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, 17 November 2022 at 3.00 pm – 5.00 pm

Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, Essex CM1 1JE

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	2
3	3.05 pm	Questions from the Public	Note	Verbal	Professor M Thorne	-
4	3.15 pm	Minutes of ICB Board meeting held 13 October 2022 and matters arising.	Approve	Attached	Professor M Thorne	6
5	3.17 pm	Review of Action Log	Note	Attached	Professor M Thorne	20
6	3.20 pm	Confirmation of Local Authority Members	Note	Attached	Professor M Thorne	22
		Items for Decision				
7	3.25 pm	Termination of Pregnancy Service Provision – Commissioning Intentions 2023/24.	Approve	Attached	Tiffany Hemming	23
		Items For Noting				
8	3.45 pm	Board Assurance Framework	To note	Attached	A McKeever	27
9	3.50 pm	Report following the Independent Investigation into East Kent Maternity and Neonatal Services	To note	Attached	F Bolger	44
10	4.00 pm	Quality Report	Note	Attached	F Bolger	54
11	4.10 pm	Performance 11.1 Performance Report 11.2 Urgent Emergency Care and Winter Plan	Note	Attached	T Hemming	 62 68
12	4.20 pm	Fuller Stocktake Update	Note	Attached	Dr A Davey	74

No	Time	Title	Action	Papers	Lead	Page
13	4.30 pm	Finance Report Month 6	Note	Attached	J Kearton	78
14	4.38 pm	Harmonisation of Commissioning Policies	Note	Attached	Ronan Fenton	85
15	4.50 pm	Basildon and Brentwood Alliance Update	Note	Attached	Pam Green	107
16	4.55 pm	General Governance: 16.1 Approved Minutes of Committee Meetings: • Audit Committee • Clinical and Multi-Professional Congress • Finance & Investment Committee • System Oversight and Assurance Committee • Primary Care Commissioning Committee 16.2 Ratification of October Board decisions	Note Ratify	Attached Attached	 Professor M Thorne Professor M Thorne	 116 157
17	4.58 pm	Any Other Business	Note	Verbal	Professor M Thorne	-
18	5.00 pm	Date and time of next Part I Board meeting: Thursday, 19 January 2023 at 3.00 to 5.00 pm, to be held in the Gold Room, Orsett Hall Hotel, Prince Charles Avenue, Orsett, Essex, RM16 3HS.	Note	Verbal	Professor M Thorne	-

MID AND SOUTH ESSEX ICB BOARD REGISTER OF INTERESTS - NOVEMBER 2022

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	
Frances	Bolger	Interim Chief Nursing Officer	Nil								
Hannah	Coffey	ICB Partner Member	Mid and South Essex Foundation Trust	x			Direct	Interim Chief Executive		Ongoing	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	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.

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	
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
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Personal relationship with Director of Operations for North East London area.	01/01/19	Ongoing	As above.
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	As above.
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								
Jennifer	Kearton	Interim Deputy Chief Finance Officer	Nil								
Benedict	Leigh	ICB Partner Board Member	Southend City Council	x			Direct	Senior Member of Staff	01/07/22	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	01/07/22	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	01/07/22	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	On-going	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	On-going	No immediate action required.

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	
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Faculty of Medical Leadership & Management (FMLM)		x		Direct	Fellow	02/03/20	On-going	No immediate action required.
Paul	Scott	ICB Partner Member	TBC	x			Direct	Essex Partnership University NHS Trust	01/07/2022	Ongoing	No immediate action required. Interest to be declared if a conflict of interest is identified.
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 13 October 2022 at 3.00 pm – 5.00 pm

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

Attendance

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.
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Frances Bolger (FB), Chief Nurse, MSE ICB.
- Ruth Jackson (RH), Chief People Officer, MSE ICB.
- Dr Neha Issar-Brown (NIB), Non-Executive Member.
- Joe Fielder (JF), Non-Executive Member.
- George Wood (GW), Non-Executive Member.

Other attendees

- Jo Cripps (JC), Executive Director of Strategy and Partnerships.
- Dr Tiffany Hemming (SH), Interim Executive Director of Oversight and Delivery, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid and South Essex) MSE ICB.
- Stephen Porter (SP), Alliance Director (Thurrock) MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood) MSE ICB.
- Ruth Hallet (RH), Alliance Director (South East) MSE ICB.
- Dr Boye Tayo (BT), GP (attending on behalf of Dr Anna Davey, Partner Member, MSE ICB).
- Ed Cox (EC), Director of Clinical Policy, MSE ICB (attending on behalf of Dr Anna Davey to present item 10).
- Jacqui Van Rossum (JVR), Acting Chief Executive, North East London NHS Foundation Trust (attending on behalf of Paul Scott, Partner Member, Mental Health/Community).
- Simon Griffiths (SG), Operational Director for Adult Social Care for South Essex (attending on behalf of Peter Fairley, Partner Member, Essex County Council).
- Barry Frostick (BF), Chief Digital Information Officer, MSE ICB.
- Mike Thompson (MTh), Chief of Staff, MSE ICB.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.
- Nicola Adams (NA), Deputy Director of Governance & Risk, MSE ICB (minute taker).

Apologies

- Ian Wake (IW), Partner Member, Thurrock Borough Council.
- Benedict Leigh (BL), Partner Member, Southend City Council
- Dr Anna Davey (AD), Primary Care Board Member.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust.
- Peter Fairley (PF), Partner Member, Essex County Council.
- Hannah Coffey (HC), Partner Member, Mid and South Essex NHS Foundation Trust.

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

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

MT noted that the Board meeting planned for 15 September 2022 was cancelled in respect of the passing of Her Majesty Queen Elizabeth II.

2. Declarations of Interest (presented by Prof. M 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 and available on the ICB website**.** MT noted that there were new members of the Board and the register would be updated to reflect this.

There were no further declarations raised.

ACTION: Sara O'Connor to update the ICB Board Register of Interest to reflect recent changes.

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

Mr Eric Watts, Member of the public, who was unable to attend the meeting, had submitted the following written questions and had confirmed he would be happy to receive a written response after the Board meeting:

"As user involvement is specified in the NHS long-term plan can the ICS advise how they intend to arrange this? A large number of initiatives are being piloted outside of MSEICS for example Patient Activation Measures - please advise if you have considered any of these or if you are waiting for patients to bring them to your attention?

Is the Partnership considering better means of patient and public representation?

It is recognised that user involvement is highly effective in bringing insight from lived experience which can lead to improvements and it is part of the NHS policy to involve

patients and the public. However, the current mechanisms do not allow for adequate involvement and representation."

Chris Gasper (Patient representative, Southend) asked the following question:

"The Statutory Guidance from NHS England on working in Partnership with People and Communities directs partners, including those place-based, to ensure residents have an active role in decision making. Place Based Alliances publish no plans or record their activities. How do they comply with the NHS England guidance and "Fully engage with those affected" by decisions?"

Peter Blackman (Chair of South Woodham Ferrers Health & Social Care Group) asked the following question:

"How (if it is) is Mid & South Essex ICB/ICS/ICP aware of the specific health and welfare needs of the people of South Woodham Ferrers and its surrounds, including the impact here of Covid, post-Covid, long-Covid, Winter Pressures and Cost of Living, and how, including by applying your belief in and value of subsidiarity, will you engage directly, transparently and effectively with our local community about our situation?"

MT thanked members of the public for their questions and noted the theme of engagement in all questions and asked CH to respond.

CH stated that at its first meeting, the Board approved the working with people communities strategic approach. CH further explained that the document, which was available on the ICS website, sets out our ambition over the next two years to truly put our communities at the heart of what we do, building on the system-wide engagement framework we co-designed in 2020.

Based on the guidance issued by NHSE for ICBs, the strategic approach described how we were reimagining traditional models of engagement, whereas we had previously expected people to come to us and listen.

Instead, the ICS was adopting a much more inclusive approach, going out into our communities of place, interest and characteristic, both virtually and in person, working side by side to design and develop solutions.

Through this approach, we had developed several outreach programmes to support working with and listening to seldom-heard communities. We also spoke directly with patients involved in service redesign programmes.

The Alliances were integral to this, reaching in and working with their local populations through primary care networks (PCNs), community and voluntary sector organisations, local authorities, and Healthwatch.

All partners brought with them a wealth of insight gathered through a variety of formal and informal mechanisms. This approach would assist the Integrated Care System (ICS) to deliver the ambitions set out within the Working with People and Communities approach.

In response to a further question from PB, CH confirmed that the strategic approach to engagement was approved in July and the strategy would be developed over the next two years with the intention to add value beyond the sum of the partner organisations. For

example, the Director of Strategic Partnerships was leading on development of the integrated care strategy for the Integrated Care Partnership (ICP) by undertaking workshops for the development of the strategy and ensuring it was co-designed with residents, including seldom-heard communities.

DD and PG gave examples of engagement at Alliance level acknowledging that the Basildon & Brentwood Alliance was yet to be established. However, all Alliances were engaging with their residents and working with HealthWatch locally to co-design and engage particularly with those residents with protected characteristics who were harder to reach.

AMcK added that there was a need to learn and improve continually around engagement and to keep working with residents and stakeholders as we develop.

Action: NA to arrange for written responses to be provided to questions from the public.

4. Minutes of the ICB Board Meeting held 1 July 2022 and matters arising (presented by Prof. M Thorne).

MT presented the minutes of the ICB Board meeting held on 1 July 2022 and asked members if they had any comments or questions on the minutes. No comments were submitted.

Resolved: The Board APPROVED the minutes of the 1 July 2022 meeting as an accurate record.

MT stated that Rachel Hearn had moved on to a new role and Frances Bolger had been appointed as Chief Nurse and consequently had been appointed as the Caldicott Guardian for the ICB.

Resolved: The Board NOTED the appointment of Frances Bolder as Chief Nurse and Caldicott Guardian.

There were no matters arising.

5. Review of Action Log (presented by Prof. M Thorne).

It was noted that outstanding actions were being progressed.

Resolved: The Board NOTED the update on the action log.

6. Appointment of Local Authority Partner Member (presented by Prof. M Thorne).

MT advised that Tandra Forster the Partner Member, Local Authority (Southend), had moved on to another role. It was noted that the appointment process was underway to replace her, but in the meantime, interim cover was being provided by Benedict Leigh.

MT updated Members on changes within Thurrock Council noting that Ian Wake (IW) was now acting Chief Executive and that Les Billingham was acting up to fulfil IW's previous role. MT noted that there would need to be a nomination process to fulfil the Local Authority Partner Member role left vacant due to changes within the council.

Resolved: The Board NOTED the update regarding Local Authority Partner Members.

Action: MTh to ensure completion of nomination process to fulfil the Local Authority Partner Member vacancy.

7. Harmonising Commissioning Policies (presented by Dr R Fenton).

RF reminded Board members that at the July Board meeting the requirement to harmonise commissioning policies was noted and that whilst almost all policies were fully aligned, there were six clinical treatment areas where the service offer differed, namely:

- Bariatric Surgery
- Breast asymmetry
- Breast reduction
- Female sterilisation
- Vasectomy (male sterilisation)
- Tertiary Fertility Services

RF explained that since July, the Clinical and Multi-professional Congress (CliMPC) had made recommendations on how services might be provided; expert clinical panels had recommended specific threshold criteria where needed; potential inequalities and health inequalities impact and resources implications had been assesse; and some early resident insights on the procedures involved were gathered.

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

Recommendations on options for consultation relating to tertiary fertility services reflected this ethos. The paper proposed that services, including in-vitro fertilisation (IVF), should be available to eligible women across the whole of the mid and south Essex system.
If approved by the Board, the recommendations on all services in this paper would go forward for public consultation.

RF recommended the Board should approve going to consultation and described the broad consultation plan.

It was noted that post consultation, the final decision regarding changes to service offer would be brought to the Board in February 2023 with service changes taking effect from April 2023. Until then, residents would continue to access services as per the service restriction policies of the predecessor CCG geographies as approved by the ICB Board in July 2022.

MT stated that it was a statutory requirement to harmonise services for our residents, noting that the ICB had pushed back on proposed timescales to ensure it could adequately engage and consult with residents as reflected in the consultation plan.

MT invited questions.

SG asked (on behalf of PF) if local Health Overview and Scrutiny Committees (HOSC) and Health and Wellbeing Boards (HWB) were being consulted and could the ICB write to them regarding the consultation. In addition, were neighbouring ICBs being consulted. RF replied that advice had been taken from local ICS colleagues as documented in the CliMPC minutes, and confirmed consultation with HOSC and HWBs was included within the consultation plan.

NIB added that discussions at Quality Committee on these policies had suggested the need to clarify where disparity was the highest.

JF asked for clarity regarding the requirement for individuals to be a non-smoker for eligibility. RF confirmed that clinicians had advised that healing was affected by smoking and so it was a necessary requirement for the clinical effectiveness of the service.

BT highlighted the need for pace to harmonise these policies and the need to manage public expectations until this was achieved.

Resolved: The Board APPROVED the proposal to commence public consultation to harmonise commissioning policies.

8. Digital Strategy & Investment Priorities (presented by B Frostick).

BF explained that as part of the establishment of ICSs there was initially a national request for each ICS to have a three year Digital Investment Plan in place by July 2022. This requirement 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 the original request as outlined in the paper for approval by the ICB.

BF confirmed that the plan had been presented at the Digital Transformation Programme Meeting in June, the Digital Data and Technology Board, and the ICS Executive Group in July. It had also been presented to the MSEFT Digital and Data Forum in August.

BF stated that within Mid and South Essex (MSE) there was a significant ask for improvements in digital and data across the system and therefore the investment plan emphasised priorities which would:

- Make a difference to the collective health and care provision across MSE 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 (national) strategic priorities:

- Shared Care Records
- Strategic Data Platform, and
- Digital Patient Interface

BF stated that a key element of this was electronic patient record convergence and also highlighted some financial challenges that needed to be resolved with the System Finance Leaders Group (SFLG).

MT invited questions.

GW focussed on what the project would do for patients and general population and asked how the ICB would reduce the number of business cases. BF confirmed that the Finance & Investment Committee would receive a report on benefits realisaiton and what was / was not cash releasing; that the national team fully supported the business case; andproviding due diligence information so that the benefits could be fully understood and measured. The project was not just about implementing a patient system, but implementing a workflow.

MT noted that whilst AD was not present at the meeting she had expressed her passion for the project as it would be transformative for primary care.

JF supported AD and the transformative intent but provided a word of caution as the details and platforms on which systems functioned were critical to the user.

AMcK thanked PS and those on the Digital Board. AMcK noted that thus far the use of IT was fragmented and GPs were concerned regarding the practicalities of how IT fitted together, noting that it was essential for patient management. AMcK stated that the suggested approach should address this. Discussions were ongoing with JVR and other Chief Executives to align patient records, noting the need to agree finances, align specified requirements and implement accordingly.

MT pointed out that the work could go ahead if the hospital could sign-off its contribution, which was awaited.

In response from a question from JF, BF stated that the scope covered acute and mental health hospitals, recognising collaboration i.e. community and primary care use SystmOne. This would then only require two systems to integrate. There was also a need to consider local authority and voluntary sector colleagues, as the shared care record was important, for example, to hospices.

DD noted that the percentage of patients using the system should be adjusted to take account of those who attended hospitals outside of the ICB area e.g. Addenbrookes and Princess Alexandra Hospital.

Resolved: The Board NOTED the approach taken to create a digital investment plan for the ICS; APPROVED the Digital Investment Plan and SUPPORTED the prioritised list of programmes.

Action: SFLG to secure investment requirements over future years.

Action: BF to provide an update at the next Board on progress with agreeing the Digital Strategy with Chief Executives across the system.

9. Performance Report (presented by T Hemming)

TH presented the performance report providing the headline position in terms of performance against NHS Constitutional Standards and outlined the governance arrangements for Board oversight of performance, planning and assurance.

TH highlighted key areas of performance, in particular workforce with vacancies remaining a key area of concern across all partner organisations, as well as system pressures across Urgent Emergency Care, Elective Care (with large waiting list backlogs for diagnostics, and treatments on both urgent / 2 week wait and routine referral to treatment (RTT) pathways) and Mental Health Services. Further details of the report were discussed.

MT invited questions.

NIB reflected on the current situation and mentioned discussions held around bringing this to a future Quality Committee meeting. NIB also noted the need to be mindful of data skews.

GW stated that the issues in Emergency Departments (ED) were well known and there was a need to get assurance that people with the most serious conditions were being triaged and prioritised correctly.

TH asked, in terms of RTT time, was prioritisation according to clinical need where possible and did we have the information to make that decision. It was noted that there was follow-up on individual patients. NIB further noted that clinical prioritision was completed as a whole process and considered co-morbidities.

MT asked whether it was possible to reduce the burden by training up staff to cover some aspects of care with less qualified staff to reduce waiting times. RJ responded that there was a need to be fully trained to supervise junior staff so this approach did not always resolve the problem.

Resolved: The Board noted the ICB performance report.

10. Fuller Stocktake Report (presented by Dr B Tayo and E Cox on behalf of Dr A Davey).

BT provided an overview of the Fuller Stocktake noting that the paper aimed to summarise the key themes articulated in the Fuller Stocktake and outlined the challenges and progress in relation to each of them.

BT outlined the four main components of the report:

1. 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).
2. Providing proactive personalised care from a multidisciplinary team of professionals for higher-need individuals in the community.
3. Helping people stay well for longer (working with communities and local organisations on the prevention agenda).
4. Delivering three distinct enablers of change: workforce, estates and data.

EC provided further detail on the content of the stocktake report and outlined the work done within the system so far, noting that the ICB had started to build a more comprehensive plan.

EC noted that there were enablers of workforce, data, digital and estates that that there was a plan to help spread innovation where it existed. EC noted six key priority projects:

1 – New winter access scheme.

2 - Implementing cloud based telephony.

3 – Signposting programme.

4 - Expanding community pharmacy.

5 – Improving websites.

6 – Support practices and PCNs in roles for digital and transformation.

EC stated that there was a significant programme of work already underway against each of the four themes of the Fuller Stocktake. However, these currently lacked scale and a consistent approach to implementation. It was noted that the ICB approach of developing early adopter PCNs, together with addressing those performing least well, aimed to provide the conditions for the effective spread of innovation across MSE. This would be underpinned by an incentives framework encouraging PCNs to pull together to deliver care for their populations as neighbourhood teams. It was proposed to continue with the strategy to deliver the recommendations of the Fuller Stocktake by developing a primary care development plan, based on a more detailed gap analysis against the Fuller Stocktake.

MT reiterated the ICB's responsibility for driving primary care forward and dealing with demands and the importance of doing so as there was now no other body charged with this.

TH welcomed the cloud based telephony project to ensure that GPs were getting the best from the system. EC stated that practices needed to understand their current telephony to improve the interface and can then progress to providing a more consistent service. BF added there were opportunities to have conversations with practices to co-join and pick up the phone with centralised telephony for a PCN to increase capacity. This would also improve access to appointments.

RJ stated that workforce was at the heart of this. New funding for the Additional Roles Reimbursement Scheme (ARRS) included GP assistants (piloted in Norfolk & Waveney) with 12 working in MSE. The scheme would upskill frontline staff i.e. reception / firstpoint of contact to better deal with queries.

RF outlined that the report tackled the whole cultural aspect of how primary care was run, and that it needed to align with how patients interacted. This could impact on how GPs dealt with long term conditions, impacting on urgent and emergency care through the effective use of integrated neighbourhood teams, and leaveraging the power of neighbourhoods.

PG recognised that there was a wider determinants of health crisis, not just medical. Alliances were working on integration and the social movement to work differently was being developed.

MT asked if the Board could be sighted on the number of available appointments and how many residents can get them on the day.

JF was encouraged by the paper, but noted we were not yet at scale and endorsed the gap analysis in the Primary Care Development Plan.

RH advised that Benfleet primary care aligned teams were operating and provided an example relating to a resident whose spouse was in hospital being treated for a stroke could not be discharged because their house was not fit for purpose. A social prescriber took specific action to address the issues with the house to enable discharge. The resident's feedback was that they were so happy to be back together at home, which had also released the hospital bed.

SG noted conversations were ongoing with Alliances about community resilience noting that neighbourhoods needed to be led by the community and not by the statutory bodies.

MT noted an example of a delayed patient discharge because the individual needed £50 added to their electricity card. Facilitating this ensured the discharge and assisted hospital capacity.

Resolved: The Board NOTED the update on the impact of the Fuller Stocktake Report on the ICB/ICS.

Action: EC/William Guy to provide the Board with performance data on GP appointments.

Action: AD/EC to provide a regular update on progress of implementation of the Fuller Stocktake recommendations to each Board meeting, to include actions being taken by Alliances.

11. Quality Report (presented by F Bolger)

FB presented the quality report noting that the Quality Committee received a detailed report covering all services commissioned by the ICB on 30 September 2022.

FB advised that work had commenced reviewing quality governance, reviewing the functionality of quality groups, data and reporting, which was planned to be completed over 3-6 months. The intention was to streamline reporting and the effectiveness of quality oversight. FB highlighted the following key points:

- There was an increase in the C.Difficile infection (CDI) rate at one site. Nationally there had been a rise. There was an acute ward outbreak to note which was being managed through the Incident Management Team with a focus on cleaning.
- In August / September, the System Overisght and Scrutiny Committee (SOAC) agreed to change the cancer harm review process based on that from Birmingham and St Barts. The change focussed on all patients over 104 days having a harm review; but those at 62+ would not have a review. This change enabled a focus on patients at greatest risk of harm. A thematic review of this is to be presented to the Cancer and Palliative Care Alliance in November.

- The Trust was working with the Cancer Champions Committee to improve patient experience and communication; timeliness of scans and treatment; service transformation; emotional support at diagnosis.
- The East Kent maternity report, which was delayed because of the state mourning period, was now expected on 19 October and would include key recommendations similar to the Ockendon report. The ICB Quality Team would review plans and implement any associated actions. With regard to maternity workforce (continuity of carer), NHSE stated this had been suspended until safe staffing was improved, although the Trust and ICB were still working towards it.
- Mental Health Services had experienced a challenging time this week as a result of the 'Dispatches' programme and resulting investigations. The Trust took immediate action to ensure the safety of patients and the outcome of investigations would be taken through ICB quality processes.
- Essex Police had highlighted that non-accidental injuries had not always been escalated to them by Emergency Departments in a timely fashion. Training was being provided to address this.

In response to a query from NIB regarding discprepancies within the report, transition plan and ratings, FB confirmed the quality team were working closely to improve the quality of reporting.

MT noted that the report stated there were no never events listed for July, however the minutes of the Quality Committee for July showed that there was a never event regarding wrong site surgery and reiterated the need to resolve data issues.

JF raised concerns regarding the number of outstanding harm reviews, and consequently there were many unknowns. FB agreed there was a need to receive more timely learning and to address the harm review process.

JVR welcomed the review on quality indicators. FB was looking at the development of a system wide dashboard to create a suite of metrics that would include reflecting patient experience.

AMcK thanked FB for the report and requested that data on suicide completed by children be shared with the Board.

AMcK advised that Care Quality Commission (CQC) visits had occurred in the last few days. FB confirmed that inspections in Acute Trust maternity and diagnostic imaging services had been undertaken as well as a 'well led' inspection at the Trust. The outcome was awaited, but positive verbal feedback had been received. Also, a visit to the Mental Health Trust had resulted in immediate action being taken with NHSE, CQC and the Police.

Resolved: The Board noted the quality report.

Action: FB to share data on suicide completed by children with the Board.

12. Finance Report Month 5 (presented by J Kearton)

JK presented the month 5 finance report noting that the financial performance of the MSE ICB Board was reported regionally as part of the overall MSE System alongside our NHS

partners, Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Foundation Trust (EPUT).

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

The forecast for MSE ICB was breakeven for 2022/23, in line with plan. However, across the system more generally there were significant unmitigated financial risks totalling £95.5m. This in part reflected failures to deliver demanding efficiency targets set within the wider system. At present, known financial risks which had materialised over the last 5 months were driving a year-to-date deficit across NHS partners of £36m. The financial improvement plan aimed to tackle the pressures driving this deficit. The system's forecast outturn would be adjusted going forward on the basis of progress made in controlling total expenditure.

AMcK informed the Board that within the last few weeks Dawn Scrafield (DS), who had stepped forward over the last couple of years to lead the system, had stepped back into undertaking the role of Director of Finance purely for MSEFT. AMcK paid tribute to DS and confirmed that JK was taking the system leadership role as Interim Director of Resources for the ICB.

MT stated that the ICB was charged with responsibility for health finance within the system, and was currently the worst performing system in the region. Consequently, the ICB should be clear regarding the position and ensure system partners worked together to resolve the overall financial position.

JF noted the finance report stated that workforce remained the single biggest budgetary pressure and the deficit within the hospital was driven largely by use of interim staffing, but queried if that was correct.

AMcK informed Members that a Chief Executive forum had been established to oversee the financial recovery work and that PWC had been commissioned to provide independent validation.

Resolved: The Board NOTED the month 5 finance report.

Action: JK to clarify budgetary pressures within the hospital relating to the use of interim staff.

13. Winter Planning (presented by T Hemming)

TH provided an overview of winter planning, noting that the escalation of winter pressures was fast moving. The ICB had been awarded money by the regional team, although only half the amount requested, to deploy the following schemes:

- Winter resilience planning.
- Additional capacity.

- Urgent Emergency Care (UEC) Winter Summit.
- Capacity and demand modelling and monitoring.
- UEC Board Assurance Framework (NHSE tool).
- Tactical control centre.

Examples were cited around bridging (supporting the return to home), virtual wards and further summits.

In response to questions from SP and GW about management at Alliance level and working with the independent sector, it was noted that championing the voluntary sector contribution was supporting the way patients were managed. JK noted that there was less winter funding than expected, working with the independent sector was not ruled out and the system could look to the private sector to support funding, but there would need to be prioritisation to reflect the level of available funding. JVB endorsed GW's comments regarding a challenged workforce, noting that new innovative, pragmatic solutions were required.

SG highlighted £500m social care funding, some of which would be available for the MSEICB (the value of which was not currently known).

Resolved: The Board NOTED the update on winter planning.

14. General Governance

14.1 Minutes of Committee meetings

The Board received copies of the latest approved minutes of the following main 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.

Resolved: The Board NOTED the minutes of the Clinical and Multi-professional Congress, Finance & Investment Committee, Quality Committee and System Oversight and Assurance Committee, and the associated updates.

14.2 Emergency Planning, Resilience and Response (EPRR)

AMcK provided an overview of ICB performance against the NHS England annual assurance process and compliance with the EPRR Core Standards.

The ICB self-assessment showed the ICB was 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 other requirements to be completed. An action plan was in place to move to full compliance. The level of compliance therefore was not considered a concern and the assumption of roles and responsibilities within the ICB would support the plans for full compliance.

Resolved: The Board NOTED partial compliance with the EPRR Core Standards.

15. Approvals made in between Board Meetings (presented by Prof M Thorne)

MT advised that as a result of the mourning of the late Queen Elizabeth II and the resulting cancellation of the September Board meeting, it was necessary to take some decisions that needed to be resolved prior to the October Board meeting, namely the amendment to terms of reference for the Finance & Investment Committee, Audit Committee and Primary Care Commissioning Committee, as well as the notification of appointment of the independent Chair of the Primary Care Commissioning Committee.

MT also noted the required amendment to the ICB Constitution to correct technical references.

Resolved: The Board ratified the approval of changes to committee terms of reference and the amendment to the ICB Constitution.

16. Any Other Business

There was no other business discussed.

17. Date and Time of Next Board meeting:

Thursday, 17 November 2022 at 3.00 pm in Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford CM1 1JE.

Mid and South Essex Integrated Care System

Action Log prepared following ICB Board Meeting meeting held on 13 October 2022

NHS Mid and South Essex

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
2	01/07/2022	7	**Establishment of Committees**: 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
4	01/07/2022	9	**Appointment of Lead Roles:** 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
6	13/10/2022	2	**Declarations of Interest**: Update Register of Board Members' Interests.	S O'Connor	31/10/2022	Register updated.	Complete
7	13/10/2022	3	**Questions from the Public:** Arrange for written responses to be provided to questions from the public.	N Adams	17/11/2022	Paul Gilham is drafting responses.	In progress
8	13/10/2022	6	**Appointment of Local Authority Partner Member**: Ensure completion of nomination process to fulfil the Local Authority Partner Member vacancy.	M Thompson	17/11/2022	Local Authority Partner Member nomination process complete. On November agenda to be noted.	Complete
9	13/10/2022	8	**Digital Strategy and Investment Priorities:** Secure investment requirements over future years.	System Leaders Finance Group/ J Kearton	Ongoing		In progress

Action Log prepared following ICB Board Meeting meeting held on 13 October 2022

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
10	13/10/2022	8	**Digital Strategy and Investment Priorities:** Provide an update at the next Board meeting on progress with agreeing the Digital Strategy with Chief Executives across the system.	B Frostick	17/11/2022	Presenting actions re electronic patient record to CEO Forum in late November/early December 2022.	In progress
11	13/10/2022	10	**Fuller Stocktake Report**: Provide the Board with performance data on GP appointments.	Dr E Cox / William Guy	17/11/2022	Included within Fuller Stocktake update report.	Complete
12	13/10/2022	10	**Fuller Stocktake Report**: Provide a regular update on progress of implemention of the Fuller Stocktake recommendations to each Board meeting, to include actions being taken by Alliances.	Dr A Davey / Dr E Cox	17/11/2022	This will be included on future Board agendas.	Complete
13	13/10/2022	11	**Quality Report:** Share data on suicide completed by children with the Board.	F Bolger	17/11/2022	November - 2022 - in 2021-22 there were 6 deaths due to suicide. Additional information relating to child deaths added to the quality report for November ICB Board (Safeguarding section).	Complete
14	13/10/2022	12	**Finance Report:** Clarify budgetary pressures within the hospital relating to the use of interim staff.	J Kearton	17/11/2022	In progress.	In progress

Part I ICB Board meeting, 17 November 2022

Agenda Number: 6

Local Authority Partner Members

Summary Report

1. Purpose of Report

As a result of Iain Wake stepping up as Acting Chief Executive of Thurrock Council and Tandra Forster moving from Southend-on-Sea City Council, there became two vacant Partner Member (Local Authority) posts on the ICB Board.

