North East London ICB Annual Report

1 July – 31 March 2023

Abbreviations used in this report

BHRUT	Barking Havering and Redbridge University Hospitals NHS Trust
ED	emergency department
ENT	ear, nose and throat

CQC	Care Quality Commission
CETV	cash equivalent transfer value
NELHCP	North East London Health and Care Partnership
ICO	Information Commissioners Office
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICPB	Integrated Care Partnership Board
ICS	Integrated Care System

IG	information governance
BAF	board assurance framework
JSNA	joint strategic needs assessment
NEL	north east London
NELFT	NELFT NHS Foundation Trust
NHSE	NHS England
PCN	Primary Care Network
RTT	referral to treatment time

Contents

PERFORMANCE REPORT **4**
Performance Overview 5
Performance analysis 10
ACCOUNTABILITY REPORT **47**
Corporate Governance Report 51
Statement of Accountable Officer's Responsibilities 53
Remuneration and Staff Report 108
Remuneration Report 109
Staff Report 112
ANNUAL ACCOUNTS **129**

PERFORMANCE REPORT

ZINA ETHERIDGE

Accountable Officer

23 June 2023

Introduction and Performance Overview from the Chief Executive

The North East London Integrated Care Board (ICB) was established on 1 July 2022 following the disestablishment of Clinical Commissioning Groups (CCGs) and the implementation of the Health and Social Care Act 2022. This put Integrated Care Systems (ICSs) on a statutory footing and the role of the ICB is to develop a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in north east London. It must also ensure the delivery of the overall purpose and priorities of ICSs: improving quality and outcomes, securing greater equity, creating value and deepening collaboration. In addition, four core system priorities were agreed for the ICS in autumn 2021 and these are at the heart of the ICB's overall approach.

From its initial establishment the ICB has been focused on setting a number of foundations: developing an overall strategy for our partnership as well as a finance strategy, establishing a population health approach to addressing health inequalities, putting in place relevant policies, establishing and embedding the appropriate governance, developing an operating plan, ensuring co-production is core to the ICB's approach, embedding clinical and professional leadership and placing a focus on our workforce across the system. Progress is already being made across all of these areas and in collaboration with partners across the system.

One of our foundations has been embedding robust governance across the organisation and system and ensuring strong partnership working is at the core of this. The Board of the ICB is meeting regularly and membership includes partners from our NHS provider collaboratives, local authorities, primary care, community and voluntary sector partnership, along with a Healthwatch collaborative participant. Our core committees are established and meeting and our Chair Marie Gabriel CBE brings partners together across the system regularly including elected representatives' and non-executive members. We also have an established Integrated Care Partnership (ICP) joint committee with local government, with wide and inclusive partner membership, and a steering group driving the work of the overall partnership. A significant focus for the ICP has been the development of the interim five-year strategy.

The development of the interim ICP Strategy has been a significant achievement over the first six months of the ICB's establishment. A broad range of stakeholders and partners were engaged and involved in this and it outlines how we will work together in partnership to deliver our core priorities as an ICS. Co-production is a core focus for the ICB and a participation strategy 'Working with People and Communities' was agreed in collaboration with system partners and the first agreed strategy of the ICB Board. A series of 'big conversation' events are planned with residents for 2023 to ensure they are co-producing the final version of the strategy for the ICP, resulting in resident-driven success measures.

As an ICB we are committed to approaching resources in a different way and a finance strategy for the ICS is also under development, outlining how funding will be allocated across north east London with a

focus on financial sustainability and supporting all organisations and partnership forums to transform and improve services for our population. The approach will support the ICP's five-year strategy and allocate resource in line with this.

There has been a renewed focus on clinical and care professional leadership. Extensive work has taken place to develop and agree a model in partnership with clinicians and professional leads across north east London. A number of place-based clinical directors have been appointed and recruitment is continuing to ensure there is a greater diversity of professions incorporating pharmacy, Allied Health Professions (AHPs), public health, adults and children's social work and others.

At the core of our approach is ensuring we address health inequalities across the population. We have adopted the Core 20 PLUS 5 approach - a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement. 'PLUS' population groups include ethnic minority communities; people with a learning disability and autistic people; people with multi-morbidities with specific consideration for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system. Tackling health inequalities is a key thread through our four ICS flagship priorities and in all our work as we take a population health approach as well as improve the use of data and digital tools. Our established population health and integration committee and health inequalities steering group play a key leadership role in driving this work forward.

In the autumn we brought partners together for a series of workshops on the priorities and held one specifically on the impact of the cost of living. At this session partners shared good practice and discussed practical ways we can collaborate as a system. The winter has been a particularly challenged time with pressures on urgent and emergency care, the ongoing recovery of services as we come out of the pandemic and additional pressures from industrial action. As a system we have come together to respond to this and ensure services continue to run as effectively as possible. In response to particular pressures on our urgent care system in outer north east London, partners have been working together on an action plan and response.

Looking ahead, the focus for the next period is on further refining our strategy and embedding delivery through our joint forward plan, ensuring we develop a robust workforce strategy for the system, a comprehensive Urgent and Emergency Care plan ahead of winter 2023/24 and delivering on our financial strategy. There are a number of challenges we will manage including reductions to the running costs of Integrated Care Boards and a difficult economic picture more broadly as we manage pressures across the system. As ever, collaboration across the partnership will be key to managing this and partners are committed to working together as a system.

The first half of this report summarises the ICB's performance against our key indicators and statutory duties, highlighting where performance is strong and (for example cancer care standards) and where we are more challenged (mental health, given the system pressures). We are clear that it is only by working together as an integrated system that we will be able to improve the access, experience and outcomes for local people. Later in the section we set out the risks to delivering against our corporate objectives, again focussed on how the system can come together to support improvement.

This annual report covers July 2022 – March 2023 and is shorter due to the timeframe for approving the legislation to establish ICBs formally, but in the following sections we reflect on what we have already achieved in our first nine months.

CCG to ICB transition and financial provision

Public sector bodies are assumed to be 'going concerns' where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. When CCGs ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a going concern basis as they will continue to provide the services in the future.

The funding for 2023/24 has already been agreed with NHS England (NHSE). On this basis, there is no reason to believe that sufficient funding will not be made available in the 12 months from the date of approval of these Financial Statements.

Corporate objectives

When the ICB was formally established on 1 July 2023 a set of objectives was agreed by the board. These focused on ensuring the ICB delivered the purpose and priorities of ICSs: improving quality and outcomes, securing greater equity, creating value and deepening collaboration. A full set of strategic objectives was developed for April 2023 and progress to date is as follows:

- Prior to its establishment the shadow ICB led the system in developing a purpose, design principles and four flagship priorities, against which we would define our success. This set a framework for our agreed interim ICP strategy, and we have continued to develop this with a broad range of stakeholders and partners engaged and involved. Whilst we worked with Healthwatch in particular and our partners to gather insight we are in the midst of going out to residents and staff as part of a 'big, long and deep conversation' ahead of the final version this autumn. This conversation will further refine the content and establish people and community defined success measures.

- A finance strategy for the ICS is and has been tested and refined with partners and is now feeding in to the operating plan and work on the North East London Joint Forward Plan. This strategy ensures our focus on the NHS Triple Aim and the four aims of the ICS.
- A shared approach to population health and an approach to data and the digital infrastructure to support this, and enable us to tackle health inequalities. This includes the population health and integration committee and its reporting arrangements such as the health inequalities steering group, which is co-chaired with a Director of Public Health and the ICB Chief Medical Officer.
- Core polices have been agreed by the ICB, and ongoing work to develop and refine these and other polices continue. Just one example of system leadership has been the revised fertility policy for north east London, developed in collaboration with residents and stakeholders and ensuring an equitable approach for all local residents, removing variation.
- A robust set of governance has been established and implemented across the ICB via committee meetings and the overall Integrated care board, as well as place-based meetings and the provider collaboratives. This is ensuring decision making and discussion is taking place regularly to deliver the overall objectives and priorities for the ICB and ICS. This is supplemented by the facilitation of input by sector groupings, mandating the decision making of their representative, for example local authority leaders' meetings and Healthwatch collaborative meetings. Importantly we hold regular Board development sessions to ensure that we work effectively as a Board and as a system, furthering learning and informing strategic decision making. For example, our first focused on the role of a system unitary board and more recently we considered our system approach to improvement, facilitated by a representative of the Institute of Healthcare Improvement.
- A system operating plan is in development with the first submission complete. Further work is underway working in collaboration across the system. In addition, a joint forward plan is being developed which will be the delivery vehicle for the overall strategy. The first draft has been considered by the ICB and tested with the ICP.
- The ICS led the system, working closely with the voluntary sector, people and communities to develop a participation strategy, which was agreed at the first Board meeting. This included core principles that will guide our co-production work and which the whole system has committed to delivering. A series of big conversation events are planned with residents in 2023 to ensure they continue to co-produce the overall strategy for the ICP and define our success measures.
- A model has been developed and agreed and recruitment is underway. All the place-based partnerships and Clinical Directors were in post from late Summer/Autumn 2022. Of the 128 total positions, 106 roles have been filled, with recruitment continuing into the outstanding posts and onboarding underway. The ICB has led the system to develop a workforce strategy, with testing at Board, and connection being made across the London region to ensure we economy of scale and once for London where appropriate.

Corporate Objectives 2023-24

Building on the transitional objectives for 2023-24 and a continued commitment to delivering the core purpose of ICSs, a set of formal objectives for the board for the next financial year have been developed as follows:

1) Making progress on the **implementation of the ICP strategy** through working with collaboratives and places to put programmes in place against the four core priorities in the strategy, with an overarching programme for each which sets out clear timescales and milestones and clarity on what action will happen at place and collaborative level.

2) **Deliver the NHS operational planning requirements** – through this plan we will ensure the elective recovery, mental health standards trajectories set in the NEL operating plan are delivered alongside the financial plans, and that there is a joined-up approach to demand, especially urgent and emergency care, ensuing residents get the care they need.

3) **Develop a system wide workforce strategy** underlined with an action plan, putting in place the foundations for a shared strategic plan for a workforce across north east London that meets capacity gaps, ensures we have the new skills we need for the future and provides great employment opportunities for our residents.

4) Work towards **our commitment to being an anti-racist ICS**. Further to the London wide commitment to a strategic anti-racism approach in London's Health and Care System, North East London ICB will develop a robust action plan to include anti-racism training and establish key networks to deliver on this commitment.

5) To further **tackle health inequalities** by supporting our place-based partnerships to develop and implement three-year plans aligned to our ICP strategy and national best practice frameworks. This will include the launch of a new NEL Health Equity Academy to improve shared learning and joint understanding of improved data and a focus on poverty, ethnicity and specific populations.

6) **Working as a system** - having spent this year putting in place the key enablers for the ICS, there will now be a focus on putting in place the organisational development and culture of system working, ensuring it is systematically worked through and embedded.

Strategy on research and innovation

We have developed a strategy on research and innovation which aims to support relevant local research and increase the number and diversity of people who take part in and influence our research

and innovation initiatives. Over the last year we supported various research projects ranging from the impact of car emissions on asthma to developing a model of culturally tailored health care for ethnic minorities.

We have worked with NHSE and with North Thames Clinical Research Network (CRN), University College London Partners (UCLP), Healthwatch and the Voluntary, Community and Social Enterprise (VCSE) alliance towards developing an inclusive research engagement network with the aim of increasing diversity and participation in research. We have held two workshops and run a local survey which helped us better understand the possible barriers and facilitators of engaging with research.

We have also collaborated with City University and other partners for building a 'Well Communities Research Consortium' as part of which we have been exploring how local health and care systems can better interface with, develop and mobilise our community assets to improve health and reduce health disparities. We co-designed, with our link workers, digital templates and dashboards to capture social prescribing data in order to evaluate the impact of our social prescribing initiatives locally and use the data for quality improvement. We are made a strong start towards developing a learning system so that our patients and communities can shape and fully benefit from local research and innovation initiatives.

Performance analysis

Elective Services

We have an established planned care recovery and transformation programme (an integrated system programme initially set up in October 2021 to recover the elective backlog and improve equity of access for our population, led by the Acute Provider Collaborative). The programme has continued throughout 2022/23 to lead on a series of activities and interventions to manage demand, optimise existing and build new capacity.

The NEL Surgical Optimisation Group (SOG) was also established in June 2022 to bring together surgical leadership teams across the system to oversee improvements in theatre utilisation and productivity, optimisation of our designated high-volume elective hub sites and plan for an expansion in theatre capacity as a result of national targeted investment funding.

We have continued to work towards restoring elective care services back to pre-pandemic levels of activity in 2022/23. In January, inpatient activity was circa 94% of 2019/20 levels, achieved through significant effort and focus across our acute trusts, including use and maximisation of collaborative capacity and mutual aid, as well as with the support of independent sector providers. Innovation has also continued through the use of 'blitz weeks' and other initiatives to increase capacity in challenged specialties, as well as targeted work to ensure accuracy and validation of waiting lists.

A significant focus in 2022/23, in line with national ambitions, has been treating patients waiting over 2-years locally, and those that will have been waiting 18-months or more at year-end. For the latest reported month of January, we had 13 patients waiting over two years, a significant improvement from 396 patients waiting at the start of the year in April 22. The number of patients waiting 18-months or more has also seen a significant improvement from 1,519 patients in April 22 to 795 patients in January. Performance against the referral to treatment standard as reported in January was 60.4% against the 92% standard for treatment of patients within 18 weeks.

Transforming Outpatient Services

Outpatient transformation is a key programme within the overarching planned care recovery and transformation programme. The aim of the outpatient transformation programme is to create sustainable, equitable and efficient outpatient and out of hospital services to improve equity of access to elective care across NEL and reduce waiting times.

In 2022/23 focus has been on benchmarking and mapping against national best practice e.g. 'Getting it Right First Time' guidance, to identify opportunities for ongoing improvement, as well as the effective use of outpatient capacity to see patients on our outpatient waiting lists.

Increased use of referral optimisation tools (e.g. advice and guidance/refer) to provide timely advice and support to GPs and patients to manage their condition, and interventions to reduce non-value adding outpatient follow-up appointments (e.g. Patient Initiated Follow-up) have also been a key focus.

Our GPs can now receive advice directly from a number of specialist consultants, reducing hospital attendance and giving speedy care. In 2022/23 we achieved against the 16% national ask for advice and guidance requests across 2022/23, and for approximately 29% of all outpatient appointments in January. One per cent of all outpatient attendances were moved or discharged to Patient Initiated Follow-up pathways in January with plans to increase this further in 2023/24. Where outpatient attendances are clinically necessary, around 20% were delivered remotely by telephone or video consultation.

Developmental work has also progressed in 2022/23 to ensure patients waiting for outpatient appointments in NEL are equipped with the information, support and advice they need to ensure they are able to 'wait well' via various mechanisms and tools (e.g. 'My Planned Care' online platform and the 'Waiting Well in NEL' website). These have been developed alongside an end-to-end review of pathways to ensure we have equity of access and reduce unwarranted variation in community pathway and out-of-hospital service provision for NEL residents, with conditions relating to ear nose and throat (ENT), muscular skeletal (MSK) and dermatology a particular focus. These services already exist and

we know they provide an alternative service offer that reduces demand on secondary care.

Prioritising Cancer Services

The ICB supports the North East London Cancer Alliance which continues to work with acute providers, GPs, voluntary and community organisations, and the local population to increase the number of people coming forward and being referred with suspected cancer, with a particular focus on under-represented groups. More information on the work of the NEL Cancer Alliance can be found on the cancer alliance website: https://www.nelcanceralliance.nhs.uk/. There are three key programmes of work across the North East London Cancer Alliance, each one supported by patient engagement. These are:

Early Diagnosis Programme

- Targeted Lung Health Checks commenced in July 2022 in Barking and Dagenham. 3040 lung health checks have been completed and over 700 scans performed. Uptake rate is currently 64% against a national average of 39%.
- The ‘Best for my Chest’ breast screening campaign was launched in October 2022 focussing on the LGBTIQ+ community. This campaign is a collaboration with the charity Live Through This and was co-produced with members of the LGBTIQ+ community in north-east London. This was supported by sensitivity training for screening services. InHealth have requested that the training be included in their induction programmes nationwide.
- The ‘It’s Not a Game’ campaign has continued with a focus on lung cancer awareness in November 2022. Additionally, with the Graham Fulford Charitable Foundation, free home testing kits have been made available to men over age 45, resident in north-east London. To quarter three, 226 kits had been tested, with 12 needing further follow-up (5%).

Diagnosis and Treatment Programme

- Faster Diagnosis Standard performance continues to be above the national standard.
- Implementation of the tele-dermatology project is successfully supporting providers to manage demand and reduce the backlog.
- The ‘Non-Symptom Specific’ pathway rollout has been completed and embedded ahead of the national expectation of 100 per cent by March 2023.
- Clinical Trial Recruitment for NEL remains one of highest in country – further work is underway to improve input from our diverse communities.

Personalised Cancer Care Programme

- All three Trusts have procured, upgraded and installed the required Somerset Remote Monitoring System (RMS). Barts Health have operationalised RMS and are “live” for colorectal and prostate patients. RMS is also “live” at Barking, Havering and Redbridge University

Hospitals NHS Trust (BHRUT) who are moving forward with a self-management pathway for Haematology patients.

- Prehab: AHP recruitment has been successful, and all three Trusts are delivering enhanced rehabilitation services to patients. Over 300 patients have benefited from receiving prehabilitative interventions that have enabled them to be fit for treatment. An evaluation framework has been agreed.
- Completed mapping for two 'Quality of Life' priority areas as below:
  - Gap analysis of psychosocial support services across NEL and a development plan has been produced.
  - Fatigue has been identified as a priority area for Quality of Life. Mapping of fatigue and sleep services across NEL has been completed.
- Established a working partnership with Improving Access to Psychological Therapies particularly in regard to training and development of community teams.

Reducing the Backlog and Improving Performance

During 2022/23, the system focused on backlog reduction and maintaining or increasing activity levels (diagnostic, outpatients and treatments) and meeting the 28-day Faster Diagnosis Standard. Tele-dermatology is the use of digital images to diagnose, monitor or assess skin conditions without the patient being physically present. This is being used at BHRUT and Barts Health and Homerton to support increased Two Week Wait Referral and Faster Diagnosis Standard activity. The system also made investments in histology biopsy benches and workforce to support recovery of Two Week Wait Referral and Faster Diagnosis Standard.

During 2022/23, we also supported acute providers with additional funding to improve histology reporting and locum capacity was secured at Barts Health to support overall backlog recovery in 'head and neck' treatment as well as urology tumour sites.

In addition, particular focus was on making sure people wait no more than 31 days between meeting with their doctor, at which a treatment plan is agreed, and the start of treatment. Despite challenges experienced through and since the pandemic, performance against the cancer constitutional standards has been very strong in NEL providers, meeting the July to March compliance against the:

- 31 Day First Treatment Standard with performance of 97.1% against the 96% standard.
- 31 Day Second Sub Surgery Treatment Standard with performance of 95.0% against the 94% standard.
- 31 Day Second Sub Chemo Treatment Standard with performance of 99.9% against the 98% standard.
- 31 Day Second Sub Radiotherapy Treatment Standard with performance of 98.8% against the 94% standard.

However, non-compliance was noted in:

- The Two Week Wait Referral Standard with performance of 89.73% against the 93% standard, which remains above the London average performance of 86.51%.
- Both the 62 Day Urgent GP Referral performance (59.92% against the 85% standard) and 28 Day Faster Diagnosis Standard (66.65% against the 75% standard) was challenged in recent months due to increase in dermatology referrals, histology and delayed diagnostics turnaround times.

NEL recovery action plans are in place to enable continuous improvements in the cancer position and create a better experience for our patients.

Improving Access to Diagnostics

The Alliance worked with the Mile End Early Diagnosis Centre and our three providers (Barts Health, BHRUT and Homerton University Hospital) to continue to provide additional diagnostic capacity of 16,500 procedures a year to ensure rapid investigation and diagnosis.

The Alliance also helped drive significant increase in the take up of innovations like colon capsule endoscopy – a pill containing a tiny camera that records detailed information of the colon - and cytosponge – a 'sponge on a string' pill test, which is a quick, easy alternative to endoscopy.

Rapid diagnostic centres, a single point of access to cancer tests for all patients with symptoms that could indicate cancer, are also in place in both inner and outer north east London. They are designed to speed up cancer diagnosis and improve patient experience.

The Alliance set up and is delivering the ‘Targeted Lung Health Check’ programme in north east London, which is providing life-saving lung scans to residents aged 55-74 who have ever smoked. Our uptake rate is 64%, one of the highest rates in the country.

King George Hospital is the first in the country to offer a robotic colonoscopy machine. Patients will benefit from a painless and non-invasive procedure compared to a traditional colonoscopy and will not require any sedation meaning faster recovery.

During 2022/23, the ICB Alliance worked with diagnostics teams with supporting the development and deployment of the national Community Diagnostics Centres (CDC) programme. This has involved achieving £6m of additional revenue funding to deliver thousands of additional diagnostic procedures, as part of the ‘early adopter’ programme.

We have also pressed ahead with the installation of a new MRI scanner in the Mile End Hospital, CDC and a CT scanner at Barking Community Hospital. The business cases for our potential full CDCs in

Mile End Hospital and Barking Community Hospital and overall strategy for the CDCs have also been developed and provisionally agreed during this period.

NEL ICS performance against the 1% diagnostics standard (less than 1% of patients should wait six weeks or more for a diagnostic test) although still challenged has seen improvements in recent months with delivery in January at 18.61%.

In January, 9,679 patients were waiting over six weeks. This is a significant reduction compared to the 15,649 patients waiting in January 2022 and performance was at 31.13%. Improvement plans, additional capacity and activity are planned across acute and community sites to address this backlog. The ICB Alliance remains committed to the delivery of no more than 5% of patients waiting greater than six weeks by 2024/25.

Community Diagnostics Procurement – informed by local people

In August 2022, a group of 12 residents, representing a range of ages, ethnicities, gender and disabilities took part in a facilitated workshop to support the procurement of a community diagnostics service for north east London. Participants were talked through the service specification and the procurement process. It was explained that NHS North East London wanted feedback on four areas key to the service specification and procurement evaluation:

- Patient dignity and privacy
- Complaints process
- Access to support
- Patient consent and confidentiality

Attendees were split into two groups and given the four areas to discuss. Conversations were rich, with lots of helpful feedback, and we themed their comments as follows:

- Access to scans, tests and results in a timely and appropriate manner for all
- Good communication in a form that works for them with a warm welcome that is flexible around their communication needs – access to support
- Protect my data and confidentiality
- To be treated as a person, not just a ‘patient’ – respect and dignity
- For it to be easy and meaningful to make a complaint

This feedback informed the final service specification and shaped questions that bidders were asked as part of the formal tendering process. This meant prospective providers were tested on their commitment and experience in supporting and involving patients, maintaining confidentiality and making complaints. This will be further tested when the new provider is in place in the next few months as part of the performance management and monitoring of the new contract.

Urgent and emergency care (UEC)

UEC services were under considerable pressure in the post-pandemic period. Nationally it was recognised that the period of December 20022 represented the lowest point of performance for many years, and this was also the case for the NE London. The speed at which patients are treated in the emergency department (ED) is important, not just for patient satisfaction, but because it is recognised that delay and congestion in ED leads to worse outcomes for patients. The national requirement is to achieve 76% by the end of March 24. Over the past reporting period an average 65.2% of those attending A&E were seen within four hours. The main challenges were experienced in the outer north east London area.

The whole health economy participated in the creation of a system winter plan, which was successfully implemented in the main, minimising the harm to patients. The same willingness to plan together across organisations meant that patients were kept safe during the industrial action in the ambulance service and in hospitals. There was a shift of resources from planned care (operations, appointments), with the priority given to UEC patients.

In the Autumn of 22/23 additional central funding became available, and the good working relationships in NEL across health, local authorities and the care sector meant that this funding could be swiftly deployed to aid the flow of patients admitted and discharged from hospital. This was achieved with additional support from primary care and community services as well. Ensuring year round system resilience remains a priority for all partners across our system, with planning well underway in quarter one of 23/24.

Prioritising Mental Health and Wellbeing

Mental health is a flagship priority for the ICS, with a strong provider collaborative established to work with communities and partners in all of our seven places to improve experience, access and outcomes for local people. There has been a sustained focus on expanding and improving mental health services, and services for people with a learning disability and/or autism. We know that Covid-19 has not only affected the delivery of services but has also caused in increase in demand, particularly for talking therapies, children and young people’s services, severe mental health and perinatal health.

We achieved the successful rollout of the two-hour crisis community health response which ensured consistent cover (8am- 8pm, seven days a week). We have also worked with local authority, community and mental health partners to achieve a reduction in long stays, and therefore free up capacity in acute settings.

Performance for mental health standards in the first three quarters of the year has remained challenged across the board. Inappropriate out of area placement bed days for patients placed within NEL have

increased across 2022, with December being at 255 bed days, compared to a 2021 average of 16, which reflects the rising levels of high acuity demand, as well as the pressure that the mental health urgent and emergency care pathway is under, as well as A&E departments. Investment is being made into additional bed capacity which should alleviate this.

Talking Therapies access remains challenged (24% against a target of 28%), although has shown a 2% improvement on the same position in 2021 (900 additional users accessing services). Similarly, for Talking Therapies waiting times between appointments (17% against a target of 10%), although the position has deteriorated since 2021 (1,200 additional users waiting). For Children and Young People's access, the position is again challenged (46% against a 52% target), although the position remains very similar to the same point in time in 2021.

Perinatal access is also falling short of the target (7% against an 8% target), however the position has improved by 1% compared to 2021. Dementia diagnosis is also below target (60% against a 67% target), and has fallen compared to 2021 (61%). Physical health checks for people with severe mental illness (SMI) is below target (52% against a 60% target), however has shown a huge improvement compared to the same point in 2021 (41%). In 2023, a new access metric has been included, monitoring users accessing services in the community, which has planned to see 5% growth across the year (3,000 additional users accessing services).

Improving mental health services

Throughout 2022-23, we have continued to expand and improve mental health services and services for people with a learning disability and/or autism. Service users have told us that what matters is having the same range of support regardless of where they live or go to school and have worked with the system to push forward with service user/patient leadership. The plans we have put place in 2022-23 have already started to address access inequalities between boroughs and this will continue in 2023-24. Service users and carers have also stated that they want to be 'active and equal partners'. In response, we have increased service user strategic engagement within the Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative, increased peer support and, in line with our North East London strategy, have advanced new approaches to personalisation and co-production through an increased use of personal health budgets linked to co-produced digitalised care planning. Our approach has been cited as a best practice example in NHSE's Quality Framework for Personal Health Budgets.

