Integrated Care Board – Meeting in Public

10.00 to 13.00 on 14 September 2022

The Assembly Hall at Lambeth Town Hall Acre Lane entrance, London SW2 1RW

Chair: Richard Douglas, ICB Chair

Agenda

No.	Item	Paper	Presenter	Timing
-	**Public Open Space** *Opportunity for members of the public to meet the board over tea and coffee as they take their seats.*	-	-	10.00
	Opening Business and Introduction			
1.	**Welcome** Apologies *To receive apologies from members unable to attend.* Declaration of Interest *To declare relevant interests not recorded on the register or declare any conflict of interest in relation to items on the agenda.* Minutes of previous meeting actions and matters arising *To receive the minutes of the meeting on 1 July 2022 and review any actions and matters arising.*	 **A** **B**	 RD RD RD	10.15
2.	**Presentation - Lambeth Living Well Network Alliance - Advancing mental health equalities for black communities** *A presentation on the work that the Lambeth Living Well Network Alliance (and championed by Black Thrive), are taking to improve mental and emotional health resilience, self-reported well-being and mental health outcomes amongst Lambeth's African and Caribbean communities.*	-	Lambeth Living Well Network Alliance & Black Thrive	10.20
	Reports and updates			
3.	**Integrated Care Partnership Update** *An update on the progress of the integrated care partnership.*	-	RD	10.35

4.	**Chief Executive Officer's report** *To receive a report from the ICB Chief Executive*	**C**	AB	10.45
5.	**ICB Committee & Provider Collaborative Reports** **i. Overall report of ICB committees and Provider Collaboratives** **ii. Report of Quality and Performance Committee** **iii. Report of the Planning and Finance Committee** *For committee chairs and provider collaborative board members to provide a summary of the activity that has taken place for the attention of the board.*	**D** **E** **F**	TF CK GV	10.55
6.	**Board Assurance Framework** *To receive the report.*	**G**	TF	11.40
7.	**ICS Delivery of integrated community-based services** *A presentation on the opportunities outlined in the Fuller report, the particular implications for south east London, and how south east London ICS will work together to implement its recommendations.*	**H**	SH	11.55
8.	**2021-22 Annual Report and accounts**	**I**	DM	12.35
Closing Business and Public Questions				
9.	**Any other business**	-	RD	12.43
10.	**Public questions and answers** *An opportunity for members of the public to ask questions regarding agenda items discussed during the meeting.*	-	-	12.45
CLOSE 13.00				

Presenters

Richard Douglas (RD)	ICB Chair
Andrew Bland (AB)	ICB CEO
Tosca Fairchild (TF)	Chief of Staff
Prof Clive Kay (CK)	ICB Partner Member Acute Care
Dr George Verghese (GV)	ICB Partner Member Primary Care Services
Sam Hepplewhite (SH)	Director of Primary Care
David Maloney (DM)	Director of Corporate Finance

NHS
South East London

NHS South East London Integrated Care Board
Register of Interests declared by Board members
Date: 14/09/2022

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Board members					
Richard Douglas, CB	Chair	1. Senior Counsel for Evoke Incisive, a healthcare policy and communications consultancy 2. Trustee, Place2Be, an organisation providing mental health support in schools 3. Trustee, Demelza Hospice Care for Children, non-remunerated role.	Financial interest Non-financial professional interest Non-financial professional interest	March 2016 June 2022 August 2022	Current Current Current
Andrew Bland	Chief Executive	1. Partner is an NHS Head of Primary Care for Ealing (a part of North West London ICB)	Indirect interest	1 April 2022	Current
Peter Matthew	Non executive director	None	n/a	n/a	n/a
Paul Najsarek	Non executive director	1. Non-executive director for Richmond Fellowship mental health charity 2. Advisor to Care Quality Commission on their approach to local authority assurance 3. Non-executive director for What Works Centre for Wellbeing 4. Policy spokesperson for health and care for the Society of Local Government Chief Executives	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	April 2022 April 2022 2017 2017	Current Current Current Current
Anu Singh	Non executive director	1. Non-executive director on Camden and Islington FT Mental Health Board 2. Non-executive director for Barnet, Enfield and Haringey NHS Trust 3. Non-executive director on Board of Birmingham and Solihull ICS. 4. Independent Chair of Lambeth Adult Safeguarding Board. 5. Member of the advisory committee on Fuel Poverty. 6. Non-executive director on the Parliamentary and Health Ombudsman.	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	2020 2020 March 2022 April 2021 2020 April 2020	Current Current Current Current Current Current

Date last saved: 07/09/2022 14:44

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Dr. Angela Bhan	Director of Place, Bromley	1. Consultant in Public Health for London Borough of Bromley.	Non-financial professional interest	1 April 2020	Current
David Bradley	Partner member, mental health	1. Unpaid advisor to Mindful Healthcare, a small start up providing digital therapy 2. Wife is an employee of NHS South West London ICS in a senior commissioning role 3. Chief Executive (employee) of South London and Maudsley NHS Foundation Trust	Non-financial profession interest Indirect interest Financial interest	April 2019 July 2019	Current Current Current
Andrew Eyres	Director of Place, Lambeth	1. Director of Lambeth, Southwark and Lewisham LIFTco, representing the class B shares on behalf of Community Health Partnerships Ltd for several LIFT companies in the boroughs. 2. Married to Managing Director, Kings Health Partners AHSC 3. Strategic Director for Integrated Health and Care – role spans ICB and Lambeth Council.	Financial interest Indirect interest Non-financial professional interest	1 April 2013 1 April 2021 1 October 2019	Current Current Current
Mike Fox	Chief Finance Officer	1. Director and Shareholder of Moorside Court Management Ltd 2. Spouse is employed by London Regional team of NHS England	Financial interest Indirect interest	May 2007 June 2014	Current Current
Dr. Toby Garrood	Medical Director	1. Shareholding in Serac Healthcare 2. Consultant rheumatologist at Guy's and St Thomas' NHS Foundation Trust (GSTT) 3. In my role at GSTT I have received research and service development grant funding from Versus Arthritis, Guy's and St Thomas' Charity, Pfizer, Gilead and NHSx 4. I undertake private practice at London Bridge Hospital 5. Honorary Treasurer for British Society for Rheumatology	Financial interest Financial interest Financial interest Non-financial professional interest	April 2020 2009 2018 July 2020	Current Current Current Current
Dr. Jonty Heaversedge	Medical Director	1. Sessional GP at Crowndale Medical Centre in Lambeth 2. Clinical director, Imperial College Health Partners 3. Director, Vitality Ltd – a wellbeing communication consultancy	Non-financial professional interest Non-financial professional interest Financial interest	1 March 2017 1 November 2019 1 March 2015	Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
Angela Helleur	Chief Nurse	1. Member of Kings Fund Council	Non-financial professional interest	May 2021	Current
Ceri Jacob	Director of Place, Lewisham	None	n/a	n/a	n/a
Prof. Clive Kay	Partner member, Acute	1. Fellow of the Royal College of Radiologists 2. Fellow of the Royal College of Physicians (Edinburgh) 3. Chief Executive (employee) of Kings College Hospital NHS Foundation Trust	Non-financial professional interest Non-financial professional interest Financial interest	1994 2000 April 2019	Current Current Current
James Lowell	Director of Place, Southwark	1. Chief Operating Officer (employee) of South London and Maudsley NHS Foundation Trust	Financial interest	January 2021	Current
Sarah McClinton	Director of Place, Greenwich	1. Director, Health & Adult Services, employed by Royal Borough of Greenwich 2. Deputy Chief Executive, Royal Borough of Greenwich 3. President and Trustee of Association of Directors of Adult Social Services (ADASS) 4. Co-Chair, Research in Practice Partnership Board	Financial interest Non-financial professional interest Non-financial professional interest Non-financial professional interest	November 2019 May 2021 April 2022 2016	Current Current Current Current
Dr. Ify Okocha	Partner member, Community	1. Chief Executive (employee) of Oxleas NHS Foundation Trust 2. Director, Dr C I Okocha Ltd, providing specialist psychiatric consultation and care 3. Director, Sard JV Software Development 4. Director, Oxleas Prison Services Ltd, providing pharmacy services to prisons and Kent and South East London 5. Holds admitting and practicing privileges for psychiatric cases to Nightingale Hospital 6. Fellow of the Royal College of Psychiatrists 7. Fellow of the Royal Society of Medicine	Financial interest Financial interest Financial interest Financial interest Financial interest Non-financial professional interest Non-financial professional interest	2021 1996 2011 27/09/16 1992 1985	Current Current Current Current Current Current Current Current

Name	Position Held	Declaration of Interest	Type of interest	Date interest commenced	Date interest ceased
		8. International Fellow of the American Psychiatric Association 9. Member of the British Association of Psychopharmacology 10. Member of the Faculty of Medical Leadership and Management 11. Advisor to several organisations including Care Quality Commission, Kings Fund, NHS Providers and NHS Confederation.	Non-financial professional interest Non-financial professional interest Non-financial professional interest Non-financial professional interest		Current Current Current
Stuart Rowbotham	Director of Place, Bexley	1. Director of Adult Social Care and Health, London Borough of Bexley	Financial interest	16 January 2017	Current
Debbie Warren	Partner member, local authority	1. Chief Executive (employee) of Royal Borough of Greenwich. 2. Lead London Chief Executive on Finance, also contributing to the London Councils lobby on such matters including health.	Financial interest Non-financial professional interest	December 2018 (acting in role from July 2017) March 2020	Current Current
Dr. George Verghese	Partner member, primary care	1. GP partner Waterloo Health Centre 2. Lambeth Together training and development hub director 3. Lambeth Healthcare GP Federation shareholder practice	Financial interest Non-financial professional interest Non-financial professional interest	2010 2022 2019	Current Current Current

Integrated Care Board meeting in public

Minutes of the meeting on 1 July 2022

Coin Street Conference Centre 108 Stamford St, London SE1 9NH

Present:

Name	Title and organisation
Richard Douglas	ICB Chair
Anu Singh	Non-Executive Director
Peter Matthew	Non Exec Director
Paul Najsarek	Non Exec Director
Debbie Warren	Partner Member Local Authorities
Prof Clive Kay	Partner Member Acute Care
Dr Ify Okocha	Partner Member Community Care
David Bradley	Partner Member Mental Health Care
Dr George Verghese	Partner Member Primary Medical Services
Andrew Bland	ICB Chief Executive Officer
Angela Helleur	ICB Chief Nursing Officer
Dr Jonty Heaversedge	ICB Joint Medical Director
Dr Toby Garrood	ICB Joint Medical Director
Mike Fox	ICB Chief Financial Officer
Dr Angela Bhan	Bromley Place Executive Director
Stuart Rowbotham	Bexley Place Executive Director
Sarah McClinton	Greenwich Place Executive Director
Andrew Eyres	Lambeth Place Executive Director
James Lowell	Southwark Place Executive Director
Ceri Jacob	Lewisham Place Executive Director

In attendance:

Name	Title and organisation
Sarah Cottingham	ICB Deputy Chief Executive and Executive Director of Planning
Ranjeet Kaile	ICB Director of Communications and Engagement
Jatinder Rai	Chief Executive BVSC Bexley
Paul Weston	Chief Executive of Blackfen Community Library
Simon Goldsmith	Digital Health Co-ordinator MENCAP Bexley.
Michael Boyce	Director of Corporate Operations
Carol-Ann Murray	Associate Director, Learning Disability & Autism Programme (ICB)
Ian Sutton	SELECT Service Manager
Shalisha Davies	SELECT Keyworker
Mikey Lynam	SELECT Information advice and guidance keyworker
Marta Garcia	SELECT Specialist Keyworker

Apologies:

Name	Title and organisation
Tosca Fairchild	ICB Chief of Staff

1.	**Welcome** The Chair welcomed members and those in attendance to the meeting.
1.01	**Apologies** Apologies for absence were noted from Tosca Fairchild.
1.02	**Receive Register of Interests** The Board received and adopted the register of interests.
2.	**Our Integrated Care Board** **Introduction to the ICB and board members**
2.01	Richard Douglas explained that the first meeting of the Integrated Care Board (ICB) marked the start of a clear change to way the NHS was run: moving from competition between service providers to partnership and collaboration; from a focus on curing illness to a focus on promoting health; and from reliance on national direction to a focus on responding to local need. He introduced members of the Board noting the diverse range of professions and experience represented.
	What working as an ICS means in south east London
2.02	Andrew Bland stated that the new system would seek to better understand the needs of populations to improve outcomes and address health inequalities which had been amplified and worsened by the COVID-19 pandemic. There was a commitment to partnership working and collaboration and maintaining strong relationships with local authorities.
2.03	The core purposes of Integrated Care Systems set out by NHS England - to improve outcomes, tackle inequalities, enhance productivity and value for money and help support broader social and economic development - would be achieved in south east London through a commitment to partnership, mutual accountability, and subsidiarity, delegating resources and authority to people who were closest to the communities who used services. An example of these approaches is found the work of the SELECT team, who would present their work to the Board.
2.04	Carol-Ann Murray introduced the SELECT team and described key-working as an important component of the transformation programme outlined in the NHS Long Term Plan. The Long Term Plan had recognised that hospital settings were not the best settings to address the needs of people with learning disabilities and autism, who were often at greater risk of admission to hospital for example when placements broke down.
2.05	Ian Sutton explained that referral criteria and waiting lists were increasingly challenging to navigate for people with learning disabilities and autism and their families. One parent had described a need for something that was “not health or social care but something in between and joined up”. He described how the SELECT team provided help to navigate the system and work with the young person and their family to create a co-produced personalised plan of support, working with all disciplines across the system.

2.06	Richard Douglas welcomed an example of care based around the needs of individuals rather than separate services and organisations, asking if there were ways in which support to navigate a complex system could be complemented by simplifying the system itself.
2.07	Stuart Rowbotham commended the work as an example of the benefit of working at scale across south east London and asked how a 'cliff edge' could be avoided for older children transitioning from 0-18 services, and how to achieve greater personalisation of care and use of personal health budgets.
2.08	Anu Singh welcomed the focus on people's lives rather than the individual services they used, highlighting opportunities to learn from work done elsewhere on learning disability and employment in the context of the ICS's anchor programme.
2.09	David Bradley asked how families could find out about the support available and how the initiative could be expanded beyond the 53 families currently supported.
2.10	Sarah McClinton emphasised concern about transition from children to adult services and asked about plans to expand the service.
2.11	Carol-Ann Murray confirmed that efforts were being made to analyse and simplify the journey from diagnosis to post-support. The service encompassed those aged 0-25 although high demand for services for 0-18 had required an initial focus. Young people aged 18-25 tended to need a different type of keyworker support and access to other services such as behavioural support. Dynamic support registers were key in identifying people including those at particular risk of admission. Ian Sutton added that a key lesson for other services might be to treat key working as a function rather than a role. A personalised approach was key using whatever budget and tools were available.
3.	**Agreeing the governance of the Integrated Care Board** **Board consideration and agreement of the governance framework**
3.01	Michael Boyce thanked the stakeholders who had helped develop and comment on the governance documents presented and asked the board to consider the committee structure with supporting terms of reference and accessible one-page functions and decisions map.
3.02	Anu Singh stated that the board would need to achieve synergies between engaging clinicians, care professionals and the public and asked if the Clinical and Care Professional Committee (CCPC) was the best forum to oversee this important work. Dr Jonty Heaversedge suggested that the CCPC would be a place to demonstrate the commitment to a synergy between those elements but would not be the only place where they would be important or discussed.
3.01	Dr Angela Bhan asked how enabling workstreams such as estates would be governed by the structure. Michael Boyce noted that the committees of the board would be able to establish sub-committees to ensure appropriate oversight of enabling areas.
3.02	Dr George Verghese asked if a commitment could be made as to when the arrangements were reviewed. Richard Douglas suggested that committee chairs

would set review points to determine effectiveness however a formal review could take place at the end of the financial year.

3.03

- **The Board agreed South East London ICB's proposed governance structure.**
- **The Board agreed the terms of reference of the SEL ICB's committees, including appointing the chairs and membership as included in those terms of reference.**
- **The Board agreed the Functions and Decisions Map.**

3.04 Michael Boyce introduced the standing financial instructions and matters delegated to officers, which ensured the organisation acted with propriety. These and other documents listed had been developed in consultation with internal partners.

3.05 Stuart Rowbotham questioned if the key principle of subsidiarity was sufficiently reflected in the new standing instructions and suggested further review points would be necessary. Michael Boyce noted that the audit committee would have oversight and there would be opportunities for review of the documents.

3.06

- **The Board agreed the Standing Financial Instructions, the Scheme of Reservation & Delegation and the Schedule of Matters Delegated to Officers.**

3.07 Michael Boyce presented the key policies prepared for the ICB and advised that staff from London Shared Services who were transferring to the ICB under the TUPE regulations would be subject to existing policies which the board were asked to adopt.

3.08

- **The Board noted the process for developing ICB policies and formally adopt those presented for NHS South East London Integrated Care Board.**
- **The Board noted the HR policies that will need to be adopted for LSS staff transferring to SEL ICB.**

3.09 Michael Boyce presented the safeguarding framework and the working with people and communities' strategic framework.

3.10 Paul Najsarek commented that the people and communities strategic framework set out some admirable ways in which the public could influence the work of the organisation but focused less on ways the ICB could work with the public and communities to promote health and influence the adoption of healthier lifestyles.

3.11 Anu Singh praised the people and communities strategic framework which covered a spectrum of engagement activities with communities in the areas of accountability as well as co-production but agreed the work on creating health was vital and could not be overemphasised.

3.12 Anu Singh commented that the safeguarding framework frequently referred to activities which would be done at place and in provider organisations, and it would be important that there was sufficient capacity and resource made available in these areas for safeguarding work.

3.13	• **The Board noted and approved the Safeguarding Governance Framework.** • **The Board endorsed the south east London working with people and communities strategic framework subject to additional emphasis on the role of the ICB to promote healthier lifestyles and wellbeing.**
3.14	Michael Boyce referred members to the board special roles and lead roles which had been approved.
3.15	• **The Board noted that the South East London ICB's audit chair is the Conflicts of Interest Guardian for South East London ICB.** • **The Board noted that the South East London ICB's Chief of Staff will be the Freedom to Speak Up Guardian.** • **The Board endorsed the proposal that the chair of the quality and safety committee is the board lead for safeguarding.** • **The Board appointed the ICB chair as founder member and joint chair of the SEL ICP.**
3.16	Michael Boyce directed the boards attention to the delegation to local care partnerships which had been set out in the paper.
3.17	Anu Singh asked how delegation would work in practice and how the board would be assured regarding the local care partnerships discharge of their responsibilities. Andrew Bland emphasised the need for an assurance process to be effective and enable solutions to any problems, rather than simply pointing out areas of concern. It was important that delegation was supported and duplication avoided. To achieve a balanced approach the board may need to improve arrangements through a number of iterations. Sarah Cottingham highlighted the importance of building trust, and for an assurance process which added value.
3.18	Richard Douglas concluded that the approach to assurance in the new way of working should give a high degree of delegation and trust to partners in the system.
3.19	• **The Board noted the proposed delegation to LCPs in 2022/23**
4.	**Our system purpose and Corporate Objectives** **Our mission and Corporate Objectives for the Integrated Care Board**
4.01	Andrew Bland introduced a draft mission and a set of corporate objectives which reflected the current ICS System Development Plan and national guidance but would need further iteration to reflect the future ambitions, refreshed vision and values to be developed by the board in coming months.
4.02	Paul Najsarek highlighted the risk that ICS's work to help residents stay healthy and well may not achieve as much traction as it otherwise could because of the focus demanded by improving and maintaining services and addressing delivery challenges following the pandemic.
4.03	Anu Singh remarked that the purpose of the ICS was to set stretching goals for resilient communities prevention and looked forward articulating this in future revisions. People with a particular passion or interest in health and wellbeing or

4.04	diversity and inclusion may wish for more detail on how these objectives would be measured, in line with the detail given for other objectives. Jonty Heaversedge suggested the main challenge would be working together on the detailed delivery of the objectives that would require contribution from roles across the whole system. It would be important to support staff as well as communities who had worked through the pandemic. Although opportunities for improvement could be taken, the current objectives were well-formulated and would need to be coupled with metrics that made progress visible so that the board could identify priority areas for improvement.
4.05	George Verghese also praised the objectives and suggested that the objectives would now need to be transposed down to organisations and places. A good start had been made on the sustainability agenda in south east London and the objective was to be welcomed and should become a clear focus over coming years.
4.06	Peter Mathew suggested delivery of all the objectives would be a challenge given the first quarter of the year had already passed. A clear measure was needed of what practically would constitute a success at the end of the current year. Some terms and references in the objectives such as the anchor programme would benefit from further definition and other elements which had carried over.
4.07	Dr Angela Bhan noted regarding prevention and role in the wider health of the community that it was pleasing to see some primary prevention activities such as vaccination referenced but there were a range of things such as screening for cancer and pulse checks to detect high blood pressure or arrythmia which could be expanded on in some of the other objectives as activities which would improve outcomes for people.
4.08	**The Board approved the mission statement and draft corporate objectives, subject to review as the Board determined its medium term and longer term strategic priorities.**
5.	**Delivering through partnership** **The opportunity at 'Place' – Bexley Local Care Partnership**
5.01	Stuart Rowbotham expressed gratitude for the board's support of the principle of subsidiarity and meaningful delegation to Place and introduced Bexley local care partnership. The partnership was formed of 17 local health and care organisations with shared goals and a shared vision, with a strong foundation developed over five years of collaboration. Its approach was to be person centred and joined-up, but always in a way that was unique to Bexley. There had been particular attention to post Covid recovery, addressing health inequalities, and an emphasis on transformation of healthcare services, and a sense of working as a team. Further delegation from the local care partnership helped to empower organisations who were already working with and trusted by communities for example Peabody housing in the Thamesmead area.
5.02	The board received a short film about the digital inclusion initiative with input from the range of care professionals who had worked together to provide support to some of the most vulnerable local people, as well as the perspectives of those who had benefitted from the programme. Stuart Rowbotham commented that by working with assets and volunteers in the community, a very small investment from the LCP was able to produce a significant benefit for local people.

Delivering through Provider Collaboratives

5.03 Prof Clive Kay introduced the South East London Acute Provider Collaborative (APC) formed of Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust and King's College London NHS Foundation Trust. The Trusts had worked very closely together during the first wave of the COVID-19 pandemic and as a result very few patients had needed to be transferred to other areas to receive critical care. The Trusts built on this successful collaboration by forming an APC in April 2020, initially focusing on the recovery of elective and other services most affected by the pandemic. After successfully working together and with the whole system to care for very significant numbers of patients during a second COVID-19 wave.

5.04 A new governance model for the APC launched in March 2022 comprising a committee in common reporting to the NHS Trust Boards as well as linking to the ICB. Colleagues from across the providers worked together committees on areas such as planning, finance and workforce as well as linking in to existing programmes such as the Cancer Alliance. Elective recovery was the responsibility of the whole health and care system and the formation of the ICB would help reinforce the need for collective working. There was already strong working with primary care colleagues on referrals, as well as on outpatients and diagnostics.

5.05 An elective recovery plan for 2022/23 included measures for increasing capacity for example by improving facilities at Queen Mary's hospital in Sidcup, improving productivity by learning from each other and standardising best practice, and making best use of collective resource across south east London. Although good progress was being made, with few patients waiting more than two years, the suffering of every patient on a waiting list was recognised and there was a shared commitment to reducing waiting lists as well as supporting those patients waiting, keeping them informed and free from harm and helping to prepare for their treatments.

5.06 Some examples of the benefits of working together as an APC included developing community diagnostic centres on behalf of the ICS, and to create two additional theatres at Queen Mary's Sidcup to provide capacity that could be used across the system, which had received good feedback from patients and surgeons. In the future the ICB could discuss how to clarify the role of the APC to ensure it had sufficient autonomy to innovate and improve, appropriate delegation and responsibility as well empowered clinical and care professional leaders and enabling resources. There would need to be co-ordination with Place, as well as the ability to develop outcomes on behalf of the ICS to be accountable for.

5.07 David Bradley observed that successful examples such as increasing surgical capacity at Queen Mary's Sidcup often depended on good clinical engagement. Clive Kay proposed that the board should promote amongst colleagues a mindset of shared responsibility to care for all south east London patients using the single set of resources available to the system. Patients and resources could no longer be viewed as 'belonging' to individual services or organisations.

