Minutes of the Executive Committee

Wednesday 16 November 2022; 3.00pm – 5.00pm; via MS Teams

Members:	
Zina Etheridge (ZE) - Chair	Chief Executive Officer, 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
Paul Gilluley (PG)	Chief Medical Officer, NHS North East London
Charlotte Pomery (CP)	Chief Participation and Place Officer, NHS North East London
Johanna Moss (JM)	Chief Strategy and Transformation Officer, NHS North East London
Francesca Okosi (FO)	Chief People and Culture Officer, NHS North East London
Matthew Trainer (MT)	Chief Executive, Barking, Havering and Redbridge University Hospitals Trust
Shane DeGaris (SD)	Group Chief Executive, Barts Health NHS Trust
Paul Calaminus (PC)	Chief Executive Officer, East London NHS Foundation Trust
Louise Ashley (LAs)	Chief Executive Officer, Homerton Healthcare NHS Foundation Trust
Brid Johnson (BJ) (for Jacqui Van Rossum)	Acting Executive Director of Integrated Care, North East London NHS Foundation Trust
Andrew Blake-Herbert (ABH)	Chief Executive, London Borough of Havering
Will Tuckley (WT)	Chief Executive, London Borough of Tower Hamlets
Heather Flinders (HF)	Strategic Director of People, London Borough of Waltham Forest
Tim Aldridge (TA)	Corporate Director of Children and Young People, London Borough of Newham
Gladys Xavier (GX)	Director of Public Health, London Borough of Redbridge
Attendees:	
Dr Jagan John (JJ)	Primary Care Partner Member
Dr Mark Rickets (MR)	Primary Care Partner Member
Nicholas Wright (NM)	Diagnostics Programme Director, NHS North East London
Archna Mathur (AM)	Director of Specialised Services and Cancer, NHS North East London
Siobhan Harper (SH)	Transition Director, NHS North East London
Laura Anstey (LA)	Chief of Staff, NHS North East London
Katie McDonald (KMc)	Governance Manager, NHS North East London
Apologies:	
Jacqui Van Rossum (JVR)	Acting Chief Executive Officer, North East London NHS Foundation Trust

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair welcomed members to the inaugural meeting of the Executive Committee of the Integrated Care Board and apologies were noted.

1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the committee. No additional conflicts were declared.
2.0	**Committee Terms of Reference**
	The Chair presented the committee draft terms of reference and explained the committee's role and responsibilities. The Executive Committee approved the committee terms of reference.
3.0	**Community Diagnostic Centre (CDC) Outcome**
	JM and NW presented the report and highlighted the following: • The consultation responses significantly agreed with the plans to build Community Diagnostic Centres (CDCs) at Mile End Hospital and Barking Community Hospital, and raised no fundamental issues with proceeding with development on these sites. • There is a planned third site, however more work is needed to determine where this one should be located as it has become clear that there are no areas with a major lack of provision. • There are various options for a third site which rank differently depending on which elements of desirability or achievability are prioritised. The committee is asked to discuss the merits of various third site options. Members discussed the report with key points including: • Receiving a copy of the equality impact assessment for this work would be welcomed as this could impact on the decision making of the third site. • The report should clearly demonstrate the reasons why acute hospital sites are not being considered as options for the centres. It is not only that it is against NHS England recommendations, but also that the majority of clinicians have indicated that diagnostic facilities would be best placed at sites where the service is currently unavailable. • Further analysis, including deprivation data, is required in order to determine third site proposals. **ACTION:** NW to circulate equality impact assessment and inequalities impact assessment. The Executive Committee approved the development of the two Community Diagnostic Centres in Mile End and Barking. Further analysis will be undertaken regarding a third site and a revised plan presented back to the committee.
4.0	**Specialised services programme overview and update on delegation**
	AM presented the report and explained: • NHS England has advised London ICB Chief Executives that the national team will confirm that 2023/24 will be a year focused on joint agreement, and that no ICB will be granted delegation of specialised services. Instead, ICBs can expect to have specialised services delegated to them from April 2024. • NHS North East London has submitted a draft Pre-delegated Assessment Framework (PDAF), which has received positive feedback from NHSE London. • There are over 150 specialised services, covering a diverse range of disparate and complex services. In addition to specialised services, there are also highly specialised services. Highly specialised services are provided to an even smaller number of patients in comparison to specialised services, usually no more than 500

	patients per year. As a result, they are typically best delivered nationally through a very small number of centres of excellence. • Members of the Clinical Expert Group and the NEL Specialised Service Steering Group, which include senior trust leaders, have endorsed the following focus areas for 2022/23, which will focus on upstream programmes, improving productivity, encourage joint working and scoping consolidation; o Sickle cell o HIV and hepatitis o Cardiology o Renal o Neuroscience o Babies, children and young people • The focus areas above have been aligned with the ICS's strategic priorities. Members welcomed the report and raised the following points: • It will be important to make the risks clear. A meeting is taking place with the Chief Medical Officers within the ICS to discuss risks as well as opportunities. • Whilst the Acute Provider Collaborative is the overarching lead for this programme of work, it would be welcomed if the mental health position is included in reports going forward. • The impact this could have on local authorities and community services will be pathway specific. • It has been proposed that resident coproduction will happen at a pathway design level in order to have residents and carers at the core of the individual specialities as they will have specific knowledge and insight. **ACTION:** AM and PC to discuss how this work can be joined up with mental health. The Executive Committee: • Noted the updated national guidance and the recommendation for NEL ICB to proceed with joint arrangements with NHSE London for the delegation of specialised services during 2023/24 • Supported NHSE London's recommendation that no further information or amendments are required on the Pre-delegated Assessment Framework ahead of final submission on Friday 18 November 2022. • Noted the programme alignment to ICB strategic aims and objectives • Noted the work programme overall, and specifically for the remainder of 2022/23 and 2023/24 prior to delegation for which substantive resource is required.
5.0	**Emergency Preparedness Resilience and Response (EPRR)**
	HB presented the report and explained the following: • The ICB is a Category One Responder under the Civil Contingencies Act 2004. Those in Category One are organisations at the core of the response to most emergencies (the emergency services, local authorities, NHS bodies). • The ICB has formally submitted documentation to NHS England for review in preparation of the annual assurance meeting scheduled on 1 December 2022. • From that meeting an assurance report and rating will be given and the ICB will develop an action plan with NHSE. • The annual assurance report, action plans and improvements in relation to EPRR, business continuity, training and exercising, and risk management will be presented to the committee as part of the ongoing assurance process. The Executive Committee approved the Emergency Planning Resilience and Response (EPRR) policy.

6.0	**Financial position update**
	HB provided a verbal update regarding the ICS financial position and noted: • A protocol has been issued by NHS England which acknowledges that systems will not be able to deliver a breakeven position and that a number of external assurances will be required. • An ICS financial recovery summit was held on 31 October with colleagues across the system which was well received and work is underway to expand existing resources. Members noted the update and made the following comments: • ELFT and NELFT are part of two different ICSs so further work is required to determine whether any issues will materialise as a result of the protocol. • An announcement is expected this week regarding the distribution of the £500m discharge fund. The Executive Committee noted the report.
7.0	**Transfer of Dental, Pharmacy and Optometry services (DOPs)**
	JM presented the report and explained: • London ICBs have come together to agree the commissioning and operating model for delegated functions across London. The ICBs have conducted an options appraisal and an expression of interest process during October 2022. • NHS North East London has been identified as the recommended ICB to host the DOPs function for London. This recommendation was endorsed by the London ICB CEOs at the end of October 2022. • NHS England will retain some responsibility such as contract negotiation and clinical performance. The operating model for London is for local/regional determination, allowing ICBs the flexibility to adapt local management arrangements to meet the needs of their population. • The ICB and the DOPs team will agree a target date for the future TUPE transfer of employment by 1 April 2023 which will give the staff in the DOPs team clarity over their future employer and the date on which that transfer will be made. It will be linked to a workplan that captures clearly what work needs to be completed by this date to mitigate risk and assure ICB Boards. Members discussed the report and highlighted: • This change presents opportunities to transform services across London and North East London, expanding the role of the ICB in planning health services for north east London and bringing change for the local population. • Collaborative working and managing contractual and practice issues locally has the potential to lead to greater understanding of the population health needs and to support more stabilised and sustainable service offers to improve equity of access and reduce health inequalities. • There are concerns regarding infection, prevention and control as dentistry is a high-risk environment. Further conversations will be required as it is likely that additional resource will be required. The Executive Committee noted the report.
8.0	**NEL Fuller Programme Implementation**
	JM presented the report and noted: • The final report of the stocktake undertaken by Dr Claire Fuller on integrated primary care was published in May 2022. It looks at what is working well, why it's working

