Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Thursday, 13 October 2022 at 3.00 pm – 5.00 pm

Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD

Part I Agenda

No	Time	Title	Action	Papers	Lead	Page
		Opening Business				
1	3.00 pm	Welcome and Apologies for Absence	Note	Verbal	Professor M Thorne	-
2	3.02 pm	Review of Register of Interests and Declarations of Interest	Note	Attached	Professor M Thorne	3
3	3.05 pm	Questions from the Public	Note	Verbal	Professor M Thorne	-
4	3.15 pm	Minutes of ICB Board meeting held 1 July 2022 and matters arising. 4.1 Appointment of Caldicott Guardian	Approve Note	Attached Verbal	Professor M Thorne Professor M Thorne	6 -
5	3.17 pm	Review of Action Log	Approve	Attached	Professor M Thorne	17
6	3.20 pm	Appointment of Local Authority Partner Member	Note	Verbal	Professor M Thorne	-
		Items for Decision				
7	3.22 pm	Harmonising Commissioning Policies	Approve	Attached	Dr R Fenton	18
8	3.35 pm	Digital Strategy & Investment Priorities	Approve	Attached	B Frostick	48
		Items For Noting				
9	4.00 pm	Performance Report	Note	Attached	T Hemming	74
10	4.10 pm	Fuller Stocktake Report	Note	Attached	Dr A Davey	80
11	4.25 pm	Quality Report	Note	Attached	F Bolger	86
12	4.35 pm	Finance Report Month 5	Note	Attached	D Scrafield	98
13	4.45 pm	Winter Planning	Note	Attached	T Hemming	112

No	Time	Title	Action	Papers	Lead	Page
14	4.50 pm	General Governance: 14.1 Minutes of Committee Meetings: • Clinical and Multi-Professional Congress (28/07/22) • Finance & Investment Committee (07/09/22) • Quality Committee (13/07/22) • System Oversight and Assurance Committee (10/08/22) 14.2 Emergency Planning Resilience & Response Core Standards.	Note Approval	Attached Attached	 Dr Ronan Fenton Joe Fielder Neha Issar-Brown Anthony McKeever Anthony McKeever	 115 116 119 127 135 145
15	4.55 pm	Approvals made in between Board meetings.	Ratify	Attached	Anthony McKeever	154
16	4.56 pm	Any Other Business	Note	Verbal	Professor M Thorne	-
17	5.00 pm	Date and time of next Part I Board meeting: Thursday, 17 November 2022 at 3.00 to 5.00 pm, to be held in the Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, Essex, CM1 1JE,	Note	Verbal	Professor M Thorne	-

MID AND SOUTH ESSEX ICB BOARD - REGISTER OF INTERESTS, OCTOBER 2022

AGENDA ITEM 2

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Hannah	Coffey	ICB Partner Member	Mid and South Essex NHS Foundation Trust	x			Direct	Acting Chief Executive of MSEFT	01/0722	Ongoing	No immediate action required. Interest to be declared if a conflict of interest is identified.
Anna	Davey	GP Partner Member	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice providing General Medical Services	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	GP Partner Member	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in any discussion, decision making, procurement or financial authorisation involving the Colne Valley PCN.
Anna	Davey	GP Partner Member	Provide	x			Indirect	Close relative is employed	20/12/21	On-going	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Anna	Davey	GP Partner Member	Essex Cares	x			Indirect	Close relative is employed	06/12/21	On-going	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x	x		Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Peter	Fairley	ICB Partner Member (Essex County Council)	Suffolk and North East Essex (SNEE) Integrated Care Partnership	x	x		Direct	ECC representative	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x	x		Direct	Employed as Consultant Anaesthetist	20/06/05	On-going	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x			Indirect	My wife is employed by MSEFT as a Consultant Anesthetist.	24/06/05	On-going	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director	01/05/17	Ongoing	No conflict of interest is anticipated, but will be declared and managed appropriately.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Personal relationship with Director of Operations for North East London	01/01/19	Ongoing	No conflict of interest is anticipated, but will be declared and managed appropriately.
Josepth	Fielder	Non-Executive ICB Board Member	Guys & St Thomas Hospital	x			Indirect	Close family member employed as senior manager in strategy	01/08/21	Ongoing	No conflict of interest is anticipated, but will be declared and managed appropriately.
Neha	Issar-Brown	Non-Executive ICB Board Member	Versus Arthritis (VA)	x			Direct	Director at VA – a UK registered charity that supports research funding, services and information for/on Arthritis.	01/04/21	Ongoing	Ensuring any potential COI is declared openly to allow for appropriate mitigation to be put in place in advance (e.g. abstaining from decisions where relevant)
Ruth	Jackson	Executive Chief People Officer	Nil								
Benedict	Leigh	ICB Partner Board Member	Southend Borough Council	x			Direct	Employed as Director of Commissioning.	2022	Ongoing	No immediate action required. Interest to be declared if a conflict of interest is identified.
Benedict	Leigh	ICB Partner Board Member	Sense		x		Direct	Trustee	2022	Ongoing	Will recuse myself from any procurement or commissioning decision that may involve the award of contracts to Sense or the negotiation of fee rates for services. Will recuse myself from discussions within Sense board if these involve Commercial relationships with MSE ICS
Benedict	Leigh	ICB Partner Board Member	Migrant Help	x			Indirect	Partner is a member of staff.	2022	Ongoing	Will not discuss commercial matters relating to either Migrant Help or MSE ICS with partner. Interest to be declared if and when a conflict of interest arises.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	MACS et al Ltd	x			Direct	Director of wholly owned company through which I contract with the NHS for interim and other services.	02/03/20	Ongoing	As of 3/10/2020 I am employed and paid through NHS payroll for my role in Mid and South Essex. However, I will declare my interest in MACS et al Ltd if and where required so that appropriate arrangements can be implemented.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Royal Society of Medicine (RSM)		x		Direct	Fellow	02/03/20	Ongoing	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Faculty of Medical Leadership & Management (FMLM)		x		Direct	Fellow	02/03/20	Ongoing	No immediate action required.
Paul	Scott	ICB Partner Member	Essex Partnership University NHS Trust	x			Direct	Chief Executive of EPUT	01/07/2022	Ongoing	No immediate action required. Interest to be declared if a conflict of interest is identified.
Dawn	Scrafield	Interim Director of Resources	Mid and South Essex NHS Foundation Trust	x			Direct	Chief Finance Officer of the Board	01/07/2022	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Dawn	Scrafield	Interim Director of Resources	Mid and South Essex Hospitals Charity		x		Direct	Chief Finance Officer of the Corporate Trustee	01/07/2022	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Dawn	Scrafield	Interim Director of Resources	Barnet, Enfield & Haringey	x			Indirect	Husband is currently the Director of Finance for Barnet Enfield and Haringey Mental Health Trust	01/07/2022	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Dawn	Scrafield	Interim Director of Resources	Healthcare Finance Management Association (HFMA)		x		Direct	Trustee for the Board of Directors – Supporting development of Finance Professionals	01/07/2022	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Mike	Thorne	ICB Chair	Nil								
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Borough Council	x			Direct	Employed as Corporate Director of Adults, Housing and Health.	01/03/21	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Joint Health and Wellbeing Board		x		Direct	Voting member	01/06/15	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Dartmouth Residential Ltd	x			Direct	99% Shareholder and in receipt of income.	01/10/15	Ongoing	Interest to be declared if and when any matters relevant to this company are discussed so that appropriate arrangements can be implemented.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.
George	Wood	Non-Executive ICB Board Member	Barking, Havering and Redbridge University Hosptals NHS Trust (BHRUT)	x			Direct	Chairman of hospital charity.	01/01/15	Ongoing	Interest to be declared if and when any matters relevant to BHRUT are discussed so that appropriate arrangements can be implemented.

Minutes of the Part I Board Meeting

Held on 1 July 2022 at 3.00 pm – 5.00 pm

Event Suite, Chelmsford City Museum, Oaklands Park, Moulsham Street, Chelmsford, CM2 9AQ

Attendees

Members

- Professor Michael Thorne (MT), Chair of Mid and South Essex Integrated Care Board (MSE ICB).
- Anthony McKeever (AMcK), Chief Executive of MSE ICB.
- Dr Ronan Fenton (RF), Medical Director, MSE ICB.
- Rachel Hearn (RH), Chief Nurse, MSE ICB.
- Dr Neha Issar-Brown (NIB), Non-Executive Member.
- George Wood (GW), Non-Executive Member.
- Dr Anna Davey (AD), Primary Care Board Member.
- Hannah Coffey (HC), Partner Member, Mid and South Essex NHS Foundation Trust.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust.
- Peter Fairley (PF), Partner Member, Essex County Council.
- Ian Wake (IW), Partner Member, Thurrock Borough Council.

Other attendees

- Jennifer Kearton (JK), Director of Finance, MSE ICB (on behalf of Dawn Scrafield).
- Dan Doherty (DD), Alliance Director (Mid and South Essex) MSE ICB.
- Jo Cripps (JC), Executive Director of Strategy and Partnerships.
- Stephen Porter (SP), Alliance Director (Thurrock) MSE ICB.
- Dr Tiffany Hemming (SH), Interim Executive Director of Oversight and Delivery.
- Mike Thompson (MTh), Chief of Staff, MSE ICB.
- Viv Barnes (VB), Governance Lead, MSE ICB.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.
- Sara O'Connor (SO), Head of Corporate Governance, MSE ICB.

Apologies

- Dawn Scrafield (DS), Interim Director of Resources, MSE ICB.
- Ruth Jackson (RH), Chief People Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member.
- Tandra Forster (TF), Partner Member, Southend City Council.

1. Welcome and Apologies (presented by Prof. Mike Thorne).

MT welcomed everyone to the meeting, noted apologies as listed above and invited those present to introduce themselves.

MT advised that membership of the new Board included the main organisations tasked with improving the health and wellbeing of the mid and south Essex (MSE) population. It was anticipated that the elimination of boundaries as a result of the formation of the ICB and the wide Integrated Care System (ICS) would enable the new organisations to significantly improve services.

MT acknowledged the considerable achievements of the five former MSE Clinical Commissioning Groups (CCGs) and put on record his thanks to the five CCG Chairs who had worked tirelessly to support MSE residents as well as himself since he had initially been appointed as Chair of the MSE Health and Care Partnership Board. MT also acknowledged the work of all CCG staff, including those who had undertaken a significant amount of work to establish the ICB and transfer CCG staff to the new organsation.

MT explained that the majority of the agenda would focus upon the approval of the suite of governance documents required to formally establish the ICB.

2. Declarations of Interest (presented by Prof. Mike Thorne).

MT reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by ICB Board and committee members are listed in the Register of Interests to be made available on the ICB website in due course**.**

There were no declarations raised.

3. Questions from the Public (presented by Prof. Mike Thorne).

Mr Peter Blackman asked the following question:

“The arrival of Mid & South Essex Integrated Care System, Board and Partnership is a welcome move. The people of South Woodham Ferrers and its surrounds would like to know how this will improve joined up health and social care for them, address the terrible waiting times and access barriers they experience in getting to see their GPs, get the hospital appointments they need, the social care to enable them to stop blocking hospital beds and have the necessary care packages to enable them to stay in their homes? We wish you all the very best in your new roles and look forward to working with you as your critical friends.”

MT thanked Mr Blackman for his well wishes and invited AMcK to respond to the question.

AMcK confirmed that in co-operation with Mid and South Essex NHS Hospitals Trust (MSEFT) and other partner organisations, significant progress had been made to reduce waiting times. AMcK advised that the number of patients waiting for 104+ weeks, which had reached in excess of 300 in March, had reduced to 4. MSEFT would ensure the

remaining patients received their treatment as soon as possible. The number of 98 week waits had dropped from 427 to 48 and 78 week waits had more than halved. Clinical prioritisation was in place for the remainder of patients waiting for treatment. AMcK advised that although significant work was still required to clear the backlog, he was grateful to colleagues for the progress made to-date.

In relation to access to General Practioners (GPs), two thirds of appointments were currently undertaken face-to-face, which was slightly down on pre-pandemic levels of circa 80%. However, work was being undertaken by the Primary Care Networks (PCNs) to improve telephony services and other innovative ways to speed-up patient access.

DD advised that the concept of local Alliances was based on the requirement for the NHS to become more outward facing. Addressing the current health and care challenges across the MSE system could not be solved by the NHS alone and required collaboration between all partner organisations. These arrangements were progressing well, however, it was also important to have a 'bottom-up' approach with input from the community and voluntary sector being vital to shape future plans.

Mr Ken Edwards, Chairman of Baddow Village Patient Participation Group (PPG), who was unable to attend the meeting, had submitted the following written question and had confirmed he would be happy to receive a written response after the Board meeting:

"Under the previous CCG structure, decision making was in the hands of Boards with a significant primary care presence, so giving GPs and their colleagues direct input into strategy and implementation. Indeed, this was part of the justification for that structure when it was introduced. Under the new ICS/ICB arrangements, that direct control through representatives of primary care is diluted. If the NHS is really all about the patient, and primary care is closest to that patient, how will the new structure preserve at least some of that influence?"

AMcK explained that the former CCGs were GP membership organisations and, via new legislation, their responsibilities had been transferred to the ICB which was a Unitary Board with broader responsibilities. As well as Dr Anna Davey, the Primary Care Board member, the new organisational structure included more clinical leadership roles than before which were multi-professional in nature and included GPs.

AMcK confirmed that clinical input would be central to the work of the ICB. The Clinical and Multi-professional Congress, Chaired by RF, included clinical membership and those appointed to clinical leadership roles would provide direct input to other groups including the local Alliances and PCNs, thus providing the clinical voice.

DD advised that Mr Edwards had invited him to the Annual General Meeting of the Baddow Village PPG which he would be happy to attend to explain clinical involvement with local Alliances.

[Action: VB to arrange for a written response to be provided to the question submitted by Mr Ken Edwards].

4. ICB Constitution (presented by Prof. Mike Thorne).

MT advised that the draft ICB Constitution had been developed in collaboration with, and endorsed by, the five former MSE Clinical Commissioning Groups; Essex County Council,

Southend City Council and Thurrock Borough Council via Health and Care Partnership (HCP) meetings; as well as input from NHS England and Improvement.

MT advised that there were mechanisms in place to facilitate amendment of the Constitution and other governance documents that the Board was being asked to approve, should this be necessary to enable the ICB to fulfil its role as a Unitary Board.

MT asked members if they had any comments on the draft Constitution. No comments were submitted.

Resolved: The Board approved the Mid and South Essex Integrated Care Board Constitution.

5. Scheme of Reservation and Delegation, including Functions and Decisions Map (presented by Anthony McKeever).

MT advised that the Scheme of Reservation and Delegation (SoRD), including the Functions and Decisions (F&D) map had undergone thorough scrutiny, including a review by himself.

AMcK confirmed that the documents reflected the templates and best practice that NHS England expected the organisation to follow.

MT asked members if they had any comments on the draft SoRD and F&D map.
No comments were submitted.

Resolved: The Board approved the Scheme of Reservation and Delegation, including the Functions and Decisions Map.

6. Standing Financial Instructions (presented by Jennifer Kearton).

MT advised that a reference to 'CCG' on page 79 would be amended in the final version of the Standing Financial Instructions (SFIs).

JK confirmed that the SFIs had been drafted in line with best practice and NHS templates and had undergone thorough peer review.

MT asked members if they had any comments on the draft SFIs. No comments were submitted.

Resolved: The Board approved the Standing Financial Instructions.

7. Establishment of Committees (presented by Anthony McKeever).

AMcK confirmed that draft committee Terms of Reference (ToR) had been developed in line with NHSE/I model ToR for the following ICB Committees:

- Alliance Committees for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock.
- Audit Committee.
- Clinical and Multi-Professional Congress.

- Finance and Investment Committee.
- Primary Care Commissioning Committee.
- Quality Committee.
- Remuneration Committee.
- Strategic Oversight and Assurance Committee.

MTh explained that NHSE/I guidance required us to choose one of a fixed range of options for the operating model for the Alliances up to April 2023. After careful consideration of the alternatives it was agreed by all parties that the model in which an Alliance would be a committee of the ICB Board was the best available option for us on the temporary basis required.

IW advised that Thurrock had a strong and vibrant Alliance which did not feel it could sign-up to the draft Alliance ToR in their current form.

MT explained that all four Alliances needed to be established as committees of the ICB and agreeing the draft ToR was the mechanism to do this, although it was acknowledged that they might need to be amended at a later date as the work of the ICB progressed.

IW advised that he envisaged that minimal changes would be required for Thurrock to approve the ToR and he would bring the suggested amendments back to the next ICB Board meeting.

VB advised that the Board was also being asked to appoint the Chairs of each ICB Committee, as follows:

- George Wood, Chair of Audit Committee.
- Dr Ronan Fenton, Chair of Clinical and Multi-professional Congress.
- Joe Fielder, Interim Chair of Finance & Investment Committee (until an independent Chair is appointed).
- Dr Neha Issar-Brown, Chair of Quality Committee.
- Joe Fielder, Chair of Remuneration Committee.
- Anthony McKeever and NHSE/I to co-chair Strategic Oversight and Assurance Committee.

Members were informed that the Chair of the Primary Care Commissioning Committee would be appointed at a later date.

MT advised that the ICB's budget was in the region of £2.9 billion and the committee framework would ensure that funding was allocated and spent appropriately.

Resolved: The Board:

- **Agreed the Committee Terms of Reference for the following committees:**
  - **Alliance Committees for Basildon & Brentwood, Mid Essex, and South East Essex.**
  - **Audit Committee.**
  - **Clinical and Multi-Professional Congress.**
  - **Finance and Investment Committee.**
  - **Primary Care Commissioning Committee.**
  - **Quality Committee.**

  - **Remuneration Committee.**
  - **Strategic Oversight and Assurance Committee.**

- **Agreed the appointment of ICB Committee Chairs as follows:**
  - **George Wood – Chair of Audit Committee.**
  - **Dr Ronan Fenton – Chair of Clinical and Multi-professional Congress.**
  - **Joe Fielder – Interim Chair of Finance & Investment Committee until an independent Chair is appointed.**
  - **Dr Neha Issar-Brown, Chair of Quality Committee.**
  - **Joe Fielder – Chair of Remuneration Committee**
  - **Anthony McKeever and NHSE/I to co-chair Strategic Oversight and Assurance Committee.**

[Action: IW to advise MT of proposed amendments to the Thurrock Alliance Terms of Reference, for submission to the ICB Board meeting on 15 September 2022 for approval].

[Action: MTh to include Appointment of Chair of Primary Care Commissioning Committee to Board agenda at the appropriate time].

8. Adoption of ICB Policies (presented by Anthony McKeever).

AMcK advised that the suite of draft ICB policies set out on Appendix A to the report, which included three core policies, namely Standards of Business Conduct Policy, Conflicts of Interest Policy and Risk Management Policy, were based upon the former CCGs' policies which had been updated in line with current best practice and NHSE/I requirements.

Resolved: The Board adopted the policies listed on Appendix A to the report.

9. Appointment of Lead Roles (presented by Prof. Mike Thorne)

VB advised that the Board was being asked to approve appointments to a number of key roles, as set out in the report.

Members were advised that the Deputy Chair of the ICB Board would be appointed at a later date.

Resolved: The ICB approved appointments to key roles as follows.

- **Conflicts of Interest Guardian – George Wood, Non-Executive Member.**
- **Freedom to Speak Up Guardian – George Wood, Non-Executive Member.**
- **Emergency Accountable Officer – Anthony McKeever, Chief Executive.**
- **Senior Information Risk Officer (SIRO) – Dawn Scrafield, Interim Director of Resources.**
- **Caldicott Guardian – Rachel Hearn, Chief Nurse.**
- **Data Protection Officer – Head of Information Governance (once appointed).**

[Action: MTh to include appointment of Deputy Chair of the ICB to the agenda of the Board meeting on 15 September 2022].

10. Appointment of Founder Member of the Mid and South Essex Integrated Care Partnership (presented by Prof. Mike Thorne).

MT advised of the proposal to appoint him as Founder Member of the Integrated Care Partnership (ICP) and asked members if they were happy to confirm his appointment to this position.

Resolved: The Board approved the appointment of Prof. Mike Thorne as the Founder Member of the Mid and South Essex Integrated Care Partnership.

11. Finance Strategy (presented by Jennifer Kearton)

JK advised that several iterations of the draft Finance Strategy had been produced and considered by the HCP Board. The strategy set out the system's ambitions and challenges. Core to its principles were: beginning to operate within a system operating budget; bringing financial risk strategy and risk management into alignment; and operating with the utmost transparency across partner organisations. The vision for the future in terms of service line reporting and clinical stewardship was key to delivery and in line with the founding principles of the ICS.

PS noted that service line reporting and stewardhip also underpinned clinical strategy. JF confirmed that the financial strategy should be seen as an enabling strategy for all areas, including clinical strategy and Alliances.

PF advised that he supported the content of the strategy but asked how the ICB would hold itself to account for ensuring that funding was shifted towards prevention measures. MT acknowledged that the ICB needed to invest in prevention to reduce the financial buden on the system and he would champion this cause.

In response to a query from NIB, JK advised that the ICB Financial Plan contained an element of risk which would continue to evolve and potentially materialise, but would be mitigated as much as possible and continually monitored, including modelling the impact of rises in the cost of living and addressing workforce concerns. As well as efficiency savings, there would be a number of investments required that the Board would be made aware of.

MT explained that the health inflation rate tended to be circa twice the rate of headline inflation and therefore NHS finances were an issue of national concern.

AMcK suggested that the ICB should consider developing an innovational development fund to shift money into prevention and other imperatives.

Resolved: The Board approved the Finance Strategy.

12. Draft Working with People and Communities Strategy (presented by Jo Cripps)

JC advised that the Board was required to have a strategy on how it would engage with its communities, although national guidance had not yet been published. Therefore the current version presented to members was an early draft pending receipt of the guidance.

The strategy included a roadmap describing an iterative approach and the tools and ways of working the ICB wished to embed within partner organisations and communities.

JC noted that all partner organisations were engaging with communities via different methods and at different times, but there was an ambition to avoid or reduce duplication by drawing the insight gained via these engagement routes into one repository which could be accessed by staff when designing services.

MT advised that, although he appreciated the strategy had been drafted to fulfil NHSE/I requirements, it would be important to ensure that the language used within the final strategy was less technical in nature.

IW noted that the strategy should build on and embed existing menchansims and work ongoing in place, for example, the long standing engagement structures and activities within Thurrock.

PF highlighted the importance of embedding the aims of the strategy across all work undertaken across the ICS and suggested that commissioning cycles and how lived experiences would be captured should be reflected within the final document.

SP welcomed the strategy which would help the ICB/ICS to better understand peoples needs.

MT commented that although it was necessary for ICSs to fulfil NHSE/I and other regulatory requirements, successful systems would be those able to balance this with taking appropriate and innovative action to address the needs of their local populations.

Resolved: The Board noted the draft Working with people and Communities Strategy.

13. 2022/23 Financial Plan / Budgets (presented by Jennifer Kearton)

JK advised that Section 2 of the report consisted a summary of the system financial plan submitted to NHSE/I. Section 3 related to the system financial budget for 2022/23 which required Board approval.

JK explained that the NHS Financial Plan related to the three organisations fully aligned to the MSE ICS, i.e. MSEFT, Essex Partnership University NHS Foundation Trust (EPUT) and the ICB, and was the sum of their submissions for their individual annual Financial Plans for 2022/23.

The organisations had worked together within the open forum of the System Leaders Finance Group (SFLG) which facilitated input from all partner organisations. The Financial Plan submissions were accordance with the requested timeline, with the final submission on 20 June 2022 including an additional allocation from NHSE/I which reflected cost of living pressures.

The system had £2.9 billion available and was planning to operate within those resources, but this relied on achievement of £84 million of efficiency savings. There was also a significant element of risk embedded within the plan which would be managed between partners.

JK advised that Section 2 of the report provide assurances to the Board and confirmed that members would be kept fully sighted on the position throughout the year. Section 3 related

to the ICB section of the financial plan which members were being asked to approve so that the Scheme of Reservation and Delegation could become operational.

MT advised that where development monies were available, the Board would need to use its discretion to ensure they were used for genuine beneficial investment in the system. However, it was likely that some monies would be ring-fenced for particular service improvements.

GW advised that in order to achieve £37 million of Elective Recovery Fund (ERF) money, the system would have to deliver in excess of its 2019/2020 activity, but was currently significantly below this level. In addition, COVID-19 remained a challenge for hospitals and whilst the number of cases had reduced, the additional controls required to manage this cohort of patients was challenging for providers. This, along with stranded patients, issues within care homes, workforce challenges, winter pressures, and rises in the cost of living represented significant risks to the system's ability to obtain ERF funding.

PS noted the plan included a financial risk to the ICB of £20 million and asked JK how this would be managed. JK confirmed that the risks predominantly related to achievement of efficiency savings and cost of living increases, particularly market pressures relating to continuing health care (CHC). Work was ongoing with partners to support patient discharges from hospitals and containment of costs to avoid cost pressures. The ICB was party to the overall financial risk management strategy being developed by SFLG, which would include escalation points relevant to the ICB and providers.

JK acknowledged that 2022/2023 would be a challenging year for the ICB and wider ICS and transparency between organisations would be key to support clear management and understanding of risk between health and social care organisations.

AMcK also acknowledged the amount of shared risk and explained that hitherto, the sharing of risk had not been a requirement. This was now being done via SFLG, which operated by consensus, to agree how to distribute resources in a way that made sense for all organisations.

AMcK explained that the former MSE CCGs were required to prepare accounts for Quarter 1 of 2022/23 and the ICB would take on responsibility for the remainder of the year. AMcK was concerned that although £84 million of efficiency savings were identified in the plan, based on the current position, these might not be achievable, but partners would continue to work collaboratively to deliver.

AMcK highlighted that paragraph 2.2 and other paragraphs dealing with allocations, highlighted some of the work occurring in the background. The 'Fair Shares' formula took money out of resources the former CCGs previously had and although it was quite right that these adjustments should be made, they were part of the financial challenge.

Paragraph 2.3.4 showed that the Government had recognised cost of living and other inflationary pressures by providing additional funding, although this did not match pressures anticipated by SFLG. However, leaders from all partner organisations were very focussed on delivering within the financial plan and increasing activity to enable access to ERF funding.

In response to comments from IW, MT suggested it would be helpful for members to receive a briefing on the implications of the Social Care Bill at it's next meeting so that the

Board could be appraised of the associated risks. MT requested IW to work with his ECC and Southend local authority colleagues to prepare such a report.

Resolved: The Board approved and signed-off the Finance Strategy.

[Action: IW to liaise with ECC and Southend local authority colleagues to prepare a briefing on the implications of the Social Care Bill to be presented to a future meeting of the Board].

14. Harmonisation of Commissioning Policies (presented by Dr Ronan Fenton)

RF advised that the report explained that there was a need to harmonise the various commissioning policies of the five former CCGs for the ICB. RF explained that whilst the CCG policies had been nearly fully aligned, the service offer for six clinical treatment areas differed, these being:

- Bariatric surgery.
- Breast asymmetry.
- Breast reduction.
- Female sterilisation.
- Vasectomy.
- Teriary Fertility Services, including:
  - Intra-uterine insemination (IUI).
  - In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI).
  - Donor Insemination (DI).
  - Sperm, oocyte and embryo cryopreservation.
  - Sperm and oocyte donation.
  - Surgical sperm retrieval.

The alignment of policies would be complex as it required full consideration of each existing policy, any financial implications and the undertaking of appropriate public engagement to develop a consistent offer to MSE residents. Consequently, the proposed timeline for completing this work extended to April 2023.

MT noted the proposed timeline would give the ICB and partner organisations sufficient time to engage with clinicians, commissioners and residents to develop a fully informed set of proposals.

In response to a query from NIB, RF advised that the level of engagement, or consultation, would depend on the options put forward and the timeline would accommodate this.

MT and JC advised that there was a national requirement for harmonisation of these policies and the ICB was committed to doing so within the proposed deadline following clinical and financial input and seeking views from the public.

HC referred to work being undertaken to reduce health inequalities and mentioned that one of the most ‘hard to reach’ groups was working age women. It was therefore important that engagement on the commissioning policies was appropriately targeted to ensure that their views, and those of other affected groups, were sought and considered.

RF assured HC that the Clinical and Multi-Professional Congress was taking the need to address health inequalities very seriously during discussions regarding commissioning policies.

PF requested that Essex residents who lived within other ICSs could also be considered via discussions with neighbouring ICBs on their approach to the relevant policies.

AD highlighted that the services under consideration significantly affected the lives of many residents and were likely to be contentious. Therefore collaborative working, coupled with effective engagement/consultation was required.

Resolved: The Board noted and approved the work required to address differences in the commissioning policies adopted from the former Clinical Commissioning Groups.

15. ICB Forward Plan (presented by Anthony McKeever)

AMcK advised that the forward plan was a draft preview of the items that the ICB anticipated the Board would need to consider during the coming months, but was subject to change. AMcK requested members to advise him of any additional issues that they wished the Board to consider.

Resolved: The Board noted the draft ICB Forward Plan.

16. Any Other Business

There was no other business discussed.

17. Date and Time of Next Board meeting:

Thursday, 15 September 2022 at 3.00 pm in Committee Room 1, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER.

Mid and South Essex Integrated Care System

Action Log prepared following ICB Board Meeting meeting held on 1 July 2022

NHS Mid and South Essex

Action No.	Meeting Date	Agenda Item No.	Action	Lead	Deadline for completion	Update / Outcome	Status
1	01/07/2022	3	Arrange for a written response to be provided to the question submitted by Mr Ken Edwards	V Barnes	ASAP	Response submitted to Mr Edwards.	Complete
2	01/07/2022	7	Advise of proposed amendments to the Thurrock Alliance Terms of Reference, for submission to the ICB Board meeting on 15 September 2022.	I Wake / Jo Cripps	31/08/2022	Continues to be worked through and intended to be brought to a future meeting.	In progress
3	01/07/2022	7	Include Appointment of Chair of Primary Care Commissioning Committee to Board agenda at the appropriate time.	M Thompson	31/08/2022	Included on agenda of ICB Board meeting, 15 September 2022.	Complete
4	01/07/2022	9	Include appointment of Deputy Chair of the ICB to the agenda of the Board meeting on 15 September 2022.	M Thompson	31/08/2022	Deferred until future Board meeting.	In progress
5	01/07/2022	13	Liaise with Essex County Council and Southend City Council colleagues to prepare a briefing on the implications of the Social Care Bill for presentation to the ICB Board.	I Wake	31/08/022	Deferred until future Board meeting.	In progress

Integrated Care Board, 15 September 2022

Agenda Number: 7

Service Harmonisation – Decision to Consult

Summary Report

1. Purpose of Report

This paper provides a business case and proposes a consultation plan for the harmonisation of services commissioned by predecessor CCGs. It is presented for Board approval.

