

## NHS North East London ICB board

2 July 2025, 12.15 – 14.15; Unex Tower

### Agenda

	Item	Time	Lead	Attached/ verbal	Action required
<b>1.0</b>	<b>Welcome, introductions and apologies</b>	12.15	Chair		Note
1.1.	Declaration of conflicts of interest			Attached	Note
1.2.	Minutes of the meetings held on 16 June 2025			Attached	Approve
1.3.	Matters arising			Verbal	Discuss
1.4.	Actions log			Attached	Note
<b>2.0</b>	<b>Questions from the public</b>	12.20	Chair	Verbal	Note
<b>3.0</b>	<b>Resident story</b>	12.25		Verbal	Discuss/ note
<b>4.0</b>	<b>Chair and chief executive reports</b>				
4.1.	Chair's report	12.45	Chair	Attached	Approve
4.2.	Chief executive officer's report	12.50	ZE	Attached	Note
<b>5.0</b>	<b>Quality</b>				
5.1.	Primary and secondary prevention for cardiovascular disease with focus on strategic commissioning opportunities	12.55	CP/ CS	Attached	Endorse
5.2.	Delivering the vision for integrated neighbourhood working in north east London	13.10	CP	Attached	Approve
5.3.	Intensive and assertive community outreach update	13.20	PG	Attached	Endorse
<b>6.0</b>	<b>Strategy</b>				
6.1.	Board Assurance Framework	13.30	CP	Attached	Note
<b>7.0</b>	<b>Finance and performance</b>				
7.1.	Financial overview	13.40	HB	Attached	Approve
7.2.	Performance report	13.50	HB	Attached	Note
<b>8.0</b>	<b>Governance</b>				
8.1.	Committee exception reports for information: <ul style="list-style-type: none"> <li>Executive Committee</li> <li>Audit and Risk Committee</li> <li>Quality, Safety and Improvement Committee</li> <li>Finance, Performance and Investment Committee</li> </ul>	14.05	Chair	Attached	Note

	Item	Time	Lead	Attached/ verbal	Action required
	<ul style="list-style-type: none"> <li>Population Health and Integration Committee</li> </ul>				
<b>9.0</b>	<b>Board forward plan</b>	14.10	Chair	Attached	Note
<b>10.0</b>	<b>Any other business and close</b>	14.15	Chair	Verbal	Note
<b>Date of next meeting – 3 September 2025</b>					

**ICB Board members and attendees**

<b>Member</b>	<b>Role</b>
<b>Dame Marie Gabriel</b>	Chair, NHS North East London and North East London Health & Care Partnership
<b>Zina Etheridge</b>	Chief executive officer, NHS North East London
<b>Diane Herbert</b>	Non-executive member
<b>Imelda Redmond</b>	Non-executive member
<b>Kash Pandya</b>	Non-executive member
<b>Dr Kevin Cleary</b>	Non-executive member
<b>Lakh Jemmett</b>	Non-executive member
<b>Paul Calaminus</b>	NHS trust partner member
<b>Shane DeGaris</b>	NHS trust partner member
<b>Cllr Maureen Worby</b>	Local authority partner member
<b>Cllr Christopher Kennedy</b>	Local authority partner member
<b>Dr Mark Rickets</b>	Primary care partner member
<b>Dr Jagan John</b>	Primary care partner member
<b>Najnin Islam</b>	VCFSE partner member
<b>Paul Gilluley</b>	Chief medical officer
<b>Diane Jones</b>	Chief nursing officer
<b>Henry Black</b>	Chief finance and performance officer
<b>Participant</b>	<b>Role</b>
<b>Andrew Blake-Herbert</b>	Local authority executive participant
<b>Abi Gbago</b>	Local authority executive participant
<b>Sally Beaven</b>	Healthwatch representative
<b>Charlotte Pomery</b>	Chief participation and place officer
<b>Ralph Coulbeck</b>	Chief strategy and transformation officer
<b>Anne-Marie Keliris</b>	Head of governance and company secretary

## Glossary of terms and abbreviations

Terms and abbreviations will also be explained within each report.

Term	Explanation
A&E	Accident and Emergency department
APC	Acute Provider Collaborative
B&D	Barking and Dagenham
BAF	Board Assurance Framework
BH	Barts Health NHS Trust
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
BCYP	Babies, Children and Young People
C&H	City and Hackney
CAMHS	Children and Young People Mental Health Services
CEO	Chief Executive Officer
CFPO	Chief Finance and Performance Officer
CHC	Continuing Healthcare
CIP	Cost Improvement Plan
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CPCO	Chief People and Culture Officer
CPPO	Chief Participation and Place Officer
CSTO	Chief Strategy and Transformation Officer
DHSC	Department of Health and Social Care
ELFT	East London NHS Foundation Trust
FPIC	Finance, Performance and Investment Committee
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
LA	Local Authority
LTCs	Long Term Conditions
MHLDA	Mental Health, Learning Disabilities and Autism
NEL	North East London
NELFT	North East London NHS Foundation Trust
NELHCP	North East London Health and Care Partnership
NEM	Non-executive Member
NHSE	NHS England
PbP	Place-based Partnership
PELC	Partnership of East London Co-operatives
PCN	Primary Care Network
PHIC	Population Health and Integration Committee
PTL	Patient Tracking List
RTT	Referral to Treatment
QSIC	Quality, Safety and Improvement Committee
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community, Faith and Social Enterprise

## **Purpose, priorities, aims and our decision-making principles**

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

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

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

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

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

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

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

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

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

### **The four aims of our integrated care system**

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

### **Our decision-making principles**

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

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

North East London Integrated Care Board Register of Interests

- Declared Interests as at 23/06/2025

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Charlotte Pomery	Chief Participation and Place Officer	Barking & Dagenham ICB Sub-committee Barking & Dagenham Partnership Board City & Hackney ICB Sub-committee City & Hackney Partnership Board Community Health Collaborative sub-committee Havering ICB Sub-committee Havering Partnership Board ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Newham Health & Care Partnership Newham ICB Sub-committee Patient Choice Panel Redbridge ICB Sub-committee Redbridge Partnership Board Tower Hamlets ICB Sub-committee Tower Hamlets Together Board Waltham Forest Health and Care Partnership Board Waltham Forest ICB Sub-committee	Non-Financial Personal Interest	Pomery McGregor Consultancy Limited	Director of consultancy company, with husband who is also a director of the company. There are no employees and I have not carried out work through the company since 2011 and have never carried out any work in north east London	2009-06-01	Current	No action required as no conflicts declared.
Christopher Kennedy	Councillor	City & Hackney ICB Sub-committee City & Hackney Partnership Board ICB Board ICB Finance, Performance & Investment Committee ICP Committee	Non-Financial Professional Interest	London Borough of Hackney	Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture in London in London Borough of Hackney	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Lee Valley Regional Park Authority	Member of Lee Valley Regional Park Authority	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Hackney Empire	Member of Hackney Empire	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Hackney Parochial Charity	Member of Hackney Parochial Charity	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Labour Party	Member of the Labour Party	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Local GP practice	Registered patient with a local GP practice	2020-07-09	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Hackney Joint Estate Charities	sit in the board as trustee	2014-04-07	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	CREATE London	LBH appointed rep	2023-04-05	Current	Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Diane Jones	Chief Nursing Officer	Clinical Advisory Group Community Health Collaborative sub-committee ICB Board ICB Quality, Safety & Improvement Committee ICS Executive Committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Professional Interest	Royal College of Nursing (RCN)	Professional membership	2020-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Midwives (RCM)	Professional membership	1994-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Nursing & Midwifery Council (NMC)	Professional membership	1992-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	London Clinical Senate	Member	2017-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Homerton Hospital	Midwife (honorary contract)	2015-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Group B Strep Support (GBSS)	Director and Trustee	2020-01-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Sign Health	I am a Trustee of the charity	2023-05-01	Current	Declarations to be made at the beginning of meetings
Dr Jagan John	Primary Care ICB Board representative	ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee Primary Care Collaborative sub-committee	Financial Interest	Aurora Medcare (previously known as King Edward Medical Group)	GP Partner	2020-01-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Parkview Medical Centre	GP Partner	2020-05-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Together First Limited (GP Federation)	Practice is a shareholder	2014-01-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Harley Fitzrovia Health Limited	Director and shareholder	2018-01-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Diagnostics 4u (previously Monifeth Ltd)	Director and Shareholder	2020-10-01	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	Aurora Medcare (previously known as King Edward Medical Group)	Other GPs are family members	2020-01-01	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	New West Primary Care Network	Brother / GP Partner is the Clinical Director	2020-11-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS England - London Region	Personalised Care Clinical Director	2017-05-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	North East London Foundation Trust – Barking and Dagenham Community Cardiology Service	GPWSI in Cardiology	2011-08-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Buxton Medica	GP partner is director and practice is a shareholder	2021-10-31	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Barking & Dagenham, Havering and Redbridge University Hospitals Trust	Associate Medical Director for Primary Care in BHRUT	2022-09-01	2025-04-01	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	New West PCN	Co lead for health inequalities	2023-04-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Faircross Medical Care	GP partner and family member (brother) is also a partner	2024-04-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Scrubs	clothing company with 4 other directors - designing medical clothing	2024-12-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Aspire Healthcare	Joined with two other GPs and my brother who is a GP as a GP partnership	2025-01-12	Current	Declarations to be made at the beginning of meetings
Financial Interest	Protecting Forever	One of the directors of the company with my brother and two others who are not related	2025-04-30	Current	No action required as no conflicts declared.			
Financial Interest	Prestige Wrap Services	Brother is co director and there are two other who are not related. I am a director of this company	2025-05-02	Current	No action required as no conflicts declared.			

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dr Mark Rickets	ICB Primary Care Partner Member	Clinical Advisory Group ICB Board ICB Finance, Performance & Investment Committee NEM Remuneration Committee Primary Care Collaborative sub-committee	Financial Interest	Nightingale Practice (NEL member practice)	Salaried GP	2022-02-02	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	GP Confederation	Nightingale Practice is a member	2022-02-02	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	2022-02-02	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Homerton University Hospital NHS Foundation Trust	Non-executive Director	2022-02-02	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	Point of Care Foundation	My wife is an Associate with the Point of Care Foundation whose work includes being a mentor for NEL ICS Schwartz Rounds	2022-03-01	Current	Declarations to be made at the beginning of meetings
Dr Paul Francis Gilluley	Chief Medical Officer	Clinical Advisory Group ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub committee Primary Care Collaborative sub-committee Primary care contracts sub-committee	Non-Financial Professional Interest	British Medical Association	I am a member of the organisation	2022-07-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Royal College of Psychiatrists	Fellow of the College	2022-07-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Medical Defence Union	Member	2022-07-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	General Medical Council	Member	2022-07-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Stonewall	Member	2022-07-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	National Opera Studio	Trustee on the Board	2023-08-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	University of East London	Health Fellowship	2024-10-01	Current	Declarations to be made at the beginning of meetings
Non-Financial Professional Interest	Greater London Authority	Appointed to the Mayoral Cultural Leadership Board	2025-02-27	Current	Declarations to be made at the beginning of meetings			
Henry Black	Chief Finance and Performance Officer	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee	Indirect Interest	BHRUT	Wife is Assistant Director of Finance	2018-01-01	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	GSTT NHS Trust	Daughter employed as a graduate trainee	2023-09-01	Current	Declarations to be made at the beginning of meetings
Imelda Redmond	Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Remuneration Committee	Non-Financial Professional Interest	Health Devolution Commission	Co Chair	2023-01-07	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Age UK East London	Chair of Trustees	2024-02-18	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Intuitive	Member of an Advisory Board	2024-06-12	Current	Declarations to be made at the beginning of meetings
Kash Pandya	Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee	Financial Interest	Essex Police, Fire and Crime Commissioner's Audit Committee	Independent Audit Committee Member	2021-01-01	2024-10-31	Declarations to be made at the beginning of meetings
			Indirect Interest	Inverts UK Ltd	Son is a Senior Procurement Consultant	2023-02-01	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	Accenture	Son is a Legal Director	2017-01-01	Current	Declarations to be made at the beginning of meetings
Lakh Jemmett	Non-Executive Member	ICB Audit and Risk Committee ICB Board ICB Finance, Performance & Investment Committee ICB Remuneration Committee	Non-Financial Professional Interest	NHS Property Services Ltd	Non Executive Director	2023-07-01	Current	Declarations to be made at the beginning of meetings

Name	Position/Relationship with ICB	Committees	Declared Interest	Name of the organisation/business	Nature of interest	Valid From	Valid To	Action taken to mitigate risk
Dame Marie Gabriel OBE	ICB and ICP Chair	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Remuneration Committee ICP Committee NEM Remuneration Committee Transition Committee	Non-Financial Personal Interest	West Ham United Foundation Trust	Trustee	2020-04-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	East London Business Alliance	Trustee	2020-04-01	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Race and Health Observatory	Chair of the Race and Health Observatory, (paid). The Race and Health Observatory are now considering the potential to enter into contracts with NHS organisations to support their work to tackle racial and ethnic health inequalities.	2020-07-23	Current	Declarations to be made at the beginning of meetings
			Non-Financial Personal Interest	Member of the labour party	Member of the labour party	2020-04-01	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	NHS Confederation	Trustee Associated with my Chair role with the RHO	2020-07-23	Current	Declarations to be made at the beginning of meetings
			Financial Interest	Local Government Association	Peer Reviewer	2021-12-16	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UK Health Security Agency	Associate NED, (paid), UKHSA works with health and care organisations to ensure health security for the UK population	2022-04-25	Current	Declarations to be made at the beginning of meetings
Paul Calaminus	Board member. Sub-Committee member	Community Health Collaborative sub-committee ICB Board ICB Population, Health & Integration Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee Waltham Forest Health and Care Partnership Board Waltham Forest ICB Subcommittee	Indirect interest	Department of Health	Wife is civil servant in Department of Health	2001-10-01	Current	Declarations to be made at the beginning of meetings
Ralph Coulbeck	Chief Strategy and Transformation Officer	Acute Provider Collaborative Joint Committee ICB Board ICB Population, Health & Integration Committee ICS Executive Committee	Non-Financial Professional Interest	Princess Alexandra NHS Trust	I am an associate non-executive director at Princess Alexandra NHS Trust and attend the board and Quality and Safety Committee	2024-05-17	Current	Declarations to be made at the beginning of meetings
			Indirect Interest	Barts Health	My spouse is a consultant haematologist at Barts Health.	2018-04-01	Current	Declarations to be made at the beginning of meetings
Zina Etheridge	Chief Executive Officer of the Integrated Care Board for north east London	Acute Provider Collaborative Joint Committee Clinical Advisory Group ICB Audit and Risk Committee ICB Board ICB Population, Health & Integration Committee ICB Remuneration Committee ICP Committee ICS Executive Committee Mental Health, Learning Disability & Autism Collaborative sub-committee NEM Remuneration Committee	Indirect Interest	Royal Berkshire NHS Foundation Trust	Brother is employed as Head of Acute Medicine at Royal Berkshire hospital	2022-03-17	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	UCL Partners	Member of the Board of UCLP on behalf of NHS NEL and by extension, a director	2023-09-18	Current	Declarations to be made at the beginning of meetings
			Non-Financial Professional Interest	Mission Employable	I have recently become a trustee of Mission Employable who provided supported employment placements for young people with a learning disability. They do not work in NEL.	2024-11-15	Current	No action required as no conflicts declared.

- Nil Interests Declared as of 23/06/2025

Name	Position/Relationship with ICB	Committees	Declared Interest
Shane DeGaris	ICB member	Acute Provider Collaborative Joint Committee ICB Board ICS Executive Committee	Indicated No Conflicts To Declare.
Abi Gbago	Local Authority Member of Committee Chief Executive of London Borough of Newham	ICB Board ICB Population, Health & Integration Committee ICS Executive Committee Newham Health and Care Partnership	Indicated No Conflicts To Declare.
Andrew Blake-Herbert	London Borough of Havering	Havering ICB Sub-committee Havering Partnership Board ICB Board ICB Population, Health & Integration Committee ICS Executive Committee	Indicated No Conflicts To Declare.
Maureen Worby	Member of Committee	Barking & Dagenham Partnership Board ICB Board ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICP Committee	Indicated No Conflicts To Declare.
Najnin Islam	Member of Committee	ICB Board ICB Population, Health & Integration Committee ICP Committee	Indicated No Conflicts To Declare.
Kevin Cleary	Non Executive Member	ICB Board ICB Finance, Performance & Investment Committee ICB Population, Health & Integration Committee ICB Quality, Safety & Improvement Committee ICB Remuneration Committee ICB Workforce & Remuneration Committee	Indicated No Conflicts To Declare.
Sally Beaven	ICB Board Member	ICB Board ICP Committee	Indicated No Conflicts To Declare.
Diane Herbert	Non Executive Member	ICB Board ICB Quality, Safety & Improvement Committee ICB Remuneration Committee ICS People & Culture Committee	Indicated No Conflicts To Declare.

**Minutes of the NHS North East London ICB board**

**16 June 2025, 2.00pm – 2.20pm, MS Teams**

<b>Members:</b>	
Dame Marie Gabriel (MG)	Chair, NHS North East London and North East London Health and Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Diane Herbert (DH)	Non-executive member, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London
Kash Pandya (KP)	Non-executive member, NHS North East London
Dr Kevin Cleary (KC)	Non-executive member, NHS North East London
Lakh Jemmett (LJ)	Non-executive member, NHS North East London
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Diane Jones (DJ)	Chief nursing officer, NHS North East London
Dr Paul Gilluley (PG)	Chief medical officer, NHS North East London
Shane DeGaris (SD)	NHS trust partner member
Paul Calaminus (PC)	NHS trust partner member
Cllr Maureen Worby (MW)	Local authority partner member
Cllr Christopher Kennedy (CK)	Local authority partner member
Najnin Islam (NI)	VCFSE partner member
Dr Jagan John (JJ)	Primary care partner member
Dr Mark Rickets (MR)	Primary care partner member
<b>Attendees:</b>	
Charlotte Pomery (CP)	Chief participation and place officer, NHS North East London
Ralph Coulbeck (RC)	Chief strategy and transformation officer, NHS North East London
Sally Beaven (SB)	Healthwatch participant
Anne-Marie Keliris (AMK)	Head of governance and company secretary, NHS North East London
Katie McDonald (KMc)	Governance lead, NHS North East London
Keeley Chaplin (KCh)	Governance systems lead, NHS North East London
<b>Apologies:</b>	
Andrew Blake-Herbert (ABH)	Local authority executive participant
Abi Gbago (AG)	Local authority executive participant

<b>1.0</b>	<b>Welcome, introductions and apologies</b>
	<p>The Chair welcomed everyone to the meeting including members of the public who had joined the board meeting to observe, and apologies were noted.</p> <p>A welcome was extended to Ralph Coulbeck, newly appointed Chief Strategy and Transformation Officer, and Sally Beaven who will be representing north east London HealthWatch organisations going forward.</p> <p>The Chair advised people of housekeeping matters before proceeding.</p>
<b>1.1</b>	<b>Declaration of conflicts of interest</b>
	<p>The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the Integrated Care Board (ICB).</p>

	<p>No additional conflicts were declared.</p> <p>Declarations declared by members of the ICB are listed on the ICB's Register of Interests. The Register is available either via the Governance Team or on the ICB's <a href="#">website</a>.</p>
1.2	<p>Minutes of the last meeting</p> <p>The minutes of the meeting held on 14 May 2025 were agreed as a correct record.</p>
<b>2.0</b>	<b>Questions from the public</b>
	There were no questions received from members of the public.
<b>3.0</b>	<b>Annual report and accounts 2024/25</b>
	<p>CP presented the annual report for 2024/25 and explained the following points:</p> <ul style="list-style-type: none"> <li>• The annual report and accounts cover the period of 1 April 2024 to 31 March 2025, and are compliant with the Manual of Accounts issued by the Department of Health and in turn complies with the Government's Financial Reporting Manual.</li> <li>• The annual report is comprised of three sections; the performance report which provides an overview of the work undertaken over the last year; the accountability report which includes our corporate governance report; and the annual accounts which include our primary statements.</li> <li>• The report provides a lookback of the work undertaken over the last year including our achievements and outlining the challenges faced. This work will be used as building blocks as we move forward into the future role of as ICB with focus transitioning to strategic commissioning and integrated neighbourhood working.</li> <li>• The Audit and Risk Committee considered early drafts of the report, and comments and feedback have been incorporated into the final version which was endorsed by the Committee on 13 June.</li> <li>• A message of thanks was extended to all who contributed to the development of the annual report, including ICB and system partner colleagues.</li> </ul> <p>HB presented the annual accounts for 2024/25 and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• The Audit and Risk Committee considered the annual accounts at its meeting on 13 June and has recommended that they are approved by the ICB Board.</li> <li>• The technical process of the annual accounts audit run smoothly due to the positive working relationship with auditors as well as the systems and processes embedded to enable the fieldwork to take place. As a result, the ICB has received an unqualified External Audit Opinion which has been reflected in the International Standard on Auditing (ISA) 260 document, which provides a detailed commentary on the accounts submitted and the audit findings.</li> <li>• The value for money section of the ISA 260 report has highlighted a significant weakness in our controls environment relating to the qualified Head of Internal Audit Opinion received by the ICB. An action plan is in place to address this, and a significant amount of work has been undertaken in-year to improve this position and to close any outstanding internal audit management actions.</li> <li>• The system-wide financial deficit was raised as an area of concern in regard to the ICB's overall management control span. Whilst this is an issue and does raise value for money concerns across the Integrated Care System (ICS), it was agreed that that this does not demonstrate a significant weakness for the ICB as a sovereign organisation, which achieved a surplus financial position at year-end.</li> <li>• There have been no material changes between the draft and final annual accounts which is positive, and no issues with reporting have been raised.</li> </ul>

	<ul style="list-style-type: none"> <li>• The ICB delivered a surplus of £12.075m against a resource limit of £5.19bn, noting that this resource limit was prior to the delegation of specialised commissioning from NHS England. Therefore, the resource limit is greater for 2025/26 at over £6bn.</li> <li>• The ICB achieved its statutory duty to operate within the running costs allowance and achieved a £132k underspend. We also met the requirement to achieve the Better Payment Practice Code for both NHS and non-NHS payments.</li> </ul> <p>KP, Chair of the Audit and Risk Committee, advised the Board of the following key points:</p> <ul style="list-style-type: none"> <li>• At its meeting on 13 June, the Audit and Risk Committee considered the annual report and accounts in detail, alongside reports from auditors.</li> <li>• Auditors had requested that some adjustments were made as they believed the ICB had made some over-prudent accruals for continuing healthcare liabilities. The Committee agreed with officers that this adjustment should not be made because, considering the current financial climate, it is better to be prudent and mitigate any potential risks.</li> <li>• A message of thanks was extended to officers and auditors for working within tight timescales to produce an excellent set of accounts and the annual report.</li> <li>• The Audit and Risk Committee’s recommendation is for the ICB Board to approve the 2024/25 annual report and accounts.</li> </ul> <p>The Chair shared a message of thanks to all ICB staff and partner colleagues for their contributions over the last year. A thank you was also extended to our residents and communities in north east London, for working with us to improve the outcomes we strive to achieve.</p> <p>The ICB Board:</p> <ul style="list-style-type: none"> <li>• <b>Approved</b> the annual reports and annual accounts and advised that no final corrections are required.</li> <li>• <b>Agreed</b> to delegate authority to the Chief Executive Officer, Chief Finance and Performance Officer and the Audit and Risk Committee chair to resolve any issues should they arise before the final submission deadline on 23 June 2025.</li> </ul>
<b>4.0</b>	<b>Any other business and close</b>
	There was no other business to note.
<b>Date of next meeting – 2 July 2025</b>	

**ICB board – action log**

OPEN ACTIONS					
Agenda item	Meeting date	Action required	Lead	Required by	Status
4.1 Chair's report (1)	26.03.25	Primary Care Collaborative to consider what more can be done to address abuse of practice staff by the public to inform the reducing violence report coming to the Board before the end of 2025.	JJ/ MR	July 25	The Collaborative will be discussing a report regarding violence and aggression at its meeting on 4 July. Discussions will then be used to inform the wider report being presented to the Board in November.
4.1 Chair's report (2)	14.05.25	Transition Committee terms of reference to be shared at a future meeting.	CP	July 25	Complete. The Terms of Reference are appended to the Chair's report for the ICB Board's approval.
5.2 Speaking up summary report	14.05.25	Further information regarding equality impacts and how the Freedom To Speak Up service is inclusive of all staff groups to provided.	RN/ DJ	July 25	The independent service does not collect Equality, Diversity and Inclusion (EDI) data as doing so is likely to lead to people being identified and therefore, to staff not trusting that the process is anonymous.
6.3 Board assurance framework	14.05.25	Confirmation to be sought regarding the establishment of a Local Infrastructure Forum in City and Hackney.	CP	July 25	Complete. Confirmation received that there is an established Local Infrastructure Forum in City and Hackney.
6.3 Board assurance framework	14.05.25	Organisation change risk to be aligned to an alternative ICS aim.	CP	July 25	Complete. This has been realigned to the following ICS aim: "To improve outcomes in

**OPEN ACTIONS**

<b>Agenda item</b>	<b>Meeting date</b>	<b>Action required</b>	<b>Lead</b>	<b>Required by</b>	<b>Status</b>
					population health and healthcare”.
7.1 Financial overview	14.05.25	Financial overview reports to include detail regarding capital going forward.	AK/HB	July 25	Complete. Detail regarding capital included in the financial overview report, and this will continue going forward.
7.2 Performance report	14.05.25	Performance report to include high-level information going forward and a year-end report to be developed.	AK/HB	July 25	The report has been revised to include an overview of content, an executive summary, and a table of key indicators including benchmarking where available. These are interim changes while more comprehensive work is undertaken during Q1 2025/26 taking into consideration the ICB Blueprint, draft NHS Performance Assessment Framework, and NHSE good practice. This work will also include a review of the presentation of data and trends, as well as report automation and accessibility.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Chair's Report
<b>Author</b>	Marie Gabriel – Chair
<b>Presented by</b>	Marie Gabriel – Chair
<b>Contact for further information</b>	<a href="mailto:Marie.gabriel1@nhs.net">Marie.gabriel1@nhs.net</a>
<b>Executive summary</b>	<p>Key issues: This report outlines key outcomes from North East London strategic discussions, regional and national work.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• That the Board receive and note the report.</li> <li>• To approve the Terms of Reference for the Transition Committee.</li> <li>• To consider whether to hold a virtual meeting, if the NHS 10 Year Health Plan is published before the end of July.</li> </ul>
<b>Action required</b>	For noting
<b>Previous reporting</b>	Integrated Care Partnership Steering Group, 18 June 2025 Non-executive Remuneration Committee 25 June 2025
<b>Next steps/ onward reporting</b>	Integrated Care Partnership, 10 July 2025
<b>Conflicts of interest</b>	None
<b>Strategic fit</b>	<p>The ICS aims this report aligns with are:</p> <ul style="list-style-type: none"> <li>• To improve outcomes in population health</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	A focus on maintaining and deepening collaboration to improve population health as we transition to a new operating model, will continue to focus on working with and for local people, addressing inequalities and achieving sustainability.
<b>Impact on finance, performance and quality</b>	The focus on delivery through the Transition Committee and Chair's Objectives will support a continued drive for financial, performance and quality improvement.
<b>Risks</b>	Being aware of and actively engaged in discussions about the future role of Integrated Care Boards and the wider NHS will enable us to better inform and understand policy, assisting us to align strategy and minimise risks.

## **1.0 Introduction**

**1.1** The pace of change for Integrated Care Boards (ICBs) and for the NHS more generally continues. In turn, we continue to recognise and seek to minimise the impact on our staff, and I would like to thank them for their continued focus on delivering outcomes for our residents. Indeed, my highlight last month was the opportunity to recognise and thank them in person through the annual ICB staff awards. We had so many brilliant nominations, and it was a struggle to choose, but all our staff were winners especially in the way they celebrated each other during the ceremony. I also thank our partners for their continued support, and Zina and the Executive Team for their leadership. It is important to recognise that this transformational change is happening at a time of increased global conflict and uncertainty, and I know that many of us will be additionally concerned for loved ones elsewhere in the world. I also know that we will continue to support and value each other and ensure our staff are reminded of the support resources that are available.

**1.2** At our meeting in May we agreed to establish a Transition Committee that would oversee and scrutinise the development of, and transition to a new ICB operating model, including the implementation of change processes, management of local risks and tracking of progress. The Transition Committee met for the first time on 28 May and agreed a Terms of Reference to put to this Board. This is attached at Appendix A and this report recommends Board approval. At its inaugural meeting, the committee also considered detailed reports on the ICB change programme and on the emerging ICB operating model, seeking assurance on timescales, financial and operational requirements, comparison through benchmarking with other Integrated Care Boards, the involvement of stakeholders, and the mitigation of risks. The Committee acknowledged that there are still areas of uncertainty which need to be clarified nationally, for example, the funding of redundancy costs and an understanding of the future role and therefore how we will relate to NHS regions. It also recognised that whilst this was a time limited committee, there would need to be ongoing organisational development once the new model was in place.

## **2.0 Integrated Care Partnership**

**2.1** The June Integrated Care Partnership (ICP) Steering Group received an update on latest government policy developments and the ICB transition plans. It was heartening to hear the support from this wider group of partners for the importance of a system convenor role and the continued joint commitment to improving population health. This commitment was also reflected in its discussions on neighbourhood health. The ICP Steering Group also considered my 2025/26 objectives as ICB and ICP Chair. This followed my 360-degree appraisal, and the resulting objectives were agreed, with only one amendment. My objectives have now been approved by the Non-Executive Remuneration Committee and build on the three personal priorities I set out at our last Board meeting; supporting and delivering for people, ensuring key North East London principles shape the new ICB operating model, and advocating regionally and nationally for our Integrated Care System.

**2.2** Chair's Objectives: In setting the objectives, it is recognised that the governance arrangements for North East London (NEL) ICB will have a transition focus for 2025/26 and within this that the responsibilities of non-executive Board members, including the

Chair, will most likely change during the year. Therefore, for the current year, all will have a similar overall responsibility focused on in-year delivery and transition, in addition to their specific committee membership. The 2025/26 objectives of the Chair are:

1. To lead the Board in ensuring effective oversight, support and scrutiny during the transition of the ICB from its current form to a new operating model, with a focus on assuring a fair, equitable, transparent and robust process, particularly for staff; the effective mitigation of risk; the reduction of required costs; the effective transfer of responsibilities and the meeting of our statutory, financial and operational responsibilities. In doing so, to have a strategic focus, within NEL and across London, on improving ICB functionality as a strategic commissioner of high quality, resident centred care that consistently tackles health inequalities, meets the needs of our diverse communities, and enables the effective establishment of neighbourhood health.
2. To Chair the ICP and the ICP Steering Group, working with system partners and wider stakeholders to improve its effective focus on the three shifts leading the partnership through the reform of the ICB, including influencing nationally where appropriate.
3. To be a member of the Finance, Performance and Investment Committee, the Population Health and Integration Committee, the Quality, Safety and Improvement Committee, the Remuneration Committee and their successor committees.

### **3.0 Chair Activities**

- 3.1** The majority of the conversations I have had over the last two months have been focused on the transition to, and the shape of, the new Integrated Care Board and the wider health system. As we anticipate the publication of the 10 Year Health Plan which will provide further guidance, the Board is asked to deliberate on whether it would be useful to reconvene virtually later this month to consider its content.
- 3.2** The focus on change is not ours alone. Nationally, I have been involved in conversations about the required refresh that the 10 Year Health Plan will bring for the NHS London Term Workforce Plan, to ensure we have the appropriate workforce for its delivery, whilst delivering education and training now. Regionally, whilst I am still involved in the London Health Board, it is being refocused into the London Health Mission Board, and our colleagues leading North West and North Central London Integrated Care Boards are considering whether to merge. Amid all this change, there has been a consistent concern raised about the importance of equity, inclusion and diversity and the need for transparency in the treatment of staff. Within London this is an area for consideration at the London People Board, and a specific focus for us within North East London as we work with our staff networks.
- 3.3** There are two specific preparation focus areas in my conversations with partners and with non-executive members. All partners are very interested in the role of health integrators at Place and how best they can work together to prepare themselves for this role, recognising that it will be the ICB decision as a strategic commissioner. There continues to be a range of conversations with places, leaders and Trusts to build on our ICB approach as already reported here. It is encouraging to see the positive intent and the collaboration that is building around this new role. The non-executive focus across each committee I have sat on over the last couple of weeks, has been on ensuring that

we have a robust understanding of the contracts we already hold as a necessary foundation of both quality and value for money. There is more work to do in this critical area, enabling us to more rapidly move towards a place where we can re-engineer services in line with the three shifts that we know will still feature in the 10 Year Health Plan. This will be an additional non-executive focus and will need to be part of our transition conversation.

**3.4** You will have seen the coverage of the 2025 Spending Review, which sets out the departmental budgets for 2026/27 to 2028/29, using a spending envelope largely outlined in the Spring Budget. For ease, I have set out a summary, drawing on briefings from NHS Confederation, NHS Providers and others:

- The Department of Health and Social Care's budget will increase by an average of 2.8 per cent in real terms overall. This amounts to a £29bn increase in annual resources budgets and by the end of the spending review period, the resource departmental expenditure limit, (RDEL) will peak at £232bn. This largely reflects increases in the revenue side, as the capital budgets have stayed largely as was outlined in the 'phase one' Autumn Budget. (Although after the publication of the Spending Review, NHS England outlined plans to introduce an off-balance-sheet capital investment model.) Health have done well compared to other Government Departments; however, the announcement falls short of the historic 3.6 per cent increase, and short of the 4% that the Health Foundation's calculated was necessary to restore services over the coming decade. In addition, the DHSC has committed to delivering at least 5% savings and efficiencies over the spending period, including £17bn in savings by improving productivity by 2%.
- The government announced further health-related statements, some of which had been made previously, which included:
  - Up to £10 billion in NHS technology and digital transformation by 2028/29, an almost 50 per cent increase from 2025/26. This will support digital investment by developing the single patient record, further expansion of the NHS App and continued adoption of the Federated Data Platform.
  - Additional funding by 2028/29 to train more GPs, (although a specific funding figure has not yet been provided).
  - Allocation of funding for 700,000 additional urgent NHS dentist appointments per year over the Spending Review.
  - A commitment to expanding mental health support teams to all schools in England by 2029/30 and employing 8,500 additional mental health staff by the end of the parliament.
  - An increase of over £4 billion of funding available for adult social care in 2028/29, compared to 2025/26. This includes an increase to the NHS's minimum contribution to adult social care via the Better Care Fund.
  - Integrated settlements will be expanded to five further Mayoral Strategic Authorities and local government will receive an additional £3.4 billion of grant funding per year by 2028/29, compared to 2024/25.

- £100 million investment in community help partnerships to bring together a range of services to better support adults with complex needs.
- £410 million per year by 2028/29 to expand Free School Meals eligibility to all pupils in England with a parent receiving Universal Credit.
- Increasing research and development (R&D) funding to £22.6 billion per year by 2029/30. This includes funding for a new research and development of the Missions Accelerator Programme, which will leverage a further £1.5 billion of private investment into innovation challenges. that support the government's mission and for a Local Innovation Partnerships Fund for local leaders to co-create research and development programmes to support local economies.
- Over £2 billion to drive the Artificial Intelligence Action Plan including a 20-fold increase in support for compute capacity, with £160 million for TechFirst to ensure people have the right skills to deliver technological change.
- Measures to tackle the wider determinants of health, including an additional £3.5 billion for employment support, over £39 billion for a new Affordable Homes Programme; utilising the Warm Homes Plan to improve energy efficiency and reduce bills for people; increase in the means test threshold for winter fuel payments; an increase in the core school budget by £2bn along with the expansion of free School Meals; and an additional £1.2 billion for skills.

#### **4.0 Recommendations**

- 4.1** To receive and note the report.
- 4.2** To approve the Terms of Reference for the Transition Committee
- 4.3** To consider whether to hold a virtual meeting, if the NHS 10 Year Health Plan is published before the end of July.

