding and continue to offer 121 support, drop-in sessions for DSPT and NHS mail.

The team have set a target to go beyond the NHSE target of reaching a further 85 Care providers and aim to increase this to 120.



	Unknown	Paper	CPS
Care Home	0	51	189
Dom Care/Others	33	112	296
Total	33	163	485

- A total of 163 care providers are paper-based, all providers have been sent the EOI link and have been invited to our weekly DiSC drop-in session.
- 66 of the those who have completed the EOI have been sent an MOU and bank details have been requested to set up payment accounts
- The team continue to support with the process from start to finish

Shared Care Records (ShCR)

The ShCR is access to the London Care Record which provides instant access to key information about residents/service users/patients from a range of health and care settings across London such as their hospital discharge summaries, medications, previous medical history or plans for their care. This is different to GP connect where only the GP information can be viewed.

Current figures indicate that 63 care homes are using PCS

21 of the 63 (33%) care homes are using the ShCR

46 care homes are currently using Nourish and 10 have signed up to the Pilot

Mi Directory of Service (MiDoS)

This is a directory where all community services that are available across NEL can be viewed by various partners. MiDoS searches the NHS Pathways from DoS and interrogates a variety of sources

The DoS is used across the NHS to store and maintain detailed information about a wide range of health and social care services

Care providers can easily register to use this service

Currently 70 searches per month by Care providers

Remote monitoring (RM)

The remote monitoring programme was successful in BHR for those who used the Feebris system. There was clear evidence form Feebris that this system reduced ambulance call outs; however, one care home Manager stated :

'We spoke at length about some of the challenges we have faced with becoming consistent Feebris users. The main concern is that our dementia patients can become distressed when having their obvs taken. They are used to how things are done. We have decided that for now using Feebris isn't for us but may be open to it in future if they have less dementia residents.'

NHS
North East London

Virtual Wards

Virtual wards and remote monitoring

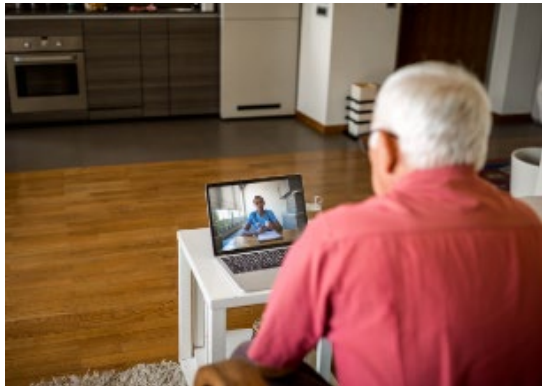
What is it?
Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The NHS is increasingly introducing virtual wards to support people at the place they call home, including care homes.

What we hope to achieve:
- Provide a safe, efficient alternative to traditional inpatient care using technology for home-based treatment.
- To expand to include heart failure, children's services, end-of-life care from Initial frailty and acute respiratory illness (ARI)
- Enhance healthcare access and outcomes, reduce hospital pressures, promote sustainability, and ensure fair access

Our achievements:
- Established 424 beds with 65%-70% occupancy rates, providing a foundation for future growth. 9087 patients admitted to date, 10392 discharged (as per NHSE Foundry data)
- Launched all virtual ward pilots across ICS, offering in-person and tech-enabled care models.
- NEL place-based partnerships deliver at least one or two wards
- Workshops garnered support, deepened understanding of virtual ward delivery and insights into skill-mix and technology

What we have learned
- Efforts to increase virtual ward capacity continue, but gaps remain against year-end targets.
- Evaluating existing services to expand and exploring new clinical pathways
- Providers face significant occupancy rate variations due to patient cohort differences, service awareness, and referral inconsistencies.
- Workforce and staffing shortages pose significant risks, particularly in specialist roles like occupational therapy and nursing recruitment.

Next steps for the work
- Plans to extend all virtual ward pilots to end of March 2025
- The initial priority is to increase occupancy rates in existing services (80% of planned 735 bed capacity) to increase productivity and efficiency.
- A system-wide approach to digital enablement across virtual wards is needed for quick adoption of proven solutions.
- Enhance connections integrated care approaches with Urgent Community Response (UCR), single point of access and Same Day Emergency Care (SDEC)
- Improve referral rates from General Practice and the London Ambulance



North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Industrial Action - A review of 2023/24
Author	Fiona Ashworth, System Transformation Director
Presented by	Dr Paul Gilluley, Chief Medical Officer
Contact for further information	Dr Paul Gilluley/ Fiona Ashworth
Executive summary	The purpose of this paper is to brief the ICB Board on the planning and delivery of the system response to Industrial Action (IA) over the 2023/24 period. The paper includes a review of the impact to patients accessing urgent and emergency care, elective and primary care over the 13 periods of action. The paper also draws out the collaboration and learning noted across system partners with an opportunity to innovate and change how workforce and digital tools may support ways of working to be adopted into business as usual practice. As part of this briefing the Board is asked to note the impact to patient experience, in addition to the staff who have supported the logistical, clinical and operational challenges over the last year, this is likely to continue as further periods of IA are planned in 2024/25. Industrial action has become a regular occurrence in the NHS since December 2022, with IA experienced across various professional colleague groups, including ambulance services, consultants and junior medical staff across all acute and mental health provider, soft Facilities Management (FM) services in north east London and nationally by the Royal College of Nursing. This paper provides an overview on the known impact of industrial action for the system, patient, financial impact and staff resulting from industrial action, focussing on the overall 2023/24 period noting that the consultant, dental and junior doctors have been the predominate clinical staff group taking industrial action over this period. This paper has been drawn together through the gathering of feedback from system partners, system co-ordination centre and Emergency Preparedness, Resilience and Response (EPRR) teams supported by an Urgent and Emergency Care (UEC) review event in April 2024. The Board is asked to note that impact reviews as a result of ongoing action remain active, and therefore this paper provides an overview for 2023/24 learning.

Action / recommendation	The ICB Board is asked to: • Note this briefing paper which has been drawn from available lessons learned at system and provider level. • Note this high industrial briefing including the impact to elective patient care and the financial risk for the system following national recommendations for no planning for industrial action in 2024/25. • Note the risk that may potentially emerge as part of the cumulative effect of IA related predominately to elective care patients. It is recommended that the established process through each organisations' governance process with oversight in the planned care collaborative • Note that during the operating planning round for 2024/25 that systems were asked to plan without Industrial Action assumption. At the time of writing this paper, the NHS is about to enter a further period of action with the risks of additional costs, impact to elective care cancellations and patient experience. • It is also recommended that the system EPRR leads share Trusts IA high level briefs for further learning through the Integrated Care System (ICS) EPRR leads group. This will support the further development of after action reviews. • Note that there has been recent announcement by the British Medical Association that General Practice is likely to engage in "collective action". This is very different from the industrial action we have experienced so far and lessons from previous industrial actions cannot be extrapolated.
Previous reporting	ICB Executive Management Team meeting. ICS Executive Committee.
Next steps/ onward reporting	Aspects of this paper will attend the following meetings: • ICB Board • EPRR – ICS Leads Group
Conflicts of interest	There are no known conflicts of interest.
Strategic fit	The ICS aims this report aligns with are: • To improve outcomes in population health and healthcare • To tackle inequalities in outcomes, experience and access • To enhance productivity and value for money
Impact on finance, performance and quality	The Board is asked to note that through the operating planning round for 2024/25 that there should be no planning

	for IA. This is a risk for the system from both the operating plan and financial perspective.
Risks	• There is a financial risk linked to operating framework guidance on planning. The scale of financial risk is not yet known • Elective care risk due to cancellations and cumulative impact. There are agreed processes in place through each organisational Chief Medical Officer (CMO)/ Chief Nursing Officer (CNO), in assessing patient harm • Risks to delivery of elective care plans if IA should continue throughout the 2024/25 period • Risk to staff of operationally, clinically and organisationally in the event of further prolonged periods of action, recognising the right of colleagues to exercise the right to implement IA.

1.0 Introduction

1.1 Industrial action (IA) has become a frequent occurrence in the NHS since December 2022, with IA experienced across various professional colleague groups, including ambulance services, consultants and junior medical staff across all acute and mental health provider, soft Facilities Management (FM) services in North East London (NEL) and nationally by the Royal College of Nursing.

1.2 This paper provides an overview on the known impact of industrial action for the system, patient, financial impact and staff resulting from industrial action, focussing on the overall 2023/24 period noting that the Consultant, Dental and Junior Doctors have been the predominate clinical staff group taking industrial action over this period.

1.3 This paper has been drawn together through the gathering of feedback from system partners, system co-ordination centre and Emergency Preparedness, Resilience and Response (EPRR) teams supported by an Urgent and Emergency Care (UEC) review event in April 2024. The ICB Board is asked to note that impact reviews because of ongoing action remain active, and therefore this paper provides an overview for 2023/24 learning.

1.4 The ICB Board is also asked to note that since 2023/24, agreements have been reached except for junior doctors, with future dates for IA in June 2024 now published and response planning underway.

2.0 Overview

2.1 In 2023/24 there were 13 periods of medical staff Industrial action over the 2023/24 financial year period totalling 45 days, and 11 days of joint action between junior and consultant medical staff. but recognising and anticipating the potential impact on other services including primary care and community care and pathways functions across place and local authority. Industrial action in relation to soft FM have not been included in this overview paper.

Strike	Professional Group	Action Dates	Number of Days
1.	Junior Doctors	11th to 15th April 2023	4
2.	Junior Doctors	14th to 17th June 2023	3
3.	Junior Doctors	13th July to 18th July 2023	5
4.	Consultants	20th July to 22nd July	2
5.	Junior Doctors	11th August to15th August 2023	4
6.	Consultants	24th to 26th August 2023	2
7.	Consultants*	19th September to 21st September	2
8.	Junior Doctors*	20th September to 23rd September	3
9.	Consultants*	2nd October to 5th October	3
10.	Junior Doctors*	2nd October to 5th October	3
11.	Junior Doctors	20th December to 23rd December 2023	3
12	Junior Doctors	3rd January to 9th January 2024	6
13.	Junior Doctors	24th February to 28th February 2024	5

Figure 1 – NB: Shaded area denotes dual IA cross over periods.

2.2 Overall periods of action commenced at 7am and ended at 7am on IA days with four strike periods over a weekend. In December 2023 to January 2024 there was action before and directly following a Christmas bank holiday period.

3.0 Industrial Action Governance

3.1 IA coordination is managed under the 2023/24 Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022, as well as the NHS Emergency Planning, Resilience and Response (EPRR) Framework 2022. Arrangements for governance, assurance and oversight for IA mitigation and evaluation follow the National EPRR principles, providing co-ordinated communication, consistent approaches and understanding of risk methodology, safe systems of working and assessing impact upon communities.

3.2 For periods of IA, this shared situation awareness is provided by a process initiated from National to Region and region to ICB working with system providers, place and primary care. The assessment process was gathered through a provision of template based, self-assessed, qualitative and quantitative responses to questions across Acute, Mental Health, Learning Disabilities and Autism (MHLDA) and Community (physical) settings, and the ICB itself.

3.3 The overall co-ordination of NEL Integrated Care System (ICS) IA is provided by the NEL System Coordination Centre (SCC), a joint operations and EPRR team who provide specialist support and leadership to the NEL ICS reporting to the ICB Incident Group. Each provider establishes their own command and coordination arrangements supported by partners, which links into daily reporting with the SCC. This is in addition to the Chief People Officer Group overseeing any key workforce or trade union linked discussions.

3.4 Providers develop a return utilising a set BRAG (Black, Red, Amber, Green) system, and the information then critically reviewed by the ICB Incident Group (Fig 2). The ICS position is collated into a regional return post Accountable Emergency Officer (AEO) sign-off. In the pre, intra and post IA meetings across national, regional, ICS,

ICB and providers monitor and manage the impact of IA against the submitted clinical situation.

BRAG definitions (by service)	
Black (4)	Significant concerns regarding sufficient capacity to ensure safety in key service area(s)
Red (3)	Limited assurance regarding sufficient capacity to ensure safety in key service area(s)
Amber (2)	Risks to safety partially mitigated, however some residual concerns regarding safety in key service area(s)
Green (1)	No concerns regarding capacity to ensure safety

Figure 2 BRAG risk assessments.

3.5 The daily rhythm during IA as a system in addition to supporting known service challenges against the assessed position, but also the impact of known or emergent factors, alongside importantly provision of discharge, community, primary, urgent treatment care and third sector demand and capacity, Operational Pressures Escalation Levels (OPEL) positions and drivers, and whether patient safety mitigations (PSM) have/ are being requested.

3.6 During IA periods, the NHS is asked to ensure the safe care of all patients and planning to ensure the delivery of safe urgent and emergency care services, cancer care, and high priority elective (Priority incident 1, cancer care, and tertiary care including stroke and trauma care). This has resulted in cancellations of lower priority elective care to release available clinicians into the emergency care provision. Elective care is further discussed in section 5.0 of this paper.

3.7 As part of the risk assessment referred to in figure 2, the Board is also asked to note there is a patient safety mitigation (PSM) request process, previously noted as derogation. Providers can request an exemption from industrial action following a safety assessment of a service. This is requested through the ICB to NHS England (London) for discussion with the relevant union.

3.8 It should be noted that PSM requests are complex and comprehensive and understood to have limited approval at a London level over the 2023/24 periods. In north east London as a result of the work completed by clinicians with providers and Place including ambulances services, in addition to mutual aid across partners, there were no PSM requests in the 2023/24 period.

4.0 Communications Plan

4.1 Throughout the periods of IA, the NEL communications team works closely with local partners to inform the public of strike days and the best ways to access NHS care, particularly for non-emergency problems with areas including:

- Press releases and interviews with local media ahead of Easter 2023 and Christmas 2023-24 strikes, including a BBC London interview with Dr Jagan John, Primary Care Partner Member.
- Strike specific content shared on our social media channels Facebook, X (Twitter prior to July 2023), LinkedIn and Next Door alongside our ongoing Find the Right Care Urgent and Emergency Care (UEC) campaign materials directing people to GPs, pharmacy, mental health services and NHS 111.
- Bursts of strike specific social media advertising on Facebook and Instagram in and around strike days targeting parents of young children, adults aged 18-40, and people from lower socioeconomic groups and then boosts on Facebook to promote the video of Paul Gilluley (this was watched 6000 times over the Christmas strikes). Search advertising on Google targeting people actively searching for urgent or emergency care has been driving 100 web views a day since November 2023. This is part of a bigger find the right care integrated digital advertising campaign.
- Social media resources, messaging and Frequently Asked Questions (FAQs) shared with around 700 contacts working for our local authority partners, NHS trusts, providers, voluntary sector and via borough partnership leads.
- Updates shared in our stakeholder newsletter and staff newsletter ahead of key strike days including our comms toolkit and update to our home page banner, urgent care campaign page and staff intranet with information about the strikes and how to get help.
- Letters to GP practices, care homes and domiciliary care agencies with actions to take ahead of and on strike days.

4.2 Communications briefings continue to be provided across the system for sign posting and supporting our patients and population during IA periods.

5.0 Impact and learning Industrial Action

5.1 Elective Care

5.2 In elective care, it is estimated that the volume of patient activity not undertaken through capacity lost to IA in 2023/24 at a system-wide level is 8,000 day case/ elective spells, 20,000 outpatient procedures and 20,000 new outpatient attendances across trusts and services.

5.3 There are several factors that drive the estimate. It is likely that cancellations are probably lower than true lost activity as the trusts would not have booked as part of their IA planning, so the slot/ session would have been cancelled to release the clinician to sustain urgent and emergency care services as described previously in this paper. In addition, the growth of the waiting list was mitigated in part by trusts working above plans to reduce waiting times as elective recovery planning.

5.4 Trusts are likely to have cancelled and rebooked patients on more than one occasion impacting on patient experience. Trusts also reported that staff who were undertaking the cancellation discussions with patients and actioning the changes to accommodate the change to clinical service provision during the strike period.

5.5 Clinical risk assessment reviews were completed in trusts, as part of a quality and potential harm review. This is a clinically led process and links to the Quality, Safety and Improvement committee in line with the overall harm review approach.

5.6 The Board is asked to note that the waiting list size grew from circa 207.5k in April 2023 to circa 215k in February 2024 (fig 3), which will have been impacted in part by IA. The patients will have been of a lower clinical priority in line with guidance, however it is recognised the patient experience potential impact.

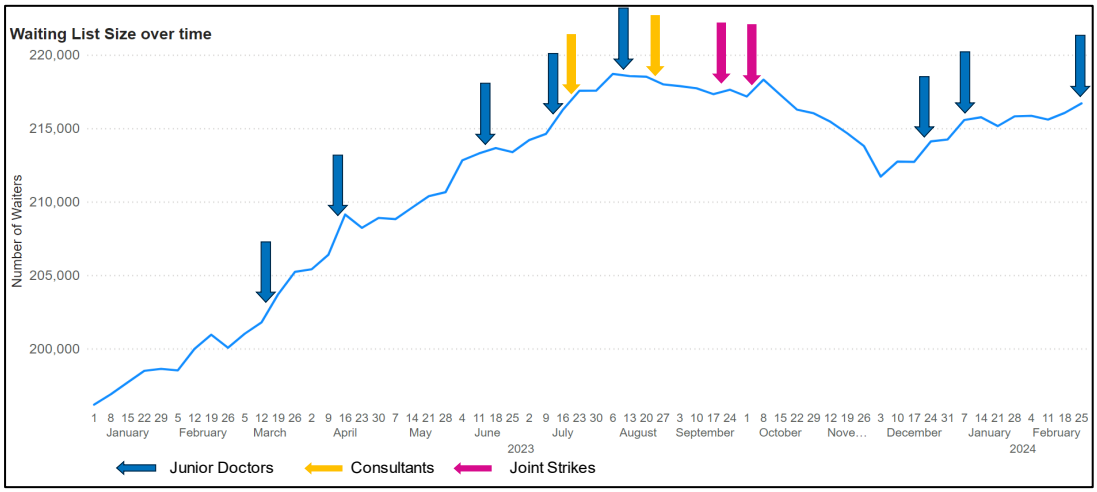


Figure 3- Growth in waiting list

6.0 Urgent and Emergency Care

6.1 At a system assessment level trusts reported that attendances, admissions and discharges remained largely in line with normal trends, we saw attendances fall in August and increase in late December. The latter may not be directly related to IA but potentially seasonal and noted to be variable across acute trusts.

6.2 The increase in attendances system wide in February 2024 between the January and February IA periods was seen at national level but is unclear if this related to IA recovery or patients choosing to attend emergency or urgent care post the IA period. Over the December, January and February periods system-wide we had periods of system OPEL level 2, however overall the system saw pressure measured at OPEL 3 at most trusts.

6.3 Mental health and acute trusts, who have shared their reviews, reported the impact of optimising discharge, and access to capacity before periods IA. For acute providers this included the Multi Agency Discharge Events (MADE), working with place colleagues on patient reviews including medically optimised and discharge ready patients in order to reduce occupancy.

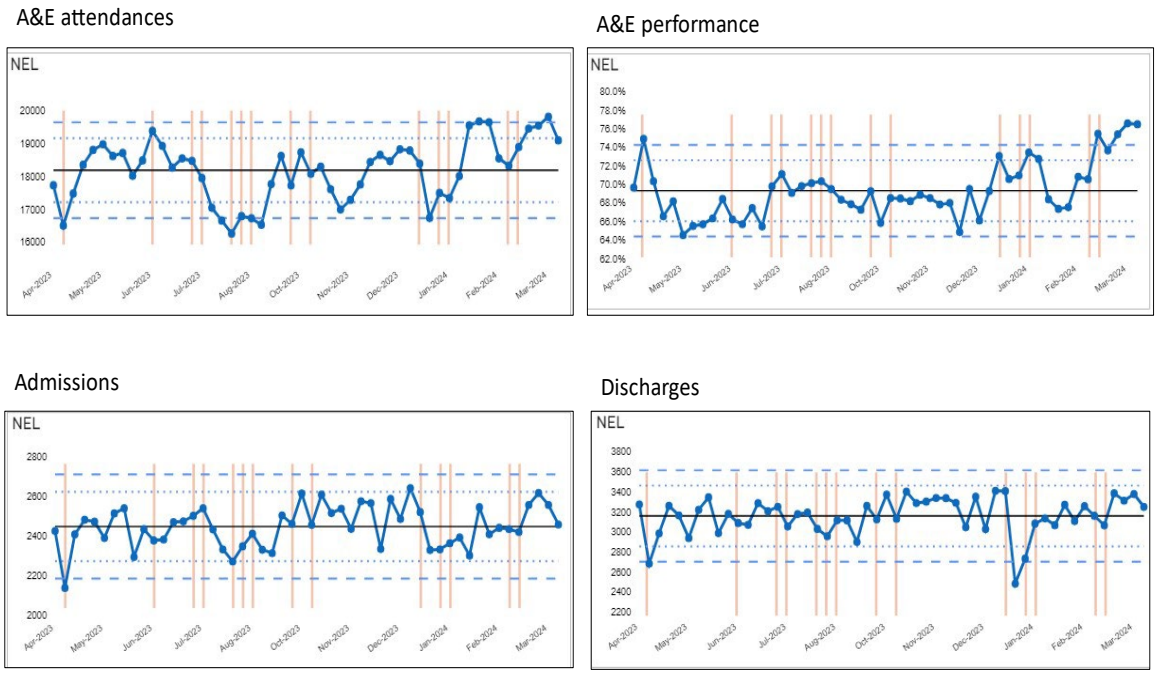


Figure 4 – urgent and emergency care

7.0 Primary Care

7.1 Primary care reported over the 2023/24 IA period that practices saw increases in demand and were busier requiring longer days working. Capacity for primary care was also challenging where practices saw IA by junior doctors.

7.2 At the start of the 2023/24 IA period, primary care commissioned extra slots to cover primacy care patients who may choose to attend Accident and Emergency (A&E) and Urgent Treatment Centres (UTCs). Additional capacity was added for same day activity including over bank holidays anticipating patient demand and probable shortage of staff.

7.3 The experience from primary care was that this capacity in some cases were not utilised for diverting patients away from A&E and UTC and patients did not access the support at the hubs. At the same time Emergency Department (ED) attendances do not appear to have significantly increased during the strike periods. This may account for accounted for by our population accessing care through primary care, alternative pathways and self-care.

8.0 Finance

8.1 The estimated costs across the system related to IA are estimated at £70.3m in 2023/24 and are broken down into cover for urgent and emergency care, impact to income loss and costs to re-provide elective work post-industrial action. (Figure 5)

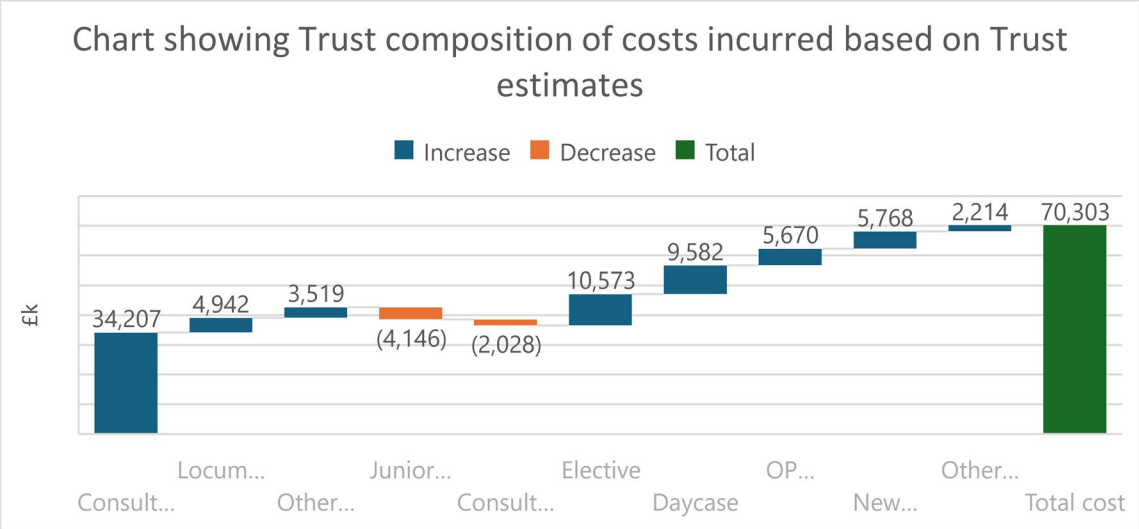


Figure 5 financial costs of IA

8.2 For 2024/25 operating planning systems were asked not to plan for industrial action and therefore this is not captured within financial or performance impact. This risk is not emerging as the first period of action takes place in June 2024/25.

9.0. Place

9.1 Within each place during industrial action there was a daily meeting between health and social care to ensure there was maximum flow from hospital back into the community. Social care gave daily reports on care home placements and were in full support of local health services.

10.0. System Learning

10.1 Trusts and the system reported the benefit of developing a strengthened command and coordination structure in managing the periods of IA for pre, during and post timelines. At a system level the NEL SCC has been positive in building coordination and support across the system for mutual aid including with ambulance services. Moving forward the system has developed an integrated documentation process, to enable a collective system after action review encompassing the BRAG assessment and cadence during IA.

10.2 The ICB Chief Nursing Officer has received assurances from provider Chief Nurses and Chief Medical Officers about their respective hospital/ Trust clinical harm review processes and specific updates are regularly planned to bring to the attention of the Quality, Safety and Improvement (QSI) Committee, this in addition to the System Incident Management calls have been implemented. The recommendation is to seek assurances of potential levels of harm as per the numbers from trusts, Planned Care Programme Board and the QSI committee.