A nominations process, in accordance with the ICB Constitution, was held and resulted in the nomination of Les Billingham and Benedict Leigh, both of which were confirmed by nominating Partner Organisations and appointed by the ICB Chair.

2. Executive Lead

Anthony McKeever, Chief Executive Officer

3. Report Author

Mike Thompson, Chief of Staff

4. Responsible Committees

The ICB Board is responsible for ensuring appropriate governance is operational including that set out within the ICB Constitution for the appointment of Board Members.

5. Conflicts of Interest

None identified for this paper.

6. Recommendation/s

The Board is asked to note the appointment of Les Billingham (Thurrock Council) and Benedict Leigh (Southend-on-Sea City Council) as the nominated Partner Members fulfilling the two vacant positions on the ICB Board.

Integrated Care Board Meeting, 17 November 2022

Agenda Number: 7

Termination of Pregnancy (TOP) Service Provision - Commissioning Intentions 2023-24

1. Purpose of Report

To inform the Board of current contractual arrangements for Termination of Pregnancy services across the Integrated Care Board and approve the recommended approach for 2023/24.

2. Executive Lead

Tiffany Hemming**,** Interim Executive Director of Oversight, Assurance and Delivery

3. Report Author

Emily Hughes, Deputy Director of System Pathway Development.

4. Responsible Committee

The recommendation being made was presented to, considered and supported by the Finance and Investment Committee on 9 November 2022.

5. Link to the ICB's Strategic Objectives

The ICB has adopted the Health and Care Partnership five-year strategy which has key ambitions to:

- Reduce health inequalities
- Create opportunities, supporting education and local employment
- Support health and wellbeing, through prioritising prevention, early intervention and self-care
- Bring as much care as is safe and possible closer to where people live
- Improve and transform our services.

6. Impact Assessments

The required impact assessments including EHIIA have commenced and will be submitted for review and approval before the commencement of the procurement process.

7. Financial Implications

There are no anticipated additional investment requirements over and above current budget values.

8. Details of patient or public engagement or consultation

Patient and public engagement will be undertaken as appropriate during the procurement exercise including the inclusion of patient representatives on the procurement evaluation panel.

The recommendation does not involve any change to service provision, as such a consultation period is not required.

9. Conflicts of Interest

None Identified

10. Recommendation/s

The Board is asked to **approve** the commencement of an Accelerated Open Tender Process and the subsequent contract award to the successful Provider, for the commissioning of Termination of Pregnancy Services from 1 April 2023.

Termination of Pregnancy (TOP) Service Provision - Commissioning Intentions 2023-24

1. Introduction

Termination of Pregnancy (TOP) services are commissioned for all patients residing within the Mid and South Essex ICB.

One Provider has held a contract with mid and south Essex since 2009. A waiver was approved in 2020 to allow Mid Essex & South Essex to direct award a 1+1-year contract with this Provider to cover the period 2021-22 and 2022-23. The contract does not allow for any further extensions.

The waiver was agreed in 2020 on the basis that this is a specialist service with limited providers; COVID pressures prevented a procurement process; and the imminent ICB merger with a new legal entity could change the strategy for commissioning of TOP services.

The expected value of this contract for 2022/23 is circa £2.4m. There is in addition a small volume of ad hoc Non-Contracted Activity totalling ~23k for months 1-6 2022/23.The total value for the services being considered is ~£2.45m per annum.

2. Consideration of Options

The ICB Executive (7 November 22) and the Finance and Investment Committee (9 November 22) were invited to consider four options for the continued commissioning of TOP services which included:

a) Direct Awarding a contract to the existing contracted Provider for a further period (subject to waiver).
b) Commence a full open tender procurement exercise to secure service provision for 2023/24 and beyond.
c) Commence an Any Qualified Provider/Framework Procurement Process.
d) Procure via an accelerated ‘restricted’ procedure (two-stage) process.

Procurement advice provided by Attain, following a detailed procurement options appraisal, recommended an Open ‘one-stage’ Procurement Process was undertaken. This option could be undertaken in the time available and would be a compliant approach to contract award, with an overall risk rating of ‘Low’ for this approach.

Noting the resource requirements and taking into account the benefits and risks of each option the Executive team and Finance and Investment Committee approved Option B (open tender procurement exercise) for recommendation to the Integrated Care Board.

3. Financial Considerations

There are no anticipated additional investment requirements over and above current budget values.

The service is currently paid at a locally agreed tariff, with tariff having recently been refreshed following sustainability risk raised by the Provider. Prices were renegotiated in 2022/23 to ensure an appropriately funded level for an effective service for our population.

It is anticipated that the procurement exercise will lead to the award of a contract for a period of five years with an option to extend for a further 24 months, with a cost per case funding model. This would result in a contract value at award of £12.3m to £17.2m.

4. Recommendation/s

The Board is asked to approve the commencement of an Accelerated Open Tender Process and the subsequent contract award to the successful Provider, for the commissioning of Termination of Pregnancy Services from 1 April 2023.

Part I ICB Board meeting, 17 November 2022

Agenda Number: 8

Board Assurance Framework

Summary Report

1. Purpose of Report

To provide the Board with an overview of the strategic risks highlighted within the Board Assurance Framework.

2. Executive Lead

Anthony McKeever, Chief Executive

3. Report Author

Nicola Adams, Deputy Director of Governance and Risk
Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

The Audit Committee are responsible for ensuring adequate arrangements operate for the management of risk.

5. Conflicts of Interest

None identified.

6. Recommendation(s)

The Board is asked to discuss and note the report and recommendation from Audit Committee.

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks, this is discharged through oversight by the audit committee and ensuring that the ICB Board is aware of strategic risks and is assured that sufficient action is being taken to address them.

2. Main content of Report

Upon establishment of the ICB, risks were reviewed and updated to reflect the role of the ICB. Each Executive Director lead has reviewed the content for their risks.

In the meantime, a Board Seminar on risk management held on 28 September 2022, provided risk management training and enabled Board Members to discuss key risks and the intended framework of how risks will be managed going forward.

Seven strategic risks have been identified as follows:

1. Workforce
2. Primary Care
3. Capital
4. Improving Hospital Flow / Unblocking the hospital
5. Diagnostics, elective care and cancer performance
6. System financial performance
7. Health Inequalities

The overarching Board Assurance Framework (BAF) was presented to and was well received by the Audit Committee on 25 October 2022, which felt that good progress had been made to establish a BAF reflective of the new role of the ICB and would recommend it to the Board. It suggested that the 'unblocking the hospital' risk be renamed to 'improving hospital patient flows'. The Committee also noted that ICB risk registers were being updated and would continue to be shared appropriately. Positive feedback had also been received from the Board sub-committees which had reviewed their associated risks and discussed mitigating action being taken.

3. Findings/Conclusion

The ICB has made good progress to establish its Board Assurance Framework and associated risk registers, which are in the process of becoming embedded within the ICB Committee workplans. The full Board Assurance Framework report has been presented to the ICB Board as a measure of best practice. In future, the full report will be presented twice annually, with highlight reports presented bi-monthly to the Board.

4. Recommendation(s)

The Board is asked to note the Board Assurance Framework and its review and recommendation by the Audit Committee.

5. Appendices

Appendix 1 – Board Assurance Framework.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

November 2022

Contents

- Highlight Report – BAF Risks
- Risk Management Plans
- Partner / Stakeholder Risks

BAF Risks – Summary Report

No	Risk and Key Elements	SRO	Key Assurances (further information on individual risk slides)	RAG	Comments
1.	**WORKFORCE:** • Workforce Strategy • Primary Care Workforce Development (see Primary Care Risk • Provider recruitment • Managing the care market	Ruth Jackson	• Regular Workforce reporting to System Oversight and Assurance Committee (SOAC) and People Board • Regional provider workforce return	**4 x 5 = 20** 	
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	Ronan Fenton	• Internal Audit Planned for 2023/24 • Patient Survey Results • Workforce Retention • Improved Patient to GP Ratio • Resulting in better patient experience and access.	**4 x 5 = 20** 	
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	Jennifer Kearton	• Developing prioritisation criteria for pipeline of investments. • Oversight by Finance & Investment Committee (FIC), System Finance Leaders Group (SFLG) and Executive / Senior Leadership Team. • Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.	**4 x 4 = 16** 	
4.	**UNBLOCKING THE HOSPITAL** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	Tiffany Hemming	• Urgent Emergency Care (UEC) Taskforce oversight and assurance • Multi-agency discharge event (MADE) audits. • MSE Strategic UEC Board (monthly) • Reports to SOAC and ICB Board. • Delayed hospital discharges monitored hourly/daily.	**5 x 4 = 20** 	
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Tiffany Hemming	• SOAC oversight of performance against all NHS Constitutional Standards. • Reporting to System Diagnostic Board and Diagnostic Performance Sub-Group. • MSEFT Cancer performance report: Meetings with National Team as a Tier 1 Trust. • Palliative and End of Life Care Board. • Elective Care Board: MSEFT Referral to Treatment (RTT) Long Wait Report.	**5 x 4 = 20** 	
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme	Jennifer Kearton	• Trajectory to break-even is being identified with region (regional oversight in place). • PWC involved in developing / reviewing the financial recovery plan. • Partnership working to develop the financial improvement plan. • Focus on system efficiency programme and improved delivery of financial plans. • Oversight by FIC, Chief Executives Forum, SLFG and SOAC. • Internal and External Audits planned.	**5 x 4 = 20** 	
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	Jo Cripps	• Reports to Population Health Improvement Board and Health Inequalities Delivery Group. • Internal Audit to review ICB systems for understanding population health needs and inequalities and the incorporation of such into operational and strategic plans (due Q3).	**4 x 5 = 20** 	

Risk Narrative:	**WORKFORCE:** Risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank/agency staff; and not taking effective action to ensure there is an reliable pipeline of staff to fill future vacancies.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Ruth Jackson, Executive Chief People Officer	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	BAF Risk Ref:	PO1

Current Performance v's Target and Trajectory

Recruitment and Retention rates remain static against recruitment trajectory.

How is it being addressed? (Current Controls)	Barriers (Gaps)
• System Workforce Strategy in place. • Data cleansing of Electronic Staff Records (ESR) by providers and focus on accurate data to facilitate agreement on current vacancy rates. • System recruitment campaign launched October 2022. • Regional funding received for further international recruitment campaign (Go-live November 2022). • Dedicated recruitment campaigns for hotspots e.g. Emergency Department, Paediatrics, Critical Care and Maternity. • System Health Care Support Worker recruitment campaign and establishment of an Academy to support recruitment, retention and progress (funding received) to support the social care and health market. • Volunteering and reservist function (recruitment commenced). • System-wide retention programme to mitigate factors which cause high levels of turnover. • Initiatives around the establishment and embedding of Physician Associates, Advanced Care Practitioners and trainee Nursing Associates. • MSEFT Senior nursing support provided to candidates, e.g. flexibility regarding interview arrangements, as well as new appointees. The above actions should considerably reduce vacancy rates across providers and professional workforce groups as per trajectory agreed by System Oversight and Assurance Committee (SOAC) (see Next Steps).	• Accurate workforce dataset required. • Very large volume of vacancies in a domestic market which is already challenged. • Reliance on international recruitment and inadequate focus on establishing a local pipeline of staff. • Reliance on bank and agency. • Limit to current supervisory capacity to support mass recruitment initiatives. • Insufficient emphasis on defining, developing and marketing system offer. • Reluctance to adopt / embed new roles.

How will we know controls are working? (Internal Groups and Independent Assurance)	Next Steps (Actions to be implemented by December 2022)
• Regular Workforce reporting to SOAC (monthly) and People Board (quarterly). • Regional provider workforce return (PWR). • Reduction in unfilled vacancies. • Improved attrition and turnover rates. • Reduction in bank and agency usage leading to positive impact on patient safety/quality. • Improved resilience of workforce.	• MSEFT data cleanse to be completed (November 2022). • Agreement of workforce forward trajectory for SOAC, which will include the trajectory for the new international recruitment campaign (November 2022). • System Workforce Strategy refresh (December 2022).

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Dr Ronan Fenton, Executive Medical Director William Guy, Director of Primary Care	Directorate: Board Committee:	Clinical and Professional Leadership Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, ARRS, Hospital performance, reputational damage.	BAF Risk Ref:	PC01

Current Performance v's Target and Trajectory

Workforce:
Additional Roles Re-imbursement Scheme (what % of available budget spend of AARS roles) to be identified.
Fellowship scheme (no of recruitment) to be identified.
Patient to GP Ration: BB/Thurrock in top 10 worst ratio in country
Demand/Capacity:
Patient Experience National Survey: Poor performance locally in terms of access
Available Appointments: 147K more delivered this year compared to pre-pandemic year – see Fuller Stocktake Update.
Impact should be noticeable in the 23/24 (July 24) survey

Barriers (Gaps)

Nationally a lack of workforce.

How is it being addressed? (Current Controls)

Introducing series of measures to support management of patients and additional capacity for winter 22/23 (see next steps below).
Workforce development e.g. Additional Roles Reimbursement Scheme (ARRS) workforce and practice level initiatives. (impact over 3-5 years)
Investment in Primary Care workforce / digital / estates (impact over 3-5 years)
Initiatives for new GPs/ Partners and to support other roles in Practice Teams
Supporting succession planning
PCN Development

How will we know its working? (Internal Groups & Independent Assurance)

- No current independent assurance – Internal Audit Planned for 2023/24
- Patient Survey Results
- Workforce Retention
- Improved Patient to GP Ratio
- Resulting in better patient experience and access.

Next Steps (Actions to be implemented by March 2023):

- Cloud based telephony (25 Practices implemented by March, full roll out 2023)
- Winter access scheme (12-15,000 additional appointments)
- Community Pharmacy Consultation Service (2000 referrals to community pharmacists)
- Care Navigation (new pathways established)
- Recruitment of ARRS roles (additional x posts recruited in Q3 & Q4)
- Project / Change Mgt Support (additional clinical leadership & project support)

Risk Narrative:	**CAPITAL:** Failure to deliver the estates strategy as a result of insufficient capital means re-prioritisation will need to be completed in order to stay in the allocation which could result in delays to improvements impacting on access to and quality / performance of services.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Interim Director of Resources Kerry Harding, Deputy Director of Estates Ashley King, Director of Finance Primary Care & Strategic Programmes	Directorate: Board Committee:	System Resources Finance & Investment Committee Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	BAF Risk Ref:	EST01

Current Performance v's Target and Trajectory

Delivering the capital plans as per the investment plan (pipeline).
Future decisions to be made based on available capital and revenue resources.

Barriers (Gaps)

- There is currently no prioritisation framework to guide the investment pipeline.
- There is insufficient capital funding to meet the needs of the strategy.
- Impact of new accounting rules relating to the capitalising of Leases.
- Potential impact of financial position ('triple lock').

How is it being addressed? (Controls & Actions)

- Developing prioritisation criteria for pipeline of investments.
- Oversight by Finance & Investment Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.

How will we know its working? (Assurance)

- Throughput of business cases to F&IC.
- Delivery of Estates Strategy
- Implementation of IMWCs
- Progress reporting on investment pipeline.

Next Steps (to be implemented by December 2022):

- Training for Board & Exec (senior managers) on capital funding framework (Dec 2022)
- Prioritisation framework (Dec 2022)
- Prioritised list of investments (Q4)
- Infrastructure Strategy (Dec 2023)

Risk Narrative:	**UNBLOCKING THE HOSPITAL:** Risk of not maximising hospital discharge opportunities by prioritising patients and appropriately identifying discharge pathways.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Tiffany Hemming, Interim Executive Director of Oversight, Assurance and Delivery. Sam Goldberg, System Urgent and Emergency Care Lead and Alliance Directors.	Directorate:	Oversight, Assurance and Delivery.
		Committee:	MSE Strategic UEC Board and SOAC.
Impacted Strategic Objectives:		BAF Ref:	OAD1

Current Performance v's Target and Trajectory

Emergency Department waiting time performance is below the constitutional standard.
Ambulance response times remain below constitutional standards. (see performance report)

Barriers (Gaps)

- Health and Social Care capacity to take or facilitate discharge into the right pathway impacting on MSEFT flow and community partners.
- Workforce challenges (See Risk PO1).

How is it being addressed? (Current Controls)

- Winter demand and capacity programme to provide additional physical and virtual beds in place overseen by the UEC System Taskforce.
- Internal provider length of stay work improvement plans in place.
- Increased focus on discharging those pathway zero patients.
- Community and Voluntary Sector (CVS) engagement in progress in addition to work with Red Cross to support discharge.
- Alliances developing local plans.

How will we know controls are working? (Internal Groups and Independent Assurance)

- UEC Taskforce to include oversight and assurance against UEC Assurance Framework.
- MADE audit (multi-agency discharge event) planned monthly commenced October 2022 which identifies themes and barriers to discharge.
- MSE Strategic UEC Board (monthly) oversees programme and reports into System Oversight and Assurance Committee (SOAC) and ICB Board.
- Delayed hospital discharges monitored hourly/daily by hospitals and shared with both social care and CHC teams via situational awareness 10.00 am system call.

Next Steps (Actions to be implemented by [DATE]):

- Ongoing review trajectory and mitigations to recovery where off plan via monthly ICB Assurance meetings pre-SOAC.
- Ongoing MADE events monthly, next w/c 31 October 2022.
- Strategic Health Resilience Early Warning Dashboard (SHREWD) implementation enabling system view and actions required where capacity challenges occur (10 week mobilisation by December 2022).
- MSE system data and BI team to adapt Deloittes' out of hospital bed model to enable local ownership to understand system capacity pressures and impact of mitigation (end Nov).
- MSEFT bed model use to understand system capacity pressures and impact of mitigation (ongoing).
- System control centre to be established to oversee UEC winter pressures and proactively work with system partners (from 31 October in shadow form, fully operational mid-November).

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Tiffany Hemming, Director of Oversight, Assurance and Delivery Karen Wesson, Director Assurance and Planning	Directorate: Committee:	Oversight, Assurance & Delivery. System Oversight & Assurance.
Impacted Strategic Objectives:	Recovery of constitutional waiting times standards for diagnostics, cancer and Referral to Treatment (RTT)	BAF Ref(s):	OAD2, OAD3 and OAD4

Current Performance v's Target and Trajectory

Diagnostics: Recovery plans being developed by modality.
Cancer: Backlog (number of patients waiting 63+ days) reduction not meeting recovery trajectory.
Referral to Treatment:

- 104+ week waits: not achieved plan to meet 22/23 planning round guidance of zero by end of July 2022.
- 78+ week waits: not meeting recovery trajectory to reduce to zero by March 2023.
- 52+ week waits: significant growing adverse position above plan putting both the 78+ week waits and 104+ week wait plans at high risk.

Barriers (Gaps)

- **Cancer -** requires one registry – business case for one Somerset due early November 2022.
- **Cancer -** requires best practice pathways in place – programme refresh to enable this work to happen – supported by Stewards.
- **Workforce -** short term funded posts risks losing staff – meeting with MSEFT and ICB workforce leads to mitigate risk planned 21/10/22.
- **Workforce BMA Rate Card -** impacting on anaesthetics capacity – affecting RTT and Cancer risk – internal escalation/mitigation within MSEFT
- **UEC pressures impacting on elective capacity -** with implementation of full capacity protocols across MSEFT sites. System support and oversight to expedite flow in place – see hospital flow BAF

How is it being addressed? (Current Controls)

Diagnostics:

- MSEFT developing recovery plans for all modalities.
- Working with Trust to ensure clinical prioritisation and chronologically booking – initial assigned risk code remaining in clinical system – escalated for review to Head of BI.
- Some plans still required including non-obstetric ultrasound – escalated ask via elective board due by 31 October 2022

Cancer:

- Further 62 day revised trajectory for skin submitted to Regional team 10 October 2022.
- Day Zero Patient Tracking List (PtL) – Skin meetings continue. Agreement at Tier I meeting (on 5th October) to commence for Urology recognising administrative risk.
- Cancer Governance refresh to ensure assurance and oversight of transformation and impact on performance
- Business case for one Somerset due 7 November 2022.

Referral to Treatment (RTT):

- Implementation and use of Gooroo software across the three MSEFT sites to maximise capacity utilisation for long waits through optimal clinical prioritisation and chronological booking.

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Tiffany Hemming, Director of Oversight, Assurance and Delivery Karen Wesson, Director Assurance and Planning	Directorate: Committee:	Oversight, Assurance & Delivery. System Oversight & Assurance.
Impacted Strategic Objectives:	Recovery of constitutional waiting times standards for diagnostics, cancer and Referral to Treatment (RTT)	BAF Ref(s):	OAD2, OAD3 and OAD4

Next Steps (Actions to be implemented by end November 2022

Cancer:

- Actions continue as per plan shared at October 2022 SOAC.
- Somerset Cancer Register alignment – Business Case to be shared 7 November 2022 – Alliance agreed funding support for this.
- Tier 1 national oversight meetings continue fortnightly

RTT:

- Ongoing use of Independent Sector capacity to support activity, work with Alliances to understand referrals, use of Tier 2 to reduce acute, uptake of Advice and Guidance.

Diagnostics:

- Regional meeting on performance and progress planned for 21 November 2022 – deferred from October 2022.

How will we know controls are working? (Internal Groups and Independent Assurance)

SOAC maintains oversight of performance against all NHS Constitutional Standards**.**

- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board and Diagnostic Performance Sub-Group.
- **Cancer:** MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust commenced 23 August 2022: Palliative and End of Life Care Board.
- **RTT:** Elective Care Board: MSEFT RTT Long Wait Report. 52+ week waiting list size growth is the significant risk overseen via elective board.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** Due to the level of operational pressure within the system there is a risk that the system will not break-even, resulting in increased regional scrutiny ('triple lock'), reputational damage and potential impact on services.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Interim Director of Resources	Directorate: Committee:	System Resources Finance & Investment Committee
Impacted Strategic Objectives:	Financial sustainability	Risk Ref:	FIN01

Current Performance v's Target and Trajectory

There is a £91.2m total net risk to the system break-even position resulting largely from difficulties delivering the system efficiency programme and system pressures to manage delivery.

(The ICB itself is expecting a break-even position, so the risk relates to the ICB responsibility for meeting the system control total)

Barriers (Gaps)

- Meeting system efficiency target
- System pressures to manage delivery (capacity)
- Headroom to make the necessary changes to deliver the traction from the last coupe of years.

How is it being addressed? (Controls & Actions)

- Trajectory to break-even is being identified with region.
- PWC involved in developing / reviewing the financial recovery plan.
- Partnership working to develop the financial improvement plan.
- Focus on system efficiency programme.
- Regional oversight
- Local oversight.

How will we know controls are working? (Internal Groups & Independent Assurance)

- Improved delivery of the financial plans.
- Being overseen by the Finance & Investment Committee and the Chief Executives Forum, also discussed at SLFG and SOAC.
- Internal and External Audits planned.

Next Steps (to be implemented by December 2022):

- Set out the financial recovery plan/programme.
- Determine financial trajectory with NHSE and partners, including the target for 2022/23.

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Jo Cripps, Executive Director of Strategy and Partnerships Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Partnerships Inequalities Board being established.
Impacted Strategic Objectives:	Reduction of Health Inequalities	**BAF Ref:**	SP1

Current Performance v's Target and Trajectory

- Public Health Management (PHM) Outcomes Framework established baseline supplemented with Health Inequalities data packs, circulated to Alliances using NHS Core20Plus5 Framework.
- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Health Inequalities Strategy that is being developed will state ambition for reducing health inequalities in the medium and long term. Key metrics and a dashboard will be established over coming months in collaboration with PHM and BI teams.

Barriers (Gaps)

- Strategic approach required to co-ordinate work across Health inequalities, PHM and prevention with system partners to identify priorities and actions.
- Availability of BI and PHM resource.
- Quality improvement support for interventions.
- Financial resources are not yet sufficiently adjusted to reflect needs of population groups (proportionate universalism).

How is it being addressed? (Current Controls)

- Population Health Improvement Board established November 2022 chaired by Director of Public Health to provide system wide co-ordination and oversight.
- Health inequalities stocktake completed against the 2022/23 planning requirements and delivery against the Core 20 plus 5 framework, reported to Health Inequalities Delivery Group.
- Strategy development commenced to address health inequalities and governance arrangements to support delivery.
- Health inequalities funding of £3.4m allocated across Alliances and to support MSE wide project. South East and Thurrock Alliances projects approved and due diligence completed with funds being committed. Basildon and Brentwood Alliance process complete with Alliance approving projects by end of October 2022. Mid Alliance will commence process shortly. Successfully awarded micro-grants scheme (£100k) which will go live in November 2022.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project. Development of digital EHIIA tool funded through the HI funding commenced to embed common approach across the system.

Impact these actions are expected to have:

- Improvements in identifying and understanding needs of the groups most at risk of health inequalities.
- Reduction in health inequalities and improvement in population health.

Expected outcome and when are we expected to reach it:

- Co-ordinated population health improvement strategy with clear priorities and accompanying work programme for delivery by March 2023.
- Improvement in identification of groups at greatest risk anticipated by March 2023, as a result of primary care implementation of Investment and Impact Fund.
- Mobilisation of Health Inequalities Funded Projects with project evaluation commencing in 2023/24.
- Continued restoration of NHS services inclusively

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Jo Cripps, Executive Director of Strategy and Partnerships Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate:** **Committee:**	Strategy and Partnerships Inequalities Board being established.
Impacted Strategic Objectives:	Reduction of Health Inequalities	**BAF Ref:**	SP1

How will we know controls are working? (Internal Groups and Independent Assurance)	Next Steps (Actions to be implemented by March 2023)
• Population Health Improvement Board. • Health Inequalities Delivery Group. • Reports to the above groups will include metrics (to be developed) measured against agreed baseline. • Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE. • Improved access to services and patient outcomes for the MSE population.	• Inaugural meeting of Population Health Improvement Board (November 2022). • Agree outputs from EHIIA workshop (November 2022). • Mobilisation of Health Inequalities funding (December 2022). • Population Health Improvement/Health inequalities strategy (March 2023) • Establishment of work programme and agreed priorities (March 2023).

Partner Organisation Self Identified Key Risks

MSEFT - 16 Red Risks at August 2022. Top 7 risks (score 20–25):

- Financial Sustainability
- Constrained Capital Funding Programme
- Workforce Instability
- Estate Infrastructure
- Patient Flow and Length of Stay
- Cancer Capacity
- Planned Care Capacity

Other lower scored red risks (scored 15/16) relate to: Governance Structure; Trust Undertakings; Delivery of clinical and operational systems; Cyber Security; Competing Priorities; Health and Wellbeing Resources; Knowledge and Understanding; Capacity to Support Staff; and Innovation and Research Opportunities.

Partner Organisation Self Identified Risks

EPUT - 4 Red Risks (all scored 20) as at September 2022

- Patient Safety
- People (workforce capacity)
- Demand and Capacity (services)
- Capital resource.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Nicola Adams
Deputy Director Governance and Risk
Nicola.adams15@nhs.net

Sara O'Connor
Head of Governance and Risk
sara.oconnor@nhs.net

www.midandsouthessex.ics.nhs.uk

Part I ICB Board meeting, 17 November 2022

Agenda Number: 9

Reading the Signals, Maternity and Neonatal Services in East Kent

Summary Report

1. Purpose of Report

The purpose of this report is to share the key recommendations and learning from the East Kent Maternity Services Independent Inquiry, and for ICB Board to consider the Independent Inquiry recommendations and NHS England's letter dated 10 October 2022 (**Appendix 3**).

2. Executive Lead

Frances Bolger, Interim Executive Chief Nurse

3. Report Author

Frances Bolger, Interim Executive Chief Nurse

4. Responsible Committees

Quality Committee

5. Conflicts of Interest

None identified

6. Recommendation(s)

The ICB Board is asked to

- Consider the recommendations from the Inquiry.
- Note the importance of being assured, against being reassured, and to consider if it is sufficiently assured it has oversight of maternity services.
- Note the importance of professional curiosity.
- To recommend any additional actions that are required.
- Agree that the Chief Nurse will bring forward a further paper setting out proposed local actions in response to the 4 areas of action in the report.

Reading the Signals

Maternity and Neonatal Services in East Kent

Independent Inquiry – Dr Bill Kirkup

1. Introduction

The Independent Inquiry into maternity and neonatal services provided in East Kent was published on 19 October 2022.

The investigation reviewed the maternity and neonatal services provided at two hospital sites within East Kent Hospitals University NHS Foundation Trust between the years 2009 and 2022.

On 10 October 2022, NHS England wrote to trust chief executives and chairs, ICB chief executives and chairs and the chair of the local maternity and neonatal system (LMNS).

'We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The purpose of this report is to share the key recommendations and learning from the Independent Inquiry, and for ICB Board to consider the Independent Inquiry recommendations and NHS England's request as of 10 October 2022.

2. The Independent Inquiry

Bill Kirkup's report into the Maternity and Neonatal Services at East Kent University Hospital's Foundation Trust was published on Wednesday 19 October 2022 following his investigation into the services provided at the Trust between 2009 and 2020 (Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK (www.gov.uk)).

The maternity service is provided over two sites - the Queen Elizabeth the Queen Mother Hospital in Margate and the William Harvey Hospital in Ashford.

The investigation panel reviewed 202 cases over the 11-year period, talking to families, healthcare workers and the review of medical records.

3. Findings from the Inquiry

Kirkup states that had the maternity and neonatal care been given to national standards, the outcome for 97 cases (out of the 202 cases reviewed) would have been different.

Maternity and Neonatal teams were identified as dysfunctional, lacking professionalism and compassion, and that the service failed to learn from incidents and listen to concerns voiced by families.