Our priorities, co-produced with our Patient Leadership colleagues, are below:

Patient Participation/Leadership

Our mental health services have experienced rising levels of acuity in part driven by the pandemic and its aftermath, combined with the rising cost of living. This has increased the demand for crisis services and psychiatric beds. By expanding, crisis services such as crisis hubs and a clinical decision-making unit, we were able to contain, some of the pressure on psychiatric beds in the first half of the year. However, by December 2022 out of area bed placements reached 255 days compared to a 2021 average of 16 and have remained high since then. In response to these pressures, our plan for 2023-24 will ensure increased investment in mental health crisis and inpatient services. This will improve the flow within our care pathways and will alleviate some of the pressure in our Emergency Departments from mental health.

Access to Talking Therapies increased by 2% achieving a rate of 24% against prevalence. Although we did not achieve our 28% access target, plans are in place to achieve this in 2023-24 and to reduce the access inequities between boroughs. Our children and young people’s mental health services have also been faced with rising levels of acuity, which has created a need to offer more crisis interventions and longer treatments. As a result, our ability to increase access rates has been challenged and we fell short of our 2022-23 target of 52% by 8%. However, plans and new investment is now in place to achieve this target in 2023-24 and also to reduce inequities in access between boroughs.

Severe mental illness (SMI) physical health check rates improved significantly from 41% (Q4 2021-22) to 65% (Q4 2022-23), with the number of service users receiving all six physical health checks

increasing by 32% since 2021-22 and there is now greater equity between places. New investment in 2023-24 will focus on outreach, peer support and health improvement. Mental Health community transformation has advanced across North East London with mental health community teams now embedded and delivering services in Primary Care Networks with a focus on severe mental illness. In 2022-23 we did not achieve the nationally set target for mental health community access (11% below plan), however we have plans in place to expand by at least 5% in 2023-24 (3,000 additional service users). Perinatal access improved by 1% against prevalence, with an increase of 15% in the number of women accessing perinatal mental health services since 2021-22, but fell short of our target (7% against an 8% target). Plans are in place to exceed 8% in 2023-24. Dementia diagnostic rates are 60% against a 67% target and the number of patients diagnosed with dementia has fallen by 9% since 2021-22. However, some boroughs are achieving the target and we plan to disseminate best practice and improve the equity between places. We are committed to a NEL wide target of 67% in 2023-24. A NEL dementia partnership model won the 2022-23 HSJ Place Based Partnership Award.

We exceeded our Learning Disability Mortality Review (LeDer) target, achieving 100%. We came very close to reaching our learning disability physical health check target, achieving 74.2% against a national target of 75%. At the time of writing, we have achieved our targets for reducing inpatient admissions for adults with a learning disability and and/or autism. Secure admissions were 19 against the target maximum of 20 and acute admissions were 14 against the target maximum of 22. Unfortunately, we exceeded the target for children and young people with 9 admissions against the target of 6. However, these appear to be driven by a recent spike in demand in one locality and we are exploring the reasons behind this. Plans are in place to build on and improve this performance and we are committed to compliance for all targets in 2023-24.

Mental Health Spend

The ICB achieved 5.82% growth in Mental Health Spend. This is 0.14% above the minimum spend requirement of the Mental Health Investment Standard. Total spend relating to this can been seen in the following table.

Financial Years	2022-23 £'m	2021-22 £'m
Mental Health Spend (spend in scope of the Mental Health Investment Standard)	£367	£342
ICB / CCG Programme Allocation	£3,728	£3,590
Mental Health Spend as a proportion of ICB / CCG Programme Allocation	9.8%	9.5%

Children and Young People (CYP) safeguarding

ICBs will have a statutory duty to safeguard children as set out in 'Working Together to Safeguard Children (2018)' statutory guidance. The NHS England Safeguarding Assurance and Accountability

Framework 2022, clearly sets out safeguarding roles and responsibilities which apply to all ICBs. ICBs are required to set out how they have discharged duties in relation to child safeguarding in their annual report.

The first safeguarding children and looked after children contribution to the ICB annual report for North East London can be read on our website here.

As set out in 'Working Together to Safeguard Children', 2018 ICBs are responsible for the provision of effective clinical, professional and strategic leadership in child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including from independent providers. This link to the NEL ICB's confirmatory statement that demonstrates that statutory assurance processes have been implemented in accordance with the Safeguarding Accountability and Assurance Framework, 2022.

This summary outlines how the ICB has discharged its duties in relation to safeguarding babies, children and young people. In addition, it incorporates the learning from national reviews and inquiries, legislative changes as well as national safeguarding priorities.

Dissemination of learning to the system

- Shared presentation and discussion at the NEL Babies, Children and Young People forum with over two hundred health and care professionals in September 2022. The keynote speech was provided by the National Deputy director for safeguarding from NHSE.
- Ongoing learning is shared via the LSCPs, NEL Quality, Safety and Improvement Committee and associated sub-groups across the system.

Key messages for health system learning included

- Improving the effectiveness of the Multiagency safeguarding hub (MASH) provision (resource and model).
- Improving information sharing within MASH by ensuring access to health information and greater participation of the heath sector.
- Promote the use of chronologies and genograms within health records.
- Introduction of multi-agency reflective practice

Leadership and culture

- Leaders have a responsibility to create working conditions to support complex work.
- There is a need to ensure: clarity of vision; responsibilities and resource; robust governance and a culture of learning, improvement and challenge.

- There should be clear management oversight of complex safeguarding work, supported by reflective supervision for practitioners.

Wider service and multi-agency context

- A failure to trigger statutory, multi-agency child protection processes.
- A rapidly evolving safeguarding agenda has overshadowed the need for sharper, *specialist* child protection skills and expertise.
- There is a need to refocus on child protection through an *expert* led, multi-agency model for child protection investigations, planning, interventions and review.

Systems and processes

- Agencies should work together to understand the lived experience of children
- There should be clear processes in place to support information sharing and information seeking, within and between agencies.
- There is a need to develop *critical thinking* and *challenge* within and between agencies.

Practice and knowledge

- The views and concerns of wider family members and those who know the child well can be too easily dismissed as malicious.
- Practitioners should appreciate the speed at which life can change and recognise the impact of change in a short space of time.
- Investigating allegations and understanding nuance when families are reluctant to engage requires great skill.
- Practitioners should sensitively support diverse communities where understanding is evolving and challenge bias – same sex couples and parenting.
- Practitioners should address the impact of domestic abuse and understand the needs of children whose parents are in prison.

NEL System response

- ‘Designated Nurses’ at place were tasked with developing and driving improvement plans for their areas.
- Associate Director for safeguarding children met with the national health facilitator for safeguarding reforms for the DHSC and has continued to be a member of the regional MASH Group.
- MASH assurance and quality improvement has been incorporated into reporting templates at place and system level.

- Designated nurses at place are members of the MASH Steering Groups at place and are working with safeguarding partners and borough directors on quality improvement and resourcing issues.
- Quarterly reporting to NHSE via governance heat maps keeps the issue visible.
- There are ongoing conversations with safeguarding partners regarding involvement of health in strategy discussions. Audits and appropriate reporting/data capture are under consideration with the use of appropriate escalation encouraged.
- The role of health agencies and professionals is captured in a seven-minute briefing which will be accessible to safeguarding partnerships and from our intranet and website from Q1 in 2023/24 to raise awareness among safeguarding partners.
- There is ongoing engagement with place-based partnerships regarding key issues requiring transformation and quality improvements such as MASH.
- To enable greater scrutiny the national safeguarding case tracker is being populated with information regarding Children Safeguarding Reviews (CSPRs), Rapid Reviews (RRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).
- There are many lessons to learn from the safeguarding failures in the case of Child Q both nationally and locally. The Partnership action plan is in place following the local safeguarding practice review with the City and Hackney Safeguarding Children Partnership Board overseeing its implementation of actions.

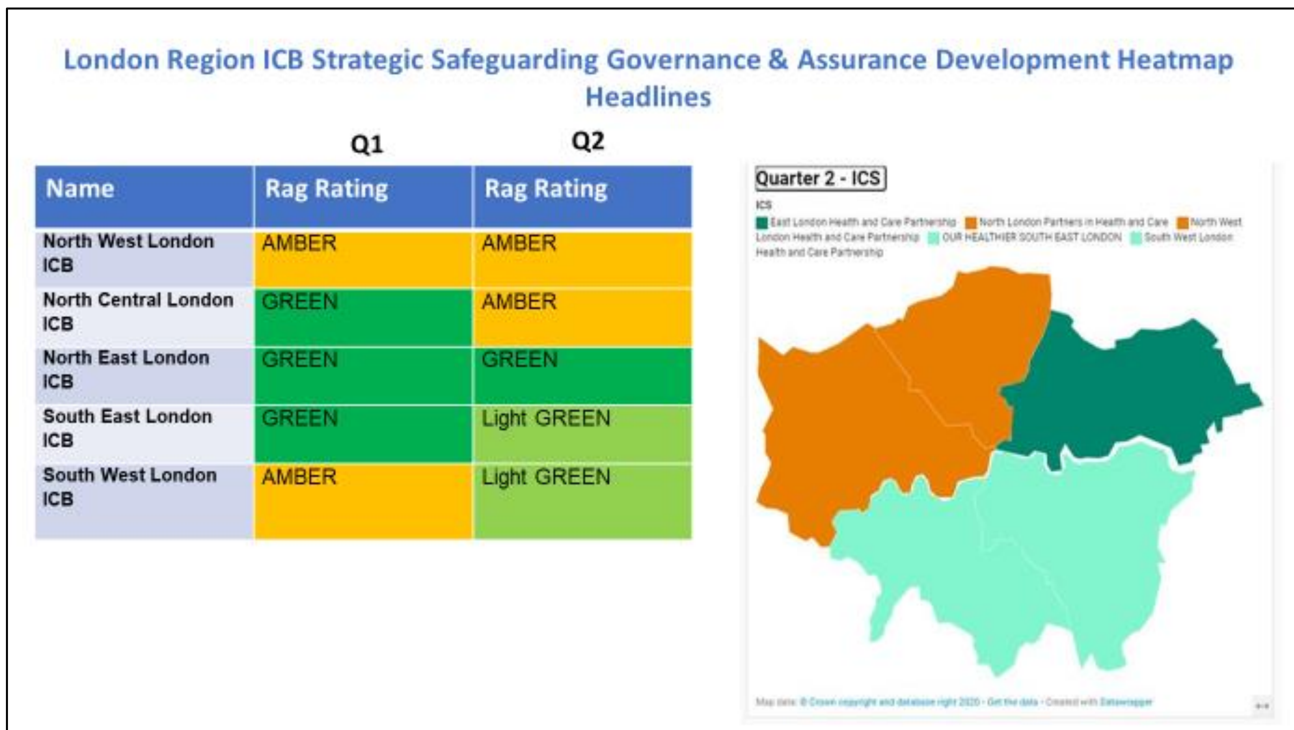
Safeguarding Assurance

During the year under review, quarterly reporting and submissions to NHS England and Improvement (NHSE) continued throughout the year. Assurance was provided via governance heat maps which enabled NHSE to assure itself regarding the preparedness of the five regional CCGs for the transition to ICBs. NEL has been consistently rated green during Q1- 3 of 2022/23. The heat maps are a matrix self-assessment tool covering:

- System leadership and accountability for action on health inequalities
- Safeguarding structures and matrix working
- Appointment of a chief nurse with executive accountability for safeguarding
- Safeguarding priorities and workplan agreed
- Partnership arrangements and understanding
- MASH information of information sharing agreements and supervision of MASH Health Team colleagues.

In addition, reporting on the safeguarding accountability and assurance tool (S-CAT) enabled an organisational assessment against the relevant domains within section 11 of the Children Act 2004 continued on a quarterly basis identifying areas requiring additional focus.

Quarterly exception and highlight reports were submitted throughout the year, which enabled formal escalation of workforce sufficiency risks for both the ICB and providers, Covid-related risks in relation to mental health and also risks associated with timely completion of statutory health assessments for looked after children and adoption medicals. Throughout the year there were periodic surges of entrants into care, driven by both Covid-impacts and also an increased number of people seeking refuge and unaccompanied asylum-seeking children (UASC) with related public health issues around health protection.



London Region ICB Strategic Safeguarding Governance & Assurance Development Heatmap Headlines

	Q1	Q2
Name	Rag Rating	Rag Rating
North West London ICB	AMBER	AMBER
North Central London ICB	GREEN	AMBER
North East London ICB	GREEN	GREEN
South East London ICB	GREEN	Light GREEN
South West London ICB	AMBER	Light GREEN

Child Protection Information sharing System in Hackney

On 12 October 2020 Hackney Council suffered a cyber-attack resulting in severe disruption to electronic systems across the council's services. The Council worked closely with the National Cyber Security Centre, National Crime Agency and other experts to investigate the attack and understand the impact on the council services and its residents.

Levels of assurance and mitigation

Colleagues in Hackney across the partnership, including safeguarding leads and designated professionals collaborated to ensure robust mitigation measures were in place, including a range of audits as requested by NHSE.

Homerton and Royal London Hospital safeguarding leads undertook two audit processes and in June 2022 Hackney CP-IS was successfully reinstated. The Child Protection Information sharing System connection to the NHS Spine was also reactivated for Hackney following the cyber-attack on their IT

system in October 2020.

Child Protection Information sharing system outage following a cyber-attack

On the 4 August 2022 the Adastra system used by some NHS unscheduled care settings was taken offline to contain a cyber security incident at the service provider. The settings within scope were:

- NHS 111
- Ambulance 111 Services
- GP Out of Hours services
- Local authorities receive Access to Service Notifications (ASNs) to a greater or lesser extent. A drop in ASNs could be seen as children's interactions with impacted NHS sites could not be recorded on Adastra during the time.

Actions taken by the NEL system:

- Mapping and scoping of affected NEL systems was undertaken to identify system risks, incident management of impacted services, workforce issues, mitigation and actions that were being implemented to manage the CP-IS access issue to assure the ICB and NHSE London Region.
- Designated professionals assisted with the development of a risk profile for the NEL system.

Female Genital Mutilation (FGM)

NEL has been part of the national FGM pilots for community clinics targeted at non-pregnant women. Formal evaluation of the pilot clinics has taken place during Quarter 3-4 of 2022/23. The final evaluation report is awaited from NHSE.

Child Death Overview Panels

There are two Child Death Overview Panels hubs across NEL. During the year and efficiency review has been commissioned and recommendations will be implemented. The Child Death Overview Panels are assurance meetings for the system and have been established to provide system oversight. These meetings and the learning from the thematic reports have identified key areas for learning in relation to sudden infant deaths although learning events have occurred at place. There is a plan for a sudden infant deaths conference in Quarter 1 -2 of 2023/24.

Looked after children and care leavers

Safeguarding children and promoting the health and wellbeing of looked after children are core duties which transitioned from the CCG to ICB. A scoping exercise to review the NEL looked after children risks was undertaken in June 2022; this desktop exercise identified a number of recurrent themes which were addressed in bi-monthly forums with a focus on quality improvement beginning from quarter two of 2022/23. Some of these recurring themes are reflected below in both the inner and the outer boroughs:

- Delays in children being seen for their initial health assessments (IHA) within 20 working days after coming into care.
- Designated Doctor for Looked after children capacity is under review due to not fulfilling the minimum requirement as per “Working Together to Safeguard Children 2018” statutory guidance.
- Equity and health inequalities are experienced by children placed out of their local area placed. Some of these are barriers to undertaking health assessments, accessing Child and Adolescent Mental Health Services and other services.

Significant backlogs for the completion of overdue Initial and Review Health Assessments (IHA and RHA) currently exist in the four outer London boroughs. The designated professionals in these places have been working with providers. Quality improvement work is in progress to address legacy risks and service delivery issues. The additional impacts of a higher number of new entrants into care during and post pandemic is also compounded by vacancies for designated doctors in some places.

A wellbeing review was undertaken in August 2022 and information from this deep dive was shared with local system chief nurses with progress updates during November 2022. Trajectories and information from the clinical harm minimisation work was also shared within NEL Safeguarding governance frameworks (NEL Quality Safety and Improvement Committee and ICB Board) in October/November 2022.

Designated professionals and NEL ICS colleagues are contributing to the development of a NEL system dashboard. It is hoped that some of the metrics proposed will provide objective assurance around the effectiveness of registered medical practitioner-initiated activity taking place following IHAs through the receipt of (at least) data on prescriptions, clinical investigations, or referrals to tertiary services. Peer review work is in progress to secure improvements to pathways.

Care leavers

The NHS long term plan commits to developing a comprehensive offer for 0-25 year olds and expectation that care leavers should benefit from improvements being made to health services. In NEL we recognise that care leavers often experience financial hardship which may impact health decisions in a context of the cost of living crisis. Our ambition is to ensure that care experienced children aged 18-25 years have access to free prescriptions.

Unaccompanied Asylum-Seeking Children (UASC)

UASC are a vulnerable group of children who are separated from their families for a variety of reasons such as forced migration, exploitation and trafficking. In NEL the best practice model in Newham, offers a 'team around the child' approach for UASC. Plans are being explored to scale up the holistic model across NEL but these are dependent on securing the requisite funding. The model utilises Health

Improvement Practitioners to co-ordinate the pathway of care for UASC in relation to the management of infectious diseases, dental, ophthalmology, Child and adolescent mental health services and emotional wellbeing resources. The model aimed at addressing inequalities in health outcomes relies on a strong interface with primary care and is underpinned by a robust academic evaluation programme.

Multiagency safeguarding arrangements

Under the Children and Social Work Act 2017, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area. The published safeguarding arrangements for each of the safeguarding partnerships within the NEL ICB footprint some of which is reflected in their annual reports for 2021/22 can be accessed via the links:

- BHR partnership multi agency children safeguarding arrangements (havering.gov.uk)
- Published-2223-Safeguarding-Arrangements-.pdf (chscp.org.uk)
- THSCParrangements.PDF (towerhamlets.gov.uk)
- Newham Safeguarding Children Partnership Published Arrangements (newhamscp.org.uk)
- New arrangements for Waltham forest local safeguarding partners (walthamforest.gov.uk/)
- Tower Hamlets Safeguarding Children Partnership (childrenandfamiliestrust.co.uk)

This summary has demonstrated how NEL ICB has fulfilled its statutory duties in relation to safeguarding children, looked after children and care leavers and outlines the NEL response areas of emerging risk, including the implementation of learning from both national and high-profile cases. In the coming year the focus will be on a number of areas which include supporting the implementation of the new serious violence duty for ICBs.

Looking at the year ahead our focus will be on strengthening safeguarding governance frameworks during the period of transition, improving workforce sufficiency and resilience. Ensuring that staff develop quality improvement skills to make a difference to experiences of children in our local population, by targeting areas of unwarranted variations to improve safeguarding and health outcomes. We will be working closely with partners including Healthwatch to embrace the opportunities presented in the new organisation for greater collaboration and integration, and to develop our safeguarding strategy.

Safeguarding adults

We appointed seven designated professionals in January 2022, who engage with wider London and national safeguarding forums, where information is then brought back to place and is shared across the system as appropriate.

The team develop relationships and contribute to a systems approach across the system which has enabled greater partnership working. They have supported primary care services by delivering safeguarding adults training and updates at Protected Time Initiative (PTI) for our GPs. These sessions refreshed practitioners around safeguarding processes, as well as updating them on tools and resources that they can use to support their safeguarding practice.

The designated professionals chair a number of safeguarding subgroups including Safeguarding Adults Review (SAR) groups. Designates work with systems partner at place to support the sharing of learning from statutory and non-statutory reviews and promote a think family focus.

LeDeR is a service improvement programme and looks to learn from the deaths of people with learning disabilities and autistic people. LeDeR reviews are carried out for all deaths of people with learning disabilities and autistic people. These reviews make recommendations to improve practice and change processes so that the lives of people with learning disabilities and autistic people, are changed for the better. There was a total of ninety-five LeDeR notifications received for 2022-23. The team work closely with the process, undertaking the function of local area coordinators and linking with system partners in the delivery and embedding of learning at place. There is an established governance group that undertakes a systems approach to the wider process.

Contribution to multi-agency and partnership working arrangements

The team engage with the 'Local Quality Surveillance Groups' to support assurance and safeguarding work in relation to care homes, supported living schemes, homecare providers, and primary care providers. This is an opportunity for ICB colleagues to come together with local authority colleagues to better understand where there may be concerns about care providers, and the work underway to support them.

The Community Safety Partnership (CSP) Boards are also attended at place as well as ad hoc workshops around the newly introduced Serious Violence Duty. The designated professionals also engage with the Safeguarding Adults Boards (SABs) and continue to support to achieve key pieces of work. In particular, to gather feedback from primary care providers for sharing purposes as and when required.

The designated professionals work closely with system partners to ensure that safeguarding remains an area of significant importance. There is close working to ensure that learning is shared and that a proactive approach is undertaken to ensure that safe and proportionate care is provided.

Examples of improvements adult safeguarding follow below:

Refugees and people seeking asylum: It has been recognised those placed in contingency hotels are at extremely high risk of exploitation and are disproportionately affected by health inequalities. In response to the safeguarding risk, the associate director for safeguarding adults, in conjunction with Redbridge Safeguarding Adult Board (SAB) chair developed a safeguarding assurance framework. This is a partnership safeguarding framework that scrutinises the partnership arrangements to safeguarding residents of the contingency hotels, as well as holds the hotel staff and delivery partners to account around their safeguarding pathways and the delivery of their safeguarding arrangements.

This framework has been used successfully in Waltham Forest when the multi-agency team undertook an assurance visit at two contingency hotels. Following the visit and the use of the safeguarding framework, a robust action plan was put into place, with the outcome of increased safeguarding practices, increased safeguarding training and direct positive safeguarding outcomes for the residents of the contingency hotels.

Learning Disability: Arising from outcomes from multiple LeDeR reviews, the ICB supported the development and funding for a community liaison learning disability nurse in City and Hackney. Supporting primary care with their duties in relation to patients and residents in City and Hackney with Learning Disabilities, and leading on bespoke programs such as needle desensitisation - vaccine outreach etc. The role has been occupied for six months. Improved local outcomes have included increased delivery on the number and quality of annual health checks and subsequent health action plans for residents with learning disabilities. The focus of this role will be the uptake of cancer screening and weight management for residents with learning disabilities.

Domestic Violence: The ICB, in partnership with public health and local authority, are funding two new posts focusing on domestic violence training for staff in health care settings. The staff members also provide guidance and consultancy to healthcare workers who support people who are experiencing domestic abuse. This has directly benefited local people as staff members have felt more confident to screen for domestic abuse in emergency health care settings, identifying issues and being able to put interventions into place much earlier, for example accessing refuge placements and referring very high-risk cases to the Multi Agency Risk Assessment Conference (MARAC).

Environmental matters

We are committed to promoting economic, environmental and social sustainability through our actions as a corporate body and commissioner. We are doing this via our Anchor Charter which can be found here: https://www.northeastlondonhcp.nhs.uk/ourplans/nel-anchor-charter.htm. We are determined to deliver a health centred response in north east London and ensure that all of our colleagues within the ICB understand the urgent need to act.

In order to support the NHS net zero ambition, our ICS has developed a system-wide Green Plan as per the NHS Net Zero Strategy. This plan was co-designed with stakeholders from across the system and sets out our aims, objectives and delivery plans for carbon reduction in collaboration with our ICS partners, presenting an opportunity to deliver a unified message to our staff, patients and residents across NEL. It includes four core carbon reduction targets in order to achieve net zero, with the first target of 80% carbon reduction by 2028. The NEL ICS Green Plan which is publicly available on the North East London Health and Care Partnership website https://www.northeastlondonhcp.nhs.uk/ourplans/green-plan.htm

In year one of the Green Plan we have:

- Formed net zero networks that link staff and leaders across the system to deliver on the aims of the Green Plan to reduce our carbon footprint by 40% by 2025
- Allocated staff to lead on net zero implementation
- Brought in over £260,000 of external funding
- Added guidance on how to consider net zero in our business case guidance
- Funded 16 places on the Royal College of GPs (RCGP) Climate Health Creation Scholarship
- Recruited four Net Zero Clinical Leads to oversee the input from Primary Care for the duration of the Green Plan
- Created a low carbon inhaler formulary
- Hosted staff sessions on active travel and joined the national Net Zero Modal Shift Network
- The ICB now provides staff with two cycle to work schemes and a low emissions vehicle salary sacrifice scheme
- Won five grants from the national Healthier Futures Action Fund
- Created a green space masterplan for the Homerton Hospital and surrounds
- Created a system-wide carbon literacy programme available to all staff from April 2023
- Committed to becoming a Fairtrade workplace.

Many staff have continued to work in a hybrid way, including remotely. This has minimised our impact on the environment through limited travel and use of consumables. We have developed and increased our ability to hold our meetings virtually, and this is set to continue through a more flexible approach to working post-pandemic.

Our procurement strategy requires us to ask providers about their approaches to sustainability and carbon reduction in the awarding of contracts. It is our responsibility to provide a minimum of 10 per cent weighting in tender scoring as per the Social Value Act. We consider and place value on local providers that can provide services and goods, as they can have associated benefits for our local population by having low emissions, job creation and local business prosperity and deliver wider local social and economic benefits. We are creating an action plan to become a London Living Wage system. Our IT and

primary care teams are proactively supporting general practice to transform the way that primary care services are more sustainably delivered, with the continued roll out and improvement in online patient consultations reducing the need for patients to travel to appointments by car or public transport.

Improve quality

Improving the quality of local health and care services is central to everything we do in north east London and indeed our work over the past year has been focussed around this. We continuously review and evaluate GP, hospital, mental health and community services to make sure they are as safe and effective as possible so that everyone, whatever their individual needs, has a good experience and easy access to excellent local services.

System working is progressing well in relation to planning for the shift from the NHS Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF). Patient safety specialists ae working collaboratively to ensure frameworks and processes are being developed to ensure we are able to learn across the System following incidents through PSIRF, thereby improving the quality of services for local residents.