5.08	Jonty Heaversedge suggested the challenge was to allow the unique solutions to flourish in each place, while also creating opportunities for successful work to be scaled-up across south east London without insisting on uniformity. Ceri Jacob reflected that successful initiatives often used short-term transformation money and asked how the impact could be better measured to help preserve effective schemes in a challenging financial environment. Stuart Rowbotham noted that the Bexley Local Care Partnership had recently discussed how it could best understand and measure the impact of schemes
5.09	James Lowell expressed optimism about the way of working now being seen in work such as community diagnostic provision focusing on achievement rather than obstacles.
5.10	**The Board noted the presentations on working in partnership**
6.	**Operating Plan - 2022/23 - delivery, performance and finance**
6.01	Sarah Cottingham noted that the plan had been developed ahead of the formation of the ICB and would be inherited by the organisation, NHS national guidance had been set out in December with further changes introduced, and the plan had responded to this working with partners, in a good example of working collaboratively across the system. Working together would continue to be required to find collective solutions to shared problems and risks as well as implement planning guidance requirements in areas such as access to services. The plan made clear that it covered only a part of the overall the work of the ICS, however there were ambitious commitments made and the delivery of them would be challenging in the context of risks related to demand and capacity and also recruitment and retention.
6.02	Mike Fox added that a balanced financial plan for the 2022/23 financial year at ICS and individual organisational level had been agreed. It was important to recognise the significant risks to the delivery of the plan, specifically in relation to securing elective recovery funding, meeting inflationary cost pressures and delivering the required savings plans.
6.03	Anu Singh noted that the board would wish to develop metrics which could be used as proxy measures of transformational change, to enable the board to maintain an overview that was sufficiently strategic and helped to keep direction.
6.04	Debbie Warren informed the Board as local authority representative of the challenged financial situation and effect of inflation on the ability to deliver its business. Government support could not be assumed and local authorities might be obliged to make difficult decisions about the services they funded. It was important that these problems were discussed and shared with all in the health and care system to avoid a destabilising effect
6.05	Richard Douglas noted the point and suggested that it would be helpful for the board to receive an overall financial position of all the partners across south east London so that decisions that were detrimental to parts of the system.
6.06	**The Board noted the deliverables and commitments made in the operating plan for 2022/23.**

7.	**Taking Action** **Children and Young People's Mental Health**
7.01	Martin Wilkinson acknowledged the challenges in relation to poor mental health faced by many children, young people and their families, which had been confirmed by work across South London Partnership as well in each Place. The COVID-19 pandemic had exacerbated existing pressure on mental health services provided by the NHS and local authorities. The initiative had undertaken work to identify ten priorities to address inequality in mental health provision for children and young people. Two of these priorities would receive initial focus: supporting children of parents with poor mental health through a peer support programme Empowering Parents, Empowering Communities (EPEC) following successful approaches in Lambeth and Southwark; and supporting children dealing with trauma by improving the support available to them in schools. A Children and Young People's Health and Well-being strategy would be brought to a future meeting of the board and would focus on specific actions against all ten priorities identified.
7.02	Richard Douglas asked how a balance would be achieved between work across the ICS and work in local care partnerships. Martin Wilkinson suggested that this balance could be achieve over time by continued work and maintaining good relationships with local partners.
7.03	Paul Najsarek asked how the programme would be resourced sustainably. Martin Wilkinson noted the finance resourcing was a mixture of recurrent and non-recurrent funding and recruiting workforce with the right skills was challenging. Further consideration of the model over time would help ensure sustainability.
7.04	Anu Singh praised the good example of working together, suggesting self-reported outcome measures as a way of listening to children and ensuring the work was truly making a difference. Martin Wilkinson agreed, adding that the feedback of wider families and support networks would also be useful.
7.05	Dr Jonty Heaversedge welcomed the clear outcomes identified and suggested framing them as positive attainment may also be helpful. He asked how work could be scaled up. Martin Wilkinson commented that metrics about ongoing support as well as treatment could be an area to identify positive outcome metrics. Directors of Children's Services were key contacts to work with headteachers to scale up the work in schools.
7.06	Dr George Verghese asked about engagement with Place in delivery and whether data for example on Core20PLUS5 framework was being used effectively for example to identify areas of focus. Martin Wilkinson noted Place would have a lead role in delivery given existing relationships and agreed on the importance of Data in selecting hub sites.
7.07	David Bradley pointed out children's mental health demand was a massive area of growth and an issue for the whole system. In particular across London large numbers of 12-16 year old girls were attending emergency departments for mental health. Martin Wilkinson described services being developed including crisis houses and crisis lines, as well as work with primary care to provide early support and prevent crisis.

7.08	• **The Board noted the Implementation of the Empowering Parents, Empowering Communities (EPEC) parenting programme across all South East London boroughs and work undertaken to further develop the model to expand mental health support in schools.** • **The Board noted the development of a South East London Children and Young People's Mental Health and Wellbeing transformation plan, with clear and deliverable actions for each of the ten priority areas.** • **The Board noted that an update on both these items would be provided in Quarter 3 of 2022/23.**
	Development of South east London's Integrated Care Strategy
7.09	Sarah Cottingham referred to the paper which sought the boards' approval to an engagement proposal to involve leaders, staff, partners and the public in the development of an Integrated Care Strategy for south east London. Some engagement with local partners had already taken place and the paper described a series of events and approaches for approval.
7.10	**The Board approved the proposed approach for submission to and in support of the South East London ICP when it is established.**
8.	**Any Other Business**
8.01	There was no other business
9.	**Public questions and answers**
9.01	**Pam Remon** *shared her longstanding concern about the entry of private providers into the NHS and asked if private health companies be allowed to sit on integrated care boards, committees and sub committees or be given delegated powers and budgets, given the Health and Care Act's ambiguous wording on the issue.*
9.02	Richard Douglas confirmed that no private companies were represented through board members, or on any of the committees and subcommittees of the board.
9.03	**Abieyuwa Ehondor** *explained that she worked on a pan-London Blue Prescribing Project. Referring to the ICBs strategy of working with local partners she asked about the ICBs approach to the long-term funding and resourcing of these partnership organisations. Social prescribers worked with the NHS and Local authority to accept referrals of patients, however there had been little robust conversation about long term resources and funding of these partnership organisations.*
9.04	Andrew Bland confirmed the ICS had a strong commitment to social prescribing and a set of investments locally for example through primary care networks.
9.05	Stuart Rowbotham noted that the Bexley local care partnership recognised the importance of sustainability of schemes and helping volunteers given outstanding outcomes they achieved and had held discussions on the funding of social prescribing at its last meeting to try to address this issue. The voluntary sector was represented as a full member in the local care partnership and included in discussions about the allocation of the budgets.

9.06	Dr Angela Bhan confirmed that in Bromley the third sector was also involved in decisions about resourcing, and there was a substantial programme of investment in the third sector including significant sums from the Better Care Fund, in recognition that the local system could not manage without these partners.
9.07	Richard Douglas reflected that a short-term approach to funding had often made such issues more difficult. He expressed an ambition that the ICB from an NHS perspective should work towards longer term financial certainty.
9.08	**Frances Hook** *commented that the lack of private sector representation on boards or changes to section 75 agreements would not stop the private sector having contact with board members and continuing to grow within the NHS. Private companies were concerned with shareholders and profit and the results of privatisation had been seen in social services. She asked about the nature of changes to Lewisham Urgent Care Centre and whether private companies such as Greenbrook would be given the opportunity of running the service.*
9.09	Martin Wilkinson confirmed that work was underway to develop an urgent care centre at the Lewisham emergency department into an urgent treatment centre, however the plan was to work with existing NHS providers, such as One Health Lewisham -the local GP Federation working with the Lewisham & Greenwich NHS trust.
9.10	Andrew Bland confirmed that NHS services remained free at the point of delivery and repeated the comments made by the chair that private companies had no membership on governance committees. There remained the ability of the NHS to procure from providers such as Greenbrook if appropriate.
9.11	**Pam Remon** *noted changes to the procurement process coming into place to allowing the NHS to decide not to go out to tender and asked about the effect of not tendering on the NHS identifying the best use of services and whether it risked more private companies coming in to the NHS.*
9.12	Ben Collins commented that the changes would make it easier to make decisions in the interests of communities on who should provide services by providing greater flexibility to decide internally if procurement was the best option to secure the right service for patients, noting that procurement would allow private providers to bid.
9.13	**Pam Remon** *added that her particular concern particular concern about recent report of deaths as a result of the failings of private providers, and as well as a recent Panorama programmes revealing GP practices run by large companies being run on occasion with no doctors.*
9.14	Andrew Bland noted that while south east London was not involved in the procurement of the particular contract discussed in the Panorama programme, it had undertaken an assessment of south east London contracts and had found no evidence of the situation described by the programme in south east London.
9.15	**Frances Hook** *referred to a comment made during the meeting that the new ICB would have more freedom and not be as constrained as in previous NHS structures and asked if this meant that that each of the 42 board in the country would do things in a slightly different way in the absence of a framework of standards and directives.*

9.16	Richard Douglas clarified that there was still a framework of national oversight and some requirements made of all ICSs however there was more flexibility to respond to local people's needs.

Integrated Care Board

Item 4
Enclosure C

Title:	**Chief Executive Officer's Report**
Meeting Date:	**14 September 2022**
Author:	Andrew Bland, ICB Chief Executive Officer
Executive Lead:	Andrew Bland, ICB Chief Executive Officer

Purpose of paper:	**To receive the report from the Chief Executive Officer**	Update / Information	*X*
		Discussion	
		Decision	
Summary of main points:	This report updates the Board on matters of interest across NHS South East London since the last Board meeting on 1 July 2022.		
Potential Conflicts of Interest	**None**		

Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**

	Equality Impact	Equality Impact Assessments are considered where applicable
	Financial Impact	N/A
Other Engagement	Public Engagement	Public engagement takes place where appropriate and this report is presented to the Board meeting in public and published on the ICS website
	Other Committee Discussion/ Engagement	N/A
Recommendation:	**The Board receive the Chief Operating Officer's Report**	

Chief Executive Officer's Report

ICB Board 14 September 2022

1. Welcome and steps taken to stand up the ICB since 1 July 2022

1.1 Since establishment on 1 July 2022 as NHS South East London ICB, all functions of the ICB have transitioned well including the on boarding of staff who came across from London Shared Services (LSS) on 1 July 2022. A comprehensive organisational development plan is in place and includes staff engagement sessions, one of which was held at the Oval. The Chief of Staff has now stood down the Transition Board and is now re-energising a comprehensive staff engagement programme which includes 'all staff briefing sessions' to be held a week after the South East London ICB board meeting alongside re-establishment of several staff network forums.

1.2 From a system perspective, there has been considerable operational pressure impacting on all parts of the system. Whilst we are of the firm conviction that the opportunities for new approaches built from and out of partnerships right across our system of systems will help us; we are aware that the challenges today are significant and stretch right across our system and our residents. We see these challenges in our front line services and now with wider challenges posed first by the Pandemic and now by the increased cost of living, we know they are growing and will be more complex to address. We are relentlessly focused upon that task.

2. Vaccination update

2.1 The South East London Integrated Care System is either delivering or about to start to deliver four vaccination programmes to eligible residents:

- Covid
- Influenza
- Polio
- Monkeypox

2.2 As detailed in NHS England's letter of 12 August 2022 "Next Steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter", South East London ICB recognises the importance of delivering an integrated covid-19 and flu

1

vaccination programme to as many residents as possible in preparation for the covid-19 and respiratory challenges the winter is likely to bring.

COVID

2.3 South east London partners in Primary Care Networks, community pharmacy and vaccination centres have continued to offer covid vaccinations to those who have either needed a primary or booster dose throughout the year. Most weeks during the summer over 3,000 vaccinations have been administered across all boroughs. At the same time the sites are preparing for the Autumn campaign where a booster will be offered to all eligible people. It is anticipated that the programme of vaccination will commence from 5 September with the focus initially being on those who are the most vulnerable in care homes and at-risk groups. Over 4 million covid vaccinations have been given since the beginning of the programme in south east London and thanks are given to the dedicated staff delivering them.

Influenza

2.4 The annual influenza vaccination programme is also due to start during September. As in past years south east London's general practice and community pharmacy teams will provide this service to the local population; however, this year, as many people who will be receiving their covid vaccination will also be eligible for a flu vaccine, the vaccination centres will also be providing this service. As with the covid vaccination the groups that are eligible for the influenza vaccination are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI).

Polio

2.5 In August 2022 the JCVI met to consider the vaccination strategy as there had been a number of incidences where poliovirus had been detected in sewage samples in north and east London. The JCVI agreed that the most immediate priority was to ensure all eligible individuals were up to date with their polio vaccinations and in addition to the ongoing catch-up, a supplementary IPV booster campaign should be implemented for children aged 1 to 9 years in London**.** For south east London this is circa 211,000 children.

2.6 The South East London Integrated Care System partners have worked together to develop a plan to ensure that every child aged between 1-9 would be contacted through their parents/carers/guardians and offered an appointment to either receive their primary course of childhood vaccinations including polio or a booster dose. This service will commence from 22 August 2022. Initially general practice and vaccination centres will provide this service, but SEL ICB is keen to work with community pharmacy colleagues, who meet the criteria, to increase the number of sites and therefore access during August and September. Boroughs are working with Local Authority colleagues to explore where it will be optimal and safe to provide this sort of vaccination service including children's centres, after school clubs, schools, when children return from the summer holidays, and community outreach.

2.7 The ICB is very grateful to system partners for their response to this immediate call to action and to the staff who continue to work tirelessly to ensure residents receive their vaccinations.

Monkeypox

2.8 Monkeypox is a rare infection most commonly found in west or central Africa. However there has recently been an increase in cases in the UK. Protection against Monkeypox can be provided by vaccination. In south east London, the three acute trusts have supported the vaccination programme. The sexual health clinics at King's College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust have administered vaccinations and Guy's and St. Thomas' Hospital NHS Foundation Trust set up a number of weekend clinics for London residents. 11,521 vaccinations have been administered across the three sites since the start of the campaign and over 25,000 people have been vaccinated nationally.

3. Overall system pressures and incident updates

3.1. The overall pressures the urgent and emergency care system has been operating under have continued since the Board last met, driven by challenges matching demand and capacity including staffing issues.

3.2. There is a significant focus on managing these pressures on a real time basis, seven days a week, including system wide approaches to mutual aid to support flow and minimise waits across the urgent and emergency care pathway. This sits alongside a range of initiatives aimed at securing more resilient and sustainable pathways, for example increasing same day emergency care capacity and pathways, expanding admission avoidance services, action to support the timeliness of hospital discharge and ensuring a timely response to patients experiencing a mental health crisis.

3.3. At all times quality and safety is a priority consideration, with regular safety checks and a focus on ensuring the balance of risk across the system is understood and reflected in agreed system management and escalation actions.

3.4. The challenges associated with these system pressures have been exacerbated by some ongoing national and local incidents that are impacting upon NHS services in south east London and elsewhere. These relate to IT issues affecting Guy's and St Thomas' NHS Foundation Trust (GSTT), caused by the extreme weather in July, and the wider impact of problems with some national third-party IT provided systems provided to the NHS by Advanced.

3.5. A number of services, including NHS 111, some Urgent Treatment Centres (UTCs), some mental health providers, including South London and Maudsley NHS Foundation Trust and some community services providers, including GSTT use these third-party IT systems and have therefore been impacted. For example, providers have needed to use slower paper-based systems and implement secure reconciliation programmes to update digital records. All providers have however been able to continue providing services throughout the summer, although there were some appointment and treatment cancellations at GSTT, which the trust will be seeking to recover during September.

3.6. Our incident management systems and processes are well established, and we have met daily as a south east London system gold command to oversee our incident response, implement a series of mitigations to minimise the impact on our residents and to ensure the safe resolution of the issues that have arisen.

3.7. Affected providers have business continuity plans that have been enacted throughout and the ICS has been linked in with national and regional colleagues. Whilst these arrangements are standard practice for incidents of this nature, the duration of them has been unusual and complete resolution may take some time. However, across the South East London ICS good progress is being made, locally and working with wider partners, in resolving the issues on a technical and service basis, always prioritising the safety and care of local residents.

3.8. NHS staff have worked tirelessly during this period, and we are very appreciative of the incredible hard work and dedication shown by staff in responding to these incidents, putting patients first and their efforts in the face of circumstances that are beyond their control.

4. Winter planning

4.1 The NHS received national guidance in relation to increasing capacity and operational resilience in urgent and emergency care for winter on 12 August 2022. The usual winter planning processes have been brought forward for 2022/23 recognising the very real pressure the urgent and emergency care system has been under so far this year, with record numbers of A&E attendances and urgent ambulance call outs nationally alongside another wave of Covid-19.

4.2 The guidance sets out a number of core objectives for the rest the year: to prepare for variants of Covid-19 and respiratory challenges, to increase capacity outside acute hospitals, to increase resilience in NHS 111 and 999 services, to improve ambulance Category 2 response times and handover delays, to reduce overcrowding in A&E departments and improve waits, to reduce hospital bed occupancy to support flow and to ensure the timely discharge of patients form hospital.

4.3 The guidance asks systems to undertake a series of winter planning exercises to support the delivery of these objectives, including the completion of a self-assessment framework against nationally recommended best practice and the completion of a tracker demonstrating progress against nationally recommended actions. ICBs have been asked to develop improvement trajectories for a number of key objectives focussed on 111 and 999 resilience and improvement, bed occupancy and discharge. The NHS has also received some additional funding to support winter preparedness, including ICB allocations to enable additional bed capacity to be secured in and out of hospital to meet increased winter pressures.

4.4 The ICB is working with ICS partners to undertake the planning required to meet the national expectations with outputs to be submitted nationally at the end of September, alongside a number of monthly monitoring returns thereafter. In addition, the ICB is coordinating the development of wider winter plans, with a winter workshop taking place on 8 September 2022 to review processes and plans and agree further action to improve resilience over winter. The outputs of this workshop will be reviewed by the South East London Urgent and Emergency Care Board on 12 September and will be placed alongside the work to respond to the national asks to secure a comprehensive winter plan for 2022/23. Notwithstanding the significant focus on winter planning, a challenging winter ahead is expected and effective and safe system management over this period will be a key priority focus for SEL ICB.

5. Engagement on the ICS strategy

5.1 Throughout July and August, extensive engagement on the integrated care strategy has been held with leaders and staff across the south east London health and care system. This includes with local authority partners, voluntary, community and social enterprise (VCSE) partners, Healthwatch, patients and the public. This included launching an online platform for people to provide their views, online events for the public and partners, and a face-to-face event for leaders from across our system.

5.2 From these discussions, there is broad agreement that the strategy needs south east London specific and ensure it provides a vehicle for genuine improvement in health and care in the system. It has been agreed that a vision is developed for how the south east London system should look in the future, a set of cross cutting themes that should guide all work, and a small number of major strategic priorities where joint working and cross system action in south east London should deliver major improvements for local people.

5.3 In the Autumn, when strategic priorities have been determined, leaders will be brought together, from across the south east London system with representatives of patients and the public, to devise a strategic approach to tackling selected challenges, reviewing what has been done to date, and how other health and care systems have approached these challenges. This will identify how progress will be made on complex long-standing issues and enable the system to move quickly into action next year.

5.4 It is hoped that the strategy, or at least an interim statement on the strategy, can be publicised by the end of the year, and will reflect the strategy in the south east London five-year NHS system plan for April 2023 onwards.

5.5 There will be continued opportunities to contribute including through the South East London ICS website and in face to face and online meetings in the Autumn.

6. Clinical and professional/ system development

6.1 The Clinical and Care Professional Leadership (CCPL) Committee has convened with the agreed overarching aims of leveraging collective ability across the system and enabling and supporting clinical leadership at all levels. Good progress has been made with recruitment to CCPL roles at borough and system level. A timetable is being established to complete this process with an emphasis on also ensuring representation from primary and secondary care.

6.2 A South East London Leadership Academy is being established to support leadership development alongside initiatives to support the spread of innovation and community networking. This will involve a multifaceted approach including structured learning in systems leadership, facilitation for spreading innovation, communities of practice peer-to-peer learning and support for improvement projects. The first cohorts of established and emerging leaders to the Academy will be recruited in the near future.

6.3 The South East London Spread and Scale Academy is a three-day programme which will train teams with an innovative idea to develop these into scalable solutions which can be spread across the ICS and beyond. This was developed by the Billions Institute and the Dragon's Heart Institute, in partnership with Cardiff and Vale University Health Board. The first cohort of sixteen diverse teams representing the breadth of the SEL ICS

has been recruited and the first programme will run in September 2022 and twice a year thereafter.

7. Sustainability

7.1 The NHS is the first national health system to commit to a net-zero future. The urgency of shifting to greener health service delivery is well understood and, with the aim of creating a greener NHS, two clear achievable targets have been set for the emissions of the NHS controls to be net zero by 2040, and the emissions the NHS influences to be net zero by 2045.

7.2 The Health and Care Act 2022, further underscored the importance of the NHS's robust response to climate change, placing new duties on NHS England, and all trusts, foundation trusts, and integrated care boards (ICBs) to contribute towards statutory emissions and environmental targets. The new Act requires NHS services to specifically address the UK net zero emissions target above, the environmental targets within the Environment Act 2021, and to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act.

7.3 South East London Integrated Care System's (ICS) sustainability commitment is to protect the health of and provide high-quality healthcare to the population of south east London whilst reducing our environmental impact and become net zero in line with the above NHS targets. To achieve this, the SEL ICB created an ICS Green Plan detailing the work to reduce carbon emissions over the next three years which is collectively underpinned by every south east London foundation trust/ trust having its own green plan, and by primary care working to its own green plan. The ICS plan is also further enhanced by its alignment to the existing sustainability work of the six south east London local authorities, drawing from some of their previous achievements and learning to date. The SEL ICS green plan can be found here.

8. Equalities

8.1 Since the first board meeting on 1 July 2022, the ICB's governance has settled into its first round of meetings. This includes the ICB's Equalities sub-committee.

8.2 SEL ICB's equalities agenda has continued to progress with the Equalities Delivery Plan (EDP) currently on track in all areas. The Race Equality Forum met on 20 July 2022, with good attendance from across the organisation. The agenda included an item on how to promote staff belonging through a focus on name pronunciation. Following feedback at the forum and from the Beyond BAME group, the ICB is endorsing the use of 'voice signatures' – a digital tool to support correct pronunciation of colleagues' names. A soft launch has taken place and a formal launch is currently being planned. The staff networks continue to thrive within SEL ICB. Multiple workstreams are underway including the establishment of a SEL ICB book and a film and music club to launch during Black History Month.

8.3 Equality analyses (EA) are increasing across the organisation with reviews undertaken on the elective recovery plan and safeguarding policies, and input into the London Maternity Network health equity audit. A review is due to take place to streamline the EA process as part of an integrated impact assessment tool to cover both the Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) processes.

8.4 Data collection for the 2022 Workforce Disability Equality Standard (WDES) is currently underway. Whilst ICB is not mandated to do so, it has opted to report on WDES as good practice, as South East London CCG did last year, to demonstrate the organisation's commitment to disability equality. A programme of engagement with staff with a disability and their line managers is being planned in September and October to support the development of the WDES report and action plan. NHS England has announced that the Workforce Race Equality Standard (WRES) has been postponed for ICBs due to the recent transition. Further updates on new timings are expected shortly.

9. Bexley Borough Update

Progress on Community Diagnostic Centre proposal

9.1 Further to invitations from NHS England (NHSE) to bid for new Community Diagnostic Centres (CDC), the Bexley Local Care Partnership has been engaging with its acute provider partners from Guy's and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust and Dartford and Gravesham NHS Trust, as well as with its community provider Oxleas NHS Foundation Trust, in a working group to progress a bid for a CDC on the Queen Mary's Sidcup site. A short-form business case was submitted to NHSE and was approved to go forward for a full business case, which the working group is currently developing for submission in the Autumn.

Intermediate Care Beds review

9.2 The Home First plan outlined the Bexley and Greenwich proposal to right size intermediate care beds due to the ongoing fall in referrals for patients suitable for these types of beds, with 96% of patients now returning home following an acute admission and the ongoing inefficient use of space at Eltham Community Hospital. The Home First model, supporting more people to return home directly from hospital, enables more patients to receive intensive health and social care support in their own home.

10. Bromley Borough Update

10.1 The first One Bromley Local Care Partnership Board was held in public in early July, providing an excellent opportunity to meet face to face again and share plans and progress with local people.

Winter Planning

10.2 The One Bromley 2022/23 winter plan builds on the successful elements of last year's plan, whilst strengthening the offer and responding to new emergency needs and system changes, based on three key pillars:

- Increasing system capacity (Primary care, Admission Avoidance and Discharge)
- Meeting seasonal demands (Respiratory pathways, Adults and Children, Christmas and New Year additional capacity, COVID-19, and Flu vaccination planning)
- Information sharing and escalation (Winter intelligence Hub, system escalation, Winter communications and engagement)

10.3 A collaborative approach to managing winter pressures is essential to monitor and respond to system pressures, surges, and issues, supported by cohesive and timely public and system communications. The One Bromley executive has agreed a new integrated care service model for hospital discharge, funded by SEL ICB and Bromley Local Authority, to cover staff and discharge to assess. Working in partnership with the Princess Royal University Hospital (PRUH) has enabled the hospital to home service to offer wearable assisted technology and at home welfare checks.