#### **5.0 Appendices**

- Appendix A - Transition Committee Terms of Reference

**Marie Gabriel – Chair**

**22/06/25**

## The Transition Committee of North East London ICB

### TERMS OF REFERENCE

<p><b>Status</b></p>	<ol style="list-style-type: none"> <li>1. The Transition Committee (“the Committee”) is established by the Integrated Care Board (“the ICB”) as a Committee of the Board of the ICB (“the Board”).</li> <li>2. These Terms of Reference (ToR) set out the membership, remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board. Additionally, the membership of the Committee must be approved by the Chair of the Board.</li> <li>3. The Committee and all of its members are bound by the ICB Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.</li> </ol>
<p><b>Authority</b></p>	<ol style="list-style-type: none"> <li>4. The Committee is authorised by the Board to take all necessary actions to fulfil the remit described within these terms of reference, including obtaining professional (including legal) advice, commissioning reports and creating groups. The Committee will follow the processes described by the Board for commissioning any professional advice. The Committee may establish groups to assist the committee to undertake its functions but it cannot delegate decisions to such groups.</li> <li>5. In reliance on its authority, the Committee has established the Change Executive Group</li> </ol>
<p><b>Purpose</b></p>	<ol style="list-style-type: none"> <li>6. The Committee has a limited role and has been set up, in accordance with the ICB Constitution, for the special purpose to oversee and scrutinise the development of and transition to a new ICB operating model and implementation of change processes including managing local risks and tracking progress. The Committee will oversee the safe transfer and delivery of ICB functions to other organisations in line with national guidance and any changes to legislation.</li> </ol>
<p><b>Responsibilities of the Committee</b></p>	<ol style="list-style-type: none"> <li>7. Oversee the establishment of robust programme management arrangements to deliver ICB transition requirements within the prescribed timeframe.</li> <li>8. Oversee the development of a fit for purpose ICB operating model. This will include ensuring that the proposed new model:</li> </ol>

## Chairing arrangements

- (a) Is designed to effectively deliver revised ICB functions and responsibilities, in line with the Model ICB and Strategic Commissioning Framework.
  - (b) Delivers required efficiencies and is affordable within the financial allocation for the ICB.
9. Receive assurance that plans are in place on the delivery of timely, open, and transparent staff and stakeholder communications throughout the transition process.
10. Oversee the safe transfer of ICB function to other organisations including identifying risks in transition to future modelling.
11. Oversee the identification and management of risks relating to the transition process and future ICB operating model.
12. To support the resolution of risks and issues escalated by the Change Executive Group.

## Membership

13. The Committee will be chaired by the Chair of the Board, appointed on account of their specific knowledge, skills and experiences making them suitable to chair the Committee and will agree the Committee's agenda and ensure that its work and discussions meet the objectives set out in these terms of reference.
14. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.
15. Committee members may appoint a Vice Chair from its members. If a Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.
16. The Committee members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Committee.
17. The Committee shall have six member as follows:
- (a) ICB Chair (Chair)
  - (b) Non-Executive Member
  - (c) Non-Executive Member
  - (d) Chief Executive
  - (e) Chief Finance and Performance Officer
  - (f) Director of People

## Participants

18. When determining the membership of the Committee, active consideration will be made to diversity and equality.
19. Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff and Non-Executive Members to the meeting as necessary in accordance with the business of the Committee.
20. Meetings of the Committee may also be attended by the following individuals for all or part of a meeting as and when appropriate:
  - (a) Head of Governance/Company Secretary
  - (b) Chief of Staff
21. The Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion on particular matters.
22. For the avoidance of doubt, the paragraph above applies equally to participants as to members.

## Meetings, Quoracy and Decisions

23. The Committee will operate in accordance with the ICB governance framework, as set out in its Constitution and Handbook and wider ICB policies and procedures, except as otherwise provided below:

### Scheduling meetings

24. The Committee will meet monthly and will meet in private. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.
25. The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

### Quoracy

26. For a meeting to be quorate, three of the six members must be present, which must include a Non-Executive and Executive member.
27. If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
28. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

### Voting

29. Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Committee may vote. Each member is allowed one vote and a simple majority will be

conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

#### Papers and notice

30. Notice of all meetings will comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed ahead of the meeting.
31. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as possible to members. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

#### Virtual attendance

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

#### Confidential information

33. Where confidential information is presented to the Committee, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

#### Meeting minutes/Action log

34. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Committee together with the action log as soon after the meeting as practicable.

#### Governance support

35. Governance support to the Committee will be provided by the ICB governance team.

#### Conflicts of interest

36. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

**Behaviours and Conduct**

- 37. Members will be expected to behave and conduct business in accordance with:
  - (a) The ICB policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business.
  - (b) The NHS Constitution.
  - (c) The Nolan Principles.
- 38. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

**Accountability and Reporting**

- 39. The Committee is accountable to the Board and will report to the Board on how it discharges its responsibilities.
- 40. Exception reports will be presented to the ICB Board by the Chair of the committee.
- 41. The Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.
- 42. The Committee will review its effectiveness in its first six months.

**Review**

- 43. These ToR will be reviewed within the first three months from establishment and more frequently if required. Any proposed amendments to the ToR will be submitted to the Chair for approval.

**Date of approval:**

**Date of review:**

**Version:** 1.0

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Chief Executive Officer's Report
<b>Author</b>	Zina Etheridge, Chief Executive Officer
<b>Presented by</b>	Zina Etheridge, Chief Executive Officer
<b>Contact for further information</b>	Laura Anstey <a href="mailto:l.anstey@nhs.net">l.anstey@nhs.net</a>
<b>Executive summary</b>	The following report provides an update on the activities of the Chief Executive Officer (CEO) and the delivery of the priorities and objectives of NHS North East London.
<b>Action required</b>	The board is asked to note the updates
<b>Previous reporting</b>	N/A
<b>Next steps/ onward reporting</b>	N/A
<b>Conflicts of interest</b>	No conflicts of interest have been identified.
<b>Strategic fit</b>	The report aligns to our strategic purpose, priorities and objectives of the ICB and ICS: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The ICB will enable us to have greater impact as we are enabled to work in a more integrated way across health and care organisations in north east London.
<b>Impact on finance, performance and quality</b>	N/A
<b>Risks</b>	N/A

### 1.0 Introduction

1.1 Since the Board last met, we have had a continued focus on our organisational change requirements, including our formal submission to NHS England (NHSE) on the 30 May of the indicative plan for how we would meet the new budget envelope. The proposed shape of our organisation has a strong focus on strategic commissioning, whilst continuing to hold important and statutory functions. There are also functions that we anticipate will be done by others in future but, until we have worked with partners to develop their capability, we will continue to do them in the ICB. The overall shape of the structure of the new organisation is now subject to consultation with staff, which we are working towards starting in the summer.

Beyond the organisational change I am really pleased with our continued progress on integrated neighbourhood teams and the Board will be able to hear more about this on the agenda today.

## **2.0 ICB changes**

2.1 Work continues on developing our new operating model and associated structures required to deliver this. Our focus is on preparing for a staff consultation which we hope to do over the summer. We have a programme structure in place to manage the change, and the overall programme is being overseen by a new Transition Committee which is overseeing and managing the risk. This continues to be a very difficult time for our staff, and I am ensuring a regular flow of updates and messaging through our weekly all staff briefing and internal communications channels. I am also ensuring we have regular updates for stakeholders and through our regular forums we are ensuring key stakeholders are involved in discussions on what the changes mean for our wider system operating model.

### **2.2 Wider system architecture**

The ICB changes are part of a set of changes to the wider system architecture on which we expect greater clarity in the 10-Year Health Plan, expected to be published shortly. Alongside the move to the ICB having a more concentrated focus on commissioning, other parts of the system will be impacted by change:

- At neighbourhood level, the move to neighbourhood working, which we have set out in previous board papers, will continue to be important (see below);
- This will be supported by place-based delivery vehicles/ integrator functions which will support neighbourhood development and potentially take on some functions currently conducted by the ICB.
- Place-based partnership working will continue to be important and we will need to work through any changes required here
- At system level, partners have indicated that they see this continuing to be an important layer for north east London (NEL), including through the Integrated Care Partnership (ICP)
- There will be a smaller London regional tier of NHSE (and subsequently the merged Department of Health and Social Care (DHSC)/ NHSE) focussed amongst other things on the regulatory role of NHSE in relation to providers.

We have started some work on the implications of these changes for the wider system, working in collaboration with partners. Clearly, we will take account of the 10-Year Health Plan as the work develops.

## **3.0 ICB priorities**

3.1 In addition to the ongoing organisational change, and focus on our core business activity, there continues to be a lot of focus regarding the ongoing development of integrated neighbourhood working and teams which the Board will hear about later in today's agenda. I am also in the process of setting up meetings with the core leadership teams from providers (including primary care) and the local authority in

each of our places to discuss the role of delivery vehicle or integrator for neighbourhood working in each borough. We will be using those conversations to understand what other development work we need to do before we can move to formally identifying what organisation, or organisations, we commission to take on those roles.

- 3.2 Linked to this work, the London case for change for Integrated Neighbourhood Working was also published on the 13 May. Partners across London, including all five ICBs, the Greater London Authority and London local government have signed up to the blueprint for delivering health through working together in the community.
- 3.3 The NHS Urgent and Emergency Care (UEC) Plan for 2025/26 has now been published and sets out a system-wide overhaul to tackle “corridor care” by shifting treatment closer to home, improving ambulance response, expanding mental health crisis support, and easing hospital bottlenecks. The plan sets clear national targets: 78% of accident and emergency (A&E) patients seen within four hours, ambulance handovers within 45 minutes, and Category 2 calls answered in 30 minutes. It also introduces a national single point of access to streamline referrals and reduce A&E demand, while boosting digital infrastructure, virtual wards, and cross-sector winter preparedness. The plan places a specific focus on winter, requiring Integrated Care Systems (ICSs) to strengthen seasonal resilience through early planning, vaccination and immunisation uptake, and targeted demand management strategies. A Winter Residence Review is also scheduled for September to assess and optimise bed capacity and flow across systems.
- 3.4 In response to the UEC Plan, North East London ICS is scaling up out-of-hospital capacity and streamlined access through our Single Point of Access programme, expanding virtual wards, urgent community response, and same-day care access. The ICS is strengthening integration via care partnerships, using real-time data to track pressures, and coordinating with local authorities to improve discharge planning, all aimed at meeting UEC targets and building long-term resilience across a more integrated, patient-focused urgent care system.

#### **4.0 Financial position**

- 4.1 There is a continued challenge in achieving financial balance and sustainability. Further detail can be found in the finance report on the agenda.

#### **5.0 Visits and key meetings**

- 5.1 We held our third annual staff awards ceremony in May, which was a fantastic opportunity to come together and recognise the array of fantastic work that has been delivered across the organisation, despite the difficult period we are currently operating in. The online ceremony underlined the real value of what people have achieved over the last year and really helped our staff come together to celebrate the amazing people, teams and work happening across our organisation. We followed this up with an in-person celebration for the winners and highly commended colleagues on the 10 June, and it was heart-warming to see and hear

how much the nominations and wins meant to our colleagues, and also how many of the winners recognised the support of others and their teams in their achievements.

- 5.2 In June, I visited adult and perinatal mental health services in Hackney with Dawn Carter Macdonald, the Chief Executive of Hackney Council. These services are innovative and patient-centred, and it was helpful to learn about the collaborative model developed by colleagues from East London NHS Foundation Trust (ELFT), Homerton Healthcare, and the council. This model includes regular multi-disciplinary meetings throughout the day to ensure risk is fully understood, especially for individuals waiting in the community for admission to a bed. Additionally, discharge planning is held collaboratively with council staff, ensuring early consideration of housing availability. During the visit, we also spent time taking about the innovative model that the Women's Health Hub has developed, but also how it is not yet managing to support women from all communities and the next steps in focussing on that.
- 5.3 I recently held an online briefing session with local councillors, and separately with some of our local Members of Parliament (MPs) to talk through our financial situation and challenges, and our high-level plans to address these. As part of the discussion around finances, they were also particularly interested in our work around using artificial intelligence (AI) as an early intervention measure to improve health outcomes and move towards prevention one of the three strategic shifts, our work to transform services for children and young people referred for an autism assessment and how we are developing special educational needs and disabilities (SEND) services across north east London. We also discussed the capital budget allocation and the impact of this being needed to address essential maintenance across our hospitals. MPs and Councillors are important to our partnership working in north east London, and we will continue to keep them updated on our work.
- 5.4 I attended the June Acute Provider Collaborative (APC) Joint Trust Board meeting, which brings together Barts Health, Homerton Healthcare and Barking, Havering and Redbridge University Hospitals Trust (BHRUT), to talk about development of our work on integrated neighbourhoods as well as the implications for the wider system of the various changes the Government is making to NHSE and ICBs. There was an engaged and positive discussion about the collective commitment across north east London to putting local people first, reshaping our services so that we most effectively support their health and wellbeing and the level of change that this requires. Colleagues raised important issues about the level of challenge of this work particularly given the lack of transitional funding to support the move to new models of care, as well as focussing on the opportunities we have in this period of change.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Primary and secondary prevention for cardiovascular disease with focus on strategic commissioning opportunities
<b>Author</b>	Charlotte Stone, Programme Director for Long Term Conditions (LTC)
<b>Presented by</b>	Charlotte Pomery, Chief Participation and Place Officer
<b>Contact for further information</b>	<a href="mailto:Charlotte.stone14@nhs.net">Charlotte.stone14@nhs.net</a>
<b>Executive summary</b>	<p>Cardiovascular disease (CVD) is one of the leading causes of preventable death and health inequality in North East London. Strengthening both primary and secondary prevention offers a significant opportunity to improve the lives of our residents and reduce system pressure.</p> <p>Primary prevention efforts focus on earlier detection of undiagnosed conditions, through culturally tailored, community-led approaches. Secondary prevention targets residents with medium complexity CVD by supporting timely, coordinated care to prevent escalation.</p> <p>North East London (NEL) is developing a strategic commissioning model for long-term conditions, focused on developing a proactive care approach, which includes core offers to reduce variation, stabilise services, and clear alignment with the role of Integrated Neighbourhood Teams (INTs).</p>
<b>Action / recommendation</b>	<p>ICB Board members are asked to:</p> <ol style="list-style-type: none"> <li>1. Endorse the direction of travel, including the focus on identifying medium complexity cohorts, scaling high-impact interventions, addressing health inequalities and embedding community-led prevention through INTs</li> <li>2. Support continued alignment and coordination through integrated neighbourhood working and core offers across the CVD pathway</li> <li>3. Acknowledge key risks and dependencies, particularly in relation to organisational change and financial constraints, and support mitigation through governance, shared leadership, and flexible commissioning</li> <li>4. Note the importance of enabling digital and virtual care tools to support local work.</li> <li>5. Champion the case for sustained investment in primary and secondary prevention, recognising the</li> </ol>

	long-term system and population benefits of early intervention.
<b>Previous reporting</b>	Core elements including CVD deep dive and approach to developing proactive care model have been discussed at <ul style="list-style-type: none"> <li>• NEL Long Term Conditions (LTC) Strategic Board</li> <li>• NEL LTC Delivery Group</li> <li>• CVD Improvement Network</li> <li>• Executive Committee</li> </ul>
<b>Next steps/ onward reporting</b>	N/A
<b>Conflicts of interest</b>	None identified
<b>Strategic fit</b>	The report aligns with all four ICS aims: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The approach outlined in the report will improve outcomes for local people by enabling earlier diagnosis and better management of CVD, particularly in communities most affected by health inequalities. It promotes more equitable access to care, reduces avoidable hospital admissions, and supports long-term system sustainability through more consistent, community-based services.
<b>Has an Equalities Impact Assessment been carried out?</b>	Equality and Impact Assessment are being integrated into the development of the Proactive Care Model, including the design of core offers
<b>Impact on finance, performance and quality</b>	The approach aims to reduce long-term costs by preventing escalation of need, disease and avoidable admissions, improve performance through more consistent service delivery, and enhance quality by embedding proactive, person-centred care across the CVD pathway
<b>Risks</b>	Key risks include programme interdependencies, organisational change, financial constraints, and variation in system wide capacity, each of which may affect delivery pace and consistency.

## 1. Introduction

1.1 Cardiovascular disease (CVD) is a major and growing challenge for North East London (NEL). It is the second leading cause of death in the system, responsible for over 1,000 preventable deaths each year and accounting for 26% of all mortality. Nationally, CVD remains the leading cause of disability-adjusted life years lost and contributes to one in four premature deaths (NHS Long Term Plan, 2019). In NEL, the impact is even more pronounced due to high levels of deprivation, ethnic diversity and complex health needs.

1.2 CVD is also a key driver of health inequalities. Premature mortality from CVD is more than twice as high in the most deprived communities compared to the least. Black and South Asian populations are more likely to experience hypertension, diabetes, and heart failure at younger ages, yet are less likely to access preventive care or to complete rehabilitation. These disparities reflect both structural inequities and suggest longstanding barriers to access, engagement and culturally appropriate care.

1.3 And CVD is also often preventable. Earlier identification, better risk management, and more coordinated care can significantly reduce avoidable harm, improving outcomes for local people and relieving pressure on health and social care.

1.4 This paper sets out how NEL is using its strategic commissioning role to lead a whole-system, integrated response to CVD, focusing on both primary and secondary prevention. This includes the development of a wider Proactive Care Model for long-term conditions aligned with the embedding of Integrated Neighbourhood Teams. Together, these efforts support our ambitions to improve population health, reduce inequalities, and deliver sustainable, locally tailored care.

## 2. Using insights to develop a better understanding of our local population

2.1 The NEL CVD Improvement Network (the Network) brings together clinical, strategic and operational partners from across the system to drive a more co-ordinated, whole-pathway approach to cardiovascular disease. Co-chaired by the Assistant Director of Public Health at the London Borough of Newham and the Consultant Cardiovascular Pharmacist at Barts Heart Centre, the Network provides strategic leadership, alignment and a platform for shared learning.

2.2 Insights from the Network and wider system intelligence have identified three key areas where there is significant potential to strengthen the CVD pathway and to change the profile of CVD in north east London:

1. **Primary Prevention** - Local population health data and community engagement indicate that earlier identification of conditions such as hypertension, type 2 diabetes and atrial fibrillation remains an area for improvement, particularly in communities disproportionately affected by health inequalities. Nearly half of people with hypertension across NEL remain undiagnosed. NHS Health Check uptake is below 40%, with the lowest participation in boroughs with the highest levels of deprivation and CVD risk, contributing toward high number of undiagnosed residents. Community voices highlight barriers such as low health literacy, inconsistent availability of culturally tailored care and mistrust in healthcare, particularly among Black and South Asian communities, younger adults and those in deprived areas.
2. **Secondary Prevention** - local system analysis shows that 54,392 people across NEL are currently living with medium complexity CVD, more than twice the number in the high complexity cohort. This group typically has multiple risk factors or early-stage disease and may benefit from timely, coordinated interventions that can support better health outcomes and prevent escalation of need. Initial modelling suggests that up to 20% of this group may deteriorate each year, representing more than 10,000 individuals and an estimated cost pressure of £53.9 million annually.
3. **Variance and service gaps** - Emerging evidence, including insights from CVD ACTION (a smart data tool developed by UCLPartners to help GP practices transform the prevention of cardiovascular disease) underlines the hypothesis that

variation in diagnosis and access to services is contributing to inequitable outcomes and increased unplanned care. Heart failure remains one of the highest areas of avoidable admissions locally (around 440 admissions annually) with inconsistent service models and non-recurrent funding for heart failure clinics a particular focus.

2.3 There is already a considerable amount of work underway across north east London to improve both primary and secondary prevention of cardiovascular disease, which starts to address these three areas of opportunity. However, it is worth noting that we have been working on atrial fibrillation (AF) and hypertension for well over a decade in north east London, without yet seeing the sharp improvement on outcomes to which we all aspire. We recognise we need a step change in approach which effectively draws in the experience and expertise held in all parts of the system, from work with voluntary and community partners to applying the learning of academic partners including the Barts Health Centre.

### **3. Established strengths in CVD prevention**

#### **3.1 Primary prevention**

3.1.1 Primary prevention efforts in NEL have been grounded in collaboration with communities, voluntary, community, faith and social enterprise (VCFSE) partners, public health colleagues, and people with lived experience to design and deliver approaches that are locally relevant, culturally appropriate, and equity led.

3.1.2 Working with local communities and VCFSE colleagues:

- Through a partnership with the West Ham Foundation, health checks and CVD awareness activities have been delivered in trusted, high-footfall settings such as football matches and faith venues engaging communities who may not routinely access traditional care.
- Local schools have taken part in awareness programmes, promoting healthy behaviours from a young age and embedding heart health messages into community outreach and physical activity sessions.
- A small grants programme co-led by the VCFSE Collaborative has supported grassroots organisations to deliver culturally tailored interventions, including South Asian and African Francophone nutrition and cooking classes, Somali-language fitness sessions, and local walking and gardening clubs making prevention and management of risk factors accessible, relatable, and responsive to local needs.

3.1.3 Working with our staff:

- NEL has delivered a series of educational sessions for staff covering renal disease, CVD, and diabetes. These sessions are well attended with strong feedback, particularly for sessions delivered with the NEL Women's Staff Network on CVD in women or a person with a womb and a focused session on renal–cardiometabolic health during Ramadan.

3.1.4 Early identification:

- In the past 10 months, more than 122,000 opportunistic blood pressure checks have been carried out in community pharmacies, placing NEL second highest ICB in London and eighth nationally.

- Joint working across the system with the Primary Care Collaborative and Medicines Optimisation Team has led to national recognition. In 2023/24 (most recent data for full year), NEL ranked first in England for cardiovascular Quality and Outcomes Framework (QOF) indicators, including hypertension, coronary heart disease, stroke, and diabetes. To further strengthen early identification, over 88% of Primary Care Network (PCN) pharmacy teams have now received training in recognising chronic kidney disease (CKD) and CVD risk, through practical, case-based education delivered in partnership with Barts Health.

## 3.2 Secondary Prevention

3.2.1 NEL continues to strengthen its approach for people already living with CVD by improving access to post-event support and standardising care:

- Five cardiac rehabilitation sites operate across NEL, four of which are rated Green by the National Audit of Cardiac Rehabilitation. These include culturally tailored approaches and social prescribing pilots.
- Pharmacist-led anticoagulation services have transformed outcomes for AF patients, with 90% anticoagulated, placing NEL among the best-performing ICBs in London. Additional models are expanding Direct Oral Anticoagulant uptake using targeted, data-driven approaches.
- Medicines optimisation is supported by rollout of point-of-care testing (POCT). Cholesterol POCT in selected pharmacies is improving detection in communities with low engagement with health services, along with greater prescribing of Inclisiran and SGLT2 inhibitors to support residents with co-morbidities.

3.2.2 These strengths provide a strong foundation for further system-wide improvement. Through strategic commissioning, NEL is positioned to align with the developing neighbourhood model and, where appropriate, scale best practice across boroughs.

## **4. Unlocking opportunities through strategic commissioning**

4.1 Towards the end of the 2024/25 financial year, the NEL Long-Term Conditions (LTC) Strategic Board agreed to shift away from a focus on delivering nationally mandated programmes toward a more holistic and impactful strategic commissioning approach. This focuses on shared accountability, involving and empowering clinical and care leaders through improvement networks to drive cross-organisational collaboration and continuous learning.

### 4.2 Proactive Care Model for LTCs

4.2.1 In partnership with UCLPartners and system stakeholders, including clinicians from across the system, we are co-developing a Proactive Care Model grounded in the three Darzi shifts. Early engagement has identified three components that underpin the model's design:

1. Synergy between the model for integrated neighbourhood working and the proactive care approach for long term conditions to deliver integrated care management of people with low and medium complexity of need. Population health data at a local level enables multi-agency teams to deliver integrated, community-based care that supports co-ordinated management for people with developing co-morbidities,

reducing fragmentation for individuals and helping to address both system pressures and health inequalities.

2. A community-centred approach to prevention. Co-developed with system partners, taking the learning from delivery of nationally mandated projects and ongoing local work with the VCFSE, we are incentivising prevention. These efforts promote models that de-medicalise the front end of the CVD pathway and shift delivery into trusted community settings. By supporting culturally tailored, community led interventions, we are aiming to reduce stigma, build trust, and improve health literacy
3. Review of Local Enhanced Services with a specific focus on the identification and management of renal–cardiometabolic conditions, including CVD. The aim is to use population health data to develop a consistent and equitable approach across practices and Primary Care Networks in all Places, reducing unwarranted variation in outcomes and supporting earlier intervention and better long-term management.

#### 4.3 Core offers

4.3.1 To support a strategic and sustainable approach, we are, through our Improvement Network, developing an all age core offer for CVD, slicing through interventions from community to specialist and based on a strong evidence base and local data. There are significant opportunities from virtual care which we are keen to exploit and maximise. We know we need to strengthen fragile pathways, review commissioning models and reduce reliance on non-recurrent funding, often linked to projects. Work during Q1 and Q2 of 2025/26 is focusing on completing the core offer and reviewing commissioning options, prioritising heart failure and cardiac rehabilitation. This timetable allows system work to be enacted through contractual changes starting from Q1 2026/27.

#### 4.4 High-impact interventions: 2025/26

4.4.1 High-impact interventions set out in our Strategic Commissioning Framework approved by the ICB Board at the end of March include a focus on addressing need earlier in long term conditions, so reducing variation, improving flow and addressing system pressure. High Impact interventions being modelled with insight colleagues focus on:

- Identifying patients who are currently unregistered or undiagnosed, particularly those with hypertension, atrial fibrillation (AF), and lipid disorders.
- Collaborating with Million Hearts and Minds to enhance hypertension detection, with community pharmacy-based checks playing a growing role in improving access to earlier diagnosis.
- Through joint work with public health and other ICBs, increasing NHS Health Check uptake, particularly communities where we can have the greatest impact.
- Exploring new models of care and the use of digital technology, for example reviewing opportunities to scale use of the ORTUS rapid titration platform. Early results show that 92% of patients discharged on all four recommended medications, show an 80% reduction in readmissions and improved access to specialist follow-up.

#### 4.5 Next steps: a strategic commissioning framework for CVD

4.5.1 Over the summer, we will work with colleagues across the system to articulate the Proactive Care Model, to agree core offers and to prioritise the high impact interventions in order to deliver a strategic commissioning framework and approach for CVD built on population health data, best practice locally and beyond and a sustainable funding model.

4.5.2 We are working to strengthen the opportunities of digital and remote care and to incorporate into the model, aligning the commissioning framework with a strategic approach to virtual care, also being developed.

4.5.3 In parallel, we are working through the Network to optimise existing capacity, reduce unwarranted variation in access and uptake through improvement plans, and to enhance shared learning e.g. delivering anti racism approach to service delivery. This joined-up approach aims to embed consistency, improve outcomes, and deliver better value across the system as we work towards a new commissioning approach.

4.5.4 We have also been approached by national colleagues with an opportunity to test out new funding and payment mechanisms in this area and are actively pursuing what this could mean for strategic commissioning of CVD, probably starting in one Place and building out from there. This would enable us to pilot some different approaches to funding complex transitional work as we seek to effect the three national shifts from treatment to prevention, from acute to community and from analogue to digital, through this work.

## 5. Key risks and dependencies

5.1 While the proposed approach offers significant potential for impact, there are several risks and dependencies that must be actively managed to ensure delivery:

- **Complexity and interdependencies:** Many of the actions to develop the proactive care approach are reliant on alignment with other developing models including integrated neighbourhood working and the evolution of Local Enhanced Services. Delays or misalignment could affect the pace and coherence of delivery.
- **Organisational change:** Implementation of the Model ICB Blueprint may affect the ambitious plans for this financial year.
- **Financial pressures across the system:** The current challenging financial position of both the ICB and provider partners may limit the ability to invest in scaling or sustaining new interventions.
- **VCFSE and community capacity:** The approach depends on strong partnerships with VCFSE organisations and community settings. Variation in local capacity and funding may limit the ability to deliver consistently across boroughs.
- **Learning from other systems:** We need to continue to learn from local and national systems and consistently apply their insights into our work.

5.2 To mitigate these risks, we are continuing to work closely with system partners to coordinate delivery, ensure alignment and maintain flexibility through a strategic commissioning approach. The role of the NEL LTC Strategic Board and Proactive Care Commissioning Group, supported by robust governance and data-driven decision-making, will be critical in navigating this complexity and maintaining focus on long-term outcomes.

## 6. Conclusion

6.1 North East London's approach to CVD is shifting from programme-by-programme delivery to a more strategic and integrated commissioning model focused on early intervention, equity, and system sustainability and reflective of a set of strong clinical voices from across the system. By aligning the Proactive Care Model with Integrated Neighbourhood Teams, strengthening primary and secondary prevention, and addressing unwarranted variation, we are laying the groundwork for more consistent, community-centred care across the CVD pathway. This work builds on strong system partnerships, national best practice, and robust local insight but also depends on continued collaboration, clear governance, and strategic alignment.

6.2 Board members are asked to:

1. Endorse the direction of travel, including the focus on identifying medium complexity cohorts, scaling high-impact interventions, addressing health inequalities and embedding community-led prevention through INTs
2. Support continued alignment and coordination through integrated neighbourhood working and core offers across the CVD pathway
3. Acknowledge key risks and dependencies, particularly in relation to organisational change and financial constraints, and support mitigation through governance, shared leadership, and flexible commissioning
4. Note the importance of enabling digital and virtual care tools to support local work.
5. Champion the case for sustained investment in primary and secondary prevention, recognising the long-term system and population benefits of early intervention.

**End: Author Charlotte Stone, June 2025**

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Delivering the vision for integrated neighbourhood working in north east London
<b>Author</b>	Nina Griffith, Interim Director of Integration
<b>Presented by</b>	Charlotte Pomery, Chief Place and Participation Officer
<b>Contact for further information</b>	Nina.griffith@nhs.net
<b>Executive summary</b>	This paper sets out the next steps in delivering the strategic vision, for integrated neighbourhood working across north-east London working with our Places and a range of providers. In its March meeting, the ICB Board approved the strategy, goals and approach to neighbourhood working for the system. This is a significant strategic objective that defines a way of working for and with local geographic communities to support improved health and wellbeing across the life course. Neighbourhoods are a fundamental building block within our system and through Place are the core way that many of our out of hospital services will function in the future.
<b>Action / recommendation</b>	The ICB Board is asked to: <ul style="list-style-type: none"> <li>• Note the progress in the development of integrated neighbourhood working to date</li> <li>• Endorse and approve the next steps regarding the integrator and the delivery road map for year 1</li> <li>• Endorse the overall direction of travel, recognising any dependencies with the new ICB operating model and the forthcoming Ten Year Plan</li> </ul>
<b>Previous reporting</b>	Population Health and Integration Committee: February and June 2025 ICB Board: March 2025
<b>Next steps/ onward reporting</b>	ICB Board: July 2025
<b>Conflicts of interest</b>	None identified
<b>Strategic fit</b>	The ICS aims this report aligns with are: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The system vision for integrated neighbourhood working is broad and encompasses how everyone in north east London can live in a healthy neighbourhood within a thriving community. The model is explicitly about community

	development and capacity; using the neighbourhood footprint to address health inequalities; networks of practitioners working together through local relationships and awareness of community; integrated teams operating in an integrated service model (or team of teams) as well as about services working together at a neighbourhood level with a direct interface with acute and other services.
<b>Has an Equalities Impact Assessment been carried out?</b>	Equality impact assessments will be undertaken as we define our neighbourhood team model.
<b>Impact on finance, performance and quality</b>	One of the four key goals for neighbourhood working is to support service sustainability of our services and wider system.
<b>Risks</b>	Risks are described in the report

## 1. Introduction

1.1 This paper sets out the next steps in delivering the strategic vision for integrated neighbourhood working across north-east London. At its March meeting, the ICB Board approved the strategy, goals and approach to neighbourhood working for the system. This is a significant strategic objective that defines a way of working for and with local geographic communities to support improved health and wellbeing across the life course. Neighbourhoods are a fundamental building block within our system and through Place are the core way that many of our out of hospital services will function in the future.

1.2 To note – the term ‘Integrated Neighbourhood Team’ (INT) has been used in national and regional guidance to describe a way of working within a neighbourhood footprint, this encompasses more than simply one team and may include multiple teams serving different populations, ways of working and community and resident engagement within the neighbourhood. As we have developed our model in north east London (NEL), we are becoming clearer about the importance of differentiating between the *teams* that get formed within the neighbourhood and *neighbourhood working*, which encompasses the broader approach.

## 2. The NEL Vision

2.1 At its March meeting, the ICB Board committed to a broad and ambitious vision for integrated neighbourhood working: *Everyone in north east London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing*. It is a whole population model that is explicitly about community development and capacity. We will use the neighbourhood footprint to address health inequalities; to bring together networks of practitioners working together through local relationships and awareness of community; to develop integrated teams operating in an integrated service model (or team of teams) as to facilitate services working together at a neighbourhood level with improved interfaces to acute and other services.

2.2 The Board also committed to four key goals of neighbourhood working:

1. Working with and for local communities
2. Work in a proactive and preventative way, addressing rising need
3. Deliver integrated, accessible care
4. Support service sustainability

2.3 Adopting the vision for neighbourhoods requires a significant culture shift at all levels in the system. This is a highly relational model of care where professionals will need to work across organisational boundaries including with residents and community groups, to adopt a holistic, person-centred approach and deliver a proactive and preventative model of care. We will need to see a renewed focus on working with and for local communities and prioritising what matters to them. Decision making will be underpinned by a robust population health management approach which drives service planning and day to day operations within the neighbourhood.

### **3. Neighbourhoods in the context of structural changes in the NHS**

3.1 Neighbourhoods remains a priority at a national and London level as a key vehicle to delivering the shifts from hospital to community and from treatment to prevention and to improving the health and wellbeing of the population overall.

3.2 London launched its vision for neighbourhoods in May; publishing their 'Case for Change' and the 'Target Operating Model'. We are active participants in the London Steering Group, contributing to the production of these documents, and were able to reflect and consider the London thinking as we developed our vision for north-East London, as our system thinking influenced the London vision. One of the aims of the London work was to respond to the deliberative dialogue which took place across London in which Londoners reflected their desire to see greater consistency of approach, in light of the porousness of borders within London. It is, therefore, not surprising that our system vision and model strongly align to that of London. Both the London and north east London work emphasise the continued important role of Place as a unit of co-ordination, partnership and delivery for neighbourhood working and more broadly.

3.3 The changes to the size, scope and focus of ICBs was announced just before the March Board meeting. At that point the Board agreed that neighbourhood integration and delivery remain a local priority for our work and our population in north east London, although we were unsure then how the changes would impact on delivery. Whilst the new organisational form of the ICB is not yet finalised we do now have more clarity on this and how we will deliver neighbourhoods within that context.

3.4 Whilst all parts of the system need to drive neighbourhood working, there will be a firm delineation between strategic commissioning, which will remain with the ICB; and place partnership functions and delivery which will move to a neighbourhood health provider in each Place over time. In addition, we anticipate that the 10-Year Plan to be published in the summer will set out further proposals in relation to neighbourhood health including potentially the vital

interface between primary care and the neighbourhood health provider. It is clear that, at this point, the neighbourhood health provider (operating in the ways envisaged for delivery of integrated neighbourhood working at a population level) does not yet exist and will need to be nurtured and developed by the ICB and partners. The Integrator functions, which we have been developing for some time and in advance of the model ICB blueprint, is distinct from, but will provide a stepping stone to this fuller role over time.

### 3.5 What does this mean for delivering neighbourhood working?

3.5.1 Acting as the strategic commissioner, the ICB will develop a commissioning strategy for neighbourhood working that fully reflects the level of ambition around integration and population health for improved outcomes within our neighbourhoods vision and also describes the transition required to get to this point. Initially, from 2026/27, we will reflect neighbourhood working into existing provider contracts. This means that the contracts for the main providers at place that deliver neighbourhood working will include consistent requirements for them to organise or orientate their teams around neighbourhood footprints, to be part of neighbourhood multidisciplinary teams (MDTs) and to take a population health management approach. We will also include aligned incentives across the suite of provider contracts to incentivise collaboration.

3.5.2 Work is already underway to review the suite of local enhanced services (LESs) with general practice, with a view to prioritising long term conditions management through the scope of LESs. We will ensure that, going forwards, our LESs with practices incentivise neighbourhood working and reflect the opportunity of neighbourhood working to support improved prevention, management and outcomes for long term conditions. This will supplement the existing requirement in the national GP contract for general practice to participate in neighbourhood MDTs.

3.5.3 The commissioning strategy will describe how, over a longer period, we will start to implement new contracting models which could include but will not be restricted to alliance or group contracts; lead provider models; joint venture vehicles; outcomes-based measures and payment mechanisms that incentivise prevention or other population health challenges. As a stepping stone towards this broader strategic shift, we have agreed to work with NHS England (NHSE) and NHS Confederation to be a national pilot to test one (or more) new payment mechanisms such as year of care tariffs or capitated budgets for a defined cohort. We will align this pilot to new models of integrated neighbourhood working to see how such payment incentives can drive or enhance the approach.

3.5.4 The commissioning strategy will also set out our approach to supporting and enabling a strong voluntary and community sector across our system which will be critical to successful neighbourhood working. Our approach will need to ensure that small and grass roots organisations are not disadvantaged due to their size, and indeed, that we recognise their value in being close to communities. We are working with our Voluntary, Community, Faith and Social Enterprise (VCFSE) collaborative on this, and considering options such as setting up a community chest model which allows a number of small organisations to be funded for their role in delivering a wider set of system or place outcomes.

