Inner North East London Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Council, Chamber,
Hackney Town Hall,
Mare St, London E8 1EA

Date of meeting: Thu 15 Dec 2022 at 7.00pm

Chair	Councillor Ben Hayhurst (Hackney)
Members in attendance	Councillor Kam Adams (Hackney) Councillor Ahmodur Rahman Khan (Tower Hamlets) Councillor Anthony McAlmont (Newham) Councillor Sharon Patrick (Hackney) Common Councilman David Sales (City of London) Councillor Richard Sweden (Waltham Forest)
All others in attendance remotely	Councillor Beverley Brewer (Redbridge) (ONEL Observer) Councillor Catherine Deakin (Waltham Forest) (Vice Chair) Councillor Susan Masters (Newham) Cllr Harvinder Singh Virdee (Newham) Rt Hon Jacqui Smith, Chair in Common Barts Health-BHRUT Shane DeGaris, Group Chief Executive, Barts Health-BHRUT Paul Calaminus, Chief Executive, East London NHS FT Jacqui Van Rossom, Chief Executive, North East London NHS FT Breeda McManus, Chief Nurse/Dir Governance, Homerton Healthcare Marie Gabriel CBE, Independent Chair, NHS NEL Zina Etheridge, Chief Executive, NHS NEL Diane Jones, Chief Nursing Officer, NHS NEL Henry Black, Chief Financial Officer, NHS NEL Hilary Ross, Director of Strategic Development, NHS NEL Malcolm Alexander, Board Member, Healthwatch Hackney Ashleigh Milson, Senior Public Affairs Manager, NHS NEL Jilly Szymanski, Scrutiny Officer, Redbridge Council
Member apologies:	Councillor Abdul Malik (Tower Hamlets) Councillor Ahmodul Kabir (Tower Hamlets) Councillor Afzal Akram (Waltham Forest)
YouTube link	The meeting can be viewed here: https://youtu.be/Q6IuL4Q-QP8
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1. Welcome and apologies for absence

1.1 Apologies for absence were received from Louise Ashley (CE, Homerton Healthcare) who would be represented by Breeda McManus (Chief Nurse and Director of Governance).

1.2 It was noted that Cllrs Deakin, Masters, Virdee and Brewer were joining remotely. The Chair welcomed Common Councilman David Sales (City of London) to his first meeting.

2. Urgent items order of business

2.1 There were none and the order of business was as on the agenda.

3. Declarations of interest

3.1 Cllr Masters stated she was employed as Director Health Transformation by Hackney Council for Voluntary Services, in a post funded by NHS NEL.

4. ICS Strategy - Draft

4.1 Members gave consideration to a briefing paper *NEL Integrated Care Strategy development.*

4.2 The Chair stated that this was discussed at the previous meeting and this would be a further update and the full document was about to be submitted to NHSE.

4.3 The Chair welcomed for the item:
Zina Etheridge (**ZE**), Chief Executive Officer, NHS NEL
Hilary Ross (**HR**), Director of Strategy, NHS NEL
Breeda McManus (**BM**), Chief Nurse and Director of Governance, Homerton Healthcare
Diane Jones (**DJ)**, Chief Nursing Officer, NHS NEL

4.4 ZE and HR took Members through the paper. It was noted that there had been systems wide workshops to develop the content and it had involved all the health and wellbeing partnerships. Recognising the backdrop of the cost of living crisis was going to be key as there will be a need to focus on the rising impact of poverty. The Strategy sets out a context and case for change, lays down priorities for system action and it puts together more measurable outcomes which will be tracked. There are 6 themes: *Health inequalities; focus on prevention and early intervention; more holistic, personalised and trauma informed care; co-production with local people and partners; working towards a high trust environment across the system* and *working as a learning system*. It will provide a clear direction for the funding planning round and the local response to the 5 year National Plan. They would also be planning a 'Big Conversation' with residents and stakeholders to highlight it further.

