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, 19 January 2023 at 3.00 pm – 5.00 pm

Gold Room, Orsett Hall Hotel, Prince Charles Avenue, Orsett, Essex RM16 3HS

Part I Agenda

No	Time	Title	Action	Papers	Lead	Page No
		Opening Business				
1.	3.00 pm	Welcome and Apologies for Absence	Note	Verbal	Professor M Thorne	-
2.	3.01 pm	Amendment to Board Meeting Conduct and Etiquette Protocol	Approve	Attached	Professor M Thorne	3
3.	3.02 pm	Review of Register of Interests and Declarations of Interest	Note	Attached	Professor M Thorne	4
4.	3.05 pm	Questions from the Public	Note	Verbal	Professor M Thorne	-
5.	3.15 pm	Minutes of ICB Board meeting held 17 November 2022 and matters arising.	Approve	Attached	Professor M Thorne	8
6.	3.17 pm	Review of Action Log	Note	Attached	Professor M Thorne	21
		Items For Noting				
7.	3.20 pm	Local Maternity & Neonatal System Consultant Midwife Update	Note	Attached	F Bolger G Hickford	23
8.	3.35 pm	Quality Report	Note	Attached	F Bolger	26
9.	3.50 pm	Performance Report	Note	Attached	T Hemming	33
10.	4.05 pm	Fuller Stocktake Update	Note	Attached	Dr A Davey	39
11.	4.20 pm	Finance Report Month 8	Note	Attached	J Kearton	43
12.	4.30 pm	Approach to Operational Planning 2023/24.	Note	Attached	J Kearton J Cripps	49
13.	4.50 pm	General Governance: 13.1 Approved Minutes of Committee Meetings: • Quality Committee • System Oversight and Assurance Committee	Note	Attached	Professor M Thorne	58 59 74

No	Time	Title	Action	Papers	Lead	Page No
		• Primary Care Commissioning Committee				81
		13.2 Decisions taken in between Board meetings	Ratify	Attached	Professor M Thorne	89
		13.3 Adoption of ICB Policies	Ratify	Attached	Professor M Thorne	92
14.	4.55 pm	Any Other Business	Note	Verbal	Professor M Thorne	-
15.	5.00 pm	Date and time of next Part I Board meeting: Extrarodinary Board meeting to be held on Thursday, 9 February 2023 at 3.00 to 5.00 pm, in Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, Essex, CM1 1JE.	Note	Verbal	Professor M Thorne	-

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Integrated Care Board Meeting,19 January 2023

Agenda Item 2

Proposed addendum to the Board's Meeting Conduct and Etiquette Protocol

Summary Report

1. Purpose of Report

It is recommended for approval that following addendum is made to the Board's Meeting Conduct and Etiquette Protocol.

"The Board has responsibility for the health and care of 1.2m residents and public funding of £3b. It is essential therefore that Board and committee meetings have the full and focussed attention of members so that they can discharge their duties effectively and transparently. Computer and other technology may only be used therefore in support of the business in hand.

It is recognised that many Board members have senior responsibilities including clinical and professional accountabilities and/or on-call / emergency response duties; therefore, it is acceptable for phones to be present at meetings. Our policy is that any board member who is likely to be to be required to attend to a call or a message should avoid disrupting meetings by ensuring that:

- Phones are always kept on silent/vibrate mode
- If an urgent call/message is received that requires immediate attention that this is signalled to the Chair and the member leaves the meeting room for the period required.

This will ensure that fellow Board members are not distracted, that the business of the Board can be conducted without interruption and to reassure the public that all Board members are focussed on their Board responsibilities during the meetings."

2. Executive Lead

Anthony McKeever, Chief Executive Officer.

3. Report Author

Mike Thompson, Chief of Staff.

4. Recommendations

The Integrated Care Board is asked to approve the above statement to be added to the Board's Meeting Conduct and Etiquette Protocol.

Agenda item 3 - ICB Board Register of Interests, January 2023

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	
Les	Billingham	Local Authority Partner Member for Thurrock Council	Thurrock Council	x			Direct	Interim Director of Adults Social Care		Ongoing	Interest included in Board register of Interests. To be declared if and when necessary so that appropriate arrangements can be made to manage any conflict of interest.
Frances	Bolger	Interim Chief Nursing Officer	Suffolk and North East Essex ICB	x			Direct	Director of Midwifery	03/01/23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Hannah	Coffey	ICB Partner Member	Mid and South Essex NHS Foundation Trust				Direct	Interim Chief Executive		Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
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
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

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)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x	x		Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Peter	Fairley	ICB Partner Member (Essex County Council)	Suffolk and North East Essex (SNEE) Integrated Care Partnership	x	x		Direct	ECC representative	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x	x		Direct	Employed as Consultant Anaesthetist	20/06/05	On-going	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.