Since establishing our new 'System Quality Group' so we have been able to look at wider system issues as well as focussing on issues that are specific to each borough via our new borough-based arrangements. This way of working continues to be embedded whilst also enable system conversations about how quality improvements can be made across parts of the system. We continue to embed our place quality governance arrangements and encouraging partnership conversations locally are happening to agree partnership quality priorities based on what the Place-based Partnerships identify as the key areas to improve for their resident. We will continue to drive improvements and outcomes for our residents through these groups.

We continue to make progress in development and implementation of our System Quality Framework and recognise the complex nature of enabling this total system way of working across all partners will take time. We have made good progress in ensuring the work of our NEL ICS Local Maternity and Neo-natal System (LMNS) works through the Acute Provider Collaborative specifically in making the improvements needed in our maternity services.

Examples of improving quality with partners and people in NEL

- **Realignment of Discharge Funding**

  Additional funding to support discharge was given to ICSs to support the system pressures that have been felt nationally. The funding is allocated on an outdated formula which does not take into the large demographic changes in North East London. This meant more pressurised places and pathways would receive less funding than other areas. The system came together with

Director of Adult Services from across North East London to agree a new formula and realign funding to areas of most need. This would not have been possible without the ICS, ICB working across multiple local authorities. The outcome of this is that North East London has the best discharge rates in the whole of London even though has one of the most pressurised acute services.

- **Avoidable Admissions**
  One of the key focus for places is to 'Keep People Well at Home' where possible. One of the main ways to do this is ensure citizens are supported in the community and are not admitted to hospital where this can be avoided. North East London ICB led work on understanding the flow across NEL between all practices, communities and acute hospitals. The data showed clear outliers within the system (acute sites and GP Practices) meaning work can now be targeted in two specific Boroughs and one main hospital site. This work will see a reduction in avoidable admissions by up to a third in outer London. The ICB has also invested in growth monies to support this work. If this was not an ICB wide piece of work there may have been a blanket support which would not have targeted the areas of most need and have the impact that has been modelled.
- **Core Connectors**
  As part of the national Core 20 plus 5 programme, core connectors is a key element where local people from communities of need are trained and supported to be advocates and signpost local people to health services, offer support and translate health messages. This programme has been piloted in one of the most deprived areas in Havering following a successful national bid. The programme recruited people who are refugees, homeless and those living with physical and mental long-term conditions. As well as supporting hundreds of local people accessing health and wellbeing services, this programme has also benefited the volunteers. One volunteer who was homeless now has found accommodation and is now working freelance in making promotional videos, another volunteer who is a refugee is applying to university and will be gaining work experience in a local pharmacy, one other volunteer is now applying for work as a community development officer. This programme is planned to be rolled out across Havering in other areas of need. This work has been developed in partnership with the ICB, local authority and the voluntary sector.
- **Cost of Living support and Warm Hubs**
  The ICB has led system wide work on understanding the cost of living impacts on the health and wellbeing of people across North East London. NEL has the most diverse populations in England so the impact of the many communities on the cost of living challenges is stark. System wide workshops were held where good practice was shared across the system as well as data shared on potential impacts. This work is now adopted and delivered in each place in partnership with local authorities and voluntary sector. This has seen the ICB support and fund work such as warm hubs and grants for those who have expensive medical equipment, Other pieces of work

include developing a risk tool with local authorities on linking household finance risks with health risks. This approach has been used to target households with packages of support such as energy doctors and falls prevention. This is the ICB working in partnership with local Place partnerships to ensure support is 'upstream' and preventative.

Clinical leadership

The ICB led an extensive programme of work to redesign the clinical and care professional leadership model for the ICS taking account of national guidance and the development of place based partnerships and provider collaboratives. A recruitment process was undertaken to establish all of the new roles in the new model and we now have a more inclusive and diverse leadership structure in place including strategic leads on areas such as research and innovation, population health management and health inequalities. We appointed Clinical Directors in all of our seven place-based partnerships, primary care development leads and clinical/care professional leads.

As part of the engagement process to develop our ICP strategy, we held a number of system wide workshops bringing clinicians, care professionals and other leads together with service users to develop our system priorities. These were in mental health, babies, children and young people, and long-term conditions. We also held similar workshops with clinical/care professional input around key strategic issues such as the cost of living increase and health inequalities. The strategy work included development of a population health profile for our system which had extensive public health input.

We established a Clinical Advisory Group (CAG) chaired by our Chief Medical Officer which brings together our most senior clinical leaders to provide advice to our ICB Board. The CAG was kept informed of the development of the strategy and participated in the sign off process.

We are also establishing a clinical and care professional forum to bring together a wider group of clinical and care professional leaders across the ICS to input into our programmes and also to act as a development space for building capability around key priorities such as population health management.

Engaging people and communities

Our NEL ICS strategy for Working with People and Communities 2022-2025 was developed in collaboration with our partners, engagement leaders from across ICS organisations, public forums and groups and local people. It was the first strategy agreed by our new ICB Board, reflecting our commitment to participation as a right for all people in north east London. It sets out our vision to ensure participation is at the heart of everything we do. This is rooted in a set of co-designed principles for participation, which are grouped under five overarching themes:

- Commitment
- Collaboration

- Insight and evidence
- Accessibility
- Responsiveness

Representatives from both the voluntary and community sector and our local Healthwatch organisations are fully embedded in our governance structures, with places on our Board - a VCSE collaborative member as full member and a Healthwatch collaborative member as a participant attendee providing constructive input and challenge. These colleagues are also members of key committees and working groups – for example all Healthwatch and VCSE umbrella bodies are on the ICP committee, with reps on the smaller steering group – equal to statutory partners.

North east London has many innovative examples of patient and community leaders being provided with training and working alongside us as partners, including the model developed by our mental health learning disability and autism colleagues cited earlier in this report. A proposal for a NEL ICS community leadership programme is currently being co-developed with input from across the system, drawing on existing best practice.

We successfully bid for NHSE funding and support to establish a VCSE collaborative in NEL. The leadership group has made positive progress, with a further commitment from the ICB to fund the next stages of development for the collaborative.

We fund an innovative community insights system, led by our eight local Healthwatch, which has received national attention. Our recent case study is cited here as a model of best practice: Community Insights – Local Voice

We have been working closely with our place based partnerships to support their governance arrangements, and to ensure that they are co-producing with our people and communities, with Healthwatch as members of each along with VCSE reps. For example, we have clear processes in Newham for local residents to put forward their experience of the health system at board-level. These discussions have directly led to shifts in service design, including reaching out to deaf residents who experience significant barriers to access healthcare services following a patient story. A partnership-wide piece of work is underway with deaf residents which has three workstreams: commissioning, primary care and learning and feedback. As a prelude to this work the partnership has reviewed all departments within Newham University Hospital and confirmed all have access to SignLive and BSL interpreters, however, this has highlighted training needs internally for staff to understand how to access the provision, which is something we are now working on. We will work across the ICS and with our people and communities to deepen our collaboration.

Building on the collaborative working during the development of the strategy, a Steering Group to oversee the strategy will meet from April 2023, and in addition to this, the first meeting of a NEL ICS Participation and Co-Production Community of Practice/Network will come together in the summer. This builds on a session we held with our chief participation and place officer, chief executive and incoming regional director of NHSE London region where partners leading on innovative co-production models exchanged information and ideas about their projects and how we could embed this approach further in NEL. This led to a further in-depth workshop session at our ICP committee meeting, for which an action plan is being pulled together.

In Tower Hamlets, work is underway to embed coproduction within the work of the place-based partnership. A task and finish group is chaired by a member of the community and involves representatives from the Council, NHS, local universities, the VCS and the community.
Alongside our partners in Barking and Dagenham, Havering and Redbridge, our Health and Faith Network continues to bring together faith leaders from across the three boroughs to support our work. The network has been sharing important messages, such as videos we have co-produced with our faith community for Ramadan, via WhatsApp, which has been shared with over two thousand local Muslim people.

In the lead up to the Babies, Children and Young People strategy workshop in November 2022, a number of sessions took place with partners across the system to understand children's health priorities both at NEL and at Place, building on existing work and conversations over the last 18-24 months. The workshop itself saw more than 200 attendees, and we continue to engage with our 600 strong stakeholder list with a fortnightly newsletter.

The maternity equity and equality strategy and action plan was published in December 2022. This piece of work saw engagement with over 1000 women and pregnant people and their families, as well as maternity advocates, via online surveys, face to face interviews and focus groups. This engagement was particularly focused on women from Black, Asian and Ethnic Minority backgrounds and those living in the most deprived areas as detailed in the NHSE guidance. The engagement work was led by Healthwatch across all our boroughs and supported by Maternity Mates. The full report, summary report and plan on a page have been shared with stakeholders and presentations has been delivered to several groups, from provider collaboratives to faith-based community events.

End of life care in Waltham Forest and Redbridge is undergoing transformation, linked to the redevelopment of Whipps Cross Hospital. In order to inform initial service proposals, engagement leads across ICS partner organisations in Waltham Forest and Redbridge (NHS North East London, Barts NHS Health Trust and NELFT) have worked together to ensure the views of residents are reflected within these service proposals. Due to the sensitive nature of the topic, independent experts were

commissioned to carry out a first phase of engagement that included confidential interviews with people from across Waltham Forest and Redbridge who are experiencing life limiting conditions or bereavement. Commissioning these experts removed any bias from conversations. Commissioning a specialist organisation also allowed for interviews to be carried out in community languages if the participant did not speak English as their first language. Interviews and focus groups were held with community stakeholder groups who support people with a life-limiting condition or support carers. These groups included community funeral directors, charities supporting people with lifelong conditions and action groups. Information was used to compile a full report, which was used to inform the development of a set of initial service proposals for end of life care transformation. A second phase of more in-depth engagement with local people will be carried out in Spring and Summer of 2023.

The City and Hackney System Influencers is a group of ten local young people recently recruited to work in collaboration with a cross section of system projects, including Homerton University Hospital, the local Neighbourhoods partnership and Public Health. The System Influencers are worked collaboratively with local professionals who acted as mentors. The System Influencers co-designed the projects. Examples of the work include co-designing and delivering workshops around healthy weight with public health, and co-designing focus groups for local young people around access to services for the Neighbourhoods programme. The System Influencers ensured the questions and content of the sessions were designed in a way that was accessible to young people. Findings will inform local services. Two of the young people involved have now progressed into paid roles within the health and care system as a direct result of the skills and experience gained. This project was co-managed by the Children and Young People Transformation Programme and Healthwatch Hackney. A project manager was recruited from the pool of young people that have previously volunteered with the system. Funding has been approved for another iteration of the programme, which will be a twelve-month programme supporting thirty young people.

We will gather insight and evidence to inform our priorities and target our participation efforts
The NEL Community Insights System, developed and managed by our NEL Healthwatch, is a valuable tool which we continue to develop. The Community Insights System currently holds over 80,000 comments from local residents that equates to approximately 280,000 separately coded issues. Insights on inequalities has allowed the ICB to focus on customising communications to meet the needs of particular ethnic and disability groups leading to better uptake of immunisation and screening programmes. A series of bespoke reports also informed the development of our system wide ICP integrated care strategy. We have a well-established People's Panel with over 2,500 local people signed up. We are going through a period of refresh and will be working with panel members to codesign how a new platform could work.

In Havering, our volunteer community connectors within our Core20plus5 programme as mentioned earlier in the quality section have been busy engaging with over 400 residents gathering feedback about health and care services.

We recognise the need to embed Accessibility Information Standards further across the system so we are developing an Accessibility Champions Programme which will draw on practice system-wide. Champions will be recruited from staff and their roles will be to ensure that our communications consider the accessibility requirements of our diverse population.

In July, the ICB board heard some powerful personal insights on accessing services from two profoundly Deaf residents. Their experiences were mirrored across primary care, acute and Mental Health Trusts and at local authority level. Engagement staff to set up a working group bringing together partners, user-led organisations and people who are deaf or hard of hearing to build on best practice and co-produce solutions. For example, in Redbridge there are plans to form a dedicated working group which will plan to address health inequalities faced by the deaf community and residents with accessibility needs.

Key to accessibility is developing opportunities for people to participate in a way that works for them. Here are some examples of innovative ways we have reached different groups.

- Targeted Lung Health Check: Working across our diverse communities to achieve one of the highest uptakes in the country, we have now scanned more than 2,000 residents in Barking and Dagenham, and we are now looking to expand the programme to other areas. We have produced a video which is available in 17 different languages: Targeted Lung Health Check Videos. Find out more: https://www.nelcanceralliance.nhs.uk/tlhc
- Best For My Chest: This is designed to help the LGBTIQ+ community come forward for life-saving breast screening appointments. It is the result of twelve months engagement with the LGBTIQ+ community to identify the issues faced by those accessing Breast Cancer Screening. Local people volunteered to become champions for the campaign, and they have played a central role in designing key messages, posters and graphics. Read a testimonial from a volunteer: https://www.nelcanceralliance.nhs.uk/best-my-chest-testimonial

We will ensure that the impact of participation is clear to people, communities and partners
The East London Women's Experience Forum continues to provide an opportunity for maternity staff and maternity advocates from community and voluntary organisations to ask questions, hear information and updates from each of the NEL maternity units and share experiences of those women and pregnant people they advocate for or represent.

We are working with partners to develop a consistent approach to patient stories and case studies, both in terms of how we share these amongst partners but also how they are communicated at Boards and

committees and how we are evidencing action taken based on the feedback.

Working with our Primary Care Networks

We continue to provide advice, insight and support to our primary care community, and are committed to supporting our Primary Care Networks (PCNs) to improve how they listen to residents and communities.

In July, we supported our PCNs to seek the views of their patients to feed into their enhanced access service offer. The team worked with them to create a patient survey which was sent out via text message and received over 30,000 responses. Members of the communications and engagement team then sat in on panel meetings where their proposed plans were presented. This gave us the opportunity to challenge how they had considered patient feedback within their plans.

We will support PCNs across north east London in their work with practice Patient Participation Groups (PPGs), which will create more opportunities for local people to be involved in the work to build healthier neighbourhoods.

Provider collaboratives and participation

Provider partners were involved in developing the Working with People and Communities strategy and next steps, ensuring that the principles and ambitions will also drive the work of our collaboratives.

Work is well underway within all of the collaboratives across north east London to consider how they will involve and listen to local people and communities. The MHLDA has established advanced arrangements in regard to service user and carer leadership – with local people developed, rewarded and supported to play a full role in the alliance, the sub-committee and wider governance.

In addition to our proactive engagement through social media, local project liaison and newsletters we continue to engage with key stakeholders through regular meetings e.g. with Healthwatch, with MPs and health overview and scrutiny committees and joint health overview and scrutiny committees.

We have set clear foundations in our initial months of operation, with our strategy setting out some clear deliverables for next year:

- In June we start the Big Conversation with local people to build on what they told us during the development of the ICP strategy. The activities will take place in different formats as we are conscious of the needs of our diverse population. We will work with local people to define the success measures for delivery of our strategy – ensuring that these are meaningful and impactful for local people. We will also explore the key issues affecting local people and how we could use our health and care budgets differently in future, aligned to their priorities.

- We are developing a system wide, consistent Reward and Recognition policy to support us to remove barriers to participation by having a clear offer of how we reimburse expenses and where applicable, offer involvement payments.
- To truly embed our principles of co-production and participation and ensure that participation is everybody's business, we are developing our training and development opportunities for staff. This is starting with development of an e-learning module, in partnership with local people, which will clearly set out the vision of engagement across NEL, expectations of our staff and support available.
- To support work across the ICS we are developing a Community of Practice which will bring together engagement leaders across the footprint to collaborate, showcase best practice and share insight.
- Local people are working alongside us to develop a Community Leadership Programme so that we fully embed a co-production approach across the organisation, including corporate services.

Polio vaccine take-up case study

The NHS had to vaccinate as many 1–9-year-old children against Polio as possible, after the virus was unexpectedly found in London sewage samples. This was a brand-new programme that started in August 2022 and by the time it ended in December 2022 we had vaccinated over 82,300 children – the highest number in London. This was a significant achievement given uptake of other vaccines is generally low in the area, and we are taking learnings forward into current and future vaccine drives.

We devised a public information campaign with trusted information, persuading parents to come forward to get their children vaccinated at their GP surgery or vaccination centre. The campaign needed to be agile so it could be mobilised rapidly, given the fast-moving public health situation.

Our strategy was to initially drive awareness so people understood the need to come forward while GPs and vaccination centres prepared to scale up to deliver this, and then to drive action and encourage people to get vaccinated once mass vaccinations were available.

The campaign needed to be inclusive given the region is home to some of the UK's most diverse communities, with high levels of deprivation and low English language levels. It prioritised the boroughs of Newham, Waltham Forest and Hackney, given risk levels and numbers of children.

A one-size-fits-all approach wasn't possible. Instead, we used a combination of:

- Conventional mass comms for informing parents, such as regional TV news opportunities, organic social media, paid social media and paid adverts on search engines.
- Direct comms to parents, including letters from schools to parents, text messages to parents, information to GPs so they could have conversations with their patients

- Tailored, community-driven and grassroots comms, including developing WhatsApp messages that community leaders could share, multilingual leaflet drops in local libraries and low uptake areas, and community champions going out to spread the word in the community.

We devised our own materials where we could. We used local networks to spread the word, including community champions and faith leaders. We also used innovative channels and platforms to raise awareness, including news updates on a parenting app called Baby Buddy.

The instant brand recognition and instinctive trust people have for the NHS was used to full effect, alongside trusted community voices. This included a local polio survivor whose powerful testimony was picked up in local media and helped persuade parents.

"Vaccination is the best way to protect children and stop the virus spreading. Otherwise, you risk catching polio and living a limited life with limb damage, pain, fatigue and muscle weakness. I wouldn't wish that on anyone." – Mahfuzur Rahman

NHS North East London outperformed all other organisations by the total number of children vaccinated (82,300 – the London average was 64,000).

Ensuring fairer access to fertility treatment across north east London

In April 2023 we launched a new single fertility policy for north east London, which replaced the previous five different policies that were created when there were separate clinical commissioning groups in the area. The harmonised policy means that all eligible people registered with a GP in north east London are now able to have the same fertility treatment, such as (IVF) in-vitro fertilisation – this was not previously the case. NHS North East London are one of the few ICBs in England offering three full cycles.

The policy has not only increased the amount of treatment local people can have and improved access to some treatments, it has also ensured fairer access across north east London while recognising people's different fertility situations and needs – the policy is for both individuals and couples with a fertility problem, regardless of their sexual orientation, gender identity or relationship status.

Dr Catherine Hill, chief executive of national charity Fertility Network UK, commented: "Fertility Network UK applauds NHS North East London for their new fertility policy, which will offer hope to so many people struggling to become parents. It is a fertility policy for the 21st century and we are pleased to have helped with their engagement work on it."

The policy was developed using the latest national clinical guidelines from the National Institute for Health and Care Excellence, research and best practice. Clinicians, including GPs and fertility experts also helped to shape it and it was subject to a public engagement period.

Funding boost for health and care research

We secured nearly £100,000 of national NHS funding to support the development of a research engagement network. The new network will drive the work of ICS partners to encourage greater public participation in research across NEL and ensure it reflects the diversity of local communities – helping them tackle health inequalities and shape services around people's needs. We worked closely with North Thames Clinical Research Network, UCL Partners, Healthwatch and the local voluntary community and social enterprise alliance.

Reducing health inequality

People's chances of enjoying good health and a longer life are not equal. They are determined by the social and economic conditions into which they are born and live their lives (which also make a difference to the way people use health services and look after their own health). These different conditions create avoidable health inequalities, which can only be addressed through action across society.

There is widespread collaborative action to tackle health inequalities at place level, close to local communities. Local health and wellbeing strategies consider the changing health and social care needs of the population, as set out in the local joint strategic needs assessment (JSNA) and identify key priorities, which then underpin service planning. Place-based partnerships bring together key health and care partners, and focus on addressing health inequalities in all that they do.

Some examples of our achievements so far include:

- Digital champions for each place to support digitally excluded patients to access digital NHS services aligning with local authority work on digital inclusion.
- Women's Health Hub pilots bringing care closer to home and streamlining services to improve access and prevent multiple appointments.
- Analysis of trust elective waiting lists resulting in successful actions to reduce inequalities in waiting times experienced by people with a learning disability.
- Targeted campaigns and projects to reduce inequalities in cancer prevention, awareness and screening, to prevent cancer and increase early diagnosis.
- NEL anchor charter and collaborative action, e.g. Health and Employment Hub supporting 750 underrepresented local people into work.
- NEL maternity equity and equality needs assessment, strategy and action plan to improve outcomes for those from minority ethnic backgrounds and deprived areas.

- Developing understanding of the health needs of our population through the NEL population health profile, and developing capability and capacity to address these.
- Mobilising tobacco dependence services and alcohol care teams in our hospitals.

As a learning system we are building on best practice. For example, Waltham Forest commissioned University College London Institute of Health Equity to review health inequalities in the borough and make recommendations. ELFT is also a Marmot Trust. We are currently exploring the system implications of this review. Another example is the community chest for social prescribing developing across all places, increasing capacity for support through the voluntary, community, faith and social enterprise sector to address health inequalities. Places are leading on activity to reduce health inequalities through work ranging from long term condition case finding, to fuel poverty and debt support, to child vaccinations and health literacy.

Recognising and building on delivery and expertise at the local level, addressing health inequalities is a responsibility of every part of the system and this is reflected in its inclusion as one of six cross-cutting themes of the interim strategy. Our North East London ICS Financial Strategy also demonstrates our commitment to addressing health inequalities through its focus on sustainable approaches to levelling up and reducing gaps across our geography.

A Population Health and Health Inequalities Steering Group provides strategic leadership to embed population health and health equity across all parts of the system. The steering group oversees four workstreams: population health management; equity in health and care services; embedding prevention; and anchor system. Delivery of these is through our wider system including place-based partnerships and collaboratives. The approach includes activity against the Core20Plus5 for adults and children and young people (the approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement).

Health and wellbeing (HWB) strategies

Our local authority and place-based partners work together across all of our place-based partnerships and through our ICB sub-committees. The new freedoms to work together in integrated partnerships locally ensures that our health and wellbeing and local partnership strategies are now more joined up than ever, read more on our website: [www.northeastlondonhcp.nhs.uk/aboutus/north-east-london-integrated-care-system.](www.northeastlondonhcp.nhs.uk/aboutus/north-east-london-integrated-care-system)

Below are just some of the examples from our partnerships about some of the positive work underway locally to realise the ambitions in each of the HWB strategies.

Pathway Team

The Pathway charity has developed a national model of complex care coordination to meet the health, housing and social care needs of people experiencing homelessness when they attend or are admitted to hospital. The Homerton and City and Hackney Centre for Mental Health Pathway team pilot commenced at Homerton hospital in January 2022, and extended to the City and Hackney Centre for Mental Health in May 2022. The current hospital team comprises a part time GP, full time nurse, occupational therapist and housing worker (seconded from Hackney Council). All members of the team are utilised in the case management of clients.

The service has been supported throughout by a Peabody Housing Association six bedded Lowri House 'step down' facility, exclusive to the team, which opened in January, and two housing support workers (provided by Providence Row), both grants funded by the Out of Hospital Care Models (Homelessness) Fund provided by the Office for Health Improvement and Disparities.

In the first year, 335 referrals were received by the Pathway team and the team accepted 304 (94%). 97% of these accepted referrals were assessed within two working days, with an average waiting time from referral to assessment of only 3.5 hours. 27 patients went to Lowri house.

Patient feedback

- 'They were very reassuring. They came to see me when they said they would, and did what they said they were going to do. You don't always get that.'
- 'I loved her, she was really fighting my corner, I felt like she was really on my side.'
- 'So many people are homeless - we need specialist services like them – they are a big help.

Staff and partner feedback

- 97% said the team were either 'Extremely Helpful' or 'Very Helpful'
- "The work the team do is to such a high standard, it goes a long way to reduce the risk and really turn a hospital admission into an opportunity for change and increased safety for homeless individuals."
- "Without the Pathways team - my client would not have received the adequate level of care. The Pathways team were easily contactable, they communicated and managed the discharge well."

Improving patient experience for deaf residents

Introduced in 2016, the Accessible Information Standard (AIS) was established to give people with a disability or sensory loss the right to receive information in a way they can understand and communication support they need. The NHS and adult social care services must comply with AIS, but evidence shows we are not yet compliant in Redbridge. This was illustrated through a powerful resident story at the first meeting of the ICB board from a couple based in Redbridge. Through engagement sessions with deaf residents, consultations with deaf charities, and national research, the Redbridge Place Based Partnership has highlighted the following issues within the partnership:

- Lack of deaf awareness amongst frontline staff.
- Severe unreliability in access to British Sign Language interpreters.
- Lack of ownership of issue across the system.
- Receiving phone calls from GP practices, hospitals and the local authorities.
- Lack of access to Covid-19 information throughout the pandemic, including the vaccine programme.
- Some clinicians telling British Sign Language users to bring family along to interpret which is not appropriate, particularly if dealing with confidential or personal information.
- Inaccurate information from London Borough Redbridge employees advising that it is not possible to get interpretation for appointments.
- Engagement forums and community activities are not accessible without a British Sign Language interpreter.

In response to this, the partnership has actioned the following:

- An improved level of understanding and training of AIS.
- Commissioned British Sign Language interpreted videos on key health topics such as winter vaccinations and mental health, which have been shared with local groups and the partnership.
- Committed to implementing *'Sign Video'* in the Council.
- Established relationships and partnership working with Royal Association for Deaf People, Sensory Specialists, Healthwatch and Empowering Deaf Society for local BSL requirements and further insight.
- Tested the new Newham Language Shop British Sign Language service.
- Commissioned a series of health engagement sessions specifically tailored with support from Sensory Specialists, designed to share key health messages with deaf residents and answer their questions with an interpreter present.
- Discussions with our digital team about how to follow best practice model and make the website more inclusive.

A key part of this work has been our Healthy Redbridge: British Sign Language sessions. In these sessions, around users living in Redbridge have access to specialists from across the partnership to learn, ask questions, and share feedback. The themes for each session were defined by the specific health needs and knowledge gaps in this cohort of residents, and are on the following:

- Mental Health
- Getting Active
- Cancer and Cancer Screening
- Diabetes and Healthy Eating
- Sexual Health
- Smoking and Alcohol

The engagement sessions are just part of a wider project to implement AIS and make Redbridge fully accessible to those with disabilities and sensory loss. Specifically relating to British Sign Language or future model will:

- Make access to BSL interpreters for residents easier and enhance web accessibility via tools such as 'SignVideo'
- Implement/develop flagging systems to easily identify residents with accessibility requirements to GP practices and council services.
- Implementing screens (or other accessible methods) for patients to make them aware a professional is available to see them.
- Mystery shop with GP practices and local services to see how accessible services are to residents.
- Address the cost of living crisis through engagement activities with the community including translated videos, community engagement sessions and easy read material.
- Work with partnership organisations to align complementing workstreams in accessibility.