Although the issues were well known by the Trust, the Trust and its Board failed to respond adequately when issues were raised, missing opportunities to properly identify the scale and nature of the problems and to put them right.

The report outlines four areas of action (see **Appendix 1**)

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England are reviewing the recommendations from the Inquiry, alongside those from Ockendon and other reviews, in order to develop a single programme of improvement work by March 2023.

4. Maternity Assurance Processes within the ICB

The ICB quality team has a number of oversight and scrutiny processes to oversee maternity care provided within Mid and South Essex ICS.

Intelligence gathered from meetings, data, and quality visits is gathered and triangulated to provide assurance. The ICB consultant midwife provides additional external challenge to quality conversations occurring inside the Trust and within the system. The ICB works closely with NHS England to share intelligence (see **Appendix 2**). The ICB is now actively recruiting to fill a vacancy for an obstetric and neonatal lead for the LMNS to assist in the delivery, and assurance, of maternity improvements.

Both nationally and within the ICB discussions are now occurring in response to Recommendation 1 – are the correct metrics captured on the maternity dashboard, does there need to be additional indicators? Alongside this, maternity metrics has been identified as a priority area for the ICB quality dashboard work and the maternity team are reflecting on how the experience of women can be captured and the culture of a service can be measured.

Work is continuing within MSEFT to address the maternity governance processes, maternity workforce and the impact of the maternity incident upon the culture on the Basildon site.

- The trust's maternity governance team has recently been restructured and the maternity improvement advisor is undertaking a deep dive into the governance processes. This is currently scored as a 12 on the ICB risk register
- Interviews for the medical lead for the trust care group occurred on 2 November 2022.
- Recruitment and retention of maternity staff continues to be a focus for workforce transformation groups however 47 new midwives and 7 consultants have recently been appointed.
- The Trust's executive team are aware of the staff distrust in management following the maternity incident and have increased their visibility within the service in order to listen to staff.

Of note, a Care Quality Commission (CQC) inspection has been undertaken recently and the report is due imminently.

5. Recommendations

The ICB Board is asked to:

- Consider the recommendations from the Inquiry.
- Note the importance of being assured, against being reassured, and to consider if it is sufficiently assured it has oversight of maternity services.
- Note the importance of maintaining professional curiosity.
- To recommend any additional actions if required
- Agree that the Chief Nurse will bring forward a further paper setting out proposed local actions in response to the 4 areas of action in the report.

6. Appendices

Appendix 1 – Recommendations from Independent Inquiry

Appendix 2 – Summary of Maternity Oversight Processes

Appendix 3 – Letter dated 20 October 2022 from NHS England/Improvement

Appendix 1 – Recommendations from Independent Inquiry

Recommendation	Key Action
Recommendation 1 The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.	**Key Action Area 1:** Monitoring safety performance – finding signals among noise: The Trust Board were falsely assured by identifying Trust outcomes were usually in line with national averages. Every trust must have reliable mechanisms in place to monitor the safety of its perinatal services and should not rely on families to identify problems following a poor outcome.
Recommendation 2 Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning. Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.	**Key Action Area 2: Standards of clinical behaviour – technical care is not enough**: Staff behaved inappropriately towards each other but also displayed an uncaring attitude towards women and families. The causes of unprofessional, unkind behaviour needs to be better understood and addressed to ensure the safety of services.
Recommendation 3 Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset. Relevant bodies, including Health Education England, Royal Colleges	**Key Action Area 3: Flawed teamworking – pulling in different directions**: The report found very poor teamworking both within and between professional groups. This resulted in bullying behaviours and conflict between professionals which was evident to women and families at critical points in their care. There was a lack of common purpose between midwives and obstetricians, and it is time to think of a better concept of teamwork for maternity services.

Recommendation	Key Action
and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development	
Recommendation 4 The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards. NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership	**Key Action Area 4: Organisational behaviour – looking good while doing badly**: The Trust were very keen to protect their reputation and as a result, reacted defensively rather than seeking to learn from criticism. The report highlights that organisational behaviour which places reputation management above honesty and openness is pervasive within the NHS, and suggests that the government should consider legislation to prevent this.

Appendix 2 – Summary of Maternity Oversight Processes

Oversight Processes	
High level meetings with ICB representation	• Weekly meeting with MSEFT Chief Nurse, ICB quality team and NHS England's Regional Chief Midwife where concerns and progress against key actions is discussed • Local Maternity and Neonatal System chaired by the ICB Chief Nurse • Maternity Assurance Committee – Trust meeting chaired by NED with ICB representation • Trust Maternity Improvement Programme Committee with workstreams including culture and leadership. Previous cultural improvement work undertaken with NMC and GMC and national programme with representations from the MSEFT maternity triumvirate • Consultant Midwife within ICB giving enhanced scrutiny and challenge – has professional curiosity • NHS England maternity improvement director provides external challenge to the service and the service is supported by the maternity safety support programme
Data/ intelligence	• Progress against Maternity Transformation Programme priorities, Saving Babies Lives Care Bundle 2 and Ockendon actions • Patient feedback surveys – monthly Friends and Family test, yearly CQC maternity survey, MVP leads within LMNS

Oversight Processes	
	• National staff survey and national HEE learner surveys • CNST submission – will benchmark performance against other services
Assurance visits	• Sixty Steps to Safety • Ockendon visits – plan to repeat to triangulate progress against key actions against reporting

To:
- Trust Chief Executives
- Trust Chairs
- ICB Chief Executives
- LMNS Chairs

cc.
- Regional Directors
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief Midwives
- Regional Obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 October 2022

Dear colleagues

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Yesterday saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units

- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Part I ICB Board meeting, 17 November 2022

Agenda Number: 10

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide the ICB Board a summary of the quality and patient safety concerns, escalations and improvement actions being taken within the Mid and South Essex ICS.

2. Executive Lead

Frances Bolger, Interim Executive Chief Nurse

3. Report Author

Frances Bolger, Interim Executive Chief Nurse

4. Responsible Committees

Quality Committee

5. Link to the ICB's Strategic Objectives

Improve outcomes by adherence to clinical policies, procedures and standards by enabling services to operate in a safe and effective way.

6. Conflicts of Interest

None identified.

7. Recommendation

- To note the contents of the report and the actions being undertaken to drive improvements.
- To note the section on child deaths in response to questions raised in the October ICB Board
- To note the work being undertaken to improve quality reporting within the Nursing and Quality team.

Mid and South Essex Quality Report

1. Introduction

1.1 The purpose of this report is to provide the ICB Board a summary of the quality and patient safety escalations. concerns and improvement actions being taken within the Mid and South Essex ICB.

1.2 The Quality Escalations received and discussed the quality concerns at its meeting held on 28 October 2022. Within the Safeguarding section, there is further detail on child deaths in response to questions asked at the last ICB Board meeting.

2. Services Reviewed by Quality Escalations Group

2.1 Infection Prevention and Control (IPC)

2.1.1 Clostridium Difficile Infection (CDI)

Clostridium Difficile infection (CDI) rates within Mid and South Essex NHS FT (MSEFT) remain above trajectory although the number of new cases is declining. Both the Trust and the System are likely to breach its annual April- March 2022 threshold.

Mid and South Essex NHS FT (MSEFT) CDI Cases														
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	Threshold
Basildon	15	13	12	13	13	10							76	
Broomfield	5	3	5	9	12	7							41	
Southend	5	8	8	6	8	5							40	
Total	**25**	**24**	**25**	**28**	**33**	**22**							**157**	**175**

CDI – All Cases (Acute and Community)														
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**	**Threshold**
BBCCG	12	12	13	12	14	11							74↑	**62**
CPRCCG	8	8	10	11	12	8							57↓	**69**
MECCG	10	8	8	13	23	19							81↓	**91**
SCCG	5	5	2	7	6	2							27↓	**56**
TCCG	12	8	8	6	7	3							44↑	**41**

Note: national data collection by former CCG area.

Driving factors for the increase in cases are

- National incidence of CDI for hospital inpatients aged 65 years and over per 1000 bed days has increased over 17% between April – June compared to the previous quarter
- Virulent strain 027 has contributed to the spread of the infection within one of the wards on the Basildon site
- Poor sampling techniques within the hospital
- Changes to antibiotic prescribing during the pandemic

NHS England and the ICB are overseeing IPC management via outbreak meetings. Support has been given to improve sampling techniques and the ICB IPC team are undertaking a site visit on 4 November 2022 to review IPC practice and environmental cleaning.

The IPC team are planning a system-wide summit to focus on Healthcare Associated Infections and the next steps.

2.1.2 Methicillin Resistant Staphylococcus Aureus Bacteraemia (MRSAB)

There have been 8 reported cases of Methicillin Resistant Staphylococcus Aureus bacteraemia (MRSAB) within Mid and South NHS FT (14 cases across the System). In September 2022, 2 new cases of MRSA bacteraemia have been notified and investigations are underway.

The cases are complex with one individual who has multiple infections, including chicken pox and Group A Strep, and is living in shared accommodation with multiple families. The other case is a Panton Leukocidin Valentine (PVL) Staphylococcus Aureus. The ICB are closely with Public Health to complete the investigation.

2.2 Complaints and Lived Experience

Within the ICB, a total of 94 complaints remain open to date, with 9 awaiting consent. No complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) for Q1/Q2 of 2022/23.

Analysis of themes has identified concerns relate to difficulty accessing GP appointments, issues with the prescribing of medication and funding requests for glucose monitoring equipment and IVF.

2.3 Serious Incidents

2.3.1 MSEFT Serious Incidents

There was a total of 13 serious incidents were declared in September 2022, with a new never event declared in October 2022. Serious incident themes continue to be delays in treatment (UEC and elective/ cancer backlogs) and pressure ulcers.

The never event was a wrong knee joint put into the wrong knee. A serious investigation is underway. Early cause identified is the clarity of ‘left’ and ‘right’ on the packaging of the implant. A new company has been sourced with improved

labelling on the package and products are now in use. The Trust is also linking with other trusts who have had a similar never event and contacting Milton Keynes University Hospital NHS FT to understand the work they have undertaken around human factors and serious incidents. Following a review of NHS England's never figures for April 2021-March 2022, 11 similar never events occurred across England.

Currently, there are 324 open serious incidents across Mid & South Essex, of which the majority belong to MSEFT (Broomfield Site = 107, Southend Site = 74 and Basildon Site = 72). A trajectory for completion of the serious incidents is in place and progress is monitored through ffortnightly meetings between the ICB and MSEFT.

2.3.2 Essex Partnership University NHS FT (EPUT) Serious Incidents

Two serious incidents have been declared and are being reviewed - the inpatient death by non-fixed ligature at Rochford hospital and overdose of an inpatient at the Linden Centre (the patient was on leave from the ward at the time of incident and has subsequently recovered).

2.4 Mid and South Essex NHS FT (MSEFT) Quality Concerns

2.4.1 Maternity Services

The CQC report from the September 2022 unannounced inspection is still awaited. The maternity service is currently on the Maternity Safety Support Programme (MSSP) and is supported by an external maternity improvement advisor. Findings from the inspection will be instrumental to deciding the next steps in relation to the service.

A maternity incident was declared on 14 October 2022 following the identification of a risk to staff health. In June 2021, it was identified, during routine environmental sampling, that staff working within the maternity unit on the Basildon site were being potentially exposed to unsafe levels of nitrous oxide (found in Entonox, an analgesic used in childbirth). A business case to improve the ventilation in the clinical area was approved in the autumn of 2021. However, the required equipment was not ordered until April 2022. Regular and long-term exposure to nitrous oxide can cause vitamin B12 deficiency and associated nerve damage, and possible infertility.

An external investigation has been commissioned by one of the Trust non-executive directors, Alan Tobias. Staff have been offered blood tests to check for B12 deficiency, and ongoing support to staff is via occupational health and helplines. A Q&A session was held on 20 October 2022. The environmental sampling is ongoing.

2.4.2 Backlog of Cancer Harm Reviews

Due to the current backlog of cancer harm reviews, a proposal to change the cancer harm review process was agreed at the Strategic Oversight Assurance Committee (SOAC) on 10 August 2022. The temporary change to process allowed teams to focus on 104+ day cancer harm reviews, where the greatest harm is likely to occur.

In 2021/2022, the Trust's cancer harm review performance was 85%. However, In September 2-22, the current cancer harm review performance is 3% with 543 overdue reviews. The situation of overdue reviews is likely to worsen by end of

October 2022 and November 2022 when there will be an additional 208 and 220 reviews due respectively.

On 27 October 2022, NHS England and the ICB met with the Trust to understand what additional support was required. MSEFT have agreed to present their current position on their 104+day cancer harm reviews at the November SOAC.

2.5 Essex Partnership University NHS FT (EPUT) Quality Concerns.

2.5.1 Willow Ward and Galleywood Ward

Essex Partnership University NHS Foundation Trust featured in a Channel 4 Dispatches documentary about mental health wards, broadcast on 10 and 19 October 2022. The programme included covert surveillance from an undercover reporter working as a member of staff on Willow ward at Rochford Hospital and Galleywood ward at the Linden Centre in Chelmsford. Both wards are (female) adult acute mental health wards. The Trust was informed of the TV company's intentions to air the filming on 26 September 2022. Following the notification, the Trust alerted the Police, Essex Safeguarding, NHS England and CQC.

On 5 and 6 October 2022, the CQC undertook an unannounced inspection of the two wards involved in the filming. Following the identification of safety concerns, CQC issued a letter of intent on 7 October 2022 with concerns raised surrounding the privacy and dignity of patients, completion of observations, safe staffing levels and safeguarding training levels.

The Trust has commenced a full investigation which includes the request to Dispatches to release the full footage taken at the Trust. Executive and senior leadership presence has been increased and staffing levels/ recruitment reviewed. The staff members identified in the film are going through the disciplinary process.

Next steps are to await the CQC report and outputs of the investigations. The ICB are reflecting on whether the quality concerns could have been identified earlier. A quality visit was undertaken in November 2021 and had identified that staffing was identified as an issue due to the large number of qualified nurse vacancies. Learning/ early warning signs will be fed into our quality dashboard/ oversight workshop on 26 October 2022 and the team have been researching whether the viewing of video footage would be possible as part of the quality assurance visits.

2.6 Primary Care Quality Concerns

Currently, of the 148 GP practices 1 practice is rated as inadequate and 3 practices are rated as 'requires improvement' by the CQC. For those practices rated 'inadequate' or 'requires improvement' action plans are in place and ongoing support is provided.

Common themes from CQC inspections relate to leadership and governance. The Nursing and Quality team are meeting regularly with CQC and are exploring how learning can be shared with other GP practices across the System.

2.7 Safeguarding

2.7.1 Non-Accidental Injury (NAI)

Essex Police (Strategic Partner) have raised concerns regarding reporting potential reporting delays of non-accidental injures (NIA) from trusts.

The Police has noted inconsistencies in reporting from hospitals across the whole of Essex. A Multi-Agency Working Group has been set up to review the 'Multi-Agency Protocol Management of Suspicious, Unexplained Injuries or Bruising in Children for all Frontline Practitioners'

2.7.2 Child Death Review (CDR) Annual Report 2021-2022

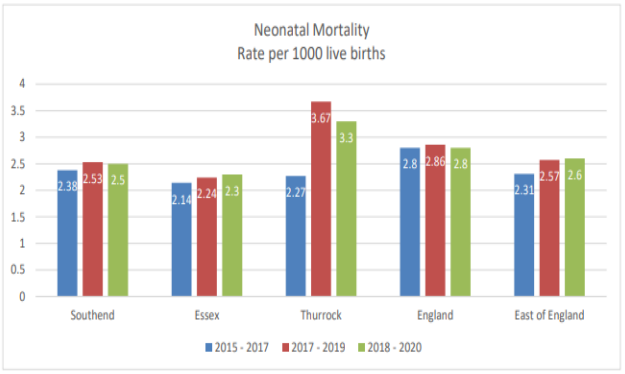
The Child Death Review (CDR) Annual Report has been published.

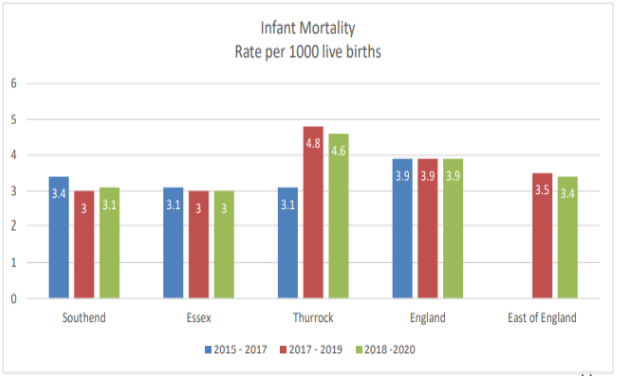
The report findings were

- No overall increase in the number of child deaths over the last 3 years
- From 2020, neonates have been included in figures (includes babies born at any gestation showing signs of life).
- Of the child deaths, 44% were 0-to-27-day neonates and that 66% of the overall child deaths were babies less than 28 weeks and 34% were age 29 weeks to 17 years.

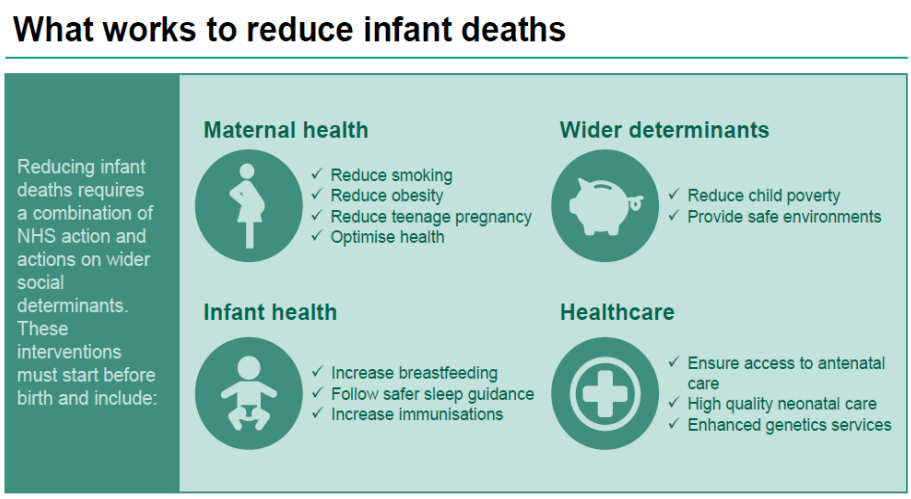
Notifications Received	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Southend	8	6	13	12	9	6
Essex	65	77	74	72	69	76
Thurrock	8	17	16	20	13	13
Total	**81**	**100**	**103**	**104**	**91**	**95**

Nationally the neonatal mortality and infant mortality rates have remained stable since 2016. However, the neonatal mortality rate for Thurrock is above the national average (see tables below). This may be due to data inaccuracies as only small numbers involved. Neonatal and infant deaths have been found to be associated with prematurity and low birth weight (nationally 27.9 deaths per 1000 live births v. 0.8 deaths per 1000 live births). Within Essex, Southend and Thurrock 78% of neonatal deaths were babies that weighed less than 2.5 kgs at birth.

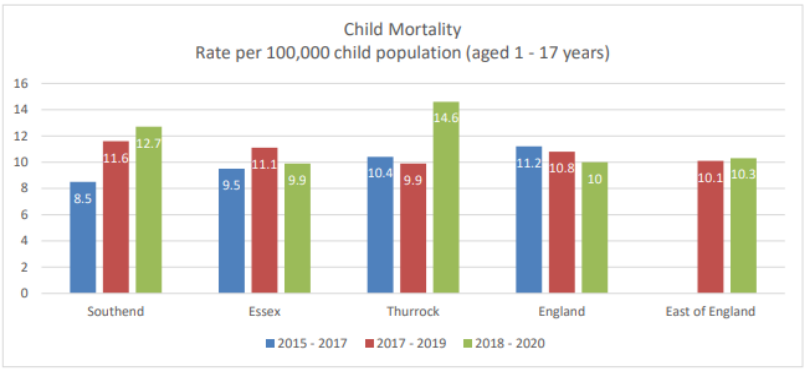




The maternity transformation work is aimed at improving the outcomes for babies. The national ambition is to *'Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025'.*



The child mortality rate in England has been declining for the past five years however, child mortality rates in Southend and Thurrock are above the rate for England.



Next steps for the Child Death Review Group is:

- Learning to be shared
- To develop a greater understanding of early pregnancy and extreme prematurity through a thematic review
- To work with partners to consider youth suicide and risky behaviours and to connect with Chief Constable in Norfolk (national Police Safeguarding Lead) regarding unsafe social media content (6 deaths due to suicide or deliberate self-harm).
- Thematic review of asthma child deaths (4 deaths between ages of 9 – 17 years)

3. Quality Reporting Review

3.1 A workshop was held on 26 October 2022 with identified system partners to discuss quality reporting and outcome measures. Next steps are to set up task and finish groups.

3.2 A session was held with the senior ICB nurse and midwifery leads to inform expectations around report writing. A new report template is being piloted with maternity and IPC teams.

3.3 Newly formed Quality Escalations Group is enabling quality and safety discussions. The purpose of the group is to enable nursing and quality teams to share escalations, actions, and risks. It is hoped as discussions become more refined, it will strengthen the quality of reporting to Quality Committee.

4. In Conclusion

The Quality report provides a summary of the key quality and safety issues across the ICS and the actions being undertaken. The ICB Board are asked to consider the following key concerns and the required Board response:

- To note that the clostridium difficile rates for the acute trust, and consequently the ICS, are above the threshold set. Actions and support to the trust are ongoing which has resulted in a decline in new cases in the most recent month. Oversight of the actions will continue via the Quality Committee, the MSEFT Infection Control Committee and ICB Antimicrobial Meeting.
- To note that two of the MSE's NHS trusts are awaiting the outputs of their recent CQC inspection and that there is likely to be a change in their CQC rating. Required actions relating to the CQC findings will be overseen via the System Quality Group and Quality Committee and a summary of the findings will be provided at a future ICB Board meeting.

5. Recommendation(s)

The Board is asked

- To note the contents of the report and the actions being undertaken to drive improvements.
- To note the section on child deaths in response to questions raised in the October ICB Board.
- To note the work being undertaken to improve quality reporting within the Nursing and Quality team.

Part I ICB Board meeting, 17 November 2022

Agenda Number: 11.1

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.
- Submitted to System Oversight and Assurance Committee (SOAC), 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
Category 1 Calls (Total category 1 calls) (Standard: Mean <= 7min; 90th Centile <= 15min)	MSE	90th Centile	Min	00:16:08	00:16:07	00:15:01	00:17:05	00:15:07	00:15:41
			Max	00:19:15	00:19:37	00:19:31	00:21:42	00:19:33	00:22:22
		Mean	Min	00:08:31	00:08:22	00:08:09	00:09:09	00:07:54	00:08:36
			Max	00:11:27	00:11:16	00:11:15	00:11:58	00:11:03	00:12:38
Category 2 Calls (Standard: Mean <= 18min; 90th Centile <= 40min)	MSE	90th Centile	Min	02:22:34	01:49:36	02:06:14	02:49:56	02:18:00	03:16:52
			Max	03:29:59	02:37:31	02:32:43	03:09:12	02:53:07	04:22:03
		Mean	Min	01:09:44	00:54:28	01:02:36	01:18:10	01:04:14	01:24:39
			Max	01:28:11	01:12:23	01:09:52	01:24:19	01:14:30	01:46:59
Category 3 Calls (Standard: 90th Centile <= 120min (02:00:00))	MSE	90th Centile		09:35:50	08:45:50	08:24:54	10:07:32	08:07:49	11:26:46
				13:53:22	12:50:45	12:12:31	14:13:53	09:55:50	13:24:03
Category 4 Calls (Standard: 90th Centile <= 180min (03:00:00))	MSE	90th Centile		11:12:38	01:07:23	00:00:00	00:21:57	03:49:23	08:56:16
				22:25:54	22:12:34	16:26:41	08:51:54	02:19:56	11:19:39

[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	Oct-22 to 25/10
Emergency Department - 4 hour standard - type 1 (Standard: >=95%)	*Total*	*28,175*	*31,117*	*29,872*	*29,832*	*27,586*	*27,695*	*24,922*
	Breaches	*9,881*	*10,342*	*10,009*	*10,605*	*10,077*	*10,754*	*9,632*
	Performance	64.9%	66.8%	66.5%	64.5%	63.5%	61.2%	61.4%

- **Elective Care**

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

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 (August 2022) with the number of patients waiting 6+ and 13+ weeks by test.

Test		Aug-22				
		13+ Weeks		6+ Weeks		Total WL size
		No.	%	No.	%	
Imaging	Magnetic Resonance Imaging	135	3%	988	20%	4,992
	Non-Obstetric Ultrasound	3,122	29%	5,421	50%	10,777
	Computed Tomography	561	13%	1,548	35%	4,392
	Barium Enema	0		0		0
	DEXA Scan	136	8%	684	40%	1,707
Endoscopy	Colonoscopy	85	8%	309	28%	1,088
	Cystoscopy	116	41%	152	54%	281
	Flexi Sigmoidoscopy	23	7%	113	35%	324
	Gastroscopy	102	9%	337	31%	1,080
Physiological Measurement	Audiology - Audiology Assessments	271	18%	705	46%	1,536
	Cardiology - Echocardiography	381	12%	1,658	54%	3,067
	Cardiology - Electrophysiology	0		0		0
	Neurophysiology	48	12%	141	36%	392
	Respiratory Physiology - Sleep Studies	44	16%	167	61%	276
	Urodynamics - Pressures & Flows	13	87%	15	100%	15
Total Diagnostic Tests		5,037	17%	12,238	41%	29,927

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 include:

- Day Zero Patient Tracking List (PtL) – Skin, Lower GI
- Insourcing and 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 continue
- 10th October: Further iteration of the 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 September 2022, there were 17 patients waiting 104+ weeks, 547 patients waiting 78+ weeks and 11,101 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 include:

- 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 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.

It is acknowledged that the report does not paint a very satisfactory position across MSE on a range of measures. Improvements in key areas will be a focus of national attention and are an immediate local priority.

4. Recommendation(s)

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

Part I ICB Board meeting, 17 November 2022

Agenda Number: 11.2

Urgent and Emergency Care (UEC) and Winter Plan Report

Summary Report

1. Purpose of Report

This paper is intended to provide members with an update on the Mid and South Essex Winter Demand and Capacity preparations. The paper will provide assurance of the approach being taken across the System on the response to the National "Going Further on Winter Resilience Plans"[1].

The report contains the following:

- Update on the Winter Monies & Additional Capacity in place and the planned dates for the further System capacity being opened to support continuation of elective capacity
- Assurance that the ICB(S) has in place a robust approach to the oversight of assessment and delivery against the winter letter requirements
- An example of a deep dive for falls which is one element/ask outlined in the winter letters received from the National Team (see Appendix 2)
- System Control Centre update on progress to implement in line with the national ask

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

- The Demand and Capacity planning is overseen via the Mid and South Essex Winter schemes group held weekly
- The Winter letters and approach to ensure oversight and assurance of feasibility of delivery of the national asks is overseen by the Mid and South Essex System Delivery Planning and Performance Meeting – weekly initially to coordinate the plan

[1] https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/

- The Mid and South Essex Urgent and Emergency Care Board oversees the system winter plan, ambulance handover system action plan

5. Financial Implications

The East of England have allocated monies to the System to purchase/open additional bedded capacity (physical and virtual) to support the continuation of elective care. The Integrated Care Board have allocated a Finance Lead who is collating and overseeing the allocation of monies to the agreed system schemes being progressed.

6. Conflicts of Interest

None identified

7. Recommendation/s

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

Urgent and Emergency Care Update and Assurance Report

1. Introduction

At the October Board meeting, the Mid and South Essex Integrated Care Board (ICB) provided an update to members on the progress on the UEC plans and actions being undertaken. This paper intends to provide:

- Update on the Winter Monies & Additional Capacity in place and the planned dates for the further System capacity being opened to support continuation of elective capacity
- Assurance that the ICB(S) has in place a robust approach to the oversight of assessment and delivery against the winter letter requirements
- An example of a deep dive for falls which is one element/ask outlined in the winter letters received from the National Team (see Appendix 2)
- System Control Centre update on progress to implement in line with the national ask

2. Board Update

Winter Monies & Additional Capacity

Table One was shared at the October Board meeting detailing the initial capacity and progress in mobilising that has been purchased with the MSE system has received a sum of £7.92m from Region.

Details	Additional Beds – Phase 1
D2A Model - SEDS and ECC (Bridging plus therapy) – commenced and in place with further recruitment underway	90
Hospice beds – Farleigh 4 beds (live 26 September 2022) St Luke's 4 beds (live from 14 November 2022)	16
Virtual ward, a combination of frailty and respiratory beds	66
	172

Table Two below shows the additional capacity that is being planned and recruitment commenced.

Details	Additional Beds – Phase 2
Hospital at Home – ongoing recruitment to scale up to the 30 – virtual beds	30
Outpatient Antibiotics Therapy (OPAT) at Home service – ongoing recruitment to scale up to the 30 – virtual beds	30
Mountnessing Court – Live date to be confirmed – physical beds	20
Halstead – Operational 1 December 2022 – physical beds	20
Basildon Hospital site – beds opened 1 November 2022 14, 6 more to open during November 2022	20
Hockley Ward Southend site – beds to open subject to recruitment from late November 2022	20
	140

Assurance Process for System to oversee the feasibility of the asks in the National Winter Letters.

Following receipt of the Winter Letters (see appendices one to six); the ICB re-constituted the System Delivery, Planning and Performance (SDPP) meeting to confirm the leads for the different elements and oversight of feasibility of delivery, financial implications to delivery, where not in place, risks and/or issues.

The below shows the leads for the different elements of this ask.