4.5 The Chair asked whether there is an underlying dataset which can form the basis of future comparisons. HR replied that they had not completed work on the KPIs to be used. The work is based on a number of datasets. She added that they have a Population Health Profile across NEL which gives a good picture on prevalence and wider determinants. They are building on use of indicators for

items they already have data on so that outcomes can be carefully tracked. The Chair asked at what point will they lock down a dataset against which they can judge performance and HR explained that a mix of longer term outcomes and shorter term metrics will be built into the forward plan and there will be close clinical input to this.

4.6 Cllr Sweden asked whether there are implications for a re allocation of resources and what those might be. HR replied that the Financial Strategy will say more about how they are going to move resources to focus on prevention and health inequality. ZE added that they will first need to work out how they are to move resources into prevention and the Strategy is aiming to do this.

4.7 Common Councilman Sales asked about the 31% having Long Term Conditions and who defined these. HR explained that LTCs refer to conditions such as cardiovascular disease or COPD or diabetes which, broadly speaking, are not curable. Some are preventable so they focus on how to manage them. LTCs refer to a generally agreed set of conditions which are ongoing and a GP would diagnose them in the first instance.

4.8 Cllr Adams asked how the Strategy will deal with Staff Retention and the 23% churn rate. HR replied that the focus is on expanding the workforce and on a local employment strategy. ZE described the pressures on the staff over the last three years, in particular the pandemic, and how they are looking at having more seamless career pathways so staff starting in social care can move easily to other posts in care but also in the health system. They are also looking at how to drive up local recruitment and looking at best practice in comparator Trusts.

4.9 Cllr Patrick asked about overseas staff not feeling fully supported/valued. BM described the operation of the Capital Nurses Programme. More was being done to recognise staff's past experience and to develop better career pathways. More were now being promoted especially in specialist areas. Housing remained a key challenge. DJ explained how the recruitment process from overseas operates and discussed staff support for foreign staff and encouraging social networking amongst them. She described how overseas recruitment is a national programme and pastoral support for internationally recruited nurses was key. Building up social networks help them feel connected and rooted. The did not wish to take health care staff from countries with shortages so a balance has to be struck. ZE replied that it was preferable to retain the staff they've got than rely on recruitment. She added it was really important too that foreign nurses feel valued.

4.10 Cllr McAlmont asked if we were depleting the health systems of less developed countries by our recruitment drives. DJ replied that under the programme there were only certain countries they could recruit from. She added that they cannot recruit from countries where there is shortage and an international agreement has to be in place. The Key Worker programme was in place to support and welcome nurses. On housing it varied, many wanted to stay together and they supportedthem to secure affordable accommodation.

4.11 The Chair thanked ZE and HR for the briefing and added that it was good to see that it was now a much more fleshed out document. He asked if the final submitted version could be shared with members.

ACTION:	**NHS NEL CE to provide Members with a copy or link to the final version of the *NEL Integrated Care Strategy.***

5. What we are doing to improve access, outcomes, experience and equity for CYP and young adults' mental health

5.1 Members gave consideration to a joint briefing from ELFT and NELFT on *What we are doing to improve access, outcomes, experience and equity for children, young people and young adults (0-25s)*

5.2 The Chair welcomed:
Paul Calaminus (**PC**), Chief Executive, ELFT
Jacqui van Rossom (**JV)**, Chief Executive, NELFT

who took Members through the presentation. PC explained that Services were planned and delivered in partnership with others (education, social care, VCS) and he highlighted the work on developing core therapy services, eating disorders service and the various crisis services.

5.3 The Chair stated that a public question has been received. Malcolm Alexander (Board Member, Healthwatch Hackney) asked the following:
Will NHS NEL give a commitment in their strategy to take action to prevent patients in a mental health crisis from ever having to wait more than 4 hours from decision to admit to admission to a mental health bed.