2. Executive Lead

Dr Ronan Fenton, ICS Medical Director

3. Report Author

Dr Peter Scolding, ICS Assistant Medical Director
Ashley King, Director of Finance Primary Care & Strategic Programmes
Claire Hankey, Director of Communications and Engagement

4. Impact Assessments

Initial Equality and Health Inequality Impact Assessments (EHIIA) have been undertaken – section 5.2 of this report describes the process, with an overview of initial findings alongside the relevant policies in section 6. The initial EHIIAs are available to members upon request from the Governance Team.

These initial assessments will help to guide our engagement and consultation process, enabling us to identify impacted groups and ensure we engage with these individuals. The EHIIAs will be refined further as part of the programme – particularly as a result of feedback received from impacted groups.

5. Financial Implications

Whilst the decision to consult does not in itself result in additional financial liabilities being incurred in relation to changes to service provision, it does by its very nature imply that there will be decisions made that will have a financial implication in relation to the costs of service provision.

The financial modelling in this business case is presented to provide context and has not been through the Finance and Investment Committee, or System Finance Leaders

Group to date. Following consultation the financial implications of recommendation will be required to go through the appropriate governance channels as part of the process.

6. Details of patient or public engagement or consultation

A targeted pre-consultation engagement approach has been undertaken with the aim to gather insight to support the options for formal consultation.

The work undertaken included:

- A desktop review of all previous engagement, consultations, and reports across mid and south Essex relating to these services.
- A review of neighbouring ICB policies and discussion with Bedfordshire, Luton and Milton Keynes (BLMK) ICB which recently underwent a similar consultation exercise for fertility services.
- Targeted conversations with key support organisations including LGBT Mummies, Healthwatch Essex, men's health groups and fertility groups.
- Targeted survey to key audiences most likely to be impacted, including groups supporting LGBTQ+, working age residents and our own staff.

The MSE service harmonisation process review undertaken by Enable East identified the following themes from the desktop review and the recent pre-consultation engagement:

- Processes need to be made easier.
- NHS funding for these services – feedback was both 'for' and 'against' funding by the NHS.
- Fairness and equity of access to services.
- There is a need to understand the impact on the LGBTQ+ community and others already experiencing health inequalities.

7. Conflicts of Interest

None identified for this paper.

8. Recommendations

The Board is asked to approve this business case and agree to proceed to a period of public consultation as outlined in section 7. The final decision-making business case, detailing the findings from consultation, final EHIIAs, and final financial impact will be brought to the Board for decision in February 2023.

Business Case – Service Harmonisation

1. Executive Summary

The service harmonisation process has, since February 2022, brought together clinical, financial and resident perspectives in reviewing how six different treatments and procedures should be provided in mid and south Essex.

Our Clinical and Multi-professional Congress (CliMPC) has made recommendations on how services might be provided, expert clinical panels have recommended specific threshold criteria where needed, potential inequalities and health inequalities impact and resources implications have been assessed, and some early resident insights on the procedures involved have been gathered.

This process has been founded on an intention to provide services equitably to those who may gain significant benefit, in line with the national evidence base and local system context. This is an opportunity to deliver on our core purposes as an ICS, including addressing previous variation and inequality of access, and to continue a focus on sustainability and value for money.

Recommendations on options for consultation relating to tertiary fertility services reflect this ethos (see Section 6). They propose that services, including IVF, should be available to eligible women across our system, expanding access from three out of five CCG areas previously. If approved by the Board, the recommendations on all services in this paper will go forward for public consultation.

2. Introduction

2.1 Background

The July meeting of the Integrated Care Board (ICB) heard that there was a requirement to harmonise the commissioning policies of the five predecessor Clinical Commissioning Groups (CCGs). While almost all policies were fully aligned, there were six clinical treatment areas (hereafter referred to as 'procedures') where the service offer differed. These were:

- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Vasectomy (male sterilisation)
- Tertiary Fertility Services – including
  - Intra-uterine insemination (IUI)
  - In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
  - Sperm and oocyte donation.

The Board received a paper outlining the work required to align polices over the course of 2022/23. The Board noted that the work would be guided by:

- Multi-professional clinical and professional advice.
- Engagement and consultation with residents.
- An assessment of the financial consequences of any decision made.
- An assessment of service capacity and capability to deliver any future changes to the service restriction policy.
- Equality and health inequality impact assessment.

The Board noted that the absence of provision in some areas must be addressed and agreed to address specific disparities while ensuring the ICB can fulfil its four key, nationally stated, purposes to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The Board noted that there is no earmarked funding to address historical disparities.

This paper provides an outline business case which details the work undertaken to date and seeks approval from the Board to proceed to public consultation on the six procedures described above.

3. Overview of Commissioning Policy Categories

The Integrated Care Board has adopted the predecessor CCG commissioning policies with regard to treatments/interventions/devices/procedures (hereafter known as procedures) which are not currently included in established care pathways (as identified for example in the schedules to the service agreements with acute care providers) or identified as being routinely funded. The commissioning policies set out approval processes for access to a range of procedures [Click here]. These categories are summarised below.

Group Prior Approvals (previously known as threshold approval) – these procedures are commissioned by the ICB for a specific population cohort only, defined through a set of threshold criteria within the commissioning policy, which can be applied at the point of referral, without a process of individual prior approval (for example, cataract surgery).

Individual Prior Approvals - procedures are commissioned by the ICB for a specific population cohort only defined through a set of threshold criteria within the commissioning policy and which require individual funding approval on a patient-by-patient and, in some circumstances, on a treatment-by-treatment basis, before the treatment can be provided.

Not Funded – these procedures have been assessed as Procedures of Limited Clinical Value in line with national guidance and will not be funded unless there are **exceptional clinical circumstances.** This requires an application to be made using the Individual Funding Request process, but funding will only be considered where the patient

demonstrates clinical exceptionality. Individual Funding Requests are considered by a panel.

Individual Funding Requests (IFR) – the ICB will enable clinicians, on behalf of their patient, the opportunity to make specific funding requests via the IFR process. Requests may include patients with conditions for which there is no commissioning policy, including patients with rare conditions, and patients whose proposed treatment is outside agreed commissioning policies (exceptional clinical circumstances) or service agreements.

Prescribing procedures are considered separately and can be found at the primary care resource hub and available to primary care and other health care staff. Click here

4. Vision for Commissioning Policies

Commissioning policies in mid and south Essex must result in access to treatments and procedures for those who may gain significant benefit, in line with the national evidence base and local system context.
As national guidance changes, including Evidence Based Intervention guidance, we will continue to review and update our policies within mid and south Essex.

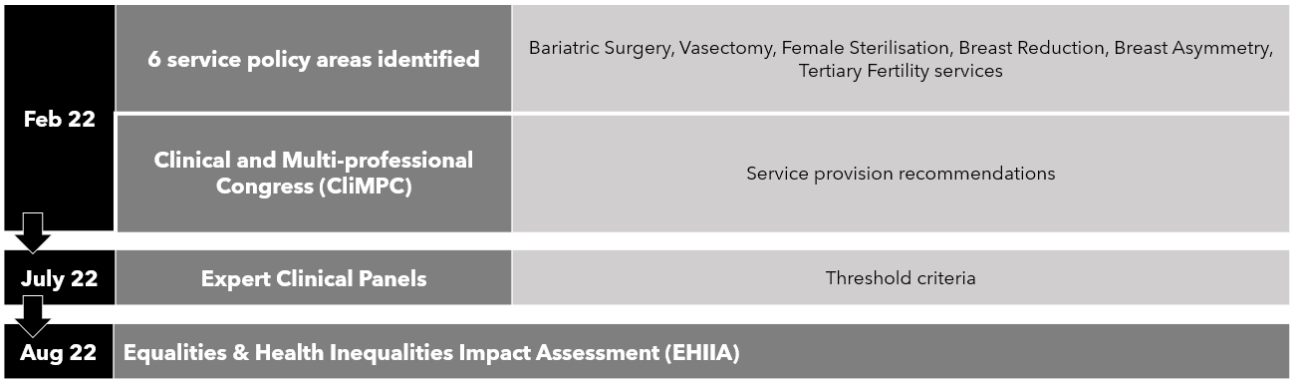
These policies are an important part of delivering on our duties as an ICS to improve outcomes in population health and healthcare, to tackle inequalities in outcomes, experience and access and to enhance productivity and value for money.

5. Process so far

The following sections outline the work completed thus far, in the pre-consultation phase.

5.1 Clinical Review Process

A review of the procedures involving frontline staff has been taking place since February 2022.



CliMPC

The Clinical and Multi-Professional Congress (hereafter referred to as Congress) is a group of experienced clinical and multi-professional staff, drawing together expertise from across our health and care system (full membership in Appendix 1 below). It is

chaired by the ICB Medical Director, with members bringing knowledge and experience from community care, mental health, patient engagement, pharmacy, primary care, public health, secondary care, social care and urgent and emergency care. It exists to review and make advisory recommendations upon complex, multi-faceted issues arising within our health and care system.

In February 2022, Congress was asked to review the six service areas (listed above) where service provision policies differed across the five CCGs. For each service area, information packs were prepared with information on:

- Current funding policies
- Prevalence and service activity
- **Clinical effectiveness**
- **Health benefits**
- **Cost effectiveness**
- **Affordability**
- **Health inequalities**
- **Strategic fit**
- Policy in other systems

The six in bold text above were pre-scored by members. At each Congress meeting, these domains were discussed, before reviewing pre-scores and developing a consensus recommendation on how each procedure should be provided.

Expert clinical panel

A panel of expert clinicians from across mid and south Essex was convened where Congress recommended the use of criteria to define the population for which care should be funded e.g. Group Prior Approval or Individual Prior Approval. Each panel had a briefing pack with:

- Context and Congress recommendations.
- Previous CCG policies.
- Relevant national standards or recommendations (e.g. from NICE).
- Practice from other systems.

The expert clinical panels reviewed these materials, considered any other relevant sources of evidence (e.g. national audits) and made recommendations on the appropriate criteria.

5.2 Equality and Health Inequality Impact Assessments

Draft Equality and Health Inequality Impact Assessments (EHIIA) were completed for all six areas in July 2022 by a panel with expertise in inequalities, public health, Place (Alliance), primary care, clinical and procurement (full EHIIAs available to members upon request).

The drafts drew upon Congress' service provision recommendations and either the threshold criteria recommended by expert clinical panels (where these had taken place),

or upon the most appropriate previous CCG threshold criteria. For these latter, the EHIIAs will be updated after the relevant expert panel has made its recommendations.

The EHIIAs are intended to guide engagement with potentially impacted residents and will need to be refined further depending on the results of that engagement, with the final service provision policies and threshold criteria set accordingly.

Notable points highlighted by the EHIIAs to date are included in section 6 below.

5.3 Findings from pre-consultation engagement

Based on the desk-top review and the pre-consultation engagement process, the following points appeared across all six treatment areas for the Board to consider:

- Fairness and equity.
- Affordability (particularly about fertility services).
- Impact on mental health.
- Potential for legal challenge.

Two clear and consistent themes were fairness and equity, ensuring that anyone in mid and south Essex should be able to access services without restriction.

Affordability, keeping a service free, was also essential to provide those on lower income or those with an inability to pay access to services.

When it comes to making decisions about access to services, people wanted there to be greater consideration of the emotional impact of infertility, dealing with larger and/or uneven breasts and obesity.

5.4 Review of Finance and Provider Capacity

Working in partnership with the Medical Directorate, the Resources Directorate have undertaken a level of analysis that helps to identify the potential recurrent cost increases for the ICB should changes to service provision be agreed as part of this process.

This modelling has been based on an approach of scaling up existing spend across the six clinical treatment areas utilising demographic data as the basis for identifying potential future annual spend.

For fertility services, the incremental cost increase has been broadly based upon the existing south-east Essex criteria. This would see an expansion in services in mid Essex and Basildon and Brentwood, and a shift of criteria in Thurrock.

The other five clinical treatment areas have only been modelled illustrating the additional cost of expanding existing service provision to mid Essex to bring it in line with service provision for south Essex.

Whilst simplistic in its nature for the purposes of identifying the potential impact on annual costs this has been considered as sufficient, as both demand and capacity for these services will be impacted by a multitude of variables outside of the ICBs direct

control. Further financial analysis will be undertaken as detailed recommendations are worked up following the outcome of the consultation process.

The outcome of this analysis can be seen in the table below:

SERVICE HARMONISATION - FINANCIAL ANALYSIS

	Baseline Assessment	Estimated Future Costs Per Annum		
Service	**Per Annum(£k)**	**Service Level**	**Value (£k)**	**Potential Pressure**
Fertility	394	Per SEE Criteria	1,174	(780)
Bariatric Surgery	190	Remove smoker status restriction	202	(12)
Vasectomies	154	Extend to Mid Essex	226	(72)
Female Sterilisation	94	Extend to Mid Essex	138	(44)
Breast Reduction	102	Extend to Mid Essex	149	(47)
Breast Asymetry	102	Extend to Mid Essex and B&B	222	(121)
TOTALS	**1,035**		**2,112**	**(1,076)**

Note we have been unable to disaggregate Breast Asymetry from Breast Reduction, given coding issues - given values though, this is unlikely to have a material impact upon affordability

The key points for the Board to be aware of are:

1. Current cost for the existing level of service provision is circa £1m across the six clinical treatment areas.
2. The scenario illustrated above results in additional annual cost being incurred by the system in the region of £1-1.1m.
3. As a system we are facing significant financial pressure and an ambitious and stretching savings programme over coming years. Any decision to increase service provision over and above existing levels of provision will result in additional costs for the system to manage as part of its overall financial planning responsibilities.

The majority of the services under consideration are delivered by a variety of both NHS and non-NHS providers outside and inside the mid and south Essex geography. Our system context includes existing service pressures, and any increased access to services which may occur as a result of this service harmonisation process will take place in this context, with prioritisation according to existing clinical frameworks. To date we have been unable to evaluate whether the capacity exists to meet the potential increase in demand. It is clear from the above modelling, the largest increase in demand would relate to fertility services with capacity provided by NHS and non-NHS providers across the pathway. The ICB has ensured that current contractual partners for fertility services have been made aware of the review and they will be engaged throughout the consultation.

6. Proposals for Consultation

Having completed pre-consultation engagement, prepared initial EHIIAs and undertaken a preliminary financial impact assessment, the preferred proposals upon which we will consult are given below.

No	Procedure	Proposal (for consultation)
6.1	**Bariatric Surgery**	**Service provision via:** Group Prior Approval **Recommended threshold criteria:** NICE criteria, e.g. ▪ The person has a **BMI** of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease (e.g. type 2 diabetes or high blood pressure) that could be improved if they lost weight. ▪ All appropriate **non-surgical measures** have been tried but the person has not achieved or maintained adequate, clinically beneficial weight loss. ▪ The person has been receiving or will receive intensive management in a **tier 3 service**. ▪ The person is generally **fit** for anaesthesia and surgery. ▪ The person commits to the need for **long-term follow-up**. **EHIIA points of note**: Race/ ethnicity - BMI threshold for different ethnic groups may be reviewed in accordance with latest national evidence.
6.2	**Breast Asymmetry**	**Service provision via**: Individual Prior Approval **Recommended threshold criteria**: The goal of surgery is to correct a significant deformity which is causing an impact on health. Patients will be eligible if all the following are confirmed: • Clinical evidence rules out any other medical/physical problems to cause these symptoms; and the wearing of a professionally fitted brassiere has not relieved the symptoms, and • There is a difference of at least 2 cup sizes (e.g. C and DD cup size differential) OR evidence of another serious functional impairment for at least one year. and • Full evidence is provided of all conservative management options that have been attempted, and • The patient is a non-smoker and • Patient has had no change in cup size for 1 year, and has reached end of puberty (referral should be delayed if end of puberty has not been reached).

No	Procedure	Proposal (for consultation)
		• Only unilateral breast reduction (not unilateral breast augmentation) will be funded. • This policy does not cover gynaecomastia. **EHIIA points of note**: Sex (Gender) - may result in increased access for women, as not previously funded in B&B or ME.
6.3	**Breast Reduction**	**Service provision via**: Individual Prior Approval **Recommended threshold criteria**: • The patient is suffering from neck ache or backache. Clinical evidence will need to be produced to rule out any other medical/physical problems to cause these symptoms; and the wearing of a professionally fitted brassiere has not relieved the symptoms, and • The patient has persistent intertrigo for at least one year and confirmed by GP OR another serious functional impairment for at least one year. and • Full evidence is provided of all conservative management options that have been attempted, including weight management services where appropriate and • The patient has a BMI <27 and evidence that the weight has been stable for 12 months, and • The patient is a non-smoker and • At least 1kg is planned to be removed from each breast. • Patients who have predictable breast changes due to pregnancy are excluded. **EHIIA points of note**: Sex (Gender) - may result in increased access for women, as not previously funded in ME.
6.4	**Female Sterilisation**	**Service provision via**: Group Prior Approval **Recommended threshold criteria**: • Family complete: The woman is certain that her family is complete or that she never wants children in the future. • Contraception: AND there is an absolute clinical contraindication to Long Acting Reversible Contraception (LARC) or has severe side effects to the use of LARC or declines a trial of LARC after counselling from a healthcare professional experienced in fitting these devices. • Capacity: AND the woman has mental capacity OR all necessary arrangements have been completed to either support her to a

No	Procedure	Proposal (for consultation)
		position of having capacity or where appropriate advocacy arrangements are in place, in compliance with latest capacity guidance. • Counselling: AND she aware that the procedure is permanent but has a failure rate, that reversal is not funded on the NHS (except via Individual Funding Requests), that other forms of LARC have a similar success rate, with lower risk profile. Counselling must also include consideration of vasectomy for her partner where appropriate. • BMI: AND she must have a BMI less than 35, due to increased clinical risk associated with BMI of 35 and above. • Exemptions: women who have a medical condition making pregnancy dangerous or where LARC is contra-indicated or inappropriate will be exempt from these criteria and female sterilisation will be routinely funded. **EHIIA points of note**: • Mental Health/ Learning disability: criteria clarified around mental capacity, to ensure equality of access for those with impaired capacity. • Sex (Gender): Not previously commissioned in Mid Essex (ME), was routinely funded in Castle Point and Rochford (CPR), Southend, Thurrock. Women in ME should have greater access. Do not expect negative impact in CPR, S & T as criteria used should reflect previous clinical decision-making criteria. • Economically deprived communities: higher rates of obesity, therefore more affected by BMI criterion than less economically deprived communities. However, criteria reflect prior clinical practice and so is not anticipated to result in a change in access.
6.5	**Vasectomy**	**Service provision via**: Vasectomy under Local anaesthetic: Routinely funded Vasectomy under General anaesthetic: Group Prior Approval **Recommended threshold criteria** for Vasectomy under General Anaesthetic: • Previous documented adverse reaction to local anaesthesia. OR • Scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or control of the spermatic cord through the skin difficult to achieve. **EHIIA points of note:** • Equality: may increase gender equality, reducing burden on women to undergo long-acting reversible contraception, female sterilisation, abortion or pregnancy.

No	Procedure	Proposal (for consultation)
		• Economically deprived communities: may increase access to permanent contraception, reduce need for abortion.
6.6	**Tertiary Fertility Services**	**Service provision via**: Individual Prior Approval **Recommended threshold criteria**: • **IVF**: A full cycle defined as up to one fresh and one frozen embryo transfer. This will include the cost of freezing and storage. For patients who do not achieve a live birth with the fresh embryo transfer, the transfer of one frozen embryo will be funded. The age of mother at the time that the embryos are frozen is required to be within the age limits set out in the policy. This also applies to the age at transfer. • **Cause of infertility**: Couples who have been diagnosed as having a male factor or female factor problems or have had unexplained infertility for at least 2 years, taking into consideration both age and waiting list times. Where the partner receiving IVF is 40-42, the period of unexplained infertility should be at least 1 year. • Eligible Couples will be offered: a maximum of 2 full cycles of IVF+/-ICSI (local definition of a full cycle) where the partner receiving treatment is between the age of 23 and 39. Where the partner is between the age of 40-42, a maximum of 1 full cycle (local definition) will be offered. • Patients younger than 23 will be considered where investigations have shown conception would be impossible without fertility treatment. • Any previous IVF cycles, whether self- or NHS-funded, will count towards the total number offered by the ICB. • The partner receiving IVF should have been registered to an MSE practice for at least 12 months preceding referral to IVF services. • **BMI**: Women will only be considered for treatment if their BMI is between 19-30 (Kg/m2). Women with BMI >30 should be referred to the appropriate obesity management pathway. • Men with a BMI of >35 will not be considered for treatment and should be referred to appropriate obesity management pathway. • **Smoking**: Couples must not be non-smoking at the time of treatment. • **Same Sex Couples**: If six cycles of privately funded IUI have been unsuccessful, demonstrating infertility, the couple will be eligible for IVF as above. • **Donor gametes**: Up to one batch (usually 6) of donor oocytes and one batch of sperm will be funded. Where more than two

No	Procedure	Proposal (for consultation)
		viable embryos are generated, up to two transfers will be funded in line with the rest of the policy. Any remaining embryos will be subject to the same criteria as if the oocytes were the couple's own. Fertility products will be stored in line with relevant national guidance. • **Living Children**: Fertility treatment will only be offered to couples where the following two criteria are met: a) where there are no living children in the current relationship b) where neither partner has children from previous relationships. This includes any adopted child within their current or previous relationships • **Intrauterine insemination** (IUI) will not be funded. **EHIIA points of note**: • Age: note age restrictions within criteria. • Sexual orientation: women in same-sex relationship have to self-fund IUI prior to being eligible for IVF. Under recommended criteria, same sex couples would now be eligible for the same number of cycles as heterosexual couples. • **Sex** (gender): Men unable to access this service.

The table below clarifies any changes proposed to service provision consultation.

	Procedure	Previous CCG service provision	ICB service provision proposal for consultation
6.7	**Bariatric surgery**	Basildon and Brentwood (BB): Individual Prior Approval (IPA) Mid Essex (ME): IPA Southend and Castle Point and Rochford (SCPR): Group Prior Approval (GPA) Thurrock: GPA	Group Prior Approval (GPA)
6.8	**Breast asymmetry**	BB: Not funded ME: Not funded S&CPR: IPA T: IPA	Individual Prior Approval (IPA)
6.9	**Breast reduction**	BB: IPA ME: Not funded SCPR: IPA T: IPA	IPA
6.10	**Female sterilisation**	BB: GPA ME: Not funded S&CPR: Routinely funded T: Routinely funded	GPA
6.11	**Vasectomy**	BB:	LA: Routinely funded GA: GPA

	Procedure	Previous CCG service provision	ICB service provision proposal for consultation
		• Local Anaesthetic (LA) = Routinely funded • General Anaesthetic (GA) = GPA ME: Not funded SCPR: • LA = Routinely funded • GA = GPA T: • LA = Routinely funded • GA = GPA	
6.12	**Tertiary Fertility services**	BB: Not funded ME: Not funded SCPR: IPA T: IPA	IPA

7. Consulting on Proposals

Once the preferred proposals are agreed preparation for the formal consultation plan will be finalised including further liaison with our health scrutiny committees and our Healthwatch organisations.

It is suggested that the consultation period would run for eight weeks from 20th October to 15th December 2022, which the potential to extend as appropriate for a further two weeks.

The consultation process will be promoted as a programme of activities with an emphasis on seeking participation from those groups most likely to be impacted by any change.

People will be encouraged to use an online feedback questionnaire to submit their views, but we will also invite feedback in any of the following ways:

- By letter or email to the ICB central get involved email
- By attending a meeting or workshop, where there will be structured notes taking and minutes

The draft consultation plan is appended to this paper at Appendix 2.

For the intervening period between now and decision-making, residents will continue to be subject to the policy according to the location of their registered GP (e.g. if registered to a practice in Basildon and Brentwood, the service offered for the registered population by the predecessor CCG would be observed).

8. Recommendations

The Board is asked to agree that the ICB commences a consultation process with our residents on the proposed harmonisation of the ICB's commissioning policy.

9. Next Steps

Subject to Board approval, the consultation will commence 20th October 2022 and run through until 15th December 2022 (8 weeks).

The Board will be presented with a decision-making business case in February 2023, with agreed changes taking effect from 1 April 2023.

10. Appendices

Appendix 1: Clinical and Multi-Professional Congress Members 2021/2022.

Appendix 2: Draft consultation plan

Appendix 1

Clinical and Multi-professional Congress members 2021-22

- Chair: Ronan Fenton
- Deputy Chair: Peter Scolding
- Community Care: Gerdalize Du Toit
- Mental Health: Steven Bush, Gbola Otun
- Patient Engagement representative: Kirsty O'Callaghan
- Pharmacy: Rahul Singal
- Primary Care: Babafemi Salako, Jose Garcia, Odutola Olubenga, Rachael Marchant, Sarah Zaidi, Sharon Hadley
- Public Health: Krishna Ramkhelawon
- Secondary Care: Stuart Harris
- Social Care: Russell White
- Urgent and Emergency Care: Donald McGeachy

Service Harmonisation Consultation Plan

Contents

Page number

Introduction

At its inception meeting in July 2022 the Mid and South Essex Integrated Care Board (ICB) recognised the need to harmonise a number of commissioning policies from the five predecessor clinical commission groups.

While almost all policies were fully aligned, there were six clinical treatment areas (hereafter referred to as 'procedures') where the service offer differed. These were:

- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Vasectomy (male sterilisation)
- Tertiary Fertility Services – including
    - Intra-uterine insemination (IUI)
    - In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
    - Sperm and oocyte donation

Following review of all policies by the Mid and South Essex Clinical and Multi-Professional Congress and pre-consultation engagement activity the ICB is preparing to undertake formal consultation to inform its decision making on the future provision of these services.

Background

The July meeting of the Integrated Care Board heard that there was a requirement to harmonise the commissioning policies of the five predecessor Clinical Commissioning Groups (CCGs). While almost all policies were fully aligned, there were six clinical treatment areas (hereafter referred to as 'procedures') where the service offer differed. These were:

- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female Sterilisation
- Vasectomy (male sterilisation)
- Tertiary Fertility Services – including
    - Intra-uterine insemination (IUI)
    - In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)
    - Sperm and oocyte donation

For IVF this included no provision in two out of the five commissioning areas.

The Board received a paper outlining the work required to align polices over the course of 2022/23. The Board noted that the work would be guided by:

- Multi-professional clinical and professional advice
- Engagement and consultation with residents.
- An assessment of the financial consequences of any decision made
- An assessment of service capacity and capability to deliver any future changes to the service restriction policy.
- Equality and health inequality impact assessment

The Board noted that the absence of provision in some areas must be addressed, and agreed to address specific disparities while ensuring the ICB can fulfil its four key, nationally stated, purposes:

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

The Board noted that there is no earmarked funding to address historical disparities.

Consultation approach

Pre-consultation engagement

The pre-consultation engagement phase is an important opportunity to engage with key interested parties to ensure when the formal consultation starts, all the aspects of the consultation have been considered.

Consultation principles

We will adhere to the principles of consultation that Government departments and other public bodies should adopt, including 'Transforming Participation in Health and Care' (2013) and NHS England's 'Consultation Principles' (2012)

We are committed to ensuring:

1. **Clarity about decisions**

We will be clear in our documentation and in discussions with local people about:

- How is this a change from current arrangements
- What are the potential benefits e.g. improved outcomes, service, efficiency, sustainability?
- What are the implications for patients and public e.g. number of people involved, access to services,

2. Clear and accessible supporting information to enable people to take a view

We will ensure that there is an easily accessible information that will include details on:

- Case for change
- Clinical evidence and relevant national guidance
- Equality
- Resource and financial issues e.g. costs, investment

3. Clarity of debate

We will ensure there are details on how we have arrived at the current proposals, including:

- What the options were and how we assessed them
- How people have been involved

4. Effective opportunities for people to have a say

We will ensure that our consultation process is fair and effective by providing:

- A reasonable period of time to access and respond to the information
- Accessible channels and methods for feedback
- Good access to information
- Demonstrable “listening” and two-way discuss
- Ensuring it is a view seeking exercise, not a vote/referendum

5. We will be proportionate in our efforts

We will ensure that our consultation is proportionate by:

- reaching out across mid and south Essex’s geography, demography and diversity

- seeking fair representation across patients, carers and the public, support groups and organisations

Main methods

The consultation period will run for eight weeks from 20th October to 15th December 2022

The consultation process will be promoted as a programme of activities with an emphasis on seeking participation from those groups most likely to be impacted by any change.

Opportunities to get involved

For key stakeholders and groups:

- Regular updates and discussions at scheduled meetings e.g. Health and Well Being Board briefings and Health Overview and Scrutiny Briefings
- Meetings on request

For diverse groups and representatives of vulnerable people:

Proactive offers to arrange discussions, tailored to the needs of each group e.g.: recognising the nine protected characteristics including:

- age
- ethnicity
- gender
- disability
- sexual orientation
- religion and beliefs

Opportunities to give views

People will be encouraged to use an online feedback questionnaire to submit their view, but we will also invite feedback in any of the following ways:

- By letter or email to the ICB central get involved email
- By attending a meeting or workshop, where there will be structured notes taking and minutes

Outline consultation plan

Phase 1 – Consultation preparation • pre consultation engagement • independent analysis report • Draft consultation plan • Draft consultation document • Draft main survey questions	September-October 2022
Phase 2 – • Board approval for consultation launch – 13th October • Liasion with X3 HOSCs • Draft Stakeholder briefing • Prepare for discussions sessions • Prepare press and media updates • Briefing and preparation with key spokespeople	Up to and including 13th Oct 2022
Phase 3 – Consultation • Publish consultation materials via website and distribution • Formal launch and media programme • Ongoing stakeholder briefings and updates • Individual stakeholder discussions and meetings • Programme of workshops • Sessions with targeted groups • Feedback via survey, letters, notes from meetings and workshops	20th Oct to 15th Dec 2022
Phase 4 – Consultation outcome and decisions • Feedback collated and prepared for analysis • Independent analysis and outcome report • Outcome report for consideration • Engagement and discussions with stakeholders	January - February 2023

• Decision-making process and post-consultation business case	

Main production and management elements

1. Production materials

- The consultation document is the anchor and centrepiece

  We will make arrangements to provide different formats on request e.g. audio version, large-print, language versions, and easy-read for people with learning disabilities

- Supporting materials include:

  - A short summary of the consultation
  - Covering letters for different audiences
  - Feedback questionnaire
  - Stakeholder briefing note
  - Press notice
  - Presentation slides for different audiences
  - Speaker support materials – core narratives, lines to take, FAQs

2. Digital support and social networking

- Use of the ICS website

Use of the website for the consultation will help to ensure accuracy of information and access to all available information e.g. background clinical evidence, links to other relevant information, more detailed documents

- Feedback survey

An online survey style feedback questionnaire will ensure efficient collection of views and also offers analytics for monitoring and analysis.

- Facebook and Twitter

Social networking is important as a channel for access to information and a means for feedback.

- Eventbrite or other meetings planner

Eventbrite will support the management and promotion of events, including email distribution, booking system and analytics.