10.3 Across the system we have seen clinicians, teams and partners continuing to work in partnership and commit to keeping our hospitals and services running. There has been significant collaboration and working across staff teams groups, ensuring safety is maintained in priority services including sustaining of trauma, stroke, maternity and critical care services. We have also noted the development of innovation in practice

including digital technology, take away medications and the roles of pharmacists, which has been adopted into business-as-usual practice.

10.4 There is feedback on the negative impact to staff both clinical and non-clinical, as a result of the cumulative impact of IA particularly in relation to the elective pathway and the requirement to operationally manage and change patient activity, This also aligns with publications by the Kings Fund and Healthwatch (National) in relation to the additional effort taken by teams over a prolonged period.

10.5 There are opportunities to continue to build on our response including the further development of the SCC to co-ordinate the response with the EPRR teams system-wide, particularly if IA should continue into the winter period. The system will continue support partners and build on its approach to after action review after each period of Industrial action through the joint EPRR governance and system coordination centre function, gathering of data and reporting including people metrics.

11.0 Risks

11.1 At a system level, there is Board Assurance Framework (BAF) risk related to Industrial Action, CNO02, with the overarching aim of “to tackle inequalities in outcomes, experience and access” with a current score of 15. Risks have also been captured at provider level.

12.0 Summary and Recommendations

1. The ICB Board is asked to note this briefing paper which has been drawn from some of the lessons learned at system and provider level.

2. The Board is asked to note this high-level briefing including the impact to elective patient care and the financial risk for the system following national recommendations for no planning for industrial action in 2024/25.

3. The Board is asked to note the risk that may potentially emerge as part of the cumulative effect of IA related predominately to elective care patients. It is recommended that the established process through each organisation’s governance process planned care collaborative and QSI committee.

4. The Board is asked to note that during the operating planning round for 2024/25 that systems were asked to plan without IA assumption. At the time of writing this paper, the NHS is about to enter a further period of action with the risks of additional costs, impact to elective care cancellations and patient experience.

5. It is recommended that the system EPRR leads share trusts’ IA high level briefs for further learning through the ICS EPRR leads group. This will support the further development of after action reviews.

6. The Board should note that there has been recent announcement by the British Medical Association (BMA) that General Practice is likely to engage in “collective action”. This is very different from the industrial action we have experienced so far and lessons from previous industrial actions cannot be extrapolated.

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	The ICS strategic priorities and progress reporting
Author	Charlotte Stone – Long Term Conditions Martin Cunnington – Babies, Children and Young People Dan Burningham – Mental Health Gareth Noble – Workforce & Employment
Presented by	Johanna Moss, Chief Strategy and Transformation Officer
Contact for further information	Hanh.Xuan-Tang1@nhs.net
Executive summary	The following reports provides an update and summary overview of the progress made to date regarding delivery against our four Integrated Care System (ICS) strategic flagship priorities – babies, children and young people; long term conditions; mental health; and workforce and employment. This report provides the following: • Recent progress against key programmes of work • Successes and new initiatives that have gone live in the past month • Key upcoming milestones • Risks to delivery The ICB Quality, Safety and Improvement Committee will continue to 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 note the progress made to date.
Previous reporting	ICB Executive Management Team ICS Strategy and Joint Forward Plan 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	Continue the bi-monthly reporting on the four strategic priorities to the ICB Board.
Conflicts of interest	There are no conflicts of interest arising from 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 improve value for money and efficiency • To support broader social and economic development
Impact on local people, health inequalities and sustainability	The report enables 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.

ICS Priority Area: Long Term Conditions (LTC) – progress report

Reporting date: June 2024

Portfolio board: NEL Long Term Condition Board (in development, scoping workshops in the summer and full start in September 2024)

Portfolio 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

Progress since the last report

Primary LTC prevention & Early identification

- Diabetes – 100 residents have started the Diabetes Prevention programme, which identifies people at risk of developing type 2 diabetes and refers them to a nine-month, evidence-based lifestyle change programme. 8,206 have been referred to the programme since November 2023
- Cardiovascular Disease (CVD) and Chronic Kidney Disease (CKD) – recruitment of specialist pharmacists to work with Primary Care Networks (PCNs)' pharmacists across NEL to identify residents at risk of CVD, CKD, diabetes and liver disease with the aim to optimise medication and provide lifestyle advice

Secondary prevention and avoiding complication

- Neurology – working with the Community Collaborative, applied to the National Neurology Programme to become a national pathfinder in neurology and secured via the Neurosurgery Specialised Services North London Clinical Network funding to support clinical leadership
- Diabetes – tested the diabetes type 1 dashboard during May 2024 to support the identification of type 1 patients and provide wrap-around care to reduce avoidable A&E admission

Co-ordinated care and equability of service

- Cancer – scoping opportunities for joint working as up to 70% of cancer patients have one or more LTC. This includes longer-term opportunities in prehabilitation and short-term making every contact count

Enabling people to live well with an LTC and tertiary prevention

- CKD—98 residents with kidney disease being monitored in acute services have signed up for a digital self-management tool to deliver exercise classes, education, and well-being support.

Successes or new initiatives that have gone live since last report

Cardiac rehabilitation – Due to extra AHP resources provided by a national bid, during May BHRUT began rehabilitation for heart failure referrals which will reduce inequity of service provision across NEL

Diabetes – 1456 residents are receiving structured digital education for type 2 diabetes, with 49% of C&H and 51% of B&D/H/R referrals from global majority residents.

Key milestones for the next reporting period

Primary LTC prevention & Early identification

- Future reporting once initiatives have been implemented including type 2 diabetes and early identification of CKD registered with hypertension and proteinuria (risk factors for CKD)

Secondary prevention and avoiding complication

- Thrombolysis –project commenced in May 2024, with pathway mapping and identification of delays in the pathway due to BHRUT and RLH in June

Co-ordinated care and equability of service

- CKD – development of CKD guidance in line with the London Kidney Network to be developed to support coordination of care and standard protocols across NEL for those diagnosed with CKD

Enabling people to live well with an LTC and tertiary prevention

- CVD – aligned to national Getting It Right First Time (GIRFT) recommendations, commence the Heart Failure (HF) Patient Initiated Follow-Up (PIFU) working group and guidance to support residents living with HF to manage their own treatment by initiating an appointment when they need one, based on their symptoms and individual circumstances.

Key issues for the Board to be aware of

- Resource constraints have resulted in a reassessment of priorities, recognising there are 61 projects focused on improving end-to-end pathways across the system. The newly established LTC delivery group and NEL Strategic Board will work together to continue to review and prioritise LTC projects across NEL.
- Stroke and Thrombolysis pathways – Peer reviews led by London and supported by the Stroke Association have highlighted some quality and staffing metrics that have not been achieved across NEL. A Development plan is being created with system partners and will be monitored by the LTC Board working in partnership with Acute Provider Collaborative and Community Collaborative who will support the improvements required across the pathway he issue was discussed in the June NEL Quality, Safety and Improvement Committee, will be considered at scrutiny committees also.
- Inequity of service provision for diabetes pump services has been identified, with quality risks related to type 1 and BYCP groups. Potential mitigations have been identified, along with a longer term business case which requires investment which has been presented at BYCP board and APC executive.

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

Long-term condition teams at place – Jointly developed report as a number of projects are co-delivered to place base teams, especially when there is a focus on local community engagement

Specialised Services – The LTC team delivers end-to-end pathways, including the delivery of specialised service priorities, including sickle cell, renal, HIV

Community Collaborative – commenced joint working on neurology, stroke and neuro-rehab pathways.

Cancer, Mental Health, Primary Care and UEC – commenced a conversation on joint working (see risk related to resources)

ICS Priority Area: Babies, Children and Young People – progress report

Portfolio vision:
To provide the best start in life for the babies, children and young people of North East London.
The Babies, Children and Young People's (BYCP) 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.

Progress since last report
Babies, Children and Young People's programme plan and priorities finalised. Progress against three BCYP priorities:

Increasing capacity for community-based care for babies, children and young people:
NEL Speech and Language Therapy Improvement Network mobilised and three priorities identified: standardising local offer for supporting children with developmental linguistic delays; staff well-being and professional development; and standardising data collection. Each priority has a lead and meetings scheduled to progress projects. Commissioning arrangements are being scoped across NEL in order to look at differences across the system.
NEL Autism Improvement Network meeting took place on 6 June bringing together key leads from across the system. Priority areas are sleep (increasing support for children and young people's needs), sensory (identifying differences in services offered and taking an evidence-based approach) and early support (including for families waiting for a diagnosis). This will be aligned to a wider project to co-design a new neuro-developmental pathway.
NEL Children's Community Nursing (CCN) there is commitment from all providers of community children's nursing services to work collaboratively to share best practice, standard operating procedures and develop a new core service specification, that reduces variation and increases the system's ability to offer care closer to home, or at home, rather than in a hospital setting.

Special Educational Needs and Disabilities (SEND)
Partnership for Neurodiversity in Schools (PINS) project – 39 schools have committed to project so far (target is 44). Deadline of 22 June for self-assessments to be completed. Parent carer forums across NEL engaged and supporting delivery of projects in schools.
NEL SEND dashboard project – design principles and process established. SEND outcomes being developed with parent carer forums across NEL. This will be aligned to a wider project to co-design a new outcomes framework for babies, children and young people and the ICB's work on population health management.

Vulnerable children
Care leavers compact – Work continues to work with care experienced young people and leaving care coaches on implementing the health element of the Care Leavers compact.
A new project has started to reduce long lengths of hospital stay across North East London.

Key milestones for the next reporting period
Project plans agreed and implemented for improvement networks.
Completion of self-assessments for Partnership for Neurodiversity in Schools project.
Agree process for developing SEND outcomes and with place leads.

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

Reporting date: July 24

Portfolio board:
Babies, Children and Young People Programme Board

Successes or new initiatives that have gone live since last report
Parents and carers engaged with and supporting development of SEND outcomes framework.
All Place's mobilised pre-paid prescriptions offer to care leavers
Pilot in North West London (benefiting whole of London) has co-designed information governance arrangements to share health, education and social care data.

Key issues for the Board to be aware of:

- Additional investments have been identified to support children and young people with Special Educational Needs and Disabilities (SEND) which address capacity gaps around community/SEND health provision.
- Alignment and levelling up of activity in secondary/tertiary care to meet needs across acute priority areas - diabetes, allergies respiratory and immunology.
- Increase awareness, resources and infrastructure to deliver engagement with children, young people, their families and carers.

ICS Priority Area: Mental Health – progress report

Portfolio vision: The aim of the Mental Health, Learning Disability and Autism (MHLDA) 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.

Portfolio vision, mission and key drivers: 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

Progress since the Last Report

1. Improving Inpatient Flow

This workstream aims to reduce out of area placements and pressures in emergency departments (ED) by increasing access to integrated local pathways that better support patient recovery and deliver improved value, which will be re-invested in local mental health and learning disability pathways.

- Costed plans to improve patient flow have been developed and are being implemented.
- System wide performance and governance structures are established.

2. Improving People's Experience of accessing mental health services

- Funded plans are in place for patient experience improvement measures. Peer support and lived experience engagement in planning and governance established.

3. Children and Young People can access different support including lived experience

- Plans to expand Mental Health Support Teams (MHSTs) in schools agreed.
- Plans to expand approaches to self-harm and eating disorders and embed Thrive model more widely.

4. People with a Learning disability have the support they need and a good experience of care no matter where they live.

- Deep dive into learning disabilities and autism services completed.

Key milestones for the next reporting period

1. Improving patient flow

- Open a crisis house in outer NEL, to deliver a non-hospital alternative to acute inpatient admission
- Increase the block contracted provision of supported stepdown beds in inner NEL (beyond the current 15 beds), to reduce delays for people when they are clinically ready for discharge, and ensure assessment for social needs happens in the most appropriate setting
- Recruit some specialist roles into our hospital discharge teams, to provide capacity around specific areas of challenge (e.g. those with no recourse to public funds)
- Mobilise our projects to improve our inpatient environments through the deployment of our Mental Health Urgent & Emergency Care capital funds. This will enable higher quality and safety of care, supportive of improved flow.

2. Improving People's experience of accessing mental health services

- System wide reporting on patient experience and waiting times.

3. Children and Young People can access different support including lived experience

- Mobilisation of new MHSTs

4. People with a Learning Disability have the support they need and a good experience of care no matter where they live.

- Implement deep dive findings: start to standardise and improve Dynamic Support Register (DSR) and Care, Education and Treatment Review (CETR) processes across NEL.

Reporting date: June 2024

Portfolio board: MHLDA Collaborative

Successes or new initiatives

111 service has been launched which links the national 24/7 telephone mental health lines with local crisis services. Community SMI access and IAPT access rates are the highest in London

Key issues for the Board to be aware of

1. Demand may continue to rise for inpatient mental health and learning disability services reducing the effect of increasing local capacity. Mitigation: close monitoring of demand trends with London wide benchmarking.
2. There may be delays and/or unforeseen costs in implementing a project of this size and complexity. Mitigation: detailed project planning, well-resourced experienced team, clear governance.

Interdependencies/interfaces to other portfolios (including Places and Collaboratives) Interdependency with the Acute Portolio over mental health presentations in ED and acute hospital beds. Joint work is being undertaken to reduce delayed transfers from ED to psychiatric beds and improve the efficiency of speciallling.

ICS Priority Area: Workforce – progress report

Portfolio vision:
To create meaningful work opportunities and employment for people in north east London

Reporting date: May 2024

Portfolio board: People and Culture Committee (Newly Formed)

Progress since last report

- Finalising metrics for workforce productivity to measure progress against the operational plan for 2024-25
- Collective agreement with providers to explore joined up approach to occupational health services across NEL providers
- System discussions ongoing with educators and providers to develop innovative pathways into employment and retention models
- Social care hub has pipeline of 71 students undertaking courses with NEL colleges to create a pipeline of employees for the care sector
- Three acute Trusts and ICB achieved London Living Wage accreditation. Community and Mental Health Trusts working towards accreditation

Successes or new initiatives that have gone live since last report

- All acute providers and ICB London Living Wage accredited
- Greater London Authority funded Social Care hub delivering opportunities for local people to work in employment
- Integrated approach
- Workforce Strategy agreed by the Board

Key milestones for the next reporting period

- Agreed and reported metrics for workforce productivity that will inform delivery of wider workforce metrics to measure delivery of the strategy
- Understanding of availability and timing of national funding streams to support long term workforce plan and strategy delivery
- Alignment with Primary Care and Training hub to deliver across primary and community care
- Workforce programme plan for 24-25 agreed
- Further work to develop a model to grow apprentices in social care
- Social care hub to convert trainees into employees

Key issues for the Board to be aware of

- Delays in release of national funding to progress delivery on the long term workforce plan and strategy.
- Delivering long term expansion plans when short term efficiencies in workforce are required to meet the 2024-25 operational plan
- Increase in workforce will require additional training capacity and infrastructure
- New initiatives funded via NHSE strategic development funds (SDF) need to consider workforce implications and ensure that funding is allocated as part of the plans to support workforce development

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, Estates, Individual Trusts, Social Care

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Financial Overview - Month 3 2024-25
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 paper outlines the financial performance for the ICB and Integrated Care System (ICS) following the final operating plan submission made in June 2024. • NHS England (NHSE) agreed operating plan set a £35m deficit control total for the ICS. Delivery of this assumes efficiency delivery of £289m across north east London (NEL) providers and the ICB. • At month 3 the ICS is reporting a £59.5m deficit, a £32.4m variance to plan. The ICB's share of the variance is £6m. • Month 3 includes the costs of the recent junior doctor industrial action. These have been estimated at £4.6m across the ICS with no mitigation confirmed by NHSE. It is possible, mitigation will be by way of an allocation increase or change to our control total. Confirmation will be provided when received. • Since reporting month 3, NHSE has provided a specific funding allocation of £3.8m to cover the costs of Bart's same day emergency care (SDEC) service. This will improve the cumulative position by approximately £1m when reporting next month. • In line with reporting requirements, the ICB and ICS are reporting a forecast breakeven position at Month 3. • There is a high level of risk associated with the delivery of the forecast position. The forecast position assumes that the ICB and ICS will deliver their savings programmes and that there will be mitigating actions to cover other run rate pressures. • An enhanced governance process supporting system wide recovery and sustainability has been put in place across the ICS, including the appointment of a Financial Sustainability Director. • The ICB Board is asked to note the month 3 financial position, and the mitigations being taken.

	• The ICB Board is asked to note the level of risk in delivering the year-end financial position.
Action required	• Note the contents of the report and the risks to the financial position.
Previous reporting	ICB Finance, Performance and Investment Committee, ICS Executive Committee.
Next steps/ onward reporting	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
Conflicts of interest	No conflicts of interest 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 24/25 budget.
Impact on local people, health inequalities and sustainability	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Act) such as disability and that is included in the report.
Impact on finance, performance and quality	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.
Risks	There is a high level of financial risk in the delivery of the 24/25 financial plan. The system has included circa £230m risk to the financial position in the financial plan submitted in June 2024. These risks will significantly impact the financial position if they materialise. 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 3 financial position and the risks associated with delivery of the Integrated Care System (ICS) and ICB financial plan.

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

2. Month 3 Finance Overview

The month 3 year-to-date position across the north east London (NEL) system is a deficit of £59.5m, which is a variance to plan of £32.4m. This is made up of a provider overspend variance of £26.4m with an ICB overspend variance of £6m.

At month 3 the ICS forecast is a year-end deficit of £35m. This is in line with the submitted operating plan deficit.

There is a high level of financial risk within the reported position that may impact the delivery of the year-end position. The year-to-date system run rate at month 3 suggests a year-end

deficit greater than the £35m deficit control total and ongoing delivery of the cost improvement programme and identification of further mitigations will be critical to the ICS and its ability to deliver the year-end position.

2.1.1 ICS Month 3 and Forecast Position

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

Organisations	Month 3 YTD			Month 12 Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	(7.5)	(12.8)	(5.4)	(10.2)	(10.2)	0.0
Barts Health	(3.0)	(11.7)	(8.7)	(14.2)	(14.2)	0.0
East London NHSFT	(2.6)	(8.2)	(5.6)	0.0	0.0	0.0
Homerton	(5.2)	(6.9)	(1.7)	(6.3)	(6.3)	0.0
NELFT	(3.6)	(8.7)	(5.2)	(4.9)	(4.9)	0.0
Total NEL Providers	**(21.9)**	**(48.4)**	**(26.4)**	**(35.6)**	**(35.6)**	**0.0**
NEL ICB	(5.2)	(11.2)	(6.0)	0.6	0.6	0.0
NEL System Total	**(27.1)**	**(59.5)**	**(32.4)**	**(35.0)**	**(35.0)**	**0.0**

All providers and the ICB are reporting year-to-date pressures at month 3.

The key pressures at a system level are as follows:

- **Efficiency and cost improvement plans** - the total system efficiency and cost improvement plan at month 3 is £51.1m. Of this £40.2m has been delivered, leaving a year-to-date under delivery against plan of £10.9m (£6m providers and £4.9m ICB).

  All organisations except for Homerton Healthcare, are forecasting full achievement of their efficiency targets at year-end. Homerton's efficiency slippage is under review and will be validated through the sustainability reporting arrangements.

Efficiencies	Month 3		
	Plan £m	Actual £m	Variance £m
BHRUT	6.0	3.5	(2.5)
Barts	26.2	23.1	(3.0)
ELFT	3.0	2.0	(1.0)
Homerton	1.7	2.3	0.6
NELFT	2.3	2.3	0.0
Total Provider Effieciency	**39.2**	**33.2**	**(6.0)**
NEL ICB	11.9	7.0	(4.9)
Total System Efficiency	**51.1**	**40.2**	**(10.9)**

- **Run rate pressures** – at month 3, mental health providers have reported pressures in relation to additional independent sector beds (ECRs) purchased above planned levels and increased acuity of patients on their wards. Run rate pressures at Barts include renal dialysis capacity and same day emergency care (SDEC) costs, which at the time of reporting the month 3 position, had no mitigation identified. However, NHS England

(NHSE) has subsequently confirmed that a £3.8m allocation will be provided to cover the Bart's SDEC pressure. The ICB has reported year-to-date pressures, mainly in continuing health care (CHC).

- **Impact of Industrial action** – Part of the provider year-to-date pressure is driven by the impact of industrial action at the end of June. Providers are in the process of fully quantifying this. Early indications show that Barking, Havering and Redbridge University Hospitals Trust (BHRUT), Barts Health and Homerton Healthcare incurred costs of circa £4.6m in relation to industrial action. Further updates will be given to the ICB Board and Finance, Performance and Investment Committee (FPIC) once the costs have been fully quantified.

- **Pay, including agency costs** – providers are required to operate within an agency pay cap and whilst this has not been breached, most NEL providers are reporting pressures with their agency staff usage. Year-to-date spend on agency staffing is £33.3m against planned spend of £37.3m. Barts Health, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) are all reporting agency costs below their plan, with BHRUT and Homerton Healthcare showing small overspends. At year-end, the ceiling set for agency usage is £134m. Providers have submitted a forecast of £134.5m.

In addition to the revenue pressures described, the system is also reporting a capital variance to allocation of circa £42m. The reason for this is that the costs submitted in the latest operating plan are more than the system allocation given. A request has been submitted to the national team for an in-year increase to match the plan. Further updates will be provided throughout the financial year.

2.1.2 – ICB Year-to-date and forecast position

The ICB year-to-date position is an adverse variance to plan of £6m. In line with the operating plan submission and national reporting requirements the forecast surplus at year end is £0.6m

The year-to-date position is driven by under delivery of efficiencies (£4.9m) and run rate pressures (£1.1m). The summary year-to-date and forecast position is shown in the table below.

	Month 3 Variance £m	FOT Variance £m
Current Variance to Plan	(6.0)	0.0
Acute	(0.2)	(2.0)
Mental Health	0.2	0.5
Community Health	(1.4)	0.0
Continuing Care	(2.8)	(3.0)
Primary Care - Co Commissioning	(0.1)	(0.3)
Primary Care - DOPs	0.0	(0.0)
Primary Care - Other	0.0	(0.2)
Running Costs	(0.0)	0.0
Programme Wide Admin (Programme Corporate)	(0.2)	(0.2)
Other	(1.6)	5.2
Total Variance to Plan	**(6.0)**	**0.0**
Planned Surplus	(5.2)	0.6
(Deficit) / Surplus	**(11.2)**	**0.6**

Efficiency slippage at month 3 is £4.9m. However, the current forecast assumes programmes will continue to deliver, recover slippage to date and that by year-end, the savings plan will deliver the £69.2m plan.

The position on ICB savings is shown in the table below:

Efficiencies	YTD Efficiency Plan £m	YTD Actual £m	YTD Efficiency Variance £m	FOT £m
CHC	2.4	0.3	(2.1)	9.8
Prescribing	3.4	3.4	0.0	13.7
Targeted Funds	1.3	0.4	(0.9)	5.0
CRG	3.0	1.1	(1.9)	33.6
Corporate	1.8	1.8	0.0	7.1
Total	**11.9**	**7.0**	**(4.9)**	**69.2**

Run rate pressures in the year-to-date position are £1.1m and are £5m at year-end. It is assumed that the ICB will deliver further mitigations of £5m to meet the year-end surplus of £0.6m. The main run rate drivers are:

i. Acute pressures in relation to the urgent care pathway with independent sector activity increases forecast, thus increasing year-end financial forecasts.
ii. Continuing Healthcare (CHC) has a run rate pressure of £0.7m with a forecast overspend of £3m.

The ICB is reporting that it will meet its revised forecast position, a surplus of £0.6m. To achieve this target the following assumptions are included in the forecast:

i. Efficiencies are assumed to be in line with the total savings target identified and will be required to deliver fully to meet the revised forecast position.
ii. Further mitigations will be identified to offset the forecast run rate risk.
iii. The risks within the ICB operating plan will be managed and mitigated.
iv. Further opportunities will be identified throughout the financial year that will contribute to financial balance.

3. Summary Month 3 Financial Position

The ICS has reported a year-to-date variance to plan of £32.4m at month 3. In line with NHSE reporting requirements and the operating plan, the full year forecast has been maintained at a deficit of £35m.

An extrapolation of the year-to-date position suggests the year-end deficit plan may be at risk. The current forecast assumes that delivery of efficiencies will increase over the remainder of the financial year and that the current run rate risks will be managed and mitigated back to plan.

Continued delivery of the opportunities identified through the programme work and management of the risks to the reported position is critical to achieving the reported year-end position.

The ICB Board is asked to note the month 3 financial position.

3.1. Financial Sustainability and mitigations

The ICB and ICS has reviewed and revised its system-wide recovery and sustainability arrangements. This includes the appointment of a Financial Sustainability Director who has overseen the introduction of a revised governance model across the ICS which includes;

- A system-wide financial sustainability committee, chaired by a Non-Executive Member and reporting into the ICB and each providers' finance and performance committees. The system-wide sustainability committee will be holding all organisations accountable for delivering the system control total and will be assuring the delivery of the ten, system-wide, workstreams that have been identified.

- The establishment of an ICB Financial Sustainability Board chaired by the Chief Executive Officer to manage delivery of the £69m efficiency programme. The Board is supported by the Commissioning Review Group which is tasked with reviewing those previous service investments that can potentially be stopped and deliver a savings target of £33m.

- Communications to staff in relation to financial sustainability has increased, along with the implementation of standardised processes and paperwork.