Ilford Exchange health centre engagement work

In September 2022, Redbridge partners launched a consultation on plans to create a new health centre in Ilford town centre. The proposals for this new health centre would provide space for primary, community and social care services from two floors in the Ilford Exchange shopping centre in the heart of Ilford, close to main amenities and transport links. The services proposed for the new health centre included, GP services, Health and Adult Social Care Team (HASS), health visiting and school nursing team, community blood testing, mental health support services and Long-term conditions.

As part of the proposals there may also be additional space with flexibility for other seasonal services and potentially some community space on which residents were invited to share their views. The consultation took place over six weeks and included a public survey; an information stand for two days in Ilford Exchange managed by people who speak multiple languages; four public engagement events and one engagement event with members of the local charity One Place East who have different disabilities. Printed versions of the survey and an easy read guide survey were also available. The consultation was also widely promoted through various community groups which ensured that the demographics of those who responded were as representative as possible of Ilford. NHS North East London, NELFT and London Borough of Redbridge worked closely together to deliver the consultation as part of the Redbridge borough partnership which allowed for a wider reach into the community.

The response to the plans for the new health centre from local people and stakeholders was overwhelmingly positive. A full report of the findings was developed and presented to the Ilford

Exchange task and finish group who reviewed the suggestions and produced a consultation response.

Understanding and managing risk

The ICB agreed a risk management policy and strategy at its inaugural meeting on 1 July 2022 to ensure the organisation manages its key risks and supports staff to manage risk effectively.
There have been a number of Board discussions on risk to develop and agree its approach to risk including risk appetite and its board assurance framework. The most recent board assurance framework was agreed by the board on 29 March 2023 and is included in the board papers here https://northeastlondon.icb.nhs.uk/events/north-east-london-icb-board-meeting-4/. The board assurance framework aligns to the strategic aims and objectives of the ICS and covers the following key areas with further details on the mitigations of these risk described below:

Collaborative working across partners - there is a risk that ICS partners do not work together and with local people and communities in collaborative and strengths-based ways and so cannot deliver on our ICS purpose, aims and priorities. This could limit impact on improving the health and wellbeing of local people and reducing health inequalities.

Mitigation: established involvement from ICP system partners to oversee development and drafting of the strategy which was socialised in forums across the ICS including Health and Wellbeing Boards, Place Based Partnerships, Healthwatch and CVS.

Quality and safety of care - there is a risk that quality and safe care will be adversely affected, reflected in increasing inequalities, poorer outcomes and service failures, when we as a system do not seek to understand and prioritise the experience of local people and to act compassionately and collaboratively with them in response.

Mitigation: established a system quality group to escalate clinical issues across system partners which included Chief Nurses and Chief Medical Officers to develop plans to request additional clinical support across the system and possible redirection of clinical support, ensure after action review and clinical harm review processes and recommendations are implemented.

The ICB Quality, Safety and Improvement Committee regularly reviews the impact of industrial action and ensures system programmes are developed to support urgent and emergency care improvements.
Delivery against control total and operating plan - There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London. In addition, a failure to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a

requirement to go into recovery and potential reductions in services to local people.

Mitigation: established an ICS Chief Finance Officers meeting with all system partners with outcomes agreed including:

- Providers have been given additional funding for elective care (Elective Recovery Fund – ERF)
- System-wide discussions are taking place to discuss the drivers of the deficit, via the financial recovery summit and system finance groups
- System wide formal recovery programme to be stood up with key groups to take forward different areas of recovery; including workforce productivity, corporate services and temporary staffing.
- System partners have internal efficiency programmes in place to deliver savings for this financial year
- Finance team continues to identify ICB savings to be enacted for this financial year to be able to deliver the breakeven position that is statutorily required
- Within the ICB - development of CIP and recovery plans for continuing health care (CHC) and prescribing.

Following further system wide discussion, we have also included a more recent risk in relation to digital and estates as follows: there is a risk that we are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population, due to underinvestment and limited options to secure investment. This could impact on our ability to deliver modern and safe care. Mitigating actions are currently being worked through across our wider partnership.

Financial review

As at 31 March 2023 North East London Integrated Care Board (NEL ICB) had net liabilities of £307.7m (£307.9m as at 30 June 2022 and £366.6m as at 31 March 2022).

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCGs). ICBs took on the commissioning functions of CCGs; CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When CCGs ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

The funding for 2023/24 has already been agreed with NHSE. On this basis, there is no reason to believe that sufficient funding will not be made available in the 12 months from the date of approval of these Financial Statements.

Financial performance

In the 9 months to the period end 31 March 2022/23 NEL ICB was given funding of £3,186.1m from NHSE and received £18m of other non-contract income (Total £3,204.1m). Within this funding the ICB is allowed to spend £33.7m on the running costs of the organisation.

The majority of the ICB's spend is used to purchase services from NHS Trusts and NHS Foundation Trusts. In the 9 months to the period end 31 March 2022/23 we spent £2,193m (£686.8m in Q1 2022/23 and £2,742.8m in 2021/22), which is 69% of our total spend this is consistent with Q1 2022/23 and 2021/22.

The ICB delivered a small surplus of £0.04m for the 9 months to the period end 31 March 2022/23. The ICB has also remained within the running costs allocation.

The financial position continues to be very difficult and so in 2023/24 we have a challenging financial plan. The ICB is working collaboratively with partners across the system to deliver the actions and mitigations required in relation to the challenging financial position.

The financial statements contained within the report provide a summary of the ICB's financial position and performance for the 9 months to the period end 31 March 2022/23. This section of the report talks about how we manage our money and how our financial performance is measured.

We are accountable for how we spend public money and achieve good value for money for our patients. This is the first year of North East London Integrated Care Board, and good financial control and management is vital for the development of the organisation.

Funding

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How we spent the money

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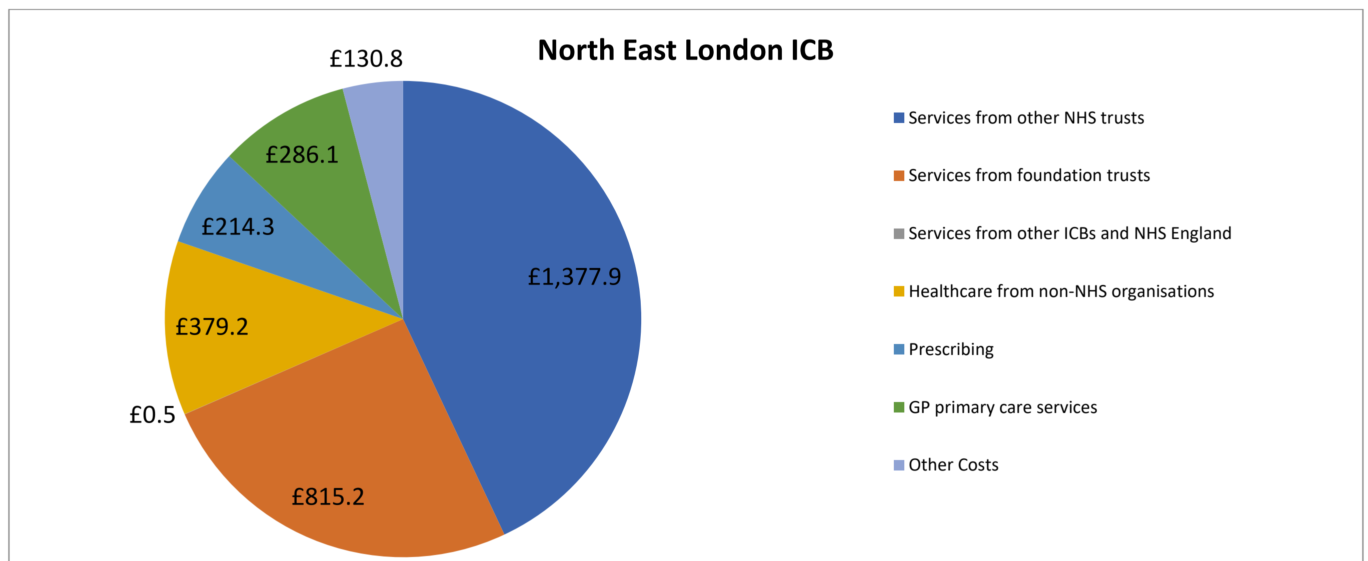
and 2021/22.

In the nine months to the period end 31 March 2022/23, spend related to delegated co-commissioning arrangements totalled £287.2m (£90.3m in Q1 2022/23 and £350.8m in 2021/22). This equates to 9% of the ICB total spend and remains in line with the Q1 2022/23 and 2021/22.

In summary we spent the money as follows:

	£'000	%
Services from other NHS trusts	£1,377.9	43.0%
Services from foundation trusts	£815.2	25.4%
Services from other ICBs and NHS England	£0.5	0.0%
Healthcare from non-NHS organisations	£379.2	11.8%
Prescribing	£214.3	6.7%
GP primary care services	£286.1	8.9%
Other Costs	£130.8	4.1%
	£3,204.0	100.0%

How we spent the money



Overall Financial Performance

During the 9 months to the period end 31 March 2022/23 NEL ICB has worked under the national financial arrangements which includes block contracts with NHS providers, specific funding for COVID 19 services, elective recovery and a greater emphasis on financial planning at an Integrated Care

System level.

The ICB delivered a small surplus of £0.04m for the 9 months to the period end 31 March 2022/23. The ICB has also remained within the running costs allocation.

Financial pressures

The ICB has faced a range of financial challenges across the year mainly impacted by Inflation, Continuing Health Care (CHC), Hospital Discharge Pathway, Prescribing and Independent Sector Contracts along with demand growth in areas such as Mental Health.

Future years

Regulators have confirmed the NHS has a fixed level of ICB funding for the financial year 2023/24 which will cover the locally agreed and NHSE set block contract values for NHS providers. The financial position continues to be very difficult and so in 2023/24 we have a challenging financial plan. The ICB Chief Finance and Performance Officer (CFPO) has constituted a finance recovery working group across the whole of the ICS. This group will review and drive forward the financial position, efficiency and savings targets and oversee the development of a 5-year system financial plan.

ACCOUNTABILITY REPORT

Zina Etheridge

Accountable Officer

23 June 2023

Accountability Report

Corporate Governance Report

Introduction

As the system convener, the ICB worked with system partners to design inclusive, collaborative and effective structures and processes for governance. In doing this we focused on building shared ambition, mutual accountability with decision making principles intended to deepen collaboration. These principles were agreed by the new Board and are at the front of each board agenda pack. We have a comprehensive Governance Handbook, which sets out our arrangements in full. We have tested, learnt from and adapted our arrangements throughout the year.

In advance of this, while we were in shadow form and establishing the ICB, we worked with the wider system and integrated care partnership to develop key design principles to guide our work, agreeing four flagship priorities and a shared ambition: ***"****We will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity****".***

Composition of ICB Board

The ICB Board (the Board) is comprised of nominated members from partner organisations, including healthcare and local government, and officers who have the duty to ensure the ICB exercises its functions effectively, efficiently and economically. The Board is responsible for ensuring that the ICB meets all its financial obligations, including accounting and auditing and performing its functions in a way which provided good value for money.

Detailed information regarding the members can be found on our website and below. Information about the work of the Board is contained in the Governance Statement.

Name	Title and/or role
Marie Gabriel CBE	Chair
Zina Etheridge	Chief Executive Officer
Diane Herbert	Non-executive Member
Imelda Redmond CBE	Non-executive Member

Name	Title and/or role
Cha Patel	Non-executive Member (from 1 February 2023 to date)
Sue Evans	Associate Non-executive Member (Interim Board member from 8 September to 31 January 2023)
Rajiv Jaitly	Non-executive Member (from 1 July 2022 to 7 September 2022)
Diane Jones	Chief Nursing Officer
Dr Paul Gilluley	Chief Medical Officer
Henry Black	Chief Finance and Performance Officer
Dr Jagan John	Partner Member (Primary Care)
Dr Mark Rickets	Partner Member (Primary Care)
Paul Calaminus	Partner Member (NHS trusts and foundation trusts)
Shane DeGaris	Partner Member (NHS trusts and foundation trusts)
Councillor Maureen Worby	Partner Member (Local Authority)
Mayor Philip Glanville	Partner Member (Local Authority)
Caroline Rouse	Partner Member (Voluntary, community and social enterprise sector)

Meetings were also attended regularly by the following people who are not voting members of the Board, but are part of the ICB's executive management team and leaders within the Integrated Care System.

Name	Role
Charlotte Pomery	Chief Participation and Place Officer
Francesca Okosi	Chief People and Culture Officer
Johanna Moss	Chief Strategy and Transformation Officer
Andrew Blake-Herbert	Local Authority Executive Participant
Manisha Modhvadia	Healthwatch Participant

In addition, we have a number of associate non-executive members, appointed on a shorter-term basis, who were formally engaged with the CCG and have supported the transition to the

new organisation, supporting with continuity and organisational memory from a non-executive perspective.

Committee(s), including Audit Committee

The ICB's Audit and Risk Committee members are detailed below and more information about the committee and its work is contained in the Governance Statement.

Audit and Risk Committee

Name of member	Role
Cha Patel	Non-executive Member (Chair of the Committee from 1 February 2023)
Sue Evans	Associate Non-executive Member (Interim Chair of the Committee until 31 January 2023)
Noah Curthoys	Associate Non-executive Member (from 7 October 2022 to 28 December 2022)
Kash Pandya	Associate Non-executive Member
Imelda Redmond CBE	Non-executive Member

Membership details of other committees is also contained in the Governance Statement.

Register of Interests

North East London ICB published a register of Board members' interests on the website which was updated as and when changes were notified to the ICB. The register gives details of company directorships or other significant interests held by members and senior managers where those companies were likely to do business, or possibly seek to do business with the NHS, where this may conflict with their managerial responsibilities.

Personal data related incidents

NEL ICB maintains an approved Information Governance (IG) Framework which includes a suite of approved IG policies and an annual evidence-based response to the NHS mandated Data Security and Protection Toolkit which covers 113 standards relating to the processing of personal data for both patients and staff. These standards include training a minimum of 95% of our staff annually on information governance and data protection and operating IG and data sharing groups to oversee our controls for how we manage and share personal data. The ICB operates a privacy by design approach and considers new projects and technology which process personal data using a Data Protection Impact Assessment (DPIA) to ensure that appropriate controls are implemented and risks mitigated.

The ICB maintains and promotes an internal incident reporting and management process which includes incidents which involve loss of data (personal data breach), breaches of the Data Protection Act and UK GDPR and inappropriately shared data. We notify the Department of Health and Social Care and the Information Commissioner's Office (ICO) of serious incidents that require investigation which meet the reporting threshold set by DHSC and ICO via the national IG incident reporting tool.

During the reporting period, the ICB had no serious incidents involving data loss or confidentiality breaches which met the requirement for formal reporting to the ICO.

Modern Slavery Act

NHS North East London fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the North East London Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and

Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England. NHS England has appointed the Chief Executive Officer to be the Accountable Officer of North East London Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the North East London ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that North East London ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

NHS North East London Integrated Care Board (NEL ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended). The NEL ICB's statutory functions are set out under the National Health Service Act 2006 (as amended). The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population. Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NEL ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my

responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NEL ICB's Accountable Officer Appointment Letter. I am responsible for ensuring that the NEL ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the ICB has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

The Constitution

The Constitution, which was approved by NHSE as part of the authorisation process in July 2022 provides that it is the ICB Board which undertakes any functions not reserved or otherwise delegated.

ICB governance structure

The ICB governance structure was created to ensure that health and care system partners and local residents are at the heart of decision making whilst delivering on the ICS priorities agreed by the Board in July 2022. The governance structure reflects the fact that there is a shared management team and operating model supporting seven place-based partnerships and provider collaboratives whilst maintaining the functions of the ICB in its own right as a statutory body with overall accountability.

ICB Board

Meetings were held in venues across the north east London footprint and members of the public were invited to join in person or online and, as always, to submit questions in advance.
Recordings of the meetings are available via the ICB's website.
The key areas of focus for the ICB Board at the meetings held between July 2022 and March 2023 were:

a. Approving the governance handbook
b. Approving the 'Working with People and Communities Strategy'.
c. Reporting on co-production with local residents in the work of the ICS
d. Development of the integrated care strategy
e. Development of the ICS workforce strategy
f. Development and agreement of the finance strategy
g. Development and agreement of the Joint Forward Plan

h. Reporting on the delegation of pharmacy, optometry and dental services
i. Reporting on and oversight of ICB and ICS finances
j. Reporting on and oversight of performance and quality issues within commissioned health providers
k. The management of strategic risk through scrutiny of the Board Assurance Framework (BAF)
l. Compliance with ICB statutory duties
m. Exception reports from the committees of the Board.

The membership and attendance record of the ICB Board is outlined in the table below:

ICB Board member	1 July 2022	28 Sep 2022	30 Nov 2022	25 Jan 2023	29 March 2023	Total attended /total possible
Marie Gabriel CBE	✓	✓	✓	✓	✓	5/5
Zina Etheridge	✓	✓	✓	✓	✓	5/5
Paul Calaminus	✓	✓	✓	✓	✓	5/5
Shane DeGaris	✓	✓	✓	✓	X	4/5
Maureen Worby – from September 2022	N/A	✓	✓	✓	✓	4/4
Philip Glanville – from September 2022	N/A	✓	X	✓	✓	3/4
Caroline Rouse – from September 2022	N/A	✓	✓	✓	X	3/4
Diane Jones	✓	✓	✓	✓	X	4/5
Henry Black	✓	✓	✓	✓	✓	5/5
Dr Paul Gilluley	✓	✓	✓	✓	✓	5/5
Dr Mark Rickets	✓	✓	✓	✓	✓	5/5
Dr Jagan John	X	✓	✓	X	✓	3/5
Diane Herbert	✓	✓	✓	✓	✓	5/5
Imelda Redmond CBE	X	✓	✓	✓	✓	4/5

Rajiv Jaitly – from 1 July 2022 to 7 September 2022	✓	N/A	N/A	N/A	N/A	1/1
Cha Patel – from 1 February 2023	N/A	N/A	N/A	✓	✓	2/2
Sue Evans – from 8 September 2022 to 31 January 2023	N/A	✓	✓	✓	N/A	3/3

The meeting was also attended regularly by:

- Will Tuckley, local authority executive participant (until 2 March 2023)
- Andrew Blake-Herbert, local authority executive participant
- Manisha Modhvadia, Healthwatch participant observer
- Francesca Okosi, Chief People and Culture Officer
- Johanna Moss, Chief Strategy and Transformation Officer
- Charlotte Pomery, Chief Participation and Place Officer

Committees of the ICB Board

The Board has authority under the scheme of delegation to establish committees or sub groups to enable it to fulfil its role. Each of the Board committees has terms of reference and the roles of each are set out broadly below. Each committee is authorised by the Board to pursue any activity within their terms of reference and within the scheme of reservation and delegation of powers.

Executive Committee

The Executive Committee oversees and takes any relevant decisions in line with the principles which have been agreed by the ICS partners, set out here. The Committee also prioritises delivery against the agreed strategic priorities of the ICS set out here.

The duties of the Committee are to:

- Provide executive oversight of the preparation and delivery of the Integrated Care Partnership (ICP) Integrated Care Strategy, the associated joint forward plan, and the joint capital resource use plan, ensuring delivery of key commitments, objections and milestones.
- Develop and recommend to appropriate partner organisations for approval related strategies for discrete areas for implementation across the ICS area.
- Provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory.
- Ensure opportunities for bidding for transformational funding are maximised and provide oversight of bids.

- Oversee system quality and safety, receiving updates and assurances from the NEL System Quality Group.
- Oversee delivery of the NEL People Plan and any workforce issues, receiving updates and assurance from the NEL People Board.
- Recommend to the Board and provide executive oversight of adherence to policies.
- Provide executive coordination of strategy and system response to incidents and emergencies, including in relation to the ICB's duties under section 252A of the 2006 Act and by virtue of being a category 1 responder under part 1 of the Civil Contingencies Act 2004.
- Drive forward the ICB's commitment to continuous development and improvement. Programmes
- Oversee delivery against the ICS programmes of work, including urgent and emergency care and specialised commissioning.

The membership and attendance record of the Executive Committee is outlined in the table below.

Name of committee member	**16 Nov 2022**	**12 Jan 2023**	**9 Feb 2023**	**9 March 2023**	**Total attended /total possible**
Zina Etheridge (Chair), CEO NHS North East London	✓	✓	X	✓	3/4
Andrew Blake-Herbert, Chief Executive, London Borough of Havering	✓	X	✓	✓	3/4
Louise Ashley, Chief Executive Officer, Homerton Healthcare NHS Foundation Trust	✓	✓	✓	✓	4/4
Henry Black, Chief Finance and Performance Officer, NHS North East London	✓	X	✓	X	2/4
Paul Calaminus, Chief Executive Officer, East London NHS Foundation Trust	✓	✓	✓	X	3/4
Shane DeGaris, Group Chief Executive, Barts Health NHS Trust	✓	✓	X	X	2/4

Dr Paul Gilluley, Chief Medical Officer, NHS North East London	✓	✓	✓	✓	4/4
Gladys Xavier, Director of Public Health, London Borough of Redbridge	✓	X	✓	✓	3/4
Heather Flinders, Strategic Director of People, London Borough of Waltham Forest	✓	X	X	✓	2/4
Jacqui Van Rossum, Acting Chief Executive Officer, North East London NHS Foundation Trust	X	✓	✓	X	2/4
Diane Jones, Chief Nursing Officer, NHS North East London	✓	✓	✓	✓	4/4
Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London	✓	X	✓	✓	3/4
Francesca Okosi, Chief People and Culture Officer, NHS North East London	✓	✓	✓	✓	4/4
Charlotte Pomery, Chief Participation and Place Officer, NHS North East London	✓	✓	✓	✓	4/4
Sarah See, Managing Director of Primary Care, NHS North East London	N/A	✓	✓	X	2/3
Tim Aldridge, Corporate Director of Children and Young People, London Borough of Newham	✓	✓	X	X	2/4
Matthew Trainer, Chief Executive, Barking, Havering and Redbridge University Hospitals Trust	✓	X	X	X	1/4
Will Tuckley, Chief Executive, London Borough of Tower Hamlets (until 2 March 2023)	✓	✓	X	N/A	2/3

The following key topics were discussed by the Committee 2022/23:

- The Integrated Care Strategy
- The Joint Forward Plan
- Delegation of pharmacy, optometry and dental services
- Monthly position of ICB and ICS finances
- 2023/24 Operating Plan
- Delegation of specialised commissioning
- Emergency Preparedness, Resilience and Response workplan
- Place partnership mutual accountability framework
- Making north east London a London living wage place

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- A positive approach to partnership working
- Professional input into discussion
- Clear commitment to make a difference and outcome focused

Areas for improvement:

- Increasing the number of items requiring decision
- Further development is needed to include social care on agenda items
- Meetings in person could improve working relationships

The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee, the details of which are outlined below.

Clinical Advisory Group

The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee of the North East London ICB. The CAG provides strategic clinical leadership and guidance across the ICB, to inform the ICB's decisions. It may receive recommendations from the Senate to inform its work. Its key remit is to provide clinical and care professional evidence-based advice and make recommendations on service transformation for issues which impact across the ICB footprint. The duties of the advisory group are to:

- Approve the work plans and priority setting for the pan-NEL Clinical Networks.
- Make clinical recommendations on transformation proposals which has an impact on the ICB's area, defined as any proposal which as impact on more than one Place.

- Provide a clear interface between the London-wide clinical advisory arrangements and NEL-wide decision making.
- Review London Clinical Advisory Group ('LCAG') guidance and determining the implications for implementation across NEL.
- Maintain effective dialogue with LCAG, notifying them of any specific issues from national level guidance that may need further review at NEL level.
- Provide professional clinical and care leadership across NEL, leading engagement with health and care professionals within organisations and the wider Clinical Senate.
- Provide strategic level clinical and care professional opinion on transformation proposals.
- Develop clinical/care led solutions where appropriate and make recommendations to the ICB for consideration or when escalation is required.
- Review the potential opportunities for improvement and rationalisation of health and care services in NEL based around the agreed principles of patient safety, improved outcomes for local people and better value for money.
- Ensure the system develops robust proposals that are safe and effective and that the reasons underpinning financial assumptions are clinically sound.
- Highlight risks regarding quality of care, safety and deliverability of plans, and support any mitigating actions which can be taken.
- Identify opportunities for new clinical pathways.
- Ensure that health and care colleagues and the wider ICS are kept informed about the CAG's work and are engaged as appropriate.

The membership and attendance record of the Clinical Advisory Group is outlined in the table below.

Name of Committee member	01 Mar. 2023	29 Mar. 2023	Total attended /total possible
Dr. Paul Gilluley, Chief Medical Officer, NHS North East London – Chair	x	✓	1/2
Diane Jones, Chief Nursing Officer, NHS North East London	✓	X	1/2
Raliat Onatade, Chief Pharmacist, NHS North East London	✓	✓	2/2
Dr Ramneek Hara, Clinical Director	✓	✓	2/2
Dr Stephanie Coughlin, Clinical Director	✓	✓	2/2
Dr Rima Vaid, Clinical Director	✓	✓	2/2

Dr Anil Mehta, Clinical Director	✓	✓	2/2
Dr Ken Aswani, Clinical Director	✓	✓	2/2
Dr Deblina Dasgupta, Clinical Director	✓	✓	2/2
Dr Mark Rickets, Inner North East London Primary Care Representative	✓	✓	2/2
Dr Jagan John, Outer North East London Primary Care Representative	✓	✓	2/2

The meeting is regularly attended by:

- Rachel Dalton - Group director of Allied Health Professionals, Barts Health
- Fiona Kelly - Director of AHPs, ELFT
- Patrick Brooks - Systems Partnership Transformation Manager - North East London, London Ambulance Service

The following key topics were discussed by the Committee in 2022/23:

- Terms of reference
- Clinical and Care Professional Advisory Group for Whipps Cross discharge framework
- IPC Updates
- Clinical and care professional leadership

Some of the areas that the Group had requested more detailed reports on in the form of 'deep dives' were: Inequalities in access to secondary and tertiary care.