Will they also give a commitment to the prevention of young people and children being sent outside their home borough for mental health crisis care?

5.4 In response to MA's question on out-of-borough placements, PC stated that there were 4 units for young people from NEL and NCL and they were being treated in local CAMHS units. These were not borough specific. There were 2 units in NEL which allowed young people to be treated closer to their families. He detailed development plans and described the huge impact the pandemic had on children and young people's mental health causing a spike in demand. NEL was spending more proportionately than is nationally allocated for CYP but the demand graph was stark and there was further to go to meet the need in the population. He described the co-production approach to supporting the 18-25 age group and the benefits of the Advantage Mentoring Programme in NEL.

5.5 In response to MAs question on mental health delays in A&E, PC stated that they wished to return to a position where they always have an emergency bed available for everyone who was deemed to require it. There was an issue about the increased acuity of the presentations partly as a result of the pandemic and

this had contributed to the recent spike but they were working hard to achieve the targets and timescales they had set for themselves here.

5.6 The Chair asked what was the waiting time for assessments. PC replied that for routine cases it was 21-22 days.

5.7 Cllr Brewer expressed concern about these waiting times and asked about the workforce challenge of securing more psychiatrists. PC explained that for the long term they were maximising their number of training places and optimising career pathways and in the shorter term developing new types of extended nursing and therapy roles who would be able to take on some of the workload. They were also developing Peer Support roles and working more with people with lived experience of therapies which was having great results for in patient services. Keeping and growing CAMHS staff was a challenge and they were working across the CAMHS collaboratives and workstreams to create more jobs with career development potential. There was also work being done on developing short term roles in Digital areas of support.

5.8 The Chair asked about delays in assessment times at designated 'Places of Safety' such as the Homerton and he asked if young people have a separate care pathway. PC confirmed that they did. He added that the key challenges were long duration of stays and people having to be sent outside London and the focus was on getting those back. Those who require beds are currently getting them but some young people, at transition stage for example, can be affected by this current blockages.

5.9 The Chair asked whether ELFT had the opportunity to flex their existing estate. PC explained that one of the advantages of working within a Collaborative was that they can flex demand across 4 units across NEL and NCL. This creates more capacity and a more advanced Home Treatment Offer to be made available. JV advised that the cohort being discussed here was a very complex one with many comorbidities e.g. eating disorders etc, and so the solutions needed will be more challenging to provide. She added that beds for these more complex cases do not sit within the local Collaborative's allocation. It wasn't that we don't have the capacity within our general adolescent units but it's rather that presentations are more complex and, if for example they are Looked After Children, they will have to be placed within NEL.

5.10 Cllr Adams asked about IAPT and early intervention in psychosis. PC detailed the services and that there is specific age-tailored support for 18-25 year olds with anxiety, depression and psychosis. They go to the Community Mental Health Team services which are generic. In Newham, Tower Hamlets and Waltham Forest they have to work more with CMH Teams to develop age specific services. He added that those services see few in their 20s. He concluded that an ongoing task is to develop general CMH Teams connected to GPs and those services need to be better able to speak to the younger cohorts.

5.11 Cllr Deakin asked how many young people were currently being supported via the Alternative At Home service and about plans on enhancing Mental Health support in schools and the risks and challenges involved. PC undertook to provide the data. He added that the teams are quite intensive, typically 15-20 patients and they deliberately work with those on the cusp of hospital services. The work to expand into schools is a national programme and they do not cover all schools so there has to be a selection.

ACTION:	**PC to provide data on the numbers supported via the Alternative At Home service.**

5.12 Cllr Sweden asked how confident officers were that A&E backup across NEL was adequate and whether S136 scenarios also applied to young people. PC replied that they did. On work with police, he highlighted a particular project with the City of London where there is a dedicated Street Triage Team with mental health professionals and the Police on the streets at night. This has really helped and they are talking to the Met Police on possibly expanding it. They do a lot of work with the Met on S136 cases and Police have access to Crisis Line Mental Health services so they can be called in quickly and a plan can be put in place. As regards support at A&E, there are a range of home services and intensive support to help people out of A&E. He reminded Members that A&E is not the main route for mental health crisis presentations or admissions to hospital; the majority come via crisis services, crisis lines or are known to services already. Referring to the chart in the report he stated that it was clear there was a gap between prevalence and demand and funding the capacity needed to bridge that gap would always be a challenge.

