NHS
North East London

North East London ICB Annual Report

1 April 2023 – 31 March 2024

Abbreviations used in this report

APC	Acute Provider Collaborative
BAF	Board Assurance Framework
BHRUT	Barking Havering and Redbridge University Hospitals NHS Trust
CATTS	Cancer Awareness in Teens and Twenties
CETV	Cash Equivalent Transfer Value
CQC	Care Quality Commission
CYP	Children and Young People
DoLS	Deprivation of Liberty Safeguarding
ED	Emergency Department
ENT	Ear, Nose and Throat
ICB	Integrated Care Board
ICO	Information Commissioners Office
ICP	Integrated Care Partnership
ICPB	Integrated Care Partnership Board
ICS	Integrated Care System
IG	Information Governance
JSNA	Joint Strategic Needs Assessment
MCA	Mental Capacity Act
NEL	North East London
NELFT	NELFT NHS Foundation Trust
NELHCP	North East London Health and Care Partnership
NHSE	NHS England
PCN	Primary Care Network

PIFU	Patient Initiated Follow-Up
RTT	Referral to Treatment Time
SOG	Surgical Optimisation Group
VCSE	Voluntary, Community and Social Enterprise
YTD	Year to Date

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ABOUT THIS REPORT

The NHS North East London Integrated Care Board (ICB) Annual Report for April 2023 to March 2024 has been produced in response to the NHS England requirements as published in the Department of Health and Social Care Group Accounting Manual 2023/24. The structure closely follows that outlined in the guidance and includes three core sections:

- **Performance Report** – including an overview, performance analysis and performance measures.

- **Accountability Report** – including the members' report, corporate governance report, annual governance statement, remuneration and staff report.

- **Annual Accounts** – including the independent auditor's report and financial statements. All the content has been checked for accuracy and consistency with reporting data sources and to make sure that all requirements are met by our auditors.

PERFORMANCE REPORT

Welcome and overview by Chief Executive Officer

Welcome to our annual report for NHS North East London Integrated Care Board. This report is our first full-year annual report and sets out our progress and achievements from 1 April 2023 to 31 March 2024.

Through our first full year of establishment, we have continued to set in place our foundations for the work needed to meet the health needs of our diverse and growing population, managing the NHS budget and arranging for the provision of health services in north east London.

We continue to build on our partnership and collaborative work to continue to deliver key programmes of work and deliver our statutory duties – to involve local people and communities, to reduce health inequalities and to improve the quality of local services – and our role in assuring delivery of performance and constitutional standards.

In line with other NHS organisations nationally, the impact of ongoing industrial action and workforce and capacity constraints, have presented challenges in terms of recovering activity to manage our waiting list and treat our long waiting patients.

Our financial situation as a system is extremely challenged. We have taken positive steps in our work to address this alongside our health and care partners, including the development of a system Financial Sustainability Plan. This focuses on reducing our underlying deficit as a system while ensuring we continue to reduce health inequalities and act earlier to help people stay well.

Alongside this, the huge and rapid growth in our population over the past ten years and for the next twenty years, and the way resources are allocated mean we have system level funding which does not keep pace with the needs of our local population. We are committed to working towards financial sustainability and making best use of our resources.

Our key purpose is to reduce health inequalities, improve outcomes and build equity with and for the people of north east London. Despite our continued financial challenges, we have committed funding for health inequalities, with work underway in each of our seven Places to ensure we work collaboratively with local partners to focus on the right priorities for the local area.

This report sets out the progress we are making in our key areas of service performance. There are clear signs that our significant focus and partnership working is ensuring that we are making measurable improvements in how our residents experience and receive care. We know, however, that there is more we can do as an ICB and with our partners as a system.

We're proud of achievements in our work to improve urgent and emergency care. While our services remain under significant pressure, there are clear signs of the positive impact that our work with NHS, Council and other partners is having. This was recognised nationally, with NEL being the only system to successfully leave the tier one intervention programme in January 2024.

We continue to see investment in key areas such as diagnostics, innovative practice in clinical care including cancer services, and some improvements in the challenging area of children's mental health services – all of which remain under great pressure nationally and locally.

Practices in north east London are delivering more primary care appointments than ever before – with more than a million appointments a month over the last 12 months. Demand remains high, and access to the right care in a timely way remains a concern for residents, carers and stakeholders. Improvements are being made as we implement the Primary Care Access Recovery Plan, with examples shared in this report.

During 2023, dentistry ophthalmology and pharmacy services were delegated to the ICB from NHS England. NEL is the highest performing ICB in London in terms of dental contract delivery, and we have invested an additional £3.1 million to increase access to NHS dentistry across all of our Places.

Our ICS priorities include a commitment to creating meaningful work opportunities and employment for people in north east London now and in the future. Our NEL Workforce Strategy was formally signed off by the ICB Board in January, and we are now working with partners to deliver this shared strategic plan which will ensure we have the skills we need now and in the future.

We have concluded our comprehensive organisational restructure, meaning our ICB staff are now working within the new teams and structure. This has not just enabled us to meet the nationally set reductions to our running costs, but also means we can focus on delivery of our core aims and priorities.

North east London is an incredibly diverse place to live, work and study. I am particularly proud of the work we have led to deliver on our commitment to

being an anti-racist system. Building on good work already in place on anti-racist approaches to commissioning in a number of Places, we are continuing the work to develop a strategy for the system as a whole.

Listening to residents' voices and working with them to find ways to improve care and experience also remains a key priority, this commitment to co-production was clearly demonstrated through our 'Big Conversation' in summer 2023, where we held conversations with around 2,000 people. Through this engagement, we have now coproduced a set of success measures for the integrated care strategy, as well as building the foundations for ongoing conversations with local people which will continue to shape our work.

This report contains many examples of how we are working with health and care partners, with the local voluntary and community sector and with local people and those who represent them. We remain committed to using the opportunities that this strong partnership ethos provides us for finding effective and financially sustainable ways to address health inequalities and make sure residents receive great care.

I want to take this opportunity to thank our Integrated Care Board and our Partnership, all of our partners from across the NHS, local authorities, our Healthwatch colleagues and those in the wider voluntary and community sector for their work and commitment to supporting our communities in north east London.

Zina Etheridge
Accountable Officer

24 June 2024

Performance Overview

This performance overview section provides an understanding of our organisation, its purpose, the outcomes we look to achieve, as well as our objectives, performance against them and the impact and management of key risks.

About us

The North East London Integrated Care Board (ICB) was established on 1 July 2022 following the implementation of the Health and Social Care Act 2022 which put Integrated Care Systems (ICSs) on a statutory footing and disestablished Clinical Commissioning Groups (CCGs). The role of the ICB remains 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 all ICSs - improving quality and outcomes, securing greater equity, creating value and deepening collaboration. In addition, four core system priorities were agreed for north east London ICS in autumn 2021 and these are at the heart of the ICB's overall approach.

Throughout our first full year of establishment the ICB has continued to set in place our foundations:

- creating an overall integrated care strategy with and for our partnership
- developing a financial strategy
- establishing a population health approach to addressing health inequalities
- putting in place relevant policies
- refining appropriate governance for Places, Collaboratives and the ICB
- reviewing and revising our Joint Forward Plan and Operating Plan
- ensuring co-production is core to the ICB's approach supported by the 'Big Conversation' embedding clinical and professional leadership and
- placing a focus on our workforce through a system Workforce and People Strategy.

Progress has continued across all these areas in collaboration with partners across the system.

Governance

One of our foundations has been embedding robust governance across the organisation and system ensuring strong partnership working is at our core. The Board of the ICB meets regularly and membership includes partners from our NHS provider collaboratives, local authorities, primary care, voluntary, community and social enterprise (VCSE) sector along with a Healthwatch participant. Our core

committees meet regularly, and our Chair - Marie Gabriel CBE, brings partners together across the system including elected representatives' and non-executive members. The Integrated Care Partnership (ICP) is established as a joint committee with local government and has wide and inclusive partner membership. A steering group drives the work of the overall partnership. A significant focus for the ICP has been the development and now implementation of our five-year integrated care strategy.

Integrated Care Strategy and co-production

Our commitment to co-production is reflected in our ambition that local people shaped the success measures of our Integrated Care Strategy which was a significant achievement of the first six months of the ICB's establishment. We launched our 'Big Conversation' in summer 2023 to ensure that local people identify priorities and co-design the criteria against which we will evaluate our impact as a health and care system. Throughout summer 2023, we held conversations with around 2,000 people through a mix of face-to-face community events, an online survey and targeted focus groups (supported by our local Healthwatch organisations) that reflect our under-represented communities in north east London. From this engagement, we have co-produced a set of success measures for the strategy and started to build the foundations of an ongoing set of conversations with local people which will continue to shape the work we do.

The strategy sets out our long term purpose and ambitions, recognising the complexity of the landscape in which we now operate. We have invested time and resource in system development across Collaboratives, Places and our wider partners, seeking to build the understanding, relationships and structures to enable us to deliver our core purpose most effectively.

Our refresh of the Joint Forward Plan, aligned fully to our Integrated Care Strategy, has been co-produced across our system as we continue to ensure it speaks to all partners including local government and the voluntary and community sector. The ICB Board has now approved this iteration and we will continue to develop it over its five year horizon as a system Forward Plan.

The Operating Plan work has followed the timelines and guidance set out by NHSE – whilst sitting within the strategic framework of the Integrated Care Strategy. We have met all deadlines as appropriate.

Workforce and People Strategy

In February 2024, the ICB Board signed off the system wide Workforce and People Strategy, reflecting a full process of engagement and conversations across our workforce and with local residents. The strategy reflects the national priorities and imperatives, whilst being shaped to meet the local demands and context in which we

operate. For local people, access to high quality work which enables them to avoid in-work poverty is a significant priority and will, we know, contribute to improved health outcomes over time. Led by a system People Board, the implementation of the strategy will enable focus on core pillars – notably to recruit and retain the workforce we need. Developing hybrid roles, building greater integration and working collaboratively to address workforce capacity issues are all areas of focus in the first phase of its implementation – and mindful of the Big Conversation voices in this area which highlighted the need to make recruitment more straightforward and based on experience as well as qualifications where possible.

Financial Strategy

Our core purpose to improve the health and wellbeing of local people across north east London can only be delivered if we commit to a sustainable approach to our finances. We recognise the critical importance of achieving financial sustainability across our complex system in north east London bound both by our statutory duty and by our responsibilities as stewards of public money to break even as a system, to operate within our means and to act wisely in allocating system level funding resources.

We have taken steps over the past year to develop our system commitment to working together to address the financial challenges we face, acknowledging too the interface with local authority funding and stability. The £4.5bn available to us is a significant investment in the health and wellbeing of our population. If we include local authority, other statutory bodies and inward investment through the voluntary, community and social enterprise sector, there are considerably larger assets the system can draw on to deliver our core and shared purpose – especially where we integrate to reduce duplication. However, we know that our resources are not always optimally deployed to meet demand which means we may spend more to treat people when issues have become acute and urgent rather than focusing on prevention, early intervention and a reduction in health inequalities. Alongside this, the huge and rapid growth in our population over the past ten years and for the next twenty years, and the way resources are allocated mean we have system level funding which does not keep pace with the needs of our local population.

We are developing a system Financial Sustainability Plan, focused on reducing our underlying system deficit, whilst continuing to work together as a system, reducing health inequalities and intervening earlier. We know we are not yet a top performer on all productivity measures and need to improve our ability to deliver good value for money consistently as a system, as well as working with others to tackle some of the systemic drags on productivity such as lack of capital investment. Our spend on temporary and agency staff remains consistently high. Underpinning our plan, we are working up a population health outcomes-based approach to resource allocation and commissioning and this is a key area of work across the system and for us an ICB.

Our emerging operating model reflects our role as a commissioning organisation which operates collaboratively to deliver improved health and wellbeing outcomes through effective resource allocation and commissioning.

Population health management and commissioning

Building on our work over the past 18 months, we have continued to take forward our population health management approach to ensure we improve health and wellbeing outcomes and address health inequalities across the population. For the ICB, it is the strategic framework of all that we do and shapes our commissioning model, our outcomes and our financial strategy. In the year ahead, we will continue to build and embed population health management, through our population health outcomes-based commissioning model, through our financial strategy and resource allocation and through the single outcomes framework we are developing. This work builds on strong foundations in health inequalities where we adopted the Core 20 PLUS 5 approach, in co-production as referenced throughout this annual report and in integration both vertically and horizontally as a system.

Our operating model recognises our role as a commissioning body within the landscape of integrated care arrangements. We have worked closely with Places, Collaboratives, programmes and across the system to define roles and responsibilities, to shape ways of working, to consider where each has most impact and to ensure what we do meets our core aims as an integrated care system. We have built integrated data capability to support measurement of impact and of progress towards our core aims. We have incorporated work on patient choice and the Provider Selection Regime to ensure that our procurement and contracting models are in line with our overarching commissioning intentions and contributing to improving population health overall. We continue to set out our approach to integration through the development of an integration road map which charts out the central role, not only collaboration but also integration can play – both horizontally and vertically – to improve health and wellbeing outcomes for and with local people.

Clinical and care leadership

We maintain a focus on clinical and care leadership in all that we do as an integrated care system and it runs through our population health approach as described above. Our model continues to strengthen with place based clinical directors supporting work in Places and at a system level and ensuring the nature of clinical and care leadership reflects the breadth of our partnerships. We collaborate with statutory officers such as Directors of Adult Social Services, Directors of Children's Services and Directors of Public Health across north east London, ensuring their perspective and viewpoints are integral to our approach. Joint working with Care Provider Voice is now embedded in each Place partnership and in the Integrated Care Partnership to ensure the voice of social care providers is effectively heard across the system. The

recent appointment of a Director of Allied Health Professionals is further strengthening the range of clinical voices which contribute to our work.

Restructure

As an organisation, the ICB has now concluded a comprehensive restructure which not only meets the nationally set requirements to reduce our running cost allowance, but also enables us to operate to support delivery of our core ICS aims and priorities through an increasingly detailed operating model. The organisational structure we are now implementing will enable us to meet our strategic objectives, in the ways we have committed to working, and to achieve wider health and wellbeing outcomes with and for our local populations.

Corporate Objectives

In summary, we have made some progress against the corporate objectives set out in last year's annual report but recognise that there is more to do. The chosen objectives were built on the transitional objectives for 2022-23 and a continued commitment to delivering the core purpose of ICSs. We highlight below our objectives and progress to date, recognising both the achievements and challenges:

Objective: **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.
Progress to date: • We now have clear programmes established in Long Term Conditions (LTC), Mental Health, Learning Disabilities and Autism (MHLDA) and Babies, Children and Young People (BCYP) with agreed leadership and a resourcing model to deliver the work. We have developed through extensive co-production and collaboration with system partners a workforce strategy which can now be translated into a programme of work to support our fourth priority. • We have held a 'Big Conversation' with residents to inform our success measures for our overarching integrated care strategy. • Our Places have developed further and led many innovative pieces of work such as the development of a holistic model of integrated neighbourhoods in City and Hackney, pop-up integrated health and wellbeing events in Barking

and Dagenham, community outreach to deliver health checks in Newham and development of ward based enablement in Havering which have supported thousands of people to access the support they need. Our Collaboratives likewise have developed, working at Place and at System, demonstrating more joined-up approaches to quality improvement through clinical networks and sharing best practice, including to support complex babies, children and young people and those with severe and enduring mental illness in urgent care.

Objective:

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, ensuring residents get the care they need.

Progress to date:

- Performance across the ICB improved considerably in a number of areas, in particular there has been progress on long waits for planned care and significant improvement in the speed with which the residents of outer north east London in particular are able to access urgent and emergency care.

- Progress on elective care has been challenged by ongoing industrial action which has also created further financial pressure, alongside the ongoing impacts from high inflation and challenges in demand. Key metrics which have improved are:
    - Four hour waits in Emergency Departments (ED)
    - Ambulance handover times
    - Access to primary care.

- Whilst we have attendances to ED for those with mental health needs stabilising, the waits for admission continue at times to exceed 72 hours, activity which is now actively monitored by NHSE.

- Our system programme approach, engaging fully with Places and Collaboratives, has enabled us to address demand through earlier interventions to support people to stay well at home, as well as avoiding admission and making sure people are getting the help they need.

- Engaging our populations to co-produce the north east London communications campaign ‘Right Care, Right Time’, has been a fundamental element of our work on delivering all aspects of the urgent and emergency care model.

Objective:

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.

Progress to date:

- The Workforce Strategy was formally signed off by the ICB Board in January 2024 following extensive system engagement and input. Further progress has been made on the London Living Wage with the ICB (and Homerton Healthcare) now accredited. We have revisited our governance in this area to ensure we have the required dedicated focus on our system Workforce Strategy and on our organisational issues.

Objective:

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.

Progress to date:

- Substantial work has been done in some of north east London's Places on anti-racism approaches to commissioning including City and Hackney, Waltham Forest and Tower Hamlets. This has highlighted the need to think comprehensively and strategically about what anti-racist work is and how it is achieved.

- An anti-racism ICS workshop was held in autumn 2023 bringing together system partners to discuss our commitment to being an anti-racist system, debate and agree what we as a system must do to make this commitment a reality. The next step is to follow-up and create a clear strategy for the system. Overall, less progress has been made at system level than we would have liked to see although as our population health outcomes-based commissioning approach becomes more established we have the opportunity to embed anti-racist principles into our commissioning models.

Objective:

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.

Progress to date:

- Sustainable funding across three years is in place for health inequalities and work is underway in each Place to ensure that the priorities selected are right for each place partnership. This has been undertaken collaboratively with partners, including the voluntary, community and social enterprise sector.

- The NEL Health Equity Academy, was launched in November 2023. So far, achievements by the academy have included:
    - developing a webspace for the sharing of learning
    - supporting a health inequalities community of practice for those leading the place health inequalities funded projects
    - launching a network for Primary Care Network (PCN) Health Inequality Leads
    - delivering, in collaboration with the London Leadership Academy, 'Influencing without Formal Authority' training to around 90 people across the system
    - holding a 'Creating Health Equity in NEL' event which was attended by people from all parts of the system working to reduce health inequalities.

- For 2023/24 we are in the process of commissioning three programmes launching this April. These include Pride in Practice - a programme delivered by the LGBT Foundation to improve the experience of and access to primary care health services for the LGBT community, a bespoke for NEL health equity curriculum for primary care staff and an evaluation of the health inequalities funding to understand the impact funded programmes have had on reducing health inequalities in NEL. We are currently recruiting to our primary care Population Health and Health Equity fellowships and plan to create a similar programme for those working in VCSE. There will also be the opportunity for some specific training and support focused on underserved groups within NEL. This will be assessed based on evidence of need and effectiveness in improving health equity.

- Our work on population health and commissioning is based on reducing health inequalities and ensuring our work has a relentless focus on inequalities and equity. The development of a single Outcomes Framework for north east London will enable us to ensure we focus with a common endeavour on inequalities in outcomes for our population.

Objective:

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.

Progress to date:

- Regular forums are in place led by the Chair and Chief Executive as well as other system leaders to bring together system partners at all levels to ensure effective ways of working and overall delivery of the Integrated Care Strategy. Each of our Places has taken forward development work to grow the local partnership working, which has involved developing and working to a set of values and shared aspirations.

- The Acute Provider Collaborative (APC) has commissioned specific development support work, and the MHLDA (Mental Health, Learning Disability and Autism) has also focused on development of ways of working. At system level we have been taking forward a piece of work to develop a system development road map.

- The focus this year will be on finalising the Financial Sustainability Strategy and our Population Health Commissioning model – both will require all system partners to work differently to deliver change across the system.

Our objectives have been shaped and co-designed using insight and feedback from residents and our wider stakeholders. This has ensured that they reflect and harness the energy, experience and positive ideas from all that we work with as an ICB.

There are already many good examples which showcase how we engage and involve our communities in our work, whether at Place, through our Collaboratives or across NEL as a whole. Some of our examples are listed below:

1. **Embedding co-production in Tower Hamlets**
   Building on the co-production framework agreed in Tower Hamlets in 2022, the Tower Hamlets Together (THT) partnership brought local people and partners together to look at how to deepen and embed good practice co-production.

   A toolkit for professionals has been co-designed with residents and stakeholders to ensure a consistent approach across health and care.

   Co-production is one of the many tools we have to improve services and involve people in our work. We recognise that for this to work, people will need to feel

they are genuinely and equally involved in it, and this is what the THT co-production guidance seeks to do. We will be looking to develop frameworks, principles and guidance for co-production with all the remaining Place partnerships in north east London in 2024/25.

2. **'Let's talk about your health' initiative in Waltham Forest**
   More than 500 people and 50 voluntary sector organisations shared their views on what matters to them to help ensure the voice of local people is embedded into all the work carried out by the Waltham Forest Health and Care Partnership. The insight gathered is shaping action plans for each area of the partnership.

   Local partners, including the voluntary and community sector, worked together to reach into communities and give unheard people a voice on health and care. Focus was given to those communities with most health inequalities, and to having personalised conversations which supported them to engage, including providing childcare and having conversations in different languages. Residents were also offered basic health checks and signposted to health-related services and support in the borough.

3. **Listening to carers to drive positive improvements in Havering**
   Feedback from local carers – including Lynn's story, a powerful account of her experiences with her mother – have shaped the partnership strategy for those who provide informal and unpaid care in Havering.

   Using carers' insight, an action plan has been agreed to increase investment in one-to-one assessments for carers in the borough to ensure their needs are met. Training for frontline staff will ensure more people are identified as carers and are then signposted to support, including training.

   Two carers, including Lyn, chair the Carers Board to oversee the delivery of the action plan, and will also be voting member of the Havering Health and Wellbeing Board to give carers a strong voice in decision-making on health and wellbeing.

4. **End of life care engagement across Waltham Forest and Redbridge**
   Comprehensive engagement with local people is shaping work to improve end of life care services across Waltham Forest and Redbridge, linked to the redevelopment of Whipps Cross Hospital.

   A community working group, made up of a diverse range of local people, work with programme staff and clinical leads to ensure future end of life care services reflect the needs of local people.
   This pioneering co-production approach has provided a positive environment where residents use their experiences to shape future provision, with insight also gathered from one-to-one in depth interviews with people with life-limiting

conditions and public surveys.

The insight gathered from this in-depth engagement has been instrumental in ongoing plans to improve services and will continue to be a core element of the work.

The focus in the coming months will be on engaging with under-served communities including our homeless community, people with both physical and learning disabilities, our LGBTQ+ communities and with people who do not speak English as their first language.

Corporate Objectives 2024/2025

Drawing this reflection on our progress towards meeting last year's corporate objectives to an end, we have proposed a refreshed set of objectives for the ICB for 2024/2025, which have been endorsed by the ICB Board. As previously, the objectives continue to be iterative, building on last year and in line with current priorities, they are as follows:

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

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

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

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

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

Future – summary

Looking ahead, the strategic and operational focus for the next period is population health management and delivering effective improvements to the health and wellbeing of our population. We will continue to build financial sustainability at pace and to advocate for resources to meet our fast growing population, which is increasing faster and further than anywhere else in the country. We will be bold in co-designing new models of care which enable us to intervene earlier to keep people well and healthy at home. We will meet what we know are a challenging set of targets in the operating plan across a range of priority service areas, including Urgent and Emergency Care, Elective Care, Cancer and Maternity, whilst bearing down on productivity and building a permanent workforce which offers continuity as well as being more cost effective. 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 where we are more challenged. 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 focused on how the system can come together to support improvement.

Going concern

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.

There is no proposed change to the requirement to have healthcare commissioning undertaken within the public sector and the ICS has developed a medium term strategy that would continue to see the commissioning of healthcare services in the location and therefore there is no reason to believe that the ICB’s services will not continue to be provided during the going concern assessment period.

The funding for 2024/25 has already been agreed with NHS England (NHSE) as well as the running cost allowance for 2025/26. 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.

Performance analysis

This section describes our key achievements as NHS East London Integrated Care Board from 1 April 2023 to 31 March 2024. It also describes how we plan to work with local health and care partners to continue to reduce health inequalities while improving service performance.

The ICB has a dedicated performance team as part of the Finance and Performance Department, the team produces regular reports for use across the organisation and for the Finance, Performance and Investment committee and the ICB Board. The Committee and Board also request in depth information to support great understanding of poor or deteriorating performance to ensure targeted interventions for improvement.