3.5.5 We will also need to support a strong delivery function at place. Service providers across sectors are already very committed to the neighbourhood vision and are sharing the system leadership for delivery of neighbourhoods in their places. However, we feel that this will need to be formalised and resourced as we make further progress within neighbourhood delivery, thus underlining the increasing importance of an 'Integrator' role at place to support and enable delivery. The Integrator function, described in the London Target Operating Model (TOM), is a function held by one or more providers (from across sectors) with a geographic presence in a Place who can facilitate the delivery of neighbourhood working. We are open, as are ICBs across London, that this Integrator could be delivered by a wide range of potential providers. With the publication of the ICB Blueprint it has become apparent that the Integrator role will over time need either to sit alongside or to broaden to incorporate wider delivery functions within the current place teams for example. We expect to see further clarity on options for this in the forthcoming 10-Year Plan. In time, the ICB place teams (which will be much smaller to reflect the overall reduction in operating costs) will transfer to the neighbourhood health provider to provide delivery resource.

3.5.6 Appendix A shows the current view of functions and criteria for the Integrator role, which has been co-produced with system partners and draws heavily on the London TOM. We expect this to evolve further but equally that it will remain consistent with local work to date.

#### **4. Where we are now in north-East London**

4.1 There continues to be wide-spread commitment to and enthusiasm for neighbourhoods across our system. We have mobilised our delivery structures for neighbourhoods, and each place-based partnership has agreed its own local priorities and delivery plan for neighbourhoods. At a system level our Neighbourhoods Steering Group has adapted to reflect moving into a delivery phase and will continue to 'hold' the vision and ensure that the system structures do enable neighbourhood working as we go through the ICB transition and build the Integrator and Neighbourhood Health Provider models over time.

4.2 All of our places have set their neighbourhood boundaries – these are set out in Appendix B (Havering is yet to ratify these at their partnership board). The neighbourhoods build on existing geographies that resonate with local people and communities and are known to community-based services. In most cases there is already basic infrastructure in place to bring partners together and many relationships already exist across neighbourhood partners.

4.3 The neighbourhoods range in population size from just under 30,000 increasing to up to 140,000. Whilst reflecting a significant variation, the range is in line with national benchmarks and reflects the requirement to be small enough to resonate with local communities and also large enough to enable sustainable service delivery.

4.4 The variation in size also reflects that places are taking a layered approach, with community networks and community engagement activities happening at the most hyper local levels (often at sub-neighbourhood or estate level, especially where the integrated neighbourhoods are larger), and in some places, where the neighbourhoods are smaller,

integrated teams will work across larger footprints and serve more than one neighbourhood, on something described as locality working in some places. It will always also be the case, that some place-based functions will operate across the whole Place, and be accessed through neighbourhood working, rather than being replicated in each neighbourhood. This may reflect scarcity of resource, rarity of need or complexity of response for example.

4.5 When we look across our place models, we can see activities and services planned or in place across the following footprints:

- Hyper-local community – up to 30,000 – the footprint for resident involvement, community engagement, insight gathering and health promotion work.
- Neighbourhood – 30,000 – 140,000 – the defined neighbourhoods vary in size, therefore the scope of planned activities also varies, where the neighbourhoods are smaller they are the footprints for delivery of more of the community engagement functions, where they are larger they are more focused on service delivery.
- Locality 60,000-150,000– where the neighbourhoods are smaller, places have identified an additional locality level for delivery of the integrated neighbourhood team(s).
- Place – 200,000 + for more specialist services that serve the whole place, but have links into the neighbourhood.

4.6 There is, therefore, much more consistency in the activities or services planned or in place around similar footprints, however there is variation in how we are labelling these footprints, and critically, where we define the neighbourhood. We will do further work within our system to reach a more consistent naming convention, recognising the sensitivities and significance of labels, and not wanting to undo existing well-formed local identities (amongst professionals and residents) that already exist around some of these footprints.

#### 4.7 Neighbourhood boundaries and Primary Care Networks (PCNs)

4.7.1 The neighbourhoods in three of our places do not align with current PCNs because the PCNs themselves are not coterminous or reflective of a locally understood neighbourhood geography. Whilst this is the case for many places across London and nationally, it does present some practical challenges to how we sustain the benefits of PCN relationships and services. General practice remains at the heart of our model and there has been specific engagement with general practice to work this through. We are focusing on enabling general practice to be active neighbourhood agents through relationships and a joint focus on population need rather than starting with structures and boundaries.

4.7.2 There are many benefits to general practice from neighbourhood working and we will continue to focus on these across the delivery. These benefits include: building relationships between practices and community based teams such as social work, community nursing and community mental health; providing a model of care that supports people with more complex social needs that general practitioners regularly describe as being very difficult to support effectively as a single agency; and providing proactive support to high users of general practice which should reduce overall pressure on practices.

4.7.3 In realising these benefits, the neighbourhood footprint will become the geography through which practices form relationships with health and social care partners, deliver integrated care and engage with communities. The ICB Population Health and Integration Committee therefore felt strongly that neighbourhood and PCNs should become coterminous. We will work with general practice partners to understand this further, noting that the forthcoming 10-Year Plan will likely also give direction in this area. Whatever the outcome, we do need to ensure we take the learning and benefits from PCNs into our neighbourhoods approach.

#### 4.8 System enablers: population health

4.8.1 In line with our clear focus as an ICB on strategic commissioning we have established a strategic system enabler group through which we will oversee and coordinate the range of system enablers to support all of our strategic ambitions, including neighbourhoods. The key system enablers needed for neighbourhoods are population health management, digital, contracting and financial flows, workforce and organisational development and estates.

4.8.2 Beyond culture and behaviours, one of the most critical enablers to delivering neighbourhood working in year 1 is implementation of our population health management approach. This is needed to move to a focus on driving improved health and wellbeing outcomes for our population and being able to evidence and evaluate impact. We have procured the Optum population health management (PHM) platform which we will utilise as our main tool for driving and monitoring population health improvement within neighbourhoods. We are working through our implementation plan which focuses both on the technical roll out of the tool and the capability and culture shift needed across teams to realise its benefits.

4.8.3 There is a huge amount of enthusiasm for this work and we expect the tool to be available to all teams working in north east London within quarter two. We are currently identifying which places can act as early adopters and learning sites for the PHM approach, which will mean they will receive facilitation and support from Optum around how to use population health management in a very practical way to support a cohort of their population.

### **5. What we will achieve in year 1**

5.1 This is a complex change model that will continue to iterate over many years, building on existing integration work in our places. Starting points and ongoing delivery are therefore not uniform across the system meaning that we cannot lay out a simple plan that shows getting to an end point within a given timeframe. We have defined the key milestones that will be achieved in 2025/26 by all parts of the system to demonstrate progress and our draft roadmap is set out below:

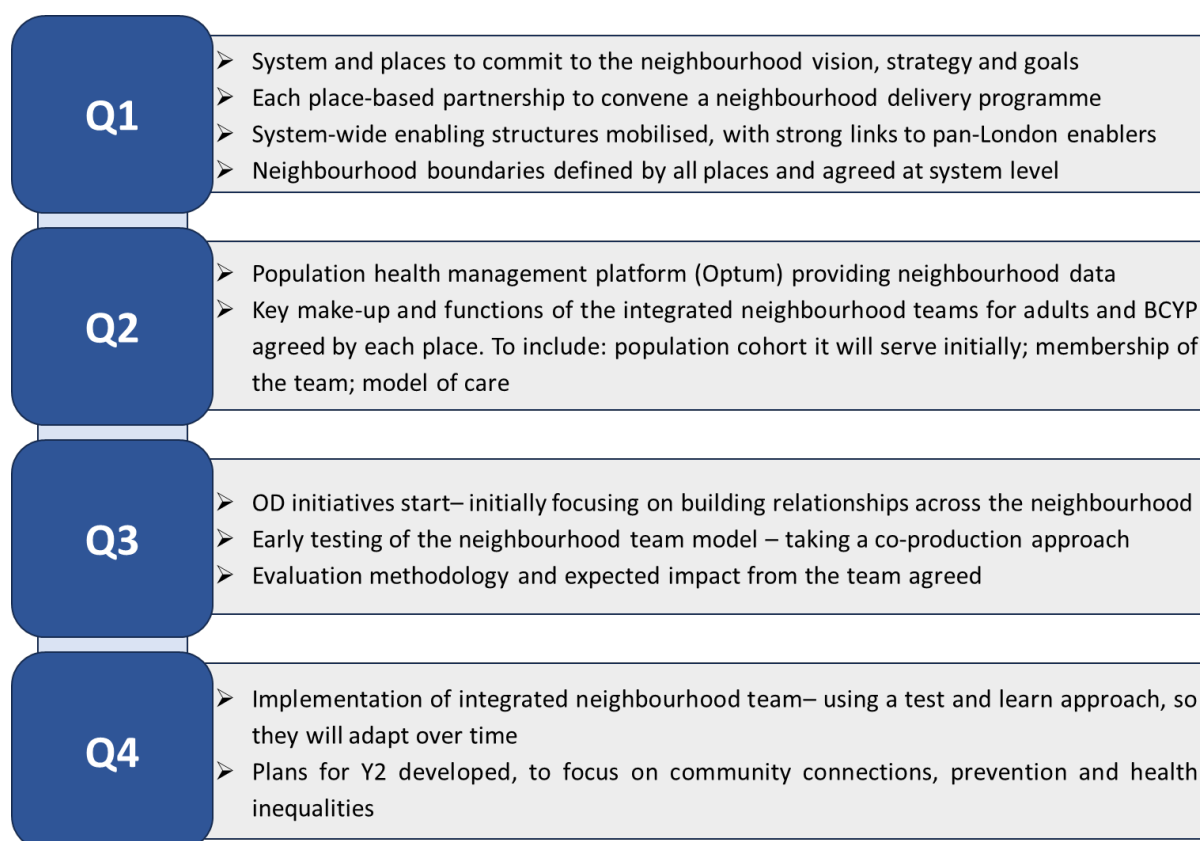
5.2 In year one we are focusing on two key areas:

5.2.1 Developing the commissioning framework for integrators, working with partners to develop the capacity to do this in each Place as part of our strategic commissioning role in shaping and developing the service delivery landscape. As a priority in the coming weeks, the ICB Chief Executive and the executive lead for Integrated Neighbourhood Working are

meeting with senior leaders in each Place (including the chief executive of the local authority, the chief executive of each local acute, community and mental health trust, senior primary care leads) to talk through our approach and start to discuss potential models locally.

5.2.2 Developing a neighbourhood team for complex adults and one for children in each Place, with strong interconnectivity and a population health management approach to define which complex cohorts they will focus on including the associated impacts. This is in line with the operating plan asks and will act as a proof of concept for wider neighbourhood working going forward. Some of our places have existing teams which may need adapting or developing to maximise their impact and ensure they align to our strategy.

5.3 In year two, our places will focus on how they work with communities to address health inequalities and promote better health and wellbeing. This is already reflected in much of the work at place, for example both Barking and Dagenham and City and Hackney have prioritised developing VCFSE structures around their neighbourhoods. Those places that already have positive momentum and opportunities to progress thin year one can certainly go faster against this element.



## 6. Risks

6.1 The following risks have been identified, as we move into our delivery phase:

*6.1.1 Financial and service pressures:* all organisations are under severe financial and operational constraints, this means that there are no resources to support double running of new ways of working and, furthermore, limits capacity and willingness for innovation. However, we also recognise the significant NHS commissioning and spend in north east London, which we will be able to deploy to improved financial and activity flows, potential savings and different ways of working to drive the change required.

*6.1.2 Workforce:* there are acute workforce pressures in many core community and primary care services, which again, limits capacity and willingness for innovation. Workforce shortages will also stall delivery if vacancy rates in existing teams mean staff cannot be structured to work in neighbourhood teams. As with the financial pressures, workforce pressures can be part of the burning platform to drive change as new ways of working can utilise teams differently as well as making NEL a more attractive place to work.

*6.1.3 Capacity across the system to lead and deliver the scale of change:* this is a large-scale transformation that requires a fundamental shift in how we work with communities and deliver local services. Many existing teams will need to pivot to delivery of integrated neighbourhood working. Leaders will need to be clear on the strategic intent and empower teams to focus on neighbourhood development within a clearly defined system approach. New ways of working will need to be supported through the change management approach and specific organisational development initiatives. This will have to be delivered within the context of a significant re-structure and down-sizing of the ICB team and also mandated reductions in corporate functions across our NHS provider partners. Whilst the development of an integrator function at place does ensure the best alignment of delivery resources, the overall demands on teams during this time of change are very hard to fully mitigate.

## **7. Conclusion and recommendations**

7.1 Integrated neighbourhood working is not new but we believe we are facing a once in a generation opportunity to nurture, develop and enhance what partners have worked on over many years in north east London to deliver the significant improvements in population health and wellbeing needed by our local communities. We look forward to the 10-year health plan and the ongoing commitment nationally, regionally and locally to working proactively with local people and communities to support people to stay healthy and well. Neighbourhood working therefore represents both a significant strategic goal for the north east London system, as well as a natural next step in our journey towards more integrated and proactive care that is better rooted in and responsive to our local communities. This is not an optional extra, and we see the approach described in this paper as the core way of working for many of our teams in the future.

7.2 The Board is asked to:

- 7.2.1 Note the progress in the development of integrated neighbourhood working to date
- 7.2.2 Endorse and approve the next steps regarding the integrator and the delivery road map for year 1

7.2.3 Endorse the overall direction of travel, recognising the dependencies with the new ICB operating model and the forthcoming Ten Year Plan.

**8. End: Author Nina Griffith, NEL ICB**

### **Appendix A: The Integrator in each Place**

#### **Introduction**

There has been considerable discussion at a national and regional level, as well as within our system around the need for an ‘integrator’ in each place to provide key leadership and facilitation to deliver neighbourhood teams. We agreed to further consider this within the context of a clearer understanding of the new ICB operating arrangements.

Whilst we have not yet agreed our final operating model for our ICB, our extensive work in this area means we are aligned with the emerging national direction that ICBs continue to drive neighbourhood working and that ICBs act as strategic commissioners, moving away from delivery. The model ICB blueprint also indicates that place partnership functions will move over time to a neighbourhood health provider and in addition, we anticipate that the 10 Year Plan to be published in the summer will set out further proposals in relation to neighbourhood health including primary care and the neighbourhood health provider.

Building on our local and London work over the past year, we continue to need a strong delivery function at place which fulfils the activities of an integrator and which sits with a provider partner, which may over time develop to become the neighbourhood health provider envisaged. It is clear, nationally and regionally, that the model of a neighbourhood health provider does not as yet exist and therefore we will need to develop it over time. The following provides the current thinking for the Integrator role and also what criteria would be used by the ICB to determine who is best placed to deliver it. We expect this to evolve further as we develop our ICB operating model.

#### **Functions of the role to deliver neighbourhoods**

The role will be vital to ensuring the effective facilitation, coordination and delivery of INTs across each place, operating at a level of scale to allow sufficient organisational resources, capacity and capabilities to be available across all associated neighbourhood teams; whilst having the local knowledge, experience and relationships to work in effective partnership with other local providers and institutions.

Given the primacy and centrality of primary care to delivering integrated neighbourhood working, Integrators will need in particular to build and maintain strong working relationships with primary care. In some models the delivery functions being envisaged will be able to provide the support functions to support sustainable primary care, and in particular general practice, and we will want to explore this potential with primary care and potential partners.

This role cannot operate in isolation or remove individual responsibility and accountability from partnering local organisations. However, it will:

- Host and facilitate the design and implementation of the team, bringing partners together as required, and keeping community at the heart of the model
- Bridge the fragmentation across existing teams

## Draft – for discussion

- Deliver key enabling infrastructure, which will vary according to the design of the team but will likely include: operational leadership, clinical governance, digital, activity and outcomes recording and organisational development
- Support and enable a population health management approach
- Over time, assume the place partnership functions as set out in the model ICB blueprint

The role will not:

- Take away from individual roles and responsibilities in the place – we will need the active engagement of all partners to deliver integrated neighbourhood working
- Provide direct employment to the neighbourhood team (unless the place partnership deems that this is a requirement for their model)
- Carry out commissioning or planning functions in fulfilling the role

The full scope of the role will vary according to the place context, however, the following provides an outline of the key functions:

- Project management function for the delivery of neighbourhoods – this will transition to a more operational function as the team is established
- Co-ordination of the different teams and sectors across the partnership supporting neighbourhood delivery, bringing them together and actively bridging fragmentation
- Facilitating partnership development
- Ensuring that the neighbourhood can deliver a core offer whilst also being able to flex to meet local needs
- Facilitation of population health improvement through development of the population health management approach – utilising the system and London-wide PHM data, tools and resources to enable this
- Enabling shared learning
- Providing support to develop relationships and mediating challenges
- Ensuring communities are at the heart of neighbourhood development
- Providing essential infrastructure: Including aligning people, finance, governance, risk and outcomes management across existing providers
- Improving sustainability: Having the ability to offer additional support options to any part of the partnership, including at individual practice level, experiencing difficulties which threaten the sustainability of the INT and the local neighbourhood health service as a whole.

In addition, we see the role taking on wider functions of the place team as we transition to a new ICB operating model although the exact route for this remains as yet unknown and it may be that an integrator and neighbourhood health provider will be roles delivered by different organisations.

## **Draft – for discussion**

### **In order to fulfil this vital role, the Integrator must meet the following criteria**

Have well established relationships across the partnership, and be represented within the place based partnership governance and geography

Deliver services that will become part of or the neighbourhood team or have a strong interaction with the neighbourhood team

Have sufficient scale to deliver the enabling functions, including significant corporate infrastructure such as Estates, Clinical Governance, Digital, workforce and OD teams

Have credibility and maturity as a service provider in the place

Be present in and able to work across the geographical footprints of the neighbourhood teams across the place

Have visible commitment to the neighbourhoods vision and ways of working

### **Governance**

The integrator will have dual accountability – into the Place Based Partnership around delivery of their priorities for neighbourhoods; and into the ICB as the commissioner.

### **How will we agree the Integrator**

In line with our strategic commissioning role, the ICB will be making decisions about which organisation/organisations to commission to carry out the Integrator role. We will work with partners in each Place to understand local capability and to identify which models, some of which may take time to develop, may work best in that Place. At the same time, we will take a strategic view across north east London to ensure coherence and strategic integrity.

Whilst we in the ICB will commission one integrator in each place, we note that the model may require work with other partners in delivering the role, either through formal or informal arrangements. It will be important to agree up front how this will work and what elements will be delivered by different partners.

Given the shifting scope of the role, and its significance, we are not at this point setting a deadline for the role to be agreed. It is important that places are given the time to work through the different models available and most applicable to their Place, whilst facilitating relationship building. We are working with Places to enable the discussions to start on this before the summer break in August as we need to see continued momentum around this agenda.

As well as commissioning the Integrator, the ICB will also step in to agree the model most suited to a Place where a decision cannot be made locally on the model. We are hopeful that relationships at place are mature and that with time partners will settle on the most reasonable approach for their places.

## Appendix B

Place	Agreed by partnership board	Number	Co-terminus with PCNs?	Names and sizes
<b>Newham</b>	Yes	8	No	<ul style="list-style-type: none"> <li>• Plaistow – 42,472</li> <li>• Forest Gate – 44,069</li> <li>• Beckton and Royal Docks – 45,860</li> <li>• East Ham – 62,262</li> <li>• Manor Park – 62,576</li> <li>• Stratford and West Ham – 64,593</li> <li>• Custom House and Canning Town – 65,791</li> <li>• Green Street – 68,942</li> </ul>
<b>Tower Hamlets</b>	Yes	4	Yes – each INT covers 2 PCNs, apart from South West which is co-terminus with one PCN	<ul style="list-style-type: none"> <li>• North East – 83,420</li> <li>• North West – 70,261</li> <li>• South East – 97,202</li> <li>• South west - 74,906</li> </ul>
<b>City and Hackney</b>	Yes	8	Yes – neighbourhoods and PCN boundaries are the same	<ul style="list-style-type: none"> <li>• Springfield Park – 31,923</li> <li>• Woodberry Wetlands – 25,821</li> <li>• Shoreditch Park and City – 55,904</li> <li>• Hackney Marshes – 40,745</li> <li>• Clissold Park – 35,922</li> <li>• Well St Common- 33,245</li> <li>• London Fields - 38,835</li> <li>• Hackney Downs - 36,217</li> </ul>
<b>Havering</b>	Not yet – likely position presented here	5	Yes – neighbourhoods and PCN boundaries are the same	Liberty – 50,592 North – 91,435 Marshalls – 47,638 Crest -40,082 South – 64,627
<b>Redbridge</b>	Yes	4	Yes – each neighbourhood except D covers two PCNs, D covers just one PCN. The neighbourhoods are on the footprint of the former Redbridge Localities and recognised by local partners and communities.	A (covering Woodford and Wanstead) – 85,142 B (covering Cranbrook and Loxford – 140,192 C (covering Seven Kings and NCA) 92,067 D (covering Fairlop) 48,240  Note these are not the agreed neighbourhood names

Place	Agreed by partnership board	Number	Co-terminus with PCNs?	Names and sizes
<b>Waltham Forest</b>	Yes	3	No	South (Leyton/Leytonstone) – 99,600 Central (Walthamstow) - 107,500 North (Chingford) – 72,000
<b>Barking and Dagenham</b>	Yes	4	No	Currently North, South, East, West. North – 58,900 South – 54,200 East – 68,800 West 84,00  There are 10 Community Networks across Barking & Dagenham Place which are community led and support and enable the four integrated neighbourhoods. These provide links into the community and the hyper local responses needed by different communities.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Intensive and assertive community outreach update
<b>Author</b>	Dan Burningham, Mental health learning disabilities and autism (MHLDA) system programme director Victoria Nock, Mental health learning disabilities and autism (MHLDA) head of programme
<b>Presented by</b>	Paul Gilluley, Chief Medical Officer Dan Burningham, System Programme Director
<b>Contact for further information</b>	<a href="mailto:dan.burningham@nhs.net">dan.burningham@nhs.net</a> ; <a href="mailto:Victoria.nock@nhs.net">Victoria.nock@nhs.net</a>
<b>Executive summary</b>	<p>This report provides an update on the development of the North-East London (NEL) Intensive and Assertive Community Outreach plan, in line with NHS England’s requirement for all systems to review and report by the end of June 2025. The ICB must also submit a progress report template to NHS England by 3 September 2025.</p> <p>This paper has been produced through the NEL Intensive and Assertive Expert Reference Group, which brings together clinicians, transformation leads, and people with lived experience from across East London NHS Foundation Trust (ELFT), North-East London NHS Foundation Trust (NELFT), and the voluntary sector. It is also informed by findings from two service user summits and grounded in local best practice. Key drivers are:</p> <ol style="list-style-type: none"> <li>1. Gaps identified in our November 2024, review of community mental health services and opportunities to consolidate good practice.</li> <li>2. Consolidation of the mental health community transformation programme – one of our largest programmes</li> <li>3. Alignment with national intensive and assertive policy and the wider neighbourhood strategy.</li> </ol> <p>We recognise the challenges of progressing transformation in the context of a constrained financial environment, and the restructure. In view of this, we are taking a phased and pragmatic approach, focusing initially on mapping, consolidating, and improving existing practice, whilst awaiting confirmation of national core standards.</p> <p><b>Phase 1: Mapping (May-August 2025).</b> The completion of data informed Key Lines of Enquiry (KLOEs) will provide a shared understanding of gaps and where good practice needs to be implemented more consistently.</p> <p><b>Phase 2: Implementing Assurance August (March 2025).</b> This will focus on the establishment of systems of assurance for four workstreams: 1. Key working and the intensive offer; 2. Identification and holding in sight; 3. Care and crisis plans; 4. Continuity of care and discharge.</p>

	Once agreed, systems of assurance will be strategically commissioned and embedded in provider contracts as detailed in Section 4 of this paper. The NHS England (NHSE) requirements focus on people with diagnosed and undiagnosed psychotic disorders. However, this paper makes the case that it would be better to design our system once, for all those with a severe mental illness and we are therefore including people with severe mood disorders and personality disorders in this programme.
<b>Action / recommendation</b>	The ICB Board is asked to: <ul style="list-style-type: none"> <li>• Endorse the proposed next steps and delivery priorities for July–December 2025</li> <li>• Support the continued development and phased implementation of the model, ensuring alignment with both national expectations and local priorities</li> <li>• Note the financial, structural, and workforce risks associated with delivery, and consider how system partners can be supported to meet the ambition of this work.</li> </ul>
<b>Previous reporting</b>	Mental Health, Learning Disability and Autism (MHLDA) Collaborative Programme Board, 15/10/24 ICB Executive Management Team, 28/10/24 MHLDA Collaborative Sub Committee 6/11/24 MHLDA Programme Board 19/11/24 ICB Board 27/11/24 MHLDA Programme Board 15/04/25 ICB Executive Management Team 02/06/25 ICB Executive Committee 19/06/25
<b>Next steps/ onward reporting</b>	Subject to the support of the ICB Board, the next steps will be to: <ul style="list-style-type: none"> <li>• Complete the mapping of the ‘as is’ situation.</li> <li>• Map ‘as is’ against NHSE Core Standards when published in July 2025.</li> <li>• Submit the NHSE Assurance Template on 3 September 2025 to the MHLDA Collaborative and ICB Executive</li> <li>• Refine and strengthen the delivery framework, including the continuation of the Expert Reference Group and establishment of a wider Serious Mental Illness (SMI) Improvement Network</li> </ul>
<b>Conflicts of interest</b>	No conflicts of interest have been identified.
<b>Strategic fit</b>	The Intensive and Assertive Community Outreach model aligns with the ICS’s strategic priorities and NHSE’s national objectives by: <ul style="list-style-type: none"> <li>• Improving outcomes in population health and healthcare through proactive engagement and tailored interventions for individuals with serious mental illness (SMI).</li> <li>• Tackling inequalities in outcomes, experience, and access by addressing barriers to care, ensuring continuity of treatment, and supporting individuals with complex needs.</li> <li>• Enhancing productivity and value for money by reducing avoidable crisis admissions, emergency service use, and out-of-area placements.</li> <li>• Supporting broader social and economic development by integrating mental health, housing, employment, and social care support to improve long-term stability and recovery.</li> </ul>

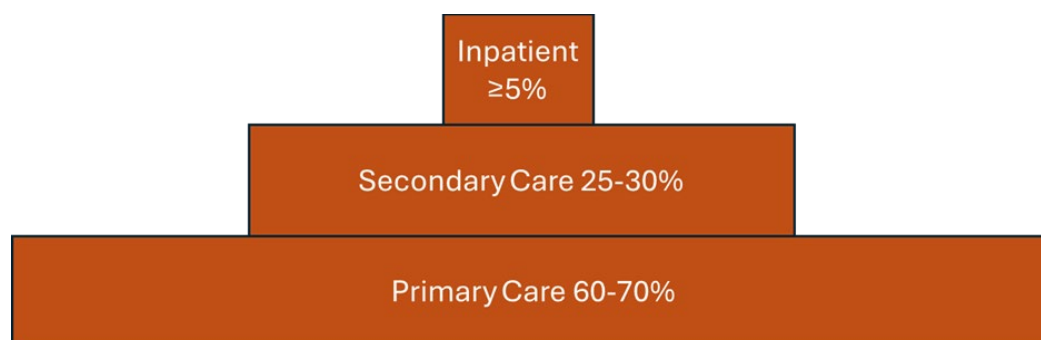
<p><b>Impact on local people, health inequalities and sustainability</b></p>	<p>People with serious mental illness (SMI) face significant health inequalities, including: a reduced life expectancy of 10-20 years compared to the general population; higher rates of long-term physical health conditions, exacerbated by limited access to preventative healthcare. Finally, there is a disproportionate representation of black and minority ethnic (BME) communities, who often face cultural, systemic, and socio-economic barriers to care. The intensive and assertive community outreach model seeks to mitigate these disparities by:</p> <ul style="list-style-type: none"> <li>• Embedding culturally competent and trauma-informed care to enhance engagement with marginalised groups.</li> <li>• Improving access to integrated care pathways, including physical health support, housing, and employment services.</li> <li>• Providing consistent and assertive support to prevent disengagement, reducing the risk of relapse, crisis episodes, and hospitalisation.</li> <li>• Promoting sustainability by ensuring the model is embedded within community services, rather than relying on costly crisis interventions.</li> </ul>
<p><b>Has an Equalities Impact Assessment been carried out?</b></p>	<p>An Equality Impact Assessment (EQIA) has not yet been completed; however, a high-level assessment is provided below. A full EQIA will be undertaken once the proposed plans are approved for implementation. The Intensive and Assertive Community Mental Health Care (CMHC) programme is designed to improve the safety, experience, and outcomes for people with Severe Mental Illness (SMI), who already face significant and well-documented health inequalities. These include:</p> <ul style="list-style-type: none"> <li>• Reduced life expectancy of 10-15 years</li> <li>• Economic disadvantage: Individuals with SMI are more likely to experience poverty, unemployment, and social exclusion.</li> <li>• Disproportionate impact on Black and Minority Ethnic (BME)/ Global Majority communities: These groups are overrepresented in the SMI population and often face compounding inequalities.</li> </ul>
<p><b>Impact on finance, performance and quality</b></p>	<p>Assuming there is no additional NHSE funding, the programme will be delivered within existing resources by focusing on changing the way we do things rather than doing new things. This programme aims to enhance performance and quality of care by improving continuity of care, care planning, risk identification and collaboration.</p>
<p><b>Risks</b></p>	<p><b>1.Non-compliance with core standards.</b> Risk that we cannot deliver the core standards due to financial constraints. <i>Mitigation:</i> review core standards when published and plan to deliver within existing resources.</p> <p><b>2.Inconsistent Implementation:</b> Variability in service models may create unequal care. <i>Mitigation:</i> NEL-wide coordination through the MHLDA Collaborative.</p> <p><b>3. Cultural Resistance:</b> Adoption of new models may be slow. <i>Mitigation:</i> Training, and supervision, use of Patient Reported Experience Measures (PREMs).</p>

## 1. Introduction

### 1.1 Background

In January 2024, Valdo Calocane was convicted for the killing of three members of the public in Nottingham. Following this, the Care Quality Commission (CQC) was commissioned to conduct a rapid review of Nottinghamshire Healthcare NHS Trust, the provider of Calocane's mental health care. The CQC report, published in August 2024, identified critical failings in risk assessment, patient engagement, and discharge processes in the community. At any one point in time, over 95% of the c20,000 patients on the Severe Mental Illness (SMI) register in north east London are in a community setting. Therefore, due to the high volume of patients, a significant amount of the risk sits within community settings. Community settings include specialist mental health teams, community mental health teams and home treatment teams provided by East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT). However, once patients are stable enough they are discharged into primary care. At any one point in time 60-70% of those with SMI are in a primary care setting where contact is often infrequent.

**Figure 1: Indicative distribution of NEL SMI patients (EMIS and RiO data analysis)**



### 1.2 Key Findings from the CQC report

The report highlighted significant areas for improvement including:

- Inconsistent risk assessment – key risk factors were minimised or omitted, failing to explicitly document the severity of potential harm.
- Poor care planning and engagement – limited response to concerns raised by family members and carers, affecting continuity of care.
- Discharge process failures – lack of follow-up after discharge to primary care led to disengagement and increased risk for individuals needing ongoing support.

### 1.3 NHS England's response and national actions

In response to these findings, NHS England (NHSE) issued directives for all Integrated Care Systems (ICSs) and NHS Trusts to:

- Ensure that Trust policies do not allow automatic case closures for individuals who disengage from mental health services.
- Undertake a system-wide review of intensive and assertive outreach services, identifying gaps in provision, workforce barriers, and resource constraints. (Submitted to NHSE in September 2024)
- Report findings and next steps at a public ICB Board meeting in Autumn 2024. (Completed November 2024)
- Develop an action plan to address key challenges and gaps in service provision.

### 1.4 NHS England's February 2025 independent investigation

In February 2025, NHSE published an independent investigation into the care of Valdo Calocane. Key findings reinforced the need for:

- Standardising risk assessment criteria.

- Embedding personalised risk assessments, rather than generic checklists.
- Moving away from the Care Programme Approach (CPA) to personalised care planning, utilising Dialog+ and personal crisis plans.
- Reviewing risk assessment at the first point of contact, considering changes in symptoms over time.
- Improving multi-agency working and working with families on risk management.

### 1.5 National Guidance for Integrated Care Systems (ICSs)

NHSE's guidance identifies the priority cohort for intensive assertive engagement as those who:

- Experience psychosis but may not have a formal diagnosis.
- Struggle to engage with services, often due to previous trauma or systemic barriers.
- Have multiple social needs, including housing, finances, and social isolation.
- Are vulnerable to relapse, deterioration, or harm to themselves or others.
- Experience co-occurring substance misuse or have a history of disengagement.

The aims of the guidance are to:

- Reduce out-of-area placements and keep individuals within their local communities.
- Standardise risk assessment criteria, ensuring consistency across regions.
- Shift towards personalised, strengths-based risk management plans.
- Enhance crisis planning and care planning through evidence-based models

Guidance on producing a local plan is set out in 'Intensive and Assertive Community Treatment Producing a Local Action Plan' (NHSE, 2024). There is an expectation that plans should be grounded in a set of principles including that care should be holistic personalised trauma informed strength-based care and address inequalities. The guidance also states that plans should focus on a set of short-term actions that require minimal resources and identify longer term actions that may be more resource intensive. Examples of short-term action include:

- Identification - services are able to identify those most at risk
- Key working and care co-ordination - ensuring those who are high risk are assigned a key worker or care co-ordinator.
- Co-produced care plans and discharge plans with personalised risk management
- Engaging family and carers
- Continuity of care – avoiding discharge when there is non-engagement (if risk is present) and rapid access back to services in the event of relapse

NHSE is working on embedding this guidance more formally in a set of core standards due to be published in July 2025. The core standards are likely to be grouped around the following areas:

1. Assessment and the communication of the offer time frame
2. Requirements for having a named key worker
3. Co-produced care planning
4. The frequency of review
5. Rapid access back, step up and step down

In their letter to ICBs on 5 February, Clare Murdock and Dr Adrian James request that ICBs report progress on developing local action plans to ICB public boards by 30 June 2025. The update should cover 'any actions you identify to make improvements locally' with particular attention paid to:

- Personalised assessment of risk across community and inpatient teams
- Joint discharge planning, co-produced with the person, their family, the inpatient team, and community services (as well as other involved agencies)

- Multi-agency working and information sharing to improve continuity and safety
- Working closely with families, recognising their role as partners in care
- Eliminating Out of Area Placements in line with the ICB's three-year plan

## 2. Progress to date

### 2.1 November 2024 findings

After a review of intensive and assertive services across north east London, the following findings were presented to the ICB Board in November 2024

#### 2.1.1 Areas of strength and innovation:

- **Open Access:** These services provide fast track flexible access to people with severe mental illness and can triage into more formal services. Crisis cafés and crisis hubs provide an alternative to emergency departments (ED). Service User Network (SUN) are open groups which support the on-going management of crisis. North East London is a national pilot site for 24/7 open access community services.
- **Transformed Primary Care.** North East London was an early adopter of transformed mental health community services in primary care settings. As a result, there are strong pathways between secondary care and primary care which create a continuity of care and a better ability to manage risk across services.
- **Dialog+ Care Planning.** ELFT was the creator of the nationally adopted Dialog+ tool. This provides a holistic assessment framework (covering mental health, physical health and social need) as recommended in the Intensive and Assertive Community guidance. It also provides co-produced care planning tools and a PROM. Dialog+ is used by some ICSs in combination with Open Dialog (see below).
- **Open Dialog Care Planning.** NELFT was an early adopted of Open Dialogue, a personalised and co-produced model, in which the service user creates a circle of support around them to enhance recovery and resilience and reduce the risk of relapse in the care planning process.
- **Digital Tools.** Management and Supervision Tool (MAST) – a system that uses local patient record data to formulate and categorise risk and acuity. PKB (Patients Know Best) the use of a patient owned digital platform to provide information and planning tools and is being implemented across mental health services.
- **RAMHP:** (Rough Sleeping and Mental Health Programme) service established in INEL to provide additional mental health support for people who are sleeping rough (some of whom might be in this cohort).
- **FACT:** (Fast Assertive Community Treatment) teams are present in some boroughs to provide rapid step up for patients at risk

### 2.1.2 Areas for Improvement:

- Identification and holding in sight. Work needed to improve the process of identification and holding site of people within this group and step up and step down could be better clarified.
- Care co-ordination. Whilst this is place for people at risk, recruitment and retention issues mean that there are gaps in care continuity in some areas of North East London and there are sometimes gaps in capacity. These are being closed.
- Care planning. Whilst co-produced care planning is in place, there could be more clarity and consistency in terms of use
- Policies on disengagement to be improved to ensure clarity
- Staff capacity: caseload sizes are too large in some services to provide the level of intensity of support provided by assertive outreach teams (AOT). Capacity needs to be defined. There is not specific dedicated staffing resource for this group, but needs are met through a number of services and functions. We need to determine whether dedicated staffing is required.