Audit and Risk Committee

The purpose of the Audit and Risk Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the ICB board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.

The duties of the Audit and Risk Committee are to:

- Provide assurance and advice to the ICB board on the following:
    - The proper stewardship of resources and assets including value for money
    - Financial reporting
    - The effectiveness of audit arrangements both internal and external
    - Risk management
    - Control and integrated governance arrangements within the ICB

The membership and attendance record of the Audit and Risk Committee is outlined in the table below.

Name of Committee member	21 Sept 2022	7 Dec 2022	1 Feb 2023	15 Mar 2023	Total attended /total possible
Cha Patel, Chair and Non-executive member *(from 1 Feb 2023)*	N/A	N/A	✓	✓	2/2
Sue Evans, Associate non-executive member *(covered the role of Interim non-executive member and Audit Chair until 31 Jan 2023)*	✓	✓	✓	✓	4/4
Imelda Redmond CBE, Non-executive member	X	✓	✓	✓	3/4
Kash Pandya, Associate non-executive member	✓	✓	✓	✓	4/4
Noah Curthoys, Associate non-executive member *(Member during Dec 2022)*	N/A	✓	N/A	N/A	1/1

The meeting is regularly attended by:

- Henry Black - Finance and Performance Chief Officer, NHS North East London
- Steve Collins – Executive Director of Finance, NHS North East London
- Sunil Thacker – Director of Finance, NHS North East London
- Rob Adcock – Finance Director, NHS North East London
- Marie Price – Director of Communication and Involvement, NHS North East London
- Dean Gibbs/Carl Van Den Berg– External Auditor, KPMG
- Nick Atkinson/John Elbake – Internal Auditor, RSM
- Mark Kidd – Local Counter Fraud Specialists, RSM

The following key topics were discussed by the Audit and Risk Committee in 2022/23:

- Governance
- Risk management
- Internal control
- External Audit
- Internal Audit
- Counter Fraud
- Procurement and contracts
- Information governance and IT
- Financial reporting
- Pharmacy, optometry and dentistry delegation

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Comprehensive agendas and reports and well chaired
- Effective scrutiny and engagement with internal and external audit
- Return to face to face meetings has helped the quality of discussion

Areas for improvement:

- Improved data analysis
- Establishing a rhythm for deep dive reports
- Clarity on ICB specific risks with an ICS view

Finance, Performance and Investment Committee

The Finance, Performance and Investment Committee (FPIC) provides assurance and reports directly to the ICB Board to ensure that there are robust and integrated mechanisms in place to ensure detailed review, oversight and assurance of the ICB's financial position and financial strategy. It also provides assurance that all aspects of financial and performance management are operating effectively, through focus upon the key financial and operational performance risk areas across the local system and ensures that the ICB is delivering its required targets.

The duties of the Committee are to:

- To review the financial allocations and budget for the current financial year and make recommendations to the ICB Board for formal authorisation.
- Provide oversight and development of the five-year strategic financial plan for the ICB.
- Review and approve allocation of contingency funding to members of the ICB based against defined metrics. This is to include transformation, productivity and to aid the reduction of health inequalities.
- Approve business cases for strategic investment that are in line with the Scheme of Reservation and Delegation (SORD) and meet the needs of the priorities of the ICB.
- To review and monitor the financial strategy and operational financial plans of the ICB and the current and forecast financial position of the overall ICB budget.
- To review and monitor system wide operational performance in accordance with national operational planning guidance and advise on risks and mitigations.
- Consider and review ongoing financial reports and the Annual Statement to be presented to the ICB Board, incorporating financial performance against budget, targets, financial risk analysis, forecasts and statements on the rigor of underlying assumptions to ensure statutory financial duties are met;
- Providing assurance to the ICB Board about delivery and sustained performance of contracts held by the ICB.

- Where required, the Committee will consider and review any external financial monitoring returns and commentary.
- To receive reports from its sub-committees and groups on their work, and the decisions made.
- To ensure there is development of policies that sit under the remit of the Chief Finance and Performance Officer.
- To approve policies that sit under the remit of the Chief Finance and Performance Officer.
- The Committee will work across the provider collaboratives and place-based partnerships in accordance with the NEL ICS Oversight and Assurance Framework to ensure a proportionate and risk-based approach to performance oversight.
- The Committee will also be updated on progress of the ICB and of Trusts in accordance with the NHS System Oversight Framework (SOF).
- The Committee will oversee the annual operational planning process for activity and performance ensuring alignment to workforce and financial planning processes.

The membership and attendance record of the FPIC is outlined in the table below:

Name of Committee member	31 Oct 2022	6 Jan 2023	27 Feb 2023	27 Mar 2023	Total attended /total possible
Kash Pandya, Associate Non-Executive Member (Chair)	✓	✓	✓	✓	4/4
Henry Black, Chief Finance and Performance Officer	✓	x	✓	✓	3/4
Cha Patel, Non-Executive Member	N/A	✓	✓	✓	3/3
Fiona Smith, Associate Non-Executive Member	✓	✓	x	✓	3/4
Dr Mark Rickets, Primary Care Partner Member	✓	✓	✓	✓	4/4
Mayor Philip Glanville, Local Authority Partner Member	✓	✓	✓	✓	4/4
Mohit Venkataram, NHS Trust Partner Member	N/A	✓	✓	✓	3/3

Cha Patel and Mohit Venkataram joined the Committee in January 2023 and were not members for the initial meeting in October 2022.

The meeting is regularly attended by:

- Steve Collins, Executive Director of Finance, NHS North East London
- Rob Adcock, Deputy Chief Finance Officer, NHS North East London
- Clive Walsh, Interim Director of Performance, NHS North East London

The following key topics were discussed by the Committee in 2022/23:

- Monthly finance overviews and reports
- Financial risk overview
- Monthly performance reports
- ICB Operating Plan, budgets and financial strategy/management
- Business cases
- Finance and Performance organisational policies and standard operating procedures
- Capital investments
- The NHS System Oversight Framework
- Oversight of the transfer of delegated responsibility for commissioning of Pharmacy, Optometry and Dental services from NHS England to London ICBs hosted by NEL ICS
- A Joint Working Agreement for Specialised Commissioning
- Primary Care Rebate Schemes
- Covid-19 restoration and recovery
- QIPP delivery
- Winter pressures
- Acute and non-acute contracts
- Developing ICS financial management and reporting

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Active participation from all members
- Positive discussions about critical and sensitive issues
- Good level of debate and challenge

Areas for improvement:

- Complexity of report content
- Performance data presentation
- Increasing the number of deep dives

The Primary Care Contracts Sub-committee is a sub-committee of the Finance, Performance and Investment Committee, the details of which are outlined below.

Primary Care Contracts Sub-committee

The Primary Care Contracts Sub-committee provides oversight of the ICB's primary care contracting functions and to make decisions on the review and procurement of primary care services in North East London and other direct commissioning under delegated authority from NHS England. The role of the sub-committee is to carry out the functions relating to the commissioning and management of primary medical care services in accordance with the agreement entered into between NHS England and the ICB.

The duties of the Sub-committee are to:

- Overseeing arrangements for ensuring effective primary medical services contract management.
- Overseeing the design and commissioning of any enhanced services.
- Overseeing the design and offer local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) or enhanced services.
- Overseeing the development of commissioning proposals for urgent care for out of area registered patients, ensuring compliance with any mandated guidance in relation to:
- Establishing new primary medical services providers.
- Approving practice mergers and closures.
- Dispersing patient lists.
- Agreeing boundary variations.
- The procurement/award of new contracts (subject to financial limits).
- Overseeing arrangements for commissioning PCN Contract Direct Enhanced Services.
- Overseeing arrangements for commissioning ancillary support services.
- Overseeing arrangements or managing primary medical services providers providing inadequate standards of care.
- Making decisions on discretionary payments and discretionary support.

The membership and attendance record of the Sub-committee is outlined in the table below.

Name of Committee member	28 Nov 2022	30 Jan 2023	22 March 2023	Total attended /total possible
Steve Collins, Executive Director of Finance, NHS North East London (Chair)	✓	✓	✓	3/3
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	X	✓	X	1/3
Diane Jones, Chief Nursing Officer, NHS North East London	✓	✓	✓	3/3
Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London	✓	X	✓	2/3
Mike Fitchett, Independent GP*	X	NA	NA	0/1
Azeem Nizamuddin, Independent GP*	✓	NA	NA	1/1

*Independent GPs were in post until December 2022

The meeting is regularly attended by:

- Sarah See – Managing Director of Primary Care, NHS North East London
- Greg Cairns - Director of Primary Care London-Wide LMCs
- Jane Lindo – Director of Primary Care, NHS North East London
- William Cunningham-Davis – Director of Primary Care, NHS North East London
- Richard Bull – Director of Primary Care, NHS North East London
- Alison Goodlad – Deputy Director of Primary Care, NHS North East London
- Lorna Hutchinson – Assistant Head of Primary Care, NHS North East London
- Gohar Choudary – Assistant Head of Primary Care, NHS North East London
- Madhu Pathak – Barking, Dagenham and Havering LMC
- Rob Dickenson – Senior Finance Manager, NHS North East London

The following key topics were discussed by the Sub-committee in 2022/23:

- Alternative Provider Medical Services (APMS)
- Local Incentive Scheme (LIS)
- Contractual actions and changes
- Risk Register
- Finance Reports
- Remedial Notice

- Deep dive reports
- Acute and non-acute contracts
- Developing ICS financial management and reporting

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Good chair with good knowledge of primary care
- Well organised and timely short papers

Areas for improvement:

- Gaps in understanding of primary care contracting knowledge
- Limited understanding of the regulations that govern the decisions
- Enablement of local decision making.

Population Health and Integration Committee

The purpose of the Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on how improved population health and integrated health and care, resulting in improved access, experience and outcomes for local people are being delivered including by the seven place-based partnerships and provider collaboratives and their ICB sub-committees.

The duties of the Committee are:

- To understand the population's needs and assets and have a broad overview of the populations and communities of north east London
- To shape and have oversight of the Improving the Health of All Populations Strategy, or equivalent, as a framework for the development and implementation of effective population health improvement across north east London
- To shape and have oversight of the Working with People and Communities Strategy as a framework for the development and implementation of effective resident participation across north east London
- To review the matrix system of integration and integrated working through the ICB's seven place partnerships and provider collaboratives to ensure that the arrangements are delivering improved access, experience and outcomes in line with the ICB's objectives, priorities and legal duties.
- To seek reports and assurance from place and collaborative leaders as appropriate, with a consistent focus on population health and integration, together with indicators of their effectiveness.
- To identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives.

The membership and attendance record of the Committee is outlined in the table below.

Population Health and Integration Committee member	26 Oct 2022	13 Dec 2022	22 Feb 2023	Total attended /total possible
Marie Gabriel CBE (Chair), ICB Chair	✓	✓	✓	3/3
Zina Etheridge, Chief Executive Officer	✓	✓	✓	3/3
Louise Ashley, NHS Trust Partner Member	x	✓	✓	2/3
Noah Curthoys, Associate Non-executive Member	✓	✓	✓	3/3
Dr Paul Gilluley, Chief Medical Officer	x	✓	✓	2/3
Dr Jagan John, Primary Care Partner Member	✓	x	✓	2/3
Councillor Maureen Worby, Local Authority Partner Member	✓	✓	✓	3/3
Charlotte Pomery, Chief Participation and Place Officer	✓	✓	✓	3/3
Imelda Redmond CBE, Non-executive Member	✓	✓	✓	3/3
Fiona Smith, Associate Non-executive Member	✓	✓	✓	3/3

The meeting is regularly attended by:

- Johanna Moss, Chief Strategy and Transformation Officer
- Adrian Loades, executive place-based partnership representative
- Andrew Blake-Herbert, executive place-based partnership representative
- Colin Ansell, executive place-based partnership representative
- Fiona Taylor, executive place-based partnership representative
- Heather Finders, executive place-based partnership representative
- Will Tuckley, executive place-based partnership representative (until 2 March 2023)
- Jacqui Van Rossum, executive provider collaborative representative
- Paul Calaminus, executive provider collaborative representative
- Ralph Coulbeck, executive provider collaborative representative

The following key topics were discussed by the Committee in 2022/23:

- Population health profile for the North East London Health and Care Partnership
- Working with people and communities strategy
- The development of place partnerships and provider collaboratives in north east London
- Integrated care strategy
- Health inequalities funding proposal
- The Big Conversation programme of events

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The focus across collaboratives, place and systems with the real opportunity to influence decisions
- Proactively seeking to make sense of areas of delegated responsibility
- Building working relationships across the partnership

Areas for improvement:

- Understanding how the items for discussion relate to the flagship priorities and how they interface with other committees.
- Avoiding duplication with health inequalities and population health reports.

The subcommittees of the Population Health and Integration Committee are detailed in the below.

Place-based Integrated Care Board Sub-Committees

The seven Place-based Sub-Committees enable the ICB to exercise delegated functions at Place in a lawful, simple and efficient way, to the extent permitted by the ICB's Constitution and as part of the wider collaborative arrangements which form the Place-based Partnerships. The Sub Committees also support the development of collaborative arrangements at Place, in particular the development of the Place Based Partnership (PBP) and Plan. It also helps support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions set out in the plans that it enters into and supports, including but not limited to the joint forward plan, the Integrated Care Strategy and joint local health and wellbeing strategies. The Sub Committees report in to, and provide assurance to the Population Health and Integration Committee (PHIC).

The duties of the Sub-committees are to:

- Exercise delegated decision making with particular regard to the objectives and priorities described in the PBP Plan.

- Support the wider ICB to achieve its agreed deliverables, and to achieve the aims and the ambitions of the Joint Forward Plan, the Joint Capital Resource Use Plan, the Integrated Care Strategy, joint local health and wellbeing strategies and joint strategic needs assessment, the Place Mutual Accountability Framework and the NHS North East London Financial Strategy and developing ICS Financial Framework.
- Support the ICS with the achievement of the 'four core purposes' of Integrated Care Systems - improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and help the NHS support broader social and economic development
- Work with the Health and Care Board on behalf of the ICB, to develop a PBP Plan including Place objectives and priorities and a Place outcomes framework.
- Undertake specific activities in relation to:
    - Health and care needs planning, through embedding population health management;
    - Market management, planning and delivery;
    - Local service quality management;
    - Communications and engagement.
- Discharge delegated financial management and control, as detailed within the ICB's Standing Financial Instructions (SFIs).
- Develop arrangements for integrated services, including primary care, through local neighbourhoods.
- Prepare or contribute to an emergency response plan for implementation at Place, coordinating with local partners as necessary if requested.

Barking and Dagenham Integrated Care Board Sub Committee

The membership and attendance record of the Barking and Dagenham Sub-committee is outlined in the table below.

Name of Committee member	29 Sep. 2022	26 Jan. 2023	30 Mar. 2023	Total attended /total possible
Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health Integration - Co-Chair	✓	✓	✓	3/3
Ann Hepworth, Director of Strategy & Partnerships, BHRUT	✓	X	✓	2/3
Dr Rami Hara, Clinical Care Director, NHS North East London	✓	✓	✓	3/3

Dr Shanika Sharma, Primary Care Network Director – Co-Chair	✓	X	✓	2/3
Fiona Taylor, Place Partnership Lead, London Borough of Barking and Dagenham	✓	✓	X	2/3
Elaine Allegretti, Strategic Director Children and Adults, LBBD	✓	X	X	1/3
Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham	✓	✓	✓	3/3
Elspeth Paisley, Health Lead, BD Collective	✓	✓	✓	3/3
Selina Douglas, Director of Partnerships, NELFT	x	✓	X	1/3
Manisha Modhvadia, Manager, Healthwatch	x	✓	X	1/3
Sharon Morrow, Place Director, NHS North East London	✓	X	X	1/3
Sunil Thakker, Director of Finance, NHS North East London	x	✓	X	1/3
Mark Gilbey-Cross, Director of Nursing/ Quality, NHS North East London	✓	X	X	1/3

NB capacity issues being explored where ICB team colleagues are members across a range of places

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Committed members wanting to make a change
- Representation from health and social care to enable wider discussion.
- Ability to hold meetings in person

Areas for improvement:

- Discussion can feel clinically-led
- Heavy agendas can lead to limited discussion time to work through complex issues

City and Hackney Integrated Care Board Sub Committee

The membership and attendance record of the City and Hackney Integrated Care Board Sub Committee is outlined in the table below.

Name of Committee member	8 Sep 2022	10 Nov 2022	9 Mar 2023	Total attended /total possible
Nina Griffith, Delivery Director for City & Hackney, NHS North East London	X	✓	X	1/3
Dr Steph Coughlin, Clinical Care Director for City & Hackney, NHS North East London	✓	✓	✓	3/3
Sunil Thakker, Director of Finance, NHS North East London	X	✓	✓	2/3
Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London	✓	✓	X	2/3
Helen Woodland, Group Director for Adults, Health and Integration, London Borough of Hackney	✓	✓	✓	3/3
Jacquie Burke, Group Director for Children and Education, London Borough of Hackney	✓	✓	X	2/3
Simon Cribbens, Director of Community and Children's Services, City of London Corporation	✓	✓	✓	3/3
Dr Sandra Husbands, Director of Public Health for City & Hackney, London Borough of Hackney	X	✓	✓	2/3
Councillor Chris Kennedy, Local Authority Elected Member, London Borough of Hackney	✓	✓	✓	3/3
Helen Fentimen, Local Authority Elected Member, City of London Corporation (Chair)	✓	✓	✓	3/3
Louise Ashley, Chief Executive & Place Partnership Lead, Homerton Healthcare NHS Foundation Trust	X	✓	✓	2/3
Paul Calaminus, Director of ELFT, East London NHS Foundation Trust	X	X	✓	1/3
Dr Tehseen Khan, Joint Primary Care Network Clinical Director	X	x	X	0/3
Dr Jenny Darkwah, Joint Primary Care Network Clinical Director	X	x	X	0/3
Dr Kirsten Brown, Place-Based Partnership Primary Care Development Clinical Lead	✓	✓	✓	3/3

Tony Wong, Chief Executive Officer, Hackney Council for Voluntary Service	✓	✓	✓	3/3

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Well attended meetings which enable effective discussion
- High quality written reports

Areas for improvement:

- More alignment with Health and Wellbeing Boards could be beneficial
- Greater authority to take decisions following the approval of the Mutual Accountability Framework

Havering Integrated Care Board Sub Committee

The membership and attendance record of the Havering Sub-committee is outlined in the table below.

Name of Committee member	14 Sep. 2022	9 Nov. 2022	11 Jan. 2023	8 Mar. 2023	Total attended /total possible
Dr Narinderjit Kullar, Clinical Care Director, NHS North East London	✓	✓	✓	✓	4/4
Cllr Gillian Ford, Councillor, Lead Member for Adult Social Care and Health, London Borough of Havering (Chair)	✓	✓	✓	✓	4/4
Dr Jwala Gupta, primary care sector Partnership Board member - Co-Chair	✓	✓	✓	X	3/4

Brid Johnson, Interim Executive Integrated Care Director, NELFT	✓	x	✓	✓	3/4
Barbara Nicholls, Director of Adult Social Care, London Borough of Havering	✓	✓	X	✓	3/4
Ann Hepworth, Director of Strategy and Partnerships, BHRUT	X	x	✓	✓	2/4
Mark Ansell, Director of Public Health, London Borough of Havering	✓	✓	✓	✓	4/4
Andrew Blake-Herbert, Chief Executive of London Borough of Havering, Place Partnership Lead and Chair	✓	✓	✓	✓	4/4
Ben Molyneux, Primary Care Development Clinical Lead	x	x	X	X	0/4
Robert South, Director of Children's Services, London Borough of Havering	x	✓	X	X	1/4
Luke Burton, Delivery Director, NHS North East London	✓	✓	✓	✓	4/4
Sunil Thakker, Director of Finance, NHS North East London	x	✓	x	✓	2/4
Mark Gilbey Cross/ Chetan Vyas, Director of Nursing/Quality, NHS North East London	✓	x	x	X	1/4

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The commitment and willingness to work as a partnership
- Local residents are at the heart of discussions

- Strengthened relationships between partner organisations

Areas for improvement:

- Improving connections with provider collaboratives
- Increasing focus on children's health, care and wellbeing
- Lengthy agendas can lead to limited discussions

Newham Integrated Care Board Sub Committee

The membership and attendance record of the Newham Sub-committee is outlined in the table below.

Name of Committee member	30 Sep. 2022	25 Nov. 2023	31 Mar. 2023	Total attended / total possible
Colin Ansell, Chief Executive/Place Partnership Lead, London Borough of Newham (Chair)	✓	✓	✓	3/3
Rima Vaid, Clinical Care Director, NHS North East London	✓	✓	✓	3/3
John Rooke, Director of Delivery, NHS North East London (until November 2022)	✓	N/A	N/A	1/1
Jo Frazer-Wise/ Marie Trueman-Able, Director of Delivery (Interim/job share), NHS North East London (from November 2022)	N/A	✓	✓	2/2
Karen Livingstone, Chief Executive Officer, Newham Health Collaborative	✓	✓	✓	3/3
Tim Aldridge, Director of Children's Services, London Borough of Newham	✓	✓	X	2/3
Nadeem Faruq, Chair, Newham Health Collaborative	✓	✓	X	2/3
Sunil Thakker. Director of Finance, NHS North East London	✓	✓	X	2/3
Richard Fradgley, Director of Integrated Care & Deputy Chief Executive Officer, East London Foundation Trust	✓	✓	✓	3/3
Simon Ashton, Chief Executive Officer, Newham University Hospital	✓	✓	✓	3/3
Muhammad Nagvi, Primary Care Development Clinical Lead, NHS North East London	✓	✓	✓	3/3

Jason Strelitz, Director of Adult Social Care and Public Health, London Borough of Newham	✓	✓	✓	3/3
Julie Pal/ Veronica Awizudike, Healthwatch Newham	✓	✓	✓	3/3
Mark Gilbey-Cross/ Chetan Vyas, Director of Nursing/ Quality, NHS North East London	x	✓	X	1/3

The meeting is also attended regularly by the members of the wider Health and Care Partnership Board and colleagues to support and provide expert guidance and advice. The following key topics were discussed by the Committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Participation is rich and colleagues are fully engaged
- Strong sense of partnership

Areas for improvement:

- Having a clear forward plan for the sub-committee
- Hybrid technology to enable face-to-face and virtual attendance

Redbridge Integrated Care Board Sub Committee

The membership and attendance record of the Redbridge Sub-Committee is outlined in the table below.

Name of Committee member	15 Sept 2022	16 March 2023	Total attended /total possible
Adrian Loades, Place Partnership Lead, London Borough of Redbridge (Chair)	✓	x	1/2

Tracy Rubery, Delivery Director for Redbridge, NHS North East London	✓	✓	2/2
Dr Anil Mehta, Clinical Care Director for Redbridge, NHS North East London	✓	✓	2/2
Sunil Thakker, Director of Finance, NHS North East London	x	✓	1/2
Mark Gilbey-Cross/ Chetan Vyas, Director of Nursing/Quality, NHS North East London	x	x	0/2
Gladys Xavier, Director of Public Health, London Borough of Redbridge	✓	✓	2/2
Councillor Mark Santos, Cabinet Member for Adult Social Care and Health, London Borough of Redbridge	✓	x	1/2
Bob Edwards, Director of NELFT, North East London NHS Foundation Trust	X	✓	1/2
Ann Hepworth, Director of BHRUT, Barking, Havering & Redbridge NHS Trust	X	X	0/2
Dr Amanjit Jhund, Barts Health NHS Trust	x	x	0/2
Jyoti Sood, Joint Place Based Partnership Primary Care Development Clinical Lead	N/A	✓	1/1
Joint Primary Care Representative (rotating between Drs Ramakrishnan, Ali, Hameed, Umrani, Tahir, Bhatti, Pazhanisami, Dhillon and Clarke)	✓	✓	2/2
Jenny Ellis, Redbridge CVS Representative	✓	✓	2/2
Cathy Turland, Healthwatch Redbridge Representative	x	✓	1/2

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Partners are considering the interfaces between agencies and what can be collectively achieved
- Strong leadership and commitment to partnership working

Areas for improvement:

- Lack of resources and infrastructure to enable meaningful and equitable voluntary sector participation,
- Meetings held entirely online affected ability to build trusting relationships

Tower Hamlets Integrated Care Board Sub Committee

The membership and attendance record of the Tower Hamlets Sub-committee is outlined in the table below.