- The ICB and providers are holding monthly one-to-one financial assurance meetings to discuss and agree plan performance, pressures and recovery actions.

In addition, the national NHSE team has implemented a process which monitors key financial metrics with a view to determining the systems requiring support to help recover positions. This is being developed by NHSE as an Investigation and Intervention (I&I) process and will see support provided by external consultancy firms. At month 2, NEL was rated as a system

that may need support and discussions are ongoing with NHSE in relation to potential targeted support to aid financial recovery and sustainability.

4. System Risks

Risks included in the operating plan total circa £230m. These risks relate to delivering the system savings programme, run rate pressures, additional costs outside of the current plan (for example, capacity pressures, winter pressures) and income risks to providers.

Whilst the year-to-date position suggests that some of these risks have materialised, the forecast assumes that the risks will be managed, and that the system will deliver its year-end control total. Failure to manage the financial risk will negatively impact the year-end financial position and the systems ability to manage within its control total as well as being required to repay the debt in future years.

Risks will continue to be reported on and regular updates will be given to the ICB Board and the Finance, Performance and Investment Committee.

North East London
Integrated Care Board

NHS North East London ICB board

31 July 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	• This is the first iteration of the 2024/2025 performance report tracking against 2024/25 operating plan trajectories. • The attached set of slides describes the performance of the overall system across seven domains of performance in April 2024. For Urgent and Emergency Care (UEC) May 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 April 2024 for the fifth consecutive month. The number of the longest waiting patients (over 104 weeks and over 78 weeks) however, continues to decrease. • The cancer faster diagnosis standard was also achieved against trajectory for the month. • Cancer 62-day performance fell slightly in April 2024 just below the 70% March 2025 requirement but was above planned trajectory for the month. • The number of patients waiting for a diagnostic test and those waiting six weeks or more for a diagnostic test increased in April 2024 at all three north east London (NEL) Trusts albeit remains the ninth best performing ICB nationally. • The May 2024 published position against the 4-hour Emergency Department (ED) standard was improved from the April 2024 position, but below trajectory for the month at NEL level, both Barts Health and Homerton Healthcare falling below trajectory for the month. • The number of GP appointments delivered for the month (April 2024) was above plan, with 90% being seen within two weeks. • NEL continues to have good discharge performance in comparison to other London systems. • Virtual ward occupancy in April 2024 was higher than the March 24 exit position and above trajectory for the month. • Referrals to urgent community response services were below planned levels for the month.

	• Due to national updates to the Mental Health Services Data Set month 1 data is not available at the time of reporting, with the exception of Talking Therapies and Dementia Diagnosis data. Performance in all three Talking Therapy measures was achieved against trajectory for the month. Dementia Diagnosis however remains challenged.
Action / recommendation	The Board is asked to note the report. Further queries may be raised with the NEL ICB Performance Team if required.
Previous reporting	Each of the performance domains has associated improvement activity and this is managed through system-wide Boards or Collaboratives, for example, the Planned Care Board, Acute Provider Collaborative, and the UEC Programme Board
Next steps/ onward reporting	The NEL ICB Performance report interfaces the Executive Management Team, Finance, Performance and Investment Committee, Quality, Safety and Improvement Committee 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 Equality Impact Assessment is not required for this report.
Impact on finance, performance and quality	Industrial action continues to impact patients, finance and performance.
Risks	The risks and issues are described against the relevant performance domains.

1.0 Purpose of the report

1.1 This is one of a regular series of performance reports which come to each meeting of the Board. The aim is to provide assurance to the Board 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 April 2024. For Urgent and Emergency Care (UEC) May 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 This is the first iteration of the 2024/2025 performance report tracking against 2024/25 operating plan trajectories.

2.2 2024/2025 operating plan trajectories are predicated on no further industrial action (IA) (a core national planning assumption) and as such, there is some risk to delivery – the latest round of IA taking place 27 June to 2 July 2024.

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

2.4 The North East London (NEL) system remains in Tier 2 for UEC (with effect of January 2024). As a Tier 2 system, NEL continues to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan.

2.5 A deep dive on diagnostics (previously presented to the Finance, Performance and Investment Committee (FPIC) on 24 June) is presented alongside this report.

3.0 Performance in April and May 2024

3.1 The total waiting list in planned care increased in April 2024 (+1,816 pathways) for the fifth consecutive month. The waiting list is now +13,927 pathways and 7% higher than the position in April 2023, driven by increases at all three Trusts across both admitted and non-admitted waiting lists.

3.2 The number of long waiting patients (more than 104weeks and more than 78weeks) decreased in April 2024 to a total of two pathways waiting over 104 weeks and 214 pathways waiting 18 months or more (over 78 weeks). The number of pathways waiting over 104 and 78 weeks is down by ten pathways and 207 pathways respectively from the December 2023 position.

3.3 The number of patients waiting greater than 65 weeks increased in April 2024 (+129 pathways), to a total of 1,877 pathways. This, however, remains nearly 1,000 pathways fewer than in December 2023. Collaborative capacity transfers between all three NEL Trusts are ongoing to support delivery of the over 65 week wait September 2024 ambition. There are however some specialty risks to delivery.

3.4 Achievement against the 28-day Cancer Faster Diagnosis Standard was 75.6% at a NEL-level, all three Trusts achieving over 75%. Performance against the 62-day combined Cancer standard for the month was 69.2%, above trajectory and only just below the 70% March 2025 requirement.

3.5 At a NEL-level diagnostic activity levels were delivered above trajectory in four modalities (MRI, CT, NOUS and Echo). The number of patients waiting for a diagnostic test (61,194) and those waiting six weeks or more (12,017) increased in April 2024, equating to 80.36% performance. A deep dive on diagnostics (previously presented to FPIC on 24 June) is included alongside this report.

3.6 The published position against the 4-hour Emergency Department (ED) standard at NEL-level was 74.86%. Performance at Barking, Havering and Redbridge University Hospitals Trust (BHRUT) remained positive (79%), meeting trajectory for the month. Barts Health performance (67%), while below trajectory, was improved on the April position but remains below March 2024 achievement. Homerton Healthcare performance was not achieved against trajectory, but delivered 80% of patients seen, discharged or transferred within 4-hours of arrival.

3.7 The number of GP appointments delivered for the month (April 2024) was above plan, with 90% being seen within two weeks (a new operating plan metric for 2024/25).

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

3.9 Virtual ward occupancy in April 2024 was higher than the March 24 exit position and above trajectory for the month at 75.96% against a trajectory of 70.89%.

3.10 Referrals to urgent community response services were -160 referrals below plan of 1,910 for the month.

3.11 Due to national updates to the Mental Health Services Data Set, month 1 data is not available at the time of reporting, with the exception of Talking Therapies and Dementia Diagnosis data. Performance in all three Talking Therapy measures (including two new measures for 2024/25) was achieved against trajectory for the month. Dementia Diagnosis however remains challenged, falling 6% below plan in April 2024 at NEL level and only Tower Hamlets achieving against threshold.

4.0 Risks and mitigations

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

5.0 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 NEL 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.

6.2 Also attached is a deep dive into diagnostics that was requested by the Board and has also been presented to the Finance, Performance and Investment Committee.

7.0 Author

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

Planned Care Recovery & Transformation – April 2024

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published April-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Planned Care	Total Waiting List (volume)	✗	219,778	221,515	▲	
	Waiting List >104 Weeks (volume)			2	▼	
	Waiting List >78 Weeks (volume)			214	▼	
	Waiting List >65 Weeks (volume)	✓	1,901	1,877	▲	
	Inpatient Elective Activity (% 19/20 BAU)		102.00%	112.03%	▲	
	Consultant Led Outpatient Attendances (% 19/20 BAU)		101.56%	103.33%	▲	
	Percentage of first appointments or follow-up appointments which attract a procedure tariff	✗	45.58%	45.47%	▼	

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 Apr-24 for the 5th consecutive month to 221,515 pathways (+1,816 pathways on the Mar-24 position) driven by increases at all three NEL Trusts (non-admitted). Barts Health above trajectory for the month.
- The waiting list is +13,927 pathways higher than Apr-23, equating to an increase of circa 7% driven by increases at all three Trusts (admitted and non-admitted).
- There were 2 pathways >104ww in Apr-24 at BHRUT (admitted), one owing to data quality and one complex pathway.
- The total number of patients waiting 18 months or more (>78 weeks) decreased for the 3rd consecutive month in Apr-24 to 214 pathways (-4 pathways on the Mar-24 position), 191 pathways at Barts Health and 23 pathways at BHRUT. This is a reduction of 81 pathways compared to Apr-23, and a reduction of more than 200 pathways since Dec-23, despite IA.
- There were 1,877 pathways >65ww in NEL in Apr-24 and increase of 129 pathways on the Mar-24 position, increase driven by Barts Health (+114 pathways, driven by the non-admitted waiting list) and BHRUT (+19 pathways, across the admitted and non-admitted waiting list).
- Consultant led activity in Apr-24 was 103% of 2019/20 levels (all outpatient appointments consultant and non-consultant led were 112%). The proportion of all outpatient attendances for clock-stopping activity (first appointments or follow-up appointments attracting a procedure tariff) was 45.5%, just below plan (Barts Health 46.3%, above plan; BHRUT 44.1%, below plan; Homerton 44.6%, above plan).
- Total inpatient admitted activity undertaken at the three NEL Trusts in Apr-24 was 112% of 2019/20 levels (114% day-case admissions and 100% ordinary admissions).

Workstream Issues and Risks

- Overall waiting list size – circa 5% growth (+11,000) pathways over the last 5 months
- The number of patients continuing to wait >78 weeks (at Barts Health, BHRUT and ISPs)
- Delivery of compliant trajectories for 0 >65ww by Sep-24. This is with risk and predicated on no further IA (IA has recently been undertaken 27/06 – 02/07) and ongoing movement of activity via the NEL Collaborative Capacity programme. There are specialty risks to delivery of >65ww at both Barts Health and BHRUT. Homerton is not currently forecasting risk to delivery, but this is subject to collaborative capacity transfers.
- Ongoing impact of IA on the long waiting position, delivery of 24/25 ambitions and to overarching programme momentum
- Potential impact of 4th July general election
- Impact of the requirement to deliver financial balance on delivery of elective activity, diagnostic capacity, waiting list initiatives / long waits and pathway transformation
- Maximisation of movement of activity via the NEL Collaborative Capacity programme and impact of patient choice as a barrier to this
- Maximisation of NEL TIF (Targeted Investment Fund) theatres as system assets

Mitigating Actions and Next Steps

- Barts Health remains in Tier 1 for elective recovery
- Daily >78ww calls with Barts sites continue, with CEO accountability of site level trajectories
- Barts Health and BHRUT continue to explore all options to deliver >78ww incl. financial discussions, waiting list initiatives, use of locum resource, use of IS capacity via subcontracting arrangements and patient choice via ICB contracts, insourcing / outsourcing, validation opportunity and patient contact, etc.,
- Collaborative capacity transfers between all three NEL Trusts have been completed via bulk transfer of large volumes of pathways via IPT to support PTL management and ability to treat >65ww risks prior to Sep-24. The scope of the NEL collaborative capacity meeting has been revised to include oversight and delivery of >65ww
- Ongoing review to of collaborative capacity arrangements to consider opportunities to expand to other specialties and move further down the pathway (<65ww) where possible
- Use and uptake of NHS capacity within the IS by NEL NHS Acute Trusts (Barts Health, BHRUT and Homerton) via the ICB contract in line with patient choice and in scope of ERF
- 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 with focus on application of RTT rules and access policy principles - 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
- Exceptional face to face meeting of the Planned Care Board in July (and each quarter going forward). The July meeting is due to focus on delivery of >65ww by Sep-24 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)
- Further development of the referral deep dive completed in Jun-24 at PCN level to support place-based partnerships and borough delivery directors
- Ongoing discussions to agree the NEL TIF theatre proposal

Outpatient Transformation – April 2024

SRO:	Claire Hogg	RAG	AMBER

	Metric	Latest Published April-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Outpatient Transformation	A&G/Specialist Advice (volume)			28,175	▲	
	A&G/Specialist Advice (% OPFA)			33.93%	▼	
	Specialist Advice Diversion rate (%)			20.00%	▼	
	Moved or Discharged to PIFU (volume)	⊗	5,550	4,892	▲	
	Moved or Discharged to PIFU (% OPA)	⊗	2.46%	2.05%	▲	

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

Key Headlines

- In Apr-24, 28,175 specialist advice requests were raised by NEL GPs, equating to 33.9% of all first outpatient attendances and 20% diversion rate (requests returned with advice and no onward booking). There is no trajectory for specialist advice in 24/25. NEL delivery continues to compare favourably to London performance - 19% of all first outpatient appointments and 18% diversion rate in Apr-24. NEL is ranked 16th out of 42 ICBs nationally in April.
- In Apr-24, 4,892 patients were moved or discharged to PIFU, equating to 2.05% of all outpatient attendances (Barts Health 1.3%; BHRUT 2%; 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 April.

Workstream Issues and Risks

- Volume of patients awaiting outpatient appointments and treatment (circa 6% increase from Apr-23, +11,026 pathways) - increase across all three NEL Trusts
- 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 – current pause to further A&R roll-out at Barts Health due to Primary Care concerns re transfer of work and associated payment. This is now escalating to LMC action
- 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
- Ongoing impact of IA on the long waiting position, delivery of 24/25 ambitions and to overarching programme momentum
- Volume and deadlines of asks stemming from national programmes e.g. 'Further Faster' and GIRFT' particularly considering IA, further compounded by lack of national and regional coordination of asks
- Complexity, risks and unintended consequences relating to the 'Provider Selection Regime' under choice regulations - there has been increased activity in terms of providers requesting a contract under the choice guidelines, leading to unintended consequences and risks in some instances including movement of activity away from Trusts, pathway changes (e.g. unplanned cessation of gastro SPA), potential financial impact and duplication

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
- Ongoing Use of the NEL 'sharing best practice group' and 'masterclasses' to share learning – masterclasses in DNAs/missed appointments and A&G/R held to date
- 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
- External review of A&G/R impact and outcomes (quantitative and qualitative) incl. Primary and Secondary Care being scoped and commissioned – funding mechanism to be agreed
- Continued participation in national GIRFT and 'Further Faster' programmes
- Continued progress in work streams for MSK, Women's Health Hub (Gynae), ENT, Ophthalmology and Dermatology – Women's Health strategy launch postponed until Sep/Oct due to pre/post general election period
- Work with NEL Community services (e.g. Communitas ENT) to streamline referral pathways to ensure referrals are directed to the most appropriate site based on clinical appropriateness and capacity (while in adherence with patient choice)
- 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. Use of Rego for Neurosurgery also being explored

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 – April 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 April-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)	✓	83.23%	84.00%	▼		✓	114.33%	131.13%	▼	
	Computed Tomography (CT)	✓	76.29%	88.43%	▲		✓	130.28%	139.61%	▼	
	Non-obstetric Ultrasound (NOUS)	✓	79.45%	81.66%	▼		✓	103.80%	110.22%	▼	
	Dexa Scan	×	80.73%	62.10%	▼		×	107.91%	89.00%	▲	
	Colonoscopy	✓	89.00%	90.25%	▲		×	130.60%	112.74%	▼	
	Flexi Sigmoidoscopy	×	78.58%	61.24%	▼		×	107.16%	80.72%	▼	
	Gastroscopy	✓	66.82%	73.34%	▼		×	135.78%	129.52%	▲	
	Echocardiography	✓	95.87%	98.43%	▼		✓	100.15%	118.24%	▼	
	Audiology	×	95.26%	38.11%	▼		×	62.95%	87.36%	▲	

Key Headlines

- **Waiting List:** The overall NEL diagnostics waiting list increased in Apr-24 to 61,194 (+1,819 Pathways compared to the previous month) driven by increases across all three NEL Acute Providers.
- **> 6 Weeks Backlog Position:** The number of pathways waiting > 6weeks (backlog) for a diagnostic test saw an increase in Apr-24 to 12,017 pathways (+1,586 pathways compared to Mar-24), driven by increases across all three NEL Providers.
- **DM01 Performance:** NEL achieved a performance of 80.36% in Apr-24, down from the Mar-24 NEL position. DM01 performance was achieved against trajectory in Apr-24 at NEL level in six of the nine modalities - MRI, CT, NOUS, Colonoscopy, Gastroscopy and Echo. >95% DM01 performance (Mar-24 ambition) was achieved at BHRUT in CT, NOUS, DEXA, Colonoscopy, Flexi-Sig, Gastroscopy, and Audiology. Additionally, >95% was achieved at Homerton in NOUS and DEXA. All three Trusts achieved >95% in Echocardiography.
- **Activity**: NEL delivered activity levels above trajectory in four(4) out of nine (9) modalities this month. MRI (All three Providers), CT (All three providers), NOUS (Barts and Homerton) and Echo (All three Providers).
- **Benchmark:** Although our DM01 position remains challenged in comparison to our peers, we are doing comparatively well and we are now back at 9th best performing system in the country from the Apr-24 DM01 data.

Workstream Issues and Risks

- **Industrial Action:** The potential for industrial action remains an unpredictable risk, affecting the timely delivery of diagnostics tests.
- **Financial Constraints:** 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.
- **Waiting List and Backlog Position:** The volume of patients on the overall NEL Diagnostics Waiting List and those waiting >6 Weeks (backlog) for a diagnostics test continues to be a risk. The residual Paeds Audiology backlog at Barts Health needing to be cleared by Communitas anticipated at the end of Q2 2024/25. Endoscopy backlog position across NEL also remains challenged but in the main attributed to Barts Health and a recovery action plan has been devised. Reviews and discussions continue via the Endoscopy Network,
- **Quantum of surveillance patients to be added to DM01**: 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 Operating Plan**: The delivery of the submitted 2024/25 Op Plan Trajectories will be difficult given NEL System's financial position, workforce challenges and demand outstripping capacity in many areas.

Mitigating Actions and Next Steps

- **Recruitment**: Four clinical Network leads – (x2 Imaging, Physiological Measurements and Endoscopy) have been appointed, 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 continues.
- **CDC Funding:** Secured around £31m of revenue to fund our CDCs in 2024/25 which is positive news for our patients and residents of NEL. A new scanner acquisition (MRI) is also in the pipelines.
- **Collaborative banking** : Trial starting with Barts Health - Royal London workforce (Nurses, admin staff and radiographers) albeit challenges with getting the parity with pay identified.
- **Demand and Capacity planning**: 2024/25 Demand and Capacity planning reviewing workforce and equipment is underway
- **Improvement Plans**: Additional capacity and activity are planned across Acute and Community sites to address this backlog during 2024/25.
- **Restoration**: Diagnostic activity across NEL remains on track with the imaging modalities delivering activity above the 2023/24 Operational Plan Trajectories.
- **Recovery Action Plan**: Barts Health recovery action plan (RAP) remains in place for the imaging modalities (MRI, Cardiac CT, NOUS) as well as Audiology
- **Backlog Clearance:** Barts Health's Paeds Audiology backlog clearance with Communitas commenced mid-Feb-24 and aim to clear the backlog at the end of Q2 2024/25 with oversight from NEL ICB Performance colleagues.
- **Performance Goals & Commitment :** The final submission of the 2024/25 Operating Plans for Diagnostics has been made in line with NHSE Guidance. NEL remains committed to delivery of no more than 5% of patients waiting greater than 6 weeks by 24/25.
- **Escalations:** Bi-weekly and Monthly discussions continue at the Diagnostics Programme Board and Networks with escalations to Planned Care Board, as necessary. Reinvigoration of the NEL Diagnostics programme to ensure issues are being mitigated locally and jointly ongoing alignment, sharing of best practice and collaboration.

Governance

- **Strategic Meetings**: 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.
- **Diagnostics Escalation Management**: Escalations are managed by the NEL Imaging, Endoscopy and Echo Networks; these are well established with regular meetings held on a bi-weekly basis. Quarterly meetings also ongoing with NHSE colleagues.
- **Performance Reviews:** The NEL Performance team holds regular discussions with Acute Providers to monitor diagnostics performance against constitutional standards and progress in line with the Operational Plan Trajectories.

Cancer – April 2024

SRO:	Femi Odewale	RAG	AMBER

	Metric	Latest Published April-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer	Faster Diagnosis Standard (%)	✓	74.84%	75.63%	▼	
	62 Day Standard -(62 day treatement combined) (%)	✓	69.16%	69.22%	▼	

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

- **Faster Diagnosis Standards:** NEL achieved a performance of 75.63% against the 28-day diagnostic standard in Apr-24, above the monthly set trajectory. All three NEL providers delivered FDS performance above trajectory this month which represents a positive start to the year. There is a national requirement to deliver 77% FDS by Mar-25 and performance indicates we on track to delivering this.
- **31-Day Combined Performance:** NEL exceeded the 31-day standard with a performance of 96.28%, with both Barts and BHRUT meeting or surpassing the 96% benchmark this month.
- **62-Day Combined Standard:** NEL achieved a performance of 69.22% against the combined 62-day standard in Apr-24, above the monthly set trajectory but marginally below the 70% NHSE requirement. Both BHRUT and Homerton delivered against plan.

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 risks.

Mitigating Actions and Next Steps

- **Collaborative Pathway Enhancement:** 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. NEL is also working closely with NHS England and all three providers to facilitate the completion of the Pathway Analyser Tool
- **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 final submission 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 against the 62-day standard by March 2025.
- **Inter Provider Transfers**: NEL CA is working on the Inter Provider Transfer Policy between the Trusts to identify and unblock pathway challenges impacting on key Tumour sites.

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 – May 2024

SRO:	Paul Gilluley	RAG	RED

	Metric	Latest Published May-2024				
		Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
UEC	Total A&E Attendances inc UTC stand alone sites (volume)	✗	85,503	92,148	▲	
	A&E 4-Hour Performance All Type inc UTC stand alone sites (%)	✗	78.30%	74.86%	▲	
	A&E 4-Hour Performance Type 1 (%)	✗	64.01%	59.27%	▼	
	A&E 4-Hour Performance Type 3 inc UTC stand alone (%)			93.95%	▲	
	12-hour Trolley waits - from Arrival (Percentage)	✗	National Req. ZERO	15.05%	▼	
	Percentage of adult G&A beds occupied by patients not meeting the criteria to reside	✗	9.47%	9.83%	▲	
	Percentage of occupied G&A beds occupied by patients with a length of stay (LoS) of 21 days and over			20.96%	▼	
	Average Category 2 Ambulance Response Time (Apr-24)	✗	00:34:54	00:38:01	▲	

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

4 Hour Performance: 75% of patients were seen within 4 hours of arrival to ED. This is an improvement on the Apr-24 position, but below trajectory for the month at NEL level. Both standalone UTCs exceeded locally agreed trajectories. Barts delivered 67% performance against 76% trajectory, Homerton delivered 80% against 83% trajectory and BHRUT were the only acute provider in NEL to achieve their trajectory: 79% against 76% plan. Performance improvement on the Apr-24 position was driven by improvements in BHRUT and Barts in the context of increased attendances compared to the previous month. Draft Jun-24 position signals similar trend with BHRUT being the only acute provider achieving their trajectory for Jun-24 as well.

12 Hour Trolley Waits: In May-24, 15.1% of our patients waited more than 12 hours from arrival (equating to 7,995 patients compared to 15.2% in Apr-24 and 7,455 patients, reflecting the increase in attendances). 12 hour trolley waits is a key area of focus for the system, overseen through refreshed Hospital Flow and Mental Health in ED and Mental health Flow transformation pillars.

Adult G&A Bed Occupancy by Patients with NCTR: The percentage of adult G&A beds occupied with patients who no longer meet criteria to reside increased compared to the previous month (9.83% in May-24 compared to 9.05% in Apr-24) and adverse to trajectory of 9.47% for the month.

Length of Stay Over 21 Days: The percentage of total G&A beds occupied with patients with a length of stay over 21 days reduced compared to previous month (20.96% in May-24 compared to 21.49% in Apr-24). This is based on the average number of long staying patients, which saw a reduction to 567 from 587 in Apr-24 but did not meet May-24 trajectory of 517.

Category 2 Response: In latest available data, LAS reported category 2 response time for NEL in Apr-24 as average of 38 minutes. This was a deterioration from 36 minutes in Mar-24 and against London-wide plan of 34 minutes and 54 seconds.

Workstream Issues and Risks

- Patients waiting for 12 hours including medical and physical health perspective. Discharge of patients who are clinically ready/ no longer meet criteria to reside. These have been taken forward as one of the areas of focus in Hospital and Mental Health Flow pillars.
- Working with Place colleagues to support improvements in T3 performance – particularly RLH/TH.

