NHS
North East London
Integrated Care Board

Agreed minutes – Audit & Risk Committee
22 June 2023, 2.00pm – 5.00pm, 4th floor, Unex Tower, Room F01

Members:	
Cha Patel (CPa) - Chair	Non-executive member
Imelda Redmond (IR)	Non-executive member – MS Teams
Kash Pandya (KP)	Associate non-executive member
Sue Evans (SE)	Associate non-executive member
In attendance:	
Auditors	
Dean Gibbs (DG)	External Auditor, KPMG
Carl Van Den Berg (CVdB)	External Auditor, KPMG - MS Teams
Nick Atkinson (NA)	Internal Auditor, RSM
Mark Kidd (MK)	Local Counter Fraud Specialist, RSM
Zina Etheridge (ZE)	Chief Executive Officer
Henry Black (HB)	Chief Finance and Performance Officer
Steve Collins (SC)	Director of Finance
Rob Adcock (RA)	Director of Finance
Tracy Rubery (TR)	Director of Partnerships, Impact and Delivery: Redbridge
Marie Price (MP)	Director of Corporate Affairs
Charlotte Pomery (CPo)	Chief Participation and Place Officer
Niall Canavan (NC)	Chief Information Officer – (Item 3.1)
William Cunningham-Davis (WCD)	Director of Primary care - MS Teams (Item 6.1)
Anne-Marie Keliris (AMK)	Head of Governance
Anna McDonald (AMc)	Senior Governance Manager
Apologies:	
Sunil Thakker (ST)	Director of Finance

1.0	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting. Apologies were noted. The Chair expressed condolences to Dr Kumar and his family on behalf of the ICB following the tragic incident that took place in Nottingham involving his daughter.
1.1	**Declaration of conflicts of interest**
	The register was noted and 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 conflicts were declared. Declarations declared by members of the Committee are listed on the ICB's register of interests. The register is available either via the Governance Team or the ICB's website.
1.2	**Minutes of the last meeting**
	The minutes of the meeting held on 24 April 2023 were agreed as a correct record.

1.3	**Actions log**
	The committee noted that the outstanding actions which were either in progress or included as part of the agenda.
2.0	**Annual report, accountable officer statement and annual accounts – CCG Q1 and ICB Q2 – Q4 22/23**
	2.1 External Audit ISA260 reports – CCG Q1 and ICB Q2-Q4 22/23 DG presented the report. The key messages were: • It is anticipated that an un-qualified opinion will be issued for both sets of financial statements and an un-qualified opinion will be issued in regard to regularity. • No significant weaknesses have been identified in the arrangements in place at the ICB for achievement of value for money. • Risks identified remain the same as previously reported and there are no items relating to risk on either of the audits to bring to the attention of the committee. • A slightly higher number of differences have been reported in regard to the CCG audit and one factual difference relating to the CCG regarding the Elective Recovery Fund (ERF) which does not require correcting as it does not impact the full year performance against resource limits. There are no concerns relating to the identified differences. • There are no concerns about the approach taken in regard to pensions which was raised as a concern earlier in the year. As part of the discussion, DG thanked everyone involved for the support and collaboration received in reaching the positive position. In turn, the Committee commended the finance team for their hard work. HB added that a huge amount of work has been undertaken with no major concerns having been identified which is a credit to everyone involved. **2.2 Head of Internal Audit Opinion** NA advised that the opinion remains positive and advised that further detail would be given as part of the discussion under agenda item 8.0. **2.3 Draft letters of representation – CCG and ICB** HB presented the standard draft letters which were noted by the Committee. **2.4 22/23 Annual reports - CCG Q1 and ICB Q2-Q4** MP presented the two reports. The key points were: • The helpful feedback provided at the Committee meeting held in April and the feedback received from NHS England has been followed up and the reports have been amended accordingly. • There have been some additional requirements for the ICB's report which reflect the additional statutory requirements in areas such as safeguarding. • Minor updates have been made to the ICB's objectives. As part of the discussion, MP thanked the Governance and Communications teams for the work achieved. Thanks were also conveyed to MP and it was noted that the reports reflect the extraordinary amount of work undertaken during 22/23. SE to feedback some very minor comments to MP after the meeting. **ACTION: SE** **2.5 22/23 Annual accounts – CCG Q1 and ICB Q2-Q4** The Committee noted the draft accounts and no additional comments were made. The Audit and Risk Committee:

	• approved the External Auditors' Summary and ISA260 report • approved the Internal Auditors' Head of Internal Audit Opinion • approved the draft annual reports, accountable officer statement and draft annual accounts (legacy CCG and ICB) • Recommended approval to the ICB board.
3.0	**Information Governance & IT**
	3.1 Draft Digital Strategy NC presented the draft strategy. The key messages were: • The digital strategy is an ICS strategy aimed at all the providers across the north east London system including social care and is being co-produced with our system partners. • It is an iteration but it is a mature strategy as the organisations involved have been working together for some time. • The focus of the strategy is on four levels; o Level 0 – Infrastructure/core systems – the plan is to maintain a strategy of minimising the number of systems across north east London and as part of this, BHRUT is submitting a business case to move onto the Barts Health Electronic Patient Record (EPR) system. o Level 1 – Shared records - this will enable information to be shared between providers. o Level 2 – Population health/advance analytics – this includes initiatives such as the 'Discovery Collaborative' and the 'London Data Service'. o Level 3 – Patient access – this includes 'Patient Knows Best'. • There is an increasing national focus on digital maturity. NHS England is looking at individual providers and a digital maturity assessment is being completed for publication. • The digital agenda is a huge demand on capital funding. Committee members welcomed the draft strategy and made the following comments: • We must ensure we prioritise the 'spend' in the right priority areas and be able to demonstrate how we determined our priorities. • The strategy needs to be ambitious for the whole system. • More needs to be included in regard to wider system partners such as social care providers and needs to include opportunities as to how we can help to digitise them. • A part of the 'residents' vision' section, the strategy needs to detail what the benefits of digital will be for our residents to make it clear to them. • The strategy needs to link to the Population Health Strategy and include population health data so that it informs the IT work. • Short and long-terms milestones need to be set so we can see where we want to be in five years. HB/NC to follow-up the comments. **ACTION: HB/NC** The Audit and Risk Committee: • Reviewed and commented on the draft strategy. **3.2 Information Governance / IT Policies and Data Security & Protection Toolkit submission 22/23** HB presented the report. The key messages were: • NHS NEL ICB is required to submit a Category 1 Data Security and Protection Toolkit (DSPT) by 30 June 2023.

	• As at 13 June, 111 out of 113 mandatory assertions had been completed and the remaining two will be completed by 23 June 2023 in advance of the submission. • All policies, frameworks and procedures have been updated to reflect the formation of the ICB and they have been reviewed and recommended by the Information Governance Steering Group to the Audit and Risk Committee for ratification. As part of the update, HB thanked Jamie Sheldrake, Strategic IG lead and Natasha Prowse, Information Governance Compliance manager for their comprehensive work in getting the ICB to this position. NA clarified that RSM has audited the self-assessment of the DSPT and are satisfied with the content. The Audit & Risk Committee: • Ratified the Information Governance (IG) and IT policies • Noted the Status of the Data Security and Protection Toolkit submission. **3.2.1 Summary of IG/IT policy changes** HB presented the summary and explained that the IG/IT policies have been reviewed by the Information Governance Steering Group. In order for the Committee to be assured that the process that these particular policies go through is robust, NA suggested that a review of the process could be undertaken as part of the work RSM undertakes on the DSPT. The Committee agreed. NA to add the review to Internal Audit's work plan. **ACTION: NA.** SC to follow-up a query in regard to the 'Network Security' policy which had a review date of December 2021 and feedback to KP outside of the meeting. **ACTION: SC** The Audit and Risk Committee noted the summary update.
4.0	**Performance and planning**
	4.1 Procurement Group progress report TR presented the report to update committee on the progress made to date. The key points were: • A review of the Procurement Group's Terms of Reference is taking place in order to address a number of issues which have arisen such as; below threshold procurements; quoracy; urgent action. • E-procurement – as previously reported to the Committee, the metrics to monitor Purchase Order (PO) performance going forward have been altered and the underlying report to generate the statistics has been reviewed. compliance for Month 2 was 50.59%. Further work is being carried out to improve ICB PO performance against revised national measures, most notably the mandated move to 100% PO compliance by NHSE from April 2024 linked to the roll out of a new finance system. An action plan in respect of this is due by the end of July 2023. Targeted work to reduce the number of "on hold" POs is being carried out which has seen a positive impact over the last 2 months. • Procurement pipeline – a pipeline for the upcoming two-year period has been requested to share with the Procurement Group on a rolling quarterly basis to enable forward planning and to inform the procurement work programme for 23/24. The first report has been presented which demonstrated that only one fifth of the clinical contract portfolio currently have plans for re-commissioning in place. Some principles around procurement at a NEL, Place or multi-place need to be set so that post consultation teams can appropriately plan for their

	procurements. To help move this forward, the pipeline is being reviewed in order to identify key priorities and align them to the ICB's chief officers. • Single Tender Waivers (STWs) - 24 waivers have been submitted to date in this financial year. This is a reduction in the number of STWs submitted when compared to January to March. • Risks - remain unchanged from those reported previously. The key discussion points were: • CHC - clarity is still awaited as to whether CHC will be included in the 100% PO compliance. SC confirmed that a single system for CHC is being procured. • Gaps in resources – it is hoped that the gaps will be made clearer once the ICB's new structure is launched and this will enable a plan to be put in place. The outcome of the re-structure will also inform who needs to undertake training on the new PO system. • KP/TR to discuss the St Joseph and St Francis procurements outside of the meeting. **ACTION: KP/TR** The Audit and Risk Committee noted the update.
5.0	**Risk**
	5.1 Risk management update MP presented the report. The key messages were: • The ICB board considered the latest version of the Board Assurance Framework (BAF) at its meeting on 31 May 2023. • Governance team members are continuing to work with the executive team and department risk champions to ensure the risks are described with sufficient detail with appropriate controls and mitigations. • The corporate risk register is due to be reviewed and scrutinised by EMT in early July. • The risk in regard to collaboration and working together is more positive and there is an event in July where all the members of the Integrated Care Partnership will meet to review how effective the work being undertaken is and how the work in regard to the four key priorities is progressing. • Governance team members are working with the executive to ensure the risk management policy and strategy is implemented across the organisation to enable the Datix risk management system to be introduced during Q3 2023/24. • A risk report template is being developed to ensure consistency across all committees. The discussion points were: • More mitigations need to be included to ensure the risks are described with sufficient detail. • Target dates need to be reviewed regularly. • The need for an update on red rated risks and an understanding of what the impact of the cumulative risk is. MP explained that this is still work in progress and more work needs to be done to embed the process across the organisation adding that the new re-structure of the organisation will help. CPo to feedback the comments to the Executive Management Team (EMT. **ACTION: CPo** The Audit and Risk Committee:

	• Noted the update • Noted that the board assurance framework was considered by the ICB board at its meeting in May. **5.2 Digital risks** HB presented the digital risks and explained that from a cyber security perspective, the Horizon View system in operation at the ICB is one of the most secure systems available. The discussion points were: • The National Cyber Security Centre – assurance was given that we do link in with the centre and receive their alerts. • The Chair suggested that it would be helpful to share with the system any lessons learnt from the experience of cyber-attacks that Barts Health and others had such as the best way to deal them. **ACTION: HB/SC.** Members were advised that the two biggest causes are not keeping up with the patches that are regularly released and human behaviour. • The need for staff to always be up to date to date with mandatory training. • The need to ensure there is enough capacity in the system for this area of work, noting that NC is working across the whole system. The Audit and Risk Committee noted the digital risks register.
6.0	**Governance**
	6.1 Update on the transfer of additional primary care services (pharmacy, optometry, dental) WCD gave a verbal update on the transfer. The key messages were: • Consultations with NHS England staff have been completed. • HR is transferring the 23 staff files across to the ICB so they can be added to the Electronic Staff Record (ESR) system. • A 'welcome meeting' has been held with the staff and was well received. All the staff have been issued with ID badges and laptops. • The Terms of Reference for the Primary Care Contracts sub-committee have been updated. • The additional primary care services (PODs) have been added to the risk register. • The team is a hub model serving the rest of London and is operating in shadow form at the moment. • There are 6000 contracts across London and there is still work to do in regard to the ledgers. • Data migration will continue to sit with NHS England and the team will still be able to access the data whilst working with IT on the migration. The Chair advised that she had attended the 'welcome meeting' and met the team and was encouraged by their enthusiasm to work with us. The Committee were pleased to learn that everything is on track for the transfer date and that there are no areas of concern to bring to the attention of the ICB board. **6.2 Feedback following the Internal Audit on the transfer of pharmacy, optometry and dental services** NA commented that this has been a positive piece of work and undertaking the audit was a helpful exercise as it was carried out in real time. He added that it was pleasing to see that lessons have been learnt from similar transfers that have taken place previously.

	The Audit and Risk Committee welcomed the positive update.
7.0	**External Audit**
	7.1 Auditor's annual report – 22/23 It was noted that this report was still outstanding. DG to share it after the meeting. **ACTION: DG** The key messages were: • It is a requirement for External Audit to provide a public facing commentary which sets out their assessment of the processes and procedures that the ICB has in place to enable the ICB to achieve value for money. • The commentary had been previously presented to the committee in March where a significant risk had been flagged relating to the financial sustainability position of the ICS as a whole. DG confirmed that it has since been determined that there is not a significant risk within the arrangements. • The public facing commentary needs to be published on the website alongside the annual report and accounts. **ACTION: CPo/HB** MP advised that the ICB is not required to hold an Annual General meeting (AGM) this year. The Audit and Risk Committee welcomed the positive verbal update and looked forward to seeing the report within the next few days. **Action: DG**
8.0	**Internal Audit**
	8.1 Auditor's Annual report including Head of Internal Audit Opinion (HoIAO) 2022/23 NA presented the annual report including the HoIAO. The key messages were: • The final HoIAO for 2022/23 was included as part of the IA annual report which provided a summary of the work undertaken for the period between 1 July 2022 and 31 March 2023. • The overall opinion has not changed from the version presented in March 2023 which concludes that the organisation has an adequate and effective framework for risk management, governance and internal control. However, the work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. • Final reports have been issued for: o Data Security Protection Toolkit – Substantial Assurance o Delegated Duties (Dental, Optometry and Pharmacy) - Advisory • The report included actions taken to remedy the issues outlined in the 2022/23 partial assurance opinion reports in 2022/23: o IR35 o Procurement and Contract Register o Medicines Optimisation • The Continuing Healthcare (CHC) - there were eight actions, four of which are now closed and progress has been made against the remaining four. NA to bring an update back to the next meeting. **ACTION:NA** The Audit and Risk Committee noted the report content.

	8.2 Internal audit Plan 23/24 and three-year strategy NA explained this was being presented later in the year than usual due to the recent tendering exercise. The key messages were: • The plan is based on analysing the ICB's corporate objectives, risk profile and assurance framework as well as other factors affecting the ICB in the coming year, including changes within the sector and the subsequent impact of any new responsibilities • The plan is similar to the version which formed part of the tendering process with slight variations in timing of work mainly resulting from feedback from Management. • The plan will be shared with the ICB's Executive Team at its meeting on 4 July 2023 for final comment. The Committee welcomed the plan and made the following comments: • Estates Strategy and Capital Program - to be brought forward. • Discovery Audit – assurance to come back to the committee as part of the follow-up. • Reports planned for February 2024 - to be shared where possible with the Committee in between committee meetings. HB/NA to update the plan where required. **ACTION: HB/NA** As part of the discussion, NA clarified that the narrative in the plan in regard to Personal Health Budgets related to the original actions and confirmed that the work has been completed. The Audit and Risk Committee: • Noted the final reports on Data Security Protection Toolkit and Delegated Duties (Dental, Optometry and Pharmacy) • Noted the Annual Report 2022/23 and Head of IA Opinion 2022/23 • Approved the Internal Audit Plan 2023/24 and three-year strategy.
9.0	**Local Counter Fraud Specialists (LCFS)**
	9.1 Annual report – 22/23 MK presented the annual report which provided a summary of the LCFS work undertaken during 2022/23. The key messages were: • The Counter Fraud Functional Standard Return 2022/23 resulted in an overall rating of green for the ICB. • Seven training sessions were provided during the year focusing on fraud and bribery and conflicts of interest with 553 members of staff taking part which equates to 50% of ICB staff, which MK advised is exceptionally high in comparison to other organisations. • In addition to the training, staff receive regular alerts and reminders. The Audit and Risk Committee: • Noted the annual report. **9.2 Draft work plan – 23/24** MK presented the draft workplan which provided details of the work planned for 2023/24. The key messages were: • The joint approach with Internal Audit will continue. • Training sessions will be organised and the sessions are likely to follow the same format as the previous year which proved successful.

	• NHS England's conflict of interest training is not going to be mandatory Discussion points included: • Population health and digital risk - an audit on population health and health in-equalities is included in the Internal Audit plan. NA to review the scope of the audit to check that it includes risk. **ACTION: NA.** • Contamination risk within the system – NA advised that an Internal Audit Working Group is being developed across north east London to share information across the system. • Pharmacy, optometry and dental services (PODs) – LCFS work relating to these services will remain with NHS England but it was agreed that it would be helpful for referrals to go via MK for monitoring purposes and to ensure the committee is sighted on them. It will still be possible for the ICB's LCFS to provide training for PODs staff. MK to include contact details for the NHSE LCFS team in training slides etc going forward. **ACTION: MK** The Audit and Risk Committee: • Approved the work plan.
10.0	**Finance**
	10.1 Finance overview HB reported that the month 2 position is very concerning and there is a lot of work to be done. Recovery plans are in place for CHC and prescribing, noting that prescribing is extremely high risk. The Audit and Risk Committee: • Noted the update and the significant challenges ahead.
11.0	**Future planning**
	11.1 Committee workplan – 23/24 DG confirmed that a report on the mental health investment standard will come to either the September or December meeting. AMc to add the report to the committee's work plan. **ACTION: AMc** The Committee members noted the committee's workplan. **11.2 Items for exception report to next ICB board meeting** The Chair advised that an exception report for the July board meeting would be drafted after the meeting. **11.3 Items to disseminate** KP in his capacity as chair of the Finance, Performance and Investment Committee advised that a deep dive on prescribing is on the agenda for the meeting on 26 June and he will be seeking assurance that we are doing everything we can that is within our control.
12.0	**Items for information**
	12.1 Procurement group minutes The committee noted the minutes of the meetings held in April and May 2023. **12.2 Information governance group minutes** The committee noted the minutes of the meetings held in April and May 2023.
13.0	**Any other business and close**

	Personal thanks, gratitude and best wishes were paid to MP as it was her last Audit and Risk Committee before moving on to a new role in a different NHS organisation. In return, MP thanked everyone for the support and co-operation she has received during her time working within north east London.
	Date of next meeting – 30 August 2023

Minutes of the Executive Committee

Tuesday 13 June 2023; 3.30pm – 5.30pm; via MS Teams

Members:	
Zina Etheridge (ZE) - Chair	Chief Executive 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
Francesca Okosi (FO)	Chief People and Culture Officer, NHS North East London
Johanna Moss (JM)	Chief Strategy and Transformation Officer, NHS North East London
Henry Black (HB)	Chief Finance and Performance Officer, NHS North East London
Shane DeGaris (SD)	Group Chief Executive, Barts Health NHS Trust
Paul Calaminus (PC)	Chief Executive Officer, East London NHS Foundation Trust
Matthew Trainer (MT)	Chief Executive, Barking, Havering and Redbridge University Hospitals Trust
Jacqui Van Rossum (JVR)	Acting Chief Executive Officer, North East London NHS Foundation Trust
Andrew Blake-Herbert (ABH)	Chief Executive, London Borough of Havering
Heather Flinders (HF)	Strategic Director of People, London Borough of Waltham Forest
Colin Ansell (CA)	Interim Chief Executive, London Borough of Newham
Mark Gilbey-Cross (MGC)	Director of Nursing and Safeguarding, NHS North East London *(representing Diane Jones)*
Basirat Sadiq (BS)	Deputy Chief Executive Officer, Homerton Healthcare NHS Foundation Trust *(representing Louise Ashley)*
Attendees:	
Hilary Ross (HR)	Director of Strategy, NHS North East London
Susan Nwanze (SN)	Interim Director of OD and Education, NHS North East London
Claire Hogg (CH)	Director of Planned Care, North East London Acute Provider Collaborative & ICS
Laura Anstey (LAn)	Chief of Staff, NHS North East London
Katie McDonald (KMc)	Governance Manager, NHS North East London
Apologies:	
Tim Aldridge (TA)	Corporate Director of Children and Young People, London Borough of Newham
Louise Ashley (LAs)	Chief Executive Officer, Homerton Healthcare NHS Foundation Trust
Sarah See (SS)	Managing Director of Primary Care, NHS North East London
Diane Jones (DJ)	Chief Nursing Officer, NHS North East London
Gladys Xavier (GX)	Director of Public Health, London Borough of Redbridge