Handling ongoing communications and feedback

- **Press and media**
  The consultation period requires a detailed press and media plan with a series of releases at intervals over the period. We have established close relationships with key outlets and they are well-informed on most of the issues.

- **FOIs and enquiries**
  There is likely to be increased workload for responses to questions that may come via the FOI route or just via email and post. This will require continual management and structured processes to ensure timely responses, often involving contributions from subject matter experts and senior management sign-off.

- **Horizon scanning and issue management**
  Controversy can escalate at any time, with a high risk of misinformation. The consultation programme requires a robust system of horizon scanning and alerts, with ability to take proactive and speedy action to avoid problems.

- **Relationship management and reporting**
  The consultation programme will need to respond to the needs of different audiences, anticipating where possible what these may be. This includes relationships within both internal and external audiences.
  This requires continual management and liaison with subject matter experts, senior management and organisational partners.

- **Management of feedback**
  There will be robust systems for receiving, acknowledging and recording feedback, and responding where necessary, sometimes involving contributions from subject matter experts and senior management sign-off.

- Feedback will be in multiple forms – via online survey, written feedback, notes from meetings and file notes of conversations

- Feedback records will need to be organised in a way that enables effective summary and analysis to be compiled in a final feedback report with recommendations for decision-making.

Governance focused stakeholders

Target audience	Communications channel	Details	Responsibility	Timescales
ICB	Discussion as part of regular meeting cycle	Papers, presentations, briefings		Ongoing
System leadership group	Discussion as part of regular meeting cycle	Papers, presentations, briefings		Ongoing
NHSE/I regional team	As part of assurance process			
Provider boards	Discussion as part of regular meeting cycle	Papers, presentations, briefings		
NHSE specialised commissioning	As part of assurance process			
CEOs and Directors of local authorities (top tier and district)	Through regular forums			
Top Tier and District Health and Well Being Chairs and Officers (for distribution to members where not captured in above groups)	As part of regular meeting cycle			

HOSC officers x 3 (for onward distribution to chairs and members) Request for Joint HOSC	Informal chairs briefing Formal meeting attendance	Presentation, papers, briefings		

Wider Stakeholders and existing channels

Target audience	Communications channel	Details	Responsibility	Timescales
INTERNAL STAKEHOLDERS				
ICB colleagues including Exec teams	Connect internal newsletter			
Provider and local authority teams	Various existing channels	MSE ICS comms will brief local comms teams for forward distribution as appropriate	Org led/ via comms network	
GPs and PCNs	GP Bulletin		MSE comms	
EXTERNAL STAKEHOLDERS – residents, voluntary organisations, political etc				
Residents – broad awareness and as appropriate	Online – PCN websites, ICS public website Media		MSE comms / Partner comms	
	Online – partner and provider websites		Org led/via comms network	
	Social media – Facebook & Twitter		MSE comms	
	Social media – paid for		MSE comms	

Target audience	Communications channel	Details	Responsibility	Timescales
	Granicus email messaging		MSE Comms	
	Virtual Views		MSE Comms	
	Public facing newsletters and bulletins		All partners to scope existing publications which can carry core messaging	
	Online – provider and partner websites (including GP sites etc)	information based on core messaging	All	As needed
	local radio Interview opportunities	Supporting specific elements of the programme to drive awareness and engagement	MSE comms,	As needed
	Media releases	Supporting specific elements of the programme to drive awareness and engagement	MSE comms	
	Media relationships	Supporting specific elements of the programme to drive awareness and engagement	MSE comms	Ongoing
	Media management	Handling media enquiries / mitigate against negative coverage and perception	MSE Comms	Ongoing
	Video media	key spokespeople to drive awareness, address specific issues, educate, support narrative etc.	MSE comms	Ongoing
Cllrs and members	Briefings – written and virtual	Supporting specific elements of the programme to drive awareness and engagement	Supported by MSE comms	Ongoing

Target audience	Communications channel	Details	Responsibility	Timescales
MPs	System level online briefings	Supporting specific elements of the programme to drive awareness and engagement	Supported by MSE Comms	Ongoing
	Place based briefings and 1-1s	Led by alliance directors Supporting specific elements of the programme to drive awareness and engagement	Alliance Directors	As needed
Health Overview Scrutiny and other health committees	Email/ virtual briefings and attendance at meetings	Supporting specific elements of the programme to drive awareness and engagement	MSE Comms	Ongoing
Healthwatch x3	Email/ briefing	programme and shared assets for onward cascade	MSE Comms	Ongoing
CVSs	Email and virtual briefing and 1-1s as necessary	Supporting specific elements of the programme to drive awareness and engagement	MSE comms Alliance Directors	Ongoing
Supporting access to diverse communities and those subject to health inequalities i.e, Ethnic minorities, LD, mental health, traveller community, homeless, CYP, unpaid carers, core 20 etc	Utilising existing trusted channels and communities' leaders			Ongoing

Part I ICB Board meeting, 13 October 2022

Agenda Number: 8

Digital Strategy & Investment Priorities

Summary Report

1. Purpose of Report

To provide the Board with details on outcomes of the digital prioritisation approach and visibility on the estimated investment profiles required to support delivery of these ambitions for our ICS.

2. Executive Lead

Barry Frostick, Chief Digital and Information Officer

3. Report Author

Barry Frostick, Chief Digital and Information Officer

4. Responsible Committees

The Digital Investment Plan has been through the following groups

- Digital Transformation Programme Meeting Jun 22
  - Supported by members of the group which are inclusive of our partners across the ICS.
- Digital Data and Technology Board 14 Jul 2022.
  - The board supported all of the recommendations, but noted that there is a finance risk for recommendation #2 and that recommendation #3 will need additional executive buy-in.
  - It was suggested that increasing focus on benefits realisation would be important.
  - The creation of a risk for investment should be incorporated into a risk log.
  - Digital investment plan to be taken to the SFLG to discuss funding risks moving forward.
- ICS Executive Group July 2022
  - Recognition of the priorities as set out and alignment with ambition of the ICS.
  - Confirmation that all digital investment was focused on tactical/key operational requirements and no investment targeted to support strategic programmes
  - A request to review sequencing of sequencing of strategic programmes
  - Request for a review of the capital plans in place for digital it seek identification of opportunities to support investment in strategic programmes.

- MSEFT Digital and Data Forum 3rd Aug 2022
  - Shared in summary. Strong support provided with a recognition of improving alignment on engagement moving forward.

5. Impact Assessments

These will be managed at the appropriate time for each programme of work.

6. Financial Implications

The investment plan highlights a significant demand on funding for future years. To support the digital investment plan will require a re-prioritisation of funding across the system. Agreement on that reprioritisation needs to be considered alongside wider system priorities.

7. Details of patient or public engagement or consultation

No direct public engagement in creating the plan, but engagement is in place with some of the key programmes such as the Digital Patient Interface. This will be managed through the governance of that programme.

8. Conflicts of Interest

None identified.

9. Recommendations

The Board is asked to:

- Note the approach taken to create a digital investment plan for the ICS
- Approve the Digital Investment Plan and support the prioritised list of programmes as set out in the appendices
- Request further work with System Finance Leadership Group (SFLG) to secure investment requirements over future years.

Digital Strategy and Investment Priorities

1. Introduction

The Digital and Data/Business Intelligence strategies for Mid and South Essex (MSE) Integrated Care System (ICS) were approved in 2021. These documents set out a clear vision for transforming health and care services in MSE through key themes of digitise, connect and transform.

As part of establishing ICSs there was a national request for each ICS to have a three-year Digital Investment Plan in place by July 2022. This request was later stood down, however creating a Digital Investment Plan was seen as a key activity for the system. Therefore, the Digital Investment Plan for MSE was developed in line with this original request and is outlined in this paper for approval by the ICB.

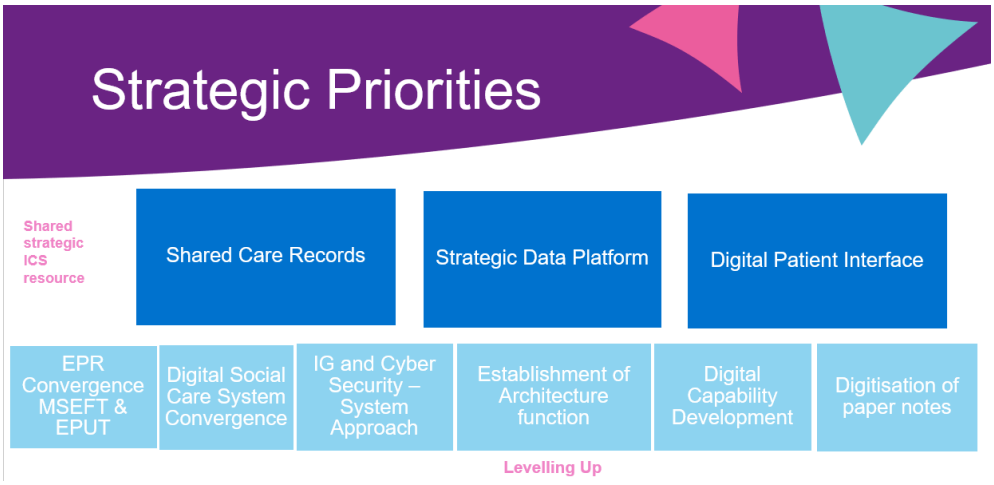
In Feb 2022 the Digital and Data Technology Board approved our approach to work collaboratively to create a Digital Investment Plan. The three-year plan was developed together with indicative costings and focused on the key strategic digital and data ambitions of the ICS.

2. Main content of Report

The attached Digital Investment Plan builds on the approved Digital and Data/Business Intelligence (BI) strategy. The Digital Investment Plan focuses on the delivery of core digital capabilities across the integrated care system. To support the prioritisation of initiatives for investment the process included a set of investment and delivery principles taken from NHS providers guidance for boards commissioned by NHS England and Improvement (NHSEI). Within Mid and South Essex there is a significant ask on improvements in digital and data across the system and therefore the investment plan emphasised on priorities which will:

- Make a difference to the collective health and care provision across Mid and South Essex and its borders.
- Improve the commonality of solutions and their ability to talk to each other to better cater for the needs of the workforce and population.
- Drive up the digital maturity in line with 'What Good Looks Like'.

The output of this work has identified the following key strategic priorities:



Our three large multi organisational transformation programmes support key ambitions of the ICS.

Shared Care Record: The ability to have information from Acute providers flowing into Primary Care to support interaction with patients or having accurate Mental Health Crisis information to provide better care for patients using our emergency services. These and more use cases are recognised requirements from our clinical and professional workforce. Having the right information to hand at the right time improves the ability for our professional workforce to be better prepared, to make improved decisions and provide a more reassuring positive experience for our services users.

Strategic Data Platform: The use of accurate, reliable, and timely data is critical for supporting our system. It will enable us to better plan and manage our operational performance by providing actionable insight to our operational and clinical teams. Better connected and more reliable data will enable us to build further on our existing Population Health Management work. It will provide increased insight to understanding the impact of preventative activities or to forecast where we might need to increase future service provision for particular conditions.

Digital Patient Interface: This can create the capability for our residents and their careers to have greater control of their care. To have a single front door for health and care services across Mid and South Essex that integrates with the NHS App. The solution can empower patients to share information with whom they choose. It can also provide the capability for patients to see upcoming appointments, change appointments and co create personalised care plans.

Underpinning these strategic programmes are a key set of supporting activities. These include the creation of a system wide approach to Information Governance (IG) and convergence of Electronic Patient Record Systems (EPR) across our provider landscape. Each of these priorities have an agreed high-level Milestone plan which is being used to focus work and activities moving forward.

The Digital Investment Plan highlights the current level of financial challenge required to deliver these ambitions *(Red/Amber/Green (RAG) rating in appendix - slide 14)*. The investment profile identified within the Digital Investment Plan highlights the need for significant investment over the next 3-5 years.

Scheme	3 Years (22/23 – 24/25)		5 Years (22/23 – 26/27)	
	Capital (£K)	Revenue (£K)	Capital (£K)	Revenue (£K)
Major Platforms raw emerging costings	71,451	12,401	81,599	14,773
Other schemes & enablers	1,750	8,248	1,750	14,107
Totals	**73,201**	**20,649**	**83,349**	**28,880**

A bottom-up costing approach has been taken to reach these figures. For our strategic programmes we have used reference costs from similar investment cases across other ICSs or health and care organisations. Whilst these costs have been created from similar investment cases it should be noted that local variations, adjustments in financial rules or supplier choice are likely to modify these figures.

Therefore, these costs should be treated as indicative with a recognition they will be refined and firmed up as part of the standard investment case process.

Other than affordability, the digital investment plan highlights the following points.

Establishment of the digital team required to support programmes. There is a core team structure included as part of the new ICB function. Recruitment to this team is recognised as a key priority and has commenced. Each programme may require specific additional capacity to deliver which will defined within the investment cases moving forward. For the Digital and Data space we know the market is extremely competitive currently so there is likely to be challenges on securing appropriate high calibre resources.

The sequencing of programmes will require a level of re-working and careful management of interdependencies. For example, to progress with Shared Care Record now will require re-work from an integration perspective when our providers replace their existing Patient Administration Systems (PAS) with Electronic Patient Records (EPR) systems.

3. Findings/Conclusion

The digital investment plan builds on our existing strategies and national guidance. It creates a prioritised portfolio of programmes for our system. It was created through engagement with partner organisations to ensure support and alignment. This Digital Investment Plan has been approved at the Digital Data and Technology Board in July.

The plan does not include detailed lines for all digital programmes which are in place within each partner organisation. Interdependencies between the programmes are managed through the Digital Transformation Programme Group.

Without identified investment the delivery of these programmes will be at risk. We may need to further refine our priorities in line with available funding limits. This may impact on our residents and staff will continue to experience the challenges in place today. There is a need to work closely with our finance community to manage the financial challenge and work to secure the right funding to support this Digital Investment Plan.

We need to work with our regional and national colleagues to seek opportunities that can support our ambition. These conversations are already in place and we are reaching a positive position of external investment to support our EPR programme of work.

These strategic programmes are transformation programmes and require clinical and operational leadership plus wider engagement with our workforce and residents to ensure success. This is recognised across our leadership team and we are securing the appropriate input and governance moving forward.

In order to meet the ambition of the ICS and to continue to improve how we care for our residents we need to continue to work together to address the challenges identified.

4. Recommendation(s)

The Board is asked to:

- Note the approach taken to create a digital investment plan for the ICS
- Approve the Digital Investment Plan and support the prioritised list of programmes as set out in the appendices
- Request further work with System Finance Leadership Group (SFLG) to secure investment requirements over future years.

5. Appendices

Appendix A - Digital Investment Plan Overview – approved at Digital Data and Technology Board July 2022.

Mid and South Essex
Health and Care
Partnership

MSE ICS
3 year Digital Investment Plan

Working together for better lives

Background

The NHS Long Term Plan includes national requirements for digital that are expected to be delivered at ICS level from July 2022. These include targets for virtual wards, resident access channels, digital inclusion and several other key areas set out in the 22/23 national priorities and operational planning guidance. What Good Looks Like (WGLL) has also been published which sets out the expectations for assessing digital maturity going forward.

NHSE/I has therefore requested initial Digital Investment Plans at ICS level by July 2022. This document sets out the approach and insights to be read alongside the more detailed plans and costing information.

The plans are extrapolated from the ICS strategy and accommodate the emerging requirements from the centre and the local clinical priorities where appropriate. A local assessment of WGLL has also been used to influence the plan to drive up the digital maturity across the ICS over time

ICS Strategic Focus

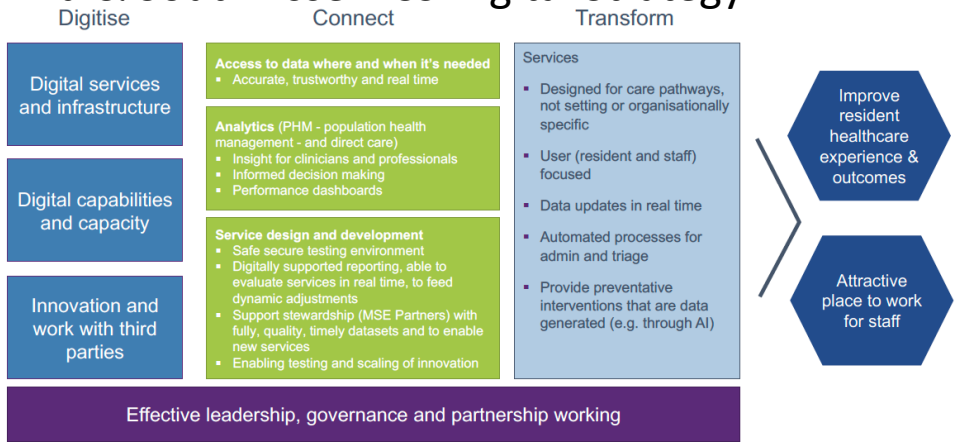
Our **Digital Vision** is to provide digital and data solutions that drive insight led decisions, support our workforce and enable better outcomes for our residents

The 3 year plan has taken the key themes for the ICS Digital Strategy and the BI Strategy to ensure alignment with achieving the Digital Vision.

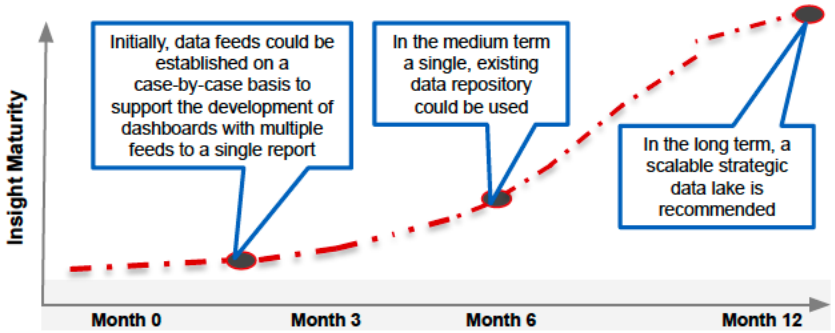
There is a clear focus on building capability and capacity, driving up the infrastructure, providing key platforms to enable access to data and supporting innovation and transformational change for the benefit of residents and staff.

This is all underpinned by the principle of partnership working with programmes led by leaders from various partner organisations.

Mid & South Essex ICS Digital Strategy



Mid & South Essex HCP BI Strategy



Headlines

The 3-year digital delivery plan developed together with indicative costings shows a greater level of detail in year one, with decreasing granularity over the following years. The planning has been created through wide engagement with stakeholders across the ICS and with specific focused involvement of the identified leads for each key workstream. The DDaT and Digital Transformation Groups have been engaged with regular updates, gaining feedback to ensure alignment across the ICS. The following points will help give context to the plans:

- Year 1 focuses on enabling activities and building cases together with some early resident benefit – principally for areas less dependent on major platforms.
- Timescales for largest schemes mean that the plan covers five years in practice (to FY 26/27).
- All major schemes make a direct identified contribution to overall digital maturity and resident benefits.
- The plan has been validated with leads, but remains indicative pre-OBC for the majority of schemes.
- The figures in this analysis are backed by a detailed plan and costings analysis.
- Major scheme costings are realistic vs comparators.
- Comparative breakdowns in this pack give an indication of the quantum required and the relative balance of funding required.
- Capacity and capability are built in through a central team to support elements of the plan including a PMO to oversee delivery and provide assurance.

The two key risks at present are:

- Funding uncertainty means that this is a full scope plan and costings picture, and therefore may be unaffordable in totality. Elements of the plan can be shifted to meet funding availability.
- The sequencing of the major platforms will have architectural interdependencies. The plan assumes continued progress on major schemes with a requirement to align these with the core architecture once it is established.

Mid and South Essex Health and Care Partnership

Planning Context

Working together for better lives

Approach to Prioritisation

To support the prioritisation of initiatives for investment and prioritisation within delivery plans the process has included a set of investment and delivery principles taken from NHS Providers guidance for boards commissioned by NHSE/I. Using these in conjunction with a clear planning and delivery review cycle will enable the plan to be refreshed and adjusted to meet emerging requirements.

Emerging Strategic Digital Investment Principles*

Prioritise the things that [residents] and staff need

Projects at ICS level will focus on resident and staff benefit and competing projects evaluated against these.

Competing benefits profiles must explicitly demonstrate direct or indirect benefit (e.g. better access - direct, or better security - more indirect)

Practical implications - All benefit cases/calls for funding must be explicit and address categories agreed by the ICB.

Invest in a dedicated, cross functional [ICS] team

Create a right sized, coordinated cross functional, cross care setting, cross place virtual digital team to maintain focus on the vision and ensure that learning and approaches are coordinated rather than reinvented.

Practical Implications - A new digital operating model across MSE.

Get the best out of digital suppliers

Develop and maintain strategic supply relationships at ICS level where this makes sense.

Aim to use the same solution where procurement rules allow, it makes strategic sense, is cost effective and appropriate contractual vehicles exist.

Practical implications - Use an established proven supply route where we can, to get economies of scale and replicate solutions and relationships that is aligned with national procurement approach.

Set clear, realistic goals

Ensure that the primary aim of digital investment is realistically achievable and has evidenced benefits for residents and staff with “optimism bias” challenged.

Practical Implications - Rigorous testing process for cases as assurance for ICB.

* Based on guidance published by NHS Providers (May 2022) in a series of guidance for Boards of NHS organisations on digital agenda. Commissioned by HEE and supported by NHSE/I.

Emerging Strategic Digital Delivery Principles*

Think long term, deliver in the short term

Rigorous assurance to ensure fit with ICS goals.

Maintain focus on a clear vision (North Star) for digital at ICS level expressed in benefits terms.

Practical implications - delivery milestone and benefits realisation tracking at ICS level through CDIO for ICS funded projects.

Build trust in digital

Address digital inclusion and exclusion explicitly through the strategy.

Ensure short cycle time for benefits.

Digital capability development for residents and staff. Work towards upskilling to a digitally mature workforce, investment in education, training etc

Practical implications – Residents and staff more able to embrace technology, realising benefits more rapidly and consistently.

Test, measure and learn

Innovate locally, test at place level, scale at system (either bigger scope or replicated instance)

Blueprint models and technology approaches for the same problems (don't solve the same problem multiple times)

Practical implications - Review all projects and pool resources around front runner. Work as an alliance with PLACE to level up. Use other people's ideas. "Fail fast".

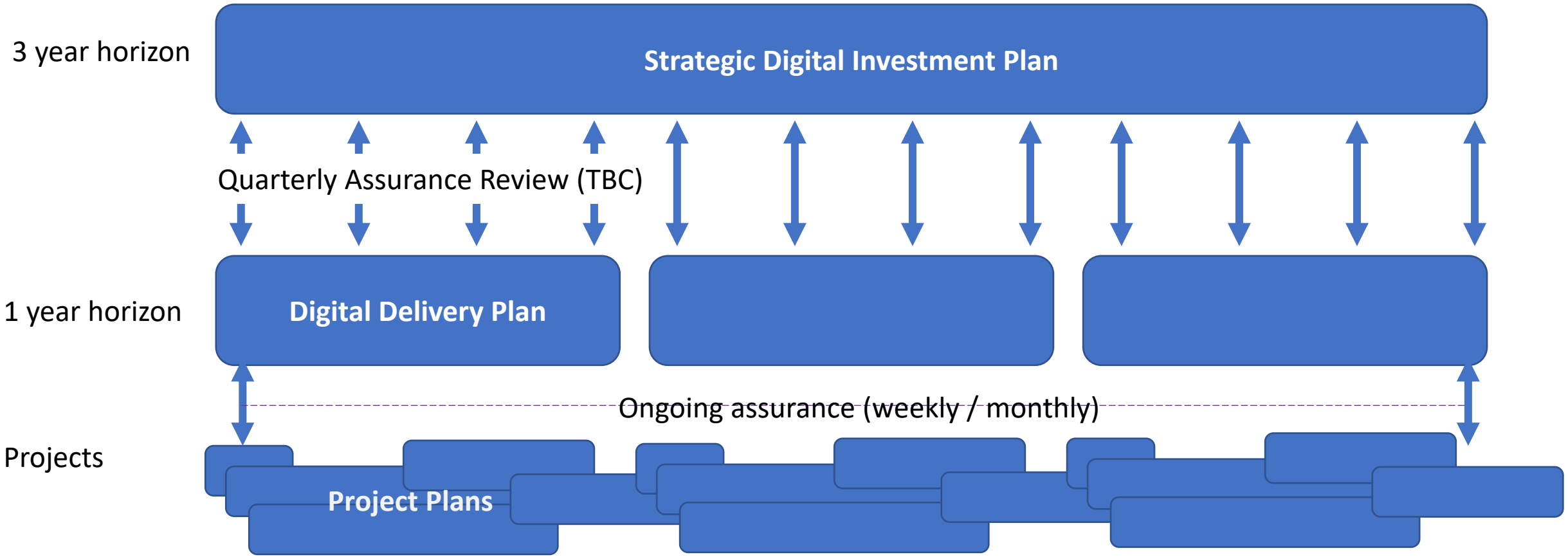
Don't stick to the wrong plan

Rigorous delivery assurance against business case.

Practical implications - Leadership and Governance for digital within ICS. Gated process with no-go decisions being made by CDIO. Some projects may be stopped if not delivering to make better use of resources.

* Based on guidance published by NHS Providers (May 2022) in a series of guidance for Boards of NHS organisations on digital agenda. Commissioned by HEE and supported by NHSE/I.

Suggested Digital Planning Hierarchy (In Pictures)



Suggested Digital Planning Hierarchy (In Words)

ICS Investment Plan

- ✓ 3 year plus strategic investment plan around major themes for the ICS.
- ✓ Used to build the cases for digital investment and provide a clear view of the overall costs
- ✓ Supports major cases and investment needs.
- ✓ Required by NHSE/I and the ICB.
- ✓ Approved by DDaT for ICB.
- ✓ Reviewed annually.

1st approved version for July 2022 DDaT

ICS Digital Delivery Plan

- ✓ Rolling 1-year operational delivery plan aligned with the agreed investments.
- ✓ Agreed with programme leads and approved by the CDIO.
- ✓ Used to track delivery with programme leads and manage agreed digital investment projects.
- ✓ Required by the CDIO and DDaT.
- ✓ Aligns with Social Care and NHS annual planning cycles
- ✓ Provides assurance against agreed investments.
- ✓ Reviewed monthly.

Current Focus: 1st version for work already started and alignment with strategic plan.

Mid and South Essex Health and Care Partnership

Detailed 3 Year Plan

Working together for better lives

Digital Investment Plan

What's In?

- ✓ Things that will make a difference to the collective health and care provision across Mid and South Essex and its borders.
- ✓ Things that will improve the commonality of solutions and their ability to talk to each other so that the needs of the population are better catered for.
- ✓ Things that drive up Digital Maturity in line with WGLL.
- ✓ Things that represent the best value for the MSE £.

What's Out?

- ✗ Lower level detailed delivery plans.
- ✗ BAU plans funded out of local budgets.
- ✗ Things that don't meet the strategic investment or delivery principles.
- ✗ Digital solutions specific to one organisation's needs.

3 Year investment plan

The enabling works for all major projects have been included in the plan, this included SOC through to FBC. The majority of these are planned for Q3 & Q4 of 22/23 and could be carried out in parallel, funded from the baseline funding. Within the plan the projects are rated:

- green = assumed affordable
- amber = partially funded
- red = unfunded at this stage

With an uncertain funding path the plan is based on some core assumptions at this stage including:

- Near proxies have been used to reflect the scale of the investment whilst projects are pre-OBC
- All schemes are assumed to be able to proceed in parallel during delivery, this will of course change to reflect funding availability
- Given that EPRs are pre OBC, the suggested timelines reflect common approaches from similar projects.

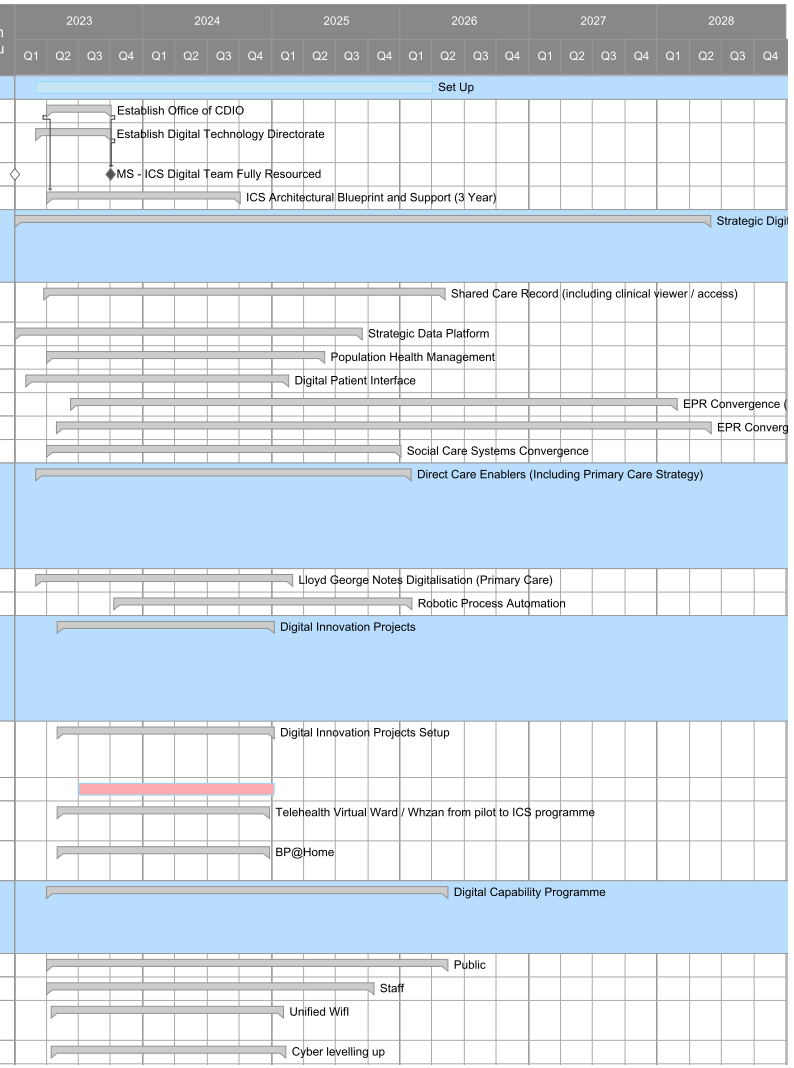
All the major capital schemes have been phased into delivery increments (sprints) to stable waypoints. This will enable some progress, with realisable benefits, that reflect costing availability without significant detriment to the overall project.

Some innovation projects have demonstrated their benefits in pilot however they will need a transformational focus if taken to scale to realise the change and associated benefits

Detailed timelines for 3 and 5 year plans are presented at Appendix A.