Estate Improvements

10.4 At the Princess Royal Hospital, work has started on a link bridge and extended car park. At Orpington a fourth state-of-the-art operating theatre and recovery suite is supporting delivery of first-class care for patients. A new staff Well-Being Hub officially opened in August. Progress is being made on plans for the Bromley Health and Wellbeing Centre. The new centre will bring together, under one roof, general practice and a range of community health services. Based in the centre of Bromley, it will be easily accessible to local people and has good transport links to other parts of the borough. Subject to all necessary approvals, it is aimed to have the new centre up and running in 2024.

Cadet Programme

10.5 The One Bromley Cadet programme aims to provide young people with a wider understanding of a range of Health and Care careers in Bromley and to improve their potential career prospects. The first pilot programme launched in April and was attended by eighteen students aged 16-18 from three local Bromley schools. The programme ran after school for eight weeks, both virtually and face to face. Sessions were designed to inform the students about various health and care careers, the routes into this kind of work, CV/ job application tips and to let them experience first-hand tours / immersive experiences in health and care settings such as the PRUH and Orpington Health and Wellbeing Centre. The pilot received fantastic feedback from the students and their teachers; the programme has been extended to another two schools and the next cohort starts in September 2022.

Dementia Strategy

10.6 A new Dementia Strategy has been developed by St. Christopher's Hospice following their successful Conference of Dementia and recent data which shows Dementia is the leading cause of death in the UK. The strategy also builds on plans to extend rehabilitative support into care homes and to those living with frailty to support their wellbeing and functionality. Delivery of the strategy will be a collaborative approach, working with organisations that have expertise in Dementia care, to address stigma, support early referral, improvements to the physical environment, hospitality and customer service. The strategy also spotlights the need to support research and education around approaches in caring for those living with dementia.

Primary care services

10.7 Like all services, the demand for primary care services remains extremely high. In July the new Bromley Primary Care campaign was launched, which highlights the various ways to get in touch with GP practices, explains how services are working, encourages people to use their pharmacy for minor ailments and promotes the range of services for self-referral without having to see a GP first. More information on the campaign is available at www.selondonics.org/bromleyprimarycare

11. Greenwich Borough Update

Healthy Greenwich Partnership Development

11.1 The Healthy Greenwich Partnership, with a newly appointed Chair, Nayan Patel, have agreed a development programme over the next six months to work on shared identity, purpose and a delivery model.

Greenwich Mental Health Alliance development and progress

11.2 The collaboration between the Royal Borough of Greenwich (RBG), Voluntary and Community Sector accommodation and support providers, Oxleas NHS Foundation Trust and South London Partnership and those with lived experience of mental health has led to a formal alliance agreement (being signed by key partners) to progress the first phase of delivering a Mental Health Alliance model in Greenwich. This will then be taken forward as part of a tender exercise expected to begin in late Autumn 2022/early 2023. Significant co-production work has been undertaken between partners to review pathways and data, assess those currently in accommodation-based support services to draw out themes and establish whether they are in the most optimum setting to reach their goals, and to establish new ways of working in the development of the Alliance. This is expected to ensure people can access the right community-based solution for them, at the right time for their needs and outcomes, and ensure best value in decision making. This model will evolve over time, with the potential for risk share agreements.

Eltham Community Hospital

11.3 The Healthier Greenwich Partnership are currently engaging, from mid-August to September 2022, with the public and staff around proposals for some of the services at Eltham Community Hospital. The proposals would see further investment in intermediate care at home (Home First), with intermediate care beds currently provided by Oxleas, at Eltham Hospital, moved to be with similar beds at Meadow View ward, Queen Mary's Hospital. This would enable the development of a new Community Diagnostic Centre (CDC) at Eltham which will have significant benefits for the residents of Greenwich and beyond. The proposed CDC would increase existing capacity for ultrasound scans, blood tests and X-rays and create new capacity for CT scans, MRI scans, respiratory and cardiac diagnostics. It will help to reduce waiting times to meet current demand and provide an opportunity for further expansion to meet future demand.

Developing Neighbourhoods/Fuller report

11.4 Greenwich has made a strong commitment to developing a joint vision about what 'good' looks like at neighbourhood level. At the heart this will be a supportive structure that enables collaboration at scale, ensuring general practice adapts to the challenges it faces without losing the essence of effective general practice as part of a wider primary care landscape. This aligns with the recommendations in the recent Fuller Stocktake Report that sets out a vision for integrating primary care and improving access, experience and outcomes for communities. Work is in progress to join up and develop local arrangements and a set of key milestones have been delivered. This year, work will include re-orientating the commissioning of Home Care and Public Health services at a neighbourhood level, as well as developing more integrated neighbourhood services, including strengthening community involvement and asset-based approaches.

The Source

11.5 The HGP is pleased to announce that The Source, will be re-opening on 5 September offering a range of community-based services to the residents in the Horn Park area including Health and Wellbeing support and nursing services. These arrangements have been developed by close working with partner providers - Oxleas, who are providing nursing services, and Eltham Primary Care Network (PCN), who provide Health & Wellbeing/social prescribing advisors.

CYP Integrated Therapies

11.6 RBG and the ICB are currently undertaking a negotiated procedure with Oxleas for the integrated therapies service; this will keep the same provider, with an updated model. There have currently been two negotiated meetings with a further three planned. Parents/ Carers and children and young people have been involved throughout the process and are feeding back and shaping the future model.

12. Lambeth Borough Update

12.1 In advance of the formal establishment of the ICB on 1 July the Lambeth Together Care Partnership Board had been operating in shadow form since January 2022 and is now operating under the formal delegated authority of the ICB. The Board membership has been refreshed with Andrew Carter appointed to the role of Strategic Director of Children's Services for Lambeth Council and joining the Lambeth Together Care Partnership Board from November. Mairead Healy has also been appointed to the role of CEO for Healthwatch Lambeth and joined the Board in August. Additionally, the process to recruit patient and public voice members to the Board is well under way, with interviews in August and offers expected to go to successful candidates during September.

12.2 The development of the refreshed Lambeth Health and Wellbeing Strategy and Lambeth Health and Care Plan continues to progress well. The early engagement phase is complete, and a new set of priorities and outcomes have been developed from that work. The Lambeth Together Care Partnership is also contributing to the development of the new Lambeth Borough Plan and ICS strategy.

Delivery Alliances

12.3 Lambeth's Delivery Alliances have continued to progress. The Children's and Young People's Alliance has invested in emotional health and wellbeing support for unaccompanied asylum-seeking children, along with South London and Maudsley NHS Foundation Trust, the Evelina, and wider ICB colleagues, and an emotional support project for vulnerable children who are not in education, training or employment or educated other than at school. The Living Well Network Alliance continues work to improve the access, experience, and outcomes of those needing mental health services through, for example, the Individual Placement Support service, delivered by Thamesreach, to help service users find meaningful work. The Living Well Network Alliance will target south east London inequalities funding through providing well-being pop up clinics in partnership with Mosaic Clubhouse, Emotional Emancipation Circles for the black community, led by Black Thrive, and a project focused specifically on the wellbeing of black carers by Carers4Carers. Work on the Neighborhood & Wellbeing

Delivery Alliance priorities continues with multiple projects relating to Thriving Communities (neighborhood health & care networks) including the use of south east London Equalities funding, chronic pain & care homes.

Lambeth Heart

12.4 Lambeth HEART has submitted all elements of an application to the National Institute for Health and Care Research (NIHR). If successful this will enable Lambeth HEART to build research infrastructure to develop a culture of using research, evidence, and evaluation to reduce health inequalities by addressing some of the factors which impact on residents' health outcomes.

Lambeth Country Show

12.5 The Lambeth Together team joined the Lambeth Country Show in July supported by the Health and Wellbeing Bus and partner teams. Over 300 blood pressure checks were carried out – forty-six people were advised to contact their GP and were given the appropriate advice and literature. Other services available were smoking cessation, pharmacy advice, mental health support and eye health. 273 residents filled in postcards to inform the team of the health issues that affect them.

13. Lewisham Borough Update

Home First programme

13.1 The Home First Programme is a joint piece of work between Lewisham Council and Lewisham and Greenwich NHS Trust (LGT), supported by the system transformation team. It is designed to improve discharge pathways from the hospital, reducing the length of time people stay in hospital after they are fit for discharge and reducing reliance on care home placements for older people, i.e., more people can be supported to their own home. The initial focus has been on organisational development - building trust and a joint approach. The next stage is to streamline processes, ensuring different elements work seamlessly together to support patients and improve outcomes and experience of care.

Population health

13.2 Lewisham Council and Lewisham Local Care Partnership (LCP) team are working together to generate a comprehensive set of benchmarking information to support development of the Lewisham LCP plan by:

- Establishing the health needs of the Lewisham population
- Benchmarking the priority areas against other London and comparator boroughs
- Undertaking more detailed reviews of outliers
- Applying a financial review of the benchmarking and data analysis

Social prescribing personal budgets

13.3 This partnership project provides bespoke, one-off highly personalised, innovative solutions to support and improve the health and wellbeing for people who have found constraints or barriers to realising their personal social prescribing/care plan. It also

supports those at higher risk of health inequalities. An evaluation will be available at the end of the project.

Streaming of patients at the front door of A&E

13.4 This is a joint piece of work between LGT and primary care and is designed to manage more patients appropriately through a primary care pathway and to release pressure in the A&E department. The impact of the service in the first five weeks of operation was:

- An average of eighteen patients per day were streamed to primary care type 3 breach reduction. Prior to the new service approximately 13% of type 3 patients breached. This reduced to 5% which is an average performance improvement of 8% for type 3 only
- The service has allowed senior nurses that would have otherwise been streaming, to support the increases in type 1 attendances and London Ambulance Service conveyances

Cost of living crisis

13.5 In common with other areas in south east London and nationally, there is significant concern about the impact of the cost-of-living crisis. The council has identified this as a key priority for the Local Strategic Partnership (LSP) and is leading work across the system to put in place plans to mitigate the impact where possible.

14. Southwark Borough Update

14.1 Following the delegation of ICB responsibilities to the borough on 1 July 2022, Partnership Southwark (the Local Care Partnership) has set out its next steps towards agreeing a health and care plan for the local system and crystalised action across the partnership on tackling inequalities. The plan will be informed by the Southwark Health and Wellbeing Strategy, aligned with partner strategies, and will respond to the framework for shared action set out in the Fuller report. Development of the plan will take place between and March for delivery in 2023/24 aligned to processes agreed across the ICS.

Investment for collaboration to reduce inequalities

14.2 In Southwark, the additional funding made available across the ICB to tackle inequalities has provided a launchpad for system-wide collaboration in Southwark to address unwarranted variation in population health outcomes. Using these additional resources a broad coalition including Southwark Council, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust and the local voluntary and community sector will work together to strengthen support for people with diabetes, support carers and build thriving communities as a result.

Early years

14.3 The local 1001 days programme, which aims to enrich the lives of children and families in Southwark by developing whole system working over a child's first three years, entered its second phase during quarter two this year. During phase one, engagement and information gathering events included the public, community groups, the frontline workforce as well as local leaders. Phase two includes a commitment by partners to

whole system transformation based on neighbourhood approaches to meeting local needs, as well as work to better understand the needs of this population.

Mental Health Transformation Programme

14.4 Southwark is entering year two of a wide-ranging community mental health transformation programme, which includes transforming primary and secondary care for people with severe mental illness. Some of the early successes are developing integrated neighbourhood services, embedding new Primary Care Network (PCN) practitioner roles, and expanding primary care-based support. These new models will offer a more diverse and personalised range of interventions to people experiencing mental health problems within the community setting for earlier access to support and recovery, also preventing mental ill health and crisis intervention. An overarching driver of the programme is to reduce inequality in access and experience of mental health and physical health care for people with severe mental illness.

Collective challenges

14.5 Following positive steps in recent years with integrating care in Southwark, capacity remains an ongoing challenge across place-based partners. Workforce shortages and infrastructure concerns at times have an impact on engagement within the Local Care Partnership (LCP). There is a collective recognition that more work needs to be done to bring local Voluntary and Community Sector partners into LCP conversations in a supportive and managed way, as traditional ways of working have not always enabled an inclusive model which helps different organisations have a voice.

15. System Leadership Appointments

15.1 Since the ICB's inception on 1 July 2022, Mike Bell has been appointed as Chair of Lewisham and Greenwich NHS Trust and remains Chair of Croydon Health Services NHS Trust. Andy Trotter has been appointed as Chair of London Ambulance Trust and remains Chair of Oxleas NHS Foundation Trust.

Integrated Care Board

Item: 5
Enclosures: D, E, F

Title:	**ICB Committee & Provider Collaborative reports**
Meeting Date:	**14 September 2022**
Authors:	Theresa Osborne, Director of Commissioning System Reform Sarah Cottingham, Executive Director of Planning Angela Helleur, Chief Nurse Mike Fox, Chief Finance Officer
Executive Lead:	Tosca Fairchild, Chief of Staff

Purpose of paper:	The purpose of the reports within this item are to give the Board an overview of the current discussions and activity of the committees that report directly to the board, including: • Decisions recommended to the Board from committees, in line with the ICBs Scheme of Reservation and Delegation • A summary of items discussed at the committees during the period being reported • Report of activities taking place in the local care partnerships of south east London • Report of activities taking place in the south east London provider collaboratives and community services provider network • Additional detail on the discussions that took place at the inaugural Quality & Performance, and Planning & Finance, committee meetings.	Update / Information	X
		Discussion	
		Decision	
Summary of main points:	There are three separate enclosures within this section comprising: i) *Enclosure D: Overall report of ICB committees and Provider Collaboratives* This report is to provide a summary of the activity that has taken place within the committees that report directly to the Board since the last meeting of the Board held in public, which was on 1 July 2022.		

	In addition the ICS benefits from two provider collaboratives and one provider network and whilst no formal delegation has been made to them from the ICB, updates upon their key activities are included in this report for the Boards awareness. ii) *Enclosure E: Report of Quality & Performance Committee* This paper reports from the inaugural meeting of the ICBs quality & performance committee, which took place on 17 August 2022, providing additional detail on areas discussed and proposed future ways of working. iii) *Enclosure F: Report of Planning & Finance Committee* This report details the discussions that took place at the first meeting of the ICBs planning and finance committee, chaired by Dr George Verghese, on 25 August 2022.			
Potential Conflicts of Interest	There are no conflicts arising from presentation of this paper to the Board. Any conflicts arising with relevant members from any committee decisions detailed in this paper were dealt with in alignment with the ICBs Standards of Business Conduct Policy by the respective committee Chair at the time the conflict arose.			
Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**
	Equality Impact	n/a		
	Financial Impact	n/a		
Other Engagement	Public Engagement	This report is designed primarily to report activity to the Board in a meeting held in public, it has not been developed by direct public engagement.		
	Other Committee Discussion/ Engagement	Committee engagement is as detailed in the report. Further information on the discussions that took place can be obtained from the minutes of the relevant committee.		
Recommendation:	The Board is asked to: 1. **Note** the contents of the Overall Committees report, and the reports on the Quality & Performance, and Planning & Finance, committees. 2. **Approve** the terms of reference for the audit committee, noting the change recommended in section 4 of the Overall Committees report 3. **Approve** the terms of reference for the quality and performance committee, noting the changes recommended in section 4 of the Overall Committees report 4. **Approve** the Board Assurance Framework presented to the planning and finance committee, as recommended in section 4 of the Overall Committees report and presented in item 6.			

Overall Report of the ICB Committees

ICB Board 14 September 2022

1. Introduction

1.1 The purpose of this report is to provide a summary of the activity that has taken place within the committees that report directly to the Board since the last meeting of the Board held in public, which was on 1 July 2022. In addition the ICS benefits from two provider collaboratives and one provider network and whilst no formal delegation has been made to them from the ICB the Board will receive updates upon their key activities through this report (and in anticipation of their future delegation).

1.2 The report highlights:

- Decisions recommended to the Board from committees, in line with the ICBs Scheme of Reservation and Delegation
- A summary of items discussed at the committees during the period being reported
- Report of activities taking place in the local care partnerships of south east London
- Report of activities taking place in the south east London provider collaboratives and community services provider network

2. Summary of Meetings

2.1 ICB Committees

	Committees						
	Planning and Finance Committee	**Quality and Performance Committee**	**Audit Committee**	**Charitable Funds Committee**	**Clinical and Care Professional Committee**	**People Board**	**Local Care Partnerships**
Meeting date	25 August 2022	17 August 2022	4 August 2022	-	-	25 July 2022	

	Bexley	**Bromley**	**Greenwich**	**Lambeth**	**Lewisham**	**Southwark**
Meeting date	21 July 2022	5 July 2022	20 July 2022	20 July 2022	28 July 2022	7 July 2022
						1 September 2022

3. Summary of the Principal Role of ICB Committees

Committee	Principal role of the committee	Chair
Planning and Finance Committee	Responsible for co-ordination of ICB strategic, financial and operational plans (including priorities, outcomes and underpinning investment framework/plan), development and implementation of ICB care pathway transformation, in-year oversight and assurance of delivery against plans (including the ICB's financial plan), and sign-off / recommendation of ICB policies as required.	Dr George Verghese, Partner Member
Quality and Performance Committee	Responsible for quality assurance, input to and understanding of standards to be secured as part of ICB strategic and operational plans, in-year oversight and assurance of plan delivery, infection prevention and control, medicines optimisation, and holding links to Local Authority assurance including safeguarding and Oversight and Scrutiny.	Professor Clive Kay, Partner Member
Audit Committee	Responsible for delegated approval of annual accounts, providing an objective view of the ICB's compliance with statutory responsibilities, arranging appropriate audit, and oversight / assurance on the adequacy of governance, risk management and internal control processes across the ICB.	Paul Najsarek, Non-Executive
Charitable Funds Committee	Responsible for discharging its duties as a corporate trustee.	Peter Matthew, Non-Executive
Clinical and Care Professional Committee	Responsible for bringing together clinicians, care professionals and south east London residents to ensure the ICB has robust care, patient and public engagement, population health management, and leadership in place to shape and that the ICB's plans are demonstrably influenced by the outputs of its engagement work.	Jonty Heaversedge and Toby Garrood, Joint Medical Directors Angela Helleur, Chief Nursing Officer

People Board	Responsible for; the design, development and delivery of plans related to the health and care workforce in South East London. This includes meeting any national targets and ensuring sufficient and consistent strategies across the ICS for equality, diversity and inclusion and staff health and wellbeing.	Dr Ify Okocha, Partner Member
Local Care Partnerships	Responsible for convening local system partners to develop plans to meet the needs of the local population, reduce inequalities and optimise integration opportunities. The ICB will delegate responsibility for the delivery of specified out of hospital care objectives and outcomes, including the management of the associated budget. A representative from each LCP will be a member of the ICB.	Iain Dimond (acting chair, Bexley) Dr Andrew Parson & Cllr Colin Smith (co-chairs, Bromley) Dr Nayan Patel (Greenwich) Dr Di Aitken (Lambeth) Dr Jacqui McLeod (Lewisham) Dr Nancy Kuchemann & Cllr Evelyn Akoto (co-chairs, Southwark)

4. Recommendations to the Board for Decision / Approval

4.1 Below are the items which have been referred to the Board for decision or approval in this period.

No.	Committee name	Meeting date	Agenda item	Items for Board decision / approval
1.	Audit Committee	4 August 2022	Terms of reference	**That the terms of reference for the SEL ICB Audit Committee are amended in section 5.5 as follows and approved** by the Board**:** • REMOVE reference to the attendance of the "director of corporate operations or a nominated deputy" • REPLACE with attendance of the "Chief of Staff or nominated deputy"
2.	Quality and Performance Committee	17 August 2022	Terms of reference	**That the terms of reference for the SEL ICB Quality and Performance Committee are amended as follows and approved** by the Board**:** • ADD a Healthwatch representative as a substantive member • ADD a finance representative as a substantive member
3.	Planning and Finance Committee	25 August 2022	Board Assurance Framework	**The Board Assurance Framework (BAF) is approved** by the Board

5. Decisions made by Committees or Sub-Committees Under Delegation

5.1 Below is a summary of decisions taken by committees under delegation from the Board, or by sub-committees under delegation from the Committees

No.	Committee name	Meeting date	Agenda item	Items for Board to note
1.	Audit Committee	4 August 2022	Terms of reference	• The audit committee agreed adoption of the terms of reference with two proposed changes, with the terms of reference being submitted to the Board for final approval.
2.	Quality and Performance Committee	17 August 2022	Terms of reference and ways of working	• The quality and performance committee agreed adoption of the committee terms of reference with two proposed additions to membership to be submitted to the Board for approval. • The committee approved the terms of reference for its sub-committees, being the safeguarding sub-committee, system quality group, infection prevention and control sub-committee, and the medicines optimisation committee.
3.	Planning and Finance Committee	25 August 2022	Medicines Optimisation	• The planning and finance committee agreed adoption of the committee terms of reference. • The Committee approved the following: ○ The primary care rebate scheme which sets out the framework for the management of rebates on medications used in primary care to enable them to be managed in a legal and ethical way, including processes for the submission, evaluation and approval of proposed schemes. ○ The implementation of NICE recommendations for the use of SGL T2 inhibitors in type 2 diabetes, to support effective blood glucose control and improved clinical outcomes.

6. Agenda Items of Note

6.1 Below is a summary of other significant actions and items of note for Board information.

No.	Committee name	Meeting date	Agenda item	Items discussed
1.	People Board	25 July 2022	n/a	• Introduction to the SEL Integrated Care Board, and how the People Board features in the governance of the ICB • Plans to refresh the People Board ToR and agreement to circulate subsequently for virtual agreement of a draft ToR • Overview of the Workforce Programme report – Q1 transition activity, future planning and programme finance • Reports from People Board sub-committees: - staff health and wellbeing committee, including the Keeping Well in SEL Hub work and appointment of Meera Nair as the new SRO for staff and health and wellbeing - equality and inclusion group, including acknowledgement of the people driving the discovery phase of this work, the critical areas of work the group has identified and the desire to expand its membership and reach - workforce supply, including an overview of the goals of the group and the next steps in the workforce supply discovery phase • Update on planned changes to the foundation school structure in London managed by HEE • Presentation to the group on the SEL Financial Recovery Plan • System leadership development plans
2.	Audit Committee	4 August 2022	n/a	• Terms of reference and ways of working – the committee agreed to set up a further informal session to discuss this further

7

				• External audit report, noting completion of 2021/22 audit with an unqualified opinion and confirmation KPMG will audit the period 1 July 2022 to 31 March 2023 • Internal audit report, confirming the internal audit workplan for 2022/23 and progress made in Quarter 1 • Counter fraud and security management report – including an update on counter fraud activity and confirmation of the nine-month workplan • Update on close down of the Quarter 1 SEL CCG accounts • Confirmation no special payments, debt write offs or tender waivers have been processed in the last quarter • Confirmation audit committees would be quarterly and not held in public
3.	Quality and Performance Committee	17 August 2022	n/a	• Terms of reference and ways of working for the Committee, including principles around assurance • Terms of reference of sub-committees • Reflections and feedback from the ICS System Quality Group • Quality and performance report detailing the year-to-date position across key national targets and expectations • A verbal discussion on current system risks.
12.	Planning and Finance Committee	25 August 2022	n/a	• Terms of reference and ways of working for the Committee, including principles around assurance • The key deliverables the Committee will need to oversee over the coming year • The 2022/23 operational plan, including a summary of commitments made, the year to date position and forward risks and mitigations • The national guidance received on next steps in increasing capacity and operational resilience in urgent and emergency

				care ahead of winter and the ICB's planned processes to address the requirements within it • The month 4 financial position for the ICB and the SEL system • The Board Assessment Framework

Appendix 1

Bexley Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 Below are the items which have been referred to the Board for decision or approval in this period.

No.	Meeting date	Agenda item	Items for Board decision / approval
1.	21 July 2022	Bexley Local Care Partnership Terms of Reference	The Board is asked to approve the recommended amendment to the Terms of Reference for the Local Care Partnership. The Hurley Group will no longer be members of the Committee.

2. Decisions made by Bexley LCP Under Delegation

2.1 Below is a summary of decisions taken by the Bexley LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	21 July 2022	Bexley Local Care Partnership Terms of Reference (4/B)	• The Bexley Local Care Partnership adopted the Terms of Reference at its Committee meeting on 21 July 2022 as approved by the NHS SEL ICB on 1 July 2022.
2.	12 August 2022	Bexley Urgent Care Procurement (6/D)	• The Bexley Local Care Partnership approved recommendations outside of the Committee meeting held on 21 July 2022 due to a series of Conflicts of Interest documented and noted for this agenda item. The non-conflicted voting members of the committee via email on 12 August 2022 approved the following recommendations:

			(i) Commence *Market Development* with the Local Care Partnership and receive feedback and recommendations. (ii) Commence the procurement of Urgent Care for Bexley in line with SEL ICB schedule of matters delegated to officers. This is in line section 7.2 of the Terms of Reference for the Committee: *7.2In the event of quorum not being achieved, matters deemed by the chair to be 'urgent' can be considered outside of the meeting via email communication.*

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	21 July 2022	Primary Care Network Contract Directed Enhanced Service (DES) for Enhanced Access (7/D)	• The Bexley Local Care Partnership Committee 'endorsed the direction of travel' given that the Primary Care Network Plans are still in development – although there is a commitment to deliver the Network Standard in addition to maintaining early morning access at individual GP Practice sites and to note the caveats and risks outlined. • The Bexley Local Care Partnership Committee reviewed the outputs from the extensive Partnership led patient/public engagement programme on Enhanced Access, which received more than 11,000 responses.