Elective Services

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

Our performance for the year overall can be summarised as follows:

Referral to Treatment (RTT) 18-week performance (%) full year 2023/24:

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Incomplete PTL	237,769	240,115	244,554	248,462	248,267	247,583	247,953	245,334	246,056	246,025	247,132	251,772
<18-weeks	145,884	148,632	150,117	151,938	150,860	151,250	153,507	150,942	146,654	147,751	148,099	150,161
18 Week RTT Performance	61.36%	61.90%	61.38%	61.15%	60.77%	61.09%	61.91%	61.53%	59.60%	60.06%	59.93%	59.64%

RTT 18-week performance (%) March 2024

Incomplete PTL	<18 Weeks	18 Week RTT Performance
251,772	**150,161**	**59.64%**

RTT >104ww, >78ww, >52ww March 2024

>104ww	>78ww	>52ww
6	228	9,463

Outpatient Transformation - Advice and Guidance March 2024

Advice & Guidance Requests	% Utilisation (OPFA)	Diversion Rate
26,857	34.52%	21.47%

Outpatient Transformation – Patient Initiated Follow Up (PIFU) March 2024

Moved/Discharged to PIFU	% Moved/Discharged to PIFU (OPA)
4,552	2.0%

Throughout 2023 the programme has continued to lead on a series of activities and interventions to manage demand, optimise existing demand 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.

As reported nationally, the impact of ongoing industrial action and workforce and capacity constraints, have presented challenges in terms of recovering activity to manage our waiting list and treat our long waiting patients. The impact of this has resulted in nearly 40,000 lost outpatient appointments and nearly 3,000 procedures. Despite this, we have continued to work towards restoring elective care services back to pre-pandemic levels of activity in 2023/24. In December 2023, inpatient activity was 95.2% of 2019/20 levels, achieved through significant effort and focus across our acute trusts, including the 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.

In line with national ambitions, NEL’s focus has been on ensuring treatment of patients waiting over two years, and those that will have been waiting 18-months or more at year-end. Ongoing industrial action has had a significant impact to deliver against waiting list ambitions. In April 2023, we had three patients waiting over two years. For the latest reported month (December 2023), we had 12 patients waiting over two years. Similar impact has been observed for those patients waiting 18 months or more for treatment. In April 2023 there were 295 patients waiting over 18 months; and in December 2023 there were 421 patients waiting 18 months or more. Every opportunity to prioritise equity across the system in terms of treating our longest waiting patients remains paramount. Clinical and operational review of all long waiting pathways remains in place and our ambition is to treat all patients by clinical priority and waiting time.

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.

Throughout 2023/24 our focus has been on benchmarking and mapping against national best practice for example:

- the ‘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.
- 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.

NEL achieved against the 16% national ask for advice and guidance requests across 2023/24. In December 2023, 24,938 requests for specialist advice requests were made by NEL GPs, equating to 35% of all outpatients first attendances. Of these requests, 20% were managed with advice back to the requesting GP. Circa two per cent of all outpatient attendances were moved or discharged to patient initiated follow-up (PIFU) pathways in December 2023. NEL continues to achieve against the

plan in 2023/24 each month to date. Where outpatient attendances are clinically necessary, around 17% were delivered remotely by telephone or video consultation on average each month (April 23 - December 2023).

Developmental work has also progressed in 2023/24 to ensure patients waiting for outpatient appointments in NEL are equipped with the information, advice and support 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).

Providers across NEL are also implementing 'Patient Knows Best' which provides residents with details of hospital appointments and is expected to reduce DNA (Did Not Attend) rates in outpatients. These tools for patients have been developed alongside an end-to-end review of pathways to ensure we have equity of access and reduce unwarranted variation in community pathways and out-of-hospital service provision for NEL residents. In 2023/24, we have focused on reviewing the provision of community ear, nose and throat (ENT), dermatology and women's health services across NEL to ensure that we have a standard offer for all residents regardless of where they live.

During 2023/24, we agreed a single service specification for community ENT and completed a competitive tendering process and the standard service offer is expected to be fully implemented in 2024/25. Alongside this, we also completed a review of community dermatology service and agreed a single service specification for NEL, which will be implemented in 2024/25. Finally, we implemented Women's Health Hubs in City and Hackney and Tower Hamlets. These models of care have influenced the development and priorities of the national Women's Health Strategy. We are now working across NEL to ensure we can offer all women access to the services provided by a Women's Health Hub during 2024/25.

Cancer Services

The nationally rationalised cancer waiting time standards concentrating on three key measures (faster diagnosis, 31-day decision to treat-to-treatment, and 62-day referral to treatment standards) came into effect from October 2023 published reporting.

Despite challenges experienced with the industrial action, performance against the cancer constitutional standards has been relatively strong in NEL and the latest published month of March 2024 saw performance as detailed in the table below:

March (M12) 2024 CWT Performance	28 Day FDS			31 Day (Combined)			62 Day (Combined)		
	Cases	Successful	%	Cases	Successful	%	Cases	Successful	%
Trust Name / Performance Standard (%)			75.00	NA	NA	96	NA	NA	85
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	2363	1805	76.39	422	409	96.92	198.5	154.5	77.83
BARTS HEALTH NHS TRUST	3096	2389	77.16	370	356	96.22	197.0	127.0	64.47
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1323	1057	79.89	53	53	100.00	56.5	42.5	75.22
North East London	6782	5251	77.43	845	818	96.80	452.0	324.0	71.68
London (NHSE Region)	40384	31376	77.69	6298	5828	92.54	2996.0	2129.5	71.08

Key findings:

- 28-day faster diagnosis standard – achieved 77.43% against the 75% standard, surpassing the national requirement.
- 31-day decision to treat-to-treatment standard - achieved 96.80% against the 96% standard. All providers in NEL met and surpassed the standard.
- 62-day referral to treatment standard – achieved 71.68% against the 85% standard. NEL's performance has surpassed NHS England's combined 62-day standard operating plan requirement of 70%.

Throughout 2023/24, NEL recovery action plans remained in place to enable continuous improvements in our cancer position and create a better experience for our patients.

Prioritising cancer services

The ICB supports the NEL Cancer Alliance which continues to work with acute providers, GPs, local authorities, public health, voluntary and community organisations, and the local population to improve local cancer services and reduce health inequalities.

Our aim is that everyone has equal access to better cancer services so that we can help to:

- prevent cancer
- spot cancer sooner
- provide the right treatment at the right time and
- support people and families affected by cancer.

More information on the work of the NEL Cancer Alliance can be found on their website at www.nelcanceralliance.nhs.uk.

There are three key programmes of work across the NEL Cancer Alliance, each one supported by communications and patient engagement. These are:

1. **Early diagnosis programme**: A key priority for north east London is to reduce the number of people coming forward at a late stage to get checked for a cancer diagnosis (for example, going straight to the emergency department rather than their GP). The aim is to reduce the number of people being seen with late-stage cancer (stages 3 and 4, rather than stages 1 and 2), where symptoms are more advanced, and it is more difficult to treat. The target is that by 2028, we will diagnose 75% of cancers at stage 1 or 2. Progress has been made in a number of areas to support this, which includes:

    - **Working at a borough level to deliver free lung checks**: We have been working in partnership with local authorities, GPs, community and voluntary groups and public health on a borough-by-borough basis to deliver the Targeted Lung Health Check Programme. The programme offers fee lung checks for people aged 55-74 who have never smoked. Our approach has led to one of the highest uptake rates in the country- we delivered over 1,000 scans in Tower Hamlets, just a couple of months after going live there. It is currently available in Barking and Dagenham, Tower Hamlets and Newham. As of 31 January 2023, we have invited 34,783 patients, completed 18,323 lung health checks and undertaken 7,493 scans.

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

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

    - **NHS multi-blood cancer test:** This is a single blood test which can detect a cancer signal for over 50 cancers. It will be offered to residents aged between the ages of 50 and 77 and will focus on areas of higher deprivation - identified by post codes. This will be a pilot and we are currently in the process of working up timelines for this.

    - **Liver trucks**: Community liver health vans, which offer a free, simple, non-invasive test to people aged 35-70 who may be at increased risk of

liver disease, based on their medical history, which will help faster diagnosis for people in areas of deprivation.

- **EUROPAC**: Pancreatic cancer is the 10th most common cancer in the UK. It is difficult to detect, is often diagnosed at an advanced stage, and survival rates are extremely poor. Primary care clinicians can now refer people who might present opportunistically to primary care, with a very strong family history of pancreatic cancer, to the European Registry of Hereditary Pancreatic Diseases (EUROPAC) for annual surveillance. This helps to spot cancer sooner.

2. **Reduce inequalities in cancer prevention and awareness**: our work this year has included:

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

    - **Womb Cancer:** We are working in partnership with The Eve Appeal (a leading UK charity raising awareness of, and funding research for, gynaecological cancers) on a campaign called 'You Need to Know' which aims to increase awareness of womb cancer amongst Black African, Black Caribbean and South Asian women in north east London. Watch a local volunteer's video here. This campaign has been shortlisted for the PM Society Awards 2024 in the category of Diversity and Inclusion in Creative Communications.

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

    - **Engaging with the 'White Other – Eastern European, Turkish and Cypriot' population**: Working with Claremont communications team, we delivered a series of 10 focus groups in the Polish, Lithuanian, Turkish and Turkish Cypriot communities to understand knowledge of, and barriers to cancer screening within these communities.

    - **Best for my chest**: partnering with leading LGBTQI+ cancer charity, OUTpatients to deliver a breast screening campaign aimed at the

LGBTQI+ community which features local volunteers. Read a story from one of the local volunteers and watch their video.

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

- **Muslim Sisterhood**: partnering with the Muslim Sisterhood to encourage young Muslim women to attend cervical screening. Our video about this programme has received over 230,000 views

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

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

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

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

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

    - **AI for chest X-ray:** Trusts across north east London have supported the development of an innovative solution using ground-breaking artificial intelligence (AI), which can help clinicians to diagnose lung cancer quickly and accurately.

- **FIT in secondary care:** Barking, Havering and Redbridge University Trust (BHRUT) and Barts Health are currently the only two hospitals in the country to take part in a pilot which offers FIT (Faecal Immunochemical Test) in their A&E department, which will help spot bowel cancer sooner.

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

- **Non-symptom specific (NSS) pathway:** The rollout for patients with non-symptom specific suspected cancer was completed and embedded ahead of the national expectation of 100% by March 2023. Symptoms considered ‘non-specific’ include unexplained weight loss, fatigue, abdominal pain or nausea; and/or a GP ‘gut feeling’ about cancer. The pathway helps patients to get a faster diagnosis and also helps reduce the number of times a GP sees a patient before a referral or having to make a referral on multiple pathways. If a patient does have cancer, we want to reduce any differences in cancer treatment, so that all residents in north east London receive the best possible care.

- **Improving multi-disciplinary team meetings:** These are central to the management of patients with cancer, and they were introduced over 20 years ago to reduce variation in decision-making and access to best care for cancer patients. Our work to improve these is an example of true collaboration across north east London, with teams from each trust coming together to help improve outcomes for patients.

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

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

Personalised Cancer Care Programme

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

We have developed a personalised cancer care pathway for patients so they can understand what support is available for them at every stage of their journey, from diagnosis through to treatment and post treatment.

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

- **Helping patients prepare for cancer treatment:** Over 900 patients have benefited from prehabilitation interventions resulting in increased fitness for treatment, reduced consequences of treatment and length of stay in hospital. Watch a short video about a patient who has benefited from this treatment.

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

- **Psychosocial:** We are working with our partners to ensure that appropriate psychological support is available to all people affected by cancer and their significant others. We are implementing our 2023/24 Psychosocial Development Plan to address inequities across the system and improve psychosocial support for people across north east London.

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

- **End of life care:** All cancer patients that enter the cancer pathway are offered a holistic needs assessment (HNA) at key points in their pathway. These key points include an HNA at the point of diagnosis, HNAs at the end of the treatment episode, and a HNA when patients enter either follow-up, curative discharge, supportive palliative care or end of life care. The NEL Cancer Alliance's Personalised Cancer Care Programme is working with NEL ICB's End of Life Programme to actively link key cancer end of life care activities for local patients.

Reducing the backlog and improving

During 2023/24, NEL continued to deliver strong cancer performance when compared to other systems nationally. The system focused on backlog reduction

whilst maintaining or increasing activity levels (diagnostic, outpatients and treatments) and meeting the 28-day faster diagnosis standard (FDS). As a result, patients waiting 62+ days (backlog position) across NEL is currently at 6.4% of patient list size 8803, marginally above the London average (6.2%) but below England (7.0%) average, despite challenges such as the industrial action has posed to the system.

The NEL Cancer Alliance also continued to work with providers to implement and strengthen best practice timed pathways (BPTPs). Four operational managers were recently recruited to support BPTPs across NEL with particular focus on the providers that are performing below the England faster diagnosis standard.

Teledermatology - the use of digital images to diagnose, monitor or assess skin conditions without the patient being physically present is being used at BHRUT, Barts Health and Homerton to support increased Two Week Wait (2WW) referral and faster diagnosis standard activity. The Cancer Alliance utilised the insourcing service at Homerton to support increased 2WW referrals and FDS activity. As a result, the system made investments in histology biopsy benches and workforce to support recovery of 2WW and FDS.

The system also supported acute providers with additional funding to improve histology reporting. Locum capacity was also secured at Barts Health to support overall backlog recovery in head and neck as well as urology tumour sites. As a result of this, improvements were made allowing Barts Health to move out of the tier 2 support process for cancer in December 2023.

Diagnostic Services

Timely access to appropriate diagnostics in the community for all those in need is fundamental to our overall approach to improving the health of the local population.

At the end of March 2024, 17.57% of patients waited more than six weeks for diagnostic tests, exceeding the national maximum target of 1%. This is attributed to residual backlog built up during the pandemic, series of industrial actions and seasonality. In March 2024, 10,431 patients were waiting over six weeks for their diagnostics procedure which represents circa 31% increase compared to the 7,805 patients waiting more than six weeks in March 2023, where performance was at 14.06%. Improvement plans, additional capacity and activity are planned across acute and community sites to address this backlog during 2024/25.

NEL ICS remains committed to the delivery of no more than 5% of patients waiting greater than six weeks by 2024/25. Restoration of diagnostic activity across NEL remains on track with most modalities delivering above the 2023/24 Operational Plan,

where all trusts are required to recover activity to 120% of the 2019/20 level of activity. See table below for our latest diagnostic wiating time.

6 Weeks Compliance and Waiting List	Diagnostic Waiters - Mar (M12) 2024			
	Diagnostic Waits <6 Weeks	Diagnostic Waits >6 Weeks	Total Diagnostic Waits	6 Weeks Compliance
MRI	9,853	1,642	11,495	85.72%
CT	5,217	843	6,060	86.09%
Non Obstetric Ultrasound	24,289	4,179	28,468	85.32%
Barium Enema	39	-	39	100.00%
Dexa Scan	1,368	398	1,766	77.46%
Audiology Assessments	987	1,587	2,574	38.34%
Echocardiography	2,341	34	2,375	98.57%
Electrophysiology	-	5	5	0.00%
Peripheral Neurophys	286	416	702	40.74%
Sleep Studies	708	87	795	89.06%
Urodynamics	38	76	114	33.33%
Colonoscopy	1,602	175	1,777	90.15%
Flexi Sigmoidoscopy	385	200	585	65.81%
Cystoscopy	342	282	624	54.81%
Gastroscopy	1,489	507	1,996	74.60%
Total	**48,944**	**10,431**	**59,375**	82.43%

Improving access to diagnostics

We have made significant progress this year with the construction of our three Community Diagnostic Centre (CDC) (based in Mile End Hospital, Barking Community Hospital and St George's Health and Wellbeing Hub), whilst also securing funding for tens of thousands of additional diagnostic tests within this year from additional NHS England revenue funding. The CDC at Barking Community Hospital opened this April whilst the CDC at Mile End Hospital is expected to open fully before the end of 2024. We have secured the capital to build our third CDC at St George's, making NEL a leading recipient of programme funding. We have secured around £31m of revenue to fund our CDCs in 2024/25 which will be positive news for our patients and residents of NEL.

There are also several improvement opportunities within diagnostics to make our processes and pathways more efficient and prioritise how we should look to

galvanise support across the system for these initiatives in challenged operational and financial times.

The NEL Imaging Network is subjected to a periodic reassessment on progress, and we have continued to advance in our development in the Maturity matrix, now scoring 9.6, solidly within “Developing”, with an agreement that there is likely to be further improvement recorded in some areas in the next three to six months, as the network progresses towards “Maturing”.

Within this last year we have continued to invest in additional diagnostics assets, building on the CDC funding and the acquisition of an additional CT scanner in Newham. We have gained support from NHSE to procure a second permanent MRI scanner for Newham University Hospital (NUH), using £3.5m research funding from the National Institute for Health and Care Research (NIHR) and around £2.5m funding from NHSE. It is also a great example of collaborative working, combining funding to achieve something that would not have been possible with the individual pots on their own. We are now finalising details including gaining agreement to procure an advanced 3T scanner which will both increase our capacity to offer routine tests and improve our ability to conduct cutting edge research within north east London, helping our patients to receive the most innovative care and making our hospitals even more exciting and innovative places for staff to work and develop their careers.

We have conducted significant work on innovative pathway design in 2023/24, which will continue next year. This has included:

- continuing to advance the targeted lung health check programme, rolling this out to more patients across north east London.
- Working on a new symptom-based breathlessness pathway, which aims to provide a range of tests within one appointment to help accelerate and direct the diagnosis phase of patients’ treatment journeys.
- Innovative endoscopy type procedures such as trans-nasal endoscopy, colon capsule and cytosponge, all of which provide new options outside of the traditional endoscopy route which can be faster, cheaper and less invasive.
- Digital innovation, both in terms of upgrading software, adding new acceleration software to some of our imaging assets to make them more efficient, and successfully bidding for a pilot of AI review of chest X-ray to enhance our ability to locate cancers and other illnesses faster.
- Beginning work on broader pathway redesign for GP direct access and “straight to test”, to try and ensure patients receive the diagnostics they need as quickly as possible and do not have to attend unnecessary additional appointments.

Also, during 2023/24, we concluded the recruitment process for our NEL diagnostic clinical leads and have successfully appointed four clinical leads to join the

programme, helping us to ensure our improvement programmes are clinically led and supported fully.

Opportunities for 2024/25 centre around making ourselves more efficient and effective with support, investment and collaborative working across the system to achieve results through the robust development of the networks, workforce transformation and significant pathway transformation.

Community diagnostics procurement – Informed by local people
This year, NEL has completed the procurement of a new series of GP Direct Access Community Diagnostics contracts. These will cover a range of diagnostic tests including MRI, cardiology, endoscopy and ultrasound. In addition to providing much needed additional capacity to serve the needs of the residents of north east London, these will provide GPs and patients greater choice, by increasing the number of physical locations across north east London where we are able to offer these diagnostic tests. The new contracts have gone live since April 2024.

We have also been working on aligning this service provision with that provided by our hospitals and our new Community Diagnostic Centres to ensure a holistic service offer that is as broad as possible and provides as many diagnostics as possible within the community, close to where people live.

Urgent and Emergency Care Services (UEC)

In January 2023, NHSE published the national Urgent and Emergency Care (UEC) Recovery Plan which set out two-year ambitions to improve waiting times and patient experience through collaborative system working with all systems designated according to performance within a "tiered" framework. The NEL UEC portfolio was established in autumn 2023/24 to support the delivery of the UEC recovery plan, which is a targeted and highly collaborative portfolio with system partners to develop the NEL UEC vision, goals and outcomes for the north east London population. Our performance for the year overall can be summarised as follows:

Category 2 (CAT2) Ambulance response
The Category 2 response time provided by London Ambulance Service (LAS) to NEL was 51 minutes in April 2022 and improved to 37 minutes in April 2023. By March 2024 it was at 36 minutes which is a 15 minute improvement on April 2022.
A&E four hour performance
Between April 2023 and March 2024, NEL saw a total of 1,010,835 attendances (954,284 attendances in hospital sites and 56,551 attendances in stand-alone site sites).

All type performance was 71% for the year as a total.
The system delivered an overall 77.3% 4-hour performance against the 76% target for March-24.
12 hour trolley waits
During 2023/24 16,682 patients in NEL spent over 12 hours from when a decision to admit was made to the actual admission to a bed. This was a 561 increase compared with 2022/23. However, this was within the context of an increase in the total admissions from 132,296 in 2022/23 to 165,351 in 2023/24. As a percentage of total admissions therefore, 10% waited over 12 hours from decision to admit in 23/24 vs 12% in20 22/23.
Ambulance handover performance
During April 2023 to March 2024 NEL hospitals saw 96,538 ambulances handed over from LAS (compared with 74,653 in 22/23) - this was an increase of 21,885.
In 2023/24 5,199 handovers breached 60 mins, compared with 12,171 in 2022/23. The percentage of handovers in 60 mins was 98% in March 2024 compared with 83% in March 2023.
Whilst there were more 30mins handover breaches in 2023/24 than the previous year, as a percentage of total handovers 30mins handover performance in March 2024 was 58% compared with 52% in March 2023.
General and Acute (G&A) beds and patients no longer meeting the criteria to reside
During 2023/24 the average number Adult G&A beds occupied remained fairly consistent, with 2,539 in March 2023 and 2,540 in March 2024.
The number of patients in these beds who no longer met the criteria to reside also remained similar, with 265 in March 2023 vs 268 in March 2024. The percentage of beds occupied with patients no longer meeting the criteria to reside therefore saw little change when comparing March 2023 (10.42%) and March 2024 (10.56%). The trajectory for March 2024 was met by all Trusts except BHRUT.
Discharge
In NEL the total number of patients discharged the same day during April 2024 (7,171) was lower than in April 2023 (8,661). This is reflected at Barts, BHRUT and Homerton.

UEC services continued to operate under significant pressure throughout 2023/24. During April 2023 to March 2024 NEL has seen 954,286 of all types of attendances, a marginal 2,9293 fewer than the same period in 2022/23. Throughout 2023/24, there has been a clear focus on attendance and admission avoidance through integrated care pathways, improving flow through the hospital from front door streaming to discharge processes (mental and physical health) and optimising ambulance performance. In 2023/24, 69.70% of patients attending A&E were seen within four

hours (against the national ambition of 76% by March 2024), which is an increase of approximately 35,000 patients compared to the same period in the previous year.

This also resulted in NEL being the only system nationally to successfully leave tier 1 in January 2024. There was also a significant improvement in ambulance handover, an improvement from 74,653 to 96,538 for ambulances being offloaded into hospital emergency department within 60 minutes, releasing ambulance hours back to the community. Category two response time reduced on average when compared to the previous year (from 57 minutes average mean response time in 2022/23 to 36 minutes 2023/24 average response time).

Good progress has also been made against our virtual ward plan, which is helping us to make sure people move back home and are supported in the community for as long as and as early as possible. We started from 174 virtual beds at the beginning of 23/24 and with the support of a wide range of partners were able to achieve 435 Virtual Ward beds by the end of March 2024. In 23/24, occupancy levels averaged 70% which is in line with both national (74%) and regional (72%) performance figures. A Virtual Ward Delivery Group has been established which includes partners across the ICB, places and providers, including clinicians. The Group monitors performance and collectively problem solves issues and is overseeing the delivery priorities for 2024/25 which are to increase capacity to 40 virtual ward beds per 100,000 population as well as complete an independent evaluation of the programme to inform 2025/26 commissioning decisions.

Month	Planned capacity	Actual capacity	Variance from plan	Occupancy	Occupancy %
Apr 23	306	174	132	136	78%
May 23	337	242	95	153	63%
Jun 23	367	242	125	191	79%
Jul 23	398	242	156	192	79%
Aug 23	429	292	137	184	63%
Sep 23	459	297	162	200	67%
Oct 23	490	342	148	226	66%
Nov 23	520	328	192	245	75%

Dec 23	551	356	195	213	60%
Jan 24	612	326	286	218	67%
Feb 24	674	424	250	294	69%
Mar 24	735	435	300	304	70%

Using insight and resident feedback to help us reduce pressure on NHS services

To help reduce pressure on our NHS services across north east London, particularly hospital emergency departments in the winter months, the ICB is running a communications campaign to encourage people to 'find the right NHS care' when they need it. The campaign has been co-designed with all local health and care partners to provide a consistent, year-round approach focused on helping residents to get the right care in the right place, first time.