Mitigating Actions and Next Steps

- **Integrated Care Transformation Pillar:** The evaluation of NEL VW patient experience, clinical and cost benefits is currently in progress. In the procurement and contract awarding phase subject to appropriately identified provider on the national framework. Procurement expected to be completed by mid July. Exploring new care pathways for virtual wards with Place leads and providers agreeing on additional pathways, increasing our current capacity and moving us closer to planned capacity as more wards go live.
- **Ambulance Flow Transformation Pillar:** First Task and Finish Group on Integrated Clinical Coordination approach held to consider the problem statement, vision and priority areas. Next step will be to further engage stakeholders to develop a case for change. Considering options to better distribute ambulance activity within NEL sites starting with BHRUT (QH and KGH). Focus on direct access to SDEC for ambulance crews.
- **Hospital Flow:** Refreshed focus and scoping exercise completed with system partners and programme aligned to National, Regional and local priorities. Assurance focus on UTC, SDEC and Acute Frailty and deep dive, action and assurance focus on 12/72 hour waits and discharges for mental and physical health patients (NCTR/ CRFD). Initial emphasis on escalations from RLH with system solution and learning across NEL approach.
- **Mental Health:** System improvement programme developed with change ideas relating to workforce, care processes and environmental factors led through CNOs. Recruitment live for Lead Nurse for MH in ED to coordinate. Place-based improvement projects underway, taking forward learning from Psych Liaison Service review, Case note audit, Flow event held 12th Oct 2023. Working Group ongoing with NELFT and BHRUT, and through Whipps Cross Improvement Programme. Standing up CRFT workstream to develop MH discharge framework

Governance

- NEL UEC Board reports into the NEL ICB Executive Committee

Urgent and Emergency Care – May 2024

SRO:	Paul Gilluley	RAG	RED

	Metric	Latest Published			
		Achievement	Trajectory	Actual	Change from prev. period
UEC	**E.T.3 - The number of people discharged by location and discharge pathway per month (Total) - Apr-24**	✗	**8,755**	**7,171**	▼
	E.T.3a - Hospital discharge pathway activity - pathway 0 - Domestic home or Other place - Apr-24	✗	7,426	6,178	▼
	E.T.3b - Hospital discharge pathway activity - pathway 1 - Domestic home or Other place or Hotel (as temp place of residence) - Apr-24	✗	962	715	▼
	E.T.3c - Hospital discharge pathway activity - pathway 2 - Care home, Designated setting, Hospice, Community rehab setting - Apr-24	✗	106	100	▼
	E.T.3d - Hospital discharge pathway activity - pathway 3 – Care Home, Designated setting - Apr-24	✗	261	178	⇔
	E.T.5 - The number of patients on the virtual ward - Apr-24	✓	**319**	**338**	▲
	The number of patients that the virtual ward is able to simultaneously manage - Apr-24	✗	450	445	▲
	Virtual ward occupancy - Apr-24	✓	70.89%	75.96%	▲

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

Hospital Discharge (Apr-24)

- Hospital discharge is one of our key priorities aligned against national, regional and local priorities to agree programme scope for Year 2. Whilst UTC, SDEC and Acute Frailty will also form part of the programme,a focus on discharges of patients who no longer meet criteria to reside will be in a form of escalation, action as well as assurance.
- Places and providers continue to place a particular focus on reviewing and discharging patients who no longer met the criteria to reside (discharge ready patients). Elevating system-wide issues to NEL Discharge Group starting with RLH but applied and implemented NEL wise
- Places, UEC portfolio and mental health LDA collaborative are working together to support mental health discharge programme and considering synergies with physical health flow and discharges.

Virtual Wards (Apr-24)

- Apr-24 occupancy is 75.96% - an improvement of over 5% compared to Mar-24 (70.34%).
- Funding approved by IRG & EFPIC circa - £9m allocated to 2024/25 VW delivery across the NEL places and provider collaborative
- Tasks and Finish Groups set up to support delivery in Clinical Pathway design and evaluation, Finance, Performance and Data & Metrics, Tech & Digital)

Workstream Issues and Risks

Hospital Discharge (Apr-24)

- Pressure remains in the system due to system demand, some industrial action challenges, in addition to optimising discharge processes.
- This is a complex pillar to the portfolio and requires optimised team infrastructure and continued partnership working across health and social care.

Virtual Wards (Apr-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.

Mitigating Actions and Next Steps

Hospital Discharge (Apr-24)

- Working on identifying common discharge challenges experiences in Mental Health and Physical Health in order to maximise system impact opportunities
- Supporting providers and system to align their efficiency plans
- Focus forum set up to work with system partners on addressing system issues and opportunities identified; Advanced Dx planning, Optimal Handed Care, Equipment Delays, Homelessness, Escalations incl repats within NEL ICS and beyond, Differential waits across boroughs for P1, P2 & P3 (KPIs), Trusted Assessor Model and Focus on reduction of 12 hour and 72 hour waits

Virtual Wards (Apr-24)

- The evaluation of NEL VW patient experience, clinical and cost benefits is currently in progress. In the procurement and contract awarding phase subject to appropriately identified provider on the national framework. Procurement expected to be completed by mid July.
- Capacity & Trajectory - Exploring new care pathways for virtual wards (e.g., heart failure, children's services, end-of-life care). Place leads and providers have agreed on additional pathways, increasing our current capacity (up 10 from the previous month to 445 in Apr-24) and moving us closer to planned capacity (735 by Mar-25) as more wards go live.

Governance

Virtual Wards (Apr-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

2-hour UCR/ Community Rapid Response (Apr-24)

- Community Collaborative Delivery Board and escalation to CHS collab sub committee
- ICB Finance and Performance Committee
- UEC Programme Board
- Individual provider governance

Health Services in the Community – Quarterly: Q1 TBC ; Monthly: Apr-24

SRO:	Charlotte Pomery and Jo Moss	RAG	AMBER

KEY

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

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

		Metric	Latest Published			
			Achievement	Trajectory	Actual	Change from prev. period
Health Services in the Community	Monthly reported	**Appointments in General Practice - Apr-24**	✓	**784,681**	**995,766**	▲
		Percentage of appointments seen within two weeks - Apr-24	✓	**64.27%**	**90.43%**	▼
		Urgent Community Response (UCR) referrals; Count of all UCR referrals planned in the period - Apr-24	×	**1,910**	**1,750**	▼
	Quarterly reported	**Percentage of learning disability registers and annual health checks delivered by GPs - Q1 24/25**	**Q1 data not yet published**			
		Community services waiting list-Number of patients waiting over 52 weeks at a point in time aggregated for a) in scope CYP and b) in scope Adult services - Q1 24/25				
		Number of CYP (0-17 years) on community waiting lists over 52 weeks - Q1 24/25				
		Number of Adults (18+ years) on community waiting lists over 52 weeks - Q1 24/25				

Key Headlines

Primary Care (Apr-24)

- In April 24 we have exceeded the trajectory for number of appointments by 211,085 (995,766 against a target of 784,681). 90.43% of these were within 2 weeks compared to a trajectory of 64.27%.
- 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 and all practices that were on non-compliant digital telephony systems will move over to systems with greater functionality to support demand management, including the 8am rush for appointments and provide appropriate patient triage.
- 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 implementing plans to move to 'modern general practice' using transitional funding enabling them to provide a smooth, equitable experience of access to patients across phone, online and walk-in routes. Payments were made to practices at the end of last year.
- Plans to implement integrated same day access, under the Fuller Programme are in place.

2-hour UCR/ Community Rapid Response (Apr-24)

- NEL is set to reach 91% at end of the last data again exceeding the national target by 2% for the 4th month in row (national target 70%)
- Decrease on volume referrals likely attributed to winter Push Pilot with LAS focused on increasing referrals into the pathway coming to an end (winter project)

Learning Disability (Q4)

- 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.

Community Waiting List (Q4)

- For adult referrals, NEL ICB is ranked is 8th out of 42 ICBs, a decline from 11th in February. For CYP referrals, NEL ICB remains 8th out of 42 ICBs, maintaining the same ranking from February.
- Adult referrals increased by 43% from 17,564 in February to 24,582 (34% above the national ICB average of 18,362) in February. CYP referrals increased by 6% to 10,097 (57% above the national ICB average of 6,435) in March from 9,541 in February.

Workstream Issues and Risks

Primary Care (Apr-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.
- Potential collective action from August 24 may impact on the number of appointments, if practices choose to limit the number of daily appointments to 25 per GP

2-hour UCR/ Community Rapid Response (Apr-24)

- While we are meeting the 2-hour target volumes, there is an opportunity to enhance productivity at the place level and across the system, particularly in our inner London boroughs.
- Providers focused on improving data

Learning Disability (Q4)

- 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.

Community Waiting List (Q4)

- There continues to be increased risks regarding the ability to reduce overall waiting lists in the wider ongoing context of financial challenges and impact on service capacity which may involve decommissioning or reducing some service capacity
- Most significant challenge is the high number of children waiting over 52ww (648 up 25 in Community Peads) in ELFT as a proportion of our total number of CYP 52wws (877 - 33% increase compared to 660 the previous month.)

Mitigating Actions and Next Steps

Primary Care (Apr-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 support practices to open to patients during core hours in order to fulfil their contractual responsibilities and all practices are now open during this time.
- Actions being put in place to assess the impact and put mitigations in place in the event of GPs taking collective action

2-hour UCR/ Community Rapid Response (Apr-24)

- Collaborative Delivery Board will also continue to develop opportunities via an improvement lens, linking to the Virtual Care/admission avoidance/flow pathways working matrix where it makes sense.

Learning Disability (Q4)

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

Community Waiting List (Q4)

- We will continue to jointly monitor and review our targets and trajectories on a bi-monthly basis at Community Delivery Board and BCYP Programme as it will take a system response – social care, schools, clinical, non-clinical.
- Business Case, Mutual aid and improvement network / QI methodologies being used to support change

Governance

Primary Care (Apr-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 (Apr-24)

- Focused Discharge Group set up as a sub-group of Hospital Flow Transformation pillar – one of the programmes within NEL UEC Portfolio. This work and will be reported through the NEL UEC Delivery Group and ultimately to the NEL UEC Board.
- Place and providers continue to work with local authority colleagues on local system level, addressing challenges and reporting through local Place/ provider governance. NEL Discharge Focus Group acts as an escalation point for issues that cannot be resolved at a local system level.

Learning Disability (Q4)

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

Community Waiting List (Q4)

- Community Collaborative Delivery Board and escalation to CHS collab sub committee
- ICB Finance and Performance Committee
- Individual provider governance

Mental Health – April 2024

SRO:	Lorraine Sunduza	RAG	AMBER

	Metric	Latest Published				
		Apr-24	*Trajectory*	*Actual*	Change from prev. Month	6 Month Trend
Mental Health	Talking Therapies Reliable Improvement (Rate)	✓	*61.99%*	*68.35%*	▲	
	Talking Therapies Reliable Recovery (Rate)	✓	*42.64%*	*48.56%*	▲	
	Dementia Diagnosis (Rate)	×	*66.70%*	*60.71%*	▲	
	Serious Mental Illness Physical Health Checks (Performance)	✓	*70.00%*	*71.31%*	▲	
	Perinatal Access (Rate)	×	*8.76%*	*8.42%*	▼	
	Children and Young Peoples Access (Volume)	✓	*24,846*	*25,395*	▲	
	Early Intervention in Psychosis (EIP) (Performance)	✓	*60.00%*	*78.13%*	↔	
	Children and Young Peoples Eating Disorders Urgent Referral (Performance)	✓	*95.00%*	*100.00%*	↔	
	Children and Young Peoples Eating Disorders Routine Referral (Performance)	✓	*95.00%*	*99.00%*	▲	
	Community Metal Health Access (Volume)	✓	*21,987*	*26,275*	▲	

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

- **Data Issues: Due to a delay in the Mental Health Services Data Set being updated to version 6, reporting for metrics pulled from this dataset is not available for month 1 (April 2025). Month 1 data will be available in July, with month 2 (May 2025) and month 3 (June 2025) data being available in August. Note; this does not affect Talking Therapies data, or Dementia Diagnosis as these come from different data sources.**
- 2024/25 sees the introduction of two new metrics for Talking Therapies, service users reporting Reliable Improvement and Reliable Recovery at the end of their treatment. Both metrics are performing well against their respective trajectories.
- Dementia Diagnosis continues to fall below national targets, although has shown a minor upward trend in recent months.

Workstream Issues and Risks

- Serious Mental Illness Physical Healthchecks System Development Funding investment is currently paused pending a financial review.
- Dementia diagnosis is at risk of not achieving target.

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
- **Children and Young Peoples access** – increasing primary care access, improving digital access by service users, and increase access in schools via Mental Health support teams
- **Dementia Access**: using the Dementia Improvement Network to disseminate best practice
- **Perinatal** – increasing capacity through recruitment, and establishing an Improvement Network
- **Serious Mental Illness physical health checks** – System Development Funding investment to improve peer support, secondary care primary care data flows and reach higher risk, under-served people who have not had a health check for over 2 years.

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

Governance

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

Learning Disabilities and Autism – April 2024

SRO:	Lorraine Sunduza	RAG	AMBER

	Metric	Latest Published			
		Apr-24	*Trajectory*	*Actual*	Change from prev. Month
Learning Disabilities and Autism	Learning Disabilities Annual Health Checks	✓	*7.50%*	*28.00%*	▼
	Inpatient Admissions to Acute Mental Health settings (Adult)	✓	*58*	*40*	▼
	Inpatient Admissions to Acute Mental Health settings (Children and Young People)	✓	*7*	*5*	▲

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 is managed at an ICB level via the monthly NEL Mental Health, Learning Disability and Autism Programme Board
- Place leads report inpatient data via AT – there is risk of human error with this impacting data quality
- Performance reporting and issues are managed via bimonthly NEL Learning Disabilities and Autism Board attended by cross-system stakeholders including place-based leads, provider representatives
- This is also monitored by the NHSE London region Learning Disabilities and Autism Programme through quarterly Delivery Assurance Monitoring meetings

Key Headlines

- At the end of 2023/24 NEL achieved 84%; 9% over target for Annual Health Checks
- NEL have increased their targets for inpatient admissions to acute mental health settings for adults and young people with learning disabilities and autistic people
- NEL are below target for pre- and post-admission Care, Education and Treatment Reviews (CeTRs)
- Challenges completing commissioning oversight checks for Learning Disabilities and Autism (LDA), and Mental Health inpatients
- ELFT and NELFT led an LDA inpatient deep dive which showed NEL's LDA Programme aren't aware of all LDA patients admitted to acute mental health settings affecting accuracy of data being considered and subsequently performance
    - There is a need to strengthen local relationships with wards and increase knowledge and awareness of specific LDA processes for mainstream mental health wards. The deep dive will provide recommendations for onward work
- Implementation and use of DSRs has been highlighted as inconsistentt across NEL impacting equity in access
- Keyworking service has been noted by NHSE and provider collaborative as having low case numbers

Workstream Issues and Risks

- Challenges with recruitment at place affecting active work on DSRs and CeTRs
- Upcoming workstream challenges with LDA Programme at ICB level
- Lack of process when there are concerns noted during oversight checks/ward visits

Mitigating Actions and Next Steps

- Challenges reporting LDA inpatient concerns escalated discussed with inpatient improvement network
- ELFT and NELFT leading on a Standards of Inpatient Care network – engaging with ICB quality and safeguarding colleagues, and LDA place leads
- Agreed monitoring and reporting framework with Keyworking service
- Awaiting deep dive recommendations to identify key areas for ongoing work
- LDA Programme scoping work to learn more about CeTR/DSR/Keyworking delivery across place to identify gaps/work needed to drive consistency
- Identify reporting pathway for concerns noted via oversight visits – additional work needed to ensure implementation
    - LDA inpatient flow and performance group to be stood up to discuss concerns with ICB MHLDA colleagues, place leads, ELFT and NELFT

North East London
Integrated Care Board

NHS North East London ICB Board

31 July 2024

Title of report	Governance update
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
Contact for further information	annemarie.keliris@nhs.net
Executive summary	At its last meeting, the Board agreed the updated Governance Handbook, which sets out the governance arrangements for the organisation, including terms of reference (ToRs) and governance policies. Since this meeting there have been updates to the governance handbook including: • A review of the Acute Provider Collaborative (APC) terms of reference and a proposed partnership agreement • Changes to the Mental Health, Learning Disabilities and Autism Collaborative (MHLDA) terms of reference. Further details on each of these developments are contained within the report below.
Action required	The ICB Board is asked to: • Approve the updated APC and MHLDA terms of reference • Approve the acute provider collaborative partnership agreement • Approve the updated Governance Handbook here.
Previous reporting	ICB Board and its sub-committees.
Next steps/onward reporting	The Governance Handbook will be further reviewed on an annual basis.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Links to overall design and governance of the ICB and integrated care system 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 Acute Provider Collaborative revised terms of reference

2.1 In north east London, the three acute providers of Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Barts Health NHS Trust, Homerton Healthcare NHS Foundation Trust and the NEL Integrated Care Board are working together as an acute provider collaborative (APC) to address mutual challenges and deliver better care with an ambition to improve quality and access for patients through collaboration.

2.2 The three acute providers, with the ICB, have been working together as an Acute Provider Collaborative for approaching two years, having had a focus on a broad range of cross-cutting strategic and clinical transformation programmes. Along with the APC leading a set of clinical change programmes, several corporate programmes have also been advanced through the closer collaboration between Barts Health (BH) and BHRUT.

2.3 In June 2023, the shadow APC Board approved the terms of reference (ToR) to establish an APC Joint Committee. The ToR received final approval from the Trust and ICB Boards in July 2023, which included an annual review. With proposed changes to the APC, this is an appropriate time to review and recommend amendments. With the APC being confirmed as the main route of collaboration, changes to the membership have been reflected in the revised ToRs based on the following principles:

- To increase overall Non-Executive Director representation at the APC Joint Committee
- To have a balance of Executive representation for each Trust
- With the BH/BHRUT Closer Collaboration programmes becoming incorporated into the APC as the main agent for collaboration, it is appropriate that each organisation is represented on the committee

- Each Acute provider to be represented by two Non-Executive Directors, the Trust Chief Executive Officer and an Executive Director
- Reflecting the changes to ICB Executive portfolios

No other changes to the APC Joint Committee ToR are proposed at this stage.

The amendments to the APC Joint Committee ToR were discussed at the June 2024 APC Joint Committee and agreed, with a recommendation to progress through Trust/ICB Boards for final approval.

3.0 APC Partnership Agreement

3.1 To strengthen our collective agreement of the priorities and commitment to the APC, a Partnership Agreement has been developed for the constituent organisations that sets out important operational and practical aspects that underpin how we operationalise a high performing provider collaborative.

3.2 This Partnership Agreement is being entered into to set out how the parties will work together, how the NEL APC will be managed and operate on a day-to-day basis, contains practical arrangements for the running of the NEL APC and expresses a set of Partnership Principles and Objectives for the members to work to as well as demonstrating the commitment of the organisations to collaborate and fulfil the objectives expressed.

3.3 The Partnership Agreement has been developed in such a way that it will evolve in phases, focussed initially on principles, objectives and priorities and then address matters such as delegation at a later point. The Partnership Agreement is for 2024/25 and includes further detail on the leadership of each of the three priority areas as well as the programmes that sit within each of the portfolios.

3.4 As the APC develops its multi-year plan, the Partnership Agreement will be reviewed and updated for 2025/26 and beyond. The draft APC Partnership Agreement was discussed at the June 2024 APC Joint Committee and approved in principle, with a recommendation to progress through Trust/ICB Boards for final approval.

4.0 MHLDA terms of reference

4.1 Following a review of ICB provider collaborative Senior Responsible Officers (SROs) – Paul Gilluley, Chief Medical Officer is now the ICB SRO for the Mental Health, Learning Disabilities and Autism Collaborative, therefore the terms of reference have been reviewed to reflect this change.

5.0 Recommendations

5.1 The ICB Board is asked to:

- Approve the attached APC terms of reference
- Approve the attached APC partnership agreement
- Approve the changes to the MHLDA terms of reference.
- Approve the updated Governance Handbook here.

North East London Acute Provider Collaborative Joint Committee

TERMS OF REFERENCE

Introduction	1. The NHS North East London Integrated Care Board ('**ICB**') and the following NHS providers of acute services, who are all partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Acute Provider Collaborative ('**APC**'). 2. The NHS providers of acute services are: (a) Barts Health NHS Trust ('**Barts Health**') (b) Barking, Havering and Redbridge University Hospitals NHS Trust ('**BHRUT**') (c) Homerton Healthcare NHS Foundation Trust ('**Homerton Healthcare**'). 3. For the purpose of these terms of reference, the providers and the ICB shall be known as the **'NHS Partner Organisations.'** 4. The APC Joint Committee, whose governance arrangements are described in these terms of reference, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to acute services. 5. It has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London, to: reduce inequalities in health outcomes, access and experience; improve resilience (e.g. through collaborative capacity); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.
Status	6. Section 65Z5 of the National Health Service Act 2006 (as amended) (the '**2006 Act'**) permits Integrated Care Boards, NHS trusts, and NHS foundation trusts to exercise their functions jointly with each other, subject to: (a) Regulations made by secondary legislation, which may constrain that joint exercise of functions, limit the power in relation to certain functions of one or more of those organisations, or impose conditions on the exercise of that power. (b) The expectations of statutory guidance about the exercise of this power, which is published by NHS England under section 65Z7 and which the NHS Partner Organisations must have regard to. 7. Section 65Z6 permits the organisations to arrange for the functions which are exercisable jointly to be exercised by a joint committee and, if they wish, for one or more of the organisations or the joint committee itself to establish and maintain a pooled fund.

	8. Arrangements made under section 65Z5 and section 65Z6 may be made on such terms as may be agreed between the organisations, including terms as to payment. 9. An NHS foundation trust is also permitted by section 47A of the 2006 Act to enter into arrangements for the carrying out, on such terms as it considers appropriate, of any of its functions jointly with any other person. NHS trusts have an equivalent power under paragraph 18 of Schedule 4 to the 2006 Act. 10. Integrated Care Boards also have powers under section 12ZA of the 2006 Act, in relation to arrangements they have made with service providers, which includes a power to confer discretions on those services providers. 11. By virtue of the powers described above, and in accordance with each of their constitutional and governance arrangements, the NHS Partner Organisations have formally established the APC Joint Committee.
Authority	12. The APC Joint Committee is authorised by the Boards of the NHS Partner Organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups. The APC Joint Committee is permitted to establish sub-committees.
Role of the APC Joint Committee	13. The APC Joint Committee has been established in order to: (a) Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to acute services in North East London; (b) Ensure the development of further collaboration between the NHS Partner Organisations; (c) Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services; and ensure that people participation is at the heart of the activities of the APC's work; (d) Coordinate improved resilience of services (e.g. through collaborative capacity) where it is the case that action across the NHS Partner Organisations and/or the ICS is required and ensure that specialisation and consolidation can occur where this will provide better outcomes and value; (e) Ensure and encourage the engagement of the partner organisations of the ICS, with a view to shaping the future of acute services across North East London; (f) Lead the development of the ICS strategy and planning for acute services, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships; (g) Provide assurance to the NHS Partner Organisations on the delivery of the ICS's strategy and plans for acute services and the

NHS Long Term Plan, and agree mitigations where there are significant delivery risks;

(h) Enable the joint exercise of the functions which have been delegated to the APC Joint Committee by the NHS Partner Organisations, in a simple and efficient way ('the **Delegated Functions**').

14. In particular, the APC Joint Committee shall oversee and assure the work of the APC Executive which has been established as a sub-committee of the joint committee.

15. **Annex 1** lists the Delegated Functions, which have been delegated to the APC Joint Committee by the NHS Partner Organisations and, in relation to which, the APC Joint Committee may take decisions which shall be binding on each of the NHS Partner Organisations. It is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope over time. For the avoidance of doubt, no party can delegate its functions into the APC Joint Committee without the agreement of all the NHS Partner Organisations.

16. Annex 1 is divided into two respective parts, setting out the functions delegated by the ICB and the functions delegated by the provider NHS Partner Organisations. It also records whether the APC Joint Committee has delegated a function to a sub-committee, and the sub-committee's role in respect of that function.

17. The Delegated Functions shall be exercised with particular regard to the APC Joint Committee's priorities and objectives, as described in the **APC Plan**, which the APC Joint Committee shall approve on behalf of the NHS Partner Organisations. A summary of the APC Joint Committee's priorities and objectives shall be contained at **Annex 2**.

18. In addition, the APC Joint Committee will support the NHS Partner Organisations to achieve the aims and the ambitions of:

(a) The Joint Forward Plan;

(b) The Joint Capital Resource Use Plan;

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

(d) The joint local health and wellbeing strategies and associated needs assessments prepared by the eight health and wellbeing boards;

(e) The plans prepared by the seven place-based partnerships, within the ICS's area; and

(f) The developing ICB Financial Framework.

19. The APC Joint Committee will prioritise its work against:

(a) The strategic priorities of the ICS and the ICS operating principles set out on the ICB's website, here;

	(b) Relevant plans and priorities developed by the NHS Partner Organisations. 20. In supporting the NHS Partner Organisations to discharge their statutory functions and deliver the strategic priorities of the ICS, the APC Joint Committee will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to: (a) Improve outcomes in population health and healthcare; (b) Tackle inequalities in outcomes, experience and access; (c) Enhance productivity and value for money; (d) Help the NHS support broader social and economic development. 21. The APC Joint Committee is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.
Chairing Arrangements	22. The Chair of the APC Joint Committee will be the Chair of Homerton Healthcare. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference. 23. The Deputy Chair of the APC Joint Committee will be the Chair in Common of Barts Health and BHRUT.
Membership	24. The APC Joint Committee shall have the following members drawn from the NHS Partner Organisations, as follows: Barts Health: (a) 2 x Non-Executive Director (b) Group Chief Executive Officer (c) Executive Director BHRUT (d) 2 x Non- Executive Director (e) Chief Executive Officer (f) Executive Director Homerton Healthcare: (g) 2 x Non-Executive Director (h) Chief Executive (i) Executive Director

	ICB: (j) Chief Executive (k) Chief Strategy & Transformation Officer 25. When determining the membership of the APC Joint Committee, active consideration will be made to diversity and equality. 26. The APC connection with Place will be led through the Trust and Hospital CEOs attending the APC Executive, thereby representing both their Trust / hospital and Place. 27. With the permission of the Chair of the APC Joint Committee, the members of the APC Joint Committee set out above may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.
Participants	28. The APC Managing Director will have a standing invitation to attend meetings of the APC Joint Committee, aside from in rare circumstances when the Chair determines that it is appropriate for only members of the APC Joint Committee to be present. 29. The APC Joint Committee may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate, at the discretion of the Chair of the APC Joint Committee. In particular, the APC Joint Committee may invite: (a) The Senior Responsible Officers for the APC programmes; (b) Individuals who can bring the perspective of the local authorities in North East London; the Voluntary, Community and Social Enterprise sector; Healthwatch; Patients and services users.
Collaborative working and substructures	30. In exercising its responsibilities, the APC Joint Committee shall work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the NHS Partner Organisations or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups. 31. In particular, the APC Joint Committee will, as appropriate, work with: (a) The place-based governance structures within the ICS; (b) The North East London MHLDA Collaborative, the North East London Community Health Collaborative, the North East London VCSE Collaborative and the North East London Primary Care Collaborative.