5.13 The Chair thanked the officers for the quality of their presentation and their thoughtful work on these complex issues. On the A&E beds issue he stated that they would endeavour to keep an eye on this at Hackney's HOSC and get an update for a future meeting if necessary and will revisit to see if the injection of capacity has been having a positive impact..

RESOLVED:	**That the report and discussion be noted.**

6. NHS North East London Health Updates

6.1 The Chair explained that this item allowed us to hear updates from the key local trusts. He welcomed for the item

Shane DeGaris (**SD**), Group Chief Executive Barts Health/BHRUT
Breeda McManuse (**BM**), Chief Nurse and Director of Governance for the CE of Homerton Healthcare
Paul Calaminus (**PC**), Chief Executive, ELFT
Jacqui van Rossom (**JV**), Chief Executive, NELFT

6.2 Members gave consideration to the report *North East London Health update* and the Homerton's additional slide which was tabled.

6.3 SD gave Barts Health's update focusing on: *planning for winter; elective patient recovery, and on staffing and workforce*. There were still great pressures on A&E departments and a lot of work was going on with the Place Based Partnerships to speed up discharges of care, this being compounded by the cold weather and various strike actions. The latter weren't having a direct impact in east London but there would be indirect impacts from the London Ambulance Service's forthcoming strike. On Elective care, most of the 2 yr plus long waits had now been cleared and they were moving on to clear 78 and 52 wk waits. On staffing they had now insourced their Soft Facility Services. Barts had also won a discharge award for work with heart patients. Good work was also taking place at the new hub at King George's. The CQC had visited A&E at Barts and performance was variable but they were looking at each stage of the flow. On the staffing front they had welcomed a new senior officer focused on Equality and Inclusion.

6.4 BM gave the Homerton Healthcare update. They'd seen a rise in ED attendance combined with wider pressures in the system and they also saw a lot of patient walk-ins. They do have ongoing staffing challenges and they have experienced a dip in performance on the 4hr waits at A&E and so are looking at flow and pathways. They're also focused on discharge so they can improve flow through the hospital. One of the challenges is admitting out of area patients which makes it more challenging to discharge them and this impacts on flow. Lousie Ashley had now completed her second month as the new Chief Executive. On staffing they're trying to reduce the vacancy rates and have introduced some new financial wellbeing support for the staff and she added that 70 overseas nurses had joined since June.

6.5 The Chair asked about the financial impact of insourcing Soft Facilities Management. SD replied it would cost more money because they would be paying comparable Agenda for Change rates as with other staff but it was the right thing to do and would generate efficiencies over time.

6.6 Cllr Brewer asked about poor A&E 4hr waits at BHRUT vs Homerton and what role ICS might have here. SD replied that they do share best practice and across NE acute trusts but the trusts vary considerably. The Homerton has fewer ambulances attendances than Queens and the nature of the care in the community across the various boroughs varies significantly. He added that hospitals that occupy the outer ring of London struggle more with A&E. They do share best practice and implement the learning and hospitals that don't have discharge problems will do better on A&E performance. ZE added that the Acute Provider Collaborative is there to take action to tackle these variations but the sites are very different. Queens is the 4th busiest in London and 12th in the country. The work that was done in City and Hackney over many years in primary care and community care and in Neighbourhoods development was vital

in reducing attendances in A&E and why the Homerton has done better here. It is a whole system issue.