Outline or headline of ask	Lead responsible for coordination/assurance of ask
Ambulance Patient Handover Delays	ICB UEC Lead
Board Assurance Framework	ICB UEC Lead
Community Acute Respiratory Infection (ARI) Hubs	ICB UEC Lead
Deliver additional beds / System capacity Plans	Collaborative Leads
Capacity tracker data	ICB UEC Lead
Invest in acute workforce training for MH	ICB Workforce Lead
	Deputy Director C&YP

Outline or headline of ask	Lead responsible for coordination/assurance of ask
Discharge	MSEFT Discharge Lead and Community Collaborative Discharge Lead
	ICB Digital Lead
	Director Community
	Deputy Director Mental Health
Ambulance Service Performance	ICB UEC Lead
Community-based falls response	ICB Community Director
Care homes ambulance conveyance avoidance	ICB UEC Lead & Alliance Directors
Supporting High Frequency Users (HFU)	Alliance Directors
Workforce	ICB Workforce Lead

Deep Dive – Mid and South Essex Community-based Falls Service.

The review provides an example of the work being undertaken to understand the System position against one element of the asks outlined in the Winter Letters received from the national team (Appendices 1 to 6)

The review was undertaken to map current services offered across the integrated care system and supports the delivery of community-based falls.

Falls and related injuries are increasingly common: emergency admissions for falls in people aged 65 and above has increased year on year, from 185,000 in 2010/11 to 234,00 in 2019/20, *(Office for Health Improvement and Disparities, Fingertips Public Health Profiles, emergency hospital admissions due to falls in people aged 65+ and over).*

The impact of falling is significant and can negatively affect functional independence and quality of life; falls resulting in a lie of over one hour in length are also strongly associated with serious injuries, admission to hospital and subsequent moves into long term care. But not all falls result in serious injury and a proportion of calls can be responded to by community-based response services. *(Going further for winter: Community-based falls response – 18 October 2022)*

The Deep Dive report is being circulated separately to Board members.

Mid and South Essex System Control Centre.

The national winter letters outline an ask for a System Control Centre (SCC), Appendix 6; the ICB UEC Operational Team together with the Emergency Preparedness, Planning and Response (EPRR) Team are working to develop a model that will meet the national asks and provide System oversight and coordination.

Currently, the SCC approach will build on the model in place during the COVID incident to support System response. The intention is this will operate in shadow form from 14 November 2022 until 1 December 2022 when it will be fully operational.

Work remains ongoing to understand the clinical model, staffing of the 0800 to 2000hrs ask for the SCC. Updates and progress on this will be provided at future Board meetings.

Recommendation

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

Appendices:

Please access NHS England » Going further on our winter resilience plans for the following Appendices.

1. Going further on our winter resilience plans letter.
2. Going further for winter: Community-based falls response.
3. Going further for winter: Care homes ambulance conveyance avoidance.
4. Combined adult and paediatric Acute Respiratory Infection (ARI) hubs (previously RCAS hubs).
5. Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators.
6. System Control Centres.

Part I ICB Board meeting, 17 November 2022

Agenda Number: 12

Primary Care: Update on the Fuller Stocktake / Our Plan for Patients

Summary Report

1. Purpose of Report

To provide a regular update to the Board on progress relating to the Fuller Stocktake / Our Plan for Patients, as agreed at the ICB Board meeting, 13 October 2022, where our action plan was first presented.

2. Executive Lead

Anna Davey, Fuller Advocate and ICB Member for Primary Care

3. Report Author

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

4. Responsible Committees

Primary Care Committee.

5. Conflicts of Interest

None Identified

6. Recommendation(s)

The Board is asked to acknowledge and discuss the update.

Fuller Stocktake Update

1. Introduction

This report forms part of a regular update to the ICB on progress against our plans to implement the Fuller Stocktake and 'Our Plan for Patients' locally.

2. Main content of Report

2.1 Assessment of need and planning

We have commenced a programme of work to develop clinical strategies for each of our 27 Primary Care Networks (PCNs), as part of wider integrated neighbourhood teams. We are doing this through the Alliances and with support from an ICB team together with a clinically led consultancy called HIP. These strategies will be aligned with the Fuller Stocktake, to help develop new models of urgent and episodic, complex and preventative care. They will be complete by March 23.

2.2 New care model development

We are currently working with several PCNs to transform their care models, taking advantage of technological solutions (e.g. cloud-based telephony, website/app improvement and digital systems such as eConsult) as well improving how roles under the Additional Roles Reimbursement Scheme (ARRS) are used to improve urgent and episodic care.

We are also in the process of rolling out the Patient-Aligned Care Teams (PACT) model (or local variations of it) for complex care which has proved effective at reducing admissions in south-east Essex. This is currently being explored by PCNs in south-east Essex, but also across PCNs in each of the other three Alliances.

In the short term, we have written to practices about the winter access scheme (offering 13k longer appointments for complex patients) and we are also working with pharmacies to increase the number of appointments by 2k over winter. The next step is to procure customer service training for receptionists and develop our protocols for patients accessing different parts of primary care more effectively.

2.3 Enablers

We have made the offer to practices in line with national expectations for new telephone lines and we are soon to commence procurement for the cloud-based telephony solution (from a framework) which will be rolled out to 25 practices by March 2023 and ultimately any practice that would benefit from it. Practices will be selected on a range of criteria including current contract, patient experience, deprivation and ability to implement the solution.

The next step will be rolling out improvements to practice websites to standardise and optimise the capabilities they offer, and then to focus on the NHS App, to ensure that patients can easily use this to book into slots offered by their practice.

We will be supporting PCNs to recruit to new staff such as the digital and transformation and new administrative roles to support transformation locally.

Support for primary care enablers will be coordinated in response to the clinical strategies that each of the PCNs are developing, including estates strategies which are a requirement of NHS England/Improvement by April 2023.

2.4 Funding and Incentivisation

We are exploring ways to align current underspend with the areas outlined above from the Fuller Stocktake, particularly in relation to improving access (through models of urgent and episodic care) and supporting people with complex needs to stay healthier at home. This will likely take the form of a new scheme for primary care incentivisation.

2.5 Progress/Achievements

Primary care and the teams supporting primary care continue to make progress against a range of key metrics;

By Consultation Method

ICB	Consultation Method	2019/20	20/21	21/22	22/23	Change on pre-pandemic (19/20)	Change on 2021/22
Total - Mid and South Essex ICB	Face-to-Face	1,955,007	1,030,045	1,442,984	1,734,092	-220,915	291,108
	Home Visit	4,653	2,025	3,777	6,790	2,137	3,013
	Telephone	225,201	796,617	807,515	569,116	343,915	-238,399
	Video Conference/Online	55,555	27,498	26,046	40,571	-14,984	14,525
	Unknown	53,906	39,355	79,014	91,006	37,100	11,992
	Total	**2,294,322**	**1,895,540**	**2,359,336**	**2,441,575**	**147,253**	**82,239**

These figures represent the period April – August for each of the years shown. Critically, 147k more appointments were delivered by primary care this year in comparison to the last year before the COVID-19 pandemic. 71% of all consultations between April and August were seen face to face (our highest percentage since the pandemic).

Again for the same April – August period, the following table gives an indication of the speed at which patients were seen in primary care. In context, between April and August 2022, over one million consultations were undertaken the same day as the patient contacted primary care. A further 200k were undertaken within 24 hours.

When appointments occurred	**Mid and South Essex**	**National**
Same day as contact	43%	44.60%
Within 24hrs	51%	53%
Within 2 weeks	84.40%	85%

We now have over 300 ARRS staff in Mid and South Essex. This includes nearly 100 pharmacists, nearly 50 social prescribers, over 30 first contact physios, paramedics and care coordinators. 65 ARRS staff have been appointed this year with a further (majority) recruitment during Q3.

From a digital perspective, over 80 of our practices provide greater use of online repeat prescriptions compared to the national average, 53% of our population over the age of 13

are now registered to use the NHS App and 104 of our practices have now gone live with their new online consultation provision.

3. Findings/Conclusion

Substantial progress has been made since the last meeting of the ICB, particularly in relation to the drive to support PCNs to develop and consolidate their plans for improving care locally, as well as in relation to the purchase and roll out of cloud-based telephony to further support improved access.

4. Recommendation(s)

The ICB Board is asked to note the report.

Integrated Care Board Meeting of 17 November 2022

Agenda Number: 13

Month 6 Finance Report

Summary Report

1. Purpose of Report

To report on financial performance for the ICB at Month 6 and offer a broader perspective on outturn across partners in the Mid & South Essex system (period ending 30 September 2022).

2. Executive Lead

Jennifer Kearton, Interim Director of Resources

3. Report Author

Resources Team

4. Committee involvement

The position at M6 was reported to the ICB Finance & Investment Committee on 9 November 2022.

(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 6 Finance Report

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 summarises the financial performance of the MSE ICB. It also provides information on system financial performance.

MSE ICB is delivering a breakeven position year to date and is continuing to forecast breakeven for the year end, in line with plan.

2. Key Points

2.1 Month 6 ICB financial performance

The forecast expenditure for the ICB is £1803.4m and this is contained within its total attributable allocation at month 6. The ICB is therefore forecast to breakeven at the end of the financial year. Table 1 below summarises the month 6, expenditure position for the ICB.

There are two adjustments to our position, which are presented in line with national guidance. The first is the retrospective allocation relating to CCG closedown at month 3, 2022/23[1]. The second reflects two reimbursement programmes which are in operation this year, these being the Additional Roles Reimbursement Scheme (ARRS) relating to primary care networks and the covid reimbursement. After adjustment for these two items the ICB continues to deliver to plan.

Table 1

Expenditure	Year to Date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m Sur/(Def)	Plan £m	Actual £m	Variance £m Sur/(Def)
Acute Services	322.3	323.1	(0.8)	952.9	952.8	0.1
Mental Health Services	58.5	61.5	(3.0)	171.3	174.3	(3.0)
Community Health Services	52.9	53.3	(0.4)	162.5	163.6	(1.1)
Continuing Care Services	27.0	29.6	(2.7)	80.9	90.3	(9.5)
Prescribing	50.2	51.5	(1.4)	150.5	151.9	(1.4)
Delegated Primary Care Commissioning	45.9	45.9	(0.1)	148.7	156.6	(7.8)
Primary Care Services	7.4	8.6	(1.2)	22.2	22.6	(0.4)
Other Commissioned Services	4.9	3.4	1.5	14.7	14.0	0.6
Other Programme Services	2.0	38.7	(36.7)	29.8	59.9	(30.1)
ICB Running Costs	6.2	6.2	0.0	17.4	17.4	0.0
Total ICB Net Expenditure	577.2	622.0	(44.8)	1,750.9	1,803.4	(52.6)
Retrospective Allocation Adjustment		(44.7)	44.7		(44.7)	44.7
ARRS and Covid Reimbursement		(0.1)	0.1		(7.8)	7.8
Final Month 6 Position		577.2	**0.0**		1,750.9	**0.0**

[1] *The ICB is unable to appropriately distribute the retrospective allocation due to national reporting requirements. As a result, expenditure areas appear overspent with the offset being within the allocation adjustment line.*

Table 2 summarises the allocation position at month 6. All additional allocations received within the month are accounted for within our expenditure position.

Table 2

Allocation	Recurrent £m	Non-Recurrent £m	Total £m
Retrospective Allocation Adjustment			44.7
ICB Allocation at Month 5			1,712.4
Total Allocation at Month 5	1,608.1	149.0	1,757.1
Pay award and Employers NI adjustments	18.2	7.4	25.6
NHS 111 Capacity Increase		1.1	1.1
Demand & Capacity Funding		7.9	7.9
Direct Action Oral Anticoagulants Rebates		0.5	0.5
Children's and Young Peoples Eating Disorders		0.5	0.5
Other SDF and Adjustments		2.9	2.9
Allocation at Month 6	1,626.3	169.4	1,795.7
Anticipated ARRS and Covid Reimbursement			7.8
Total Allocation attributable to Month 6			1,803.4

2.2 ICB Risk Position

The ICB faces 3 key risks to its breakeven position, these are presented in table 3 with an assessment of the best, likely and worst-case impact. It is likely the risks will be mitigated in-year to deliver a breakeven position. In the worst-case scenario, we may experience additional inflationary pressures specifically across continuing healthcare and prescribing that will outstrip our ability to mitigate in year. In the best-case scenario, the pressure will be lower, and our mitigations will continue to be available therefore improving the ICB financial position by £1.9m. Due to the system wide position, risks are now collected and reported on weekly. The Board is in receipt of the most recent information at the time of writing and a verbal update of any changes will be provided at the Board meeting.

Table 3

Risk Summary	£m	Best	Likely	Worst
Market Pressures (CHC)	(4.3)	(4.0)	(4.3)	(4.3)
Pathway Harmonisation	(0.5)	0.0	(0.5)	(1.0)
Additional Inflationary Pressures	(5.1)	(4.0)	(5.1)	(6.0)
Total Risks	(9.9)	(8.0)	(9.9)	(11.3)
Non-Recurrent Mitigations	9.9	9.9	9.9	9.9
Total Mitigations	9.9	9.9	9.9	9.9
Net Risk Position	(0.0)	1.9	0.0	(1.4)

2.3 ICB Efficiencies

All organisations within the system have a targeted level of efficiencies which they are required to meet to deliver their breakeven positions. At the start of the financial year the ICB set its budgets net of its efficiency challenge and delivery is monitored within the outturn. Budgets are currently delivering in line with plans and the ICB is reported as delivering both its year-to-date and forecast outturn efficiency challenge.

Table 4

Area of Efficiencies	Year to Date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m Sur/(Def)	Plan £m	Actual £m	Variance £m Sur/(Def)
Contract Changes	1.3	1.3	0.0	2.6	2.6	0.0
Primary Care Prescribing	4.2	4.2	0.0	8.4	8.4	0.0
Continuing Healthcare	1.7	1.7	0.0	3.3	3.3	0.0
Running Cost Review	0.2	0.2	0.0	0.5	0.5	0.0
Other	0.4	0.4	0.0	0.8	0.8	0.0
Total	**7.7**	**7.7**	**0.0**	**15.5**	**15.5**	**0.0**

2.4 ICB Finance Conclusion

The ICB continues to forecast a breakeven position for the year ending 2022/23 and is on track to deliver this. There are some risks to the position, mainly driven by inflationary pressures. However, the ICB continues to manage and mitigate to stay on plan. Efficiencies continue to deliver on plan.

Our whole health and care system faces increased pressure from market conditions and inflation. The ICB is ensuring it takes all appropriate measures to maintain financial balance, working closely with system partners to deliver financial sustainability. This is a particular priority as we plan for 2023/24.

Please note **Appendix 1** presents the ICB cashflow and Better Payment Practice Code (BPPC) performance. This appendix will be included on a quarterly basis and developed to include additional financial control metrics.

2.5 Overall System Finances as at M6

At the end of month 6 the overall health system position is a deficit of £44.3m. MSEFT accounts for £42.2m of the overall deficit and is £33.3m adverse to their year-to-date plan. The balance of the system deficit, £2.1m is in EPUT and is £0.1m favourable to their planned position at month 6.

The deficit in MSEFT has 2 key drivers, increased and sustained system pressures, which are driving continued pressure in workforce costs and under delivery of efficiencies.

As previously reported, a continuation of this trend would frustrate attempts to deliver a balanced position for the system at the year end. The system is fully engaged in financial improvement actions with Chief Executive oversight. The ICB Finance Investment Committee and the respective finance committees of MSEFT and EPUT are in receipt of regular reports on actions and impacts.

Our local authority partners are reporting a forecast deficit of £16.5m. Essex County Council £3.9m, Southend City Council £9m and Thurrock Council £3.6m (Thurrock Council's position is as at month 3). Councils are experiencing pressure across children's services because of higher demand for placements. Adult Social Care budgets also continue to experience high and rising costs for social care packages.

2.6 System Risk Position

The system is currently reporting a net risk position of £86.7m. There are two significant risks in the system position, both impacting on MSEFT's ongoing deficit. The under delivery of system efficiencies (£40.4m) and the costs to manage delivery (£40.3m). System financial improvement is dependent on mitigating these risks. The Trust has begun its internal improvement programme, 'Foundations for the Future', which is reported into the work at system level to deliver financial improvement in-year.

Table 5 presents the latest system risks and mitigations position. Due to the level of risk in the system, updates are collected on a weekly basis, the Board is in receipt of the latest information at the time of writing.

Table 5

Area of Risk	Risks £m	Mitigations £m	Net Risk Position £m
Under Delivery of Efficiencies	(42.6)	2.2	(40.4)
Elective Recovery - additional costs	(7.1)	0.0	(7.1)
System Pressures to manage delivery	(40.3)	0.0	(40.3)
Net trading income	(6.9)	0.0	(6.9)
Revenue consequences of capital	(5.3)	0.0	(5.3)
Additional Cancer delivery costs	(2.5)	0.0	(2.5)
Service reviews	0.0	4.7	4.7
Technical balance sheet adjustments	0.0	12.8	12.8
Inflationary Pressures	(4.2)	0.0	(4.2)
Winter funding pressures	0.0	0.0	0.0
Market Pressures (CHC)	(4.3)	0.0	(4.3)
Out of area pressures	(0.4)	0.4	0.0
Pathway harmonisation	(1.0)	0.0	(1.0)
Costs associated with increased improv	(2.7)	0.0	(2.7)
Musculoskeletal (MSK) - contract disput	(0.1)	0.1	0.0
Release/Reduce investments	0.0	3.0	3.0
Non-Recurrent Mitigations	0.0	7.5	7.5
Other	(0.2)	0.2	0.0
Total	(117.6)	30.9	(86.7)

2.6. System Efficiency Position

The plan for efficiencies has two elements - local schemes which relate to organisation specific savings and the MSE financial sustainability programme (FSP). The latter is a 3-year plan of efficiency opportunities, 2022/23 is year 1.

Our local schemes account for £34.3m of the overall efficiency plan this financial year. Our current forecast shows delivery of £28m (82%) against these schemes.

The MSE FSP, is targeted to deliver £49.7m. At month 6 forecast delivery is £12.7m (25%) a further £23.8m has been identified, however, plans are not mature enough to provide confidence of in-year delivery.

Currently, the likely case for efficiency delivery in 2022/23 is £40.7m (£28m Local + £12.7m FSP).

The Board will recall that our system plan was for a breakeven position and this relied on delivery of the full £84m of efficiencies. The lack of delivery is driving our current year-to-date system deficit. Focused action is underway to maximise in-year delivery, timelines have been set to bring plans forward and additional programme support is being identified.

Momentum is required on slippage this year to ensure we continue to progress towards financial sustainability.

2.7 System Capital Position

The system has a local capital allocation of £65.1m (£63.1m Provider and £2.0m Primary Care). We have £24.9m of nationally allocated funding for specific projects, and a further £1.7m pending, bringing our total capital plan to £92m for 2022/23.

The system has a month 6 year-to-date underspend of £14m (M5: £10.5m) against its total capital programme, £9.1m within MSEFT and £4.9m in EPUT. Both providers have completed reprioritisation and reprofiling exercises during October and it is anticipated that programmes which have slipped will still deliver for the year-end.

2.8 System Finance Conclusion

As a system, MSE continues to be financially challenged due to increased and sustained system pressures and a lack of financial efficiency delivery. The financial deficit in our acute sector makes it increasingly difficult to assert a system breakeven position for 2022/23. The development of our system financial improvement plan is in progress, all reasonable measures are being taken to mitigate the in-year financial position, however it is essential that a sustainable transformation offering is in place to enable our system to deliver its wider ambitions.

2.9 Recommendation

The Board is asked to note this report for information.

3. Appendices

Appendix 1 – ICB Cashflow and BPPC performance

Appendix 1 – ICB Cashflow and BPPC performance

MID AND SOUTH ESSEX ICB CASHFLOW STATEMENT

As at 30 September (M6)

	£000
ICB Cash Limit as at 30 September	**1,733,511**
Anticipated Adjustments	
Income and Opening Cash	**15,904**
Capital Cash	**0**
Forecast Maximum Cash Available	**1,749,415**
Forecast Cash Used	**1,748,894**
Balance of Cash Limit not utilised	**0**
Forecast Cash Balance in Bank as at 31st March 2023	**520**

	July to Sept Actuals £000	Sept to Dec Forecast £000	Jan to March Forecast £000	TOTALS £000
BALANCE BROUGHT FORWARD	7,088	23,712	858	**7,088**
CASH IN				
Cash Limit - Main Funds	538,400	522,744	537,000	**1,598,144**
- Prescribing Income	45,367	45,000	45,000	**135,367**
VAT Refund	1,577	1,500	1,500	**4,577**
Other Income	3,544	694	0	**4,238**
Total Cash Income	**588,889**	**569,937**	**583,500**	**1,742,326**
CASH OUT				
Service Level Agreements/Contracts	478,717	490,293	479,257	**1,448,267**
PPA Topslice	45,367	45,000	45,000	**135,367**
Salaries, Tax, NI & Pensions	10,690	11,336	10,920	**32,946**
BACS	36,204	45,500	48,000	**129,704**
Capital Expenditure	0	0	0	**0**
Other	1,286	662	662	**2,610**
Total Cash Expenditure	**572,265**	**592,791**	**583,838**	**1,748,894**
BALANCE CARRIED FORWARD	**23,712**	**858**	**520**	**520**

BPPC	On Time Value £k	%	On Time Invoices Number	%
Jul-22	163,615	100.00%	2775	99.07%
Aug-22	178,227	97.75%	4859	92.29%
Sep-22	176,258	95.52%	4234	95.66%
Total	518,100	97.67%	11868	95.00%

Part I ICB Board meeting, 17 November 2022

Agenda Number: 14

Update on Service Harmonisation Public Consultation

Summary Report

1. Purpose of Report

To provide the Board with an update on the launch of the service harmonisation public consultation.

2. Executive Lead

Dr Ronan Fenton, Medical Director.

3. Report Author

Claire Hankey**,** Director of Communications and Engagement.

4. Responsible Committees

The programme has previously been considered by the integrated care board at its meetings on 1 July 2022 and 13 October 2022.

5. Impact Assessments

Draft Equality and Health Inequality Impact Assessments (EHIIA) were completed for all six areas by a panel with expertise in inequalities, public health, Place (Alliance), primary care, clinical, and procurement.

6. Financial Implications

Following consultation, the financial implications of any recommendations will be required to go through the appropriate governance channels as part of the process.

7. Details of patient or public engagement or consultation

A targeted pre-consultation engagement approach has been undertaken which gathered insight to support the options for formal consultation.

This report provides details of the formal consultation process.

8. Conflicts of Interest

None identified

9. Recommendations

The Board is asked to:

- Note the launch of the consultation process, including the attached consultation document and associated activities, following the decision made by the ICB Board at its meeting on 13 October 2022 to proceed to formal consultation.
- Support the promotion of the consultation and ways to get involved.
- Agree to receive the analysis of public consultation at a future meeting.

Service Harmonisation Consultation

1. Introduction

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 (MSE).

Our Clinical and Multi-professional Congress (CliMPC) 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.

Subsequently, a set of proposals for single policies across mid and south Essex were developed.

At its meeting on 13 October 2022, the Board agreed to embark on a period of public consultation to seek wider resident views on those proposals before final decision-making in February 2023.

This report provides an update to the Board on the launch of the consultation period, the consultation document, and associated activities.

2. Main content of Report

The purpose of this report is to update on the Service Harmonisation Consultation for MSE Integrated Care Board (ICB).

Through the consultation process, we are seeking the views of our local population on our ambition to harmonise the provision of six service areas due to differing historic commissioning policies within the five clinical commissioning groups.

The six service areas are:

- Bariatric Surgery (weight loss surgery).
- Breast asymmetry (surgery for uneven breasts).
- Breast reduction (making breasts smaller).
- 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.

We want to change the policies for the six clinical services that are only provided by the NHS in our area under certain circumstances.

Currently, the policies for these six services differ depending on where you live in our area. For example, people living in the commissioning areas of Basildon, Brentwood, and Mid Essex cannot access IVF services through the NHS, while people living in other areas of MSE can.

We want to change these policies, so everyone living in MSE has the same opportunities.

Having looked at the latest clinical evidence and practice for all six services nationally and locally, taken advice from a range of doctors, nurses, and other health and care professionals, and undertaken targeted pre-consultation engagement a series of proposals were developed.

On 31 October 2022 we launched the formal consultation process, anchored by the consultation document, attached at **Appendix 1,** which sets out the rationale and expected impact of the proposals. It is supported by a consultation survey which provides a convenient way for residents to share their views.

The launch date of the consultation was slightly later than previously set out to enable refinement and review of the documents by several stakeholders and readers and ensure an easy-read version could be produced in a timely way. Options for large print versions and foreign languages are available on request.

The consultation period has therefore been adjusted accordingly and will now run until 19 December 2022.

The consultation document is supported by a dedicated section on the integrated care system website which can be viewed here.

The consultation process has been launched and continues to be promoted using a variety of methods including local media, social media, email marketing, and through partner communications channels, for which a communications toolkit has been produced and issued to communications teams across our system.

To support those without access to digital technology, printed copies of the consultation document and survey have been supplied to local libraries thanks to the support of the library services in Essex, Southend, and Thurrock.

A series of discussion events have been scheduled across the consultation period as follows:

- Thurrock – 9 November 2022, 6:30pm to 8:00pm
  The Beehive, Voluntary and Community Resource Centre, West Street, Grays, Essex, RM17 6XP.

- Mid Essex – 10 November 2022, 5:00pm to 6:30pm
  Witham Public Hall, Collingwood Rd, Witham, Essex, CM8 2DY.

- Basildon and Brentwood – 22 November 2022, 6:30pm to 8:00pm
  The Place, Pitsea Leisure Centre, Northlands Pavement, Pitsea, Basildon, Essex, SS13 3DU.

- South East Essex – 24 November 2022, 5:30pm to 7:00pm
  The Forum Southend, Elmer Square, Southend-on-Sea, Essex, SS1 1NS.

- Online (virtual) – 30 November 2022, 7:00pm to 8:30pm
  The online event via Zoom – details provided when you sign up here.

The general discussion events are complemented by a series of targeted focus groups aimed at seeking the views of those residents most likely to be impacted by one of the six service areas and those whose views are not traditionally heard through more general engagement methods.

Examples of these groups include LGBT Mummies, fertility support groups, men's health groups, faith groups, travellers, the homeless, and learning-disabled communities.

The engagement plans have also ensured information about the consultation has been shared with our MPs, elected members, and wider stakeholders.

A programme of attendance at and engagement with our three health overview and scrutiny committees has commenced in line with our statutory responsibilities.

3. Recommendation(s)

The Board is asked to:

- Note the launch of the consultation process, including the attached consultation document and associated activities, following the decision made by the ICB Board at its meeting on 13 October 2022 to proceed to formal consultation.
- Support the promotion of the consultation and ways to get involved.
- Agree to receive the analysis of public consultation at a future meeting.

4. Appendices

Appendix 1 – Consultation Document

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Service Harmonisation

Bringing equity to services across mid and south Essex

Consultation document
31st October to 19th December 2022

Contents

Who are we?

Mid and South Essex Integrated Care Board (ICB) was formed on 1st July 2022.

We are responsible for commissioning services which is the planning, organising, and buying NHS-funded healthcare for the 1.2 million people living across mid and south Essex.

We are committed to delivering local, high quality healthcare services while making sure we achieve the best value for money and equity of access for our growing population.

This includes hospital services, community health services, community pharmacies, mental health services and 149 general practices.

The four key purposes of integrated care boards as set out by NHS England are:

01 **Improve outcomes in population health and healthcare**

02 **Tackle inequalities in outcomes, experience, and access**

03 **Enhance productivity and value for money**

04 **Help the NHS support broader social and economic development.**

This publication is available in alternative formats; including Easy Read and large print options. It will also be available at your local library.

purposes

What is this document about?

We want to harmonise policies for six clinical services that are only funded by the NHS in our area under certain circumstances.

At the moment, the policies for these six services differ depending on where you live in our area. For example, people living in the commissioning areas of Basildon, Brentwood and Mid Essex (Maldon, Chelmsford and Braintree council areas) can't access IVF services on the NHS, but people living in other areas of mid and south Essex can. We want to update these policies, so everyone living in mid and south Essex has the same access.

The policies we want to update cover:

Weight loss surgery (bariatric surgery)

Correction for uneven breasts (breast asymmetry)

Breast reduction

Female Sterilisation

Vasectomy (male sterilisation)

Special Fertility Services including:

- Intra-uterine insemination (IUI)

- In vitro fertilisation (IVF), with or without intra-cytoplasmic sperm injection (ICSI)

- Sperm and egg donation (sperm and oocyte donation)

policies

This document describes our proposals for updating the policies, to help bring them into a new single policy for each of the six service areas, and gives you the opportunity to tell us what you think about them.

The current policies covering these areas can be found **www.midandsouthessex.ics.nhs.uk/publications/srp/**

If you need printed copies of any of the current polices, please contact us. Our details can be found at the end of this document.

We believe this will support our ambition to end the variation that has existed up until now in accessing these services.

We want your feedback to help us make these important decisions that will affect how people gain access to these services in mid and south Essex in the future.

Who can receive these services?

All six of the service areas identified in our review are only funded by the NHS under certain circumstances, which can vary according to where you live.

Doctors will use the criteria in the policies to help decide if a patient would benefit from the procedure and is suitable to undergo the type of care needed.

Sometimes this criteria is based on a group of patients. This is known as **Group Prior Approval** (previously known as threshold approval). Procedures with group prior approval are provided for a specific group of people only, defined through a set of threshold criteria within the commissioning policy, which can be applied at the point of referral, for example, by a GP.

At other times these criteria are applied to an individual. This is known as **Individual Prior Approval**. Procedures are provided for a specific group of people only defined through a set of threshold criteria within the commissioning policy and which requires funding approval on a patient-by-patient and, in some circumstances, on a treatment-by-treatment basis, before the treatment can be provided.

When procedures are **Not Funded** they have been assessed as Procedures of Limited Clinical Value in line with national guidance. These procedures will not be funded unless there are exceptional clinical circumstances. If someone wishes to have one of these procedures, this requires an application to be made using the **Individual Funding Request (IFR)** process, but funding will only be considered where the patient demonstrates clinical exceptionality. 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. Individual Funding Requests are considered by a panel.