	well and how the implementation of integrated primary care (incorporating the current four pillars of general practice, community pharmacy, dentistry and optometry) can be accelerated across systems. • The report creates a new vision and case for change for integrated primary care, recommending system leadership at every level to support and enable place-based partnerships to deliver three key changes to the way in which primary and community care services are delivered at neighbourhood/Primary Care Network levels of the system. • In north east London a programme approach has been developed that consolidates the recommendations into manageable work streams and to ensure that a whole system approach to the actions is created. The programme will be launched at a whole system event on the 29 November with Claire Fuller in attendance as a guest speaker. Members welcomed the report and raised the following points: • There is a need to ensure that good practice is shared in north east London in order to avoid reinventing existing methods. • It would be beneficial to demonstrate the engagement with local authorities in regards to the four workstreams. Part of the opportunity is to integrate care around residents, so involving local authorities will help to enable tackling the wider determinants. The Executive Committee noted the report.
9.0	**ICP Strategy update**
	JM presented the report and thanked colleagues for their participation and coproduction on the strategy. The following key points were noted: • The integrated care partnership is expected to produce an interim strategy to provide direction for the system including the new NHS 5-year plan due next March. • Work to develop the strategy includes engagement with local health and wellbeing boards, place based partnerships and a series of stakeholder workshops focusing on our four system priorities. • Participation in the system workshops has been very high with over 100 attendees at every workshop so far. • There is universal support for a central focus on equity and tackling health inequalities as well as a desire to see an ambitious approach to working differently with residents through co-production. • Workforce has been a central theme in all the workshops and other discussions to date. • The draft strategy will be presented to the ICP Committee for approval in January 2023. The Executive Committee noted the report.
10.0	**Integrated Care Board - draft board agenda**
	The Chair presented the draft Integrated Care Board agenda and invited members to raise any queries. Members discussed the draft agenda with key points including: • The ICS workforce strategy item is a position statement to highlight the work undertaken to date. The detail of the strategy will be presented at a future executive meeting. • The Board will be informed of the decisions taken by the committee and any key messages by way of an exception report at each meeting.

	The Executive Committee noted the draft agenda for the Integrated Care Board being held on 30 November 2022.
11.0	**Any other business**
	There was no other business to note.
	Date of next meeting – 12 January 2023

North East London
Integrated Care Board

Agreed minutes – Audit & Risk Committee
21 September 2022 at 2.00pm – 4.30pm - room F01, Unex Tower, 4th Floor

Members:	
Sue Evans (SE) – Chair	Interim non-executive member
Kash Pandya (KP)	Associate non-executive member
In attendance:	
Steve Collins (SC)	Executive director of finance
Marie Price (MP	Director of corporate affairs
Sunil Thakker (ST)	Director of finance
Rob Adcock (RA)	Director of finance
Chris Cotton (CC)	Director of integrated care system transition
Auditors	
Dean Gibbs (DG)	External Auditor, KPMG
Nick Atkinson (NA)	Internal Auditor, RSM
Anna McDonald (AMc)	Senior governance manager
Tracy Rubery (TR)	Borough director-Redbridge (item 4.0)
Rob Meaker (RM)	Director of innovation (item 3.0)
Apologies:	
Imelda Redmond (IR)	Non-executive member
Henry Black (HB)	Chief finance and performance officer
Mark Kidd (MK)	Local counter fraud specialist

1.0	**Welcome, introductions and apologies**	
	The Chair welcomed members to the first meeting of North East London ICB's Audit & Risk Committee. It was noted that the meeting was not quorate. The Chair confirmed the meeting could still proceed, noting that although it is not a decision-making committee, anything requiring sign off by members would be sent to Imelda Redmond after the meeting.	
1.1	**Declaration of conflicts of interest**	
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. No additional conflicts were declared. The registers of interests held for ICB members and staff are available from the Governance Team.	
2.0	**Committee draft terms of reference**	
	MP recapped that the draft terms of reference (ToR) had been presented to ICB board members on 1 July and were being presented to the committee for comments. The key discussion points were: • The need to consider adding an additional associate non-executive member due to recent changes in membership.	

	• The need to review the quorum. • The committee's responsibility to undertake a review of the ICB's Freedom to Speak Up (FTSU) arrangements going forward. NA suggested the review could become part of the annual governance review undertaken by RSM. MP advised that an external FTSU service called 'Guardian Service' is being put in place for ICB staff and suggested bringing the detail to the next meeting for a further discussion on how best to review the overall FTSU arrangements going forward. **ACTION: MP.** The chair confirmed she would discuss the ToR with Imelda Redmond (IR) and seek her approval outside of the meeting. **ACTION: SE.** The Audit & Risk Committee: • Approved the ToR on the understanding that the membership and quorum are reviewed and pending approval from IR.	MP SE
3.0	**Information governance and IT**	
	3.1 Framework for digital integrity and current IT risks RM presented the report and highlighted the following points: • The ICB conducts three separate audits on its IT services, to ensure they operate and maintain the highest security standards; Data Security and Protection Toolkit (DSPT); Cyber Essentials Plus audit; independent security testing. • Currently, the ICB is exceeding standards on the DSPT, holds a current Cyber Essentials Plus certificate and has undertaken all the corrective actions detailed in the independent security audit conducted in September last year. • The next round of IT certifications are due to start in November 2022. An update report on this was requested for the December meeting. • IT network services are monitored by NHS Digital who also provide a threat alert notification. • All NHS Digital threat alerts have to be responded to within 24 hours and are monitored on a national level. Any non-compliance has to be signed off by the ICB Senior Responsible Information Officer [SIRO] • IT risks are reviewed monthly and RM reported that currently there are no high risks in relation to the IT service. The key discussion points were: • The 'Discovery' review undertaken by RSM which NA advised had highlighted a number of weaknesses. NA asked whether there are any other systems that need to be considered from a security perspective. RM referred to the London Support Service (LSS) (previously CSU) and explained that the equipment they used is being phased out and everything is being migrated to what the ICB has in place. RM confirmed that the Internal Audit reports are shared with the relevant Information Governance groups. • The recent cyber attack experienced by NELFT was discussed and RM assured the committee that contingency plans are in place and are tested frequently.	HB

	• Log4j - RM explained this risk needs to remain on the risk log and is fully mitigated. He also confirmed that the ICB has a map showing the different systems that feed into the ICB systems. The Audit and Risk Committee noted the report. *Rob Meaker left the meeting.*	
4.0	**Performance and planning**	
	4.1 Procurement group progress report including risks TR presented the report to update the committee on progress made to date in regard to the procurement pipeline, the forecast position relating to Single Tender Waivers (STWs) and the STWs endorsed by the Procurement Group. The key points in the report were highlighted: • Work on improving the accuracy of the contracts register is continuing. • The procurement pipeline is subject to regular reviews and the Procurement Group is reviewing contract end dates 2 years in advance. • As part of the new business case process, teams are asked to consider procurements as multi-borough schemes. • A significant number of STWs continue to be submitted to the Procurement Group for endorsement. The number is reducing but there is still a lot of work to be done. • E-procurement performance continues to be positive, however further work is required to improve Purchase Order (PO) compliance. • In regard to risks, capacity constraints will need to be managed if the procurement pipeline is to be delivered as it stands. The procurement team is a shared service across four London ICBs and each ICB has been tasked with providing an accurate pipeline of procurement activity for the next 18-24 months to allow prioritisation of work across the ICBs. The key discussion points were: • The contracts register – a session is planned with borough directors in order to identify where there are gaps. • The Procurement Strategy – this will be a strategy for the ICS that underpins the four priorities of the ICS and will link to the prioritisation work being undertaken. Some contracts may need to be extended. • The increased focus in regard to social value and the sustainability agenda. • The need for a strategic approach in terms of the areas that will sit within the ICB and the areas that will sit within the provider collaboratives. • Grant funding – it is anticipated that benefits will be seen as more work will be done in partnership. • PO compliance – RA suggested the need to consider areas where this can be extended further. **ACTION:RA/TR.** The Audit & Risk Committee noted the report. **4.2 Single Tender Waivers** The Committee noted the STWs.	RA/TR