	32. The APC Joint Committee may delegate any of the Delegated Functions to the APC Executive and any other sub-committees which it establishes in accordance with these terms of reference. 33. Where a function has been delegated by the APC Joint Committee to a sub-committee it shall be recorded in **Annex 1.** All sub-committees established within the APC's governance must operate under terms of reference approved by the APC Joint Committee. 34. The APC Joint Committee or its sub-committees may establish transformation boards, working groups or task and finish groups. All groups established within the APC's governance must operate under terms of reference approved by the APC Joint Committee or the APC sub-committee which established them.
Key duties relating to the exercise of the Delegated Functions	35. When exercising any Delegated Functions, the APC Joint Committee will ensure that it acts in accordance with, and that its decisions are informed by, the relevant policies and procedures which have been developed by the NHS Partner Organisations to support those functions and to inform the commissioning, provision and delivery of any relevant services. 36. When exercising a function which has been delegated by an NHS Partner Organisation, the APC Joint Committee will have particular regard to the statutory obligations imposed on that organisation, and that organisation's policies and procedures. As particularly relevant to the Delegated Functions, these include, but are not limited to, the statutory duties set out in the 2006 Act. Key duties are listed in **Annex 3.** The NHS Partner Organisations will also have due regard to the public sector equality duty under section 149 of the Equality Act 2010. 37. All sub-committees or groups established within the APC's governance must also have due regard to the applicable statutory duties which apply to the NHS Partner Organisations.
Resource and financial management	38. The NHS Partner Organisations have made arrangements to support the APC and the exercise of the Delegated Functions. 39. Further information about resource allocation and financial management is contained in the NHS Partner Organisations' standing financial instructions and associated policies and procedures, which includes the ICB Financial Framework. The NHS Partner Organisations are currently working together to finalise the formal aspects of accountability and responsibility for financial decision-making for activities in scope of the APC Joint Committee and will update the terms of reference once finalised. 40. Financial decisions need to be made in the line with the Standing Financial Instructions of the organisation at the source of the funding; where this is multiple organisations this will need to be taken through all organisations' approval routes.

APC Partnership Agreement	41. In due course, the NHS Partner Organisations will consider entering into a partnership agreement to address operational matters including: (a) Details of the operational resource to support the APC Joint Committee to meet its responsibilities with regards to the Delegated Functions; (b) Risk and gain share agreements between the NHS Partner Organisations; (c) The process for commissioning / securing professional advice (including external advice); (d) Terms for withdrawal from the APC Joint Committee; (e) Dispute resolution; (f) Information sharing; (g) Management of conflicts of interest; (h) Complaints handling. 42. The partnership agreement will supplement these terms of reference. To the extent that there is any conflict between the terms of reference and the agreement, these terms of reference shall prevail.
Meetings	*Scheduling meetings* 43. The APC Joint Committee will ordinarily meet quarterly, and, as a minimum, shall meet on three occasions each year. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 44. The Chair of the ICS, the Boards of the NHS Partner Organisations, or the ICB's Population Health and Integration ('PH&I') Committee may ask the APC Joint Committee to convene further meetings to discuss particular issues on which they want the APC Joint Committee's advice. *Quoracy* 45. In order for a meeting to be quorate there must be at least seven members in attendance, which shall include: (a) A non-executive and an executive from Barts Health (b) A non-executive and an executive from BHRUT (c) A non-executive and an executive from Homerton Healthcare (d) An executive from the ICB 46. If any member of the APC Joint Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Nominated deputies who have been authorised by the Chair shall count towards quorum.

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

Voting

48. The APC Joint Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the APC Joint Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the APC Joint Committee will hold the casting vote. The result of the vote will be recorded in the minutes. Decisions taken shall be binding on each of the NHS Partner Organisations.

Papers and notice

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

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

Virtual attendance

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

Recordings of meetings

52. Except with the permission of the Chair, no person admitted to a meeting of the APC Joint Committee shall be permitted to record the proceedings in any manner whatsoever, other than in writing.

Minutes

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

	Governance support 54. Governance support to the APC Joint Committee will be provided by the ICB's Governance Team. *Confidential information* 55. Where confidential information is presented to the APC Joint Committee, all attendees will ensure that they treat that information appropriately considering any confidentiality requirements and information governance principles.
Conflicts of interest	56. Conflicts of interests will be managed in accordance with relevant policies, procedures and joint protocols developed by the ICS, which shall be consistent with the NHS Partner Organisations' respective statutory duties and applicable national guidance.
Disputes	57. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the APC Joint Committee in its capacity as a decision-making body, including uncertainty about whether the matter relates to: (a) a matter for determination by a Board or other governance structure of an NHS Partner Organisations; or (b) determination by a placed-based committee of the ICB or another provider collaborative, then the matter will be referred to the relevant Trusts' Board in the case of a provider function, or the PH&I Committee or Board of the ICB in the case of an ICB function. 58. Where any other dispute arises between the NHS Partner Organisations, which is connected to the operation of the APC and its work, this shall be resolved in accordance with the dispute resolution procedure which has been agreed between the NHS Partner Organisations.
Referral to the ICB's Population Health & Integration Committee	59. Where any decision before the APC Joint Committee which concerns an ICB function is novel or contentious or repercussive across services which fall outside its remit, then the APC Joint Committee shall give due consideration to whether the decision should be referred to the PH&I Committee of the ICB and reported to the ICB Board, as per the arrangements described at paragraphs 65-70 below. Where the APC Joint Committee does decide to make such a referral, the Chair will action this on behalf of the APC Joint Committee. 60. Where a matter is referred to the PH&I Committee under paragraph 59, the Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB, one its committees or subcommittees, or to a joint committee or other collaborative for determination. The PH&I Committee will keep the Chair of the Committee informed of its actions in relation to

	any referral from the APC Joint Committee and the Chair shall in turn ensure that the APC Joint Committee is keep updated. 61. In addition to the APC Joint Committee's ability to refer a matter to the PH&I Committee of the ICB, the Board of the ICB, or its Chair and the Chief Executive (acting together), may also require a referral of any decision falling with paragraph 59 to the Board of the ICB.
Behaviours and Conduct	62. Members will be expected to behave and conduct business in accordance with: (a) The policies, procedures and governance documents that apply to them, including any jointly developed procedures or codes developed by the ICS. (b) The NHS Constitution; (c) The Nolan Principles. 63. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make. 64. Members will seek to act in the best interests of the population of the ICS area, rather than representing the individual interests of the NHS Partner Organisations.
Accountability, reporting, and shared learning	65. The APC Joint Committee is established by and ultimately accountable to the Boards of the NHS Partner Organisations and the Joint Committee shall report to the Boards accordingly through the provision of the information described at paragraph 67 below. 66. In addition to this, a committee of each of the NHS Partner Organisations' Boards may be given operational oversight of the exercise of the relevant organisation's respective functions. This includes: (a) The ICB's Population Health and Integration Committee in respect of the ICB functions. 67. A copy of the meeting minutes along with a summary report shall be shared with the above committee(s) for information and assurance. The report shall set out matters discussed and pertinent issues, together with any recommendations and any matters which require disclosure, escalation, action or approval. 68. The APC Joint Committee will also report to the NHS Partner Organisations' committees for quality and finance, where its work is relevant to the functions of those committees, or as otherwise requested by those committees. 69. **Annex 4** shows the APC Joint Committee's governance, including its usual reporting lines.

	Sharing learning and raising concerns 70. Where the APC Joint Committee considers that an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Chair or Chief Executive of the ICB, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees as appropriate.
Review	71. The APC Joint Committee will review its effectiveness at least annually and provide an annual report to the PH&I Committee and Boards of the NHS Partner Organisations on its work in discharging its responsibilities, delivering its objectives and complying with its terms of reference. 72. These terms of reference, including membership and chairing arrangements, will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Boards of the NHS Partner Organisations for approval.

Annex 1 – Delegated Functions (for the commencement of year one)

Part A: Functions delegated by the Board of the ICB

Role of the APC Joint Committee:		Role of the APC Executive:
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the PH&I Committee of the ICB in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan and other system plans, in so far as it relates to the provision of, and the need for, acute services in the ICB's area and the exercise of the ICB's functions.	To prepare such recommendations for consideration by the APC Joint Committee.
2	Overseeing, and providing assurance to the PH&I Committee regarding, the implementation and delivery of the Joint Forward Plan, and Joint Capital Resource Use Plan, the Integrated Care Strategy and other system plans or strategies (including the joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of ICB functions relating to acute services.	To monitor implementation and report to the APC Joint Committee, as appropriate.
3	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of ICB functions. *The APC Plan shall be developed by drawing on population health management tools and in coproduction with service users and residents of North East London. It is aimed at ensuring delivery of the Joint Forward Plan, the Integrated Care Strategy and other system plans (including joint local health and wellbeing strategies and associated needs assessments), in so far as they require the exercise of functions relating to acute services.* *In particular, this shall include the development and approval of the APC's priorities and objectives set out in Annex 2.* *The APC Plan shall be tailored to meet particular local needs in specific places, where appropriate, but shall always maintain ICB-wide operational, quality and financial performance standards.*	To lead on developing and preparing the plan for approval by the APC Joint Committee and overseeing its implementation.
4	Reviewing plans developed by the seven place-based partnerships in relation to the provision of services relating to acute services, with a view to ensuring appropriate cohesion across the ICB area. This shall include reviewing such plans, making recommendations to the relevant Place ICB Committee and sharing learning.	To lead on such matters.
Leadership and engagement		

The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to acute services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
2	Providing leadership, on behalf of the ICB, on matters relating to acute services across the ICB's area and working with ICS partners and NHS England as required. This shall include responsibility, on behalf of the ICB, for developing the vision and culture of the Collaborative, and engaging staff in that regard.	To lead on such matters.
3	Driving and overseeing service user and citizen participation, in relation to the exercise of ICB functions relating to acute services.	[ ]
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-
1	Responsibility on behalf of the ICB for developing the governance framework of the APC, including: • making recommendations to the ICB on the commissioning functions which should be within the scope of the APC; • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Part B: Functions delegated by each of the Boards of Barts Health, BHRUT and Homerton Healthcare
(for the purposes of this section, "the Trusts")

Role of the APC Joint Committee:		Role of the APC Executive:
Planning		
The APC Joint Committee will undertake the following specific activities in the domain of Planning:		-
1	Making recommendations to the Trusts' Boards in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as it relates to the provision of, and the need for, acute services in the ICB's area and exercise of the Trusts' functions.	To prepare such recommendations for consideration by the APC Joint Committee.
2	Developing and approving the APC Plan and assuring implementation and delivery of the plan, in so far as that requires the exercise of the relevant Trust's functions.	To lead on developing and preparing the plan for approval by the APC Joint Committee and overseeing its implementation.
3	Overseeing, and providing assurance to the Trusts' Boards regarding, the implementation and delivery of the Joint Forward Plan and Joint Capital Resource Use Plan, and other relevant system plans or strategies, in so far as they require the exercise of the APC functions.	To monitor implementation and report to the APC Joint Committee, as appropriate.
4	Providing information to the Trusts' Boards for the purposes of each Trust's duty to prepare its annual report for provision to NHS England, in so far as NHS England has requested, or those reports require, information connected with the exercise of the APC's functions.	[ ]
Leadership and engagement		
The APC Joint Committee will undertake the following specific activities in the domain of Leadership and engagement:		-
1	Responsibility on behalf of the Trusts for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, acute Services with a view to ensuring that such needs are considered within wider system planning.	To lead on such matters.
Governance		
The APC Joint Committee will undertake the following specific activities in the domain of Governance:		-

1	Responsibility on behalf of the Trusts for developing the governance framework of the APC, including: • making recommendations to the Trusts' Board on the functions which should be within the scope of the APC, • establishing the sub-structures necessary to facilitate delivery of the Delegated Functions; • putting in place the documentation necessary to ensure robust governance and assurance.	To make recommendations to the APC Joint Committee in relation to such matters. Leading on horizon scanning for examples of best practice.

Annex 2- APC Joint Committee objectives and priorities

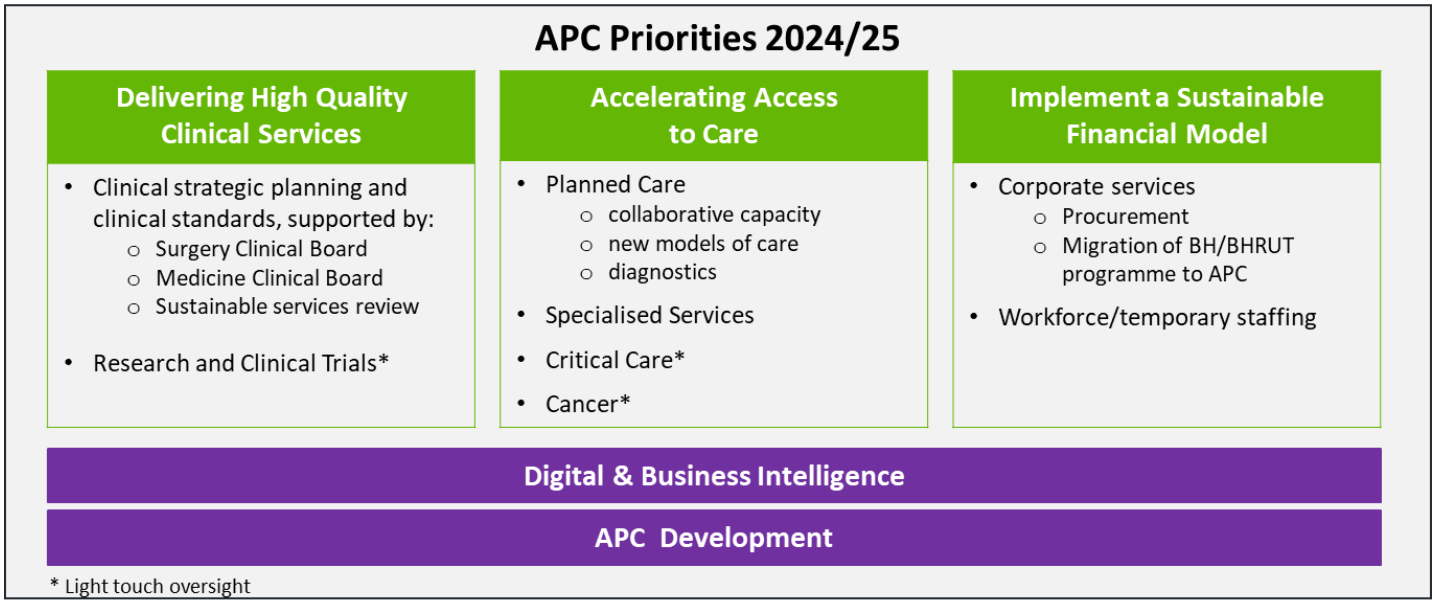
The following priorities and objectives are summarised from the current APC Plan:

Statement of intent

To enable ***resilient acute hospitals*** to provide improved, sustainable and safe care to the population of North East London now and into the future, as three acute Trusts, eight hospitals working together with all our partners for the benefit of our patients and communities.

We believe that by working together as an APC we can deliver better results:

- **For our Patients,** ensuring faster access to better care for all our communities by optimally utilising our shared assets
- **For our People,** by being outstanding, inclusive places to work with more opportunities to develop meaningful careers
- **With our Partners, particularly at Place,** by sharing and learning we can accelerate our work together for our local communities acting to reduce health inequalities



Annex 3 – Key statutory duties

Key duties of the ICB:

- Section 14Z32 – Duty to promote the NHS Constitution
- Section 14Z33 – Duty to exercise functions effectively, efficiently and economically
- Section 14Z34 – Duty as to improvement in quality of services
- Section 14Z35 – Duty as to reducing inequalities (and the separate legal duty under section 149 of the Equality Act 2010, the Public Sector Equality Duty)
- Section 14Z36 – Duty to promote involvement of each patient
- Section 14Z37 – Duty as to patient choice
- Section 14Z38 – Duty to obtain appropriate advice
- Section 14Z39 – Duty to promote innovation
- Section 14Z40 – Duty in respect of research
- Section 14Z41 – Duty to promote education and training
- Section 14Z41 – Duty to promote integration
- Section 14Z43 – Duty to have regard to the wider effect of decisions
- Section 14Z44 – Duties as to climate change etc
- Section 14Z45 – Public involvement and consultation (and the related duty under section 244 and the associated Regulations to consult relevant local authorities)
- Section 14Z30 – Registers of interests and management of conflicts of interest
- Section 223GB – Financial requirements on the ICB [where set by NHS England]
- Section 223GC – Financial duties of the ICB: expenditure
- Section 223L – Joint financial objectives for the ICB [where set by NHS England]
- Section 223M – Financial duties of the ICB: use of resources
- Section 223N – Financial duties of the ICB: additional controls on resource use
- [Section 223LA – Financial duties of the ICB: expenditure limits]

Key statutory duties of Barts Health, BHRUT, Homerton:

Foundation trusts

- Section 63 - Duty to exercise functions effectively, efficiently and economically
- Section 63A - Duty to have regard to the wider effect of decisions
- Section 63B – Duties in relation to climate change

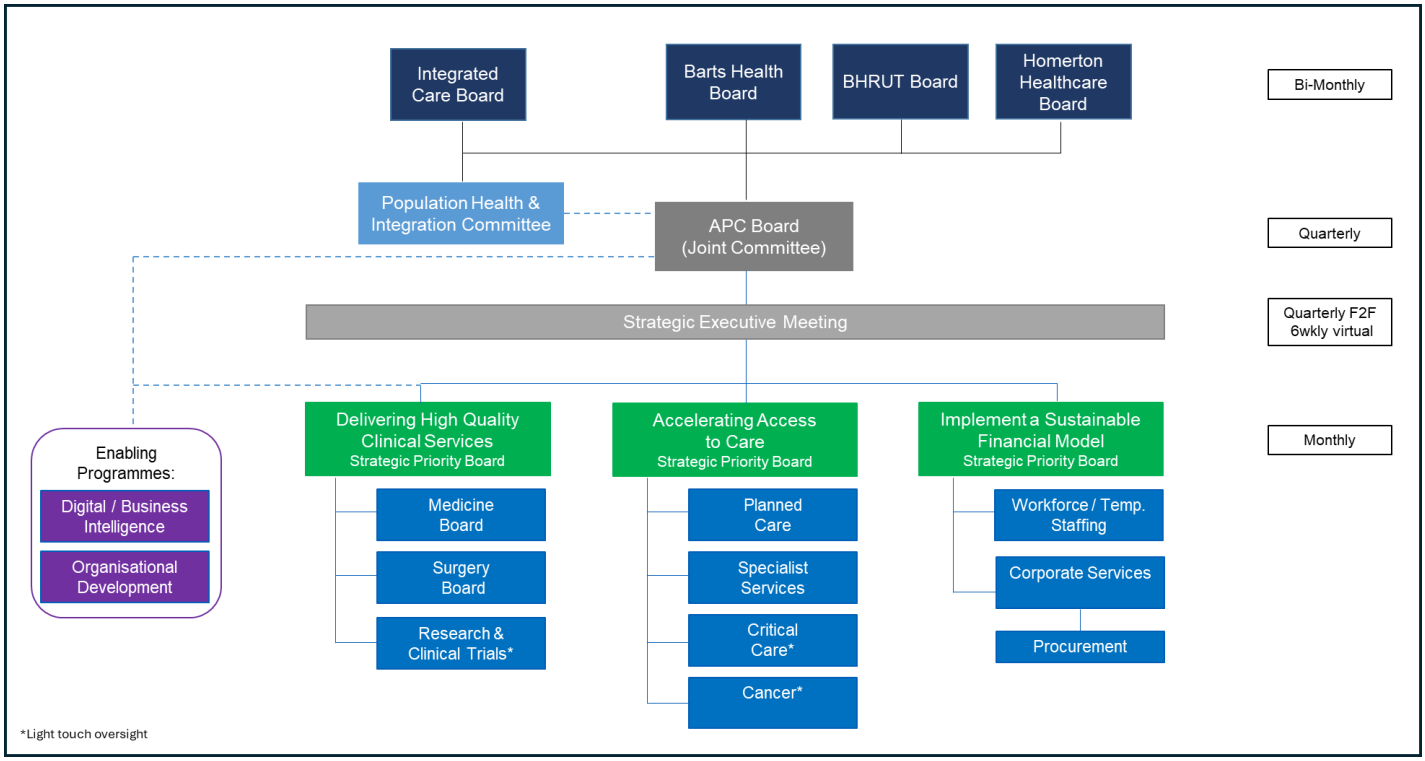
Trusts

- Section 26 - Duty to exercise functions effectively, efficiently and economically
- Section 26A - Duty to have regard to the wider effect of decisions
- Section 26B – Duties in relation to climate change

Foundation trusts and trusts

- Section 223L – Joint financial objectives [where set by NHS England]
- Section 223M – Financial duties: use of resources
- Section 223N – Financial duties: additional controls on resource use
- [Section 223LA – Financial duties: expenditure limits]
- Section 242 – Public involvement and consultation

Annex 4 – Governance Diagram



Barking, Havering and Redbridge University Hospitals NHS Trust

Barts Health NHS Trust

Homerton Healthcare NHS Foundation Trust

North East London Integrated Care Board

North East London

Acute Provider Collaborative

Partnership Agreement 2024/25

June 2024

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DATE: [XXX XX 2024]

Parties:

(1) **Barking, Havering and Redbridge University Hospitals NHS Trust** of Rom Valley Way Romford RM7 0AG **('BHRUT')**;

(2) **Barts Health NHS Trust** of 80 Newark Street London E1 2ES **('Barts Health');**

(3) **Homerton Healthcare NHS Foundation Trust** of Homerton Row, London E9 6SR **('Homerton Healthcare'),** and

(4) **NHS North East London Integrated Care Board** (**NEL ICB**) of 4th Floor, Unex Tower, 5 Station Street, London E15 1DA,

known collectively in this Agreement as the **'NHS Partner Organisations'**.

1. Introduction

1.1 The NHS Partner Organisations, who are all partners of the North East London Integrated Care System (the '**NEL ICS**'), have come together to form the North East London Acute Provider Collaborative (the '**NEL APC**').

1.2 The NEL APC has established a Joint Committee (the '**APC Joint Committee**'), to be the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to certain acute healthcare services across the NEL ICS. The governance arrangements for the joint committee are described in the agreed terms of reference.

1.3 The APC Joint Committee has been established to enable the NHS Partner Organisations to work collaboratively, with shared purpose and at scale across multiple places in North East London, to:

- reduce inequalities in health outcomes, access and experience;
- improve resilience;
- ensure that specialisation and consolidation can occur where this will provide better outcomes and value for the population (all as further described in the Terms of Reference) (the **Purpose**).

1.4 The NHS Partner Organisations agree that it is desirable to set out how the Purpose will be managed, how operational matters relating to the NEL APC will be addressed and how costs in relation to it will be shared.

1.5 Accordingly, this Agreement sets out:

- the terms and conditions upon which the NHS Partner Organisations have agreed that such Purpose may take place;
- a framework to govern the management of the Purpose;
- the management infrastructure and details of the day-to-day operation of the NEL APC;

- the roles and responsibilities of the NHS Partner Organisations in relation to delivering the Purpose; and
- the shared principles and objectives for collaboration.

1.6 The parties together serve local communities across Barking & Dagenham, City & Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest, which experience significant variations in health needs and outcomes. The APC connection with Place is led through the Trust and Hospital CEOs attending the APC Strategic Executive.

The parties believe that their collaboration activities to deliver economies of scale, closer working within clinical teams and accelerating access to care add value to the North East London Integrated Care System (ICS).

The parties also recognise the Closer Collaboration arrangements that spans across Barking, Havering and Redbridge University Hospitals NHS Trust and Barts Health NHS Trust.

1.7 The parties recognise that there are many variations in the challenges they face individually, and each party has its own unique identity. Each of the parties believes that they know their own local places best and will need to continue to work individually alongside partners in other sectors (social care, primary, mental and community health services among them) to respond to the health needs of each place.

1.8 The parties recognise that they can build on the collective work to date to achieve their shared ambition of collaboration for the best outcomes in:

- Workforce
- Quality
- Performance
- Finance
- Innovation

1.9 The parties also acknowledge that in the changing healthcare landscape – the move towards place-based population health management and the impetus towards greater partnership working and collaboration that comes with that – health providers will need to work ever more closely together.

1.10 The parties have already collaborated through the formation of clinical boards, along with a portfolio of programmes (Elective, Outpatients, Diagnostics, Workforce, Corporate Services, Critical Care, Cancer, Specialised Services, Digital, Research & Clinical Trials).