6.7 The Chair asked what the CQC had recently concluded about Queens' A&E. SD replied that the departments were just too congested. He had asked the system leadership to a Quality Summit on this the following week and he hoped that this collaborative approach would bear fruit.

6.8 The Chair thanked the Chief Executives for their updates and their attendance.

RESOLVED:	**That the reports be noted.**

7. Financial Strategy for the ICS

7.1 The Chair stated that he had invited the Chief Financial Officer of the ICS to this meeting to discuss the financial strategy, following up on issues raised at recent meetings.

7.2 He welcomed to the meeting: Henry Black (**HB**), Chief Finance and Performance Officer, NHS NEL.

7.3 Members gave consideration to a report *NEL Financial Strategy Update*.

7.4 HB took Members through the report in detail. It covered the following themes:

- *Context – How we've used our budget in 21/22 and 22/23*
- *Comparison of spend on different types of care, by place (22/23 budget)*
- *The ambitions of our financial framework*
- *We face significant challenges, both now and over the longer term*
- *Moving to a population-based approach*
- *Reflecting the costs of care provision to support partnership working*
- *Creating headroom for investment*

He stated how the ICS represents a profound change from that past when health and social care worked separately and the NHS worked within an internal market which incentivized competition rather than collaboration. The Financial Strategy was about devising a way of making the funding work at Place level and it was tied into the Accountability Framework. The Place Based Partnerships (PBPs) are brand new entities which are non statutory but which sit within the statutory ICB. It will take time to mature and ensure they have the resources they need. There will be some aggregation of back office functions at NEL as would be expected and the 7 Delivery Directors at Place Level will have business partners from analytics and finance to assist them. Subsidiarity is the main principle and the Financial Framework will give PBPs responsibility over the majority of the budgeting. The Acute and Primary Care Collaboratives will manage their budgets but everything else will go to Place. There will be full

visibility of the entirety of spend at Place level. There will be opportunities to make decisions about shifts of resources in the various pathways. The Financial Framework will also secure funds for investing in prevention and transformation and they are trying to ring fence 1% for transformation.

7.5 The Chair thanked HB for a very helpful presentation and stated that Members need an understanding of the new financial system from April '23 and to what extent will the different 'Place Based Systems' within NEL have the staff resource to research and make their own decisions or will all the staff be at ICS level. He also asked how the projected £42m deficit (discussed at the previous meeting) was being brought under control. HB replied that some reporting in the press was not reflective of where they were at. At month 8 it's similar to the rest of the country. Everywhere was financially challenged and the NHSE position was to aim for balance. A deficit of around £30m should be absorbed by NHSE, he added. There was a need for a clear stabilisation of run rate in the second part of the year. The financial overhang of Covid funding in the first part of the year was now largely stabilised in the second half. Inflation and winter pressures were creating huge pressures. The Chair stated it would not be in NHS NEL's interest to be the worst in the country. HB replied it wouldn't.

7.6 Cllr Masters asked about the Local Accountability Framework. HB replied that he would be happy to bring this document to a future meeting when it's ready. The NEL ICB is a statutory body but the PBPs are where the partnership work takes place close to the community and the LAF will outline what will happen at each level. Again the principle is subsidiarity. There is a need within the overall £4bn budget to reduce the need for unwarranted variations and reduce health inequalities and how the PPBs hold the centre to account for that will be outlined in it.

7.7 The Chair asked how many staff will be Place level vis-a-vis the centre. City and Hackney for example had c. 26 FTEs and how many of these would remain at Place level? HB explained that it will be one senior member of staff and a team to support them. It will be important to balance the small local team who work closely with their local authority with their role in the centre. It won't be massively skewed one way or the other and the detail can be brought back once agreed. ZE added that there will be a core team in each borough but it will vary depending on whether they are NHS or joint appointments and this is entirely appropriate as it builds on what was already in place. In addition there will be Clinical Director and Primary Care Improvement Lead for each Place.