The main objectives of the campaign are:

- To help people understand which service is their first point of contact, to receive the right treatment, first time, such as NHS 111, GP practices, local pharmacies, and self-care.
- To help reduce pressure on A&E departments by making sure people in need of care for urgent but non-life-threatening conditions understand above.
- Encourage more people to register with a GP practice and understand how to access GP practices, including online, and the different ways you can be seen and treated by the range of healthcare staff, including after hours.
- Help people in mental health crisis understand what support is available.
- To work with our partnerships to help vulnerable groups stay well over winter.

Strands of the campaigns are phased across the year to maximise impact and to align with seasonal or data-driven priorities. In winter 2023/4, we co-produced winter wellness guides with our local authorities as part of our work with the seven place-based partnerships. We designed these with a focus group of older residents to find a design and layout that was both accessible and relevant for them as they were a key demographic. We also worked to target more vulnerable residents in a number of boroughs in line with their priorities and resources. In all Places, we used local insight to design and target the guides in different ways that aligned with local priorities.

Our insight on the drivers of A&E attendance in north east London was drawn from both qualitative and quantitative reports which helped us develop our urgent care messaging and target it at those most likely to attend unnecessarily, particularly

younger people, parents of young children and those who live close to an A&E. Evaluation of the impact of the campaign will be completed in coming months, but early indications are that this campaign is having a positive impact on resident's awareness and their choices when they need urgent care.

Winter planning started early in 2023/24 supported by a year-round communication plan for our patients, workforce and population led by Place partnerships. Planning was based on learning from 2022/23 and the system priorities outlined above. The core bed capacity will increase by 31 beds in 2023/24 (from 2,882 at the end of 2022/23 to 2,913 at the end of 2023/24) which will be maintained into 2024/25 and further development of our virtual beds ambition to 735 system wide by the end of March 2024. Places and providers worked collaboratively to deliver the high impact interventions and local initiatives that would build resilience in the system ahead of winter and periods of industrial action.

The NEL System Coordination Centre (SCC) launched in December 2023, which had a demonstrable impact on access to timely data and partnership working throughout winter and the periods of industrial action, underpinned by clinical governance and leadership. The SCC supports NEL's delivery against the UEC recovery plan by providing greater visibility across different providers and acute sites which supports operational teams to identify opportunities to improve flow, as well as identifying and proactively managing areas of pressure and risk.

Mental Health Services

Mental health learning disabilities and autism

Improving mental health and wellbeing is one of the four flagship priorities for the ICS, with a strong Mental Health Learning Disabilities and Autism Collaborative established to work with communities and partners in all our seven Places to improve experience, access and outcomes for local people.

Our performance for the year overall can be summarised as follows:

	23-24 Average	22-23 Average
Inappropriate out-of-area placements (23-24 average)	844	88
	Mar 24	**23-24 National Target**
Children and Young People's access	25,395	24,846
Talking Therapies access	29%	30%

Talking Therapies waits between first and second appointment	15%	10%
Perinatal access	8%	10%
Dementia diagnosis	60%	67%
Serious mental illness physical healthchecks	71%	70%
Serious mental illness community access	26,275	21,987

We achieved the mental health investment standard and the proportion of ICB spend on mental health increased from 9.8% in 2022/23 to 10.1% in 2023/24. There has also been a sustained focus on expanding and improving mental health services, and services for people with a learning disability and autism. People with lived experience and carers co-design our services, through leadership roles from operational to board level. Our current set of objectives are based on our service user and carer priorities, which include embedding peer support across north east London, improving people's experience of accessing mental health services and improving cultural competence and cultural awareness. We are committed to improving the way we deliver our services through our improvement networks, which are clinically led with lived experience input.

The ICB is projecting to achieve 9.33% growth in mental health spend. This is 0.01% above the minimum spend requirement of the mental health investment standard. Total spend relating to this can been seen in the table below:

	2023/24 annual projection based on month 09 £'m	2022/23 £'m
Mental health spend (spend that is in the scope of the mental health investment standard - MHIS)	£402	£367
ICB programme allocation	£3,980	£3,728
Mental health spend as a proportion of ICB programme allocation	10.1%	9.8%

Since the pandemic, we have seen an increase in the level of complexity and acuity of those experiencing a mental health crisis. Despite these pressures, we have

managed to keep the level of inpatient admissions constant through the resilience of our community services and crisis teams. However, this increased complexity combined with a shortage of suitable supported accommodation has meant that lengths of stay have increased, reducing our bed capacity. As a result, out of area placement bed days increased during 2023/24 averaged 456 per month compared an average of 86 in 2022. We are planning to reduce these pressures in 2024/25 through the short-term purchase of extra bed capacity and in the medium to long term, through improvements in the discharge pathway and supported accommodation.

The pandemic severely affected the mental health of our children and young people. School absenteeism in London is now 19%-20% and rates of self-harm and eating disorders have also increased. Children and Young People's (CYP) mental health access in 2023/24 increased this year, resulting in 2,500 more children and young people accessing community therapy services in North East London, allowing us to hit the NHSE access target.

North East London also has the lowest initial CYP mental health waiting time in London with an average wait of 28 days. Often mental health problems for children and young people are identified in schools. In 2023/24 our Mental Health Support Teams (MHST) in schools programme expanded with five new waves, nine teams and 42 additional staff. In addition, our MHST pilot using the 'Tree of Life' model with students from the African and Caribbean diaspora, won the 2023/24 HSJ Reducing Health Inequalities award. 'All About Me' events have taken place and 'I-statements' have been co-produced with children and young people, identifying priority areas for improvement, including self-harm, choice and control, along with access and workforce. These have informed transformation priorities in our clinical network. Our north east and central London provider collaborative has been successful in reducing lengths of stay for those admitted to a children and young people's mental health ward and has been able to reinvest the savings into community services including intensive eating disorder and home treatment teams.

Talking Therapies access has improved across the year (29% of prevalence against a national target of 30%). However, for Talking Therapies waiting times between appointments performance remains challenged (15% against a target of 10%). As at the mid-point 2023/24 our services achieved the highest access rates in London and the second highest black and minority ethnic access rate. Our Talking Therapies improvement collaborative will be building on this and improving equity of access further in 2024/25.

Perinatal access is falling just short of the target (8.3% against a 10% national target) however, the position has improved by 1% compared to 2022, and has been trending upwards since then. Dementia diagnosis is also below target (60% against a 67% target) and has been in a similar position for the last 18 months. Physical health checks for people with severe mental illness (SMI) is currently above 60% and the

second highest in London, however achieving the new national target of 70% will be challenging by year end.

In 2023 a new access metric was included, monitoring users accessing services in the community, which planned to see 5% growth across the year (3,000 additional users accessing services), and is performing well (15% above target, and seeing 5,000 additional service users compared to the same period in 2022).

In 2023/24 intensive support teams for people with learning disabilities and autism became operational across the whole of north east London. These play a valuable role in reducing unnecessary inpatient admissions and also in supporting admissions to mainstream wards. North east London has achieved its learning disability and autism NHSE targets for non-specialist adult inpatient admissions and for CYP admissions. At the time of this report, we are three admissions above target for specialist and secure bed use. We appear to be on track to achieve our physical health check targets and achieved 97.7% in our Learning Disability Mortality Review (LeDeR). The demand for a neuro-diversity diagnosis for either autism and/or ADHD has increased dramatically and waiting times for assessment are high. It is not clear yet what funding will be available to address this but in 2024/25 we aim to redesign our services to improve the experience of assessment and waiting times and increase productivity. We also plan to improve our ability to avoid admission for people with a learning disability and/or autism and our ability to support those, who are admitted.

Primary Care Services

Improving primary care access

Ensuring primary care is a universal offer, accessible to all our residents at a time when they need it, remains a recurring area of focus for us. We have implemented the Primary Care Access Recovery Plan and seen improvements in primary care access and support. Improvements made so far include:

- providing urgent same day access to primary care throughout the week through the provision of access hubs across north east London.
- implementing the Pharmacy First scheme, making it easier for residents to access the care they need by getting support and medication from their local pharmacy to treat a range of conditions that would have previously been treated by their GP practice.
- upgrading of over 60% of our GP practice telephone systems which will improve the experience of accessing general practice.
- local residents can now register with a GP practice online as well as access their GP records online.

- the opening of a brand-new GP practice in Beam Park - Dagenham, ensuring access to primary care in an area of significant population growth.

Access to services continues to be a key issue of concern for patients, carers and stakeholders. Practices in north east London are delivering more appointments than ever before - over a million appointments a month were provided in primary care last year, a three percent increase compared to the previous year. However, demand for appointments with GPs or other health professionals at practices remains high.

Practices are actively exploring how advances in digital technologies can support more effective and efficient access through a combination of local and national training and support.

People without digital skills or access are amongst the group already most likely to experience health inequalities – whether this is due to digital literacy, disability, language, location or a poor internet connection. It's clear there's a growing need to increase digital health literacy and skills.

While practices across north east London are increasingly identifying digital champions to support patients who want to improve their skills and make use of digital tools, we are also working with those considering changes to their systems to ensure it takes account of the needs and skills of their own patients.

We have strengthened the governance for primary care, partly considering the delegation of Dentistry, Ophthalmology and Pharmacy from NHS England to the ICB but also to ensure we can meet in public, respond to the broad provider landscape for primary care and build relationships. The delegation of these three contractor groups to the ICB was a smooth transition despite a significant amount of activity across both dentistry and pharmacy.

The ICB invested an additional £3.1m to increase access to NHS dentistry across all its boroughs. The additional funding was awarded to 72 dental practices and equates to an additional delivery of 95,500 units of dental activity. NEL ICB is highest performing in London, in terms dental contract delivery at around 91% and is also one of the highest performing ICBs in England. The introduction of the national Dental Recovery Plan in March 2024 supplemented the initiatives already in place across the ICB and will enable the ICB to continue to address the issues associated with access to NHS Dentistry. The implementation of Pharmacy First in January 2024 has led to major developments within community pharmacy. The new Pharmacy First Service enables community pharmacists to complete episodes of care for patients without the need for the patient to visit their general practice. This, alongside expansions to the pharmacy blood pressure checking and contraception services, will significantly reduce the number of general practice team appointments a year and help patients access quicker and more convenient care, including the supply of appropriate medicines for minor illness.

Implementing the recommendations of the Fuller Review continues at pace, with a particular focus on Same Day Access, and on Continuity of Care through the development of Integrated Neighbourhood Teams. This transformational work involves testing with various approaches to improve integration across different Places. These initiatives include collaboration between primary care, the voluntary, community, and social enterprise sectors, local authorities, secondary care, and community services. The goal is to address the needs of local people comprehensively, not just focusing on health care but considering the broader social and wellbeing needs to keep people well, prevent ill health and improve patient and population health outcomes.

In October 2023, as part of Primary Care Improvement Week, the EQUIP team (Enabling Quality Improvement in Practice) ran five quality improvement events to identify ways to improve patient care and experience. The daily events hosted at local GP practices focused on bringing all local services providers (NHS, local authority, voluntary and community sector) together in one space over five working days, to use real-time data and experience of patient demand and presentation to discuss and agree ways to quality improve patient care and experience.

The deep-dive sessions saw:

- over 150 patient interviews being conducted to hear first-hand about some of the primary care issues patients faced (with the biggest barrier being interpretation).
- 500 pieces of qualitative data that is giving us fantastic insight into many shared issues that health and care partners are dealing with every day.
- more than 650 opportunities identified where improvements can be made within primary care.

Key themes that we heard from patients, stakeholders and partners are being used to help us plan how we can make impactful changes for the community.

To further support the improvement and development of primary care services we have continued to invest in our primary care workforce during 2023/24. Those investments were aimed at:

- Identifying the current and future workforce needs for primary care services as part of long term investment strategies.
- Improving the numbers of GPs and nurses working in NEL by expanding the numbers of training locally, especially in areas with low numbers of GPs and nurses.
- Retaining the current workforce through training, education and development opportunities that improve staff satisfaction and the quality of local services.

- Expanding the range of roles working in general practice through the recruitment of other professional roles and staff. We have increased this workforce by 20% in 2023/24.
- Developing our local community pharmacies to work with GP services to offer new pharmacy services that reduce the need to see a GP. We have increased the number of consultations in pharmacies from 5000 per month to 15,000 per month in March 2024.
- Improving the numbers of nurses moving into practice nurse roles, we have successfully established and rolled out a NEL General Practice Nurses Vocational Training Scheme (VTS)
- Recruiting 18 trainees to undertake an academic training programme to equip them with the clinical skills to deliver high quality nursing care in NEL.

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.

PCNs and practices have continued to use the feedback gathered in extensive engagement that shaped the enhanced access services in 2022/23 to make ongoing improvements to their services and to help people to find it easier to access help.

A procurement process for providers to run six practices in north east London saw insight gathered from patients used to inform bidders of the expectation and needs of their potential patients. Patient representatives also supported the evaluation of bids, with patient experience, complaints management and management of patient confidentiality, dignity and privacy among key factors being assessed during the process.

Safeguarding Children and Young People (CYP)

ICBs have a statutory duty to safeguard children as set out in the updated guidance, Working Together to Safeguard Children 2023. The second NEL ICB safeguarding children and looked after children annual report for 2022/23 can be read on our website. NEL ICB's confirmatory statement, demonstrating that statutory assurance processes have been implemented in accordance with the Safeguarding Accountability and Assurance Framework, 2022 is also available on our website.

The summary in the succeeding sections 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 and national safeguarding priorities.

Learning from reviews
The ICB contributes to the national safeguarding tracker to enable greater scrutiny

and better understanding of themes from statutory reviews across Children Safeguarding Reviews (CSPRs), Rapid Reviews (RRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) conducted across the NEL footprint.

In response to the national review into the tragic deaths of Arthur Labinjo Hughes and Star Hudson in 2020, NEL ICB has implemented a comprehensive supervision framework for its safeguarding workforce. This offer includes access to restorative safeguarding supervision training for supervisors and an externally facilitated safeguarding supervision offer for the ICB safeguarding workforce in line with the NEL Safeguarding Supervision Policy. Additional investment has also been made to enhance the health resource for Multi-Agency Safeguarding Children Hub (MASH) in Redbridge and Tower Hamlets.

The City and Hackney Safeguarding Children Partnership Board is overseeing implementation of the partnership action plan in place following the safeguarding failures in the case of Child Q, which resonate both nationally and locally.

Safeguarding assurance

Quarterly reporting and submissions to NHS England (NHSE) provide assurance via governance heat maps. In addition, reporting via the safeguarding accountability and assurance tool (S-CAT) enabled an organisational assessment against the relevant domains within section 11 of the Children Act 2004. This is continued on a quarterly basis identifying areas which require additional focus. Risks escalated through this route have been workforce sufficiency, mental health and timely completion of statutory health assessments for looked after children and adoption medicals. Throughout the year there were periodic surges of entrants into care, and an increased number of people seeking refuge and unaccompanied asylum-seeking children (UASC) with related public health issues around health protection.

Safeguarding priorities

The ICB facilitated a virtual system learning event enabling priority setting (see Figure 1) for ICS safeguarding and an after-action review of the impact of Clinical Reference Groups which were established to drive priorities using a whole family and program management approach. Out of this work, we have developed the priorities which will inform our approach over the next two years.

Figure 1- NEL Safeguarding Priorities

NEL looked after children and care leavers
We are ambitious for our vulnerable children placed in Local Authority care.

The reporting period has provided an opportunity to review the data and utilise the themes to inform the Looked after children strategy which is in development working with looked after children. NEL ICB has led the work to ensure access to free prescriptions for care leavers in the pan London care leavers compact and has made significant progress on promoting a robust emotional wellbeing model for this group.

Multiagency safeguarding arrangements
Under the Children and Social Work Act 2017 and Working together to safeguard children 2023 statutory guidance, three safeguarding partners (local authorities, chief officers of police, and ICB) 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 2022/23 can be accessed via the links:

- Barking and Dagenham Multi-Agency Safeguarding Partnership Arrangements.
- City of London Safeguarding Children partnership annual report
- City and Hackney Safeguarding Children Partnership annual report

- Havering Safeguarding Children Partnership
- Newham Safeguarding Children Partnership
- Redbridge Multi-Agency Safeguarding Children arrangements
- Tower Hamlets Safeguarding Children Partnership arrangements
- Waltham Forest Safeguarding Children Board

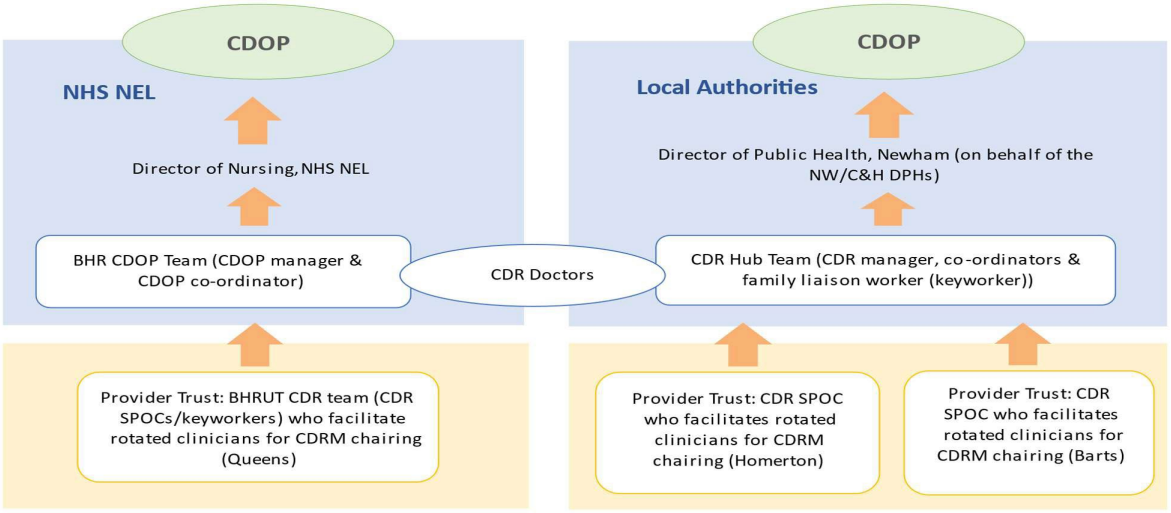
Child Protection Information Sharing (CPIS)
CPIS is active across the NELFT footprint and there have been no outages or incidents reported, unlike the previous years. The ICB has supported reporting to NHSE in response to information requests.

Female Genital Mutilation (FGM)
NEL has participated in the national FGM pilots for community clinics targeted at non-pregnant women and contributed to the formal evaluation of the pilot clinics. During the year under review there have been no CSPRs or reports of safeguarding incidents relating to FGM. However, identified child victims continue to access the trauma informed commissioned therapeutic resources to promote their wellbeing.

NEL Child Death arrangements
In NEL there are two child death overview panels (CDOPs) across the inner and outer London footprint.

NEL quarterly assurance meetings for the two CDOPs (please see figure 2 below) have been established to provide system oversight and assurance. 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 also occurred at place.

Figure 2- NEL CDOP Structures for inner and outer London



Outer London Inner London

Through our Equity Learning Network, we are using Quality Improvement to enable equity of access, improve experience, and outcomes. NEL ICB is leading a programme of work across the seven places and the City of London to oversee provision of sudden unexpected deaths in infancy (SUDI) training resources. The aim of the programme is to reduce the number of SUDIs across NEL within which modifiable causes related to unsafe sleep practices and known family vulnerabilities have been identified. The team has developed improvement initiatives aimed at the challenges faced by the low levels of literacy, numeracy, and health literacy in our population.

Key system issues

Building a learning culture and approach to all aspects of safeguarding across the system has been a core focus of work for the ICB over the past year, including:

- A NEL safeguarding conference in which learning from local and national reviews and experts by experience was shared.
- A number of learning events through the year have attracted hundreds of practitioners from across the system, supported by national colleagues.
- Regular updates and learning are also shared with the Executive Management Team, Quality, Safety and Improvement Committee, NEL Safeguarding and Looked after children forums and associated sub-groups of the Local Safeguarding Children Partnerships (LSCPs) across the system.

Workforce capacity has been an area of challenge for both health and care organisations across NEL, and despite significant recruitment there remain hard to fill

posts, particularly in relation to Designated and Named doctor roles for safeguarding children and Looked after children.

Health system quality related issues have been addressed through an ICS Peer Review Group which adopted an improvement approach including development of standardised NEL audit and assurance tools, training and bespoke packages for relevant groups working with looked after children together with alternative models and governance for areas hard to recruit to.

As a system we are proud of the work undertaken with unaccompanied asylum seekers in Newham and are working to support the roll out of this best practice model across NEL.

Conclusion
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, with a particular focus on the dissemination of and response to learning from both national and high-profile cases.

Safeguarding Adults

The safeguarding adult team have fostered relationships and contribute to a systems approach 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. 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.

The Learning Disability Mortality Reviews (LeDeR) 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 109 (adults) LeDeR notifications received for 2023-24. The team work closely with the 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 and working groups 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.

There has been positive working between the ICB designate and Whipps Cross Hospital, this has included a joint audit on the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguarding (DoLS) with presentation at the internal assurance board, in addition the Designate attended and presented learning from SAR Harry at their All Age Safeguarding Conference.

There has been joint work in identifying and escalating complex cases which has resulted in progressing discharge pathways and utilising support and escalation with colleagues with in NELFT and the place-based system to progress and identify blocks in the system to facilitate discharge to specialist placement.

Examples of improvements in 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. All Designates at Place contribute to planning and supporting the safeguarding of high risk residents of contingency hotels and have been working closely with partners to ensure that housing providers are held to account.

- **Safeguarding Standards Tool:** This tool was developed to provide an all-age set of minimum safeguarding standards to cover children, adults and looked after children. It has been developed collaboratively with system partners from a range of services and piloted in January 2023 and will be used by the ICB at the contracting stage of acquiring new services, to provide an overview of safeguarding arrangements in place.

- **Serious violence duty:** Designated professionals continue to engage with serious violence duty work taking place at Place. The ICB has also produced a problem profile that will go towards serious violence needs assessments completed by local authorities.

- **Learning from reviews:** The Designated Professional for Safeguarding Adults has been involved in supporting the setting up of the new BD One

Panel which will be where any new SAR (Safeguarding Adult Reviews), CSPR (Child Safeguarding Practice Reviews) and DHR referrals will be considered. The Designated Professional for Safeguarding Adults will also be co-chairing the BD Partnership Practice, Learning and Development Group. This will aim to take a think family approach to sharing learning from reviews across the partnership.

- **Learning and improvement forums at Place:** have continued to work with partners to ensure that themes and trends are identified from all-age reviews and are shared with partners and appropriate boards to ensure learning is disseminated and embedded in work moving forward.

- **Transitions and learning disabilities and autism:** There has been positive progression across the all-age safeguarding team relating to transitional pathways, specifically extremely positive outcomes following escalations and joint working in regard to two young adults with complex needs. This has incorporated the learning disability and autism programme manager facilitating a multi-agency approach to patient care at Place.

Environmental Matters

As an ICB, we are committed to promoting economic, environmental and social sustainability through our actions as a corporate body and commissioner and in our role as convenor across the NHS and wider system. Our main route for doing this is via our Anchor Charter which can be found on the NEL Anchor Charter - North East London Health & Care Partnership website. We are determined to deliver a health centred response in north east London and support all our colleagues within the ICB and more widely across the system to 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 to achieve net zero, with the first target of 80% carbon reduction by 2028, based on a 2019/20 baseline.

The NEL ICS Green Plan is publicly available on the North East London Health and Care Partnership website. We have confidence that our trusts are meeting their regulatory requirements and are working towards delivering low-carbon health services. In the ICB we have focused on primary care and working at Place to better understand the impact of climate on our population.

NHS North East London's contribution to net zero in 2023/24:

- Net zero networks continue to 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.

- Our four Net Zero Clinical Leads who oversee the input from primary care have engaged over 500 peers.