## 2.2 The Expert Reference Group

To develop a North-East London plan for intensive and assertive community outreach, a monthly Intensive and Assertive Expert Reference Group was established in September 2024, including clinicians, managers, and people with lived experience.

At the May 2025 meeting, the group reviewed progress and agreed that the function of the Expert Reference Group should continue as a shared assurance and peer review mechanism, supporting local implementation while enabling system-wide visibility and coordination. It was agreed that:

- Delivery will largely happen at trust level, and each provider will progress transformation at their own pace.
- The role of the group is to map existing practice, understand variation, and agree rationale for differences where appropriate.
- The group will focus on aligning delivery with national expectations while retaining local flexibility.
- A system-wide mapping exercise will be carried out, with a set of Key Lines of Enquiry (KLOEs) agreed for phase 1 of this work.:

The Expert Reference Group will:

- Oversee and assure progress across the four reporting areas.
- Provide peer challenge and support, surfacing learning from local practice.
- Ensure service user, carer and clinical voice remains central.
- Avoid duplication of local work by drawing on existing trust activity but create added value through system-wide insights and learning.

The group's role is not to standardise practice for its own sake unless the variation is clearly unwanted. Where wanted variation exists, the group will ensure that this is understood, justified, and clearly communicated across the system.

## 2.3 Mental Health Summit findings

Two workshops were held in March and April 2025 as part of the NEL Mental Health Summit, bringing together service users, carers, clinicians, and voluntary sector partners to test ideas and co-produce solutions for improving Intensive and Assertive Community Outreach. Discussions focused on what helps people feel safe and supported, what makes care planning meaningful, and how services should work with families and support networks.

Key insights are summarised below, supported by direct quotes from participants:

### Feeling Safe and Supported

- People emphasised the importance of being listened to, followed up with, and not being treated as a “problem to solve.”
- Supportive relationships, peer support, and clarity on how to access help during a crisis were seen as vital.

“I need to know someone will follow up. Not just listen but really hear me.”  
“Empathy is what reminds me that I deserve to be treated with dignity.”

### Personalised Care Planning

- Care plans should be dynamic, co-produced, and built on conversations, not checklists.
- Participants wanted one shared plan across services, updated regularly, and written in partnership with them.

“Start with a conversation, not a form.”  
“Include me in ALL plans. Provide me with a copy and the changes too”  
“We have lost the essence of the care plan.”

### Involving Family and Support Networks

- Involvement must be led by the person receiving care and based on trust, consent, and context.
- While some found family support healing, others found it triggering—underscoring the need for flexibility.

“My mum is the last person I want involved in my care.”  
“Families can be triggering, but they can also be part of the healing if they’re supported.”

These findings affirm the core principles of our model, personalisation, co-production, curiosity, and relationship-based care and will shape both short-term actions and the longer-term design of services across NEL.

## **3. Our improvement plan**

### **3.1 The focus of the plan**

The North East London (NEL) Intensive and Assertive Community Outreach plan has been produced through the NEL Intensive and Assertive Expert Reference Group, established in September 2024. The group includes clinical and operational leads from ELFT and NELFT, transformation partners, and people with lived experience. It also reflects learning from two system-wide service user summits, and draws on local best practice including the Barnsley Road pilot, Dialog+, and digital tools such as MAST.

The plan has been developed in the context of:

- The forthcoming Community Mental Health Core Standards, expected in July 2025
- Significant financial and workforce constraints across the system
- Structural changes following the ICB reorganisation and the transition of NHSE functions

Given these challenges, our approach is both phased and pragmatic. Phase 1, running from May to July 2025, focuses on achievable improvements that consolidate existing good practice, while building the foundations for more structured delivery aligned with national guidance.

### 3.2 Governance and delivery

At its meeting in May 2025, the Expert Reference Group agreed to act as an oversight and delivery body for the programme, providing coordination, assurance, and system-wide peer review. Delivery of changes will primarily take place within trusts, while the group will:

- Monitor progress
- Challenge inconsistent practice
- Build shared understanding of risks, needs, and responsibilities

The group will report on a quarterly bases to the MHLDA Board, the MHLDA Collaborative Sub-committee, the NEL ICB Board and to NHSE when required. The Group will report by exception in between quarterly reports.

#### Key Lines of Enquiry (KLOEs) – May to August 2025

To support our mapping and assurance exercise, the following KLOEs are currently being collated. The table below outlines the KLOE and the expected data collection methods. KLOES are being mapped by ELFT, NELFT and ICB quality and performance leads. lived experience leads, particularly those already involved in the Dialog+ pathway will play a critical role.

Our KLOEs have been shaped by the recently published (June 25) ICB template, which needs to be submitted to NHS England by 3 September. This includes the following areas: care plans, assessments, caseload, discharge, care plans.

**Figure 2: KLOEs**

KLOE	Proposed measure	Tracking
1. What proportion of the target cohort is currently on CPA?	Comparison of CPA with MAST tool in NELFT, where both are in use.	Metrics drafted. Reporting to be completed end July 25
2. How comprehensive and consistent is the offer for the patient cohort defined as those on CPA and/or those identified through the MAST tool.	1. % patients with key worker 2. % patients with care plan 3. % patients with crisis plan 4. % with a psychological, social and clinical assesment. 4. Frequency of contacts & reviews. 5. Case load size.	Metrics drafted. Reporting to be completed end July 25
3. How well is risk flagged or tracked in the system? Are red/amber indicators or other tools used?	Analysis of ELFT) and NELFT risk identification systems including MAST.	Mapping of ELFT London, ELFT BLMK and NELT has started. TBC end July 25.
4. How do service users experience the quality and usefulness of their care plans?	Service user feedback from summit	Completed
5. Are people consistently followed up after discharge or disengagement?	DNA policy. Data on discharges plans and DNA discharges	To be completed end of August 25
6. How is the workforce supported to deliver relational, recovery-oriented care (e.g. supervision, training)?	Map training in ELFT and NELFT.	To be completed end of August 25

### 3.3 Four reporting areas (August 2025 onwards)

To structure our system-wide mapping and assurance work, we have agreed four key reporting areas into the Expert Reference Group. Each area is underpinned by shared principles set out later in this document. The Expert Reference Group will also make recommendation for incremental change based on the KLOEs, the assurance reports and the publication of Core Standard (expected in Q2 2025-26).

#### 1. Key Working and the intensive offer

- Who is receiving assertive or enhanced support?
- What does the “offer” look like for those on and off CPA?
- Are there named professionals with clear roles?

- Are contact frequency and relational continuity consistent?
2. Identification and holding in sight
    - How are people identified as at risk, both via systems (e.g. MAST) and clinical insight?
    - Is there a shared set of risk indicators?
    - How do services keep people in view if they're not consistently engaged?
  3. Care planning and crisis planning
    - Are care plans personalised, meaningful, and reviewed regularly?
    - Is Dialog+ used for assessment, care planning, and safety planning?
    - Do service users feel involved in shaping their own plan?
    - Does the training support care planning that is meaningful to patients?
    - What is the feedback loop that lets staff know when they have delivered meaningful care plans?
    - Are plans portable across settings?
  4. Continuity of care and discharge
    - What happens during transitions and step-downs?
    - Are people safely handed over, and is risk re-evaluated?
    - Do people fall out of sight after discharge, or is there follow-up?
    - Are there systems for early intervention and re-access?

### 3.4 Core principles

Four core principles have been agreed to underpin the development of the Intensive and Assertive Community Outreach model across north east London. These principles reflect both lived experience insight and good clinical practice.

- i) Strength-Based Approach  
Focusing on what matters to the individual, building on their existing strengths (internal and external) and goals rather than solely on deficits or risks.
- ii) Curiosity About the Person  
Moving beyond form-led, transactional assessments toward relational practice, where practitioners are encouraged to be curious, listen deeply, and understand the individual's story, needs, and context. To provide formulation frameworks which help service users, families and staff to understand and make meaning of the persons experiences and symptoms. This was widely supported by group members as a shift from "doing to" toward "working with".
- iii) Circle of Support  
Involving family, friends, or other trusted individuals as part of a co-created support system, where the individual consents and feels safe to do so. Providing a framework and guidance for staff in navigating this area when the person doesn't consent, but the family are reaching out with concerns. Participants highlighted the value of this in reducing isolation, offering continuity, and responding to early warning signs.
- iv) Relational and Personalised Care Planning  
Prioritising meaningful, co-produced care plans that are built through relationships and shared understanding. The group called for care planning to feel like a conversation, not a formality, with Dialog+, personal crisis plans, and Open Dialogue cited as key tools. While tools and frameworks can help, we need to focus on supporting clinicians to develop and maintain their professional skills and interpersonal capacity to provide compassionate care. Staff supervision and support (e.g. reflective practice) are critical to ensuring any tool is used to support the work, rather than becoming the work itself.

These principles reflect a shift towards trauma-informed, culturally responsive, and relationship-centred models of care. They provide a shared foundation across the NEL system to ensure consistency in values, even where delivery may differ locally.

#### **4. The role of strategic commissioning**

Strategic commissioning can play an important role in terms of:

- The delivery of service improvement against agreed standards
- Greater consistency of service delivery
- Assurance about continuity of care and the management of risk

Each of these elements could be embedded into the ELFT and NELFT contracts, as early as 2025/20206 as an interim position to provide a transparent and consistent set of delivery expectations for both the ICB and providers.

To underpin the delivery expectations set out in the contracts, key performance indicators (KPIs) will need to be developed. There are a number of measures which could be used including the following, these measures are aligned to the assurance template the ICB will submit to NHSE by 3 September 2025. Many of these are already being mapped as a one-off exercise through the KLOEs. This will provide a good test of the usefulness of the measure. It is assumed that in 2026-27 these measures will be reported on without targets to create a base line. Then, from 2027-28 onwards targets may be set.

##### Indicators of the consistency of the service offer

- Percentage of the cohort, who have a completed assessment, which covers psychological, social and clinical risks.
- Percentage of the cohort with a completed co-produced care plan
- Percentage of the cohort with a completed co-produced safety plan/crisis plan
- Percentage of the cohort with an assigned key worker
- Frequency of contact
- Frequency of care plan and crisis plan review
- Case load size limits for keyworkers

##### Indicators of risk management

- The comprehensive implementation of a risk assessment tool such as the MAST (Management and Supervision Tool) to identify patients at risk through factors such as complexity, lack of contact/ did not attend (DNAs), recent use of crisis, emergency or inpatient services
- Percentage of re-admissions to psychiatric inpatient service or mental health crisis services
- Discharges from cohort, as a result of DNAs
- Number of people at risk who are not engaging in services
- Successful re-engagement for those at risk, who have disengaged
- Percentage of cohort discharged/transferred to another service with a co-produced discharge plan

##### Patient rated experience measures

Notably, none of the above indicators measure whether our interactions with patients are regarded as meaningful by them. In the Mental Health Summit workshops, people with lived experience stated that they valued care plans and crisis/safety plans but questioned whether they were meaningfully engaged in the process. Without a sense of meaning and ownership it is unlikely that plans will have much value in sustaining resilience in the community. This finding is supported by research into the use of coproduced goal setting in mental health

settings. There is appetite for creating a Patient Rated Experience Measure (PREM) that measures the strength of coproduced care planning. The PREM would support one of the MHLDA Collaborative's key service user objectives: to improve the experience of the first contact with mental health services and the Collaborative's commitment to create a NEL wide PREM that improves on the Friends and Families test. System wide reporting of an NEL wide PREM and feedback loops to operational level staff could be strategically commissioned.

#### Patient rated outcome measures

There is currently no system wide reporting in NEL of outcome measures for the SMI cohort, although work is already underway to address this.

#### Tackling health inequalities

All of the above metrics could be split by place and also by protected characteristics in order to provide a measure of health inequalities.

### **5. The strategic challenge**

As we develop a sustainable model for Intensive and Assertive Community Outreach, the Expert Reference Group has identified three key challenges that must be addressed system-wide:

i) Narrow definition of cohort vs. broader definition NHSE defines the cohort as those with diagnosed or undiagnosed psychosis, who are at risk to themselves or others. However, a broader definition of people with severe mental illness, who are at risk would include people with a severe mood disorder and people with a personality disorder. Sticking with the NHSE definition makes reporting to NHSE easier and will ensure the project is more focused. However, this means we will need to create another set of process for people with non-psychotic disorders, who are at risk. On balance, there is a consensus that we should design our risk management systems once and include all those with a severe mental illness i.e. people with psychosis, severe mood disorders and personality disorders.

#### ii) Standardisation vs. personalisation

How do we ensure consistent risk management and service delivery across North East London, while preserving the flexibility to respond to individual needs in a truly personalised way?

- There is concern that form-based risk assessments may become detached from the realities of people's lives.
- The group emphasised the importance of relational judgement, shared understanding, and contextual formulation over checklists or rigid tools.

#### iii) Workforce capacity and cultural shift

How do we support staff to work relationally, collaboratively, and across organisational and disciplinary boundaries?

- The group highlighted a need for workforce development, particularly around risk formulation, shared language, and recovery-oriented practice.
- Supervision and reflective practice are essential to support emotionally demanding relational work and to resist procedural "fixes" (e.g. new forms or templates) in place of meaningful engagement.

#### vi) Balancing crisis and recovery

How do we prevent a "cliff edge" between those who receive intensive support and those who do not, ensuring graduated access, re-engagement, and early intervention?

- There is strong support across NEL for models that allow people to re-access services rapidly when early signs of deterioration emerge.
- Some members raised the need for greater clarity on how early warning signs and red flags are picked up, recorded, and acted on across teams and pathways.

To respond to these challenges, a structured NEL-wide model is required that supports consistency in values and approach, while allowing local flexibility in delivery. The Expert Reference Group has been clear that the system must avoid becoming “locked into a model war” and should instead agree on shared principles, giving space for local innovation to flourish within a common framework.

## 6. Improvement delivery plan

Time period	Key milestones and activities	Roles / leads
May - July 2025	Phase 1: Mapping and assurance exercise led by the Expert Reference Group, using agreed KLOEs across the four reporting areas <ul style="list-style-type: none"> <li>• Engage ELFT and NELFT to complete local assessments</li> <li>• Identify good practice, variation, and gaps</li> <li>• Prepare system-wide synthesis for reporting</li> </ul>	Expert Reference Group (oversight)  ELFT & NELFT Performance Leads, Lived Experience Executive Lead and Lived Experience Leaders involved in key working and dialog+  MHLDA Collab Leads
Summer 25	CMH Core Standards published (Summer 2025)	NHSE National MH Team,
Sept – Dec 2025	-Phase 2: Refine and enhance service model in response to national guidance - Revisit each reporting area and update delivery plans - Define how core standards will be measured -Prepare for national review	Expert Reference Group
January 2026	<ul style="list-style-type: none"> <li>• NHSE review of ICB progress</li> </ul> Evaluate assurance against CMH Core Standards	MHLDA Collab

## 7. Conclusion and next steps

The NEL Intensive and Assertive Community Outreach Review has made strong progress, co-producing a set of shared principles, delivery priorities, and a strategic direction for system change. Through the Expert Reference Group, we have built a collaborative structure that brings together clinical leaders, transformation teams, and people with lived experience to guide delivery.

However, significant challenges remain. No dedicated funding has been allocated through the 2025/26 NHSE planning process, and the model must therefore be delivered through better coordination and more effective use of existing resources. In view of the financial constraints, it is proposed that the work aims to build on the approaches already in place in North-East London, for example the use of Dialog+ as an holistic assessment tool and as a means of delivering co-produced care planning and risk management. It is also proposed that we build on current processes in place for CPA and the MAST tool.

This work is also taking place within a wider context of ICB efficiency requirements, organisational change, and the transition of NHSE functions into local systems, all of which may impact future oversight and national support.

### **7.1 Next steps**

- Complete the mapping and assurance exercise against the four agreed reporting areas and KLOEs, with oversight from the Expert Reference Group
- Align the evolving NEL model with the national Community Mental Health Core Standards once published in July 2025
- Refine and strengthen the delivery framework, including the continuation of the Expert Reference Group and establishment of a wider SMI Improvement Network
- Embed personalised risk assessment, planning, and crisis support as core components of service delivery across all localities
- Support cultural and workforce development, including the use of relational practice, co-produced care planning, and clinical supervision

### **7.2 The ICB Board is asked to:**

- Endorse the proposed next steps and delivery priorities for July–December 2025
- Support the continued development and phased implementation of the model, ensuring alignment with both national expectations and local priorities
- Note the financial, structural, and workforce risks associated with delivery, and consider how system partners can be supported to meet the ambition of this work.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Board Assurance Framework
<b>Author</b>	Anne-Marie Keliris, Head of Governance and Company Secretary
<b>Presented by</b>	Charlotte Pomery, Chief Participation and Place Officer
<b>Contact for further information</b>	<a href="mailto:Annemarie.keliris@nhs.net">Annemarie.keliris@nhs.net</a>
<b>Executive summary</b>	<p>The paper outlines progress to date and presents the Board Assurance Framework (BAF) which captures the highest risks to meeting the integrated care system (ICS) aims, our purpose and four priorities.</p> <p>A further review of the BAF has been undertaken to ensure our risk registers and BAF reflect the potential impacts of the organisational change in light of the recently submitted operating model to NHS England.</p> <p>The current key risks on the BAF relate to:</p> <ul style="list-style-type: none"> <li>• Collaborative working across partners</li> <li>• Wider determinants of health/environment</li> <li>• Quality and safety of care</li> <li>• Delivery against control total and operating plan</li> <li>• Workforce</li> <li>• Population growth</li> <li>• Mutual accountability for commitments</li> <li>• Digital and estates</li> <li>• Being outward looking</li> <li>• Population growth – long-term conditions and specialist services</li> <li>• Cyber security</li> <li>• Organisational change</li> </ul>
<b>Action required</b>	The ICB Board is asked to consider and note the report.
<b>Previous reporting</b>	ICB executive management team
<b>Next steps/ onward reporting</b>	<ul style="list-style-type: none"> <li>• Audit and Risk Committee for assurance.</li> <li>• ICB and ICS executive management team to review the corporate risk register in June</li> <li>• Board to receive updated BAF in September 2025</li> </ul>
<b>Conflicts of interest</b>	No conflicts of interest have been identified in relation to this report.
<b>Strategic fit</b>	Implementing the risk strategy and policy for the ICB will support achievement of the ICB's corporate objectives through managing risks to delivery. It relates to all ICS aims:

	<ul style="list-style-type: none"> <li>To improve outcomes in population health and healthcare</li> <li>To tackle inequalities in outcomes, experience and access</li> <li>To enhance productivity and value for money</li> <li>To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The paper sets out key risks within the ICB and system in order to achieve our aims for the health and wellbeing of our population.
<b>Has an Equalities Impact Assessment been carried out</b>	An Equality Impact Assessment is not required for this report.
<b>Impact on finance, performance and quality</b>	Relates to achievement of our corporate objectives on these matters.
<b>Risks</b>	This report relates specifically to risk. With continued pressures within the system there is a risk that leaders and staff to not pay the necessary attention to complying with, identifying and mitigating risks. This will be mitigated through clear leadership from the executive team and clarification on what the ICB operating model will be going forward.

## 1.0 Background

1.1 As both a statutory NHS organisation and the integrated care system (ICS) convener, the Integrated Care Board (ICB)'s risk register includes those risks affecting delivery of the wider ICS aims, purpose and objectives. The purpose of the Board Assurance Framework (BAF) is to set out the key risks to the ICB in achieving its objectives and priorities and to identify the controls and actions in place to manage those risks.

1.2 The ICB has a responsibility to maintain sound risk management processes and ensure that internal control systems are appropriate and effective and where necessary to take remedial action. It is a key part of good governance. The risk review uses the standard NHS methodology that considers the likelihood of the risk alongside the severity of its impact if it materialises. The risk score takes account of the mitigating action proposed. This then gives a risk score and categorisation of:

<b>1-3 Low Risk Low Priority</b>	<b>4-6 Medium Risk Moderate Priority</b>	<b>8-12 High Risk High Priority</b>	<b>15-25 Very High Risk Very High Priority</b>
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1.3 The BAF is constructed around the aims of the ICS:

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

## 2.0 Process for escalation

2.1 Risks managed through the committees of the ICB that are rated 15 or above should be considered for escalation to the Board. The escalated risk will continue to be

maintained in the committees' and relevant Chief Officer portfolio register. In addition, risks raised through the Board and the Integrated Care Partnership will be considered for inclusion.

### **3.0 Progress to date**

- 3.1 The BAF has been thoroughly revised and reviewed by each chief officer - this includes target scores, target dates and updated mitigations.
- 3.2 The BAF has been presented alongside the corporate risk register to the last meeting of the Audit and Risk Committee on 13 June 2025.
- 3.3 A new organisational change risk which was presented for review at the last ICB Board on 14 May 2025, and will continue to be updated to reflect the comments and suggestions made by members. Following the publication of the Model Integrated Care Board Blueprint, the ICB has now established a Transition Committee to ensure a safe and coherent transition of functions and to manage local risks including tracking progress, the first meeting of this committee was held on 28 May 2025. The new organisational change risk will be reviewed regularly through the Transition Committee who will also oversee the risk register for the organisational change programme.
- 3.4 As the governance of the ICB is reviewed in line with the new operating model, a review of the risk management strategy and policy will be undertaken.

### **4.0 Risks on the BAF**

- 4.1 The current risks escalated to the Board Assurance Framework are as follows, with the detail included in the appendix:
  - There is a risk, against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.
  - There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower range of local peoples' needs and risk not bringing into account wider community assets.
  - There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of intervention from regulators such as the Care Quality Commission (CQC).
  - There is a risk that the lack of a coherent, whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, to support the wellbeing of our diverse workforce and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.

- There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the Integrated Care Partnership (ICP) Strategy to improve equitably the health and wellbeing of people across north east London, to reduce inequalities and to invest in prevention and were we to fail to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.
- There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer-term sustainability.
- There is a risk that the failure to share mutual accountability for the delivery of current and future operating plans and constitutional standards, could result in clinical variation and have a negative impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.
- There is a risk that without a collaborative and innovative plan to address the significant growth in population across north east London over the coming years, there will be a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.
- There is a risk that existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.
- There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health, particularly in the context of the increasing levels of poverty. Effects will include: Wider determinants such as availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation, and the quality of the environment including air pollution and access to green spaces, quality; and social networks and connections are linked to health outcomes. A failure to address these factors as a system will lead to poorer health outcomes for our population, widening inequalities and unsustainable demand for health 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. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms.
- There is a risk that the increasing cyber-attacks in healthcare could leave the ICB and our partner organisations vulnerable to an attack. An attack could impact our services and also risk the exposure of our residents' data. In turn, this could lead

to services being halted which would impact on patient safety and also breach the Data Protection Act.

- There is a risk that the requirement to reduce the ICB running cost by 50% will impact the delivery of the ICB's objectives and overall will be a significant distraction for our workforce as they face a substantial reorganisation. There are a number of risks associated with this including: overall impact on the delivery of BAU, impact on staff morale/behaviours/wellbeing, risk of staff leaving during the process thus leading to an impact on delivery, an impact on the local population during the period of change through potential delays and disruptions to services and contracts and wider impact on the ability of the ICB to deliver its role across the system during this time.

## **5.0 Next steps**

- 5.1 Risk reviews will continually take place to ensure our risk registers and BAF reflect the potential impacts of the organisational change and 10-year health plan.
- 5.2 A review of the risk management strategy and policy will be undertaken in line with any changes to the governance of the ICB in light of the recently submitted operating model.

## **6.0 Attachments**

- 6.1 Board Assurance Framework

Board Assurance Framework June 2025 – Dashboard

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score						Target	Risk Appetite	Order in BAF
				Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr	May/ Jun			
To improve outcomes in population health and healthcare	There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower range of local peoples' needs and risk not bringing into account wider community assets.	Charlotte Pomery	Population Health and Integration Committee	12	12	12	12	12	12	8	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	2
	There is a risk that, if the rapid rise in long term conditions continues as predicted, especially where individuals suffer from more than one long term condition, more people may become more unwell earlier in life, resulting in poorer quality of life, safety and outcomes. An increasing proportion of our resources needing to be spent on specialist and acute care with a risk that we run out of capacity in these areas. There is a risk we would see widening health inequalities and create additional financial pressure in both revenue and capital terms because of unfunded growth in activity.	Paul Gilluley	Population Health and Integration Committee	20	20	20	16	16	16	16	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	11
	There is a risk that the requirement to reduce the ICB running cost by 50% will impact the delivery of the ICBs objectives and overall will be a significant distraction for our workforce as they face a substantial reorganisation due to the requirement to redesign the operating mode for the ICB. There are a number of risks associated with this including: overall impact on the delivery of BAU, impact on staff morale/behaviours/wellbeing, risk of staff leaving during the process thus leading to an impact on delivery, an impact on the local population during the period of change through delays and disruptions to services and contracts, wider impact on the ability of the ICB to deliver its role across the system during this time.	Zina Etheridge	Transition Committee					20	20	8	<b>Open:</b> We are willing to take reasonable risks, balanced against reward potential	13
To tackle inequalities in outcomes, experience and access	There is a risk that existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.	Diane Jones	Quality, Safety and Improvement Committee	15	15	15	15	15	15	8	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	5

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score						Target	Risk Appetite	Order in BAF
				Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr	May/ Jun			
	There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of intervention from regulators such as the CQC.	Diane Jones	Quality, Safety and Improvement Committee	16 ↔	16 ↔	16 ↔	16 ↔	12 ↓	12 ↔	8	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	7
	There is a risk that the failure to implement our whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.	Director of People	People and Culture Committee	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	6	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	6
To enhance productivity and value for money	There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London, to reduce inequalities and to invest in prevention and were we to fail to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.	Henry Black	Finance, Performance and Investment Committee	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	20 ↔	6	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	1
	There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer-term sustainability.	Ralph Coulbeck	Finance, Performance and Investment Committee	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	6	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	8
	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.	Henry Black	Finance, Performance and Investment Committee	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	6	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	9

ICS Aim	Risk Description	Risk Owner	Responsible Committee	Risk Score						Target	Risk Appetite	Order in BAF
				Aug/ Sep	Oct/ Nov	Dec/ Jan	Feb/ Mar	Apr	May/ Jun			
	There is a risk that the increasing cyber attacks in healthcare could leave the ICB and our partner organisations vulnerable to an attack. An attack could impact our services and also risk the exposure of our residents' data. In turn, this could lead to services being halted which would impact on patient safety, and also breach the Data Protection Act.	Henry Black	Finance, Performance and Investment Committee	15 NEW RISK TO BAF	15 ↔	15 ↔	15 ↔	15 ↔	15 ↔	10	<b>Averse:</b> Avoidance of risk is a key objective	12
To support broader social and economic development	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.	Ralph Coulbeck	Population Health and Integration Committee	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	8	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	4
	There is a risk against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.	Charlotte Pomery	Population Health and Integration Committee	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	12 ↔	8	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	10
	There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health, particularly in the context of the current cost of living crisis. Effects will include: Wider determinants such as the quality of the environment including air pollution and access to green spaces, quality and availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation; and social networks and connections are linked to health outcomes. A failure to address these factors as a system will lead to poorer health outcomes for our population, widening inequalities and unsustainable demand for health services.	Paul Gilluley	Population Health and Integration Committee	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	16 ↔	6	<b>Cautious:</b> We have limited tolerance of risk with a focus on safe delivery	3

Board Assurance Framework – June 2025

ICS Aim	To enhance productivity and value for money				Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO048 (previously CFPO01/ 04)	
					✓	✓			
ICS priority	Children and young people	Mental health		Employment and workforce		Long term conditions		Risk owner	Henry Black
	✓	✓		✓		✓		Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓		

**Risk description** There is a risk that the financial challenges we face as a system mean we are unable to achieve the ambitions set out in the ICP Strategy to improve equitably the health and wellbeing of people across north east London, to reduce inequalities and to invest in prevention and were we to fail to meet our statutory duties to achieve financial breakeven, would lead to increased scrutiny from NHS England, a requirement to go into recovery and potential reductions in services to local people.

Score history and targets	Initial rating (LxS)	Initial date	Rationale
<p>The chart displays the risk rating (red line) and target (yellow line) over time. The rating starts at 20 (4x5) in August 2022, drops to 6 (2x3) in April 2030, and returns to 20 (4x5) in June 2025. The target remains at 6 (2x3) from April 2030 onwards.</p>	20 (4x5)	August 2022	The system has a break-even control total (CT) agreed with NHSE that is required to be delivered. There is considerable risk detailed within the NEL operating plan around the achievement of the CT due to the level of in-year savings required through long-term transformation and delivery of cost improvement programmes (CIPs), elective recovery backlog, ongoing operational pressures and workforce changes. The risk goes beyond a financial risk and impacts on all areas of the system.
	Target rating (LxS)	Target date	Rationale
	6 (2x3)	April 2030	Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system. The target date of 2030 has been set as we will be working to the 5-year medium-term financial strategy which should enable us to reduce the risk score.
Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report	
20 (4x5)	June 2025	Work is continuing across the system to address the financial risk with progress and delivery being monitored through the Financial Sustainability Joint Oversight Committee (FSJOC) and discussed at recovery forums including CFO meetings and the ICB's Financial Sustainability Board. Mitigations in place should aid the reduction in the risk score and allow the system to deliver its statutory financial duty. However, the prerequisite to this is the reduction in spend across the system. Further detailed updates are included in the financial overview report.	

**Controls and assurances**

- Progress and delivery being monitored through the Financial Sustainability Joint Oversight Committee (FSJOC) and discussed at recovery forums including CFO meetings and the ICB's Financial Sustainability Board.
- Financial performance reported and reviewed by regional/national teams.
- Agreed Internal Audit and Counter Fraud Programmes with RSM which are reported to the bi-monthly Audit and Risk Committee
- Annual External Audit with KPMG which is reported to the Audit and Risk Committee
- Internal ICB processes to deliver greater transparency on future spend; including business case process where assurance on investment decisions is provided by the Investment Review Group
- New governance established within the ICB to support financial sustainability through the ICB Commissioning Board

**Mitigations/ actions to address the risk**

Mitigations/ actions to address the risk	Target date
System wide financial sustainability programme continues to engage and oversee key groups, ensuring different areas of recovery are taken forward. This includes provider facing programmes including workforce productivity, corporate services, temporary staffing and commissioner facing workstreams such as CHC, medicines optimisation and commissioning changes	Ongoing
ICB savings programme developed with risk rating applied to all schemes. Work continues to identify further savings and develop plans to meet ongoing efficiency targets as well mitigation where programmes slip. Each work programme contains a number of workstreams and plans and report into the Financial Sustainability Board chaired by the Chief Executive Officer	Ongoing
System level triple-lock process in place to ensure appropriate spend only	Ongoing
System level communications and engagement plan agreed to allow partners to contribute ideas and ways of working for efficiency savings and review	Ongoing
Efficiency programmes are being led by individual organisations, with some cross-organisational transformation programmes led through the collaboratives	Ongoing
Development of the medium-term financial strategy with system partners to plan, invest and transform across the system in the medium-term (5years).	November 2025

ICS Aim	To improve outcomes in population health and healthcare				Risk applies to ICB		Risk applies to ICS		Risk reference	CPPO15 (previously CSTO01)
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Charlotte Pomery
	✓		✓		✓		✓		Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious	
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that ways of working continue to focus more on meeting deficits than building on strengths which means they will continue to meet a narrower range of local people's needs and risk not bringing into account wider community assets.									
Score history and targets			Initial rating (LxS)	Initial date	Rationale					
			16 (4x4)	Nov 2022	At the point of this risk being identified the extent of engagement required to co-produce the strategy whereby it was jointly owned by all partners was challenging. The reputational and operational impact of not developing a coproduced strategy would be severe as it's one of the key purposes of the ICP to provide the strategic framework for the local health system.					
			Target rating (LxS)	Target date	Rationale					
			8	March 2026	Significant work has been planned to ensure there is full engagement with a wide variety of stakeholders and partners reducing the likelihood. The target, and risk as a whole, is currently under review following the recent national announcements on the role of ICBs, to determine how the new model could have impacts to the mitigations in place or underway.					
			Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report					
			12 (4x3)	June 2025	This will always remain an important risk for the ICS which we will need to pay attention to. The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project. These involve co-design by large groups from across the ICS and additional communication with those not directly engaged. This risk will continue to be reviewed and refreshed each risk cycle considering the recent national announcements regarding NHS organisational changes.					
Controls and assurances										
Review of current data and information including JSNAs from all 7 PBP and NEL population profile										
ICP strategy development - key focus on securing PBP and provider collaborative input including engaging executives from provider collaborative e.g. Trust Chairs and Senior executives										
ICP strategy discussed at CAG to ensure clinical engagement and input										
ICP strategy refresh to ensure alignment with the 10-year health plan										
The ICB Executive Management Team, ICP Committee, to receive regular updates										
Integrated neighbourhood model approved at the ICB Board in March 2025, and neighbourhood boundaries endorsed by PHIC in June 2025.										
Mitigations/ actions to address the risk									Target date	
The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project.									Existing	
Population Health Improvement approach presented to and endorsed by Population Health and Integration Committee, with next steps identified									May 2024 and ongoing through system partners at PHIC and implementation	
Segmentation model enables a focus on keeping people healthy and well, reducing the risk of developing one or more long term conditions									July 2024 and ongoing iteration and use across the system	
Development of strategic commissioning framework – building blocks include PHI and segmentation models									Commissioning governance agreed for future decision	

	making by the ICB Board in March 2025.
VCFSE strategy development getting underway – reporting to Integrated Care Partnership and to Population Health and Integration Committee through the VCFSE Collaborative – will focus on positive change through involvement of sector in a range of ways from engagement through to delivery.  State of the Sector report being developed across north east London to support the strategy and to recognise the role of the whole sector, including community assets.	From July 2024  Presentation at April ICP committee completed.
The development of Integrated Neighbourhood Working and Integrated Neighbourhood Teams follows an assets-based model which recognises all a neighbourhood and a community has to offer. The work also focuses on co-designing a clinical and service model which will respond to local population need. Co-design with a wide set of stakeholders and implementation are underway – reporting through to PHIC.  A System Steering Group has been established with multi-agency and multi-sector membership overseeing system work.  Each Place partnership leading a programme of work.  Development of integrated neighbourhoods is embedded into future operating model and commissioning framework at a local, London and national level.	Integrated neighbourhood model approved at the ICB Board in March 2025, and boundaries endorsed by the Population Health and Integration Committee in June 2025..
The Integration Roadmap is being developed with partners to set out the future direction of integration, its intended outcomes and the required enablers, building on the strengths and assets of all system partners.  A System Enablers Group has been established to drive new ways of working.  The ICP has a focus on the three strategic shifts (from treatment to prevention, from hospital to community, from analogue to digital) to support continued strengths-based working beyond the NHS.	Approved by PHIC in February 2025 and continuing.
The ICB plays an active role in London and national developments, to ensure the impacts for north east London are understood and to build a strengths-based approach on a wider footprint including focus on a coherent London approach for revised operating model.	Ongoing.

ICS Aim	To support broader social and economic development				Risk applies to ICB	Risk applies to ICS	Risk reference	CSTO009
					✓	✓		
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions	
	✓		✓		✓		✓	
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)
	✓	✓	✓	✓	✓	✓	✓	

**Risk description** There is a risk that health and wellbeing outcomes for local people are adversely affected by our failure as a system to work together to address the wider determinants of health, particularly in the context of the increasing levels of poverty. Effects will include: Wider determinants such as availability of housing, wider economic drivers, levels of child and household poverty, educational attainment, employment rates and occupation, and the quality of the environment including air pollution and access to green spaces, quality; and social networks and connections are linked to health outcomes. A failure to address these factors as a system will lead to poorer health outcomes for our population, widening inequalities and unsustainable demand for health services.