Item No.	**Item title**
1.0	**Welcome, introductions and apologies**
	The Chair welcomed members to the 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.
1.2	Minutes of the meeting held on 9 March 2023
	The minutes of the meeting held on 9 March 2023 were agreed as an accurate record.
1.3	Actions log
	Members noted the actions taken since the last meeting and agreed to close ACT003 and ACT006.
1.4	Matters arising
	The Chair advised members that the committee terms of reference have been amended to state that the frequency of meetings is bi-monthly. This amendment was approved by the ICB Board as part of the Governance Handbook review on 31 May 2023. The Executive Committee noted the update.
2.0	**Major conditions strategy - call for evidence**
	HR presented the report and explained: • The major conditions strategy will seek to address the need to refocus clinical pathways toward prevention, diagnosing early and preventing avoidable exacerbation. • On 17 May 2023 a call for evidence for the Major Conditions Strategy was launched. The call for evidence will build on the insights from recent evidence calls in respect of cancer and mental health during 2022. • The call for evidence will be important strategically and provides the opportunity to highlight personalised care and health inequalities. • The strategy now includes mental health and cancer, which has been a source of contention. • To input to the major conditions strategy call for evidence, the ICB is coordinating a system response by the deadline of 26 June 2023. Members discussed the report, with key points including: • Concerns were raised regarding the government not providing a separate 10-year mental health strategy. • Consideration should be given as to whether the strategy can be more specific and reference types of mental health, age (children and young people's or adults' services), and populations; at present it is quite a broad scope. • There are significant differences between preventing mental health crisis and managing long-term mental illness, therefore including mental health in this strategy may be problematic. • Consideration should be given as to how best practice can be scoped in north east London. • There is the opportunity to include the wider determinants of health in this strategy. • The strategy implies that effective primary care is needed in order to enable residents living with long-term conditions to live well. • HR agreed to share the response with members once finalised. **ACTION:** HR to share the response to the call for evidence with members once finalised. The Executive Committee:

	• Endorsed the approach being taken to collate responses • Provided a steer on any particular areas and / or content that should be included in the NEL response noting that the opportunity to respond in some areas is limited. • Considered the mental health response in the context of the recent national change which saw it included in the major conditions strategy rather than as a separate strategy. • Considered any additional information for the cancer response in light of previous cancer call for evidence results highlighting the need to prioritise prevention.
3.0	**NEL System People and Workforce Strategy**
	FO and SN presented the paper and highlighted the following points: • The final five-year strategy will be approved in the autumn and the ask of the executive committee is to approve the strategic priorities ahead of being presented to the ICB board in July. • There are seven strategic priorities which have been a co-designed with the system and involved partners from across the voluntary sector, independent and social care providers. The priorities are: o Parity; pay and employment - how we can achieve better equity in pay and benefits between health and care employment terms and conditions. o Portability; one workforce - how we can use digital systems and other interventions to support 'one workforce' development and enable effective joint teams, seamless working and deployment across health and care employers. o Planning; operational planning - how we will strengthen our capability for pro-active, joined up, system-wide operational and strategic planning o Partnership; addressing health inequalities - how we will address inequities in the system and ensure access to employment opportunities for young people, older people and under-representative groups in our populations. o Purpose; grow our talent - how we will strengthen collaboration between education institutions and health and care providers to develop a continuous supply pipeline of talent to be channelled into innovative flexible careers. o Population; diversity and inclusion - how we will engage with our residents, under-represented groups, young people and older people in our diverse communities to co-design work opportunities. o Productivity; health and wellbeing - how we will put in place interventions to support, develop and ensure the health and mental well-being and resilience of all our system health and care workforce to enable and retain a productive, motivated and sustainable 'one workforce'. • Task and finish groups for each of the seven high-level strategic priorities will be established to develop detailed short, medium, and long-term action plans. Each task and finish group will develop key performance indicators and outcome measures to support action plans. Members discussed the report with key points including: • The strategy should outline how it can reliably improve outcomes through an anchor institution lens. • A system-wide strategy would be welcomed and further inclusion of social care is required to deliver this. • The NHS long-term workforce plan and social care strategy have yet to be published, however the development of the NEL system strategy should continue in order to maintain momentum. • The final strategy will be presented to the Executive Committee in October, prior to seeking approval from the ICB board.

	The Executive Committee agreed the proposed high-level strategic priorities.
4.0	**Joint Forward Plan and next steps**
	JM presented the report and explained: • Since distribution of the paper, the request of the committee has changed. Delays to starting the Big Conversation has meant that resident-shaped metrics have yet to be developed. • As engagement with residents is an important part of the plan, it has been agreed that an interim plan will be submitted with the final plan being finalised in autumn following engagement with residents. • An online questionnaire is due to be launched this week as part of the engagement. • There is live discussion as the whether national guidance will be issued regarding the development of strategies. The Executive Committee noted the update. *Jacqui Van Rossum joined the meeting at 4.15pm.*
5.0	**Delegation of primary care complaints**
	CP presented the report and highlighted the following points: • North East London ICB became responsible for the management of primary care complaints on 1 April 2023 and will become operationally responsible on 1 July 2023 when the staff resource to take on this additional work is transferred over to ICBs and to NHS North East London specifically. • The clinical review process required for complaints cases involving the performance of clinical staff will continue to be provided by NHSE for a period of 12 months as options for its future delivery are explored. • From 1 July 2023, NEL ICB will: o Be responsible for, and will manage, primary care complaints, including from Members of Parliament, as well as enquiries, calls and correspondence o Manage the complaints staff who deal with the primary care complaints for NEL ICB. They will transfer to the ICB following a staff consultation which started on 26 April. These staff will continue to manage any open complaints cases for NEL ICB on 1 July 2023 o Integrate the staff from NHSE into the existing team – creating one team to work across NEL ICB o Have access to the complaints data from NHSE for up to 12 months o Have revised its complaints policy to incorporate relevant processes, including, consent and the clinical review processes o Have developed a new process for the management of enquiries for NEL ICB. Members discussed the report and points included: • It could be beneficial to provide Health and Wellbeing Boards and Health and Scrutiny Committees with an update on the process. • Stakeholders have been formally written to in order to advise them where complaints should be directed to. The Executive Committee noted the report.
6.0	**Patient choice – new NHS guidance**
	CH presented the report and explained:

	• On 25 May NHS England published a letter to the NHS regarding measures to improve patient choice which sets out actions to be taken in primary care, acute care and by ICBs. • Primary care and clinical assessment services are expected to offer patients a choice of a minimum of five providers, which can include independent sector and out of area. Referrers are asked to actively encourage patients to manage their own referral on eRS or the NHS app. • The Covid recovery programme has meant that there have been restrictions to referrals in place, however the Planned Care Board have now agreed to lift these. The lifting of restrictions will be timed across the system appropriately in phases and it is anticipated that all restrictions will be removed by the end of August 2023. • By 31 August, all NHS Trusts should have rolled-out the Digital Mutual Aid System (DMAS) to support the provision of mutual aid for long waiters. A Patient Initiated system (PIDMAS) is in development which will allow patients to 'opt-in' to move providers where waiting for over 40 weeks. • ICBs have been asked to ensure that patient transport costs are not prohibitive to patients exercising choice. • The ICB is required to identify a Senior Responsible Officer for patient choice. Members discussed the report and key points included: • The implications of this will be unknown until residents begin to exercise choice, however it is anticipated there will be no significant change as evidence suggests that patients would rather wait longer for an appointment if the site is closer to home. • There is a diverse population in north east London, therefore it would be beneficial to conduct an equality impact assessment and identify mitigations to demonstrate whether this could exacerbate any health inequalities. It is possible that residents who are more economically deprived will wait longer for treatment as they cannot afford to travel further than their local hospital. • Further thought is required to determine what support can be given to GPs in discussing choice with their patients and help to reduce inequalities. • There could be scope to involve patients in this work. • If evidence shows that this leads to an increase in boundary crossing, then discharge pathways may need reviewing. **ACTION:** Equality impact assessment to be conducted and mitigations identified. The Executive Committee noted the contents of the letter and the actions required of ICBs, primary and secondary care.
7.0	**Month 12 2022-23 finance overview**
	HB presented the M12 report and provided a verbal update on the M2 position, with key points including: • The final ICS year-end M12 reported position is a deficit of £24m. This is approximately the same as the month 11 reported deficit. • The deficit position is driven by two system providers, Barts Health and BHRUT. Their combined deficit at year-end is £27.4m which has been partly offset by a reported surplus at ELFT, NELFT and Homerton, resulting in a provider year-end variance to plan of £24.1m. The ICB reported a very small surplus of £0.04m. • At M2 the ICS is approximately £24m off plan, however this is not a significant cause for concern as M2 is typically difficult as there are many new schemes starting which are yet to demonstrate the benefits. This also does not mean the ICS cannot achieve a breakeven position. • A clearer understanding of the overall position can usually be expected during Q2, however the impacts of the industrial action may affect this.

	Members discussed the report, with points including: • The industrial action taking place poses a significant risk to Elective Recovery Fund. If junior doctors strike every month for the rest of the year, this could cause an additional 2500 patients being added to the waiting list. • The amount the industrial action could cost is being quantified at a London level with system Chief Finance Officers and Directors of Finance. The Executive Committee noted the report.
8.0	**Clinical Advisory Group update**
	PG presented the report and explained: • The Clinical Advisory Group (CAG) is a sub-committee of the Executive Committee and is required to report into the committee on a regular basis and to escalate any issues as required. • The sub-committee conducted a further review of its membership and revisions were agreed to strengthen the membership to ensure it was representative of the whole system, including allied health professionals. These changes were approved by the ICB Board in May as part of the governance handbook. The Executive Committee noted the report.
9.0	**Committee effectiveness survey results**
	ZE presented the effectiveness survey results to members, highlighting the comments on what has worked well and what could be improved. Members suggested that meetings held in person should be reserved for development sessions, but that business and decision-making can continue on a virtual platform. The Executive Committee noted the report.
10.0	**Any other business**
	ZE raised three items of other business and discussions included: <u>Letter from Metropolitan Police regarding mental health callouts</u> • Several conversations have been held with local authorities across London, as well as mental health Trusts. • A small roundtable event has been organised and will include ZE, PC, JVR, ABH and three Basic Command Unit (BCU) commanders from the Metropolitan Police. • A partnership board is being established to review the implications and work through mitigations. • An ICB and ministerial roundtable meeting is being held on 14 June to set out the London ICBs' views on the announcement. • Local-level data by borough, not BCU, is being sought to understand what this could mean for north east London. <u>Asylum seeker hotels</u> • At its meeting earlier today, the ICP Steering Group discussed that the Home Office's proposal to moor a barge in Newham to house asylum seekers is in abeyance due to strong opposition. However, there is a request to increase the number of beds, but not rooms, in contingency hotels. • There are significant safeguarding concerns in addition to concerns regarding overcrowding and the wellbeing of individuals. • There could be considerable impact on local services as healthcare resources will become more pressured. It would be beneficial to know whether each place-based partnership is aware of their potential pressures.