7.8 Cllr Adams asked what is known about the settlement for 23/24. HB replied that a population health approach is focused on an analysis of patient need as opposed to in the past when hospitals were funded just on volume of work they do. Under Payment By Results it didn't matter who the patient was or where they came from, it was all volume driven activity based funding and they were trying to move away from that, he added. It was also important however to ensure stability and that hospitals are funded for their costs. On the issue of financial constraints, the whole public sector was facing enormous challenges.

Barts Health has a big issue with hyperinflation on utilities and PFI costs and we don't yet know what the NHS NEL financial settlement is for 23/24 and will probably get it, as is often the case, as late as 23 Dec. He added that he didn't expect the settlement to be inflation busting but it would be very tight.

7.9 Cllr McAlmont asked about NHSE potentially writing off up to £30m NEL deficit and plans to balance the budget. HB explained that that is how NHS funding works. It has a budget for its entirety. Some parts may over spend and some underspend in-year and as long as that works through nationally there are a set of agreements. From an accounting perspective the organisation has to record a deficit in its balance sheet but it's not the same as with private businesses that has to go into debt. Cllr McAlmont questioned whether there was no incentive to not incur deficits therefore. HB stated that the incentive would be for the organisation not to go into Financial Special Measures as that is incredibly onerous and challenging. In NEL's case £30m is less than 1% of total budget and they will be expected to land a balanced budget for next year. To achieve balance there are short and long term measures in place. At the halfway point there had been a projected deficit of under £50m which if extrapolated to the year-end would be £100m but they have pulled back and there has been a significant improvement in the run rate in-year. In the medium to long term their Financial Strategy is to focus on prevention and on early intervention to reduce costs further downstream. Other than that they are always engaged in cost improvement programmes and every year they implement cost efficiency programmes to bring themselves back to balance.

7.10 The Chair asked how a return of some form of Payment By Results (PbR) squares with Place Based working. HB stated that they developed the Financial Strategy on the basis that they wouldn't return to PbR but there has been a growing sense that it might return to some form of it. The expectation is that it won't be the same and it will involve a greater focus on reducing long waits in elective care, as there is a need to divert more resources to that. They were assured however that it won't be a return to everything being volume driven but rather that there is likely to be some element of volume based payments.

7.11 The Chair commented that didn't Payment by Results work against the idea of all hospitals within an ICS working together. HB replied that what it would do is make it easier to shift resources around where they have mutual aid and high volume low complexity work which helps to reduce the waiting lists. In some cases being able to shift the money where the patients are will help but it won't be a return to the old days of a trading system.

7.12 The Chair asked whether the 3.4% increase 21/22 to 22/23 was a real term decrease. HB stated that on a like for like basis it was a real term cut but that's the nature of public sector funding during inflation. He added that 21/22 was a high year for additional Covid funding, that got reduced in 22/23, so that 3.4% increase was more like 5%. He added that he expected that the settlement for 23/24 will be a reduction of the Covid spend but an increase for inflation and

higher population growth. It will probably work out at 2.5-3% when you take all that into account.

7.13 The Chair asked what budget line items would get devolved down to Place. HB replied essentially everything other than the spend for the Acute and Mental Health collaboratives. The Community Collaborative was not yet as mature as the others and community funding sits better at Place level as it is linked to wraparound care. So effectively, everything rather than Acute and Mental Health will be within the Place based budgets he added.

7.14 The Chair asked how iterative the financial devolution framework would be. HB replied that this was a very important point. One of the benefits of having a single statutory body for NEL and non-statutory committees at the PBP level is that they can make those changes and the Local Accountability Framework will be a key part in how this works. It will work both ways and expectations will be placed on PBPs but these can of course be changed by mutual agreement.