Score history and targets	Initial rating (LxS)	Initial date	Rationale
	<b>16 (4x4)</b>	September 2022	NEL currently has the highest rates of air pollution in the UK and the impact of air pollution on ill health is known and individuals suffer harm because of it. The additional pressure put on the NHS system due to ill health arising from air pollution has a severe operational and reputational risk.
	Target rating (LxS)	Target date	Rationale
	<b>6</b>	April 2029	We will fail to deliver and sustain improvements to health and wellbeing outcomes and address inequalities without working as a system to address wider determinants of health including housing, education, poverty and the local environment. Opportunities to address wider determinants align to the integration agenda for local systems, the government shift towards prevention and the development of the neighbourhood health model and population health management.
	Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report
	<b>16 (4x4)</b>	June 2025	The risk description and mitigations have been amended to reflect conversations at the Population Health and Integration Committee in June 2025 where members reflected on the ICP and ICS housing priority and also the work under way to support those experiencing and facing household poverty. The Model ICB Blueprint suggests that providers will be responsible for sustainability, although the ICB is still required to submit a Green Plan by October 2025. Ongoing arrangements to be reviewed as part of ICB operating plan work. A neighbourhood health model is the key route around tackling wider determinants of health. We are expecting greater clarity around this through the anticipated 10-Year Plan.

Controls and assurances	
ICS Net Zero SROs meet regularly as a system group	
NEL DsPH monthly meeting with senior ICB attendance	
Reports presented to the Population health management and health inequalities steering group	
Reports presented to the Population Health and Integration Committee	
Anchor Strategy work developing across north east London	
Establishment of NEL Strategic Long Term Conditions Board with focus on interface of wider determinants and health and care services including impact on long-term health and wellbeing	
Mitigations/ actions to address the risk	Target date
Worked with ICB partners to promote and support active staff travel approaches across NEL including walking, cycling and use of public transport. Taking part in national NHSE programme for Net Zero Modal Shift Exemplar Programme to increase active travel in staff commute.	Ongoing commitment to promote active travel
Introduce low emission car salary sacrifice rental scheme	Complete - December 2022
Scoping requirements and need for an air quality strategy for NEL including clinical lead and PMO support to be in place to champion air quality and drive strategic relationships with wider system to focus on addressing air quality and to highlight health cost of poor air quality on people's health outcomes	Complete - April 2024
Travel and transport working group established with involvement from across ICB system	Complete

Introduced salary sacrifice staff bike scheme across ICB	Complete - Jan 2023
The Babies Children and Young People (BCYP) Air Quality Clinical Lead role was extended and ended in March 2024. They have worked with the Net Zero Lead and BCYP team to develop a case study for an Air Quality Programme to be discussed with the Chief Transformation and Strategy Officer (CTSO) and Chief Medical Officer (CMO) in May.	Work continuing
Net Zero report is being socialised with the appropriate fora and will be presented to the ICB Board at its meeting in November.	November 2024
Adoption by ICP and ICB of housing and homelessness as a priority, development of Homelessness Strategy for north east London, data reflective of housing impacts	From July 2024 – focused action plan being developed
Development of VCFSE Strategy with focus on wider determinants of Health and funding provided to the VCFSE to support capability and capacity building to tackle health inequalities including wider determinants	Work continuing
Funding provided to place based partnerships to tackle health inequalities including wider determinants working in partnership with local authorities and VCFSE partners	Up to 2025/2026
Health Equity Academy and associated projects addressing poverty eg. training for social prescribers to improve access to social, legal and welfare advice	March 2026
Investment in population health analytics platform will support integration of data on wider determinants and related interventions through local neighbourhoods	July 2025
Development of neighbourhood health model supporting the government shift to community and prevention including a more holistic view of people, their health needs and the community assets around them	Indicative roadmap for 2025/26 developed, timelines for 2026+ to be established.
NEL ICS Air Quality Action Group formed February 2024 which is administrated by the Health Improvement and Inclusion Team.	Complete
Clinical Session time, previously allocated across NEL, for Air Quality Lead currently funded via the Training Hub for Newham to May 2025 (to support Newham Asthma and Wheeze pilot)	Complete
Risk discussed at the Population Health and Integration Committee at its meeting in October. The risk was discussed in detail at its meeting in June following a comprehensive review undertaken by the CMO.	Complete June 2025
ICB Board agreed to adopt housing as a key system issue, following a recommendation from the Integrated Care Partnership.	July 2024
The ICP reflected on the connection between health and employment at its meeting in October and how as partners we could collaborate to ensure residents with long term conditions can gain employment in health and care.	Complete
The next iteration of the Green Plan is being developed and will be taken through the appropriate governance routes in the summer of 2025	Summer 2025

ICS Aim	To support broader social and economic development				Risk applies to ICB		Risk applies to ICS		Risk reference	CSTO012 (previously CPPO11)
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Ralph Coulbeck
	✓		✓		✓		✓		Responsible committee	Population Health and Integration Committee
Boroughs impacted	B&D	C&H	Harving	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious	
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that partners fail to work collaboratively and innovatively to plan for and address the significant growth in population across north east London over the coming years, with a weakening of our health and care infrastructure, poorer health and wellbeing outcomes and impacts on social and economic development for our whole population.									
Score history and targets			Initial rating (LxS)	Initial date	Rationale					
			16 (4x4)	November 2022	Given the rapid population growth expected in north east London, there is a need to develop the infrastructure required to support people's health and wellbeing against a challenging economic backdrop.					
			Target rating (LxS)	Target date	Rationale					
			8	July 2030	Establishment of the ICS and ICB and all associated structures and governance are still in progress which keeps this as a risk					
			Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report					
			16 (4x4)	June 2025	The ICB is leading development of a medium-term financial strategy that will improve our understanding of the challenges that population growth will continue to present in NEL. It will also support development of interventions that will help us manage demand across our system with a focus on improving productivity, optimising care and reducing variation as well as driving a greater focus on prevention / moving care upstream.					
Controls and assurances										
The implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners. Minutes of these meetings can be provided for assurance										
All Place-based local infrastructure forums are meeting regularly with representation from across partners.										
A system-wide 20-year forecast programme team has been established.										
Mitigations/ actions to address the risk									Target date	
Establishment of Local Infrastructure Forums following long-term Strategic Infrastructure plan submission									Ongoing	
Dedicated work with local authorities through Place Partnerships and cross-Place Partnership working									Borough-based working is underway.	
Demand, growth and interventions model developed to understand impact of service models on demand and to push for greater focus on prevention and early intervention									Underway	

ICS Aim	To tackle inequalities in outcomes, experience and access				Risk applies to ICB		Risk applies to ICS		Risk reference	CNO02
							✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Diane Jones
	✓		✓		✓		✓		Responsible committee	
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious	
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that existing inequalities in outcomes and experience which result from structural discrimination of all types, and particularly structural racism, are not effectively tackled and these communities continue to experience poorer outcomes.									
Score history and targets			Initial rating (LxS)	Initial date	Rationale					
			20 (5x4)	December 2022	Considerable system risks that may have an impact on quality and safe care					
			Target rating (LxS)	Target date	Rationale					
			8	October 2025	Significant programmes of work are planned or underway that will enable greater oversight across the System. The Quality and Safety teams are working to understand whether the new ICB operating model will have implications to the target date.					
			Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report					
			15 (5x3)	June 2025	Programme Boards and improved ways of working/ collaboration across the system are starting to be more explicit that this should result in good practice and greater collaboration becoming embedded. Quality and Safety teams are actively reviewing the mitigations and will be considering any potential impacts to delivery as the new operating model develops.					
<b>Controls and assurances</b>										
System Oversight Command Group stood up across NELHCP.										
The NEL System Quality Group meets quarterly to discuss System Quality issues										
Mental Health/ Learning Disability and Autism (MHLDA) Programme Board in place to review System MHLDA issues										
Urgent and Emergency Care Programme Board in place to review system urgent and emergency care (UEC) risks and programmes of work to support improvement										
Partnership of East London Co-operatives (PELC) Assurance and Improvement Groups meets to assure PELC actions against Care Quality Commission actions and support improvement conversations across NHR geography										
Quality, Safety and Improvement Committee (QSI) in place to review System/ Place quality issues										
BHR Urgent and Emergency Care (UEC Place Programme Board in place meeting monthly										
NHS NEL Quality Team embedded within Provider Quality Assurance meetings as a way of understanding their quality issues and mitigation plans										
Staff in NEL ICS have access to Freedom To Speak Up/ Whistleblowing/ Guardian services to raise concerns regarding quality and safe care.										
The use of demographic profiling to understand the impacts to local residents.										
Undertaking equality impact assessments in all areas of work with Board papers required to record completion or non-completion										
Ensuring that all partners have the relevant tool; such as training and access to information.										
Working with local government partners at place-level to codesign anti-racist approaches.										
Recruitment panels to reflect local populations to support the recruitment processes.										
<b>Mitigations/ actions to address the risk</b>									<b>Target date</b>	
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP									Ongoing conversations	
Monthly London Clinical Executive Group									Ongoing	
After Action Review and Clinical Harm Review processes to be determined – done through Provider quality Meetings									Ongoing	
Provide Trust, Clinical huddles, Ops huddles and Quality and Patient Safety huddles take place across each hospital site daily. Issues feed into ICS System meetings. Some Trust also have nursing workforce daily hub discussions.									Ongoing	

Impact of industrial action discussion at Quality Safety and Improvement Committee (QSI) Committee – Committee will continue to review at every meeting	08/02/23 & 26/04/23 & 14/06/23 <b>Complete</b>
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 <b>complete and planned for Feb 24 meeting</b>
BHR UEC Place Programme Board around BHR UEC Improvement Plan and Strategy, avoidable admissions, discharge funding programmes	26/04/23 & 31/05/23 & 28/06/23 <b>Complete</b>
Strengthening of staff networks to support protected characteristics.	September 2024
Ensuring coproduction reflects local diverse populations.	Continual
Maintaining our commitment to the Health Inequalities funding which can affect employment opportunities.	Continual
Co-creating and implementing the Equality, Diversity and Inclusion Strategy.	Continual
Ensuring that our core communications include community languages.	Continual
Anti-racist Strategy under development across the system building on Place work on anti-racist commissioning models (Hackney, Tower Hamlets most advanced)	Complete. Strategy has been approved by the ICB Board and work is underway to implement this in all areas of our work to embed culture.

<b>ICS Aim</b>	<b>To tackle inequalities in outcomes, experience, and access</b>				<b>Risk applies to ICB</b>	<b>Risk applies to ICS</b>	<b>Risk reference</b>	<b>CPCO02</b>
						✓		
<b>ICS priority</b>	Children and young people		Mental health		Employment and workforce		Long term conditions	
						✓		
<b>Boroughs impacted</b>	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	<b>Risk appetite level (1-5)</b>
	✓	✓	✓	✓	✓	✓	✓	2: Cautious
<b>Risk description</b>	<b>There is a risk that the failure to implement our whole system workforce strategy, with effective and integrated workforce planning and additional capacity, means we are unable to meet our statutory duties, and deliver the range of services needed by local people, adversely impacting on their health and wellbeing.</b>							
<b>Score history and targets</b>			<b>Initial rating (LxS)</b>	<b>Initial date</b>	<b>Rationale</b>			
			<b>12 (3x4)</b>	December 2022	Given our current service requirements and workforce pressures, if we do not plan and deploy effectively, we will not be in a position to deliver the range of services required which may impact on the health and well-being of our workforce.			
			<b>Target rating (LxS)</b>	<b>Target date</b>	<b>Rationale</b>			
			<b>6 (2x3)</b>	December 2025	To ensure a consistent and health and well-being offer is maintained for all staff across north east London (NEL). Plans developed and in place to allow flexible deployment and minimum employment of staff across NEL. Development of new roles that can be trained and deployed quickly to NEL utilising apprentice pathways, new roles, and retention initiatives. Also, to ensure pathways and processes are in place to support and encourage local people into health and care employment. The wellbeing offer to social care and primary care was funded non-recurrently by the ICB - no funding has been identified past June 2024 and has been decommissioned through the Investment Review Group. We have begun working with system partners to develop system wide approach to developing a consistent occupational health offer in the future.			
			<b>Current Rating</b>	<b>Latest review date</b>	<b>Rationale and key progress/ updates since last report</b>			
			<b>12 (3x4)</b>	June 2025	Key priority identified by provider CPCOs to implement our People digital plan to streamline and automate recruitment processes. Aligns to our "Attract" pillar in the strategy and the key aim of attracting staff from our local communities. Work ongoing to develop a specification for a single occupational health service and pricing and costing this. Current approach to build on existing work and ensure sustainability and flexibility pending any changes following the ICB restructure and corporate posts reductions in Trusts in 2025-26.			
<b>Controls and assurances</b>								
ICS People and Culture Strategy approved by the ICB Board in January 2024								
Through existing health and care recruitment hubs, over 300 posts have been offered to local residents which are funded by the GLA during 2024.								
Social Care hub in place until March 2025								
The people and culture committee was established to oversee the delivery of the people and culture strategy and will hold 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								
<b>Mitigations/ actions to address the risk</b>								<b>Target date</b>
Initial engagement with Local Authorities, providers voluntary sector since October 2022								Completed – engagement continues as required
High level system people and workforce strategic priorities presented to the ICB Executive Management Team in June 2023								Complete
High-level system people and workforce strategic priorities to be signed off via ICB Board by July 2023								Complete
Set up a task and finish group to develop and agree a minimal employment offer and flexible deployment of staff								Complete
Ensure full utilisation of the levy and infrastructure to support learning in the workplace. Building cohorts of up skilled staff incrementally								Complete
Through existing health and care recruitment hubs a commitment to offer 900 posts to local residents - incrementally up to 2024 funded by the GLA								Complete and ongoing
Working with system partners to develop system wide approach to developing a consistent occupational health offer in the future.								March 2025
Exploring further extension of GLA funding for Social Care hub for year commencing April 2025								April 2025
Priorities and delivery plan for the strategy to be developed following the People Board being held in September.								March 2025
Productivity and having a permanent workforce are in alignment with our work to achieve financial sustainability.								Continuing

Inclusion of priority supporting people with long term conditions to enter and/or stay in employment agreed in the Long-Term Conditions Portfolio	September 2024
Outline Priorities and delivery plan for the strategy to be discussed at the next People and Culture Committee, with areas of work to be assigned SROs Programme Management capacity to develop the programmes when agreed.	This was originally scheduled for 13 March but has been postponed in light of the recent announcements regarding NHS organisations.
Options for delivery of People and Culture and Strategy discussed at CPCO group in April 2025. Agenda item for discussion, June NEL People and Culture Committee.	June 2025

ICS Aim	To tackle inequalities in outcomes, experience and access				Risk applies to ICB		Risk applies to ICS		Risk reference	CNO01
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Diane Jones
	✓		✓		✓		✓		Responsible committee	Quality, Safety and Improvement Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	2: Cautious	
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that workforce and resource capacity challenges, adversely impact on the quality of, and safe care to residents, thereby increasing health inequalities, poorer outcomes and service failures. These challenges could further mean that local people don't experience a compassionate approach, impacting on the quality of service they receive and the trust they hold in services and have an impact on our ability to improve existing services and drive innovation, leading to a risk of intervention from regulators such as the CQC.									
Score history and targets				Initial rating (LxS)	Initial date	Rationale				
				20 (5x4)	December 2022	Considerable resource and workforce capacity risks that may have an impact on quality and safe care				
				Target rating (LxS)	Target date	Rationale				
				8 (2x4)	December 2025	Significant programmes of work are underway that will enable greater oversight across the System. All system changes are being asked to understand wider system impact i.e. through Cost Improvement Plans Target date set as December to enable time to understand impact following the national cost cutting ask from the national team/ Govt.				
				Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report				
				12 (4x3)	June 2025	Range of Boards in place and improved ways of working/ collaboration across the system are more embedded and increased controls and assurances are in place across the system. This has resulted in reduction in the likelihood score.				
Controls and assurances										
Incident Management calls across the ICS have been implemented.										
NEL ICB Quality, Safety and Improvement Committee meets every 2 months										
NEL ICS system Safety Group meets every 2 months										
NEL ICS System Quality Group meets every quarter										
System Oversight Command Group stood up across NELHCP.										
The NEL System People Board are in place										
Recruitment across Clinical Leadership roles to support improvement programmes to address risk i.e. Director of Allied Health Professionals role										
International recruitment campaigns in place across all NEL Providers i.e. NELFT programme in Africa										
Nursing and Midwifery Workforce Expansion Board – regional group to deliver against the Government promise to increase nursing and midwifery numbers										
National CNO strategy to be launched in Sept followed by an implementation plan – NEL CNO Group priority is workforce										
NEL ICS system emergency control centre in place										
Substantive Director of Nursing and Safeguarding in post										
The Quality & Safety Team continues to work closely with providers via our PSIRF Peer Forum to understand progress in implementing PSIRF to enable a learning approach through patient safety incident investigations										
Updates regarding capacity issues obtained from providers at their monthly safeguarding assurance meetings.										
NEL ICS Strategic quality risks developed and agreed through Quality, Safety and Improvement Committee and System Chief Nursing Officer Forum										
ICB Quality and Safety Team Operating Model developed and team are more embedded across wider programmes of work ie programme boards, provider collaboratives, Place-based partnerships										
ICB Quality and Safety Team attend Provider Quality meetings to provide support										
MHLDA Quality Surveillance Group developed to enable wider information sharing regarding quality and patient safety issues										
Clinical and quality represented at all levels of decision making										

Mitigations/ actions to address the risk	Target date
Escalation discussions taking place across London Chief Nurse network and Chief Medical Officer network - also replicated across NELHCP	Monthly
Consideration to be given to areas of clinical activity that could be stood down if needed. – ongoing conversations through CAG and Incident Management Meeting	Ongoing
Nursing retention discussions ongoing across NEL and will be part of NEL response to national CNO Strategy and Implementation Plan	Continual
Impact of industrial action discussion at QSI Committee	08/02/23 & 26/04/23 & 14/06/23 <b>Complete</b>
System programmes to support UEC improvements discussion at QSI Committee	08/02/23 <b>complete</b>
Revision to ICB Quality and Safety Team Operating Model to maintain oversight of risks/ issues through attendance at System Programme Boards	September 2024 - <b>complete</b>
Ongoing reporting through ICB Quality, Safety and Improvement Committee, System Programme Boards, Place-based partnerships and Collaboratives	Ongoing

ICS Aim	To enhance productivity and value for money				Risk applies to ICB		Risk applies to ICS		Risk reference	CSTO02
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Ralph Coulbeck
	✓		✓		✓		✓		Responsible committee	
Boroughs impacted	B&D	C&H	Havinging	Newham	Redbridge	Tower Hamlets	Waltham Forest		Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that without access to longer term, sustainable capital we focus on meeting today's pressures, are not able to maintain and improve our digital and estates infrastructure in line with the needs of our population and fail to deliver digital innovation which in turn increases our longer term sustainability.									
Score history and targets				Initial rating (LxS)	Initial date	Rationale				
				10 (2x5)	May 2023	NEL-wide Infrastructure Strategy required by NHS England before July 2024. Options and priority areas for investment need to be reviewed to enable better future planning of investment and spend.				
				Target rating (LxS)	Target date	Rationale				
				6 (2x3)	July 2030	As work on the strategy starts, this will drive down the severity score as mitigations will be identified.				
				Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report				
				15 (3x5)	June 2025	Infrastructure Strategy draft is completed, and all Local Infrastructure Forums are established at each Place and have been running for the last 12 months.  Capital and especially backlog maintenance continue to be an area of concern for Trusts.				
Controls and assurances										
Internal ICB processes to deliver greater transparency on future spend.										
Implementation of ICB and ICS governance structures which include various committees and sub-committees which are held on monthly or bi-monthly basis with ICS partners.										
Establishment of Local Infrastructure Forums.										
The risk is actively monitored at the new ICS Capital Planning and Delivery Board which will oversee the implementation of the infrastructure strategy and the management of any associated risks.										
Mitigations/ actions to address the risk										Target date
Development of long-term (20 year) Strategic Infrastructure Approach and plan, reviewing options and priority areas for investment to enable better future planning of investment and spend.										Ongoing
Options and priority areas for investment reviewed to enable better future planning of investment and spend.										Ongoing
Ongoing development of Medium-Term Financial Strategy underway aligned to Strategic Infrastructure Plan										November 2025

ICS Aim	To enhance productivity and value for money					Risk applies to ICB	Risk applies to ICS	Risk reference	CFPO14/ CFPO15	
						✓	✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Henry Black
	✓		✓		✓		✓		Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest		Risk appetite level (1-5)	2: Cautious
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that if ICS partners do not share mutual accountability for the delivery of current and future operating plans and constitutional standards, this could result in clinical variation and negatively impact on quality and performance improvement. In turn, this could lead to poorer experience and outcomes for service users.									
Score history and targets			Initial rating (LxS)	Initial date	Rationale					
			15 (3x5)	May 2023 <i>Risk reconsidered in April 2025 and rationale updated</i>	<p>Final 25/26 Operating Plan submission made at the end Apr-25. Overarching delivery against national priorities and trajectories remain unchanged for the April submission (as previously presented to the Board). Continued collaborative working to mitigate and manage risks associated with delivery of financial balance vs. delivery of operating plan priorities.</p> <p>BHRUT was moved out of the recovery support programme under the NHS Oversight Framework in May-24 in recognition of improvements in UEC, quality and finances - the ambition is to move down into the next category of the NHS Oversight Framework (oversight at a North East London level rather than at national level). Barts Health are in SOF3 - SOF3 exit criteria were approved by the London Regional Support Group in Nov- 24, with formal review of progress in Apr-25.</p> <p>The NEL system remains in Tier 2 for UEC (with effect of January 2024). As a Tier 2 system, NEL continues to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan. The domain with the highest likelihood of poor outcomes is Elective Care, requiring the highest level of intervention and support.</p>					
			Target rating (LxS)	Target date	Rationale					
			6 (3x2)	March 2030	The target date has been revised to reflect the aims of the developing 5-year medium-term financial strategy, which will be presented to the Board for approval following the 2025/26 operating plan submission.					
			Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report					
			15 (3x5)	June 2025	The ICB has an operating plan performance report that is reported to FPIC and the ICB Board, with performance being monitored by collaboratives, providers and places. Reporting against the 25/26 Operating Plan will commence once M1 validated data is available in June 25.					
Controls and assurances										
Monthly/weekly reviews of all areas are in place along with project governance.										
Acute Provider Collaborative in place for NEL to address the acute delivery through local clinically led recovery programmes, reviews of strategy and approach based around High Volume, Low Complexity (HVLC) care and robust operational oversight and challenge supported by the regional team										
UEC, Community, Mental Health are led through a provider collaborative devolved model of delivery with central ICB co-ordination.										
Research and recommendations commissioned from external consultancy on UEC operational framework										
The FPIC will extend its scrutiny to patients awaiting treatment in Community Services										
A UEC Delivery Group has been established to track, mitigate, and escalate key risks relating to UEC performance.										
Winter planning is in place to ensure patient safety										
An operating plan performance report is regularly presented to the FPIC and ICB Board, with performance being regularly monitored by collaboratives, providers and places. Reporting against the 25/26 Operating Plan will commence once M1 validated data is available in June 25.										
Mitigations/ actions to address the risk									Target date	
The APC is in the process of revising its governance for 25/26, with a view to structure work programmes around 2/3 specific specialty challenges									Ongoing	

Establishment of the Acute Commissioning Board to reflect Acute Commissioning as core business via an MDT approach	Complete and work is continuing
Reinvigoration of the NEL Diagnostics programme to ensure issues are mitigated locally and jointly, together with ongoing alignment, sharing of best practice and collaboration. CDC delivery continues which will be positive for patients and residents of NEL.	Ongoing
Provider collaborative led programmes of work to feed into development of NEL ICB SOF 3 exit criteria, driving system-wide solutions, partnership and ICB executive leadership to exit SOF 3.	Ongoing
Refresh of Long Term Conditions Portfolio supported by NEL Strategic LTC Board	Complete and work is continuing
North East London Cancer Alliance in place and leads on NEL cancer performance and delivery.	Complete and work is continuing
A UEC dashboard has been developed by the NEL business insights (BI) team in cooperation with UEC Programme Board members. Monthly trajectories track progress against the six mandated metrics aligned to the national programme for winter planning and delivery.	Complete and work is continuing
The Winter Plan was presented at the Executive Committee on 15 November 2024 and is included as an appendix to the CEO report at the ICB Board meeting on 27 November 2024	Complete
The development of the medium-term financial strategy and commissioning framework will enable us to plan our resources effectively as a system and will mitigate some of this risk once approved and implementation begins.	July 2025
Provider collaborative led programmes of work to feed into development of NEL ICB SOF 3 exit criteria driving system wide solutions, partnership and ICB Exec leadership to exit SOF 3.	Continuing

<b>ICS Aim</b>	<b>To support broader social and economic development</b>				<b>Risk applies to ICB</b>	<b>Risk applies to ICS</b>	<b>Risk reference</b>	<b>CPPO13</b>
					✓	✓		
<b>ICS priority</b>	Children and young people		Mental health		Employment and workforce		Long term conditions	
	✓		✓		✓		✓	
<b>Boroughs impacted</b>	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest	<b>Risk appetite level (1-5)</b>
	✓	✓	✓	✓	✓	✓	✓	2: Cautious
<b>Risk description</b>	<b>There is a risk against a backdrop of rising financial and demand pressure, that partners within the ICS begin to focus more on organisational agenda, meaning unwarranted variation is not tackled, services are not integrated around the need of local people and the priorities local people want to see are not delivered.</b>							
<b>Score history and targets</b>				<b>Initial rating (LxS)</b>	<b>Initial date</b>	<b>Rationale</b>		
<p>Rating: 16 (4x4) in May 2023, 12 in March 2023, 12 in June 2025. Target: 8 (4x2) from Nov-22 to May-25.</p>				<b>16 (4x4)</b>	May 2023	The system is facing significant financial challenges and the ICB is going through a restructure, meaning that learning from regional and national can be challenging and time consuming.		
				<b>Target rating (LxS)</b>	<b>Target date</b>	<b>Rationale</b>		
				<b>8 (4x2)</b>	September 2026	It is anticipated that over a year will be required to fully mitigate this risk - allows significant lead in time following the organisational change, as well as understanding the implications of the 10-year health plan and wider policy context.		
				<b>Current rating (LxS)</b>	<b>Latest review date</b>	<b>Rationale and key progress/ updates since last report</b>		
				<b>12 (3x4)</b>	June 2025	<p>We continue to participate actively in national, regional and indeed cross north east London forums to share and learn from best practice. We have built communities of practice in a number of areas and are represented well on leadership forums across sectors including for example community work, care services and co-production.</p> <p>We are part of London forums on a range of topics and actively learning from each other.</p> <p>We will undertake a further review of this risk in light of the recent announcement regarding the organisational change required in the NHS. We will be considering if/ how this could impact on our existing mitigations and whether this raises wider associated risks.</p>		
<b>Controls and assurances</b>								
Full engagement with partners on regional group and initiatives, including the Greater London Authority.								
A focus on learning within and outside of London and attending site visits.								
Receiving active delegations from NHS England and hosting services on behalf of London, e.g. Dental, Optometry and Pharmacy Services (DOPS).								
Focus on Big Conversation next steps – success measures, Good Care Framework, revisit of views from our communities through reiterated conversations								
<b>Mitigations/ actions to address the risk</b>								<b>Target date</b>
Involvement in research and pilot initiatives.								Continuing
System leaders participating in national and regional groups.								Continuing
The ICB's Managing Director of Primary Care is chair of the Primary Care PODS Group.								Complete.
Participating in national, regional and local forums to share and learn best practice								Continuing
Communities of practice have been built in a number of areas, including community nursing, care services and co-production								Complete and continuing
People's Panel reinvigorated providing opportunity to ensure people needs and insights are reflected in real time								Complete and ongoing
Community Insights System continues to evolve, providing rich insights from local people's experience of services and their wishes for the future. Current focus on expanding to include wider voluntary and community sector insights and data								Complete and continuing
The wider ICS operating model is being developed principally through the leadership and governance work themes, along with critical inputs from the clinical and care professional leadership work theme and the transformation cycle project.								Existing

<p>The Integration Roadmap is being developed with partners to set out the future direction of integration, its intended outcomes and the required enablers, building on the strengths and assets of all system partners.</p> <p>A System Enablers Group has been established to drive new ways of working.</p> <p>The ICP has a focus on the three strategic shifts (from treatment to prevention, from hospital to community, from analogue to digital) to support continued strengths-based working beyond the NHS.</p>	<p>Approved by PHIC in February 2025 and continuing.</p>
<p>The commissioning framework sets out an equitable approach to commissioning including core offers across north east London</p>	<p>Commissioning framework approved by the ICB Board on 27.03.2025</p>
<p>Outcomes framework submitted to the Population Health and Integration Committee in February 2025 reflects resident-led success measures and outcomes.</p>	<p>Direction of travel endorsed by PHIC on 26.02.2025</p>
<p>Neighbourhood boundaries agreed by the Population Health and Integration Committee in June as we work toward integrated neighbourhood working.</p>	<p>Approved by PHIC on 4 June 2025.</p>

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

<b>Score history and targets</b>	<b>Initial rating (LxS)</b>	<b>Initial date</b>	<b>Rationale</b>
<p>The chart displays the risk rating over time. The y-axis represents the rating score from 0 to 25. The x-axis shows monthly intervals from Jan-24 to Apr-26. A solid red line indicates the current rating, which starts at 20 (4x5) in Jan-24, drops to 16 (4x4) in Feb-25, and remains at 16 (4x4) through Apr-26. A dashed red line indicates the target rating, which is set at 16 (4x4) from Feb-25 onwards.</p>	<b>20 (4x5)</b>	January 2024	The risk has been identified owing to a specific challenge in NEL related to renal dialysis capacity, a specialised service, currently commissioned by NHSE, and due for delegation in April 25. The capacity challenge has arisen due to unfunded growth in demand which is marked in NEL owing to the aetiology of the population. Risks in unfunded growth for other specialised services are therefore likely to arise where funded capacity is likely to be insufficient to meet rising demand for complex specialist care as the population needs increase in response to new drugs, technology and advances in specialist provision. Quality and safety impacts of reduced capacity and access to certain specialist treatments can be extremely detrimental to patient outcomes in addition to the financial pressures on the NHS more broadly.
	<b>Target rating (LxS)</b>	<b>Target date</b>	<b>Rationale</b>
	<b>16 (4x4)</b>	April 2026	The risk remains as red with a target for April 26 as this will be one-year post delegation of specialised service commissioning to ICBs with improved ability to assess impact. The risk is likely to remain at a high score as preventative interventions to manage specialist demand will take time to demonstrate impact. Simultaneously, the volume of specialised services to be delegated will increase over time, potentially leading to a greater imbalance in demand and capacity owing to increasing population demands based on complexity and multiple pathology. For renal dialysis capacity specifically however, the risk rating should reduce to amber by April 2026.
	<b>Current rating (LxS)</b>	<b>Latest review date</b>	<b>Rationale and key progress/ updates since last report</b>
<b>16 (4x4)</b>	June 2025	The London Kidney Network (LKN) have provided an independent review of NEL growth assumptions for 1,2, 5 and 10 years against which current capacity plans and future options to increase capacity have been reviewed in the NEL Renal Dialysis Capacity group. A rolling programme of 20 dialysis stations is required to reduce safety metrics to acceptable levels. The plan to commission the initial 20 dialysis stations is progressing well, with a target go live date of October 25 and a service/workforce model also agreed. Revenue funding is close to finalised, with further discussion to secure the required capital. The risk rating score has reduced to 16 on account of progress to secure the initial 20 stations but remains red until all funding sources are secured.	

<b>Controls and assurances</b>
Maintenance of the Delegation Legacy Risk Log where the issue of continued pressure on in centre renal dialysis capacity is listed
Service portfolio analysis for specialist services to be delegated and clarity on impacts of needs-based funding formula.
Speciality deep dives to assess compliance with national service specs and early identification of demand and capacity imbalance
Reports and updates provided to: <ul style="list-style-type: none"> <li>• NEL Specialised Services Programme Board</li> <li>• NEL Specialised Services Transformation sub group</li> <li>• NEL Specialised Services Contracts and Finance Committee</li> <li>• North London Programme Board for specialised services (as renal dialysis capacity is also constrained in NCL)</li> <li>• London Joint Committee for Specialised Service Delegation</li> <li>• Acute Provider Collaborative Executive Committee</li> </ul>

- Acute Provider Collaborative Joint Committee
- ICS Executive Leadership Team/ Executive Management Team
- London Regional Executive Team

Establishment of NEL Strategic Long Term Conditions Board with focus on prevention and early intervention as well as across the pathways to specialised	
Mitigations/ actions to address the risk	Target date
Development of a legacy risk log identifying current provider, specialised service level risks	Completed
Unlocking of national specialised commissioning growth to support recurrent revenue costs for renal dialysis stations	Completed
Internal approach integrating specialised commissioning with the LTC agenda, ensuring prevention initiatives and whole pathway transformation for the priority specialised service pathways for longer term impact	Completed
Work with the NEL insights team to forecast demand for certain specialised services	Completed
Working together across the system to invest in prevention with each part of the system needing to identify how to move more resources into investment in prevention i.e the cardiometabolic approach	Completed
Work with London Kidney Network to obtain an independent view of growth assumptions and associated options to build future capacity	Completed
Establish NEL Renal Group to ensure dedicated governance to co design an approach, oversee implementation and highlight risks	Completed
Development of integrated neighbourhood working (model approved by ICB Board and programmes are well underway in each Place). This will have a tangible impact on reducing need and demand in relation to long-term conditions.	Continuing
Long-term conditions framework adopted which sets out key outcomes for long-term conditions, with focus on diabetes and cardiovascular disease (CVD) as our most prevalent.	Continuing
High impact interventions identified to deliver a proactive model for long-term conditions, focussing on diabetes and aligned to integrated neighbourhoods.	From May 2025

ICS Aim	To enhance productivity and value for money				Risk applies to ICB		Risk applies to ICS		Risk reference	CFPO74
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Henry Black
	✓		✓		✓		✓		Responsible committee	Finance, Performance and Investment Committee
Boroughs impacted	B&D	C&H	Harvering	Newham	Redbridge	Tower Hamlets	Waltham Forest	Risk appetite level (1-5)	1: Averse	
	✓	✓	✓	✓	✓	✓	✓			
Risk description	There is a risk that the increasing cyber attacks in healthcare could leave the ICB and our partner organisations vulnerable to an attack. An attack could impact our services and also risk the exposure of our residents' data. In turn, this could lead to services being halted which would impact on patient safety, and also breach the Data Protection Act.									
Score history and targets			Initial rating (LxS)	Initial date	Rationale					
<p>The chart displays a red arrow representing the current rating of 15 (5 x 3) starting in August 2024 and extending to the right. A yellow arrow represents the target rating of 10 (5 x 2), starting in August 2024 and extending to April 2026. The x-axis shows months from August 2024 to April 2026, and the y-axis shows a score from 0 to 16.</p>			15 (5 x 3)	August 2024	This reflects the current level of perceived risk. While each organisation has implemented appropriate controls within their own networks and devices, at an ICS level there remains a high risk in terms of assurance because the cyber dashboard (to provide risk visibility) is still being implemented.					
			Target rating (LxS)	Target date	Rationale					
			10 (5 x 2)	April 2026	The revised date from NHS England for completion of the implementation plan is 30 April 2026 and this will be a rolling plan.					
			Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report					
			15 (5 x 3)	June 2025	Planning for the development of an ICS cyber strategy is underway and cyber security assurances are regularly reported the Audit and Risk Committee.					
<b>Controls and assurances</b>										
Digital risks are regularly reported on at the Finance, Performance and Investment Committee and the Audit and Risk Committee										
The System Coordination Centre (SCC) is established and would manage any emergency or business continuity issues should the risk materialise.										
The Information Governance Steering Group meets on a monthly basis to consider any risks.										
Firewalls have been installed and network hardening is taking place										
Multiple tools have been deployed, including Sophos, Microsoft Defender for Endpoint (MDE) and the enablement of Multi-Factor Authentication (MFA)										
The ICB IT system has a 100% redundancy back up site in a separate geographic location and annual tests are conducted to ensure it is possible to switch over seamlessly, should the need arise.										
The cyber dashboard will surface the risks that exist within each trust. Discussions need to take place as to how each organisational risk is combined to give an accurate overall ICS score.										
<b>Mitigations/ actions to address the risk</b>									<b>Target date</b>	
Continual work with services and staff to ensure that MFA is configured or that risks are appropriately managed.									Ongoing	
Work with a software security provider to enable Advanced Software Management to further automate software updates and patching.									Ongoing	
Develop a proposal to introduce on-call provision to enable response to cyber attacks out of hours.									30/6/25	
A 'grab-bag' is being developed, which will contain all of the forms needed to gather data in each organisation, to support cyber leads that have to deal with successful attacks, including forensics preparation									30/6/25	
Developing the ICS Cyber Strategy and Cyber Programme reflects the ICB's commitment to addressing cybersecurity challenges as part of its compliance obligations, establishing a vision and framework to protect healthcare services, safeguard data, and ensure resilience in a changing threat landscape.									30/6/25	