1.11 The parties will continue to collaborate in areas where working together will give more system benefit than working individually, particularly in areas outlined within their shared ambition. The established APC Joint Committee will provide a framework for the governance of the current and future collaboration activity.

1.12 The parties acknowledge that following the enactment of the Health and Care Act 2022 there are new powers available to them to move from the model of aligned decision-making to different forms of governance, including a joint committee structure.

1.13 This Agreement provides practical evidence of commitment by the NHS Partner Organisations to working together as part of the NEL APC towards the Purpose and to fulfilling the role of the NEL APC as set out in the Terms of Reference.

2. Status and Purpose of this Partnership Agreement

2.1 The parties wish to record the basis on which they will collaborate with each other in this Partnership Agreement.

2.2 The parties are working together to deliver more integrated, high quality and cost-effective care to the patients and population they serve, supporting sustainability across the NHS in North East London.

This Partnership Agreement sets out:

- The key objectives for the development of the APC
- The principles of collaboration
- The governance structures in place.

2.3 While this Partnership Agreement provides a framework for the parties to undertake planning and decision making in alignment with one another, the provisions of this Partnership Agreement will have effect without prejudice to the autonomy or legal status of the parties, each of which retain their legal personality and functions as conferred by law, and the Partnership Agreement is not intended as a step on a journey towards a merger or the creation of a new legal entity.

2.4 The parties agree that this Partnership Agreement shall not be legally binding.

3. Establishment of the APC Joint Committee

3.1 The parties have established the APC Joint Committee in accordance with this Partnership Agreement and, through the Joint Committee, to deliver the APC Programme.

3.2 The role of the APC Joint Committee is to oversee all elements of APC activity. This will include future strategic direction and current programmes across the NEL system, in accordance with the Principles of Collaboration.

3.3 The APC Joint Committee replaced the APC Shadow Board on the 20th of September 2023.

3.4 The APC Joint Committee is supported by an APC Executive which in turn is supported by three Strategic Priority Boards consisting of a Chief Executive Senior Responsible Officer (SRO) and key leads from each of the NHS Partner Organisations.

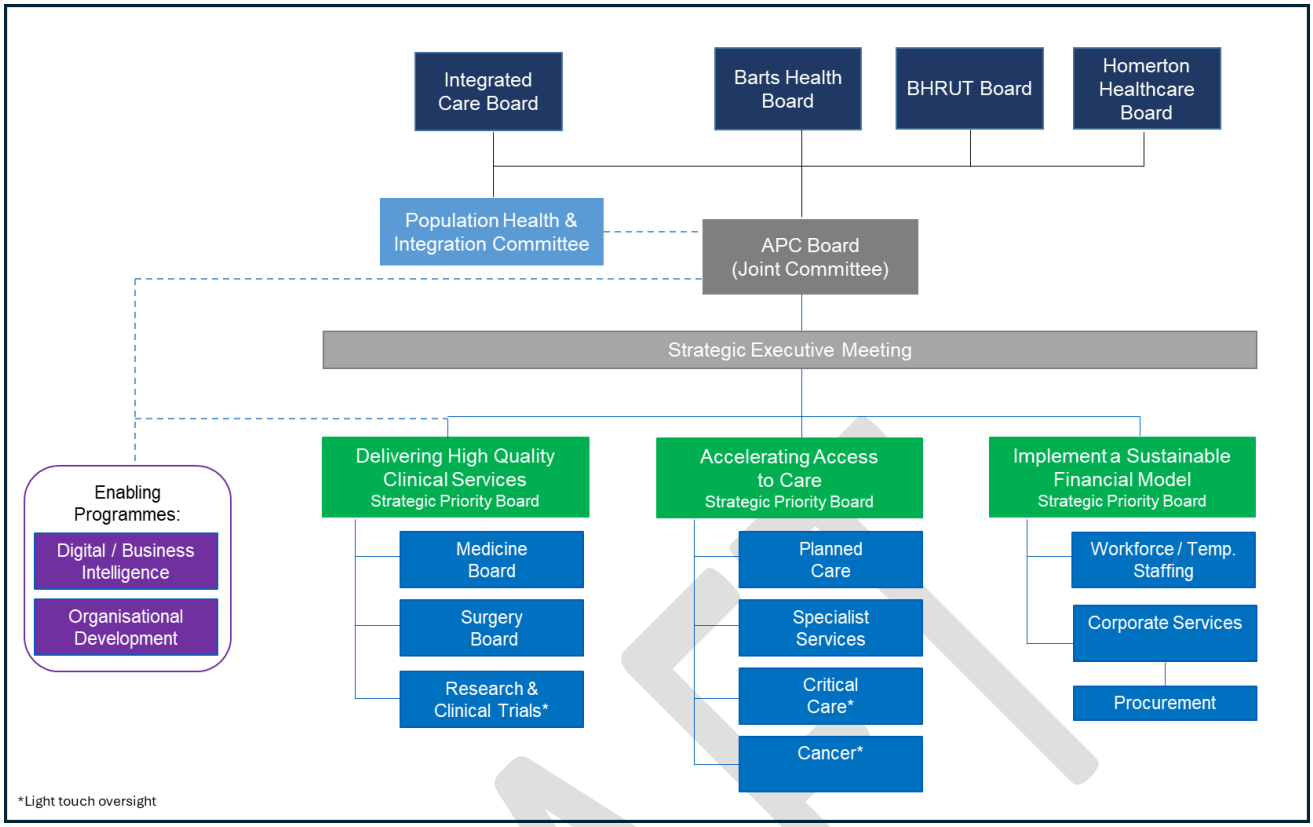
3.5 The APC Joint Committee membership consists of: The Chairs and non-executive directors from each acute provider, and the Chief Executive Officers and executive leads from the NHS Partner Organisations.

3.6 In attendance (non-members) will be the APC Managing Director.

3.7 The APC Joint Committee is chaired by one of the Chairs from the acute providers with membership and chairing arrangements reviewed at least annually and more frequently if required. The Joint Committee is held on a quarterly basis.

3.8 Any invitees, will only be present for discussions about those collaborations of which they are members, unless they are specifically invited otherwise.

3.9 The membership and purpose of the groups (within the below image) are laid out in the Terms of Reference of each group.



4. Priorities and Objectives

4.1 The parties have established the following priorities and objectives:

Statement of intent

To enable ***resilient acute hospitals*** to provide improved, sustainable and safe care to the population of North East London now and into the future, as three acute Trusts, eight hospitals working together with all our partners for the benefit of our patients and communities.

We believe that by working together as an APC we can deliver better results:

- **For our Patients,** ensuring faster access to better care for all our communities by optimally utilising our shared assets
- **For our People,** by being outstanding, inclusive places to work with more opportunities to develop meaningful careers
- **With our Partners, particularly at Place,** by sharing and learning we can accelerate our work together for our local communities acting to reduce health inequalities

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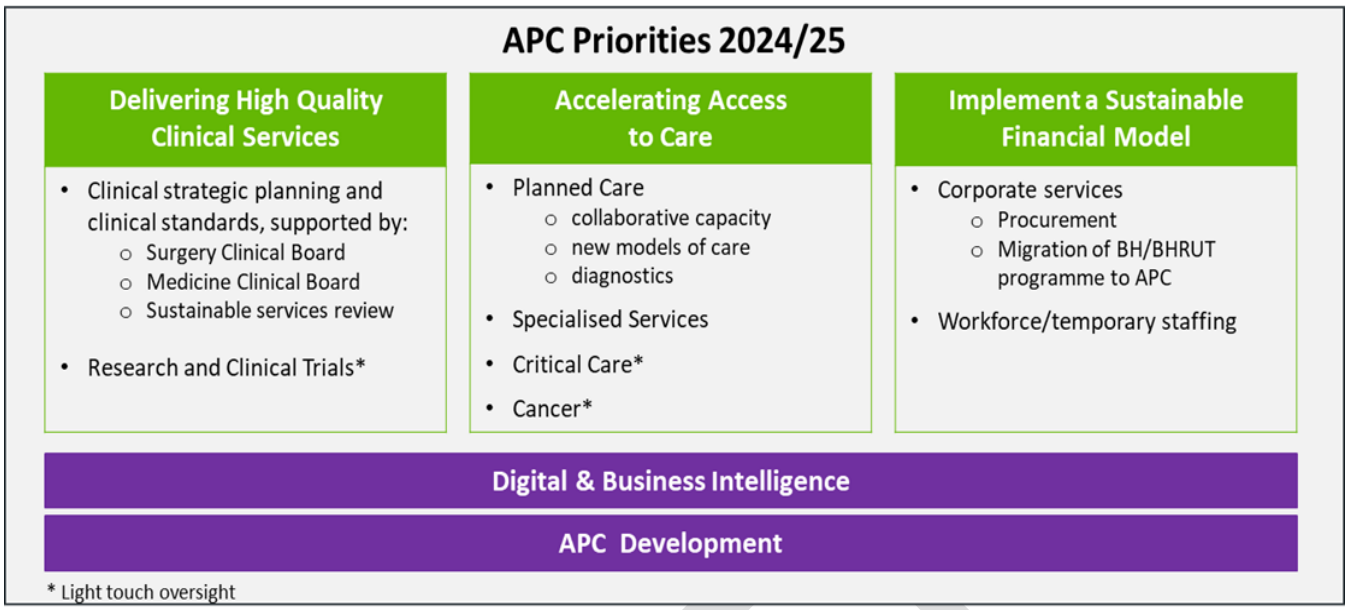
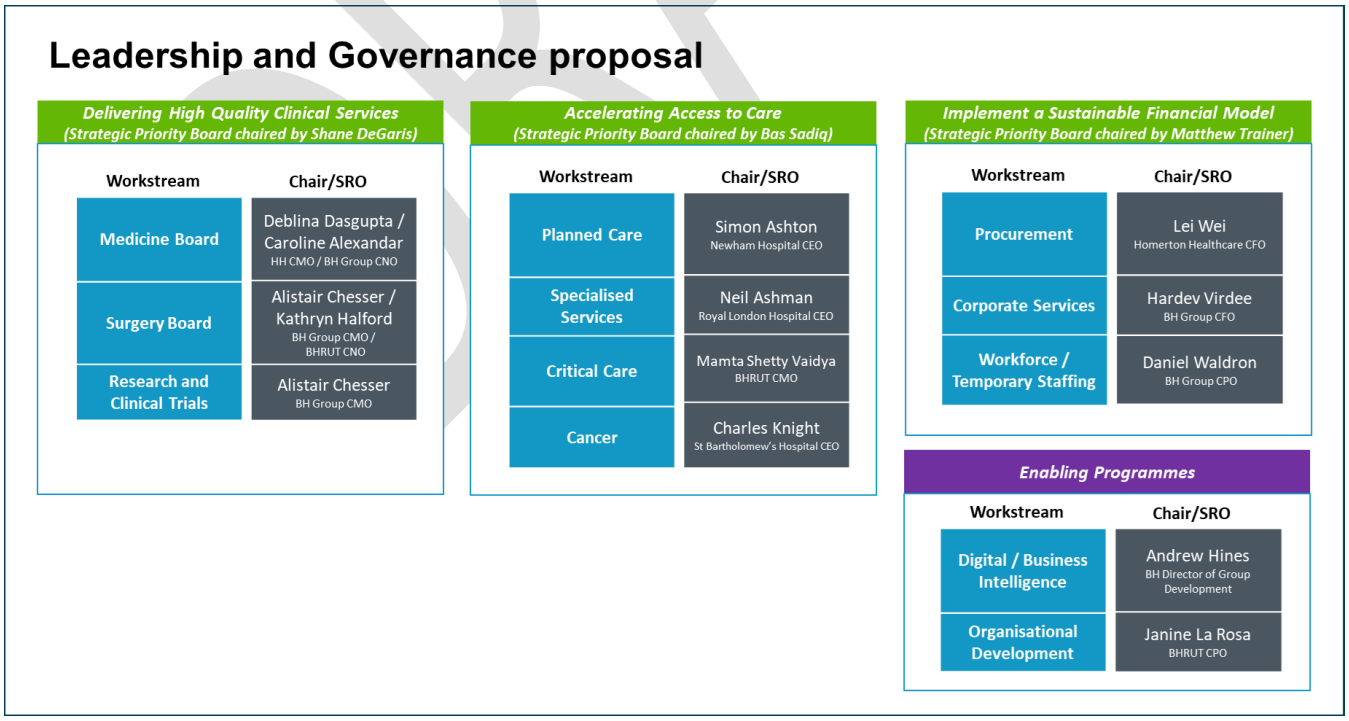


4.2 Each of the three priority areas of *Delivering High Quality Clinical Services, Accelerating Access to Care* and *Implement a Sustainable Financial Model* will be led by a Chief Executive SRO through a Strategic Priority Board with the responsibility for and oversight of programmes within their portfolio.

4.3 Each of the programmes will be led by an executive SRO through their Programme Boards who will in turn oversee the responsibility for and oversight of individual workstreams.

4.4 Each collaborative programme will consist of clearly defined objectives and expected outcomes.



5. Principles of collaboration

As previously stated, the parties will continue to collaborate in areas where working together provides more system benefit than working individually, particularly in areas outlined within their shared ambition. The parties will develop ways for the NHS Partner Organisations to work together to put the acute health sector in North East London (NEL) onto a more clinically and financially sustainable footing. The parties agree to adopt a set of principles and behaviours to govern their collaboration activities (the 'Principles of Collaboration'). Drawing on learning from other collaboratives, these are provisionally set out below. This remains work in progress, to be developed further in year through the APC OD Group.

5.1 Principles:

- Collaboration to improve clinical outcomes, inequalities and unwarranted variation for patients.
- Ensure actions and decisions are taken by the NEL APC to reflect what is in the best interests of the local population considering what is fair and equitable for each NHS Partner Organisation.
- To improve workforce health and wellbeing, with NEL as the best place to work.
- To deliver improved performance in quality, efficiency, and national standards.
- Deliver value for money to our populations and sustainability of our Trusts.
- Use innovation and research to improve productivity (digital and technology).

5.2 Behaviours

Each party commits to giving timely, reasoned responses to any proposal for collaboration between them and to consult with the other parties before unilaterally taking any step related to, or having a significant impact on, current or planned collaborative activities.

The parties will innovate, share knowledge and trial new ways of working. Sharing any learning experiences and quickly scaling up good practice that has been shown to work well.

Each party will always have regard to each other's needs and views, irrespective of the relative contributions of the NHS Partner Organisations and will support each other in achieving the Partnership objectives.

Recognising the significant financial challenges confronting the health service, the parties will work together to deliver efficiencies while continuing to improve quality and sustainability and will engage constructively with other stakeholders in developing the Integrated Care System Joint Forward Plan, shared capital plans and other system wide planning initiatives.

The parties will look to adopt a collective ownership of risk and reward, including identifying, managing and mitigating all risks in respect of their performance of the obligations under this Agreement. Partner Organisations will engage in open and regular communication, with early raising of risks and issues and a shared commitment to their resolution wherever possible.

The parties recognise that their workforces are central to the achievement of their collaboration ambitions and will commit to allocating representatives to each of the programme groups.

The parties recognise the importance of their collaboration being underpinned by robust systems of governance and the need for compliance with the Nolan Principles.

The parties recognise the time-critical nature of the APC programmes and will respond accordingly to requests for support. The parties will ensure sufficient and appropriately qualified staff and other resources are made available to fulfil the responsibilities set out in this Partnering Agreement.

5.3 Responsibilities

Senior Responsible Officer (SRO)	• Chair the relevant Board/governance forum that they are acting as SRO for • Provide direct and hands-on leadership to the portfolio, working with other representatives on the Programme Board • Ensure that the programme is designed on the principles of collaboration, meeting the needs of the parties involved, and ensuring that parties have had the opportunity to engage in the development of the programme. • Be accountable for keeping the other Chief Executives sighted on the project, and any matters arising on quality, performance, and financial impact. This includes making recommendations to the APC Strategic Executive and APC Joint Committee for final approval, on behalf of the Strategic Priority Board / Programme Board.

5.4 Staff Sharing Agreement

This Partnership Agreement will also recognise any staff sharing agreement that is put in place across North East London acute hospital trusts which is aimed at giving flexibility to each party in how they collaborate in the future on a sustainable workforce plan.

6. Decision Making

6.1 The parties agree to adopt a model for aligned decision-making to support the making and taking of decisions in relation to their collaboration activities based on the following:

Formation of proposal. Meetings of the APC will act as forums in which discussion can take place, informed by the views of each of the parties as relayed through their nominated representatives. Following that discussion, the representatives of the parties in attendance at the meeting will seek to form a consensus as to the text of a resolution outlining the decision to be taken.

Adoption of proposal. Once a consensus on a proposal has been reached in a meeting of the APC, and the text of a resolution has been agreed, either

The duly authorised representatives of each of the parties in attendance at the meeting, acting in accordance with the delegated authority conferred on them, will formally agree the resolution and take the decision; or

Where the resolution is required to be adopted and a decision taken on a matter which is reserved to the Board of any of the parties the agreed text of a resolution will be put on the agenda of the next scheduled meeting of that party's Board for determination.

This Partnership Agreement and the APC Joint Committee Terms of Reference provide the framework to delegate decisions from the Trust and ICB Boards to the APC Joint Committee. A scheme of delegation has not yet been agreed and is to be developed, with an ambition that this can be incorporated into a refreshed 2025/26 Partnership Agreement, subject to all other consents being in place.

6.2 Each of the parties confirms that these arrangements are in accordance with their Standing Orders, Standing Financial Instructions and Schemes of Delegation and in particular the delegation of functions to nominated representatives in their Schemes of Delegation.

6.3 In the event that the parties wish to delegate further functions to the APC in future they will seek the agreement of their respective Boards to amend their Standing Orders, SFIs and Schemes of Delegation as necessary.

6.4 In making decisions about their own organisations the parties agree to consider and promote the interests of the North East London acute sector, and not just their own organisational interests.

7. Dispute Resolution

7.1 If any party has any issues, concerns or complaints regarding the operation of this Partnership Agreement or the APC Programme that party shall notify the other parties promptly and the parties will seek to resolve the issue via discussion between them.

7.2 In a case where it has not been possible or appropriate to resolve a dispute informally, the dispute shall be referred to the APC.

7.3 The APC Joint Committee will consider and reach a position on the dispute which, in the view of the APC, is the most consistent with the Key Principles in this Partnership Agreement.

7.4 The parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each party.

7.5 If a party disagrees with a decision of the APC Joint Committee they may withdraw from the Partnership Agreement at any point.

8. Conflicts of Interest

8.1 The parties agree to follow the Protocol for Managing Conflicts of Interest as per their current organisation's requirements.

8.2 NHS Partner Organisations will disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement, immediately upon becoming aware of the conflict of interest whether that conflict concerns the NHS Partner Organisation, or any person employed or retained by them for or in connection with the performance of the Purpose.

8.3 NHS Partner Organisations will not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this Agreement (without the prior consent of the other NHS Partner Organisations) before they participate in any decision in respect of that matter.

8.4 If one party is considered by the other parties to have committed a material breach of the Protocol for Managing Conflicts of Interest, the other parties may agree to continue with any aspect of the collaboration between them to the exclusion of the other party.

9. Compliance

9.1 The parties shall comply with:

applicable Laws and standards, including (for the avoidance of doubt) their respective Provider Licences, procurement rules, competition law, data protection, patient choice and transparency legislation; and applicable guidance issued by a Regulatory Body.

9.2 If, as a result of change in applicable laws, the parties are prevented from performing their obligations under this Partnership Agreement but would be able to proceed if a variation were made to the Partnership Agreement, then the parties shall consider this.

9.3 In the event that that the parties are prevented from performing their obligations under this Partnership Agreement because of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all parties, then the parties shall agree to terminate this Partnership Agreement on immediate effect of the change in applicable law.

10. Term and Termination

10.1 This Partnership Agreement shall commence on the date on which it is executed by all the parties (the “Commencement Date”) and will continue until the parties agree between themselves that it should come to an end. There will be an annual review built in which will be carried out alongside the development of the APC Plan (the business plan for the activities) for the following year. This also aligns with the expectations around the review of ToRs.

10.2 This Partnership Agreement may be terminated in whole and with immediate effect by mutual agreement in writing by all parties.

10.3 Any party may withdraw from this Partnership Agreement giving at least six calendar months’ notice in writing to the other parties. The Partnership Agreement will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining parties will agree such amendments required to the Partnership Agreement.

10.3 A withdrawing party and each remaining party shall act to ensure an orderly departure of the withdrawing party and that any disruption to the collaborative arrangements between the remaining parties is limited to what is strictly necessary.

11. Variation

11.1 This Partnership Agreement may only be varied by written agreement of the parties signed by, or on behalf of, each of the parties.

12. Charges and Liabilities

12.1 The APC operating costs shall be set with the parties within this Partnership Agreement on an annual basis. The basis on which costs are shared across all the parties within this partnership Agreement will be developed for approval in 2024/25 with implementation from 2025/26. Additional resource requirements outside of this will be incorporated into the project initiation documents or relevant investment business cases as required.

12.2 The parties shall each bear their own costs and expenses incurred in complying with their obligations under this Partnership Agreement, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

12.3 No party intends that any other party shall be liable for any loss it suffers as a result of this Partnership Agreement.

13. No Partnership

13.1 Nothing in this Partnership Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the parties, constitute any party as the agent of another party, nor authorise any of the parties to make or enter into any commitments for or on behalf of the other parties.

14. Confidentiality

14.1 Each party shall keep the other parties' confidential information confidential and shall not:

use such confidential information except for the purpose of performing its rights and obligations under or in connection with this agreement; or

disclose such confidential information in whole or in part to any third party.

14.2 The obligation to maintain confidentiality of confidential information does not apply to any confidential information:

which another party confirms in writing is not required to be treated as confidential information;

which is obtained from a third party who is lawfully authorised to disclose such information without any obligation of confidentiality;

which a party is required to disclose by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law, including the FOIA or the EIR;

which is in or enters the public domain other than through any disclosure prohibited by this agreement;

which a party can demonstrate was lawfully in its possession prior to receipt from the other party; or

which is disclosed by a party on a confidential basis to any central government or regulatory body.

14.3 A party may disclose the other party's confidential information to those of its Nominated Representatives who need to know such confidential information for the purposes of performing or advising on the party's obligations under this agreement, provided that:

it informs such representatives of the confidential nature of the confidential information before disclosure; and

it procures that its representatives shall, in relation to any confidential information disclosed to them, comply with the obligations set out in this clause as if they were a party to this agreement, and at all times, it is liable for the failure of any representatives to comply with the obligations set out in this clause.

15. Data Protection

15.1 The parties shall (and shall procure that any of their representatives involved in the performance of the parties' obligations under this Partnership Agreement of the agreement) comply with any notification requirements under the Data Protection Legislation and the parties will duly observe all their obligations under the Data Protection Legislation, which arise in connection with this Partnership Agreement.

15.2 The parties agree to work openly and co-operatively together, sharing information with the APC and with each other where required to support the shared work of the collaborative. This includes sharing of financial and performance data where required.

16. Freedom of Information

16.1 The parties acknowledge that each is a public authority subject to the requirements of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

16.2 All FOIA requests in relation to the APC should be directed to Barts Health NHS Trust who will coordinate responses across partners within the APC.

16.3 Each party shall, in respect of any requests for information which touch on or relate to the APC and/or this Partnership Agreement:

provide all necessary assistance and cooperation as reasonably requested by the other parties to enable them to comply with their obligations under FOIA and EIR;

notify the other parties of requests for information that it receives as soon as possible.

provide to the other parties a copy of any information it holds, and which is required to respond to a request for information within a timely manner (or such other period as the parties may reasonably specify) of any request for such Information; and

not respond directly to a request for information unless without first consulting with the other parties.

17. Governing Law and Jurisdiction

17.1 This Partnership Agreement shall be governed by and construed in accordance with the laws of England and Wales.

17.2 The parties agree that the courts of England shall have exclusive jurisdiction to hear and settle any action, suit, proceeding or dispute in connection with this Partnership Agreement and irrevocably submit to the jurisdiction of those courts.

18. Further Assurance

18.1 Each party shall do all things and execute all further documents necessary to give full effect to this Partnership Agreement.

19. Signature Page

The parties have signed this Partnership Agreement on the day and year first above written.

Signed on behalf of:	**Barking, Havering and Redbridge University Hospitals NHS Trust**	**Barts Health NHS Trust**	**Homerton Healthcare NHS Foundation Trust**	**NHS North East London Integrated Care Board**
Signature:				
Name:	**Matthew Trainer**	**Shane DeGaris**	**Bas Sadiq**	**Zina Etheridge**
Title:	**Chief Executive**	**Group Chief Executive**	**Chief Executive**	**Chief Executive**
Date:				

DRAFT

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Board Assurance Framework
Author	Anne-Marie Keliris, Head of Governance
Presented by	Charlotte Pomery, Chief Participation and Place Officer
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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 September. • Board to receive updated BAF in September 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 Process for escalation

2.1 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.

3.0 Progress to date

3.1 The BAF has been updated including the templates for all risks.

3.2 A new risk management policy and strategy was approved by the audit and risk committee on 20 June 2024. The audit and risk committee also received a risk management update this meeting which included the BAF, the following comments were noted:

- At a meeting of the Population Health and Integration Committee on 19 June, members considered one of the risks specifically relating to that committee and the helpful suggestions given are being taken forward.
- A further meeting of risk champions took place in May in order to support the development of the risk management process and revise the risk management policy and strategy.
- Provider governance leads continue to discuss system risk with the outputs of a review of links between the ICB's Board Assurance Framework (BAF) and the BAF of our providers expected shortly.
- The risk management policy and strategy reflects the need to regularly review risk target dates and scores, which in turn, addresses an action from external audit to ensure that mitigating actions can be carried out.
- Committee members welcomed the update and the revised risk management policy and strategy.
- The need to quantify what success looks like by reviewing outcomes was suggested to ensure risks including system risks are seen to be improving.
- Mitigation dates need to reflect that the risks are evolving.