7.15 Cllr Masters expressed a concern that putting e.g. Newham Hospital's budget within the Acute Collaborative militates against Place being the main driver here. HB replied that there would be full visibility of all spend at PBP level but direct accountability of funding will sit with the Acute Collaborative. The Mutually Agreed Framework effectively binds the PBPs and the Acute Collaboratives into a mutual agreement and he added that Homerton was a core part of the PBP and this is a big step change from single borough CCGs where the Homerton was not at the table. The Chair commented that if a PBP is doing well it is stopping people going into A&E and at the back end helping the flows out of the hospitals but at NEL level you are now taking the hospital out of the structure and imposing a top down approach for them. HB reiterated that the Homerton was a lead member of the PBP and it will be important that the right mechanisms for mutual accountability between the provider collaboratives and the PBPs is in place. With the Homerton at the table it will work as a direct decision making partner in a way it couldn't in the past.

7.16 Cllr Masters commented that the Homerton has that advantage as it is standalone but she was more worried about Barts Health hospitals. To them in Newham their local hospital was very much a body they wanted to be integrated with and the very fact that HB focused on the Homerton illustrated her point. Homerton was stand alone but Newham was part of a bigger trust and in her view there is far more of a challenge involved in that. SD added that Newham Hospital was absolutely a full part of its local PBP. The question here is about why it became part of a bigger group to begin with. It was because on its own with the volume of patients it had it wouldn't be financially viable. He added that it was in the interests of everyone that there is less activity in hospitals and more in the community and by doing so spend can be better directed to the community whilst keeping the overall Acute element at the Barts Health level.

7.19 Cllr Virdee asked how councils (led by elected members) can be more involved and the Chair asked about how locked were Adult Social Care Directors to

these budget discussions. He added that City and Hackney had been driving joint commissioning locally and was good at it. HB replied that the PBPs are partnerships of health and social care providers as well as commissioners and in the past providers and Local Authorities were more on the sidelines and joint commissioning arrangements weren't the significant core model they needed to be across east London until the advent of the ICS.

7.20 The Chair asked how did the ICS ensure that Acutes don't swallow up more and more of the budget. HB replied that this was the perennial balance the NHS has to strike. The central challenge is to balance the extent to which they devolve and give local autonomy with holding onto the necessary financial control. Devolved Place Based Budgets are an attempt to reach that balance. And having acute budgets in one place and economies of scale and risk sharing as part of integration was how financial grip can be maintained. ZE added that this is why ICSs were set up. She stated that NHS funding was not sustainable as demand was going up and sufficient capacity and workforce wouldn't exist unless changes were made. If they don't collectively find ways of investing further upstream in community support systems for example the NHS can't be viable. She concluded that it was a really complex process and they are learning as they go along.

7.18 The Chair thanked HB and ZE for their report and attendance and asked if both Frameworks could come back to the Committee once there was further clarity on what it all means in terms of staffing at each Place level.

ACTION:	**The Local Accountability Framework and the Financial Framework to come back to a future meeting.**

RESOLVED:	**That the report and discussion be noted.**

8. Redevelopment of Whipps Cross - update from Chair of Whipps Cross JHOSC update

8.1 Cllr Sweden gave a verbal update on the work of the special JHOSC. He stated that they had met again on 2 November and steady progress was being made. They had produced a pro forma for use when determining 'case for change' proposal requests. Cllr Brewer, also on the Whipps Committee, commented that it had been massively disappointing that on 6 Dec the DoH had postponed yet again some key decisions on funding. They had stated that the "timetable would be released at some time in the new year". The Chair commented that he shared their frustration at this and hoped the Committee would keep a close watching brief on it.

9. Minutes of previous meeting

9.1 Members gave consideration to the draft minutes for the meeting on 19 October 2022 and noted the matters arising..

RESOLVED:	**That the minutes of the meeting held on 19 Oct 2022 be agreed as a correct record.**

10. INEL JHOSC future work programme 2022/23

10.1 Members gave consideration to the updated work programme.

RESOLVED:	**That the update work programme be noted.**

11. Any other business

11.1 There was none.