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	
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.
Joseph	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	Executive Director of Resources	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

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
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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	Royal Society of Medicine (RSM)		x		Direct	Fellow	02/03/20	On-going	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care	Faculty of Medical Leadership & Management (FMLM)		x		Direct	Fellow	02/03/20	On-going	No immediate action required.
Paul	Scott	ICB Partner Member	Essex Partnership University NHS Foundation Trust	x			Direct	Chief Executive Officer	01-Jul-23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Mike	Thorne	ICB Chair	Nil								
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 17 November 2022 at 3.00 pm – 5.00 pm

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

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.
- Joe Fielder (JF), Non-Executive Member.
- Dr Neha Issar-Brown (NIB), Non-Executive Member.
- George Wood (GW), Non-Executive Member.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust.
- Les Billingham (LB), Partner Member, Thurrock Council.
- Peter Fairley (PF), Partner Member, Essex County Council.
- Benedict Leigh (BL), Partner Member, Southend City Council
- Trust.
- Dr Anna Davey (AD), Primary Care Board Member.

Other attendees

- Andrew Pike (AP), Managing Director, MSE NHS Foundation Trust (MSEFT). on behalf of Hannah Coffey
- 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.
- Mike Thompson (MTh), Chief of Staff, MSE ICB.
- Sara O'Connor (SO), Head of Governance and Risk (minute taker).

Apologies

- Hannah Coffey (HC), Partner Member, Mid and South Essex NHS Foundation Trust.

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

MT welcomed everyone in to the meeting, noting that BL and LB were attending the ICB Board meeting for the first time and that AP was attending on behalf of HC.

MT noted apologies as listed above.

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

MT advised that the register of Board members' interests would be updated to include recent changes to Board membership.

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**.**

There were no further declarations raised.

ACTION: SO to update the ICB Board Register of Interest to reflect recent changes to Board membership.

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

Peter Blackman (Chair of South Woodham Ferrers Health & Social Care Group), who was present at the meeting, asked the following question:

"How can the Alliances/Places engage effectively with their local communities and other stakeholders and partners without their own communications resource? It is not cost effective for the non-communications professionals fulfilling the operational roles in the Places & Alliances either to be saddled with the communications requirements of Alliances/Places or lack that crucial support."

JC advised that when the structure of the Alliances teams was being decided, colleagues felt it important to establish that transformation leads and managers working in each Alliance would also engage with local partners and communities to establish more collaborative solutions to problems the NHS could not always address on its own.

This activity tied into one of the statutory responsibilities for integrated care boards (ICBs), addressing local health inequalities, and was covered by the strategy "Working with People and Communities" which the ICB was developing with our stakeholders over the next two years.

Since the ICB's inception on 1 July 2022, the central communications and engagement team had provided support to Alliance teams including, but not limited to:

- Centrally co-ordinated primary care communications and engagement.
- Media relations.
- Issues and crisis management.

- Internal communications to share Alliance information with the wider workforce.
- Advice and guidance on stakeholder management, especially around primary care estates.
- Multi-agency, integrated communications campaigns.
- Communications liaison via the Essex Communications Network, Southend City Council and Thurrock Better Care Together.
- Helping Alliances to give local nuance to system-wide campaigns, such as vaccination drives.
- Ensuring local voices are heard in system-wide engagements and the formal consultation on service harmonisation currently running.
- Supporting inequalities work, for example by producing accessible communications and identifying vaccination and other outreach opportunities.
- Support and advice for Alliance transformation and engagement teams.

Chris Gasper (Patient representative, Southend), who was not present at the meeting, asked the following question:

"How can Patients be involved in the design, planning and delivery of primary care services at the GP and PCN level in MSE please?".

MT confirmed that a written response would be provided to Mr Gasper.

Mr Owen Richards (Chief Officer, Healthwatch Southend), who was not present at the meeting, asked the following questions:

"Much of the data presented in the Board's papers are at system level. How does the Board receive assurance that the residents of one Place are experiencing the same outcomes as those of another Place – 4 hour waits at the three A&E departments, or ambulance response times in different areas?" and

"I note that the Primary Care Commissioning Committee no longer meets in public. Whilst the CCGs were in existence, these meetings were held in public, so that (for example) plans to close a surgery would allow members of that practice to witness the decision-making process. Access to general practice and NHS dentistry are probably top of the list for most of the residents in Mid & South Essex. Would the Board reconsider this, allowing local people greater transparency?"

MT confirmed that a written response would be provided to Mr Richards.