High Level Plan

Task Name	Description	Funding in Place	Priority (Must/Should/Could)
Set Up	Establishment of the key ICS enablers		Must
Establish Office of CDIO		Full	
Establish Digital Technology Directorate		Full	
MS - ICS Digital Team Fully Resourced		Full	
ICS Architectural Blueprint and Support (3 Year)	Establishment of an end to end EA and architecture team to support its delivery	Partial	Must
Strategic Digital Platforms	Major platforms developed once for the ICS as a whole, or as a fully integrated landscape of local platforms (e.g. EPRs, patient access). Essential information, intelligence and data for all care settings as needed by services users, residents and clinicians.		Should
Shared Care Record (including clinical viewer / access)	Current plan assumes FBC by 16/2/22 and contract by 11/05/22. No gates with NHSE/I. Plan below is ours.	Partial	Must
Strategic Data Platform	Need to validate 1. NHSE/I requirements for BC progression and funding, and 2. OBC sign	Partial	Must
Population Health Management		No	Must
Digital Patient Interface	Need to validate 1. NHSE/I requirements for BC progression and funding, and 2. OBC vs F	Bidding	Must
EPR Convergence (MSEFT)	Reflects current view from MSE FT and is aligned with EPUT timelines up to FBC. Needs r	Partial	Must
EPR Convergence (EPUT)	Reflects current view from KPMG / EPUT and is aligned with MSE FT timelines up to FBC.	Partial	Must
Social Care Systems Convergence	Social Care Systems Improvements in line with National funding. Bidding for funding (£500	Bidding	Should
Direct Care Enablers (Including Primary Care Strategy)	Projects based on previous initiatives using proven technology projects (distinct from innovation projects with new technology / pathways) capable of wider scaling. Keeping people well in their homes and improving their overall life chances. Supporting people with long term conditions to live well. Admission avoidance. Safe care. Examples will be clinically focussed - eg virtual condition management. Based on 90 day sprints.		Could
Lloyd George Notes Digitalisation (Primary Care)	Digitalisation of legacy paper notes in GP practices with aim of releasing space for other se	Full	
Robotic Process Automation		No	Could
Digital Innovation Projects	Innovation at smaller scale that has the potential to be grown and be deployed more widely. Encouraging targeted inwards investment and innovation at the front line that has scalable benefits involving AHSNs, universities, and the private sector. Only 1 project at a time. FBC developed in parallel with an initial POC. Future sprints may be none or multiple depending on benefits realisation. Based on 60 day sprints.		Could
Digital Innovation Projects Setup	Establish digital innovation programme to support stewardship programme with candidate digital enablers using an innovation led approach. Targets for pipeline of projects agreed along with Governance during setup.	No	
	Projects to be confirmed	No	Could
Telehealth Virtual Ward / Whzan from pilot to ICS programme	Potential project to take from proven pilot to ICS wide programme with significant benefits case. Linked to Multiple Stewardship programmes run by MSE Partners	Bidding	Should
BP@Home	Blood Pressure at home from pilot to ICS wide. Linked to Stewardship programme run by MSE Partners	No	Should
Digital Capability Programme	A coordinated approach with to address barriers to accessing health and care services digitally, and providing kit, information and navigation to those least able to access digital services. Building digital capability at all levels in HWE teams via targeted training. Improving digital literacy and inclusion where appropriate.		Could
Public			Should
Staff		No	Should
Unified Wifi	Provide unified wifi provision across the ICS to enable users to move seamlessly between locations with simple, secure, consistent approach to connectivity	Partial	Must
Cyber levelling up	Programme to level up Cyber compliance across ICS and constituent organisations	No	Must



Key issues

- Overarching business, application and information architecture roadmap required for OBCs addressing sequencing of programmes. ShCR, Data Platform, EPRs (MSE FT and EPUT) and the Digital Patient Interface (DPI) are all critically dependent on architectural landscape as they are interdependent. Current planning assumes projects will progress and retro-fit to architecture to support early benefits realisation.
- DPI platform, ShCR and Data Platform deliverability is dependent on interfacing with EPRs in EPUT and MSEFT that are themselves to be redeveloped.
- PHM Strategy will inform PHM digital requirements which will be enabled by strategic platforms.
- Time to establish core ICS digital team required to support programme (assumed to be in place by 23/24).
- NHSE/I investment approvals timescale for EPRs – assumed these processes don't extend to ShCR, data platform and social care systems, but this may not be a valid assumption.
- Short term project options in next FY to deliver improvement in direct care and progress maturity still need further development.
- Overall affordability.

Approach to EPRs

National funding for EPRs is being allocated against centrally defined criteria. Both EPUT and MSEFT have been classified as having an EPR and therefor have lower funding indicated than might have been expected. The ICB and Trusts have the opportunity to determine what outcome they desire from the PER programmes. For each EPR there are two main options;

Option A – do minimal within available central and trust funding. Unlikely to meet wider ICS strategic objectives including opportunities for data sharing and transformation change in pathways and partnership working.

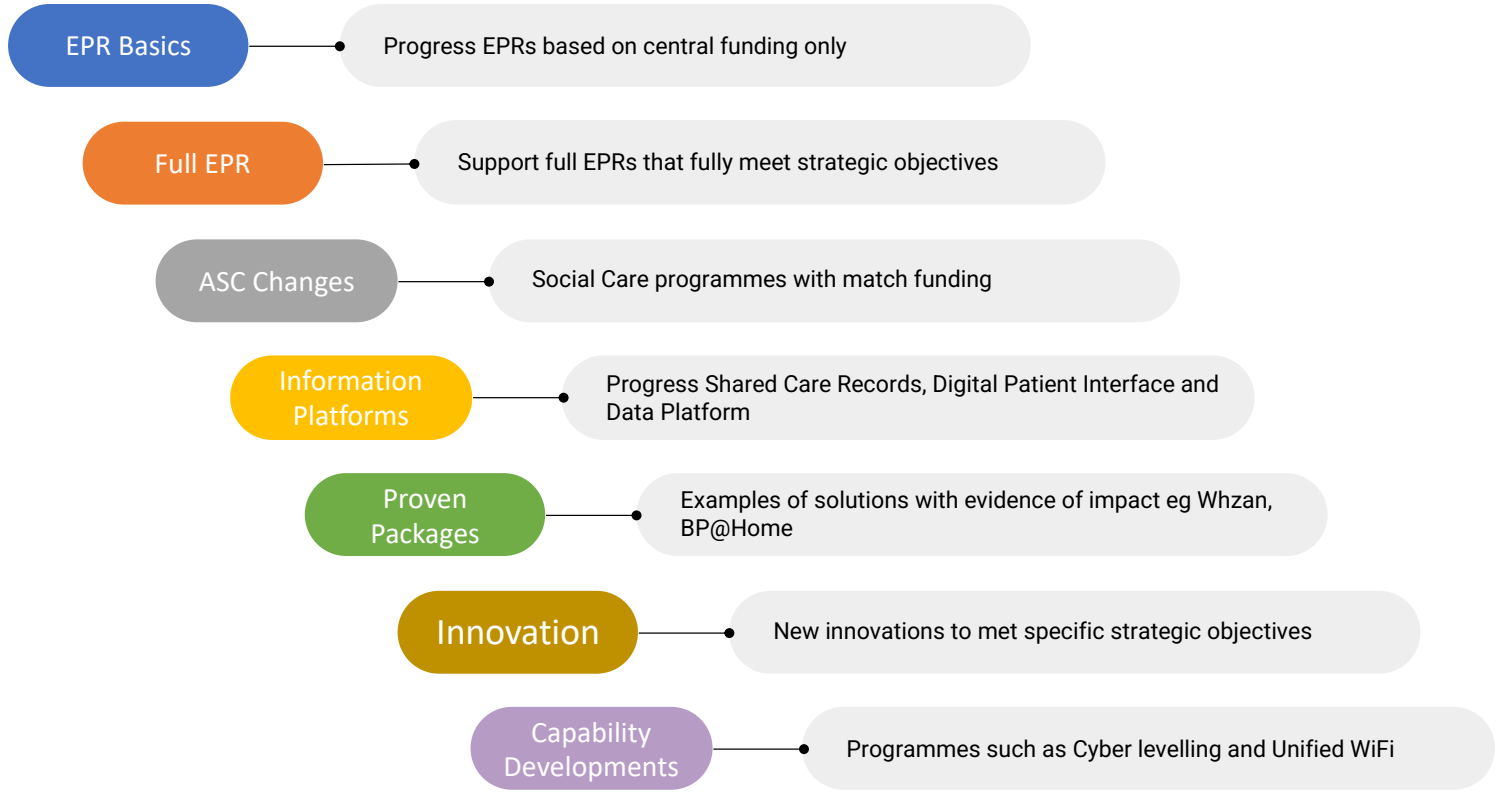
Option B – Further funding supported through the ICS to deliver full EPRs targeted at meeting the trust and ICS strategic goals, specifically around data sharing and supporting transformational change across partners.

These potential variance in the costing of these options have been highlighted in the costing summaries. The plan currently assumes progress towards strategic objectives (Option B)

Affordability

The programme may not be affordable in its entirety. The plan enables different elements to be grouped dependant on priorities, alignment with the strategy, costs and potential benefits. These could be framed against the ICBs strategic objectives, the funding available and assessed using the agreed principles.

A process is recommended to identify the potential benefits, alignment with the strategy to help inform any process so that available funding may be targeted to maximise the opportunity for the ICS

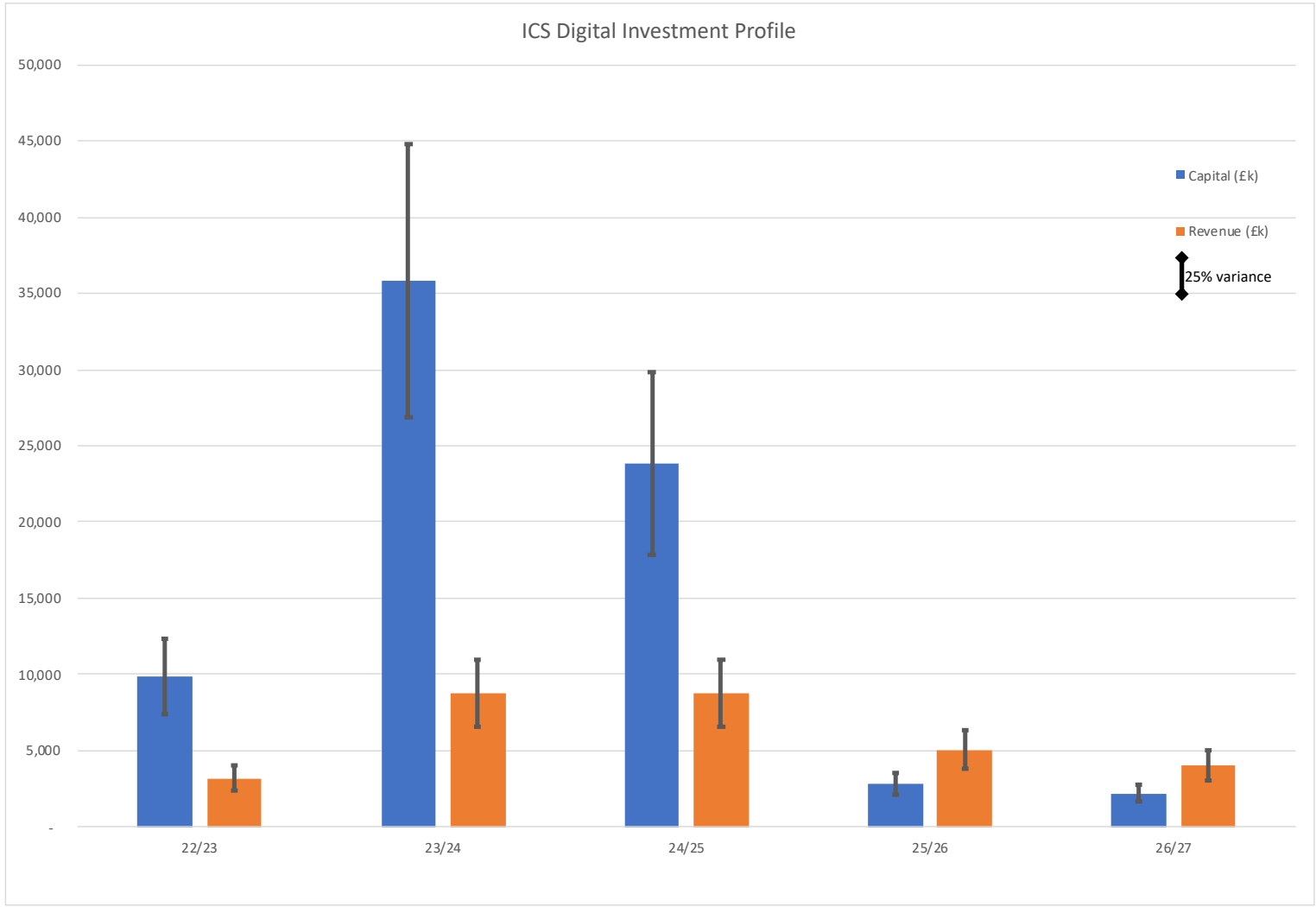


Mid and South Essex Health and Care Partnership

Investment Profile

Working together for better lives

Emerging Investment Profile



Total Investment minus matched funding

Scheme	3 Years (22/23 – 24/25)		5 Years (22/23 – 26/27)	
	Capital (£K)	Revenue (£K)	Capital (£K)	Revenue (£K)
Major Platforms raw emerging costings	71,451	12,401	81,599	14,773
Other schemes & enablers	1,750	8,248	1,750	14,107
Totals	**73,201**	**20,649**	**83,349**	**28,880**

Notes:

1. Figures are estimates pre SOC, OBC or FBC.
2. Estimates are at best +/- 25% at this stage of development.
3. Assume all schemes run in parallel – dependencies mean that phasing will be required between these schemes post year 1.
4. Assumed that the core programme team will provide resource for the majority of the care enabler and innovation projects.
5. Assumed not possible to capitalise costs at this stage although this may be possible once schemes are developed.
6. Capital/Revenue split may shift over time in line with industry transition capital to revenue.

Part I ICB Board meeting, 13 October 2022

Agenda Number: 9

Performance and Assurance Report

Summary Report

1. Purpose of Report

This paper is intended to provide members with an overview of the current position (where available) against the NHS constitutional standards and to provide the governance arrangements for oversight and assurance of each area.

2. Executive Lead

Tiffany Hemming, Interim Executive Director Oversight, Assurance and Delivery.

3. Report Authors

Karen Wesson, Director of Assurance and Planning.
James Buschor, Head of Assurance and Analytics.

4. Responsible Committees

This inaugural Board paper has not been reviewed at any committee/board.

Future papers will be:

- Developed further using information shared within the ICB assurance cycle meetings commencing throughout September 2022.
- Submitted to System Oversight and Assurance Committee (SOAC) from October 2022 committee onwards, as part of the assurance and planning papers.

5. Conflicts of Interest

None identified

6. Recommendation

The Board is asked to discuss and note the performance and assurances contained within the report.

Performance and Assurance Report

1. Introduction

The following section gives the headline position in terms of performance against the NHS constitutional standards[1] and outlines the governance in terms of boards overseeing performance, planning and assurance.

2. Performance

Urgent and Emergency Care (UEC)

The UEC Strategic Board oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS111, A&E, Urgent Community Response Team (UCRT), Mental Health Emergency Department (ED) and has members from both health and social care.

Key issues for the UEC programme include the following where performance is below standards:

Ambulance Response Times

Standards:

- *Respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes.*
- *Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes.*
- *Respond to 90% of Category 3 calls in 120 minutes.*
- *Respond to 90% of Category 4 calls in 180 minutes.*

The ambulance response times remain below the NHS constitutional standards.

The following table shows the range of 90th centile and mean response times across Mid and South Essex Alliances for each of the four categories of calls and respective standards.

Metric			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Category 1 Calls - (Standard: Mean <= 7min; 90th Centile <= 15min)	90th Centile	Min	00:16:08	00:16:07	00:15:01	00:17:05	00:15:07							
		Max	00:19:15	00:19:37	00:19:31	00:21:42	00:19:33							
	Mean	Min	00:08:31	00:08:22	00:08:09	00:09:09	00:07:54							
		Max	00:11:27	00:11:16	00:11:15	00:11:58	00:11:03							
Category 2 Calls - (Standard: Mean <= 18min; 90th Centile <= 40min)	90th Centile	Min	02:22:34	01:49:36	02:06:14	02:49:56	02:18:00							
		Max	03:29:59	02:37:31	02:32:43	03:09:12	02:53:07							
	Mean	Min	01:09:44	00:54:28	01:02:36	01:18:10	01:04:14							
		Max	01:28:11	01:12:23	01:09:52	01:24:19	01:14:30							
Category 3 Calls - (Standard: 90th Centile <= 120min (02:00:00))	90th Centile	Min	09:35:50	08:45:50	08:24:54	10:07:32	08:07:49							
		Max	13:53:22	12:50:45	12:12:31	14:13:53	09:55:50							
Category 4 Calls - (Standard: 90th Centile <= 180min (03:00:00))	90th Centile	Min	11:12:38	01:07:23		00:21:57	03:49:23							
		Max	22:25:54	22:12:34	16:26:41	08:51:54	02:19:56							

[1] Handbook to the NHS Constitution for England - GOV.UK (www.gov.uk)

Emergency Department – waiting times.

Standard:

- *95% of patients have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge*

Within MSEFT A&E (Type 1), the 95% four-hour performance is below the constitutional standard as per following table.

Metric		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22 to 27/09	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Emergency Department - 4 hour standard - type 1 (Standard: >=95%)	*Total*	*28,175*	*31,117*	*29,872*	*29,832*	*27,586*	*24,790*						
	Breaches	*9,881*	*10,342*	*10,009*	*10,605*	*10,077*	*9,429*						
	Performance	64.9%	66.8%	66.5%	64.5%	63.5%	62.0%						

Elective Care

Key issues for the Elective programme include waiting time performance being below standards for Diagnostics, Cancer and Referral To Treatment (RTT).

Diagnostics Waiting Times

Standard:

- *The constitutional standard is no more than 1% of patients waiting 6 weeks or more for a diagnostic test and no patients waiting 13+ weeks.*

The waiting times for diagnostic tests remain below the NHS constitutional standards.

The following table shows the latest MSEFT position (July 2022) with the number of patients waiting 6+ and 13+ weeks by test.

Test	Jul-22				
	13+ Weeks		6+ Weeks		Total WL size
	No.	%	No.	%	
Audiology - Audiology Assessments	225	14%	609	38%	1,596
Barium Enema	0		0		0
Cardiology - Echocardiography	388	12%	1,280	38%	3,327
Cardiology - Electrophysiology	0		0		0
Colonoscopy	69	6%	232	21%	1,099
Computed Tomography	372	8%	1,313	30%	4,441
Cystoscopy	89	34%	121	46%	264
DEXA Scan	115	7%	544	33%	1,663
Flexi Sigmoidoscopy	45	14%	112	34%	330
Gastroscopy	81	9%	187	20%	915
Magnetic Resonance Imaging	166	3%	1,267	23%	5,587
Neurophysiology	43	13%	122	36%	343
Non-Obstetric Ultrasound	2,857	25%	5,259	46%	11,525
Respiratory Physiology - Sleep Studies	34	13%	89	34%	258
Urodynamics - Pressures & Flows	16	70%	20	87%	23
Total Diagnostic Tests	4,500	**14%**	11,155	**36%**	**31,371**

The System Diagnostic Board oversees performance and planning for diagnostics across MSE supported by sub-groups including assurance.

As highlighted above, a significant acute challenge lies in non-obstetric ultrasound. An identified

issue includes workforce capacity regarding Sonographers.

Cancer Waiting Times

Standards: For people with suspected cancer:

- *To see a specialist within 14 days of being urgently referred by their GP or a screening programme.*
- *To not wait more than 28 days from referral to getting a cancer diagnosis or having cancer ruled out.*
- *To receive first definitive treatment within 31 days from decision to treat*
- *To start drug, radiotherapy, and surgery subsequent treatments within 31 days*
- *To receive their first definitive treatment for cancer within 62 days of receipt of urgent referral.*

The waiting times for patients on a cancer pathway remain below the NHS constitutional standards.

The following table shows the latest MSEFT position (August 2022) for each of the waiting time standards.

Two week wait	Two week wait breast symptomatic	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day standard	62 day standard (Screening)	62 day standard (Upgrade)
Standard (>=93%)	Standard (>=93%)	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=90%)	
52.4%	19.5%	62.2%	81.5%	96.3%	95.5%	57.4%	43.8%	59.2%	49.3%

The MSE HCP Cancer, Palliative & End of Life Care Board oversees cancer assurance and transformation supported by sub-groups including the Cancer Programme Delivery Group (for assurance and focus on national, regional, and local commitments and deliverables); Quality Cancer meeting; and the Palliative Care Delivery group.

Action undertaken includes:

- Day Zero Patient Tracking List (PtL) – Skin, Lower GI.
- Insourcing commenced 25 August, Outsourcing continues.
- 5 key pathways (skin, gynae, breast, prostate, lower GI) are our transformation areas and working towards best practice pathways to improve the front end of the pathway diagnosis and be able to inform patients of a cancer diagnosis sooner or have cancer ruled out.
- Working with Primary Care Networks (PCNs) regarding Telederm roll out and significant prevention/screening work in progress with them led by Macmillan GPs.
- Fortnightly meetings with National Team as a Tier 1 Trust commenced 23 August 2022.
- 31st August: Recovery improvement plan submitted to NHSE/I regional team.

Referral to Treatment (RTT) Waiting Times

Standards:

- *The constitutional standard is starting consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Since the significant increase in waiting*

times following the global pandemic the NHS is working to achieve the following 2022/23 planning round asks:

- *eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer).*
- *Reduce the number of patients waiting 78+ weeks on an RTT pathway to zero by March 2023.*
- *Reduce the number of patients waiting 52+ weeks on an RTT pathway to zero by March 2025.*

As of August 2022, there were four patients waiting 104+ weeks, 532 patients waiting 78+ weeks and 10,439 patients waiting 52+ weeks on an RTT pathway at MSEFT. The 52+ week waiting list is a growing position which is a future risk to the 78+ week recovery.

The Elective Board oversees RTT assurance.

Action undertaken includes:

- Gooroo and Patient Plus data management systems to be fully implemented across MSEFT sites to support through automation strict operational scheduling and booking of patients by priority and then chronological. This is an essential process to recover backlogs.
- Daily Patient Tracking List (PTL) meeting in place with each specialty to go through each patient whose RTT wait will breach 98+ weeks if not treated. This includes:
    - Firming up to come in dates and contacting patients requiring surgery to ensure availability.
    - Planning 'packages of care' for those on the non-admitted waiting list i.e., booking all next steps in parallel rather than in sequence.
    - Specialties are visiting clinicians in real time after outpatient appointments to get hold of these plans to progress the next steps. This is a different way of working with clinicians that is being adopted rapidly to mitigate the position.
- Weekly reporting and refreshed modelling are in place and operationally overseen daily and weekly at the MSEFT Managing Director meeting. Modelling outlines weekly requirement in terms of treatments to meet 2022/23 planning round guidance regarding eliminating 104+, 98+, 78+, 65 and 52+ week waits.
- Fully maximising outsourcing capacity and working with Independent Sector Providers.

Mental Health

A key issue for the mental health work programme is workforce capacity and constraints with recruitment to mitigate against workforce vacancies. In terms of governance, performance is overseen at the Mental Health Partnership Board.

Improving access to psychology therapies (IAPT)

Standards include:

- *75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral*

The six and 18-week waiting time standards for people referred to the IAPT programme to start treatment is being sustainably achieved across Mid and South Essex ICS.

A priority for MSE ICS is to increase IAPT in terms of number of people accessing the programme.

Early Intervention in Psychosis (EIP) access

Standard:

- *More than 50% of people experiencing first episode psychosis commence a National Institute for Health and Care Excellence (NICE)- recommended package of care within two weeks of referral.*

The EIP access standard is being sustainably met across Mid and South Essex ICS.

3. Findings/Conclusion

The main area to note is workforce with vacancies remaining a key area of concern across all partners together with the system pressures across Urgent Emergency Care (UEC), Elective care (with large waiting list backlogs for diagnostics, and treatments on both urgent/2 week wait and routine RTT pathways) and Mental Health services.

4. Recommendation

The Board is asked to discuss and note the performance and assurances contained within the report.

Part I ICB Board meeting, 13 October 2022

Agenda Number: 10

Review of Progress in MSE Against the Main Themes of the Fuller Stocktake

Summary Report

1. Purpose of Report

This paper aims to summarise the key themes articulated in the Fuller Stocktake and outline the challenges and progress in relation to each of them.

2. Executive Lead

Ronan Fenton, ICS Medical Director

3. Report Authors

Ed Cox, Director of Clinical Policy
William Guy, Director of Primary Care

4. Conflicts of Interest

None identified

5. Recommendations

The Board is asked to note and support the actions being taken, as outlined in this report, to deliver the recommendations of the Fuller Stocktake.

Fuller Stocktake

Review of Progress in MSE Against the Main Themes

1. Introduction and Executive Summary

1.1. Claire Fuller published her report on integrated primary care on the 26 May, ahead of the transition to integrated care systems on the 1 July. As part of her national review, she explored what is working well, why it's working well and how we can accelerate the implementation of integrated primary care. The review excluded from scope issues relating the General Medical Services (GMS) contract and the GP partnership model. Mid and South Essex (MSE) Integrated Care System (ICS) participated in this review through involvement in various workstreams and through providing written feedback which was reflected in the final report.

1.2. This paper aims to summarise the key themes articulated in the Fuller Stocktake and outline the challenges and progress in relation to each of them.

1.3. The Fuller Stocktake report outlined four main components:

- **Streamlining access to care and advice for people who get ill but only use health services infrequently (essentially building urgent care systems at Primary Care Network (PCN) level).**
- **Providing proactive personalised care from a multidisciplinary team of professionals for higher-need individuals in the community.**
- **Helping people stay well for longer (working with communities and local organisations on the prevention agenda).**
- **Delivering three distinct enablers of change: workforce, estates and data.**

1.4. Fundamentally, it recommends that primary care networks shift in emphasis to become integrated neighbourhood teams, built around communities. In this way, the stocktake expands the scope of primary care beyond general practice to encompass a 'team of teams' that can be wrapped around patients and communities.

2. Main content of Report

2.1. Streamlining access to care and advice for people who get ill but only use health services infrequently

2.1.1. Patients do not have a good experience of accessing primary care services in Mid and South Essex currently. The 2022 GP satisfaction survey published in July broadly reflect the same trends that saw previous years: our scores were lower than regional and national averages in relation to how patients perceived access to services. Streamlining access to care and advice must therefore be a priority if we are to meet the expectations of our population.

2.1.2. Whilst we have implemented a range of measures to improve urgent and episodic care, this is not yet working as effectively as it could. For instance:

2.1.3. The dominant model for GP access across MSE still involves queuing via telephone at 8.00 am each morning. This represents poor patient experience and as such patient survey scores relating to getting through to practices by telephone are consistently low. We aim to learn from practices that use technology to address this, such as Stowhealth in Suffolk, who use the AskMyGP system to provide a range of ways that patients can access care. Locally, Pall Mall surgery in Southend is trialling a similar 'total triage' approach using the eConsult system to help people contact the practice via an app in the first instance. The Patches and eConsult systems have been made available to all practices so this can be rapidly scaled up.

2.1.4. Patients should have the ability to book an appointment with their practice through the NHS app or through NHS 111. However, many practices have disabled this feature during the pandemic, so we will need to work with practices to resume this service. Currently IC24, our provider of 111 services, has stated there is a large gap in appointments available. Patients unable to book into GP slots may seek alternative routes for urgent care such as visiting their local ED.

2.1.5. Two of our Accelerator Programme PCNs are trailing approaches to accessing care across their PCNs. Chelmsford West is implementing a model in which one site acts as the urgent and episodic 'hub' in which patients are treated by different professionals according to need. Similarly, Stanford le Hope is implementing a new telephony system to ensure patients are effectively triaged and communicated with.

2.1.6. We have expanded our workforce to incorporate new Additional Roles Reimbursement Scheme (ARRS) roles and there has been significant recruitment to these across the 27 PCNs. New paramedic, pharmacist and physiotherapist roles have all been recruited, bolstering PCNs' ability to see and treat urgent and episodic needs, however they are not yet well coordinated and working at the top of their license. For instance, there are 79 pharmacists working across PCNs with weak links to the ICS and its Medicines Management Team.

2.2. **Providing proactive personalised care from a multidisciplinary team of professionals**

2.2.1. The NHS Long Term Plan talked about PCNs as networks of GP practices and community teams. However, over time the focus has shifted back to general practice, reinforced by NHSE policy such as the Network Direct Enhanced Service (DES). The Fuller Stocktake calls for a shift towards 'neighbourhood teams' that stretch beyond general practice. Whilst many PCNs are still focusing on providing at-scale general practice service, there has been progress in this area. For instance:

2.2.2. The PCN Aligned Community Team (PACT) model first developed in Benfleet PCN has strengthened relationships between primary care, community teams and social care services to better support frail patients and prevent readmissions to hospital. This has been facilitated by technology that allows information sharing between all parties. This is already being spread to SS9 PCN in Southend and is being considered by a number of other PCNs across MSE. Similarly, the Dengie neighbourhood pilot in Mid Essex has seen the collaboration of a range of community providers to provide more integrated care for the local community, and local NHS services have been reconfigured accordingly to become coterminous.

2.2.3. The Ageing Well programme and our Ageing Well stewards have been working to embed the Frail+ model across MSE, including a new approach to care planning.

This aims to support multi-agency working at neighbourhood level for this cohort of patients.

2.2.4. The community collaborative has appointed integrated care directors at place level who have responsibility for driving the multidisciplinary team (MDT) approach that will underpin neighbourhood working.

2.2.5. We have overseen the systematic identification and recording of carers registered with GP practices and have worked with Essex County Council to clarify what support offers are available.

2.3. Helping people stay well for longer

2.3.1. Better health for everyone is a core component of the Triple Aim, which was enshrined in statute as part of the Health and Care Act (2022). For PCNs this represents a shift towards more proactive care, for instance through a population health management (PHM) approach for the 30-50k people each PCN covers. Health inequalities are still substantial across Mid and South Essex, and we are still a long way off effectively and proactively addressing the needs of the 'Core 20 Plus 5' population cohorts (those groups most at risk of health inequalities).

2.3.2. PHM approaches have so far been piloted in relatively small projects across several PCNs. It is not happening routinely or at-scale yet. The ICS is currently conducting a review of its PHM programme to ensure that this is supported effectively and consistently in the future.

2.3.3. Local initiatives have emerged to support specific population needs. For instance, Colne Valley PCN has developed its low carb programme, helping manage the issue of obesity in the community locally.

2.3.4. Southend West PCN similarly developed an initiative for homelessness, creating access to a wide range of interventions that this cohort of people wouldn't usually have access to. The initiative was shortlisted for a Health Service Journal (HSJ) award last year.

2.3.5. This sort of outreach approach was implemented more broadly across MSE in relation to immunisations (including for COVID) through the vaccinations bus, which was highly successful in boosting rates of admissions for harder to reach groups.