ICS Aim	To improve outcomes in population health and healthcare				Risk applies to ICB		Risk applies to ICS		Risk reference	CEO01
					✓		✓			
ICS priority	Children and young people		Mental health		Employment and workforce		Long term conditions		Risk owner	Zina Etheridge
					✓				Responsible committee	Transition Committee
Boroughs impacted	B&D	C&H	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest		Risk appetite level (1-5)	3: Open
	✓	✓	✓	✓	✓	✓	✓			
Risk description	<p>There is a risk that the requirement to reduce the ICB running cost by 50% will impact the delivery of the ICB's objectives and overall will be a significant distraction for our workforce as they face a substantial reorganisation. There are a number of risks associated with this including: overall impact on the delivery of BAU, impact on staff morale/behaviours/wellbeing, risk of staff leaving during the process thus leading to an impact on delivery, an impact on the local population during the period of change through potential delays and disruptions to services and contracts and wider impact on the ability of the ICB to deliver its role across the system during this time.</p>									
Score history and targets				Initial rating (LxS)	Initial date	Rationale				
				20 (4x5)	20 March 2025	The ICB has been asked to reduce its running cost by 50% and this will require a fundamental redesign of the operating model. This has to be submitted to NHSE by the end of May (following the publication of a model ICB reference model at the start of May). This will be a significant period of change for the organisation and time spent re-designing the operating model, consulting and then delivering a restructure could impact the overall delivery of the ICB's objectives				
				Target rating (LxS)	Target date	Rationale				
				8 (2x4)	March 2026	The required changes are to be implemented by the end of December 2025. At this point there will be clarity on the future structures and a new operating model in place. Through identified mitigations it is hoped that the overall impact can be reduced.				
				Current rating (LxS)	Latest review date	Rationale and key progress/ updates since last report				
				20 (4x5)	June 2025	<p>An ICB change process has been stepped up with immediate effect, this is meeting 3 times a week to oversee the work required. Within this, urgent decisions are being made, a robust system is in place to capture all decisions, actions and risk and a timeline and process for developing an operating model is in place. Overall, there is a nationally led process which means the ICB is limited in how much progress it can make outside of the national timelines but the process in place is ensuring the ICB is in the best possible position to proactively manage and lead through the required changes over the coming months, including mitigating core risk. An ICB transition committee will also be stood up to oversee the process, manage risk and track progress.</p> <p>The next steps are now to develop the necessary structures and job descriptions as well as the consultation document and associated detail in order to consult with staff on the proposals. This will be a significant period of change for the organisation and time spent re-designing the operating model, consulting and then delivering a restructure could impact the overall delivery of the ICB's objectives</p>				
Controls and assurances										
New ICB change process meeting in place – meeting twice a week										
Operating model development underway working with key system stakeholders and partners. Draft model submitted to NHSE on 30 May.										
Chief Officers linked in to the national process which is fast moving (at both London and national level)										
A robust HR process has been set up – with developing timelines and ensuring all the necessary data and information is in place ahead of a consultation launch										
A comprehensive staff support programme has been stood up to ensure staff are supported through the change (practical support including CV writing, interview skills, pension clinics, financial support) and wider staff wellbeing focus to ensure people have the tools they need to manage through the difficult period.										
Managers guidance has been provided to equip managers with the information and detail they need to manage through change										
Regular communications in place with staff and stakeholders to ensure accurate, transparent and consistent messaging throughout the process.										
Transition Committee, which reports to the ICB Board, has been established to manage risk, oversee and track progress (comprised of exec and non-exec directors)										
Mitigations/ actions to address the risk										Target date
Ensuring sufficient HR support in place to manage the change process and ensure continuity through the process										May 2025 and continuing

Draft ICB operating model to be developed and submitted to NHSE by 30 May – from this a consultation document is being prepared.	Submission sent in May 2025
Ensuring data and staff information is accurate ahead of a consultation launch	June 2025
EQIAs to be undertaken to ensure accurate information and impacts on staff are clear as the consultation launches.	June 2025
Financial impact of any redundancies to be managed effectively (anticipated this will be steered nationally)	October 2025

**SUPPORTING INFORMATION**

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

**Committees of the Integrated Care Board:**

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

**Aims of the Integrated Care System:**

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

**Risk grading matrix**

Risk Category	Severe	
	High	
	Medium	
	Low	

Likelihood					
Rating	1	2	3	4	5
Description	Rare	Unlikely	Possible	Likely	Certain
Probability	<10%	10% - 24%	25% to 45%	50% - 74%	>75%

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

## NHS North East London ICB Board

2 July 2025

<b>Title of report</b>	Financial overview
<b>Author</b>	Ahmet Koray, Director of Finance
<b>Presented by</b>	Henry Black, Chief Finance and Performance Officer
<b>Contact for further information</b>	<a href="mailto:henryblack@nhs.net">henryblack@nhs.net</a>
<b>Executive summary</b>	<p><b>Key Items:</b></p> <ul style="list-style-type: none"> <li>• The paper updates the ICB Board on the key information submitted to NHS England (NHSE) in month 2.</li> <li>• The Integrated Care System (ICS) operating plan expected a system breakeven position by year-end (£2.5m surplus for the ICB and £2.5m deficit for providers).</li> <li>• To deliver this there is an expectation that efficiencies of £367.7m will be delivered (£37.8m ICB and £329.9m providers).</li> <li>• At month 2, the expected year-to-date position was a deficit of £18m (ICB £1.2m, providers £16.8m). Actual delivery against this was a deficit of £32m, which is an adverse variance to plan of £14m (ICB positive variance of £0.1m).</li> <li>• At month 2, £30m of efficiencies were delivered against planned delivery of £39.3m, resulting in year-to-date slippage of £9.3m (£0.3m over delivery in the ICB and £9.6m under delivery with providers). Forecast efficiency slippage is expected to be circa £19.1m.</li> <li>• The month 2 deficit to plan is largely attributable to efficiency slippage. Additionally, North East London NHS Foundation Trust (NELFT) has cited pressures against legal costs and out of area beds.</li> <li>• The month 2 ICS position suggests an extrapolated overspend by year-end. There is a high level of risk associated with delivery of efficiencies and providers are reporting unidentified mitigations and run rate risks.</li> <li>• NHSE will review system performance at quarter two (Q2) in relation to deficit support funding provided to the system in the operating plan.</li> <li>• Across the ICS, delivery of efficiencies remains a major risk to the delivery of the overall financial position. 33% of efficiencies are categorised as non-recurrent which will impact the underlying position moving into 2026/27.</li> </ul>

<b>Action required</b>	<ul style="list-style-type: none"> <li>The ICB Board is asked to note the month 2 financial position and the level of risk associated with delivery of the financial plan.</li> <li>The ICB Board is recommended to <b>approve</b> the 2025/26 Better Care Fund plans and delegate authority to the Chief Executive Officer and Chief Finance and Performance Officer under the Scheme of Reservation and Delegation (SORD) for signature to execute new and existing Section 75 agreements..</li> </ul>
<b>Previous reporting</b>	Previous reporting to Finance, Performance and Investment Committee.
<b>Next steps/ onward reporting</b>	Future financial and risk updates will be given to the ICB Board, ICB Finance, Performance and Investment Committee and the ICB Audit and Risk Committee.
<b>Conflicts of interest</b>	No conflicts of interest have been identified
<b>Strategic fit</b>	North East London (NEL) wide plans are set on the financial resources available. The report provides an update of the financial position against the finance operating plan and 25/26 budget.
<b>Impact on local people, health inequalities and sustainability</b>	Update of financial sustainability and performance of the system. Specific performance indicators address performance against the needs of those with protected characteristics (as defined by the Equalities Act) such as disability and that is included in the report.
<b>Impact on finance, performance and quality</b>	Delivery of the financial plan and meeting the control total and delivery of performance metrics and constitutional standards are mandated requirements.
<b>Risks</b>	<p>There is a high level of financial risk in the delivery of the 2025/26 financial plan. At month 2 the main risks flagged are in relation to efficiency slippage and run rate pressures. There is a further risk in relation to the potential withdrawal of deficit support funding.</p> <p>Further updates will continue to be given to the Board and the Finance, Performance and Investment Committee.</p> <p>The ICB risk rating is 20.</p>

## 1. Purpose of the report

The purpose of the report is to update the ICB Board on the month 2 financial position. There is also an update on the Better Care Fund (BCF) section 75 arrangements.

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

The ICB is recommended to approve the BCF plans and to formally approve the signing of the plans.

## 2. Month 2 finance overview

The operating plan submitted at the end of April expected a breakeven position at year-end (ICB surplus of £2.5m and provider deficit of £2.5m). The system planned to deliver deficits each month for the first half of the year, with an expectation that the financial position starts to recover from month 7 onwards.

At month 2, four providers have reported a deficit above their plan however East London NHS Foundation Trust (ELFT) and the ICB have both reported a slightly lower deficit than planned. This has resulted in a year-to-date deficit position across the north east London (NEL) system of £32m, which is a £14m variance to plan.

The £14m variance to plan is almost entirely the providers' with a small £0.1m positive variance reported by the ICB.

Capital discussions continue between the ICB, NHS England (NHSE) and providers with scrutiny of plans at a regional and national level. The Integrated Care System (ICS) is currently balanced, but the capital allocation is not sufficient to meet all the capital requirements of providers.

## 2.1. ICS month 2 reported position

The reported year-to-date variance and forecast variance is summarised by statutory organisation in table 1 below.

Organisations	Month 2 YTD - Reported			Month 12 Outturn			Risks and Unidentified Mitigations
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m	Total £m
BHRUT	(0.4)	(5.6)	(5.2)	0.0	0.0	0.0	(23.9)
Barts Health	(7.9)	(13.9)	(6.0)	(0.0)	0.0	0.0	(50.9)
East London NHSFT	(3.5)	(3.4)	0.1	0.0	0.0	0.0	(0.0)
Homerton	(0.4)	(2.0)	(1.6)	(2.5)	(2.5)	0.0	(5.2)
NELFT	(4.5)	(5.9)	(1.4)	0.0	0.0	(0.0)	(31.7)
<b>Total NEL Providers</b>	<b>(16.8)</b>	<b>(30.9)</b>	<b>(14.1)</b>	<b>(2.5)</b>	<b>(2.5)</b>	<b>0.0</b>	<b>(111.8)</b>
NEL ICB	(1.2)	(1.1)	0.1	2.5	2.5	(0.0)	0.0
<b>NEL System Total</b>	<b>(18.0)</b>	<b>(32.0)</b>	<b>(14.0)</b>	<b>0.0</b>	<b>0.0</b>	<b>(0.0)</b>	<b>(111.8)</b>
Non-Recurrent Deficit Support	(7.0)	(7.0)	0.0	(42.0)	(42.0)	0.0	
<b>Surplus / (Deficit) excluding Deficit Support</b>	<b>(25.0)</b>	<b>(39.0)</b>	<b>(14.0)</b>	<b>(42.0)</b>	<b>(42.0)</b>	<b>0.0</b>	

Table 1

Providers are reporting a year-to-date deficit of £30.9m at month 2 and the ICB is reporting a deficit of £1.1m.

The system has been capturing risks and mitigations within the overall position reported to NHSE. In month 2 the risk and unidentified mitigations are £111.8m.

As part of the operating plan submission, the system received deficit support funding of £42m. Arrangements are currently being confirmed by NHSE and there is a risk the funding may not be made available for the period the system remains off-plan. This position will be confirmed as soon as it is made available, but to note, that it may impact the year-to-date and forecast positions in the event some of this funding is not made available.

The key pressures and performance indicators at a system level are as follows:

- **Efficiency and cost improvement plans** (see table 2) - the total system efficiency and cost improvement plan at month 2 is £39.3m. Of this, £30m has been delivered, leaving a year-to-date balance against plan of £9.3m (£9.6m under delivery for providers and an over delivery of £0.3m for the ICB).

Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and Homerton Healthcare are forecasting efficiency slippage of £19.3m at year end. The other providers and the ICB are on plan, with a small forecast over delivery reported by ELFT (£0.2m).

Efficiencies	Month 2			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
BHRUT	6.2	2.9	(3.3)	61.5	45.6	(15.9)
Barts	20.3	14.3	(6.0)	168.0	168.0	0.0
ELFT	1.3	3.0	1.7	31.9	32.1	0.2
Homerton	4.1	2.5	(1.6)	24.5	21.1	(3.4)
NELFT	2.8	2.4	(0.4)	44.0	44.0	0.0
<b>Total Provider Efficiency</b>	<b>34.6</b>	<b>25.0</b>	<b>(9.6)</b>	<b>329.9</b>	<b>310.8</b>	<b>(19.1)</b>
NEL ICB	4.7	5.0	0.3	37.8	37.8	0.0
<b>Total System Efficiency</b>	<b>39.3</b>	<b>30.0</b>	<b>(9.3)</b>	<b>367.7</b>	<b>348.6</b>	<b>(19.1)</b>

Table 2

- **Run rate pressures** – North East London NHS Foundation Trust (NELFT) is reporting run rate pressures in relation to above plan independent sector beds (ECRs) purchased along with increased acuity of patients on wards requiring greater nursing care.

At month 2, the ICB has reported year-to-date pressures in relation to the mental health and learning disability and autism areas of spend. There are continued run rate pressures on attention deficit hyperactivity disorder (ADHD) and section 117 packages of care.

- **Pay, including agency** (see table 3) – providers are reporting a year-to-date whole time equivalent (WTE) variance of 54 WTE's (0.1% above plan). However, the year-to-date pay variance is an overspend of £10.1m (1.7%).

Within the cost position, agency, bank and other pay spend are reporting a net underspend of circa £0.6m at month 2, with a reported overspend of £10.7m against substantive staff. Bank and agency WTEs are currently 240 above plan with substantive staff 186 below plan. The correlation between WTE's and pay costs, changes in skill mix, and the impact on future projections are being reviewed by providers.

	25/26 Plan Month 2	25/26 Actual Month 2	25/26 Variance Month 2	25/26 Variance Month 2	25/26 M2 Pay costs Plan	25/26 M2 Pay costs Actual	25/26 M2 Pay costs Variance	25/26 M2 Pay costs Variance
	WTE	WTE	WTE	%	£m	£m	£m	%
BHRUT	9,484	9,539	(55)	(0.6%)	104.3	107.5	(3.1)	(2.9%)
Barts	22,126	22,620	(494)	(2.2%)	262.2	265.1	(2.9)	(1.1%)
ELFT	8,261	8,064	197	2.4%	87.8	86.4	1.4	1.6%
Homerton	4,558	4,566	(8)	(0.2%)	55.9	57.8	(1.9)	(3.3%)
NELFT	8,667	8,361	306	3.5%	83.4	86.9	(3.5)	(4.0%)
<b>Total NEL Providers</b>	<b>53,096</b>	<b>53,150</b>	<b>(54)</b>	<b>(0.1%)</b>	<b>593.6</b>	<b>603.7</b>	<b>(10.1)</b>	<b>(1.7%)</b>

Table 3

**Cash and Cash Equivalents** - with the exception of BHRUT, providers are reporting cash and cash equivalent balances in excess of the operating plan target in month 2. BHRUT, Barts Health and NELFT have reported variances to plan as a result of working capital

management. ELFT and Homerton Healthcare have reported cash receipts higher than forecast at month 2.

Provider - Cash and cash equivalents	Plan	Actual	Variance	Plan	Actual	Variance
	Month 1	Month 1	Month 1	Month 2	Month 2	Month 2
	£m	£m	£m	£m	£m	£m
BHRUT	29.4	12.8	(16.6)	29.4	12.8	(16.6)
Barts	50.0	47.9	(2.1)	20.0	45.6	25.6
ELFT	113.6	119.7	6.1	113.6	123.1	9.5
Homerton	55.3	55.3	0.0	50.1	59.0	9.0
NELFT	9.4	22.7	13.3	7.1	15.0	7.9
<b>Total NEL Providers</b>	<b>257.7</b>	<b>258.3</b>	<b>0.7</b>	<b>220.1</b>	<b>255.5</b>	<b>35.3</b>

- **Capital** (see table 4) - The capital spend includes an agreed over-programming in line guidance.

All providers are on plan to fully utilise their allocation. The adverse variance with Barts Health is in relation to a net zero scheme. Funding is expected to be allocated in month 3.

Business cases in respect of constitutional standards are currently being prepared by providers for agreement.

Capital spend in relation to the ICB relates to primary care. This is managed by the ICB but is accounted for by NHSE.

Organisation	YTD Budget	YTD Actual	YTD Variance	Annual Plan	Forecast	Forecast Variance
	£m	£m	£m	£m	£m	£m
BHRUT	2.9	1.3	1.6	23.9	23.9	0.0
Barts Health	7.1	2.2	4.9	85.7	86.0	(0.3)
East London NHSFT	4.1	3.9	0.2	24.1	24.1	0.0
Homerton	3.9	0.9	3.0	28.1	28.1	0.0
NELFT	0.7	0.7	0.0	18.6	18.6	0.0
<b>Total NEL Providers</b>	<b>18.8</b>	<b>9.1</b>	<b>9.7</b>	<b>180.4</b>	<b>180.7</b>	<b>(0.3)</b>
NEL ICB	0.7	0.0	0.7	4.5	4.5	0.0
<b>NEL System Total</b>	<b>19.5</b>	<b>9.1</b>	<b>10.4</b>	<b>184.9</b>	<b>185.2</b>	<b>(0.3)</b>

Table 4

## 2.2. ICB Year-to-date and forecast position (see table 5)

The ICB year-to-date position is a deficit of £1.1m, resulting in a small underspend against plan of £0.1m.

The summary year-to-date and forecast position is shown below.

	Month 2 Variance £m	FOT Variance £m
Acute	(0.0)	0.0
Mental Health	(0.3)	(2.3)
Community Health	(0.2)	(0.2)
Continuing Care	0.1	(0.6)
Primary Care - Co Commissioning	(0.0)	0.0
Primary Care - DOPs	0.0	0.0
Primary Care - Other	(0.1)	0.6
Running Costs	(0.0)	0.0
Specialised Commissioning	0.0	0.0
Programme Wide Admin (Programme Corporate)	(0.0)	(1.1)
Other	0.7	3.7
<b>Total Variance to Plan</b>	<b>0.1</b>	<b>0.0</b>
Planned (Deficit) / Surplus	(1.2)	2.5
<b>(Deficit) / Surplus</b>	<b>(1.1)</b>	<b>2.5</b>

Table 5

**Acute** – is reported as break-even in month 2. There is limited activity information for the independent sector in month 2, which has traditionally been a volatile area of spend. Pathway changes are also expected to impact acute spend later in the financial year.

**Mental Health, Learning Disabilities and Autism (MHLDA)** - there are run rate pressures in mental health as a result of ADHD and section 117 placements (both mental health and LDA). Mental health overspends are included in the mental health investment standard (MHIS) collection of costs, with LDA sitting outside this. The mental health related overspends have been covered by the MHIS risk reserve held by the ICB in the operating plan. The remaining year-to-date overspend of £0.3m and forecast overspend of £2.3m is in relation to ADHD and LDA services. The MHLDA Collaborative is reviewing the ADHD pathway and there are efficiency schemes in place that are expected to target section 117 and other high-cost packages of care. The ICB is reporting spend in line with the mental health investment standard in 25/26.

**Community health** – there is a small overspend of £0.2m as a result of cost and volume contracts.

**Continuing healthcare (CHC)** - within the year-to-date position there is an underspend of £0.1m in CHC. This is partly due to an underspend as a result of the delivery of efficiency schemes (£0.3m), offset by an over spend on the costs of CHC assessment and support (£0.2m). Efficiency is expected to breakeven at year-end with a continued forecast overspend on CHC assessment and support.

**Primary care other** – prescribing data is received by the ICB two months in arrears. At month 2, there is no available in-year prescribing data, and the position has been reported as break even, in line with operating plan assumptions. This will continue to be reviewed, and updates given as more data is available.

- **ICB efficiencies** (see table 7) - the position on ICB savings is shown in the table below:

Efficiencies	YTD Efficiency Plan £m	YTD Actual £m	YTD Efficiency Variance £m	FOT £m
Prescribing	1.6	1.6	0.0	9.9
Continuing Healthcare	0.5	0.7	0.2	6.0
Other Internal CIPs	0.6	0.6	0.0	3.5
Commissioning Efficiencies	1.4	1.5	0.1	11.5
Pathway Changes	0.0	0.0	0.0	2.2
Voids	0.0	0.0	0.0	1.0
Decommissioning	0.6	0.6	0.0	3.7
<b>Total</b>	<b>4.7</b>	<b>5.0</b>	<b>0.3</b>	<b>37.8</b>

Table 7

At Month 2, the ICB is delivering continuing healthcare and commissioning savings slightly ahead of plan. The ICB expects to deliver £37.8m of efficiencies to deliver the expected surplus at year-end. Delivering efficiencies carries risks due to the non-recurrent nature of some schemes and challenges in implementation.

36% (£13.6m) of the ICB schemes are categorised as non-recurrent. This will impact on the underlying position moving into 2026/27. Additionally, only 67% of schemes (£25.2m) are categorised as low risk, with the remainder categorised as high or medium risk (33%, £12.6m). The ICB will continue to explore further areas of potential delivery to offset the risk of delivery.

Efficiency delivery and oversight continues to be reviewed at the ICB Financial Sustainability Board (FSB).

- **ICB risk and mitigations** - the ICB is reporting that it will deliver a surplus of £2.5m at year-end. To achieve this target the following assumptions are included in the forecast:
  - i. Efficiencies are assumed to continue in line with performance to date.
  - ii. The risk associated with the delivery of efficiencies will be mitigated by oversight of delivery and corrective action taken where required.
  - iii. Further opportunities continue to be identified to manage the ongoing requirement to manage risks, balance the forecast and deliver recurrent benefits.
  - iv. The run-rate of existing spend will remain in line with current trends.
  - v. Deficit support funding may impact the system financial position if it is withdrawn from systems not achieving plan.

### 3. System risks and mitigations

The risk to the delivery of the ICS breakeven position is reported as part of the run rate return to NHSE. There is a risk to delivery of the financial position of circa £112m in month 2. The ICB expects to manage its risk through the development of further opportunities. This means that the outstanding risk is within the provider position and is reported as circa £112m. The largest proportion of this relates to the delivery of efficiencies, circa £82m. There are unidentified mitigations within the run rate of circa £12.5m. NELFT have also flagged risks to the delivery of the forecast in relation to run rate pressures, particularly in relation to ECR beds, pay costs and capital.

### 4. Better Care Fund (BCF) Section 75 (s75) agreement

National guidance requires NEL ICB to create and agree a BCF plan with each local authority and then enter into a Section 75 Agreement that creates a pooled budget, referred to as the Better Care Fund.

Following approval at Health and Wellbeing Boards, the place-based partnerships have submitted their 2025/26 BCF Plans to NHS England for regional assurance and approval; Letters of Approval have been received for each place.

Each Place is required to create a 2025/26 plan, in line with the conditions set out in the BCF Policy Framework.

The purpose of this paper is to request approval from the ICB Board to execute variations to new and existing Section 75 agreements that will include the Better Care Fund Plans for 2025/26.

The ICB Board is recommended to formally approve the signing of variation to an existing Section 75 agreement to add the BCF Plan and BCF financial schedules for 2025/26 with:

- i. The City of London Corporation
- ii. The London Borough of Hackney
- iii. The London Borough of Newham
- iv. The London Borough of Tower Hamlets
- v. The London Borough of Waltham Forest

And recommended to formally approve the signing of New Section 75 agreement to include BCF Plan and BCF financial schedules for 2025/26 for BHR boroughs. New section 75s to be issued following notice to the BHR tri-borough agreement:

- vi. The London Borough of Barking and Dagenham
- vii. The London Borough of Havering
- viii. The London Borough of Redbridge

The value of the BCF plans by borough are shown in the table below.

Borough	NHS Minimum Contribution	Additional ICB Contribution	Additional LA Contribution	DFG	LA Better Care Grant	Total
	£m	£m	£m	£m	£m	£m
Barking and Dagenham	21.7	0.0	0.0	2.3	13.2	37.3
Havering	28.2	0.0	0.9	2.6	8.4	40.0
Redbridge	27.8	0.0	0.0	3.0	12.4	43.2
City of London	1.0	0.0	0.1	0.0	0.4	1.5
Hackney	29.7	0.0	0.0	2.1	20.5	52.4
Newham	33.7	30.2	119.8	3.5	21.2	208.4
Tower Hamlets	29.7	13.4	0.8	2.9	20.7	67.5
Waltham Forest	26.8	0.0	0.1	2.9	11.7	41.5
<b>Total</b>	<b>198.6</b>	<b>43.6</b>	<b>121.6</b>	<b>19.4</b>	<b>108.6</b>	<b>491.9</b>

To note that ICB and LA discharge funds have now been integrated into, respectively, NHS Minimum Contribution and LA Better Care Grant.

## 5. Recommendation

The ICB Board is asked to:

- (i) Note the month 2 financial position and the level of risk associated with delivery of the financial plan.
- (ii) Approve 2025/26 Better Care Fund plans and delegate authority to the Chief Executive Officer and Chief Finance and Performance Officer under the Scheme of Reservation and Delegation (SORD) for signature to execute new and existing Section 75 agreements.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Performance report
<b>Author</b>	NEL ICB performance team
<b>Presented by</b>	Henry Black, Chief Finance and Performance Officer
<b>Contact for further information</b>	Olu Omotayo, Head of Performance; <a href="mailto:o.omotayo@nhs.net">o.omotayo@nhs.net</a> Helen Pace, Head of Performance; <a href="mailto:helen.pace@nhs.net">helen.pace@nhs.net</a>
<b>Executive summary</b>	<ul style="list-style-type: none"> <li>• The attached set of slides describes the performance of the overall system across seven domains of performance in March 2025. For Urgent and Emergency Care (UEC) April 2025 data is available. The detailed description and analysis for each of the domains is included in these slides.</li> <li>• The total waiting list in planned care increased marginally in March following six consecutive months of sustained reduction, driven by increases in the non-admitted waiting list at Barking, Havering and Redbridge University Hospitals Trust (BHRUT) and Homerton Healthcare.</li> <li>• The number of reported long waiting patients (more than (&gt;) 78 weeks and &gt;65 weeks) continued to decrease in March. There is however risk in the position at Barts Health due to the planned go-live of the Luna waiting list management and reporting solution (for reporting of the May validated position onwards).</li> <li>• There were two complex pathways &gt;104 weeks reported at BHRUT for the month (both pathways have since been treated).</li> <li>• Cancer performance improvement was sustained in March and was achieved against the 28-day Faster Diagnosis Standard (FDS) and 31-day standards. Performance against the 62-day standard was also improved and achieved the 70% NHS England (NHSE) 2024/25 Operational Plan requirement.</li> <li>• The total number of patients waiting for a diagnostic test and the number of patients waiting more than six weeks decreased in March 2025, albeit performance fell marginally for the month.</li> <li>• The April 2025 published position against the 4-hour Accident and Emergency (A&amp;E) standard was 76.4%.</li> <li>• In April, overall bed occupancy and the percentage of all general and acute (G&amp;A) beds with a length of stay (LOS) &gt;21-days fell (positive movement). The number of adult G&amp;A beds occupied with patients who no longer meet the criteria to reside however increased in month (adverse movement).</li> </ul>

	<ul style="list-style-type: none"> <li>Virtual ward occupancy increased in April above planned trajectory of 80%.</li> <li>The number of appointments delivered in general practice in March was above plan for the month, with those seen within two weeks &gt;90%.</li> <li>Referrals to urgent community response services remain above planned levels for the month.</li> <li>Community services waiting list data is updated to Q4 2024/25.</li> <li>Serious Mental Illness (SMI) physical health checks, early intervention in psychosis, and community mental health access met year end (March 2025) trajectories.</li> </ul>
<b>Key areas of improvement / concern</b>	<ol style="list-style-type: none"> <li>Cancer performance improvement was sustained in March and was achieved against two of the three cancer waiting time standards (FDS and 31-day) across all three north east London (NEL) acute Trusts. Performance against the 62-day standard was also improved at NEL level, with all three acute Trusts achieving &gt;70% (the March 2025 Operational Plan ask).</li> <li>Within the mental health workstream, SMI physical health checks, early intervention in psychosis, and community mental health access met year end trajectories.</li> <li>Following national review of elective and diagnostics performance, Barts Health has been moved into Tier 1 for both elective recovery (following de-escalation to Tier 2 in January 2025) and diagnostics (Barts Health was initially moved into Tier 2 for diagnostics in January 2025) for Q1 2025/26. Tiering remains a core part of national oversight and support with focus on delivering improvements in referral to treatment (RTT) and cancer performance standards in 2025/26.</li> </ol>
<b>Action / recommendation</b>	The Board is asked to note the report. Further queries may be raised with the NEL ICB performance team if required.
<b>Previous reporting</b>	Each of the performance domains has associated improvement activity and this is managed through system-wide Boards or Collaboratives, for example, the Planned Care Board, Acute Provider Collaborative, and the UEC Programme Board
<b>Next steps/ onward reporting</b>	The NEL ICB Performance report interfaces: <ul style="list-style-type: none"> <li>The Executive Management Team</li> <li>Finance, Performance and Investment Committee</li> <li>Quality, Safety and Improvement Committee</li> <li>ICB Board</li> </ul>
<b>Conflicts of interest</b>	No known conflicts of interest

<b>Strategic fit</b>	This report aligns with the following ICS aims: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Improving access to healthcare and the speed of treatment is likely to benefit disadvantaged groups among residents, as well improve performance, quality, equity of access and reduction of health inequalities for the NEL population.
<b>Has an Equalities Impact Assessment been carried out?</b>	An Equalities Impact Assessment is not required for this report.
<b>Impact on finance, performance and quality</b>	Ongoing risk of underperformance, due to recovery from previous industrial action (2024/25 planning was predicated on no further action, a core national planning assumption) and impact of GP collective action from August 2024.  Risk in Q4 2024/25 and across 2025/26 associated with the balance between delivery of the required financial position versus delivery of performance and activity requirements.
<b>Risks</b>	The risks and issues are described against the relevant performance domains.

## 1.0 Introduction

- 1.1 This is one of a regular series of performance reports which come to each meeting of the Board. The aim is to provide assurance to the Board with regards to the effective monitoring of performance, identification of risks to delivery and the mitigating actions put in place.
- 1.2 The attached set of slides describes the performance of the overall system across seven domains of performance in March 2025. For Urgent and Emergency Care (UEC) April 2025 data is available. The detailed description and analysis for each of the domains is included in these slides.
- 1.3 Following feedback from the May Board, the report has been revised to include an overview of content, an executive summary, and a table of key indicators including benchmarking where available. These are interim changes while more comprehensive work is undertaken during quarter one (Q1) of 2025/26 taking into consideration the ICB Blueprint, draft NHS Performance Assessment Framework, and NHS England (NHSE) good practice. This work will also include a review of the presentation of data and trends, as well as report automation and accessibility.
- 1.4 The Board is asked to note the interim revisions made to the report and further work being undertaken.
- 1.5 The system's performance against the agreed activity volumes and standards has an impact on all four of the Integrated Care System (ICS) strategic aims:

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

## 2.0 Key messages

- 2.1 Formal 2025/26 Operating Plan guidance was published at the end of January 2025 with technical guidance subsequently issued in early February 2025. A final ICS submission was made to NHSE in April 2025. Full reporting against 2025/26 Operating Plan metrics and trajectories will commence once April (M1) data is available in June 2025 (the exception to this is UEC where M1 data is already available).
- 2.2 Barts Health moved into Tier 1 for elective recovery with risk in the position due to the planned go-live of the Luna waiting list management solution for May validated reporting to provide a single, inclusive, and reportable waiting list. Benefits and functionality of Luna include artificial intelligence (AI)/ automation, streamlining, reduced clinical risk, pathway management, productivity improvements, reduced manual validation, and optimisation of clinical decision making.
- 2.3 Barts Health has also been moved into Tier 1 for diagnostics with formal written confirmation received from NHSE on 15 May 2025.
- 2.4 The north east London (NEL) system remains in Tier 2 for UEC (with effect of January 2024). As a Tier 2 system, NEL continues to receive regionally led support to help achieve the ambitions of the UEC Recovery Plan. From Q4 2024/25 onwards, NEL system level reporting has been amended in accordance with national reporting methodology to include North East London NHS Foundation Trust (NELFT) Orsett Minor Injury Unit activity.

## 3.0 Performance in March 2025 and April 2025

- 3.1 The NEL patient tracking list (PTL) increased marginally in March 2025 (following six consecutive months of sustained reduction prior) to 215,929 pathways (+71 pathways from the February 2025 position), driven by increase at Barking, Havering and Redbridge University Hospitals Trust (BHRUT) (+964 pathways) and Homerton Healthcare (+968 pathways). The PTL at Barts Health fell in month (-1,861 pathways). Barts Health and Homerton Healthcare adverse to trajectory for the month.
- 3.2 The total NEL waiting list in March 2025 is -2% lower compared to the position in March 2024, this remains driven by BHRUT (-16%, driven by non-admitted). The waiting list at both Barts Health (+2%, driven by non-admitted) and Homerton Healthcare (+14%, driven by admitted and non-admitted) is higher than in March 2024.
- 3.3 The number of reported long waiting pathways (more than (>) 65 weeks) decreased by a further 47 pathways in March 25 to a total volume of 330 pathways (26 pathways >78weeks and two pathways >104weeks. Both >104-week waits were reported at BHRUT, a complex mutual aid patient from East Kent, and a complex

gynaecology pathway case. Both pathways were treated in April and there are no patients currently waiting >104weeks across NEL.

- 3.4 In March 25, Faster Diagnosis Standard (FDS) performance was 80.5% for the month (improved on February 2025). All three NEL acute Trusts achieved >80%. 62-day performance at NEL level was 77.1% for the month and above the 70% ask 2024/25 year-end ask. This is further improved on February 2025, driven by an improved position at all three acute Trusts.
- 3.5 The total number of patients waiting for a diagnostic test (50,771) fell in March, driven by reduction at all three acute NEL Trusts. The number of patients waiting more than six weeks (8,372 pathways) also fell in month, driven by reduction at Barts Health and Homerton Healthcare. However, this equates to performance of 83.5% (BHRUT 95.3%, Homerton Healthcare 87.6% and Barts Health 78.6%), a marginal deterioration on the previous month (-0.97%). Significant work is ongoing at Barts Health in Magnetic resonance imaging (MRI), audiology and DEXA (bone density), monitored via the Tier 1 process. There has been improvement in the diagnostics waiting times and activity position in the last three months.
- 3.6 The published position against the 4-hour emergency department (ED) standard at NEL level in April was 76.4%, Barts Health and Homerton Healthcare falling below trajectory for the month. All three NEL acute Trusts have seen decrease in attendances when compared to the previous month (BHRUT and Homerton Healthcare below plan; Barts Health above plan).
- 3.7 In April, overall bed occupancy (90.4%) and the percentage of all general and acute (G&A) beds with a length of stay >21-days fell (20.7%), (positive movement). The number of adult G&A beds occupied with patients who no longer meet the criteria to reside however, increased in month (13.5%), (adverse movement).
- 3.8 In April 2025, NEL reported a virtual ward capacity of 365 patients, with an occupancy rate of 87.1%.
- 3.9 The number of appointments delivered in general practice in March was above plan, with 91% seen within two weeks.
- 3.10 Referrals to urgent community response services continue to be above planned levels in March.
- 3.11 Community services waiting list data is for Q4 2024/25. The community services data group continues to work to improve data quality across providers.
- 3.12 Serious Mental Illness (SMI) physical health checks, early intervention in psychosis, and community mental health access met year end (March 2025) trajectories. Despite improving trends in some areas, both Talking Therapies metrics (reliable recovery and reliable improvement), dementia diagnosis, perinatal access, children and young people access and eating disorder waits, and inappropriate out-of-area placements did not meet year end trajectories.

#### **4.0 Risks and mitigations**

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

## **5.0 Conclusion**

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

## **6.0 Attachments**

- 6.1 Attached is the standard set of PowerPoint slides covering the detail of each of the performance domains and is the main body of the performance report. An electronic copy is available to committee members and a hard copy of the slides will be available on request.

## **7.0 Author**

- 7.1 NEL ICB performance team. Each of the performance domains is reported by the subject expert.

# NEL ICB Performance Report

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## Overview of delivery against national performance standards and operational plan

- Acute Services
- Mental Health, Learning Disability and Autism
- Health Services in the Community

March-25 (UEC M1 April-25)

## Contents

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## Executive Summary

### Planned Care Recovery & Transformation:

The total NEL waiting list size in planned care increased marginally in Mar-25 following six consecutive months of improvement, Barts Health and Homerton above plan. The volume of reported long waits continues to fall overall (at risk from May). RTT performance in Mar-25 was 60.4% (all Trusts are asked to make a 5% improvement in 25/26, to deliver 65% nationally by Mar-26).