Mr Stuart Scrivener, who was present at the meeting, asked the following questions:

"Given this ICB is running a deficit budget, how will financial balance be achieved for 2022/23 without damaging the clinical transformations planned for all the people who need care, both mental health care and physical care?" and

"How are you beginning to address health inequalities for the MSE population?" and

"How are you beginning to address health inequalities for the MSE population?

MT confirmed that a written response would be provided to Mr Scrivener.

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

4. Minutes of the ICB Board Meeting held 13 October 2022 and matters arising (presented by Prof. M Thorne).

MT presented the minutes of the ICB Board meeting held on 13 October 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 13 October 2022 meeting as an accurate record.

There were no matters arising.

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

The updates on the action log were noted.

MT referred to Action 10 (Digital Strategy and Investment Priorities) and advised that there was circa £60 million available to fund an electronic patient record system across mid and south Essex (MSE). To access this funding, a commitment from the acute and mental health partner organisations was required. MT asked when this would be forthcoming.

PS confirmed his support and that he had signed this off, on behalf of Essex Partnership University NHS Foundation Trust (EPUT), that morning.

AP advised that he would seek an update from Mid and South Essex NHS Hospitals Trust (MSEFT) and advise the ICB as soon as possible.

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

Action: AP to provide an update to the ICB regarding MSEFT's commitment to the MSE wide electronic patient record system.

6. Confirmation of Local Authority Partner Members (presented by Prof. M Thorne).

MT asked members to note the paper confirming the process undertaken to appoint the new local authority partner members, namely Les Billingham (Thurrock Council) and Benedict Leigh (Southend-on-Sea City Council).

Resolved: The Board NOTED the update regarding the appointment of new Local Authority Partner Members, namely Les Billingham for Thurrock Council and Benedict Leigh for Southend-on-Sea City Council.

7. Termination of Pregnancy Service Provision – Commissioning Intentions 2023/24 (presented by T Hemming).

TH advised that the ICB had last procured termination of pregnancy (TOP) services in 2021/22 on a one plus one year basis, which was not extendable. There were various options to go out to market as set out on page 25 of the papers.

Following receipt of advice from the ICB's procurement specialist, Attain, and consideration by the Finance and Investment Committee (FIC), the recommendation was to proceed with an accelerated open tender process to enable the new service to commence from 1 April 2023. This would be for a five year plus two year contract of a total value of £12.3 - £17.2 million, which required Board approval.

TH advised that £2.4 million would be spent on these services during 2022/23 and confirmed that additional funding was not being requested.

JF, Chair of FIC, confirmed that he supported the recommendation to go to market for these services.

AMcK advised that when the paper was considered by the Executive Team, PG had highlighted that the service model had changed since this service was last procured. The updated model would be applied.

Resolved: The Board APPROVED 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.

8. Board Assurance Framework (presented by A McKeever)

AMcK advised that the first iteration of the new ICB Board Assurance Framework had been developed with the assistance of lead officers and the Audit Committee and would be further developed. AMcK advised that the BAF would enable the Board to focus on the ICB's main objectives and addressing the issues that might prevent it from achieving these.

MT asked members if they agreed with the seven key areas covered by the BAF and if there were additional risks that should be included.

JF advised the document was comprehensive but asked whether mental health services should also be included. AMcK confirmed that the ICB needed to support and develop mental health services that EPUT and others provided and he would liaise with MTh to consider how that should be articulated within the BAF.

In response to a query from NIB regarding provider and ICB BAFs, AMcK advised that the ICB BAF was an overarching framework for the system and that provider organisations maintained well-developed BAFs of their own Further work would be undertaken to align them where appropriate..

GW advised that he welcomed the concise format of the ICB BAF and that it was a good start. The plan was in future to incorporate arrangements at Alliance level which would feed up to the BAF, as well as improved horizon scanning to identify new risks at an early stage.

Resolved: The Board noted the Board Assurance Framework.

Action: AMcK / MTh to consider how mental health services should be articulated within the BAF.

9. Report following the Independent Investigation into East Kent Maternity and Neonatal Services (presented by F Bolger)

MT advised that the recommendations contained within the report relating to the independent investigation into East Kent maternity and neonatal services would help other organisations to take appropriate action to ensure the safety and quality of their maternity services. In particular, Boards were required to ensure that they were not either knowlingly, or as far as possible, unknowingly not aware of things they ought to be.

FB summarised the main themes and findings within the investigation report and referred to the letter from NHS England dated 20 October 2022 (Appendix 3) which required the ICB Board to review the findings at its next public Board meeting so it could be clear about the action it would take and how effective assurance mechanisms were at 'reading the signals'.

NHS England and Improvement (NHSE/I) was due to publish a single improvement plan encompassing the recommendations from the East Kent report, Ockenden and other relevant reports in March 2023.