In this document, we have set out the criteria we are proposing for each of the six service areas.

How have we developed the proposals?

We looked at the latest clinical evidence and practice for all six service areas nationally and locally, and taken advice from doctors, nurses, and other professionals.

We have engaged with residents and stakeholders to understand what is important for people when we make these decisions. We reviewed the cost of providing these services and the potential consequences of harmonising, because we need to balance the cost of providing these services with the cost of all the other care provided by the NHS in our area.

Looking at our finances, we found:

- The current cost of providing these services is around £1 million.
- We estimate adopting the policies across mid and south Essex will result in an additional annual cost of around £1 - 1.1 million.
- The largest increase in demand would relate to fertility services.

The proposals we have set out mean a greater cost to the NHS as more people would have access to the services than under the current policies.

A key purpose of the ICB is to 'tackle inequalities in outcomes, experience and access'. The updates we are proposing would correct these inequalities, for example, IVF would now be available to eligible individuals across mid and south Essex.

We have assessed potential health inequalities for different groups within society and have surveyed those likely to be impacted including the LGBTQ+ community, working age residents as well as our own staff. In the draft Equality and Health Inequality Impact Assessments (EHIIA) impact on groups of people will guide our engagement and discussions. For example, we will specifically target our engagement resources towards those with a mental health condition or a learning disability, the traveller community, (including Gypsies and Roma) and those from a deprived communities.

What have we already heard?

To help understand people's views on the policies, we conducted an online survey of a representative sample of mid and south Essex residents for 21 days in August 2022. The results were independently analysed.

Two clear and consistent themes from residents were fairness and equity, ensuring that anyone in mid and south Essex should be able to access services.

Affordability for the NHS was also highlighted, as was the need to balance providing services to those on lower income or those with an inability to pay for access to these services.

When it comes to making decisions about access to services, people want there to be greater consideration of the emotional impact of these types of conditions. This was particularly the case for: infertility, dealing with larger and/or uneven breasts, and obesity.

What are the proposals?

The National Institute for Health and Care Excellence (NICE) develops guidelines for health and care services in England. The guidelines are recommendations only and need to be considered within a local context when commissioning services.

In this section, we have set out our preferred options for each of the six service areas in mid and south Essex.

These proposals have taken into account the input of clinicians, and the views of local people, whilst ensuring equity and the affordability of the local NHS.

We did not propose keeping the current policies in place an option as they do not provide fair and equal access for all residents in mid and south Essex.

We have grouped the information according to policy. For each service, we show the proposed policy, key points from the current policy, and the impact of the proposed policy.

The term 'threshold criteria' means what must be in place for patients to qualify for treatment.

proposals

Weight loss surgery (bariatric surgery)

New policy
Group Prior Approval

Recommended threshold criteria:

- ✔ The person has a body mass index (BMI) of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant diseases (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 three service. (A tier three service is a weight management programme that supports adults with severe and complex obesity to lose weight through a range of interventions including psychological approaches and dietary changes).
- ✔ The person is generally fit for anaesthesia and surgery.
- ✔ The person commits to the need for long-term follow-up.

Mid Essex

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Patient has BMI is greater than 35 for at least 5 years with significant co-morbidities (for example type 2 diabetes, hypertension, cardiovascular disease, osteoarthritis, dyslipidaemia and sleep apnoea), OR Patients with BMI ≥ 40 for at least 5 years without co-morbidities.
- ✔ Patient has completed a Tier 3 weight management programme or has kept a 12 month (minimum) diary recording physical exercise undertaken, diet consumed and weight progress which has been reviewed and signed by a registered healthcare professional at least once every 3 months.
- ✔ Cases for surgery to meet Complex and Surgery Obesity Surgery policy.
- ✔ Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ The weight threshold increase could mean that less people in Mid Essex have access to surgery however;
- ✔ The removal of the five-year time requirement may result in more people having access overall.
- ✔ Patients in all areas could have the same BMI threshold - 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant diseases (e.g. type 2 diabetes or high blood pressure) that could be improved if they lost weight.

Basildon and Brentwood

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Surgery offered to adults with BMI of 40k/m2 or more.
- ✔ Surgery only considered for people with morbid obesity who also meet specific criteria.

Impact of proposed update:

- ✔ The change to group approval could mean patients in Basildon and Brentwood no longer need individual prior approval. This may mean that more people have access to the service.
- ✔ Patients in all areas could have the same BMI threshold - 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant diseases (e.g. type 2 diabetes or high blood pressure that could be improved if they lost weight).

Thurrock

Key points of the current policy:

- ✔ Group prior approval.
- ✔ Patients only considered if they meet NHS Complex and Specialised Obesity Surgery.
- ✔ Patients must meet criteria. Those not meeting criteria will only be funded in clinically exceptional circumstances.

Impact of proposed update:

- ✔ No change – patients from other parts of mid and south Essex will now be able to access the surgery at the BMI threshold for already set for Thurrock residents – 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 with other significant diseases (e.g. type 2 diabetes or high blood pressure) that could be improved by weight loss.

Castle Point and Rochford and Southend

Key points from the current policy:

- ✔ Group prior approval.
- ✔ Patients only considered if they meet NHS Complex and Specialised Obesity Surgery.
- ✔ If criteria are not met, surgery is only carried out in clinically exceptional circumstances.

Impact of proposed update:

- ✔ Patients in all areas could have the same BMI threshold - 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant diseases (e.g. type 2 diabetes or high blood pressure) that could be improved if they lost weight.

Correction for uneven breasts (breast asymmetry)

New policy Service provision via **Individual Prior Approval**

Recommended threshold criteria:

The goal of surgery is to correct a significant deformity that 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 bra has not relieved the symptoms, and
- ✔ There is a difference of at least two 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 one year and has reached the end of puberty (referral should be delayed if the end of puberty has not been reached), and
- ✔ Only unilateral breast reduction (not unilateral breast augmentation) will be funded, and
- ✔ This policy does not cover gynecomastia (when boys' and men's breasts swell and become larger than normal).

Mid Essex

Key points of the current policy:

- ✔ This is currently not funded in Mid Essex.

Impact of proposed update:

- ✔ Patients in Mid Essex would be able to access this service if they meet the threshold criteria.

Basildon and Brentwood

Key points of the current policy:

- ✔ This is not currently funded in Basildon and Brentwood.

Impact of proposed update:

- ✔ Patients in Basildon and Brentwood would be able access this service if they meet the threshold criteria.

Thurrock

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Funding will only be considered if there is gross disparity of breast cup sizes on initial consultation with the patient's GP.
- ✔ Patients eligible for surgery if they meet all criteria and confirmed by a consultant plastic surgeon.
- ✔ Procedures for cosmetic purposes only will not be funded.
- ✔ Any post-surgical cosmetic irregularities will not be funded.
- ✔ Only unilateral breast reduction will be funded.
- ✔ Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ Patients would have to be non-smokers to be eligible under the new policy.

Castle Point and Rochford and Southend

Key points from the current policy:

- ✔ Individual prior approval.
- ✔ Funding will only be considered if there is gross disparity of breast cup sizes (two sizes) on initial consultation with the patient's GP.
- ✔ Funding will only be considered if patients meet all criteria and are confirmed by a plastic surgeon. Patients must meet all criteria which also includes a BMI of less than 25kg/m2 and evidence that the weight has been stable for two years.
- ✔ Only unilateral breast reduction will be funded.
- ✔ Procedures for cosmetic purposes only will not be funded.
- ✔ Any post-surgical cosmetic irregularities will not be funded.

Those not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ The BMI criteria would be removed, meaning that more people could access services.

Breast Reduction (making breasts smaller)

New policy Service provision via **Individual Prior Approval**

Recommended threshold criteria:

- ✔ The patient is suffering from neck ache and/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 bra has not relieved the symptoms, and
- ✔ The patient has had persistent intertrigo (inflamed skin caused by friction/rubbing) 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 less than 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.

Mid Essex

Key points of the current policy:

- ✔ This is currently not funded in Mid Essex.

Impact of proposed update:

- ✔ Patients in Mid Essex would in future be able to access this service if they met the threshold criteria.

Basildon and Brentwood

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Surgery is only considered if the patient meets one specific criteria set or there are clinically exceptional circumstances.
- ✔ Patients who have predictable breast changes due to pregnancy are excluded.

Impact of proposed update:

- ✔ The proposal would mean the minimum amount of tissue removal would rise from 500g to at least 1kg. This could mean fewer patients would qualify for the service.

Thurrock

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Patient to meet criteria.
- ✔ Patients who have predictable breast changes due to pregnancy are excluded.

Impact of proposed update:

- ✔ The proposal would mean the minimum amount of tissue removal would rise from 500g to at least 1kg, while anyone with a BMI of less than 27 kg/m2 (rather than the current 25) would be eligible.

Castle Point and Rochford and Southend

Key points from the current policy:

- ✔ Individual prior approval.
- ✔ Patient to meet criteria.
- ✔ Funding will only be considered if patients meet all criteria and are confirmed by a plastic surgeon.
- ✔ Patients must meet all criteria which also includes a BMI of less than 25kg/m2 and evidence that the weight has been stable for 2 years.
- ✔ Patients not meeting criteria not funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ The proposal would mean the minimum amount of tissue removal would rise from 500g to at least 1kg, while anyone with a BMI of less than 27 kg/m2 (rather than the current 25) with weight stable for only one year (rather than the current two) would be eligible.

Female Sterilisation

New policy 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: 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: the woman has mental capacity OR all necessary arrangements have been completed to either support her to a position of having capacity or where appropriate advocacy arrangements are in place, in compliance with the latest capacity guidance.
- ✔ Counselling: she is aware that the procedure is permanent but has a failure rate, that reversal is not funded on the NHS (except via Individual Funding Requests), and that other forms of LARC have a similar success rate, with a lower risk profile. Counselling must also include consideration of vasectomy for her partner where appropriate.
- ✔ BMI: she must have a BMI less than 35, due to increased clinical risk associated with a 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.

proposals

Mid Essex

Key points of the current policy:

- ✔ This is not routinely funded in Mid Essex. Patients are only funded in clinically exceptional circumstances.

Impact of proposed update:

- ✔ Patients would be able to access services if they met the criteria.
- ✔ Mental Health/ Learning disability: criteria clarified around mental capacity, to ensure equality of access for those with impaired capacity.

Basildon and Brentwood

Key points of the current policy:

- ✔ Group prior approval.
- ✔ Patients must meet threshold criteria.
- ✔ Patients not meeting the criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ Patients would have to have a BMI of less than 35kg/m2. This could exclude some patients.
- ✔ Mental Health/ Learning disability: criteria clarified around mental capacity, to ensure equality of access for those with impaired

Thurrock

Key points of the current policy:

- ✔ Currently there is no service restriction - the service is commissioned.

Impact of proposed update:

- ✔ The patient must have a BMI less than 35kg/m2 and consider during counselling the possibility of vasectomy for their partner.
- ✔ Mental Health/ Learning disability: criteria clarified around mental capacity, to ensure equality of access for those with impaired capacity.

Castle Point and Rochford and Southend

Key points from the current policy:

- ✔ Currently there is no service restriction - the service is commissioned.

Impact of proposed update :

- ✔ The patient must have a BMI less than 35kg/m2 and consider during counselling the possibility of vasectomy for their partner.
- ✔ Mental Health/ Learning disability: criteria clarified around mental capacity, to ensure equality of access for those with impaired capacity.

Vasectomy

New policy Service provision via Vasectomy under Local anaesthetic: **Routinely funded**

Vasectomy under General anaesthetic: **Group Prior Approval**

Recommended threshold criteria or Vasectomy under General Anaesthetic:

- ✔ Previous documented adverse reaction to local anaesthesia.

OR

- ✔ Scarring or deformity that distorts the anatomy of the scrotal sac or content making identification and/ or control of the spermatic cord through the skin difficult to achieve.

Mid Essex

Key points of the current policy:

- ✔ This is not currently routinely funded. Funding is only available in exceptional clinical circumstances.

Impact of proposed update:

- ✔ Patients in mid Essex would have the same access as patients in other areas.

Basildon and Brentwood

Key points of the current policy:

- ✔ Group prior approval.
- ✔ Carried out by general anaesthetic on a restricted basis.
- ✔ Other cases referred to primary care providers.

Impact of proposed update:

- ✔ More patients across all areas would have access to this service due to the additional provision for vasectomy under local anaesthetic (routinely funded).

Thurrock

Key points of the current policy:

- ✔ Group prior approval.
- ✔ Carried out by general anaesthetic on a restricted basis.
- ✔ Other cases a referral should be made to a Primary Care Provider.
- ✔ Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ More patients across all areas would have access to this service due to the additional provision for vasectomy under local anaesthetic (routinely funded).

Castle Point and Rochford and Southend

Key points from the current policy:

- ✔ Group prior approval.
- ✔ Carried out by general anaesthetic on a restricted basis.
- ✔ Other cases a referral should be made to a Primary Care Provider.
- ✔ Patients not meeting the above criteria will not be funded unless there are clinically exceptional circumstances.

Impact of proposed update:

- ✔ More patients across all areas would have access to this service due to the additional provision for vasectomy under local anaesthetic (routinely funded).

Tertiary Fertility Services

New policy 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. The transfer of one frozen embryo will be funded for patients who do not achieve a live birth with the fresh embryo transfer. The age of the 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 two 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 one year.
- ✔ **Eligible Couples will be offered:** a maximum of two 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 one 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 GP 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 higher than 30 should be referred to the appropriate obesity management pathway.
- ✔ Men with a BMI of higher than 35 will not be considered for treatment and should be referred to the appropriate obesity management pathway.
- ✔ **Smoking:** Couples must 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. Under recommended criteria, same-sex couples would now be eligible for the same number of cycles as heterosexual couples.
- ✔ **Donor gametes (eggs and sperm):** Up to one batch (usually six) of donor oocytes (immature eggs) and one batch of sperm will be funded. Where more than two 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 and 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.

Mid Essex

Current policy and impacts of the proposed updates:

IVF (in vitro fertilisation)

- ✔ These services are not currently routinely funded in Mid Essex. Funding is only available in exceptional clinical circumstances.

Intra-uterine insemination (IUI)

- ✔ These are currently not funded except under exceptional clinical circumstances, and there would be no change under the new policy.

Donor oocyte (immature egg) donation

- ✔ These are not currently available.

Donor sperm donation/insemination

- ✔ These are not currently available.

Impact of proposed update:

Under the new proposals, patients would have access to the following services

- ✔ IVF (in vitro fertilisation)
- ✔ Donor oocyte donation – under the new policy patients would have access to up to one batch (usually six) of donor oocytes.
- ✔ Donor sperm donation/ insemination - under the new policy patients would have access to these services up to one batch

Basildon and Brentwood

Current policy and impacts of the proposed updates:

IVF (in vitro fertilisation)

- ✔ These services are not currently routinely funded. Funding is only available in exceptional clinical circumstances

Intra-uterine insemination (IUI)

- ✔ These are currently not funded except under exceptional clinical circumstances, and there would be no change under the new policy

Donor oocyte (immature egg) donation

- ✔ These are not currently available.

Donor sperm donation/insemination

- ✔ These are not currently available

Impact of proposed update:

Under the new proposals, patients would have access to the following services

- ✔ IVF (in vitro fertilisation)
- ✔ Donor oocyte donation – under the new policy patients would have access to up to one batch (usually six) of donor oocytes.
- ✔ Donor sperm donation/ insemination - under the new policy patients would have access to these services up to one batch

Thurrock

Current policy and impacts of the proposed updates:

Key points of the current policy:

IVF (in vitro fertilisation)

- ✔ Individual prior approval
- ✔ Criteria/detail in Specialist Fertility Commissioning Policy.
- ✔ Eligible couples will be offered: three cycles of IUI, and/or two full cycles of IVF+/-ICSI.
- ✔ 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
- ✔ The partner who is to receive treatment must be aged between 23 and 39 years old (up to 39 years and 364 days) at the time of treatment
- ✔ 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
- ✔ The female partner should not have had any previous NHS funded attempts at IVF or ICSI and not more than three NHS funded attempts at IUI.
- ✔ Women will only be considered for treatment if their BMI is between 19 and 30Kg/m2). Women with BMI greater than 30 should be referred to the appropriate obesity management pathway.
- ✔ Men with a BMI greater than 35 will not be considered for treatment and should be referred to appropriate obesity management pathway.

Impact of proposed update:

- ✔ Under the new proposals, there would be no change to the number of IVF cycles offered for heterosexual couples under 40.
- ✔ **Same-Sex Couples:** If six cycles of privately funded IUI have been unsuccessful, demonstrating infertility, the couple will be eligible for IVF as above. Under recommended criteria, same-sex couples would now be eligible for the same number of cycles as heterosexual couples.
- ✔ **Age:** The age limit would be increased and where the partner is between the age of 40-42, a maximum of one full cycle (local definition) would be available if criteria are met.

Intra-uterine insemination

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Specialist Fertility Treatment Policy criteria.
- ✔ Couples where both partners are male will not be funded.
- ✔ Funding of assisted conception for single women is not available.
- ✔ Where both partners are female, funding can be provided as long as the relevant criteria are met. Infertility needs to be demonstrated in the partner who is seeking to become pregnant. These couples must also meet requirements for parenthood and that both partners consent to be parents of the child.

Impact of proposed update:

- ✔ Patients in Thurrock would no longer be funded for this service.

Donor oocyte (immature egg) donation

Key points of the current policy:

- ✔ Individual prior approval
- ✔ Specialist Fertility Treatment Policy criteria
- ✔ Funding up to one batch (usually five) of donor oocytes. Where

more than two viable embryos are generated funding is only provided for the transfer of up to two 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.

Impact of proposed update:

✔ Patients in Thurrock would be able to access one batch (usually six) donor oocytes. This is an increase of one oocyte.

Donor sperm donation/insemination

Key points of the current policy:

✔ Individual prior approval.

✔ Specialist Fertility Treatment Policy criteria.

✔ Fund one batch of donor sperm.

Impact of proposed update:

✔ There would be no change - one batch of donor sperm would be funded.

Castle Point and Rochford and Southend

Current policy and impacts of the proposed updates

IVF (in vitro fertilisation) Castle Point and Rochford

Key points of the current policy:

✔ Individual prior approval.

✔ Criteria/detail in Specialist Fertility Commissioning Policy.

✔ For women under 40 years old - maximum of four embryo transfers with maximum of two fresh cycles of IVF. Any previous cycles will count towards the number offered.

✔ For women aged 40 - 42 - limit determined by local area, maximum of two embryo transfers including a maximum of one fresh cycle of IVF.

✔ Service users should have experienced unexplained infertility for three years or more of regular intercourse or 12 cycles of artificial insemination over a period of three years.

✔ Couples who do not meet the criteria and consider they have exceptional circumstances should be considered under the Individual Funding Request.

Impact of proposed update:

✔ No change to the number of IVF cycles offered.

✔ Patients in Castle Point and Rochford could access services after two years of unexplained infertility taking both age and waiting lists into consideration. This is a reduction of one year. Where the partner receiving IVF is 40-42, the period of unexplained infertility would be at least one year.

✔ **Same-Sex Couples:** If six cycles of privately funded IUI have been unsuccessful, demonstrating infertility, the couple will be eligible for IVF as above. Under recommended criteria, same-sex couples would now be eligible for the same number of cycles as heterosexual couples.

IVF (in vitro fertilisation) Southend

Key points of the current policy:

✔ Individual prior approval.

✔ Criteria/detail in Specialist Fertility Commissioning Policy.

✔ Service users should have experienced unexplained infertility for three years or more of regular intercourse or 12 cycles of artificial insemination over a period of three years.

✔ For women less than 40 years old, the policy supports a maximum of two embryo transfers with one cycle of IVF, with or without ICSI, this includes any abandoned cycles. Any previous full IVF cycles, whether self- or NHS-funded, will count towards the total number of full cycles offered. Women up to the age of 40 years and meeting all eligibility criteria will be able to access one cycle of IVF funded by the CCG.

✔ Offer one cycle of IVF to women aged 40-42 years

Impact of proposed update:

✔ No change to the number of IVF cycles offered.

✔ Patients in Southend could access services after two years of unexplained infertility taking both age and waiting lists into consideration. This is a reduction of one year. Where the partner receiving IVF is 40-42, the period of unexplained infertility would be at least one year.

✔ Same-Sex Couples: If six cycles of privately funded IUI have been unsuccessful, demonstrating infertility, the couple will be eligible for IVF as above. Under recommended criteria, same-sex couples would now be eligible for the same number of cycles as heterosexual couples.

Intra-uterine insemination Castle Point and Rochford and Southend

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Criteria/detail in Specialist Fertility Commissioning Policy.
- ✔ Couples who do not meet the criteria and consider they have exceptional circumstances should be considered under the Individual Funding Request.
- ✔ Maximum of six cycles of IUI (as replacement for IVF/ICSI and without donor sperm) will only be offered under exceptional circumstances.

Impact of proposed update:

- ✔ Patients in Castle Point and Rochford and Southend would no longer be funded for this service.

Donor oocyte (immature egg) donation Castle Point and Rochford and Southend

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Egg donation where no other treatment is available - The patient may be able to provide an egg donor; alternatively, the patient can be placed on the waiting list, until an altruistic donor becomes available. If either of the couple exceeds the age criteria prior to a donor egg becoming available, they will no longer be eligible for treatment.
- ✔ This will be available to women who have undergone premature ovarian failure before the age of 40 years or to avoid transmission of inherited disorders to a child where the couple meet the other eligibility criteria.

Impact of proposed update:

Patients will have access to one batch (usually six) of donor oocytes and one batch of sperm will be funded. Where more than two viable embryos are generated, up to two transfers will be funded in line with the rest of the policy. This means that patients no longer have to find an egg donor or be placed on a waiting list for an altruistic donor.

Donor sperm donation/insemination

Castle Point and Rochford

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Funded up to the same number of cycles of IVF.
- ✔ Donor insemination is funded up to a maximum of six cycles of Intrauterine Insemination (IUI).

Impact of proposed update:

- ✔ Patients would have access to one batch of donor sperm. Removal of IUI services across mid and south Essex could mean patients will not be able to access this service.

Southend

Key points of the current policy:

- ✔ Individual prior approval.
- ✔ Donor semen is used for same sex couples as part of IVF/ICSI treatment.
- ✔ A maximum of six cycles of IUI (as a replacement for IVF/ICSI and without donor sperm) will only be offered under exceptional circumstances.
- ✔ Funded up to the same number of cycles of IVF for women younger than 40 years - a maximum of four embryo transfers with a maximum of two fresh cycles of IVF.
- ✔ For women aged 40-42 years, NHS treatment limit will be determined by local CCG up to maximum of two embryo transfers, including a maximum of one fresh cycle of IVF.

Impact of proposed update:

- ✔ Patients would have access to one batch of donor sperm with no change to the number of IVF cycles offered.
- ✔ Removal of IUI services across mid and south Essex could mean patients would not be able to access this service

proposals

What happens to those currently receiving treatment?

All patients accessing treatment, or those who start treatment under the current policies, will continue to be entitled to the eligibility criteria within each policy for the area in which they live.

Once this consultation is complete and the new policy is agreed upon, the new criteria will be applied to all new referrals for treatment.

How will a decision be made?

When the public consultation closes on 19th December 2022, a report will be written which brings together all the feedback received during the consultation and independent analysis of the public feedback will be carried out.

This report will then be shared with the Mid and South Essex Integrated Care Board. At a meeting held in public, the Board will consider the views of the public when they are asked to decide what the final criteria are for each of the six service areas and to agree on a single policy. The ICB Board meeting will take place on Thursday 9th February 2023 and any agreed service changes will take affect from 1st April 2023.

How can I give my views?

We would like to hear your views on the proposals for each service area. The easiest way is to complete the consultation survey at **www.midandsouthessex.ics.nhs.uk/get-involved/how/consultations/**.

We are also happy to receive your views by:

Email: mseicb.getinvolved@nhs.net

In writing: NHS Mid and South Essex ICB, Phoenix Court, Christopher Martin Road, Basildon, Essex, SS14 3HG.

You can also attend to one of our in-person discussion events below. To register visit **www.midandsouthessex.ics.nhs.uk/events** or call **01268 594350**.

Location	Date	Timing
The Beehive, Voluntary and Community Resource Centre, West Street, Grays, Essex, RM17 6XP	9th Nov	6:30 - 8:00pm
Witham Public Hall Collingwood Rd, Witham CM8 2DY	10th Nov	5:00 - 6:30pm
The Place, Pitsea Leisure Centre, Northlands Pavement, Pitsea, Basildon, Essex SS13 3DU	22nd Nov	6:30 - 8:00pm
The Forum Southend Elmer Square, Southend-on-Sea, Essex SS1 1NS	24th Nov	5:30 - 7:00pm
Online event via Zoom – details provided when you sign up	30th Nov	7:00 – 8:30pm

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Mid and South Essex Integrated Care Board, 17 November 2022

Agenda Number: 15

BASILDON AND BRENTWOOD INAURURGAL ALLIANCE COMMITTEE UPDATE

Summary Report

1. Purpose of Report

To provide the Board with an overview of the progress to date in the establishment of the Basildon and Brentwood Alliance, its governance and place and partnerships strategy and priorities

Pam Green, Basildon and Brentwood Alliance and Director, MSE ICB

2. Report Author

Pam Green with Support from Simon Williams, Deputy Alliance Director, Basildon, and Brentwood.

3. Responsible Committees

This has been circulated for members of the Alliance Committee for approval.

4. Link to the ICB's Strategic Objectives

The Alliance committee's content and aims to meet the ICB's Objectives to

1. **Reduce health inequalities** – through the deployment of health inequalities funding and the development of an
2. **Create opportunities, supporting education and local employment** – specific jobs opportunities and inclusive recruitment programme agreed as well as partners Economic Development
3. **Support health and wellbeing, through prioritising prevention, early intervention, and self-care** – embedded in the Integrated Neighbourhood Teams (INTs) with the support of the voluntary sector and public health to ensure a hyperlocal response
4. **Bring as much care as is safe and possible closer to where people live** – this is the equally the aim of the INTs and Primary care Networks with the
5. **Improve and transform our services -** Alliance focus is on the transformation and sustainability of primary care and the transformation of services around Primary Care Networks (PCNs)

5. Financial Implications

No Budget implications

Break down of allocation of the NHSE Health Inequalities funding.

Awareness raised that the Alliance Committee would be responsible for the ratification and sign off the Basildon and Brentwood Better Care Fund (BCF) and the Improved BCF

6. Details of patient or public engagement or consultation

No public engagement undertaken at this stage, though Healthwatch are a partner in the Alliance and will be presenting the citizen voice in all discussions. Specific engagement will be undertaken on any projects and strategic development

7. Conflicts of Interest

Simon Johnson of Basildon, Billericay, and Wickford Community Voluntary Sector (BBWCVS) who was present at the meeting, rightly declared his interest in the community asset mapping initiative. Simon's conflicts were recorded and register of interests is being populated for the Alliance. Regarding the Community Asset mapping project this will be run through an open light touch procurement process and no preferential information was disclosed at the meeting nor were any of the procurement paperwork shared with the committee.

8. Recommendation/s

The Board is asked to note the contents of this paper and note the progress made to date in the Basildon and Brentwood Alliance to date and the strategic direction to tackle the most significant health inequalities gap in the MSE geography.

Basildon and Brentwood Alliance Update

1. Introduction

Prior to the commencement of the new Integrated Care Board (ICB) and the NHS white paper for reform and integration became statute on 1 July 2022, the place of Basildon and Brentwood had not established an Alliance Committee anything past the conceptual basis of working together and starting to discuss a local all age strategy based on the Livewell Approach. This report details the progress thus far on partnerships, governance, strategy, primary care, health inequalities funding deployment and community asset mapping approach. The local place-based leadership of the ICB have been in place since 1 August 2022 and we are grateful to partners and staff mobilising this change of approach so quickly.

The inaugural Basildon and Brentwood Alliance Committee was held on 25 October 2022 at the Brentwood Council Chambers. Thanks must go to Jonathon Stephenson, the Chief Executive of Brentwood Borough Council, and team for hosting the Alliance. The location of the meeting will be rotated around the geographical area in future.

It was also agreed at the meeting that formal meetings would be every other month (Bimonthly) and in the intervening month there would be a programme of development sessions for the place level integrated leadership.

There has been good feedback from partners following the first meeting that the approach felt different and fitting to the challenges seen in the population health and wellbeing data and continued support to the Alliance way of working. There was a clear shared purpose to tackle the health inequalities experienced by the residents of Basildon and Brentwood through a focus on the wider determinants of health approach.