Appendix 2

Bromley Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by the Bromley LCP Under Delegation

2.1 Below is a summary of decisions taken by the Bromley LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	5 July 2022	Draft Terms of Reference for One Bromley Local Care Partnership Board	Terms of reference for the One Bromley Local Care Partnership Board were agreed by members.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	5 July 2022	Partnership Report	• Updates from One Bromley organisations were noted.
2.	5 July 2022	Winter Planning 2022/23	• Winter planning processes and progress were outlined, with a further update to come to the next meeting on 27 September 2022.

3.	5 July 2022	Bromley Carers BTSE update	• Updates on current work to better understand the number of carers in Bromley and how the system can work further with carers in the borough.
4.	5 July 2022	Housing Support Mental Health Services	• The long-term plan for additional housing support mental health services was noted.
5.	5 July 2022	Finance Month 2 update	• An update on the Month 2 financial position was discussed and noted.

Appendix 3

Greenwich Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Greenwich LCP Under Delegation

2.1 Below is a summary of decisions taken by the Greenwich LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	20 July 2022	Inequalities – Bids and Prioritisation	• The Board was asked to agree to progress the Tackling Health Inequalities Submission Recommendations from the Greenwich Health Inequalities task & finish group. The Task & Finish Group had met four times since the May meeting of the Healthier Greenwich Partnership (HGP), at which the Tackling Health Inequalities proposal was approved with costing of £1,285,000, including contributions for Royal Borough of Greenwich public health. • A Health Inequalities Oversight & Governance Group was also established, with further subgroups in relation to: Data, Community Infrastructure & Assets, and Workforce. • This work was subsequent to the Tackling Health Inequalities proposal, approved by the HGP on 12 May 2022.

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	20 July 2022	Eltham Community Hospital (Matters Arising)	• Proposed engagement from mid-August to September on the future proposal on intermediate care services, and development of the new Community Diagnostic Centre.
2.	20 July 2022	Our approach to developing our Partnership – Key Priorities / Building Resilience / Facilitated Team-Building	• Facilitated session on the continued development of the Local Care Partnership for next six months, working on our identify, priorities and delivery mechanism. Awayday planned for end of September.
3.	20 July 2022	Next steps for integrating Primary Care: Fuller Report	• Update on the proposed next steps for implementing the Fuller Stocktake, the LCP was asked specific questions in relation to: organisational culture, individual action, partnership transformation, population health management, local flexibility and what success looks like.
4.	20 July 2022	Primary Care Enhanced Access	• Update on Primary Care Enhanced Access following the 31 March publication of the enhanced access service specification. • The HGP was asked to endorse the assurance and governance process and note the wider briefing, noting that primary care access was a high priority for our population
5.	20 July 2022	SEL Integrated Care Strategy	• Update to the HGP on the development of the SEL ICS strategy, how partners can contribute, and how this will link into the borough's updated Health & Wellbeing Strategy which is being revised.
6.	20 July 2022	Governance items for noting	• Confirmation on Terms of Reference (previously agreed at June HGP) • Membership of HGP (as per ToR)

15

			• Primary Care Delegation – establishing the borough governance
7.	20 July 2022	For information items	• Summary feedback from the ICB & Executive • Public Health Update (covid / monkeypox) • Virtual Ward Update – approval process for Greenwich submission • Forward planner

Appendix 4

Lambeth Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lambeth LCP Under Delegation

2.1 Below is a summary of decisions taken by the Lambeth LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
5.	20 July 2022	Bid to National Institute for Health research (NIHR)	The Lambeth Together Board received and supported the outline bid to NIHR from Lambeth Council for a 'Health Determinants Research and Evaluation Network (Lambeth HEART).

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting dates	Agenda item	Items discussed
2.	20 July 2022	Assurance	• The Lambeth Together Care Partnership Board received the report from the Chair of the Assurance Sub-Group, including the Integrated Assurance Report covering the full range of delegated responsibilities and programmes.
3.	20 July 2022	Governance & Leadership	• The LCP was informed of the newly established South East London Integrated Care System, including the full membership of the SE London Integrated Care Board and associated governance.

4.	20 July 2022	Strategy Development	• The Lambeth Together Care Partnership Board was updated on time frames with SE London ICS and Place-based strategies/plans and progress in developing the Lambeth Health and Wellbeing Strategy.
5.	20 July 2022	Integrating Primary Care – Next Steps	• The Lambeth Together Care Partnership Board received a summary of the *Fuller Stocktake Review* and discussed the local implications.
6.	20 July 2022	Child Friendly Lambeth	• The LCP was updated on progress with the Child Friendly Lambeth Programme, including areas of collaboration and engagement.

Appendix 5

Lewisham Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Lewisham LCP Under Delegation

2.1 Below is a summary of decisions taken by the Lewisham LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	28 July 2022	Minutes of the previous meeting held on 7 June 2022	• Minutes of the Lewisham Shadow Borough Based Board/Local Care Partners meeting held on 7 June 2022 for approval. Approved.
2.	28 July 2022	Terms of Reference (ToR)	• Lewisham Local Care Partners Strategic Board Terms of Reference (ToR) for approval. Approved.
3.	28 July 2022	Terms of Reference (ToR)	• Lewisham Primary Care Group Terms of Reference (ToR) for approval. Approved.
4.	28 July 2022	Developing the Lewisham LCP Plan	• Developing the Lewisham LCP Plan, process and direction of travel for approval. Approved.
5.	28 July 2022	Risk Register	• Risk Register overview– The Lewisham LCP Strategic Board were asked to note the current borough risk register and consider future presentations to the Board (content and format).

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	28 July 2022	Fuller Review: Implications for Lewisham	• Ceri Jacob, Place Executive Lead updated the Board on the Fuller Review: Implications for Lewisham.
2.	28 July 2022	Finance & Efficiencies	• Finance & Efficiencies update presented by Michael Cunningham, Associate Director for Finance.
3.	28 July 2022	Local Authority Finance	• Lewisham Council Finance update presented by Abdul Kayoum, Strategic Finance Business Partner, Community Services.

Appendix 6

Southwark Local Care Partnership

1. Recommendations to the Board for Decision / Approval

1.1 No items are referred to the Board for decision or approval in this period.

2. Decisions made by Southwark LCP Under Delegation

2.1 Below is a summary of decisions taken by the Southwark LCP under delegation from the Board

No.	Meeting date	Agenda item	Items for Board to note
1.	7 July 2022	Terms of reference	• Adoption of the terms of reference for the meeting
2.	PEL decision (26 July 2022)	On the recommendation of Southwark Primary Care Group	• Following the CQC inspection of Acorn and Gaumont House Surgery on 25 March 2022 and work done by the practice to address areas of concern: ○ Issue a remedial notice in respect of those areas of contractual non-compliance which have not yet fully been resolved ○ Require the contractor to produce and implement a timed action/improvement plan
3.	PEL decision (31 August 2022)	On the recommendation of Southwark Primary Care Group	• Agreement of a 12-month extension to the Quay Health Solutions caretaking arrangements for the New Mill Street Surgery
4.	1 September 2022	Extended Access Service	• Investment in addition to the DES to maintain current service levels for extended access that are in excess of national requirements

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Meeting part	Agenda item	Items discussed
1.	7 July 2022	Part I (Public)	Introduction to Partnership Southwark	Ambitions and aims of the partnership
			Working arrangements	Who is who in Partnership Southwark, how people can get involved and development of the Health and Care Plan
			Integrated Care System	The ICB and LCP arrangements as part of journey over last few years, core objectives of the ICS and the important role of place
			Place executive's report	Overview of the work of the Partnership
		Part II (Private)	Partnership Southwark Workshop feedback	Feedback from development workshops held in advance of receiving delegated responsibilities
			Delegation	Review of the MOU and responsibilities delegated to Partnership Southwark
			Legacy and next steps	Items of CCG business carried into Partnership Southwark
2.	1 September 2022	Part I (Public)	Community spotlight	Presentation of the LinkAge Southwark hospital buddies project
			Developing our Health and Care Plan	Roadmap for the development of the Southwark Health and Care Plan
		Part II (Private)	System finances	Overview of finances across Partnership Southwark
			Economic strategy	Discussion of Southwark Council's draft economic strategy and opportunities for Partnership Southwark

Appendix 7

Acute Provider Collaborative

1. Key decisions made by the Acute Provider Collaborative (APC)

1.1 Below is a summary of decisions taken by the Acute Provider Collaborative, for the Boards awareness.

No.	Meeting date	Agenda item	Items for Board to note
1.	APC Steering Group 22 June 2022, with follow up through July and August	National intensive support team – "SOF4" KCH and SEL system funding	APC and ICB submitted a combined proposal for a package of national NHSE Intensive Support funding across 2021/22 and 2022/23, covering UEC and elective recovery, with identification of elective recovery system priorities co-ordinated through the APC Steering Group. The funding has now been approved subject to final sign off of KPIs for each of the workstreams
2.	APC Steering Group 6 July 2022 and 20 July 2022, APC Executive 15 July 2022	Community Diagnostics Centre (CDC) business cases	Following submission of the agreed CDC Strategic Investment Plan (approved via the APC governance structure and & ICS Executive during April/May 2022), the scope, content, and timing of submission of CDC business cases has been under discussion through the APC Diagnostic Board, the APC Steering Group and the APC Executive, as well as via individual Trust decision-making infrastructure (eg Investment Boards). The first business case was approved for submission to regional and national review in July. Discussions continue on the other two proposed business cases for CDCs.
3.	APC Steering Group 24 August 2022	Right Procedure Right Place pilots	The APC was invited by NHS England to submit proposals for pilot schemes as part of the new national Right Procedure Right Place workstream focused on providing appropriate procedures in outpatient/treatment room facilities. The APC Steering Group approved a process of engagement across the APC during August to identify appropriate areas for pilots; submissions were made for initiatives in ENT and in Urology.

4.	APC Steering Group 10 August 2022 and 24 August 2022	"Super September/October" submission	The Steering Group agreed that the APC approach to the national "Super September/October" programme should be to summarise a range of ongoing projects within our clinical networks and across partner trusts that are designed to increase activity, reduce waits and improve services and outcomes for patients. The Steering Group also agreed that the summary should be shared widely across the collaborative and the wider system, promoting shared learning and awareness of the work that is under way.

2. Agenda Items of Note

2.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	APC Steering Group 20 July 2022, 10 August 2022, 24 August 2022	GSTT IT disruption	Ongoing discussions have been taking place between operational colleagues at all levels within partner Trusts since the disruption began on 19 July. There has been ongoing discussion of immediate priorities, impact of the disruption and potential mitigations at the APC Steering Group
2.	APC Steering Group 6 July 2022 & 10 August 2022	Overall elective and diagnostic performance	Overall elective and diagnostic performance is discussed at the APC Steering Group every month including issues escalated from the fortnightly Operational Delivery Group. Overall programme progress is also discussed at this meeting, including escalations from all of the Executive Advisory Groups.
3.	APC Steering Group 20 July 2022 & 24 August 2022	Strategy update(s)	APC Interim Director of Strategic Planning provided updates on the process of APC surgical strategy development, including the establishment of a small working group to take forward the detailed discussion and analysis required. These discussions take place monthly at the Steering Group meeting.

4.	APC Executive 15 July 2022	Communications	The APC Executive approved a plan to put in place a new communications infrastructure for the APC, linking in and aligning appropriately with ICB and Trust partner comms; this is now in the process of implementation

Appendix 8

Mental Health Collaborative

1. Recommendations to the Board for consideration

1.1 Below are the items which have been referred to the Board for consideration in this period.

No.	Meeting date	Agenda item	Items for Board consideration
1.			The ICB is asked to endorse the previous agreement that the South London Partnership (SLP) acts as the Mental Health Provider Collaborative for south east London. The SLP already holds delegated budgets in excess of £100m and has a track record of delivering system and patient benefits. Programmes of work will be progressed jointly across SWL and SEL ICSs, or SEL/SEL programmes will remain closely aligned if different approaches are required to reflect local context.

2. Key decisions made by the Mental Health Collaborative

2.1 Below is a summary of decisions taken by the Mental Health Collaborative, for the Boards awareness.

No.	Meeting date	Agenda item	Items for Board to note
1.	N/A	N/A	N/A

3. Agenda Items of Note

3.1 Below is a summary of other significant actions and items of note for Board information.

No.	Meeting date	Agenda item	Items discussed
1.	1 August 2022	SLP Portfolio Board – item on Provider Collaborative development.	The SLP Portfolio Board has agreed to progress the following seven programmes as part of the further development of the Provider Collaborative. 1. Acute and Urgent Care 2. CAMHS 3. Complex Care 4. Perinatal 5. Learning Disabilities and Autism 6. Workforce 7. Population health (data driven improvement) These areas reflect recognised system priorities (the SEL Mental Health Board agreed Acute and CAMHS as immediate 2022/23 priorities, and the inaugural ICB on 1 July 2022 endorsed CYP mental health and wellbeing priorities). All but two of these programmes are building on existing SLP workstreams (LDA and population health are new areas), and will focus on efficiencies of at scale working, shared learning, and reducing unwarranted variation and health inequalities. The SLP Portfolio Board are working to strengthen our Place relationships, providing consistent levels of engagement and communications across all Places from both trusts. We will be actively engaging with all systems partners to help us shape these programmes going forwards. Decision-making within SLP is formally via the Partnership Committees in Common, which meet regularly and have delegated authority from the three trust boards. The MoU for SLP is currently being reviewed by Trust Secretaries and Directors of Finance to ensure that this will remain fit for purpose as and when further delegations to the Mental Health Provider Collaborative are agreed.

NHS
South East London

Integrated Care Board

Audit Committee

Terms of Reference

22 June 2022

1. Introduction

1.1. The NHS South East London Integrated Care Board (ICB) Audit Committee [the "committee"] is established as a committee of the ICB. The committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2. These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3. All members of staff and members of the ICB are directed to co-operate with any requests made by the Audit Committee.

2. Authority

2.1. The Audit Committee is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

2.2. For the avoidance of doubt, the committee and its members will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD.

3. Purpose

3.1. To contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

3.2. The duties of the committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.3. The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

4. Duties

4.1. The committee's duties can be categorised as follows.

Integrated governance, risk management and internal control

4.2. To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

4.3. To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

4.4. To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives and the effectiveness of the management of principal risks.

4.5. To have oversight of system risks where they relate to the achievement of the ICB's objectives.

4.6. To ensure that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

4.7. To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.8. To identify opportunities to improve governance, risk management and internal control processes across the ICB.

Internal audit

4.9. To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework

- Considering the major findings of internal audit work, including the Head of Internal Audit Opinion (and management's response) and ensure coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation and
- Monitoring the effectiveness of internal audit and carrying out an annual review

External audit

4.10. To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the performance of the external auditors, as far as the rules governing the appointment permit
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee and
- Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

4.11. The Audit Committee shall not have responsibility for appointment or selection of the external auditors. This will be the responsibility of the Auditor Panel.

Other assurance functions

4.12. To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

4.13. To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

4.14. To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

4.15. To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution and CQC.
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

Counter fraud

4.16. To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and review the outcome of work in these areas.

4.17. To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

4.18. To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

4.19. To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining work undertaken during each financial year to meet the NHS Standards for Commissioners, Fraud, Bribery and Corruption.

Security

4.20. To assure itself that the ICB has adequate arrangements in place for local security management services (LSMS) and review the outcome of work in these areas.

4.21. To review, approve and monitor LSMS work plans, receiving regular updates on activity, monitor the implementation of action plans and review annual reports on security management.

4.22. To ensure that the LSMS provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

Freedom to Speak Up

4.23. To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical, management, or other matters. The committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Information Governance (IG)

4.24. To receive regular updates from the information Governance Sub-Committee on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

4.25. To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Financial reporting

4.26. To monitor the integrity of the annual financial statements of the ICB and any formal announcements relating to its financial performance.

4.27. To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

4.28. To approve the annual report and annual financial statements (including accounting policies) for submission, and reporting to the Board, focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the

Terms of Reference of the committee

- Changes in accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the Financial Statements
- Significant judgements and estimates made in the preparation of the Financial Statements
- Significant adjustments resulting from the audit
- Letter of representation and
- Qualitative aspects of financial reporting.

Conflicts of Interest

4.29. The chair of the Committee will be the nominated Conflicts of Interest Guardian.

4.30. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB's policy and procedures relating to conflicts of interest.

Management

4.31. To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.32. The committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

4.33. To receive reports of breaches of policy and normal procedure or proceedings including suspensions of the ICB's standing orders in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

4.34. To receive regular reports on tender waivers approved within the ICB.

Communication

4.35. To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

4.36. To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

5. Membership and attendance

5.1. The committee members shall be appointed by the Board in accordance with the ICB constitution.

5.2. The Board will appoint four members of the committee including two non-executive members of the Board and two partner members of the ICB board (who are not the usual members of the remuneration committee).

5.3. Neither the chair of the Board, nor employees of the ICB will be members of the

committee.

5.4. Members will possess between them knowledge, skills and experience in accounting, risk management, internal, external audit and technical or specialist issues pertinent to the ICB's business. When determining the membership of the committee, active consideration will be made to diversity and equality.

5.5. Only members of the committee have the right to attend committee meetings, however all meetings of the committee will also be attended by the following individuals who are not members of the committee:

- ICB Chair
- ICB Chief Executive
- Chief Financial Officer or their nominated deputy
- Representatives of both internal and external audit
- The Director of Corporate Operations or their nominated deputy
- Individuals who lead on corporate governance, risk management, counter fraud and security matters
- Other relevant attendees as requested by the Audit Committee chair

5.6. The chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.7. The chair may ask for a meeting in private with the external and internal auditors at the end of any meeting.

5.8. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Board(s), secondary and community providers.

5.9. The Chief Executive should be invited to attend the meeting at least annually.

5.10. The chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the committee's operations.

5.11. Where an attendee of the committee (who is not a member of the committee) is unable to attend a meeting, a suitable alternative may be agreed with the chair.

5.12. Regardless of attendance, external audit, internal audit, local counter fraud and security management providers will have full and unrestricted rights of access to the Audit Committee.

6. Chair and vice chair

6.1. In accordance with the constitution, the committee will be chaired by a Non-Executive Member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the committee.

6.2. The chair of the committee shall be independent and therefore may not chair any

other committees. In so far as it is possible, they will not be a member of any other committee.

6.3. Committee members may appoint a Vice Chair from members of the committee.

6.4. The chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

7. Meetings Quoracy and Decisions

7.1. The Audit Committee will meet a minimum of four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

7.2. The Board, chair or chief executive may ask the committee to convene further meetings to discuss particular issues on which they want the committee's advice.

7.3. In accordance with the Standing Orders, the committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7.4. For a meeting to be quorate 75% of members are required including one non-executive member of the Board.

7.5. If any member of the committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

7.6. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

7.7. Decisions will be taken in accordance with the Standing Orders. The committee will ordinarily reach conclusions by consensus. When this is not possible the chair may call a vote.

7.8. Only members of the committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

7.9. Where there is a split vote, with no clear majority, the chair of the committee will hold the casting vote.

7.10. If a decision is needed which cannot wait for the next scheduled meeting, the chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

8. Behaviours and Conduct

8.1. Members will be expected to conduct business in line with the ICB values and objectives.

8.2. Members of, and those attending, the committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

8.3. Members must demonstrably consider the equality and diversity implications of decisions they make.

9. Accountability and reporting

9.1. The committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

9.2. The minutes of the meetings shall be formally recorded by the secretary and key discussions and decisions will be submitted to each meeting of the Board in accordance with the Standing Orders.

9.3. The Audit Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements and
- The robustness of the processes behind the quality accounts
- The effectiveness of the committee.

10. Secretariat and Administration

10.1. The Committee shall be supported with a secretariat function which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the chair those meetings that do not meet the minimum quoracy requirements
- Records of members' appointments and renewal dates are kept and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The chair is supported to prepare and deliver reports to the Board
- Action points are taken forward between meetings and progress against those actions is monitored.

11. Review

11.1. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to

the Board for approval.

NHS
South East London

Integrated Care Board
Quality and Performance Committee

Terms of Reference

22 June 2022

1. Introduction

1.1 The NHS South East London Integrated Care Board (ICB) Quality and Performance Committee [the "committee"] is established as a committee of the ICB. The committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2 These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3 All members of staff and members of the ICB are directed to co-operate with any requests made by the Quality and Performance committee.

2. Purpose

2.1. The committee will bring together system partners to undertake assurance and oversight on behalf of the ICB for the identification, monitoring and escalation of quality, safeguarding and operational performance issues and concerns across the system alongside the identification and sharing of best practice.

2.2. The committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

2.3. The scope of the committee's activities will be the services commissioned by the Integrated Care Body on behalf of the resident population of south east London, within and outside of south east London. In addition, the committee will oversee the delivery of quality and performance standards on a Trust wide basis for the ICB's five hosted acute and mental health providers.

3. Duties

3.1. The committee is responsible for ensuring the robustness of the systems in place across the ICB to secure effective quality governance, performance management, safeguarding governance and assurance, and internal control across the ICB.

3.2. The committee will see that these systems and processes allows the ICB to comply with all relevant legislation, to effectively deliver its strategic objectives and provide sustainable, high-quality care and ensuring appropriate safeguards are in place to protect the most vulnerable.

3.3. The committee will pro-actively identify and address declining performance and quality indicators, ensuring deterioration is managed rapidly by a designated responsible officer or responsible group. In this the committee will ensure the development and delivery of system remedial action plans where these are required due to variance against agreed standards.

3.4. The committee is expected to work across the system to review and endorse mitigating actions at south east London, Local Care Partnership / borough and provider collaborative level, as put forward by these partnerships and collaboratives for their agreed areas of responsibility.

3.5. The System Quality Group (SQG) is a designated sub-committee of the Quality and Performance Committee. The Q&P committee will act both directly and through its direction of the SQG sub-committee to:

- input into the development shared ambitions and priorities
- act to ensure inequalities and variation in the quality of care and outcomes are addressed
- ensure serious quality and safeguarding concerns are managed effectively; and that learning, intelligence and improvement are shared across the system and beyond to inform ongoing improvement
- ensure that actions are delivered in keeping with agreed timescales.

3.6. The committee will undertake the following specific activities:

3.6.1. Receive and review a risk report to agree the main risks (internal and external) related to quality and performance. The committee will oversee the ICB's objective to minimise risk related to its responsibilities and remit to secure continuous improvement in quality, performance and outcomes for the resident population.

3.6.2. Receives reports from the SQG to review identified themes and shared learning from Serious Case Reviews, Adult Learning Reviews and Domestic Homicide reviews drawing on intelligence and collaboration with place based Local

Safeguarding Partnerships, Safeguarding Adult Boards and Safer Community Partnerships, working collaboratively with ICB partners to do so.

3.6.3. Oversee and scrutinise the ICB's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE), including giving guidance to the system as required and gaining assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

3.6.4. Maintains an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

3.6.5. Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD report).

3.6.6. Provide the ICB with assurance that it is delivering its statutory duties for safeguarding adults, children, children looked after and SEND as laid out in Section 11 - The Children Act, 2004, Working Together to Safeguard Children, 2018, The Care Act, 2014, Promoting the Health and Wellbeing of Looked After Children 2015, SEND code of practice 0-25yrs, 2015.

3.6.7. Comprehensively scrutinise the robustness of the arrangements for, and assure compliance with, the ICB's statutory responsibilities for:

- infection prevention and control
- medicines optimisation and safety
- equality and diversity where these relate to specific performance standards or matters of care quality.

3.6.8. To arrange a rolling programme of deep-dive reviews across both the committee and SQG sub-committee with the aim of understanding in detail key areas of ICB performance and quality and contributing through this process to improvement activities and the promotion of shared learning.

3.6.9. Ensure that the SQG maintains effective processes for system-wide learning from significant events including themes and trends from incidents and safeguarding reviews. This assurance will be provided via SQG reports and supplementary papers. The committee's role is to ensure that lessons learned are implemented and make a difference.