With regard to assurances in place across MSE, FB explained the Local Maternity and Neonatal System (LMNS), set up in response to the Morecambe Bay investigation, initially focussed upon transformation but following Ockenden, its function developed further. LMNS representatives from across the system including providers, public health, ICB, and NHSE/I considered recommendations within reports and data to agree on action required, which was then considered by System Quality Group and the ICB Quality Committee.

FB advised that she also attended meetings with MSEFT, the main provider of maternity services,. The ICB's Consultant Midwife also worked closely with MSEFT to improve maternity care. Assurance visits also took place and included checking progress against the Ockenden recommendations.

FB asked members to consider whether they were adequately assured that sufficient oversight of maternity services across MSE was being maintained.

MT informed members in the light of ongoing CQC concerns and conversations with LMNS members that, other than receiving information via the Quality Committee reports, it was his view that further assurance was required and suggested that the ICB's Consultant Midwife, on behalf of the LMNS, should attend the next meeting to ensure the Board was fully sighted on any significant issues as well as highlighting areas where improvements had been made.

FB mentioned that the report following the most recently Care Quality Commission (CQC) inspection of maternity services might be available by the next Board meeting.

AP advised that a report on maternity services was provided to each MSEFT Board meeting. Action had been taken to address air quality issues identified within the maternity unit and the paediatric and maternity division of the Trust had recently appointed a new external medical director to further strengthen arrangements.

AMcK advised that the East Kent report contained 'areas for action' which was a new and deliberate approach to assurance within the NHS. Those charged with providing assurance to Boards needed to be confident in the accuracy and validity of information they provided, and those who received assurance must also be satisfied that it was robust.

BL advised that as a result of local conversations regarding mental health services, it was vital to use the experience of service users and asked the Board to consider how that could be effectively conveyed to members.

PS agreed with this suggestion and highlighted the importance of checking that organisations were effectively engaging with their populations on the design and delivery of all services in order to learn and identify potential problems at an early stage.

NIB confirmed that she, as Chair of the ICB Quality Committee (QC), and FB acknowledged the overlap between maternity and mental health services and the importance of hearing peoples' lived experience which was a central part of deep dives undertaken by QC. NIB acknowledged that gauging compassion and kindness was difficult, but using different methods and interventions made it possible to provide adequate levels of assurance.

JF agreed and highlighted the importance of ensuring assurances were tracked and monitored across the system in full collaboration with providers to ensure prioritisation.

MT highlighted the importance of addressing closed culture by reviewing the outcome of staff surveys, and not allowing certain behaviours to continue. FB confirmed that the NHS Staff Survey provided a significant amount of information, including staff views on issues such as culture, bullying and harassment. In addition, the CQC undertook an annual maternity staff survey, the Trust analysed the outcome of the 'Friends and Family Test' and the General Medical Council undertook trainee surveys. The Maternity Voices Partnership were also represented on the LMNS and undertook their own surveys.

In response to a query from MT, RJ advised that survey data collated by universities regarding the experience of students and other national/local data, would be made available to the People Board and could be triangulated against patient experience data.

SP highlighted the importance of reviewing comments and complaints and ensuring that people were able to raise their concerns easily.

GW advised that he recently attended a maternity walkround and spoke with midwives, whose views bore no reflection on the staff survey responses. They provided examples where management were not communicating and problems with their salaries, which highlighted a disconnect between management and individuals providing care. GW therefore recommended further face-to-face interaction with staff should be undertaken.

AP advised that MSEFT worked with the Good Governance Institute and had engaged other support and he would be happy to work with colleagues to ensure that the ICB received robust assurance regarding the quality and safety of services.

MT advised that he was mindful of the sovereignty of each partner organisation, but highlighted the ICB was responsible for holding them to account via a supportive partnership approach, underpinned by an honest exchange regarding the position of organisations on all fronts, as well as celebrating the positives.

Resolved: The Board:

- **Considered the recommendations from the Inquiry.**
- **Noted the importance of being assured, against being reassured, and considered if it was sufficiently assured it had oversight of maternity services.**
- **Noted the importance of professional curiosity.**
- **Agreed that the ICB Consultant Midwife, as a representative of the Local Maternity and Neonatal System, should attend the next Board meeting.**
- **Agreed that the Chief Nurse will bring forward a further paper setting out proposed local actions in response to the four areas of action in the report.**

10. Quality Report (presented by F Bolger)

MT advised that further work was being undertaken to improve the content and format of the Quality Report to ensure the Board was sighted on key patient safety and quality risks in order to fulfil its responsibilities.

FB confirmed that she was in the process of clarifying whether there were any mandatory requirements regarding the content of quality reports to ICB Boards before making any changes. A workshop had been held to develop future metrics and reporting and a report writing session was held with the Quality Team, who were piloting a new style of report for the Quality Committee.