- Medicine optimisation teams are improving the quality of respiratory care and as a result have reduced our emissions relating to inhalers prescribed, by reducing waste and improving adherence.

- Our system wide carbon literacy programme has trained over 300 staff. This included coaching, leadership development, foundation and technical skills in sustainable healthcare as well as specific carbon literacy courses for primary care. The programme won a Sustainability Partnerships award at the 2023 NHS Sustainability Awards.

- Contributed to regional activities and forums to review the progress towards anchor aims and London's climate resilience.

- Hosted staff session on active travel with local authorities and taken part in the national Net Zero modal shift network. This aims to improve air quality and increase active modes of commuting to work and meetings.

- Convening the system on issues of air quality and taking part in clean air campaigns

- Provided staff with a choice of two cycle to work schemes and a low emissions vehicle salary sacrifice scheme.

- Our data servers, holding all our digital information and software capability, are powered by renewable energy.

- In our ICB offices we have reduced the use of single-use plastic consumables, are buying eco-friendly stationery and have become a fairtrade workplace.

Many ICB staff have continued to work in a hybrid way, including remotely. This has minimised our impact on the environment through limiting travel and use of consumables, although it should be recognised that there are discussions ongoing about increasing the requirement for staff to be in the office, given the benefits to developing our system culture and values. We have developed and increased our

ability to hold our meetings both virtually and in a hybrid way, 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 have an action plan to become a London Living Wage ICS system by 2024, with one of our five NHS Trusts accredited and the remainder, alongside the ICB, working towards accreditation by spring 2024.

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 of dedicated spaces for learning, and improvement in online patient consultations reducing the need for patients to travel to appointments.

Task force on climate related financial disclosure
Please see the ICBs climate related financial disclosures below:

Governance Pillar
Describe the Board's oversight of climate related issues: • At every meeting the ICB Board discusses risks relating to environment and climate emergency through consideration of the board assurance framework. This highlights a significant system risk posed by failure to address the wider determinants of health including the impact of climate change. • The population and health inequalities steering group is aligned to the population health and integration committee of the ICB Board. • The ICB Chief Medical Officer is the SRO for climate change and is a statutory board member. • The template for the ICB board requires each board paper to consider impact on local people, health inequalities and sustainability. • The NEL Green Plan's overarching aim is to reduce the carbon footprint of the NEL NHS to 'net zero by 2040'. • The ICB recognises the plan does not currently outline how the ICB will manage or mitigate the impacts of climate change on service delivery. This is an area that has been highlighted as requiring more action through working with system partners.

Describe management's role in assessing and managing climate-related issues:

- A member of NEL Executive Management Team (EMT) is the Senior Responsible Officer (SRO) for climate related issues as SRO.
- A Green Plan Strategy Group is in place to oversee the delivery of the ICS Green Plan. The SRO for the climate related issues is also the ICB's Accountable Emergency Officer (AEO), who leads on response to incidents and emergencies which are often exacerbated or caused by climate related issues.
- Climate related issues are reviewed by the EMT through a maturing framework through system forums.
- We have included an Environmental Matters chapter above that outlines our Green Plan Programme. Our Emergency Preparedness, Resilience and Response (EPRR) policies and processes outline our organisational commitment to plan, prepare and response to climate related emergencies.

Risk Management Pillar

Describe the organisation's processes for identifying and assessing climate related risks:

- The ICB has a comprehensive risk management strategy which requires all risks to be logged, reviewed and escalated according to the process set out. Risks above 15 are escalated to the ICBs Board through the Board Assurance Framework. The ICB discusses, assesses and records its risks through the use of its programme boards and committee structure. This ensures a comprehensive view of our risks by subject matter experts and non-executive members. By the nature of the ICBs work and the widespread impact that climate related issues can have, climate is discussed in a number of forums.
- Risks identified associated with the delivery of the Green Plan and its impact on climate related risk if not met, are added to the Strategy and Transformation Department's Risk Register.
- The EPRR risk register identifies and assess risks relating to climate related emergencies which are escalated via the risk management framework to the appropriate risk register. These risks are identified and assessed using borough risk registers, the GLA risk register, infrastructure planning and analysis and historical knowledge of our system. The ICB discusses these risks in its ICB EPRR Steering Group which is chaired by the Accountable Emergency Officer.

Describe the organisation's processes for managing climate related risks:

- All ICB risks are required to have mitigating actions to either reduce the impact or severity of that risk. Risks, especially that related to climate, are often jointly held across the system, with the Greater London Authority (GLA), or across the country and so the ICB's mitigations and managing actions form part of a wider response with our partners. Each risk in the ICB is required to have an action owner, an executive owner and a responsible committee. This ensures senior management of our most high level risks.
- The ICB has a number of actions in place that manage ICB-level climate related risks. These mitigating factors include the stringent use of the risk management strategy, our long term strategic planning, climate specialists and tailored emergency response when climate-related risks become emergencies.
- The ICB holds an ICS-level Infrastructure Strategy, which assesses the long-term implication of climate related issues and compounding factors such significant urban development which is occurring in North East London. The regeneration and infrastructure team works with the Healthy Urban Development Unit to assess the health impacts of climate change using evidence from the GLA, Environment Agency, think tanks and academia. The outcome of this work is factored in to the ICB's long term planning both for services it commissions and infrastructure development.
- The ICB also holds specific emergency-related planning for the following areas - severe weather (including heatwaves, cold weather and flooding), system evacuation plans and major incidents. These plans are reviewed by our partners in forums called Borough Resilience Forums. The ICB contribute to the risk assessments and response in these forums with other category one responders. All of the ICB plans are compliant with the latest guidance released by NHS England, HM Government and UKHSA.
- Risks have been included in the Strategy and Transformation Department Risk Register which is reviewed as part of the wider organisation's risk processes.

Describe how processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach:

- We have submitted a response to the GLA on our organisation's status on climate resilience. A chapter on health services in London's climate change resilience and needs is due to be analysed and published later in 2024.

Metrics and target pillar	
Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line withs its strategy and risk management process.	We use the GLA Climate Change Risk metrics to gauge the climate-related risks to our population and use these in our engagement on the Green Plan and wider system work on climate change.
Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets.	NHS targets are to reduce our carbon footprint. Based on the 2019/20 baseline and relate to the following areas of energy; travel; supply chain; and medicines consumption - as prescribed in the national Greener NHS dashboard. Key targets are. **Target 1 – ICS Carbon Footprint** • An 80% reduction in the emissions we control directly (by 2028-2032), and net zero by 2040 Interim Target • A 40% reduction in the emissions we control directly (NHS Carbon Footprint) by 2025. **Target 2 – ICS Carbon Footprint plus** • An 80% reduction in the entire emissions profile by 2036- 2039, and net zero by 2045

Improve quality

Quality improvement runs through all we do as an ICB and as an ICS, ensuring that improving health and wellbeing outcomes with and for our population is at the heart of our work. We continue to develop a system approach to quality improvement which draws on the excellent work already underway across our Places, Collaboratives, Trusts and local authorities in north east London as well as learning from elsewhere through a continuous testing, learning and improvement model. We have brought together people working on quality improvement and are aligning our thinking to the development of population health management and an outcomes-

based commissioning model, as well as feeding in our ongoing engagement with local people and specifically the outputs of the Big Conversation. Local residents clearly talked to us about the importance of their experience of care, and we will now be focusing on building a high level system framework for good care across north east London based on the things they told us are important: accessibility, competence, person-centredness; trustworthiness.

System working is progressing well in relation to the transition from the NHS Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF). Patient safety specialists are working collaboratively across the ICS to ensure new mechanisms and approaches to learning from patient safety events are well embedded and evolving at pace to achieve the intended outcomes of the NHS Patient Safety Strategy and improvements in the quality of care received by our residents.

Our new System Safety Group brings together a range of stakeholders across our ICS to share learning related to patient safety incidents, experiences of those impacted by patient safety incidents, and findings from safety improvement projects to support the necessary culture change and quality improvement at scale.

Patient safety partners are working across the ICS to promote the involvement of patients, families and carers in our system's governance and management processes for patient safety. Work to design a Patient Safety Partner Network is underway, which will bring together our patient safety partners from across the ICS and leverage their collective voice to promote patient-led improvements in quality across the system.

We continue to develop and embed the equality and quality impact assessment process across our governance, corporate functions and programme boards, ensuring we place the quality of care received by our populations at the centre of our decision-making processes and recognise the impact our decisions have on our diverse communities.

Reporting to our Quality, Safety and Improvement Committee is now enhanced through the introduction of a system quality dashboard that enables a system overview of key quality metrics, supporting quality oversight, assurance and planning, as well as highlighting early any emerging concerns that may be identified.

In response to quality issues which have been highlighted to us through the year, the ICB quality team have led a number of improvement and assurance activities, a few of which are highlighted here:

1. **Visits to mental health facilities in Hackney and Newham**
   These visits have focused on standards of care and how in-patient services

may be able to better support people with learning disabilities and autistic people for example by developing sensory rooms.

2. **Waiting times in ED for people with mental health needs**
   NEL ICB has worked in partnership with colleagues in East London Foundation Trust to map waiting times for people in mental health crisis in emergency departments in various trusts in east London. Trusts have been able to identify where there may be blocks to these patients getting assessed and either admitted or discharged in a timely way. A huge amount of work is taking place to address long waits in emergency departments for people in mental health crisis and we know this issue is of great concern to patients and staff caring for them. The ICB is focusing on how to better support people in the community and enable groups of GPs and community staff working together within a neighbourhood to support people before they become severely unwell.

3. **111 resident satisfaction**
   NEL ICB has also been focusing on improving the way we measure patient satisfaction for 111 services and introducing a new patient experience survey for 111 during 2023. This survey is currently by telephone but other methods including text are being developed to get better feedback. The ICB undertook a quality visit to the 111 call handling centre in Newham in 2023 where we listened to a selection of calls, spoke to staff and made a number of suggestions for how the London Ambulance Service could improve patient and staff experience. We have also been working hard to put in place more mental health support for 999 callers.

4. **Paediatric audiology**
   In September 2023 NEL ICB set up a working group to improve children's hearing services in east London. The quality team have been working with NHS England on this national programme of work to improve key standards of care. Barts Health and NELFT have undertaken a review of hearing tests and quality oversight of their services and will be creating action plans in 2024 to address any areas of improvement and seek national accreditation for their services. This will ensure children get the highest standard of care including early identification and support for any hearing loss.

Engaging People and Communities

Embedding the principles and commitments of the ICB strategies
Work continues to deliver our NEL ICS strategy for Working with People and Communities 2022-2025. 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

This year, we have focused on embedding the principles and commitments into our work, as an ICB, across the NEL system and through our place-based partnerships and collaboratives as we develop co-production.

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 (Voluntary, Community and Social Enterprise) 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 representatives on the smaller steering group – equal to statutory partners.

We continue to support our place-based partnerships to ensure resident experience and voice is informing their work in each borough, as part of governance arrangements or through co-production or involvement of local people. Healthwatch are members of each partnership, along with VCSE representatives. Local residents can share their experience of the health system at board level, and these discussions have led to proactive work to address the issues raised. Examples of this best practice working are included in this report.

Our VCSE Collaborative has continued to develop, with dedicated funding provided by the ICB to develop a clear framework, appoint a development lead, identify priorities and enable the collaborative to look at how it will involve organisations representing underrepresented communities and smaller community groups across north east London.

We also fund a number of VCSE bodies for specific services or programmes, including a number of dedicated staff to connect with local communities. We are working with our VCSE collaborative to identify where we together need to build capacity so that we have a more consistent investment and services across all our places in NEL.

Engagement and communications networks are bringing NHS and local authority staff together with Healthwatch and VCSE leads to work together at both place level and across NEL. This partnership approach to gathering and sharing insight has helped to shape joined-up campaigns across the area – making best use of resources and ensuring we are able to best tailor our engagement and communications to meet the needs of our diverse communities.

Our emerging immunisations strategy has been developed using resident insight alongside health data to develop a campaign plan. It focuses on where we can make a difference – by targeting our highest priority and most vulnerable groups and making best use of finite resources to ensure our communications and engagement can deliver a tangible impact.

The campaign approach sees NHS, VCSE and council partners working with our communities to co-produce resources for our residents as well as delivering targeted engagement with underserved communities and individuals who are vaccine hesitant – especially in areas of higher deprivation. We want to work collaboratively with our underserved communities to tailor the campaign activity and engagement to their needs. Our approach has been praised by NHSE London for its strategic focus and approach and is helping to inform national planning.

Keeping our stakeholders informed and engaged remains a key priority. 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.

How we are delivering on our key actions from the Working with People and Communities Strategy:

Sharing community insights across north east London

The innovative NEL Community Insights System, developed and managed by NEL local Healthwatch organisations, continues to build and develop, providing the ICB and partners with insight and evidence to inform our priorities and target our participation efforts. It currently holds 112,358 comments from local residents, which equates to 387,541 separately coded issues that we can use to rapidly generate reports. 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 and has helped to further embed resident voice into service improvement work at the earliest possible stage. Our system, which has been cited as good practice, will also help inform a regional approach to sharing insights across the five

London ICBs.

Refresh of the People's Panel
Following a review and research into good practice approaches, we have refreshed and are relaunching our NEL People's Panel (previously known as the Citizens' Panel) to provide an engaging online research tool to explore the views of local people on a range of topics across the year.

We aim to build on the existing 2,500 residents signed up to participate and to continue to maintain a focus on ensuring that the membership reflects the diversity of our population. New software has been purchased and the team is working towards a relaunch following the pre-election period.

During the remainder of 2024/25, we are aiming for regular newsletters to panel members, a review of the current panel membership to assess that its continued diversity reflects our local population, and a targeted recruitment drive to ensure we build membership and improve diversity of the membership across all our Places and demographics. We are also raising awareness across the workforce and system of the Panel and of how it can be used to understand people's experiences, test out ideas and source people willing to focus on particular service and thematic areas.

Accessibility training and good practice
Focus in 2023/24 has been on researching and delivering training to ICB staff to embed understanding of accessibility into those who plan and commission services. Informed by research into best practice approaches to training from experts in the VCSE and charity sector, a training module is now available as part of the ICB's training and development programme.

As an organisation, we are committed to ensuring our communications are accessible. Our ICB website is currently ranked 19th nationwide in terms of its accessibility in the nationwide Silktide accessibility index and we passed a Cabinet Office accessibility audit in 2023.

In Redbridge, the place-based partnership is committed to working with primary care and other health professionals to embed understanding of the Accessibility Information Standards (AIS). A focus was given to improving services and access for BSL (British Sign Language) users, with deaf and hard of hearing residents involved in focus groups and engagement work to help scope the priorities of the local working group. Work is continuing, with an audit of GP practices to provide extra guidance and support on how to improve how they communicate with deaf patients. A range of accessible supporting materials have been created including an accessible video for residents explaining how to register their communications needs with their GPs and a toolkit for practice staff to help them to better support their patients with communications needs.

Training programme to embed resident involvement and co-production skills
We recognise that listening to residents and understanding insight data are skills that we want to see across the health and care workforce in north east London. An online training module and supportive learning programme is in development for ICB staff and will compliment training provided in other partner organisations.

Reward and recognition
We have developed a Reward and Recognition policy for the ICB, which provides clear guidance to both residents and our staff on how we reimburse expenses and, where appropriate, offer involvement payments. This is a key part of our drive to remove barriers to participation and is consistent with NHS England's policy. More work is needed to fully align our approach with other local partners, but we now have funding dedicated to support place-based engagement and involvement as well as to reimburse those who get involved in work across north east London.

Community Leaders programme
North east London has many innovative examples of patient and community leaders being provided with training and collaborating with us as partners. One of the priority actions set out in our Working with People and Communities strategy was the development of NEL ICS community leadership programme. While resourcing issues meant we were not able to take this forward in 2023/24, we aim to prioritise this in 2024/5. It will be co-developed with input from across the system, drawing on existing best practice.

Creating a 'patient community of practice' to shape local cancer services
We have established a patient community of practice for the North East London Cancer Alliance, which consists of local patients and carers who have an interest in helping shape and improve local cancer services.

Their involvement is already helping to ensure resident voice and experience is improving how we provide information and support to people living with cancer and those who care for them – from giving advice on digital apps that provide cancer care, wellbeing and relaxation, to co-designing patient survey to ensure we capture the best possible insight, to sharing their stories on less common cancers to raise greater awareness.

The group has increased from nine to 25 members in the last year, and a campaign is underway to encourage more patient partners to be involved and to recruit people from diverse local communities to ensure the group is more representative of each borough and our wider population in north east London.

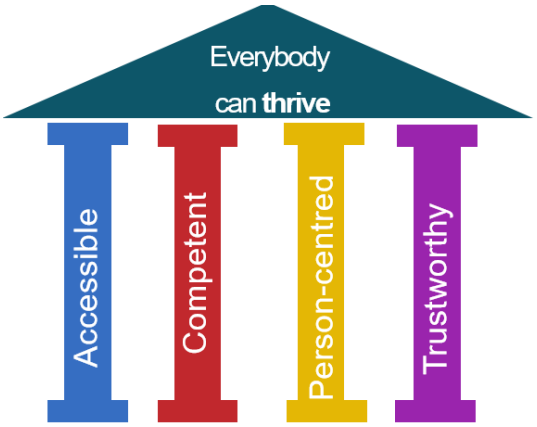
Our Big Conversation in north east London
As the next step in our work to deliver the commitments to listen to and involve people in the way we shape and improve services, we launched our 'Big

Conversation' in summer 2023. This builds on the commitment made in the 'Working with People and Communities' strategy to work with local people to identify priorities and to co-design the criteria against which we will evaluate our impact as a health and care system. In the Integrated Care Partnership's Interim Integrated Care Strategy, we agreed that these success measures would be initiated and shaped by local people through a 'Big Conversation' approach. The Integrated Care Partnership has now adopted the success measures identified as most important by local people through the Big Conversation – enabling us to take a whole population approach to measuring the impact of our strategy and interventions and to approve the final version of the Strategy.

Throughout summer 2023, we had conversations with around 2,000 people through a mix of face-to-face community events, an online survey and targeted focus groups (supported by our local Healthwatch organisations) that reflect our under-represented communities in north east London. This included Turkish mothers in Hackney, South Asian men in Newham and Tower Hamlets, Black African and Caribbean men in Hackney, older people in the City of London, patients with Long Covid in Hackney, men in Barking and Dagenham, Deaf BSL (British Sign Language) users in Redbridge, young people in Barking and Dagenham and Pakistani women in Waltham Forest.

The Big Conversation explored local people's views and experiences of

- how we are ensuring good care which is human and person-centred
- how we are supporting people's wellbeing through taking a genuinely broad focused approach
- how we are ensuring organisations work well together
- how we are enabling good access to services for everyone equitably
- how we are supporting opportunities to work in health and care with flexible and accessible routes to apprenticeships, work experience and employment



We listened to what people told us about what they would like to see more of and what they believe makes a difference to their care and have identified key themes. These have developed into a 'good care' framework and four pillars of good care.

Reducing health inequalities

Understanding the needs and concerns of our diverse population is key to building strong local partnerships as well as to addressing health inequalities and improving the health outcomes for our most vulnerable and underrepresented communities. As

noted in the section about our progress against corporate objectives, we have established a Health Equity Academy to lead our work on health inequalities across the system, recognising the fundamental importance of working with local communities differently to address the health inequalities they experience. Our population health management approach is also firmly rooted in taking action to reduce health inequalities by working to agreed outcomes for an agreed population.

Over the last 12 months, we have collaborated with community and faith leaders, the VCSE and other partners to develop better opportunities for people to participate in a way that works for them. Here we give some examples of how working with our communities enables us to recognise the stark inequalities faced by the diverse communities we serve in north east London and to strengthen our approaches, ultimately reducing the inequities experienced.

Working with the African and Caribbean community in Barking and Dagenham
Across north east London, health and care partners are working to encourage residents to protect themselves and their families from common conditions by taking up the offer of immunisations. This included skin-based conditions, such as measles, while exploring the reasons why people are unsure about vaccinations, we heard feedback from residents of an African and Caribbean heritage and from clinicians about the lack of images that showed skin conditions on darker skin colours. This made it difficult for them to understand what a condition like measles looks like and meant they did not feel information about these conditions were relevant to them.

Building on the very popular programme of ‘pop-up’ health clinics organised in Barking and Dagenham by the local health and care partnership, work is underway to hold a dedicated ‘pop-up’ dermatology clinic in early spring focused on engaging with the African and Caribbean community.

The NHS North East London team is also working with REFRAME, a national programme funded by NHS England and working with UWE Bristol to capture digital images on conditions on people with a wide range of skin tones to create a diverse photo library available for free to clinicians, educators and the public.

Local residents who join the event will be asked to volunteer for images that will be used across the country to help to identify conditions in all skin tones, leading faster diagnosis and offering patients better experiences in healthcare.

Engaging with our Jewish population
We have been working on a cancer awareness project which supports our local Charedi Jewish community. The project provides funding to a local charity, Acheinu Cancer Support (ACS), to drive a programme of cancer awareness, engagement events and communications across north east London.

Working with the Somali community in Tower Hamlets

Part of our work involves seeking enduring engagement with communities who face challenges accessing and navigating health and care services. In-reach work with the Somali community in Tower Hamlets identified their concerns about high level of prevalence of autism in the community, leading to anxiety about the safety of vaccinations, particularly MMR (Measles, Mumps and Rubella). This evolved as we made connections with community advocates and academics who had also identified this an issue of concern. Following a presentation to the Tower Hamlets Together Board, under their community voice item, local partners will work with the Somali community to research this issue in more detail.

Building on this, a focus group involving members of the community was held at Tower Hamlets town hall. The community reported how challenging it found accessing support when autism in the community was identified and called for local services to be re-shaped to be better able to support the community. In addition, we supported scoping research by a Somali academic at Queen Mary's University London. This showed there needed to be more comprehensive research extending beyond Somali community. As next steps, Tower Hamlets is looking at how its services can better engage and support the Somali community. Tower Hamlets Together is also utilising the Better Care Fund to research into the prevalence of autism in the global majority.

Exploring the experience of LGBTQIA+ residents in Hackney

One in every 100 people that lives in Hackney identifies as a member of the LGBTQIA+ community. We know from national and local data that people from these communities have disproportionately worse health outcomes and experiences of health and care.

Members of the LGBTQIA+ community helped to co-design a review of people's experiences and recommend steps that all health and care partners could take to make improvements and build greater trust in local services. A focus group involved 15 community members from Hackney, who were able to draw on their own experiences as well as speak on behalf of their community, worked with community leaders, VCS frontline staff and other partners involve in supporting members of the LGBTQIA+ community.

The discussion highlighted the impact of a lack of sensitivity from healthcare professionals and staff attitudes that could be interpreted as discriminatory, although it is likely they result from a lack of training or understanding.

Examples shared included trans women being referred to by their dead name when accessing GP services, caused by a refusal to acknowledge their trans status because the patient is listed in registration paperwork by their dead name (the term for when *somebody refers to a trans person using the name they had before they*

transitioned). Another example was excessive and intrusive questioning of lesbian women about their personal life when attending routine appointments.

The review confirmed that these experiences can result in members of the community disengaging with or avoiding healthcare. The City and Hackney Place Partnership is now working on plans to act on the recommendations, including LGBTQIA+ awareness training for healthcare staff, educating healthcare providers on the diversity and complexities within the LGBTQIA+ community, and identifying support for voluntary organisations to create safe inclusive spaces for the community that do not centre on nightlife or alcohol.

"You Need To Know"

We have been working in partnership with The Eve Appeal (a leading UK charity raising awareness of, and funding research for, gynaecological cancers) on a campaign called 'You Need to Know' which aims to increase awareness of womb cancer – and the main symptom being bleeding after the menopause - amongst Black African, Black Caribbean and South Asian women in north east London.

Local volunteers were involved right from the very start of the campaign, helping us understand key barriers and challenges from within the community and then working with us on the campaign messaging and visuals. As well as helping us design it, the volunteers even appeared in the campaign on posters, adverts and in the campaign video. You can watch the video here.

North East London Cancer Alliance and Eve Appeal have also been delivering interactive awareness sessions to community groups, speaking to over 300 women and people with a womb about the key messages of the campaign.