3.6.10. Contribute to the development and utilisation of a common ICS quality and performance framework to measure the impact of the actions taken by the board or the ICS more broadly (including ICS transformation programmes). This

framework may include quantitative and qualitative intelligence relating to service performance and the quality and safety of care, including patient experience and outcomes.

4. Accountabilities, authority, and delegation

4.1. The authority delegated to the committee is set out in the ICB's Scheme of Reservation and Delegation.

4.2. The committee will act to agree and report against all duties within its scope as recorded in section 3 (above). It will report on risks and planned improvements related to its performance and quality assurance activities and update on improvement work to the ICB Board.

4.3. The committee will receive reports from its sub-committees / groups as well as minutes of meetings and relevant supplementary reports.

4.4. The committee will be provided with a regular opportunity to hear from representatives of its sub-committees / groups. It will be able to act on recommendations or proposals that arise at its sub-committees in line with the ICB Scheme of Reservation and Delegation.

4.5. The committee will link with local authority assurance processes including safeguarding and Oversight and Scrutiny.

4.6. The committee may establish a working group or task and finish group to lead work under a defined term of reference/ engagement. The committee must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

5. Membership and attendance

5.1. The committee members shall be appointed by the Board in accordance with the ICB Constitution.

5.2. The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members of the Board (from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

5.3. When determining the membership of the committee, active consideration will be made to equality, diversity and inclusion.

5.4. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.5. The committee will be constituted of the following members:

a. Partner member (Chair)
b. Non-Executive Director (Deputy Chair)
c. ICB Chair
d. ICB Chief Executive
e. ICB Chief Nurse
f. ICB Chief Medical Officer
g. 2 x LCP / Borough Executive Lead
h. ICB Director of Planning
i. ICB Chief of Staff

5.6. The committee will meet with the following in attendance:

a. 3 x Provider Collaborative / Network leads
b. ICB Director of Quality
c. ICB Primary Care Lead
d. Director of Public Health
e. Healthwatch representative

5.7. Any member of the ICB Board additional to those listed as committee members may join the committee in attendance.

5.8. Other individuals from across the Integrated Care System may be invited to attend as required for specific items.

5.9. The committee is permitted with agreement of the chair and a majority of members to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary.

5.10. Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

5.11. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

5.12. Members must demonstrably consider the equality and diversity implications of decisions they make.

6. Chair of meeting

6.1. The meeting will be chaired by a partner member of this committee. The deputy chair will be a non-executive member of this committee that is not the ICB chair.

6.2. At any meeting of the committee, the chair if present shall preside. If the chair is absent, the deputy chair shall preside. If the chair is temporarily absent on the grounds of conflict of interest, the deputy chair shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of members of which the following must be present:

- The ICB Chief Nurse or Chief Medical Officer
- ICB Director of Planning
- One non-executive member
- 1 x LCP / Borough Executive lead
- 1 x Provider collaborative / partner lead

7.2. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICS's standards of business conduct. Compliance will be overseen by the chair of the committee.

7.3. The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

7.4. Committee members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote. In the event of equal votes, the chair will have a casting vote.

9. Procedure of decisions made outside of formal meetings

9.1. The committee chair will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the committee chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

9.2. The ICB's corporate and business support team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of this meeting.

10. Frequency

10.1. The committee will meet monthly and at least six times over the course of a year.

10.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

10.3. Members are responsible for identifying a suitable deputy should they be unable to attend a committee meeting which needs to be agreed with the chair, and notified to the meeting secretariat, in advance.

10.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the committee chair.

10.5. Members and staff from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the committee.

11. Reporting

11.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

11.2. The committee will report on its activities to the ICB Board via minutes. In addition, an accompanying report will summarise key points of discussion, items recommended for decisions, the key assurance and improvement activities undertaken or coordinated by the committee; any actions agreed to be implemented.

11.3. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

12. Committee support

12.1. The committee will be supported by members of the ICB's governance team.

12.2. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

13. Monitoring adherence to the Terms of Reference

13.1. The chair of the committee will be responsible for ensuring the committee abides by the terms of reference.

14. Review of Arrangements

14.1. The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.

14.2. These terms of reference shall be reviewed by the committee chair and ICB chair on an annual basis, with changes proposed for approval to the ICB board.

Quality and Performance Committee Report

ICB Board 14 September 2022

1. Introduction

1.1 This paper provides the Integrated Care Board with a report from the inaugural meeting of the ICB's Quality and Performance Committee, which took place on 17 August 2022. The first committee meeting was reflective of this inaugural status with Committee members spending the first part of the meeting familiarising themselves with the scope of the Committee and its sub committees, alongside considering ways of working and approaches in the context of the key deliverables that it will have responsibility for overseeing on behalf of the ICB. The Committee also considered a report setting out the ICB's position against key national quality and performance metrics year to date across acute, mental health, community and primary care.

1.2 The Committee intends going forward to ensure that it is able to consider overall quality and performance at a high overview level but also have the opportunity to deep dive into specific areas to provide a more detailed understanding of performance drivers, challenges and issues as well as consider opportunities and solutions. The committee expressed its desire to move over time to a quality and performance framework that encompasses both national metrics but also local quality and performance outcome measures that are important to south east London from a population and health outcome improvement perspective plus the development of quality and performance dashboards that take a whole integrated care pathway focus.

2. Terms of Reference, ways of working and key areas of focus

2.1 The Committee considered its terms of reference alongside the draft terms of reference for its sub committees – the Safeguarding sub-committee, the System Quality Group, the Infection Prevention and Control sub-committee and the Integrated Medicines Optimisation Committee. The terms of reference for these four sub committees were approved noting the commitment to keep all under review as the work of the Committee progresses. The Committee also discussed the important relationship with the Planning and Finance Committee recognising the interplay of quality, performance and finance plus the link to overall planning processes and outcomes.

2.2 The Committee considered a paper setting out a proposed approach to assurance to be utilised as a framework across the ICB's prime committees to guide the Committee in undertaking its assurance functions. The paper considered value add approaches to

assurance that align with the core principles the ICB has already agreed in relation to ways of working, namely partnership, subsidiarity and delegation. Committee members provided comments on the paper and were broadly supportive of the proposals set out, recognising the need to keep reviewing and iterating as we operate our new governance structures.

2.3 The Committee considered the reliance it will need to place on sovereign organisations providing self-assessment assurance around quality and performance to the ICB. The Committee recognised the need for wider engagement and communication with ICB partners to ensure respective roles and responsibilities and asks of sovereign organisations are clear, respecting both organisational sovereignty but also enabling the ICB to fulfil its assurance function effectively. The paper will be reviewed in the context of the comments received from both the Quality and Performance Committee and the Planning and Finance Committee to produce an agreed assurance framework within which these two prime committees will work to fulfil their assurance function.

2.4 The Committee received a report from the first meeting of the ICB's System Quality Group focussed on providing reflections to the Quality and Performance Committee on ways of working to enable the group to fulfil its functions with regards securing a system wide approach that puts quality, safety, patient experience and safeguarding at the forefront of planning and decision making. The group, which has representation from a wide range of stakeholders including external partners and system regulators, had discussed collective ambitions for the group, ensuring a value add and different feel to quality improvement going forward and the opportunities offered for improving insights, learning and the spread of best practice enabled by collaborative and system wide approaches. To support transparency the group had agreed a set of underpinning operating principles to ensure a collaborative and open approach.

3. Quality and Performance report

3.1 The Committee received papers providing an overview of system quality and performance, including a narrative overview of quality and performance setting out system issues, challenges and successes plus a supplementary data pack providing the quantitative position against key metrics showing monthly performance against plan and over the previous year.

3.2 The Committee noted that the report represents work in progress in that it focusses on core national quality and performance metrics that systems are committed to securing. The Committee welcomed the plan to further develop the report over time and felt that adding a focus on population and clinical outcomes measures alongside the prime current focus on access would be helpful. Committee members also expressed a desire to consider approaches that support an integrated end to end care pathway consideration rather than a silo approach that considers primary care, community, mental health and acute performance as stand-alone metrics rather than placing these in the context of outcomes and links across care pathways. It was recognised that meeting these aspirations would take some time, with a need to build further the data and insights available as well as define the key outcomes that the Committee will wish to review and consider.

3.3 The Committee focussed its discussion on three key areas, in the context of recent issues that had implications for quality and performance, current system pressures and recent regulatory review.

3.4 The Committee received an update on the ongoing incidents related to IT outages and attacks – the Guy's and St Thomas' IT outage incident that occurred during the July heat wave and the subsequent attack on Advanced systems, a third party supplier of IT systems to a number of NHS organisations across the country. In South East London the Advanced incident had impacted111 services, GP out of hours, some Urgent Treatment Centres, Guys and St Thomas' community services and South London and Maudsley.

3.5 The Committee noted specifically the enhanced clinical and quality risks associated with managing patient pathways on a paper based rather than electronic systems and as a result of historic records being inaccessible for a period of time. The management of quality and safety had been paramount throughout the incidents. A clinical harms review would be carried out retrospectively to assess and provide assurance around harm whilst also identifying lessons learnt for the future.

3.6 In performance terms it was recognised that the incidents and adoption of paper based systems had resulted in a slowing down of flow impacting on waiting times and also that the Guy's and St. Thomas' incident had resulted in some elective cancellations and postponements. Providers impacted by the incidents had also been unable to capture data to support performance reporting which would mean a gap in our understanding of performance for a period of time. The committee noted how well the system and staff had come together to manage the incident and collaborate around mutual aid approaches.

3.7 The Committee also discussed the ongoing pressures across the system in relation to urgent and emergency care (UEC), with usual seasonal pressures having continued into the late spring and summer. Key drivers were a finely tuned and very tight capacity plan for the year, in the context of the need to manage covid demand which had been higher than expected year to date, urgent and emergency care demand and cancer and elective recovery. In addition, staffing remained a key challenge, with ongoing recruitment and retention challenges combined with staff sickness.

3.8 The committee will have a more in-depth discussion about urgent and emergency care at a future meeting in the context of the work underway to improve resilience for winter. The Committee recognised that alongside care pathway and flow challenges there are opportunities for improvement too, with work to optimise management of the A&E front door, expand our same day emergency care offer, enhance and further develop our urgent community response and admission avoidance services and improve the timeliness of discharge and mental health crisis response.

3.9 The Committee noted the winter planning process that had commenced nationally with the release of planning guidance on 12 August 2022, noting too that work on winter planning had already commenced across South East London at organisation level and through local Urgent and Emergency Care Boards. The ICB was coordinating an overarching planning process that would bring these outputs together over September. The Committee noted the need for the ICB to develop performance improvement trajectories as part of the winter planning submissions – these had a key emphasis on front door management through 111 and 999 performance plus the need to reduce bed occupancy and improve the number of discharges from hospital of patients who are medically fit.

3.10 The Committee noted on going external assurance of NHS organisations including by the Care Quality Commission. This had included recent visits to King's College Hospital

across the Trust's Denmark Hill, Princess Royal and Orpington hospital sites with outcome reports awaited.

Planning and Finance Committee Report

ICB Board 14 September 2022

1. Introduction

1.1 This paper provides the Integrated Care Board with a report from the inaugural meeting of the ICB's Planning and Finance Committee, which took place on 25 August 2022. The first committee meeting was reflective of this inaugural status with Committee members spending the first part of the meeting familiarising themselves with the scope of the Committee and the key deliverables that it will have responsibility for overseeing on behalf of the ICB. The Committee also considered and agreed some items of core business focussed on medicines optimisation.

1.2 The Committee intends going forward to split its agenda into a Part One core business part of the meeting and a more discursive and developmental Part Two, recognising our ambition to ensure the ICB's planning processes and outputs are enabling, facilitating transformation and innovation to secure improved outcomes across health, operational delivery and finance.

2. Terms of Reference, ways of working and key areas of focus

2.1 The Committee considered its terms of reference and in the context of its responsibilities - a paper setting out a proposed approach to assurance. The paper considered value add approaches to assurance that align with the core principles the ICB has already agreed in relation to ways of working, namely partnership, subsidiarity and delegation. Committee members provided comments on the paper and were broadly supportive of the proposals set out, recognising the need to keep reviewing and iterating as we operate our new governance structures. The paper will be reviewed in the context the comments received from both the Planning and Finance Committee and the Quality and Performance Committee to produce an agreed assurance framework within which these two prime committees will work to fulfil their assurance function.

2.2 The Committee also considered a paper that unpacked the terms of reference from a planning cycle perspective, setting out the key deliverables that the Committee will need to oversee in support of the delivery of our agreed 2022/23 operational and financial plans for the year and wider in year planning requirements plus the areas of work that will be required in year to support an effective 2023/24 planning process. The paper set out the requirements, timeframes and planning considerations across the following key areas:

1

- 2022/23 in year delivery requirements – delivery of the operational and financial plan, assurance process for the delegation of specialised services and dentists, opticians and community pharmacists and oversight of information governance.
- 2022/23 work to support 2023/24 planning – ICB contribution and response the Integrated Care Partnership integrated care strategy, the ICB five year forward plan and two year operational plan, go live delegation of specialised services and dentists, opticians and community pharmacists, next steps for the ICB's delegation to place and provider collaboratives.

2.3 The paper will be used to inform an agreed work plan for the year. The Committee will also be discussing the framework, principles and optimal approaches that the ICB might adopt in taking forward its planning responsibilities to ensure we are challenging ourselves to think differently to secure a holistic and integrated strategy, population health and outcomes driven approach enabled by our planning, contracting and funding mechanisms.

3. Operational Plan for 2022/23

3.1 The Committee received a paper that set out in some detail the key commitments that the ICB has inherited in relation to its response to national operating plan guidance for 2022/23. These cover a range of operational delivery and improvement commitments, focussed mainly on improving access and reducing waiting times across acute, mental health and community services plus a financial plan that commits the ICB to an overall financially balanced position for 2022/23 year end. It was noted that the operational plan does not represent the full extent of the work being undertaken across the ICS around care pathway development and improvement but a sub set linked specifically to planning requirements against which the ICB's performance will be measured nationally during the year.

3.2 It was noted that year to date positive progress has been made against the commitments made in relation to planned care (elective, cancer and diagnostics) in the context of a very challenged urgent and emergency care system and a further Covid 19 wave. Securing a continuation of the positive progress to date will however be challenging in the context of expected winter pressures and exacerbated demand challenges in a system where demand and capacity is already very finely balanced.

3.3 From a financial perspective the ICB's position was showing an overspend against plan, at month 4. There is a need to recover the year to date £50m deficit position in addition to securing a sustained reduction in the current expenditure run rate, through reduced spend over the remainder of the year, if our year end targets are to be met. The committee noted the very significant risks associated with delivering our financial breakeven plan over the remainder of the year in the context of the current higher than sustainable run rate, the efficiency challenge contained within plans, continued income uncertainty around activity related funding through the Elective Recovery Fund and uncertainty around spend, in particular, the impact of excess energy and inflation costs, further covid-19 waves and winter.

3.4 The Committee agreed to review year to date performance in greater detail in its September meeting with a specific focus on finance, with a consideration of expenditure drivers, including those beyond the control of the ICB and potential mitigations, noting the need to seek to maximise recurrent efficiencies to avoid an over reliance on non recurrent solutions which will add to the 2023/24 financial challenge.

4 Winter Planning 2022/23

4.1 The Committee received and considered the requirements set out in the national planning guidance in relation to improving urgent and emergency care resilience for winter that ICBs received in mid-August 2022.

4.2 The Committee received details of the planning outputs from ICBs that had been requested, comprising improvement trajectories for a number of key metrics, demand and capacity planning, a response to a series of actions set out nationally and a self-assessment against best practice. There are a series of initial submissions required over end August and September to the national team with monthly reporting against deliverables thereafter.

4.3 The Committee noted the significant review and coordinating expectations embedded within the requirements but also the complimentary work underway to consider wider approaches to winter planning and effective system management over Quarters Three and Four across the ICS. The Committee further noted the planned winter plan engagement and sign off process across the ICB, including further discussion at the ICB's Urgent and Emergency Care Board, the ICB Executive and the Board.

5 Medicines Optimisation

5.1. The Committee endorsed and agreed two recommendations from the ICB's Integrated Medicines Optimisation Group related to medicines management, as follows:

- The primary care rebate scheme which sets out the framework for the management of rebates on medications used in primary care to enable them to be managed in a legal and ethical way, including processes for the submission, evaluation and approval of proposed schemes.
- The implementation of NICE recommendations for the use of SGL T2 inhibitors in type 2 diabetes, to support effective blood glucose control and improved clinical outcomes.

5.2 The agenda item also enabled the Committee to understand the system wide groups that are in place to support medicines management across the ICB, including a new group focussed on medicines value and the medicines leadership team that comprises leads across ICB, mental health, acute, primary care and community pharmacy. This provides a pan sector approach to medicines optimisation as well as an approach that enables medicines to be considered in the context of wider care pathways.

6 Board Assurance Framework

6.1 The Committee received the first draft Board Assurance Framework which sets out the key risks that the ICB will need to manage over 2022/23 and a consideration of likelihood and impact pre and post mitigation. The Board Assurance Framework has been recommended to the Board by the Chair of the Planning and Finance Committee in the context of comments and feedback from Committee members on the draft received at the meeting.

Integrated Care Board

Item: 6
Enclosure: G

Title:	**SEL ICB Board Assurance Framework**
Meeting Date:	14 September 2022
Author:	Various ICB risk owners and risk sponsors as listed on pages 6-7. BAF designed, coordinated, and edited by the ICB assurance team.
Executive Lead:	Tosca Fairchild, Chief of Staff

Purpose of paper:	The Board Assurance Framework is designed to enable the ICB Board to identify and oversee the main risks to the successful delivery of the organisation's corporate objectives. The BAF document describes the key risks in detail and for each provides an assessment of how likely that risk is to materialise and what impact it would have should it do so. The Board has delegated the detailed monthly review of the BAF to the Planning and Finance Committee. The committee reviewed and endorsed the most recent BAF at its meeting on 25 August 2022. The committee recommends the BAF to the Board for approval.	Update / Information	X
		Discussion	X
		Decision	
Summary of main points:	This is the first edition of the ICB's BAF. It provides an assessment of risk against the achievement of the set of corporate objectives approved by the ICB Board on 1 July 2022. Proposed BAF risks, risk scores, mitigations, assurances, and future actions have been drafted by designated risk owners before being reviewed and approved by the named risk sponsor. Risk owners and sponsors for each risk are listed on pages 6-7 of the BAF document. The current BAF identifies 21 risks to the achievement of the ICB's 16 corporate objectives. The current highest rated risks relate to urgent and emergency care waiting times and to the ICB delivering a breakeven financial position for 2022/23.		

	The Board should review the content of the BAF and consider the extent to which it is assured that all known risks to delivery of the agreed objectives have been identified; that BAF risks are suitably scored; and that the mitigating actions in place and planned are sufficient to address the risk described.			
Potential Conflicts of Interest	None identified.			
Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**
	Equality Impact	Not directly applicable to the production of this report.		
	Financial Impact	Not directly applicable to the production of this report.		
Other Engagement	Public Engagement	The ICB BAF is designed primarily as an organisational management tool to support the ICB Board to oversee and manage risk within the organisation. It has not been developed by direct public engagement, though is available on the ICB's website in the interests of transparency and good governance.		
	Other Committee Discussion/ Engagement	Planning & Finance Committee, 25 August 2022.		
Recommendation:	• The Board should note risks against the delivery of its 16 corporate objectives for the financial year 22/23. It should note the mitigations already implemented and those that are proposed. • The Board should note the endorsement of the Planning & Finance committee and approve the BAF.			

SEL ICB Board Assurance Framework 2022/23

ICB Board, 15 September 2022

Introduction

Background and context

- The ICB's Board Assurance Framework (BAF) has been developed and is maintained in line with the process and guidance outlined in the SEL ICB Risk Management Framework.
- The structure of the SEL ICB BAF is set around the ICB's corporate objectives agreed by the ICB Board. The BAF details risks related to the successful delivery of the ICB's corporate objectives and is not designed to detail only the highest level risks facing the organisation.
- To complement the strategic level risks identified in the BAF, SEL ICB also holds a risk register which details risks and planned mitigations for risks relating to the operational activities of the organisation. Risks included in the risk register are not those which are deemed to threaten the achievement of the ICB's corporate objectives, but instead are operational risks that require active steps to be taken within the organisation to manage and mitigate. The ICB risk register is held by the ICB Governance Team.

Structure of the BAF

- Each BAF risk is updated monthly by the designated risk owner working with their teams and other colleagues. The previous month's residual risk score is recorded at the top of each slide together with the 'baseline' residual risk score recorded at the time when the BAF risk was first added to the BAF. Changes to the risk scores for each risk are recorded from both the initial date the risk was included in the BAF and from the previous month.
- Each BAF risk includes a brief description of the nature of the risk; an initial assessment of the risk in terms of its likelihood and impact; a detailed description of the mitigating actions in place to manage the risk; a residual risk score which assesses the likelihood and impact of the risk in light of the mitigations in place; details of assurances that demonstrate the evidence for the mitigations identified; and a 'forward view' of any further mitigating actions planned but not yet implemented. Each risk is also linked to one of the 16 ICB corporate objectives.

Role of the ICB Finance & Planning Committee and ICB Board

- The Finance and Planning Committee is responsible for the oversight of risk on behalf of the ICB Board, and will receive, scrutinise and monitor the BAF document in detail. The committee uses its regular reports to gain a sense of the key organisational risks. Committee members use this intelligence to assess whether strategic risks are adequately reflected and appropriately scored in the ICB's BAF.
- The ICB Board reviews and approves the latest BAF at its bi-monthly meeting in public.