	• There is no statutory framework for quality of care in place; i.e. not CQC or Ofsted, therefore it is the responsibility of local authorities. • GPs need to be enabled to work with this cohort of people. • It is challenging to have discussions directly with the Home Office on this topic as most aspects of the contingent are subcontracted. • A system-wide strategic workshop is being arranged to set out the implications in north east London and to share best practice and data. <u>NHS Parliamentary awards</u> • ZE was a judge at the NHS Parliamentary awards which included some very good nominations from within north east London. • Nominations and winners will be shared once announced.
11.0	**Key messages to feedback to the ICB Board (exception report)**
	There were no items of exception to escalate to the ICB Board.
	Date of next meeting – 7 September 2023 (TBC)

Minutes of the Executive Committee

Thursday 13 July 2023; 4.15pm – 4.45pm; via MS Teams

Members:	
Zina Etheridge (ZE) - Chair	Chief Executive 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
Francesca Okosi (FO)	Chief People and Culture Officer, NHS North East London
Johanna Moss (JM)	Chief Strategy and Transformation 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
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
Matthew Trainer (MT)	Chief Executive, Barking, Havering and Redbridge University Hospitals Trust
Heather Flinders (HF)	Strategic Director of People, London Borough of Waltham Forest
Gladys Xavier (GX)	Director of Public Health, London Borough of Redbridge
Attendees:	
Lorraine Sunduza (LS)	Chief Nurse and Deputy CEO, East London NHS Foundation Trust
Malcolm Young (MY)	Executive Director of Finance, North East London NHS Foundation Trust
Dr Ben Molyneux (BM)	Associate Medical Director for Primary Care, NHS North East London
Laura Anstey (LAn)	Chief of Staff, NHS North East London
Katie McDonald (KMc)	Governance Manager, NHS North East London
Apologies:	
Tim Aldridge (TA)	Corporate Director of Children and Young People, London Borough of Newham
Sarah See (SS)	Managing Director of Primary Care, NHS North East London
Jacqui Van Rossum (JVR)	Acting Chief Executive Officer, North East London NHS Foundation Trust
Andrew Blake-Herbert (ABH)	Chief Executive, London Borough of Havering
Colin Ansell (CA)	Interim Chief Executive, London Borough of Newham

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair welcomed members to the 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	**Same day access hubs**
	JM and BM presented the report and highlighted the following points: • GP extended access hubs were established in 2015/16 and were nationally funded and intended to support 8am-8pm, 7-day primary care same-day access. From October 2022, national funding for these services was redirected through the Enhanced Access Directed Enhanced Service (DES) but due to the differences in the historic services and the new Enhanced Access DES there was a risk that there would be cuts to same day access coverage across London, leading to the services being extended for six months from October 2022 to March 2023. This was funded in part by NHSE via London Region. • This extension left the same risks in place and another six-month extension was approved by the Finance, Performance and Investment Committee with instruction to serve notice to terminate the current contracts from end of September 2023. • The access hubs are a critical service particularly during the winter months and provide over 200,000 appointments per year. This provision has met demand in the system that would otherwise put pressure upon already stretched Urgent and Emergency Care (UEC) services. There is general census that without this service, urgent primary care activity would present at A&E or Urgent Treatment Centres (UTCs) which adds increased demand upon the system throughout the winter months. • The business case proposes a more cost-effective model for the access hubs and requests three years funding, from 01.10.23 – 31.09.26 at a total cost of £22,881,021 (£7,627,007 annually). This would allow the system to develop a new approach to Primary Care Network (PCN) led models within the context of a three-year plan aligned with the System Integration Programme (Fuller). The business case has been endorsed by the ICB's Executive Management Team, Business Case Assurance Group and Finance, Performance and Investment Committee and now requires final approval by the Executive Committee due to the total value of investment required. Members discussed the report with points including: • The proposed funding arrangements are complex to understand; therefore, it would be beneficial to receive further detail ahead of taking a decision. • It would be helpful to understand whether consideration has been given to the impacts of investing this funding into UTCs rather than general practice. The Executive Committee agreed to further consider the proposal following receipt of an amended report which includes the additional information requested by members. The proposal will then be circulated to members by the governance team for decision by way of virtual approval via email. **ACTION:** JM to amend report to include the additional information requested by members. **ACTION:** KMc to circulate proposal to members for virtual approval via email.
3.0	**Any other business**
	There was no other business to note.
	Date of next meeting – 7 September 2023

NHS
North East London

Minutes of the NEL Finance, Performance and Investment Committee meeting

Monday 26 June 2023, 1400 – 1630 meeting in room FO1, 4th Floor, Unex Tower, Station Street, Stratford, London, E15 1DA

Members:	
Kash Pandya (KP) - Chair	Associate Non-Executive Member, NHS North East London
Cha Patel (CP)	Non-Executive member for Audit, NHS North East London
Fiona Smith (FS)	Associate Non-Executive Member, NHS North East London
Henry Black (HB)	Chief Finance and Performance Officer, NHS North East London
Dr Mark Rickets (MR)	Primary Care Partner Member
Mayor Philip Glanville (PG)	Local Authority Partner Member
Mohit Venkataram (MV)	NHS Trust Partner Member
Attendees:	
Marie Gabriel (MG)	Chair, NHS North East London
Rob Adcock (RA)	Deputy Chief Finance Officer, NHS North East London
Clive Walsh (CW)	Interim Director of Performance, NHS North East London
Michael Duff (MD)	Deputy Director of Finance – North East London, NHS England - London
Matthew Knell (MK)	Senior Governance Manager, NHS North East London
Sarah See (SS)	Managing Director of Primary Care, NHS North East London for agenda item 6
Nick Wright (NW)	Programme Director Diagnostics and Deputy Director, Programme Management Office, NHS North East London for agenda item 7
Zeshan Mahmood (ZM)	Senior Transformation Lead – Planned Care, NHS North East London for agenda item 7
Julie Van Bussel (JVB)	Deputy Director - Planned Care, NHS North East London for agenda item 7
River Calveley (RC)	Senior Programme Manager, NHS North East London for agenda item 7
Sanjay Patel (SP)	Deputy Director of Medicines Optimisation, NHS North East London for agenda item 8
Apologies	
Steve Collins (SC)	Executive Director of Finance, NHS North East London

Item No.	**Item title**
1.	**Welcome, introductions and apologies:** • Declaration of conflicts of interest The Chair, Kash Pandya (KP) welcomed those in attendance to the June 2023 meeting of the NHS North East London (NEL) Finance, Performance and Investment Committee (FPIC), noting apologies as indicated above. 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. Mohit Venkataram (MV) flagged that as an employee of East London NHS Foundation Trust (ELFT), he held a potential interest in agenda item 7, as ELFT were the provider for the Newham Musculoskeletal service and wouldn't take part in the decision-making process for

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	the item. Mark Rickets (MR) added that as a GP working in NEL, he held something of a potential conflict of interest in agenda item 6, the same day access hubs, although this was more of a general interest rather than any specific involvement with the proposed providers.
2.	**Committee business:** • Minutes of the last meeting • Action Log • Matters Arising The Committee received minutes of the meeting that had taken place on Tuesday 30 May 2023, requested that the date of the next meeting reflected at the end of the minute be updated to reflect the accurate date and otherwise agreed that they represented an accurate record of the meeting. The Committee recognised that 4 actions arising from previous meetings remained open, noting that work was underway to confirm reporting arrangements to the FPIC from sub groups as they started meeting. Work was also underway in the Performance team to add coverage of discharge, including delayed discharge to the Urgent and Emergency Care (UEC) dashboard and the team was also preparing to take account of any requirements in the soon to be published NHS England (NHSE) Integrated Commissioning Board (ICB) oversight framework.
3.	**Month 12, 2022-23 Performance Overview** CW briefed the Committee on the circulated performance report, highlighting that: • NEL had been placed in tier one (T1) UEC recovery and tier two (T2) cancer recovery by NHSE, with work underway within the ICB to produce detailed response plans and regular catch-up sessions with NHSE. • The focus of the UEC recovery work centred on performance at Barking, Havering & Redbridge NHS Trust (BHRUT), the four hour ambulance service standard and ambulance handovers. A tripartite concordat was expected to be developed between the ICB, Providers and NHSE, committing all parties to an agreed set of interventions / support and results to support the recovery. • Discussions with NHSE continued around cancer waiting times in NEL, with an assurance framework under development. The plan in development would address both outstanding waiting lists and front door performance simultaneously, recognising that there was a significant cohort of patients waiting for first outpatient department (OPD) assessments, which may further drive activity through the cancer pathways as initial assessments are conducted. • While industrial action continued to impact across the area, recent activity by Junior Doctors had been thought to result in fewer cancellations in the past due to the London wide agreement on Consultant cover pay helping mitigate cancellation of appointments. However, a five day strike was expected to commence in July 2023, and the results of the Royal College of Nursing (RCN) ballot was expected shortly, along with a ballot of Consultants also due soon. The net results of these actions would continue to impact on planned care and diagnostics waiting lists, while the cost of implementing cover arrangements would be seen in financials. The Committee thanked CW for the briefing and discussed the following points: • That Performance reporting links with the Quality, Safety and Improvement Committee (QSIC) needed to be clear and roles in providing assurance around the recovery plans clear within the ICB. The Performance report had covered the

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	production of a clinical harm review in relation to the tier two cancer recovery position, which would need to flow to the QSIC from the Clinical Advisory Group (CAG), which is producing this report. • That Performance reporting across the ICB needed to become more focussed on outcomes, with information on action, response and clear commitments to resolutions and expected due dates provided to Committees. • More information on community service waiting times was needed in reporting, and that while it was understood that NHSE were working on a framework for this area of work, there was evidence that long waits were present in the local community. • A briefing from the Performance team on how the response to the T1 UEC position was being managed would be required at the next meeting, to cover the process and measures being monitored, and where ownership sat within the ICB. **ACTION:** CAG to share any clinical harm review report that looks at cancer performance across NEL with the QSIC when available. **ACTION:** CW to include coverage of T1 UEC recovery plan measures and arrangements for assurance in the next Performance report to the Committee.
4.	**Month 2, 2023-24 Finance Report** Henry Black (HB) briefed FPIC members on the circulated Month 2, 2023/24 Finance Report, highlighting that month two had been historically difficult in terms of presenting data with a high degree of certainty, so early in the financial. Regardless, the picture presented in the circulated report was not positive and did not set out a healthy position, with work continuing to the validate the data and it was hoped that the Month 3 reporting cycle would start to provider a clearer indication of the systems position. HB continued to outline that: • Industrial action had impacted significantly on efforts to address the use of agencies across NEL, and these efforts were expected to continue to be challenging in the current climate. • The ICB was reporting a year to date deficit of £7m against plan, with a reported deficit of £4.4m against the planned surplus of £2.6m. This was being driven by run rate pressures, largely relating to Continuing Health Care (CHC), prescribing and under delivery of efficiencies. • The NEL Integrated Care System (ICS) was reporting a year to date £25.7m adverse variance against plan with a deficit at month 2 of £28.6m. The main drivers are inflation, under delivery of the efficiency targets and run rate pressures in CHC and prescribing. • Similar positions were being reported on across the country and NEL reporting was in line with other London ICBs. • The significant ramp up in prescribing costs at the end of 2022/23 had not reversed in 2023/24 and continued to rise, while CHC was seeing a similar pattern, although it was hoped that the London-wide Nursing Home Any Qualified Provider (AQP) revisions would impact on these costs in the near future. • A recovery plan was expected to be in place in early August 2023, with Directors of Finance across the NEL system working together to assess data and management processes. • Agency spend was being driven by costs resulting from industrial action, and if these were removed, the trend of spend on this area was looking positive, although it was not possible to quantify the precise costs of industrial action, with immediate cover only being part of the complicated picture.