4.0 Risks on the BAF

4.1 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.

5.0 System risk

5.1 The NEL governance leads are continuing to develop a framework for system risk following a review of provider and ICB board assurance frameworks.

5.2 A recent internal audit on risk management has proposed a number of recommendations to support the development of system risk management which will be reviewed by the governance leads group. The most recent meeting of Audit Chairs across north east London expressed their support for actions at a system level through the governance leads group.

5.3 In addition, the governance team is supporting each Place team to ensure a Place Partnership risk register is in place, which reflects the local system risks. This aligns with the findings of the internal audit and ensures visibility of system risks held within local arrangements which may not otherwise have been widely understood.

6.0 Risk management training

6.1 The recent internal audit on risk management also recommended that training is provided to all staff throughout the organisation to ensure staff understand and implement the principles of risk management and the newly agreed risk management policy. This will enhance effective risk identification and management throughout the organisation.

6.2 We have recently explored options for this training with our internal auditors RSM and we are currently developing a training programme for risk champions and all staff.

7.0 Next steps

7.1 The ICB risk management strategy and policy will be included in the governance handbook.

7.2 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.

7.3 Further updates on the development of the system risk framework will be reported to the audit and risk committee.

8.0 Attachments

8.1 Board Assurance Framework

North East London
Integrated Care Board

Board Assurance Framework July 2024 – Dashboard

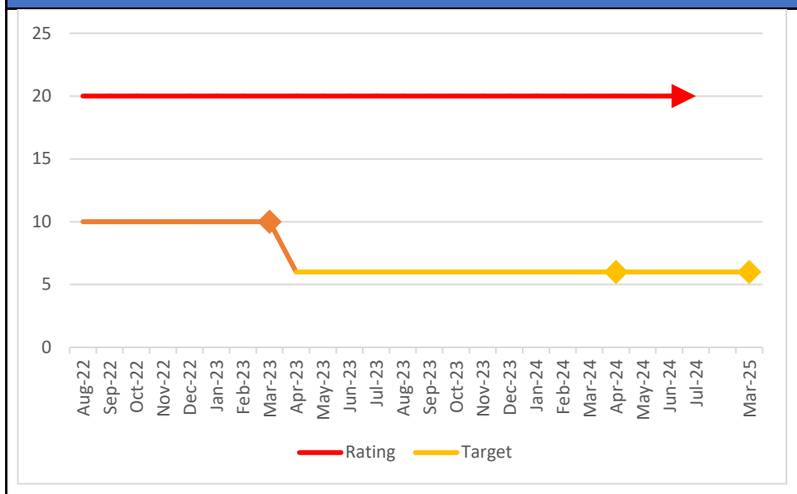
ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score							Target	Risk Appetite	Order in BAF
				Jun/ Jul	Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr/ May	Jun/ Jul			
To improve outcomes in population health and healthcare	There is a risk that ways of working continue to focus more on meeting 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	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	15	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	16	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	Michelle Hodgkinson	Workforce and Remuneration Committee	12	12	12	12	12	12	12	6	**Cautious:** We have limited tolerance of risk with a focus on	6

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score							Target	Risk Appetite	Order in BAF
				Jun/ Jul	Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr/ May	Jun/ Jul			
	wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.											safe delivery	
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	10	10	10	10	10	15	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	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	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	10

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score							Target	Risk Appetite	Order in BAF
				Jun/ Jul	Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr/ May	Jun/ Jul			
	the priorities local people want to see are not delivered.												
	There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.	Paul Gilluley	Population Health and Integration Committee	16	16	16	16	16	16	16	6	**Cautious:** We have limited tolerance of risk with a focus on safe delivery	3

Board Assurance Framework – July 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.**						

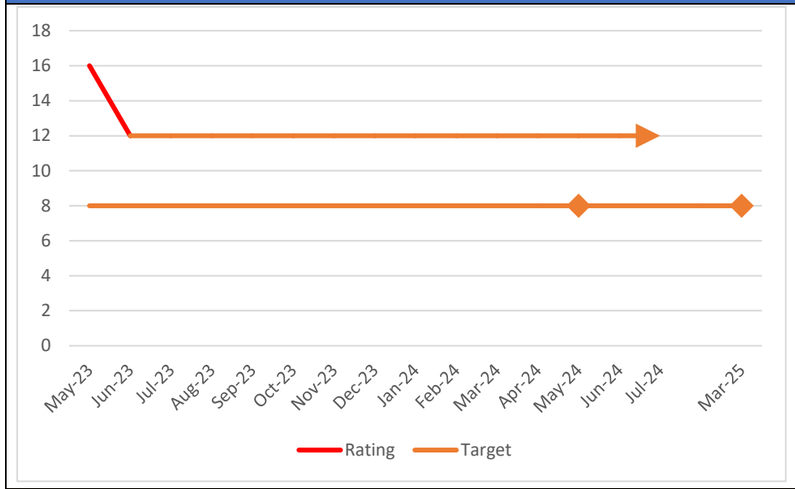
Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (4x5)**	August 2022 Risk reconsidered in April 2024.	The system has a control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk detailed within the operating plan for NEL at present to the 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)	July 2024	Work is continuing across the system to address the financial risk held by both local authorities and the NHS system across north east London. Progress and delivery will continue to be monitored across the system through the Financial Sustainability Joint Oversight Committee and discussed at recovery forums including CFO meetings and the ICB's Financial Sustainability Board. 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 Sustainability and Oversight Committee and the Finance, Performance and Investment Committee bi-monthly
Financial performance reported and reviewed by regional/national teams. Potential regional NHSE support through the Investigation and Intervention (I&I) programme.
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
Internal ICB processes to deliver greater transparency on future spend; including business case process where assurance is provided by the Investment Review Group
ICS Sustainability Director appointed and system-wide Financial Sustainability and Oversight Committee.
New groups and governance established to aid the financial sustainability programme including the ICB's Commissioning Review Group and Financial Sustainability Board.

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 financial sustainability programme established with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.	Complete and ongoing
System partners have identified internal efficiency programmes in place to deliver savings for this financial year	Complete and ongoing
Finance team continues to identify ICB savings to be enacted for this financial year to be able to deliver the position that is statutorily required	Ongoing
ICB working to identify savings and development of plans to meet efficiency targets and mitigation where these are slip	Ongoing

Review of investments being undertaken.	Ongoing
Efficiency programmes are being led by individual organisations, with some cross organisational transformation programmes.	Ongoing
Detailed analysis of the drivers of the deficit for the NHS and local authorities at a place level. To be delivered as place based reporting develops.	31.10.24
Session to share detail of financial risk held by local authorities and the ICB	Complete but additional sessions to be arranged
The establishment of the System Development Funding (SDF) group with a specific focus on current year fund management and reporting.	Complete
A savings programme across the ICB with particular emphasis on those two greatest areas of cost pressures i.e. prescribing and CHC.	31.03.24 and continuing
A savings programme looking specifically at previous commissioning/investment decisions	31.03.24 and continuing

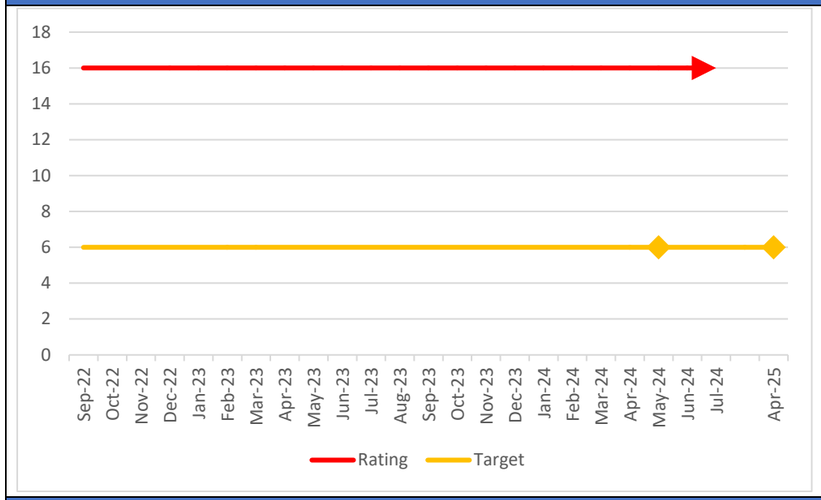
ICS Aim	To improve outcomes in population health and healthcare							Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO15 (previously CSTO01)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Charlotte Pomery
	✓		✓		✓		✓			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	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)	July 2024	This will always remain an important risk for the ICS which we will need to pay attention to. The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project. These involve co-design by large groups from across the ICS and additional communication with those not directly engaged.

Controls and assurances
Review of current data and information including JSNAs from all 7 PBP and NEL population profile
ICP strategy development - key focus on securing PBP and provider collaborative input including engaging executives from provider collaborative e.g. Trust Chairs and Snr executives
ICP strategy discussed at CAG to ensure clinical engagement and input
ICP strategy task and finish group established to ensure system wide engagement and involvement
The ICB Executive Management Team, ICP Committee, to receive regular updates

Mitigations/ actions to address the risk	Target date
Task and finish group established with broad range of involvement from ICP system to oversee development and drafting of the strategy	Complete. Jan 2023
ICP strategy socialised at staff meeting, and shared with senior leadership for cascading to partners	Complete. March 2023
ICP strategy discussed at borough level with 8 x Health & Well Being Boards and 7 Place Based Partnerships	Complete. May 2023
PPE engagement on the ICP strategy through working with Healthwatch and CVS in NEL	May 2023
Series of workshops that include wide range of partners from across the system - over 200 attendees for BCYP and over 100 participants for all the others	Complete. Dec 2022
The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project.	Existing
Seeking a development partner who will work with key leadership groups across the ICS to help us agree what working together more effectively and closely means in NEL. Procurement for this partner is due to commence in September.	October 2023

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO009
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Paul Gilluley
	✓	✓	✓	✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health. Effects will include: the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	September 2022	NEL currently has the highest rates of air pollution in the UK and the impact of air pollution on ill health is known and individuals suffer harm because of it. The additional pressure put on the NHS system due to ill health arising from air pollution has a severe operational and reputational risk.
	Target rating (LxS)	**Target date**	**Rationale**
	6	April 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)	July 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
Worked 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	Complete - April 2024
Travel and transport working group established with involvement from across ICB system	Complete
Introduced salary sacrifice staff bike scheme across ICB	Complete - Jan 2023
The Babies Children and Young People (BCYP) Air Quality Clinical Lead role has been extended. They have worked with the Net Zero Lead and BCYP team to develop a case study for an Air Quality Programme to be discussed with the Chief Transformation and Strategy Officer (CTSO) and Chief Medical Officer (CMO) in May.	Complete

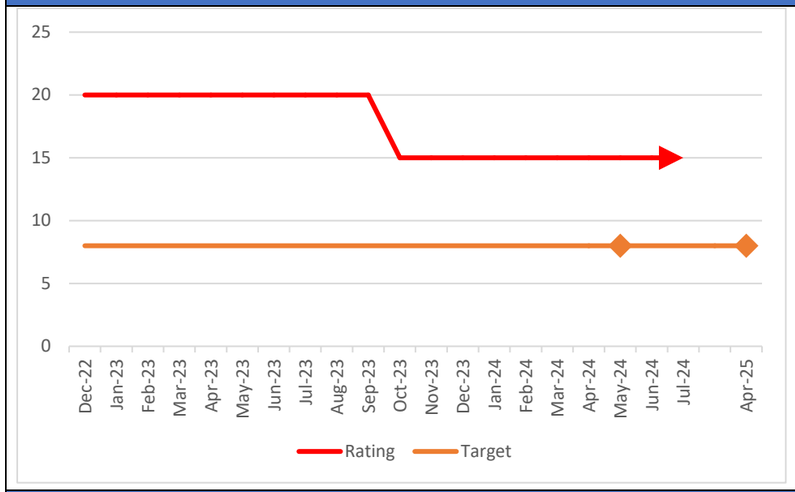
ICS Aim	To support broader social and economic development							Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO012 (previously CPPO11)
								✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions			Risk owner	Johanna Moss
	✓		✓		✓		✓			Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest			Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓				
Risk description	**There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.**										

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**16 (4x4)**	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.
	Target rating (LxS)	**Target date**	**Rationale**
	8	April 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)	July 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 2025
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)	July 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

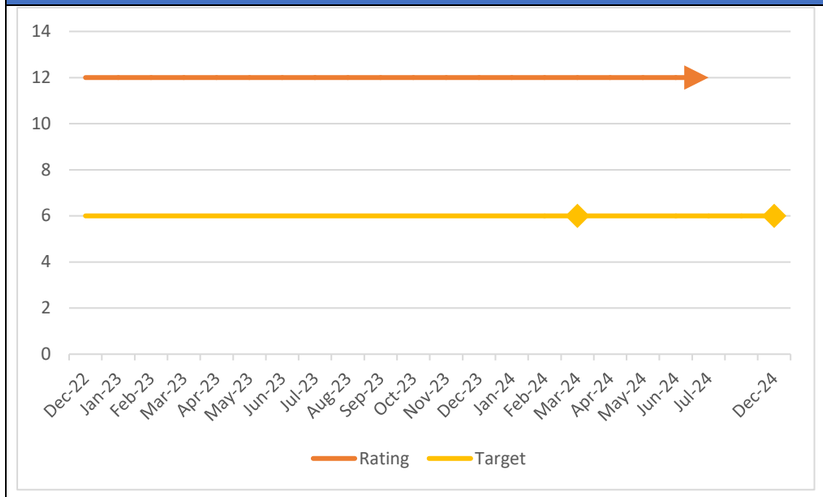
	Complete
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 **complete and planned for Feb 24 meeting**
BHR UEC Place Programme Board around BHR UEC Improvement Plan and Strategy, avoidable admissions, discharge funding programmes	26/04/23 & 31/05/23 & 28/06/23 **Complete**
Strengthening of staff networks to support protected characteristics.	September 2024
Ensuring coproduction reflects local diverse populations.	Continual
Maintaining our commitment to the Health Inequalities funding which can affect employment opportunities.	Continual
Co-creating and implementing the Equality, Diversity and Inclusion Strategy.	September 2024
Ensuring that our core communications include community languages.	Continual

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	Michelle Hodgkinson
			✓		Responsible committee	Workforce and Remuneration Committee

Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		

Risk description	There is a risk that the failure to produce and implement a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.

Score history and targets



Initial rating (LxS)	Initial date	Rationale
12 (3x4)	December 2022	Given our current service requirements and workforce pressures, that cuts across organisations, if we do not plan and deploy effectively we will not be in a position to deliver the range of services required. And, may impact on the health and well-being of our workforce.

Target rating (LxS)	Target date	Rationale
6 (2x3)	December 2024	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles and retention initiatives. Also, to ensure pathways and processes are in place to support and encourage local people into health and care employment. The wellbeing offer to social care and primary care was funded non-recurrently by the ICB - no funding has been identified past June 2024 and has been decommissioned through the Investment Review Group. We have begun working with system partners to develop system wide approach to developing a consistent occupational health offer in the future.

Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report
12 (3x4)	July 2024	Work is ongoing to operationalise the NEL People Strategy. The Director of Workforce Transformation and other key supporting roles are now out to advert and appropriate governance is being explored. Work is ongoing to reestablish the NEL People Board, with an initial meeting scheduled for September 2024.

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.
Over 300 posts achieved up to June 2024
Social Care hub in place until March 2025

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
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	Complete

Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally	Complete
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA	Complete and ongoing
Working with system partners to develop system wide approach to developing a consistent occupational health offer in the future.	March 2025

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.**										

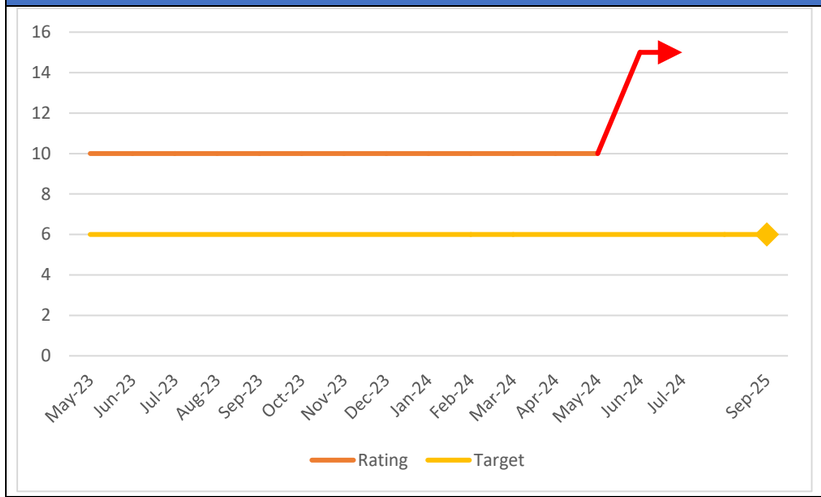
Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (5x4)**	December 2022	Considerable resource and workforce capacity risks that may have an impact on quality and safe care
	Target rating (LxS)	**Target date**	**Rationale**
	8 (2x4)	April 2025	Significant programmes of work are 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**
	16 (4x4)	July 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.
NEL ICB Quality, Safety and Improvement Committee meets every 2 months
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
Substantive Director of Nursing and Safeguarding in post

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	Continual
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 ~~180~~ **complete**

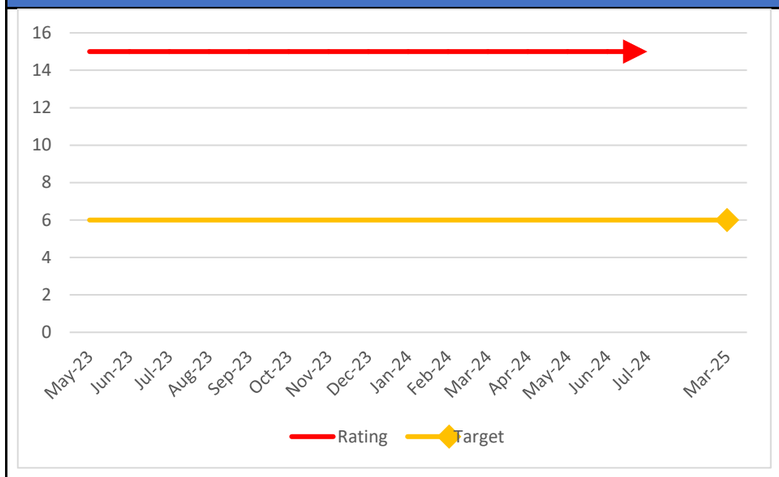
Revision to ICB Quality and Safety Team Operating Model to maintain oversight of risks/ issues through attendance at System Programme Boards	September 2024

ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO02
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Johanna Moss
	✓	✓	✓	✓			Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer term sustainability.**							

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**10 (2x5)**	May 2023	NEL-wide Infrastructure Strategy required by NHS England before July 2024. 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**
	15 (3x5)	July 2024	Infrastructure Strategy draft is completed, and all Local Infrastructure Forums are established at each Place and have been running for the last 12 months. Capital and especially backlog maintenance continue to be an issue for Trusts.

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.	Complete
Development of long-term Strategic Infrastructure Approach.	Draft Infrastructure Strategy has been developed.
Options and priority areas for investment reviewed to enable better future planning of investment and spend.	Ongoing
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.	Draft Infrastructure Strategy has been developed.

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

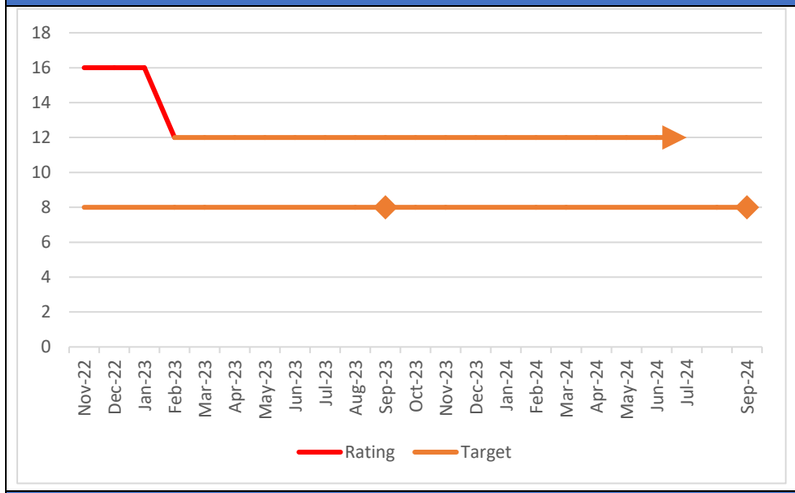
Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**15 (3x5)**	May 2023	There is current experience of co-operation on the 23/24 Operational Plan with shared financial accountability. The exit criteria or the SOF4 status for BHRUT have yet to be clarified. The domain with the highest likelihood of poor outcomes is UEC, where the NEL system has been designated as Tier 1, requiring the highest level of intervention and support.
	Target rating (LxS)	**Target date**	**Rationale**
	6 (3x2)	March 2025	The NEL system was moved to from Tier 1 to Tier 2 for UEC with effect of Jan 2024. As a Tier 2 system, NEL continues to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	15 (3x5)	July 2024	Ongoing risk in planned care due to continued industrial action. 24/25 planning was predicated on no further IA (a core national planning assumption) and as such, there is some risk to delivery – the latest round of IA taking place 27/06 – 02/07. The total waiting list in planned care increased in Apr 2024 for the 5th consecutive month. The waiting list is now +13,927 pathways and 7% higher than the position in Apr 2023. There are also some specialty risks to delivery of the Sep-24 >65ww long wait ambition (all three NEL Trusts submitted Operating Plan trajectories to achieve 0 >65ww by end of Sep-24). Barts Health remain in Tier 1 (from Nov-23) for elective recovery.

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

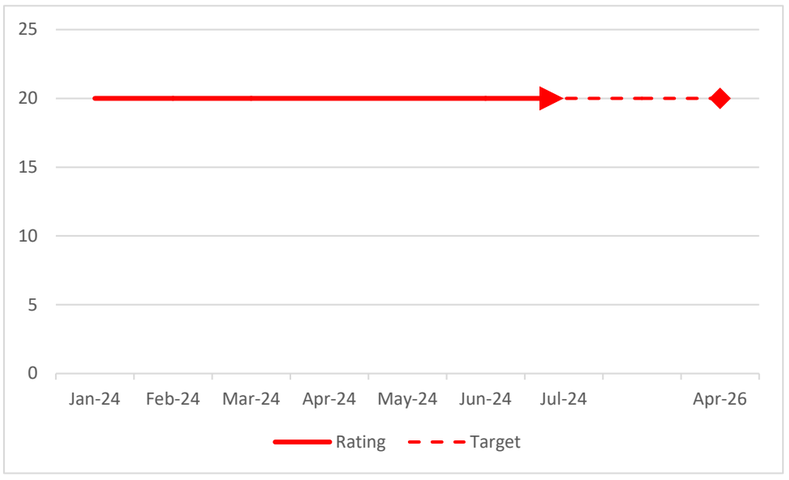
ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CPPO13
					✓	✓		
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions			Risk owner	Charlotte Pomery
	✓	✓	✓	✓			Responsible committee	Population 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
	**16 (4x4)**	May 2023	The system is facing significant financial challenges and the ICB is going through a restructure, meaning that learning from regional and national can be challenging and time consuming.
	Target rating (LxS)	**Target date**	**Rationale**
	8 (4x2)	September 2024	It is anticipated that over a year will be required and able to fully mitigate this risk - allows significant lead in time following the organisational restructure, as well as understanding the implications of the Hewitt review and wider policy context.
	Current rating (LxS)	**Latest review date**	**Rationale and key progress/ updates since last report**
	12 (3x4)	July 2024	We continue to participate actively in national, regional and indeed cross north east London forums to share and learn from best practice. We have built communities of practice in a number of areas and are represented well on leadership forums across sectors including for example community work, care services and co-production. We are part of London forums on a range of topics and actively learning from each other.

Controls and assurances
Full engagement with partners on regional group and initiatives, including the Greater London Authority.
A focus on learning within and outside of London and attending site visits.
Receiving active delegations from NHS England and hosting services on behalf of London, e.g. Dental, Optometry and Pharmacy Services (DOPS).