Maternity services

Taking a different approach, focusing on the landscape of maternal healthcare, disparities persist, reflecting a complex interplay of socioeconomic factors, cultural nuances, and healthcare access. In north east London, data illuminates a concerning trend - women from global majority backgrounds often interface with healthcare services later in their pregnancies than their white counterparts. Moreover, they are more likely to grapple with pre-existing health conditions, such as diabetes, adding layers of complexity to their care journey.

The statistics unveil stark realities - stillbirth rates among black and Asian women surpass those of white women, and the incidence of low birth weight babies is disproportionately higher among black and Asian mothers. Furthermore, black women face a higher likelihood of hospital admission during gestation, while women from global majority populations are more prone to unplanned caesarean sections compared to white women.

In response to these pressing challenges, the NEL Local Maternity and Neonatal System (LMNS) has embarked on a proactive journey of engagement and intervention. Collaborating closely with Healthwatch and Maternity Mates, the LMNS has undertaken a robust effort to amplify the voices of staff, advocates, and service users within maternity services. This concerted engagement seeks to glean insights, gather feedback, and solicit suggestions aimed at reshaping maternity care dynamics to better serve the needs of global majority communities and those hailing from deprived areas.

The outcomes of this collaborative endeavour have crystallised into a comprehensive action plan, currently in the throes of implementation. Key pillars of this strategic roadmap include:

- **Cultural competency training:** Recognising the imperative of cultural sensitivity in healthcare delivery, the LMNS is spearheading initiatives to enhance cultural competency among maternity care providers. By fostering a deeper understanding of diverse cultural norms and practices, healthcare professionals are better equipped to navigate the intricacies of patient care with empathy and respect.

- **Improving interpreting services:** Effective communication lies at the heart of quality healthcare delivery. Acknowledging linguistic barriers as potential impediments to effective communication, the LMNS is dedicated to bolstering interpreting services. By ensuring language access for all, the aim is to facilitate seamless communication channels between healthcare providers and patients, fostering trust and understanding.

- **Community asset mapping:** Harnessing the strength of community resources is paramount in fortifying maternal healthcare ecosystems. Through community asset mapping exercises, the LMNS endeavours to identify and leverage existing community networks, support systems, and resources. By forging robust partnerships with community stakeholders, the aim is to cultivate a nurturing environment conducive to maternal health and well-being.

- **Trauma-informed care:** Recognising the enduring impact of trauma on maternal health outcomes, the LMNS is championing trauma-informed care practices within maternity settings. By adopting a holistic approach that acknowledges and responds to the unique needs of trauma-affected individuals, healthcare providers strive to create safe, empowering spaces that promote healing and resilience.

In line with NHSE recommendations, NEL will be incorporating three of the nine recommendations that NHS England are reviewing into their Equality and Equity strategy. These include:

- Provide national support to help identify and overcome the barriers to local, equitable provision of interpretation services at all stages of perinatal care. This should include resources to provide written information and individual parent follow-up leaflets in languages other than English.

- Develop training and resources for all maternity and neonatal staff, so they can provide culturally and religiously sensitive care for all mothers and babies.

- Ensure that all relevant staff in trusts and health boards have adequately resourced time in their work plans and contracted hours and are supported to participate in local perinatal mortality review tool (PMRT) multidisciplinary review panels as internal and external members, so that these safety critical meetings are constituted and conducted in an appropriate manner and are never cancelled.

Health and wellbeing (HWB) strategy

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.

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.

The ICB:

- has developed a committees-in-common approach in Barking and Dagenham of the Integrated Care Board (ICB) Sub-Committee and Health and Wellbeing Board HWB, in order to promote consistent decisions being taken between organisations at Place. The closer alignment of the HWB and the ICB sub-committee streamlines the current governance arrangements; speeds up decision making, improves alignment of actions on priorities and in doing so will improve services through greater collaboration and reduction in duplication.

- has developed proposals to hold regular integrated meetings of the ICB sub-committee/Health and Care Partnership with the London of Waltham Forest Health and Wellbeing Board (HWB). A closer alignment of the HWB and the ICB sub-committee/Health and Care Partnership has streamlined the previous governance arrangements.

- has worked alongside wider system partners as it has developed itself as an organisation over the past two years. It has set out key ambitions and priorities, that mirror some of our local priorities, particularly around improving the wider health outcomes of our residents and tackling health inequalities.

- is developing closer relationships with wider partners and is on a journey to becoming more effective at supporting local areas to tackle challenges together.

- has worked with us, as the Health and Wellbeing Board, to build the NEL Integrated Care Partnership forward plan, so we are able to see our priorities reflected in this piece of work. A sense of local places is now more explicit in the NHS Forward Plan, allowing us to focus on real change for local communities.

- has prioritised tackling health inequalities and dedicated three-year Place level grants to support the implementation of these, leading to some excellent and innovative work at Place. Some tangible examples of this include:

    - A place collaboration between ELFT / LBH / and our CAMHS provider Alliance, delivering early mental health and wellbeing support to Black and Global majority young people, through young people (The ‘Tree of Life' initiative), which won several awards:https://www.hsj.co.uk/partnership-awards/hsj-partnership-awards-2024-most-impactful-project-addressing-health-inequalities/7036804.article.

    - A strong immunisations and vaccinations partnership, whereby NEL ICB have funded a local partnership, led by LBH, to deliver a range of targeted outreach to local communities through the voluntary sector, (e.g., town hall events) alongside increased interventions in primary care. Joint funding has enabled us to employ a joint immunisations co-ordinator across the whole partnership (public health, ICB, Primary Care), which is securing significant improvements in uptake of immunisations and vaccinations.

    - has ensured that there is ongoing Clinical Leadership at NEL level, supporting our local place clinical leadership, and championing key improvements.

- Central ICB teams are developing to support the work of Places, and allocating Place-level engagement leads has ensured the voice of residents will be paramount in guiding our work ahead.

Understanding and managing risk
The ICB has continued to develop its Risk Management Policy and Strategy to ensure the organisation manages its key risks and supports staff to manage risk effectively. Further detail on the ICB's risk management arrangements and effectiveness are set out in the governance statement.

The ICB recognises the complexity of the landscape in which we are operating and the strength and depth of our ambition. Looking forward, there are a number of key strategic and system risks that are likely to affect achievement of the ICB priorities and objectives, in relation to which we have varying levels of mitigations in place both as the ICB and with system partners:

Resources:
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 Integrated Care Strategy to improve equitably the health and wellbeing of people across north east London

Collaborative working across partners - There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means we as system partners will continue to meet a narrower range of local people's needs and risk not bringing into account wider community assets.

Workforce: There is a risk that the failure to implement the agreed whole system workforce strategy at pace, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support our workforce effectively and to achieve our wider ambitions.

Digital and estates: There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures and are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population.

Population health improvement
Wider determinants of health/environment: There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health, including the impact of the climate emergency on the health and wellbeing of local people.

Population growth: There is a risk that partners fail to work collaboratively and

innovatively to plan for and address the significant and rapid growth in population and therefore in need and demand across north east London over the coming years.

Population growth – specialist services: There is a risk that, if the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes.

Quality, equity and fairness
Quality and safety of care: There is a risk that workforce and resource capacity challenges adversely impact on the quality and safety of care to residents, thereby increasing health inequalities, poorer outcomes and service failures.

Structural discrimination: There is a risk that existing inequalities in outcomes and experience which result from structural discrimination of all types continue, as underlying structural inequalities are not addressed.

Partnership and system working

Mutual accountability for commitments: There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement.

Being outward looking: There is a risk against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda.

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 27 March 2024 and is included in the board papers online here. The board assurance framework aligns to the strategic aims and objectives of the ICS.

Financial Review

As of 31 March 2024, NEL ICB had net liabilities of £294.7m (£307.7m as at 31 March 2023).

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.

The funding for 2024/25 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 12 months to 31 March 2024, NEL ICB was given funding of £4,753.7m from NHSE. Within this funding the ICB is allowed to spend £45m 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 12 months to the period ending 31 March 2024, we spent £3,215m (£2,193m for the period ended 31 March 2023), which is 68% of our total spend this is consistent with 2022/23.

The ICB delivered a surplus of £14.4m for the year ended 31 March 2024. The ICB has also remained within the running costs allocation.

The financial position continues to be very difficult and so in 2024/25 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 12 month period to end 31 March 2024. 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 for the North East London Integrated Care Board, and good financial control and management is vital for the development of the organisation.

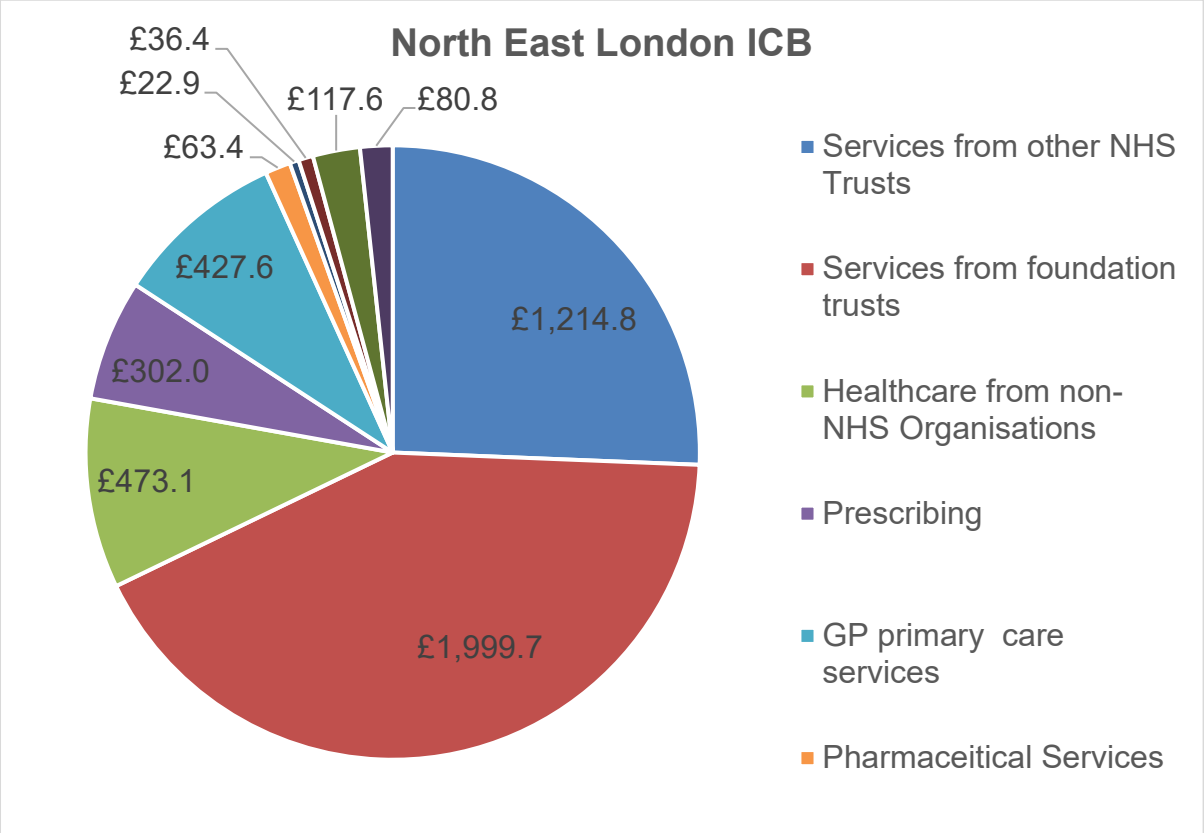
How we spent the money

In summary we spent the money as follows:

	£m
Services from other NHS trusts	£1,214.8
Services from foundation trusts	£1,999.7
Healthcare from non-NHS organisations	£473.1

Prescribing	£302.0
GP primary care services	£427.6
Pharmaceutical services	£63.4
General ophthalmic services	£22.9
Purchase of social care	£36.4
General dental services	£117.6
Other costs	£80.8
Total	**£4,738.3**

A.1: How we spent the money



Overall Financial Performance

During the financial year end 31 March 2024, NEL ICB has worked under the national financial arrangements which includes block contracts with NHS providers, elective recovery and a greater emphasis on financial planning at an Integrated Care System level.

The ICB delivered a surplus of £14.4m for the year ended 31 March 2024. 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 2024/25 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 2024/25 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
24 June 2024

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises of three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

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 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.

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 the 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
Cha Patel	Non-executive Member
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) (until 22 September 2023)
Councillor Christopher Kennedy	Partner Member (Local Authority) (from 31 January 2024 to date)
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

Name	Role
Abi Gbago	Local Authority Executive Participant
Manisha Modhvadia	Healthwatch Participant
Jenny Hadgraft	Healthwatch Participant

In addition, we have a number of associate non-executive members, appointed on a shorter- term basis, who support 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)
Sue Evans	Associate Non-executive Member
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
During the reporting period 1 April 2023 – 30 March 2024, the ICB has had no serious incidents involving data loss or confidentiality breaches that required formal reporting to the ICO.

Information governance incidents

A total of 17 incidents were reported. Among the 17 incidents recorded, none were reportable to the ICO. This indicates that NEL ICB incident response procedures and security measures were effective in mitigating risks and ensuring compliance with data protection regulations.

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 Integrated Care Board'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 Integrated Care Board'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

Introduction and context

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 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 April 2023 and 31 March 2024 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).

The arrangements set out below have been in place throughout the year and where there have been changes during the year these have been referenced below.

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 governing body is to ensure that the group 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. 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 April 2023 and March 2024 were:

- Approving the governance handbook
- Approving the People and Culture Strategy.
- Approving the operating plan and 2023/24 ICB budget
- Reporting on freedom to speak up services across the partnership
- Development of the quality dashboard
- Development of clinical care and professional leadership
- Development of our approach to system recovery
- Development of the Joint Forward Plan
- Reporting on the impact of industrial action and development of next steps
- Reporting on and oversight of ICB and ICS finances
- Reporting on and oversight of performance and quality issues within commissioned health providers
- The management of strategic risk through scrutiny of the Board Assurance Framework (BAF)

- Exception reports from the committees of the Board.

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

Board member	31 May 2023	26 July 2023	27 Sept 2023	29 Nov 2023	31 Jan 2024	27 March 2024	Total attended /total possible
Marie Gabriel CBE	✓	✓	✓	✓	✓	✓	6/6
Zina Etheridge	✓	✓	✓	✓	✓	✓	6/6
Paul Calaminus	✓	✓	✓	✓	✓	✓	6/6
Shane DeGaris	X	✓	✓	✓	✓	✓	5/6
Cllr Maureen Worby	✓	✓	✓	✓	✓	✓	6/6
Philip Glanville (until 22 Sep 2023)	X	✓	N/A	N/A	N/A	N/A	1/2
Caroline Rouse	✓	✓	✓	✓	✓	✓	6/6
Diane Jones	✓	✓	✓	✓	✓	✓	6/6
Henry Black	✓	✓	✓	X	✓	✓	5/6
Dr Paul Gilluley	✓	✓	✓	✓	✓	✓	6/6
Dr Mark Rickets	✓	✓	✓	X	✓	✓	5/6
Dr Jagan John	✓	✓	✓	✓	X	✓	5/6
Diane Herbert	✓	X	✓	✓	✓	✓	5/6
Imelda Redmond CBE	✓	X	✓	✓	✓	✓	5/6
Cha Patel	✓	✓	X	✓	✓	✓	5/6
Cllr Christopher Kennedy (from 31 January 2024)	N/A	N/A	N/A	N/A	✓	✓	2/2

The meeting was also attended regularly by:

- Andrew Blake-Herbert, local authority executive participant
- Abi Gbago, local authority executive participant (who started her role in September 2023).
- Manisha Modhvadia, Healthwatch participant observer
- Jenny Hadgraft, 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.

Committee member	13 June 2023	13 July 2023	7 Sept 2023	9 Nov 2023	11 Jan 2024	Total attended /total possible
Zina Etheridge (Chair), CEO NHS North East London	✓	✓	X	X	X	2/5
Andrew Blake-Herbert, Chief Executive, London Borough of Havering	✓	X	✓	✓	✓	4/5
Louise Ashley, Chief Executive Officer, Homerton Healthcare NHS Foundation Trust	X	✓	✓	✓	✓	4/5
Henry Black, Chief Finance and Performance Officer, NHS North East London	✓	✓	✓	✓	✓	5/5
Paul Calaminus, Chief Executive Officer, East London NHS Foundation Trust (until July 2023), and NELFT (from July 2023 to date)	✓	✓	✓	✓	✓	5/5
Shane DeGaris, Group Chief Executive, Barts Health NHS Trust	✓	✓	X	✓	✓	4/5

Committee member	13 June 2023	13 July 2023	7 Sept 2023	9 Nov 2023	11 Jan 2024	Total attended /total possible
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	✓	✓	✓	✓	X	4/5
Gladys Xavier, Director of Public Health, London Borough of Redbridge	X	✓	✓	X	✓	3/5
Heather Flinders, Strategic Director of People, London Borough of Waltham Forest (until October 2023)	✓	✓	X	N/A	N/A	2/3
Christopher Spencer, Interim Strategic Director of People, London Borough of Waltham Forest (from October 2023)	N/A	N/A	N/A	✓	✓	2/2
Jacqui Van Rossum, Acting Chief Executive Officer, NELFT (until July 2023)	✓	N/A	N/A	N/A	N/A	1/1
Lorraine Sunduza, Interim Chief Executive Officer, East London NHS Foundation (from July 2023 to date)	N/A	N/A	✓	✓	✓	3/3
Diane Jones, Chief Nursing Officer, NHS North East London	X	✓	✓	X	✓	3/5
Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London	✓	✓	✓	✓	✓	5/5
Francesca Okosi, Chief People and Culture Officer, NHS North East London	✓	✓	X	✓	✓	4/5
Charlotte Pomery, Chief Participation and Place	✓	✓	✓	✓	✓	5/5

Committee member	13 June 2023	13 July 2023	7 Sept 2023	9 Nov 2023	11 Jan 2024	Total attended /total possible
Officer, NHS North East London						
Sarah See, Managing Director of Primary Care, NHS North East London	X	X	✓	✓	X	2/5
Tim Aldridge, Corporate Director of Children and Young People, London Borough of Newham (until September 2023)	X	X	X	N/A	N/A	0/3
Matthew Trainer, Chief Executive, Barking, Havering and Redbridge University Hospitals Trust	✓	✓	X	X	✓	3/5
Colin Ansell, Chief Executive, London Borough of Newham (until September 2023)	✓	X	X	N/A	N/A	1/3
Abi Gbago, Chief Executive, London Borough of Newham (from September 2023 to date)	N/A	N/A	N/A	X	X	0/2

The following key topics were discussed by the Committee 2023/24:

- The People and Culture Strategy
- Delegation of primary care complaints from NHS England
- Delegation of specialised services from NHS England
- Monthly position of ICB and ICS finances
- The System planning cycle
- Delivery of the national patient choice programme
- Urgent and emergency care priorities
- Approval of primary care same day access hubs
- Emergency Preparedness, Resilience and Response workplan
- Implementation of the Provider Selection Regime
- A review of the impact of industrial action
- Regular exception reports from the Clinical Advisory Group

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 collaborative discussions across system partners
- Positive discussion regarding the impacts of industrial action and how partners are working together to tackle the arising issues
- Meeting online allows executives to come together to consider agenda items effectively, as meeting in person could be difficult given the nature of members' sovereign roles.

Areas for improvement:

- Governance routes could be communicated clearer, particularly regarding improvement programmes.
- Agendas tend to have a health focus and the forum could be strengthened by including more social care items.
- The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee, the details of which are outlined below.

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	24 April 2023	22 June 2023	30 Aug 2023	18 Oct 2023	13 Dec 2023	21 Feb 2024	Total attended /total possible
Cha Patel (Chair), Non-executive member	✓	✓	✓	✓	✓	✓	6/6
Sue Evans, Associate non-executive member	✓	✓	✓	✓	X	✓	5/6
Imelda Redmond CBE, Non-executive member	✓	✓	✓	✓	✓	✓	6/6
Kash Pandya, Associate non-executive member	✓	✓	X	✓	✓	✓	5/6

The meeting is regularly attended by:

- Henry Black - Chief Finance and Performance 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

- Charlotte Pomery - Chief Participation and Place Officer, NHS North East London
- Anne-Marie Keliris – Head of Governance, 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 Specialist, RSM

The following key topics were discussed by the Audit and Risk Committee in 2023/24:

- Governance
- Risk management
- Internal control
- External Audit
- Internal Audit
- Counter Fraud
- Procurement and contracts
- Information governance and IT
- Financial 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:

- The committee is clearer about its areas of responsibility and has less duplication with the Finance, Performance and Investment Committee
- Meetings are well attended, and participation is good with a variety of views adequately aired
- There is an effective level of challenge that focuses on issues while also allowing open discussion
- Agendas have a strong focus on the areas of greatest risk

Areas for improvement:

- Mechanisms could be developed for triangulating the work programmes of other committees, particularly regarding audit outcomes.
- The frequency of meetings or meeting length could be reviewed as the committee meets more regularly than other ICBs.

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:

Member	24 April 2023	30 May 2023	26 June 2023	4 Sept 2023	30 Oct 2023	30 Nov 2023	8 Jan 2024	26 Feb 2024	25 March 2024	Total attended /total possible
Kash Pandya (Meeting Chair), Associate Non-executive member	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9
Henry Black, Chief Finance and Performance Officer	✓	✓	✓	✓	✓	X	✓	✓	✓	8/9
Mayor Philip Glanville, Local Authority Partner Member (until September 2023)	✓	X	X	X	N/A	N/A	N/A	N/A	N/A	1/4
Cllr Christopher Kennedy, Local Authority Partner Member (from February 2024)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓	2/2
Dr Mark Rickets, Primary Care Partner Member	X	✓	✓	✓	✓	X	✓	✓	✓	7/9
Fiona Smith, Associate Non-Executive Member	X	✓	✓	X	✓	✓	✓	X	✓	6/9
Cha Patel, Non-Executive Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/9

Member	24 April 2023	30 May 2023	26 June 2023	4 Sept 2023	30 Oct 2023	30 Nov 2023	8 Jan 2024	26 Feb 2024	25 March 2024	Total attended /total possible
Dr Mohit Venkataram, NHS Trust Partner Member	✓	X	X	✓	✓	X	✓	✓	✓	6/9

The meeting was regularly attended by:

- Marie Gabriel CBE, Chair, NHS North East London
- 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 meeting was attended by the following ICB Board members on occasion to ensure the quorum was achieved when identified members had sent apologies:
- Cllr Maureen Worby
- Dr Jagan John
- The following key topics were discussed by the Committee in 2023/24:
- Monthly finance overviews and reports
- Monthly performance reports
- Monthly finance and performance risk registers
- Review of the previous financial year's annual accounts
- Review and approval of the 2023/24 Operating Plan and budgets
- Financial impacts and details of the ICB restructure
- Development, mobilisation and ongoing progress updates around the ICS's financial recovery plan
- Approval of business cases and procurement/contract award recommendations
- Deep Dive's on Prescribing, Estates and Infrastructure, Mental Health Investment Standard and the Community Health Services Collaborative

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 chairing with effective engagement from partner members
- A focus on performance that is linked with impacts on the system

- Scrutiny of ICB investments and the system's financial position.

Areas for improvement:

- A focus on productivity could be enhanced whilst recognising the transition needed to move resources for care closer to home
- The demand from regulators can mean that there is not enough capacity for the committee to request specific analysis
- Financial information presented is usually several months behind due to the systems in place, meaning quick action may not be possible if required.
- The Primary Care Contracts Sub-committee is a sub-committee of the Finance, Performance and Investment Committee, the details of which are outlined below.

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.