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	Committee members thanked HB and the Finance Team for the report and raised or discussed the following points: • The landscape present in the prescribing arena was becoming more complicated, and data in the area of work tended not to be available in a timely manner, which made responding to issues in prescribing challenging. More clinicians were now able to prescribe than in the past and different approaches were being taken across staff groups. • More work on CHC, including a probably pivot to a risk share approach across partners may be required, with differences present currently in how each area within NEL works on CHC. An approach that can ensure that the best care, in the best place for the best outcomes for local patients would be beneficial for everyone. • It may be useful to seek clarity on how Better Care Fund investments and spend is being monitored and managed, to ensure that there is no duplication present with NEL core investments and that efforts are best aligned to produce results at the Place and NEL wide levels. **ACTION:** Matthew Knell (MK) to ensure that deep dives on CHC and Agency Spend are added to the Committee's forward plan for discussion as soon as possible.
5.	**CFPO Risk Register** Henry Black (HB) briefed the FPIC on the minimal revisions to the Chief Finance and Performance Officer's (CFPO) Risk Register since the previous month's meeting. Committee members discussed the following points: • That a covering report was required to set out the risk movements and changes since the previous iteration was required for future meetings, in order to focus FPIC discussions. • That the cover report submitted with the circulated papers indicated that no changes had taken place, which was not re-assuring, as the report was indicating that planned mitigations were not impacting on risk scores. • That new risks needed to be considered across several areas of work, particularly in relation to the financial recovery plan and achievement of the operating plan as originally set out. • Further risks needed to be explored around the ICBs possible role in terms of health and safety across NEL in order to clarify what responsibility, if any, the ICB held for the system. **ACTION:** Risk Register to be accompanied with summary report details movements in score, drivers and changes in the register for future meetings.
6.	**Recommendations from the Business Case Assurance Group:** a. Same day access hubs Sarah See (SS) briefed the Committee members on the circulated paper, which set out a recommendation from the Business Case Assurance Group (BCAG) to approve £22,881,021 (£7,627,007 per annum) for Same Day Access Hubs, led by Primary Care Networks (PCNs) across NEL from 1st October 2023 – 31st September 2026. The services will be funded through a combination of Primary Care transformation funding (£2.2m per annum) and Winter Pressures funding and includes a 10% efficiency reduction and an additional adjustment to take increased 111 usage on weekends and bank holidays. The proposed contracts will include break clauses to ensure our ability to change the service as

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	required and the team is currently planning on pursuing single tender waivers for the procurement, depending on further advice in the coming weeks. Committee members welcomed the proposals and flagged the following points: • That careful conversations with GP Federations across NEL would be needed, considering the movement of these services from Federations to PCNs and the team may need to model and consult widely on these changes. Support may also be needed for some area's PCNs to work together at scale, although it was recognised that there were examples and models present in NEL where this was happening successfully that may be able to be expanded on. • It may be useful to look at the primary, community and secondary sectors as a whole to start to produce both a baseline of what services and Healthcare Resource Groups (HRGs) are seen in what setting currently, and about where the system needs to be in 3 to 5 years in terms of what is delivered, where. • It may be useful to double check to ensure that the system efficiencies set out in the circulated paper are realistic and achievable, as they appeared very positive. Some additional assurance on this front would be helpful to prevent any possible issues in the future in terms of under-delivery. • The FPIC was supportive of the proposal, subject to further assurances on the financials through HB and the Finance Team, on the condition that: o This work proceeds on a basis of empowering PCNs, not defunding Federations. o Efforts to keep patients closer to their own practice are maximised, for better, more efficient care. o The potential to bring in wider professions at the PCN to extend their support is explored in future years, including pharmacists and social prescribers. o The wider Primary Care Strategy is socialised across NEL and at the Place level with all partners. • The Committee recognised the importance of break clauses in the contracts for these services, noting that sensible, co-operative use of them could help drive innovation, adapt to local communities and changing conditions. Members hoped that what returned to the Committee in three years' time would be an evolution of this model. **APPROVAL:** The FPIC approved of the Same Day Access Hubs business case, requesting £22,881,021 over three years (£7,627,007 per annum) from 1st October 2023 – 31st September 2026. The case was referred on to the Executive Committee or ICB Board for final decision. **ACTION:** Progress report on transformation achievements through the Same Day Access Hubs service to be provided to the Population Health and Integration Committee (PHIC) at a future meeting and FPIC to be updated on the financial aspects and impacts of the service in a years' time.
7.	**Recommendations from Procurement Group:** a. GP Direct Access Community Diagnostics b. Newham Musculoskeletal Nick Wright (NW) joined the FPIC to present the GP Direct Access Community Diagnostics Procurement Award Report approved by the NEL Procurement Group on 9 June 2023 and recommend further approval by the FPIC that the highest scoring bidders be appointed as recommended bidders by the ICB Board. The contract will then be awarded within the

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	terms of the tender to enable contract mobilisation to commence on successful completion of the 10-day standstill period. The contract will provide diagnostic services closer to home in the community setting, and help support waiting time reduction and backlog clearance, based on a based on a cost and volume model at £97,479,375 over five years, with an option to extend for a further three years (an eight-year potential term in totality), which has been met from within existing resources. NW continued to highlight the following points: • The contract award was not yet public information and remained commercially sensitive. • Final decision had been placed temporarily on hold while further information is assessed. Bidders had been informed of this fact, although initial notifications should not have been made while the decision-making process remained underway. Consequently, there was some risk present in this procurement. FPIC members thanked NW for his teams work and raised or discussed: • While it was recognised that this was a re-procurement, with an existing budget in place to draw on, it would help to illustrate and make clear any savings being secured through the procurement over the current arrangements. • The interface with other diagnostic services needed to be understood, and the capacity provided by this contract clear in the context of the NEL system. Members were informed that the contract under discussion was essentially a 'call off' contract and that the services under discussion were a choice, but not the only choice in terms of diagnostic services available in NEL. The capacity provided under the Community Diagnostics services were likely to become the primary choice for most local people when they launch, but the capacity provided under this contract would be useful to handle any unexpected spikes in demand and in clearing waiting lists. • These services would be re-assessed in three years' time to assess their role in the system wide context. **APPROVAL:** The FPIC approved of the GP Direct Access Community Diagnostics Procurement Report, which set out a contract value of £97,479,375 over five years, with an option to extend for a further three years (an eight-year potential term in totality). The Procurement Report was referred on to the ICB Board for final decision. Zeshan Mahmood (ZM), supported by colleagues Julie Van Bussel (JVB) and River Calveley (RC) presented a single tender waiver (STW) for the extension of the Newham musculoskeletal (MSK) integrated service from August 2023 for a 20-month period at a value of £19.9m. ZM briefed the FPIC members that the Procurement Group had endorsed three STWs in total, for Waltham Forest, Tower Hamlets and Newham. The Newham contract also required approval from the FPIC due to the value and ZM continued to inform the Committee that: • The value for this contract was the same as in the previous year, but for a period of 20 months while the NEL wide transformation programme conducted its work. • This contract was a prime provider arrangement with Barts Health, who worked with sub providers to deliver these services. **APPROVAL:** The FPIC approved of the Single Tender Waiver for the Newham MSK Service Contract with Barts Health in a prime provider arrangement, which set out a contract value of £19.9m over a 20-month period.

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8.	**Deep Dive: Prescribing** Sanjay Patel (SP) joined the FPIC to share information on the work of the Prescribing team and key efforts underway in relation to prescribing spend across NEL. SP continued to brief the members on the circulated paper and that: • While NEL tended to exhibit fewer prescribing actions per 1000 patients than other areas of the country, there was some evidence that prescriptions in the area tended to be for longer periods of time. • Significant inflation across many drug's costs was being experienced, particularly in drugs relating to respiratory, cardiovascular and diabetes conditions. • Prescribing spend was trending for both increasing numbers of prescriptions and increasing costs of drugs and the NEL team had worked to model the expected impacts to produce more accurate forecasts in 2023/24. This work included the production of a single decision-making tool to help support prescribing at the NEL level. • A Medicines Value Group was being mobilised to help support Quality, Innovation, Productivity and Prevention (QIPP) delivery and monitoring of performance against budgets. The CAG was also engaged to provide expert clinical advice and to host clinical conversations through the year. FPIC members thanked SP and team for their work and discussed the following points: • Clarity was required on what the ICB could – and couldn't – control in this area of work, recognising that inflationary issues were being experienced across the country. • Engagement with PCNs and the pharmacists working with the networks would be valuable, potentially based on the City & Hackney model of pharmacist advice in primary care. • Similarly, engagement with Place teams could help bring local knowledge and experience to bear on these issues. • There was recognition that a widening of staff groups able to prescribe across health settings was likely contributing to changes in prescribing activity, with differing work cultures and inconsistent approaches to prescribing in place. • It was noted that there were often caveats around prescribing date, which can tend to be crude and not timely. It was often challenging to link information between prescribing actions and the complexity of patients, or where the patient was within the care pathway. This made responding to emerging variations challenging, both in terms of timeliness and effectiveness. • The ScriptSwitch software was in operation across NEL to help mitigate some of the issues being encountered, and further work was underway to look at benchmarking and the sharing of good practice at the NEL, Place and PCN levels, although national guidance was lacking on this front currently. • Work was being explored in partnership with long term conditions teams to look at potential early interventions to avoid some early prescribing actions in favour of targeted support. Other work was underway to look at minimising prescribing waste and over prescribing, working in partnership with local care homes and local people.
9.	**Updates from Committee sub groups:** • **Primary Care Contracting Sub-Committee** The Committee received and noted an update report from the 22 May 2023 Primary Care Contracts Sub-Committee.