ICB Corporate Objectives 2022/23 (1 of 2)

Headline Objective	Corporate objective description
A. Improve outcomes in population health and healthcare	1. Agree an outcomes focussed ICP integrated care strategy and ICB strategic plan.
	2. Establish population health management (PHM) as the way of working in SEL, using data and local insights to improve population health and delivery of care and health equity.
	3. Enhance prevention and address inequalities by making progress on delivery of CORE20Plus5 and 'The Vital 5'.
B. Tackle inequalities in outcomes, experience and access	4. Establish effective ways of hearing from and engaging with people from all communities across south east London to address unfair, avoidable and systematic differences in health between different groups of people.
	5. Develop a single and shared understanding of quality, patient safety and risk, with clear accountabilities for decision-making and ownership that improve outcomes for the SEL population.
	6. Embed a safeguarding culture that ensures the identification of common themes, shared learning, and a system-wide focus on the delivery of national and local safeguarding priorities.
	7. Deliver elective care transformation to increase elective capacity, improve patient outcomes and contribute to addressing inequalities of access.
	8. Improve the responsiveness of urgent and emergency care by addressing long waits in emergency care pathways, and by building community care capacity to prevent people from hospital admission and to support improved hospital discharge.
	9. Improve timely access to primary care by expanding capacity and increasing the number of appointments available to patients.
	10. Grow access to mental health services and services for people with a learning disability and/or autistic people.
	11. Maximise the uptake of routine immunisations (including childhood, influenza and covid-19 vaccinations) with a focus on addressing inequalities in uptake

ICB Corporate Objectives 2022/23 (2 of 2)

Headline Objective	Corporate objective description
C. Enhance productivity and value for money	12. Delivery of system financial balance, efficiency and savings plans
	13. Establish a joint system-wide process for capital planning.
	14. Invest in our workforce: achievement of workforce growth and retention targets across secondary, community, mental health and primary care.
D. Help the NHS support broader social and economic development	15. Improve social value through initiation of the ICS Anchor Programme.
	16. Begin implementation of the ICS action plan to reduce carbon footprint to Net Zero by 2040

Summary of Board Assurance Risks 2022/23 (1 of 2)

Headline Objective	Ref	Description of risk	Risk Sponsor	Risk Owner(s)	Current risk score
A. Improve outcomes in population health and healthcare	SELICS_01	Development of the Integrated Care Strategy is inhibited by misalignment with local strategies across the ICP as well as challenges related to the availability of pan-system data and information.	Sarah Cottingham	Ben Collins	6
	SELICS_02	Operational and performance pressures and processes mean there is limited capacity to establish population health management (PHM) as the way of working in SEL and it becomes de-prioritised impacting the pace at which it can be implemented.	Jonty Heaversedge and Toby Garood	Shaun Danielli	12
	SELICS_03	The ICB is committed to reducing health inequalities through prevention and intervention programmes. There is a risk the programme of work is spread too thin to deliver measurable and tangible improvements in health inequalities resulting in communities continuing to experience inequalities in their outcomes and care.	Sarah Cottingham	Sam Hepplewhite and Rupi Dev	9
B. Tackle inequalities in outcomes, experience and access	SELICS_04	The ICB does not establish effective ways of hearing from and engaging with people from all communities across south east London to address unfair, avoidable and systematic differences in health between different groups of people.	Tosca Fairchild	Ranjeet Kaile and Rosemary Watts	12
	SELICS_05	The System Quality Group (SQG) has been established with a view to develop a single and shared understanding of quality, safety and risk across SEL. There is a risk that partners do not engage in the process in an open and transparent way, that learning is not shared effectively across all organisations and that reporting into the ICB is not sufficiently robust or equitable.	Angela Helleur	Sonia Colwill	9
	SELICS_06	The Safeguarding Sub-committee will be a forum for health providers and commissioners in partnership with the local authorities to collaborate and develop a shared understanding of the safeguarding themes and shared learning across South East London. There is a risk that partners will not engage sufficiently to agree a collaborative approach across the six LCPs.	Angela Helleur	Susie Barker	9
	SELICS_07	A range of elective care transformation programmes are on-going across SEL to increase capacity and productivity, improve outcomes and responsiveness and reduce inequalities. However, the ability of these programmes to deliver could be constrained by the limited bandwidth of clinical and operational teams.	Sarah Cottingham	Annabel Appleby and David Reith	12
	SELICS_08	There is a risk that competing pressures in the system decrease capacity available for elective work, and lead to a consequent reduction in elective activity and ability to meet targets to reduce patients waiting for treatment.	Sarah Cottingham	Annabel Appleby and David Reith	12
	SELICS_09	Urgent and emergency care (UEC) waiting times do not improve because of high levels of acuity driven by the way patients access services and by challenges in accessing out of hospital care pathways.	Sarah Cottingham	Kelly Hudson and Sara White	16

Summary of Board Assurance Risks 2022/23 (2 of 2)

Headline Objective	Ref	Description of risk	Risk Sponsor	Risk Owner(s)	Current risk score
B. Tackle inequalities in outcomes, experience and access	SELICS_10	Mental health access performance trajectories are not achieved due to workforce availability, capacity and competition.	Sarah Cottingham	Rupi Dev	12
	SELICS_11	There is a risk that we will continue to experience high demand for mental health inpatient beds and on-going crisis presentations if community-based mental health programmes are not delivered.	Sarah Cottingham	Rupi Dev	6
	SELICS_12	Risk that the learning disability and autism inpatient reduction target will not be achieved	Sarah Cottingham	Carol-Ann Murray	9
	SELICS_13	The learning disability and autism programme will not achieve the operational target of 75% for the completion of annual health checks (AHC)	Sarah Cottingham	Carol-Ann Murray	6
	SELICS_14	Risk of increased non-contracted activity costs due to patient choice referrals to private providers because of increased waiting times for a diagnostic assessment for autistic spectrum disorder (ASD) for adults and children.	Sarah Cottingham	Carol-Ann Murray	12
	SELICS_15	Risk that achieving timely access to primary care is not delivered due to constrained capacity and increased demand.	Sarah Cottingham	Sam Hepplewhite and Holly Eden	12
	SELICS_16	Insufficient proportions of the population will be vaccinated making them vulnerable to vaccine preventable diseases and increased risk of outbreaks.	Angela Bhan	Angela Bhan and Sam Hepplewhite	12
C. Enhance productivity and value for money	SELICS_17	Risk that the ICS does not deliver its planned breakeven position for 2022/23	Mike Fox	Tony Read	16
	SELICS_18	Risk that the absence of a joint system wide process for capital planning will lead to; an overcommitted system capital plan; a disconnect between capital spend and system strategic and quality priorities; and short term annual approaches	Mike Fox	Mike Fox and David Maloney	6
	SELICS_19	Failure to effectively invest in the workforce, resulting in non-achievement of workforce growth and retention targets across secondary, community, mental health and primary care.	Julie Screaton	Angela Paradise and Rebekah Middleton	12
D. Help the NHS support broader social and economic development	SELICS_20	The Anchor System Programme falls behind schedule and isn't sufficiently joined up with other system programmes.	Ben Collins	Shaun Danielli and Maria Higson	4
	SELICS_21	The ICB will not be able to achieve the year 1 targets set out in the South East London ICS green plan.	Tosca Fairchild	Tosca Fairchild	12

Development of ICP integrated care strategy and ICB strategic plan

Baseline risk score:	**2 x 3 = 6 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Agree an outcomes focussed ICP integrated care strategy and ICB strategic plan**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_01	The ICP is responsible for the development of the Integrated Care Strategy for South East London. The Strategy must support more integrated approaches to delivering health and care, and to address local challenges including reducing health inequalities. There are specific risks in the development process for the integrated care strategy, which include; falling behind schedule; securing good quality data and effective information engagement; ensuring alignment with local strategies; and producing a strategy which is actionable.	2	3	6	• DHSC guidance published on 29 July 2022 clarifies the expectation that by December 2022 an "initial strategy" is required. Pre-existing information has been gathered to support the development of the strategy. This has focused on four areas: population health data, system performance data, prior engagement with our people and communities, and existing strategies at place and organisation level. • The Strategy Steering Group is meeting regularly to lead the work. A workshop is planned for members of the ICB and ICP in mid-September to determine high-level priorities and ensure appropriate oversight. • All boroughs are represented at the Strategy Steering Group, and there is an ongoing focus on managing the symbiotic relationship between local strategies, including the Joint Local Health and Wellbeing Strategies, and the Integrated Care Strategy, • It is recognised that many of the boroughs are in the process of updating their Joint Strategic Needs Assessments based on new census data; the public health analyst network has been engaged in the Integrated Care Strategy development work to ensure that the latest information is shared.	2	3	6

Risk assurances	Forward view on risk and planned further mitigating actions
• The Strategy Steering Group meets regularly and receives written updates on progress and discusses ongoing risks.	• Progress against the agreed plan will continue to be monitored. Given the DHSC guidance issued on 29th August 2022 there is an expectation that the strategy will continue to develop past the submission of the initial strategy in December 2022, reducing the level of risk. • DHSC guidance published on 29 July 2022 clarifies the expectation that by December 2022 an "*initial strategy*" is required. Pre-existing information has been gathered to support the development of the strategy. This has focused on four areas: population health data, system performance data, prior engagement with our people and communities, and existing strategies at place and organisation level. • A workshop is planned for members of the ICB and ICP in mid-September to determine the high-level priorities and ensure appropriate oversight.

Establishment of population health management (PHM)

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Establish population health management (PHM) as the way of working in SEL, using data and local insights to improve population health and delivery of care and health equity**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_02	Operational and performance pressures and processes mean there is limited capacity to establish PHM as the way of working in SEL and it becomes de-prioritised impacting the pace at which it can be implemented. There are also specific concerns around the limited understanding of PHM tools in the system, limited resources available to progress the programme and the potential lack of good quality data if the digital and data infrastructure is not developed in the required timescales.	4	4	16	• A business case has been developed which has been supported by the ICB Executive. Further discussion are ongoing to identify the source of funding (circa £6m/5 years). • Mobilisation planning is currently identifying next steps to implement the PHM Catalyst • The limited resources of the PHM Catalyst will prioritise support for programmes, places and providers in waves, to scale up PHM as a way of working. Simultaneously PHM training for the workforce will aid our objective to scale PHM. • A data strategy for SEL has been supported by both the KHP Board and SEL ICB.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• Risk assurances will be reported as the risk is further mitigated	• Additional capacity is proposed as part of the PHM Catalyst to support in particular analytics and change management in the short term as we build capability and capacity for PHM as an ICS • The proposed PHM Catalyst will establish a PHM training programme and an engagement programme across the ICS to educate the workforce and increase awareness, and will build internal capability in an applied way through support delivered to programmes, places and providers • Enabler functions, including business intelligence and digital, will work as part of the PHM Catalyst to embed the necessary infrastructure and PHM tools and techniques. • Work will begin to develop a clear and coherent delivery plan in regards of a) integrated data services and b) PHM and change capability – ensuring that these dimensions are strategically aligned and governed under a single oversight structure.

Reducing health inequalities

Baseline risk score:	**3 x 3 = 9 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Enhance prevention and address inequalities by making progress on delivery of CORE20Plus5 and 'The Vital 5'.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_03	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. The ICB is committed to reducing these inequalities through prevention and intervention programmes. There are however several opportunities and ways in which to reduce health inequalities, and therefore there is a risk that the ICB spreads the programme of work too thin to deliver measurable and tangible improvements in health inequalities resulting in communities continuing to experience inequalities in their outcomes and care. This may also result in resources continuing to be focused and driven at managing the outcomes, as opposed to the underlying cause. Furthermore, given the commitments we have made as an ICS in reducing health inequalities and increasing our focus on prevention, there is a reputational risk for the ICB in not reducing any form of health inequalities.	3	3	9	• **Ring-fenced health inequalities funding**: The ICB has ring-fenced funding for proposals that look to address health inequalities. Funding has been allocated to system-wide proposals which support delivery of the ICB's operating plan and also to individual Places to then agree relevant proposals in line with their Local Care Partnership priorities. • **Monitoring of operational plan commitments:** the ICB's operational plan included a number of commitments with regards inequalities related actins to be taken forward in 2022/23. We will be monitoring the effective implementation and delivery of these commitments, including upwards reporting.	3	3	9

Risk assurances	Forward view on risk and planned further mitigating actions
• Risk assurances will be reported as the risk is further mitigated	• **Tracking impact of HI proposals**: Approach to tracking delivery and impact of the proposals agreed as part of the health inequalities funding to be agreed by September. • **Focus on prevention**: Development of proposal to explore how the system can focus resources and delivery on a few key areas such as immunisation/vaccination, physical health checks and screening (scoping exercise to be completed by September). • **Embedding health inequalities in all programmes of work**: Development of a framework to support all ICS programmes to embed health inequalities into their work programmes (due end of September). • **CORE20PLUS**: Identification of CORE20PLUS population groups both at Place and SEL-wide to support framework referenced above – delivery date TBC. • **Development of the Vital5**: For each of the vital 5, leadership teams are being assembled with expert experience in these areas to drive the overall ICS approach.

Working with people and communities

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Establish effective ways of hearing from and engaging with people from all communities across south east London to address unfair, avoidable and systematic differences in health between different groups of people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_04	The ICB does not establish effective engagement structures and methods to hear from a diverse range of people from all communities across south east London. This could adversely affect the successful delivery of programmes aimed at improving services and patients' experience of them, and also risks compromising the ICB's aim of reducing health inequalities.	4	4	16	• The ICS working with people and communities strategic framework has been approved and published on the ICS website. The framework sets out the ICB vision for working in partnership with people living and working in our local communities and what we need go do to achieve the ICS ambition of working in partnership with local people in order to address service transformation and heath inequalities. • The ICB has established an on line engagement platform - Let's Talk Health and Care South East London (letstalkhealthandcareselondon.org). This has a range of functions to expand our reach more easily to hear what matters to local people including open and closed chat functions, questions, quick polls and surveys. The platform is a SEL hub and a hub for each LCP. • An ICS Engagement Practitioner's Network has been established to share good practice, share insight and align engagement over time which meets every other month. A mini review was carried out in June to inform its development. • The ICB has funded a South East London Director of Healthwatch role, part of whose function is act as a critical friend and to bring the voice of local people into ICB decision making and governance processes.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• An evaluation of the Engagement Practitioner's Network was carried our which have highlighted and will inform areas for development. • An evaluation of the open public forum session prior to the first ICB meeting in pubic was carried out which demonstrated that this approach was well received and will inform the approach to the open public forum sessions in future. • Feedback from NHS England on the working with people and communities strategic was positive: "This was an excellent example of a strategy in scope, detail, expressed values and commitment to genuine engagement with communities. There is a real sense of the maturity of the system and how positive practice at place level is shared across the ICS as well as an awareness that while each place is unique it is possible to learn and share across".	• Recruitment of the Clinical and Care Professional Lead for engagement and for public members of the EAC will take place. • The ICB has received funding to establish a People's Panel. A specification for social marketing / research agencies has been developed for recruitment to the panel. Meetings and procurement to take place over the summer. • Community engagement working with Citizens UK with more seldom heard communities will take place over the summer as part of the ICS strategy development process. • As part of the development of the ICS strategy, two public facing webinars took place on 22 and 25 July with more than 150 local people working in the VCSE attending. The outcome of these events is currently being evaluated. • The role outline for the Clinical and Care Professional lead for engagement is drafted prior to recruitment. This role will chair the ICB Engagement Assurance Committee • The terms of reference for the ICB Engagement Assurance Committee (EAC) have been drafted • Evaluation of the two public engagement webinars held in July is currently taking place.

Development of the System Quality Group

Baseline risk score:	**3 x 3 = 9 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Develop a single and shared understanding of quality, patient safety and risk, with clear accountabilities for decision-making and ownership that improve outcomes for the SEL population**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_05	The System Quality Group (SQG) has been established with a view to develop a single and shared understanding of quality, safety and risk across the south east London ICS. There is a risk that partners do not engage in the process in an open and transparent way, that learning is not shared effectively across all organisations and that reporting into the ICB is not sufficiently robust or equitable.	4	3	12	• Each provider organisation has its own quality governance structure reporting to a Board. This will ensure there is direct oversight and mitigation for emerging and existing quality risks. The ICB quality team attends provider quality meetings on a regular basis. • Substantial engagement with partners including regulators over 2021 resulting in agreed principles of working. • Smaller focus group of provider Directors of Quality or equivalent to share methodologies for learning in large providers meeting on a monthly basis. • Terms of reference SQG include reporting to ICB, NHSE.	3	3	9

Risk assurances	Forward view on risk and planned further mitigating actions
• Partners and regulators are engaging in the process and the terms of reference were agreed at the first SQG meeting.	• Working group to be established to drive forward the agenda and workplan with full SQG approval. • The SQG will develop and hold an issues log for escalation to risk registers of relevant organisations. • Active recruitment into all member spaces on the SQG including Patient Safety Partners, Local Authority and Place.

Securing a collaborative approach to safeguarding across LCPs

Baseline risk score:	**3 x 3 = 9 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Embed a safeguarding culture that ensures the identification of common themes, shared learning, and a system-wide focus on the delivery of national and local safeguarding priorities.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_06	The Safeguarding Sub-committee will be a forum for health providers and commissioners in partnership with local authorities to collaborate and develop a shared understanding of the safeguarding themes and shared learning across South East London. There is a risk that partners will not engage to agree a collaborative approach across six LCPs.	4	3	12	• Each place based Board has existing safeguarding structures and governance in place. The SEL ICB safeguarding team is part of this structure and information is shared. • Engagement with NHS providers and Terms of Reference for the Safeguarding Adults Board and Children's Partnerships have been agreed. • Agreement of membership of NHS providers, Independent chair of the adults boards and Children's partnership and independent scrutineer to attend the Safeguarding Sub-committee. • A safeguarding tracker has been implemented where all safeguarding reviews themes are captured and actions tracked to ensure the learning is embedded. • Designate 6 weekly meetings in place to monitor actions and risk across 6 boroughs already in place.	3	3	9

Risk assurances	Forward view on risk and planned further mitigating actions
• Terms of Reference agreed prior to the first meeting. • Reported outputs from place based Boards.	• Deep dive being carried out into Domestic Homicide Reviews to identify common themes. • Working group to convene and agree reporting and agenda for the sub-committee. • A project officer will be employed to manage the SEL ICB response to local and national priorities. • Safeguarding tracker in place to monitor safeguarding themes and actions. It is too early at this stage to report the impact of using the tracker. • Deep dives into safeguarding adult reviews and children's practice reviews.

Delivering successful elective care transformation programmes

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Deliver elective care transformation to increase elective capacity, improve patient outcomes and contribute to addressing inequalities of access.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_07	A range of elective care transformation programmes (theatres, admitted, non-admitted) are on-going across SEL to increase capacity and productivity, improve outcomes and responsiveness and reduce inequalities. However, the ability of these programmes to deliver could be constrained by the limited bandwidth of clinical and operational teams. This could be because of: • Multiple asks of the same clinical and operational teams (e.g. a single specialty is asked to introduce a range of initiatives simultaneously). This could result in confusion over priorities, teams being overwhelmed and lead to non-delivery in most or all areas • Inadequate capacity for clinical leads to engage and co-design initiatives with partners across primary and secondary care, leading to lack of awareness, buy-in and adherence to new pathways/ways of working. • Insufficient oversight and awareness of the range of asks on teams (e.g. elective, cancer, urgent care), and what support might be needed to enable delivery	4	4	16	• Acute Provider Collaborative governance has been reviewed to ensure that there are clear structures in place between clinical networks, cross-cutting workstreams and the APC Executive. These structures should ensure that there is clarity on responsibility and accountability, and better oversight of the range of programmes underway (across elective and non-elective and ability to prioritise/deprioritise work as pressures increase). • Clinical leadership capacity has been increased with each specialty network having a secondary care clinical lead in place, and primary and community leads also being appointed. These leads have protected time to develop initiatives, and to engage with clinicians across the ICS. This will be kept under regular review to ensure that sufficient clinical capacity is in place, and that it can be supplemented as necessary. • Funding from SOF4 (system Oversight Framework segment 4) and TIF (Targeted Investment Fund) processes is being used to fund additional capacity to support transformation programmes. Examples include additional project management resource to implement initiatives such as Patient Initiated Follow Ups, and funding for additional clinical sessions to allow 'double-running' whilst clinical triage models are implemented.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• Trust recovery plans. • Trust performance reports for performance meetings. • Minutes of APC Executive meetings. • Minutes of key workstreams (e.g. Non-Admitted, Theatres). • Joint appointments with APC to ensure join up with ICB.	• Ongoing discussions with regional NHSE team through system meetings to highlight where disproportionate levels of asks are being placed on individual specialty teams. • Clinical leadership development programme being developed to support GP Clinical Leads in maximising engagement with primary care to discuss need for and approach to transformation of services to mitigate risk of non-engagement.

Competing priorities for non-admitted and admitted capacity

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Deliver elective care transformation to increase elective capacity, improve patient outcomes and contribute to addressing inequalities of access.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_08	Agreed clinical prioritisation criteria set out that elective capacity is first used for urgent and cancer related work and then non-urgent elective work to ensure patients are treated in order of clinical priority. There is a risk that competing pressures in the system decrease capacity available for elective work, and lead to a consequent reduction in elective activity and ability to meet targets to reduce patients waiting a very long time for appointments / treatment. For example, an increase in non-elective admissions, urgent elective activity and cancer activity can decrease the admitted capacity available for non-urgent admitted elective work. An increase in cancer two week wait referrals can decrease the capacity available for routine non-admitted work.	4	4	16	• APC work to establish and drive activity through elective hubs, which offer elective capacity that is protected from non-elective / urgent pressures and means that admitted care is more likely to continue in times of significant operational pressure. • APC system level and internal trust work on theatre productivity to maximise activity that is carried out in the capacity available for non-urgent elective work. • APC work on non-admitted care – specialist advice, PIFU and use of community services – to make best use of outpatient capacity available. • Annual work on winter planning to minimise disruption on elective care by planning for likely increases in non-elective activity over the winter period and wider transformation work in UEC.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• Trust recovery plans. • Trust performance reports for performance meetings. • Minutes of APC Meetings – particularly Operational Delivery Group and Steering Group for oversight of activity impacting on elective recovery. • Winter Plans produced.	• APC work to develop an elective clinical strategy for high volume low complexity specialties to develop sustainable plan which minimises disruption on elective activity from other parts of they system

Ongoing pressures across SEL UEC services

Baseline risk score:	**4 x 4 = 16 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Improve the responsiveness of urgent and emergency care by addressing long waits in emergency care pathways.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score

SELICS_09	Demand and flow continue to challenge our SEL system which means we are not able to improve waiting times, or support timely discharge. If we continue to have high levels of acuity driven by both by the way patients access services and by challenges in accessing out of hospital care pathways. This will continue to put pressure on the system.	5	4	20	• **Robust daily intensive system support**: SEL surge meet daily with site DOOs to review pressures across the system, agree mutual aid and support site safety.
					• **UEC improvement plans are reviewed monthly**
					  • **Local system actions:** each local system has an action plan to support improvement including reviewing estate, workforce, pathways, protocols, and escalation. Local improvement plans report into local UEC boards or equivalent. Proactive work to develop community offer including the roll out of urgent community response and development of our virtual ward offer.
					  • **SEL System actions**: SEL improvement work across the system to develop and implement supportive measures, for example, increasing direct access to SDEC, direct booking from 111, increasing crisis support for Mental Health. This work is manged via system groups: SEL Acute Flow Improvement Group; MH UEC Task and Finish Group; SEL Discharge Solutions and Improvement Group.
					• **SEL Governance:** System groups and local UEC Boards report into the SEL UEC Board which meetings every 2 months.
						4	4	16

Risk assurances	Forward view on risk and planned further mitigating actions
• The daily calls are providing the immediate system support to retain site safety across all SEL sites. • Urgent care performance dashboard • Winter planning process and outputs	• In September 2022 a winter workshop is being held across SEL to support winter preparedness. • Winter planning process will provide an opportunity to further de risk and secure assurance • Site visits are being arranged with the new SEL Clinical leads to provide peer support and supportive challenge for site processes.

Delivering mental health access performance metric trajectories

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Grow access to mental health services and services for people with a learning disability and/or autistic people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_10	The NHS Long Term Plan sets out a series of ambitions for all mental health and learning disability/autism services to expand access to service provision. Expansion targets are in place for the whole country and there is a risk that due to workforce availability, capacity and competition, these access targets may not be delivered for 2022/23. There is a risk that services are unable to meet demand and waiting lists either grow or stagnate. Furthermore, as several of these access targets are part of our early intervention and prevention approach, there is a risk that this demand then presents through unplanned care routes impacting urgent and emergency care pathways, bed capacity and overall outcomes for service users.	4	4	16	• **Development of clinically-led and profiled performance trajectories**: Access trajectories for 2022/23 have been developed with clinical and operational teams across the service providers with improvement trajectories proposed for several service lines (including CAMHS, CYP eating disorders, IAPT, perinatal and physical health checks) to account for the onboarding of new staff and slower expansion of capacity as a result. These trajectories have been agreed with NHS England. • **Funding allocation to support expansion:** Funding has been allocated from both the Mental Health Investment Standard and Service Development Funds to support workforce growth and expansion for the key service lines to deliver the agreed trajectories. • **Monthly review of performance with the service providers**: Performance against access trajectories is reviewed on a monthly basis by the ICB with service providers, working collaboratively to identify areas of risk and improvement actions as required. Individual service providers are also reporting and monitoring compliance against trajectories through their Boards. • **Workforce expansion plans including diversification of roles and profiling through planning:** Detailed workforce return submitted as part of the operational planning process for mental health to understand how investment will be used to grow and expand posts not only through the clinical roles but through non-clinical roles to support overall service expansion.	3	4	12

Risk assurances

- Profiled trajectories for access to various service lines – submitted as part of ICS' operational planning return.
- Workforce plan – submitted as part of the ICS' operational planning submission.
- Monthly published mental health performance and access report which captures current performance and improvement actions which are being undertaken.
- Minutes/actions from the monthly performance meetings with service providers.
- Board papers and minutes from both South London and Maudsley NHS Foundation Trust and Oxleas NHS Foundation Trust tracking and monitoring their individual progress.
- Action log and improvement plan from the IAPT Steering Group.

Forward view on risk and planned further mitigating actions

- **Q2 Stocktake at the ICS Mental Health Board:** At the September ICS Board meeting, there will be a deep dive of performance against the 2022/23 mental health access trajectories as submitted as part of our operational planning return.
- **Exploration of dedicated mental health workforce support**: Working collaboratively with the 'people' function of the ICB, we will explore dedicated workforce support.
- **Deep dives or detailed action plans for service lines most at risk**: IAPT has been identified as key risk area for the ICB. Through the IAPT Steering Group, each service is developing an improvement plan supported by the ICB's performance team to ensure all opportunities for delivering the trajectory for 2022/23. This should be in place by October 2022.

Delivering community-based mental health transformation programmes

Baseline risk score:	**2 x 3 = 6 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Grow access to mental health services and services for people with a learning disability and/or autistic people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_11	Transforming and expanding mental health community service provision is key in supporting service users to stay well in their communities and maintain their independence, as well as reducing crisis presentations and admissions to inpatient beds. There is a risk that due to competing priorities across the system, including front door crisis pressures, resources and time are diverted from these community transformation programmes across adults and children and young people's services. Without delivery of these community-based programmes, we will continue to experience high demand for our inpatient beds and ongoing crisis presentations.	3	3	9	• **Funding allocation to support expansion:** Funding has been allocated from both the Mental Health Investment Standard and Service Development Funds to support the development of community services with key deliverables agreed across system partners as part of the annual operating cycle and contracting round. • **Regular review and oversight of progress with transformation programmes:** For community mental health transformation, this is monthly via a dedicated steering group which tracks progress with delivery of the core offer and recruitment into new roles.. A CYP mental health network is also in place to oversee CYP transformation. All programmes are accountable to the ICS Mental Health Board. • **Dedicated project management resource**: For community mental health transformation dedicated project management support in place to ensure focus on programme delivery both at individual borough level and at provider level with nominated leads and SROs overseeing and driving transformation.	2	3	6

Risk assurances	Forward view on risk and planned further mitigating actions
• Papers from the community mental health transformation steering group including meeting papers, recruitment updates, delivering against core offer). • Quarterly data collection return to NHS England (capturing progress with core offer delivery for community at PCN level).	• **Development of the Children and Young People's Mental Health Transformation Plan**: this plan will capture all the actions underway through community children and young people's mental health and LDA services to provide early intervention in the community, including focusing on parental mental health.