Committee member	26 April 2023	21 June 2023	5 Sept 2023	25 Oct 2023	6 Dec 2023	7 Feb 2024	Total attended /total possible
Marie Gabriel CBE (Chair), ICB Chair	✓	✓	X	✓	✓	✓	5/6
Zina Etheridge, Chief Executive Officer	✓	✓	✓	✓	✓	✓	6/6
Louise Ashley, NHS Trust Partner Member	✓	✓	✓	✓	X	✓	5/6
Noah Curthoys, Associate Non-executive Member	X	✓	X	X	✓	✓	3/6
Dr Paul Gilluley, Chief Medical Officer	✓	X	✓	X	✓	✓	4/6
Dr Jagan John, Primary Care Partner Member	✓	✓	X	✓	✓	✓	5/6
Councillor Maureen Worby, Local Authority Partner Member	✓	✓	✓	✓	✓	✓	6/6
Charlotte Pomery, Chief Participation and Place Officer	✓	✓	✓	X	✓	✓	5/6
Imelda Redmond CBE, Non-executive Member	✓	✓	✓	✓	✓	✓	6/6
Fiona Smith, Associate Non-executive Member	X	✓	✓	✓	✓	X	4/6

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
- Amanjit Jhund, executive place-based partnership representative
- Lorraine Sunduza, executive provider collaborative representative
- Paul Calaminus, executive provider collaborative representative
- Neil Ashman, executive provider collaborative representative
- The following key topics were discussed by the Committee in 2023/24:
- Health inequalities funding
- Allocation of the shared ambition funding
- Effective system working
- Supporting equity and sustainability in north east London
- Strategic commissioning
- Work happening to address poverty and benefits entitlements
- Health literacy awareness
- Growing well in north east London
- Risks
- Regular update reports from the Place and Provider Collaborative Sub-committees

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:

- Inclusive and nuanced chairing
- The committee has an improved understanding of its role and what it should be discussing
- Effective discussion and challenge from partners.

Areas for improvement:

- To better focus on the integration of care and how the different parts of the system work together across pathways

- To develop a plan that enables members to focus on the shift from in hospital to care closer to home, with a focus on building ability within the latter through our commissioning strategy

- Clarification on the next steps that will enable better population health and integration outcomes

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.

Committee member	26 April 2023	14 June 2023	13 Sept 2023	18 Oct 2023	6 Dec 2023	14 Feb 2024	Total attended /total possible
Imelda Redmond CBE (Chair), Non-executive member, NHS North East London	✓	✓	✓	✓	✓	✓	6/6
Marie Gabriel CBE, Non-executive member, NHS North East London	✓	✓	✓	✓	✓	✓	6/6
Diane Herbert, Non-executive member, NHS North East London	✓	X	✓	✓	✓	✓	5/6
Fiona Smith, Associate non-executive member, NHS North East London	X	✓	X	✓	✓	✓	4/6
Diane Jones, Chief Nursing Officer, NHS North East London	✓	X	✓	✓	✓	✓	5/6
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	X	✓	✓	✓	✓	✓	5/6
Dr Jagan John, Primary care partner member	✓	✓	X	✓	✓	✓	5/6
Cllr Maureen Worby, Local Authority partner member	✓	X	X	✓	✓	X	3/6
Charlotte Pomery, Chief Participation and Place Officer, NHS North East London	✓	✓	✓	✓	✓	✓	6/6

Committee member	26 April 2023	14 June 2023	13 Sept 2023	18 Oct 2023	6 Dec 2023	14 Feb 2024	Total attended /total possible
Mamta Vaidya, NHS Trust partner member	X	X	X	X	X	X	0/6

The meeting is also attended regularly by:

- Director of Nursing, NHS North East London
- Director of Quality, NHS North East London
- The following key topics were discussed by the Committee in 2023/24:
- Quality governance
- Industrial action impact on quality and patient safety
- Violence reduction duties for NHS North East London
- Safeguarding Strategy
- Quality exception assurance reports
- Strategic risks
- Patient Safety Incident Response Framework (PSIRF)
- Performance Reports
- Urgent and emergency care programme
- System maternity services
- Deep dives into system priorities
- Escalation and diversion policy
- Clinical Negligence Scheme for Trusts (CNST)
- Safeguarding annual reports
- Learning from the lives and deaths of people with a learning disability and autism (LeDeR) annual report
- Safeguarding strategies

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 committee is consistently improving with a focussed Chair
- Better focus on added value of system oversight
- Improving sense of where the areas of concern are.

Areas for improvement:

- Having a more focussed agenda will enable us to develop a single quality report for the system and reduce the number of reports
- Greater time should be available for each agenda item to enable more effective discussion and challenge.
- Holding hybrid meetings (online and in person) can make meetings difficult to navigate.

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 People and Culture 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.

Committee member	4 April 2023	2 May 2023	14 July 2023	25 July 2023	10 Aug 2023	3 Oct 2023	30 Oct 2023	14 Nov 2023	9 Jan 2024	7 Feb 2024	15 Mar 2024	Total attended /total possible
Diane Herbert (Chair), Non-executive member, North East London ICB	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	10/11

Marie Gabriel CBE, Chair, NHS North East London	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/11
Sue Evans, Associate non-executive member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	10/11
Noah Curthoys, Associate non-executive member	X	✓	✓	X	X	X	✓	✓	✓	✓	✓	7/11
Mark Ricketts, Primary care partner member	✓	✓	X	✓	X	✓	X	✓	✓	✓	✓	8/11
Andrew Blake-Herbert, Local authority executive participant	✓	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
Colin Ansell, Local Authority partner member (from April 2023, until September 2023)	N/A	X	X	X	X	N/A	N/A	N/A	N/A	N/A	N/A	0/4
Daniel Waldron, Trust partner member	✓	X	X	X	✓	✓	X	X	✓	X	✓	5/11

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

The following key topics were discussed by the Committee in 2023/24:

- ICB Organisational change program
- Voluntary redundancy scheme
- Staff survey
- NEL ICS People and Culture Strategy
- North east London workforce productivity
- Clinical and care professional leadership
- Executive management team objectives and performance reporting
- Board and executive recruitment policy
- Workforce risks

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:

- Overseeing the ICB restructure and associated financial savings
- Having oversight and direction setting of the People and Culture Strategy
- Extremely focusses and productive chairing.

Areas for improvement:

- Considering effectiveness indicators for our Human Resources (HR) processes.
- Reports to be provided in the timeframes stipulated in the committee's terms of reference
- Meeting dates to be scheduled a year in advance to minimise the need for extraordinary meetings.

Workforce and Remuneration governance review

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

The outcome of this review proposed the disestablishment of the current workforce and remuneration committee and to establish separate committees of the Board which was approved by the ICB Board on 27 March 2024 - the new committees will have the following responsibilities:

Remuneration committee

- Seek assurance in relation to ICB statutory duties in relation to people, such as compliance with employment legislation, including Fit and Proper Person Regulation (FPPR) and Freedom to Speak Up (FTSU).
- Determine ICB pay policy and oversee contractual arrangements for all staff
- Determine all aspects of remuneration and contractual arrangements for VSM and Executive Directors including agenda for change band 9.
- Approve changes to organisational structures and changes in the establishment which may increase funding requirements or reductions in cost or which may result in redundancies.
- Approve any proposed redundancy, severance or settlement costs and payments, where necessary providing this in advance of any authorisation needed from NHS England and the Treasury.
- Board succession planning.

ICS People and culture committee

- Responsibility for the workforce priority on behalf of the ICS including the delivery of the Long Term Workforce Plan. This will include creating

meaningful employment for the local population across North East London. Creating a 'One NEL' workforce across Health and Social Care which contributes to creating a healthy community across NEL and creates a set of working environments in which a diverse and inclusive workforce can work and develop their careers.

- Oversee the delivery of the NEL System people and culture strategy.
- Establish a people board to deliver the NEL system strategy.

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 membership and attendance record for the meeting is outlined in the table below.

Committee member	4 April 2023	Total attended /total possible
Marie Gabriel, ICB Chair	✓	1/1
Zina Etheridge, Chief Executive Officer	✓	1/1
Mark Ricketts. Primary care partner member	✓	1/1
Daniel Waldron, Trust partner member	X	0/1

The meeting is also attended by:

- Francesca Okosi, Chief People and Culture Officer, NHS North East London

The following key topics were discussed by the Committee at its meeting on 4 April 2023:

- Non-executive member objectives and tenure

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
During 2023/24 sub-committee members agreed to develop a committees-in-common approach of the Integrated Care Board (ICB) Sub-Committee and Health

and Wellbeing Board HWB). On 31 May 2023, the ICB Board approved that the HWB and the Place ICB Sub-committee will meet as committees-in-common (CsIC) from June 2023, in order to promote consistent decisions being taken between organisations at Place. Decisions taken by the London Borough of Barking and Dagenham and the ICB within the forum of the aligned meeting can be taken simultaneously but they will remain separate decisions that each organisation is accountable for.

The closer alignment of the HWB and the ICB sub-committee streamlines the current governance arrangements; speeds up decision making, improves alignment of actions on priorities and in doing so will improve services through greater collaboration and reduction in duplication.

The following key topics were discussed by the Sub-committee and Committees-in-common in 2023/24:

- Governance
- Progressing the ambition for Barking and Dagenham
- Better Care Fund
- Improving Urgent and Emergency Care (UEC) across Barking & Dagenham, Havering and Redbridge
- Winter Plan
- System planning cycle
- Joint Forward Plan
- ICB Finance overview
- Risk Register
- Joint local Health and Wellbeing Board Strategy 2023/2028 refresh framework for delivery
- Health inequalities programme plans
- Carers charter and action plans
- Extension to 0-19 integrated healthy children and young people's therapy services
- Safeguarding Adults Board annual report
- Annual report from the Director of Public Health

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:

- Establishment of the Committees in Common with the Health and Wellbeing Board has streamlined decision making, strategic input and oversight of delivery

- Regular development sessions have built up trust and enabled partners to shape how we do our business
- Good chairing and participation of members

Areas for improvement:

- Delegation of functions to place from the ICB as the committee cannot fully exercise its responsibilities
- Better communication from the Population Health and Integration Committee
- An increased focus on acute care would be welcomed and establishing target dates to improve things by.

City and Hackney Integrated Care Board Sub Committee

The following key topics were discussed by the Sub-committee in 2023/24:

- Integrated delivery plan
- VCS Enabler Sustainability Plan
- Winter plan
- Unified GP provider organisation consultation
- Right care, right person
- Proposals for the use of the health inequalities fund
- Regular updates on finance and performance

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:

- Meetings are well chaired and well attended
- Secretariat function is working well.

Areas for improvement:

- Delegation to Place by the ICB
- Receiving finance reports that are specific to the partnership rather than north east London-wide
- Reports to be more concise and easily digestible.

Havering Integrated Care Board Sub Committee

The following key topics were discussed by the Sub-Committee in 2023/24:

- Health inequalities
- Financial position

- Clinical and Care Leadership
- Ageing Well
- Carers Strategy
- Joint Forward Plan
- Designing our approach to communications and engagement in Havering
- Public protection; mould and damp
- Children's Safeguarding Board quarterly report
- The Big Conversation
- Better Care Fund
- Overview of Babies, Children and Young People's group
- Private rented sector and the impact on housing demand
- Vaccination strategy
- St Georges development
- Regular Primary Care Network updates
- Community Chest
- Patient Safety Incident Response Framework (PSIRF) and learning from patient safety events
- Havering Annual Health Protection Report 2022/23
- Combating substance misuse strategy
- Tackling poverty in Havering
- Mental health pathways

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:

- Discussions have started that have a focus on the wider determinants of health
- Inclusive membership
- Greater focus on babies, children and young people

Areas for improvement:

- It has taken some time to disaggregate and set up the individual Local Authority groups.

Newham Integrated Care Board Sub Committee

The following key topics were discussed by the Sub-Committee in 2023/24:

- Joint Forward Plan

- Health inequalities fund
- Frailty proactive care
- Update from Local Infrastructure Forum
- The Big Conversation
- Primary Care health inequalities
- London Polio Vaccination Campaign
- Housing in Newham
- Newham outcomes framework
- Financial prioritisation and planning
- Population growth programme
- Winter plan
- Communications plan
- Place-based climate action
- Special Educational Needs and Disabilities (SEND): Guidance and inspection update, local investment impact and pressures
- System development plan
- Health-based place of safety
- Long Term Conditions

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 Chairing
- Rich discussions

Areas for improvement:

- Forward planning

Redbridge Integrated Care Board Sub Committee

The following key topics were discussed by the Sub-Committee in 2023/24:

- Joint Forward Plan
- Better Care Fund
- Winter Plan
- Patient Safety Incident Response Framework
- Health Inequalities Funding
- The Big Conversation

- Whipps Cross Hospital End of Life Care (EOLC) Programme
- Clinical care and professional leadership
- Approach to integrated neighbourhood teams
- Demand and capacity funding
- Diagnostics strategy
- System planning cycle 2024/25
- Accessible Information Standards programme
- Keeping people well at home
- Early years strategy
- Whipps Cross Hospital Redevelopment

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:

- Very effective collaborative working, and ongoing work to leverage the benefits of partnership working
- Commitment to equitable partnership and involving a diverse range of voices and perspectives.
- Reports are well presented, and meetings are well organised.

Areas for improvement:

- It could be beneficial to hold more meetings in person to strengthen working relationships
- A lot of NHS terminology can make reports inaccessible for some partners and members of the public
- Full agendas can mean that there is insufficient time to provide extensive challenge and scrutiny.

Tower Hamlets Integrated Care Board Sub Committee

The following key topics were discussed by the Sub-Committee in 2023/24:

- Joint Forward Plan
- Better Care Fund
- Winter Plan
- Patient Safety Incident Response Framework
- Health Inequalities Funding
- The Big Conversation
- Community voice
- Health and housing

- Anti-racist commissioning
- Locality and neighbourhoods case for change
- GP access
- Promoting independence and living well

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:

- Hearing from community voices, tracking actions that come from those voices, and having a focus on voluntary, community and social enterprises
- Effective information sharing across the partnership
- Meetings are well attended with good representation from across the system.

Areas for improvement:
- Forward planning would enable greater alignment with the community voice
- Delegated authority from the ICB.

Waltham Forest Integrated Care Board Sub Committee
The Waltham Forest Health and Care Partnership developed proposals to hold regular integrated meetings of the ICB sub-committee/Health and Care Partnership with the London of Waltham Forest Health and Wellbeing Board (HWB) from December 2023. Partners from the ICB and London Borough of Waltham Forest worked to develop the arrangements. A closer alignment of the HWB and the ICB sub-committee/Health and Care Partnership has streamlined the previous governance arrangements; speed up decision making, improve alignment of actions on priorities and in doing so will improve services through greater collaboration and reduction in duplication.

The following key topics were discussed by the Sub-Committee in 2023/24:

- Joint Forward Plan
- Better Care Fund
- Winter Plan
- Patient Safety Incident Response Framework
- Health Inequalities Funding
- The Big Conversation
- Community transformation programme
- CQC local assurances
- End of life care transformation
- Population health management
- Data sharing

- Energy efficiency upgrades to support better health
- Homelessness
- Babies, children and young people

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:

- Establishing a strong partnership ethos
- Greater discussions on the wider determinants of health
- Good representation from across the partnership.

Areas for improvement:

- Meetings are well attended, however active participation in meetings could be improved.
- Having an increased focus on assurance of planning and delivery of workstreams would be beneficial.
- Governance processes and the roles and responsibilities of members could be refreshed.

Acute Provider Collaborative Joint Committee
The Acute Provider Collaborative (APC) Joint Committee, is the collective governance vehicle for joint decision-making by the NHS Partner Organisations in relation to acute services. It has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London, to reduce inequalities in health outcomes, access and experience; improve resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.

The duties of the Joint 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 acute services in North East London
- Ensure 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; and ensure that people participation is at the heart of the activities of the APC's work

- 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 and encourage the engagement of the partner organisations of the ICS, with a view to shaping the future of acute services across North East London
- Lead the development of the ICS strategy and planning for acute services, and put in place arrangements to ensure its delivery with ICS partners including the seven place-based partnerships
- Provide assurance to the NHS Partner Organisations on the delivery of the ICS's strategy and plans for acute services and the NHS Long Term Plan, and agree mitigations where there are significant delivery risks
- Enable the joint exercise of the functions which have been delegated to the APC Joint Committee by the NHS Partner Organisations, in a simple and efficient way.

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 secretariat function
- Agenda planning has worked well

Areas for improvement:

- Having a greater focus on opportunities to drive better efficiency outcomes as a result of providers working together.

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 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 following key topics were discussed by the Sub-Committee in 2023/24:

- Creating an inclusive and effective committee
- Service user and career priorities for mental health
- Service user and carer summit
- Place-based mental health partnerships
- Priorities for people with a learning disability
- Mental health, learning disability & autism system diagnostic
- Mental health in urgent and emergency care deep dive
- Attention Deficit Hyperactivity Disorder (ADHD) deep dive
- Joint Forward Plan
- 2024/25 Planning Framework
- Commissioning Framework for mental health inpatient services
- The Big Conversation
- Multi-disciplinary interventions including prescribing and talking therapies for people with common mental health problems

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:

- Having patient representatives on the sub-committee and their active participation in meetings
- Varied focus across different population segments.
- Good collaborative discussions taking place.

Areas for improvement:

- Defining the assurance function of the sub-committee
- Establishing whether the sub-committee can have any delegated authority.

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.

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 following key topics were discussed by the Sub-Committee in 2023/24:

- Approval of the terms of reference for the general practice provider group and the pharmacy provider group.

- The approach and input into the Big Conversation as well as output relating to primary care services.
- The Joint Forward Plan, with a focus on areas relevant to primary care.
- Regular reports are received from the primary care managing director and associate medical director, community pharmacy and general practice provider groups and updates received on the development of the dentistry and optometry provider groups.
- A regular discussion on high level primary care risks and on primary care finances, including prescribing and system development funds, are held.
- Updates on the Fuller programme workstreams.
- Progress updates on the primary care access recovery plan.
- Community pharmacist consultation service.
- ICB priorities – Babies, Children and Young People, and Long-Term Conditions

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 information sharing between members
- Good partnership and collaborative discussions
- Good clinical representation and a plan for including optometry and dentistry representatives.

Areas for improvement:

- Defining governance routes more effectively as reporting lines and approval routes are not always clear.
- Forward planning across the ICB as meeting deadlines can be difficult.

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. 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 following key topics were discussed by the Sub-Committee in 2023/24:

- A deep dive into Virtual Wards
- Babies, children and young people's speech and language therapy services.
- NEL Joint Forward Plan.
- The Big Conversation
- Community health services diagnostic.
- Patient Safety Incident Response Framework (PSIRF)
- Improvement networks
- Framework for developing the community services collaborative plan for 2024/25.
- Community health services planning, prioritisation and risks
- Waiting times and risks
- Priorities and resource

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 chairing
- A more focussed and strategically coherent approach
- Good collaborative discussions

Areas for improvement:

- Forward planning

Voluntary, Community and Social Enterprise Collaborative
Our voluntary, community and social care enterprise have been working closely with the ICB to develop a formal Collaborative over the past year. The huge diversity of the sector across north east London has led to a range of in-depth discussions about how we best work together to improve the health and wellbeing of local people and ensure the voluntary, community and social care enterprise sector are considered as equal partners in all the work we do, reflecting their uniqueness and the reality and much of what they do is focused on working at Place rather than at system.

We have worked on a number of joint enterprises including the Big Conversation, reducing health inequalities and enhancing volunteering opportunities across north east London. Work is underway to develop terms of reference for the Collaborative as a new Sub Committee of the ICB; planned to be established during 2024/25.

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.

Revised terms of reference were approved by the ICB Board on 31 January 2024 which changed the chair to the Associate Non Executive Member (in the absence of an independent clinical chair which is currently a vacant position).

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 following key topics were discussed by the Sub-committee in 2023/24:

- 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
- Pharmacy, optometry and dentistry delegation
- 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:

- The sub-committee has held some good discussions and made difficult decisions in light of the financial position.
- Effective collaborative working

Areas for improvement:

- Governance routes for approvals and reporting could be clearer.

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.

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.

Committee member	5 April 2023	6 July 2023	4 Oct 2023	10 Jan 2024	Total attended /total possible
Marie Gabriel CBE, Chair	✓	✓	✓	✓	4/4
Zina Etheridge, Chief Executive, NHS North East London	X	X	✓	X	1/4
Dr Paul Gilluley, Chief Medical Officer, NHS North East London	X	✓	X	X	1/4
Cllr Neil Wilson, London Borough of Newham	✓	✓	✓	✓	4/4
Cllr Naheed Asghar, London Borough of Waltham Forest	X	X	✓	X	1/4
Cllr Maureen Worby, London Borough of Barking and Dagenham	✓	X	✓	✓	3/4
Cllr Gillian Ford, London Borough of Havering	✓	X	✓	✓	3/4
Cllr Gulam Choudhury, London Borough of Tower Hamlets	X	✓	X	X	1/4
Cllr Mark Santos, London Borough of Redbridge	✓	X	✓	✓	3/4
Cllr Mary Durcan, London Borough of City of London	X	X	✓	✓	2/4
Cllr Christopher Kennedy, London Borough of Hackney	✓	X	✓	✓	3/4
Rt Hon Jacqui Smith, Chair, Barts Health and BHR Hospitals Trust	✓	X	✓	X	2/4
Eileen Taylor, Chair, East London NHS Foundation Trust	X	✓	✓	✓	3/4
Sir John Gieve, Chair, Homerton Healthcare NHS Foundation Trust	✓	✓	X	X	2/4

Committee member	5 April 2023	6 July 2023	4 Oct 2023	10 Jan 2024	Total attended /total possible
Caroline Rouse, VCSE representative, Newham	X	X	X	X	0/4
Catherine Perez Philips, Healthwatch, Hackney	✓	✓	X	✓	3/4
Cathy Turland, Healthwatch, Redbridge	✓	X	X	X	1/4
Dianne Barham, Healthwatch, Waltham Forest	✓	X	✓	✓	3/4
Ian Buckmaster, Healthwatch, Havering	X	X	✓	X	1/4
Jenny Ellis, VCSE representative, Redbridge	✓	✓	X	✓	3/4
Manisha Modhvadia, Healthwatch, Barking and Dagenham	X	X	X	N/A	0/3
Jenny Hadgraft, Healthwatch, Barking and Dagenham	N/A	N/A	N/A	X	0/1
Matthew Adrienne, Healthwatch, Tower Hamlets	✓	X	X	X	1/4
Johanna Moss, Chief Strategy and Transformation Officer, NHS North East London	✓	X	✓	✓	3/4
Pip Salvador-Jones, VCSE representative, Barking and Dagenham	X	X	X	X	0/4
Vicky Scott, VCSE representative, Tower Hamlets	X	✓	X	✓	2/4
Rachel Cleave, Healthwatch, City of London	✓	X	✓	X	2/4
Tony Wong, VCSE representative, Hackney	X	✓	✓	X	2/4
Veronica Awuzudike, Healthwatch, Newham	✓	N/A	N/A	N/A	1/1
Jasmine Smith, Healthwatch, Newham	N/A	N/A	N/A	X	0/1

Committee member	5 April 2023	6 July 2023	4 Oct 2023	10 Jan 2024	Total attended /total possible
Elspeth Paisley, VCSE representative from the ICP Steering Group	✓	✓	X	X	2/4
Vanessa Morris, VCSE representative, Waltham Forest	N/A	✓	X	X	1/3

The meeting was also attended regularly by:

- Charlotte Pomery, Chief Participation and Place Officer, NHS North East London
- Anne-Marie Keliris, Head of Governance, NHS North East London
- The following key topics were discussed by the Committee in 2023/24:
- A showcase on co-production highlighting good practice and learning.
- The 'Big Conversation' - a large engagement exercise to get input from people in our local communities into what they think is important when it comes to health, care and wellbeing.
- The NEL ICS people and culture strategy.
- Progress on community cohesion in local authorities.
- The refresh of the joint forward plan
- Supporting sustainability and equity in north east London.

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:

- Increased leadership from partner members, including presenting agenda items.
- Holding meetings in person to allow effective participation and engagement from partners
- Influencing the ICB Board agenda.

Areas for improvement:

- To apply the success measures identified to our work.
- Developing a comprehensive forward planner for the year ahead.
- Highlight and demonstrate how the work of the partnership is achieving the impact it desires.

UK Corporate Governance Code
NHS Bodies are not required to comply with the UK Code of Corporate Governance.