FB highlighted that Clostridium Difficile Infection (CDI) rates remained above trajectory, noting that national data was currently collected by former CCG areas and there was a timelag as Trusts were given three months in which to report. A virulent strain, 027, had contributed to the rise in CDI rates within a ward at Basildon Hospital. FB was trying to ascertain how MSE compared against other ICBs, but confirmed that appropriate infection, prevention and control (IP&C) action was being taken.

In response to a query from MT regarding the outcome of a visit by the ICB's IP&C Team on 4 November 2022, FB advised that the IP&C Lead had confirmed to her that cleaning issues previously identified in a particular area had been addressed. AP confirmed that the MSEFT Trust Board were aware of and were monitoring CDI rates.

JF highlighted the number of outstanding harm reviews and Serious Incidents (SIs) and asked if trends could be included in future reports.

FB advised that the ICB relied on data from various sources, including providers and public health, but the Business Intelligence Team were building a new platform to bring this together and improve accuracy and reporting.

MT asked that notwithstanding this work, he would appreciate receiving a simple indication of trends in future reports.

AMcK advised that he looked forward to receiving a summary of the outcome of recent CQC inspections once reports were available. AMcK requested that information on safeguarding of people with learning disabilities, mental health conditions and the frail elderly was included in future reports.

DD noted the neo-natal death rate in Thurrock was significantly above the national average. FB explained that the small numbers involved, which could skew data, might be a factor, but information currently available indicated that Thurrock was an outlier with lifestyle choices being relevant. This was a good example of where the ICB and Alliances required accurate information to reduce health inequalities. FB offered to discuss with DD and other colleagues ongoing work being undertaken by her team in this respect.

Resolved: The Board noted the Quality Report.

Action: FB to consider how best to cover trends and on which issues (for example outstanding harm reviews, serious incidents and safeguarding information regarding those with learning disabilities/mental health conditions and frail elderly) in future Quality updates to ICB Board.

11. Performance (presented by T Hemming)

11.1 Performance Report

TH advised that despite the significant amount of work being undertaken to improve performance, the position had not changed significantly since the last Board meeting.

A plan to ensure that diagnostics capacity and demand were aligned was being developed and she expected this would be finalised in spring 2023. With regard to cancer waiting times, although the performance against constitutional standards did not appear to have changed, the underlying data had improved significantly, with those patients waiting longer than 62 days having reduced significantly.

TH confirmed that 78+ week waits were on track to reduce to zero by March 2023, although this would be challenging. However, there was concern that 52+ week waits were increasing and would therefore be focussed upon.

Patient Pathway Plus had gone live and provided a single data list for RTT. GooRoo, an analytical tool, would be implemented in 2023.

Mental Health standards for improving access to psychological therapies (IAPT) and early intervention in psychosis access were being met. Further work to encourage greater number of people to access these services was being undertaken.

MT acknowledged the huge amount of work being undertaken to improve performance across MSE and thanked AP and his colleagues in particular for this.

RJ advised that a workforce plan to increase the number of sonographers was under development with a new programme under development at Anglian Ruskin University. There was also an international recruitment programme for allied health professionals to fill current gaps, although it was important to build a domestic pipeline for these and other roles.

In response to a query from PF, AP advised that the main reason for the large number of 52+ week waits was an increase in post-pandemic out-patient referrals and confirmed that MSEFT was focussed on reducing this by improving efficiency and controlling demand via other routes. AP confirmed that although MSEFT's 52+ week waits were high, it was not significantly out of step with other organisations of a similar size, although it was currently performing poorly against cancer standards.

AMcK provided examples of the action AP and his colleagues were taking to address the backlog, including clinical prioritisation and addressing the longest waits. A programme was also in place to reduce cancer waits and urgent and emergency care was also being focussed upon, including agreement of an improvement trajectory, which should be available the following month.

Resolved: The Board noted the ICB performance report.

11.2 Urgent Emergency Care and Winter Plan

TH summarised her report and advised that the planned additional capacity on table 2 might be subject to change. Establishment of the System Control Centre (SCC) was slightly ahead of plan and would go live from 1 December 2022.

TH advised that she intended bringing further information back to the Board in due course to provide assurance that appropriate action had been taken to fulfil the 'winter letter' requirements.

In response to a query from MT regarding local authority input to the SCC, TH advised that it replaced the Tactical Control Centre and RF confirmed that local authority colleagues were due to attend a meeting in relation to preparations for its operation.

AMcK confirmed that operational arrangements were in place which involved partner organisations, including social care and the community/voluntary sector, to manage winter emergency care pressures. The SCC would consolidate and strengthen the co-ordination of current arrangements to ensure that agreed actions were quickly acted upon.