Item No.	Item title
10.	**Any Other Business** FPIC members raised that the Committee forward plan needed to set out the planning process for 2024/25 development, including discussion of any required changes in system financial rules, revisions to the ICBs financial strategy and development of the next year's operating plan. An upcoming system planning workshop was likely to start to shed light on this process to inform FPIC planning. No further business was discussed.
Date of next meeting: Monday 4 September 2023, 1400-1700	

NHS
North East London

Minutes of the Population Health and Integration Committee

Wednesday 21 June 2023; 2.00pm - 4.00pm; 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 *via MS Teams*
Cllr Maureen Worby (MW)	Local authority partner member
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*
Dr Jagan John (JJ)	Primary care partner member *via MS Teams*
Louise Ashley (LA)	Chief Executive, Homerton Healthcare NHS Foundation Trust *via MS Teams*
Attendees:	
Adrian Loades (AL)	Corporate Director of People, London Borough of Redbridge *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*
Selina Douglas (SD)	Executive Director of Partnerships, North East London NHS Foundation Trust *via MS Teams for item 5.0 only.*
Hilary Ross (HR)	Director of Provider Development and Collaboration, NHS North East London *via MS Teams*
Jo Frazer-Wise	Newham Director of Delivery, NHS North East London *via MS Teams*
Katie McDonald (KMc)	Governance Manager, NHS North East London (minute taker)
Apologies:	
Paul Gilluley (PG)	Chief medical officer, NHS North East London
Colin Ansell (CA)	Interim Chief Executive, London Borough of Newham
Fiona Taylor (FT)	Chief Executive, London Borough of Barking and Dagenham
Dr Neil Ashman (NA)	Chief Executive, The Royal London and Mile End Hospitals
Johanna Moss (JM)	Chief strategy and transformation officer, NHS North East London

Item No.	Item title
1.0	**Welcome, introductions and apologies**
	The Chair welcomed those in attendance to the meeting and apologies were noted. The Chair congratulated Paul Calaminus following the announcement of his appointment as Chief Executive Officer of North East London NHS Foundation Trust from the end of August 2023.

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.
1.2	Minutes of the meeting held on 26 April 2023
	The minutes of the meeting held on 26 April 2023 were agreed as an accurate record.
1.3	Matters arising
	<u>The Big Conversation</u> CP provided a verbal update regarding the progress being made with The Big Conversation and points included: • Earlier today Waltham Forest Health and Care Partnership hosted a 'Let's talk about women's health' event alongside Waltham Forest Islamic Association. • Approximately 250 local women attended and were able to have a health check with local GP staff, find out about health and wellbeing information, as well as have the opportunity to talk about what is important to them locally. • Women described their experiences in using maternity services, what they need from mental health services, and discussed what could help to support them to live with long-term conditions. • The event was open to all women, but there was a focus on engaging with Muslim women and those from the Pakistani community who experience high levels of health inequality within Waltham Forest. The Population Health and Integration Committee noted the update.
1.4	Actions log
	Members noted the actions taken since the last meeting and agreed to close ACT011 and ACT012.
2.0	**Committee effectiveness survey results**
	MG presented the effectiveness survey results and discussions ensued as to how the committee could be improved. Key points included: • Population health management is now included in a combined report with health inequalities in order to reduce duplication. • The committee needs to be active in sharing information with its sub-committees and committees of the ICB board. Information flow between the committees requires review across the whole organisation. • Place partnerships should have conversations to determine what their local success measures are for integration. These should be simple with 5-6 priorities. • Members of the committee should attend meetings in person, but attendees presenting one item can attend online. • Whilst sub-committee update reports are themed, any matters requiring escalation to the committee should be included within the update reports. **ACTION:** Information flow to/ from committees and sub-committees to be discussed at the fortnightly governance meeting with MG, ZE and CP.

	The committee noted the report and agreed next steps in terms of future improvements as to how the committee operates in future.
3.0	**Population Health and Integration Committee risks**
	CP presented the report and highlighted the following points: • The three risks presented for discussion are included in the ICB Board Assurance Framework (BAF) and the committee holds responsibility for regularly monitoring these. • The Chief Participation and Place Officer and Head of Governance will develop a risk register for the committee to review on a regular basis which will include additional risks that are not part of the BAF, but relevant to the Committee. Members discussed the risks and the following key points were raised: • There is a need to be open and honest about the risks and issues being faced by the system; for example, the framework used to calculate population growth funding is inadequate and S106s cannot support health infrastructure. • London Ambulance Service (LAS) had one of its busiest days on 12 June with a 66% increase in asthma presentations which was due to an increase in temperature, air pollution and a pollen bomb. The risk relating to the wider determinants of health could be expanded to reference these issues being faced. • There are some factors which the committee is unable to address directly, such as housing and the cost of living crisis, therefore it is important that effective mitigations are in place to prepare for arising issues. The Population, Health and Integration Committee noted the report.
4.0	**Sub-committee update reports: working through a health inequalities lens**
	CP provided a summary of the reports and highlighted the range of work underway to address the significant health inequalities experienced by the population across north east London, with examples of: • A full set of partners are involved across local government, the NHS, the voluntary, community and social enterprise sector, wider statutory partners and local people. • Alignment of strategic priorities and outcomes. There are links between Health and Wellbeing Strategies, Integrated Care Partnership Strategy, Core 20 Plus 5 and Collaborative and Place Partnership priorities. • A framework approach; for example: Health Inequalities Programme, Health Equity Programme, Poverty Reduction Framework, Marmot implementation. • Proactive, targeted approaches for specific communities. • Prevention, early intervention and personalisation. The reports also underlined the need for a range of enablers to be in place to support increasing focus on health inequalities: • Funding; whilst the Health Inequalities Funding is very much welcomed, it is not sufficient as we seek to embed health inequalities approaches across all areas of work and recognition that there is inequity across some of the core budgets directly affecting this work. • Data and insights across partners, including granular detail on specific populations. • The ability to take opportunities when they arise, including the use of external funding and partnerships.

- Building infrastructure across all partners; for example, capacity building in Voluntary, Community and Social Enterprises (VCSE).

A summary of each sub-committee's report is outlined below:

Barking and Dagenham

- The Locality Leads model, led by Community Resources, have appointed Leads in the six localities of the borough. As Locality Leads these organisations develop networks across and beyond the VCSE sector, support residents to access appropriate help and facilitate design groups with residents to address challenges presented by cost of living and health inequalities. Locality Leads have made significant progress in building relationships and trust, working with other key partners in the community to support and give a voice to residents. These workstreams have had positive feedback, support and commitment by the partnership to continue their work into 2023/24.
- The partnership held a health inequality workshop at the end of April to prioritise and agree workstreams to continue into 2023/24. Following the workshop, a working group confirmed the projects to be continued as well as new schemes.

City and Hackney

- A Money Hub has been mobilised which supports residents who are struggling to access all benefits that they are entitled to. The Money Hub includes expertise in complex areas like disability allowance and can support residents with debt management planning.
- Work has commenced with community and voluntary sector partners at a neighbourhood level to ensure there are a range of accessible services for residents. This includes culturally appropriate food banks and advice services.

Havering

- Local Area Coordinators have been deployed primarily within neighbourhoods that are in deprived parts of Havering, which support people with a range of personal issues that can be related to physical health, housing, mental health, domestic violence, debt and money problems, isolation, sudden change in family circumstances and a wide range of other challenges. So far 431 people from deprived communities have been supported, which is estimated to have saved health and social care services approximately £1.3m.
- Havering has a disproportionally high number of overweight or obese children aged 5 to 11 than its North East London peers. Working closely with the schools in the deprived parts of Havering a new system weight management programme has been launched to work with families over those children who would benefit from the lifestyle interventions offered.

Newham

- The nine Primary Care Networks have used the Core20Plus framework to take forward their activities focused on health inequalities in their network areas, guided by local population health data. They have appointed dedicated health inequalities leads and agreed programmes of action, which commenced last spring.

Redbridge

- Following the success of the Covid bus during the pandemic, the Partnership supported a scheme to hire a purpose-built vehicle to enable taking services out to residents and particularly hard to reach communities. The bus has been used widely across the Borough for a variety of purposes including substance misuse events, clinics for vaccinations, and to pilot a Point of Care Testing (POCT) offer – blood pressure, BMI, HBa1c and cholesterol checks at a local Eid Festival.
- The ICB holds a contract with PELC to deliver homeless and rough sleeper outreach services. However, in Redbridge Healthy Living Healthy Lives (HLHL) has supplemented the PELC offer and provided a vast range of services to homeless patients including support with GP registrations, comprehensive initial health check, acute care referrals, and health promotion.

<u>Tower Hamlets</u>

- The partnership has adopted an anti-racism action plan which seeks to improve racial equity across health and wellbeing. The Executive Board has undertaken anti-racism training, with a wider training programme for staff, including HR professionals, across the system to embed ant-racist culture and understanding. A culturally appropriate communications checklist has been coproduced with residents from diverse backgrounds which will assist services to communicate more effectively with the population and move on from a one-size fits all approach.

<u>Waltham Forest</u>

- Conversations between London Borough of Waltham Forest, NEL ICB and The King's Fund are ongoing to discuss working as delivery partners to assist in taking practical steps to realise a whole system approach to tackling health inequalities and developing a plan to implement a robust system of health equity. The system of health equity will strengthen existing place-based partnerships, embed, align and integrate recommendations from Marmot, the Fuller stocktake and 15-minute neighbourhoods approach with existing strategic programmes to tackle the root causes of health inequalities.
- The King's Fund bespoke proposal complements and builds on the work developed by Marmot and will provide access to their recognised leadership and expertise in the area of population health equity, deeper understanding of the health and care system, policy research and analysis.

<u>Acute provider collaborative</u>

- Chief Medical Officers have been developing proposals to establish Clinical Boards that will be integrated with the collaborative's transformation programmes. These boards will be forums for cross trust clinical collaboration and will bring together senior clinical leaders and speciality representatives to influence the development of system wide clinical delivery and clinical strategy.
- Work is happening to determine which decisions can be made by the collaborative and which require approval by individual organisation Boards.