	Tracy Rubery left the meeting.	
5.0	**Governance**	
	5.1 ICS transition programme close down report (NEL CCG) CC presented the report and outlined the key messages: • Outstanding actions from the end of June 2022 are now complete. • In terms of the risks transferred from the CCG, one will be closed by the end of September and the remaining seven will transfer to relevant ICB departmental risk logs. • NHS England has confirmed that close down is complete. The key discussion points related to the seven remaining risks. The need for the right people to be sighted on the risks was emphasised. SC explained that amendments have been made to the Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegations (SoRD) and the updates will be presented to the ICB board on 28 September 2022. MP clarified that the chief officers are reviewing the risks they have inherited. The Audit & Risk Committee noted the report. **5.2 Update on CCG quarter one annual accounts closedown 2022/23** MP presented the update. The key points highlighted were: • The draft report is currently being produced with a very short timescale in advance of submission on 5 October 2022. • The content relates solely to the former CCG and as such, the draft will be shared with non-executive members who were lay members of the former governing body and audit and risk committee for comments on 23 September with a deadline for feedback on 28 September. • The Finance Team has received clarification from NHSE in regard to the timeline for the Qtr1 accounts and they will be included with the Qtr1 report when it is submitted on 5 October. • The draft Head of Internal Audit Opinion has been received and will also be included. The key discussion points were: • Q1 accounts – the submission to NHSE on 5 October will be an un-audited version. Audit work and sign off will follow later in the year. • Pension data - will not be available for the remuneration report and it was agreed that a pragmatic approach is needed. • Q2-4 accounts and annual report - will follow the normal national timetable. The Audit & Risk Committee: • Noted the timetable and process. • Noted the timeline for comments and suggestions in line with NHSE's deadline.	
6.0	**Risk**	
	6.1 Risk management update	

	MP presented the report which outlined the proposed approach for risk management in the ICB and progress made to date. The highlighted points were: • The ICB's risk management policy and strategy have been developed by the governance team and RSM colleagues, working with key stakeholders across north east London, including place-based partnerships leads. • NHS Trust Chairs and ICB non-executives met on 15 September to discuss their views on what the overall system risks are, beyond those within individual organisations. • Each chief officer has nominated a risk champion. The champions will not hold responsibility or accountability for the risks, that will sit with the chief officer. The role of the risk champions is to help embed a culture of effective risk management within their departments and with partner colleagues. • Legacy risks from the CCG have been collated and shared with each chief officer to ensure that ongoing risks are managed, and to ensure that each is considered as the new risk registers are developed. • The ICB Board meeting on 28 September will receive an update on the proposed risk management process and discuss the ICB and system risk The key discussion point was on accountability. NA welcomed the system risk discussions and highlighted the importance of having visibility in order to receive the right level of assurance needed. MP added that we are working closely with governance leads within each of the trusts and the provider collaboratives and confirmed that the ICS will deliver the overall risk strategy. The Audit & Risk Committee: • Noted the proposed process and the development of the Board Assurance Framework (BAF) for the subsequent board development session and next board meeting. • Requested a progress report at the next meeting. **ACTION: MP**	MP
7.0	**External Audit**	
	7.1 progress report DG presented the report. The key points were: • Work on the 3 months CCG audit and the 9 months ICB audit is commencing. The audit for CCG part-year accounts is expected to be substantially complete by January to February 2023. Final sign-off is likely to take place in May 2023 due to specific 3rd party evidence being unavailable until April 2023, such as NHS pension information. • The Mental Health Investment Standard (MHIS) audit for the year ending 31 March 2022 is commencing. The Audit & Risk Committee noted the report. **7.2 Technical update** DG gave an overview of the auditing standards and summarised the key changes, explaining that the significant change relates to IT and how that is	

	considered within the audit. IT is integral to finance reporting and DG and his team will continue working with management as they embed the methodology. The key discussion points were: • Service Auditor Provision – SC asked whether there is anything that needs to be done differently and DG suggested the need to have a good understanding of the potential consequences of any weaknesses. It was noted that some areas that were outsourced have now been brought back in-house and NA advised he would include exceptions in Internals Audit's next report. • Existing controls – SC and RA gave assurance that these have been built on and improved. • Service Auditor reports – NA advised that the expectation is that the reports for Q1 will be bridging reports and not full reports. The Audit & Risk Committee noted the update.	
8.0	**Internal Audit**	
	8.1 Progress report NA summarised the progress report. The key messages were: • Recommendations given remain relevant. • Two management actions are ongoing relating to the 2021/22 Procurement and Contract register report and the 2021/22 Primary Care report. • 2021/22 Continuing Healthcare and Personal Health Budgets – partial assurance given which NA explained is in line with ratings given in other areas. This is one of the biggest risks for 'CCG Plus'. An action plan is in place and there is good engagement with the team. It was noted that CHC has always been an area of significant concern and the various reasons were discussed. SC clarified that there is a strong commitment to harmonising how things are done. NA suggested looking at who does what. MP advised that as part of the consultation that starts next week a director of CHC is proposed. The chief nurse is sighted on the audit report and one of the things she is currently undertaking is an engagement process in order to align CHC policies. It was noted that the health inequalities agenda is a key consideration. • Discovery - Patient Information Database – received partial assurance. SC advised that it has been a relatively secure system overall but it is a growing area. • Data Security & Protection Toolkit – received a moderate risk assurance rating and a high veracity assurance rating. • Estates Management – received reasonable assurance. There is one high priority action in regard to formalising the process of looking at void spaces. KP asked what the status of the maintenance backlog is on the estate that the ICB is accountable for. SC clarified that all the ICB offices are rented and added that the big risks are system risks with most sitting with the acute providers. • Due Diligence and Risk Management, phase two – received substantial assurance. NA fed back that all the projects he has been involved in with RA have all operated as a very smooth process.	

	The Audit & Risk Committee noted the progress report. **8.2 Annual internal audit report – Q1 22/23 including the draft head of Internal Audit Opinion (HoIAO)** NA presented the report which included the draft HoIAO for the CCG covering Q1 of 2022/23. The Audit & Risk Committee noted the report. **8.3 Internal Audit Plan Q2-4 2022/23 and three-year strategy** NA recapped that the audit plan and strategy had been presented at the final CCG Audit & Risk Committee meeting and now requires approval from the new ICB Audit & risk Committee. The chair confirmed she would discuss the audit plan with IR and seek her approval outside of the meeting. **ACTION: SE.** The Audit & risk Committee: • Approved the Internal Audit Plan Q2-4 2022/23- and three-year strategy report pending approval from IR. **8.4 Healthcare benchmarking report 2021/22** NA presented the report for information. **8.5 HFMA financial sustainability checklist scope** NA explained that this will commence during the first week of October. The objective is to review the self-assessment and confirm the existence of the supporting evidence the ICB has in place to demonstrate how it is planning to improve its financial sustainability and regain 'financial grip' following the financial challenges caused by the Covid-19 pandemic. KP suggested it would be helpful to share the document with the Finance, Performance & Investment Committee. **ACTION: HB/SC.** RA confirmed that a first draft of the assessment has been completed. It was noted that it requires chief executive sign off. The Audit & Risk Committee noted the checklist scope.	SE HB/SC
9.0	**Local counter fraud specialist**	
	9.1 Progress report NA presented the report on behalf of MK which provided an update in respect of counter fraud work undertaken at NEL CCG during April – June 2022 and the ICB since 1 July 2022. The key points covered were: • Completed workplan activities • An update in regard to on-going investigations • Emerging risks and alerts issued SC updated the committee on the pro-active approach in regard to LCFS awareness and gave an overview of a recent 'all staff briefing session' which highlighted fraud, particularly relating to scams. Mores sessions are planned going forward. The Audit & Risk Committee noted the report.	