Resolved: The Board noted the update on the Urgent Emergency Care and Winter Plan.

12. Fuller Stocktake Report (presented by Dr A Davey).

AD advised that work had commenced with a partner organisation, HIP, to develop a clinical strategy for each of the 27 Primary Care Networks (PCNs) by March 2023, with a request that the Fuller Stocktake approach was taken for this. The Patient-Aligned Care Teams model was also being rolled out to support practices and pharmacies to manage patients with complex care needs, including offering additional / longer appointments.

AD outlined action being taken to improve practice telephony, websites and use of the NHS App, which would be supported by a new role to develop this area.

AD highlighted yearly data regarding consultation methods set out on page 76 of the papers which showed that 147,253 more appointments had been offered this year than prior to the pandemic, although there was an increase in telephone consultations and fewer face-to-

face appointments. The following table showed that MSE practices were slightly below the national average for when appointments occurred.

MT asked AD to include the total number of practices within future reports.

DD noted that there was not a national standard for when appointments should occur, but the timeliness of these could affect performance against NHS constitutional standards in other areas. AD advised that under the General Medical Practice contract, GPs were required to assess anyone who is ill, or believes themselves to be ill, within 48 hours of contacting the practice, but that did not relate to same day emergency care. Increasingly, as highligihted within the Fuller Stocktake report, the idea of same day emergency care within primary care to reduce demand on hospitals was being explored. MT suggested this could possibly be the subject of a future Board seminar.

RH advised that one of the advantages of primary care Alliance teams was the respiratory care model which reduced the amount of urgent care.

RF commented that the neighbourhood concept, involving all partners, would help to improve the care and health of local populations.

Resolved: The Board NOTED the Fuller Stocktake Report update report.

Action: AD to include the total number of practices within future Fuller Stocktake reports and to liaise with MT to consider whether to hold a Board seminar on the future role of general practice.

13. Finance Report Month 6 (presented by J Kearton)

JK confirmed that at month 6 the ICB was forecasting a break even position in line with its plan, noting that Q1 accounting related to the former CCGs. However, there were key risks in relation to managing market pressures for continuing health care; potential service harmonisation; and some additional inflationary pressures. The ICB was delivering on its own efficiencies and its financial position was as expected for this point in the year. Planning for 2023/24 had commenced and would involve social care colleagues.

The wider system financial position was off plan for month 6, reporting £44 million in deficit. The the system now had a financial improvement and recovery plan in place. Both EPUT and MSEFT finance committees were fully informed of this and the ICB's FIC was regularly updated. Regional oversight was also in place.

The deficit position was mainly driven by workforce pressures and a failure to achieve sufficient traction on three year sustainability plans.

JF advised that he was keen to receive trend information and to hear more about the work being undertaken by PWC. JF asked if he could meet with JK and AMcK during December prior to the next FIC meeting in January to receive an update on the latest position.

MT advised that he understood that MSE was likely to report the largest financial deficit in the East of England for 2022/23 and was required to take action to reduce this as far as possible. Historically, budget underspends in specific areas, some of which included transformation funding, were used to offset overspends in others. However, the system needed to ensure that services were transformed to realise efficiencies and suggested that

a seminar should be held, before year-end, to show members national and other data that would help them to understand where inefficiencies were occurring.

Resolved: The Board NOTED the Month 6 Finance Report.

Action: JK to arrange a meeting with JF and AMcK during December to provide an update on the latest financial position.

Action: JK/MFT/AMcK to consider holding a Board seminar to highlight national and other data to understand where ineffiencies are occurring.

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

RF advised that the public consultation on the harminisation of six commissioning policies had been extended to 19 December 2022 and outlined engagement undertaken so far.

Resolved: The Board NOTED the update on the harmonisation of commissioning policies.

15. Basildon and Brentwood Alliance Update (presented by Pam Green)

PG advised that she would take the Basildon and Brentwood Alliance update as read, which represented her plans for the Alliance.

AMcK advised that he recently met representatives from Basildon and Brentwood Council who had substantiated the work described within the report and thanked PG and her team for all the hard work undertaken to-date.

Resolved: The Board NOTED the Basildon and Brentwood Alliance update.

16. General Governance

16.1 Approved Minutes of Committee meetings

The Board received copies of the latest approved minutes of the following main committees:

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

Resolved: The Board NOTED the latest approved minutes of the 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

MT advised that due to the absence of a number of Partner Members at the meeting on 13 October 2022, the Board was now asked to ratify decisions taken at that meeting.

Resolved: the Board RATIFIED the following decisions:

- **Approval of the ICB minutes and action log, 1 July 2022.**
- **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).**

17. Any Other Business

There was no other business discussed.