<u>MHLDA collaborative</u>

- The children and young people's mental health improvement network held an in-person workshop with children and young people and their families to explore how children and young people can contribute to the delivery of the 'I Statements' they created. The event has provided the collaborative with a clear sense of children and young peoples' priorities for improving mental

	health and emotional wellbeing. There is an appetite for service users and families to be more actively involved in co-designing, coproducing and leading those improvements. As a result, a regular coproduction space has been established with children and young people. • The collaborative has commissioned a system diagnostic to help understand the outcomes, experience, equity and value that patients receive for the money spent on mental health services across the system. The outputs of this work will help to identify the inequities between boroughs, but also between communities and groups with protected characteristics <u>Primary care collaborative</u> • The ICB is currently progressing a business case through its governance, to continue the GP access hubs offer, as these appointments enable a specific cohort of people who struggle to access regular GP practice appointments. This service will continue to support the NEL system during out of hours weekdays, weekends and on bank holidays. • The collaborative agreed its key priorities for the next year which include the development of improved signposting for health care professionals and residents to ensure they are directed to the full range of services available, and also piloting the use of cloud-based telephony in order to deliver a more aligned approach to the same day access needs of residents. <u>VCSE collaborative</u> • Funding has been agreed for a development role hosted by Tower Hamlets CVS, which will enable the collaborative to progress its work which is currently in its infancy. Members discussed the reports with keys points including: • There are concerns regarding health inequalities being faced by refugee and asylum seeker populations which has been raised in several committees. As a result, a round table event is being planned which will enable different parts of the system to discuss and share information. • It would be beneficial to begin linking in with existing research to expand the system's evidence base. • A wider system approach to supporting the homeless population is needed due to the complexities involved. A comprehensive update should be presented at a future meeting. **ACTION:** An update on homelessness to be presented at a future meeting. The Population Health and Integration Committee noted the report.
5.0	**<u>Deep dive: addressing health inequalities through the community collaborative</u>**
	JVR and SD presented the deep dive into addressing health inequalities through the community collaborative. Key points included the following: • The Community Collaborative is a collaboration of providers including system NHS community providers, VCSE and clinical leads to tackle and deliver services to address inequalities in the community. The collaborative has been established to support a partnership approach to reducing variation in community health services, and identify opportunities to share learning across partners alongside other system-wide ambitions. • A strategic population health approach is being used to ensure places receive fairer investment levels for residents. Decisions on budgetary splits per place were considered and agreed on collaboratively. For Virtual Wards,

	to make decisions on investment envelopes, ONS, G&A, primary care population data was combined with weighted health inequalities such as age, gender etc. • The population health data is showing a need to focus on variation reduction. Baselining work of falls admissions in care homes is underway to see where it can have a greater impact. • An outcomes framework is being developed which will identify standards that each patient can expect: common standards on access, uptake and expectations across NEL, ensuring that these can be achieved linked to different population needs across the boroughs. The framework will have aligned measures, data collection and reporting which will enable the tracking of a resident's journey across different services. • Data has shown that people in the most deprived areas develop long-term conditions approximately ten years earlier than people living in less deprived areas. They were also more likely to develop multiple long-term conditions. Members discussed the report with key points including the following: • It would be beneficial to link this work to the workforce strategy as staff will be working across places and there is also a need to focus on their wellbeing. • It is important that residents who experience falls in care homes are linked back in with community services following an admission to an acute setting as deconditioning in hospital can occur quickly and could have detrimental impacts on residents. • It would be beneficial to understand how the outcomes framework links to the work of the other provider collaboratives. The Population Health and Integration Committee noted the report.
6.0	**Any other business and close**
	There was no other business to note.
Date of next meeting: 5 September 2023	

Final

NHS
North East London

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

Held on 14th June 2023

Members:	
Imelda Redmond (IR) - Chair	Non-Executive Member
Marie Gabriel (MG)	NEL ICB – Chair (V)
Fiona Smith (FS)	Associate Non-Executive Member
Dr Paul Gilluley (PG)	Chief Medical Officer
Charlotte Pomery (CP)	Chief Participation and Place Officer
Dr Jagan John (JJ)	Primary Care Partner Member
Attendees:	
Mark Gilbey-Cross (MGC)	Director of Nursing & Safeguarding, NHS NEL
Polly Pascoe (PP)	Head of Quality Development, NHS NEL
Dawn Newman-Cooper (DNC)	Assistant Director of Maternity Programmes, NHS NEL (V) – for item 9.0
Douglas Tanner (DT)	Childrens Services Programme Lead (V)
Celia Jeffreys (CJ)	Associate Director of Safeguarding Adults, NHS NEL – for item 6.0
Philippa Cox (PC)	Assistant Director of Maternity Programmes NHS NEL (V) – for item 9.0
Korkor Ceasar (KC)	Associate Director of Safeguarding Children NHS NEL – for item 6.0
Dotun Adepoju (DA) - minutes	Senior Governance Manager, NHS NEL
Apologies:	
Diane Herbert (DH)	Associate Non-Executive Member
Cllr Maureen Worby (MW)	Local Authority Partner Member
Diane Jones (DJ)	Chief Nursing Officer
Chetan Vyas (CV)	Director of Quality, NHS NEL

Item No.	Item title	Action
1.0	**Welcome, introductions and apologies**	
	The Chair welcomed all members and attendees to the meeting. Apologies were noted as above. (V) connotes attendees who joined the meeting virtually otherwise all other listed attendees attended in person. • The Chair raised the issue of the number of apologies to this meeting. She reviewed the Terms of Reference and noted that the meeting was not quorate. The Terms of reference state clearly that present must be either the Chief Nursing Officer or Chief Medical Director and that a representative from a Partner must be present. The chair asked for the following actions to be taken in future: o That either the Chief Nursing Officer or Chief Medical Officer must lead on this Committee.	

Item No.	Item title	Action
	o At the next meeting of the Committee we review the Terms of Reference to allow for deputies in occasional circumstances. o The Chair also asked that she is informed of the apologies in advance and informed well in advanced if there is any chance that the meeting may be inquorate. • Though the meeting was inquorate the Chair decided to proceed with the meeting noting that the majority of papers were for information and not decision. • **Action Point :** ➢ ***Committee to review the ToR to allow for deputies in occasional circumstances.*** ➢ ***DA to inform Chair of the apologies in advance of the meetings to enable early assessment of Quoracy before the meetings.***	**DA**
1.1.	**Declaration of conflicts of interest (DoI)**	
	• 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 of interests were declared.	
1.2	**Draft Minutes of meeting of the previous meeting of 26-04-23**	
	The minutes were agreed as accurate.	
1.3	**Actions Log**	
	• Almost all the action points had been completed. • With regards to the action point on Quality Highlight report, there was an update on Sudden Unexpected Deaths in infancy (SUDI). The Committee would like to see progress report on cases after the next 6 months, i.e. December. ➢ ***Korkor Ceasar to provide progress/update on SUDI in 6 months' time, that is December 2023.*** • ACT 013.2 **Review of Risk Register** - The Committee to have session on risk appetite to enhance understanding of the risks it holds. ➢ ***This is to be re-scheduled for one of the future meetings.***	**KC** **DJ**
2.0	**Industrial Action – Impact on quality / patient safety.**	
	Mark Gilbey-Cross (MGC) gave a brief verbal update on the industrial action as follows: • The current junior doctors strike commenced today, 14th June at 7.00a.m and will end on Saturday the 17th also at 7.00a.m. • There have been discussions across NEL and with partners across the London region. The ICB has agreed to pay *enhanced rates* which has encouraged a greater number of consultants on duty. It has also allowed for Providers to cover for wider areas of immediate needs. • Nonetheless a number of electives (Surgery appointments) have been cancelled but also noteworthy that some electives were not booked for the period of the strike action.	

Item No.	Item title	Action
3.0	**Patient Safety Incident Response Framework (PSIRF)**	
	Polly Pascoe (PP) presented her paper. In 2019, the NHS Patient Safety Strategy was published by NHSE which seeks to embed transformational changes in the way we understand and address issues of patient safety within our organisations. It brings with it: • The Patient Safety Incident Response Framework (PSIRF), which is a national programme to transform the way we review and explore issues of safety and replaces the Serious Incident Framework. • The Learn from Patient Safety Events (LFPSE) service is a new national service for the recording and analysis of patient safety events that occur in healthcare ; it will replace the National Reporting and Learning System(NRLS) and Strategic Executive Information System(StEIS). • Patient Safety Partners, who will be should be recruited by all NHS organisations to ensure there is compassionate engagement with service users, patients, families, and carers who may have experienced harm while in our care. • Patient Safety Syllabus, which sets out a new approach to understanding patient safety, with a focus on culture, systems and how human factors impact the safety of care. • An increased focus on "Just Culture" which ensures the fair treatment of staff and supports a culture of fairness, openness and learning in the NHS. • The paper detailed the approach the ICB will take to implement the requirements of the NHS Patient Safety Strategy and meet our responsibilities as an ICB. • The ICB have, and will continue to, engage with providers in the development of all aspects of our approach; collaboration and coproduction is undertaken through a range of provider, system and regional meetings and is supported by stakeholders including the UCLP Patient Safety Collaborative and NHS England regional teams. *Comments* • To the question raised as to whether Safety Partners are paid, the Committee was informed that there are four levels of partners from volunteers up to those fully paid for their services. The ICB is looking at those within Level 3 whose expenses are paid. Nonetheless most of them within the NHSE and the ICB do receive 'involvement' payments. • However, and due to challenges with recruitment, the remuneration policy will be reviewed with a view to encouraging recruitment of partners. • There is ongoing work of the Implementation group with Comms, HR and member organisations to facilitate how this can linked with other key roles and functions of the ICB. • Questions raised by the Committee were, what does the QSI Committee need from the patient safety system established to help it understand what the challenges are, what should be the focus of the Committee in seeking assurances so that we are streamlining meetings and finally, are we really sure that there are no further actions related to Just Culture at this time? • The Committee was informed that the actual impact on patient safety incident is one that the Committee would need to see, there is a positive tie-in with the work the ICB is doing with regards to culture of patient	

Item No.	Item title	Action
	safety within the system and finally it is very 'NHS' and it involves integration with other services, local authorities, Commissioning authorities, local care service providers, etc where patient safety will also be key. Furthermore, the Organisation Development (OD) team will be looking to addressing the issue of culture. • With regards to meetings, these are delineated into Provider Meetings, Patient Safety Partner Network, Cross System Response Group and a finally PSIRF Peer forum. These meetings each focus on separate elements of PSIRF and in most cases would be attended by different partners due to the nature of their purpose and aims. The terms of reference for the various groups have been developed and are being reviewed by providers to ensure coproduction of the new system • It is expected that the PSIRF will be established by the end of November by all the providers of secondary care and more importantly the template is not restrictive as it allows for adaptation. • In response to question of where the role of the ICB sits in relations to patients' safety incidents in primary care, the Committee learnt that the PSIRF is not mandated for primary care but there are guard rails and strategies within the system for addressing patient safety. However, getting Places and secondary care providers on to the PSIRF is itself a big ambition and a basic foundation which need to be established before Primary Care. Work is being undertaken to communicate with partners across the health and care system (e.g. primary care, local authorities etc.) to promote smooth implementation of PSIRF. • It was also noted that PSIRF only replaces the Serious Incident Framework, which is only a small element of the overarching patient safety agenda. The ICB are embedding checks and balances into their work to ensure 'cracks' don't begin to show in other parts of the system. The Chair thanked PP for her presentation and invited her back to the next meeting in September for assessment or review of what needs to go before the ICB Board in October. • **Action Point :** ➢ ***Polly Pascoe to bring a detailed update on progress against PSIRF to the QSI.*** ➢ ***Polly Pascoe to bring NEL ICB PSIRF policy to the QSI for approval***. ➢ ***QSI to determine what will go before the ICB Board.***	**PP**
4.0	**Quality Highlight Report**	
	The report was presented by Mark Gilbey-Cross (MGC) for discussion and noting. The paper outlined the range of exceptions across the Chief Nursing Officer portfolio areas (following agreement with the Chair to move away from individual area exception reports). Each area provides an update (were possible reported across Place) and North East London, with an outline of actions that have been undertaken or are being planned to support improvements. • The report presented covered areas such as: o NEL System Issues across the NEL o Barking and Dagenham	