LDA inpatient bed reduction

Baseline risk score:	**3 x 3 = 9 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Grow access to mental health services and services for people with a learning disability and/or autistic people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_12	Risk that the inpatient target for the reduction of inpatients to 59 adults and 5 children and young people by March 2023 will not be achieved. Reducing inpatients will reduce reliance on institutional care and ensure patients are moved into less restrictive care settings which will enable them to live healthier, safer and more rewarding lives.	4	3	12	• Monthly inpatient surgery to review inpatients with a learning disability and or autism to support discharge and step down when clinically appropriately to the least restrictive environment. • Quarterly and six (6) monthly review of patients by length of stay (LoS) using learning from Safe and Wellbeing reviews undertaken in 2021/22. • Detailed review of care and support needs and utilise Community Discharge Grant (CDG) or Personalised Care/personal heath budgets as required. • Utilisation of Dynamic Support Registers (DSRs) and Care Education Treatment Reviews (CETRs) in admission prevention. • Implementing the expansion of ASD Support services to support admission prevention. • Maintaining dedicated Case Management function to support CETRs and discharge • Dedicated Community CETR lead for children and young people.	3	3	9

Risk assurances	Forward view on risk and planned further mitigating actions
• SEL LDA Strategic Board Agenda and Minutes List the assurance evidence • SEL LDA Operational Board Agenda and Minutes • Minutes from the 6-8 weekly Joint Region and System LDA heath Partnership meeting.	• Development of SEL LDA Pathway Fund Strategy and Principles by end Q3 2022/23

LD and Autism Annual Health Checks

Baseline risk score:	**2 x 3 = 6 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Grow access to mental health services and services for people with a learning disability and/or autistic people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_13	The risk is that the learning disability and autism programme will not achieve the operational target of 75% for the completion of Annual Health Checks (AHC). On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population. Completing AHC will help to reduce the health inequalities being experienced by people with learning disabilities and autism.	3	4	12	• A dedicated SEL AHC Steering group chaired by a clinician (meets three times a year) that reports to the LDA Operational board (meets monthly). The Steering Group will monitor performance and quality and will share best practice across SEL. • £30k secured from regulator to implement exemplar site work for 12 months – there was extensive learning from the pilot which will be disseminated across SEL • Facilitation and support to practices/PCNs that have not achieved 75% during 2022/23. • A large engagement event undertaken called 'LD BIG Health week' in December 2021. The feedback from service users was collected and based on this improvement actions were agreed like new resources and training required. The next event will be in November 2022. • LD and ASD Health Ambassador service implemented. Eight ambassadors have been recruited and will promote the programme and help shape training needs. • Learning disability and Autism Specialist Prescribing Advisors are in place to actively support general practice and improve quality of Annual Health Checks. The advisors are focusing on upskilling primary care workforce and improving data quality. • Utilisation of LD Dashboard to better understand needs and trends • Clinical and Care Professional Leads have been recruited to support the AHCs workstream.	2	3	6

Risk assurances	Forward view on risk and planned further mitigating actions
• SEL LDA Strategic Board Agenda and Minutes List the assurance evidence. • SEL LDA Operational Board Agenda and Minutes. • Minutes from the 6-8 weekly Joint Region and System LDA Heath Partnership meeting. • Minutes from the SEL LDA Annual Health Check Steering Group. • Report outlining the learning from the exemplar site work produced and being implemented. • Performance dashboard produced by the central BI team is regularly reviewed.	• By end of Q3 2022/23 a quality and performance delivery plan will be produced for each LCP. The plans would cover the period to March 2024. • By end of Q3 2022/23 an overarching SEL delivery plan will be developed around the required enablers for the programme.

Increased waiting times for ASD diagnostic assessments

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Grow access to mental health services and services for people with a learning disability and/or autistic people.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_14	Increased waiting times for a diagnostic assessment for Autistic Spectrum Disorder (ASD) for adults and children and resulting non-contracted activity costs due to patient choice referrals to private providers. Achieving timely access to assessment will reduce diagnosis waiting times and ensure support can be put in place earlier and help improve patient outcomes.	4	4	16	• Implementation of actions from the ASD Task and Finish group following the Neurodevelopmental Services Review that was completed in Autumn 2021. • Implementation of services for backlog clearance by Oxleas and SLaM and plans to reduce the waiting time by end of March 2023 including development of services to meet the demand and maintain waiting times within 6 months. • Clinical and care professional leaders recruited to focus on autism across all ages, particularly post-diagnostic support for autism only diagnoses.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• SEL LDA Strategic Board Agenda and Minutes List the assurance evidence. • SEL LDA Operational Board agenda and minutes. • Minutes from 6-8 weekly Joint Region and System LDA heath Partnership meeting. • Minutes from Monthly monitoring of ASD Support services and workforce with providers (Oxleas and SLaM).	• The cost per case budget and funding assessments will be reviewed across all SEL boroughs for referral made under Patient Choice. • Initial steps taken to work with main providers to ensure national performance reporting is completed.

Timely access to primary care appointments

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Improve timely access to primary care by expanding capacity and increasing the number of appointments available to patients**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_15	Primary care is defined as "healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment". This includes a wide range of services from general practice and pharmacy services, to NHS 111 and some urgent care services. Achieving timely access to primary care is being impacted by two main risks; a) constrained capacity due to workforce shortages, lack of digital enablement, inadequate estate or changes to commissioned services b) Increased demand due to population growth, increased acuity, backlog of care as a result of covid, pathway changes which increase activity and/or changes in patient expectations	4	4	16	• **Workforce controls** - Work is being undertaken across Local Care Partnerships and in conjunction with Training Hubs to develop schemes to encourage more staff into primary care and offer support to retain them. This includes a programme of work to maximise the use of investment in additional roles within primary care. • **Backlog of care and pathway changes** – Local Care Partnerships and SEL programmes are putting additional investment into areas of care where a backlog remains to enable primary care services to bring in additional locum workforce to support backlog clearance. In relation to pathways changes, SEL ICB are working with GSTT to develop and test partnership approaches to managing patients on waiting lists aimed at reducing demand on primary and secondary care whilst improving patient experience and wellbeing • **Changes in patient expectations** – A behaviour change campaign has been developed, focussed on improving patient and public trust and confidence in new clinical and professional roles in primary care (such as first contact physiotherapists, care coordinators etc). Stage two of the campaign will then focus on increasing patient trust and confidence in receiving care remotely. The campaign has launched in August, with a microsite promoting new roles due to launch in September.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• Risk assurances will be reported as the risk is further mitigated. Risk assurances will be provided via Local Care Partnership governance processes.	• Local Care Partnerships are reviewing the impact of the national changes to the PCN DES on their local primary care capacity, and developing proposals to bridge these gaps. These proposals are currently unfunded which limits the impact of this control. • Proposed changes to SMS and Accurx services could further increase the risk. Work is underway to review proposed changes and develop alternative proposals which will provide primary care with the functionality required to retain existing capacity.

Proportion of the population being vaccinated

Baseline risk score:	**4 x 3 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Maximise the uptake of routine immunisations (including childhood immunisations, influenza and covid-19 vaccinations) with a focus on addressing inequalities in uptake**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_16	The risk is that insufficient proportions of the population will be vaccinated making them vulnerable to the vaccine preventable diseases, and increasing the risk of outbreaks, The increase in levels of infectious disease may have consequences for other services, such as delay in routine procedures. There is also a risk that certain parts of the population, may suffer from illness disproportionally. This may because of a lack of access or culturally issues.	5	3	15	• Governance arrangements in place, jointly with London Region. SEL immunisation board and each 'place' has overarching immunisation committees/groups to address. Review of data at borough level, and SEL wide. SEL 'gold' immunisation group set up to oversee immediate arrangements and priorities • Focus on comms and engagement at SEL level and local level, working with local partners to encourage uptake in communities with lower levels of uptake. • Practices are being supported to deliver vaccination programmes. • GSTT taking lead provider and employer role to support the SEL system, e.g. mass vaccination centres.	4	3	12

Risk assurances	Forward view on risk and planned further mitigating actions
• Minutes from the regional meeting and SEL Immunisation Board • Performance reports including borough level uptake rates	• New vaccination programmes may need to be setup at short notice e.g. polio

System financial balance, and delivery of efficiency and savings plans

Baseline risk score:	**4 x 4 = 16 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Delivery of system financial balance, efficiency and savings plans**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_17	Risk that ICS does not deliver its planned breakeven position for 2022/23, due to: • Inability to deliver planned savings • Excess inflation above available funding • Continuation of COVID leading to increased cost and underachievement of planned ESRF income	4	4	16	• Breakeven plan for 2022/23 agreed by ICS Executive. • Monthly review and reporting to ICS Executive on delivery against financial plans and risk of organisational efficiency plans. • Oversight of financial position by SEL CFO group, meeting fortnightly. • Excess inflation being tracked by trusts and reported on monthly basis. • Agency cap and monitoring of spend reported routinely each month.	4	4	16

Risk assurances	Forward view on risk and planned further mitigating actions
• Breakeven plan in place per 20th June submission to NHSE. • Year end breakeven forecast as per Month 3 reporting. • Elective activity reporting against ESRF baselines produced.	• Targeted savings workstreams arising from PA identified opportunities (CFOs). • Review of forecast out-turns and underlying positions to be completed and reported to CEOs end September (CFOs). • Use on non-recurrent flexibilities as required. • Submitted ESRF baseline adjustment request to NHSE – awaiting response.

System-wide capital planning

Baseline risk score:	**2 x 3 = 6 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Establish a joint system-wide process for capital planning**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_18	There is a risk that the absence of a joint system wide process for capital planning will lead to: • An overcommitted system capital plan • Disconnect between capital spend and system strategic and quality priorities • Short term annual approaches.	3	3	9	• Distribution of 2022/23 capital and prioritisation principles agreed by CEOs (Feb 2022). • 2022/23 capital finance plan agreed by ICS Exec (June 2022). • 20% reserved for system prioritisation. • Indicative capital values for 203/24 shared with trusts (Feb 2022). • Regular monthly reporting against capital programmes to ICS Executive. • Successful additional capital awards for e.g. TIF2, Mental health.	2	3	6

Risk assurances	Forward view on risk and planned further mitigating actions
• Capital finance plan as per 20th June submission to NHSE • Notification from NHSE of additional capital	• Prioritisation approach to be further developed for capital finance planning (ICB CFO) • Request to NHSE CFO for QEH infrastructure funding (ICB CFO) • Anticipate frontline digitisation capital confirmation by NHSE in Q2 2022/23

SEL workforce investment

Baseline risk score:	**3 x 4 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Invest in our workforce: achievement of workforce growth and retention targets across secondary, community, mental health and primary care**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_19	Failure to effectively invest in our workforce, resulting in non-achievement of workforce growth and retention targets across secondary, community, mental health and primary care.	3	4	12	• Oversight of all SEL ICS workforce programme activities through the SEL People Board. • Collaboration between SEL ICS Finance teams against clear workforce priorities, and system-wide commitment to collaborative not competitive approaches to matters of pay. • Robust approach to securing available HEE funding through close attention to bidding processes. • ICS CPO in place to provide leadership, with allocation of resources to ICS workforce programme. • ICS workforce programme has a medium term focus on 3 priorities of supply, EDI and wellbeing, identified as critical to recruitment and retention each supported by sub committees with partner membership • HR resource in place to support acute and community provider collaboratives to enable agile response to workforce challenges • Education and Workforce collaboratives to drive operational effort and sharing best practice • Core HEE workforce development allocations applied and agreed by the SEL People Board • Further external investment in workforce, largely from HEE allocation and the GLA, are managed through the SEL People Board.	3	4	12

Risk assurances	Forward view on risk and planned further mitigating actions
• ICS workforce governance provides oversight through the SEL People Board chaired by CEO of Oxleas/partner ICB board member for community services. All partner constituencies represented. Minutes are produced for the SEL People Board and the sub-committees.	• Local Care Partnerships (LCP) to undertake a diagnostic to enable us to describe the common workforce priorities across the LCPs, how these priorities relate to aspects of the existing ICS workforce programme, what could / should be done at scale to best support LCPs; this will also feed the design of the substantive people function. • Future plan for mental health provider collaborative support across SLP in development. Community mental health transformation programme people resource to be agreed. • On designing the Future Substantive People Function (April 23 onwards), stakeholder engagement and a review of the current programme is underway, local and national priorities to identifying what should be delivered at scale, sector, and organisational level and the necessary constituent projects / workstreams within the programme. Establish a centralised repository of ESR and other key workforce data across KCH, LGT, GSTT and Oxleas (community) to enable improved workforce insight, modelling and planning. • Identify impact of NHS workforce programme priorities on social care workforce and where workstreams need to align cross-sector/system-wide (not just health focus). • Development of SEL ICS workforce strategy and plan to identify long term priorities due for completion in March 2023.

Implementation of the ICS Anchor Programme

Baseline risk score:	**2 x 2 = 4 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Improve social value through initiation of the ICS Anchor Programme.**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_20	The Anchor System Programme is part of our ICS approach to addressing health inequalities, one of our key priorities as a system. In December 2021 the process of designing and agreeing an ICS approach began, recognising work ongoing at multiple levels including at Place and organisation levels as well as across the London region. This commitment to addressing health inequalities has been reiterated since, including as a South East London Corporate Objective as set by the ICB on 1st July 2022. A fundamental aspect of our approach to the Anchor agenda is that it must be based on the needs of our communities; engaging with the public and our community and voluntary sector partners will be critical. It has therefore been agreed that the Programme will build on the success of the South London Listens programme, including working with the same delivery partner, CitizensUK. There is a risk that the programme falls behind schedule and isn't sufficiently joined up with other system programmes.	2	2	4	• A working group comprising colleagues from the ICB, South London Listens (which was hosted by South London and Maudsley NHS FT), and Citizens UK is in place and meeting regularly. • We continue to discuss the programme with our partners and other parts of the system, and will be seeking to convene an 'Anchor Alliance' with representatives from across the system, including NHS partners, local authorities, ICB colleagues, and VCSE partners, to lead this work and ensure that it develops and co-designs specific, actionable projects which support the work of the system in tackling health inequalities. • Resource is being recruited to support the development of the Anchor System programme, which will be hosted by South London and Maudsley NHS FT and our delivery partner Citizens UK.	2	2	4

Risk assurances	Forward view on risk and planned further mitigating actions
• Minutes from Working Group meetings	• Recruitment for the additional resource for programme management, research and communications is expected to be completed by the end of September, with the roles filled by successful applicants by the end of 2022. • In the coming three months the Anchor Alliance will be set up. The Anchor Alliance will have two roles: to allow the sharing and spreading of good practice and successful projects, and to oversee the Anchor System Programme. Membership of the Anchor Alliance will be open to relevant Anchor leads from all parts of the system, including NHS partners, local authorities, ICB colleagues, and VCSE partners. The reporting route from the Anchor Alliance has yet to be agreed.

Implementation of the ICS Green Plan

Baseline risk score:	**4 x 3 = 12 (August 2022)**	**Last month's score**	**Not applicable to initial risk score**
Change in risk score:	**Not applicable to initial risk score**		
Corporate objective:	**Begin implementation of the ICS action plan to reduce carbon footprint to Net Zero by 2040**		

Ref	Description of risk	Likelihood	Impact	Initial risk score	Ongoing controls	Likelihood	Impact	Residual risk score
SELICS_21	There is a risk that the ICB will not be able to achieve the year 1 targets set out in the South East London ICS green plan, which aim to reduce the carbon footprint of the organisation by 2040. This plan includes targets both specifically for the ICB but also the wider system. Both sets of targets have risk attached to their delivery.	4	3	12	• A Sustainability Oversight Board has been established, which includes in its membership the Sustainability SROs for all health organisations in SEL and is chaired by the ICB Sustainability SRO. • A delivery plan has been produced to summarise the targets in the green plan with individuals assigned to provide oversight on delivery. • A governance structure is in place with workstreams identified. Workstream leads are in the process of being confirmed in order to move this forward. • External parties have been engaged to support particular aspects of delivery (e.g. Sustrans to support primary care active travel). • The ICS is represented at Regional sustainability groups and is linked into sustainability leads in the other London sectors to share best practice. • A sustainability network group has been set up within SEL to bring together operational leads on sustainability from each of the NHS Trusts, the ICB and Bromley Healthcare on a monthly basis to discuss progress.	4	3	12

Risk assurances

- Green plans in place for ICB, primary care, and each Trust. Trusts have resource in place, or are in the process of recruiting, to move forward on delivery of their own Trust targets.
- Sustainability Oversight Board and network groups are meeting regularly with minutes and action logs in place.
- Delivery plan is being used to RAG rate current progress to identify quick wins and areas of concern requiring focus.
- Governance structure agreed by Oversight Board.
- Quarterly reporting mandated by NHS England, which enables monitoring of progress against other sectors in London, once outputs shared.
- c£1m funding committed to sustainability schemes in 2021/22 by SEL CCG with delivery of funded schemes continuing into 2022/23.
- Updates from Trusts indicate good progress on delivery of their own plans, however the current lack of reporting means we cannot report measurable outcomes of the reported successes

Forward view on risk and planned further mitigating actions

- Workstream leads to be finalised and work plans for each workstream to be devised.
- Reporting suite to be developed to provide information to Sustainability Oversight Board on progress, this will enable meaningful discussion and monitoring of progress against targets and identify areas of concern which require Board attention and support.
- Plans in place by APC to recruit an associate director for sustainability and to develop a single team approach across SEL acute trusts to maximise use of expertise for the benefit of the system. SEL ICB requires some dedicated sustainability resource to support the programme.
- Regional Greener NHS team have been engaged to support all sectors in some areas with guidance and co-ordination once-for-London – for example, adaptation plan design and development of a walking aids re-use scheme.
- Potential funding opportunities arise to support delivery, but are dependent on external assessment.
- Current stocktake of the programme position underway to confirm progress and identify challenges to delivery, with a view to recommending the actions and resources required to reset the programme and provide continuing support.

Appendix A: risk scoring matrices

Risk scoring matrices (1 of 3)

The matrices below are taken from the ICB's Risk Management Framework and represent the possible combined risk scores based on a measurement of both the likelihood (probability) and severity (impact) of risk issues. A combination of likelihood and severity score provides the combine risk score.

Likelihood x Severity = Risk Score

			Likelihood				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Severity	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

Likelihood Matrix:

Likelihood (Probability) Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency Time-frame	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency Will it happen or not?	<0.1%	0.1 to 1%	1 to 10%	10 to 50%	>50%

Risk scoring matrices (2 of 3)

Severity matrix

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service Business Interruption	Loss interruption of 1-8 hours Minimal or no impact on the environment /ability to continue to provide service	Loss interruption of 8-24 hours Minor impact on environment / ability to continue to provide service	Loss of interruption 1-7 days Moderate impact on the environment / some disruption in service provision	Loss interruption of >1 week (not permanent) Major impact on environment / sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of service or facility Catastrophic impact on environment / disruption to service / facility leading to significant “knock on effect”
Personal Identifiable Data [Information Management Risks]	Damage to an individual’s reputation. Possible media interest e.g. celebrity involved Potentially serious breach Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team’s reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Damage to a service reputation. Low key local media coverage. Serious breach of confidentiality e.g. up to 100 people affected.	Damage to an organisations reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected.

Risk scoring matrices (3 of 3)

Severity matrix (contd.)

Severity (Impact) Score	1	2	3	4	5
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Complaints / Claims	Locally resolved complaint Risk of claim remote	Justified complaint peripheral to clinical care e.g. civil action with or without defence. Claim(s) less than £10k	Below excess claim. Justified complaint involving lack of appropriate care. Claim(s) between £10k and £100k	Claim above excess level. Claim(s) between £100k and £1 million. Multiple justified complaints	Multiple claims or single major claim >£1 million. Significant financial loss >£1 million
HR / Organisational Development **Staffing and Competence**	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces service quality.	Late delivery of key objectives/service due to lack of staff. Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training.	Uncertain delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory / key training	Non-delivery of key objectives / service due to lack of staff Ongoing unsafe staffing levels or incompetence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis
Financial (damage / loss / fraud) **[Financial Risks]**	Negligible organisational / financial loss (£< 1000	Negligible organisational / financial loss (£1000- £10000)	Organisational / financial loss (£10000 -100000)	Organisational / financial loss (£100000 - £1m)	Organisational / financial loss (£>1million)
Inspection / Audit	Minor recommendations Minor non-compliance with standards	Recommendations given Non-compliance with standards Reduced performance rating if unresolved	Reduced rating Challenging recommendations Non-compliance with core standards Prohibition notice served.	Enforcement action Low rating Critical report. Major non-compliance with core standards. Improvement notice	Prosecution. Zero rating. Severely critical report. Complete systems change required.

South East London Integrated Care System

NHS South East London

Integrated Care Board

Item 7
Enclosure H

Title:	**ICS Delivery of Integrated Community-based Services**
Meeting Date:	**14 September 2022**
Author:	Sarah Cottingham, Executive Director of Planning Sam Hepplewhite, Director of Primary Care
Executive Lead:	Sarah Cottingham, Executive Director of Planning

Purpose of paper:	• An overview of the approach that the SEL ICS will take to the further development and delivery of integrated community based care and how the recommendations set out in the Fuller review will support this development. • The opportunities that this approach will afford us along with some of the challenges we will need to manage. • The proposed approach to the development of an integrated community based service delivery plan and next steps, including the proposed governance and suggested timelines.	Update / Information	
		Discussion	***X***
		Decision	***X***
Summary of main points:	• For South East London the Fuller Review review offers a great opportunity to bring our ICB ambition and strategy for community based care to life and delivering on key priorities aligned to the outcomes set out in the review. • The Local Care Partnerships will lead the development of the integrated neighbourhood teams through that very local level collaboration • SEL ICB will take a system-wide approach to managing integrated urgent care and therefore enable same-day care for patients and a more sustainable model for practices. • The ICS will use its scale and combined power to develop relationships between sectors and to deploy collective resources to support workforce planning and development, digital solutions, estate utilisation and wider infrastructure support. • Taking the opportunity to address the disparities in access to services, health outcomes and experience of care and to tackle variation.		
Potential Conflicts of Interest	None identified at this stage		

Relevant to the following Boroughs	**Bexley**	X	**Bromley**	X
	Greenwich	X	**Lambeth**	X
	Lewisham	X	**Southwark**	X
	Equality Impact	In our approach to design of our system, we are focusing specifically on the need to tackle health inequalities and to work in stronger partnerships with our communities. Once developed the delivery plans will be reviewed to identify the equality impact.		
	Financial Impact	Delivery plans will be reviewed and costed. However there is an assumption that this will be cost neutral after local and nationally agreed growth funding as part of the integrated care strategy to support specific and tangible improvement have been applied.		
Other Engagement	Public Engagement	Each Local Care Partnership will be undertaking a process of public engagement during the development of their delivery plans		
	Other Committee Discussion/ Engagement	The implementation approach was discussed and agreed at the South East London Integrated Care Board Executive.		
Recommendation:	For the Board to: 1. To note the contents of the report 2. Note and endorse the delivery approach, timescales and governance arrangements at both Local Care Partnership and SEL ICB level 3. Commit to the opportunity to be brave and to encourage the SEL system to embrace new ways of working and how care can be delivered in the future, to organise our services for the benefit of our residents and to work together, no matter what part of the system we are in. Enabling our community-based teams, regardless of who they are employed by, to operate as one team. This will require building local leadership capability and capacity. 4. Commit to supporting the Local Care Partnerships to utilise their local relationships, infrastructure and staffing through the delegation agreement to maximise the opportunity 5. Commit to the co-development of a digital strategic roadmap and delivery plan to enable more integrated working, enhance access and empower patients, and proactively address population health needs			

ICS Delivery of Integrated Community-based Services

ICB Board 14 September 2022

1. Purpose

1.1 This purpose of this paper is to provide the Integrated Care Board with:

- An overview of the approach the ICS will take to the further development and delivery of integrated community based care and how the recommendations set out in the Fuller review will support this development.
- The opportunities that this approach will afford south east London along with some of the challenges we will need to address.
- Our proposed approach to the development of an integrated community based service strategic vision, outcomes and objectives and associated delivery plan.
- Next steps, including the proposed governance and timelines.

1.2 The paper provides details of the Fuller review itself to ensure Board members are familiar with the content of and recommendations set out in the review, in the context of a clear alignment across the review and our own aspirations for the delivery of integrated local community based care for south east London residents.