	9.2 Workplan 2022/23 NA summarised the work plan which was noted by the Committee. **9.3 Benchmarking report 2021/22** NA presented the benchmarking document and commented that the organisation is quite good at coming forward in regard to reporting issues. The Audit & risk Committee noted the report.	
10.0	**Finance**	
	10.1 Finance overview SC presented the report on behalf of HB which gave the month 4 position and advised that a month 5 report would be presented to the ICB board on 28 September. The key messages were: • The final closing position of the CCG was a breakeven position. • At month 4, the ICB reported a year-to-date underspend of £6m. This constitutes a £6m overspend in the ICB position, offset by the return of the £9.2m funding adjustment and a further £3m Elective Recovery Fund (ERF) clawback relating to month 4. • System providers have a year-to-date pressure of £36.8m • There are significant risks to the financial position which may impact on the planned year-end break-even position. The system and ICB will need to develop plans to offset the risk. As part of the discussion, SC clarified the ERF position. The Audit & risk Committee noted the update.	
11.0	**Key message to bring to the attention of the ICB board**	
	The Chair confirmed that a verbal update will be given to the ICB board 28 September in regard to the ICS transition programme close down report presented earlier in the meeting under 5.1. **ACTION: SE**	SE
12.0	**Any other business**	
	12.1 Workplan The Chair explained that the committee's draft workplan was based on the CCG's version and asked External Audit, Internal Audit and LCFS colleagues to review the draft workplan and advise AMc of any changes.	DG/NA/ MK
13.0	**Items for information**	
	13.1 Procurement group minutes The committee noted the minutes of the meeting held on 29 July 2022. **13.2 Information governance group minutes** The committee noted the minutes of the meeting held on 8 July 2022.	
	Date of next meeting – 7 December 2022	

Final

North East London

Minutes of the Quality, Safety, and Improvement (QSI) Committee

Held on 12 October 2022

Members:	
Imelda Redmond (IR) - Chair	Non-Executive Member, NHS NEL board member
Marie Gabriel (MG)	Chair, NHS NEL
Fiona Smith (FS)	Associate Non-Executive Member, NHS NEL
Cllr Maureen Worby (MW)	Councillor, London Borough of Barking & Dagenham
Dr Jagan John (JJ)	Primary Care board member, NHS NEL board member
Diane Jones (DJ)	Chief Nursing Officer, NHS NEL
Dr Paul Gilluley (PG)	Chief Medical Officer, NHS NEL (part) – Item 4.0
Attendees:	
Mark Gilbey-Cross (MGC)	Director of Nursing, NHS NEL- for items 4.0 & 9.5
Chetan Vyas (CV)	Director of Quality and Safety, NHS NEL – for item 8.1
Korkor Ceasar (KC)	Associate Director, Children's Safeguarding, NHS NEL – for items 5.0, 9.2 & 9.3.
Celia Jeffreys (CJ)	Associate Director, Safeguarding Adults, NHS NEL (part) – for item 9.1
Beatrice Kivengea (BK)	Learning Disability Mortality Review (LeDer) Coordinator, NHS NEL – for item 9.4
Moira Coughlan (MC)	Deputy Director for Screening, Prevention and Vaccination, NHS NEL – for item 6
Philippa Cox (PC)	Assistant Director of Maternity Programmes NEL LMNS – for item 7
Alison Glynn (AG)	Head of Commissioning and Contract Management, NHS NEL – for item 8
Eleanor Durie (ED)	Communications Manager, NHS NEL – for item 8
Ryan Hainey (RH)	IFR Manager – for item 8
Durie Eleanor	Communications Manager , NHS NEL
Polly Pascoe	Head of Quality Development, NHS NEL
Dotun Adepoju (minutes)	Senior Governance Manager, NHS NEL
Keeley Chaplin	Governance Manager, NHS NEL
Apologies:	
None	

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	• The Chair welcomed all members and attendees to the meeting. As this was the first meeting of the Committee under the new ICS structure, the Chair gave an overview of how effective she will want the Committee to be. Examples included: ▪ Non duplication by the Committee of work already carried out elsewhere by other groups within the ICS. ▪ Ensure that papers presented help deliver the strategic objectives of the ICB and system.	

Item No.	Item title	Action
	▪ Meeting agenda should ensure value added. • The timing and the volume of the meeting papers for this meeting were noted. These will be improved upon for future meetings. • With this being a new group, Diane Jones (DJ) informed the meeting of the difference between the system Quality Group, which is an operational group focussing on system improvement and the Quality, Safety & Improvement Committee (QSI) which is a statutory group to ensure system oversight, improvement and assurance. • With the advisory role of the Committee to the Board, it will sometimes be necessary to have as much details as possible in the meeting papers. However, it will be helpful if presenters at the meetings directed the Committee to salient points and areas in their reports, where necessary indicate if papers were for information and noting purposes.	
1.1.	**Declaration of conflicts of interest (DoI)**	
	• The register of interest was noted. However, the Chair advised that the DoI print out need not always be attached with the meeting papers for future meetings. She would rather changes/updates to the existing DoI records instead., if any. • Fiona Smith (FS) advised that her updated declaration has been submitted that needed to be reflected in the DoI printout circulated with the meeting papers. • No further conflicts were noted pursuant to this Committee. ➢ **<u>Action Point</u>:** Dotun Adepoju (DA) to note the presentation of DoI for future meetings and ensure FS's updated DoI is reflected in the QSI records.	**Action: DA**
2.0	**Approval - QSI Terms of Reference**	
	• The Chair introduced the item informing the meeting that the Board has approved Committee's terms of reference (ToR). The document showed that there was a lot of work that will need to be done and brought to the Committee over the next 12- 18 months. • The Chair, DJ and DA will work to ensure the remits of the Committee as detailed in the ToR are met in the scheduling and agenda-setting of the Committee's meetings This will also include how the QSI Committee is delivering on the strategic objectives of the ICB. ➢ **<u>Action Point:</u>** To bring a paper on how the Committee will meet its remit as detailed in the ToR (DJ/IR)	**Action: DJ/IR**
3.0	**Risk Planning**	
	• The Chair informed the meeting that DJ and her team have been working on risks and these will be presented at the next meeting. She then conducted a short exercise to get a feel for what were the strategic Quality, Safety & Improvements risks members had in their spheres of operation. • The following risk areas were put forward: ▪ Workforce capacity and its impact on service delivery e.g. Maternity service, safeguarding responsibilities to name two areas. ▪ Service users' demands due to Covid and as we approach winter.	

Item No.	Item title	Action
	▪ Mental health services - e.g. autism and pressure for beds. ▪ The assessment and management of risks in everyday operations were themselves challenging risks. ▪ Risk of low uptake of child immunisations, Covid vaccinations and consequent exposure to outbreaks. ▪ Cost of living crisis and its impact e.g. inability of service users to engage healthcare services, impact on workforce themselves, impact on vulnerable adults and health inequalities. • DJ informed the meeting that the risks referenced above will need to be articulated indicating their impacts and what mitigations are in place to manage them. These were the sort of details expected in risk registers and said these have been duly captured. Where the risks had a QSI strategic impact, they will need to be brought to the Committee for review. • The Chair will expect papers presented at future meetings to reflect how these risks are being managed. ➢ **<u>Action Point</u>:** DJ to present risk register at the next meeting.	**Action: DJ**
4.0	**Quality, Safety & Improvement Exception Report**	
	• Mark Gilbey-Cross (MGC) presented his paper: • The report was a work in progress and his team would welcome feedback on what future iterations should look like. It gave an example of going forward, of how we would like to highlight areas of inequalities, variation for our populations with an increased focus on outcomes, therefore taking a more integrated approach in a shift away from traditional assurance reporting. • This will be achieved by the continuation of quality leads working with places to support the identification of local quality priorities and by such initiatives as the new health inequalities work stream, quality and safeguarding colleagues are leading this. The paper then listed the key areas of focus as follows: ▪ What does health inequalities mean and what are the nuances across NEL. ▪ In the role of quality & safeguarding professionals, what can we do about it. ▪ Can we pull anything from JARs/ScRs/SARs/S.I[1]'s in relation to health inequalities. ▪ Identification of barriers to access - Interpreters, virtual clinics, literacy, use of wording, online self-referral form, sight, impairment, access to data, digital poverty, ACEs[2]. • Areas of focus and next steps include: ▪ Working together as specialists to look at themes from serious incidents and other intelligence. What were the barriers to access? What does the demographic look like? What could the early intervention have been?	

[1] JAR = Joint Agency response (to child death), SCR = Safeguarding Children Reviews
SAR = Safeguarding Adult Reviews , S.I =Serious Incident
[2] ACE = Ambulatory Care Experience.