Item No.	Item title	Action
	o City & Hackney o Havering o Redbridge o Newham o Tower Hamlets o Waltham Forest o Covid Vaccination Programme o Infection, Prevention and Control o Individual Funding Requests o Adults Safeguarding o Children's Safeguarding o Maternity *Comments* • Issues of domestic violence resulting in homicide was noted and the involvement of the Metropolitan Police (Met) was raised. • Developments such as the intention of the Met to stop responding to mental health issues including welfare checks or public disorder situations and leaving it to the appropriate NHS services was raised. The Met had reported that this was beginning to take a lot police time from other key functional front line duties. • There are concerns about the asylum hotel accommodation which may result in a rise in the numbers of people accommodated and potentially having to place up to four persons in rooms meant for two and the resultant difficulties this will pose when it comes to managing situations that may arise. • With regards to BHRUT in the report, the question was raised on how assurance could be sought from e-PRO[1]. The Committee was informed that deep dive had been done and recommendations made on the incidents reported. The Chair thanked MGC for his report.	
5.0	**NEL UEC Programme Update**	
	• Urgent and emergency care is under significant pressure across the country. These pressures are also felt within the North East London footprint by our providers, particularly in the acute provider setting. Consequently, several measures have been put in place across the ICB to ensure the effectiveness of the UEC pathway. • This has resulted in several improvement programmes being developed. This paper presented was to provide an oversight and provide assurance for the work that is being undertaken in regards to improvement. • He added further that majority of the work has been on BHRUT improvement plan as CQC finding had placed it under Tier 1. • PWC has been commissioned to do a piece of work to look at the overall same day emergency care plan in the whole system and to also review the UTC in the Primary Care system. • Healthwatch have also provided useful insight.	

[1] Electronic patient-reported outcomes (ePRO) are patient-provided information about symptoms, side effects, drug timing and other questions recorded on an electronic device during a clinical trial.

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	• The PWC and the HW reports will be shared with the Committee. *Comments* • Cultural believes about urgent care across NEL Places vary. For example, some of the residents do not see Pharmacies in that role. • In response, the Committee was informed that the ongoing programme on UEC covers all the communities across NEL. • Healthcare watch is also doing work on emergency care and sitting in at EDs and UTCs to get a feel of some of the experiences reported. • To the request for time lines, the Committee was informed that the PwC report will have details of the timelines and responsible owners for delivery of milestones in the Programme. For example, there will be work to develop academic doctors at least 20 GPs to go into Barking & Dagenham and also Havering. They will develop academic hubs for research into quality and innovations. Secondly, the risk on UEC is noted in the risk register. • It was suggested that there is need to review UEC across the whole system seeing as we tend to use the Operations Pressure Escalation Levels (OPEL)[2] system and Primary Care does not get the feel for the sort of pressure on system. There is a need for a Systems Control Centre. • As requested, a copy of the PwC report will be brought to the next meeting. • **Action Point :** ➢ ***PG to bring a copy of the PwC review report on UEC to the next meeting.*** ➢ ***PG to bring information on the Systems Control Centre to the Committee***.	**PG**
6.0	**Safeguarding Strategy**	
	• The report had been presented to the Committee at a previous meeting and following from feedback an updated version was again brought back for approval. The amendments advised by the Committee has all been adopted in the copy version presented and shown in purple coloured fonts for identification in the document. The paper was noted.	
7.0	**Quality horizon scanning report**	
	Polly Pascoe (PP) presented the report. • The purpose of the paper was to provide an update on the planned regulatory activity that will assess quality within and across Integrated Care Boards. The paper outlined current plans communicated to Integrated Care Boards from NHS England and the Care Quality Commission and highlighted proposed dates for future action. The Committee was asked to note the content of the paper.	

[2] Operations Pressure Escalation Levels (Opel) is a method used by the NHS to measure the stress, demand and pressure a hospital is under, with Opel 4 representing the high escalation level. Opel 4 is declared when a hospital is "unable to deliver comprehensive care" and patient safety is at risk

Item No.	Item title	Action
	Highlights • NHS England have stated that NHS Assessments based on the NHS System Oversight Framework will begin in Q2 of 2023/24. Assessments will cover providers, ICBs and ICSs. We expect further guidance to be released in May, following the publication of the Hewitt report. • The Care Quality Commission (CQC) have confirmed, that in the latter part of 2023, they will introduce a new Single Assessment Framework which covers providers, local authorities and ICSs. • The Hewitt Review sought to consider how the oversight and governance of integrated care systems (ICSs) can best enable them to succeed, balancing greater autonomy and robust accountability. The report and related recommendations have now been published. • The delivery and continuous improvement (DCI) review, undertaken by NHS England, considered how the NHS, working in partnership through integrated care systems (ICSs), delivers on its current priorities while continuously improving for the longer term. • Polly added that CQC have started pilot assessments for 5 local authorities, none of which are located within the NEL footprint. It was also noted that the ICS (and not the ICB) will be assessed. The report from the pilots will be reflected in further updates of the horizon scanning report. • In relation to the NHS System Oversight Framework Annual Assessments, providers, ICBs and ICSs will be assessed. • The Committee was asked if it would want future updates to reflect National Institute for Health and Clinical Excellence (NICE) needs. It was decided that the Committee would welcome a summary report. *Comments* • The question was asked that if and whenever the ICB is assessed, who would be responsible for preparations for the inspection and for what policies? • The Committee was informed that the CQC pilot assessment process will be in stages, firstly providers, then the ICS. • It was suggested that the horizon scanning work would have identified some potential risks and more so due to the current need for savings as requested by the NHSE. The Committee heard that the 2022/23 annual report currently being prepared would also reflect identified risks. The chair thanked Polly for a useful paper and suggested that this should be brought forward for a Board development session. • **Action Point :** ➢ ***The Quality Horizon Scanning paper to be brought to the Board development session. Date to be determined by the Committee***	

Item No.	Item title	Action
8.0	**SEND – Learning from Barking and Dagenham**	
	The Special Education Needs & Disability (SEND) was presented by Douglas Tanner and Sharon Morrow. • The report and accompanying slides deck related to the Thematic Review of Alternative Provision in the London Borough of Barking and Dagenham (LBBD) carried out in March 2023 by OFSTED and CQC. • The inspection was not 'graded' but outcomes were to be aggregated into a national report to support whole-system improvement. • The inspection provided an opportunity to assess partnership working across the Integrated Care System (ICS) within a formal inspection framework. • Areas for review included Strategic Planning, Joint Commissioning and oversight. • The current timetable means that LBBD will be subject to a SEND Joint Area Inspection in the near future. The Thematic Review provided an invaluable opportunity to assess how partners responded to inspection obligations and how systems were working collaboratively. • The system lessons learned from the Review and the actions being taken to ensure best practice going forward were noted. • In relation to the learning, Comms needs to be strengthened so that everybody is clear about their responsibility. • There was an identified gap around the ownership of the dynamic support register for children and adults and young people with autism. However, a local lead has now been found. *Comments* • The Committee heard that one of the learnings from the process and as fed back from the CQC inspection was that we know where everyone in Barking & Dagenham is located and what care they are receiving. • The Committee advised that it would be helpful if such good practice as this one by LBBD was shared across NEL.	
9.0	**System Maternity update**	
	Due to I.T challenges Dawn Newman-Cooper as co-author was not able to present the paper. Mark Gilbey-Cross presented the paper instead. The paper outlined: • The three-year Delivery Plan for maternity and neonatal services was published in March 2023. It summarised the responsibilities for each part of the system including Trusts, Integrated Care Boards (Local Maternity and Neonatal Systems), Neonatal Operational Delivery Network and NHS England. https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternityand-neonatal-services/ • The plan aims to deliver change rather than set out new policy. It seeks to help each part of the system to plan and prioritise NEL actions by bringing together learning and action from a range of national reports into one document across four themes. • The paper gave an oversight into the actions required following the gap analysis (Technical Guidance NHSE bench-marking exercise) due for	

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	completion in quarter two 2023/24 by Trusts and the LMNS. In addition, this paper included risks impacting on the delivery of performance. • The LMNS are requesting to update the Committee progress of the NEL three-year Single Delivery Plan in quarter two 2023/24. • There are no exception items to pick out in the report. *Comments* • Seeing as some women involved and rely on the voluntary sector support and faith groups, the question was asked whether there was assurance that such groups would receive support from the LMNS. Health inequality was also an area that has been identified in the report. This is more so as some groups such as Afro-Caribbean, Polish and Pakistanis find it difficulty to access services. • There may be a need to consider where other organisations, such as Maternity Mates/Voices, who also provide services to assist with maternity care, and where this would sit within the System. • Attention was drawn to one of the reported strategic risks described as "*The risk around Maternity workforce has been increased through the NEL ICS Local Maternity & Neonatal System and the Register outlines the mitigations in place*". The Committee advised that future reports on System Maternity might want to include how this risk is being managed. The Chair thanked the authors and MGC for the report and its presentation.	
10.0	**Strategic Risk Register**	
	The register reflected strategic risks on the following corporate objectives: o There was one new risk on providing safe maternity care & women to have a good experience when using maternity services; o There were also five key risks on tackling inequalities in outcomes, experience and access I the risk register presented. • The Committee advised the risk "*to quality of care and patient safety due to the current winter pressures being experienced across the Northeast London System*" needed to be redefined to reflect that it was to do with UEC. Mitigations documented in the risk register should also reflect the discussions and presentation on NEL UEC Programme discussed earlier at the meeting. • **Action Point:** ➢ ***The risk on quality of care and patient safety due to the current winter pressures in the strategic risk register to be re-worded to reflect concerns with UEC and mitigations to include updates on the UEC Programme.***	**CV**
11.0	**Any Other Business** • The Committee want to consider how all the learnings from Primary Care Complaints, Freedom to Speak Up, OPEL will be brought to the QSI as a safety issue. A business meeting amongst the Committee could be planned in future to review how these evolving elements could be assimilated into the assurance work of the Committee. • It was suggested that there is a need for feedback on quality issues to frontline operations such as GPs and/or at Place. In response, the	

Item No.	Item title	Action
	Committee was informed that quality update reports do go to the Board whose meetings are held in public, which makes the information publicly available. However, this could be improved via sharing information on the intranet inhouse. • The Committee would be looking at Improvement Programme Plans across the system so that it can have oversight of them. A paper is expected at the September meeting from management from which the Committee could pick top line items for regular review. • **Action Point** ➢ ***Issue around improvement plan to be included in the QSI FJP and a paper brought to the September meeting.***	
	Information Paper	
	Transfer of Primary Care Complaints function to ICB - Question was raised on how are patients being currently communicated with? - Will the QSI expecting a themes' report, at least annually - Need for Primary Care to understand Comms more so as news is usually only picked up via media. The paper was noted.	
Date of Next meeting: 13th September 2023 @ 2:00 PM – 4:00 PM		