Name of Committee member	1 Sept 2023	2 March 2023	Total attended /total possible
Amy Gibbs, Independent Chair	✓	✓	2/2
Warwick Tomsett, Director of Integrated Commissioning, NHS North East London & London Borough of Tower Hamlets	✓	✓	2/2
Roberto Tamsanguan, Clinical Care Director for Tower Hamlets, NHS North East London	✓	✓	2/2
Sunil Thakker, Director of Finance, NHS North East London	✓	x	1/2
Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London	✓	x	1/2
Denise Radley, Corporate Director Health, Adults & Community, London Borough of Tower Hamlets	✓	x	1/2
James Thomas, Corporate Director of Children and Culture, London Borough of Tower Hamlets	✓	✓	2/2
Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets	x	✓	1/2
Neil Ashman, Chief Executive Officer, Royal London and Mile End Hospitals, Barts Health NHS Trust	✓	x	1/2

Richard Fradgley, Director of Integrated Care, East London NHS Foundation Trust	✓	✓	2/2
Chris Banks, Joint Chief Executive, GP Care Group	✓	✓	2/2
Zainab Arian, Joint Chief Executive, GP Care Group	N/A	✓	1/1
Peter Okali, Chief Executive Officer, Tower Hamlets CVS	✓	/N/A	1/1
Vicky Scott, Chief Executive Officer, Tower Hamlets CVS	N/A	✓	1/1
Matthew Adrien, Representative, Healthwatch	✓	✓	2/2
Khyati Bakhai, Place Based Partnership Primary Care Development Clinical Lead	N/A	✓	1/1
Julia Slay, Resident and community representative	✓	N/A	1/1
Muna Hassan, Resident and community representative	N/A	✓	1/1

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Members were engaged and worked in an integrated way
- Strong resident voice

Areas for improvement:

- Prioritising system issues
- Finance reports could be clearer

Waltham Forest Integrated Care Board Sub Committee

The membership and attendance record of Waltham Forest Sub-Committee is outlined in the table below:

Name of Committee member	5 September 2022	9 January 2023	6 March 2023	Total attended /total possible
Ken Aswani, Clinical Care Director for Waltham Forest, NHS North East London	✓	✓	✓	3/3
Sue Boon, Delivery Director for Waltham Forest, NHS North East London & North East London NHS Foundation Trust	✓	x	✓	2/3
Mark Lobban, Director of Integrated Commissioning NHS North East London & London Borough of Waltham Forest	x	N/A	N/A	0/1
Sunil Thakker, Director of Finance, NHS North East London	x	x	✓	1/3
Mark Gilbey-Cross, Director of Nursing/Quality, NHS North East London	x	x	x	0/3
Heather Flinders, Strategic Director of People (Co-Chair), London Borough of Waltham Forest	x	✓	✓	2/3
Joe McDonnell, Director of Public Health, London Borough of Waltham Forest	x	X	✓	1/3
Daniel Phelps, Corporate Director Children's Social Care, London Borough of Waltham Forest	✓	✓	✓	3/3
Darren McAughtrie, Director Adult Care and Quality Standards, London Borough of Waltham Forest	✓	x	✓	2/3
Ralph Coulbeck, Chief Executive, Whipps Cross Hospital (Co-Chair), Barts Health NHS Trust	✓	✓	✓	3/3
Oluremi Odejinmi, Medical Director, Whipps Cross Hospital, Barts Health NHS Trust	x	✓	x	1/3
Selina Douglas, Executive Director Strategy, North East London NHS Foundation Trust	x	✓	✓	2/3
Dr Naheed Khanlodhi, Primary Care Network Primary Care Representative	✓	✓	x	2/3

Dr Janakan Crofton, Place Based Partnership Primary Care Development Clinical Lead	✓	x	x	1/3
Vanessa Morris, Chief Executive, Waltham Forest Healthwatch	✓	✓	✓	3/3
Dianne Barham, Representative, Community and Voluntary Sector	✓	✓	x	2/3

The meeting is also attended regularly by the members of the wider Partnership Board and colleagues to support and provide expert guidance and advice.

The following key topics were discussed by the Sub-committee in 2022/23:

- The Terms of Reference
- The NHS North East London Mutual Accountability Framework
- The NHS North East London Financial Strategy
- The local Better Care Fund

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Effective forward planning
- Strong senior leadership

Areas for improvement:

- Resident participation to be further developed
- Local priorities conflicting with ICS system demand.

Mental Health, Learning Disability and Autism Collaborative Sub Committee

The Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Sub-committee 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 improve outcomes, quality, value and equity for residents of north east London with, or at risk of, MHLDA. The duties of the Committee/ Sub-committee are to:

- Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to in-scope MHLDA services in North East London;
- Support the development of further collaboration between the NHS Partner Organisations (including working together towards the Sub-Committee receiving a formal delegation for the functions associated with the Mental Health Investment

Standard and other investment into mental health, and exploring opportunities for formal joint working).

- 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 to ensure the needs and experiences of communities can be considered over whole pathways of care;
- Ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of MHLDA services across North East London;
- Coordinate work to reduce inequalities in health outcomes, access and experience where it is the case that action across the NHS Partner Organisations and/or the ICS is required;
- Coordinate improved resilience of services (e.g. by mutual aid) where it is the case that action across the NHS Partner Organisations and/or the ICS is required and ensure that specialisation and consolidation can occur where this will provide better outcomes and value;
- Ensure that people participation is at the heart of all the activities of the Sub-Committee, and of the collaborative's wider work;
- Leading the development of the ICS strategy for MHLDA, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships;
- Provide assurance to the ICB on the delivery of the ICS strategy for MHLDA, including service user and carer led priorities, and the NHS Long Term Plan; and agree mitigations where there are significant delivery risks;
- Lead annual planning to meet the needs of people for MHLDA services in North East London across the ICS;

The membership and attendance record of the Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Sub-committee is outlined in the table below.

Name of Committee member	23 Nov 2022	25 Jan 2023	22 Mar 2023	Total attended /total possible
Eileen Taylor, Chair (from January 2023) and Joint Chair of ELFT and NELFT	✓	✓	✓	3/3

Marie Gabriel CBE, Chair of NHS North East London and North East London Health & Care Partnership (Interim sub-committee Chair)	✓	N/A	N/A	1/1
Zina Etheridge, Chief Executive Officer, NHS North East London	✓	✓	✓	3/3
Henry Black, Chief Finance and Performance Officer, NHS North East London	✓	✓	X	2/3
Professor Dame Donna Kinnair, Non-Executive Director, ELFT	✓	X	X	1/3
Paul Calaminus, Chief Executive Officer, ELFT	✓	✓	✓	3/3
Selina Douglas, Executive Director of Partnerships, NELFT	✓	✓	✓	3/3
Richard Fradgley, Executive Director of Integrated Care - ELFT	✓	✓	✓	3/3
Dr Mohit Venkataram, Lead Director for New Models of Care, ELFT	✓	✓	X	2/3
Jacqui Van Rossum, Acting Chief Executive Officer, NELFT	X	X	X	0/3
Sultan Taylor, non-executive Director, NELFT	✓	✓	✓	3/3
Johanna Moss, Chief Strategy and Transformation officer, NHS North East London	X	✓	✓	2/3

The meeting is also attended regularly by:

- Participant observers from ELFT, NELFT, Healthwatch and the voluntary sector
- Brid Johnson, Acting Executive Director of Integrated Care, NELFT
- Sue Boon, Director of Delivery Waltham Forest, NELFT and NHS North East London

- Wellington Makala, Executive Chief Nursing Officer/ Executive Director AHP & Psychological Professions, North East London NHS Foundation Trust
- Carys Esseen, Deputy Director of Integrated Care, East London NHS Foundation Trust

The following key topics were discussed by the sub-committee in 2022/23:

- Outputs from the Mental Health Summit 2022 and NEL ICS Mental Health Strategy Workshop
- Draft ICS Mental Health Strategy
- Operational planning 2023-2024/5
- Mobilising the MHLDA diagnostic
- Urgent and emergency care
- NEL Lived Experience Leadership proposal
- Mental health joint forward plan
- Perinatal Provider Collaborative development
- Learning disability & autism final plan
- Mental Health final plan

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- The meetings and discussions were service user driven

Areas for improvement:

- Scheduling around all members' commitments was difficult and often led to some apologies which may have lessened discussions.

Primary Care Collaborative Sub-Committee

The North East London Primary Care Collaborative Sub-Committee has been established by the Population Health and Integration Committee to enable primary care leaders from general practice, pharmacy, dentistry and optometry to work collaboratively, with a shared purpose, and at scale across north east London. As 2022/2023 is a transitional year, the sub-committee focussed on determining the vision and arrangements for future collaboration.

The duties of the sub-committee are to:

- Agree the clinical consensus for primary care services strategy and transformation programmes at scale across north east London;
- Work to reduce inequalities in care provision and unwarranted variation in outcomes for patients and residents;

- Act as a forum for learning and sharing best practice based on robust data;
- Provide a forum for other provider collaborative groups to engage with primary care services across the ICS;
- Support work occurring across and within the place-based partnerships to improve population health and healthcare;
- Ensure primary care services are delivering and are focused on continuous quality improvement.
- Support the ICB to achieve the aims and ambitions of the joint forward plan, joint capital resource use plan, the integrated care strategy and where applicable the join health and wellbeing strategies and plans prepared by the seven place based partnerships.

The membership and attendance record of the Primary Care Collaborative Sub-Committee is outlined in the table below.

Member	18Jan 2023	8 Mar 2023	Total attended /total possible
Johanna Moss, Chief Strategy & Transformation Officer, NHS NEL	✓	✓	2/2
Sarah See, Managing Director of Primary Care, NHS NEL	✓	✓	2/2
Dr Mark Rickets, Primary care partner member (Co-Chair)	N/A	✓	1/1
Dr Jagan John, Primary care partner member (Co-Chair)	N/A	✓	1/1
Henry Black, Chief Finance and Performance Officer, NHS North East London	X	X	0/2
Mark Gilbey-Cross, Director of Nursing, NHS North East London	✓	✓	2/2
Dr Mohammed Naqvi, General practice provider	✓	✓	2/2
Dr Sanjoy Kumar, General practice provider	✓	✓	2/2
Yogendra Parmar, Pharmacy provider	✓	✓	2/2
Shilpa Shah, Pharmacy provider group rep	✓	✓	2/2

Representation from optometry and dentistry provider groups will be members of this collaborative in 2023/24.

The meeting is also attended regularly by:

- Dr Kanika Rai, Place based clinical lead
- Dr Kirsten Brown, Place based clinical lead

- Dr Ben Molyneux, Place based clinical lead
- Dr Khyati Bakhai, Place based clinical lead
- Dr Janakan Crofton, Place based clinical lead

The following key topics were discussed by the sub-committee in 2022/23:

- strategic context and how the collaborative will operate;
- terms of reference;
- progress on the establishment of the provider group sub groups
- primary care governance review
- its role in the system integration programme.

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Active engagement from members
- Development of effective terms of reference

Areas for improvement:

- Inclusion of wider primary care partners
- Developing an effective forward plan

Community Health Collaborative Sub-Committee

The North East London Community Health Collaborative Sub-committee 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, improve access and experience; strengthen resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value. It has been acknowledged that 2022/2023 is a transitional year and, accordingly, the focus of the Community Health Collaborative will be on determining the vision and arrangements for future collaboration with a view to shaping the future of community services across North East London and enable the joint exercise of Delegated Functions in a simple and efficient way in the future. The Sub Committee reports to, and provides assurance to the Population Health and Integration Committee (PHIC)

The duties of the Sub-committee are to:

- Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to in-scope community health related services in North East London;

- Support the development of further collaboration between the NHS Partner Organisations;
- Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services;
- Ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of community services across North East London;
- Enable the joint exercise of any Delegated Functions in a simple and efficient way;
- Making recommendations to the PH&I Committee 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, Community Services in the ICB's area and the exercise of the ICB's functions;
- Developing and approving the North East London Community Services Plan and overseeing implementation and delivery of the initial workplan, in so far as that requires the exercise of ICB functions;
- Holding responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, Community Services with a view to ensuring that such needs are considered within wider system planning.

The membership and attendance record of the Community Health Collaborative Sub-committee is outlined in the table below.

Name of Committee member	16 Jan 2023	20 Mar 2023	Total attended /total possible
Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London	✓	✓	2/2
Charlotte Pomery, Chief Participation and Place Officer, NHS North East London	✓	✓	2/2
Mark Turner, Director of Strategy and Integration, Barts Health NHS Trust	✓	x	1/2
Ann Hepworth, Director of Strategy and Partnerships, Barking, Havering & Redbridge NHS Trust	x	✓	1/2
Dylan Jones, Director of Strategic Implementation and Partnerships, Homerton Healthcare NHS Foundation Trust	✓	✓	2/2

Richard Fradgley, Director of Integrated Care and Deputy Chief Executive Officer, East London NHS Foundation Trust	✓	✓	2/2
Ruth Bradley, Clinical Director (Nursing / AHP or Medical), East London NHS Foundation Trust	x	✓	1/2
Jacqui Van Rossum, Chief Executive, North East London NHS Foundation Trust (Chair)	✓	✓	2/2
Selina Douglas, Executive Director of Partnerships, North East London NHS Foundation Trust	✓	✓	2/2

Some members are still in the process of being selected for membership of the Sub Committee, including from partner NHS Trusts and attendees to provide input from Places and service users or carers. The meeting is also attended regularly by the following colleagues to provide expert advice and support:

- Helen Woodland, Nominated Local Authority representative, London Borough of Hackney
- Mags Farley, Divisional Operations Director for Community and Children's Services, Homerton Healthcare NHS Foundation Trust

The following key topics were discussed by the Committee/ Sub-committee in 2022/23:

- The Terms of Reference
- Community Collaborative Development - Framework for delivery and Programme Structure
- 2023/24 Priorities and Operational Planning Update
- Community reference group proposal
- User of services and carers proposal
- Deep Dives on Virtual Wards and Children and Young People's Speech and Language Therapies (SALT)

Committee effectiveness review

Comments were received on what had gone well this year and what could be improved.

Things that went well:

- Deep dives into areas including virtual wards and BCYP SALT.
- Proposals to develop a service user and carers voice.
- Good discussion on proposals to improve outcomes and reduce variation.

Areas for improvement:

- Resources to deliver plans

Acute Provider Collaborative

Our acute providers, Barts Health, BHRUT and Homerton Healthcare have been working ever closer over the past year – focussed on reducing elective waits, but also exploring and developing further integrated working arrangements. Work is underway to develop terms of reference for a new Joint Committee of the ICB and acute providers; planned to be established in the first quarter of 2023/24.

Quality, Safety and Improvement Committee

The Quality, Safety and Improvement Committee is a sub-committee of the ICB Board. It provides assurance to the ICB Board that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality, and as enshrined in law by National Health Service Act 2006 (as amended by the Health and Care Act 2022). The Committee exists to scrutinise the robustness of, and gain and provide assurance to the Board that there is an effective system of quality governance and internal control that supports the ICB to effectively deliver its strategic objectives and provide sustainable, high quality care.

The duties of the Committee are to:

- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.
- Agree and put forward for Board approval the key quality priorities that are included within the ICB's Joint Forward Plan and the North East London (NEL) Integrated Care Partnership's Integrated Health and Care Strategy and be assured of their delivery. The Committee will contribute to the development of those plans/strategies, as appropriate and relevant to quality matters.
- Be assured of the delivery of the ICB's statutory duties relating to Quality.
- Review and monitor such risks on the Board Assurance Framework and Corporate Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.
- Inform and assure the Committee, that relevant Quality related national and regional guidance/ legislation has been reviewed and relevant actions have been undertaken.
- Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes, across NEL, at Place, within programmes, at Provider Collaboratives, supporting the development of one system approach to quality improvement.

- Receive assurance that the ICB has continuous regard to ensuring and improving its systems and processes to maintain patient safety, including identifying lessons learned from all relevant sources including: incidents; never events; complaints and claims; and ensure that learning is disseminated and embedded across the ICS.
- Receive updates in relation to any investigations relevant to matters in the purview of the Committee.
- Insofar as relates to quality matters, approve and oversee the adaption of legacy policies for use across the ICB until new policies are developed.
- Receive thematic updates regarding learning from Quality matters across NEL i.e. learning from deaths, complaints, serious incidents and PFD reports.
- Be assured that people receiving services are systematically and effectively involved as equal partners in quality activities.
- Approve Terms of Reference and work programmes for, any groups reporting into the Committee.

The membership and attendance record of the Quality, Safety and Improvement Committee is outlined in the table below.

Name of Committee member	12 Oct. 2022	7 Dec. 2022	12 Feb. 2023	Total attended /total possible
Imelda Redmond CBE, Non-executive member, NHS North East London - Chair	✓	✓	✓	3/3
Marie Gabriel CBE, Non-executive member, NHS North East London	✓	✓	X	2/3
Fiona Smith, Associate non-executive member, NHS North East London	✓	✓	✓	3/3
Dr Jagan John, Primary care partner member	✓	✓	X	2/3
Councillor Maureen Worby, Local Authority partner member	✓	✓	X	2/3
Mamta Vaidya, NHS Trust partner member	N/A	N/A	X	0/1
Diane Jones, Chief Nursing Officer, NHS North East London	✓	✓	✓	3/3
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	✓	✓	X	2/3
Charlotte Pomery, Chief Participation and Place Officer, NHS North East London	N/A	✓	✓	2/2

The meeting is also attended regularly by:

- Chetan Vyas - Director of Quality Development, NHS NEL
- Mark Gilbey-Cross – Director of Nursing, NHS NEL
- Korkor Ceasar - Associate Director, Children's Safeguarding, NHS NEL
- Celia Jeffreys - Associate Director, Safeguarding Adults, NHS NEL
- Moira Coughlan - Deputy Director for Screening, Prevention and Vaccination, NHS NEL
- Philippa Cox - Assistant Director of Maternity Programmes, NHS NEL

The following key topics were discussed by the Committee in 2022/23:

- Terms of Reference.
- Quality Exception Reports
- Local Maternity & Neonatal Services
- Immunisations and Screening
- Urgent Treatment Care Pathways
- Quality at Place
- Strategic risk register

Some of the areas that the committee requested more detailed reports on in the form of 'deep dives' were: Resident Access to Urgent and Emergency Care and CQC Assessment of Integrated Care.

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Willingness from members to learn from feedback
- Good representation from different partners

Areas for improvement:

- Developing a forward plan that adds value and allows a focus on improvement
- Defining the system's key quality issues

Workforce and Remuneration Committee

The Workforce and Remuneration Committee is responsible for shaping and approving the ICB's internal People and Culture Strategy, assuring the implementation of the Integrated Care System People Plan and for overseeing the delivery of the ICS Workforce Strategy. The committee determines all aspects in regard to pay and remuneration for employees of the ICB, in particular very senior staff.

The duties of the Committee are to:

- Determine the ICB's remuneration/pay policy and standard terms and conditions.
- Determine the ICB's pay policy

- Make decisions on the remuneration and conditions of service in regard to ICB board members and very senior managers (VSM) managers.
- Appointment, Appraisal and board succession planning.
- Have responsibility for the workforce priority on behalf of the ICS. This includes creating meaningful employment for the local population across north east London. Creating a 'One NEL' workforce across Health and Social Care which contributes to creating a healthy community and creates a set of working environments in which a diverse and inclusive workforce can work and develop their careers.

The membership and attendance record of the Workforce and Remuneration Committee is outlined in the table below.

Name of Committee member	**1 July 2022**	**20 July 2022**	**19 Oct 2022**	**5 Dec 2022**	**22 Feb 2023**	**Total attended /total possible**
Diane Herbert, Chair and Non-executive member, North East London ICB	✓	X	✓	✓	✓	4/5
Marie Gabriel CBE, Chair of NHS North East London and North East London Health and Care Partnership	✓	✓	✓	✓	✓	5/5
Fiona Smith, Associate non-executive member (*Member until August 2022)*	✓	✓	N/A	N/A	N/A	2/2
Sue Evans, Associate non-executive member *(from February 2023)*	N/A	N/A	N/A	N/A	✓	1/1
Noah Curthoys, Associate non-executive member	✓	✓	✓	✓	✓	5/5
Dr Mark Rickets, Primary care partner member	N/A	N/A	✓	✓	X	2/3
Will Tuckley, Local authority Partner member	N/A	N/A	X	✓	X	1/3
Daniel Waldron, Trust partner member	N/A	N/A	N/A	N/A	✓	1/1

The meeting is also attended regularly by:

- Zina Etheridge – Chief Executive Officer, NHS North East London
- Francesca Okosi - Chief People and Culture Officer, NHS North East London
- Jennifer Burton - Interim Head of HR, NHS North East London

The following key topics were discussed by the Committee in 2022/23:

- Development of the ICS workforce strategy
- ICB re-structure
- Speak up Guardian
- Clinical care leader population

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Effective leadership and good Chairing
- Good cross section of expertise and representation of system members

Areas for improvement:

- Increased oversight of the workforce strategy to enable straight forward things
- Reports should be written to a high level with less intricate detail

Non-Executive Member Remuneration Committee

The Non-executive Remuneration Committee has a limited role for the special purpose of:

- considering the remuneration of non-executive members of the ICB and associate non-executive members.

The inaugural meeting of this committee was held on 1 July 2022. A further meeting during 2022/23 has not been required. Since the inaugural meeting on 1 July 2022, the Terms of Reference have been reviewed and the membership has changed and now includes a local authority partner member. The next meeting of the committee with its revised membership is scheduled for July 2023

The membership and attendance record for the meeting held on 1 July 2022 is outlined in the table below.

Name of Committee member	1 July 2022	Total attended /total possible
Marie Gabriel CBE, Committee Chair and Chair of NHS North East London and North East London Health and Care Partnership	✓	1/1
Zina Etheridge, Chief Executive, NHS North East London	✓	1/1

Paul Calaminus, Trust partner member	✓	1/1
Shane DeGaris, Trust partner member	✓	1/1
Dr Mark Rickets, Primary care partner member	✓	1/1

The meeting is also attended regularly by:

- Francesca Okosi - Chief People and Culture Officer, NHS North East London
- Jennifer Burton - Interim Head of HR, NHS North East London

The following key topics were discussed by the Committee at its meeting on 1 July 2022:

- Remuneration for NHS North East London non-executive members
- Remuneration for NHS North East London associate non-executive members.

North East London Integrated Care Partnership

The North East London Integrated Care Partnership (ICP) is a statutory joint committee that brings together a broad alliance of organisations concerned with improving the care and health and wellbeing of the population of North East London. Alongside the Integrated Care Board, the ICP gives a statutory underpinning to the North East London Health and Care Partnership. Additionally, the ICP has a role in the relation to the Place-Based Partnership arrangements established in the seven places across North East London.

The duties of this joint committee are to:

- Meet the five expectations of integrated care partnerships. It shall:
    - Drive the direction and policies of the ICS;
    - Be rooted in the needs of people, communities and places;
    - Create a space to develop and oversee population health strategies to improve health outcomes and experiences;
    - Support integrated approaches to subsidiarity;
    - Take an open and inclusive approach to strategy development and leadership, involving communities and partners, and utilising local data and insights.
- Develop an integrated care strategy which sets out how assessed needs in relation to its area are to be met by the exercise of functions of the ICB, NHS England and/or the eight local authority partner organisations.
- Have a lead role in co-ordinating partners to develop the Strategic Priorities of the ICS.
- Make recommendations to the partners of the ICS on the development and refinement of the North east London ICS Operating Principles.
- Address key system issues and:
    - Focus on facilitating agreement between partners on key health and well-being issues and responses;

- Identify key outcomes and ensure the experience of service users and patients remain at the centre;
- Set the culture and tone for the ICS through leading by example;
- Openly discuss difficult issues with a focus on what is best for the North East London population;
- Provide constructive challenge to the established ways of working;
- Ensure that the needs of people, places and communities are widely understood.

The membership and participant record of the North East London Integrated Care Partnership (ICP) is outlined in the table below.

Name of Committee member	23 Nov 2022	11 Jan 2023	Total attended / total possible
Marie Gabriel CBE, Chair	✓	✓	2/2
Zina Etheridge, Chief Executive, NHS North East London	✓	✓	2/2
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	✓	✓	2/2
Johanna Moss, Chief Strategy & Transformation Officer, NHS North East London	✓	✓	2/2
Eileen Taylor, *Chair, East London Foundation Trust	✓	✓	2/2
Sultan Taylor, *Interim Chair, North East London Foundation Trust	✓	N/A	1/1
Sir John Gieve, Chair, Homerton Healthcare	✓	✓	2/2
Rt Hon Jacqui Smith, Chair, Barts Health and BHR Hospitals Trust	✓	✓	2/2
Councillor Maureen Worby, London Borough of Barking & Dagenham	x	✓	1/2
Councillor Mary Durcan, London Borough of City of London	✓	x	1/2
Councillor Christopher Kennedy, London Borough of Hackney	✓	✓	2/2
Councillor Gillian Ford, London Borough of Havering	✓	✓	2/2
Councillor Neil Wilson, London Borough of Newham	✓	✓	2/2
Councillor Mark Santos, London Borough of Redbridge	✓	✓	2/2
Councillor Gulam Choudhury, London Borough of Tower Hamlets	x	x	0/2
Councillor Naheed Asghar, London Borough of Waltham Forest	✓	✓	2/2
Pip Salvador-Jones, VCSE rep, Barking & Dagenham	x	x	0/2
Tony Wong, VCSE rep, Hackney	x	✓	1/2
Paul Rose, VCSE rep, Havering	✓	x	1/2

Name of Committee member	23 Nov 2022	11 Jan 2023	Total attended / total possible
Caroline Rouse, VCSE rep, Newham	x	x	0/2
Jenny Ellis, VCSE rep, Redbridge	✓	x	1/2
Peter Okali, VCSE rep, Tower Hamlets	x	N/A	0/1
Vicky Scott, VCSE rep, Tower Hamlets	N/A	x	0/1
Manisha Modhvadia, Healthwatch, Barking & Dagenham	x	✓	1/2
Rachel Cleave, Healthwatch, City of London	✓	✓	2/2
Catherine Perez Philips, Healthwatch, Hackney	✓	✓	2/2
Ian Buckmaster, Healthwatch, Havering	✓	✓	2/2
Veronica Awuzudike, Healthwatch, Newham	✓	✓	2/2
Cathy Turland, Healthwatch, Redbridge	x	x	0/2
Matthew Adrienne, Healthwatch, Tower Hamlets	✓	✓	2/2
Dianne Barham, Healthwatch, Waltham Forest	✓	✓	2/2

* *Eileen Taylor became joint Chair of East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) with effect from 1 January 2023*

Meetings are usually open to the public however the first meeting held in November 2022 was held as a development session and was not held in public.

The meeting was also attended regularly by:

- Charlotte Pomery, Chief Participation and Place Officer, NHS NEL
- Marie Price, Director of Communication and Involvement, NHS NEL
- Hilary Ross, Director of Strategic Development, NHS NEL

The following key topics were discussed by the North East London Integrated Care Partnership in 2022/23:

- Role and purpose of the partnership and how it works as a system
- Population health profile
- Development and approval of the interim integrated care partnership strategy
- Development of the joint forward plan

Committee effectiveness review

Comments were received from members on what they felt had gone well this year and what could be improved.

Things that went well:

- Broad membership allowed for good debate and challenge.
- Meetings well attended from all sectors

Areas for improvement:

- Holding a meeting in person would enable relationships to be built on further and engage the audience more effectively
- The membership could reflect the population better in terms of diversity

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.
Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the ICB's compliance with the principles set out in the Code (insofar as this applies to ICBs).

Discharge of Statutory Functions

North East London ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Chief Officer. Departments have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The ICB recognises that the establishment of effective risk management systems is fundamental to ensuring effective governance. The ICB has a risk management assurance framework in place, the aim of which is to continually improve the quality of an integrated health service through the identification, prevention, control and containment of risks of all kinds. It is based on good practice and Department of Health (DH) guidance. The framework supports the assessment and management of risk throughout the organisation through a defined structure and clear systems and processes. It applies to all members, office holders and employees, permanent or temporary, of the ICB.