2. Main content of Report

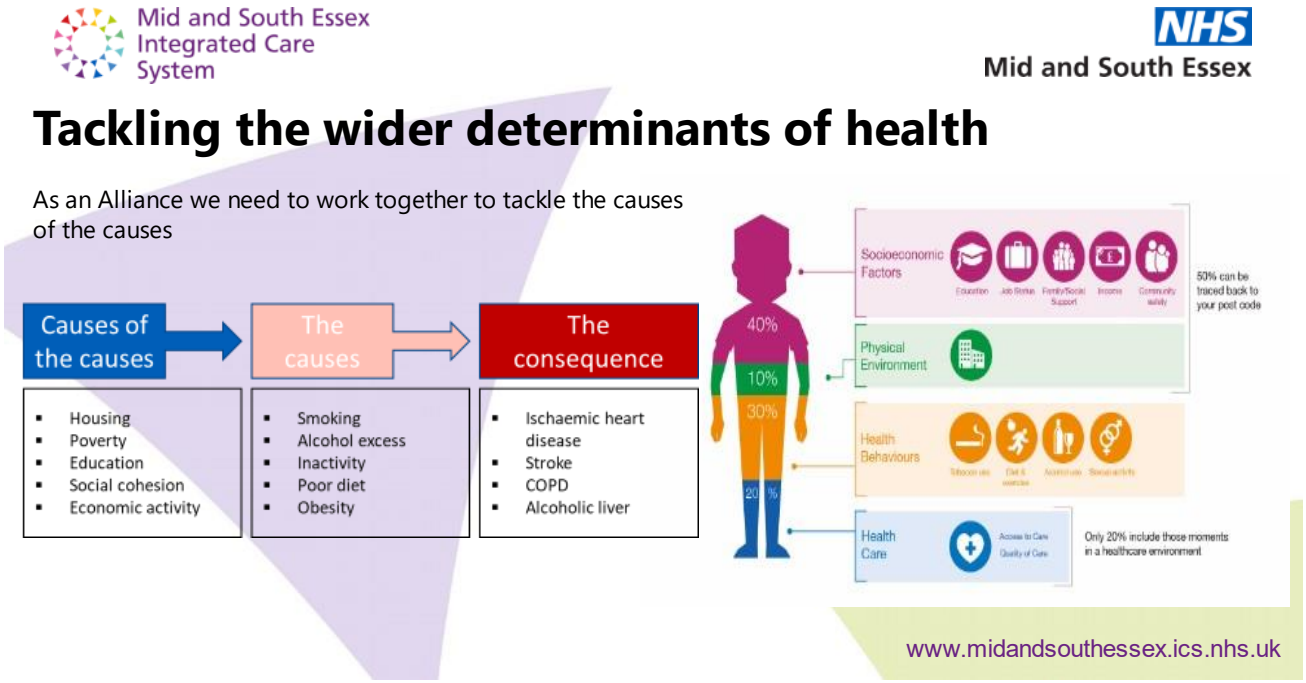
The Main items on the agenda were as follows

1. Terms of Reference
2. The Integrated Care System/Board (ICS/ICB), Alliance and Live Well Strategy
3. Alliance Governance and Sub-structure
4. Community Asset Mapping
5. Integrated Neighbourhood Teams
6. Primary Care Position and Actions
7. Alliance Wide Communications Function – Carrier forward to next meeting
8. Health and Care Academy, support for skills and work readiness
9. Health Inequality Funding

The Integrated Care System/Board (ICS/ICB), Alliance and Live Well Strategy

A summary of the MSE ICB structure was given and the local all age strategy was presented and agreed by the committee.

Very influential in the thinking is the Robert Wood – Johnson theory of the wider determinants of health. The Basildon and Brentwood Alliance to date has been designed with an Asset Based Community Development (ABCD) approach, heavily influenced by Cormac Russell's theory on community develop and authentic and meaningful engagement with citizens.



The live well all age strategy was proposed and agreed by the committee. It is important to the six demand areas will have a domain lead from the wider system and these leaders will become a peer to support the approach and the collaborative leadership to the system as subject matter experts and those that have influence on organisational resources.

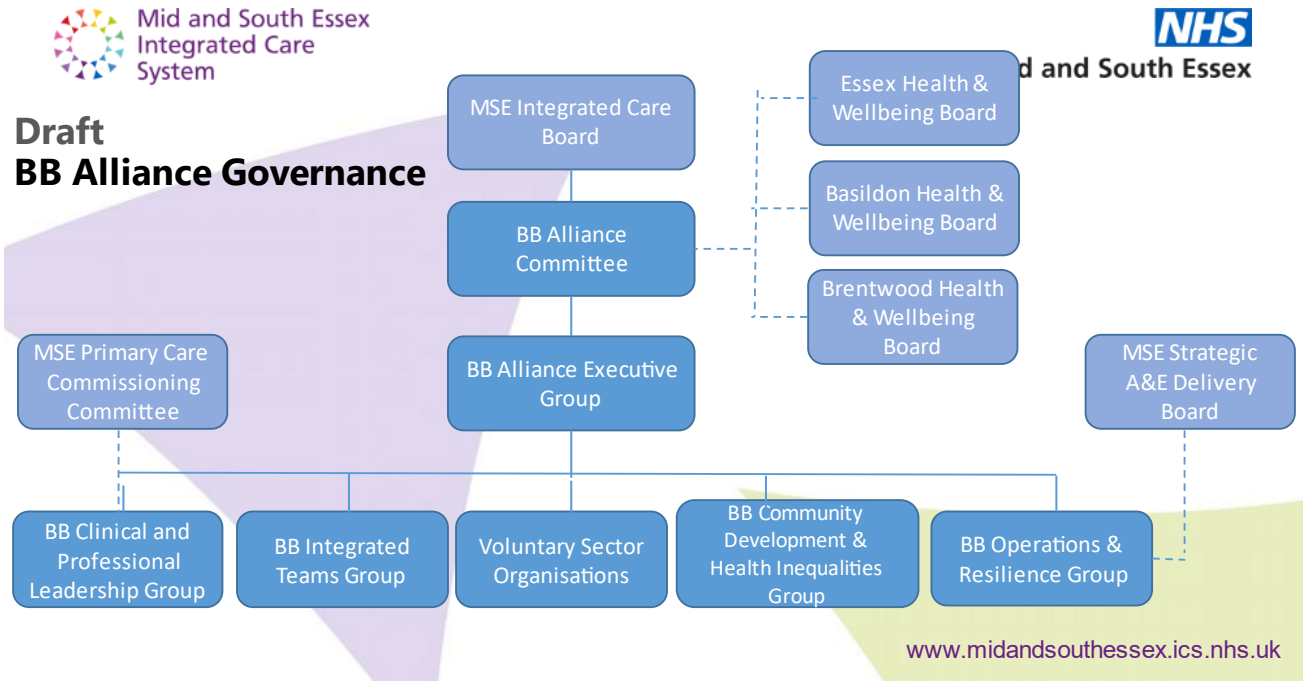
The change methodology that will be implemented will be Outcome Based Accountability (OBA) Framework to support the development of true system outcomes where all partners can see their contribution to a common purpose, adding the value and create much greater visibility of system wide intelligence to support good decision making.

OBA was trialled with the Start Well engagement event work shop and it worked very well and will be used for all further domain discovery workshops

System leaders requested that as an Alliance there is a coordinated approach to all partners data and intelligence, public health colleagues agreed to lead on this work. The same ask was made of the communications resources across partners to be coordinated the alliance progress and strategy. Further development of these intentions will be presented to a subsequent committee meeting.

Alliance Governance and Sub-structure

The alliance governance and substructure were agreed on the condition of the addition of the domain leadership group. Leaders agreed to populate this Alliance sub-structure to ensure we have good governance pathways.



Community Asset Mapping

(Simon Johnson from BBWCVS – declared his interest in this item)

As a new integrated partnership system in Basildon and Brentwood, that is adopting the ABCD approach to working with communities and people as well as partners and the staff we employ. It is essential that there is comprehensive community asset mapping to protect and raise the profile of the micro infrastructure of our communities, to enable moral investment into our community assets to matches the needs of the local population in a sustainable way and to enable the foundation of social prescribing to navigate all community assets with a rich narrative around them.

The advice gained from the ICB procurement partner - Attain indicated that we must go through an open and transparent procurement process to appoint an organisation/agency/individual to undertake the work

The full process was outlined but the documents were not shared at the meeting to avoid preferencing organisations over others.

The Alliance committee agreed to progress with an open and light touch procurement process for comprehensive asset mapping for Basildon and Brentwood

Integrated Neighbourhood Teams

The Committee considered the concept of Integrated Neighbourhood Teams, the national direction of travel, local work and the benefits to our residents and staff in working this way.

The government directive for integration in health and social care

Health and social care integration: joining up care for people, places and populations

https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

Next steps for integrating primary care: Fuller Stocktake report
https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/

www.midandsouthessex.ics.nhs.uk

What is an Integrated Neighbourhood Team ?

Integrated Neighbourhood Teams (INT) bring together different teams / organisations/ individuals that can support with physical, mental health and social care needs.

Teams work along side General Practices within a locality to provide a single coordinated response for people, families and carers.

We want our residents to live healthy, resilient and independent lives, with simple access to support and care when needed as close to home as possible. Allowing people in our communities to experience health and wellbeing outcomes that matter to them.

www.midandsouthessex.ics.nhs.uk

The Alliance Committee agreed with the proposed direction of travel and to disseminate this way of working within individual organisations. There was also agreement to undertake some Organisational Development to support and embed the cultural change required to work in this way. Also agreed to further develop the model in one neighbourhood with ambition to roll out across the whole area. Plans to be shared at next meeting.

Primary Care Position and Actions

The Alliance Committee received a report which provided an update on the current position in primary care and proposed areas of focus over the next few months.

Key points included:

- Update on Additional Roles Reimbursement Scheme (ARRS), a centrally funded scheme designed to allow Primary Care Networks to create multi-disciplinary teams and create more capacity in primary care
- ARRS allocation is approximately £4.6million for Basildon and Brentwood for 2022-23
- To date 84 additional staff recruited through the scheme across a range of 15 professions
- A small increase in the number of GPs in the area since 2015 (increase of 22)
- 64% of GP appointments delivered face to face (slightly below national average)
- Percentage of patients receiving an appointment on same day or within 2 weeks for non-urgent is higher than national average
- Recognised that patients are struggling to access primary care and can be left waiting on the phone for long periods even though there are more appointments available

The following areas were discussed as priorities to be taken forward with immediate effect:

- Better use of telephony systems and online services
- Promote ARRS roles to our residents and health and care professionals
- Consider rise in paediatric attendances
- Target low uptake groups for flu and COVID vaccinations
- Increase number of NHS Health Checks
- Greater understanding of high intensity users (those visiting A&E more than 10 times per year)
- Develop Integrated Neighbourhood Teams and make best use of combined resource

These actions will be taken forward in collaboration with Alliance partners.

Alliance Wide Communications Function – Carrier forward to next meeting. However, there was a very clear ask for Alliance level communications

Health and Care Academy, support for skills and work readiness

The Alliance committee heard from the Health and Care Academy (HCA) lead about the function of the HCA and its remit to improve the recruitment into the Health and Care vacancies that we currently see, to inspire and support young people to consider a career in Health and Care and for adult learners to consider a career change, return to work or enter the workplace and support them. There is a real opportunity to address equitable recruitment through this initiative, to view having meaningful employment as a health intervention and address the fears and lack of trust for those that have experienced worklessness.

Health Education England (HEE) support Health Care Academies, however the beauty of the work is that it can work with other partners recruitment initiatives to offer an alliance-based careers service. This approach enables us to work more seamlessly with partners like the universities, adult learning services, Essex wide Skills team and schools.

The committee heard from two organisations to support internships and work placements for those experiencing autism disorders and children from deprived areas to access workplace opportunities.

With regard to the specific ask of the committee by Project Choice and Career Ready, multiple Alliance partners offered opportunities and these wider determinants of health approach was warmly welcomed. Rachel Sestak – HCA Lead is to follow up with all partners.

Health Inequality Funding

Alliance based processes for Health Inequalities Fund 2022/23:

- Principle of subsidiarity applied, with local Alliances based processes
- 48 bids received, totalling >£2m
- Above objectives applied and worked through by Pam Green (B&B Alliance Director), Simon Williams (B&B Deputy Alliance Director), Sarah Hurst (Transformation Officer) and Maggie Pacini (Essex County Council, Public health)
- £540,000 allocated: Approximately £340k for Mental Health and Wellbeing, £75k for increasing physical activity, £75k for social prescribing in children, £50k dementia
- Age range: Approximately £345k targeted for all ages, £135k specifically for children and young people, £60k specifically for adults
- Geography: Approximately £283k specifically for Basildon, £50k each for Brentwood, Wickford, and Billericay. Remainer for schemes that work across all

The schemes are awaiting final ratification by the MSEICB inequalities team, and a list of successful bidders will be brought to the next board. Successful and unsuccessful bidders will be written to by the Alliance Director

3. Findings/Conclusion

The document is designed to provide an update to the Board to progress in Basildon and Brentwood Alliance as a sub-committee of the ICB

4. Recommendation(s)

No further action required this paper is for noting and for assurance of progress on integration at place level.

Part I ICB Board meeting, 17 November 2022

Agenda Number: 16.1

Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee, 11 August 2022
- Clinical and Multi-Professional Congress (CliMPC), 29 September 2022.
- Finance & Investment Committee (FIC), 9 November 2022.
- System Oversight and Assurance Committee (SOAC), 9 November 2022.
- Primary Care Commissioning Committee (PCCC), 22 September 2022.

2. Chair of each Committee

George Wood, Non-Executive Member and Chair of Audit Committee.
Dr Ronan Fenton, Medical Director and Chair of CliMPC.
Joe Fielder, Non-Executive Member and Chair of FIC.
Anthony McKeever, Chair of SOAC.
Sanjib Ahluwalia, Chair of PCCC.

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 above committee meetings.

Minutes of the Audit Committee Meeting

Held on 11 August 2022 at 9.00 – 11.30 am

Via MS Teams

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB - Chair
- Peter Fairley (PF), Partner Board Member, MSE ICB

Other attendees

- Dawn Scrafield (DS), Chief Finance Officer MSEFT & Interim Director of Resources, MSE ICB
- Jennifer Kearton (JK), Director of Finance Operations & Delivery, MSE ICB
- Mike Thompson (MT), Chief of Staff, MSE ICB
- Nicola Adams (NA), Deputy Director of Governance & Risk, MSE ICB
- Sara O'Connor (SOC), Head of Governance and Risk, MSE ICB
- Jane King (JKi), Governance Lead (Minute Taker), MSE ICB
- Paula Saunders (PS), Incident Management Team, MSE ICB (Item 8 only)
- Iain Gear (IG), Head of Information Governance, MSE ICB
- Colin Larby (CL), Deputy Head of Audit and Assurance, WMAS
- Jamie Phillips (JP), Security Management Specialist & Counter Fraud Officer, WMAS
- Emma Larcombe (EL), Director, KPMG LLP
- Nathan Ackryod (NAc), External Audit Manager, KPMG LLP

Apologies

- Eleni Gill (EG), Lead Counter Fraud Manager, WMAS

1. Welcome and Apologies

GW welcomed everyone to the first Audit Committee meeting of the Mid and South Essex Integrated Care Board (MSE ICB) and set out his vision and expectations for the Committee. Introductions took place and 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

GW 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.

There were no declarations raised.

3. Minutes and Action Log

The following Audit Committee minutes were received:

- Mid and South Essex CCGs Audit Committees in Common meeting – 20 May 2022
- Basildon and Brentwood CCG Audit Committee – 28 June 2022
- Castle Point and Rochford CCG Audit Committee – 28 June 2022
- Mid Essex CCG Audit Committee – 28 June 2022
- Southend CCG Audit Committee – 28 June 2022
- Thurrock CCG Audit Committee – 28 June 2022

The Action Log was reviewed and noted that all actions were complete.

Resolved: The minutes of meetings listed above were noted.

4. Audit Committee Terms of Reference

NA advised that comments had been received from the internal auditors regarding the membership and quoracy of the Audit Committee set out in the Terms of Reference (ToR). NA reminded the Committee that any revisions to the ToR would need to be taken back to Board for approval.

GW commented that the intention was to recruit an Associate Non-Executive Member (NEM) to provide the required attendance and level of quoracy to the Audit Committee. MT asked the auditors for their thoughts on the independence or status of an Associate NEM vs other members of the Committee in order to provide clarity and proceed appropriately.

CL expressed concerns regarding the current number and balance of members set out in the ToR and highlighted the requirement to ensure Non-Executive representation on the Audit Committee, and therefore reflected on the ICB Board. CL pointed out there were

three members on the Audit Committee and the Chair was the only Non-Executive ICB Member. The ToR referred to the possibility of appointing a Vice Chair, either someone not on the ICB or a partner member, which raised concerns regarding independence of that member.

CL advised that a committee membership benchmarking exercise had been undertaken against other ICB Audit Committees and agreed to share the findings with GW and MT for their consideration.

Action: CL to share ICB Audit Committee membership benchmarking findings with MT and GW.

MT enquired whether an additional Associate NEM would fulfil the need for independence or whether this would be an area of concern as they were not intended to be a member of the Board, although they were likely to attend the Board meetings. MT highlighted that the ICB was keen to make the most of the flexibility afforded to ICBs to be able to appoint people who were not members of the ICB.

CL accepted that that person acting on the Audit Committee would be independent and objective but would question whether they represent the ICB at Board level.

DS highlighted that the Chief Finance Officer / Director of Resources were both attendees of the Audit Committee and Board Members therefore would provide a direct link between the two. Additionally, the Partnership Board played a dual role in providing assurance across ICB and System, so there would be three people that were of the System governance and ICB governance. DS reiterated the need to develop the ICS in the spirit of collaboration and integration of a system and accepted that work was required to achieve this.

GW and MT agreed to have further discussion around Audit Committee membership to ensure appropriate independence advised they would take the matter to the Board for discussion.

Resolved: The Committee Noted the Audit Committee Terms of Reference and the proposed change to enable an associate non-executive committee member.

Action: GW and MT to have further discussion regarding Audit Committee membership to ensure appropriate independence and take to the Board for discussion.

Action: NA to expand ToR to include participation of an associate non-executive member.

5. Audit Committee Workplan

NA highlighted that the Audit Committee Workplan was an iterative process and would be updated accordingly to discharge Committee business. NA invited comments.

EL advised that the Annual Audit Report, alongside ISA260, replaced the Annual Audit Letter.

GW suggested that in future, additional focus may be required in particular areas now the organisation was an ICB and would welcome direction from the auditors.

CL requested the approval of the Internal Audit Plan and Fraud Annual Report was moved from May to March and that the ISA 260 reference was not appropriate.

Resolved: The Committee Noted the Audit Committee Work Plan

Action: Update Audit Committee Workplan in line with suggestions provided by Committee.

6. Board Assurance Framework

SOC explained that the final Risk Register of the CCGs was being updated while the new ICB register and framework arrangements were further developed with the first iteration of the new BAF to be presented to the October Board. SOC advised that a Risk Management computer system was under consideration which, amongst other benefits, would enable managers and staff to access and manage risks at a local level.

MT confirmed that a Board seminar covering the BAF and top organisation risks would be arranged and would provide members with the opportunity to share their views before the October Board meeting. MT explained that a key role of the Senior Leadership Team (SLT), was the management of risks and maintenance of the risk register and was closely linked to the Executive Team.

PF emphasised the need for the Board to have visibility of wider risks across the System, for example the care market sat with the Local Authority but could directly or in directly impact the ICB.

GW felt the BAF should be an agile document available across the organisation, without the need for creating separate reports, and should allow people to have clear access to their risks and associated responsibilities. GW emphasised the need to identify the top risks as soon as possible and suggested the BAF was shared with Audit Committee and Local Authority colleagues to ensure alignment across the System before presentation to the October Board.

Resolved: The Committee Noted the Board Assurance Framework update.

Action: SOC to share the new BAF with Audit Committee prior to presentation to Board in October.

Action: NA to draft email for PF to send to counterparts at Thurrock Council and Southend Council to explain the Audit Committee's suggestion for Local Authorities to share key risks with the ICB to assist with the risk management process across the system.

7. Predecessor CCGs Annual Reports and Accounts

NA advised that NHS England had issued the 2022/23 Annual Report and Accounts timetable and guidance which confirmed that annual report and accounts were required for all five predecessor CCGs. NA highlighted that the risk this presented would be around changing organisational structures which may result in difficulties in producing the information required for the Annual Report and Accounts process.

JK confirmed the ICB had not inherited any financial delivery risks from the predecessor CCGs during the first three months of the 2022/23 financial year.

GW voiced concerns the impact of producing reports for each CCG would have on staff and stressed the importance of supporting staff and encouraged a light touch be undertaken wherever possible. GW noted the ICB and CCG reporting timetables were similar and enquired whether the ICB had adequate resources if they were planned for the same time.

JK was comfortable that the annual reporting process could be resourced effectively and confirmed the audit would cover a full 12 month period (CCG and ICB accounts). The CSU had supported the three month reporting period and some of those staff were expected to come into the ICB, therefore corporate and background knowledge would be retained to support the auditors.

Resolved: The Audit Committee Noted the update on Predecessor CCGs Annual Reports and Accounts

8. Emergency Preparedness Resilience & Response (EPRR) Quarterly Report

PS reported that NHS England had categorised the ICB as a Category One responder however, as NHS England had delegated the majority of Category One responsibilities to CCGs during Pandemic response and so this change would not have a huge operational impact. Prior to the formation of the ICB, the Emergency Planning Team undertook a series of transition checklists mandated by the NHS England national team which received positive feedback from the NHS regional team.

Following the publication of the 2022/23 EPRR NHS Core Standards for commissioners and providers, the EPRR Team have requested that the ICB and their commissioned providers undertake an initial self-assessment against the standards relevant to their own organisation. PS advised that NHS England had also included Primary Care in the Core Standards.

PS advised there were no issues to escalate to the Committee.

GW enquired whether PF felt there were any issues the ICB and local authorities in Essex, Southend and Thurrock should focus on. PF observed that the paper clearly set out emergency planning arrangements but enquired whether consideration had been given to whether the processes work as robustly as they should and was there assurance that adequate capacity and resilience would be available for a next incident. Given the infrequency of meetings, PF questioned how the Committee would get assurance that robust processes were in place.

PS explained that the ICB was a key member of the Essex Resilience Forum and Local Health Resilience Partnership and worked very closely with all three local authorities. PS offered to provide a more detailed overview of how the organisations link in on EPRR matters, if required by the Committee.

GW suggested it would be helpful to identify the risks and weaknesses the ICS may face in respect of winter pressures, acute and primary care services, and care home staffing for the next Audit Committee.

CL was able to offer assurance that a review of EPRR and Business Continuity Planning was scheduled for Q3 in the internal audit plan.

Resolved: The Audit Committee Noted the Emergency Preparedness Resilience and Response Quarterly Report.

Action: EPRR Team to identify the risks and weaknesses the ICS may face in respect of winter pressures, acute and primary care services, and care home staffing for the next Audit Committee.

9. Information Governance (IG) Quarterly Report

IG confirmed that mid and south Essex CCGs Data Security Protection Toolkit (DSPT) requirements were met by all predecessor organisations.

As a Category One responder, the ICB was required to evidence a Category One DSPT, consequently, there was an increase in the number of mandatory assertions that must be complied with. An action plan was in progress in order to achieve necessary standards.

The report outlined the future management of IG across the Integrated Care Board and Integrated Care System. It was noted there was a very low breach rate for CCG FOIs and no breaches had occurred for the ICB.

The Senior Information Risk Owner (SIRO) role had been assigned to the ICB Director of Resources and the responsibilities of Caldicott Guardian to the Executive Chief Nurse. The Information Governance Steering Group was in the process of being set up, as well as a monthly ICS Information Governance working group.

IG advised that Data Protection Compliance Management software system was being considered for the ICB. The system would be particularly beneficial for the management of information assets which was an outstanding recommendation from the last Information Governance audit. IG confirmed that all outstanding audit recommendations from 2020/21 would be revisited and, with the support of the software system, was expected to be able to address and close down the recommendations.

The ICS recently undertook a Cyber benchmarking exercise to review Information Governance and IT processes across the system to identify good practice and gaps. The Information Governance team were supporting six remaining GP practices within MSE who were yet to submit their DSPT.

GW expected the outstanding audit recommendations to be implemented as quickly as possible across the organisation.

Resolved: The Audit Committee NOTED the Information Governance Quarterly Report.

10. Draft Internal Audit Plan and Internal Audit Charter

Draft Internal Audit Plan

CL advised that Audit Plan guidance from NHS England and discussions with the Executive Team helped form the proposed Internal Audit plan for 2022/23 which covered Governance, Quality, Performance and Contracting, Finance, Information Management & Technology, Workforce, and mandated reviews.

The proposed plan was previously shared with the MSE CCGs Audit Committees in Common where it was requested that the Mental Health Review was brought forward.

DS remarked that, as the ICS matured, consideration would be required in relation to integration opportunities and to identify where assurance begins and ends, particularly in respect of integrated roles and management of delivery and costings.

GW and PF both agreed that a number of audit areas are likely to cut across both the ICB and Local Authorities, for example the safeguarding children audit, therefore would be worth reaching out at the scoping stage to avoid duplication. GW emphasised that work on safeguarding children should be undertaken sooner rather than later.

CL acknowledged that a protocol for joint working with local authorities needed to be developed and was keen to connect with the local authority internal audit providers to explore how the organisations can work together.

GW noted that the Equality, Diversity and Inclusion (EDI) review was scheduled for 2024/25 and enquired whether DS would ask the Executive Team that, given the latest staff survey results highlighted a need for significant improvement, whether they were comfortable to leave the review for couple of years or bring it forward.

DS agreed the timing of the EDI audit could be reviewed. DS was confident that the EDI agenda actions were underway and, if the scope of the audit was about the effectiveness and delivery of the plan, then a period of time would be required before assessment took place but if the purpose of the audit was to ensure appropriate arrangements were in place, the review could be brought forward. DS highlighted that although the prioritisation of audits was a decision for the Executive Team, she suggested the Audit Committee clarify what assurance was required before the Executive Team can review the timing.

GW suggested that the People Board should be advised of the challenge from the Audit Committee on timing and consider whether they were satisfied with the EDI actions undertaken and if comfortable with the timing of the audit.

In response to the enquiry from PF, CL explained that regular follow-up on the implementation of recommendations were undertaken and included in the Progress Report, particularly on high and medium priority recommendations. Requirements for a formal follow-up audit following a poor outcome would be discussed with Management and the Audit Committee and could be resourced out of contingency, if necessary. CL highlighted that the strategy included in the plan for years two and three was indicative only and would change to align with ICB risks as they occur.

GW stressed that he wanted all Audit recommendations to be progressed as a priority.

DS suggested taking the feedback from the Audit Committee around the timing and pace of audits to the Executive Team in order to consider and challenge themselves on whether the timing and pace of audits was appropriate. If appropriate, CL would be invited to attend the Executive Team meeting.

GW suggested it would be useful for the local authorities to share their internal audit plans with CL.

Action: MT to schedule discussion with ICB Executive Team around timing and pace of Audits and potentially invite CL to attend a discussion with ICB Executives.

Action: PF to share Local Authority Audit Plan with CL.

Action: NA to draft email for PF to send to counterparts at Thurrock Council and Southend Council to explain the Audit Committee's suggestion to share internal audit plans with the ICB internal auditors.

Audit Committee Charter

CL explained that the Audit Committee Charter was a key requirement of the Public Sector Internal Audit Standards and required approval by the Audit Committee. CL invited comments on the Audit Committee Charter from members. No comments were received.

GW reiterated his request that where issues were raised, commentary on the impact on the population should be clearly included.

Resolved: The Committee Noted the Draft Internal Audit Plan and Supported the Internal Audit Charter.

11. Internal Audit Progress Report and Follow-up of predecessor CCG Audit Recommendations

CL proposed that future ICB progress reports would contain details on the implementation progress, summary of assignments, full detailed report of any audits receiving a 'requires improvement' or 'insufficient' opinion and a summary of works undertaken since the last Audit Committee. A summary of works undertaken since 1st July 2022 was included in the latest report.

The report contained the follow up and audit tracker which detailed the carried forward recommendations from the predecessor CCGs. CL confirmed the internal audit team were working to get updates on progress of the implementation of recommendations.

GW expressed frustration with repeat follow-up or inactions on outstanding recommendations and asked for CL to liaise with respective Executive Officers in between Audit Committees to get outstanding recommendations resolved as a priority.

Resolved: The Committee Noted the Internal Audit Progress Report and Follow-up of predecessor CCG Audit Recommendations.

12. Counter Fraud Annual Work Plan and Progress Report

It was noted that the ICB had received one referral in relation to a contractor undertaking work for another organisation during the same period. The matter was investigated and found to be a contractual issue rather than fraud therefore referred back to the contractor to look into.

Fraud and security updates had been disseminated via the staff newsletter and intranet. Two fraud notices had been issued since last Audit Committee but neither affected the ICB. In response to the concerns raised by GW regarding the low number of fraud referrals received, JP agreed that awareness and promotion would be beneficial to illicit referrals.

DS agreed and added that there was opportunity to refresh fraud awareness using the new ICB branding and via Primary Care and CHC arrangements. CL added that nationally the number of referrals within commissioning bodies was considerably lower than provider bodies.

GW enquired whether there was a need for staff to undertake fraud awareness refresher training. JP advised that there were plans to run fraud awareness training for staff and that training was automatically included on the induction programme for new staff. JK agreed to discuss fraud awareness training requirements with the ICB Senior Leadership Team (SLT).

CL highlighted that the Counter Fraud appendix set out boundaries of jurisdiction for investigation on fraud matters.

Resolved: The Committee Noted the Counter Fraud Annual Work Plan and Progress Report.

Action: JK to discuss fraud awareness training with Senior Leadership Team and link in with EG and JP to take forward.

13. Security Management Progress Report

JP advised that the Security Management Service was new to the ICB, and a draft plan was in the early stages of development. An introductory meeting was scheduled with MT and NA to discuss future plan requirements.

GW stressed the importance of prioritising a review of lone working arrangements in order to ensure those staff were appropriately supported. JP noted comments made by GW.

CL advised that, as part of transition due diligence, the Lone Worker Policy was reviewed as it was developed. GW explained he was more concerned that the organisation adhered to the policy and the practicalities of lone working.

Resolved: The Committee Noted the Security Management Progress Report.

14. External Audit Update

NAc confirmed the audit opinions for the five predecessor CCGs were signed on 30 June 2022 and Annual Audit Reports issued. One significant deficiency was raised around the accruals process which was detailed in full in the progress report. Planning work was due to commence for the three month predecessor CCG audits, as well as for the nine month ICB audit.

DS was supportive of the audit plan set out by KPMG and confirmed there was a strategy to ensure capacity and corporate knowledge was retained and stressed that good communication and forward planning was crucial to the process.

Resolved: The Committee Noted the External Audit Update.

15. Finance Risks by Exception

DS explained the purpose of the Finance Risks by Exception paper was to alert the Audit Committee of the framework approach and discussions with risk colleagues to ensure

standard approach to managing risk. The Finance Framework had been put in place by the System Finance Leadership Group (SFLG) to harmonise and understand finance risks across the system, ensure a consistent approach and understand, recognise ICB responsibility around resource management and accountability for the system. The Finance and Investment Committee were supportive of Finance Framework.