### Outpatient Transformation:

In Mar-25, the equivalent of 40% of all first outpatient attendances received specialist advice, 18% of which were returned with advice and no onward booking. 2.6% of all outpatient attendances were placed on a PIFU pathway (vs. 5% ask).

### Diagnostics:

NEL diagnostics waiting list and backlog position has been improving in recent months, albeit there are still long waits for diagnostics tests and distance from national targets in some modalities - MRI, NOUS, DEXA and Audiology remain the most challenged modalities. Significant work is ongoing at Barts Health in MRI, Audiology and DEXA, monitored via the Tier 1 process. DM01 performance in Mar-26 was 83.5% (vs. 95% ask).

### Cancer:

NEL cancer waiting time performance improvements were sustained in Mar-25, with the 24/25 asks for all three standards being met. NEL continues to perform very well both within the region and nationally.

### Urgent and Emergency Care:

NEL 4-hour ED performance in April-25 (latest published) was 76.4% (the ask for Mar-26 is 80%), Barts Health and Homerton behind trajectory.

### Health Services in the Community:

Community Services waiting list data is for Q4 2024/25. NEL is not meeting CHS operating targets for long waits due to recent changes in data collection requirements and ongoing data quality cleansing. The Community Services data group continues to work to improve data quality across providers.

### Primary Care:

Primary care delivery was positive against plan for the total number of appointments delivered, and the percentage of appointments seen within 2-weeks. The percentage of annual health checks in primary care for people with a learning disability was also positive to plan.

### Mental Health, Learning Disability and Autism (MHLDA)

SMI Physical Health Checks, Early Intervention in Psychosis, and Community Mental Health Access met year end (Mar-25) trajectories. Despite improving trends in other areas, the remaining indicators did not meet year end ambitions. Performance for mental health indicators are challenged across London.

## Summary Table by Indicator - NEL

The report covers the main Operating Plan metrics and other key performance requirements. This covers key indicators in Elective, Outpatient Transformation, Diagnostics, Cancer, Urgent Care, Health Services in the Community and Mental Health. The latest Nationally published data is for **Mar-25** and **Apr-25** (where available).

The table below highlights how North East London (NEL) currently performing and benchmarks for several of the key indicators (where available) at the time of reporting.

**RAG Rating: North East London is: Better (G) / the same (A) / Worse (R) (Comparison to Target, Performance in same period the previous year\* and regional benchmark\*\* )**

Core Metrics		RAG (Standardised Status of Programme)	Latest Published Date	Trajectory	Actual	Previous Year's Position	Achievement	6-Month Trend	Mar-25 Benchmark (London / National)
Planned Care	Total Waiting List (Volume)	A	Mar-25	215,676	215,929	219,699	✗		2nd lowest (positive position) PTL volume in London (NCL, NWL and SEL all have higher waiting lists). NEL is in quartile 3 (just behind the top performers)
	Waiting List >65 weeks	R	Mar-25	0	330	17	✗		2nd highest (negative position) >65ww wait volume in London (SEL has the highest volume at c.400 >65ww). NEL has the 6th highest >65ww when benchmarked nationally (out of 42 ICBs)
Diagnostics	% of Patients > 6 weeks for a diagnostic test	R	Mar-25	95.00%	83.54%	82.43%	✗		Ranked 2nd lowest (positive position) PTL volume and breaches in London behind SWL. Ranked 16th (out of 42 ICBs) nationally.
Cancer	28-day faster diagnosis standard (FDS) (%)	G	Mar-25	77.34%	80.50%	77.50%	✓		Ranked highest performing Cancer Alliance in London (positive position)
	62 Day Combined Performance (%)		Mar-25	72.63%	77.13%	72.11%	✓		Ranked 4th highest-performing Cancer Alliance and ranked 5th in the ICB league (out of 42 ICBs)
UEC	Urgent and Emergency Care – A&E 4hr Performance including UTC standalone sites	R	Apr-25	76.46%	76.35%	77%	✗		Ranked 3rd out of the 5 London ICBs behind NWL and SWL.
Health Services in the Community	(Appointments in General Practice)	A	Mar-25	1,023,882	1,041,103	981,686	✓		
	Urgent Community response referrals			2,148	2,640	2,120	✓		
	Community service waiting list Over 52 Weeks		Q4	631	2,692	890	✗		
	% of learning disability register and annual health checks delivered by GP			37.50%	86.37%	26.67%	✓		
Mental Health	Talking Therapies Reliable Improvement	A	Mar-25	66%	63%	66%	✗		Ranked 4th in London out of 5 ICS's
	Talking Therapies Reliable Recovery		Mar-25	47%	39%	48%	✗		Ranked poorest performing in London
	Community Mental Health Accesss		Mar-25	24,763	34,445	26,275	✓		Ranked 1st in London out of 5 iCS's
	Serious Mental Illness Physical Healthchecks		Q4	70%	76%	71%	✓		Ranked 2nd in London behind NWL out of 5 ICS's

# Planned Care Recovery & Transformation – March 2025

**SRO:** Archana Mathur / Jan Flint **RAG** **AMBER**

Metric	Latest Published March-2025				
	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Total Waiting List (volume)	✘	215,676	215,929	▲	
Waiting List >104 Weeks (volume)			2	▲	
Waiting List >78 Weeks (volume)			26	▼	
Waiting List >65 Weeks (volume)	✘	0	330	▼	
Inpatient Elective Activity (% 19/20 BAU)		156.73%	165.26%	▲	
Consultant Led Outpatient Attendances (% 19/20 BAU)		126.02%	127.75%	▲	
Percentage of first appointments or follow-up appointments which attract a procedure tariff	✔	46.57%	47.68%	▼	

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

**Governance**

- NEL Planned Care Recovery and Transformation Programme
- Bi-weekly assurance meetings held with NHSE region and Barts Health
- APC Governance - in the process of being revised
- Acute Commissioning Board
- Ongoing Trust and site theatre productivity and utilisation programmes, overseen via the NEL Surgical Optimisation Group

## Key Headlines

- The total waiting list increased marginally in Mar-25 to a total of 215,929 pathways (+71 pathways from the previous month) following 6 consecutive months of sustained reduction prior. In-month increase driven by BHRUT (+964 pathways, the first month of increase in the last 7-months, driven by the non-admitted PTL) and Homerton (+968 pathways, the 3<sup>rd</sup> consecutive month of increase, driven by the non-admitted PTL). The waiting list at Barts Health fell in month (-1,861 pathways) and for the 3<sup>rd</sup> consecutive month.
- Despite the small increase in month, the total NEL waiting is -2% lower compared to the position in Mar-24, this remains driven by BHRUT (non-admitted). The waiting list at both Barts Health (+2%, driven by non-admitted) and Homerton (+14%, driven by admitted and non-admitted) is higher than in Mar-24.
- There were 2 pathways waiting >104ww in Mar-25 at BHRUT, this is the same complex East Kent mutual aid ENT pathway reported in January, alongside a complex Gynae pathway. Both patients have been treated in April, as of mid-April there are 0 patients waiting >104ww across NEL.
- There were 26 pathways >78ww reported in Mar-25 (17 pathways at Barts Health and 9 pathways at BHRUT). This is a reduction of -2 pathways from the February position, driven by an improved position at BHRUT (-3 pathways), offset by an increase of +1 pathway at Barts Health.
- There were 330 pathways >65ww in NEL in Mar-25 (-47 pathways on the previous month), driven by reduction at BHRUT (-43 pathways) and at Barts Health (-4 pathways). The volume of long waits continues to fall overall (>78ww down by circa -88% in last 12-months, >65ww -81% and >52ww -53%).
- Consultant led activity in Mar-25 was 128% of 2019/20 levels (all outpatient appointments consultant and non-consultant led was 135%). The proportion of all outpatient attendances for clock-stopping activity (first appointments or follow-up appointments attracting a procedure tariff) was 47.7%, meeting the monthly ask at NEL level, Barts Health positive against plan.
- Total inpatient activity undertaken at the three NEL Trusts in Mar-25 was 165% of 2019/20 levels (165% day-case admissions and 166% ordinary admissions).

## Workstream Issues and Risks

- Sustainability of overall waiting list reduction
- The number of patients continuing to wait >65 weeks
- Change in approach to collaborative capacity in 25/26 via COO agreement for ad-hoc transfers if / when support is required, rather than transfer of established weekly volumes in set specialties (as has been the approach in 24/25).
- Overarching delivery against national priorities and trajectories remained unchanged for the April Operating Plan submission. Planned RTT performance in Mar-26 is 64.5% across the three NEL Trusts, below the 65% national ambition. Trusts also continue to show a reduced activity plan to align with finance. RTT performance at the Homerton has declined from the Nov-24 baseline position of 67.98% to 62.9% in Mar-25, which presents a significant challenge.
- The APC remains in the process of revising its governance for 25/26, with a view to structure work programmes on specific specialty challenges in ENT, Dermatology and Gynae.
- Impact of go live of the Luna waiting list management solution at Barts Health on the total waiting list and volume of long waits.
- Potential impact of Cerner implementation at BHRUT planned for Sep-25. Based on the latest weekly position BHRUT continues to have the highest RTT performance in London (behind Moorefields and Royal Marsden specialist Trusts).

## Mitigating Actions and Next Steps

- Barts Health have been moved into Tier 1 for elective recovery for Q1 2025/26 (following de-escalation to Tier 2 in Jan-25). Barts Health have also been placed in Tier 1 for Diagnostics in Q1 2025/26 (Barts Health were initially moved into Tier 2 for Diagnostics in Jan-25). The move to Tier 1 also acts as a re-set to focus on 18-week RTT delivery.
- Move to the Luna waiting list management solution at Barts Health for validated and weekly reporting delayed by one month for reporting of the May validated month-end position to reduce waiting list volatility and enable additional patient contact validation.
- NHSE planned care governance proposal shared with recognition of need for flexibility as new NHSE / ICB arrangements evolve. A regional director level NHSE and ICB group to explore future performance management and assurance at London level has also been established.
- Establishment of the Acute Commissioning Board to reflect Acute Commissioning as core business via an MDT approach.
- Barts Health and BHRUT continue to mitigate the >65ww position into Q1 (incl. impact of the planned go-live of the Luna waiting list solution at Barts Health).
- As part of Homerton's ongoing commitment to recovery and transformation, the Trust continues to maintain a strategic focus on maximising efficiency and improving patient outcomes through its Outpatient Transformation and Theatre Productivity programmes. Key areas of focus include optimising clinic and theatre utilisation, developing alternative service models and clinical pathways, strengthened waiting list management, and increasing admitted capacity.
- Continued close working between Trusts and the ICB to mitigate and manage risks associated with delivery of financial balance vs. delivery of elective priorities. Continued work to review opportunities to maximise / repatriate activity to be delivered through improved productivity.17
- Participation of all three NEL trusts in the national 25/26 Q1 validation sprint with national funding.
- NEL GIRFT system on 12<sup>th</sup> May, priority areas of focus include clinic templates (NEW capacity vs FUP capacity), PIFU and DNAs. Follow-up letter from national GIRFT team awaited.

# Outpatient Transformation – March 2025

**SRO:** Archna Mathur / Jan Flint **RAG** **AMBER**

Metric	Latest Published March-2025				
	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
A&G/Specialist Advice (volume)			37,613	▲	
A&G/Specialist Advice (% OPFA)			40.08%	▲	
Specialist Advice Diversion rate (%)			17.84%	▼	
Moved or Discharged to PIFU (volume)	⊗	9,202	6,215	▼	
Moved or Discharged to PIFU (% OPA)	⊗	3.93%	2.53%	▼	

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

- ### Governance
- Outpatient and Out-of-Hospital workstreams within all three NEL Trusts
  - The NEL Planned Care Recovery and Transformation Programme continues to lead the overarching transformation and programmes of work to support planned care performance and delivery against national priorities
  - Acute Commissioning Board
  - NEL Demand Management Delivery Group

- ### Key Headlines
- In Mar-25, 37,613 specialist advice requests were raised by NEL GPs, equating to 40% of all first outpatient attendances and 18% diversion rate (requests returned with advice and no onward booking). There is no trajectory for specialist advice in 24/25 or 25/26 however, this is above regional (25% of all first outpatient attendances; 18% diversion rate) and national (28% of all first outpatient attendances; 17% diversion rate) performance.
  - In Mar-25, 6,215 patients were moved or discharged to PIFU, equating to 2.6% of all outpatient attendances (Barts Health 1.3%; BHRUT 3.4%; Homerton 6.6%). While PIFU remains more challenged, NEL is not a regional outlier. This compares to circa 2.3% across London and 3.5% nationally. Provider PIFU trajectories are a requirement in 25/26 with the 'Reforming Elective Care Guidance' asking systems to work together to enable PIFU to hit 5% of all outpatient attendances (via more specialties offering PIFU) including through enhanced identification of suitable patients using AI and automation.

- ### Workstream Issues and Risks
- Sustainability of non-admitted waiting list reduction. The volume of patients awaiting outpatient appointments and treatment is lower than the Mar-24 position (-3% overall; -19% at BHRUT).
  - System functionality and interoperability to support and expedite key initiatives and interventions e.g. PIFU.
  - Resource implications and job planning to support and expedite key initiatives and interventions e.g. GIRFT and A&G/R.
  - Volume of referrals to Trusts outside of NEL e.g. SEL. SWL have also raised concerns re Bariatric referrals into St Georges from across all 'North' London sectors.
  - The 2025/26 Planning Guidance asks Trusts to improve the % of patients waiting no longer than 18-weeks for a first appointment with an expected 5% improvement (to a minimum of 67%). Homerton has submitted a non-compliant trajectory against the 5% improvement ask.
  - PIFU trajectories submitted within the NEL Operating Plan submission do not meet 5% utilisation (5% of all outpatient attendances), with the exception of Homerton - Barts Health has submitted a PIFU trajectory to 3.5% in Mar-26 (month on month increase); BHRUT forecasting 2.4% each month across 25/26.
  - Ongoing complexity, risks, and unintended consequences relating to the 'Provider Selection Regime' under choice regulations.

- ### Mitigating Actions and Next Steps
- Revised ICB governance via the newly formed ICB Acute Commissioning Board to reflect Acute Commissioning as core business via an MDT approach. This also includes the establishment of the 'NEL Demand Management Delivery Group' - first meeting held in May and ToR agreed.
  - Continued participation in national GIRFT and 'Further Faster' programmes – NEL GIRFT visit took place on 12<sup>th</sup> May, priority areas of focus are clinic templates (NEW capacity vs FUP capacity), PIFU and DNAs. Follow-up letter from national GIRFT team awaited.
  - External review of A&G/R impact and outcomes (quantitative and qualitative) incl. Primary and Secondary care has now concluded with next steps and strategic approach to be agreed. A task and finish group has been set up to include this work.
  - Approach for £20 payment to GPs for pre-referral specialist advice requests (as per enhanced GP specification) developed jointly with Primary Care and agreed with LMC. Q1 to be used to gain insight re potential system impact across a small number of outcome monitoring measures to be agreed. Development of BI dashboard underway to support this alongside reconciliation of payments.
  - Block payment approach to Acute Trusts for A&G in 25/26 agreed.
  - Further meeting with SEL re NEL referral volumes due to take place in mid-June, alongside colleagues from GSTT who have been working with their Urology service to develop a new RAS triage clinic to help manage demand.
  - Pan London work on Bariatrics underway following concerns raised by SWL re bariatric demand. KLOEs shared with NEL for response in advance of a London wide meeting for Bariatric Surgery providers and London ICBs to discuss the increase in demand across London, share best practice, to identify useful next steps and strategy for the management of demand and capacity across London.
  - Workstreams for MSK, Women's Health Hub (Gynae), ENT, Ophthalmology, and Dermatology remain in train.
  - Ongoing work with Communitas as the single NEL CHS Provider for ENT to streamline referral pathways to ensure referrals are directed to the most appropriate site based on clinical appropriateness and capacity (while in adherence with patient choice). ENT development underway across the Barts Group. ENT GIRFT meeting held with NHSE and Barts Health on 16<sup>th</sup> May. Follow-up meeting including Communitas to be arranged for end June.
  - Significant work to support DNA reduction at Barts Health with key driving specialties identified with ambition to reduce first appointment DNAs to from 11.7% to 9.7% and follow-up DNAs from 12.4% to 8.7%.
  - Ongoing implementation of patient facing digital platforms (Patient Knows Best and Dr Dr) via the NHS App in 25/26.

SRO: Archna Mathur RAG RED

**KEY**  
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 ▼/▲ deterioration ▼/▲ improvement

Metric	Latest Published March-2025									
	Waiting List Performance					Activity (% BAU 19/20)				
	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Magnetic Resonance Imaging (MRI)	✗	87.42%	74.34%	▲		✓	154.13%	179.87%	▲	
Computed Tomography (CT)	✓	84.53%	94.52%	▼		✓	168.14%	193.15%	▲	
Non-obstetric Ultrasound (NOUS)	✓	75.69%	92.30%	▼		✗	163.02%	145.89%	▲	
Dexa Scan	✗	77.53%	56.06%	▲		✓	197.28%	289.33%	▲	
Colonoscopy	✗	98.05%	94.92%	▼		✗	168.40%	147.69%	▲	
Flexi Sigmoidoscopy	✗	92.95%	86.44%	▼		✗	115.72%	95.67%	▲	
Gastroscopy	✗	96.86%	86.38%	▲		✗	168.45%	165.03%	▼	
Echocardiography	✗	96.73%	91.62%	▼		✓	165.14%	177.69%	▲	
Audiology	✗	93.42%	65.23%	▲		✓	142.01%	144.94%	▲	

**Key Headlines**

- **NEL DM01 Performance:** NEL achieved 83.54% DM01 performance in Mar-25 against the 95% Mar-25 ambition ( a marginal deterioration on the Feb-25 position of 84.51%).
- **NEL Provider DM01 Performance:** DM01 performance at Provider level in Mar-25 - Barts Health (78.62%), BHRUT (95.25%) and Homerton (87.61%) vs. 95% Operational Standard by Mar-25. BHRUT delivering against the Mar-25 ask since May-24.
- **NEL Waiting List:** The overall NEL Diagnostics waiting list decreased further in Mar-25 to 50,771 (-3,285 pathways) compared to the previous month's W/L size of 54,056 driven by decreases at all three NEL Providers.
- **NEL > 6 Weeks Backlog Position:** The no. of pathways waiting > 6weeks for a diagnostics examination saw a decrease in Mar-25 to 8,356 pathways (-16 pathways compared to Feb-25), driven by decreases at Barts Health and Homerton.
- **Performance vs. Op Plan Trajectory:** NEL delivered against the 24/25 Op Plan trajectories for Mar-25 at modality level in CT and NOUS. >95% DM01 performance (Mar-25 ambition) was achieved at Trust level in CT (BHRUTand Homerton) and NOUS (BHRUT and Homerton).
- **Activity vs. Op Plan Trajectory:** NEL delivered against 2024/25 Op Plan activity trajectories for Mar-25 in eight of the nine modalities with only Gastroscopy below plan.

**Mitigating Actions and Next Steps**

- **Tier-1 Escalation:** Barts Health moved into Tier-1 for Elective and Diagnostics for Quarter 1 of 25/26 and formal written confirmation from NHSE received on 6<sup>th</sup> May 2025. Bi-weekly meetings with Trust and ICB colleagues to ensure improvements in diagnostics pathways and monthly at the Programme Board. DM01 performance across the Barts Health Group has been improving in recent months albeit performance dipped marginally to 78.62% in March 2025 from the 80.10% attained in February 2025.
- **Mitigations and opportunities to address challenges at Barts Health include:** MRI performance has improved over the last two months with 66.5% of tests provided within six weeks. This has been achieved by making capacity available across the Group to all hospitals including Mile End and Barking CDC's. Improvements in MRI performance expected to continue as additional capacity will be available at Newham Hospital when the new R&D scanner is operational in May 2025, providing capacity for NHS patients as well as research patients. Barts Health to focus on these immediate priorities – (demand and capacity improvements in MRI; improving radiology reporting backlog and developing options to reduce reliance on outsourcing and insourcing capacity as well as workforce transformation in radiology). The endoscopy waiting time position is improving with work on the decontamination room completed and short-term staffing issues addressed. Paediatric audiology remains the most significant challenge and driver of the DM01 position. Investment in paediatric audiology has been agreed and a recruitment plan in now in place. However, a national shortage of paediatric audiologist means recovery against the waiting time standard is expected to take up to 12 months.
- **Diagnostics Transformation Projects:** Focus on key priority areas including GP Direct Access, Straight to Test, Community Diagnostic centres and UEC Diagnostics Utilisation are lined up for review in 2025/26.
- **Imaging Networks:** Focus on improving effectiveness and efficiency of NEL imaging services to meet demand and save money – UEC demand deep dives, refresh Trusts outsourcing contracts to drive cost efficiencies and training academies
- **Physiological Sciences Network:** Focus on further developing the PS Network and support the development of physiological Sciences diagnostic service models, including key focus on audiology, DEXA and other DM01 challenges
- **Endoscopy Network:** Continues to support the implementation of innovative endoscopy models and services. TNE/ Endo lite: continue the rollout of TNE & other endo lite diagnostics, across the NEL geography, focussing on the CDCs.
- **Pathology Network:** 2025/26 capital investment plan developed with ESEL & BHRUT to maximise use of available NHSE capital support
- **Community Diagnostic Centres (CDC):** The CDC's at St Georges Health Wellbeing Hub and the Barking Community Hospital CDC are open and fully operational and offers collaborative capacity across NEL.
- **Acute Commissioning Board:** Established to reflect Acute Commissioning as core business via an MDT approach across NEL.
- **NHSE Planned Care Governance Proposal:** shared and recognises the need for flexibility as new NHSE / ICB arrangements evolve. A regional executive level NHSE and ICB group to explore future performance management and assurance at London level has also been established.

**Workstream Issues and Risks**

- **Tier-1 Escalation:** Barts Health moved into Tier-1 for diagnostics on 15<sup>th</sup> May 2025 following receipt of formal written confirmation from NHSE.
- **Waiting List and Backlog Position:** The volume of patients on the overall NEL Diagnostics Waiting List and those waiting >6 Weeks and >13 Weeks (backlog) for a diagnostics examination is reducing but still poses specific concern and risk particularly at Barts Health. Improvements in performance noted this month albeit the challenges persist in these modalities – (MRI, NOUS, Audiology, Dexa and Endoscopy).
- **Scanner Downtime:** MRI Scanner downtime at Homerton is also impacting on Imaging performance with the acquisition and replacement scanner anticipated to last 12-18 weeks whilst system collaborative support (CDC and other NEL Acute Trusts) has been explored.
- **EPR Upgrade:** The EPR upgrade at BHRUT scheduled this year presents a significant risk which is discussed at the NEL system CRG meetings.
- **Triple Lock and Spending Controls:** Impact of the financial position and triple lock process on delivery of diagnostic capacity, waiting list initiatives and long waits and impact of ERF.
- **Underinvestment:** North East London has a severe underinvestment issue in its diagnostic services, with us trying to match the service levels of the rest of London with 3-500 fewer staff in imaging alone than if we matched our comparator ICSs.
- **2025/26 Operating Plan:** Two submissions to NHSE have been completed – (narrative submission 27/02 and a full submission 27/03) respectively. The operating plan trajectories have been set for diagnostics albeit delivery against 2025/26 Op Plan ask will be a challenge.

**Governance**

- **Strategic Meetings:** NEL diagnostics performance and risks to delivery is discussed at the monthly Diagnostics Programme Board and bi-weekly assurance meetings continue with NHSE region and Barts Health.
- **Diagnostics Escalation Management:** Escalations are managed by the NEL Imaging, Endoscopy and Echo Networks; these are well established with regular meetings held on a bi-weekly basis.
- **Performance Reviews:** The NEL Performance team holds regular discussions with Acute Providers to monitor diagnostics performance against constitutional standards. Discussions also held at the Acute Commissioning Board as the ICB moves to being a Strategic commissioner.

**SRO:** Femi Odewale **RAG** **GREEN**

Metric	Latest Published March-2025				
	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Cancer Faster Diagnosis Standard (%)	✓	77.34%	80.50%	▼	
62 Day Standard -(62 day treatment combined) (%)	✓	72.63%	77.13%	▲	

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## Workstream Challenges and Risks

- Faster Diagnosis Standard (FDS)**
- The PTL position has significantly improved, and compliance attained in Mar-25. A significant factor previously impacting the performance is the delays associated with non-site specific (NSS) and sarcoma at Barts Health.
  - The Sarcoma service is going through a transition to be hosted by St Bartholomew's for resilience and the proposed model going forward will be radiology-led, including interim support and face-to-face clinics.
- 62-Day Combined Performance**
- Diagnostic Delays:** Barts Health is addressing diagnostic delays in the Urology, Gynaecology, and Colorectal with concerns about endoscopy capacity, increased requests for GA hysteroscopies, collaboration with radiology to reduce backlog, and the need for improvement in bowel prep conversion causing patient delays. Delays in histopathology and imaging (CT PET scans and MRI reporting) are affecting treatment timelines across all hospital sites for lung, gynaecology, head and neck, and gastroenterology tumour sites, impacting the Faster Diagnosis Standard (FDS)
  - Increased Referrals:** Notable rise in referrals for Skin and Head + Neck Pathways, leading to increased demand.
- Spending Controls and Model ICB**
- The spending controls has limited the implementation of key pathway improvements funded by the Cancer Alliance. Impact of proposed changes to the Model ICB is also a key risk going forward.

## Governance

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

## Key Headlines

The overall NEL CWT Performance was sustained this month with all three NEL Trusts delivering against the three CWT (28 Day FDS, 31 Day Combined and 62 Day Combined) Trajectories.

- Faster Diagnosis Standard:** NEL's Faster Diagnosis Standard (FDS) performance in Mar 2025 was 80.50%, delivering the 28-day diagnostic target and the monthly aggregated trajectory. All three NEL Trusts also achieved their Op-Plan Trajectories this month. Nationally, a 77% FDS Target must be achieved by March 2025. NEL FDS performance has improved in the last five months and was the highest performing Cancer Alliance in London against this standard in March 2025.
- 31-day cancer treatment against 96% standard (new combined metric from October 2023):** In March 2025, NEL ICB recorded a performance of 98.02%, an improvement on the previous month and all three NEL Trusts met or surpassed the 96% benchmark during this period. We were also the best performing Cancer Alliance and ICB for this measure nationally in March 2025.
- 62-Day Combined Standard:** NEL recorded a performance of 77.13% against the 62-day combined standard in March 2025, above the monthly trajectory and the 70% NHSE 2024/25 Operational Plan requirement. All three NEL Trusts also delivered against Op- Plan Trajectories as well as delivering performance surpassing the 70% target. We were ranked 4th highest-performing Cancer Alliance and ranked 5th in the Integrated Care Board (ICB) league.

## Mitigating Actions and Next Steps

- Faster Diagnosis Standard (FDS)**
- Oversight:** Weekly oversight meetings with NELCA and ICB are ongoing, with recovery plans on track.
  - Rapid Diagnostics Clinic Backlog:** The RDC backlog has now been cleared and expected to deliver the FDS Standard going forward.
  - Sarcoma Backlog:** A mitigation recovery plan was developed which has cleared the overarching backlog, bi-weekly meetings ongoing and is overseen by NEL Cancer Alliance and the NHSE regional team.
- 62-Day Combined Performance**
- Diagnostic Delays:** Trusts are working to resolve diagnostic delays in Urology, Gynaecology, and Colorectal departments due to endoscopy capacity, increased GA hysteroscopy requests, and bowel prep issues. Delays in histopathology and imaging (CT PET scans and MRI) for various tumour sites are affecting treatment timelines and the Faster Diagnosis Standard (FDS). Mitigation plans include Improvement groups at BHRUT are focusing on Gynae patients over 104 days, while Trusts are reviewing processes in Urology, Gynaecology, and Lower GI.
  - Increased Referrals:** Barts Health has successfully continued to reduce its backlog by implementing additional clinics to effectively manage the impact of increased referrals. BHRUT is actively monitoring skin referrals, noting a positive downward trend, supported using the tele-derm service. Meanwhile, Homerton University Hospital (HUH) is managing its patient tracking list (PTL) with the help of enhanced documentation during the first outpatient appointments.
  - Drive to 4% Sustainable Backlog:** Work ongoing with NEL Providers to drive down the >62 Day PTL backlog to a sustainable level.
- 2025/26 Operating Plan**
- For Cancer, the 2025/26 ask is to deliver performance improvements against the headline 28-day Cancer Faster Diagnosis Standard to 80%, 62-day combined cancer standard to 75% by March 2026 and maintain 31-day combined standard at 96%.
  - NEL Providers (Barts Health, BHRUT and Homerton) have all submitted compliant trajectories in the final submission – 27/03/25.

# Urgent and Emergency Care – April 2025

SRO: Paul Gilluley

RAG **RED**

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

Metric	Latest Published April-2025				
	Achievement	Trajectory	Actual	Change from prev. Month	6 Month Trend
Total A&E Attendances inc UTC stand alone sites (volume)	✗	91,147	91,891	▼	
A&E 4-Hour Performance All Type inc UTC stand alone sites (%)	✗	76.46%	76.35%	▼	
A&E 4-Hour Performance Type 1 (%)	✗	60.76%	60.55%	▼	
A&E 4-Hour Performance Type 3 inc UTC stand alone (%)			95.19%	▼	
12-hour Trolley waits - from Arrival (Percentage)	✗	National Req. ZERO	13.72%	▲	
Percentage of general and acute (G&A) overnight beds that are occupied	✓	92.83%	90.04%	▼	
Percentage of adult G&A beds occupied by patients not meeting the criteria to reside			13.46%	▲	
Percentage of occupied G&A beds occupied by patients with a length of stay (LoS) of 21 days and over			20.69%	▼	
Average Category 2 Ambulance Response Time (April-25)	✗	00:29:12	00:30:09	▼	
Hospital discharges for pathways 0-3 per month (Total)			8,489	▼	
Virtual ward occupancy	✓	80.00%	87.11%	▲	

## Key Headlines

**4 Hour Performance:** In April-25 76.35% of patients were seen within 4 hours of arrival to ED. This is slightly reduced on the March-25 position; and it is 0.21% below trajectory for the month at NEL level. BHRUT met its trajectory for March 2025, whilst Homerton and Barts did not achieve their respective trajectory for April-25. BHRUT achieved 78.49% performance against 78% trajectory (0.49%); Homerton achieved 82% performance against 84.61% trajectory (-0.61%); Barts Health delivered 70.28% performance against 71.00% trajectory (-0.98%) . All three providers have seen a decrease in attendances compared to the previous month. This trend was also observed against plan for BHRUT and Homerton. However, Barts recorded 2% more ED attendances than its planned trajectory.

**12 Hour Trolley Waits:** The operating plan trajectories for this metric only include Type 1 attendances, as per the operating plan guidance. However, the published data for over 12-hour waits encompass both Type 1 and Type 2 attendances. As a result, the trajectory for these waits cannot be included in the report as this will not be a like for like comparison. In April-25, 13.72% of our patients waited more than 12 hours from arrival (equating to 7,090 patients) compared to 13.39% in March-25 and 7,125 patients

**G&A Bed Occupancy:** In April-25, across NEL, G&A bed occupancy was reported as 90.04%. Homerton reported 90.73%, BHRUT reported 89.85% occupancy whilst Barts was at 90.05%.

**Adult G&A Bed Occupancy by Patients with NCTR:** Please note that this metric is not included in the 2025/2026 operating plan, which is why the trajectory for it is absent in the report. However, this metric remains in this report for continuity purposes. The percentage of adult G&A beds occupied with patients who no longer meet criteria to reside deteriorated compared to the previous month (13.46% in April-25 compared to 11.49% in March-25). An average of 334 patients were remaining in hospital with NCTR by the end of April.

**Length of Stay Over 21 Days:** Please note that this metric is not included in the 2025/2026 operating plan, which is why the trajectory for it is absent in the report. However, this metric remains in this report for continuity purposes. The percentage of total G&A beds occupied by patients with a length of stay over 21 days saw a slight decrease compared to previous month (20.69% in April-25 compared to 20.87% in March-25). This percentage is based on the average number of long staying patients who occupy adult General & Acute beds. Long staying patients saw a decrease from 566 in March-25 and 586 in April-24 to 550 in April-25

**Category 2 Response:** In latest available data, LAS reported category 2 response time for NEL in April-25 as average of 30 minutes and 9 seconds. This was an improvement from 32 minutes and 12 seconds in March-25. London-wide plan is 29 minutes 12 seconds for April-25.

**Hospital Discharge:** Places and providers across the system continue to prioritise patient discharges. In April-25, a total of 8,489 patients were discharged — an increase of 18.4% compared to the same period last year (7,171 discharges in April-24).

**Virtual Wards:** As of April 25, NEL reports a bed capacity of 365 with an occupancy rate of 87.11%, above the 80% The target has been consistently sustained over the past six months. An external evaluation—focused on cost efficiency and system flow through virtual ward beds—has now been completed. The report is currently under review against the Key Lines of Enquiry (KLOEs). The trajectory remains aligned with the 2024/25 plan, with additional pathways beyond NEL-funded routes being explored to maximise capacity and occupancy.

NB: From Q4 24/25 onwards, NEL system level reporting has been amended in accordance with national reporting methodology to include NELFT Orsett MIU Type 3 activity

## UEC Programme Issues and Risks

- UEC Transformation is a complex portfolio and requires optimised transformation support and continued partnership working across all ICS partners including health, place and social care.
- The NEL UEC Portfolio Risk Register focuses on system-level UEC transformation risks and issues.
- A system-wide UEC Workshop was held on 30<sup>th</sup> April and priorities, governance and approach to NEL UEC Transformation was discussed and agreed for 2025/26. Once signed off at the UEC Board, current UEC risk log will be reviewed and updated accordingly and submitted to UEC Board.

## Mitigating Actions and Next Steps

- **Integrated Care Transformation Pillar (further Virtual Wards Update):** An internal review by Place and Provider Leads has been completed to support capacity growth toward the 735-bed target by Q4 2026. Proposals for additional beds—outside of the ICB-funded virtual ward allocation—are currently awaiting approval from the UEC Board. NEL continues to aim for sustained delivery of last year’s bed target while maintaining occupancy above 80%. Although there have been delays, the evaluation report now published will inform ongoing performance improvements. The Terms of Reference have been reviewed to maximise the role of Clinical Task & Finish Groups in expanding pathways and refining operational criteria.
- **SPoA:** Single Point of Access Roadmap signed off by NEL UEC Board and NEL EMT which enables the progress from Discovery Phase to Clinically-Led Tests for Change. The NEL SPoA Strategy Group meeting was held on 23<sup>rd</sup> May and It was agreed that clinical reference group will recommend the NEL approach for the test for change pilot for Frailty. The implementation group will be supported by task and finish groups including data and finance, and commissioning and service review work. The priority is to achieve a sustainable medium-term system-wide solution, as per the Roadmap. There is a need to ensure that this piece of work is connected to work ongoing on 111 procurement and Same Day Access models in primary care, as well as exploring with national colleagues what models exist elsewhere and what lessons can be learnt, especially in relation to data analysis and KPIs. This is also aligned to Fuller and Darzi (shift care closer to community).
- **Hospital Flow:** Acute providers are focusing on internal processes to improve pre 1 discharges, weekend discharges, management of patients with length of stay of up to 7 days and reduction in delays on Pathway 0. Place are coordinating IDH reviews to ensure flow optimisation on pathways 1, 2 and 3 and standardisation across NEL. We have seen an 18.4% increase in the number of discharges in April-25 compared to the same month last year. Sustained reduction in delays caused by equipment provision and for patient with homelessness status. Optimal Handed Care pilot demonstrates success in effective patient management and care resulting in reduced requirement for reablement. Continued support to Barts Health relating to UTC services improvement work including sharing of best practice across the system. We are in the process of agreeing the system priorities for 2025/26 in line with national and regional priorities as well as NEL specific areas of improvement (eg: Admission Prioritisation Criteria). System OPEL framework now incorporates OPEL framework for Community and Mental Health. Corresponding action cards have been developed with delays being managed in hours in order to retain focus and improvements to date.
- **Mental Health:** ICAH crisis hub showing early indications of providing alternative to emergency departments, including transfer of patients to more suitable assessment facilities from EDs. Collaborative work remains ongoing between Acute and MH providers in ED to improve quality and safety of care for MH. Special observation (Enhanced Care Team) pilot in NUH continues to thrive and gives us insights that are helping think about how this model can support other EDs across NEL. Projects remain ongoing for LAS/Crisis Line and Crisis assessment team, including regular forums with HBPOS, Police to support. Crisis beds, step-down beds are all now running to support with patient flow.