Capacity to Handle Risk

The Chief Executive Officer provides leadership to the risk management process and, as a member of the ICB Board, ensures that the ICB's approach to risk management is transparent and the organisational structure supports effective systems and processes. The management of risk across each department is led and reported by the relevant Chief Officer with support from the corporate services team. Chief Officers are involved in regular reviews of the risk register and the assurance framework. The Chief Participation and Place Officer presents the Board Assurance Framework (BAF) to each ICB Board meeting. Training is key to encouraging a culture where risk management is seen by the ICB Board members and our staff as essential. Presentations on counter fraud have been provided for all members of staff by the counter fraud officer.

Risks are explicitly discussed and mitigations reviewed at the following meetings which include partners from across the ICS:

- Executive management team meetings
- Finance, performance and investment committee
- Quality, safety and improvement committee
- Population Health and Integration committee
- Audit and risk committee
- ICB Board

The process in place ensures that there are regular forums to collaboratively review the common risks, raise new risks, discuss and constructively challenge the effectiveness of the mitigating actions and suggest changes as appropriate.

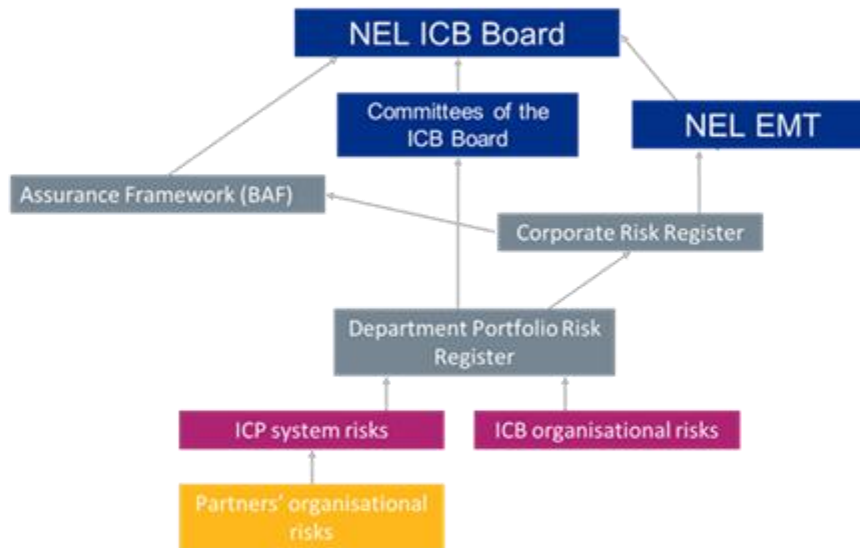
Risk Assessment

The key risks for the ICB during July 2022 – March 2023 have been aligned to the four ICS priorities. The ICB monitors risks closely, as described within the governance statement in this report. The risks on the BAF for the past year related to the following:

- Collaborative working across partners
- Wider determinants of health/environment
- Quality and safety of care
- Delivery against control total and operating plan
- Workforce challenges
- Population growth and impact on services
- Mutual accountability for system wide commitments
- Digital and estates capacity and infrastructure
- Anti-racist commitment

- Being outward rather than inward looking

The risk management structure of the ICB is shown below:



The risk management structure shows the links between the operational level risks at department level, and the strategic risks which are managed at senior organisational or ICB Board level.

Risks are identified in various ways:

- Proactive risk assessments
- Incident reports (including serious incidents and never events)
- Complaints
- Audits
- Serious case reviews
- Feedback from Healthwatch, the patient engagement groups and Health Scrutiny Committees
- Service improvement programmes
- General stakeholder feedback

Risk management is embedded in the organisation in a number of ways. The BAF is presented to every ICB Board meeting to provide context for items related to finance, quality, performance, and strategy.

Declarations of conflicts of interest features at the start of each Board meeting and the register of interests is included at the start of the agenda and within the pack. The register of interests is reviewed periodically by the Audit Chair and a smaller working group of governance and legal officers.

All reports to the Board, Audit and Risk Committee and other committees require a cover sheet which asks document authors to consider the following:

- Risk implications
- Impact on equality, finance and performance
- Impact on local people, health inequalities and sustainability

The risk management policy and strategy are available on the ICB's website, together with policies in relation to standards of business conduct, conflicts of interest, gifts and hospitality, freedom to speak up and fraud prevention.

Risks were discussed with the Chief Officers' Risk Champions bi-monthly and at the ICB's executive management meeting.

Based on criteria set out in the risk management policy and the current risk rating, significant risks are escalated from the corporate risk register to the BAF. Some of the risks that are rated as severe (red rated) are escalated to the BAF where that risk is deemed to pose a significant threat to the achievement of the ICS's strategic objectives. When rating risks, other factors are also taken into consideration, such as whether they are common to a number of departments/functions or where additional controls have not succeeded in reducing the risk grading.

The risk management scoring system is used systematically in each review of the risk register. This ensures that risks are escalated appropriately to the BAF. Risks escalated to the BAF are reviewed with the relevant Chief Officer prior to Board meetings. There is also a yearly audit of our BAF and risk management processes undertaken by the ICB's internal auditors which checks our adherence to policy and best practice.

The Audit and Risk Committee periodically reviews the management process that is in place for the management of risks and receives reports on specific emerging risks and risk mitigation. The organisation's 'risk appetite' is captured for each risk on the BAF.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework. Our internal auditors RSM have completed this audit for the most recent year (2022/23) and gave a rating of substantial assurance. The policy for managing conflicts of interest, building on the good practice and experience within the ICB, is included in the ICB's Governance Handbook.

Data Quality

Data is provided from a range of sources – through our in-house teams and NHS England. There have been no issues of concern raised, however as we progress we look to develop more sophisticated integrated data to support our place-based partnerships and provider collaboratives to succeed.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training. There are processes in place for

incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report. No business critical models have been identified that require information about quality assurance processes for those models to be provided to the Analytical Oversight Committee chaired by the Chief Analyst in the Department of Health and Social Care.

Third party assurances

From 1 July 2022, the ICB and other London ICBs brought many former London Shared Services (LSS), in house. Many services, including contracting, business intelligence and medicines optimisation are now managed within the ICB. Where services are still shared, but hosted by a single organisation, activities are reviewed and monitored through a London wide board. The ICB still contracts for its financial accounting systems with NHS Shared Business Services. The service standards and performance are monitored as part of a service level agreement and the Audit and Risk Committee receives an annual service auditor report on these contracted-for services.

Control Issues

There are no significant control issues currently facing the ICB.

Review of economy, efficiency and effectiveness of the use of resources

The ICB has a comprehensive governance and reporting framework in place to monitor use of resources, identify any issues and ensure the appropriate measures are taken to address any variance from plans. The board receives regular summary reports concerning the ICB's financial performance, and the finance committee has authority to conduct more detailed scrutiny and report back.

The Finance, Performance and Investment Committee convenes regularly to scrutinise the detailed operational financial performance of the ICB.

The Audit and Risk Committee is chaired by the board's Non-executive Member for Governance with additional non-executive membership. The Committee performs the role of oversight and scrutiny of ICB policies, procedures and systems of internal control, and had a focus on ensuring that conflicts of interest are managed in line with the ICB's Constitution.

Underpinning the ICB's governance framework are the Prime Financial Policies, which set out the key business rules that govern the organisation, including internal control, audit, standards of business conduct and budgetary control. They also incorporate the scheme of delegation. This sets out the level of authority to act and make decisions, which has been delegated from the board to the various executive committees, in addition to the authorisation limits set by the board for the management posts within the organisation to authorise expenditure.

Delegation of functions

ICBs were not permitted to delegate any functions externally over the past year. In establishing the new governance arrangements for the organisation and system we have worked with internal and external stakeholders to design governance arrangements that will safely support delegation in future – as intended by the new legislation that established ICBs and which put ICSs and ICPs on a statutory footing.

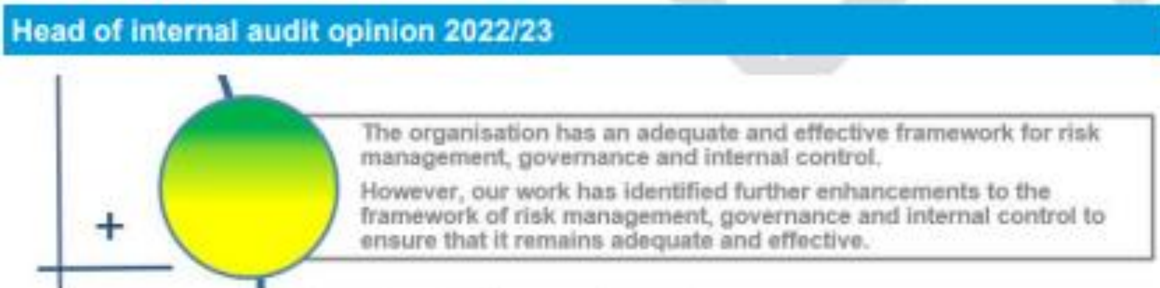
Counter fraud arrangements

An Accredited Counter Fraud Specialist, RSM UK, is contracted to undertake counter fraud work proportionate to identified risks.

- The ICB Audit and Risk Committee receives a report against each of the 'Standards for Commissioners' at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.
- Regular reports are presented to the ICB's Audit and Risk Committee with progress against the work plan, updates on cases and policy updates.
- A member of the board is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period July 2022 to March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:



During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
IR 35	Partial Assurance
Continuing Healthcare follow-up	Little progress
Procurement and Contracts Register	Partial Assurance
Medicines Optimisation	Partial Assurance
Financial Ledger – Transfer of Balances	Substantial Assurance
Conflicts of Interest	Substantial Assurance
Data Security and Protection Toolkit	Substantial Assurance
Primary Care Commissioning	Reasonable Assurance
Governance and Risk Management	Reasonable Assurance
Healthcare Financial Management Association Financial Sustainability checklist	Advisory review
Delegated Duties – Dental, Optometry and Pharmacy	Advisory review

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on

performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.
I have been advised on the implications of the result of this review by:

- The board
- The audit and risk committee
- Internal audit

Conclusion
No significant internal control issues have been identified.

Remuneration and Staff Report

Remuneration Report

Please see the previous section for details on the Remuneration and Workforce Committee.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in NHS North East London in the financial period ending 31 March 2023 was £245k to £250k.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022/23	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	42,471	58,051	75,394
Salary component of total remuneration (£)	42,471	58,051	75,394
Pay ratio information	5.83	4.26	3.28

During the reporting period 2022/23, 0 employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £0 to £5k and £245k to £250k. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

The NHS has adopted the recommendations outlined in the Greenbury report in respect of the disclosure of senior managers' remuneration and the manner in which it is determined. Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the ICB. This means those who influence the

decisions of the ICB as a whole rather than the decisions of individual directorates or departments. This report outlines how those recommendations have been implemented by the ICB

The remuneration of senior managers is determined by the Remuneration and Workforce Committee in line with national NHS 'Agenda for Change' and very senior manager pay guidance. The Committee reviews information about director and board member responsibilities, as well as comparing remuneration in similar organisations to set pay. In addition there is a Non-executive Remuneration Committee has a limited role for the special purpose of considering the remuneration of non-executive members of the ICB and associate non-executive members.

Remuneration of Very Senior Managers

During July to April, seven very senior managers combined salary was more than £150,000 per annum (the salary of the prime minister). The chief executive's pay was determined by NHS England and discussed through the former CCG's Remuneration Committee in line with national guidance in 2021/22. In establishing the new Integrated Care Board, a smaller executive team, including mandated board roles was appointed to. The overall number of executive directors to that of the former CCG was reduced, and a smaller team of chief officers with broader portfolios and departments established. The salaries were set in line with ICB executive pay guidance issued by NHSE and agreed by the ICB's Remuneration and Workforce Committee. Salary levels are benchmarked and in line with equivalent roles.

Senior manager remuneration (including salary and pension entitlements) – subject to audit

	2022/23					
Name and Title	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5000)	All Pension related benefits (bands of £2,500) ^	Total (bands of £5,000)
	£000s	£s	£000s	£000s	£000s	£000s
Marie Gabriel Chair 01/07/2022 - 31/03/2023	50 - 55	0	0	0	n/a	50 - 55
Zina Etheridge Chief Executive Officer 01/07/2022 - 31/03/2023	185 - 190	0	0	0	42.5 - 45	230 - 235
Rajiv Jaitly Non-executive Member for Audit 01/07/2022 - 07/09/2022	0 - 5	0	0	0	n/a	0 - 5
Sue Evans Non-executive Member for Audit (Interim) 08/09/2022 - 31/01/2023	5 - 10	0	0	0	n/a	5 - 10
Cha Patel # Non-executive Member for Audit 12/12/2022 - 31/03/2023	5 - 10	0	0	0	n/a	5 - 10

Diane Herbert Non-executive Member for Remuneration and Workforce 01/07/2022 - 31/03/2023	10 - 15	0	0	0	n/a	10 - 15
Imelda Redmond CBE Non-executive Member for Quality 01/07/2022 - 31/03/2023	10 - 15	0	0	0	n/a	10 - 15
Dr Paul Gilluley Chief Medical Officer 01/07/2022 - 31/03/2023	160 - 165	0	0	0	85 - 87.5	245 - 250
Diane Jones Chief Nursing Officer 01/07/2022 - 31/03/2023	110 - 115	0	0	0	62.5 - 65	175 - 180
Henry Black Chief Finance and Performance Officer 01/07/2022 - 31/03/2023	115 - 120	0	0	0	22.5 - 25	140 - 145
Charlotte Pomery Chief Participation and Place Officer 01/07/2022 - 31/03/2023	110 - 115	0	0	0	15 - 17.5	125 - 130
Francesca Okosi Chief People and Culture Officer 01/07/2022 - 31/03/2023	110 - 115	0	0	0	30 - 32.5	140 - 145
Johanna Moss Chief Strategy and Transformation Officer 24/10/2022 - 31/03/2023	65 - 70	0	0	0	20 - 22.5	85 - 90

Dr Jagan John Partner member (Primary care) 01/07/2022 - 31/03/2023	10 - 15	0	0	0	n/a	10 - 15
Dr Mark Rickets Partner member (Primary care) 01/07/2022 - 31/03/2023	10 - 15	0	0	0	n/a	10 - 15
Paul Calaminus* ELFT Partner member (NHS trusts and foundation trusts) 01/07/2022 - 31/03/2023						
Shane De Garis* Barts/BHRUT Group Partner member (NHS trusts and foundation trusts) 01/07/2022 - 31/03/2023						
Councillor Maureen Worby* London Borough of Barking & Dagenham Partner member (Local Authority) 20/07/2022 - 31/03/2023						
Mayor Philip Glanville* London Borough of Hackney Partner member (Local Authority) 20/07/2022 - 31/03/2023						
Caroline Rouse* Partner member (Voluntary, community and social enterprise sector) 01/08/2022 - 31/03/2023						

* Partner Member of the ICB Board for whom no costs are incurrred by the ICB

^ Pension Related Benefits reflect a proportion of the full increase for the year ended 31 March 2023.

Induction Period 12/12/2022 - 31/01/2023

Pension benefits of senior managers as at 31 March 2023 - subject to audit

The following schedule discloses further information regarding pension entitlements

Name & Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31st March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1st July 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31st March 2023	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Zina Etheridge	2 - 2.5	0	5 - 10	0	21	18	65	0
Diane Jones	2 - 2.5	2.5 - 5	40 - 45	65 - 70	663	56	750	0
Dr Paul Gilluley	5 - 7.5	5 - 7.5	80 - 85	160 - 165	1,439	89	1,583	0
Henry Black	2 - 2.5	0	40 - 45	65 - 70	621	14	665	0
Charlotte Pomery	0 - 2.5	0	0 - 5	0	0	7	30	0
Francesca Okosi	0 - 2.5	0	15 - 20	0	229	24	285	0
Johanna Moss	0 - 2.5	0 - 2.5	40 - 45	65 - 70	546	13	596	0

The ICB was only able to obtain information for pension entitlements for the period ending 31 March 2023. As a result estimated values for CETV as at 1 July 2022 have been calculated incorporating a proportion of the increase during 2022-23; this is considered to be reasonable approximation for the values reported for 1 July 2022. The real increases in pension and lump sum have been calculated as a proportion of the full increase for the year ended 31 March 2023.

Note: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office

No compensation on early retirement for loss of office was made during the financial year.

Payments to past directors

No payments were made to past directors during the financial year.

Staff Report

Number of senior managers

Senior Manager	Head Count
Band 9 + Clinical Lead	129
Consultant Lead	1
VSM	14
Total	144

Staff costs

	Total Permanent Employees £'000	Other £'000	2022-23 Total £'000
Employee Benefits			
Salaries and wages	38,056	10,033	**48,089**
Social security costs	4,712	84	**4,796**
Employer contributions to the NHS Pension Scheme	6,528	88	**6,616**
Other pension costs	6	-	**6**
Apprenticeship Levy	198	-	**198**
Termination benefits	673	-	**673**
Total employee benefits expenditure	**50,173**	**10,205**	**60,378**

Staff composition

Employee group

NEL ICB	Female	Male	Total
NEL ICB Employees	599	394	993
NEL ICB office holders - (engaged to provide specific roles but not engaged on contracts of employment e.g. clinical leads)	79	46	125
Total	**678**	**440**	**1118**

Gender

Gender	Head Count
Female	**599**
Male	**394**
Total	**993**

Declared disability

Disability Flag	Headcount
No	**774**
Not Declared	**107**
Prefer Not To Answer	**20**
Unspecified	**36**
Yes	**56**
Grand Total	**993**

Ethnicity

Ethnic Group	Headcount
A White - British	334
B White - Irish	21
C White - Any other White background	35
C2 White Northern Irish	2
CA White English	14
CB White Scottish	3
CC White Welsh	1
CF White Greek	1
CK White Italian	2
CN White Gypsy/Romany	2
CP White Polish	2
CS White Albanian	1
CX White Mixed	1
CY White Other European	7
D Mixed - White & Black Caribbean	11
E Mixed - White & Black African	5
F Mixed - White & Asian	4
G Mixed - Any other mixed background	10
GA Mixed - Black & Asian	2
GC Mixed - Black & White	2
GD Mixed - Chinese & White	1
GF Mixed - Other/Unspecified	4
H Asian or Asian British - Indian	83
J Asian or Asian British - Pakistani	24
K Asian or Asian British - Bangladeshi	62
L Asian or Asian British - Any other Asian background	14
LB Asian Punjabi	7
LC Asian Kashmiri	1
LD Asian East African	2
LF Asian Tamil	3
LH Asian British	4
LK Asian Unspecified	3
M Black or Black British - Caribbean	44

N Black or Black British - African	82
P Black or Black British - Any other Black background	4
PA Black Somali	1
PC Black Nigerian	5
PD Black British	27
PE Black Unspecified	1
R Chinese	10
S Any Other Ethnic Group	8
SA Vietnamese	1
SC Filipino	4
SD Malaysian	1
SE Other Specified	5
Unspecified	25
Z Not Stated	107
Grand Total	**993**

Religion

Religious Belief	Headcount
Atheism	127
Buddhism	6
Christianity	335
Hinduism	52
Islam	117
Jainism	3
Judaism	9
Not Disclosed	223
Other	59
Sikhism	25
Unspecified	37
Grand Total	**993**

Age

Age Band	Headcount
<=20 Years	2
21-25	20
26-30	70
31-35	128
36-40	171
41-45	169
46-50	128
51-55	130
56-60	114
61-65	50
66-70	7
>=71 Years	4
Grand Total	**993**

Sexual orientation

Sexual Orientation	Headcount
Bisexual	14
Gay or Lesbian	37
Heterosexual or Straight	738
Not Disclosed	165
Other sexual orientation not listed	1
Undecided	1
Unspecified	37
Grand Total	**993**

Sickness absence data

	Average FTE for 2022	Average Annual Sick Days per FTE	Sum of FTE Days Sick	Sum of FTE Days Available
North East London ICB	813	4.8	4,203	197,844

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2022

NHS Digital Statistics

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Staff turnover percentages

	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09	2022 / 10	2022 / 11	2022 / 12	2023 / 01	2023 / 02	2023 / 03
Turnover Rate (Headcount)	1.18%	1.31%	1.31%	1.57%	2.35%	1.31%	1.57%	1.31%	2.09%	1.05%	0.52%	1.18%

Staff policies and support

The ICB continued with a developmental programme of work to create a more compassionate, inclusive and collaborative environment, where people can bring their whole selves to work create meaningful improvements in health, wellbeing and equality for the people of north east London.

Reverse mentoring

The ICB launched and ran a second round of reverse mentoring where a person in a senior position is mentored by someone in a more junior position; giving senior staff insight into what it is like to be working at our organisation with a protected characteristic, with mentors sharing their lived experience of this. The relationship provides a space for staff to explore areas of good practice and generate ideas and priorities for improving inclusion and equity in the organisation. This round saw 20 new pairs matched and meet in a reverse mentoring relationship for six months, with all members of the senior team being mentored. Learning from the evaluation with evidence impact and steer next steps for this important intervention.
Staff support programme as part of our organisational restructure

To support people through our organisational restructure and consultation we commissioned training and support for staff and managers to equip them with the skills and knowledge to undertake consultation and selection well, support and manage mental wellbeing, build resilience and equip people to move forward successfully during this period of transition.
The mental wellbeing for all programme supported staff to be more aware of and manage their own wellbeing, with managers undertaking a second session to enable them to discuss mental wellbeing with their teams, how to spot if a team member is showing signs of mental distress and what to do if that is the case. Skills based training for leaders focussed on managing teams through organisational change and for all staff, selection skills including CV, application writing and interview skills, aims to ensure people are well equipped to undertake change processes, with support about how to make the best decision for them.

Staff wellbeing support and resources

Our 'one stop shop' staff wellbeing hub, brings together the most important and impactful resources to enable and support the wellbeing of staff, including links and resources to support people with the rising cost of living. KeepingWellNEL provides confidential, independent and inclusive wellbeing support, advice and resources to health and care staff across north east London. With a holistic approach the service supports wellbeing in ways that are most reflective of people's needs, with wellbeing advisors available 8am-8pm Monday-Saturday Keeping Well Nel.

Always learning

We continue to support staff with access to the range of interactive webinars, virtual workshops and learning resources, across topics and themes, through NHS Elect and promote the best learning opportunities available externally through partners such as the NHS Leadership Academy, King's Fund and local training hubs.

We have a number of staff completing coaching apprenticeships; equipping them with the skills to support experiential learning so vital in changing and complex environments and seeing them develop their coaching practice, as well as supporting people in the organisation with coaching opportunities.

With a current focus on supporting people with the skills and resources to undertake and manage organisational change well, we then plan to focus on establishing a learning and development approach that supports our organisation and our people to be successful now and into the future, with a clear priority around equality of opportunity and access to learning and development.

Staff engagement

72% of staff responded to the 2022 staff survey. Working with staff and senior leaders, we are establishing a set of priority improvements that can be undertaken quickly to improve staff experience, as well as working with our survey provider to understand the areas that have the biggest impact on staff experience, giving us a thematic focus to design changes with staff that matter most to them.

Staff networks

Our staff networks have been formed to find innovative solutions to systemic problems, further our organisational commitment to equality and diversity, discuss issues affecting staff with senior leaders and provide a safe space for people to raise their concerns. Having been established for a over two years, the networks continue to develop and build their areas of focus, with events, resources and training across a range of topics and activities for important national campaigns, observances and celebrations including LGBTQ+, Black History and Disability History Months.

Guardian service

A new independent and confidential Freedom to Speak up Guardian Service was launched at the beginning of 2023, available for any members of staff to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment, and work grievances. Available 24/7, the service provides information and emotional support in a strictly confidential, non-judgemental manner and in an off-the-record discussion. As an alternative and impartial way to

speak up and be supported with next steps, the service works with the organisation to address the concerns and incidents raised. it is also assisting in thinking through a system approach to F2SU as we work towards more integrated teams.

Hybrid working

Our hybrid working and estates working group is focussing on how we use our office estate and the development of our hybrid working model. With representatives from across the organisation and our staff networks, the group has recently focussed on using space effectively, developing our desk booking system and improving our IT infrastructure.

Our hybrid working model will continue to develop, with a focus on culture and best practice ways of working to support people to work well and effectively for the people of north east London.

Staff policies

Following work by the former CCG a number of staff policies including Pay Protection and Organisational Change Policies were revised with input from Trade Union, staff network and management representatives. These provide greater equity and consistency acrpss the organisation, with a focus on ensuring more inclusive language and processes to ensure improvements of experiences for staff and potential candidates who have protected characteristics. This work has been important given the nationally mandated management savings for ICBs, and subsequent all-staff consultation launch proposing a new structure including a reduction in headcount.

Improvements to recruitment and selection processes and practices continue. These are include improving access and experience for disabled candidates through the recruitment process. We offer interviews to all disabled applicants, providing their application scores sufficiently highly against the essential criteria for the job.

Trade Union Facility Time Reporting Requirements

Percentage of pay bill spent on facility time

	£000's
Provide the total cost of facility time	12

	£000's
Provide the total pay bill	60,378
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	12.5%

Other employee matters

NHS London Shared Service consulted its staff on a move to other NHS organisations in London. The 30-day consultation launched on 26 April for staff at NHS London Shared Service (formerly NEL CSU), who were consulted on their proposed assignment to four London CCGs and other receiving organisations in London. The consultation concluded on 26 May 2022. The mechanism of transfer for LSS staff to their receiver organisations was a combination of Transfer Scheme, TUPE and COSOP (also known as TUPE-like), underpinned by the overarching principles of an employment commitment for all and protection of employment, which guided the consultation. Staff joined the new organisation in July, but were engaged as much as possible in advance of the transfer.

Expenditure on consultancy

Consultancy expenditure in 2022-23 was £1,087k.

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2023 for more than £245* per day:

	Number

Number of existing engagements as of 31 March 2023	94
Of which, the number that have existed:	
for less than one year at the time of reporting	94
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The ICB confirms that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 July 2022 and 31 March 2023, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	162
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	152
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	10
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements.	15

Exit packages, including special (non-contractual) payments

Exit package cost band (inc. any special payment element)	Compulsory redundancies	
	Number	£s
£10,000 - £25,000	1	14,861
£150,001 - £200,000	2	320,000
TOTALS	3	334,861

This table reports the number and value of exit packages agreed in the financial period. No special payments were made. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Compulsory Redundancy Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there was one ill health early retirement during the reporting period, cost £107,058.