It was important to note, in terms of delivery, that there was a challenging financial outlook for the system; the biggest challenge would be the management of system resource with operational pressures building across the system. In response, there were management and mitigating actions being taken through the SFLG and the Finance & Investment Committee. No questions were raised.

Resolved/Outcome: The Committee Noted the Finance Risks by Exception Report.

16. Waiver Report

JK advised that the period covered in the Waiver Report predated the ICB in order to provide continuity of reporting. There had been eleven new waivers since the ICB was formed, reasons for the waivers were included. JK and NA were working together on developing policy and processes for the management and decision making around business case proposals and rolling out additional budget holder training to address some of the issues around waivers. The Committee were informed that a number of waivers were due to the piloting of different projects and extension of contracts as the five predecessor CCGs were aligned. JK considered the reduction in the number of waivers presented to the Audit Committee as high priority.

PF noted a number of waivers were for the same organisation and enquired whether there were adequate safeguards in place around extended contracts.

JK acknowledged that Standing Financial Instructions (SFI) should be waived by exception only and that a number of waivers related to a continuing project with an existing provider. The Contract Team have been asked to pull together information on the reasons for slippage to enable a due diligence exercise to identify resolution and encourage a proactive response of the management of contracts.

GW added it would be useful for the Finance & Investment Committee to receive list of the major contracts coming up for renewal over next two or three years which would provide opportunity to take a deep dive into the procurement process and also consider a cost improvement plan. GW commented that the Audit Committee required assurance that ICB had suitable controls and checks in place to forward plan and make good procurement decisions.

PF highlighted that the Health and Social Care Act was due to update the procurement approach which may present further challenges to the procurement process, therefore it would be useful for the Audit Committee to receive a paper on the new procurement policy and approach required. JK agreed it would be useful for the Committee to be sighted on the changes.

Resolved: The Committee Noted the Waiver Report.

Action: When available, JK to provide details of the new procurement policy and approach to the Audit Committee.

17. Losses and Special Payments

JK advised there were no losses or special payments to report to the Committee and none inherited from the predecessor CCGs.

Resolved: The Committee Noted the Losses and Special Payments update.

18. Items for Information

The following items were included for information:

- Minutes of Part I Quality Committee Meeting - 13 July 2022

GW advised, it had been agreed that the Non-Executive Members (NEM) would receive agendas for all committees to ensure the NEMs were aware of reports going to and responsibilities of each committee and to ensure no issues were overlooked. MT confirmed he would be leading the process to share agendas with NEMs and Chairs and would offer supplementary papers on request or ad hoc basis. GW took the opportunity to highlight the benefit of online access to papers.

Resolved: The Committee Noted the Minutes presented.

Action: MT to lead process to share Committee agendas with Chairs and NEMs for oversight.

19. Any other Business

No other business was raised.

20. Items to Escalate

To Executive Team – Audit Plan (to discuss timing and pace of audits)

To Senior Leadership Team – Raising Counter Fraud awareness amongst staff.

To Peoples Board – Timing and scope of Equality, Diversity, and Inclusion audit

21. Date of Next Meeting

JKi advised that the provisional dates of 4th and 25th October 2022 had been identified for the next Audit Committee. Holding invites would be sent and once the date was confirmed final invites would be issued.

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

29th Sept 2022
9:00 - 11:00 am
Via MS Teams

Attendees
Roshni Maisuria (RsM) Sarah Zaidi (SZ), Gbola Otun (GO), Olubenga Odutola (OO), Babefemi Salako (BS), Peter Scolding (PS) Donald McGeachy (DM), Stuart Harris (StH), Krishna Ramkhelawon (KR), Kirsty O'Callaghan (KO) – (leaving at 10:am), Gerdi De Toit (GDT), Russel White (RW), Rachel Marchant (RM), Robert Spackman (RS)

Apologies
Jose Garcia (JG) Scott Baker (SB), Ronan Fenton (RF)

Meeting Summary

Item No	
1.	**Welcome**
	PS welcomed colleagues to meeting and deputed as chair for RF who sent apologies. 11 members of the CliMPC were present, and received 3 apologies, the meeting was quorate. PS reviewed progress of the group so far and thanked them for their contributions. Outlined two potential models for operation moving forward. Agile review and Senate review for discussion later in the agenda. Sam Bartlett was thanked for his contribution to the group and Robert Spackman welcomed in the role of senior clinical fellow. There were no new conflicts of interest from the group. The minutes from the previous meeting were circulated and agreed.
2.	**Service Harmonisation (SH) update**
	PS reviewed the work to date in this area and suggested moving forward congress would broaden its remit. KR stated the collective worked well on the SH of policies remit and was confident in the process with the challenge now being to broaden the remit of the group as per the ToR.

Item No	
3.	**Review after 1 year of Congress**
	PS circulated the paper on 1 year of congress and asked what worked well other than in area of SH of policies and asked for thoughts on the role of congress. RM stated it was a well-functioning group and that it's model and processes can be applied from lessons learnt with SH of policies. Suggested close consideration of how projects and ideas are brought before congress, Stewardship groups should present projects at a stage where they were more considered and worked up DM expressed the opinion that having subject matter expert opinion and input was useful, particularly in a senate process. RM made the point that the role of congress was to have a wider system level view. PS pointed out that there was a balance between a congress viewpoint and an expert subject matter viewpoint and this balance was evolving. SZ suggested that we learn from the NHSE regional senate process and emphasised the importance of broadening perspective. OO reflected on the changing landscape and the link between congress and the ICB and ways to ensure ongoing attendance in light of workload pressures. PS reminded the group of the chance to support with 'back fill' and OO and PS took this outside the group for further discussion. PS discussed membership after Rahul Singal and Steven Bush left the group and ways to ensure pharmacy representation.
4.	**New Processes - Agile review and Senate models**
	PS: Introduced models from outline paper circulated to members. Agile review process intended as a system view 'is proposal a right fit' with group meeting outside of congress with or without external experts then bringing findings to congress with a briefing paper. KS agreed in principle and welcomed the concept of external partners and expert involvement. BS welcomed the proposals as workable. KO noted the successful experience of the voluntary and communities model and whether this could be adapted for clinicians. RM suggested congress could bring its experience to innovative proposals via the agile review process. PS concluded the discussion on the agile review by emphasising the pace, thresholds and appropriateness of this form of review. PS introduced the senate model as a form of review for more weighty ideas more suited to a substantial review process. He outlined the model with reference to the

Item No	
	template included in the paper and suggesting a half day session by members for in depth discussion. With an outcome report plus formal recommendation. KR shared his experience of the senate model and suggested group needs a shared set of principles with shared learning from external stakeholders. RM discussed the capacity around half day review sessions for clinicians and suggested setting aside advance diary time to ensure availability otherwise attendance may drop and avoid bias set of views PM stated that the meeting frequency will depend on board/system issues, may not need a monthly meeting. DM highlighted the need to avoid duplication with other review processes, need to be clear on the principles. PS mentioned deciding who would be involved in review process and the cost thresholds and recruitment. KR mentioned the risk of becoming internal facing and felt there would be greater reassurance if external stakeholders were involved. These participants could also share good practice and enable the process to withstand scrutiny. PS clarified that role of external view would need discussion. KR mentioned also was need for transparency and accountability of process. RM agree with KR regarding role of external viewpoints and not to review in isolation. OO stated it was important to learn from others but to also remember what is unique to our system and recall the importance of locality and place with an emphasis on mitigation of health and population inequalities. He highlighted widening geographical health and wealth inequalities at a system and population level. KR added that we need primary care public health champions. DM ask is if the SRPs will go to public consultation? PS clarified that Congress and expert panel, health inequalities reports will go to the ICB. If it is agreed by the board, it will then go for public consultation from Jan-March 2023, with the aim of all services being harmonised by April 2023. PS stated that the of work of the group would include inequalities mitigation. He concluded discussions by acknowledging that the breath of the group had much experience to draw on and recognised its value to date.
5	**Any Other Business**
	No AOB was raised for discussion.

Minutes of ICB Finance & Investment Committee Meeting

Held on 5 October 2022 at 10.00am

Marconi Room, Wren House, Chelmsford, CM2 5PF

Attendees

Members (Voting)

- Joe Fielder (JF), Non-Executive Member, Committee Chair
- Anthony McKeever (AM), Chief Executive Officer, MSE ICB (via Video link)
- Jo Cripps, (JC), Executive Director, Strategy & Partnerships, 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 – Voting Deputy
- Jason Skinner (JS), Director of Finance for System Planning & Reporting, MSE ICB
- Nina Van-Markwijk (NV-M), Finance Director – Efficiency and Care Group 4, 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)
- Kerry Harding (KH), Interim Deputy Director of Estates

Apologies

- Dawn Scrafield (DS), Chief Finance Officer, MSE FT and Interim Director of Resources, MSE ICB

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 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.

3. Minutes of meeting

The minutes of the last meeting of the ICB Finance & Investment Committee on 7 September 2022 were received.

Outcome: The minutes of the meeting held on 7 September 2022 were approved as an accurate record.

4. Action log

The action log was reviewed and noted. TH advised that data (in relation to capacity and demand on Primary Care) was being collated and the aim was to map a visual representation/heatmap of capacity and demand issues in Primary Care.

NA confirmed that Mental Health funding had been added to the committee workplan, but noted the timing had not been confirmed.

Action: *JK/NA to determine the timing of Mental Health funding on the Finance & Investment Committee workplan.*

5. Committee Membership Update

JF explained that due to the current demands on the respective roles of the Non-Executive Members from partner organisations, they were not in attendance and re-consideration had been given to their involvement as part of the Committee membership at this time.

The ICB would therefore look at the recruitment of Non-Executive Members to support the committee meeting, its objectives and to ensure quoracy.

MT added that the recruitment of Non-Executive Members would support the FIC and Audit committees, and with equality and diversity work. The ICB Non-Executive Members would be involved in the recruitment process.

JK enquired if and how joined up FICs could be convened. JF and MT agreed further discussion would be required to ensure fruitful relationships with provider organisations.

Action: *JF, JK and MT to discuss the potential of future 'joint' committee meetings with provider organisations, where this was feasible and advisable given the current financial challenges across the system.*

Outcome: The Committee NOTED the Membership Update.

6. Ratification of virtual decisions

<u>Optum (ScriptSwitch) Business Case</u>

Due to tight procurement timescales, in between the September and October meetings, the Finance and Investment Committee were asked to virtually consider and approve the Optum (ScriptSwitch) business case (a primary care web based prescribing decision support tool embedded into clinical systems to provide information at the point of prescribing). It was noted that the business case provided the appropriate assurance as to the due diligence of the contract award decision and that procurement regulations had been

followed. It was noted that there was an increase in cost per patient, but that it is likely the team can negotiate to existing costs per patient.

Action: *JK to provide ScriptSwitch progress update to FIC, confirming whether the cost per patient had been negotiated down to current cost levels.*

Outcome: The Committee RATIFIED the virtual decision to APPROVE the recommendation to direct award Optum (ScriptSwitch) with MSE ICB contract, via the compliant award process.

7. Business Case Approvals

Hedingham Medical Centre Business Case

KH explained that the proposal was for a new build 827m² (Net Internal Area (NIA)) Health Centre in Sible Hedingham to be built by a third party developer, One Medical, to purchase the land from Braintree District Council and fund the new build in return for the practice taking a 20-year Tenant Internal Repair (TIR) lease, subject to District Valuer (DV) Value for Money review.

The new build would replace the existing three premises meaning the closure and disposal of Hilton House Surgery, Castle Surgery in Castle Hedingham and the branch surgery in Great Yeldham, which recently had a fire and was out of action. All buildings were currently not fit for purpose for delivering modern clinical services. The new build would provide opportunity to increase the services provided by the practice, Primary Care Network and community for the existing and growing population from a compliant modern health care premises. Additionally, the practice was working from premises that were not fit for purpose and the lease on the existing Hedingham Practice had a long stop date of August 2023, the landlord was not willing to extend past that point. The ICB Estates Team were working with the practice to ensure the business case was robust and to ensure the existing premises would still be available until such time the new build was ready to be occupied.

Revenue implications were under review by the District Valuer (DV), who was carrying out a value for money review and would be adjusted accordingly within the Full Business Case (FBC). It was expected to be around £240 per square metre.

JS highlighted that the figures detailed in the Outline Business Case (OBC) were based on the older proposal and queried whether an update was available. KH confirmed the figures had been reviewed and were from a delegated budged, using s106 monies, with the remainder of spend programmed in. JK clarified that capital was approved separately by NHSE in the bidding process.

JC enquired what the relative priority of this build was in comparison to the need of the PCN estate. JF agreed it would be useful to know and hoped the heatmap work being undertaken around primary care would show priorities and context of wider picture.

KH explained that review at the early expression of interest stage would identify primary need, what the issues were and would provide a ‘rag’ rating. KH confirmed there was an alliance sub-group, but business cases went through the system process before review by NHSE.

TH remarked that prioritisations must be identified across the system, but recognised this would take time and could be necessary for the ICB to approach some practices. JF agreed that when capital and resource was scarce, it was important to ensure priorities were correct.

JK stressed that the decision taken by the FIC on this business case should not set a precedent and we needed to work through any legacy issues we have inherited carefully against our priorities. Work was being undertaken to identify other works in the estate pipeline.

JS clarified that as the new build was a third party develpment, it was not a capital asset on the ICB books. It would be a revenue cost

MT commented that it was important to be clear on the governance for the business case. The Finance & Investment Committee supported the Hedingham business case to progress to the next stage but before the project was committed to, more information was required. It was noted that should the Hedingham business case require further work, which was in train and it should be presented again to the Finance & Investment Committee before recommendation to Board.

Outcome: The Finance and Investment Committee SUPPORTED the Outline Business Case to move to Full Business Case for the Hedingham Practice to be presented to a future meeting of the committee for support and recommendation to the Board.

Chafford Hundred Building Extension and Refurbishment

The business case set out the proposal for the extension and refurbishment Full Business Case (FBC) for the Chafford Hundred Medical Practice and the associated financial implications.

The current premises of the Chafford Hundred Medical Practice were significantly undersized for the practice population. Although a purpose-built facility, the original design did not take account of the way in which the Chafford Hundred Development and surrounding area had subsequently grown. The scheme aimed to increase the size of the premises as far as the building and site would allow and maximise capacity at the site. The scheme would also see an internal reconfiguration and upgrade as well as an extension to the site. Minor surgery suites were only one per locality so must allow other practices to use.

The capital cost of all works would be funded by the Landlord in exchange for a lease renewal for 20 years on Tenant Internal Repairing (TIR) basis. The current Fully Repairing and Insuring lease was due to expire on 23 December 2023. As a result of the works to be undertaken, there would be no dilapidation charges to the Practice in concluding the current lease.

There is a revenue consequences for the ICB which would be incurred through additional rent reibursal of c£70k over an indicative 20 year period this was a £1.4m increase against baseline, JK confirmed that the Primary Care budget could absorb the cost and it would form part of the ongoing planning against the budget.

As there was no evidence provided to support the telephony costs the business case recommended that the funding request was rejected for this cost. As premises costs directions do not provide for funding to cover furniture & equipment, it was recommended that the request for £6,000 was rejected.

Due to continued growth in the surrounding area a future plan was in place to deliver a sister site to this surgery within the planned Arena Essex Strategic development site; to which the closest GP services were delivered by the Chafford Hundred Medical practice.

KH clarified that the minor surgery suite would be for the use of the Grays area of the Thurrock Alliance and would meet the standard required for use by provider services, including dermatology Service. KH confirmed the Community Diagnosic Centre would not be linked to the Chafford Hundred Practice.

JF enquired whether a benchmarking exercise was undertaken during initial scrutinisation of business cases and whether the ICB was able to scrutinise third party capital costs where leases were over 20 years and enquired how confidence and assurance could recorded in relation to third party costs.

KH explained that full business cases were not approved until full tender documentation was received and scruitinised. Once underway, projects had a dedicated planning offer and team linked in with practice with strict guidelines in place. If a project was not delivered to expectation, rent would be reduced.

JK concurred that immense due diligence was undertaken in assessing business cases. As the number of business cases for consideration increased, more benchmarking data would be obtained.

It was agreed that the work being undertaken on a Primary Care heatmap would be useful for estates consideration and that a development session with executives and the board would be beneficial to understand the background and the assurance required by Finance & Investment Committee.

Action: *JK and TH to discuss the next steps in respect of development session around Primary Care Estates.*

NA explained that items relating to primary care estates, from a governance perspective, should be escalated to the Primary Care Commissioning Committee.

Action: *JK/KH to confirm the roles of ICB committees in regard to estates (i.e. Finance & Investment Committee and the Primary Care Commissioning Committee)*

JF stressed how important it was to investigate how energy bills could be contained and suggested this was discussed at the heatmap workshop.

AMcK confirmed the decision did not require Board approval. JK suggested a quarterly exeption report outlining decisions taken was presented to Board to keep them informed.

Action: *Exception reports around primary care estate decisions to be provided to the ICB Board.*

KH stressed that the S106 money was a legal obligation and already allocated to the Chafford Hundred project. KH highlighted the need for urgent work to be undertaken in order for the project not to stall and incur rising costs. It was requested that the team confirm the arrangements around prioritising Chafford Hundred in order to assure the committee that it wouldn't cause detriment to other needs within the area.

Outcome: The Finance and Investment Committee agreed in principal the Chafford Hundred Medical Practice Business Case at the current stage subject to further assurances outside of the meeting and discussion with executives leading the prioritisation of primary care schemes.

Items for Assurance

8. Finance Update – Month 5 Financial Performance Update

JS stated that the Month Five (M5) report covered the ICB financial performance and wider Mid & South Essex system performance. The system continued to plan to deliver a breakeven position by the year end, with unmitigated risks of £95.4m and a need to deliver £84m efficiencies.

At the end of M5, the system position was a deficit of £40.3m, £29m adverse to the £11.3m deficit expected in the profile for delivering a breakeven position by the year end. The forecast remained breakeven for NHS partners; however development of a financial improvement plan was in progress. Local Authorities continued to forecast a £6.6m deficit.

The year to date position for NHS bodies, with a deficit in MSEFT driven largely by the utilisation of interim staffing needed to deliver activity recovery, had been consistent across the year so far. A continuation of this level of activity was likely to impact on the ability to deliver a balanced forecast for NHS partners and was under review with NHSE/I. Additional funding was received in August relating to Virtual Wards Service Development Funding (SDF) and Long Covid SDF.

The System Covid-19 expenditure at Month 5 was £18.4m, £6.7m of which was reimbursable by NHSE/I and £11.7m within the system funding envelope. JK highlighted that the total ICB net expenditure figure of £47,710 was not surplus and stressed the importance to be clear on this.

JF stated that the ICB needed to understand the trajectory turning point which was currently unclear. JK explained the risks in the plan had become a reality in MSEFT and referenced the work with PriceWaterhouse Coopers (PWC)

The system is currently having had twice weekly meetings and forecast outturn reviews with PWC. Oversight of the financial improvement plan sits with the Chief Executives Forum.

It was noted that the Financial improvement plan would be a standing agenda item for the FIC.

Action: *To include a standing item on the FIC agenda for 'financial recovery'.*

A National Improvement Framework was in development, details were yet unknown.

AMcK commented that SFLG/PWC was an effective piece of work and acknowledged that the ICB wanted to change the forecast outturn but the specifics were for FIC to agree. AMcK confirmed that we could not countenance the system dropping into soft 4 category on the grounds of finance, but should ensure measures to retain soft 3 status by identifying what measures are needed. It was noted that there needs to be a shift of focus from one of process to a focus on the yield of efficiency schemes and that the FIC should understand how the broad programme effects the run rate.

Action: *JK to to provide future reports that will need to be presented to the FIC.*

Focus was on whether the risk position was the forecast outturn, is central to the PWC work.

Action: *JK to share with JKi the FIC document link in with risk for circulation.*

Outcome: The Finance & Investment Committee NOTED the Month 5 Financial Performance Update

9. Efficiency Programme Update Report

The report provided an update on the current System Efficiency position and the work undertaken to support the delivery of the full System Financial Sustainability Programme for 2022/23. The Month 5 delivery was £8.7m behind plan with £12.3m delivered for the year to date, compared to plan of £21m. Forecast outturn delivery was reported to NHSI as in line with plan, but was being reviewed given the adverse delivery to plan for the year to date. The system had £69.4m of identified schemes, of which £30.8m were cash releasing. Of the remainder, the majority were productivity schemes, and due to operational pressures at MSEFT it had been challenging to convert these to cash releasing due to the requirement to reduce backlogs and high levels of non-elective activity. The Committee noted that further actions were underway to improve the reported efficiency position.

In addition to the efficiency discussion covered under item 8, there were SFLG discussions around projection yield in the future.

Outcome: The Committee NOTED the Efficiency Programme Update Report and the actions being undertaken to improve the delivery of efficiency.

10. Key System issues or risks

JK commented that the key systems risks had been covered with in the previous items and reiterated that PWC were supporting the ICB with the work on risks.

Outcome: The Committee NOTED the update on key System issues and risks.

11. Business Case Management / Decision Making Process

MT explained that a template had been developed in conjunction with the procurement, finance and governance teams (and was presented to the Senior Leadership Team) for documenting business cases which would ensure a consistent approach to the development and approval of business cases across the ICB. The template documented the management; strategic; economic; finance; and clinical (rather than commercial) cases to support the proposal for committing ICB funding and included sections on options appraisal; engagement; procurement routes; benefits realisation and timelines. A management checklist to guide the 'approver' was also included. It was noted that Estates cases and those specifically prescribed by NHS England may have to be completed on mandated templates, but the template would be used across the ICB (for expenditure exceeding £50k) to ensure consistency in documentation and process. For cases less than £50k a one-page case template was being developed.

JF remarked that it was a comprehensive and useful document but may require some tweaks.

Outcome: The Committee NOTED the business case template and guidance on ICB Decision Making.

12. Feedback from System Groups

The following minutes were presented to the Committee for information:

- Mid & South Essex System Finance Leaders Group on 6 September 2022
- System Efficiency Programme Board – 15 September 2022

AMcK explained that it was no longer possible for DS to continue to cover both MSE FT and System finances, therefore it was necessary to implement changes in financial leadership and JK was to become Interim Director of Resources for the ICB. The Committee noted the change would affect the chairman ship of the SFLG.

JF expressed extraordinary thanks on behalf of AMcK and the Committee to DS for her hard work and commitment to the System over the past couple of years.

In relation to the minutes presented, JS commented that SFLG was in the process of identifying how to utilise funding which would need to be taken through the Finance & Investment Committee.

JF enquired whether 'Did Not Attend's' (DNA's) were followed up, because the volume of those not attending had a particular impact on delivery within the system. JS confirmed they were and improvements had been seen.

Outcome: The Committee NOTED the feedback from system groups

13. Items to Escalate

To the ICB Board

- Ensuring that the quarterly Finance exception report was clear on what was meant by 'break-even'.

To PCCC

- Hedingham Medical Centre and Chafford Hundred Building Extension Update.

14. Any other Business

Thurrock Community Diagnostics Centre (CDC)

The Committee was informed that the Thurrock CDC business case had been agreed by the System Finance Leaders Group but required formal approval by the ICB, that although nationally funded, it was necessary to take through ICB governance as the ICB was authorising MSEFT to deliver the scheme.

The Committee noted that as it was not an investment request it did not require Board approval. If necessary, due to timing constraints, the proposal would be approved virtually by the Finance & Investment Committee. AMcK advised there were future business cases in the pipeline from MSEFT.

JF agreed the business cases could be considered virtually, it was important to be agile but ensure adequate secruitny.

JC commented that System Transformation Board was set up to ensure the ICB engages with residents, to provide system oversight and impact of decisions taken.

Next years plan

JC explained the guidance outlining the Joint Forward Plan between the ICB and NHS provider partners was due next march but remarked that planning should commence before guidance was received. JK agreed and added that there was an expectation that the financial plan would be delivered regardless. The Finance & Investment Committee would be involved in the planning and was agreed that a Spring reflection would be beneficial.

AMcK stressed the need to focus on capital contrainsts. The Chief Executives Forum would be key to ensuring this. For the Finance & Investment Committee early planning was a priority before christmas.

ACTION: *JKi to ensure a 'Spring Review' is factored into the FIC workplan.*

15. Date of Next Meeting

10.00am – 12.30pm, 9th November 2022, via Microsoft Teams

Meeting finished at 12.04pm.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 12 October 2022 at 1.00 pm – 2.30 pm via Teams

Attendees

Members (Voting)

- Anthony McKeever (AMcK), Chief Executive Officer and Chair of Committee, MSE Integrated Care Board (ICB).
- Jennifer Kearton, Interim Director of Resources, MSE ICB.
- Andrew Pike (AP), Managing Director, MSE NHS Foundation Trust (MSEFT).
- Lynnbritt Gale (LG), Director of Community Delivery and Partnerships, South East Essex, Essex Partnership University NHS Trust (EPUT).
- Selina Douglas (SD), Executive Director of Partnerships North East London NHS Foundation Trust (NELFT).
- Ruth Jackson (RJ), Executive Chief People Officer, MSE ICB.
- Dr Tiffany Hemming (TH), Executive Director of Oversight, Assurance and Delivery, MSE ICB.
- Claire Hankey (CH), Director of Communications & Engagement, MSE ICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress.
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Alan Whitehead (AW), East of England Ambulance NHS Trust (EEAST.)
- Stephanie Dawe (SD), Group Chief Nurse and Chief Operating Officer, Provide Community Interest Company.

Other attendees

- Mike Thompson (MT), Chief of Staff, MSE ICB.
- Maggie Maxwell (MM), Head of Planning, Restoration and Reset, NHS England and Improvement, East of England (on behalf of Simon Wood/Elizabeth McEwan).
- Danny Hariram (DH), Chief People & Organisational Development Officer, MSE NHS Foundation Trust.
- Diane Sarkar (DS), MSE NHS Foundation Trust.
- James Wilson (JW), Transformation Director, Mid and South Essex Community Collaborative.
- Sara O'Connor (SO), Head of Governance and Risk, MSE ICB.
- Holly Randall (HR), Senior Head of Workforce Transformation, MSE ICB.

Apologies

- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England.
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England.

1. Welcome and Apologies (presented by Anthony McKeever)

AMcK welcomed everyone to the meeting and noted apologies as listed above.

AMcK informed members that he first wished to focus on the significant challenges faced by the NHS and the MSE system. A Chief Executives meeting held the previous day had discussed that performance against NHS Constitutional Standards was well below where any of them wished. The MSE system was currently classified under the NHS England and Improvement (NHSE/I) System Oversight Framework (SOF) as SOF3 and effective action was required to prevent the system dropping further to SOF4. Should this occur, the risk is that the system would lose its autonomy and external oversight would be brought in to address local shortcomings. The Chief Executives led organisations responsible for £3 billion worth of public services and it was incumbent upon them, individually and collectively, to ensure they provided effective leadership at all times.

AMcK advised that despite the current workload and challenges, it was necessary to focus on the key issues that truly mattered, albeit they might be difficult to resolve. The most obvious challenges included ambulance delays and handovers, patients sleeping overnight in Emergency Departments (ED) and length of time spent in ED. The committee papers illustrated that MSE continued to struggle on a number of fronts and it was vital that tight control on all resources was maintained to address poor performance and the financial situation. The Chief Executives had agreed that each of their organisations would respond accordingly.

AMcK advised that AP and his MSEFT colleagues responded to a wide range of pressures and they must be able to rely upon planned and agreed responses from all partners to effectively address these challenges.

AP agreed with AMcK's analysis, but highlighted that although cancer performance was currently poor, subject to responsibility and accountability being tightened up in some areas, coupled with additional support from regional colleagues, he was confident that MSEFT would deliver against cancer standards. AP also advised that Referral to Treatment (RTT) issues predominantly related to outpatients and should be within the control of the Trust, but it was currently doing approximately half of the 'clock stops' for long waiters required to get the 52+ week number under control and deliver the 78+ weeks standard. However, as long as elective capacity for 78+ weeks was protected, delivery was possible.

The areas still requiring greater collective effort were improving pathway zero lengths of stays and the ability to discharge complex or medically optimised patients. If these were not addressed it could undermine performance in other areas, including meeting the 78+ standard by 31 March 2023.

In addition, resolving unplaced patients within ED would immediately have a positive effect on ambulance performance and improving length of stay would benefit elective performance.

In response to a query from RJ relating to areas that posed the greatest risk to the system being categorised as SOF4, AMcK advised that the following issues must be focused upon:

- Effective leadership, both individually and collectively.
- Urgent and Emergency Care (UEC), including discharges and ambulance delays.
- Finances.

- Business Intelligence (BI) as it was vital that data was accurate. Barry Frostick and his team had been asked to help the system achieve this. AMcK acknowledged that AP had to deal with three different systems which recorded data slightly differently, thereby producing different forecasts.

AMcK advised that in relation to leadership, UEC and finances, it was vital that BI could be relied upon to enable organisations to plan effectively. It was therefore vital that organisations carefully verified information.

AW advised that the impact of the current situation upon EEAST's workforce and staff within EDs was extremely significant and stressful, but the openness and honesty regarding current challenges was welcomed. AW gave an example of a recent situation to illustrate the pressure on services and the potential for patient harm, as evidenced by an increase in serious incidents (SIs).

AW confirmed that EEAST was working to better utilise its 'stack' and pathways, with open discussions with colleagues resulting in a better understanding of action required. The winter period would be difficult, but AW noted that when EEAST declared a major incident standby the previous week, the response provided by MSEFT and colleagues within the MSE system was fantastic, which was echoed by AMcK.

AW advised it was his opinion that organisations must focus on supporting their MSEFT colleagues, which would in turn improve ambulance performance.