18. Date and Time of Next Board meeting:

Thursday, 19 January 2023 at 3.00 pm in the Gold Room, Orsett Hall Hotel, Prince Charles Avenue, Orsett, Essex, RM16 3HS.

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.To be discussed with newly appointed Alliance Director for Thurrock.	In progress
4	01/07/2022	9	**Appointment of Lead Roles** Include appointment of Deputy Chair of the ICB to the agenda of a future Board meeting.	M Thompson	31/08/2022	Deferred until future Board meeting.	In progress
7	13/10/2022 and 17/11/2022	3 3	**Questions from the Public** Arrange for written responses to be provided to questions from the public.	N Adams	17/11/2022	Responses provided to all questions.	Complete
9	13/10/2022	8	**Digital Strategy and Investment Priorities** Secure investment requirements over future years.	System Leaders Finance Group/ J Kearton	Ongoing	Digital priorities discussed at System Finance Leaders Group, however deep dive planned for 7 February 2023.	In progress
10	13/10/2022 and 17/11/2022	8 5	**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	EPUT and MSEFT have confirmed their support for the Electronic Patient Record programme.	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	J Kearton seeking clarification - verbal update to be provided at meeting on 19 January 2023.	In progress

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
18	17/11/2022	3	**Board Assurance Framework** Consider how mental health services should be articulated within the BAF.	A McKeever/ M Thompson	16/03/2022	To be reflected as appropriate in future iteration of the BAF.	In progress
19	17/11/2022	10	**Quality Report** Include information on trends, including outstanding harm reviews, serious incidents and safeguarding information regarding those with learning disabilities/mental health conditions and frail elderly in future Quality updates to ICB Board.	F Bolger	16/03/2022	New version of Quality report being presented 19 January 2023. Work continues to refine.	Complete
20	17/11/2022	12	**Fuller Stocktake** Include the total number of practices within future Fuller Stocktake reports and to liaise with Prof Mike Thorne to consider whether to hold a Board seminar on the future role of general practice.	A Davey R Fenton	05/01/2022	Total number of practices included in January Fuller update report to ICB Board. Board seminars on primary care arranged for 19/01/23 facilitated by Dr Ronan Fenton and Dr Anna Davey and also 31 January facilitated by Prof Claire Fuller.	Complete
21	17/11/2022	13	**Finance Report (M6)** Arrange a meeting with JF and AMcK during December to provide an update on the latest financial position.	J Kearton	09/12/2022	Meeting held 13/12/2022.	Complete
22	17/11/2022	13	**Finance Report (M6)** Consider holding a Board seminar to highlight national and other data to understand where ineffiencies are occurring.	J Kearton M Thorne A McKeever		Finance and efficiency seminar held for board members on 08/12/22.	Complete

Part I ICB Board meeting, 19 January 2023

Agenda Number: 7

Maternity Services Update

Summary Report

1. Purpose of Report

To provide the Board with assurance in relation to oversight of local maternity services, following the publication of the East Kent independent investigation report.

2. Executive Lead

Frances Bolger, Interim Executive Chief Nurse.

3. Report Author

Gemma Hickford, Consultant Midwife.

4. Responsible Committees

MSE Local Maternity and Neonatal System (LMNS) Steering Board and MSE ICB Quality Committee.

5. Impact Assessments

None identified for this report

6. Financial Implications

None identified for this report.

7. Details of patient or public engagement or consultation

Maternity services are subject to annual patient surveys and the findings incorporated into local action plans. 2.5 of this report notes local engagement activities with women and families.

8. Conflicts of Interest

None identified for this report.

9. Recommendation(s)

The Board is asked to:

- Note the summary actions being undertaken against the 4 key areas.
- Note the current maternity oversight and assurance mechanisms in place with and within MSEFT.

Maternity Services update paper

1. Introduction

1.1 Following the publication of the Independent Investigation into maternity and neonatal services provided by East Kent Hospitals University NHS Foundation Trust, every Trust has been asked to review the findings and take action by considering how effective assurance mechanisms are at ‘‘reading the signals’’.

1.2 The purpose of this report is, following discussion at the ICB Board on 17 November 2022, to provide assurance regarding the safety and quality of local maternity services, based on current intelligence and evidence.

2. Maternity Oversight

2.1 The East Kent report identified four areas for action, the themes from these have been identified below, with reference to sources of assurance.

2.2 **Monitoring safe performance**
Intelligence is gathered from various sources, including from regional and national and Trust reported levels, the triangulation of this information is key to Local Maternity and Neonatal System (LMNS)/ICB assurance. Intelligence is quantitative and qualitative and includes direct feedback from staff and service users.