Item No.	Item title	Action
	▪ To link in with work that is already being completed at place e.g SARs/SI's/SCR/Rapid review action plans. ▪ Link in with wider system partners to make links to JSNA[3] and any mapping already completed. • The main learning to gain from this was that a significant amount of Prevention of Future Deaths (PFD's) 75% relate to poor practice. The work has resulted in providers across NEL working together to share details of learning of serious incidents and Reg 28's to ensure a consistent approach to improvement and a systems view of issues. <u>Comments</u> • The Chair advised that the 75% quoted could be misleading, more so as the number involved was three. It was best to use the number for future exception reports. The content of exception reports could reflect the range of responsibilities for the ICS and focus on key issues at the front end to avoid being swarmed with long literature in reports. • Trusts are not just the main providers to receive PFD notices, there are federations and care groups in some areas that could hopefully be added in future reports. The quality issues with Places could have been listed in the report. That ELFT and Homerton Healthcare had not provided data on their number of PFDs was noted and concerning; it did not allow for an overall assessment of the entire system. • The impact of the pandemic (and lockdown) on the number of Coroners' Office caseloads and the resultant backlogs being worked through, could influence the number of serious cases in future PFD reports. • The data provided whilst showing an increase in PFDs did not reflect comparison with a known/given benchmark thus the inability for a deeper assessment of the NEL's position. The report was also noted as being too focused on the organisation and on the NHS rather than the wider system which will include, for example, local authorities and going forward, would have allowed for the development of more effective mitigations within the system. ➢ **<u>Action Point</u>**: DA to set up meeting of the Chair, FS , DJ, MGC and other invitees before the next meeting to discuss what sort of information will be required in future QSI Exception reports.	**Action: DA**
5.0	**Safeguarding Looked After Children**	
	Korkor Ceasar (KC) presented her paper: • The report provided an update on the recent Children in Care wellbeing Review conducted in August 2022. It outlined system risks associated with performance on completion of statutory health assessments, workforce capacity and data quality. • The report updated the Committee with progress on quality improvement measures implemented because of the system conversation of 10th August 2022. The recommendations within the report were based on statutory guidance and system oversight to support/ influence best practice to ensure system accountability.	

[3] JSNA = Joint Strategic Needs Assessment

Item No.	Item title	Action
	Comments • Councillor Maureen Worby (CMW) informed the Committee that the issue of backlogs in the report was not new and had been going on from before the inception of the newly formed ICS. It had also been escalated, back then, up the management of the then CCG. She hoped that the issue will now be addressed by the ICB. • The Committee was reassured that the new personnel in place will be dealing with the issue in a way different from that in the past i.e. a system approach to the issue will be applied. • Efforts should made to reduce variations in approach in the safeguarding of Looked After Children and a best practise should be developed and/or adapted. • There was need for clarity on the timeliness for when the backlogs will be cleared and what was the expected outcome from the additional resources already provided . • KC addressed the issues raised: ▪ The legacy issue is not restricted to just NEL but is also a national issue, however our approach has executive Trust input and on the Trust risk register. ▪ The Covid pandemic contributed to the build-up of the backlogs. ▪ There is a national shortage of paediatricians, who undertake the initial heal assessments (IHA). ▪ Long-term solutions will involve peer review and workforce models within a multi-professional approach. • DJ informed the Committee that workforce was the biggest challenge, and it is systemic. However, it is a risk captured in the NEL strategic risk register. • The Chair would want reports to be presented in tabular format and with the corresponding risks. This will allow for better visibility of what is going on and in which part of the system as whole. It will also help the Committee keep an eye on the movement/management of the risks and issues within the system.	
6.0	**Vaccinations, Immunisations and Screening Campaign Updates**	
	• Moira Coughlan (MC) presented her paper: • Providers across NEL have risen to the challenges as set by NHSE to establish clinics and offer vaccines for the different programmes, often at short notice. System partners have continued active engagements with eligible populations to raise awareness and promote access to the vaccines. • Uptake of the polio vaccine whilst increasing was still low at 16%. Children will need to complete their course of vaccines after this initial campaign thus making the ongoing engagement vital. • The main risks to the overall immunisation programmes relate to: (1) The capacity to deliver multiple vaccination programmes simultaneously (as well as all other core health activities) and (2) Ongoing engagement with eligible populations especially those who are seldom heard. • These risks are being managed through several interventions including additional funding and training to upskill staff to deliver these vaccinations and focused local engagement work with eligible populations to encourage uptake.	

Item No.	Item title	Action
	Comments • The bigger problem was the communication strategy. The strategy needs improvement across the seven boroughs in NEL. Work has commenced amongst certain groups in terms of engagement, and this was a good foundation that could be built up. • There are challenges and thus a need for how we will collaborate with partners and local authorities in encouraging higher take up rate of vaccinations. • Consideration should be given for a wider group of system providers of vaccination services. The Pharmacy route, for example, has seen some level of success in take up rate. • The Chair would like the report to have shown graphical data representation e.g. data charts on the take up rates of vaccinations and within which groups in the population so as to give a clearer picture. It was noted that the report did not indicate the role of the Directors of Public Health in the boroughs and the learnings that came from their work on the Covid vaccination campaign. • MC, in providing assurance, informed the Committee that a national strategy was being developed and included in that is the use of wider providers. There was also the use of a hub which maximises access for people, the use of community health centres sites, there are local borough immunisation meetings and indeed other models. These details had been left out to minimise too much literature in the report. • The Committee noted the report.	
7.0	**Local Maternity & Neonatal Service (LMNS)**	
7.1.	Ockenden Assurance Visits	
	• Philippa Cox (PC) gave a summary of her report: • The interim Ockenden report, was published in December 2020. It outlined the local actions for learning (LAfL) and the immediate and essential actions (IEAs) to be implemented at the Trust and across the wider maternity system in England. The final Ockenden report builds upon the interim report in that all the LAfL and IEAs within that report remain important and must be progressed. • In the final Ockenden report, the independent maternity review team identified a number of new themes that are required as a matter of urgency to bring about positive and essential change. • Since the interim Ockenden report has been published, maternity services have been asked to complete a self-assessment tool to outline their progress against the seven initial IEAs with an action plan to achieve full compliance. These have been submitted along with the maternity workforce plans in February 2021 and April 2022 to the London Regional maternity team. Since June 2022, the regional maternity teams have been completing Ockenden assurance visits to all maternity services. In London, these will be completed by 31/10/22. • In April 2022 none of the maternity services in North East London (NEL) were fully compliant against the seven IEAs although progress has been made since 2021. • All maternity services in NEL have had their Ockenden assurance visit. Only two Trusts have received their reports.	

Item No.	Item title	Action
	• She concluded by informing the Committee that the final reports were expected by the end of this month, and she would like to come back to share this with the Committee. <u>Comments</u> • DJ informed the Committee, based on visits and those published to date that there were concerns around The Royal London, mainly affecting Tower Hamlets residents. An enhanced quality meeting with the Trust , and ICB took place 2 days ago. The women in Tower Hamlets usually prefer to go to Royal London, but the Trust are seeing some movement where the borough has not been the first choice of the residents. Work is being planned with residents and providers from primary care through to the hospitals to see what could be done to improve and make Tower Hamlets the choice for residents in the borough. • DJ said Redbridge councillors (Task and finish group) are concerned that their local residents do not have in borough maternity option. For example, Redbridge does not have a local maternity unit and service users go to Whips Cross and BHRUT. There is planned engagement work with residents in Redbridge to understand their views with this current arrangement. • There is also the equity and equality assessment which gives a picture across NEL; the report will be brought to the Committee. • The Committee would want assurance on the outcome of the efforts by NEL to address the impact of maternity workforce. Issues of recruitment and renumeration are key. • PC informed the Committee that the Local maternity and neonatal system (LMNS) has undertaken work to provide support to maternity services and staff. The national team has bid for funding support for the recruitment of workforce. • The Committee will like future reports to indicate what kind of support is expected from system response to the issues raised rather than local authorities' concerns.	
8.0	**Policy for Approval**	
8.1.	NHS NEL Individual Funding Request (IFR) Policy	

	Ryan Hainey presented his paper, the summary of which was:
	• The paper represented an established legacy policy which the ICB must have in place to provide an IFR function requiring formal approval by the ICB.
	• NHS North East London IFR policy wording has been updated to reflect the establishment of the NHS North East London ICB on 1 July 2022; operational updates and improvements/developments to the IFR function that had already been agreed with the predecessor CCG organisations have also been reflected.
	• Specifically, these updates are:
	  • Updated NEL ICB IFR triage arrangements and terms of reference.
	  • Updated NEL ICB IFR panel arrangements and terms of reference.
	  • Updated NEL ICB IFR Appeal panel arrangements and terms of reference.	