Mitigations/ actions to address the risk	Target date
Involvement in research and pilot initiatives.	September 24
System leaders participating in national and regional groups.	September 24
The ICB's Managing Director of Primary Care is chair of the Primary Care PODS Group.	Complete.
Participating in national, regional and local forums to share and learn best practice	Continuing
Communities of practice have been built in a number of areas, including community work, care services and co-production	Complete and continuing

ICS Aim	To improve outcomes in population health and healthcare							Risk reference	CMO001
ICS priority	Children and young people	Mental health	Employment and workforce	Long term conditions				Risk owner	Paul Gilluley
	✓	✓	✓	✓				Responsible committee	Population Health and Integration
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		
Risk description	**There is a risk that, if the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms.**								

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	**20 (4x5)**	January 2024	The risk has been identified owing to a specific challenge in NEL related to renal dialysis capacity, a specialised service, currently commissioned by NHSE, and due for delegation in April 25. The capacity challenge has arisen due to unfunded growth in demand which is marked in NEL owing to the aetiology of the population. Risks in unfunded growth for other specialised services are therefore likely to arise where funded capacity is likely to be insufficient to meet rising demand for complex specialist care as the population needs increase in response to new drugs, technology and advances in specialist provision. Quality and safety impacts of reduced capacity and access to certain specialist treatments can be extremely detrimental to patient outcomes in addition to the financial pressures on the NHS more broadly.
	Target rating (LxS)	**Target date**	**Rationale**
	20 (4x5)	April 2026	The risk remains as red with a target for April 26 as this will be one-year post delegation of specialised service commissioning to ICBs. The risk is likely to remain at a high score as preventative interventions to manage specialist demand will take time to demonstrate impact. Simultaneously, the volume of specialised services to be delegated will increase 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)	July 2024	• The Joint Working Agreement with NHS England regarding the delegation of specialised services was agreed by the ICB Board at its meeting on 27 March 2024. • NHSE non recurrent support of £1.8m provided in M12 23/24 to support Barts Health with immediate mitigations. • Tracking and monitoring of the Barts Health in centre dialysis plan in April 24, demonstrating a reduction in growth for renal dialysis in Q4 from 17.9% to 6%, 24/25 forecast growth for in centre dialysis revised to 8% however ongoing pressure related to timing of the St Georges development. • Next meeting to track progress, and refresh demand vs capacity position for May and August scheduled end of July 24.

Controls and assurances
Maintenance of the Delegation Legacy Risk Log where the issue of continued pressure on in centre renal dialysis capacity is listed
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 (as renal dialysis capacity is also constrained in NCL) • 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	Completed
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 i.e the cardiometabolic approach	Completed

SUPPORTING INFORMATION

Appetite description	Appetite level
Averse: Avoidance of risk is a key objective	1
Cautious: We have limited tolerance of risk with a focus on safe delivery	2
Open: We are willing to take reasonable risks, balanced against reward potential	3
Bold: We will take justified risks.	4

Committees of the Integrated Care Board:

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

Aims of the Integrated Care System:

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

Risk grading matrix

Risk Category	
	Severe
	High
	Medium
	Low

											Likelihood					
											Rating	**1**	**2**	**3**	**4**	**5**
											Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
											Probability	**<10%**	**10% - 24%**	**25% to 45%**	**50% - 74%**	**>75%**
Severity	**Rating**	Description	A Objectives/ projects	B Harm/injury to patients, staff visitors & others	C Actual/potential complaints & claims	D Service disruption	E Staffing & competence	F Financial	G Inspection/ Audit	H Adverse media						
	1	**Insignificant**	Insignificant cost increase/time slippage. Barely noticeable reduction in scope or quality	Incident was prevented or incident occurred and there was no harm	Locally resolved complaint	Loss/ interruption more than 1 hour	Short term low staffing leading to reduction in quality (less than 1 day)	Small loss <£1000	Minor recommendations	Rumours	1	**1**	**2**	**3**	**4**	**5**
	2	**Minor**	Less than 5% cost or time increase. Minor reduction in quality or scope	Individual(s) required first aid. Staff needed <3 days off work or normal duties	Justified complaint peripheral to clinical care	Loss of one whole working day	On-going low staffing levels reducing service quality	Loss of 0.1% budget.	Recommendations given. Non-compliance with standards	Local media	2	**2**	**4**	**6**	**8**	**10**
	3	**Moderate**	5-10% cost or time increase. Moderate reduction in scope or quality	Individual(s) require moderate increase in care. Staff needed >3 days off work or normal duties	Below excess claim. Justified complaint involving inappropriate care	Loss of more than one working day	Late delivery of key objectives/service due to lack of staff. On-going unsafe staff levels. Small error owing to insufficient training	Loss of more than 0.25% of budget.	Reduced rating. Challenging recommendations. Non-compliance with standards	Local media lead story	3	**3**	**6**	**9**	**12**	**15**
	4	**Major**	10-25% cost or time increase. Failure to meet secondary objectives	Individual(s) appear to have suffered permanent harm. Staff have sustained a "major injury" as defined by the HSE	Claim above excess level. Multiple justified complaints	Loss of more than one working week	Uncertain delivery of services due to lack of staff. Large error owing to insufficient training	Loss of more than 0.5% of budget.	Enforcement action. Low rating. Critical report. Major non-compliance with core standards	Local media short term	4	**4**	**8**	**12**	**16**	**20**
	5	**Severe**	>25% cost or time increase. Failure to meet primary objective	Individual(s) died as a result of the incident	Multiple claims or single major claims	Permanent loss of premises or facility	No delivery of service. Critical error owing to insufficient training	Loss of more than 1% of budget.	Prosecution. Zero rating. Severely critical report.	National media more than 3 days. MP concern	5	**5**	**10**	**15**	**20**	**25**

NHS North East London ICB board

31 July 2024

Title of report	Executive Committee exception report
Author	Katie McDonald, Governance Lead
Presented by	Zina Etheridge, Chief Executive Officer
Contact for further information	Katie McDonald, Governance Lead katie.mcdonald3@nhs.net
Executive summary	This report provides a summary of the key items from the meeting of the Executive Committee held on 9 July 2024. The key items detailed in the report include: • London Fire Brigade enforcement notice at Newham Hospital • Population growth in Newham • Developing a roadmap to integration • System approach to coproduction
Action required	Note
Previous reporting	None – this is an exception report from the meeting held in July 2024.
Next steps/ onward reporting	The committee meets again on 12 September 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.

1.0 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 July 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 In July the committee received a paper outlining the work underway to address the London Fire Brigade (LFB) enforcement notice at Newham Hospital, and the associated risks. The hospital was built in the late 1970s under Crown Immunity, but since its construction Hospital Technical Memorandums have been implemented which require higher building standards. An outline business case is being developed to address the fire safety issues which will confirm the costs and timeframes; however, it is anticipated that it will cost a significant amount over multiple years to complete all phases of the work. Barts Health NHS Trust has taken the necessary steps to ensure the safety of patients, staff and the public, with the hospital remaining operational whilst the remedial works are completed. There are several associated risks which are being managed through Newham Hospital's risk register which include capital funding and population growth in surrounding boroughs. Members discussed the need to strategically plan our estates for the medium and longer term, and the importance of continuing to work collaboratively with LFB and partners on this issue.

2.2 Members discussed a report which was closely linked with the Newham Hospital paper in that it highlighted the projected population growth in Newham and the need for us to plan strategically. Over the next ten years Newham is projected to have the highest level of growth across all London boroughs and the forecasted levels of growth in Newham are significantly over and above those seen across England and will likely impact on future demand for services. By achieving full, system-wide investment delivered through Integrates Neighbourhood Teams there is the potential to mitigate some of Newham's future demand growth. This would need to be delivered through a model of integrated care which will enable wider preventative, early-intervention and neighbourhood-focussed approaches; as well as supporting the future sustainability across providers. The committee discussed the importance of this work and how it will assist in creating a blueprint for our other boroughs who are all facing the challenges with population growth, and also the importance of triangulating this with housing.

2.3 The committee received a report regarding some early thinking on what integration means and what we may want to consider when codesigning a roadmap to integrated care. The report detailed the reasons why integration is needed, some different definitions of what integration is, as well as some examples of integration already in place across north east London. Members were asked to pull out some examples of where integration is difficult, such as temporarily funded integrated roles, to highlight areas where we can work together to improve. The committee

recommended that the paper is presented to our Provider Collaboratives and other system fora to hear their examples of where integration is working well and where it can be improved.

2.4 Members noted a report that was being brought to the Integrated Care Partnership meeting on 18 July regarding our system approach to coproduction. The importance of taking forward coproduction has been discussed and agreed in a range of settings in recognition of the benefits to the commissioning cycle and how we use our assets and resources across the system to improve health and wellbeing outcomes, as well as to local people and wider stakeholders in being agents in their own health and wellbeing. It was recognised that not all parts of our system are equally mature in approaching and embracing coproduction and there is much to learn from each other and from colleagues beyond north east London to build coproduction into all that we do. There is currently no shared definition of coproduction for the system and there are times when the phrase is used to describe good engagement and not the fuller process of coproduction, meaning distinctions can be hard to draw. There are many definitions to consider, and it will be important to adopt a shared definition for north east London. It will be beneficial to agree a small set of principles beneath the definition which enables development of coproduction throughout our system all within a culture of learning and improvement.

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

- A review of the 2023/24 industrial action
- Financial overview

3.0 Risks and mitigations

3.1 The duties of the committee will be driven by the Integrated Care System and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Audit and Risk Committee exception report
Author	Cha Patel, Audit and Risk Committee Chair
Presented by	Cha Patel, Audit and Risk Committee Chair
Contact for further information	anna.mcdonald@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 20 June 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 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.
Has an Equalities Impact Assessment been carried out?	An equalities impact assessment is not required for this report.
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 is agreed before the start of each 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 20 June 2024.

1.2 The board is asked to note this report.

2.0 Key messages

2.1 Following a robust review undertaken during April and May, the committee received final draft versions of the annual report and accounts for 2023/24. The External Auditor's audit on the financial statements and final Head of Internal Audit Opinion were also presented, and no significant issues were identified. The committee approved the final drafts of the annual report and accounts and recommended their submission to the ICB board for final sign off before the submission to NHS England.

2.2 The committee approved the ICB's Internal Audit policy and a revised risk management policy and strategy. Other revised governance polices are due to be presented to the committee for approval in October along with a final draft of the procurement policy.

2.3 The committee received assurance regarding the Data Security and Protection Toolkit (DSPT) and approved the submission subject to completion of two outstanding areas.

2.4 The Chief Information Officer attended the meeting to provide an update on digital risk and the development of a system-wide dashboard. Committee members were encouraged and reassured by the work being done, noting the complexities in this area.

2.5 Committee members noted updates from our External Auditor, Internal Auditor and our Local Counter Fraud Specialist. As part of the Internal Audit discussion, members were assured that appropriate action has been taken in response to concerns raised previously about the number of outstanding management actions. The committee welcomed the news that the ICB is fully compliant in regard to the Counter Fraud Functional Standards return which has recently been submitted.

2.6 Members were advised by the finance team that a new date for the implementation of the new national finance system is still awaited. In the meantime, the committee received assurance that the internal commitment to having 100% purchase order compliance remains, noting the exceptions, and the committee fully supported the decision and the continued commitment by the finance team.

3.0 Risks

3.1 External Auditors advised that commentary to the full value for money findings will acknowledge that 2024/25 will be a challenging year and will refer to the level of risk the ICB is facing as a system going forward.

3.2 Work continues to understand the links between the Board Assurance Frameworks (BAF) of the ICB and the providers as a precursor to developing a system level risk framework.

3.2 Cyber security is an ongoing concern with issues faced by a number of NHS organisations. We continue to learn lessons from recent attacks, have introduced Multi Factor Authentication where possible and ongoing training is mandatory. The need to continue to manage supplier risks which impact our system was acknowledged. A system-wide digital risk dashboard is also under development.

3.3 Progress continues to be made in procurement activities using the NHS Provider Selection Regime which is complex, and the status of the Atamis system which is the key tool for developing the pipeline. Work continues to ensure we meet the

requirement for all procurements to use purchase orders ahead of the introduction of the new national finance system.

3.4 The committee will continue to follow up on outstanding actions from previous Internal Audit reports, acknowledging delays caused by the restructure, industrial action, the introduction of new systems and financial targets.

3.5 Finance in 2024/25 continues to be a risk with possible further industrial action and very tight control total requirements.

July 2024

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Finance, Performance and Investment Committee exception report
Author	Matthew Knell, Senior Governance Manager
Presented by	Kash Pandya, Non-Executive Member / Chair of the Finance, Performance and Investment Committee
Contact for further information	matthew.knell@nhs.net
Executive position summary	The Finance, Performance and Investment Committee (FPIC) last met on Monday 24 June 2024. The meetings discussed the following business: • The 2024/25 North East London (NEL) operating plan, 2024/25 financial framework and the ICB's budgets for 2024/25 • An outline update on the 2024/25 Month 2 financial position • The Month 12, 2023/24 performance report • A deep dive on imaging and diagnostics • A deep dive on the NEL Infrastructure Strategy • The Chief Finance and Performance Officer's (CFPO) Risk Register • Updates from Committee sub-groups • Approval of five contract awards following the outcomes of a procurement process
Action required	The Board is asked to note the report.
Previous reporting	None – this is an exception report from the June 2024 Committee meeting.
Next steps/ onward reporting	The Committee next meets on Monday 29 July 2024 and a regular exception 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 does 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.

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 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 Purpose of the report

1.1 The last meeting of the Finance, Performance and Investment Committee (FPIC) took place on Monday 24 June 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 updates on the 2024/25 financial framework that had been drawn up by NHS England (NHSE) to recognise gaps in operating plans across the country and to provide incentives and levers to encourage achievement of operating plans in the financial year. Additionally, the latest revisions to the 2024/25 North East London (NEL) Operating Plan were presented, which included movement in the control total to a £35 million deficit position for the system, from the previous £55 million deficit in the previous return to NHSE. This movement had been achieved through specialist commissioning income being revised upwards, and Trust partners addressing same day emergency care (SDEC) and Private Finance Initiative (PFI) depreciation costs. The overall NEL deficit position included a £636,000 surplus for the ICB.

2.2 The FPIC recognised that under the revised financial framework, if NEL did not meet the £35 million deficit position, then the system may be penalised in 2025/26 to make up any shortfall from this year in terms of capital or revenue funding.

2.3 There was a significant cost improvement plan (CIP) ask of the system as a whole, totalling £289 million, which included £69.2 million for the ICB. Additionally, it was thought that risk in the region of £200 million was attached to the delivery of the plans across partners.

2.4 The FPIC endorsed the 2024/25 ICB budgets and use of its running cost allowance (RCA) approval by the ICB Board, noting that they included the application of a vacancy factor to enable the ICB to meet the needs of the RCA reduction.

2.5 Members acknowledged that the initial available data was indicating an ICS deficit variance to plan of £16.4m at month 2, 2024/25. Providers were reporting a variance to plan of £16.1m and the ICB is reporting a variance to plan of £0.4m. In line with month 2 reporting guidance no forecast position was reported at month 2. It is expected that this will be a requirement from month 3 onwards.

2.6 The Financial Sustainability Director briefed the FPIC on the revised approach being put in place to support the system and members discussed how efforts to address costs and secure savings would be directed differently in 2024/25 than in the past, with a renewed focus on securing recurrent savings early in 2024/25 and taking action as soon as possible. It was recognised that unlike in the previous financial year, there wouldn't be the option to turn to non-recurrent funding in 2024/25 and that colleagues needed to be aware of the risks around secondary impacts caused through the NHS systems work on financial recovery, particularly in relation to local authority partners. Committee members were clear that they would need to see firm assurances around progress and achievements in the coming months in relation to this work, along with information on emerging risks and issues.

2.7 The FPIC received the latest month 12, 2023/24 performance report that highlighted that NEL providers were not performing against trajectory in waiting list recovery, despite good improvements in almost all areas of activity; while NEL was reporting cancer performance close to target, with the lowest backlog of activity in London. The FPIC engaged in a detailed, deep dive discussion around diagnostics and imaging across NEL, exploring the drivers behind diagnostic services performance, noting that changes in demand and demographics from pre to post pandemic were driving much of the waiting lists and activity. Members recognised that the system was currently facing a 20% increase in higher total activity since before the pandemic and that the total numbers of patients moving through services were significantly higher than in the past. Opportunities were being seized to address these challenges, for instance in an active pilot underway to bring artificial intelligence (AI) online and into chest x-rays and chest computed tomography (CT) scans to assist in cancer diagnostics, alongside upgrading of scanners to take advantage of AI driven opportunities for faster scanning and reporting performance, helping to support more activity.

2.8 The FPIC received a detailed briefing on the ICB's draft Infrastructure Strategy and explored key points, including that the ICB and partners needed to investigate alternative models for investment and the opportunities available through the NHS's role as an anchor organisation, perhaps through joint working with local authorities and universities. Proper, transparent and evidence-based prioritisation and local discussions would be vital in face of limited resources and the challenges facing the public sector.

2.9 The FPIC approved the award of five contracts, following the outcomes of the ICB's procurement process.

2.10 Updates from Committee sub-groups were received from the 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 directorate risk register at both meetings, containing red 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: 16/07/2024

NHS North East London ICB board

31 July 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 19 June 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 2024.
Next steps/ onward reporting	The committee meets again on 4 September 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 19 June 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 Kash Pandya, Non-Executive Member, was welcomed as a new member of the Committee following a recent review of all Committee memberships and some changes within our non-executive team. This was also my last meeting chairing the Committee; I will continue to be a member of the Committee but Imelda Redmond, Non-executive Member, will take up chairing responsibilities from the next meeting in September.

2.2 The Committee received a report that explained how we can take forward population health improvement through segmentation and outcomes. The segmentation tool was presented, and it was explained how residents who are registered with a GP are exclusively assigned to a single segment, based on their 'pre-dominant' health needs; i.e. healthy, healthy with risk factors, has a long-term condition etc. Our rich data sources will study all parts of the healthcare system to identify distinct characteristics, needs, and risk factors associated with each group. This enables the development of targeted interventions and customised care plans specific to each segment's unique needs. The goal is to use segmentation to support decision-making and commissioning with consistent and accurate monitoring of population group outcomes over time. It was explained that when the tool is overlayed with a single outcomes framework, it will enable us to develop a holistic view of our local population with a detailed understanding of their needs, their resource use and any inequalities across these areas. It will benefit the promotion of integration, innovation and prevention and enable the design of communication and education programmes that resonate with the specific interests and needs of different groups.

Members had a rich discussion on the approach and highlighted the importance of building on the data we have, which is predominantly medical-based, and how we will need to incorporate local government data to understand social determinants that can affect outcomes for our residents. Aligning outcomes across our Places and Provider Collaboratives is a real enabler to support natural integration and would allow us to maximise our collective impact. The importance of having the Start Well programme running in parallel to this work was also recognised; we should work to prevent our young population being in certain segments when they reach adulthood and beyond.

2.3 Members discussed a report that provided a stocktake of the work to date on delivering our key actions from the Working with People and Communities Strategy that was approved by the ICB Board on 1 July 2022. The report highlighted how we are building on sharing our community insights across north east London, the refresh of the People's Panel, development of a training package for staff to understand what participation and engagement is, the reward and recognition policy, as well as working with specific local communities. It was also suggested that we take forward a review of the strategy by mid-2025 and agree the emerging framework for coproduction across the system.

The Committee highlighted that it will be important to systemise and establish clear definitions for quality improvement as well as coproduction so that we can have shared principles for teams and partner organisations to build into. However whilst we can have common principles, we will enact co-production in different way and it needs to be part of our culture, embedding coproduction in all work including providing evidence of this in business cases, procurements, contracts and job descriptions.

2.4 The Committee also considered one of the key risks it holds responsibility for. The risk reviewed at the meeting in June is also included on the Board Assurance Framework: *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.*

Members discussed the mitigations that are in place and indicated that we should include some of our population health improvement work as an assurance and that the work of this Committee can be included as a control. In north east London we have real assets, particularly our relationships with local authorities, and in the wider

context of Integrated Care Systems across London we may be underselling ourselves and are not necessarily reflecting enough on the positive work that is underway. It will be important to review this from a Strengths, Weaknesses, Opportunities and Threats (SWOT) lens to frame the system challenge, and work to ensure that people within this risk segment are healthier. It was also recognised that there is poor air quality in north east London which is a wider determinant of health and can create unwarranted variation; a report on our Net Zero approach will be presented to the ICB Board in November which will outline the work underway to address the associated risks.

Author: Katie McDonald, Governance Lead
Date: 15.07.2024

North East London
Integrated Care Board

NHS North East London ICB board

31 July 2024

Title of report	Quality, Safety and Improvement (QSI) Committee exception report
Author	Keely Horton, Governance Officer
Presented by	Imelda Redmond/ Fiona Smith, Non-executive Members
Contact for further information	Keely.horton1@nhs.net
Executive summary	This report provides a summary of the key items from the meeting held on 12 June 2024.
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 11 September 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?	An Equalities Impact Assessment is not required for this report.
Impact on finance, performance and quality	There are no additional resource implications/revenue or capitals costs arising from this report.
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 is agreed before the start of each 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 the Board with an overview of the items discussed at the Quality, Safety and Improvement (QSI) Committee held on 12 June 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 comprehensive quality exception assurance report to update members on quality assurance exceptions and provide assurance through a quality lens. Further assurance was requested regarding fertility services along with a progress report from the Mental Health, Learning Disabilities and Autism collaborative on the improvement programme and how East London NHS Foundation Trust (ELFT) is being supported as a provider. The Committee also requested an improvement report on the performance of health assessments for looked after children.

2.2 A system quality report with a focus on patient experience was presented to the Committee for discussion.

2.3 A summary of Patient Choice regulations and the measures that the ICB has taken to implement the regulations locally was shared with the Committee. Members acknowledged that NHS North East London (NEL) has a duty to implement the regulations relating to choice.

2.4 An update on the work undertaken to date and future plans relating to the development of the embedding quality work programme was presented. The Committee welcomed the model and acknowledged the importance of quality ensuring that quality is at the core of our processes.

2.5 Committee members received a report relating to quality reviews of stroke services in London. Further assurance was requested regarding quality issues raised together with an update on progress made at the Long Term Conditions Programme Board. Members discussed the possibility of a having a spotlight on stroke at a future ICB board meeting.

2.6 A maternity demand and capacity case for change was presented to the Committee. The document outlined the areas of opportunity that have been identified during the programme to best meet the needs of the population. Members noted that the outcome will be shared following further service user engagement and care model workshops.

2.7 The Committee received a thematic review into still births and neonatal deaths and members supported the development of an action plan to implement the recommendations.

2.8 The NEL mortality update provided the Committee with an overview of child deaths, safeguarding reviews, and improvement measures within the ICB. Members noted the cross-cutting themes and learning points for improvement. The report will be presented to the Committee on a quarterly basis going forward.

3.0 Risks and mitigations

3.1 The Committee is highlighting a risk regarding oversight of specialist commissioning and quality issues across stroke pathways. Mitigations and improvement work is being undertaken by the NEL long term conditions specialised services team to implement focused improvement projects.

Author: Keely Horton, Governance Officer
25 June 2024

North East London
Integrated Care Board

NHS North East London ICB board

31 July 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	This report provides an overview of the items discussed at the meeting held on 16 July 2024.
Action required	The board is asked to note the report.
Previous reporting	A report was presented to the board at its meeting in May 2024.
Next steps/ onward reporting	An exception report will be presented to the board going forward.
Conflicts of interest	No conflicts of interest have been identified in relation to this report.
Strategic fit	Employment and workforce – to work together to create meaningful work opportunities and employment for people in north east London now and in the future.
Impact on local people, health inequalities and sustainability	The Committee will receive assurance on the ICB's employment flagship priority, ensuring that we utilise the ICB's ability to provide meaningful and positive employment opportunities for local residents.
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 agenda items discussed at the meeting held on 16 July 2024.

1.2 The Board is asked to note this report.

2.0 Key messages

2.1 Non-conflicted committee members noted and discussed a summary of the ICB's chief executive and chief officers' performance appraisal for 2023/24 and objectives for 2024/25.

2.2 An update on compulsory redundancy cases was presented to the committee, and following a detailed discussion, committee members approved a small number of additional compulsory redundancies resulting from the outcome of phase three of the consultation. As part of the discussion, the committee also considered a detailed qualitative analysis of the Equality Impact Assessment (EIA) undertaken as part of the voluntary redundancy scheme, which identified themes and patterns. The committee agreed that the helpful analysis provides valuable learning for the organisation, for example, following up with individuals whose application for voluntary redundancy was refused to understand their reasons for wishing to leave.

2.3 The committee discussed a progress report on the 2023 national staff survey action plan and welcomed the update, noting that the 2024 staff survey will be launched in October.

2.4 An update on the people and culture department's risk register and progress made on actions from internal audits completed within the last 12 months was noted and discussed.

2.5 A helpful update was provided on the comprehensive work being undertaken regarding workforce data going forward and the review of existing Human Resources (HR) policies that is taking place.

2.6 The committee approved the Fit and Proper Person Test (FPPT) policy put in place as part of the overall framework to strengthen and reinforce accountability and transparency for board members.

2.7 A summary report on Freedom to Speak Up (FTSU) cases between April 2023 – March 2024 was presented to the committee.

3.0 Risks and mitigations

3.1 The committee's duties will be driven by the ICB's objectives and the associated risks.

3.2 A key risk is the reduced capacity of the People and Culture department due to current vacancies.

July 2024

Integrated Care Board Forward Plan

	31-Jul-24	25-Sep-24	27-Nov-24	29-Jan-25	26-Mar-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					
Remuneration committee exception report					
Approval of governance handbook amendments					
Finance and Performance					
Overview report					
Assurance					
Board Assurance Framework					
Quality					
Deep dives	Digital strategy	Urgent and Emergency Care	Long term conditions	End of Life care	Dentistry
Programme of care for maternity					
Strategy					
Joint forward plan (5 year plan)					
Update on Clinical and Care Professional Leadership and Clinical Advisory Group					
Operating plan					
Infrastructure strategy					
Industrial Action review					
ICB staff survey report (to be included in CEO report)					
Big Conversation success measures					
ICS strategy progress report					
Net Zero review					
Community Health Services - investments and delivery 2024/25 (request following deep dive in May)					