2.3.6. Another important initiative locally is the Preparing Well programme, helping people to access support and care whilst they wait for an elective treatment. Given the increased waiting times currently this mitigates the potential decline in people's health whilst they are on waiting lists.

2.3.7. Whilst there are therefore good examples of initiatives underway across our ICS, neighbourhood teams are not yet routinely planning and delivering such programmes across our ICS. There is therefore opportunity to embed principles of PHM within PCNs and rapidly spread innovation where it exists.

2.4. Enablers: Workforce, Estates and Data

2.4.1. **Workforce:** Our primary care workforce in under strain across the ICS. Thurrock and Basildon and Brentwood are two of the six places with the lowest ratio of GPs per capita nationally. The proportion of GPs over the age of 55 is significantly higher than average across the system so we can expect a significant loss of experienced GPs over the coming years. Finally, additional roles such as allied health professionals employed by PCNs are not yet effectively coordinated and utilised to mitigate these issues.

2.4.2. We are embedding the local Primary Care Training Hub (part of the ICB People Directorate) which aims to tailor our workforce approach for our primary care providers. This function provides a link between Health Education England and our local stakeholders to roll out regional and national initiatives as well as developing local approaches.

2.4.3. We have developed a new GP Fellowship, for newly qualified GPs to develop a portfolio career, which includes specialist clinical training, to operate form Corringham Integrated Medical Centre in Thurrock. These positions are to commence from September onwards.

2.4.4. We are also supporting networks for our First Five GPs to ensure that those GPs early on in their careers are supported and provided with adequate opportunities to progress within our system.

2.4.5. We are supporting health and clinical leaders, including allied health professionals such as those in ARRS roles, in a range of ways as part of our Clinical and Care Professional Leadership Framework.

2.4.6. We have implemented practice nursing schemes that mirror some of the GP equivalent schemes e.g., Fellowships, portfolio roles.

2.4.7. We are supporting the development of administrative and practice management staff across Mid and South Essex including training in pathway navigation.

2.4.8. **Estates:** The Fuller stocktake acknowledges the challenges and complexities relating to GP estate, including the ownership and reimbursement model, where perverse incentives can arise. It also recognises that many buildings that accommodate primary care services are not fit for purpose. In Mid and South Essex, we have a number of initiatives we can build upon to ensure that the built environment effectively supports integrated primary care services across the system.

2.4.9. Our programme to build four Integrated Medical Centres in Thurrock will provide a significantly improved environment for delivering primary care services at scale. Corringham IMC will be commissioned first and will provide a home for the new GP Fellowship as well as new PCN services.

2.4.10. Some PCNs have also been working with partner organisations to identify local space that can be utilised collaboratively. For instance, Chelmsford West PCN have worked with a local leisure centre to accommodate the PCN physiotherapists.

2.4.11. New premises developments are taking place across Mid and South Essex:

Laindon Health Centre (Basildon), Manor Street (Braintree), Witham Health Centre, Shoebury Health Centre,

2.4.12. We have also introduced a new policy to support the subsidy of service charges with new premises increasing likelihood of moving into new premises.

2.4.13. **Data:** The Fuller Stocktake report states that PCNs should be given the tools to make routine use of population data. They should be supported with appropriate analytical expertise to understand the data, and to address unwarranted variation and inequalities. They need to be able to share clinical information seamlessly across the neighbourhood team to underpin integrated care. They need to do all of this in a safe way that meets the requirements of the General Data Protection Regulation (GDPR).

2.4.14. A new task and finish group has been established to develop a new primary care & PCN scorecard that better demonstrates delivery, impact and transformation.

2.4.15. The MSE Population Health Management (PHM) approach is being reviewed as part of a strategy refresh to ensure that our system PHM capabilities (including the use of the segmentation approach) underpin the transformation of primary care as part of neighbourhood teams and the effective stewardship of system resources.

2.4.16. Three PCNs have continued to work as early adopters of the PHM approach and are now at the stage of implementing new models of care to address identified needs. These are Stanford le Hope (Obesity pilot), Chelmsford West (Serious Mental Illness) and West Basildon (women's health, diabetes and CVD)

2.4.17. A digital "Tiger team" has been established to support PCNs with the effective use of digital solutions. As well as supporting the adoption of new systems, the team will help improve data quality which is currently a significant issue across practices.

3. Findings/Conclusion

3.1. A significant programme of work is already underway against each the four themes of the Fuller Stocktake. However, these currently lack scale and a consistent approach to implementation.

3.2. Our approach of developing early adopter PCNs, together with addressing those performing least well, aims to provide the conditions for the effective spread of innovation across Mid and South Essex. This will be underpinned by an incentives framework that encourages PCNs to pull together to deliver care for their populations as neighbourhood teams. We propose to continue with this strategy to deliver the recommendations of the Fuller Stocktake.

3.3. We propose developing a primary care development plan, based on a more detailed gap analysis against the fuller stocktake.

4. Recommendation(s)

4.1. The Board is asked to **note and support** the actions being taken, as outlined in this report, to deliver the recommendations of the Fuller Stocktake.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Part I ICB Board meeting, 13 October 2022

Agenda Number: 11

Quality Report

1. Purpose of Report

This report provides a high-level summary of the quality and patient safety issues reviewed by the Quality Committee on 30 September 2022. The Quality Committee receives more detailed reports covering all services commissioned by the MSE ICB. Quality areas reported on:

- Infection Prevention and Control
- MSEFT
  - Care Quality Commission (CQC)
  - Serious Incident
  - Cancer Harms review
  - Referral To Treatment Harms review
- Maternity Services
- East of England Ambulance Service Trust (EEAST)
- Primary Care
- Mental Health
- Care Sector
- Learning Disabilities
- Mid and South Essex (MSE) - Safeguarding

2. Executive Lead

Frances Bolger – Interim Chief Nursing Officer

3. Report Author

Stephen Mayo, Director of Nursing – Patient Experience.

4. Responsible Committees

Report information taken from the Quality Committee meeting held on 30 September 2022.

5. Conflicts of Interest

None identified.

6. Recommendation

The Board is asked to note the contents of the report and seek any additional assurances/clarification.

Mid and South Essex Quality Report

1. Introduction

This report provides a high-level summary of the quality and patient safety issues reviewed by Quality Committee at its meeting on 30 September 2022. The Quality Committee receives more detailed reports covering all services commissioned by the MSE ICB.

2. Services Reviewed by Quality Committee

INFECTION PREVENTION AND CONTROL - SYSTEM

Community associated Methicillin-resistant Staphylococcus aureus bacteraemia (MRSAB) cases are episodes where patients have a blood culture taken within 48 hours of admission. Hospital cases are episodes where patients have a blood culture taken 48 hours post admission.

MRSAB – All Cases (Acute and Community)													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
BB	0	1	0	1	1								**3**
CPR	0	0	0	1	0								**1**
Mid	1	0	1	2	1								**5**
Southend	0	1	1	0	0								**2**
Thurrock	0	0	0	0	0								**0**
Total	**1**	**2**	**2**	**4**	**2**								**11**
MRSAB MSEFT Cases													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Basildon	0	0	0	1	0								**1**
Broomfield	2	0	1	1	0								**4**
Southend	0	1	1	0	0								**2**
Total	**2**	**1**	**2**	**2**	**0**								**7**

Nil new healthcare associated healthcare onset MRSAB cases reported for August.

Clostridioides difficile infection (CDI)

CDI – All Cases (Acute and Community)														
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
BB	12	12	13	12	14								63↑	**62**
CPR	8	8	10	11	12								49	**69**
Mid	10	8	8	13	23								62	**91**
Southend	5	5	2	7	6								25	**56**
Thurrock	12	8	8	7	7								42	**41**
Total	**47**	**41**	**41**	**50**	**62**								**241**	**319**

MSEFT CDI Cases														
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
Basildon	15	13	12	14	13								67	
Broomfield	5	3	5	9	12								34	
Southend	5	8	8	6	8								35	
Total	**25**	**24**	**25**	**29**	**33**								**136**	**175**

CDI cases across the MSEFT are higher than the same reporting period last year (107). This is noted across all organisations across the East of England.

Outbreaks and Periods of Increased Incidence (PII)

- **SARS-CoV-2**
  Reported cases of the SARS-CoV-2 Omicron ba.4 and ba.5 variants have started to reduce, due to a change in testing methodology.
- **Nosocomial SARS-CoV-2 (Covid-19) outbreaks**
  Three new outbreaks have been reported since last report.
- **Burns Unit - Broomfield MRSA outbreak (ongoing)**
  The Trust await outstanding ribotyping results.

MSEFT – CQC

The CQC have undertaken an inspection of Diagnostic Imaging at Southend Hospital (16/08/2022). Report to follow. This precedes a well led inspection in October.

Mitigation

The Quality Team continue to join a schedule of internal compliance visits to provide quality support, and preparation for forthcoming CQC visits.

MSEFT - SERIOUS INCIDENTS

There was a total of 46 Serious Incidents (SIs) reported in July 2022, 14 cases have been closed/de-escalated. This leaves a balance of 324 open SIs across Mid & South Essex. Of these, 253 belong to MSEFT which is the largest reporter (Broomfield Site = 100, Southend Site = 76 and Basildon Site = 77). Zero Never Events were declared in July. There remains a total of 19 active 2020/21 cases.

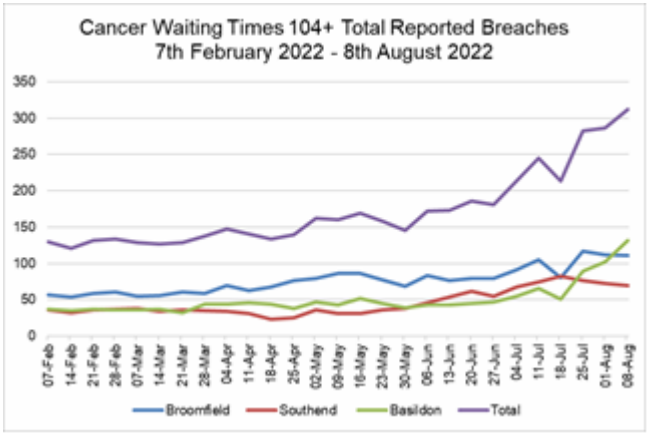
There are currently 166 'stop the clocks' (STC - agreed that any Root Cause Analyses (RCAs) that now become overdue will be marked as STC due to the Covid Pandemic rather than breaching). There are also 13 RCAs breaching their agreed submission date.

	MSEFT						
SIs raised July 2022 by StEIS Category and Organisation	**Basildon**	**Broomfield**	**Southend**	**EEAST**	**Spire**	**NELFT**	**Total**
Diagnosis Incident Including Delay Meeting SI Criteria	0	0	1	0	0	0	**1**
Healthcare/Infection Control Incident Meeting SI Criteria	1	0	0	0	0	0	**1**
Maternity/Obstetrics Incident Meeting SI Criteria - Baby Only	3	0	2	0	0	0	**5**

Maternity/Obstetrics Incident Meeting SI Criteria - Mother & Baby	0	2	1	0	0	0	**3**
Pressure Ulcer Meeting SI Criteria	0	1	1	0	0	11	**13**
Slips/Trips/Falls Meeting SI Criteria	0	1	0	0	0	0	**1**
Sub-Optimal Care of Deteriorating Patient Meeting SI Criteria	0	1	1	0	0	0	**2**
Surgical/Invasive Procedure	0	2	2	0	0	0	**4**
Treatment Delay Meeting SI Criteria	3	2	1	7	1	0	**14**
VTE Meeting SI Criteria	0	1	0	0	1	0	**2**
Total	**7**	**10**	**9**	**7**	**2**	**11**	**46**

MSEFT - CANCER HARM REVIEWS

104+ BREACHES



The number of breaches is generally on an upward trajectory with 312 outstanding. There are 783 harm reviews outstanding of which 559 are overdue.

Mitigation

The National Cancer Team confirmed that MSEFT are to be placed in the Tier 1 category for cancer in the new "integrated oversight and support process" as part of a supportive intervention.

MSEFT have undertaken a process review and recommendations presented to SOAC which were endorsed and the temporary cessation of 62-day harm reviews is proceeding on the basis that NHSE consent is given.

Harm Review Outcomes – April 2021 to present:

The ICB quality team and the MSEFT Cancer team are working together to produce a detailed synopsis of the current position of 9 cases where potential moderate harm has been identified, this will be available in the December 2022 paper.

MSEFT - REFERRAL TO TREAT (RTT) ESCALATIONS

Harm Review Data (as of 30 July 2022)

Total MSEFT completion rate of harm reviews for 2021/22 is at 99% (from 96% in June reporting period). Operational pressures across MSEFT have impacted the completion of harm reviews. However, the services are aware of their outstanding harm reviews and are recovering well.

MATERNITY SERVICES

Following the publication of their CQC inspection report which rated maternity services as 'Requires Improvement' in December 2021, the Mid and South Essex NHS Foundation Trust has updated and realigned their Maternity Improvement Plan to reflect its findings, along with the national recommendations reflected in the Ockenden report, and the requirements of the Maternity Incentives Scheme (Clinical Negligence Scheme for Trusts (CNST) year four). The Trust remains focused on the sustainability of its key performance indicators (KPIs) with consideration of current workforce challenges, prior to considering exit from the Section 31 warning notice that is currently in place.

Workforce

A key challenge for MSEFT remains the high levels of midwifery vacancy across the maternity service currently. In September 2022, there are an anticipated 36 full time equivalent, newly qualified midwives joining MSEFT, with additional posts offered and awaiting start dates. MSEFT have recruited a number of obstetricians with individuals expected to commence in post in October 2022.

CQC Action Plan

There are 49 CQC actions across maternity services within MSEFT currently

CQC 'Must Do' actions:

Domain	Complete	In progress	Total
Safe	2	20	22
Well Led		1	1
Total	**2**	**21**	**23**

CQC 'Should Do actions:

Domain	Complete	In progress	Total
Safe	3	11	14
Well Led		10	10
Effective		1	1
Responsive		1	1
Total	**3**	**23**	**26**

The LMNS Steering Board will regularly seek assurance of the progress of these CQC actions being completed, and in conjunction with this, monthly quality assurance visits will continue, with a focus on seeking assurance that the actions identified are being embedded in practice. A trajectory is also expected to provide details of anticipated completion dates.

Ockenden Immediate and Essential Actions compliance

The Ockenden Final report, published in March 2022, has provided additional recommendations which the Trust have been asked to benchmark against by NHSE to gain insight relating to future areas of focus. In July the Trust presented their current position to the Local Maternity and Neonatal System (LMNS) Steering Board, and reporting will continue until full compliance is achieved.

EAST OF ENGLAND AMBULANCE TRUST (EEAST) ESCALATIONS

EEAST are declaring the highest-pressure response alert levels as have all ambulance trusts in the country. In addition, demand surge levels and patient acuity remain high, and there are long ambulance handover waiting times at acute hospitals. This in turn affects EEAST's ability to respond to 999 calls in accordance with expected times.

Care Quality Commission (CQC) visit May 2022

The CQC undertook a well led inspection on 4 and 5 May 2022. The report has now been published and the Trust remains at 'Requires Improvement'. It is acknowledged that whilst the overall rating remains the same, there has been significant improvement at EEAST since the last visit.

EEAST Serious Incidents (SIs)

Number of reported serious incidents regionally (locally) 2022/23												
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
8 (4)	10 (3)	18 (6)										**36 (13)**

PRIMARY CARE

Within MSE there are 27 Primary Care Networks (PCNs) that are formed of 148 GP practices.
CQC Ratings below

Alliance	Number of practices	Rating
Basildon and Brentwood	**1**	Inadequate
	1	Requires Improvement
	31	Good
	2	To be inspected
CPR and Southend	**0**	Inadequate
	0	Requires Improvement
	46	Good
	1	To be inspected
Mid Essex	**0**	Inadequate
	1	Requires Improvement
	30	Good
	4	Outstanding
	4	To be inspected
Thurrock	**0**	Inadequate
	1	Requires Improvement
	25	Good
	1	To be inspected

The ICB Primary Care Quality team and wider system provides active support to practices with a rating of inadequate and requires improvement.

Access

NHS Digital data for the month of July 2022 shows that 487,270 appointments were offered within Primary Care across MSE, a decrease of 2,535 appointments from June 2022.

Incident Reporting

There are currently 9 open Serious Incident (SI) reviews within Primary Care.

Alliance	Number of open Serious Incidents
Basildon and Brentwood	3
Castle Point Rochford / Southend	2
Mid Essex	3
Thurrock	1
Total	**9**

MENTAL HEALTH - (inc Serious Incidents)

Patient Safety Incidents

There has been one new Patient Safety Incident raised since the previous report:

- Inpatient death by ligature of a South-East locality patient; this did not occur through use of a fixed ligature point.

Inquests

A high-profile case listed to be heard by His Majesty's Coroner began on Monday 12 September 2022. The legacy organisation of Southend CCG is listed as an interested party. The case was adjourned on 30 September 2022 and will be reconvened on 4 January 2023 pending a request for further evidence to be reviewed.

EPUT Workforce

EPUT currently have a qualified nursing vacancy of approximately 500 mental health, learning disability and general nursing staff. EPUT are in the process of international recruitment of band 5 nursing staff, with a desire to achieve 157 recruitments by the end of 2022/23. EPUT successfully recruited 10 nurses in April 2022 and plan for a further 50 by October 2022. The MSE ICB have allocated £3million to aid this recruitment and settling in period upon arrival to the United Kingdom.

COMMUNITY CARE ESCALATION

Workforce

Community providers are challenged in terms of workforce and capacity. System Quality Group (SQG) identified that capacity and demand issues needed to be raised as a significant risk. Recruitment and retention remain a concern alongside the acuity of the patients that they are caring for. Capacity and demand within Speech and Language Therapy remains a significant area of concern.

Mitigations - The Community Nursing Safer Staffing tool is due to be implemented. This will enable staff to articulate the impact on community nursing.

Community Estates

The combination of post pandemic recovery of backlogs and increased demand is being impacted by the lack of suitable clinic rooms to hold face to face clinics.

Mitigations - Discussions have begun across MSE estate to identify any shared space that clinic activity could be undertaken.

CARE SECTOR

The Care Sector quality team covers 282 Care Homes

Safeguarding - There are 18 high risk Safeguarding concerns across the Mid and South Essex Integrated Care System requiring health input. There is a focus on the lessons learnt to utilise improvement of sector wide good practice. The themes and trends are used to inform the future work of the Care Sector System within the Care Sector Group.

Care Quality Commission Escalations - Currently there are three homes across the system with inadequate CQC ratings and fifty requiring improvement. These homes are monitored through the Care Sector Hubs. This includes joint oversight from the Local Authorities and the Care Sector Nurses.

LEARNING DISABILITIES

Workforce

Workforce and recruitment remain a challenge across the ICB for adult specialist Learning Disability (LD) professions. Data highlights that there is currently a gap of 17-25 whole time equivalents which

impacts on the delivery of services to those living with a learning disability. A Business Case will shortly be presented to address this.

SAFEGUARDING

Workforce	
Reason for raising concern with Quality Committee	Reduced capacity of safeguarding professionals continues to impact MSE ICB's ability to meet the demands of the safeguarding statutory function.
Describe the concern/risks	May impact on organisational reputation, may impact on response times, may impact on level of support to providers.
List what actions have already been taken in relation to the issues/risks identified	Frontline work is prioritised to ensure all immediate responses are delivered and mitigate impact on the safety of our vulnerable populations.
Next steps – suggested solution	All vacant posts with the exception of one Band 7 post have been recruited to. This post is currently out to advert. New staff will take up post throughout September to December. The revised structure identifies both Place specific work as well as strategic programmes of work across the ICB. Place based teams will work with local statutory boards and partners.
Safeguarding Statutory Partners Board	Updates provided at meetings - no concerns raised.
Current Surveillance Rating	**Amber**
Proposed Surveillance Rating	**Green**

Child Death by Suicide	
Reason for raising concern with SQG	Increase in the number of deaths by suicide in children
Describe the concern/risks	The regional suicide prevention leads held a session on cluster and contagion with a reminder that each suicide prevention board should have a plan in place to respond to the possibility of this happening.
List what actions have already been taken in relation to the issues/risks identified	PH lead and Director for Children Social Care reviewed national guidance and agreed there was no evidence of cluster and contagion locally. The Southend, Essex and Thurrock (SET) Children's Well Being Board have oversight of all child deaths by suicide and direct all reviews and recommendations regarding child death by suicide. Public Health (PH) lead will continue to progress the work of the SET Suicide Prevention all age Strategy. ECC Children's services will also undertake the 5 year review as planned in 2023. ESAB and ESCB Chairs have commissioned a separate piece of work to review what services are in place to reduce the number of suicides and to identify some clarity on the work of the Suicide Prevention Strategic Group.
Next steps – suggested solution	On-going system work on all age strategy, Statutory Partners Board and continued oversight by Children's WBB

Safeguarding Statutory Partners Boards	Discussed at Essex Children Board and Essex Joint Adult and Children Board, Chair requests clarity across the system on who is undertaking investigations and the governance supporting the various approaches.
Current Surveillance Rating	Following the discussion with PH and Social Care identifying no evidence of cluster and contagion the decision is to stand this down to an amber risk until there is evidence of the positive impact of the all age strategy and the outcome of the planned review in 2023.
Proposed Surveillance Rating	Green

Liberty Protection Safeguards (LPS)	
Reason for raising concern with SQG	Consultation now ended. Update from NHSE Regional webinar identifies final guidance will not be available until Oct 2023 with an implementation date in 2024. Compliance will have a financial consequence for the ICB with regard to CHC.
Describe the concern/risk s	Mobilisation of required systems and processes will require specific change/project management with statutory partner organisations and system providers.
List what actions have already been taken in relation to the issues/risks identified	Essex wide LPS working group in progress preparing financial estimates and work programme. Review of risk register by Designate working group agreed to step down risks pending publication of final guidance and assessment of proposed impact across the system
Next steps – suggested solution	LPS programme lead now appointed to. Post will focus on preparing a state of readiness for system and assess any financial/other resource risks as information becomes available.
Safeguarding Statutory Partners	Updates provided at Board meetings; no escalations raised
Current Surveillance Rating	Revised by working group to step down risk to green as no basis to measure risk on pending release of guidance.
Proposed Surveillance Rating	Green

Non-accidental Injury Escalation	
Reason for raising concern with SQG	Concerns raised by statutory safeguarding partners in the delay in escalation by acute providers to police departments of potential non-accidental injury cases
Describe the concern/risk	Further harm/injury to children because of the delay in referral and insufficient action to ensure the safety of the child
List what actions have already been taken in	SET Multi-Agency Protocol Management of Suspicious, Unexplained Injuries or Bruising in Children for all Frontline Practitioners, publication was an update of the Dec 2018 protocol (May 2022), however Police
relation to the issues/risks identified	are raising concerns that the procedures within the acutes does not reflect the referral process required to ensure safety of children presenting in Emergency Departments (EDs). There are currently 3 Serious Incident (SI) investigations underway and 5 additional reported delays identified

Next steps – suggested solution	Essex Police are in the process of pulling together a task and finish group to review the concerns, system working and current Standard Operating Procedures (SOPs). Full multi-agency and provider involvement.
Safeguarding Statutory Partners	Statutory Board aware of concerns and have requested an update for September Board
Current Surveillance Rating	**RED**
Proposed Surveillance Rating	**Green**

Update from Statutory Partner Boards

Group	Update
Essex Safeguarding Children Board (ESCB)	21 July Board – Non-Accidental Injury (NAI) deep dive in planning Next meeting 20 September.
Essex Safeguarding Adults Board (ESAB)	Statutory Partners and Chair attended People and Families Scrutiny Committee ECC on the 15 September to provide an update on the provision of statutory duties. ESAB Executive Leads met on 14 September to review risk register, update business plan. No immediate risks identified and business plan actions on track. Board Planned for 19 October.
Summary Learning from Domestic Homicide Reviews and Safeguarding	*Information reporting in development from previous CCG to ICB assurance. Will be provided for next committee*
Thurrock Local Safeguarding Children Partnership	Next Board 28 September
Summary Learning from Domestic Homicide Reviews and Safeguarding	*Information reporting in development from previous CCG to ICB assurance. Will be provided for next committee*
Thurrock Local Safeguarding Adult Partnership	Next Board 11 October.
Summary Learning from Domestic Homicide Reviews and Safeguarding	*Information reporting in development from previous CCG to ICB assurance. Will be provided for next committee*
Southend Safeguarding Partnership Adult and Children	Children 6 September Board Children's Services provided a progress report of the improvement plan following the Ofsted focused visit which reviewed Children in Care. Escalated issues:

Group	Update
	• There is concern that children are still not routinely being offered a health assessment within timescales, in part due to lack of capacity within the NHS. EPUT reporting that wait times have improved. Further assurance to be gained from Children and Young People (CYP) commissioning team. • T4 bed access continues to delay treatment times for children presenting with emotional dysregulation and self-harming behaviours having unmet need due to insufficient availability of the right services. Further training being rolled out on trauma informed practice. National Commissioning team have vastly reduced wait times and continue to work on solutions to resolve delay on T4 access. • There is also a waiting list for local authority placements in secure accommodation. Constantly under review and escalation. Adults 5 September Board - Consultant engaged to audit Board form and function in preparation for Care Quality Commission (CQC) accreditation. Repill be due in December
Summary Learning from Domestic Homicide Reviews and Safeguarding	*Information reporting in development from previous CCG to ICB assurance. Will be provided for next committee*

Update from Health Executive Forum

Agenda Item	Update
Initial Health Assessments for looked after children	Essex wide multi-agency digital process at pilot stage with Southend social care and EPUT. Pilot will run until April and look to expand to other areas thereafter. Outcome will be improved co-ordination and information sharing and more timely delivery of IHAs. Will need Executive sign-up as there will be cost implications for full roll-out.
Child Death Review Annual Report	Annual Review about to be published. The review demonstrates no overall increase in the number of child deaths over the last 3 years. It demonstrates a reduction from 2019/20. Neonates now included in figures (from 2020) including any gestation showing signs of life. Large proportion (44%) were 0-to-27-day neonates. 66% were babies less than 28 weeks, 34% were age 29 weeks to 17 years. Programme of work for Child Death Review Group: • Learning from review to be shared following sign-off on 22/09/22 Further child suicide review planned for 2023 • Early pregnancy and extreme prematurity - greater understanding of the British Association of Perinatal Medicine framework around extreme prematurity. • Social media - Petition to Chief Constable in Norfolk, Lead for Safeguarding within Police across England in relation to police response to online issues and removal of unsafe content from the internet. • Thematic review of asthma child deaths.

Agenda Item	Update
Domestic Homicide Review (DHR)	DHR 3rd thematic review undertaken. 8 cases reviewed. Findings: • all victims were female, with one male killed at the same time as the female victim • all perpetrators were male. • there was often an overlap between mental health and substance misuse issues, • one victim had dependent children, the review highlighted the theme around think family and the visibility of children and the importance of looking behind presenting issues. • 2 cases were known to Multi Agency Risk Assessment Conference. • all the victims and most of the perpetrators were in contact with health services. Report will be published on DHR website.

3. Recommendation

The Board is asked to note the contents of the report and seek any additional assurances/clarification.

Board Meeting of 13 October 2022

Agenda Number: 12

Month 5 Financial Performance Report

Summary Report

1. Purpose of Report

To report on financial performance for the ICB as at Month 5 and offer a broader perspective on outturn across partners in the Mid & South Essex system (period ending 31 August 2022).

2. Executive Lead

Dawn Scrafield, Director of Resources

3. Report Author

Jennifer Kearton, Director of Finance, Operations & Delivery.
Jason Skinner, Director of Finance, System Planning & Reporting.

4. Committee involvement

The position at M5 was reported to the ICB Finance & Investment Committee on 5 October 2022.

(Corresponding reports on the system financial position are also provided routinely to System Financial Leadership Group, System Oversight and Assurance Committee and to the Health & Care Partnership Board.)

5. Conflicts of Interest

None identified.

6. Recommendation

The Board is asked to receive this report for information.

Month 5 Financial Performance

1. Introduction

The Financial Performance of the Mid and South Essex Integrated Care Board (MSE ICB) is reported regionally as part of the overall Mid and South Essex System alongside our NHS Partners, Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT).

Our wider Health and Social Care position including Essex County Council, Southend City Council and Thurrock Council, is collated for information and reviewed with stakeholders in the MSE System.

This paper details the Financial Performance of the MSE ICB. It also provides information on System Financial Performance.

The MSE ICB Finance and Investment Committee (FIC) reviewed the Month 5 position (as set out in appendix) on 5 October 2022. The Committee had concluded previously that assurance needed to be enhanced by the rapid development of a robust system financial improvement plan. At its meeting this month, the approach to developing a system financial improvement plan was discussed and agreed. Scrutiny of progress and achievement will now be a regular standing item on the FIC agenda, supported as necessary by deep dive reviews.

The forecast for MSE ICB is breakeven for 2022/23, in line with plan. Across the system more generally however there are significant unmitigated financial risks totalling £95.5m. This reflects in part failures to deliver demanding efficiency targets set within the wider system.

At present, known financial risks which have materialised over the last 5 months are driving a year-to-date deficit across NHS partners of £36m. The financial improvement plan is being aimed at tackling the pressures driving this deficit. The system's forecast outturn will be adjusted going forward on the basis of progress made in controlling total expenditure.

2. Key Points

2.1 Month 5 ICB financial performance

Table 1 below summarises the month 5, year to date, financial position for the ICB.

Whilst this is the fifth reporting period for the financial year this is the second month of ICB reporting, as the ICBs predecessor organisations, Mid Essex, Southend, Basildon & Brentwood, Castle Point & Rochford and Thurrock CCGs, did not close until the end of month 3. A single adjustment was made following the consolidation of CCG budgets this can be seen at the bottom of Table 1. This is not unique to the MSE CCGs and is a technical adjustment as part of national the CCG to ICB transition.

The ICB is largely delivering on plan during its first [two] months. Our profile of spend across Prescribing and Continuing Health Care (CHC) has increased marginally in the last 2 months, however this was anticipated and is largely offset by the adjustment described above. Remaining risks associated with current market conditions is summarised in Table 2 below. *Table 1*

ICB Expenditure Analysis	Plan 31/08/2022 YTD £'000	Actual 31/08/2022 YTD £'000	Variance 31/08/2022 YTD £'000	Plan 31/03/2023 Year Ending £'000	Forecast 31/03/2023 Year Ending £'000	Variance 31/03/2023 Year Ending £'000
Acute Services	210,080	209,120	960	924,750	922,245	2,504
Mental Health Services	36,418	39,802	(3,384)	161,583	164,583	(3,000)
Community Health Services	32,008	31,720	288	144,034	144,313	(279)
Continuing Care Services	18,121	20,069	(1,948)	81,543	87,304	(5,761)
Primary Care Services	6,641	6,397	244	29,886	29,894	(9)
Prescribing	32,717	34,385	(1,668)	147,226	153,015	(5,789)
Other Programme Services	11,179	15,606	(4,427)	57,352	89,729	(32,377)
Delegated Primary Care Commissioning	33,027	33,027	0	148,621	148,621	0
ICB Running Costs	3,877	3,877	0	17,444	17,444	0
Total ICB Net Expenditure	384,067	394,002	(9,936)	1,712,439	1,757,149	(44,710)
Retrospective Allocation Adjustment			9396			44,710
Final Month 5 Position			0			0

2.2 ICB Risk Position

Our ICB forecast outturn requires us to deliver our efficiencies and mitigate our risks. Table 2 presents the risk position as at month 5. We monitor our risks and mitigations on a weekly basis within the system to ensure we have rapid assessment of potential pressures.