Parliamentary Accountability and Audit Report

NEL ICB is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report at page 51. An audit certificate and report is also included in this Annual Report at page 124.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS NORTH EAST LONDON INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS North East London Integrated Care Board ("the ICB") for the nine month period ended 31 March 2023 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of the anti-fraud and bribery policy as to the ICB's high-level policies and procedures to prevent and detect fraud as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We also identified a fraud risk related to the completeness and accuracy of expenditure as the requirement to meet a revenue resource limit may create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual account combinations and journals adjusting the split between admin/programme functions.
- Evaluating the business purpose of significant unusual transactions.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Assessing the completeness and accuracy of accruals recognised before and after the year end period to unsure they are recorded in the correct period.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board (as required by auditing standards), and from inspection of the ICB's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the regulated nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial period is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 53, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 53, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS North East London Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS North East London ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Dean Gibbs
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square

29 June 2023

ANNUAL ACCOUNTS

Zina Etheridge

Accountable Officer

23 June 2023

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the period ended 31st March 2023	131
Statement of Financial Position as at 31st March 2023	132
Statement of Changes in Taxpayers' Equity for the period ended 31st March 2023	133
Statement of Cash Flows for the period ended 31st March 2023	133

Notes to the Accounts:

Accounting Policies	134
Other Operating Revenue	139
Revenue	129
Employee Benefits and Staff Numbers	139
Operating Expenses	141
Better Payment Practice Code	142
Finance Costs	142
Net Loss on Transfer by Absorption	142
Property, Plant and Equipment	143
Intangible Non-current Assets	143
Leases	144
Trade and Other Receivables	145
Cash and Cash Equivalents	145
Trade and Other Payables	145
Provisions	146
Contingencies	146
Financial Instruments	147
Related Party Transactions	148
Operating Segments	149
Joint Arrangements - Interests in Joint Operations	149
Losses and Special Payments	149
Events after the End of the Reporting period	149
Financial Performance Targets	149

Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

	Note	2022-23 £'000
Other operating income	2	(18,014)
Total Operating Income		**(18,014)**
Staff costs	4	60,378
Purchase of goods and services	5	3,140,537
Depreciation and impairment charges	5	2,434
Provision expense	5	462
Other operating expenditure	5	214
Total Operating Expenditure		**3,204,025**
Net Operating Expenditure		**3,186,011**
Finance expense	7	76
Net Expenditure for the Period		**3,186,087**
Comprehensive Expenditure for the Period		**3,186,087**

The ICB received a revenue resource limit of £3,186,125k for 2022-23; Net Expenditure for the period was £3,186,087k, therefore, the ICB recorded an underspend of £38k.

Statement of Financial Position as at 31 March 2023

	Note	31st March 2023	1st July 2022
		£'000	£'000
Non-current Assets			
Property, plant and equipment	9	763	1,053
Right-of-use assets	11	9,547	11,185
Intangible assets	10	-	43
Total Non-current Assets		**10,310**	12,281
Current Assets			
Trade and other receivables	12	24,846	29,076
Cash and cash equivalents	13	38	-
Total Current Assets		**24,884**	29,076
Total Assets		**35,194**	41,357
Current Liabilities			
Trade and other payables	14	(314,472)	(305,751)
Lease liabilities	11	(2,497)	(1,964)
Borrowings		-	(14,319)
Provisions	15	(18,686)	(17,097)
Total Current Liabilities		**(335,655)**	(339,131)
Non-current Assets less Net Current Liabilities		**(300,461)**	(297,774)
Non-current Liabilities			
Lease liabilities	11	(7,158)	(9,241)
Provisions	15	(100)	(907)
Total Non-current Liabilities		**(7,258)**	(10,148)
Assets less Liabilities		**(307,719)**	(307,922)
Financed by Taxpayers' Equity			
General fund		(307,719)	(307,922)
Total Taxpayers' Equity		**(307,719)**	(307,922)

The notes on pages 134 to 149 form part of this statement

The balances as at 1st July 2022 relate to those transferred by modified absorption (note 8).

The financial statements on pages 131 to 149 were approved by the Board on 23rd June 2023 and signed on its behalf by:

Zina Etheridge
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the period ended 31 March 2023

	Note	General Fund 2022-23 £'000
Changes in Taxpayers' Equity for the Financial Period		
Balance at 1 July 2022		-
Transfers by modified absorption from other bodies	8	(307,922)
Adjusted Balance at 1 July 2022		(307,922)
Changes in NHS Integrated Care Board Taxpayers' Equity for the Financial Period		
Net operating expenditure for the financial period		(3,186,087)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Period		**(3,186,087)**
Net funding		3,186,290
Balance at 31 March 2023		**(307,719)**

Statement of Cash Flows for the period ended 31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial period		(3,186,087)
Depreciation and amortisation	5	2,434
Movement due to transfer by modified absorption	8	(308,998)
Interest paid	7	76
Increase in trade and other receivables	12	(24,846)
Increase in trade and other payables	14	314,472
Increase in provisions	15	18,786
Net Cash Outflow from Operating Activities		**(3,184,163)**
Cash Flows from Financing Activities		
Grant in aid funding received		3,186,290
Repayment of lease liabilities - Capital		(2,014)
Repayment of lease liabilities - Interest		(75)
Net Cash Inflow from Financing Activities		**3,184,201**
Net Increase in Cash and Cash Equivalents	13	**38**
Cash and Cash Equivalents at the beginning of the Financial Period		**-**
Cash and Cash Equivalents (including bank overdrafts) at the end of the Financial Period		**38**

The notes on pages 134 to 149 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
As at 31st March 2023 the ICB had net liabilities of £307,719,000.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future and there is no expectation that commissioning will cease to be delivered by the public sector within North East London.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCGs). ICBs took on the commissioning functions of CCGs; CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach was applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint Arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.5 Pooled Budgets

The ICB has entered into pooled budget arrangements with the London Boroughs of Barking & Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest and the City of London in accordance with section 75 of the NHS Act 2006. These are joint arrangements in the form of joint operations.

The ICB has assessed the accounting treatment of the pooled budget arrangements having regard to IFRS10, IFRS11, and IAS28. The ICB has assessed that while joint control over the pooled budgets is present, the substance of the arrangements is that the parties to the pooled budgets are each responsible for commissioning services from providers, with the risks and rewards arising from the contractual obligation remaining with each respective commissioner. The ICB has therefore recognised in its financial statements:

- The assets it controls
- The liabilities it controls
- The expenses it incurs
- Its share of the income from the pooled budget activities

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

Notes to the financial statements

The main source of funding for the ICB is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Notes to the financial statements

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

No revaluations took place during this period.

1.9.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 Intangible Assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:
- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

Intangible assets acquired separately are initially recognised at cost.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10.3 Depreciation, Amortisation and Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The ICB assesses whether a contract is or contains a lease, at inception of the contract. Leases are accounted for in accordance with IFRS 16.

1.11.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

Irrecoverable VAT is expensed in the period to which it relates and, therefore, not included in the measurement of the lease liability and consequently the value of the right-of-use asset.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.13 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.14 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the ICB.

1.15 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

All the ICB's financial assets are categorised as financial assets at amortised cost.

1.16.1 Financial Assets at Amortised Cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

Notes to the financial statements

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18 Value Added Tax

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign Currencies

The ICB’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB’s surplus/deficit in the period in which they arise.

1.20 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Critical accounting judgements and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical accounting judgements in applying accounting policies

These are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The ICB made no judgements in the period that would have a material effect on the amounts recognised in the financial statements.

1.21.2 Sources of estimation uncertainty

These are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The ICB had no material key sources of estimation uncertainty in the period.

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 New and revised IFRS Standards in issue but not yet effective

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

IFRS 14 is not applicable to the ICB and IFRS17, if applied in 2022-23, would not have a material impact on the accounts.

2. Other Operating Revenue

	2022-23 Total £'000
Other non contract revenue	18,014
Total Other Operating Revenue	**18,014**

Other Operating Revenue does not include cash received from NHS England; this is drawn down directly into the ICB's bank account and credited to the General Fund.

3. Revenue

Revenue is generated wholly from the supply of services; the ICB receives no revenue from the sale of goods.

4. Employee Benefits and Staff numbers

4.1 Employee Benefits

			2022-23
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	38,056	10,033	**48,089**
Social security costs	4,712	84	**4,796**
Employer Contributions to NHS Pension scheme	6,528	88	**6,616**
Other pension costs	6	-	**6**
Apprenticeship levy	198	-	**198**
Termination benefits	673	-	**673**
Gross Employee Benefits Expenditure	**50,173**	**10,205**	**60,378**

4.2 Average Number of People Employed

			2022-23
	Permanently Employed Number	Other Number	Total Number
Total	**799.39**	**145.49**	**944.88**

4.3 Exit Packages Agreed in the Financial Period

	2022-23	
	Compulsory Redundancies	
	Number	£
£10,001 to £25,000	1	14,861
£150,001 to £200,000	2	320,000
Total	**3**	**334,861**

This table reports the number and value of exit packages agreed in the financial period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Compulsory Redundancy Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there was one ill health early retirement during the reporting period, cost £107,058.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating Expenses

	2022-23 Total £'000
Purchase of Goods and Services	
Services from other ICBs and NHS England	469
Services from foundation trusts	815,205
Services from other NHS trusts	1,377,872
Purchase of healthcare from non-NHS bodies	351,601
Purchase of social care	27,627
Prescribing costs	214,320
General ophthalmic services	127
GPMS/APMS and PCTMS	286,103
Supplies and services – general	35,823
Consultancy services	1,087
Establishment	15,282
Transport	106
Premises	6,206
Audit fees	258
Other non statutory audit expenditure	
· Other services	18
Other professional fees	5,051
Legal fees	764
Education, training and conferences	2,618
Total Purchase of Goods and Services	**3,140,537**
Depreciation and Impairment Charges	
Depreciation	2,391
Amortisation	43
Total Depreciation and Impairment Charges	**2,434**
Provision Expense	
Provisions	462
Total Provision Expense	**462**
Other Operating Expenditure	
Chair and Non Executive Members	188
Expected credit loss on receivables	26
Total Other Operating Expenditure	**214**
Total Operating Expenditure	**3,143,647**

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the ICB is required to disclose the limit of its external auditors liability. The contract signed states that the liability of KPMG, its members, partners and staff (whether in contract, negligence, or otherwise) shall in no circumstances exceed £1m, aside from where the liability cannot be limited by law. This is in aggregate in respect of all services.

External Audit Fees Payable (Excluding VAT)

	2022-23 £
Statutory audit fee	215,000
Other audit services	15,000
Total Audit Fees	**230,000**

These amount exclude VAT; the audit fees included within Note 5 include VAT.

6.1 Better Payment Practice Code

Measure of Compliance		2022-23
	Number	£'000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the period	71,561	800,821
Total Non-NHS trade Invoices paid within target	69,236	784,176
Percentage of Non-NHS Trade Invoices Paid within Target	**96.75%**	**97.92%**
NHS Payables		
Total NHS Trade invoices paid in the period	3,559	2,215,486
Total NHS Trade invoices paid within target	3,474	2,209,496
Percentage of NHS Trade Invoices Paid within Target	**97.61%**	**99.73%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23 £'000
Amounts included in finance costs from claims made under this legislation	1
Total	**1**

7. Finance Costs

	2022-23 £'000
Interest	
Interest on lease liabilities	75
Interest on late payment of commercial debt	1
Total Finance Costs	**76**

8. Net loss on Transfer by Absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. For the transfer of assets and liabilities from the CCG to the ICB a modified absorption approach was applied; the resulting gain or loss was, therefore, recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

	2022-23 NHS England Group Entities (non parent) £'000
Transfer of property plant and equipment	1,053
Transfer of right of use assets	11,185
Transfer of intangibles	43
Transfer of receivables	29,076
Transfer of payables	(305,751)
Transfer of provisions	(18,004)
Transfer of right of use liabilities	(11,205)
Transfer of borrowings	(14,319)
Net Loss on Transfers by Absorption	**(307,922)**

9. Property, Plant and Equipment

2022-23	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Cost or Valuation at 1 July 2022	-	-	-	-
Disposals other than by sale	-	(3,676)	-	(3,676)
Transfer from other public sector body	1,498	4,560	698	6,756
Cost/Valuation at 31 March 2023	**1,498**	**884**	**698**	**3,080**
Depreciation 1 July 2022	-	-	-	-
Disposals other than by sale	-	(3,676)	-	(3,676)
Charged during the period	103	131	55	289
Transfer from other public sector body	1,064	4,244	396	5,704
Depreciation at 31 March 2023	**1,167**	**699**	**451**	**2,317**
Net Book Value at 31 March 2023	**331**	**185**	**247**	**763**
Purchased	331	185	247	763
Total at 31 March 2023	**331**	**185**	**247**	**763**
Asset Financing				
Owned	331	185	247	763
Total at 31 March 2023	**331**	**185**	**247**	**763**

Revaluation Reserve Balance for Property, Plant and Equipment
No balances are held in the revaluation reserve for any of the Property, Plant and Equipment Assets.

9.1 Economic Lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	2	5
Information technology	1	5
Furniture & fittings	3	6

10. Intangible Non-current Assets

2022-23	Computer Software: Purchased £'000
Cost or Valuation at 1 July 2022	-
Disposals other than by sale	(284)
Transfer from other public sector body	284
Cost / Valuation At 31 March 2023	-
Amortisation 1 July 2022	-
Disposals other than by sale	(284)
Charged during the period	43
Transfer from other public sector body	241
Amortisation At 31 March 2023	-
Net Book Value at 31 March 2023	-
Purchased	-
Total at 31 March 2023	-

Revaluation Reserve Balance for Intangible Assets
No balance is held in the revaluation reserve for any of the Intangible Assets.

11. Leases

11.1. Right-of-use Assets

2022-23	Buildings excluding Dwellings £'000	Information Technology £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Cost or Valuation at 1 July 2022	-	-	-	-
Additions	-	464	464	-
Transfer from other public sector body	11,685	172	11,857	4,099
Cost/Valuation at 31 March 2023	**11,685**	**636**	**12,321**	**4,099**
Depreciation 1 July 2022	-	-	-	
Charged during the period	1,951	151	2,102	1,047
Transfer from other public sector body	646	26	672	349
Depreciation at 31 March 2023	**2,597**	**177**	**2,774**	**1,396**
Net Book Value at 31 March 2023	**9,088**	**459**	**9,547**	**2,703**

Net Book Value by Counterparty	
Leased from other group bodies (NHS Property Services and Community Health Partnerships)	2,703
Net Book Value at 31 March 2023	**2,703**

11.2 Lease Liabilities

	2022-23 £'000
Lease Liabilities at 1 July 2022	-
Additions purchased	(464)
Interest expense relating to lease liabilities	(75)
Repayment of lease liabilities (including interest)	2,089
Transfer from other public sector body	(11,205)
Lease Liabilities at 31 March 2023	**(9,655)**

11.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	2022-23 £'000	Of which: leased from DHSC group bodies £'000
Within one year	(2,575)	(1,351)
Between one and five years	(5,369)	(1,452)
After five years	(1,964)	-
Balance at 31 March 2023	**(9,908)**	**(2,803)**
Effect of Discounting	253	29
Included in		
Current lease liabilities	(2,497)	(1,332)
Non-current lease liabilities	(7,158)	(1,442)
Balance at 31 March 2023	**(9,655)**	**(2,774)**
Balance by Counterparty		
Leased from other group bodies (NHS Property Services and Community Health Partnerships)		(2,774)
Balance as at 31 March 2023		**(2,774)**

11.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	2022-23 £'000
Depreciation expense on right-of-use assets	2,102
Interest expense on lease liabilities	75

11.5 Amounts Recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	2,089

The majority of the ICB's leases, set up as right-of-use assets, relate to buildings used as administrative centres at locations across its geographical area. The most significant of these are at Unex Tower in Stratford and North House in Romford. Space is also leased at a number of properties from both Community Health Partnerships (Vicarage Lane Health Centre in Stratford, Kenworthy Road Health Centre in Hackney and Beaumont House at Mile End Hospital) and NHS Property Services (St Leonards Hospital).

Two additional building leases, with West Drylining & Facades Limited and Moreland Limited, are held for the management of IT services. Leases relating to the rental of servers are also held with Crown Hosting Data Centres Limited.

12.1 Trade and Other Receivables

	Current 2022-23 £'000
NHS receivables: revenue	9,079
NHS accrued income	2,834
Non-NHS and other WGA receivables: revenue	7,819
Non-NHS and other WGA prepayments	487
Non-NHS and other WGA accrued income	3,605
Expected credit loss allowance-receivables	(54)
VAT	1,068
Other receivables and accruals	8
Total Trade and Other Receivables	**24,846**

12.2 Receivables Past their Due Date but not Impaired

	2022-23 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000
By up to three months	4,050	607
By three to six months	74	1,877
By more than six months	108	(251)
Total	**4,232**	**2,233**

12.3 Loss Allowance on Asset Classes

	Trade and Other Receivables - Non DHSC Group Bodies £'000
Balance at 1 July 2022	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(26)
Transfer by absorption from other entity	(28)
Total	**(54)**

13. Cash and Cash Equivalents

	2022-23 £'000
Balance at 1 July 2022	-
Net change in period	38
Balance at 31 March 2023	**38**
Made up of:	
Cash with the Government Banking Service	38
Cash and Cash Equivalents as in Statement of Financial Position	**38**
Balance at 31 March 2023	**38**

14. Trade and Other Payables

	Current 2022-23 £'000
NHS payables: revenue	29,230
NHS accruals	3,574
Non-NHS and other WGA payables: revenue	53,054
Non-NHS and other WGA accruals	216,141
Social security costs	847
Tax	807
Other payables and accruals	10,819
Total Trade and Other Payables	**314,472**

Other payables and accruals include a total pension liability of £2,841,860. This includes outstanding pension contributions for ICB employees of £932,900 as at 31 March 2023; the balance relates to GP Pension contributions.

15. Provisions

	Current 2022-23 £'000	Non-current 2022-23 £'000
Restructuring	3,627	-
Redundancy	320	-
Continuing care	1,814	-
Other	12,925	100
Total	**18,686**	**100**
Total Current and Non-current	**18,786**	

	Restructuring £'000	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 1 July 2022	**-**	**-**	**-**	**-**	**-**
Arising during the period	3,627	320	217	1,923	**6,087**
Reversed unused	-	-	(1,816)	(3,489)	**(5,305)**
Transfer from other public sector body under absorption	-	-	3,413	14,591	**18,004**
Balance at 31 March 2023	**3,627**	**320**	**1,814**	**13,025**	**18,786**
Expected timing of cash flows					
Within one year	3,627	320	1,814	12,925	**18,686**
Between one and five years	-	-	-	50	**50**
After five years	-	-	-	50	**50**
Balance at 31 March 2023	**3,627**	**320**	**1,814**	**13,025**	**18,786**

Restructuring

The ICB has recognised a restructuring provision in line with IAS 37 for an organisation wide consultation which has commenced and will be completed in 2023-24.

Redundancy

The ICB recognised a £320,000 contractual redundancy provision in respect of two employees.

Continuing Care

The ICB continues to recognise a provision under IAS 37 in respect of continuing healthcare retrospective claims received for activities covering periods post 1 April 2012.

The amount carried forward represents the estimated value of outstanding restitution payments still currently under review. Cases are reviewed in line with the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care guidance.

The ICB has recognised a new provision in respect of a CHC patient for which the total care package entitlement was being disputed. The amount recognised represents the expected settlement for care costs which the family incurred themselves outside of the ICB's care package offer.

Other

The majority of this category relates to a provision for back dated rental reimbursements for a number of GP practices, £12,924,694; the balance relates to a provision for dilapidations in relation to the vacating of leased office space, £100,000.

NHS Resolution

A provision for £128,250 in respect of CNST claims is held in the accounts of NHS Resolution as at 31 March 2023; this is held on behalf of the ICB.

16. Contingencies

A contingent liability is a potential obligation that may result, but is not likely to result because the event causing the obligation is improbable.

There were no contingent liabilities in the financial period.

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the ICB and internal auditors.

17.1.1 Currency Risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations. The ICB and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest Rate Risk

The ICB could borrow from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB has used the HM Treasury incremental borrowing rate, a fixed rate, in the measurement of lease liabilities. The ICB, therefore, has low exposure to interest rate fluctuations.

17.1.3 Credit Risk

The majority of the ICB's revenue comes from parliamentary funding, therefore, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity Risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

17.2 Financial Assets

	Financial Assets measured at Amortised Cost 2022-23 £'000
Trade and other receivables with NHSE bodies	8,701
Trade and other receivables with other DHSC group bodies	6,664
Trade and other receivables with external bodies	7,980
Cash and cash equivalents	38
Total at 31 March 2023	**23,383**

17.3 Financial Liabilities

	Financial Liabilities measured at Amortised Cost 2022-23 £'000
Trade and other payables with NHSE bodies	780
Trade and other payables with other DHSC group bodies	34,559
Trade and other payables with external bodies	287,133
Total at 31 March 2023	**322,472**

18. Related party transactions

Employees of NHS North East London ICB are required to disclose any relevant and material interests they may have in other organisations (related parties). This is recorded in the Register of Interests.

The transactions listed below are payments made to the related parties declared by NHS North East London ICB's Board members (other than payments to practices and other NHS bodies) :

	2022-23 Payments to Related Party £'000	2022-23 Receipts from Related Party £'000	2022-23 Amounts owed to Related Party £'000	2022-23 Amounts due from Related Party £'000
Compost London CIC	5	-	-	-
City & Hackney GP Confederation	13,020	55	1,234	-
Community Health Partnerships	2,784	-	145	-
Greater London Authority (GLA)	-	183	-	-
Hertfordshire Partnership University NHS Foundation Trust	14	-	-	-
London Borough of Hackney	21,781	2,653	2,695	134
London Borough of Havering	12,415	34	7,394	148
London Borough of Tower Hamlets	11,212	1,723	7,021	6,813
MacMillan Cancer Support	-	-	-	5
Together First Limited (GP Federation)	1,651	-	138	-

The Department of Health and Social Care is regarded as a related party. During the period NHS North East London ICB has had a significant number of material transactions (more than £1m) with the Department, and with other entities for which the department is regarded as the parent department, and NHS England the parent entity, including:

- Barking, Havering & Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- Chelsea And Westminster Hospital NHS Foundation Trust
- Community Health Partnerships
- East London NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Health Education England
- Homerton Healthcare NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- King's College Hospital NHS Foundation Trust
- Lewisham & Greenwich NHS Trust
- London Ambulance Service NHS Trust
- London North West University Healthcare NHS Trust
- Mid and South Essex NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- NHS England
- NHS North Central London ICB
- NHS Property Services
- NHS South East London ICB
- NHS South West London ICB
- North East London NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Royal Free London NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- St George's University Hospitals NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Whittington Health NHS Trust
- University College London Hospitals NHS Foundation Trust

During the period NHS North East London ICB has had a number of material transactions with other government departments and other central and local government bodies. The material transactions have been with:

- London Borough of Barking and Dagenham
- London Borough of Hackney
- London Borough of Havering
- London Borough of Newham
- London Borough of Redbridge
- London Borough of Tower Hamlets
- London Borough of Waltham Forest
- NHS Pensions
- HM Revenue and Customs

The transactions listed below are payments made to those practices where one of the GPs of that practice is or has been a member of NHS North East London ICB's Board during the period. These payments include GMS/PMS contract and adhoc payments, but exclude prescribing payments:

	2022-23 Payments to Related Party £'000	2022-23 Receipts from Related Party £'000	2022-23 Amounts owed to Related Party £'000	2022-23 Amounts due from Related Party £'000
Aurora Medcare - Dr. Jagan John	1,983	-	161	-
Nightingale Practice - Dr. Mark Rickets	1,492	-	-	-
Parkview Medical Centre - Dr. Jagan John	476	-	31	-

19. Operating Segments

The ICB considers it has only one operating segment that being commissioning of healthcare services.

20. Joint Arrangements - Interests in Joint Operations

20.1 Interests in Joint Operations

The ICB has section 75 pooled budget arrangements, transferred from the CCG, with the following local authorities - London Borough of Barking and Dagenham (from 1 April 2015), London Borough of Havering (from 1 April 2015), London Borough of Redbridge (from 1 April 2015), London Borough of Newham (from 6 November 2015), London Borough of Tower Hamlets (from 1 April 2019), London Borough of Waltham Forest (from 1 April 2019), London Borough of Hackney (from 1 April 2020) and the City of London (from 1 April 2020). All the local authorities host the pooled budgets.

In line with IFRS 11 joint control over each of the pooled funds exists, however, the members of the fund have agreed to have one lead body to commission services from providers. As a result the ICB has entered into lead commissioning arrangement whereby the risks and rewards of the contractual obligations of the pool fund budgets lay with each respective commissioner.

All financial risks and rewards appropriate to the ICB are included within the Statement of Comprehensive Net Expenditure.

The ICB's shares of the assets, liabilities, income and expenditure handled by the pooled budgets in the financial year were:

Name of Arrangement	Other Party to the Arrangement	2022-23			
		Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund	London Borough of Barking & Dagenham	-	1,504	-	13,260
Better Care Fund	London Borough of Havering	-	1,993	-	17,027
Better Care Fund	London Borough of Redbridge	-	606	-	17,205
Better Care Fund	London Borough of Newham	-	-	-	20,453
Better Care Fund	London Borough of Tower Hamlets	-	2,484	-	23,657
Better Care Fund	London Borough of Waltham Forest	-	-	-	16,141
Better Care Fund	London Borough of Hackney	-	98	-	18,306
Better Care Fund	City of London	-	267	-	634

21. Losses and Special Payments

The ICB made no special payments and incurred no losses during the period.

22. Events after the End of the Reporting Period

There are no events to report after the end of the reporting period.

23. Financial Performance Targets

NHS ICBs have a number of financial duties under the Health and Care Act 2022
The ICB's performance against those duties was as follows:

	2022-23 Target £'000	2022-23 Performance £'000	2022-23 Achievement £'000	Duty Achieved
Capital resource use does not exceed the amount specified in Directions	464	464	-	Yes
Revenue resource use does not exceed the amount specified in Directions	3,186,125	3,186,087	38	Yes
Revenue administration resource use does not exceed the amount specified in Directions	33,690	33,473	217	Yes