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

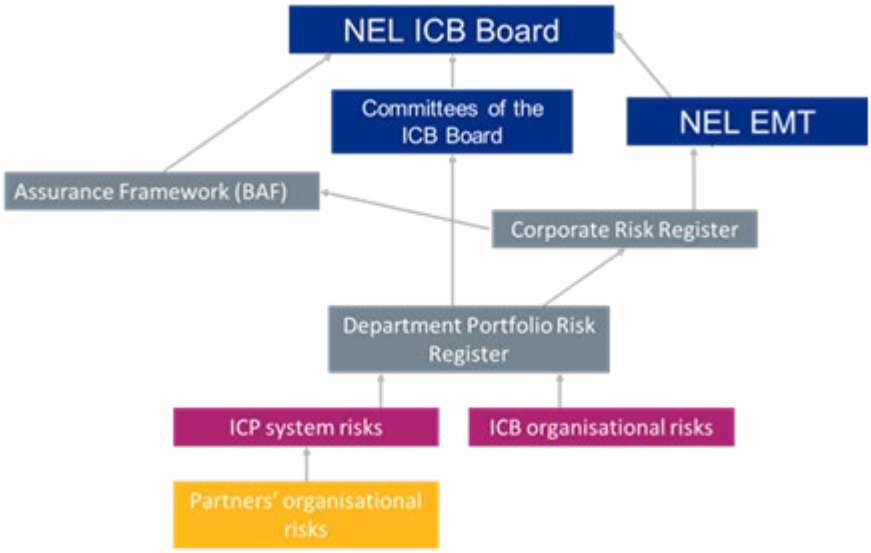
- Quality, safety and improvement committee
- Population Health and Integration committee
- Audit and risk committee
- Workforce and Remuneration Committee
- ICB Board

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 April 2023 – March 2024 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
- Population growth
- Mutual accountability for commitments
- Digital and estates
- Being outward looking
- Specialist services

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 and we have as a Board embarked on a process of reviewing our approach to risk appetite for the system and for the ICB. This involves ensuring that we are approaching risk appetite from a system perspective and ensuring that we are capturing the reality of system working, balancing a range of considerations and factors to deliver improved outcomes in health and wellbeing.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS North East London 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 (2023/24) 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 continue 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 (the Data Security and Protection Toolkit - DSPT) 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 DSPT. We ensure all staff undertake annual information governance training. There are processes in place for incident reporting and investigation of serious incidents. We are evolving our information risk assessment and management procedures and further embed the 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 & 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 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.

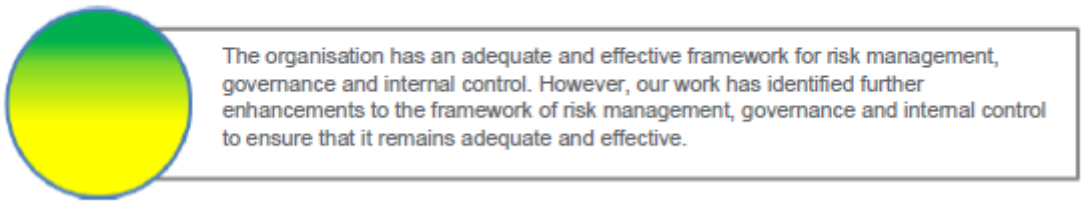
Counter fraud arrangements
An Accredited Counter Fraud Specialist, RSM UK, is contracted to undertake counter fraud work proportionate to identified risks.

- 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 April 2023 to March 2024 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:

For the 12 months ended 31 March 2024, the head of internal audit opinion for North East London Integrated Care Board is as follows:



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

Area of Audit	**Level of Assurance Given**
Delegated Duties (DOPs)	Reasonable Assurance
Continuing Healthcare and Personal Health Budgets follow up	No Opinion/ Little Progress

Area of Audit	Level of Assurance Given
Population Health and Health Inequalities	No Opinion/ Advisory
Workforce Strategy	No Opinion/ Advisory
Financial Planning, Management and Financial Recovery	Reasonable Assurance
Resilience	Reasonable Assurance
Procurement and Contract Management follow up	No Opinion/ Some Progress
Digital Strategy	Reasonable Assurance
Risk Management and Board Assurance Framework	Reasonable Assurance
Conflicts of Interest	Substantial Assurance
Assurance Mapping	No Opinion/ Advisory
Fed Net Development Review - Advisory	No Opinion/ Advisory

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

Remuneration Committee

Remuneration Committee details are provided within the 'Governance arrangements and effectiveness section' above on page 123.

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	4%	%

Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of renumeration of the organisation's workforce. Total renumeration 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 year 2023-24 was £260k to £265k (2022-23, £245k to £250k).

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

2023/24	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	£41,497	£57,802	£75,853
Salary component of total remuneration (£)	£41,497	£57,802	£75,853

Pay ratio information	6.33	4.54	3.46
2022/23 (for the period 1 July 2022 to 31 March 2023)			
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

In 2023-24, 0 (2022-23, 0) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £0 to £5k and £260k to £265k (2022-23 £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 that 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 the financial year, 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. 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)

	2023/24					
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 £5,000)**	**All Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**
	£000s	**£s**	**£000s**	**£000s**	**£000s**	**£000s**
Marie Gabriel CBE Chair 01/04/2023 - 31/03/2024	**70 - 75**	**0**	**0**	**0**	**n/a**	**70 - 75**
Zina Etheridge Chief Executive Officer 01/04/2023 - 31/03/2024	**260 - 265**	**0**	**0**	**0**	**62.5 - 65**	**325 - 330**
Cha Patel Non-executive Member for Audit 01/04/2023 - 31/03/2024	**15 - 20**	**0**	**0**	**0**	**n/a**	**15 - 20**
Diane Herbert Non-executive Member for Remuneration 01/04/2023 - 31/03/2024	**15 - 20**	**0**	**0**	**0**	**n/a**	**15 - 20**
Imelda Redmond CBE Non-executive Member for Quality and Performance 01/04/2023 - 31/03/2024	**15 - 20**	**0**	**0**	**0**	**n/a**	**15 - 20**
Dr Paul Gilluley+# Chief Medical Officer 01/04/2023 - 31/03/2024	**225 - 230**	**0**	**0**	**0**	**390 - 395**	**620 - 625**
Diane Jones+ Chief Nursing Officer 01/04/2023 - 31/03/2024	**160 - 165**	**0**	**0**	**0**	**0**	**160 - 165**
Henry Black+ Chief Finance and Performance Officer 01/04/2023 - 31/03/2024	**165 - 170**	**0**	**0**	**0**	**0**	**165 - 170**
Charlotte Pomery Chief Participation and Place Officer 01/04/2023 - 31/03/2024	**155 - 160**	**0**	**0**	**0**	**37.5 - 40**	**195 - 200**
Francesca Okosi Chief People and Culture Officer 01/04/2023 - 31/03/2024	**155 - 160**	**0**	**0**	**0**	**40 - 42.5**	**195 - 200**
Johanna Moss+ Chief Strategy and Transformation Officer 01/04/2023 - 31/03/2024	**160 - 165**	**0**	**0**	**0**	**0**	**160 - 165**
Dr Jagan John Partner member (Primary care) 01/04/2023 - 31/03/2024	**15 - 20**	**0**	**0**	**0**	**n/a**	**15 - 20**
Dr Mark Rickets Partner member (Primary care) 01/04/2023 - 31/03/2024	**15 - 20**	**0**	**0**	**0**	**n/a**	**15 - 20**
Paul Calaminus* NELFT Partner member (NHS trusts and foundation trusts) 01/04/2023 - 31/03/2024						

Shane DeGaris* Barts/BHRUT Group Partner member (NHS trusts and foundation trusts) 01/04/2023 - 31/03/2024						
Councillor Maureen Worby* London Borough of Barking & Dagenham Partner member (Local Authority) 01/04/2023 - 31/03/2024						
Councillor Christopher Kennedy* Corporate of London Partner member (Local Authority) 01/01/2024 - 31/03/2024						
Mayor Philip Glanville* London Borough of Hackney Partner member (Local Authority) 01/04/2023 - 22/09/2023						
Caroline Rouse* Partner member (Voluntary, community and social enterprise sector) 01/04/2023 - 31/03/2024						

+ Senior Manager affected by the public services pensions remedy; their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 scheme on 1 October 2023. Negative values arising in 'All Pension related benefits' as a result of this are not disclosed but are substituted with a zero.

Dr Paul Gilluley received a pay award in February 2024 that was backdated to cover the 2023-24 financial year. The request for pension information had already been made to the NHS Pension Agency prior to the pay award being finalised and it was not possible to get updated figures for inclusion within the remuneration report. The disclosures above have therefore been prepared based on the salary prior to the pay award.

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

2022-23

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

This consists of salaries for qualifying services and pensions related benefits only.

	2022/23 (for the reporting period 1 July 2022 - 31 March 2023)					
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 £5,000)**	**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 incurred 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 2024 - 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 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2023	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Zina Etheridge	2.5 - 5	0	10 - 15	0	65	49	156	0
Diane Jones+	0	37.5 - 40	40 - 45	110 - 115	750	161	1008	0
Dr Paul Gilluley+#	15 - 17.5	112.5 - 115	105 - 110	290 - 295	1,583	764	2,537	0
Henry Black+	0	35 - 37.5	40 - 45	110 - 115	665	145	900	0
Charlotte Pomery	2.5 - 5	0	5 - 10	0	30	30	85	0
Francesca Okosi	2.5 - 5	0	20 - 25	0	285	66	401	0
Johanna Moss+	0	40 - 42.5	45 - 50	115 - 120	596	192	870	0

+ Senior Manager affected by the public services pensions remedy; their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 scheme on 1 October 2023. Negative values arising from this are not disclosed in this table but are substituted with a zero.

Dr Paul Gilluley received a pay award in February 2024 that was backdated to cover the 2023-24 financial year. The request for pension information had already been made to the NHS Pension Agency prior to the pay award being finalised and it was not possible to get updated figures for inclusion within the remuneration report. The disclosures above have therefore been prepared based on the salary prior to the pay award.

2022-23

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

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 31 March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 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.

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 or 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

Payscale Description	Count
Band 9	20
Clinical Leads	131
Consultant grade	1
Senior Manager – Non-Board Members	6
VSM – Board Members	9
Grand Total	**167**

Staff numbers and costs

Staff Costs

	Total		2023-24	Total		2022-23
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	51,038	14,571	**65,609**	38,056	10,033	48,089
Social security costs	5,952	151	**6,103**	4,712	84	4,796
Employer contributions to the NHS Pension Scheme	8,929	172	**9,101**	6,529	87	6,616
Other pension costs	4	-	**4**	6	-	6
Apprenticeship Levy	278	-	**278**	198	-	198
Termination benefits	1,607	-	**1,607**	673	-	673
Total employee benefits expenditure	**67,808**	**14,894**	**82,702**	50,174	10,204	60,378

Staff composition

Employee Group

NEL ICB	Female	Male	Total
NEL ICB Employees	492	328	820
NEL ICB office holders - (engaged to provide specific roles but not engaged on contracts of employment e.g. clinical leads)	84	52	136

Total	**576**	**380**	**956**

Gender

Gender	Headcount
Female	492
Male	328
Grand Total	820

Declared disability

Disability Flag	Headcount
No	657
Not Declared	96
Prefer Not To Answer	16
Yes	51
Grand Total	820

Ethnicity

Ethnic Group	Headcount
A White - British	283
B White - Irish	18
C White - Any other White background	32
C2 White Northern Irish	2
CA White English	12
CB White Scottish	3
CC White Welsh	2
CK White Italian	2
CN White Gypsy/Romany	2
CX White Mixed	1
CY White Other – Eastern European, Turkish and Cypriot	6
D Mixed - White & Black Caribbean	10
E Mixed - White & Black African	5
F Mixed - White & Asian	2
G Mixed - Any other mixed background	9

GA Mixed - Black & Asian	1
GC Mixed - Black & White	3
GD Mixed - Chinese & White	1
GF Mixed - Other/Unspecified	3
H Asian or Asian British - Indian	68
J Asian or Asian British - Pakistani	17
K Asian or Asian British - Bangladeshi	59
L Asian or Asian British - Any other Asian background	13
LB Asian Punjabi	4
LC Asian Kashmiri	1
LD Asian East African	1
LE Asian Sri Lankan	1
LF Asian Tamil	2
LH Asian British	5
LK Asian Unspecified	2
M Black or Black British - Caribbean	38
N Black or Black British - African	75
P Black or Black British - Any other Black background	4
PA Black Somali	1
PC Black Nigerian	5
PD Black British	24
PE Black Unspecified	1
R Chinese	10

S Any Other Ethnic Group	7
SA Vietnamese	1
SC Filipino	4
SD Malaysian	1
SE Other Specified	5
Z Not Stated	74
Grand Total	**820**

Religion

Religious Belief	Headcount
Atheism	100
Buddhism	5
Christianity	306
Hinduism	42
Islam	103
Jainism	2
Judaism	6
Not Disclosed	184
Other	51
Sikhism	20
Unspecified	1
Grand Total	**820**

Age

Age Band	Headcount
<=20 Years	2
21-25	16
26-30	47
31-35	95
36-40	129

41-45	140
46-50	108
51-55	116
56-60	105
61-65	51
66-70	8
>=71 Years	3
Grand Total	**820**

Sexual orientation

Sexual Orientation	Headcount
Bisexual	12
Gay or Lesbian	33
Heterosexual or Straight	644
Not Disclosed	129
Undecided	1
Unspecified	1
Grand Total	**820**

Sickness absence data

2023-24				2022-23			
Average FTE for 2023	Average Sick Days per FTE	FTE-Days recorded Sickness Absence	FTE-Days Available	Average FTE for 2022	Average Sick Days per FTE	FTE - Days recorded Sickness Absence	FTE - Days Available
831	5.3	7,192	303,384	813	4.8	4,203	197,844
Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse Period covered: January to December 2023 **NHS Digital Statistics** Copyright © 2023 and 2024, NHS Digital. All rights reserved.				Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse Period covered: January to December 2022 **NHS Digital Statistics** Copyright © 2022 and 2023, NHS Digital. All rights reserved.			

Staff turnover percentages

	2023 / 04	2023 / 05	2023 / 06	2023 / 07	2023 / 08	2023 / 09	2023 / 10	2023 / 11	2023 / 12	2024 / 01	2024 / 02	2024 / 03
Turnover Rate (Headcount)	1.43%	1.02%	1.53%	1.23%	1.74%	1.23%	1.12%	0.71%	0.71%	0.71%	1.33%	2.45%

Staff engagement percentages

As an ICB, we are committed to building and enabling an inclusive, empowering and compassionate culture in line with our values, set out below. Developing our values as an ICB through a series of all staff away sessions, in person, reflects our commitment to involving our workforce in shaping how we work as an organisation. These away days gave all colleagues the opportunity to come together, connect with each other across the organisation, hear from senior leaders, reflect on the ICB one year on and discuss topics including our operating model, our approach to anti-racism, our culture and values and our vision for the ICB over the coming years.

As the ICB's senior leadership team, we are creating a number of ways for staff to engage actively in developing the organisation including a diverse Staff Panel, a two way Managers' Cascade, all-staff briefings as well as a range of work at Departmental, Directorate and team level. We participated in the NHS Staff Survey, to which 63% of staff responded in 2023. We acknowledge the results to be disappointing and have continued to build a three pronged programme in response to its findings: finalising our operating model; improving basic processes and building our organisational value and culture. Working with staff and senior leaders, we are reflecting on our engagement to date and working together to establish a set of priority improvements that can be undertaken to improve staff experience.

Staff policies
With our Trade Union colleagues and ICB management and staff, we are scheduling a review and harmonisation of HR policies and procedures. This will ensure a consistent approach throughout the ICB, underpinning a fair and just culture, and promoted via training sessions and workshops.

Organisational values
In collaboration with staff, a set of organisational values have been designed through away-days, drop-in sessions and focus groups. The values will underpin everything we do, guiding how we work together to deliver the ICS vision and priorities and setting the ambition for the culture we aspire to. They also set out how we will work with and for all the people of north east London to create meaningful improvements in health, wellbeing and equity.

Our values are:

- Ambitious – we strive for the best and make a difference by being innovative, courageous and boldest
- Collaborative – we work together with local people and each other to find the best solutions
- Inclusive – we are resolute in our pursuit of equity and equality, with mutual respect for all in everything that we do
- Kind – we are open, honest and kind to each other in all our work.

The values launched in April 2024 and will be embedded in a range of organisational policy, process and practice and will steer the ongoing development of the organisation over time.

Trade Union Facility Time Reporting Requirements

Percentage of pay bill spent on facility time

	£000's
Provide the total cost of facility time	30
Provide the total pay bill	82,702
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.036%

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

Support through organisational change

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, aimed to ensure people were well equipped to undertake change processes, with support about how to make the best decision for them. Coaching sessions were also offered for those staff who were further impacted by the restructure, to help provide further support in developing skills, understanding strengths and building resilience to move forward positively.

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 webinars, 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.

A wellbeing fortnight was held with a period of activities specifically designed for staff to dedicate time focussed on both physical and mental wellbeing as well as connecting with colleagues.

Guardian service

We have an independent and confidential Freedom to Speak up (F2SU) Guardian Service which was launched at the beginning of 2023 and is available to any

member of staff to discuss matters relating to patient care and safety, whistleblowing, bullying and harassment, and work grievances. The service is available 24/7 via telephone, email, face-to-face and virtual sessions and 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 Guardian service works with the ICB to address any concerns and incidents raised.

Between April 2023 and March 2024, the ICB has had 53 concerns raised through speaking up. Types of concerns raised are provided in the table below:

Concern	Number
A Patient and Service User Safety / Quality	-
B Management Issue	22
C System Process	13
D Bullying and Harassment	4
E Discrimination / Inequality	4
F Behavioural / Relationship	5
H Worker Safety	2
Other	3

NB. Within our ICS, our trusts also have F2SU systems embedded and working well within their organisations – reporting cases to the National Guardian Office, however the ICB recognises the need for a speak up or equivalent service to be available to primary care staff, which could be through networks or an external organisation similar to some of our provider trusts and ICB. The ICB has offered to support the development of an appropriate service recognising the number of primary care practices across north east London but would expect the primary care provider collaborative to identify the funding for it.

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.

This year, we also introduced some mandatory processes to improve our approach to open and fair recruitment and to ensure that our equality and diversity goals are

being met. This included mixed interview panels ensuring at least one member has received recent Equality, Diversity and Inclusion training. The purpose of the training is to remove bias from the recruitment process, train recruiting managers on our expectations and legal responsibilities for fair and open recruitment and to improve the candidate experience, particularly for those with additional needs or from minority backgrounds. More than 100 recruiting managers have been trained and we are integrating the processes and training into our business as usual recruitment process.

Expenditure on consultancy

2023-24 £'000	2022-23 £'000
4,954	1,087

Off-payroll engagements

Table 1: Length of all highly paid off-payroll

For all off-payroll engagements as of 31 March 2024, for more than £245[(1)] per day:

	Number
Number of existing engagements as of 31 March 2024	85
Of which, the number that have existed:	
for less than one year at the time of reporting	47
for between one and two years at the time of reporting	38
for between 2 and 3 years at the time of reporting	n/a
for between 3 and 4 years at the time of reporting	n/a
for 4 or more years at the time of reporting	n/a

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

For all off-payroll engagements between 1 April 2023 to 31 March 2024, for more than £245[(1)] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	197
Of which...	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[1]	179
No. subject to off-payroll legislation and determined as out of scope of IR35[1]	17
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	1

Notes:

(1) 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 April 2023 to 31 March 2024:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year [1]	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 financial year. This figure must include both on payroll and off-payroll engagements [2]	15

Note

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Table 1: Exit Packages

	2023-34					
Exit package cost band (inc. any special payment element)	**Compulsory redundancies**		**Other Agreed Departures**		**Total**	
	Number	**£s**	**Number**	**£s**	**Number**	**£s**
Less than £10,000	1	8,522	-	-	1	8,522
£10,000 - £25,000	1	21,469	3	46,946	4	68,415
£25,001 - £50,000	4	133,096	5	201,065	9	334,161
£50,001 - £100,000	1	80,000	3	223,274	4	303,274
£100,001 - £150,000	-	-	5	640,865	5	640,865
£150,001 - £200,000	2	320,000	2	320,000	4	640,000
TOTALS	**9**	**563,087**	**18**	**1,432,150**	**27**	**1,995,237**

	2022-23					
Exit package cost band (inc. any special payment element)	Compulsory redundancies		Other Agreed Departures		Total	
	Number	£s	Number	£s	Number	£s
£10,000 - £25,000	1	14,861	-	-	1	14,861
£150,001 - £200,000	2	320,000	-	-	2	320,000
TOTALS	3	334,861	-	-	3	334,861

Table 2: Analysis of Other Departures

	2023-24		2022-23	
	Agreements	**Total Value of agreements**	Agreements	Total Value of agreements
	Number	**£000s**	Number	£000s
Voluntary redundancies including early retirement contractual costs	**1**	**1,432,150**	-	-
TOTAL	**1**	**1,432,150**	-	-

These tables report the number and value of exit packages agreed in the financial year; these have arisen as a result of the re-structuring exercise undertaken by the ICB during 2023-24.

Compulsory redundancies have been agreed in accordance with the provisions of the NHS Compulsory Redundancy Scheme; voluntary redundancies have been agreed in accordance with Agenda for Change contractual requirements. There were no special payments made.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there were no ill health early retirements during the reporting period (2022-23, one at a cost £107,058).

Parliamentary Accountability and Audit Report

North East London 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 78. An audit certificate and report is also included in this Annual Report at page 153.

Disclosure in relation to fees and charges is detailed below.

Cost allocation and setting of charges

NHS NEL ICB certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2023/24	Note	Income £000s	Full Cost £000s	Surplus/(deficit) £000s
Dental	2&5	18,090	(117,621)	(99,531)
Prescription	2&5	21,503	(63,777)	(42,274)
Total fees and charges		39,593	(181,398)	(141,805)

The fees and charges information in this note is provided in accordance with section 5.120 of the Department of Health and Social Care Group Accounting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2023/24, the NHS prescription charge for each medicine or appliance dispensed was £9.65. However, around 55% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £31.25 for 3 months or £111.60 for a year.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. In 2023/24, the charge for Band 1 treatments was £25.80, for Band 2 was £70.70 and for Band 3 was £306.80.

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 year ended 31 March 2024 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 financial position of the ICB as at 31 March 2024 and of its income and expenditure for the year 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 22 April 2024 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24; 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 policy documentation 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.
- 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 therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to the completeness and accuracy of non-pay expenditure. We consider this would be most likely to occur through understating or omitting year end non-NHS accruals.

We did not identify any additional fraud risks

We 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 those posted to unusual accounts combinations and other unusual journal characteristics.
- Evaluating the business purpose of significant unusual transactions.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices after year end, where applicable.
- Performing cut-off testing of expenditure in the period after 31 March 2024 to determine whether amounts have been 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 and other management (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: data protection laws, anti-bribery, employment law recognising the 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 fraud 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 year 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 2023/24. 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 2023/24.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 81, 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

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

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.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether 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. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

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 81, 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 Integrated Care Board for the year ended 31 March 2024 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

27 June 2024

ANNUAL ACCOUNTS

Zina Etheridge
Accountable Officer

24 June 2024

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The Primary Statements:

Notes to the Accounts:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023-24 £'000	2022-23 £'000
Income from sale of goods and services	2	(39,593)	-
Other operating income	2	(26,813)	(18,014)
Total Operating Income		**(66,406)**	(18,014)
Staff costs	4	82,702	60,378
Purchase of goods and services	5	4,720,205	3,140,537
Depreciation and impairment charges	5	3,071	2,434
Provision expense	5	(1,972)	462
Other operating expenditure	5	608	214
Total Operating Expenditure		**4,804,614**	3,204,025
Net Operating Expenditure		**4,738,208**	3,186,011
Finance expense	7	87	76
Net Expenditure for the Year/Period		**4,738,295**	3,186,087
Comprehensive Expenditure for the Year/Period		**4,738,295**	3,186,087

The ICB received a revenue resource limit of £4,752,703k for 2023-24; Net Expenditure for the period was £4,738,295k, therefore, the ICB recorded an underspend of £14,408k (2022-23, an underspend of £38k against a revenue resource limit of £3,186,125k).

The 2022-23 prior year comparators in these accounts relate to the period 1st July 2022 to 31st March 2023.