Table 2

Risk Summary	£'000
Underdelivery of Efficiency Plans	(1,779)
Market Pressures (CHC)	(4,300)
Pathway Harmonisation	(1,000)
Additional Inflationary Pressures	(4,929)
Elective Services Recovery	(694)
Total Risks	(12,702)
Delay Reduce Investments	3,000
Non-Recurrent Mitigations	8,711
Total Mitigations	11,711
Net Risk Position	(991)

2.3 ICB Efficiencies

Table 3 shows the efficiencies position within the ICB. Whilst delivery is on track to meet the forecast outturn plan for efficiencies, it should be noted that a risk of under delivery is still evident in Table 2. ICB Budgets have been set net of efficiencies targets, so any failure to deliver against the efficiency programme will require swift action. The ICB will continue to monitor the delivery and de-risk the position as it progresses from its first month's reporting.

Table 3

ICB Area of Efficiencies	Year to Date £'000	Forecast Outturn £'000
Contract Changes	1,065	2,554
Continuing Healthcare	1,375	3,300
Primary Care Prescribing	3,500	8,403
Running Cost Review	200	481
Other		759
Total Efficiencies	6,140	15,497

2.4 Overall System Finances as at M5

At the end of month 5 the overall health and care system is reporting a deficit of £40.3m, £29.0m adverse to the £11.3m deficit expected in the profile for delivering a breakeven position by the year end. NHSE's accountability regime does not allow for ad hoc changes to plans submitted previously. Thus, for the time being, our System forecast remains breakeven for NHS partners. Discussions are in train which will enable this to be updated in the light of agreed recovery plans. However as the wider system risks have already begun to materialise the NHS system is committed to a reassessment of the forecast outturn position. Local Authority partners are anticipating a forecast deficit of £6.6m for 22/23.

Within the NHS, the overall position at month 5 is a deficit of £38.1m, £27.1m adverse to the £11.3m deficit expected in the profiled plan. Local authorities (using month 5 For Southend City Council, month 4 for Essex County Council and month 3 for Thurrock) are showing a £1.9m deficit position against a balanced plan.

Workforce remains the single biggest budgetary pressure. The deficit in MSEFT is driven largely by the utilisation of interim staffing deployed to deliver activity recovery, As previously reported, a continuation of this trend would frustrate attempts to deliver a balanced position at year end.

Headlines by sector are summarised in Appendix 1 attached.

2.5 System Risk Position

Overall, our system is currently reporting a net risk position of £95.5m. This is under weekly review.

At the end of month 5 the most significant risk to the system is the underlying run rate at MSEFT, the position has been impacted by the ongoing pressure on service delivery and the delayed delivery of the system efficiency plans. This is further compounded by the additional revenue consequences of national capital allocations, lost trading income which has not been recovered pre-COVID and slower conversion of productivity to cash.

The Trust has launched an integrated improvement plan ('Foundations for the Future') to improve the overall run rate position and discussions with system partners and region are in progress to define the partnership working required to reduce operational pressures and therefore financial impact in MSEFT.

2.6. System Efficiency Position

As at month 5, £69.4m of efficiencies for 2022/23 have been identified (a positive movement of £2.4m on last month), of which £30.9m are currently classified as cash releasing, £23.5m productivity and £15.0m cost avoidance

£16.3m of the total efficiencies are at delivery stage.

Progress continues to be made in documenting new schemes, particularly in the length of stay/admissions avoidance/readmissions, elective referrals and non-elective flows workstreams of the Financial Sustainability Programme.

T*able 5*

		PIDs in Gateway Process				
Workstream	**NHSI Target**	**Cash releasing**	**Productivity**	**Cost avoidance**	**Grand Total**	**Variance**
Financial Sustainability						
Continuing Healthcare	3.3	3.3	-	-	3.3	0.0
LoS, Readmissions & Admissions Avoidance	10.3	-	2.2	4.5	6.8	- 3.5
Medicines Management	8.4	4.3	-	2.2	6.5	- 1.9
Non-elective flows	-	-	-	0.5	0.5	0.5
Outpatient Transformation	16.6	-	8.4	-	8.4	- 8.2
PoLCE	0.9	-	0.5	-	0.5	- 0.4
Sub-scale services	2.7	-	1.4	-	1.4	- 1.3
Workforce	3.0	3.4	-	3.8	7.2	4.2
Theatres	4.5	-	8.2	-	8.2	3.7
Total Financial Sustainability	**49.7**	**11.0**	**20.7**	**10.9**	**42.7**	**- 7.0**
Local Schemes						
Local schemes - ICB	3.8	2.9	-	-	2.9	- 0.9
Local schemes - MSE FT	16.2	6.9	2.2	2.9	12.0	- 4.2
Local schemes - EPUT	14.3	10.0	0.6	1.2	11.8	- 2.5
Grand Total	**84.0**	**30.9**	**23.5**	**15.0**	**69.4**	**- 14.6**

2.7 System Capital Position

System plans for 2022/23 are to invest £90m in capital programmes. This plan was oversubscribed at the time of submissions with a further £62m of unfunded investments for future pipeline consideration.

The forecast capital investment for providers for 2022/23 has increased this month from £88m submitted at plan stage to £88.4m. This increase relates to confirmed central funding of £350k for two mental health high dependant units within EPUT. A further £2m is to be invested by the ICB, increasing total capital investment by health, to £90.3m, with £63.1m being a charge against the system provider envelope.

As at the end of month 5, the system is underspent by £10.5m (month 4: £4.5m). Please see appendix 1 for a breakdown of the system capital plan.

3. Recommendation(s)

The Board is asked to receive this report for information.

4. Appendices

Appendix 1 – Month 5 Summary System Financial Performance report.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Agenda Item 12 - Appendix 1
M5 Financial Performance
ICB Board

Contents

Headline System M5 summary

Forecast Outturn as at Month 5

Health: Breakeven Social care: Deficit £6.6m	The Health year to date position at month 5 is a deficit of £38.4m, £27.1m adverse to the £11.3m deficit expected in the profiled plan. NHS Partners are continuing to forecast a breakeven position at the end of the financial year, however financial improvement plans are in place and the forecast outturn position is subject to change. The Social care forecast outturn deficit is £6.6m deficit. Local authorities (using M4 for ECC, M3 for Thurrock and M5 for Southend City Council) a currently showing a £1.9m deficit position against a balanced plan. **Slides 3 and 4 provide more sub sector information.**

Risk

£95.5m Net Risk	At the end of M5 gross risks are £168.2m with mitigations of £72.8m leaving net risks of £95.5m to be managed during the year. This position shows little improvement on M4 with the majority risk manifesting in MSEFT due to operational pressures. **See slide 6 for the Risk and Opportunities summary across NHS partners**

Efficiencies

Full year target £84m Delivered to date £12.3m (15%)	£69.4m efficiencies have been identified for 2022/23 against the £84m target. Month 5 delivery is £4.6m behind plan with £12.3m delivered for the year to date compared to a plan of £21m. Forecast outturn delivery is currently reported to plan, however delivery is behind, this is under continuous review by the System Efficiencies Programme Board. Underachievement of efficiencies is reported as part of the system risk. **See slide 7 for the System Efficiency Programme summary across NHS partners.**

Capital

Year to Date Plan vs Actual £10.5m underspend Forecast Outturn Plan vs Actual £0.3 Overspend	System plans for 2022/23 are to invest £90m in capital programmes. This plan was oversubscribed at the time of submission with a further £62m of unfunded investments for future pipeline consideration. **See slide 8 for the System Capital Expenditure across NHS Partners**

Headline system M5 by sector

NHS System Partners	Year to Date Position	Forecast Position	Net Risk	Efficiency	Comment
MID AND SOUTH ESSEX INTEGRATED CARE BOARD	**On Plan** **Breakeven**	**On Plan** **Breakeven**	**£1.0m**	Full year target **£15.5m** Delivered to date **£6.1m (40%)**	The ICB continues to forecast breakeven. Delivering efficiencies across Prescribing and Continuing Health Care via the Connect Programme. Where savings are planned the value has been removed from the budget. However, the main areas of risk for the ICB relate to the inflationary pressures being felt in the market and the potential impact on our net budgets. Some mitigations have been identified, however risk management continues to be a priority.
MID AND SOUTH ESSEX FOUNDATION TRUST	**Below Plan** **£36.0m Deficit** **£27.4m adverse to plan**	**On plan** **Breakeven**	**£89.9m**	Full year target **£51.2m** Delivered to date **£3.8m (7%)**	MSEFT had planned to deliver a deficit during quarter 1 which would be offset throughout the remainder of the year by a small surplus each month. However, the Trust continues to feel significant operational and workforce pressures driven by increased length of stay and higher acuity of attendances, which account for c50% of the emerging gap. The Trust has also had to absorb additional revenue consequences of national capital allocations, lost trading income which has not been recovered pre-COVID and slower conversion of productivity to cash. An integrated improvement plan ('Foundations for the Future') is underway in the Trust.
ESSEX PARTNERSHIP UNIVERSITY TRUST	**Above Plan** **£2.3m Deficit** **£0.3m favourable to plan.**	**On plan** **Breakeven**	**£4.5m**	Full year target **£17.3m** Delivered to date **£2.4m (14%)**	The Trust is slightly above plan due to an in month reduction in temporary staffing costs. The Trust continues to identify additional schemes with a forecast of £14.8m against the £17.3m target. An Agency spend ceiling target of £18.2m has been set, compared to 21/22 outturn of £25.9m, representing a 30% reduction. Key risks include full delivery of the efficiency programme; uncertainty of the future payment mechanism associated with cost recovery of the vaccination programme and achievement of the agency spend ceiling target.

Headline system M5 by sector continued

Local Authority System Partners	Forecast Position	Comment
ESSEX COUNTY COUNCIL	£3. 0m Overspend (M4)	The council's forecast has moved favourably since last month to an overall deficit of £3.0m. This is mainly driven by higher volumes in Adult Social Care, notably residential care, nursing care (along with a higher average price) and spot purchased reablement, partly offset by reduced spend in domiciliary care. The forecast makes no prediction about further savings delivery, which is being actively pursued in order to improve the position. There remain significant risks due to uncertainty in the cost and demand for Adult Social Care (particularly in nursing care) at the point of discharge from hospital, as well as inflationary pressures and social care workforce challenges.
THURROCK COUNCIL	£3.6m Overspend (M3)	Thurrock Council - The main gross pressure in Adult Social Care continues to be centred around placements costs, driven largely by volume increases in older people for home care services, and increasing complexity in mental health and learning disabilities. In addition, there is an increasing level of need for people being discharged from hospital requiring continued support to live independently. The longer term ramifications of the Covid 19 pandemic are also contributing to increased demand for care services. Public Health is forecast to come in within the grant allocation. For Children's' services there is a financial risk associated with increased demand for placements particularity for Looked after Children and school transport for specialist provisions.
SOUTHEND CITY COUNCIL	To be reported	Southend City Council - The position is as previously stated, cost pressures in both adults and children's services are being driven by the cost of placements, with increasing pressures from the market in terms of price but also an increase in demand and complexity which is pushing the cost even further. The year to date and forecast positions now represent the latest month 5 position for the council.

Emerging risks & opportunities

System Risks and Mitigations	Gross Risks	Mitigations	Net Risk
	£	£	£
Efficiency under delivery	(4.2)	0.0	(4.2)
Elective Recovery Funding Clawback	(32.5)	23.9	(8.6)
Underlying run-rate (MSEFT)	(102.3)	29.3	(73.0)
Inflationary Pressures	(6.4)	1.4	(5.0)
Winter Funding Pressures	(6.0)	0.00	(6.0)
Market Pressures (CHC)	(4.3)	0.00	(4.3)
Pathway Harmonisation	(1.0)	0.00	(1.0)
Cost associated with Improvement	(3.0)	0.00	(3.0)
Covid pressures inc.mass vaccs	(5.2)	4.9	(0.3)
Non Recurrent Mitigations	0.0	8.7	8.7
Delay/Reduce Investments	0.0	3.0	3.0
Other	(3.3)	1.5	(1.8)
Total	(168.2)	72.7	(95.5)

System efficiency programme (2)

		PIDs in Gateway Process				
Workstream	NHSI Target	Cash releasing	Productivity	Cost avoidance	Grand Total	Variance
Financial Sustainability						
Continuing Healthcare	3.3	3.3	-	-	3.3	0.0
LoS, Readmissions & Admissions Avoidance	10.3	-	2.2	4.5	6.8	- 3.5
Medicines Management	8.4	4.3	-	2.2	6.5	- 1.9
Non-elective flows	-	-	-	0.5	0.5	0.5
Outpatient Transformation	16.6	-	8.4	-	8.4	- 8.2
PoLCE	0.9	-	0.5	-	0.5	- 0.4
Sub-scale services	2.7	-	1.4	-	1.4	- 1.3
Workforce	3.0	3.4	-	3.8	7.2	4.2
Theatres	4.5	-	8.2	-	8.2	3.7
Total Financial Sustainability	**49.7**	**11.0**	**20.7**	**10.9**	**42.7**	**- 7.0**
Local Schemes						
Local schemes - ICB	3.8	2.9	-	-	2.9	- 0.9
Local schemes - MSE FT	16.2	6.9	2.2	2.9	12.0	- 4.2
Local schemes - EPUT	14.3	10.0	0.6	1.2	11.8	- 2.5
Grand Total	**84.0**	**30.9**	**23.5**	**15.0**	**69.4**	**- 14.6**

As at 13th September **£69.4m** of efficiencies for 2022/23 have been documented in PIDs (£2.4m increase from last month's report), of which **£30.95m** are currently classified as cash releasing **(£23.5m** productivity and **£15.0m** cost avoidance).

£16.3m of the total efficiencies are in Gateway 5 (delivery), of which **£6.2m** are cash releasing.

Since 15th August the total value of PIDs has increased by **£2.4m**, comprising increases of **£2.7m** productivity and **£1.3m** cost avoidance and a reduction of **£1.6m cash releasing** PID values. The value of PIDs in Gateway 5 has remained unchanged.

Progress continues to be made in documenting new schemes into PIDs, particularly in the length of stay/admissions avoidance/readmissions, elective referrals and non-elective flows workstreams of the Financial Sustainability Programme.

NHS system capital expenditure

As at the end of month 5, the system is underspent by £10.5m. Forecast remains broadly on plan but with additional emerging priorities, especially for Primary Care.

System plans for 2022/23 are to invest £90m in capital programmes. This plan was oversubscribed at the time of plan submissions with a further £62m of unfunded investments for future consideration.

The forecast capital investment for providers for 2022/23 has increased this month from £88m submitted at plan stage to £88.4m. This increase relates to confirmed central funding of £350k for two mental health high dependant units within EPUT. A further £2m is to be invested by the ICB, increasing total capital investment by health, to £90.3m, with £63.1m being a charge against the system provider envelope.

As at the end of month 5, the system is underspent by £10.5m (M4: £6.8m), of which £8.5m is against envelope.

Within MSEFT, the position is an underspend of £7.1m (M4: £4.5m). The local programme is behind by £5.1m, predominately in estates.

EPUT is underspent by £3.4m (M4: £2.3m) which relates to the charge against the system envelope. Most of the slippage relates to the delivery of the BAU and strategic ICT projects, as well as a number of estates related work.

As at the end of month 5, the ICB is recording a small underspend of £8k against plan. To date, no expenditure has been incurred

It is noted that the demand on the capital programme far outstrips the CDEL availability and any cost runs or in year urgent requests will investments will require a thorough review of the programme to reprioritise need, and the delaying or stopping planned investment may be required.

MSE	2022/23 YTD			2022/23 Forecast		
	Plan* £k's	Actual £k's	Variance £k's	Plan £k's	F'cast £k's	Variance £k's
2021/22 Carry Forwards	1,633	1,172	461	2,319	2,319	0
RAAC	2,635	97	2,538	7,300	7,300	0
BAU - Clinical systems	590	666	-76	5,450	5,450	0
BAU - Digital Refresh/Infrastructure	1,858	1,925	-67	10,007	10,007	0
BAU - Equipment replacement enabling works	2,301	984	1,316	6,860	6,860	0
BAU - ICT	487	76	411	650	650	0
BAU - Carbon Reduction	50	0	50	50	50	0
BAU - MEMS / Other Equipment	3,550	4,231	-681	8,536	8,536	0
BAU - Safety & Ligature	555	113	443	909	909	0
BAU - Backlog Maintenance	2,007	945	1,062	5,849	5,849	0
BAU - Health & Safety	1,085	139	946	1,340	1,340	0
BAU - Other Estates	4,698	3,618	1,080	8,773	8,773	0
Strategic - E-Prescribing	222	0	222	743	743	0
Strategic - ICT	787	218	569	2,755	2,755	0
Strategic - Estates & Clinical Transformation	470	343	128	470	470	0
Other (incl contingency)	302	168	134	1,096	1,096	0
CHARGE AGAINST SYSTEM CDEL (internally financed)	**23,230**	**14,694**	**8,536**	**63,107**	**63,107**	**0**
Digital Services	65	0	65	198	198	0
Targeted Investment Fund - Opthamology	272	0	272	1,228	1,228	0
Targeted Investment Fund - Cath Lab	400	50	350	1,800	1,800	0
Diagnostic Funding	0	0	0	16,500	16,500	0
STP Wave 2 Clinical Reconfiguration (£118m)	0	0	0	0	0	0
Larkwood - High Dependancy Unit	0	0	0	0	150	-150
Poplar - High Dependant Unit	0	0	0	0	200	-200
Leases (new in-year) - Fleet Replacement	0	0	0	877	877	0
Leases (new in-year) - Canvey Island	1,311	0	1,311	1,311	1,311	0
Leases (new in-year) - IMCs	0	0	0	0	0	0
PFI - Residual Interest	1,243	1,299	-56	2,981	2,981	0
EXTERNALLY FINANCED SCHEMES	**3,291**	**1,349**	**1,942**	**24,895**	**25,245**	**-350**
TOTAL PROVIDER CAPITAL PLAN	**26,521**	**16,043**	**10,478**	**88,002**	**88,352**	**-350**
Primary Care Capital	8	0	8	1,986	1,986	0
TOTAL SYSTEM CAPITAL PLAN	**26,529**	**16,043**	**10,486**	**89,988**	**90,338**	**-350**
EPUT	5,861	2,466	3,396	12,285	12,635	-350
MSEFT	20,660	13,577	7,083	75,717	75,717	0
ICB	8	0	8	1,986	1,986	0
EXTERNALLY FINANCED SCHEMES	**26,529**	**16,043**	**10,486**	**89,988**	**90,338**	**-350**

Appendix 1: Glossary

BAU	Business As Usual
CDEL	Capital Departmental Expenditure Limit; the limit for capital spending in a financial year
CHC	Continuing HealthCare
EPUT	Essex Partnership University NHS Foundation Trust
ERF	Elective Recovery Fund
H&CP	Health & Care Partnership
HDP	Hospital Discharge Programme
HI	Health Inequalities
ICB	Integrated Care Board
ICS	Integrated Care System
ITU	Intensive Treatment Unit; sometimes known as Intensive Care Units ICU) or Critical Care (CC)
MSEFT	Mid & South Essex NHS Foundation Trust
NOACS	Non-vitamin K Oral Anti-Coagulants
PMO	Programme Management Office
RAAC	Reinforced Autoclaved Aerated Concrete; a form of pre-cast concrete that has been identified as needing replacement and which was used in some NHS buildings.
SDF	System Development Fund; non-recurrent funding received in addition to system allocations for spend on specified transformational programmes
SFLG	Senior Finance Leaders Group
SLEG	System Leaders Executive Group
SRO	Senior Responsible Officer
TIF	Targeted Investment Fund (related to Elective Recovery)
WTE	Whole Time Equivalent (staffing)

Part I ICB Board meeting, 15 September 2022

Agenda Number: 13

Winter Planning

Summary Report

1. Purpose of Report

To provide the Board with an overview of 2022/23 Winter Planning arrangements.

2. Executive Lead

Tiffany Hemming, Interim Executive Director Oversight, Assurance and Delivery

3. Report Author

Tiffany Hemming, Interim Executive Director Oversight, Assurance and Delivery

4. Financial Implications

Please refer to Winter Monies & Additional Capacity section in report.

5. Conflicts of Interest

None identified.

6. Recommendation

The Board is asked to note 2022/23 Winter Planning arrangements.

7 October 2022

Mid & South Essex 2022/23 Winter Resilience Planning

NHSE and MSE ICB recognises that 2022 has been an incredibly demanding a challenged year to date for urgent emergency care services across the system, whilst managing the tail end of a Covid pandemic along with balancing the restoration of elective and cancer services.

The acute hospital bed modelling suggests a bed deficit of circa 180 beds to manage the continuation of the expected pressures that are anticipated for the 2022/23 winter (November 2022 – 29 April 2023). The pressures are further compounded by the workforce and capacity challenges experienced with our Social Care and Community Health workforce.

Winter Monies & Additional Capacity
National monies have been made available and the East of England region has worked with ICBs to identify schemes that will provide additional bed capacity across the system supporting our urgent emergency care system, as well as intermediate care services working smoothly to keep people out of hospital and at home. The outcome of the bids is that MSE system has received a sum of £7.92m to invest in the schemes below; these are all subject to successful recruitment, which has commenced:

Details	Additional Beds
D2A Model - SEDS and ECC (Bridging plus therapy)	33
Hospice beds	8
OPAT (intravenous medication at home)	15
Other beds – being scoped at present	38
Baseline capacity	
Virtual ward, a combination of frailty and respiratory beds – baseline capacity (outside of winter monies)	105 + 15

Furthermore, during a super surge/extremist requirement, an additional 40 beds can be opened across MSEFT, by adding one additional bed to specific wards. Work is taking place to understand if the model of temporarily increasing capacity (North Bristol model) can be safely implemented across MSEFT to support capacity pressures.

Urgent Emergency Are (UEC) & Winter Summit
On 17 August the MSE System pre-meet for the UEC & Winter Summit was held, whereby the session provided the opportunity to share the objectives and agenda for the first upcoming Summit originally scheduled for 19 September 2022, now due to be held 11 October 2022. The pre-meet provided an overview and aligned the system behind a shared understanding of the current UEC challenges and opportunities. Agreed the principles that we will follow to enable success and develop a plan for UEC transformation, to get ahead of next winter and put us in a sustainable position for winter 23/24.

Capacity & Demand Modelling and Monitoring
The MSEFT has a well-established and comprehensive bed model, by hospital site. The model tracks the bed volume required to deliver the modelled non-elective and elective demand predicted by month, as well as seasonality and surge growth.

NHSE East of England (EoE) Region provided resource from Deloittes to work with system partners to produce a system demand and capacity model. The model provides an overview of the current service provision across the system, together with the deficit requirements. As well as having the ability to be an interactive model allowing for increasing and decreasing capacity assumption. Partners' workshop with Deloittes has been held to understand the model assumptions and agree further development which will include testing scenarios and working through required system

response or risks should these then occur or be implemented. This model will be further developed in-house to support predictive modelling across the system.

NHSE Urgent Emergency Care (UEC) Board Assurance Framework (BAF)
The UEC BAF is an NHSE document intended as a tool to support ICBs to deliver committed deliverables. The self-assessment tool allows providers to assess themselves against the key metrics. This was submitted on 26 September 2022. The outcome of this is an action plan where there are amber and red risks to enable the taskforce and partners to focus effort and capacity. The submitted plan will be used by the ICB to monitor progress and delivery in collaboration with NHSE EoE Regional team; the format is a scorecard and indicative to a dashboard.

Tactical Control Centre
The MSE System Tactical Control Centre model for this winter is being developed and will work in conjunction with the Central Incident Management Team, operating a system command and control functionality. The structure and team will have autonomy to make decision on behalf of all system providers utilising key decision-making tools. One of the tools to be deployed ahead of December 2022 is the deployment of the SHREWD system, which will be deployed across all system partners to demonstrate real time incoming demand and current capacity.

Recommendation
The Board is asked to note the 2022/23 Winter Planning arrangements.

Part I ICB Board meeting, 13 October 2022

Agenda Number: 14.1

Committee Minutes

Summary Report

1. Purpose of Report

To provide the Board with a copy of the approved minutes of the following committees:

- Clinical and Multi-Professional Congress (CliMPC), 28 July 2022.
- Finance & Investment (F&I) Committee, 7 September 2022.
- Quality Committee (QC), 13 July 2022.
- System Oversight and Assurance Committee (SOAC), 10 August 2022.

2. Chair of each Committee

Dr Ronan Fenton, Medical Director and Chair of CliMPC
Joe Fielder, Non-Executive Member and Chair of F&I Committee
Neha Issar-Brown, Non-Executive Member and Chair of Quality Committee
Anthony McKeever, Chair of SOAC

3. Report Author

Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

The Board is asked to note the content of the approved minutes of the following committee meetings:

- Clinical and Multi-Professional Congress (CliMPC), 28 July 2022.
- Finance & Investment (F&I) Committee, 7 September 2022.
- Quality Committee (QC), 13 July 2022.
- System Oversight and Assurance Committee (SOAC), 10 August 2022.

Mid and South Essex Health and Care Partnership
Clinical and Multi-Professional Congress (CliMPC)

28th July 2022
9:00 - 11:00 am
Via MS Teams

Attendees
Ronan Fenton (RF), Sarah Zaidi (SZ), Jose Garcia (JG), Babefemi Salako (BS), Peter Scolding (PS), Kirsty O'Callaghan (KO), Sam Bartlett-Pestell (SBP), Roshni Maisuria (RsM), Anna Ramsey (representing Russell White); Krishna Ramkhelawon (KR); Gbola Otun (GO); Olubenga Odutola (OO)

Apologies
Stuart Harris (StH), Rahul Singal (RS), Donald McGeachy (DM), Gerdi De Toit (GDT), Scott Baker (ScB).

Meeting Summary

No	Item
1.	**Welcome**
	RF welcomed colleagues to meeting. Nine members of the CliMPC were present therefore the meeting was quorate as per the ToR. There were no new conflicts of interest from the group. The minutes from the previous meeting were taken as accurate. RF explained Tertiary Fertility Services will be the last SRP in the current workplan for CliMPC to review, the complied reports will undergo consultation and a final decision will be undertaken by the Integrated Care Board (ICB).
2.	**Breast Reduction Scoring Remarking**
	RF highlighted that the group were unable to reach a final decision in the June meeting due to not being quorate. The report reflecting the discussions from the previous meeting was circulated – this was reviewed by the congress members. RF concluded the final recommendation by checking with all Congress members who were in agreement that breast reduction should be funded as IPA. Congress members did not have any objections and agreed this is the final recommendation to ICB.
3.	**Tertiary Fertility Services**

No	Item
	PS presented the paper to refresh the group of the differences amongst the current policies against NICE guidance, high-lighting the variations for example clarifying the definition of a cycle – 1 cycle is complete once all frozen embryos have been transferred (see executive summary). RF checked with the group if they were all clear on the information that was presented to them – members had no further questions. PS presented the scores for each domain. **Clinical Effectiveness** – overall score was 2 from score range (-16 to +16), where 2 members voted "do not agree", 2 members voted "neither agree or disagree" and 4 members voted "agree". The majority agreed that Tertiary Fertility Services are likely to achieve the intended clinical effect. Congress members that did not agree due to the evidence being patchy and variation in the centres and believe the money could be better used for other services and interventions. **Health Impact** – the lowest score was for option 4 "not routinely funded" closely followed by option 1 "continue funding policies" with scores of -7 and -5 respectively as those funding options were deeming by congress to have the most negative health impact. The highest score was given to option 2 "funding in-line with NICE criteria", thought to have greatest impact on health, congress members weighted up the impact on mental health greater than physical health when considering this. The group questioned what the impact having IVF leading to hyperstimulation of the ovaries and resulting in ectopic pregnancy. SBP confirmed the risk was estimated at 1-3% of a pregnancy resulting in an ectopic with IVF, therefore the risk was deemed low. Some congress members views were that funding or not funding will have minimal effect on health impact as many patients do not wait for NHS waiting lists and fund privately and this will not open up the flood gates. A couple of members were concerned that now reversing the decision to fund in areas where historically funding was stopped, that reinstating it may open up the flood gates. KO raised there could be retrospective claims from a legal point. RF – responded and advised that the group that the legal consideration will be made by the ICB and this group should make best recommendation based prospectively and not based on what we previously did. The group expressed that the group found this very difficult and emotive to score. RF appreciates that this is a difficult decision and stressed that legal and finances have not been disregarded. Overall the group agreed with the health impact score. **Cost-effectiveness** – PS summarised to the group they were asked to consider how much benefit is gained from a unit of cost, as QALYs cannot be used in this situation due to improvement to individuals health cannot be measured. PS explained this section was scored out of 24 with option 1 with the lowest score (10 points) and the other three options all 1 point difference from one another. However, option 2 had been scored the highest score (15 points) as it was deemed cost-effective by NICE who have an established process. The group high-lighted that this was very complex and some members scored it from an affordability point of view. **Affordability** – PS explained this section was scored out of 24 with option 2 – funded in line with NICE criteria had a distinct low score of 4. The highest score was awarded to option 4 – do not routinely fund as it is the most affordable option.

No	Item
	Group discussions concluded that option 3 – "fund with a restrictive criterion" will depend on what the criteria will be. Members agreed that it was difficult to score as the specific criteria has not been determined, along with the available budget for the service. **Health Inequalities** – PS summarised the score range was from -16 to 16. The policy with the lowest score, and the greatest negative impact on health inequalities was the current funding policy, as it creates postcode lottery with a score of -10. The highest score was awarded to funding in line with NICE followed by option 3 with scores of 3 and -1 respectively. Congress members agreed with this score on discussion. KR – the final policy must promote equal access. **Strategic fit** – the group had scored all the options to have a negative score, the least fit was option 1. The best fit was option 4 with a score -1 closely followed by option 3 (score -2). PS concluded the presentation with the overall scores; - Option 3 – 22 - Option 4 – 21 - Option 2 – 20 - Option 1 - 4 RF acknowledged the scores were very tight and reflected the difficulty of assessing this topic. The conclusion was agreed to recommend being funded with a more restrictive criteria than NICE with IPA to the ICB. It was agreed by the group the restrictive criteria would need IPA versus Threshold to make it a robust process.
4.	**Breast Asymmetry**
	RF – asked congress members what nuances with would make versus breast reduction comments. SZ – BMI would be a parameter to consider. No other comments from the group. Noted information pack on breast asymmetry – similar issues to Breast Reduction overall. Recommended that Breast Asymmetry should be provided via IPA.
5.	**AOB**
	PS – confirmed to the group that there would be no meeting in August, a date for September will follow shortly. September meeting will be a recap of the work and the group will be focussing on going forward.