FB advised that in addition to the four points mentioned above, poor Care Quality Commission (CQC) inspections identifying a deterioration in patient safety and quality also had the potential to move the system into SOF4. To-date a full CQC inspection had not been undertaken in MSE, but how well organisations were led affected public confidence in their ability to deal with the wide range of risks NHS organisations faced.

AMcK advised that he would tighten up personal and organisational accountability arrangements over the coming weeks. The Chief Executives had agreed a system control centre would be established in anticipation of a national requirement for this.

TH advised that MSE wished to establish the centre quickly to embed processes and manage the situation proactively ahead of any national requirement, initially operating 5 days a week from 8.00 am until 6.00 pm.

AMcK summarised by saying that he wished leaders and managers to be deliverant by focussing on the things that truly mattered, albeit they might be difficult or uncomfortable to address.

2. Declarations of Interest (presented by Anthony McKeever)

The Chair 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 members are listed in the Register of Interests available on the ICB website.

There were no declarations of interest raised.

3. Minutes (presented by Anthony McKeever)

The minutes of the last SOAC meeting held on 14 September 2022 were reviewed.
No amendments were suggested.

Outcome: The minutes of the meeting held on 14 September 2022 were approved.

4. Action log (presented by Mike Thompson)

The action log was reviewed, and updates noted.

- **Action 49** – Data quality issues regarding the ESR system – to be discussed under agenda item 8 (Workforce).
- **Action 68** – MT advised that it was proposed that this action should be closed, which was agreed by AP and JH.
- **Action 74**: Quantification of gains by reducing reliance on agency/bank staff – to be discussed under agenda item 8 (Workforce). Action to be closed.
- **Action 76**: Declarations of Interest for SOAC members – in progress.
- **Action 77**: Specific performance data – to be discussed under agenda item 5 (Performance). Action to be closed.
- **Action 78:** Cancer performance – plan submitted and a half day workshop would focus on this. Action to be closed.
- **Action 79:** Clinical Risks – MSEFT to take North Bristol Protocol to their clinical executive on 19 October 2022 – to remain on action log. AMcK had provided information to Chief Executives on the clinical form established for real-time advice on balancing clinical risk across the system.
- **Action 80:** SROs reminded that efficiency delivery should not be affected by process delays – action closed.
- **Action 81:** Review Terms of Reference for System Quality Group. In progress.
- **Action 82:** System vacancy numbers. Discussed under agenda item 8 (Workforce). Action closed.
- **Action 83:** Core workforce metrics. Discussed under agenda item 8 (Workforce). Action closed.

5. Key Risks – Performance (Presented by Dr Tiffany Hemming)

TH advised that in terms of system ambition and commitment, only 3 out of 17 promises had been met so far. Some commitments already had improvement plans in place and plans for the remainder would be developed. TH summarised performance information contained within her report, as below:

104+ week waits had reduced to almost zero, but the number had increased again. AP was working to manage this.

UEC and Elective Care (Diagnostics, Cancer and RTT): All UEC and most elective targets were not currently met and the local commitment to stop overnight beds in ED had not been achieved. The UEC Taskforce had been stood up to resolve this, focussing on increasing the effective capacity of the system, with a strong link to winter plan monies. Bridging had been

exceptionally successful as evidenced by early data from Southend in particular, and would be more obvious the following month due to the time-lag for receipt of data.

OPAT at Home: To be rolled out further, subject to funding.

Virtual wards: Progressing well. Discussions ongoing regarding improvements in efficiencies and releasing staff to re-start the community rehabilitation service.

Neurorehabilitation discarges: Active conversation ongoing with region as to how these discharges would be achieved, as the number had increased.

Community Beds: Plan to increase community beds providing care and get best value for money from a mix of virtual and actual beds. An update would be provided at the next SOAC meeting.

Cancer: Improving trajectory overall and doing well in moving to zero day Patient Tracking List (PTL) approach. Some challenges regarding data and there was a future requirement for one Somerset cancer register across the whole Trust, which would be challenging until addressed.

Dermatology: Programme Board set up which to pull together all activity, not just cancer, within this specialty, to support GPs to refer appropriately.

Workforce: Remained very challenging, but there was an improving situation at EPUT and lots of initiatives in place to improve recruitment and retention of staff.

Mental Health: Improvement in trajectory for many constitutional standards, but risk remained in relation to dementia diagnoses due to diagnostic imaging backlog.

Maternity: Risk to midwifery continuity of care pathway due to workforce challenges. However, St Peter's Hospital had reopened having closed temporariliy during the summer.

Babies, Children & Young People: Positive picture with the exception of routine eating disorder referrals which were just below target.

FB advised that midwifery continuity of care workforce challenges existed nationally and although work to improve recruitment and retention must continue, the timeline to address this had recently been removed.

MM mentioned that the number of 104+ breaches reported to NHSE/I was 8 whereas the report stated 10. TH explained that the number fluctuated on a weekly basis and 10 was the most recent number, although in August it was less. AMcK asked MT to contact Barry Frostick to request that he liaised with MM to ensure accuracy of data.

MM agreed to email AMcK and TH with a few other queries regarding timelines, although AP advised that LMcE had already been briefed in this regard.

In relation to the 104+ position, a data cleanse had been undertaken in preparation for Gooroo Pathway Plus to assist in capacity forward planning. However, due to historic problems at Southend, it was likely that a higher number of patients would be identified as having been incorrectly 'clock stopped' and it was important therefore not to conflate separate issues.

AMcK advised that Chief Executives had agreed to identify risks in hierarchy and address each in succession.

AMcK requested TH to link with SD regarding the establishment of the system control centre and with AP on how to pinpoint the specific issues that must be addressed to improve key areas such as UEC, RTT and finance, and for TH to ensure that Barry Frostick takes appropriate action to ensure accuracy and confidence in data.

Outcome: The System Oversight and Assurance Committee noted the Performance and Assurance Report

Action 84: TH to provide an update on plan to increase community beds and obtain best value for money from mix of virtual and actual beds at SOAC 9 November 2022.

Action 85: MT to liaise with Barry Frostick regarding accuracy of data on 104+ breaches reported to NHSE/I and within internal performance reports.

Action 86: MM to email AMcK and TH with details of queries relating to timelines for actions.

Action 87: TH to link with SD regarding the establishment of the system control centre

Action 88: TH to link with AP on how to pinpoint the specific issues that must be addressed in order to improve key areas within UEC, RTT and finance.

Action 89: TH to ensure that Barry Frostick takes appropriate action to ensure accuracy and confidence in data across the system.

6. Key Risks – System Finance Update (presented by Jennifer Kearton)

JK advised that page 32 of the papers provided the Month 5 (M5) headline summary of the system financial position with a year to-date position being a deficit of circa £40 million once M6 was taken into account. However, there was a forecast of break-even due to technical reasons. The ICB was working with region on this and next steps.

There was £95.4 million of risk and £84 million of efficiencies, of which we are delivering below what is already a low trajectory for this time of year. There was a small capital underspend which the team were currently reprofiling. The report provided a breakdown by partner organisations outlining the relevant drivers of the deficit, with most pressure emanating from MSEFT where expenditure was driven by all the factors previously mentioned in agenda items 1 and 5 above. Key financial actions being taken by the Trust were outlined in the report.

JK advised that Essex County Council and Thurrock were reporting an overspend at M4 and M3 respectively and updated figures for M5 were awaited. Southend City Council reported break-even at M5.

JK referred to a deep dive of emerging risks and opportunities, as set out on page 35 of the papers. Weekly monitoring was being undertaken. A small improvement was seen at 6 October 2022 and a further update was due 14 October 2022. Other deep dives were being undertaken regarding capital and Elective Recovery Fund (ERF) and it was anticipated that these would also identify an improved position. However, it was important to ensure that this reporting identified the ICB's risk position and was not an forecast outturn position which was a concern being managed at the moment. Price Waterhouse Coopers (PWC) were undertaking work on the

forecast outturn for 2022/23 and supporting the ICB to achieve a sustainable footing in terms of medium term financial planning and recovery.

The Systems Efficiency Programme was currently not being delivered and the 'Foundations for the Future' programme now held weekly service reviews. A number of deep dives were also supporting this work.

JK advised that she understood that there were further opportunities being explored for system efficiencies relating to model hospital and the ICB was widening some of the work in terms of sub-scale services to identify potential opportunities across the system. The ICB was working closely with PWC and region to improve the financial position and it was anticipated that a conversation with region on the forecast outturn would occur the following Monday.

JK advised that she was of the view that the ICB would need to consider non-recurrent mitigations to bridge the gap within this financial year and a review was being undertaken of the triple lock to ensure the step before that, i.e. review of investments and business cases, was working well.

AMcK advised that at the Chief Executives meeting held the previous day, all had agreed to the following:

- Independent scrutiny and challenge from PWC regarding how existing resources were utilised.
- In relation to efficiencies, action to strengthen schemes and their yield, not to progress the paperwork through gateways and to do that through the Senior Responsible Officers (SROs) that each Chief Executive confirmed in the summer.
- To reduce the run rate swiftly and by a known amount through remedial actions that would be set in train immediately.
- Action required to fill vacancies and to reduce bank and agency expenditure.
- Reviewing investments in train this year to ensure that benefits were actually being realised.
- Review of all uncommitted system funding and actions to identify whether any budgets need to be 'red-lined'.

The ICB's recent staff restructuring had resulted in expenditure being reduced as far as possible and vacancy control measures remained, but other organisations would need to take similar steps.

Outcome: The System Oversight and Assurance Committee Noted the Month 5 System Financial Performance Summary Report.

7. Key Risks – Quality (presented by Frances Bolger)

FB advised that workforce challenges was the underlying theme at the recent System Quality Group (SQG) meeting.

Publication of the East Kent maternity report had been delayed due to the period of national mourning and was now due on 19 October 2022.

The CQC had undertaken inspections in MSE providers during the past two weeks and it was anticipated reports would be available towards Christmas/New Year.

The Channel 4 'Dispatches' programme on Monday, 10 October 2022, covertly filmed at EPUT, had not been viewed prior to it being aired. Issues identified would be taken through quality assurance processes.

A programme of work regarding the work of SQG, the ICB's Quality Committee and its oversight functions was being undertaken. Changes to the format and content of reports would be seen during the coming months.

LG advised that as well as dealing with issues identified within the Dispatches programme, EPUT was currently involved with several high profile HM Coroner's Inquests. Ongoing workforce challenges meant that EPUT continued to struggle to adequately staff wards. Paul Scott was holding regular meetings/briefings for staff and senior leaders, and the Trust's communications team was resonding to enquiries arising from the programme and Inquests.

Outcome: The System Oversight and Assurance Committee noted the Quality Report.

8. Key Risks – Workforce (presented by Dr Ruth Jackson)

RJ shared a set of updated workforce slides which had been circulated to members shortly before the meeting and confirmed that the NELFT and Provide workforce data had been included as per the action log (No 82).

Cleansing of workforce data at MSEFT had been undertaken and an improved overall vacancy rate had been identified, moving from 14% to 13%. EPUT's rate had also improved from 11% to 10%, although this was expected due to new under-graduates seeking work.

RJ confirmed that workforce remained very challenged, with nursing being the area of greatest concern, although the data cleanse at MSEFT had identified a reduction in vacancies. Unfortunately the available pipeline of staff from domestic and international campaigns would not meet demand and there would therefore be enduring vacancies at MSEFT as well as EPUT.

The data cleanse in relation to health care support workers had not been included on the slides but RJ understood vacancies were currently circa 330 not 430.

There was an improved position within medicine at MSEFT as circa 25 medics had been recruited in the last month which would support oingoing work to improve skill mix.

RJ advised that the workforce trends had reached 'status quo' because the number of staff that could be brought in, the retention of those people and the rate of turnover, translated into a flattish trend in terms of the number of agency and bank staff employed. The anticipated reduction in bank and agency staff had not been realised through system efficiencies because we were not seeing the reduction in vacancies expected since the plan was implemented.

Regional funding had been received for a campaign for additional support worker staff going live within the next month, but more work was required to retain these staff due to higher turnover rates for this cohort.

Slide 7 provided vacancy date for NELFT and Provide. The most recent data indicated the vacancy rate for NELFT was increasing, however, this was complicated as it was necessary to identify those staff working within MSE. Provide's position had improved considerably.

AMcK advised that a forward trajectory plan, based on reliable data, was required and must be executed, whilst considering any cross-over with MSEFT's 'Foundations for the Future' programme, EPUT's efficiencies programme and how the required reduction in the run-rate would be achieved.

RJ advised that following the data cleansing and agreement on current vacancy rates, there was an opportunity to re-profile the trajectory of recruitment. However, the system had not yet undertaken work to build a reliable pipeline of staff to avoid the same problems occuring in years to come.

DH presented separate slides (to be circulated to members with these minutes) and confirmed there had been a focus on the reliability of data to agree vacancy rates, as well as continued recruiting to vacancies. Senior nursing leaders were regularly following up with candidates and being as accommodating as possible regarding interview arrangements.

137 Nurses had commenced in post and a further 115 external recruits would commence shortly. In relation to internationally recruited nurses, 32 had been processed with a further 197 with scheduled appointments between now and March/April 2023. A further 74 international nurses would be joining in October/November. However, it was expected that some candidates would withdraw before this, although the Trust was doing everything possible to avoid this.

DH agreed with RJ that there would be insufficient nurses joining the Trust to provide capacity during the winter. Funding had been received for a further international nurse recruitment campaign and there were dedicated campaigns for particularly challenged areas such as ED, peadiatrics, critical care and maternity. Although nearly 50 additional nurses had been recruited to maternity during the summer, gaps remained. Support for health care support workers, including enabling them to become qualified nurses via Anglia Ruskin University was ongoing. Last year 20 qualified, 38 would qualify in November 2022 with a further 50 anticipated. The Trust was working with the system and RJ to recruit Physician Associates and Advanced Care Practitioners to support areas such as ED.

DH confirmed that the Trust was committed to improving the retention and recruitment of the nursing workforce, with medium and long-term plans in place, including support for staff throughout the winter.

RJ advised that workforce trends within EPUT were similar to MSEFT and they had for the first time commenced an international recruitment campaign. The priority was to identify the number of international nurses that would need to be recruited to fill gaps. Currently, the number coming through for each organisation was literally balancing out the number leaving once 'business as usual' domestic recruitment and undergraduates were taken into account. A bid had been made for 300 nurses for MSEFT and 200 for EPUT which would help considerably, but the challenge of bringing in such large numbers of staff put a lot of strain on existing staff who were already very stretched. Once this had been done, a conversation would be held with Philip Regent regarding additional support required. There were also other infrastructure concerns relating to housing/accommodation for these staff. A pipeline for trainee nursing associates also needed to be established to enable who would undertake degree apprenticeships.

In response to a query from SD asking about alternatives to accommodate overseas nurses, RJ confirmed that this was being taken into account.

AMcK advised that workforce challenges directly impacted on safety and quality and, in constructing a foreward trajectory for workforce, it was necessary to consider that a high vacancy rate combined with an excessive reliance on bank and agency was a key factor in several quality and safety risks as identified by CQC inspections. AMcK asked DS and SD to link with RJ, DH and colleagues in EPUT to explore the dynamic between workforce and actions that needed to be taken in a consistent way going forward.

FB advised that the biggest concern across organisations was workforce and when she went to the Chief Nursing Officer conference she heard it was a key priority for NHSE/I. FB was therefore happy to support RJ and DH in anyway possible to ensure a joined up approach.

DS commented mental health services experienced similar safety and quality risks. LG advised that these types of conversations were already occurring in EPUT but it was important to ensure there was commonality regarding terms and conditions, including on-call payments, London weighting, etc. across the system.

RJ agreed that this could be considered but, assuming this would result in levelling up, it had the potential to cause a financial pressure which could be quantified if necessary. AMcK suggested that a reduction in bank and agency staff should counter-balance this.

AMcK summarised by asking that a trajectory driven by quality, safety and risk balanced against the need to reduce outgoings in accordance with the Financial Improvement Plan was developed and asked RJ, DH, DS, SD and FB to do this to ensure that the MSE workforce was right for service reasons.

Outcome: The System Oversight and Assurance Committee noted the Workforce Report.

Action 90: RJ, DH, DS, SD and FB to liaise to develop workforce recruitment trajectory driven by quality, safety and risks, set against the need to reduce outgoings in accordance with the Financial Improvement Plan, to ensure workforce was right for service reasons.

9. Any other business (presented by Anthony McKeever).

9.1 Intensive Support Team visit to MSEFT

AP advised that the Intensive Support Team (IST) would visit the Trust on 20 to 25 October to look at Cancer and RTT recovery.

10. Date of Next Meeting

9 November 2022 – 1.00 pm to 3.00 pm via MS Teams.

Minutes of ICB Primary Care Commissioning Committee Meeting

Thursday, 22 September 2022 at 9.30 am

Via MS Teams

Attendees

Members

- Sanjiv Ahluwalia(SA), Associate Non-Executive Member – Chair
- Viv Barker (VB), Director of Nursing, ICB
- William Guy (WG), Director of Primary Care, ICB
- Pam Green (PG), NHS Alliance Director for Basildon Brentwood, ICB
- Ruth Hallett (RH), NHS Alliance Director for South East Essex, ICB
- Dan Doherty (DD), NHS Alliance Director for Mid Essex, ICB
- Dr Anna Davey (AD), ICB Primary Care Partner Member, ICB

Other attendees

- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes, ICB
- Jennifer Speller (JS), Deputy Director of Primary Care, ICB
- Alison Birch (AB), Head of Primary Care, ICB
- James Hickling (JH), Associate Medical Director for Quality, Assurance & Governance, ICB
- Simon Williams (SW), Deputy Alliance Director Basildon & Brentwood, ICB
- Elaine Roe (ER), Contracts Manager (Primary Care), NHS England
- Romi Bose (RB), Deputy Alliance Director Thurrock, ICB (Deputy for Stephen Porter)
- Vicky Cline (VC), Head of Nursing, Primary Care
- Nicola Adams (NA), Deputy Director of Governance and Risk, ICB
- Jane King (JK), Governance Lead, ICB (Minutes)

Apologies

- Ronan Fenton (RF), Medical Director, ICB
- Dawn Scrafield (DS), Director of Resources
- Stephen Porter (SP), Alliance Director Thurrock, 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.

It was noted the meeting was quorate.

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 **I**CB Board and committee members are also listed in the Register of Interests available on the ICB website.

There were no declarations raised.

3. Minutes

The minutes of the last predecessor MSE CCG PCCC meetings in common Part I and Part II on 16 June 2022 were received.

Outcome: The minutes of the last predecessor MSE CCG PCCC meetings in common Part I and Part II on 16 June 2022 were noted.

4. Action log

The action log was reviewed and noted that one outstanding action was carried over from the CCGs PCCC in Common.

5. PCCC Terms of Reference

WG advised that, whilst not a national requirement for ICBs, the ICB felt the need for a PCCC to provide oversight and assurance in undertaking decisions for its delegated function of Primary Care.

NA presented the revised PCCC Terms of Reference (ToR). In planning the work of the Non-Executive Members and on review of how the committee could best operate, it was proposed 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 was no longer required following formal delegation). Quoracy for the PCCC was 4 members, however the caveat that it was 50% of the members had been removed to ensure that quoracy requirements were clear. An amendment to the duties of the committee had been made to clarify its role i.e. to 'promote and champion' primary care within the system, regionally and nationally. The Board must approve changes to committee ToRs; however, the September (public) meeting was cancelled in accordance with national guidance for the period of mourning, consequently the TORs were approved using provisions within the constitution for urgent decisions to ensure that the committee was properly established prior to its first meeting.

AD enquired whether the committee's membership would be widened following delegation of Pharmacy, Optometry and Dental Services (collectively known as POD Services) in April 2023. NA advised membership would be reviewed as part of ToR review and would reflect the requirements of the committee in accordance with its role and responsibilities.

AK questioned whether due diligence for POD delegation would fall outside of the PCCC. NA explained there were project streams and workplans in place for POD delegation (with expectation to bring matters back to PCCC). WG stressed the need to ensure PCCC were sighted on key contractional obligations and risks around how services were currently commissioned and would be commissioned in the future. The process for delegation and the assurance framework would be overseen by Delegation Board but agreed that former issues and risks inherited must be brought back to PCCC as due diligence progresses. Decisions around receiving delegation were with ICB, overseen by the Delegation Board. Some Members of the PCCC were actively involved in the delegation assurance process. AK sought clarification on whether nominated deputies were able to vote in the absence of their respective member. NA would review and confirm outside of meeting.

Action: NA to provide clarification outside of meeting on whether nominated deputies were able to vote in the absence of their respective member.

Outcome: The Committee NOTED the amended Terms of Reference for the Primary Care Commissioning Committee, subject to review of voting rights for nominated deputies.

6. Balfour List closure extension request

On 7 February 2022, Balfour Medical Centre (F81155) applied for a formal closure of their patient list for a period of 12 months. The practice had stated that they were hopeful to arrange more clinicians to manage the workload during that 12-month closure period. On 14 April 2022, the Primary Care Commissioning Committee in Common (of the five mid and south Essex CCGs) took the decision to approve a formal closure for a period of 6 months which was due to conclude on 24 October 2022. In line with regulations, the practice had the opportunity to apply to extend this closure period, with the application submitted no less than 8 weeks prior to the end of the formal closure notice period. On 25 August 2022, within the timeframe set, Balfour Medical Centre applied for an extension to their formal closure period.

RB confirmed that Thurrock Alliance agreed with the proposed six-month period closure extension for the practice.

Outcome: The Committee APPROVED the extension to the current formal list closure for a further six-month period (from 25 October 2022 to 24 April 2023).

7. APMS Procurement Update

WG explained that currently Mid and South Essex ICB held twelve APMS (Alternative Provider Medical Service) contracts which were fixed term contracts (unlike General Medical Service (GMS)/Personal Medical Service (PMS) contracts, which were in perpetuity). Five of the contracts, all in Thurrock, have end dates in March 2023 or June 2023. Additionally, one short term GMS agreement in Southend had an end date of March 2023.

In June 2022, the Primary Care Commissioning Committee in Common (of the five mid and south Essex CCGs) endorsed the recommendation to proceed with new APMS contracts.

Since then, a full Procurement Project Group had been established to take forward the procurement process (led by procurement advisors, Attain) and was on track to deliver the programme as planned. The proposed contract length of 15 years was approved by the Commercial Executive Group of NHS England in August 2022. Bidder events were currently underway.

WG explained that funding was based on weighted populations, rather than actual populations. Therefore, PCCC approval was sought for the recommendation to subsidise Thurrock Health Centre's (one of the practices for reprocurment) annual contract value to mitigate the low Carr Hill formula weighting that GMS rates would remunerate. This would be based on the exceptionality criteria which was detailed in full in the paper presented to the committee. Namely that the contract duration was still fixed and therefore there was still additional risk to providers with these contracts when compared to GMS Contracts which were in perpetuity, in addition that historically, this practice had received on of the highest levels of funding per patient (£146) albeit for a different specification of services. Transition to GMS funding was a significant reduction that could destabalise provision even with a reduced scope of specification.

The additional funds required to cover the additional cost was within the budget and was not a cost pressure.

WG explained the reason for the rating was due the low number of older populations compared to their peers. RB added that Thurrock Health Centre also had a significant number of patients that were homeless or from vulnerable groups, who often were younger.

AK stated that that the proposal to go out to APMS contracts at GMS rates was the lowest minimum viable rate for the contracts.

In response to SA, WG explained that one of the key drivers to go out to procurement with GMS rates on fixed term contracts was because APMS contracts do not always offer value for money, therefore the ICB specified that contracts would be to GMS specification. Additionally, there had been interest received from practices to deliver this particular contract model which had already seen success in some areas of the system. It would also bring a level of parity in investment across the population.

Outcome: The Committee NOTED the progress in the process to reprocure primary care services for the five APMS and one GMS contracts expiring in March 2023 and June 2023.

Outcome: The Committee APPROVED the recommendation to subsidise Thurrock Health Centre's annual contract value to mitigate the low Carr Hill formula weighting that GMS rates would remunerate. This was based on the exceptional circumstances identified.

8. Pharmacy, Dental and Optometry Delegation Update

As part of the changes introduced on 1 July 2022, several functions currently undertaken by NHS England (at a regional level) had been identified to be delegated to ICS level over a period of time. The two key early functions for delegation were the commissioning of

Pharmacy, Dentistry & Optometry (collectively known as POD Services) and Specialised Commissioning.

WG gave an overview on the process of POD delegation and advised that there was a nationally established programme for delegation assurance which consisted of four key workstreams: Transformation and Quality; Governance and Leadership; Finance; and Workforce, Capability and Capacity.

Because of the level of due diligence still required in process and lack of clarity on some the functions to be fulfilled by the ICB there was a level of concern around delegation of services - need to know what was expected of the ICB, therefore the areas of Finance and Workforce, Capabitlity and Capacity have been rag rated red and further due diligence work was required.

It was collectively agreed across the region that Herts and West Essex ICB would host pharmacy and optometry procedural contracting on behalf of all ICBs within the region. Mid and South Essex ICB would be fully responsible for dental and transformational pharmacy and optometry. The PCCC would be kept appraised of the committee's role and service provision/key risks.

VC informed Members that the ICB was still waiting for NHSE to confirm oversight requirements for serious incidents and quality therefore it was difficult to plan and organise proactive quality assurance. Further information was expected imminently from NHSE.

AK explained that financial arrangements were still being worked through with region and hoped to be rated amber by March 2023.

WG confirmed the POD associated risks would be managed by the Delegation Board, but the PCCC would be kept informed.

SA enquired whether the risks arising from the transition from contracted values to the population/needs-based model were being considered as the delegation process was worked through. AK explained the proposal for the financial element was for the regional allocation to be spilt on historical usage. The transition to a needs-based allocation arrangement was still under national discussion, therefore the risks were unclear. The finance workstream were monitoring the potential impact and risk attached to not having the details of the allocation arrangement in advance of the transition. SA agreed that it was important the risk was closely monitored.

SA requested clarification on the relationship between transformation and commissioning and where the work sat, particularly in respect of developing integrated teams and neighbourhoods. WG outlined the opportunity for community pharmacies to be part of integrated teams and primary care networks providing opportunity to build relationships and understand role of community pharmacy. The dentistry transformation would be more challenging given workforce challenges and would require a centralised approach to transform services.

SA enquired where transformation discussions take place. WG advised these discussions were across multiple forums which included the PCN Development & Delivery Group which was attended by central and Alliance Teams.

PG concurred that place-based development of integrated teams sits within Alliances, and it was critical for high street pharmacies to be included. As Alliance committees develop and work on integrated teams was progressed, PG would expect to update the PCCC.

AD noted that there were variations in the way ICBs across the region were approaching their primary care strategy and transformation work and felt that MSE needed to work out where the strategy and transformation sat for the whole system.

JH referred to the ToR which stated that the committee's objective was to improve and transform primary care services, therefore was the right place to recommend plans for transformation. In terms of development, the central team had a key part to play with common elements across all Alliances. It was agreed that precise areas for primary care development discussions were yet to be decided but noted there were good structures to provide clinical input.

PG highlighted that although Alliances were not currently delegated any specific functions, as they mature this might change to allow local sign off for place-based developments.

In response to SA, it was PG's view that the commissioning role had transitioned into a facilitative, qualitative assurance role in the functions delivered as an ICB. The Directed Enhanced Services (DES) responsibility sits with place whilst the General Medical Service (GMS) responsibility sits centrally.

SA concluded that the ICS needed to identify the approach to take in supporting the development of placed based role and the role of the committees.

Outcome: The Committee NOTED the Pharmacy, Dental and Optometry Delegation Update.

9. Draft Work Plan / Meetings Schedule

NA presented the draft work plan and explained it was an iterative process to allow for flexibility and review, particularly in respect of delegation. The PCCC would be held monthly and would have an operational / tactical focus on a bi monthly basis.

AB queried whether Primary Care Decisions should be scheduled monthly. NA explained that although the work plan was based on a bi monthly operational / tactical cycle there was flexibility in the work plan to approve unscheduled where necessary, additionally there was opportunity for virtual approval.

NA confirmed PCCC was not a public meeting but for transparency PCCC minutes were presented to the Board for information.

VC highlighted that due to the timings of committees, data presented to PCCC may not be consistent with Quality papers. NA did not envisage this to be an issue as the reports were written at a point in time, it was important to be pragmatic on reporting and clear on when written so as not to create additional work.

JH enquired whether the Fuller Stocktake review needed to be included on the work plan as a Deep Dive. NA stated that it was important work plan also covered one off items to reflect work undertaken as serves as a record of committee's work throughout the year.

Action: Include Deep Dive on Fuller Stocktake on work plan.

Outcome: The Committee APPROVED the draft PCCC Work Plan subject to the changes discussed.

10. Any other Business

No other business was raised.

11. Date of Next Meeting

19 October 2022 - 9.30–11.30 am via MS Teams

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 17 November 2022

Agenda Number: 16.2

October Board Decisions

Summary Report

1. Purpose of Report

In the absence of Partner Members at the 14 October 2022 Board meeting constitutional provisions for decision making via the Chair, Chief Executive and at least one other non-officer member were enacted to approve:

- 1 July 2022 minutes and action log,
- Harmonising Commissioning Policies Consultation,
- Digital Strategy & Investment Priorities,
- Emergency Planning, Resilience & Response Core Standards, and
- Approvals made in between Board Meetings (as a result of the September Board meeting being cancelled to respect the national period of mourning).

2. Executive Lead

Anthony McKeever, Chief Executive Officer

3. Report Author

Mike Thompson, Chief of Staff

4. Responsible Committees

As per the relevant constitution provisions, the audit committee will receive a note of formal decisions taken other than at a Board meeting.

5. Conflicts of Interest

None identified for this paper.

6. Recommendation/s

The Board is asked to ratify the decisions taken to approve the July 2022 minutes and action log, Harmonising Commissioning Policies Consultation, the Digital Strategy & Investment Priorities, Emergency Planning, Resilience and Response Core Standards and the ratification of approvals made in between Board meetings.