1.3 Whilst we have had a significant focus on the development of community based care in south east London it will be important that we now undertake work across our new Local Care Partnerships to rapidly develop the shared strategic vision, outcomes and objectives that we will collectively sign up to securing, aligned to the process currently underway to confirm the Integrated Care Partnership's overall integrated care strategy and strategic priorities. We will also need to take forward work to support more detailed implementation and delivery planning. This must be aligned to the work we will be doing as an Integrated Care Board to articulate our Five Year Forward View and its annual deliverables, including a detailed focus on the next two years.

1.4 Taking forward our work in this way will ensure that we stay true to the commitments we have made as a Board around delegation, subsidiarity and partnership whilst also ensuring that we are able to define a common vision and set of standards to be delivered across our ICB footprint and for our whole population.

2. Introduction

2.1 In November 2021 the Chief Executive of NHS England, Amanda Pritchard asked Dr Clare Fuller to undertake a review to set out how systems could accelerate implementation of the primary care, out of hospital care and prevention ambitions of the NHS Long Term Plan and drive more integrated primary, community and social care services at a local level.

2.2 In May 2022 the review was published and quite uniquely, with it was a letter signed by each of the 42 Integrated Care Board Chief Executive designates, making a personal commitment to take forward the actions in their own systems and neighbourhoods. This demonstrated the importance of this agenda and the need for systems to coalesce around optimising the opportunities associated with integrated community based services and care.

2.3 For south east London the report is consistent with our thinking in relation to integrated community based care, accepting that with the delegation to new Local Care Partnerships there is now a need for us to rapidly review, refresh and confirm strategic vision, outcomes and objectives. This process must ensure collective buy in to the vision and ambition to which we will commit as a new Board and wider Integrated Care Partnership. We will be working to ensure that the Fuller recommendations are incorporated in to this work and the development and delivery plans we agree in support of it.

2.4 The ICB and wider Integrated Care Partnership give us a real opportunity to build a consensus and ambitious vision and to take collectively agreed steps to realise the transformation opportunities that exist whilst also building a resilient and sustainable community based care model for the future. Incorporating the Fuller review recommendations will help us systematise approaches and outcomes across south east London whilst also responding to local issues, recognising that the pandemic impact followed by recovery priorities such as vaccinations have slowed progress in further developing integrated community based services locally.

3. Overview of Fuller Review - Next Steps for Integrating Primary Care

3.1 The Fuller Review was published in May 2022. In the six months that it took to produce the final report there was a significant amount of engagement with general practice, plus a wide range of other stakeholders, driven by a collective desire to create the right conditions for securing the development, integration and sustainability of primary care.

3.2 The report outlined the current state of primary care as a key context for the recommendations, highlighting teams stretched beyond capacity, with staff morale at a record low. It also highlighted the special relationship that primary care has with its local community, providing a first point of contact for people accessing the NHS and an on-going relationship with local patients and residents.

3.3 The report is supported by a literature review by the King's Fund Levers for change in primary care: a review of the literature (kingsfund.org.uk), with the objective of ensuring the report sets out evidence based recommendations.

3.4 The body of report describes much more than a vision for primary care, setting out a vision for an integrated community based care system spanning general practice/primary care, community services and social care plus elements of secondary care. The recommendations create an environment for systems to build momentum and energy for change, encourages local collaborations by putting aside silo sector approaches and behaviour to work together for and with their collective population.

3.5 The proposed partnership approach to secure integrated neighbourhood teams is intended to drive a community based care offer that addresses some of our key opportunities and challenges, for example integrated same day urgent care, continuity of care and prevention, alongside a collective focus on workforce, estates, population health management and other delivery enablers. All these areas resonate for us in south east London as areas of challenge and opportunity.

3.6 There are a set of detailed and far reaching recommendations both for the Integrated Care Boards and the national bodies in the report. **Appendix one** outlines the recommendations and these are summarised below, noting they represent a combination of delivery expectation and offer, infrastructure and support development and requirements. Again they represent a set of expectations that we would recognise as appropriate and helpful, albeit with a need to focus our efforts on the tangible actions and outcomes that we will wish to secure in relation to each recommendation.

- Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.
- Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sector.
- Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams from all sectors.
- Develop a primary care forum or network at system level and local level.
- Embed primary care workforce as an integral part of system thinking, planning and delivery.
- Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care.
- Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.
- Work alongside local people and communities.

4. The Opportunity

4.1 The Fuller review reinforces the opportunity for our new ICB and its LCPs to develop and bring our ambition and strategy for community based care to life. Our planned

work to secure an agreed overarching approach across our ICS presents us with several important opportunities as summarised below:

- For our Local Care Partnerships to lead the way, building on the work that has started, to secure an agreed strategic vision, outcomes and objectives along with a clear delivery plan to develop integrated neighbourhood teams through a blend of very local level collaboration and system wide work across the ICS to positively impact the outcomes for our residents.
- To enable all south east London residents to receive the same outcomes and standards of care wherever they live and access services.
- For the ICS to use its scale and combined power to develop relationships between sectors and to deploy collective resources to support workforce planning and development, digital solutions, estate utilisation and wider infrastructure support
- To create a system-wide approach to managing integrated urgent care, working through the established pan-borough urgent and emergency care boards, to guarantee same-day care for patients and a more sustainable model for practices.
- For collaborative approaches and integrated working to provide the NHS and wider partners a real opportunity to deliver a more joined up, effective and sustainable offer.
- To improve the experience that residents have of using local services and to build trust and confidence in these services across health and care.
- To create multi-organisational and sector teams working in each community, helping individual PCNs, PCN groupings and teams better manage demand and capacity, building resilience and sustainability.
- To break down some of the traditional barriers between various sectors of health and care due to historic arrangements.
- To address the disparities in access to services, health outcomes and experience of care and to tackle variation.
- To shift the majority of the effort from treating people who have already become sick to providing proactive care and improving outcomes - helping our residents lead more active happier lives.
- To explore and develop novel contractual arrangements that will remove disincentives and barriers that have hindered integration historically and together with incentives and team development enable our neighbourhood teams to thrive.

4.2 Delivering true integration will require all of us to work differently and try new things and we will need to consider the how as well as the what if we are to optimise the opportunities offered through implementing our own vision for community based care and integrated neighbourhood teams. We will need to ensure that we define the expected outcomes associated with taking forward these opportunities, the delivery milestones and tangible actions that will be required to secure specificity and traction. We will also need to consider enabling approaches including investment and funding flows, infrastructure, data and insights, levers and incentives, transformation and change management capacity and capability.

4.3 As a system of systems we have invested heavily in the establishment of Primary Care Networks, geographically aligned to our neighbourhoods and supported by ‘at-scale’

support vehicles – our Federations; and aligned to community and social care teams. To realise the opportunities listed above we will need to convert that co-existence to meaningful integration of service delivery on a population basis. The 35 PCNs the system has created over the past three years serve our neighbourhoods and have the potential to join up primary care with wider community based services at local level, what south east London has referred to as Local Care Networks or Fuller's Integrated Neighbourhood Teams.

5. The challenge

5.1 Alongside the opportunities offered there are also a number of known or potential challenges that we will equally need to be mindful of and take action to manage, to ensure we address barriers as well as identify and secure enablers. Some of the key challenges we will need to mitigate are summarised below.

- A shift towards a psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and the realignment of the wider health and care system to a population-based approach represents a major change in culture and approach – we will need to work to facilitate and support this change.
- Developing the current 35 general practice Primary Care Networks (PCN) we have across South East London into integrated neighbourhood teams that are more than a collection of people who share a cupboard or office space. Recognising that there is variation across the PCNs in size and operating models. The South East London neighbourhood teams will need to meet the needs of their residents by bringing together multi-organisational and cross sector, dedicated, named professionals including specialists from acute, social care, palliative care and public health to work together to get the very best outcomes. This will not only be a challenge for the PCNs but also the wider partners. For example King's College Hospital NHS FT would be working with 18 PCNs across Bromley, Lambeth and Southwark.
- Ensuring that local residents have access to same-day urgent care services - recognising same day urgent care and access represents a major current challenge for our residents and system.
- Enabling a multi-disciplinary team to provide continuity of care for their patients who need it most and supporting the changes in the way services are currently delivered to secure this.
- Reducing silo approaches and the number of hand offs and referrals between sectors across primary, community, acute and tertiary services to secure joined up, seamless and integrated service offers that reduce complexity and make services accessible.

5.2 The table below provides some context to the challenge and complexity of securing integrated neighbourhood community teams across our patch, noting that in addition to complexity associated with the portfolio provision we are also faced with current variation across primary care and community service offers, driven by a range of factors including historic commissioning decisions, investment, resourcing and staffing.

5.3 Conversely it conveys the huge opportunity to align and embed the resources of our Providers (and Councils) in Neighbourhood teams if we are able to develop and balance the right blend of core and bespoke offer.

	GP Practices	Federations	PCNs	SEL main acute provider	Community services provider	Mental Health Provider
Greenwich	30	2	6	LGT	Oxleas	Oxleas
Bexley	21	1	4			
Bromley	43	1	8	KCH	Bromley HC	
Lewisham	27	1	6	LGT	LGT	SLaM
Southwark	33	2	2	GSTT/KCH	GSTT	
Lambeth	41	1	9			

6. Implementation Approach

6.1 In SEL the development and delivery of primary care and community services plus joint working on social care with Local Authorities is delegated to our six Local Care Partnerships through Place Executive Leads. We will wish to reflect this delegated responsibility in our development and implementation approach whilst also ensuring a pan borough and system overlay where it makes sense to do so e.g. ensuring we adopt appropriate subsidiarity in our approaches.

6.2 It is therefore anticipated that the implementation model will need to take forward our development planning across three key footprints:

- Our six Local Care Partnerships (borough), with these LCPs working with and supporting the borough based Primary Care Networks and their transition to Integrated Neighbourhood Teams.
- Collaboration across two or more of the Local Care Partnerships.
- South East London ICB wide – where a system level framework or infrastructure and development is required alongside areas where a pan LCP approach is optimal to support shared learning.

6.4. The Fuller review describes a model of integrated care. Overlapping this are a range of national priorities which the ICB, often through places, will need to deliver. We will therefore need to recognise in our work that these priorities should be delivered in line with the Fuller model to be successful and to enable a placed based unifying strategy.

6.5 We will need to review and confirm our strategic vision and ambition to inform the development of a community based care implementation plan through our Local Care Partnerships which will incorporate the 8 ICB recommendations set out in the Fuller report. The plan will be made up of the six Local Care Partnership plans plus the further actions required by the system through the ICB with all plans aligned to the recommendations, underpinned by a collectively agreed vision and set of common standards and outcomes.

7. Governance

7.1 Each Local Care Partnership (LCP) will have a Community Based Care and Fuller implementation forum, which with oversee the implementation of the delivery plan. This forum will report regularly on progress and any associated risks to the LCP Board.

7.2 A SEL Placed Based Care Board will be established which will enable collaboration between place-based partnerships and SEL programmes to support transformation of out of hospital community based care and the delivery of shared outcomes and standards for our population, across South East London.

8. Next Steps

8.1 This section sets out a number of next steps focussed again on our work to address the Fuller report recommendations, recognising the need for clarity in this area. We will however also wish to dovetail the outputs with our wider work around our integrated care strategy and within it the vision for integrated community based teams. We will also need to dovetail our implementation and delivery plan with our wider Five Year Forward View and operational planning processes. The October and December 2022 outputs described below will therefore feed in to these wider processes and outputs.

8.2 The Fuller related next steps are therefore to:

- Complete the six Local Care Partnership (LCP) initial delivery plans (noting there may be some changes once a gap analysis is completed) and incorporate them into one overarching SEL delivery plan by the 21 October 2022.
- Complete the system wide initial delivery plans and incorporate them in to the overarching SEL delivery plan by the 21 October 2022
- Undertake a gap analysis of the requirements to implement the plan for both the enabling functions of the ICB, system wide and LCP specific actions by the 2 December 2022.
- Ensure all governance arrangements are in place including the establishment of the SEL Place Based Care Board and the LCP forums by the 1 October 2022.
- Co-design between ICB and LCPs an outcomes framework, which will include the common characteristics of the service and associated outcomes, which all residents of South East London can expect to receive by the 2 December 2022.
- Consider the development that is required both within and across organisations that will have teams working in integrated models. Integration fails to often because staff work under the autonomy and within the culture of their own organisation rather than as part of an integrated team.

9. Recommendations to the Board

9.1 To note the contents of the report.

9.2 Note and endorse the delivery approach, timescales and governance arrangements at both:

- Local Care Partnership
- SEL ICB level

9.3 Commit to the opportunity to be brave and to encourage the system to embrace new ways of working and how care can be delivered in the future, to organise our services for the benefit of our residents and to work together, no matter what part of the system we are in. Enabling our community-based teams, regardless of who they are employed by, to operate as one team. This will require building local leadership capability and capacity.

9.4 Commit to supporting the Local Care Partnerships to utilise their local relationships, infrastructure and staffing through the delegation agreement to maximise the opportunity.

9.5 Commit to the co-development of a digital strategic roadmap and delivery plan to enable more integrated working, enhance access and empower patients, and proactively address population health needs.

Appendix One – Framework for Shared Action

1	Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face	**ICS**
2	Assist systems with integration of primary and urgent care access, specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice	**NHS England**
3	Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards	**ICS**
4	Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multi professional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	**ICS**
5	Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.	**ICS**

6	Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	**ICS**
7	Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England). Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce	**DHSC with NHS England and HEE**
8	Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead. Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision making on any future discretionary investment, beyond DDRB and pay uplifts.	**NHS England**
9	Improve data flows including by (i) solving the problem of data sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams	**NHS England**
10	Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.	**ICS**
11	DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues, and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	**DHSC and NHS England**
12	Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider	**ICS**

	collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	
13	Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	**ICS**
14	In support of systems, set out how the actions highlighted for NHS England will be progressed	**NHS England**
15	DHSC and NHS England should rapidly undertake further work on the legislative, contractual, commissioning, and funding framework to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes	**DHSC and NHS England**

Integrated Care Board

Item: 8
Enclosure: I

Title:	**NHS South East London CCG Annual Report and Accounts 2021/22**
Meeting Date:	**Wednesday 14 September 2022**
Author:	David Maloney, Director of Corporate Finance Simon Beard, Associate Director for Corporate Operations
Executive Lead:	Mike Fox, Chief Financial Officer

Purpose of paper:	Following the closure of the accounts of NHS South East London CCG (SEL CCG) for the year ended 31 March 2022, this report is submitted to a meeting of the Integrated Care Board held in public, following the disestablishment of the CCG.	Update / Information	**X**
		Discussion	
		Decision	

Summary of main points:	The attached paper summarises the key headlines of the annual report and the final audited financial position for SEL CCG for the period 1 April 2021 to 31 March 2022. Given that SEL CCG was disestablished on 30 June 2022, this report is submitted to the Board of the Integrated Care Board in lieu of an annual general meeting of the CCG. The annual report and accounts were submitted to NHS England in draft form on 25 April 2022, and following external audit by KPMG, were submitted as final annual accounts to NHS England on 21 June 2022, in line with national timescales. The annual accounts demonstrated that all financial targets and duties for the year had been delivered. An unqualified opinion was given by our external auditors on the annual accounts.			
Potential Conflicts of Interest	None			
Relevant to the following Boroughs	**Bexley**	**X**	**Bromley**	**X**
	Greenwich	**X**	**Lambeth**	**X**
	Lewisham	**X**	**Southwark**	**X**
	Equality Impact	n/a		
	Financial Impact	The Board is asked to note the final financial position reported for the year ended 31 March 2022.		

Other Engagement	Public Engagement	The annual report and accounts have previously been discussed at a meeting held in public of NHS South East London CCG's governing body.
	Other Committee Discussion/ Engagement	The annual report and accounts were considered and approved for submission by the CCG audit committee and have been presented previously to the CCG governing body.
Recommendation:	The Board is asked to **note** that the annual report and accounts is presented at this meeting in accordance with guidance received from NHS England.	

NHS South East London CCG annual report and accounts for the year ended 31 March 2022

ICB Board 14 September 2022

1. Introduction

1.1 The purpose of this paper is to provide to the Board an overview of the key highlights of the annual report and accounts process for NHS South East London CCG (SEL CCG) for the year ended 31 March 2022.

1.2 Following dis-establishment of the CCG on 30 June 2022, this report is required to be submitted to and received by the Board of the CCGs successor organisation at a meeting held in public.

2. Process

2.1 A draft annual report and accounts for 2021/22 was submitted to NHS England on 25 April 2022, in line with NHS England guidelines.

2.2 The final audited annual report and accounts for 2021/22 were submitted to NHS England on 21 June 2022, following review and sign off by the CCGs external auditors. This document was then published on the SEL CCG website by the deadline date of 30 June 2022.

2.3 This was the final full year annual report and accounts for NHS South East London CCG, following the establishment of Integrated Care Boards from 1 July 2022. A CCG report and accounts will be produced for the period 1 April 2022 to 30 June 2022, as per NHS England guidance, with a draft report for this period to be submitted to NHS England in early October.

3. Performance

3.1 The annual report comprises a “performance summary” section, which provides a high level overview of the performance of the system in the year, and a “performance analysis” section which includes detailed commentary on the activities carried out and achievements delivered in the year by the CCG to meet its statutory obligations and ensure the residents of south east London received high quality NHS services.

A summary of the performance reported for acute and mental health services in south east London is detailed below:

Acute performance

Metric	Standard	SEL CCG		SEL Trusts	
		March 2022	March 2021	March 2022	March 2021
RTT 18 week wait performance	92%	68.8%	68.4%	68.2%	67.4%
RTT 52 week wait performance	0	3,818	9,537	4,240	13,915
RTT 104 week wait performance*	0	100		112	
Diagnostics 6 week waits	1%	6.1%	19.6%	6.6%	22.3%
A&E 4-hour performance**	95%			69.3%	88.3%
Cancer 2 week waits	93%	82.1%	93.9%	81.3%	93.9%
Cancer 62 day waits	85%	71.0%	69.5%	68.7%	68.7%
Cancer 28 day faster diagnosis standard	75%	71.5%	73.4%	71.4%	73.6%

Mental Health performance

Metric	2021/22 Target	Period	Latest position	March 2021
IAPT access rate	6.9%	Q3 2021/22	4.6%	4.6%
IAPT recovery rate	50%	Feb 2022	50.9%	55.1%
Dementia diagnosis	66.7%	Mar 2022	69.1%	66.6%
SMI physical health checks	60%	2021/22	33.4%	21.7%
CYP access	35%	Feb 2022	37.5%	33.5%
CYP eating disorder wait times – routine	95%	Mar 2022	41.2%	82.2%
CYP eating disorder wait times – urgent	95%	Mar 2022	27.3%	42.9%
OAP bed days	0	Feb 2022	1,035	2,085
EIP waiting times	60%	Feb 2022	65.2%	68.7%

3.2 Other successes during the year that were highlighted in the annual report included:

- Success of the Covid and Flu vaccination programmes in south east London
- Engagement with the local community to identify priorities and develop strategy
- Significant progress in implementing the CCG's Equality Delivery Plan
- The continuing development of our Local Care Partnership arrangements
- Innovations to deliver care to people in their homes and local communities
- Publication of a sustainability plan across the ICS
- Preparations for the establishment of South East London Integrated Care Board from 1 July 2022

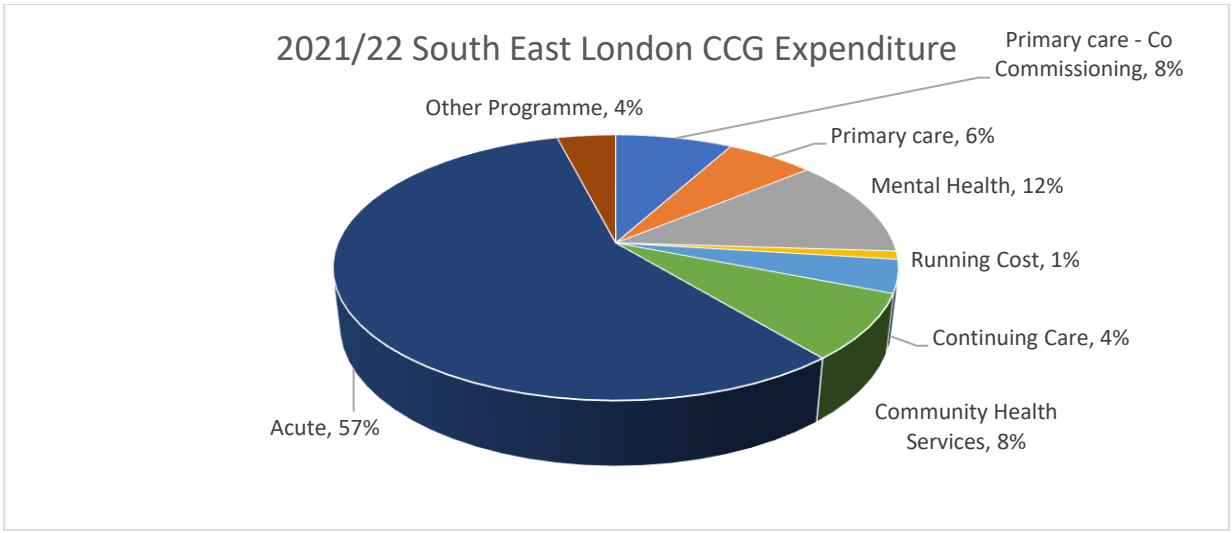
Full details of these and other activities that took place in the year are available in the annual report, which can be obtained via the SEL CCG website at https://selondonccg.nhs.uk/what-we-do/our-publications/annual-reports-2021-22/

4. 2021/22 Financial performance

4.1 In accordance with the national NHS year-end timetable, the audited 2021/22 Annual Accounts for the CCG were submitted by 21 June 2022, following review and approval by the CCG's Audit Committee on 15 June 2022.

4.2 Total CCG expenditure for the financial year was £4,088.7m against a target of £4,089.2m. Therefore, the CCG delivered its target of break-even; the final audited underspend for the year was £0.462m (0.01% of allocation).

Circa 1% of the total budget was spent on running costs, with 99% therefore spent on patient and clinical services. A high-level breakdown of the spend is shown in the pie chart below:



4.3 The 2021/22 Annual Accounts for the CCG also show that all other financial targets and duties for the year have been delivered, including:

- The duty to remain within maximum cash draw down levels;
- The duty to remain within the Running Cost Allowance. Total CCG administrative expenditure for the financial year was £36.602m against a target of £36.863m. Therefore, the CCG delivered its target of administrative costs being within its running cost allocation; the final audited underspend for the year was £0.261m;
- The requirement to meet the Better Payment Practice Code, namely to pay 95% of suppliers within 30 days.

5. 2021/22 External audit opinions

5.1 The 2021/22 Annual Accounts were audited by KPMG, our external auditors.

5.2 We are pleased to report that the CCG received unqualified audit opinions. These are summarised below:

- **Financial Statements** – the auditors issued an unqualified opinion on the CCG's 2021/22 Annual Accounts. This means that the Accounts gave a true and fair view of the financial affairs of the CCG and of the income and expenditure recorded during the year. The auditors did not identify any unadjusted audit differences.
- **Regularity** – unqualified opinion issued. This means that the auditors reviewed the CCG's expenditure and income, and, in their opinion, it was applied to the purposes intended by Parliament.
- **Value for Money** - unqualified opinion issued. The auditors are required to report if there are any matters that indicate the CCG did not have sufficient arrangements to achieve Value for Money; the auditors had nothing to report in this regard.

6. Conclusion

6.1 The Board is asked to note the report on the submission of the annual report and accounts of NHS South East London CCG for the year ended 31 March 2022.

South East London Integrated Care System

NHS South East London

NHS South East London – Understanding system language

September 2022

Understanding system language

NHS South East London

Integrated Care Systems (ICS)	The full range of organisations – the NHS, our local authorities, the voluntary, community, social enterprise (VCSE) sector, that play a role in organising and providing health and care in south east London and need to work together to better serve local people.
NHS South East London Integrated Care Board (ICB)	A group of senior leaders appointed from across our health and care system responsible for allocating resources, high-level planning and overseeing the performance of our health and care system. The NHS South East London ICB is the legal name for the board and the public name for the ICB is NHS South East London.
Integrated Care Partnership (ICP)	A group of senior leaders including representatives of the Integrated Care Board, our local authorities, our NHS providers, the VCSE and Healthwatch with specific responsibilities for helping to set and oversee strategic direction for our system.
Provider Collaboratives (PCs)	Partnerships between groups of NHS providers such as our acute providers and our mental health providers, responsible for working together to make better use of resources and improve the quality of more specialist services.
Local Care Partnership (LCP)	Partnerships between our local authorities, NHS organisations and the VCSE in our boroughs responsible for developing and overseeing out of hospital care.
Primary Care Networks (PCNs)	GP practices working together with community, mental health, social care, pharmacy, hospital, voluntary, community and social enterprise services in their local areas.