Minutes of ICB Finance & Investment Committee Meeting

Held on 7 September 2022 at 10.00am

Via MS Teams

Attendees

Members (Voting)

- Joe Fielder (JF), Non-Executive Role, Committee/Organisation – Chair
- Julie Parker (JP), Finance Committee Chair, MSE FT
- Manny Lewis (ML), Non-Executive Director and Deputy Chair, EPUT
- Anthony McKeever (AM), Chief Executive Officer, MSE ICB
- Dawn Scrafield (DS), Chief Finance Officer, MSE FT and Interim Director of Resources, MSE ICB
- Dr Tiffany Hemming (TH), Executive Director of Oversight, Assurance and Delivery MSE ICB

Other attendees

- Jennifer Kearton (JK), Director of Finance for Operations & Delivery, MSE ICB
- Mike Thompson (MT), Chief of Staff, MSE ICB
- Nicola Adams (NA), Deputy Director of Governance & Risk, MSE ICB
- Jane King (JK), Governance Lead, MSE ICB (Minutes)
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB (Item 6a only)
- Nina Van-Markwijk (NV-M), Finance Director – Efficiency and Care Group 4, MSE ICB (Item 9 only)
- Helen Farmer (HF), Interim Director of Children & Young People, ICB (Item 6b only)
- Sanjeev Sharmer (SS), Head of Integrating Pharmacy and Medicines Optimisation, ICB (Item 5b only)

Apologies

- Jo Cripps, (JC), Executive Director, Strategy & Partnerships, MSE ICB
- Loy Lobo (LL), Finance Committee Chair, EPUT (represented by Manny Lewis)
- Karen Wesson (KW), Director of Assurance & Planning, MSE ICB

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and a round of introductions took place. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking and deleted after 30 days.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by ICB Board and committee members are also listed in the Register of Interests available on the ICB website**.**

The following declarations of interest were raised:

- The Chair declared a personal relationship with the Director of Operations at North East London Foundation Trust, but noted this did not conflict with any agenda items.
- ML declared his interest as the Deputy Chair of the continence provider, Essex Partnership University Foundation Trust, which was for discussion under Item 6b.
- JP reminded the Committee she was a Non-Executive Member of Mid and South Essex NHS Foundation Trust and declared she did not have a conflict of interest at the meeting but would be happy to provide details of interests to the Governance Team for transparency.

3. Minutes

The minutes of the last meeting of the ICB Finance & Investment Committee on 27 July 2022 were received.

Outcome: The minutes of the meeting held on 27 July 2022 were approved as an accurate record.

4. Action log

The action log was reviewed and noted.

5. Committee Terms of Reference

Finance & Investment Committee

JF explained the role of the independent Non Executive Members from provider organisations was to provide insight and a balanced view of provision, whilst also acting as a conduit into the committee for other system colleagues that were not part of the committee. JF hoped the partner members felt part of the FIC team to ensure the highest quality care and services to population, value for money and to inspire and motivate staff to give their best.

MT agreed that Non Executive Member colleagues were not directly representing their respective provider organisations on the Committee in terms of accountability, but to bring

their experience and expertise of the sector/provision they represent, with the added value of being system partners.

DS added that the role of the Finance & Investment Committee was to provide assurance to the ICB Board. Foundation Trusts had a requirement to regard and support the delivery of system control totals and manage system resources, the provider organisation Non Executive Members would join up assurance provided to the Board.

Following the first meeting of the Finance & Investment Committee in July, MT explained that further consideration had been given to the terms of reference and was proposed that the reference to 'and/or Community Interest Companies providing NHS services' be removed from the membership of the Committee. The establishment of subcommittee to enable work to be delivered, e.g. MSEMOC, was also reflected in the updated terms of reference.

Outcome: The Committee APPROVED the amended Finance & Investment terms of reference and recommended to the Board for formal approval.

Establishing the MSE Medicines Optimisation Committee (MOC)

SS advised the MOC had been well set with clear audit trail around process with pathways and documents developed with liaise with specialist, then 4 week consultation period, receive comments then final decision is made. Finance was also linked in to the process.

AMcK concurred that MOC round drugs used in primary care was a well-established format, now need to get a drug formulary that spanned primary and secondary care. It is essential the Committee is dovetailed into clinical leadership structures. MT advised that consideration was given to Quality or Primary Care Commissioning Committees, but the consensus was that FIC was the best home for MOC but would be kept under review.

JP enquired whether the committee were noting or making decisions regarding the MOC and would need to address the removal of items. SS confirmed that procedural matters would not be dealt with by the FIC.

SS enquired whether it was acceptable for the MOC to make minor changes to TOR and reporting. JF agreed that minor tweaks would be acceptable but let MT be the guide. MT agreed to work with SS to shape reporting and assurance for the committee.

Outcome: The Committee APPROVED the establishment of the Mid and South Essex Medicines Optimisation Committee as a sub-committee of the Finance & Investment Committee.

6. Business Case Approvals

Digital AGEM CSU

BF presented the options available to MSE ICB as the Essex wide Corporate and GP IT Service (ITSM) and Primary Care Enabling service (PCES) contracts with Arden and GEM CSU came to the end of their term on 30 June 2023. The future commissioning decision was required from Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB on their future commissioning strategy and whether there were any opportunities for MSE ICB to collaboratively commission IT and Digital Services in the future.

The options for the Committee to consider were as follows:

Option One – 'Bundle' GP, Corporate IT and PCES into one contract award.
Option Two - Separate Corporate IT contract award on similar T&Cs.
Option Three - Separate GP IT and PCES contract award on similar T&Cs.
Option Four - Corporate, GP IT and PCES, service review and Call-Off exercise utilising Health Systems Support Framework (HSSF).

The outcome of the options appraisal identified that options Two and Three were the recommended strategy. MSE ICB to issue two Voluntary Ex-Ante Transparency Notices (VEAT) to the market detailing MSE ICBs intention to Direct Award two contracts to AGEM CSU. One for Corporate IT and the other for GP IT and PCES provision. After a sufficient standstill period has expired, and in the event the market had not responded to the ICB's decision, the two contracts would be awarded to AGEM CSU, under similar terms and conditions as the existing contracts.

JF enquired in the case of market challenge, how would that affect the process and approval agreed by the FIC and the consequences. BF said the risk of challenge was low which was in line with the advice provided by Attain, the ICB's procurement specialists. However if the risk materialised the team would need to follow the procurement approach to provision services.

Approving 2 and 3, and by default 4 if faced challenge.

JP enquired how the current approach by Hertfordshire and West Essex ICB and Suffolk and North East Essex ICB would affect the decision taken by the committee and whether their future intention might change the ICB's level of risk. BF explained that MSE ICB could extend directly with AGEM on existing contract with no affect, if the other ICB's were to join, they would continue to pay in line with their existing agreement. If they chose to go reprocure the service, the ICB would still be able to secure an extension to the existing contract. In terms of the risk, BF explained there might be a slight impact on risk should the other ICBs decide to remain with AGEM and the MSE ICB faced challenge from the market, Option Four would need to be considered.

ML stated that we need to challenge rationale and be more rigorous on the terms of contracts – it was not ideal to have long running contracts, as in the case of the potential four year contract for the proposed GP IT & PCES contracts was not good practice. ML stressed after this process is complete contracts must be tendered to test value for money.

JF noted the paper and also the plan to test the market for services which would be welcomed.

AMcK strenuously agreed that the CSU must be tested on value for money. The Chair agreed with the suggestion from AMcK to discuss with MT the balance between the level of technical rigour and basic detail included within procurement documentation for the Finance & Investment Committee consideration.

Outcome: The Committee APPROVED Option 2 and Option 3 (and by default Option 4 should the ICB face market challenge).

CYP Continence

TH explained the CYP Continence business case was as a result of a complaint made against the Mid Essex Children's Continence Service which the Parliamentary and Health Service Ombudsman which was upheld. The complaint related to the age in which children are eligible for support from the Level 2 children's continence service, and the number of containment products that families are eligible for. The ombudsman instructed the Mid Essex CCG to undertake a gap analysis against national guidance, and to put plans in place to address these gaps. There was also an instruction for Mid Essex CCG to pay compensation to the family. A review of Mid and South Essex pathways for children's continence services was undertaken, and a number of gaps were identified, including lack of early identification, poor constipation support, under resourced teams and long waits for follow up appointments and reviews.

TH was confident that predicted savings identified in the business case would be achieved. The health inequalities impact assessment was underway, and anything found that was not included in the current planning would be included.

JF was supportive of the business case and stressed the importance of reporting the benefits and delivery achieved. TH agreed and would decide where results would be appropriate presented. JS need to be clear that this was an investment and given current financial position do not have a contingency fund. There is a small investment reserve that can be considered.

The consensus of the committee was that a less detailed business case was needed, instead a focused executive summary for future business cases.

The Committee were fully supportive of the CYP Continence programme.

Outcome: The Committee APPROVED the proposed CYP Continence Business Case

Items for Assurance

7. Review of Financial Risks

NA explained the BAF would be relaunched after Board Seminar in October and that in the meantime the finance team continue to manage financial risks on a day to day basis, which is reported on within the Finance Update and other agenda items as appropriate.

JP welcomed risk sharing and enquired how the BAF could be shared with partner organisations which would provide opportunity for challenge. MT agreed. NA stated that this would be the case as time progressed and that the governance team are currently working on the logistics of how this would be embedded in the future.

Outcome: The Committee NOTED the Financial Risk update.

8. Finance Update – M4/5

The M4/5 report covered both the ICB financial performance and system performance and highlighted that financial risk within system continued to be high. Significant work had been undertaken on the drivers of deficit but, to give assurance around delivery of the plan, the system needed to look at a financial recovery and improvement plan.

JS reported that the system continued to have an ambitious financial plan to deliver a breakeven position by the year end, with unmitigated risks of £94.5m and a need to deliver £84m efficiencies. Key points to note were that at the end of M4, the system position was a deficit of £34.0m, £22.6m adverse to the £11.4m deficit expected in the profile for delivering a breakeven position by the year end. The forecast remained breakeven for NHS partners however recovery arrangements were needed to achieve this plan. Local Authorities were forecasting a £6.6m deficit for 2022/23. The Efficiency Programme of £9.5m delivery was against plan of £14m so slightly behind.

JK highlighted that it was Month 1 for the ICB and the combined 12 month plan for the CCGs and ICB was profiled evenly across the financial year. At month 3, the CCG expenditure run rate was lower than 3 months of the planned 12 month allocation and the reduction in run rate was adjusted via the national allocation process.

DS explained the two main drivers fuelling the financial position were operational challenges around care, length of stay and emergency and the reliance of the efficiency programme on cash release. Although the forecast remained at a breakeven position, with the work undertaken around drivers of deficit and understanding the reason for the current position, unless changes were made, the system would continue to run at the same run rate. Discussions therefore were underway with regional colleagues regarding a recovery plan before forecasts were shifted.

JP agreed that it was important to drive efficiency, but schemes were not cash releasing they should not be deterred.

DS said that, as the ICB matured the committee would need to consider how assurance is obtained and understand how pieces of system work together. This is the skill needed to develop as a committee to get to the root challenge of the consequences of system decisions.

AMcK thanked DS for the system approach and remarked that this would enable the system to plan resources. In summary, the system was expecting £27.4m from an efficiency programme that had identified in excess of £100m of efficiency opportunities. A target was set of £84m but the system was yet to substantiate what needed to be done to use resources. The key issues highlighted in the report were that there were too many risks crystalising to achieve breakeven position, the workforce was fundamental to financial position and the system must see a reduction in bank and agency staff costs. Before the forecast outturn is agreed, discussions with regional team must be concluded.

AMcK advised there was a plan for a Chief Executives group which would enable wider planning and would take ownership of system recovery plan. The initial strategy to recover the underlying financial position was set over three years, but it was likely that a further year would be needed following. An independent validation of the forecast outturn would be required. There was opportunity to take stock of benchmarks to see where opportunities were to bear down on overall costs.

JK remarked that inclusion of activity and performance data in reporting would be key in identifying how good or how poor the situation was and would give context to the numbers.

JF was not assured by the data contained in the M4/5 Finance Performance report and welcomed the need for a recovery plan and external third party expertise. The discussions between the finance executives with regional colleagues offered some assurance.

ML suggested deep dive reviews should be included on the workplan. JF was not in favour of deep dive reviews at this stage and commented that executive and financial leadership must settle first, however if no progress was noted then deep dive reviews would be considered.

DS suggested that contextual information was shared in between meetings as appropriate to be kept up to date in between committee meetings and which would ensure Board conversations would be informed.

ML was comfortable with suggestion of a recovery plan and agreed that, as work progressed, the committee and non-executive members should be kept up to date.

AMcK agreed that non-executive members were essential and critical in resolving financial issues the ICB faced, and that recovery plan would be brought back to the committee. The Chief Executive group would also help understand system cause and effect and identify a system response.

AMcK advised that since the committee papers had been issued, there had been substantive changes in Thurrock Council commissioning arrangements.

Outcome: The Finance & Investment Committee NOTED the M4/5 Finance Update

9. Efficiency Programme (SFLG)

DS explained that the financial sustainability work provided the framework for driving forward ambitions financial efficiency programme for the system. Encouraging that compared to same time last year, there are clear identified programmes and opportunities, but there had been same challenge in converting this into cash out.

The report summarised the current performance (as at the end of July 2022) against the system efficiency target for 2022/23 of £84m. This target is comprised of opportunities identified as part of the 2021 System Financial Sustainability review of £49.7m, and local schemes delivered by NHS partner organisations of £34.3m. Month 4 delivery was £4.6m behind plan with £9.5m delivered for the year to date compared to a plan of £14.1m. Forecast outturn delivery is reported to NHSI as in line with plan, but this is being reviewed given the adverse delivery to plan for the year to date.

NVW advised that the system currently has £67m of identified schemes, of which £32.5m were cash releasing. Of the remainder, the majority are productivity schemes, and due to operational pressures at MSEFT it has been challenging to convert these to cash releasing due to the requirement to reduce backlogs and high levels of non-elective activity. Further actions were underway to improve the reported efficiency position, as follows:

- Establish the timeline to convert productivity schemes to cash releasing (where possible), particularly for the Financial Sustainability Programme.

- Continue to progress ideas into PIDs and PIDs through the gateway process into delivery.
- Continue to meet with Financial Sustainability Programme workstream SROs to ensure PIDs are developed against all recommendations within the report – spanning the 2022/23- 2024/25 financial years where possible.

• Identify potential efficiency schemes using the HFMA NHS Value and Efficiency Map and other sources of opportunities.

GW concluded that there needed to be accountability for the programme as well as working together to achieve results. It was suggested that it would be beneficial to revisit the efficiency programme to identify priority efficiencies.

Outcome: The Committee NOTED the Efficiency Programme update

10. Draft Work Plan / Meetings schedule

NA presented the draft Work Plan which had been produced with the Finance Team and was an iterative process.

JF welcomed the continual review that would provide flexibility to Executive Team to add items to work stream.

JP suggested it would be helpful for the annual plan to be driven by BAF once it is in place.

Outcome: The Committee APPROVED the Draft Work Plan

11. Items to Escalate

To the ICB Board – Finance and Investment Committee Terms of Reference

To MOC - The establishment of the Mid and South Essex Medicines Optimisation Committee as a sub-committee of the Finance & Investment Committee.

12. Any other Business

Mental Health PTS

JK made the Committee aware that the financial consequence of funding the regional Mental Health PTS would be absorbed by mental health finance. EPUT were closely involved and did not require formal approval.

ACTION: *Mental Health funding – useful to be on future Finance & Investment agenda.*

AMcK appreciated feedback received from the non-executive members and welcomed the opportunity for fresh thoughts, shared understanding, and appreciation.

The committee noted that the previous year's accounts and first three months of 2022/23 for the CCGs will be taken through local committees.

13. Date of Next Meeting

10.00am – 12.30pm, 5th October 2022. Chair advised that the next meeting would be face to face and that venue details would be shared.

Minutes of Part I Quality Committee Meeting

Held on 13 July 2022 at 9.00 am – 11.00 am

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member, MSE ICB – Chair
- Rachel Hearn (RH), Executive Director of Nursing & Quality, MSE ICB

Attendees

- Gemma Hickford (GH), Consultant Midwife, MSE ICB
- Carolyn Lowe (CL), Head of Children and Young People's Continuing Care Commissioning, MSE ICB
- Matt Gillam (MG), Interim Head of Nursing, MSE ICB
- Stephen Mayo (SM), Director of Nursing for Patient Safety
- Greer Phillips (GP), Patient Safety & Quality Manager, MSE ICB
- Jackie Barrett (JB), Interim Head of Nursing, MSE ICB
- Cheryl Gerrard (CG), Interim Designated Nurse Safeguarding Adults, MSE ICB
- Eleanor Carrington (EC), Quality Assurance Nurse, MSE ICB
- Sharon McDonald (SMc), Head of Nursing and Midwifery Transformation, MSE ICB
- Linda Moncur (LM), Interim Director of Safeguarding, MSE ICB
- Eleanor Sherwen (ES), Interim Head of Nursing, MSE ICB
- John Swanson (JS), Infection Prevention & Control Specialist, MSE ICB
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB
- Helen Farmer (HF) – Item 23 only, Interim Director for C&YP and LD, MSE ICB
- Sara O'Connor (SO), Head of Corporate Governance, MSE ICB
- Charlotte Tannett (CT), Corporate Governance Support Officer, MSE ICB

Apologies

- Dr Ronan Fenton (RF), Medical Director, MSE ICB
- Viv Barker (VB), Director of Nursing - Patient Safety

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking.

2. Declarations of Interest

NIB reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by Integrated Care Board (ICB) and committee members are also listed in the Register of Interests available on the ICB website**.**

There were no declarations of interest made.

3. Minutes

The minutes of the last Patient Safety and Quality Committes in Common held on 10 May 2022 were noted. SO advised that the minutes had been signed-off by the Chairs of the former mid and south Essex Clinical Commissioning Groups' Patient Safety and Quality Committees.

Resolved: The minutes of the MSE CCGs Patient Safety and Quality Committees in common meeting held on 10 May 2022 were noted.

4. Matters Arising

There were no matters arising.

5. Action log

The action log was reviewed and the following updates noted:

- Action 1 was completed but not closed and would remain on the action log until updates on the Mental Health Strategy and NICE Guidance had been received. SM to link in with Alfie Bandakpara-Taylor regarding the estimated timeline.

6. Quality Committee Terms of Reference

NIB summarised the Terms of Reference (ToR) and noted that a Vice Chair would need to be appointed once the full membership had been established. RH noted that the committee would be inviting members from system partners / provider organisations and suggested letters were sent formally requesting nominations from their organisations. The committee were in agreement. PW highlighted a minor typographical error in the ToRs, which was noted for correction.

Resolved: The Quality Committee Terms of Reference were noted.

- Action: SO to draft letters to partner organisations requesting them to nominate a representative to become a member of the Quality Committee.
- Action: Committee members to nominate a Vice Chair once full membership established.

7. Lived Experience Story – Workforce

The committee were shown a video of the lived experience of Nisha Mathew and Jayva Veerasamy, two nurses who had trained in the Mid and South Essex (MSE) system.

Resolved:The Committee noted the Lived Experience Story.

8. Deep Dive – Workforce

SMc provided a presentation on MSE workforce planning for 2022/23 which included an update on the following areas of work:

- Looking after our people.
- 50k Manifesto.
- Working differently.
- Improving belonging.
- Grow for the future.

NIB commended the comprehensive and positive nature of the item and the discussion and noted that future Deep Dive items would need more time on the agenda.

RH noted the positive work ongoing around domestic and international recruitment and the retention of legacy nurses and midwives which would be key for the system moving forward.

PW stated the importance of considering medicines administration to avoid barriers in optimising the use of a range of professionals joining the workforce. SMc confirmed a focus group had been established to address this. Members agreed that this would be a helpful future deep dive potentially linked to a lived experience case study for a future meeting. Where relevant and helpful, deep dives are linked to the lived experience case study and/or an update or progress from a previous escalation.

Resolved: The Committee noted the Deep Dive on Workforce

- Action: SM/SO to ensure that Future Deep Dive items are given more time on the agenda and committee members consulted on topics.

9. Maternity Services, including update from the Local Maternity and Neonatal System (LMNS)

GH highlighted the midwifery workforce was a key area of focus. The three Mid and South Essex NHS Foundation Trust (MSEFT) sites had significant workforce vacancies. To mitigate this, a workforce workstream had been established to explore all key areas. Job offers had been made to all current final year student midwives. The LMNS had oversight of workforce vacancies and were working closely with RH and the MSEFT Chief Nurse on mitigations. It was noted there was a national shortage of midwives and MSE was one of the worst affected regions.

RH confirmed MSEFT maternity services had received a request to produce focus groups of maternity staff for the Care Quality Commission (CQC) over the next two week period which indicated the CQC might carry out a formal unannounced inspection. The Quality Committee would be updated in due course.

Resolved: The Committee noted the update on maternity services.

10. Patient Safety and Quality Risks

RH confirmed 21 risks had been handed over to the committee from the former CCG's Patient Safety and Quality Committees. There were 4 red risks relating to general

workforce, mental health quality, children's autism services and maternity workforce. One new amber rated risk had been added relating to maternity services governance. No risks had been put forward for closure.

PW confirmed a large number of adults with suspected autism were being referred into the system as well as children. RH confirmed she was aware of this and that the level of risk around adult autism was being closely monitored.

Resolved: The update on patient safety and quality risks was noted.

11. Patient Safety Framework update

MG highlighted that the patient safety specialists were looking to recruit 'patients for patient safety' which aimed to involve patients in considering patient safety issues up to Board level. Healthwatch had been contacted to explore if a system-wide approach might be used. MG added that there was an expectation that all staff would undertake a level of patient safety awareness training.

NIB queried how completion of patient safety awareness training would be monitored. RH confirmed the level 1 training was mandatory for all staff and available on the Electronic Staff Record (ESR) system. Discussions were ongoing regarding the other levels and which staff should undertake these.

SMc suggested the patient safety awareness training might be linked into the Health and Care Academy platform which could enable it to be circulated system-wide. RH thanked SMc for the offer and confirmed that the patient safety specialist role, which was being recruited to currently, would consider this as a priority.

Resolved: The Committee noted the Patient Safety Framework Update.

- Action: New Patient Safety Specialist (once appointed) to consider SMc's suggestion that patient safety awareness training could be linked into the Health and Care Academy platform.

12. NHS Patient Safety Updates

The committee received the NHS Patient Safety updates dated 31 May and 28 June 2022.

Resolved: The Committee noted the content of the NHS Patient Safety Updates.

13. Acute Care

JB highlighted a number of escalations for noting regarding backlogs in a number of processes across MSEFT as follows:

- Complaints outstanding – 430 with 246 overdue.
- 104+ day cancer breaches – 172 outstanding.
- Cancer Harm and Referal to Treatment (RTT) Harm Reviews – 275 open across the system.

JB assured the committee that internal processes were in place to mitigate the backlogs and the team were working closely with MSEFT colleagues to monitor progress. JB noted

the East of England Ambulance Service Trust (EEAST) were under significant pressure due to the current heatwave and a rise in Covid-19 (C-19) infections causing significant staff sickness absence.

RH advised the committee that the whole MSE system was currently on Operations Pressure Escalation Level (OPEL) 4 due to extreme pressures caused by very hot weather and rising cases of C-19. Business continuity processes were being implemented, including full Personal Protective Equipment (PPE) for all visitors and potential visitor restrictions. A quality assurance visit to MSEFT had been cancelled in response to these pressures. The Chair of the Urgent and Emergency Care Board was working closely with the Interim Head of Nursing to identify whether patient harm was occurring and how these experiences might be used to improve patient journeys in the future.

RH highlighted that MSEFT had recorded its first Monkey Pox case. Cases regionally and nationally were growing and the Infection Prevention & Control (IP&C) team would be able to update more on this at future committee meetings. PW confirmed some community pharmacists across MSE were taking part in a pilot to provide Monkey Pox vaccinations.

JB highlighted a further Never Event (NE) for wrong site surgery since the report was written. MSEFT were in the process of producing a 'three-day' report into this occurrence which involved the wrong lesion being removed from a patient. There were serious concerns due to continuous occurrence of NEs of a similar nature. The Trust had been asked to undertake a look-back exercise into these events to understand the root causes, with early investigation having highlighted issues with communication, translation and a reluctance to challenge.

NIB suggested that, when possible and appropriate, this particular NE should be brought back to committee to share progress and also lessons learnt to understand how the identified causes were addressed.

Resolved: The Committee noted the Acute Care update.

- **Action**: SM to request VRB to provide an update on Never Events relating to wrong site surgery to a future Quality Committee meeting.

14. Mental Health

SM noted some key risks within the report relating to Serious Incidents (SIs), quality assurance visits, Eating Disorders (ED), Dementia diagnosis and suicide reduction. SM also highlighted several high profile legal cases ongoing around suicides. SM had received agreement to recruit a pan-Essex team to mitigate the impact of these investigations.

Resolved: The Committee noted the Mental Health update.

- **Action**: SM to ensure updates on ongoing legal cases are provided to the committee.

15. Infection Prevention and Control (including approval of IP&C Annual Report 2021/22)

JS highlighted a rise in Clostridioides difficile infection (CDI) cases across MSEFT and in particular at the Basildon site. The IP&C team had undertaken supportive assurance visits which had been reported against and the Trust were happy with the learning provided. The

team continued to provide ongoing support. JS noted that part of the significant upturn was due to an outbreak of 027 strain of the infection.

Resolved: The Committee noted the IP&C update.

16. Community Care

ES highlighted issues around speech and language therapy services which had been under business continuity arrangements for some time. Possible mitigations included plans to create a MSE leadership team to explore the redeployment of staff, review waiting lists and more efficient ways of working.

Resolved: The Committee noted the Community Care Update report.

17. Alliance Primary Care Quality Report

EC highlighted there were 13 GP practices rated as red receiving ongoing support from the team. All formal complaints continued to be monitored by NHS England/Improvement (NHSE/I) and the table on page 86 of the papers reported on trends from Quarter 4 of 2021/22.

There was an outstanding action for quality from the MSE CCGs Primary Care Commissioning Committee outlined on page 87 of the report to ensure that the Mid Essex Medicines Management Team provided an update and closure paper relating to Trinity practice in Mayland.

Resolved: The Committee noted the Alliance Primary Care Quality Report.

18. Adults and Children Safeguarding System Report (including feedback from Safeguarding Board)

LM outlined several amber areas of risk within the report which had been well mitigated. These included workforce, delivery of Liberty Protection Safeguards (LPS) Code of practice, child death by suicide, childrens community support services availability, backlog in Initial Health Assessments (IHAs) post C-19, sexual assault referral centre service restrictions and Southend, Essex and Thurrock (SET) policy and procedures for non-accidental injury. Strategic Partnership Boards were developing business plans for the next three years and deliverables from those plans would be incorporated within the Health Executive Forum.

NIB queried the current status of the Safeguarding Boards. LM confirmed there were five Safeguarding Boards within the ICB's remit which included representation from system partners, e.g. the police, local authorities and education. LM advised that she would be happy to meet with NIB to discuss the priorities of each of the Boards if this would be helpful.

Resolved: The Committee noted the Adults and Children Safeguarding System Report.

- Action: LM to meet with NIB to arrange introductions with Safeguarding Board Chairs.

19. Medicines Optimisation

PW highlighted opioids as a high risk area. There had been good work in reducing the overall number of patients prescribed opioids across the system, however the proportion of complex patients on high doses of opioids had risen and flagged nationally. Suggestions to mitigate this were to support primary care with the de-prescribing of opioids via a support programme as well as a system-wide communications campaign. However, both of these actions would require funding. Work was ongoing with the pain management group across the MSE system and there was an opioid workstream in place within the MSE Prescribing Efficiency Programme.

NIB suggested this issue be brought back to the committee as a deep dive at a future meeting.

Resolved: The Committee noted the Medicines Optimisation update.

- Action: SM to arrange for a deep dive on opioids at a future committee meeting.

20. Care Sector Report

GP highlighted there were increasing levels of C-19 outbreaks within care homes. This had negatively impacted upon staffing levels and the number of residents affected was increasing quicker than during previous outbreaks. Help and support was being offered by the care home hubs. GR also highlighted some practical mitigations were being explored to limit the impact of the impending hot weather.

Resolved: The Committee noted the Care Sector update.

21. All Age Continuing Care Update

SM highlighted issues around workforce vacancies within the team which had been further impacted by the transition process from CCGs to an ICB. To mitigate this, a robust structure had been developed going forward and plans on how to communicate this to staff effectively were in progress. Recruitment processes were also underway, agency staff were in place and the team were mindful of the risk of backlogs.

Resolved: The Committee noted the All Age Continuing Care Update.

22. Complaints Report

MG confirmed the format and content of the complaints report was under review. NIB queried the granularity and usefulness of the data within the report. MG explained that the report was an almalgamation of information from the previous five MSE CCGs and was difficult to assess for the purposes of quality. The team would be looking at the format of future reports and how to feedback patient experience into the MSE system more effectively.

Resolved: The Committee noted the Complaints report.

23. Little Havens

HF confirmed there had been an urgent escalation to the System Quality Group and ICB Executives regarding Little Havens Hospice and concerns around staffing and their ability to care for inpatient children at the end of life facility. A lot of urgent work had taken place with immediate effect around short, medium and long term mitigations which would be put in place to move this forward. HF emphasised the issue was surrounding one element of hospice care and the wider offer around respite, short breaks and the Woodlands suite following death which were still available for families. The issue was currently affecting one family. The CQC had been formally notified of the position by Little Havens.

NIB queried if the numbers of families affected was expected to rise. HF confirmed they had received assurance from Little Havens that the position would remain the same until at least October 2022, however the team were planning mitigations into 2023. HF confirmed the level of risk on the Board Assurance Framework (BAF) would be increased and the risk would be re-aligned to the Quality Committee.

Resolved: The Committee noted the report on Little Havens and requested an update at the next quality committee.

- Action: HF to submit an update on Little Havens to next Quality Committee meeting.

24. Any other Business

NIB asked for suggestions regarding the format and timings of future committees and suggested that extra time be given for future Deep Dives on the agenda.

RH requested that members did not focus only on Deep Dives relating to red risks but that there was also a focus on positive elements of work within the system. All agreed.

SO advised the format of templates for reporting would be further reviewed and discussions were ongoing around this for all committees. SO added that she understood a Board seminar on risks and risk appetite would be held in the near future.

RH advised a quality dashboard workshop would be held to develop a more intelligent dashboard with ‘heat maps’ to clearly indicate where escalations would be made. RH stated this would be her last committee as Chief Nurse and SM would be overseeing the committee in the interim.