Item No.	Item title	Action
	• Financial limit for IFR panel approvals of £50k/year (previously agreed). • Robust definitions of clinical exceptionality and rarity of indication for application across the IFR function. • IFRs must be managed in accordance with the IFR policy to mitigate the risk of successful appeals and legal challenges against IFR panel decisions. Some inconsistencies between the IFR policy and process have arisen over time and these have been addressed in the policy update. • The NHS North East London IFR triage group and IFR panel have been established and needs to be reflected in the IFR policy update. <u>Comments</u> • For clarification purpose and because the policy had been updated to take onboard the new systems and structures of working, the Committee was informed that the updated policy had no impact on the public. • Assurance was also provided that the impact assessment in the report was based on the Quality Equality Health Inequality Impact Assessment method. • The Committee approved the policy.	
8.2.	**Fertility Policy**	
	Alison Glynn (AG) presented the paper, summary of which was as follows: • In August 2021, NEL CCG SMT agreed to review the five legacy CCG Fertility Policies and create a single North East London policy to reflect the establishment of a single Integrated Care Board (ICB). • A Clinical Review Group (CRG) comprising of GPs and specialist clinicians was set up and the CCG commissioned an external public health specialist to produce a review of existing policies comparing it with the latest clinical evidence and guidelines, against equality legislation and other CCG policies. • The CRG then reviewed a set of possible changes to the policy using an assessment of their impacts on outcomes, hospital capacity, cost and equality issues and put forward recommendations for a new policy. • The paper presented set out a summary of the feedback received in the engagement exercise on the proposed policy, the changes made to the draft policy as a result, and the rationale for areas where we have not reflected requested changes in the policy. Appendix A of the paper sets out the draft policy for agreement. Appendix B contained the Health Inequality, Equality and Quality Impact Assessment. • The Committee was asked to: • Review the proposed changes to the policy post engagement (outlined on slide 11 of the report) and agree the draft policy prior to submission of the Business Case at the Finance, Performance and Investment Committee and the Integrated Care Board. • Review the updated Equality, Health Inequality and Quality Impact Assessment. <u>Comments</u> • In response to the use of Body Mass Index (BMI) in the assessment of fertility treatment which could be disadvantageous to women body	

Item No.	Item title	Action
	types, the Committee was informed that policies have been aligned with National Institute for Care and Health Excellence (NICE) guidelines. • The Committee was assured that costings have been considered in the development of the policy. Feedback from the expected approval by the Finance, Performance and Investment Committee will be brought back to the Committee. • The Committee approved the policy.	
9.0	**Annual Reports for Approval**	
	• DJ spoke about the safeguarding papers. They demonstrated work done in these areas over the past year, examples of keeping residents safe and priority areas for the coming year. The committee will be asked to approve the reports on behalf of the Board. The reports were all part of the statutory requirements of the ICB, which is the one place that gives system oversight. • FS shared that we are required to show that we can demonstrate to the Board the work we have done in these areas and showing the priorities and improvements in each of these areas. • DJ shared that the reports have highlighted achievements in some of the key areas and where improvement was needed. The areas needing improvement will be taken into the strategy development programme for the following year. DJ & FS assured the committee that the reports have been reviewed by them and the senior officers of the ICB.	
9.1	Safeguarding Adults (report not discussed due to time constraint)	
9.2	Safeguarding Children	
9.3	Looked After Children	
	• KC spoke to the Safeguarding Children and Looked after Children annual reports. She informed the Committee that the annual reports allowed the Safeguarding team to demonstrate that they had discharged their statutory responsibilities. The reports were presented to the Committee for system approval. . • The two reports were approved by the Committee.	
9.4	LeDeR, , report not discussed due to time constraint.	
9.5	Child Death Overview Panel,	
	• Having read the reports, FS assured the Committee that they could be approved. • The annual reports were approved by the Committee. ➢ **<u>Action Point:</u>** The LeDeR report and wider issues around Learning Disability and Autism (LDA) to be brought back by Celia Jeffreys to the next meeting for further scrutiny by the Committee. ➢ **<u>Action Point.</u>** IR and DJ will meet and discuss the details of the report in advance of the Board meeting before presenting to the Board.	**Action: CJ** **Action: IR & DJ**
10.0	**AOB**	

Item No.	Item title	Action
	• The Chair acknowledged the work done prior to the meeting and expressed gratitude to the team and attendees. • There were no other A.O.Bs raised.	
Date of Next meeting – 7 December 2022		

NHS
North East London

Minutes of the NEL Finance, Performance and Investment Committee meeting

Monday 31 October 2022 2.15pm – 4.00pm
Unex Tower, Station Street, Stratford, E15 1DA and via MS Teams

Members:	
Kash Pandya (KP) - Chair	Associate non-executive member, NHS North East London
Henry Black (HB)	Chief finance and performance officer, NHS North East London
Mayor Philip Glanville (PG)	Local authority partner member
Dr Mark Rickets (MR)	Primary care partner member
Fiona Smith (FS)	Associate non-executive member, NHS North East London
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health & Care Partnership *via MS Teams*
Attendees:	
Steve Collins (SC)	Executive Director of Finance, NHS North East London
Rob Adcock (RA)	Deputy Chief Finance Officer, NHS North East London
Sunil Thakker (ST)	Executive Director of Finance, NHS North East London *via MS Teams*
Dr Jagan John (JJ)	Primary care partner member *via MS Teams*
Steve Beales (SB)	Assistant Director, ICS Implementation, NHS North East London
Alison Glynn (AG)	Head of commissioning and contract management, NHS North East London – for item 6 *via MS Teams*
Sanjay Patel (SP)	Deputy Director of Medicines Optimisation, NHS North East London – for items 9, 10, 11 *via MS Teams*
Katie McDonald (KMc)	Governance manager, NHS North East London

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair welcomed those in attendance to the inaugural meeting of the North East London (NEL) Finance, Performance and Investment Committee and introductions were made. No apologies were received. A Trust representative is to be nominated and to join the next meeting.
1.1.	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the committee. MG advised that her interest regarding Norfolk and Suffolk NHS Foundation Trust is historic and can be removed from the register. MR advised his declaration was not included in the register and that he had updated his declaration. No additional conflicts were declared.

2.0	**Terms of Reference (ToR) for:** • Finance, Performance and Investment Committee • Procurement Group • Business Case Assurance Group • Primary Care Contracts Sub Committee
	HB presented the terms of reference which have been adapted and enhanced from those in place for the legacy CCG equivalent groups to reflect the broader scope and duties that the ICB holds around wider determinants of health, enhanced support for communities and improving the health and wellbeing of the residents of NEL. Members discussed the terms of reference with key points including: • The Finance, Performance and Investment Committee ToR has similarities with those of the Audit and Risk Committee. Further emphasis should be given to the Scheme of Reservation and Delegation (SORD) to ensure that it is clear that the Audit and Risk Committee's remit is focussed on governance and scrutiny. • Budget holding should be made clearer in the SORD to demonstrate that places do not hold formal delegation. • Consideration should be given to having service user/ resident representation at the Finance, Performance and Investment Committee as the content of meetings can be disclosed under the Freedom of Information Act. • Consideration should be given to having clinical practitioner representation at the Business Case Assurance Group, despite clinicians being involved in business case development. • The Business Case Assurance Group and Procurement Group ToRs reference equality impact assessments, however they should include quality impact assessments too. • It would be beneficial to hold effectiveness survey more frequently than annually considering these committees and sub-committees are in their infancy. **ACTION:** HB to review the feedback on the Terms of Reference and consider whether any changes should be made to the ToRs. If changes are made, updated versions should be circulated prior to the next meeting. The Finance, Performance and Investment Committee approved the Terms of Reference for: • Finance, Performance and Investment Committee • Procurement Group • Business Case Assurance Group • Primary Care Contracts Sub-committee
3.0	**Month 6 2022/23 Financial Reporting**
	HB presented the report and highlighted the following: • The ICB has reported a year to date underspend of £7.5m which includes the clawback of £18.6m of Elective Recovery Funds from system partners. • The ICS has reported a system variance to plan at month 6 of £49.7m, primarily due to inflationary pressures and slower than planned delivery of system savings and cost improvements. • A financial recovery summit was held earlier in the day which included chief executive, chief finance officer, chief nurse and chief operating officer representation from all Trusts and local authorities in north east London. Discussion at the summit included:

	○ A workforce productivity group could be established to bring together collective resources and to share best practice. ○ An agreement in principle was made to breakeven in the second half of the year, however non-recurrent fixes will be required to achieve this. ○ Regional regulators have set an unofficial target of having a maximum £25m deficit at year end. Members discussed the report with key points including: • It is reassuring that the system is looking at this work together and there is a need to focus on admission avoidance and prevention. • The voluntary sector tends to receive short term funding which can be detrimental to long term issues. • Strong clinical leadership is required in order to drive changes. • Green shoots are being seen in recovery - BHRUT has reduced its off-framework staff from 300 per week to 100 per week and there has been an increase in recruiting whole time equivalent staff. • The Financial Recovery Group, which is a sub-committee of this forum, should present regular updates to the committee to allow members to challenge appropriately. • Further work is underway at place-level to determine key performance metrics which will enable enhanced performance reporting in excess of constitutional standards. • The interplay between improving performance and managing spend is difficult so quantifying risks should be captured in the financial strategy. The Finance, Performance and Investment Committee: • Noted the content of the report and the key risks to the expected year-end breakeven position. • Noted the performance report *Marie Gabriel left the meeting at 3.00pm*
4.0	**NHS NEL Financial Strategy Update: Our new ICS financial framework**
	SB presented the report and explained: • NHS North East London is working with partners to develop a financial framework for the system that enables improving health and wellbeing outcomes for residents. This will be achieved by adopting a model of joint stewardship for resources. • The approach is based on feedback following engagement with partners across the system and seeks to support the twin goals of financial stability and supporting all organisations and partnership forums to transform and improve services for our population. • The financial framework will: ○ Move, over time, to a population-based financial planning and funding approach ○ Allocate funding in a way that recognises the costs of care provision ○ Support transformation via a system investment pool • For 2023/24 a proportion of the ICB's budget will be allocated to the ICS investment pool. This should be set at an ambition of 1%, although recognising the financial climate is expected to be extremely challenging. Based on the 2022/23, the 1% would equate to approximately £40m. • It is expected that the majority of transformation will be delivered at place, however the prioritisation will be held centrally to ensure there is focus on system priorities. Members welcomed the report and raised the following points:

	• It would be helpful to see whether there are examples from elsewhere that can demonstrate the effectiveness of these frameworks. • The intention of the strategy is to drive activity away from acute hospitals, therefore consideration may be required as to whether this would lead to money being tapered out of acutes in the longer term. • There will be approximately £40m available in the investment pool budget, therefore it will need to be deployed wisely. Consideration should be given as to how the opportunities can be brought to life and generate innovative ideas. • In section 5.1 of the report, the term "reducing inequalities" should be amended to "reducing "inequities". • It would be beneficial to see a forecast version of the graphs in appendix B to visualise the aims we hope to achieve. The Finance, Performance and Investment Committee noted the report.
5.0	**Capital**
	SC presented the report and highlighted: • Year to date capital expenditure is £13.9m behind Capital Departmental Expenditure Limit (CDEL) plan and £7.2m behind national programmes. • Risk to delivering the agreed position is dependent on a new funding source in 2022/23 for the Newham modular build. • The system is experiencing issues regarding inflation, shortages of building materials and long lead in times which put delivering the full programme at risk. • The mitigations will be to review in the context of clinical need and the availability of funds the capital pipelines for the next 2-5 years while seeking additional national funding for Newham's issue with the modular build. Members discussed the report with key points including: • Sites, such at St Leonard's Hospital, could be utilised more efficiently which could assist in lowering costs. Work is underway to update the estates strategy which will include a review of the assets in north east London. • All infrastructure, including digital, could improve the position in the longer term. BHRUT is being actively encouraged to implement an electronic patient system. • There could be further opportunities with Section 106s. The Finance, Performance and Investment Committee noted the report.
6.0	**Business Cases for FPIC approval:**
6.1.	Creating a single fertility policy for North East London
	AG presented the policy to the committee and explained: • The five legacy CCG fertility policies were reviewed in order to create a single north east London policy to reflect the establishment of a single Integrated Care Board. • A Clinical Review Group (CRG) comprising of GPs and specialist clinicians from fertility services was set up and the legacy CCG commissioned an external public health specialist to produce a review of existing policies, comparing it with the latest clinical evidence and guidelines, against equality legislation and other organisations' policies. • The CRG then reviewed a set of possible changes to the policy using an assessment of their impacts on outcomes, hospital capacity, cost and equality issues and put forward recommendations for a new policy. • The policy has been endorsed by the Quality, Safety and Improvement Committee. Members welcomed the new policy and noted:

	• The new policy means that all boroughs in north east London will have equity of service as well as meeting NICE guidance. This is a very good example of levelling up. • Funding will need to be built in, however it is imperative that all residents have equity of service as they are now within the same legal body. • The business case was built using tariff figures, but block contracting may mean that the figures change. • There is a need to ensure that residents are aware of the policy as some communities may be unaware of the services available due to language barriers. • Going forward, business realisation should be demonstrated for all business cases. The committee approved the business case for the investment required for the new single north east London fertility policy.
7.0	**NHS System Oversight Framework (SOF) 2022/23**
	HB provided a verbal update on the system oversight framework and advised that the ICS is in SOF3 due to BHRUT being in SOF4. Further clarification is required on how to support BHRUT and move the system from SOF3 to SOF2. A report on this will be presented at a future meeting. Members noted the verbal update. *Marie Gabriel re-joined the meeting at 3.55pm.*
8.0	**NHS North East London financial policies:**
8.1.	Virement policy
	HB presented the report and explained that the virement policy is a technical policy that ensures safe and effective budget management. Budget virement is a key budgetary control tool that enables funding to be transferred between budgets in accordance with changes to service and business requirements, within a compliant controls environment. Members agreed that the virement delegation limit for the Director of Finance should increase from £1m to £10m. Subject to the amendment noted above, the Finance, Performance and Investment Committee approved the virement policy.
8.2.	Credit card policy
	HB presented the report and explained that the credit card policy has been reviewed and additional controls put in place to ensure only certain items are paid for via credit cards. Members discussed the report with key points including: • Further discussion is required as to whether the credit card policy should be approved by a committee of the Board going forward. • Training on NHS finance terminology would be welcomed as not all partners within the system are health-focussed. **ACTION:** KP, HB and MG to discuss the policy approvals process outside of the meeting. The Finance, Performance and Investment committee approved the credit card policy.
9.0	**NHS NEL Primary Care Prescribing Efficiency Plan 2022/23**

	SP presented the report and explained that the NHS NEL Primary Care Prescribing Efficiency Plan 2022/23 has been endorsed by the Integrated Medicines Optimisation Committee and aims to: • Promote efficient medicines use across NEL ICB GP practices • Reduce the current variation in primary care prescribing across NEL ICB • Support collaboration with key partners to identify opportunities for system wide prescribing efficiencies Members discussed the report and noted the following: • Savings made by each borough is different due to their difference in spend. • There is a need to improve ineffective prescribing in order to reduce spend. Reviewing prescribing behaviours could highlight areas where prescriptions are not necessary. The Finance, Performance and Investment Committee approved the scoped primary care prescribing efficiency plan.
10.0	**Standard Operating Procedure (SOP) for operating Primary Care Rebate Schemes (PCRS)**
	SP presented the report and highlighted that the Standard Operating Procedure (SOP) provides a set of underlying principles and a governance framework to manage the implementation of primary care rebates schemes (PCRS) as offered by the Pharmaceutical Industry. The updated SOP sets out a single central process for managing primary care rebates across NEL ICB. When evaluating schemes, clinicians will not be involved in the process due to conflicts of interest. The Finance, Performance and Investment Committee approved the updated governance process for signing up and administering Primary Care Rebate Schemes (PCRS) across NEL ICB.
11.0	**Approval of new NEL rebate schemes**
	SP requested that the new NEL rebate schemes are presented to the committee prior to the next meeting via email and that a decision is taken virtually as an exception. Members agreed to receiving a paper for virtual approval prior to the next meeting.
12.0	**Financial Sustainability – HFMA Checklist**
	RA presented the report and explained: • As part of the conditions set within the 2022/23 planning round, all NHS trusts and ICBs are required to complete a self-assessment against the Healthcare Financial Management Association's (HFMA) 'Improving NHS Financial Sustainability' checklist. The ICB has completed the self-assessment which has been reviewed and signed off by the Chief Finance and Performance Officer, Audit Chair and Chief Executive Officer. • The ICB has engaged its Internal Auditors (RSM UK) to complete an audit of the checklist, the audit scope was reviewed and agreed at the Audit and Risk Committee. RSM UK has commenced the audit and aim to issue their final report during November, which will be presented at Audit and Risk Committee on 7 December 2022. • Updates of the audit and the action plan will be brought back to a future committee as required.