## Governance

- NEL UEC Board reports into the NEL ICB Executive Committee
- Hospital Discharges and Virtual Wards improvement work form part of wider UEC Transformation work (currently being redesigned) that reports into NEL UEC Board. NEL UEC Board reports into the NEL ICB Executive Committee
- Mental Health pathway work sits under the governance of the NEL MHLDA Collaborative with a link into the UEC programme.

# Health Services in the Community – Quarterly: Q4; Monthly: March 2025

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

SRO:  RAG AMBER

	Metric	Latest Published					
		Achievement	Trajectory	Actual	Change from prev. period	6 Month Trend /Quarterly Trend	
Health Services in the Community	Monthly reported	Appointments in General Practice - Mar-25	✓	1,023,882	1,041,103	▲	
		Percentage of appointments seen within two weeks - Mar-25	✓	63.00%	91.34%	▲	
		Urgent Community Response (UCR) referrals; Count of all UCR referrals planned in the period - Mar-25	✓	2,148	2,640	▲	
	Quarterly reported	Percentage of learning disability registers and annual health checks delivered by GPs - Q4 24/25	✓	37.50%	86.37%	▲	
		Community services waiting list-Number of patients waiting over 52 weeks at a point in time aggregated for a) in scope CYP and b) in scope Adult services - Q4 24/25	✗	631	2,692	▼	
		Number of CYP (0-17 years) on community waiting lists over 52 weeks - Q4 24/25	✗	631	1,987	▲	
		Number of Adults (18+ years) on community waiting lists over 52 weeks - Q4 24/25	✗	0	705	▼	

## Key Headlines

### Primary Care (March-25)

- In March we exceeded the trajectory for number of appointments by 17,221 (1,041,103 against a target of 1,023,882). 91.34% of these were within 2 weeks compared to a trajectory of 63.00%.
- Face to face appointments are the most frequently used mode of contact.
- The Primary Care Recovery Plan Programme has now concluded, but there will be continued work to implement and embed the 'Modern General Practice' access model. All 60 practices that were on analogue systems transferred to digital cloud telephone systems and all practices that were on non-compliant digital telephony systems have moved over to systems with greater functionality including 'call back' functions. This will help to support demand management, including the 8am rush for appointments and provide appropriate patient triage. In 25/26, training will be provided to help practices make best use of the capabilities of cloud-based telephony systems.
- Capacity and Access Improvement payments will help practices to improve patient experience of contacting the practice, manage demand and capacity and ensure accurate recording in appointment books. This will help to ensure that all appointments are captured in the data. Payments were made to all PCNs for performance against their plans in 23/24 and payments were made to PCNs for 24/25 following declarations of compliance in three areas by end April 25. The majority of PCNs have declared compliance against all three areas by end March with 37/48 declaring compliance in use of online consultation during core hours.. The three areas are: use of cloud-based telephony, use of online consultation, and care navigation.
- Practices also implemented plans to move to 'modern general practice' using transitional funding enabling them to provide a smooth, equitable experience of access to patients across phone, online and walk-in routes. Initial payments were made to practices at the end of last year and practices worked to deliver their plans to get further payments in 24/25. All practices received payments by end March 25.
- Plans to implement integrated same day access, under the Fuller Programme are in place.

### 2-hour UCR/ Community Rapid Response (March-25)

- NEL will be at 90%, exceeding the national UCR 2hr target by at least 20% fourth month in row (national target 70%). NEL is consistently in the top 10 nationally top threshold in London outperforming its operating target volume.
- Total number of 2-hour standard UCR referrals in March 2025 was 1490 (provisional data). Count of all referrals 2640 (provisional data).
- London continues to have low ambulance, and 111 referral rates compared to most other regions and the England average.
- National UCR trajectory, based on an age-sex standardised rate is set at 157 referrals (all referrals) per 100,000 population. January data also shows that NEL is set to exceed the 157 national trajectory at 289 for this period. This will be increased to threshold of 170-180 in the new financial year, national have not yet announced the rate agreed

### Learning Disability (Q4)

- NEL has exceeded the LD AHC target of 75%, achieving 86.37%

### Community Waiting List Headlines

- **Community Data:** Data quality remains a challenge for all London ICBs monitoring CHS services. While NEL has consistently complied with national monitoring requirements and maintained strong NHSE relationships, the current SitRep submission process, requiring provider-level reporting, raises concerns about accuracy. NEL is actively supporting NHSE's push to move to Faster Direct Data flows quickly. NELFT is participating in national pilot tests. All providers in NEL are registered and this work is being closely monitored in terms of test progress by the data team.
- **Data Quality Initiative:** This is starting to yield some results as we now have more specific NEL information coming through and we have moved to being within a month of the latest data sets and known narrative. This is also playing into an improved relationship and culture with data in NEL.
- **National data Portal Limitations:** The data portal does not support geographical splits, so figures must be explained in narrative sections. The NEL data team is working with providers to add detailed reports and improve the internal data reports at provider / PLACE splits. We are a month or two away from a NEL picture of the data.
- **Performance:** NEL is not meeting CHS operating targets for long waits due to recent changes in data collection requirements and ongoing data quality cleansing. But we are now making headway on getting a clearer picture on what data is there and getting adults waits down. We are reporting at Provider level not NEL specific due to national reporting rules.
- **Data Timings and narrative reporting on our long waits:** NEL data leads are working to get more current narrative against provisional data in performance reports, but this will take time to get right. NEL has developed a dashboard to make it easier for providers to see the totality of their published data sets quickly. This is now making it easier to see and report on previous month data and get a more live and informed narrative returns as well as support local improvement discussions
- **ELFT & Barts Reporting Impacts:** Since June 2024, ELFT has jointly submitted Bedfordshire and East London CHS wait times in the national SitRep. Barts reports ongoing challenges with tracking responsible parties and implementing quality checks, the team is actively addressing these issues. Barts adult services, patients waiting over 52 weeks for spirometry not covered by the CHS contract. NHSE has confirmed ELFT should present a full waiting times view for NEL and BLMK ICS separately post submissions of SitRep and we are working towards this..
- **Impact of Changes:** New submission guidelines have led to an increase in recorded patients waiting over 52 weeks. ELFT will include NEL figures in local reports and is aiming to reflect accurate data in monthly returns pending NHSE agreement on ASD. ELFT & Barts are both working hard to improve data quality and are being supported by ICB

## Workstream Issues and Risks

### Primary Care (March-25)

- The general practice appointments (GPAD) data had significant data quality issues, with a proportion of activity 'unmapped' or 'inconsistently mapped' for instance 14% of appointments in NEL were uncategorised at the start of the year.
- The data set available shows a limited view of appointment information and does not show appointment status e.g. attended or DNA (non-attended appointments).
- Access and patient satisfaction: despite appointment numbers increasing, the 2024 GP Patient survey shows significant variation of experience when making an appointment within NEL.
- Collective Action been stood down following the introduction of the new GP Contract.

### 2-hour UCR/ Community Rapid Response (Q4)

- **Checks on Productivity at PLACE level:** While we are meeting the 2-hour target volumes, there is an opportunity to enhance productivity at the place level and across the system, particularly in our inner London boroughs. NEL data team has given a report to each PLACE on their rate per population to review.
- **Deep Dive UCR Review to support contracts and compliance:** NEL has started a deep dive check on UCR variation again (last check was in 2022). An Urgent Community Response (UCR) service is a team of health and social care professionals who provide urgent care for people in their homes. The goal of UCR services is to help people avoid hospital admissions and remain independent for longer. This is supposed to be 8am-8pm. Urgent Community Response (UCR) services provide crisis care for nine clinical conditions: falls, decompensation of frailty, reduced function or mobility, palliative or end-of-life crises, urgent equipment needs, confusion or delirium, urgent catheter care, urgent diabetes support, and unpaid carer breakdown.
- **Productivity gains with LAS via improvement networks:** There continues to be a lack of referrals into UCR from LAS (MiDoS data) across London. NHSE want all ICBs to improve this. NEL continues to use improvement networks to explore opportunities and has started with Care Homes and Catheter Care. There is an emerging need for providers ; LAS, Acute Community and UCR teams to all plan and work together. .
- **Urgent Community Response Referrals coding:** Referral reasons information has been identified as an area for key data improvement. Currently 79% of referral reasons are not being coded. This is an improvement from last months by 10% and this is because of ongoing quality change support to providers resulting in improved data sets. This needs to continue to improve. Data teams have been notified across providers of this issue and asked to improve it. .

### Learning Disability (Q4)

- System target has been achieved for the fifth year running, current oversight will be continued to ensure this remains consistent.
- Areas for improvement continue to be explored including improving the quality of health checks and medication reviews. NEL has been selected to run a pilot project to deliver a Combined Annual Health Check for people with a learning disability, people with SMI, and autistic people.

### Community Waiting List (end of Q4 data emerging)

- **Demographic Context:** NEL has a significantly high CYP population, with over 25% of residents under 18, reaching 32% in some boroughs. The area faces substantial levels of deprivation and need..
- **Over SitRep Submission:** Despite guidance from national and regional teams, confusion remains about SitRep submission requirements, as data is still reported at the provider level without regional breakdowns. NEL is working with the London regional team to clarify and enhance submission quality.
- **Data Quality Initiative:** The Community Collaborative has launched a data workstream to improve data accuracy across major providers, establishing a standard dataset and a reporting framework for consistent insights. The aim is to build a data-driven culture and facilitate service improvement through shared monthly reports. This group continues to help us monitor and manage the data better and manage risks. NHSE welcomes this approach. Data Quality Initiative: To improve data quality, a Community Collaborative data workstream was established and has become a permanent but requires more links across to contracts and needs a Chair. Meetings are monthly and focus on the NEL CHS data quality and reporting. The workstream has implemented a data reporting and monitoring cycle and framework benefiting both the ICS and its providers. The long-term goal is to enhance data governance and promote data-drive planning. There is also some work to do on reducing duplicate data conversations.
- **Improvement Networks for Adult and Children's Services:** : NEL has launched "Adult Productivity" networks focused on dietetics, adult SALT, and podiatry, while children's networks will address ASD assessments and SALT transformation. These initiatives support the SEND investment to improve access and reduce wait times. NEL has recently conducted deep dive review.
- **Investment and Improvement Schemes:** NEL ICB approved £3million investment to enhance early intervention and preventive support for children, families, early years settings, and schools. This includes rollout of online training and support resources. Improvement schemes are being implemented across Special Educational Needs and Disabilities (SEND), community paediatrics, and children's therapies, focusing on productivity gains. The investment is targeted at early intervention, responding to high local demand and deprivation and well be closely tracked for outputs and outcomes for residents.
- **Impact and Timeline:** Due to ongoing recruitment and mobilisation efforts, and increasing demand, a noticeable impact on wait times is not expected until Q4 of the current financial year, and more likely Q1 of 2026/27. The investment and service changes aim to have a gradual impact as staff are recruited, and services are mobilised.

## Mitigating Actions and Next Steps

### Primary Care (March-25)

- Improvements in coding were incentivised through the Capacity and Access Improvement Plan.
- The NEL Data Quality Accreditation scheme was rolled out across all practices which will improve coding.
- Using digital technology such as Edenbridge APEX which has been rolled out across NEL to get the most accurate appointments and clinical data directly from practice clinical systems. Completed episode data will be included into the forward plan.
- Each PCN worked to deliver Capacity and Access Improvement Plans to work towards improving patient experience of contacting the practice, manage demand and capacity and ensure accurate recording in appointment books.
- The GP Access Recovery Plan committed to using digital telephony by March 2024 to enable improved queuing systems and call management. All practices that were on analogue systems are now on digital systems and practices already on digital systems that are non-compliant with the national requirements will be on compliant systems by end 24/25.
- Opening Hours' exercise had been undertaken to support practices to open to patients during core hours to fulfil their contractual responsibilities and all practices are now open during this time.
- Actions were put in place to assess the impact and put mitigations in place in relation to GPs taking collective action. Collective Action has now been stood down.

### 2-hour UCR/ Community Rapid Response (Q4)

- **Improvement approach and collaboration:** Community Improvement Network for Rapid Response is focused on optimising and improving service core offer and is working towards a set of recommendations being landed to PLACEs in May/June. This also includes cost modelling for invest to save into community services in NEL.
- **Increasing referrals during winter:** NEL launched Catheter Improvement & Care Homes / Dom Care Networks to support with maximising referrals routes into UCR and improving productivity even more is also helping to drive up productivity. This work continues to look for quick wins as well as long term options for Standard UCR service.
- NEL continues to work to improve visibility of UCR service options in the Directory of Services and is working to host a meeting with place leads on ways to improve this. National have now standardised UCR as a service – NEL needs to ensure it is fully adhering to the full standards to reduce variation but also it is responding to the optimisation ask of the service according to national standard as a “reactive care” set of service supporting interface between acute and primary care. The recommendations will help PLACE leads look for opportunities to do this but also hopefully enhance the service offer.
- **Data Improvement and joined up working:** Reporting of UCR pathways into wider system UEC programme continues to be developed to enable us to monitor productivity at Place and Provider levels better and more regularly. SHREWD tool interface continues
- **111 transformation continues to look at ways to optimise opportunities:** UCR services review will support wider 111 procurement work to improve referrals into UCR via an improved 111 offer and Single Point of Access.
- **Training & Education:** Improvement Networks have worked up an outline of a standard training offer which includes two tiers – 1) an integrated OOH induction 2) Advance learning for Clinical Staff and leaders. This will be a yearly course to focus better relationships and joined up working. Work started would mean enhancements to training and learning regimes already in place including i.e. UCP and Optimum tools to enhance proactive care and case finding in UCR service etc.

### Learning Disability (Q4)

- Place leads to work with primary care leads in Q4 to maximise take up of remaining AHCs.
- To review impact of quality improvement projects

### Community Waiting List (end of Q4 emerging)

- **Improvement Networks /Data Quality and Provider Collaboration:** NEL is working closely with providers through a data group to enhance local accountability, governance to help reduce wait times. Sessions in this group initially focused on data accuracy, cycle standardisation, assurance, better service management including best practices from Homerton and NELFT, to build a culture of transparency and joint ownership across PLACE and ICS levels to improve positions.
- **System-Wide Interventions:** NEL has launched various initiatives to address wait times, including MSK pathways. This comprehensive approach spans primary, planned, and community care to reduce pressures, though significant impacts on wait times are expected by 2025/26. For 2024/25, mutual aid options also being explored
- **New Networks for Adult and Children's Services:** : NEL is launching "Adult Productivity" networks focused on dietetics, while children's networks will address ASD assessments and SALT transformation. These initiatives support the SEND investment to improve access and reduce wait times
- **Governance and Monitoring:** NEL continuously track targets for Community Health and Babies, Children, and Young People's Programs within ICB governance, reporting wait times to the Finance and Performance Subcommittee. The aim is to continue to improve this
- **BCYP** - For children, there are also Improvement Networks coming online in relation to our neurodevelopmental pathways looking at the clinical pathway for children awaiting an assessment for ASD, and a network looking at children's SALT transformation which will complement the SEND investment referred to above and equally support waiting list and access challenges. This also includes a review into tech tools that could be used and optimised to reduce long waits.
- **Monitoring Data & owning shared accountability** - We will continue to jointly monitor and review targets and trajectories within existing governance across both the Community Health Services and Babies Children and Young Peoples' Programmes. Within the ICB, waiting times and performance is also reporting to the Finance and Performance Sub Committee – currently this is a formal subcommittee of the Board. The CYP programme is also looking at a required data set that all stakeholder services must know and review regularly. This is to ensure long term ownership of the data across the system is shared fully across key delivery partners. .

### Primary Care (March-25)

- Operating plan monitoring. Monthly data provided from national GPAD reporting.
- Primary Care Delivery Plan, Primary Care Collaborative, GP Provider Group.
- Collaboration with Pharmacy Provider Group and close working with urgent care colleagues
- Regular reports on Access Recovery plan to Primary Care Delivery Group as part of the primary care transformation portfolio.
- Performance Report including information on access presented to NEL Primary Care Contracts Sub Committee.
- Update on Access Recovery Plan was taken to the ICB Board in November.

### 2-hour UCR/ Community Rapid Response (Q4)

- Community Collaborative Delivery Board and escalation to CHS collab sub committee
- ICB Finance and Performance Committee
- UEC Programme Board
- Ambulance & Flow Transformation Group (under discussion).
- Individual provider governance

### Learning Disability (Q4)

- Strategic oversight for Annual Health Checks is provided by the Learning Disabilities and Autism Transformation Board at NEL level, in collaboration with the Mental Health, Learning Disabilities, and Autism (MHLDA) Strategic Board.
- Quarterly performance reviews are conducted during NHS England assurance meetings, ensuring alignment with overarching goals and standards.

### Community Waiting List (Q4)

- Operating Plan
- Community Collaborative Delivery Board and escalation to CHS Collab sub-committee
- ICB Finance and Performance Committee
- Individual provider governance
- CYP Programme Board

SRO: Lorraine Sunduza, Paul Gilluley RAG AMBER

Metric	Latest Published					
	National Annual Target	Trajectory	Actual	Mar-25	Change from prev. Month	6 Month Trend
Talking Therapies Reliable Improvement (Rate)	67%	65.99%	62.50%	✘	▼	
Talking Therapies Reliable Recovery (Rate)	48%	47.19%	39.43%	✘	▼	
Dementia Diagnosis (Rate)	67%	66.70%	61.58%	✘	▲	
Serious Mental Illness Physical Health Checks (Performance) (Q4 2023-24)	60%	70.00%	76.11%	✔	▲	
Perinatal Access (Rate)	10%	9.68%	8.11%	✘	▼	
Children and Young Peoples Access (Volume)	32,415	27,491	26,410	✘	▼	
Early Intervention in Psychosis (EIP) (Performance)	60%	60.00%	80.00%	✔	▼	
Children and Young Peoples Eating Disorders Urgent Referral (Performance)	95%	95.00%	64.00%	✘	▼	
Children and Young Peoples Eating Disorders Routine Referral (Performance)	95%	95.00%	77.00%	✘	▼	
Community Mental Health Access (Volume)	13,793	24,763	34,445	✔	▲	
Inappropriate Out of Area Placements (Volume)	0	0	47	✘	▼	

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

**Governance**

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

**Key Headlines**

**Talking Therapies** did not meet the year end trajectories for either reliable improvement or reliable recovery. Only three places met the trajectories for reliable improvement, and none for reliable recovery. Feedback from the talking therapies improvement network is that there have been issues with some boroughs moving to IAPTUS as well as staffing issues. There remains an underlying inequality of access between the 7 places, which is being investigated through the expanded performance framework reporting. Our South Asian population also has significantly lower rates of access and approaches to address are being developed in the Talking Therapies Improvement Network. NEL ICB is in the middle for Talking Therapies metrics across London (latest benchmark Feb 25). Waiting times between first and second appointments continue to be a challenge due to a significantly high volume of referrals. Self-referrals continue to be exceptionally high for NEL Talking Therapies (between 80-85%).

**Dementia Diagnosis** performance is improving, however NEL ICB ended the year below the national target and has the lowest rate in London. **Perinatal access** ended the year below the trajectory and national target, although has been showing an upward trend in recent months. Work is ongoing with the Perinatal Improvement network to understand and mitigate this, as well as understand the ongoing data quality issues. NEL's access rate is in the middle of the London ICBs.

**Children and Young People's access** sees a downward trend recent months whilst ending the year below our Long-Term Plan target. As of February 2025 NEL have the highest level of access in London. There is an ongoing deep dive into data reporting to ensure accuracy and data quality.

**Children's and Young People's Eating Disorder wait times:** both urgent and routine referrals ended the year below the 95% target. Work is ongoing to understand the drivers behind this with the CYP programme, however due to small number of service users, only a few young people missing the target can have a large impact. There is also a risk that some service users being placed out of area are having an impact on the reported performance.

**Community Serious Mental Illness Access** is above our national target and is the highest in London. BME groups have relatively high levels of access.

**SMI Physical Health Checks** achieved the 70% year end target in Q4.

**Inappropriate Out of Area placements** has had data quality issues identified in the national published reporting, this is being reflected with locally reported data. Local data shows the ICB with 47 Inappropriate Out of Area Placements at March 2025. Whilst numbers have decreased significantly, work continues to decrease the volumes of patients being placed out of area.

**Emergency Department Waits** around 64% mental patients are waiting more than 6 hours in ED and around 39% more than 12 hours as of March 2025.

**Average Lengths of Stay** for adults inpatients show a decrease to 48 days at the end of March 2025 for discharged hospital spells and 22days for closed ward stays. Work is ongoing to understand how the ELFT data quality issues are affecting these figures.

**Workstream Issues and Risks**

- Reducing Out of Area Placements will require investment. Whilst this should reduce our overall cost there a risk that a) the investment is not sufficient given our financial constraints b) out of area placements remain above zero.
- All targets are at risk as a result of our financial constraints.

**Mitigating Actions and Next Steps**

**The Dementia Improvement Network** has developed Place- based improvement plans to improve diagnosis, which include: improving scanning use, data consistency, Mild Cognitive Impairment recall, and assessment efficiencies. Our Asian diaspora has a significantly lower rate of diagnosis in proportion to the population size. The Dementia Improvement Network is developing initiatives to address this.

**The Talking Therapies Improvement Network** is addressing disparities in access through greater standardisation and the increased use of group work and an exploration of culturally aligned approaches.

**The Crisis and Acute Improvement Networks** are developing plans to reduce Out of Area Placements to zero through an expanded bed base, improvements in the discharge pathway and reductions in length of stay.

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Executive Committee exception report
<b>Author</b>	Katie McDonald, Governance Lead
<b>Presented by</b>	Zina Etheridge, Chief Executive Officer
<b>Contact for further information</b>	Katie McDonald, Governance Lead <a href="mailto:katie.mcdonald3@nhs.net">katie.mcdonald3@nhs.net</a>
<b>Executive summary</b>	<p>This report provides a summary of the key items from the meeting of the Executive Committee held on 19 June 2025. The key items detailed in the report include:</p> <ul style="list-style-type: none"> <li>• Electronic patient record update at Barking, Havering and Redbridge University Hospitals Trust (BHRUT)</li> </ul>
<b>Action required</b>	Note
<b>Previous reporting</b>	None – this is an exception report from the meeting held in June 2025.
<b>Next steps/ onward reporting</b>	The committee meets again on 14 August 2025 and a regular exception report will be presented to the Board.
<b>Conflicts of interest</b>	There are no conflicts of interest identified in relation to this report.
<b>Strategic fit</b>	<p>The ICS aims this report aligns with are:</p> <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The committee has an overall focus on addressing inequalities, reducing variation and improving equity for all the people of north east London while ensuring participation and co-production is central to our collective approach.
<b>Has an Equalities Impact Assessment been carried out?</b>	An equalities impact assessment is not required for this report.
<b>Impact on finance, performance and quality</b>	The committee is established to provide executive oversight of the ICS system budget and financial delegations to ensure delivery of system control total and financial improvement trajectory. Provide executive oversight of system finance and associated risks. Ensure opportunities for bidding for transformational funding are maximised and provide oversight of bids. Approve matters in line with the scheme of reservation and delegation.

<b>Risks</b>	The duties of the committee will be driven by the ICS and organisation’s objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.
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**1.0 Purpose of the report**

- 1.1 This report provides a summary of the key items from the meeting of the Executive Committee held on 19 June 2025.
- 1.2 The Board is asked to note this report.

**2.0 Key messages**

- 2.1 The Committee received an update report from Barking, Havering and Redbridge University Hospitals Trust regarding the Electronic Patient Record (EPR) programme, whereby paper medical records are being transferred to a digital format. Members received assurance that the programme is on track to go live in September 2025, which will mean that the acute hospitals in north east London will all be using the same platform and make us one of the most joined up systems in the country.
- 2.2 The committee also discussed the following topics which are being presented at this ICB Board meeting:
  - Integrated neighbourhood working
  - Primary and secondary prevention for cardiovascular disease
  - Intensive and assertive community outreach
  - Financial overview

**3.0 Risks and mitigations**

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

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Audit and Risk Committee exception report
<b>Author</b>	Anna McDonald, Governance Manager
<b>Presented by</b>	Kash Pandya, Audit and Risk Committee Chair
<b>Contact for further information</b>	<a href="mailto:anna.mcdonald@nhs.net">anna.mcdonald@nhs.net</a>
<b>Executive summary</b>	This report provides a summary of the key items from the Audit and Risk Committee meeting held on 13 June 2025.
<b>Action required</b>	The board is asked to note the report.
<b>Previous reporting</b>	A report was presented to the board at its meeting in May 2025.
<b>Next steps/ onward reporting</b>	An exception report will be presented to the board going forward.
<b>Conflicts of interest</b>	No conflicts of interest have been identified in relation to this report.
<b>Strategic fit</b>	The ICS aims this report aligns with are: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The remit of the Committee is to contribute to the overall delivery of the ICB's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management, internal control processes and arrangements to manage conflicts of interest within the ICB.
<b>Impact on finance, performance and quality</b>	N/A
<b>Risks</b>	The Committee will be driven by the organisation's objectives and the associated risks, and its duties will be governed by the Terms of Reference. An annual programme of business is agreed before the start of each financial year; however, this will be flexible to new and emerging priorities and risks.

### 1.0 Purpose of the report

1.1 This report provides a summary of the key items from the Audit and Risk Committee meeting held on 13 June 2025.

1.2 The board is asked to note this report.

### 2.0 The following key items were considered

2.1 The Committee recommended that the ICB's Annual Report for 2024/25 and the Financial Statements for year ended 31 March 2025 be adopted by the ICB Board.

- 2.2 The ICB has received an unqualified audit opinion on its financial statements from external auditors, however, they did draw attention in their value for money report to a significant weakness reported in the qualified Head of Internal Audit Opinion for 2024/25 to the inadequate follow up of internal audit recommendations. Action to address these matters is in progress.
- 2.3 The ICB will require a comprehensive contract register as it transits into its new role as a strategic commissioner. Progress in implementing a new contracts register, ATAMIS, for the ICB is continuing but the Committee remains concerned about the progress made in terms of implementation, including its accuracy and use as a management tool.
- 2.4 North East London ICB and all other ICBs across the country have been asked by NHS England to implement a new financial management system by October 2025. There is a significant risk in implementing the new system to time, given the slow progress in moving this development forward at a national level and the changes taking place within the ICB. The Committee has recommended that this risk be escalated to NHS England.

June 2025

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Quality, Safety and Improvement (QSI) Committee exception report
<b>Author</b>	Keely Horton, Governance Officer
<b>Presented by</b>	Kevin Cleary, Non-Executive Member
<b>Contact for further information</b>	<a href="mailto:Keely.horton1@nhs.net">Keely.horton1@nhs.net</a>
<b>Executive summary</b>	This report provides a summary of the key items from the meeting held on 18 June 2025.
<b>Action / recommendation</b>	The Board is asked to note the report.
<b>Previous reporting</b>	The topics covered in this report have previously been considered and scrutinised by the QSI Committee.
<b>Next steps/ onward reporting</b>	The Committee next meets on the 10 September 2025 and a regular exception report will be presented to the Board.
<b>Conflicts of interest</b>	There are no conflicts of interests.
<b>Strategic fit</b>	The ICS aims that this report aligns with are: <ul style="list-style-type: none"> <li>• To improve outcomes in population health and healthcare</li> <li>• To tackle inequalities in outcomes, experience and access</li> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	Each topic is an area of service delivery which aims to improve the quality of care for local people through recognising opportunities for quality improvement.
<b>Has an Equalities Impact Assessment been carried out?</b>	An Equalities Impact Assessment is not required for this report.
<b>Impact on finance, performance and quality</b>	There are no additional resource implications/revenue for this report.
<b>Risks</b>	The Committee will be driven by the organisation's objectives and the associated risks, and its duties will be governed by the Terms of Reference. An annual programme of business is agreed before the start of each financial year; however, this will be flexible to new and emerging priorities and risks.

### 1.0 Purpose of the report

- 1.1 This report provides the ICB Board with a summary of the key items from the Quality, Safety and Improvement (QSI) Committee held on 18 June 2025.
- 1.2 The Board is asked to note this report.

### 2.0 Key messages

- 2.1 The Committee received an update on the community anticoagulation service programme. Members has an in-depth discussion in relation to the clinical harms<sup>133</sup>

review, provider audits, service model evaluations, financial assessments, and improved oversight. The Committee has requested further assurance around the Duty of Candour process.

- 2.2 A summary of the support and oversight provided to Barking, Havering and Redbridge University Hospitals Trust (BHRUT) maternity services was presented to the Committee. BHRUT has been part of the Maternity Safety Support Programme due to prior inspections indicating a need for improvement following an unannounced Care Quality Commission (CQC) inspection in October 2024. BHRUT has implemented a comprehensive action plan and has shown measurable improvements in staffing, governance, and safety systems, with ongoing support from the Local Maternity and Neonatal System Board. A final CQC inspection report is pending, with the next site visit scheduled for June 2025.

Author: Keely Horton, Governance Officer  
19 June 2025

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Finance, Performance and Investment Committee exception report
<b>Author</b>	Matthew Knell, Senior Governance Manager
<b>Presented by</b>	Lakh Jemmett, Non-executive Member and Chair of the Finance, Performance and Investment Committee
<b>Contact for further information</b>	<a href="mailto:matthew.knell@nhs.net">matthew.knell@nhs.net</a>
<b>Executive position summary</b>	<p>The Finance, Performance and Investment Committee (FPIC) last met on Monday 2 June 2025 and discussed the following business:</p> <ul style="list-style-type: none"> <li>• The finance reports for month 1, 2025/26</li> <li>• The performance reports for months 11 (month 12 for urgent and emergency care metrics)</li> <li>• The Committee’s risk register</li> <li>• An update on the operating plan and ICB cost improvement plan for 2025/26</li> <li>• Updates from Committee sub-groups</li> <li>• Business cases and contract approvals</li> </ul>
<b>Action required</b>	The Board is asked to note the report.
<b>Previous reporting</b>	None – this is an exception report from the June 2025 Committee meeting.
<b>Next steps/ onward reporting</b>	The Committee next meets on Monday 30 June 2025 and a regular exception report will be presented to the Board.
<b>Conflicts of interest</b>	No conflicts of interest have been identified in relation to this report.
<b>Strategic fit</b>	<p>The ICS aims this report aligns with are:</p> <ul style="list-style-type: none"> <li>• To enhance productivity and value for money</li> <li>• To support broader social and economic development</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	One of the Committee’s responsibilities is to review and approve allocation of contingency funding which is to include transformation, productivity and to aid the reduction of health inequalities for the residents of North East London.
<b>Impact on finance, performance and quality</b>	The Committee is established to provide assurance and oversight to the Board on the robustness of the short- and long-term financial strategy and management for the ICB. It will provide assurance to the ICB on operational performance as it relates to the Operational Planning guidance for acute and non-acute metrics, both constitutional and non-constitutional standards as appropriate.

	The Committee's current key priorities are recovery, sustainability and transformation.
<b>Risks</b>	The duties of the Committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

## 1.0 Introduction

- 1.1 The Finance, Performance and Investment Committee (FPIC) last met on Monday 2 June 2025 since the last exception report was produced for the ICB Board. This report raises any key items for Board member attention by exception.
- 1.2 The Board is asked to note this report.

## 2.0 Key messages

- 2.1 At the June 2025 meeting, the FPIC was updated on the latest financial position and the risks to delivering the year-end forecast position and mitigations being taken. Members discussed how work has been planned across system partners to examine cash, actuals and approaches to forecasting, as there are varying approaches being taken at present. It is anticipated that NHS England (NHSE) will produce a formal process that will be shared to clarify the approach to be taken through the rest of the year.
- 2.2 The June 2025 Committee was briefed that provider whole time equivalents (WTEs) were expected to reduce in 2025/26. Members recognised the encouraging WTE numbers, which seemed to set out a positive position for the future months to build on and provide good opportunities for the extraction of workforce costs where appropriate. It was highlighted that members should wait to see the data for months two and three before drawing firm conclusions, as it is common to see swings and lags on a month-to-month basis in this data.
- 2.3 The June 2025 meeting approved two contract renewals and one business case, also authorising the commencement of a procurement exercise.
- 2.4 The Committee meets again on 30 June, which is after the distribution of this report, so any exceptions from this meeting will be given to the Board by way of a verbal update.

## 3.0 Risks and mitigations

- 3.1 The Committee noted that extensive work had taken place to revise the Chief Finance and Performance Officer's Risk Register for the meeting, with further work required to reflect the future format and role of the ICB under its evolving operating model. It was flagged that cost improvement programmes (CIPs), relative to the ICBs financial position, were driving the majority of red rated risks
- 3.2 There were no specific additional risks arising as a result of the Committee's discussions.

Author: Matthew Knell, Governance Manager  
Date: 18/06/2025

## NHS North East London ICB board

2 July 2025

<b>Title of report</b>	Population Health and Integration Committee exception report
<b>Author</b>	Katie McDonald, Governance Lead
<b>Presented by</b>	Imelda Redmond, Non-executive Member
<b>Contact for further information</b>	<a href="mailto:katie.mcdonald3@nhs.net">katie.mcdonald3@nhs.net</a>
<b>Executive summary</b>	This report provides a summary of the key items from the meeting held on 4 June 2025.
<b>Action required</b>	The board is asked to note the report.
<b>Previous reporting</b>	A report was presented to the board at its meeting in May 2025.
<b>Next steps/ onward reporting</b>	The committee meets again on 1 October and a further report will be presented to the board.
<b>Conflicts of interest</b>	No conflicts of interest have been identified in relation to this report.
<b>Strategic fit</b>	The ICS aims this report aligns with are: <ul style="list-style-type: none"> <li>To improve outcomes in population health and healthcare</li> <li>To tackle inequalities in outcomes, experience and access</li> </ul>
<b>Impact on local people, health inequalities and sustainability</b>	The remit of the committee is to identify opportunities to support and improve effective population health management and integration of health and care services at place and within collaboratives for the residents of north east London.
<b>Has an Equalities Impact Assessment been carried out?</b>	An equalities impact assessment is not required for this report.
<b>Impact on finance, performance and quality</b>	There are no direct impacts resulting from this paper.
<b>Risks</b>	The duties of the committee will be driven by the ICS and organisation's objectives and the associated risks. An annual programme will be agreed before the start of the financial year which will be flexible to new and emerging priorities and risks.

### 1.0 Purpose of the report

1.1 The Population Health and Integration Committee (the Committee) was held on 4 June and this exception report outlines the key messages and actions taken by its members in accordance with its terms of reference.

1.2 The Board is asked to note this report.

### 2.0 Key messages

2.1 The Committee considered the 2025/26 priorities and delivery plans of the Provider Collaboratives, which provided the Committee the opportunity to consider its role in relation to the Collaboratives and to identify any themes for future reporting and activity. Members welcomed the report and discussed the importance of interconnectivity and cross-fertilisation across the Collaboratives and Place-based Partnerships. This interfacing will develop as the Collaboratives mature which will

enable a 360-degree system approach across pathways and minimise the risks of autonomy and siloed working.

- 2.2 The Committee had a lively discussion regarding the next steps in delivering the strategic vision for integrated neighbourhood working in north east London, which is also being presented to the ICB Board at this meeting.

Integrated Care Board Forward Plan

	26-Mar-25	14-May-25	16-Jun-25	02-Jul-25	03-Sep-25	05-Nov-25	07-Jan-26	04-Mar-26
<b>Resident story</b>								
Resident story to be themed in line with the scheduled deep dive								
<b>Chair and chief executive reports</b>								
Chair's report								
Chief executive officer's report								
<b>Governance</b>								
Executive committee exception report								
QSI committee exception report								
FPI committee exception report								
PHI committee exception report								
Audit and risk committee exception report								
Remuneration committee exception report								
Transition committee exception report								
Approval of governance handbook amendments								
Annual report and accounts								
Approval of corporate objectives <i>(to be included in CEO report)</i>								
Behaviours framework <i>(to be included in CEO report)</i>								
Governance Improvement Plan (annual - included in Chair's report)								
<b>Finance and Performance</b>								
Overview report								
Approval of budget and operating plan								
<b>Assurance</b>								
Board Assurance Framework								
EPRR annual report <i>(to be included in CEO report)</i>								
<b>Quality</b>								
Deep dives	Integrated neighbourhood working	Stocktake against statutory aims of an ICB		Secondary and primary prevention (CVD)	Digital	Children and young people	Working and supporting employment	CAMHS resilience
Maternity and neonatal services								
Intensive and Assertive Community Mental Health Care review								
Annual Freedom To Speak Up report								
Compassionate care and staff experience								
Reducing violence								
<b>Strategy</b>								
Updated working with people and communities strategy								
Joint forward plan (5 year plan)								
ICS strategy cross-cutting themes (6monthly update)								
Green Plan								
Sexual health strategy								
Commissioning framework								
10-year plan and what it means for north east London								
Medium-term financial strategy								
Winter plan 2025								
ICP strategy refresh								
Research and innovation strategy								
Integrated neighbourhood working update								