NIB thanked RH on behalf of the committee for all of her hard work and wished her all the best in her new role.

The committee agreed that a summary report from todays meeting would to go to the ICB Board on 15 September 2022 with a view to hold the next meeting in late September 2022. Suitable dates would be sought for all further meetings.

- Action: SO/CT to identify suitable dates for future meetings.

25. Date of Next Meeting

Friday 30 September 2022 at 10.00 am to 12 noon.

Minutes of ICB System Oversight & Assurance Committee Meeting Held on 10 August 2022 at 1pm

Via MS Teams

Attendees

Members (Voting)

- Anthony McKeever (AMcK), Chief Executive Officer MSEICB.
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England.
- Hannah Coffey (HC), Interim Chief Executive MSE NHS Foundation Trust/ Andrew Pike (AP), Managing Director MSE NHS Foundation Trust.
- Alan Whitehead (AW), Clinical Director EoE Ambulance Service Trust.
- Lynnbritt Gale (LG), Associate Director, Community Mental Health Services EPUT.
- Stephanie Dawe (SD), Group Chief Nurse & Chief Operating Officer, PROVIDE.
- Selina Douglas (SD), Executive Director of Partnerships NELFT.
- Ruth Jackson (RJ), Executive Chief People Officer Mid & South Essex Integrated Care Board.
- Dawn Scrafield (DS), Interim Director of Resources MSE ICB/ Director of Finance MSEFT & nominated lead from System Finance Leaders' Group.
- Dr Tiffany Hemming (TH), Executive Director of Oversight, Assurance and Delivery MSEICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance/ Nominated lead from Clinical and Multi-Professional Congress.

Attendees

- James Wilson, Transformation Director, Mid and South Essex Community Collaborative.
- Viv Barker (VB)Director of Nursing - Patient Safety, MSE ICB, Nursing and Quality Directorate.
- Stephen Porter (SP), Alliance Director (Thurrock), Mid & South Essex ICB.
- Simon Williams (SW), Deputy Alliance Director (Basildon and Brentwood), Mid & South Essex ICB.
- Caroline McCarron (CM), Deputy Alliance Director (South-East), Mid & South Essex ICB.
- Holly Randall (HR), Senior Head of Workforce Transformation, Mid & South Essex ICB.
- Diane Sarker (DS), Chief Nurse, MSE NHS Foundation Trust.
- Barry Frostick (BF), IM&T Programme Director, Mid & South Essex ICB.
- Matt Gall (MG), EPUT.
- Danny Hariram (DH), MSE NHS Foundation Trust.
- Mike Thompson (MT), Chief of Staff, Mid & South Essex ICB.
- David Triggs (DT), Governance Lead, Mid & South Essex ICB.

Apologies

- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England.
- Claire Hankey (CH), Executive Director of Communications & Engagement Mid and South Essex ICB.
- Karen Wesson (KW), Director of Assurance & Planning.
- Melissa Dowdswell (MD), East of England Ambulance Service Trust.
- Dan Doherty, Alliance Director, MSE ICB.
- Ruth Hallett (RH), Alliance Director, MSE ICB.
- Jo Cripps (JC), Executive Director, Strategy & Partnerships MSE ICB.
- Dr Ronan Fenton (RF), System Medical Director MSE ICB & Nominated lead from Clinical and Multi-Professional Congress.
- Sean Leahy (SL), Executive Director of People & Culture EPUT.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above..

2. Declarations of Interest

The Chair asked members to declare any interests in relation to items under discussion. None were raised.

3. Minutes

The minutes of the meeting of SOAC held on 14 July 2022 were approved as a correct record.

4. Action Log and Matters Arising from minutes of July 2022.

The action log was reviewed and the updates noted.

Action 61 referred to the Cancer Harm paper which featured on the agenda at item 9.

Actions 63 & 64 referred to completed actions that were included as part of items 8 & 10 respectively.

5. Key Risks – Performance

TF introduced the Performance and Planning paper for August 2022. It provided an overview of the current position against 2022/23 planning requirements and to provide an update on the governance arrangements for oversight and assurance of each area prior to submission to SOAC. In introducing the performance data TF explained that it shows performance was poor in most areas.

Workforce: It was noted that the workforce data summary had been updated and this would be reviewed as part of the separate item on the agenda.

Urgent and Emergency Care (UEC): It was noted that the UEC Strategic Board oversees performance and planning for all UEC services (EEAST, NHS111, A&E, UCRT, Mental Health ED) and had representatives from health and social care. The Chair proposed that this item be discussed as part of the UEC Action Plan at item 10.

Elective (Diagnostics, Cancer and RTT): The Committee noted the SOAC performance oversight report – elective.

Diagnostics: June figures across all acute providers:

- 13+ weeks: Below standard at 4,281 patients (an increase of circa 500 patients to May position).
- 6+ weeks: Below standard at 10,624 patients which was 31.8% of the waiting list (an increase of circa 900 patients to May position).

Noted that a significant acute challenge lies in non-obstetric ultrasound with an identified issue being the workforce capacity regarding Sonographers. The actions already being taken included the recruitment of an additional sonographer at MSEFT who would be starting shortly. Recovery plans would be shared with the Diagnostic Performance and Delivery Group in August.

Cancer: All cancer performance was below the constitutional standards. It was noted that a number of actions had been undertaken including:

- Turnaround improvement national cancer performance lead (Liz Rippon) working with us as a system leading on implementing the pathway transformation work required to achieve standards.
- 5 key pathways (skin, gynae, breast, prostate, lower GI) are agreed transformation areas and working towards best practice pathways to improve the front end of the pathway diagnosis and be able to inform patients of a cancer diagnosis sooner or have cancer ruled out.
- The biggest and highly significant proportion of delays , 60%, of the 62+ day backlog, lies within skin.
- Work progressing with PCNs regarding Telederm roll out and significant prevention/screening work in progress with them led by Macmillan GPs.
- The Cancer Improvement Plan as discussed at the Cancer Board was noted. Next steps included measures to achieve the detailed 62 day recovery trajectory are delivered in August 2022.

AMcK thanked AP for his detailed appraisal and the actions being taken to bring the trajectories for the different specialities under control with the ambition of meeting all targets proposed. Having discussed the situation with AP outside of the meeting he was satisfied that every effort was being made locally to turn around performance in UEC, Workforce, Cancer Waits and Maternity. Clearly, therefore, if the actions being undertaken did not have the desired effect then there was a high probability that the System would be seen by NHS England as needing external assistance. Committee members did not identify or suggest any further actions that could sensibly be initiated at this time.

EM indicated that it was good news to have a reduction in the 62 day cancer numbers for a third week in a row albeit a small one. In her view there was an improved grip on cancer

and the System was pursuing effective plans at the present time. There was a discussion around conflicting planning trajectories were being used locally and nationally to measure progress and this needed to be agreed with the NHSE Regional team.

It was agreed that EM would take forward the possibility of mutual aid.

***Action**: EM to pursue the possibility of mutual aid to support cancer performance.*

In conclusion AMcK asked for a clear narrative on the position regarding Cancer 62 day waits. He had asked Karen Wesson to lead this piece of work with help from Claire Hankey.

***Action**: TH/ KW/ CH to develop a clear narrative on the position re Cancer 62 day performance.*

AMcK as Chair asked AP to take back to the relevant people the appreciation and thanks of the Committee for the hard work of all staff involved in supporting the work that he was reporting on.

Referral to Treatment (RTT): this was overseen by the System's Elective Board which AP Chairs. It was noted that the waiting list was around 159,299 patients (week ending 24/07) an increase of 20,000 in the financial year.

AP reported that the expectation was that 104 waits would be eliminated by the end of July, with a few P6 'stragglers' in August. The reported number of patients waiting over 52 weeks had increased during the financial year to date by circa 3,000 to 8,633 patients as at week ending 24/07. There were 620 patients waiting 78+ weeks as at week ending 24/07 which had decreased seven weeks in a row. The 52 week-wait backlog was an increasing trend and there was a concern that this was being fuelled by non-admitted growth. There was a lot of work being undertaken to understand the reasons for the growth and the multiple ways of patients being referred. One of these was through primary care/ GP colleagues and an action was to discuss with them alternatives to hospital referral.

AP explained that there were issues around the need to expand diagnostic capacity with particular constraints from ultrasound and workforce.

During discussion SW requested analysis of the data supporting referrals from GPs compared with referrals from other sources. He asked if the information could identify variations at Primary Care Network (PCN) level as well as across specialities.

JH followed this up with a comment about the work being undertaken to reduce inappropriate referrals. There were opportunities to look at the IFR Team, the outpatient transformation programme, advice and guidance. The Elective Board's GP/ primary care lead would need to develop tools to take the effective action and help reduce long-term referral rates.

Actions:

a) The Chair asked key individuals including SW, BF, JH, TH, AP to work with Emily Hughes and as part of the outpatient transformation program to bring back to SOAC a set of proposals that would enable the System address the issues that would support the objective of bringing down referral rates.

b) The Chair asked that as part of the work in a) above, AP consider providing information that helps those involved understand the way in which existing capacity was being used. Reference was made to the fact that routine 'clock stops' account for 30% of capacity and the importance of making best use of this activity around the distribution of waiting times.

Mental Health, Maternity & Diagnostics: The Chair asked for any exception reports covering these three areas.

Mental Health: GL reported that mental health urgent and emergency care would be going onto black alert today with a set of proposed actions being approved by the EPUT Executive Team to mitigate the impact including support for A&E. These would be shared as soon as they were approved.

In referring to other areas in the report TH explained that there was a recurring theme around workforce. One example being diagnostics and the impact felt by the lack of a sonographer.

Maternity: DS gave a brief update on the outcomes from CQC following their recent inspection/ visit of maternity services at MSEFT. Overall there were some positive comments relating to

- teamwork and MDT working
- staff described the Trust as one organisation rather than three separate sites
- the senior leadership team was strengthened
- front line teams could articulate the positive changes although some staff remained stressed around the workforce
- there was still some uncertainty around how to escalate issues and concerns and this was left for us to action as part of one of their recommendations
- visibility of the senior leadership team was good
- it was proposed that the Trust undertake a deep dive of the governance review & particularly the risk management strategy
- understand work to do on workforce
- need to strengthen administration
- some issues around triage and strengthening fetal medicine provision
- overall there were no surprises and no issues that we weren't aware of

AM thanked DS for a very encouraging report based on the very latest perspective.

The Chair indicated that with agreement of the Committee he proposed to re-order the agenda.

6. UEC Action Plan

AM introduced the UEC pack dated 6 July which was included with the papers. He invited AP (as Chair of the UEC Board) and TH to talk through the Urgent Emergency Care (UEC) taskforce approach slides that had been circulated to the Committee yesterday following the UEC Board meeting on Monday.

AP introduced the slides which proposed a strong focus on an overarching aim of preventing patients with a DTA having to sleep / wait in ED. AP explained the task force approach being proposed by the UEC Board through a focus on the following four key themes:

- Front Door/ Admission Avoidance.
- Virtual Ward.
- Discharge to Assess (D2A)/ Home First.
- Internal Improvement Plans/ Flow.

The Committee was asked to support the ambitions outlined in the taskforce approach with an aim to return to sustainable and acceptable levels of performance before October/ November.

AP acknowledged the need for close working with local authority colleagues and to commit additional resources to areas like bridging and hospital at home. As referred to elsewhere on the agenda there was a critical workforce dimension to delivering on each of the four themes. AP referenced the length of stay issues, the delays and the ability to manage acute patients in the mental health sector carried equal weight with the aim of seeking a half a day improvement between now and the autumn. TH confirmed a keen desire to provide support for the key themes through the Alliances. AP agreed that Alliances could play an important supportive role and that he had met with Alliance Directors and TH to start this work. AM emphasised the need for a unified and coordinated response across the whole system, including primary and community services, social care and the voluntary sector.

HC referenced the MSEFT internal work around the foundation for the future program which would focus on ward process and ED as part of the Trust's contribution. The Clinical Congress could assist internal processes by advising on how clinicians might best shape protocols around clinical risks.

Action: *AM/ RF to advise HC on how the Clinical Congress can support this piece of work.*

The Committee agreed the task force's approach. In doing so, AM asked colleagues to make this programme of work a priority, by ensuring that partner organsations cut through current practices that were not working.

Accordingly, AMcK expected the taskforce to have operational authority and control using his authority on behalf of this committee. He asked participants to have a focus on getting results. This would then enable changes inside and outside hospital that to restore the required levels of patient flow.

It was agreed that some KPIs about prospective planning should be generated to show how we anticipate variables to move in the right direction over time, affording confidence that specific measures were indeed leading to overall goal(s).

Action*: to define suitable KPIs and some 'quick wins'.*

Action*: to further strengthen the remit/ membership of the taskforce and the four workstreams as necessary.*

Resolved: the workforce approach and the direction of travel was agreed by SOAC

7. Key Risks - Workforce

RJ introduced the workforce slides updated and circulated earlier in the day. It was noted that discussions at this meeting highlighted that workforce was at the centre of many if not most issues facing the health system. The dashboard showed actual vacancy rates and trajectory against the planning submission for EPUT and MSEFT. It was noted that corresponding primary care and community dashboards would be made available in the near future.

RJ introduced Matt Gall (MG) from EPUT and Danny Hariam (DH) from MSEFT who outlined the work being undertaken by their organisations.

RJ noted that one of the biggest costs to the NHS was the use of bank and agency staff and this was a key part of the system efficiency program.

When reviewing the data AM asked if we were nearer to having consistent data that all partners could agree on. RJ explained that it had been agreed at a system level that we would use the provider workforce returns which are pulled from ESR. RJ acknowledged that there was still some work to be done on some of the data in MSEFT. The Trust had PWC giving some support with this work but it was critical that at system level, the Committee was able to view what the regional and the national teams see through ESR. The Committee noted that the information relating to NELFT and Provide should be available for the next meeting of SOAC.

MG highlighted that with regard to the EPUT data, one of the concerns was around community nursing vacancies. He referred to some of the plans being developed by a task and finish group that had made progress with making significant efficiencies around delays in recruitment and he reported that recruitment time to hire had been reduced to 19 days measured from the shortlisting through to the issue of an unconditional offer. This seeks to address one of the biggest issues of dropout faced within the NHS. He was looking to share this learning and make similar improvements within community recruitment. MG was happy to share the learning with colleagues.

DH talked through some of the challenges in MSEFT and the responses that are in place focusing on three things a) reconciliation, b) recruitment and c) retention.

Referring to nursing vacancies and the need for one agreed set of information/data, DH talked about the work being undertaken to maintain recruitment activity and increase front line capacity so the Trust was ready for winter. Some of the measures being introduced to reduce levels of attrition included improved communication with candidates, and follow ups to ensure employment checks were completed promptly. DH shared some of the Trust's statistics including 283 nurses in their pipeline, with 19 midwifes, and 48 newly qualified students joining in September/October. There was a program to recruit international nurses and a campaign to recruit healthcare support staff. DH acknowledged the need to reduce turnover with the Trust reviewing its onboarding process, induction, support and initial training. During discussion DH explained that time to hire was 30 days for MSEFT.

AM asked for a breakdown to be provided of those being recruited into key jobs e.g. Urgent Emergency Care. He asked if the Trust could similarly provide data showing vacancies for outpatient transformation and progress in filling key roles.

AM then linked into the financial issues faced by the ICB. For example approximately £150m was spent on temporary staff. This was part of the ICB proposed efficiencies as it currently involved paying a £50m premium. He asked by how much the 283 nursing appointments would enable the ICB to reduce the £50m premium and when the untoward reliance on agency staff would begin to reduce?

DH agreed to take these matters away as a piece of work. However, the calculation in terms of the premium was not just nursing staff but also included medical staff with some areas like ED and Paediatrics having greater vacancy rates and higher reliance on agency staff.

MG highlighted an EPUT safer staffing project called 'bank to perm' and RJ agreed to take an action on working up data system wide so partners can see month on month the reliance on agency. This would highlight factors like winter as well as the impact on permanent staff. RJ would look to establish what funding would be required to run a collaborative recruitment campaign targeting critical/high risk areas. This might include other ideas like self-rostering where it had been shown to encourage movement from bank contracts into permanent employment.

AM summarised the useful progress. He asked RJ to cross reference the areas where we have submitted recovery plans to see how successful progress actually is. He reminded colleagues that we need to measure progress against the recovery plan so we can contribute to the areas of pressure and the financial aspects that must be tackled urgently as part of our efficiency plans.

8. Key Risks – System Finance Update

DS referred to the papers previously circulated based on the month 3 summary and outlined the latest headlines based on the month 4 summary.

The Committee noted some of the drivers for what the system was experiencing in terms of financial pressures, including operational and workforce factors.

The M3 deficit of £26.4M had increase to £32.3M as of month 4. This meant the variance to plan had increase from £14M (M3) adverse £20.9M (M4). DS explained that the jump in month 4 was due to:

- Some of the phasing of some of the delivery that we are expecting to have kicked in post Q1.
- Operational drivers, about 50% of the picture was associated with issues already discussed – such as UEC and workforce challenges.
- Although ambulance arrivals were down overall, the acute trust had not been able to extract some planned efficiencies because of longer length of stays / delayed discharges.

The issues being faced by the health system means using more staff not necessarily using staff in the most efficient way, so there had been a knock on increase in temporary staffing costs. It was noted that MSEFT was forecasting a spend of around £51 million in agency and about £115 million in bank.

DS summarised the other half of the challenge as being to demonstrate that every partner had specific actions underway to improve efficiency.

AM thanked DS for her update and stressed that stakeholders needed to be on top of the issues mentioned in order to make services safe for the winter and to head off the medium term financial pressures described.

9. Cancer Quality Report – Cancer Harm Reviews: Case for Change

VB presented a paper that invited the Strategic Oversight Assurance Committee (SOAC) to review/ endorse proposals from Mid and South Essex Foundation Trust relating to the risk stratification of Cancer Harm Reviews. The report included the following clarifications:

- There was no continuing expectation that MSEFT would need to clear further back logs of harm reviews.
- All patients treated in July/Aug/Sept 2022 at 104+ days would have a harm review completed, the rationale for this requirement being to align reviews with the agreed data submission.
- All patients treated in July/Aug/Sept 2022 at 62 days do not require a harm review (see section 2c).
- From 1st July to 30th September 2022 the current 90 days to complete a harm review was paused, as it was essential to obtain the data from this period to ensure learning was embedded.
- A further progress report to be presented at SOAC in November 2022. This would:
    a) provide evidence that 100% of all patients treated over day 104 from 01/07/2022 to 30/09/2022 have had a completed harm review.
    b) outline the impact that this process had on the recovery of the Cancer Pathways within MSEFT.
- Thematic report to include learning on all reviews from 01/07/2022 – 30/09/2022 was presented to Cancer & Palliative Care Quality Assurance Group (CPQAG) in November 2022.
- All patients breaching 104 days get raised as an incident via Datix.
- MSEFT identified in February 2022 that there were 9 potential cases of moderate harm. At this time of reporting, there had been no outcome of this escalation. There was an expectation that a review and outcomes report of these 9 cases would be presented to CPQAG in November 2022.

AM advised that although the Committee/ all parties were supportive, these changes would technically need to be approved by NHSE/I. He agreed to write to Simon Wood explaining the proposed exceptions which set aside national requirements. These would be enacted locally unless the ICB was instructed to do otherwise.

During discussion VB outlined the savings that would arise from taking this approach. This amount to 120 per [week] (ie vs previously undertaken) which would release 744

administrative hours and 186 clinical hours, which equates to approximately 1.5 whole time equivalent clinicians and two whole time equivalent administrators.

AM summarised that 1.5 clinicians equates to some 12 extra sessions per week and many extra patients could thus be offered an outpatient clinic making inroads into much of the backlog that were seeking to address.

DS supported the approach. She explained that we could enhance the explanation of proportionality in terms of the levels of harm.

EM summarised that following a discussion with Geraldine Rogers she raised the same issue in terms of being clear what the benefits are / clinician time saved. She also asked for confirmation as to what would happen after October.

AM confirmed that the intention was to implement a short term change and then pick up national requirements after October. As stated earlier he would write to SW following the meeting to confirm the proposed action.

Resolved: the Committee supported the proposed actions set out in the "Cancer Harm Reviews: Case for Change" from the Mid & South Essex Foundation Trust and would notify NHSE/I of the intention to implement the variation for the specific limited period up until October 2022.

Action: *AM to write to SW to explain the proposed action as outlined above.*

10. Terms of Reference

The Committee noted the SOAC terms of reference.

11. Date of Next Meeting

Resolved: the next meeting of the Committee be held on 14 September 2022 1.00 pm to 3.00pm.

Part I ICB Board meeting, 13 October 2022

Agenda Number: 14.2

Emergency Planning Resilience & Response (EPRR) Core Standards

Summary Report

1. Purpose of Report

To provide the Board with an overview of performance against the NHS England EPRR Annual Assurance process 2022/23 and assesses the ICB's compliance against the NHS England EPRR Core Standards.

2. Executive Lead

Anthony McKeever, Chief Executive Officer

3. Report Author

Viv Clements, EPRR Lead

4. Responsible Committees

Reviewed by the Audit Committee on 15 September 2022 and approved.

5. Conflicts of Interest

None identified.

6. Recommendation/s

The Board is asked to endorse the EPRR Annual Assurance Process submission to NHSE for 2022/23.

NHS ENGLAND EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL ASSURANCE PROCESS 2022

Submitted by: **Viv Clements, EPRR Lead**

Status: **For assurance**

Purpose

This report provides the Board with the actions taken by the Integrated Care Board (ICB) to complete the NHS England (NHSE) EPRR Annual Assurance process for 2022-23 that we are required to undertake annually.

Background

As part of the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Framework, NHS providers and commissioners must undertake this assurance process to demonstrate that they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. The NHS Core Standards set out the minimum requirements expected of NHS organisations in respect of EPRR.

ICBs are responsible for monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with their applicable core standards. ICBs lead the local assurance process they then submit to the NHSE Region a consolidated report providing assurance for their System.

The assurance process is detailed at Appendix 1 – Letter sent to Systems.

MSE ICB submitted a statement of assurance on 13 September 2022 to the East of England Regional team. The next step is a meeting between NHSE Region and ICB EPRR team on 17 October 2022 where a review, check and challenge of the submission is held.

NHS Mid & South Essex ICB's Compliance

The ICB's Emergency Accountable Officer (who is also the Chief Executive Officer) has approved the ICB Compliance assessment.

The ICB self-assessment shows the ICB as being fully compliant with 36 of the 47 indicators, giving an overall organisation rating of "partially compliant". The compliance reflects the move from CCG to ICB and the need to complete a full governance cycle to enable policies and requirements to be completed. Appendix 2 provides the ICB action plan to move us to full compliance. The level of compliance therefore is not considered a concern and the assumption of roles and responsibilities within the ICB wills support the plans for full compliance.

References

The full detail of the EPRR core standards can be found at:

https://www.england.nhs.uk/publication/emergency-preparedness-resilience-and-response-core-standards/

Appendix 2 - Mid & South Essex ICB Annual EPRR Core Standards Action Plan

Standard	Detail	Self-Assessment RAG	Action to be taken	Lead	Timescale
EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Partially compliant	Currently EPRR Lead in post, along with a responsible director however other posts remain out to advert. Interviews are currently taking place to fill vacancies.	Karen Wesson	December 2022
Risk Assessment/ Management	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Partially compliant	Partial compliance given as a full governance cycle has not yet been completed and therefore robust and substantial evidence is not available at the time of submission.	Karen Wesson	December 2022
Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Partially compliant	To review business continuity plans specifically in relation to incidents involved fuel availability and cyber. We will engage with system partners via the Essex Resilience Forum (ERF) and Local Health Resilience Partnership (LHRP) in order to review the current multi-agency and health processes and procedures, as well as drawing on learning from recent / forthcoming exercises.	Viv Clements	March 2023
Warning and Informing	The organisation aligns communications planning and	Partially compliant	Communications training to all on call staff to be delivered to fulfil requirement for trained comms support.	Karen Wesson	December 2022

Standard	Detail	Self-Assessment RAG	Action to be taken	Lead	Timescale
	activity with the organisation's EPRR planning and activity.				
Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Partially compliant	Out of hours communication system for staff to be tested.	Karen Wesson	December 2022
Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Partially compliant	Communications training for on-call and senior staff to be delivered.	Karen Wesson	December 2022
Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Partially compliant	Agreement that Mid and South Essex will lead on appropriate pan- Essex incidents to be formalised.	Karen Wesson	December 2022

Standard	Detail	Self-Assessment RAG	Action to be taken	Lead	Timescale
Business impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Partially compliant	ICB versions of the BIAs to be adopted	Viv Clements	March 2023
Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant	BCP is currently being drafted - pending BIA completion	Viv Clements	March 2023
BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Partially compliant	Partial compliance given as a full governance cycle has not yet been completed and therefore robust and substantial evidence is not available at the time of submission.	Viv Clements	March 2023

Classification: Official

Publication reference: PAR1664_ii

To:
- NHS accountable emergency officers
- NHS England regional directors, regional heads of EPRR, regional directors of performance and improvement, regional directors of performance
- LHRP co-chairs

cc.
- Mike Prentice, National Director for Emergency Planning and Incident Response
- NHS England Business Continuity Team
- CSU managing directors
- Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, DHSC

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

29 July 2022

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2022/23

I thank you and your teams once again for your leadership and delivery of patient care during another exceptional year. The NHS continues to respond to a number of challenging events, as we recover from the COVID-19 pandemic and experience increased demands on our urgent and emergency care services.

The ability of the NHS to remain resilient and responsive over a sustained period is due to our collective commitment to emergency preparedness, resilience and response (EPRR).

NHS England is responsible for gaining assurance that the NHS is prepared to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

Due to the demands on the NHS, the 2020 and 2021 assurance processes were amended; however the 2022 EPRR process aims to return to many of the previous mechanisms.

With the introduction of the Health and Care Act 2022, this year's assurance process will reflect the establishment of integrated care boards (ICBs) as Category 1 responders and their local NHS leadership role. This includes: the requirement to undertake a self-assessment against the core standards; and lead the NHS locally to agree the process to gain confidence of organisational ratings.

This letter notifies you of the start of the 2022 EPRR assurance process and the initial actions for organisations to take.

Core standards

The NHS core standards for EPRR are the basis of the assurance process. This year the standards, including the interoperable capabilities standards, have undergone a triannual review in advance of the assurance process.

Domain 10-CBRN will be reviewed separately as part of the CBRN work programme. As such, for this year's assurance process, these specific standards remain unchanged. The new core standards are attached to this letter.

You are asked to undertake a self-assessment against the individual core standards relevant to your organisation type and rate your compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Following the publication of the updated Evacuation and shelter guidance for the NHS in England, and recent work driven by the heightened risk associated with reinforced autoclaved aerated concrete (RAAC), the 2022/23 EPRR annual deep dive will focus on local evacuation and shelter arrangements.

The deep dive questions are applicable to those organisations indicated in the NHS Core Standards for EPRR self assessment tool

The outcome of this process is used to identify areas of good practice and further development for future guidance. It should also guide individual organisations in the further development of their shelter and evacuation arrangements.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

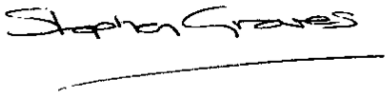
Action to take/next steps

- All NHS organisations should undertake a self-assessment against the 2022 updated core standards (attached) relevant to their organisation. These should then be taken to a public board or, for organisations that do not hold public boards, be published in their annual report.
- ICBs are required to work with their organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process should be agreed with the NHS England regional head of EPRR and their teams.

- NHS England regional heads of EPRR and their teams to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.
- NHS England regional heads of EPRR to submit the assurance ratings for each of their organisations and a description of their regional process to myself before Friday 30 December 2022.

If you have any queries, please contact your regional head of EPRR or EPRR NHS system lead in the first instance.

Yours sincerely,



Stephen Groves
Director of Emergency Preparedness, Resilience and Response
NHS England

Part I ICB Board meeting, 13 October 2022

Agenda Number: 15

Approvals made in between meetings.

Summary Report

1. Purpose of Report

To notify the Board of decisions made under the constitutional provision for making decisions outside of Board meetings.

2. Executive Lead

Anthony McKeever, Chief Executive Officer

3. Report Author

Mike Thompson, Chief of Staff

4. Responsible Committees

As per the requirements of the Constitution, the audit committee will receive a note of formal decisions taken under the provisions for urgent or decisions outside of meetings as ratified by the Board.

5. Conflicts of Interest

None identified.

6. Recommendation/s

The Board is asked to ratify the decisions taken to approve the amended committee terms of reference, appointment of the Chair of the Primary Care Commissioning Committee and note the submission of the amended Constitution to NHS England.

Approvals Made Between Board Meetings

1. Introduction

The meeting of the ICB Board planned for 15 September 2022 was cancelled in respect for the mourning period of the late Queen Elizabeth II.

2. Main content of Report

Items 14.2 (proposed changes to committee terms of reference) and 14.3 (appointment of the Chair of the Primary Care Commissioning Committee) were approved via the provisions for taking urgent decisions as these items needed to be resolved prior to the October Board.

The changes to the **committee terms of reference** were as follows:

Finance & Investment Committee

It was agreed that 'and/or Community Interest Companies providing NHS services' be removed from the membership of the Committee and an option to include Associate Non-Executive Members was included.

A change was agreed to enable it to establish, where necessary, a formal sub-committee to support the discharge of the ICB functions related to financial delivery.

Audit Committee

It was agreed to include Associate independent Non-Executive Members, who will provide further independence to the committee, one of whom will act as the Vice Chair of the committee.

Some further minor changes have been made to the ToR to clarify this change and to alter quoracy of the committee to 2 members, one of whom must be independent.

Primary Care Commissioning Committee

It was agreed to appoint an 'Associate Non-Executive Member' to Chair the PCCC.

A further minor amendment was to remove NHS England as an attendee (as their role is no longer required following formal delegation).

Quoracy for the committee is 4 members, however the caveat stating that it is 50% of the members has been removed to ensure that quoracy requirements are clear.

An amendment to the duties of the committee has been made to clarify its role i.e. to 'promote and champion' primary care within the system, regionally and nationally.

The Chair of the Primary Care Commissioning Committee was confirmed as Sanjiv Ahluwalia, Head of Anglia Ruskin School of Medicine, Faculty of Health, Education, Medicine & Social Care.

Constitution

NHS England requested that all ICBs update their Constitutions to correct technical references included within the model constitution that were inaccurate. These

corrections were made and approved by the ICB Chair and the updated Constitution will be included on the ICB website.

3. Findings/Conclusion

The decisions made under Constitution provisions for making urgent decisions were discharged as required by the Chair, Chief Executive and a Non-Executive Member of the ICB. These decisions are to be ratified by the ICB Board and noted at the next Audit Committee meeting.

4. Recommendation(s)

The Board is asked to ratify the decisions taken to approve the amended committee terms of reference, appointment of the Chair of the Primary Care Commissioning Committee and note the submission of the amended Constitution to NHS England.