	The Finance, Performance and Investment Committee noted the report.
13.0	**Any Other Business**
	The Chair advised that he will work with HB to develop a work plan for the committee and that an exception report will be drafted following the meeting and presented to the Board. Members discussed the date of the next meeting and agreed to change it from 3 January to 6 January 2023.
Date of next meeting: Friday 6 January 2023 10.00am- 12.00pm	

NHS
North East London

Minutes of the Population Health and Integration Committee

Wednesday 26 October 2022; 10.30am-12.30pm; F01 Unex Tower and MS Teams

Members:	
Marie Gabriel (MG)	Chair, NHS North East London and North East London Health & Care Partnership
Zina Etheridge (ZE)	Chief executive officer, NHS North East London
Cllr Maureen Worby (MW)	Local authority partner member
Dr Jagan John (JJ)	Primary care partner member, *via MS Teams*
Charlotte Pomery (CP)	Chief participation and place officer, NHS North East London
Imelda Redmond (IR)	Non-executive member, NHS North East London, *via MS Teams*
Fiona Smith (FS)	Associate non-executive member, NHS North East London
Noah Curthoys (NC)	Associate non-executive member, NHS North East London, *via MS Teams*
Attendees:	
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London
Fiona Taylor (FT)	Acting Chief Executive, London Borough of Barking and Dagenham, *via MS Teams*
Colin Ansell (CA)	Interim Chief Executive, London Borough of Newham, *via MS Teams*
Adrian Loades (AL)	Corporate Director of People, London Borough of Redbridge, *via MS Teams*
Ralph Coulbeck (RC)	Chief Executive, Whipps Cross Hospital, *via MS Teams*
Paul Calaminus (PC)	Chief Executive, East London NHS Foundation Trust
Jacqui Van Rossum (JVR)	Acting Chief Executive, North East London NHS Foundation Trust, *via MS Teams*
Siobhan Harper (SH)	Transition Director, NHS North East London
Hilary Ross (HR)	Director of Provider Development and Collaboration, NHS North East London, *via MS Teams*
Ellen Bloomer (EB)	Consultant in Public Health, NHS North East London
Katie McDonald (KMc)	Governance Manager, NHS North East London (minute taker)
Debbie Harris (DH)	Governance Officer, NHS North East London
Apologies:	
Paul Gilluley (PG)	Chief medical officer, NHS North East London
Andrew Blake-Herbert (ABH)	Chief executive officer, London Borough of Havering
Heather Flinders (HF)	Strategic Director of People, London Borough of Waltham Forest
Louise Ashley (LA)	Chief Executive, Homerton Healthcare NHS Foundation Trust
Will Tuckley (WT)	Chief Executive, London Borough of Tower Hamlets

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair welcomed those in attendance to the inaugural meeting of the Population Health and Integration Committee and introductions were made.

	The Chair explained that the initial meeting had been designed to set the scene and context of north east London's position which is why a group broader than the core membership had been invited. Going forward there will be a series of deep dives into place-based partnerships and collaboratives, so some colleagues may not need to attend.
1.1	Declaration of conflicts of interest
	The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the ICB. The Chair advised that her interest regarding Norfolk and Suffolk NHS Foundation Trust is historic and can be removed from the register. FS advised that she has completed a declaration, however the register has not been updated to reflect this. No additional conflicts were declared.
2.0	**Committee draft terms of reference**
	The Chair presented the committee draft terms of reference and explained the committee's role and responsibilities. The Population Health and Integration Committee approved the committee terms of reference. *At this point the order of agenda items was changed. Item 3.0 was reviewed at the end of the meeting so that discussions could inform the forward plan.*
4.0	**Population health profile for the North East London Health and Care Partnership**
	HR presented the report which supports the shift towards a population health approach for the system with clarity on the shared population health and inequalities challenges across north east London. The profile was published in May 2022 and has had support from the ICS Population Health and Inequalities steering group, which includes Directors of Public Health. Members discussed the report with key points including: • There is a need to have assurance as to how the health profile can assist the committee in diving into key issues. • This document should be held at the forefront when writing reports in order to clearly demonstrate how investments or changes to services will improve the health profile for our population. • There is a need to connect with wider data sets and to promote its contents widely so that it can be applied in a number of contexts and to continue to develop the profile. • There is an opportunity to for data and insight colleagues from across the system to work together in a more integrated way to further enrich the profile. • There is an important link to capturing community assets and strengths across north east London as we further develop this work. • The data should be used at Place Partnerships and in Collaboratives to drive change.

	The Population Health and Integration Committee noted the report.
5.0	**Introduction to Health Inequalities in North East London**
	HR presented the report which reflects an emerging approach and work in progress. HR highlighted the following key points: • There are significant health inequalities within north east London which are linked to wider social and economic inequalities, as well as structural racism and discrimination. • Action to reduce inequalities is primarily delivered at place and neighbourhood level through partnership working across the NHS and local authorities in addition to the voluntary, community and faith sector. • £6.4m has been allocated for place-based partnership investment to tackle health inequalities, support understanding of the inequalities affecting local communities and enhance community resilience and widen participation. • A further report regarding the ICS approach to health inequalities will be presented at the next committee meeting. Members welcomed the report and key discussions included: • As a system we need to evolve our approach to addressing inequalities so that it is fully embedded in our work and we can evidence the change we are seeking to make. • Coproduction with residents will be instrumental in driving change. • The £6.4m funding was welcomed by places, however the short timescale to spend was detrimental. • Barts Health is developing its strategy, therefore having alignment across all partners will be important. • Prevalence is often used as proxy for diagnosed prevalence, therefore some reporting has been presented inaccurately in the past. • There is a need to explore poverty explicitly as a driver for inequality as well as the broader frame of deprivation. • It is important to recognise power dynamics and creating equality of power with residents and service users. • An important cohort to focus on is our workforce. The majority of staff are also residents of north east London so including and engaging with them could be beneficial. The Population Health and Integration Committee noted the report.
6.0	**Working with People and Communities Strategy**
	CP presented the report which outlined the work to date in developing the North East London Working with People and Communities Strategy. The strategy is central to our approach to engaging with local residents in order to improve health and wellbeing and to deliver our wider objectives, including system sustainability. Members discussed the report and key points included: • We should be mindful of the language we use when discussing working with residents and communities; the stronger term “coproduction” should be used instead of “collaboration” as that is what we are aiming for. • The strategy should set out an ambitious vision and roadmap to implementation including a focus on moving beyond collaboration to co-production, on user/patient led models and on reciprocity and recognition as examples.

	• Residents should inform metrics to enable them to judge and evaluate the ICS which would also assist in creating equality of power. This would be enabled through a Big Conversation with residents. • Places and collaboratives will need to provide evidence of coproducing with residents by way of case studies. **ACTION:** Update to be provided at the next meeting to outline the key changes being made as a result of this discussion. The Population Health and Integration Committee noted the report.
7.0	**The development of Place Partnerships in north east London**
	CP presented the report which explained that place partnership leads have been nominated for each place and each also have a clinical director appointed. Each place ICB sub-committee has held its inaugural meeting where terms of reference and enabling documents were approved. CP provided an overview of the areas of work that places are looking at such as reducing waiting times for autism and cost of living. Members welcomed the update and noted the following: • There can be difficulties in explaining how the relationships and governance structures work at place and whole system level. It was explained that the committee's purpose is to provide oversight and assurance to the Board on how improved population health and integrated health and care, resulting in improved access, experience and outcomes for local people are being delivered by the seven place-based partnerships and provider collaboratives and their ICB sub-committees. The provider collaboratives and place-based partnerships are the drivers of delivery and the 'engine room' of innovation and transformation. The Population Health and Integration Committee noted the report.
8.0	**Provider collaborative updates and emerging workplans**
	Progress updates were presented by collaborative leads on developments since the formation of the ICS in July 2022. Discussion ensued with key points including: • There is a need to avoid silo working with transformation programmes such as Urgent and Emergency Care as a whole system approach is imperative. Further work is required to understand where social care wants to be represented. • It is important that conversations continue across collaboratives and with places as each further develops, including how pathways are created, how accountability is understood across those pathways and how delegation will support this. • It was agreed that using deep dives to feedback on developments across the system in terms of place partnerships, collaboratives and north east London would be helpful. These should be thematic rather than sectoral in their approach – for example, focusing on improving mental health and wellbeing across the system and how each element enables better outcomes for all residents. • The Voluntary Community and Social Enterprise Collaborative is still in development and will provide an update on its progress at the next appropriate opportunity.

	The Population Health and Integration Committee noted the report.
3.0	**Committee forward plan**
	The Chair presented the committee's forward plan and welcomed feedback and suggestions from members. It was suggested that the place and collaborative priorities items scheduled for December should be merged into one item to discuss priorities and emerging methods. The Population Health and Integration Committee noted the forward plan.
9.0	**Any other business and close**
	There was no other business to note.