Statement of Financial Position as at 31 March 2024

	Note	2023-24 £'000	2022-23 £'000
Non-current assets			
Property, plant and equipment	9	379	763
Right-of-use assets	10	7,897	9,547
Total Non-current Assets		**8,276**	10,310
Current Assets			
Trade and other receivables	11	27,357	24,846
Cash and cash equivalents	12	98	38
Total Current Assets		**27,455**	24,884
Total Assets		**35,731**	35,194
Current Liabilities			
Trade and other payables	13	(306,114)	(314,472)
Lease liabilities	10	(2,644)	(2,497)
Provisions	14	(16,041)	(18,686)
Total Current Liabilities		**(324,799)**	(335,655)
Non-current Assets less Net Current Liabilities		**(289,068)**	(300,461)
Non-current Liabilities			
Lease liabilities	10	(5,516)	(7,158)
Provisions	14	(100)	(100)
Total Non-current Liabilities		**(5,616)**	(7,258)
Assets less Liabilities		**(294,684)**	(307,719)
Financed by Taxpayers' Equity			
General fund		(294,684)	(307,719)
Total Taxpayers' Equity		**(294,684)**	(307,719)

The notes on pages 163 to 180 form part of this statement

The financial statements on pages 160 to 180 were approved by the ICB Board on 24 June 2024 and signed on its behalf by:

Zina Etheridge
Chief Accountable Officer

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	Note	General Fund 2023-24 £'000	General Fund 2022-23 £'000
Changes in Taxpayers' Equity for 2023-24			
Balance at 1 April/1 July		(307,719)	-
Transfers by modified absorption from other bodies	8	-	(307,922)
Net Operating Expenditure for the Year/Period		(4,738,295)	(3,186,087)
Net Funding		4,751,330	3,186,290
Balance at 31 March		**(294,684)**	(307,719)

Statement of Cash Flows for the year ended 31 March 2024

	Note	2023-24 £'000	2022-23 £'000
Cash Flows from Operating Activities			
Total net expenditure for the financial year		(4,738,295)	(3,186,087)
Depreciation and amortisation	5	3,071	2,434
Movement due to transfer by modified absorption		-	(308,998)
Interest paid		87	76
Increase in trade and other receivables	11	(2,511)	(24,846)
Increase/(decrease) in trade and other payables	13	(8,358)	314,472
Provisions utilised	14	(673)	-
Increase/(decrease) in provisions	14	(1,972)	18,786
Net Cash Outflow from Operating Activities		**(4,748,651)**	(3,184,163)
Cash Flows from Financing Activities			
Grant in aid funding received		4,751,330	3,186,290
Repayment of lease liabilities - Capital		(2,532)	(2,014)
Repayment of lease liabilities - Interest		(87)	(75)
Net Cash Inflow from Financing Activities		**4,748,711**	3,184,201
Net Increase in Cash and Cash Equivalents	12	**60**	38
Cash and Cash Equivalents at the beginning of the Financial Year		38	-
Cash and Cash Equivalents at the end of the Financial Year		**98**	38

The notes on pages 163 to 180 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 2023-24 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 2024 the ICB had net liabilities of £294,684,000 (31st March 2023, £307,719,000).
Public sector bodies are assumed to be a going concern 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.

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.

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

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

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

Notes to the financial statements

1.5 **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.

The main source of funding for the ICBs 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.

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **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.

1.7 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements

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 required to be 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 for non-specialised buildings by market value for existing use.

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.

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 2023-24.

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.

Notes to the financial statements

1.9.4 **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, 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. Right-of-use assets are depreciated over the lease term.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment 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.

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.

1.10 **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.

1.10.1 **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; and 4.72% to new leases commencing in 2024 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.

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.

1.11 **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.

1.12 **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.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **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 ICB.

1.14 **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.

Notes to the financial statements

1.15 **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.

1.15.1 **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.

1.15.2 **Impairment of Financial Assets**

For all financial assets measured at amortised cost the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables at an amount equal to lifetime expected credit losses.

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.

1.16 **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.

1.17 **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.

1.18 **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.

Notes to the financial statements

1.19 **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).

1.20 **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.

1.20.1 **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 2023-24 that would have a material effect on the amounts recognised in the financial statements.

1.20.2 **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 2023-24.

1.21 **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.

1.22 **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 2023-24, would not have a material impact on the accounts.

● IFRS 18 Presentation and Disclosure in Financial Statements - issued in April 2024 and applicable to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FReM and therefore it is not yet possible to confirm its impact on the accounts.

2. Other Operating Revenue

	2023-24 Total £'000	2022-23 Total £'000
Revenue from Sale of Goods and Services (Contracts)		
Prescription fees and charges	21,503	-
Dental fees and charges	18,090	-
Total Revenue from Sale of Goods and Services	**39,593**	**-**
Other Operating Revenue		
Other non contract revenue	26,813	18,014
Total Other Operating Revenue	**26,813**	18,014
Total Operating Revenue	**66,406**	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

3.1 Disaggregation of Revenue - Revenue from Sale of Goods and Services (Contracts)

	2023-24		2022-23	
	Prescription Fees and Charges £'000	Dental Fees and Charges £'000	Prescription Fees and Charges £'000	Dental Fees and Charges £'000
Source of Revenue				
Non NHS	21,503	18,090	-	-
Total	**21,503**	**18,090**	-	-
Timing of Revenue				
Over time	21,503	18,090	-	-
Total	**21,503**	**18,090**	-	-

3.2 Transaction Price to remaining Contract Performance Obligations

All contract revenue is recognised in the current period

4. Employee Benefits and Staff numbers

4.1.1 Employee Benefits

	2023-24			2022-23		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	51,038	14,571	**65,609**	38,056	10,033	48,089
Social security costs	5,952	151	**6,103**	4,712	84	4,796
Employer contributions to NHS Pension scheme	8,929	172	**9,101**	6,529	87	6,616
Other pension costs	4	-	**4**	6	-	6
Apprenticeship Levy	278	-	**278**	198	-	198
Termination benefits	1,607	-	**1,607**	673	-	673
Gross Employee Benefits Expenditure	**67,808**	**14,894**	**82,702**	50,174	10,204	60,378

4.2 Average Number of People Employed

	2023-24			2022-23		
	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total	**784.07**	**141.63**	**925.70**	799.39	145.49	944.88

4.3 Exit packages Agreed in the Financial Year

	2023-24 Compulsory Redundancies		2023-24 Other Agreed Departures		2023-24 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	1	8,522	-	-	1	8,522
£10,001 to £25,000	1	21,469	3	46,946	4	68,415
£25,001 to £50,000	4	133,096	5	201,065	9	334,161
£50,001 to £100,000	1	80,000	3	223,274	4	303,274
£100,001 to £150,000	-	-	5	640,865	5	640,865
£150,001 to £200,000	2	320,000	2	320,000	4	640,000
Total	**9**	**563,087**	**18**	**1,432,150**	**27**	**1,995,237**

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

Analysis of Other Agreed Departures

	2023-24 Other Agreed Departures		2022-23 Other Agreed Departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	18	1,432,150	-	-
Total	**18**	**1,432,150**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year; these have arisen as a result of the re-structuring exercise undertaken by the ICB during 2023-24.

Compulsory redundancies have been agreed in accordance with the provisions of the NHS Compulsory Redundancy Scheme; voluntary redundancies have been agreed in accordance with Agenda for Change contractual requirements.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table; there were no ill health early retirements during the reporting period (2022-23, one at a cost £107,058).

4.4 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

4.4.3 Other Defined Contribution Workplace Pension Schemes

The ICB offers an additional defined contribution workplace pension to its employees, the National Employment Savings Scheme (NEST). A small number of employees pay into the NEST scheme and in 2023-24 the ICB has incurred employer contributions of £13,231 (2022-23 £13,067).

5. Operating Expenses

	2023-24 Total £'000	2022-23 Total £'000
Purchase of Goods and Services		
Services from other ICBs and NHS England	406	469
Services from foundation trusts	1,214,807	815,205
Services from other NHS trusts	1,999,753	1,377,872
Purchase of healthcare from non-NHS bodies	473,116	351,601
Purchase of social care	36,368	27,627
General dental services and personal dental services	117,620	-
Prescribing costs	302,038	214,320
Pharmaceutical services	63,487	-
General ophthalmic services	22,936	127
GPMS/APMS and PCTMS	427,631	286,103
Supplies and services – clinical	10	-
Supplies and services – general	26,352	35,823
Consultancy services	4,954	1,087
Establishment	12,402	15,282
Transport	183	106
Premises	9,802	6,206
Audit fees	269	258
Other non statutory audit expenditure		
· Other services	19	18
Other professional fees	6,989	5,051
Legal fees	598	764
Education, training and conferences	465	2,618
Total Purchase of Goods and Srvices	**4,720,205**	**3,140,537**
Depreciation and Impairment Charges		
Depreciation	3,071	2,391
Amortisation	-	43
Total Depreciation and Impairment Charges	**3,071**	**2,434**
Provision Expense		
Provisions	(1,972)	462
Total Provision Expense	**(1,972)**	**462**
Other Operating Expenditure		
Chair and Non Executive Members	273	188
Grants to other bodies	350	-
Expected credit loss on receivables	(15)	26
Total Other Operating Expenditure	**608**	**214**
Total Operating Expenditure	**4,721,912**	**3,143,647**

The budgets for Dental, Pharmaceutical and Ophthalmic services transferred to the ICB from 1st April 2023.

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)

	2023-24 £	2022-23 £
Statutory audit fee	224,000	215,000
Other audit services	15,600	15,000
Total Audit Fees	**239,600**	230,000

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

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of Compliance	2023-24 Number	2023-24 £'000	2022-23 Number	2022-23 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	90,419	1,143,281	71,561	800,821
Total Non-NHS Trade Invoices paid within target	88,170	1,087,502	69,236	784,176
Percentage of Non-NHS Trade Invoices Paid within Target	**97.51%**	**95.12%**	96.75%	97.92%
NHS Payables				
Total NHS Trade invoices paid in the year	3,803	3,228,862	3,559	2,215,486
Total NHS Trade Invoices paid within target	3,629	3,204,285	3,474	2,209,496
Percentage of NHS Trade Invoices Paid within Target	**95.42%**	**99.24%**	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	2023-24 £'000	2022-23 £'000
Amounts included in finance costs from claims made under this legislation	-	1
Total	**-**	**1**

7. Finance Costs

	2023-24 £'000	2022-23 £'000
Interest		
Interest on lease liabilities	87	75
Interest on late payment of commercial debt	-	1
Total Finance Costs	**87**	**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.

For the transfer of assets and liabilities which took place in 2022-23, 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.

	2023-24 £'000	2022-23 £'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

2023-24	Plant & Machinery £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Cost or Valuation at 1 April 2023	1,498	884	698	3,080
Disposals other than by sale	(10)	-	-	(10)
Cost/Valuation at 31 March 2024	**1,488**	**884**	**698**	**3,070**
Depreciation 1 April 2023	1,167	699	451	2,317
Disposals other than by sale	(10)	-	-	(10)
Charged during the year	136	174	74	384
Depreciation at 31 March 2024	**1,293**	**873**	**525**	**2,691**
Net Book Value at 31 March 2024	**195**	**11**	**173**	**379**
Purchased	195	11	173	379
Total at 31 March 2024	**195**	**11**	**173**	**379**
Asset Financing:				
Owned	195	11	173	379
Total at 31 March 2024	**195**	**11**	**173**	**379**

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 Cost or Valuation of Fully Depreciated Assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2023-24 £'000	2022-23 £'000
Information technology	805	-
Total	**805**	-

9.2 Economic Lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	1	4
Information technology	1	4
Furniture & fittings	2	5

10. Leases

10.1 Right-of-use Assets

2023-24	Buildings excluding Dwellings £'000	Information Technology £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Cost or Valuation at 1 April 2023	11,685	636	12,321	4,099
Lease remeasurement	1,037	-	1,037	277
Disposals on expiry of lease term	(448)	(172)	(620)	(269)
Cost/Valuation at 31 March 2024	**12,274**	**464**	**12,738**	**4,107**
Depreciation 1 April 2023	2,597	177	2,774	1,396
Charged during the year	2,520	167	2,687	1,426
Disposals on expiry of lease term	(448)	(172)	(620)	(269)
Depreciation at 31 March 2024	**4,669**	**172**	**4,841**	**2,553**
Net Book Value at 31 March 2024	**7,605**	**292**	**7,897**	**1,554**
Net Book Value by Counterparty				
Leased from other group bodies (NHS Property Services and Community Health Partnerships)				1,554
Net Book Value at 31 March 2024				**1,554**

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

10.2 Lease Liabilities

2023-24	2023-24 £'000	2022-23 £'000
Lease Liabilities at 1 April 2023	(9,655)	-
Additions purchased	-	(464)
Interest expense relating to lease liabilities	(87)	(75)
Repayment of lease liabilities (including interest)	2,619	2,089
Lease remeasurement	(1,037)	-
Transfer from other public sector body	-	(11,205)
Lease Liabilities at 31 March 2024	**(8,160)**	**(9,655)**

10.3 Lease Liabilities - Maturity Analysis of Undiscounted Future Lease Payments

	2023-24 £'000	Of which: leased from DHSC group bodies £'000	2022-23 £'000	Of which: leased from DHSC group bodies £'000
Within one year	(2,707)	(1,435)	(2,575)	(1,351)
Between one and five years	(4,313)	(349)	(5,369)	(1,452)
After five years	(1,336)	-	(1,964)	-
Balance at 31 March 2024	**(8,356)**	**(1,784)**	(9,908)	(2,803)
Effect of Discounting	196	10	253	29
Included in				
Current lease liabilities	(2,644)	(1,427)	(2,497)	(1,332)
Non-current lease liabilities	(5,516)	(347)	(7,158)	(1,442)
Balance at 31 March 2024	**(8,160)**	**(1,774)**	(9,655)	(2,774)
Balance by Counterparty				
Leased from other group bodies (NHS Property Services and Community Health Partnerships)		(1,774)		(2,774)
Balance as at 31 March 2024		**(1,774)**		(2,774)

10.4 Amounts Recognised in Statement of Comprehensive Net Expenditure

	2023-24 £'000	2022-23 £'000
Depreciation expense on right-of-use assets	2,687	2,102
Interest expense on lease liabilities	87	75

10.5 Amounts Recognised in Statement of Cash Flows

	2023-24 £'000	2022-23 £'000
Total cash outflow on leases under IFRS 16	2,619	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 and Beaumont House at Mile End Hospital) and NHS Property Services (St Leonards Hospital).

Two additional building leases, with Ian B Woolf 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.

11.1 Trade and Other Receivables

	Current 2023-24 £'000	Current 2022-23 £'000
NHS receivables: revenue	9,855	9,079
NHS accrued income	335	2,834
Non-NHS and other WGA receivables: revenue	6,112	7,819
Non-NHS and other WGA prepayments	1,166	487
Non-NHS and other WGA accrued income	8,850	3,605
Expected credit loss allowance-receivables	(39)	(54)
VAT	1,067	1,068
Other receivables and accruals	11	8
Total Trade and Other Receivables	**27,357**	24,846

11.2 Receivables Past their Due Date but not Impaired

	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000	2022-23 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000
By up to three months	3,116	1,273	4,050	607
By three to six months	126	1,134	74	1,877
By more than six months	129	(151)	108	(251)
Total	**3,371**	**2,256**	4,232	2,233

11.3 Loss Allowance on Asset Classes

	Trade and other Receivables - Non DHSC Group Bodies 2023-24 £'000	Trade and other Receivables - Non DHSC Group Bodies 2022-23 £'000
Balance at 1 April 2023	(54)	-
Lifetime expected credit losses on trade and other receivables-Stage 2	15	(26)
Transfer by Absorption from other entity	-	(28)
Balance at 31 March 2024	**(39)**	(54)

12. Cash and Cash Equivalents

	2023-24 £'000	2022-23 £'000
Balance at 1 April 2023	38	-
Net change in year	60	38
Balance at 31 March 2024	**98**	38
Made up of:		
Cash with the Government Banking Service	98	38
Cash and Cash Equivalents as in Statement of Financial Position	**98**	38
Balance at 31 March 2024	**98**	38

13. Trade and Other Payables

	Current 2023-24 £'000	Current 2022-23 £'000
NHS payables: revenue	17,675	29,230
NHS accruals	36,084	3,574
Non-NHS and other WGA payables: revenue	40,460	53,054
Non-NHS and other WGA accruals	202,488	216,141
Social security costs	850	847
Tax	935	807
Other payables and accruals	7,622	10,819
Total Trade and Other Payables	**306,114**	314,472

Other payables and accruals include a total pension liability of £3,260,055 (2022-23: £2,841,860). This includes outstanding pension contributions for ICB employees of £946,083 as at 31 March 2024 (31 March 2024: £932,900); the balance relates to GP Pension contributions.

14. Provisions

	Current 2023-24 £'000	Non-current 2023-24 £'000	Current 2022-23 £'000	Non-current 2022-23 £'000
Restructuring	-	-	3,627	-
Redundancy	-	-	320	-
Continuing care	1,232	-	1,814	-
Other	14,809	100	12,925	100
Total	**16,041**	**100**	18,686	100
Total Current and Non-current	**16,141**		18,786	

	Restructuring £'000	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 1 April 2023	**3,627**	**320**	**1,814**	**13,025**	**18,786**
Arising during the year	-	-	266	2,021	**2,287**
Utilised during the year	(353)	(320)	-	-	**(673)**
Reversed unused	(3,274)	-	(848)	(137)	**(4,259)**
Balance at 31 March 2024	**-**	**-**	**1,232**	**14,909**	**16,141**
Expected timing of cash flows:					
Within one year	-	-	1,232	14,809	**16,041**
Between one and five years	-	-	-	50	**50**
After five years	-	-	-	50	**50**
Balance at 31 March 2024	**-**	**-**	**1,232**	**14,909**	**16,141**

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. As a result of this review a number of cases were resolved and have been released during 2023-24.

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, £14,809,022, relates to a provision for back dated rental reimbursements for a number of GP practices; this balance is reviewed on an annual basis and adjusted accordingly. The remaining balance relates to a provision for dilapidations in relation to the vacating of leased office space, £100,000.

NHS Resolution

A provision for £375,290 in respect of CNST claims is held in the accounts of NHS Resolution as at 31 March 2024 (£128,250, 2022-23); this is held on behalf of the ICB.

15. 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 2023-24 (£nil in 2022-23)

16. Financial instruments

16.1 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 ICB Board. Treasury activity is subject to review by the ICB and internal auditors.

16.1.1 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 and therefore has low exposure to currency rate

16.1.2 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.

16.1.3 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, NHS integrated care board 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.

16.1.4 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.

16.1.5 Financial Instruments

As the cash requirements of the ICB 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 the ICB's expected purchase and usage requirements; the ICB is, therefore, exposed to little credit, liquidity or market risk.

16.2 Financial assets

	Financial Assets measured at amortised cost 2023-24 £'000	Financial Assets measured at amortised cost 2022-23 £'000
Trade and other receivables with NHSE bodies	4,254	8,701
Trade and other receivables with other DHSC group bodies	14,786	6,664
Trade and other receivables with external bodies	6,123	7,980
Cash and cash equivalents	98	38
Total at 31 March 2024	**25,261**	23,383

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2023-24 £'000	Financial Liabilities measured at amortised cost 2022-23 £'000
Trade and other payables with NHSE bodies	702	780
Trade and other payables with other DHSC group bodies	54,932	34,559
Trade and other payables with external bodies	256,856	287,133
Total at 31 March 2024	**312,490**	322,472

17. Related Party Transactions

Employees of North East London ICB are required to disclose any relevant and material interests they may have in other organisations. This is recorded in the Register of Interests.

The transactions listed below are payments made to the related parties declared by North East London ICB's Board members (other than payments to practices, other NHS bodies, and other government departments):

	2023-24 Payments to Related Party	**2023-24 Receipts from Related Party**	**2023-24 Amounts owed to Related Party**	**2023-24 Amounts due from Related Party**	2022-23 Payments to Related Party	2022-23 Receipts from Related Party	2022-23 Amounts owed to Related Party	2022-23 Amounts due from Related Party
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Age UK East London	611	-	49	-	-	-	-	-
City & Hackney GP Confederation	11,053	-	2,942	-	13,020	55	1,234	-
Community Health Partnerships	-	-	-	-	2,784	-	145	-
Compost London CIC	21	-	30	-	5	-	-	-
Greater London Authority (GLA)	-	-	-	-	-	183	-	-
Hertfordshire Partnership University NHS Foundation Trust	18	-	-	-	14	-	-	-
London Borough of Hackney	26,781	450	9,563	154	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
NHS Confederation	30	-	-	-	-	-	-	-
Together First Limited (GP Federation)	2,291	1	116	-	1,651	-	138	-
UCL Partners	393	-	-	-	-	-	-	-

The Department of Health and Social Care is regarded as a related party. During 2023-24 North East London ICB has had a significant number of material transactions (expenditure 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
- Camden & Islington NHS Foundation Trust
- Central & North West London NHS Foundation Trust
- Chelsea And Westminster Hospital NHS Foundation Trust
- Community Health Partnerships
- Dartford & Gravesham NHS Trust
- East London NHS Foundation Trust
- East Suffolk and North Essex NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Homerton Healthcare NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Kent Community Health NHS Foundation 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 Property Services
- 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
- Tavistock & Portman NHS Foundation Trust
- The Princess Alexandra Hospital NHS Trust
- The Whittington Health NHS Trust
- University College London Hospitals NHS Foundation Trust

During 2023-24 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 North East London ICB's Board during 2023-24. These payments include GMS/PMS contract and adhoc payments, but exclude prescribing payments:

	2023-24 Payments to Related Party	**2023-24 Receipts from Related Party**	**2023-24 Amounts owed to Related Party**	**2023-24 Amounts due from Related Party**	2022-23 Payments to Related Party	2022-23 Receipts from Related Party	2022-23 Amounts owed to Related Party	2022-23 Amounts due from Related Party
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Aurora Medcare – Dr. Jagan John	2,758	-	155	-	1,983	-	161	-
Nightingale Practice - Dr. Mark Rickets	2,189	-	82	-	1,492	-	-	-
Parkview Medical Centre – Dr. Jagan John	673	-	32	-	476	-	31	-

18. Operating Segments

The ICB considers it has only one operating segment that being commissioning of healthcare services.

19. Joint Arrangements - Interests in Joint Operations

19.1 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	2023-24				2022-23			
		Assets	**Liabilities**	**Income**	**Expenditure**	Assets	Liabilities	Income	Expenditure
		£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Better Care Fund	London Borough of Barking & Dagenham	-	125	-	18,735	-	1,504	-	13,260
Better Care Fund	London Borough of Havering	-	191	-	23,298	-	1,993	-	17,027
Better Care Fund	London Borough of Redbridge	-	22	-	23,308	-	606	-	17,205
Better Care Fund	London Borough of Newham	-	-	-	28,814	-	0	-	20,453
Better Care Fund	London Borough of Tower Hamlets	-	-	-	38,883	-	2,484	-	23,657
Better Care Fund	London Borough of Waltham Forest	-	-	-	22,739	-	0	-	16,141
Better Care Fund	London Borough of Hackney	-	164	-	25,790	-	98	-	18,306
Better Care Fund	City of London	-	699	-	893	-	267	-	634

20. Losses and Special Payments

The ICB made no special payments and incurred no losses during the period (£nil in 2022-23).

21. Events after the End of the Reporting Period

There are no events to report after the end of the reporting period.

22. Financial Performance Targets

NHS ICBs have a number of financial duties under the NHS Act 2006 (as amended).
The ICB's performance against those duties was as follows:

	2023-24				2022-23			
	Target	**Performance**	**Achievement**	**Achieved**	Target	Performance	Achievement	Achieved
	£'000	**£'000**	**£'000**		£'000	£'000	£'000	
Expenditure not to exceed income	4,753,740	4,739,332	14,408	Yes	3,186,589	3,186,551	38	Yes
Capital resource use does not exceed the amount specified in Directions	1,037	1,037	-	Yes	464	464	-	Yes
Revenue resource use does not exceed the amount specified in Directions	4,752,703	4,738,295	14,408	Yes	3,186,125	3,186,087	38	Yes
Revenue administration resource use does not exceed the amount specified in Directions	45,088	45,084	4	Yes	33,690	33,473	217	Yes