In December 2022 the Care Quality Commission (CQC) undertook unannounced inspections of all three maternity services within Mid and South Essex NHS Foundation Trust and rated the service as ‘Requires Improvement’. This rating has been maintained since December 2021, however there is a continued focus to improve the rating to ‘Good’. Progress is being driven by the Maternity Improvement Programme which incorporates all service priorities and actions.

The Trust have proposed a Maternity Data Intelligence Committee to be chaired by the Care Group Medical Director, which is planned to commence this month. It will include the Consultant Midwife for the LMNS and will seek to review local and national intelligence, to identify trends and areas of concern from a multi-disciplinary perspective.

2.3 **Teamworking and leadership**
In the last twelve months the Trust has appointed various key roles including a Director of Midwifery, two Heads of Midwifery, two Consultant Midwives, seven Obstetric Consultants, a Managing Director for the recently established Care Group 5 (Women’s and Children’s Services) and most recently a new Medical Director for the Care Group. The establishment of the senior leadership team is fundamental to ongoing and sustained improvement within maternity services.

2.4 **Culture**
Maternity services have recognised there is a need to address collaborative working and professional behaviours within their workforce. The LMNS undertake regular Quality Assurance Visits, seeking feedback both directly and indirectly from staff in relation to the culture of the service. The CQC recently acknowledged staff demonstrated good team working and supported each other to provide good care.

2.5 **Listening to women and families**

The MSE Maternity and Neonatal Voices Partnership (MNVP) is a service user voice mechanism which ensures representation of those using our maternity services is reflected within local service transformation. The LMNS, Trust and MNVP are leading a co-production workshop for maternity and neonatal staff and service users in February 2023 as an opportunity to establish collaborative working.

3. Recommendations

3.1 The ICB Board is asked to:

- Note the summary actions being undertaken against the 4 key areas.
- Note the current maternity oversight and assurance mechanisms in place with and within MSEFT.

Part I ICB Board meeting, 19 January 2023

Agenda Number: 8

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations and actions being taken in response.

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. Impact Assessments

None required for this report.

7. Financial Implications

None relevant to this report.

8. Details of patient or public engagement or consultation

None applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is asked to:

- Note the key quality concerns and escalations as identified by Quality Committee.
- Receive assurance that mitigating actions are being undertaken to address concerns.
- Agree that Clostridium Difficile Infection (CDI) rates continue to be monitored via Quality Committee with an update after the current year which completes in March 2023. Oversight of Mid and South Essex NHS Foundation Trust (MSEFT) actions will continue via the MSEFT Infection Control Committee and ICB Antimicrobial Meeting.
- Note the recent adverse media attention received by MSEFT resulting from an incident impacting the maternity services; the recent Channel 4 Dispatches programme which featured Essex Partnership University NHS Foundation Trust (EPUT); the resulting potential impact on confidence in services by the public and staff; and the consequent remedial actions being undertaken by the Trusts and, where appropriate, the ICB.
- Note the MSEFT Care Quality Commission (CQC) report publication, findings and ICB oversight processes for supporting improvement of services.
- Agree that the rates of overdue serious incident (SI) and cancer harm reviews backlog continue to be monitored via the Quality Committee. ICB oversight of MSEFT actions will continue via the formal meetings held with the Trust.

Mid and South Essex Quality Report

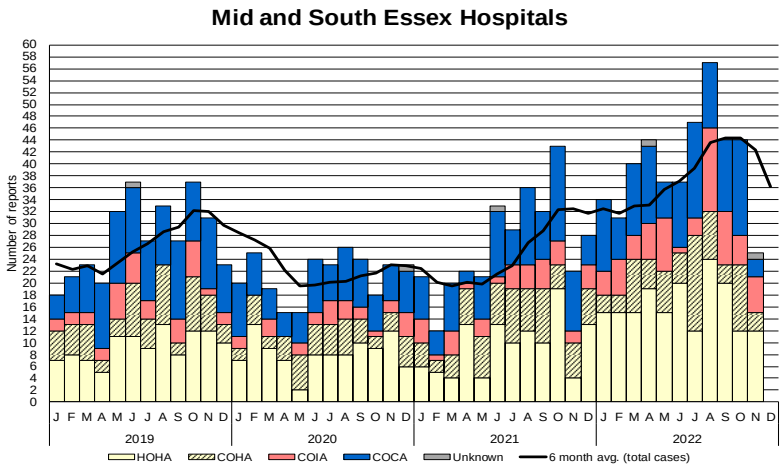
1. Introduction

1.1 The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations and actions being taken in response

2. Clostridium Difficile Infection Rates within Mid and South Essex NHS Foundation Trust

2.1. Clostridium Difficile Infection (CDI) remains a high priority for NHS organisations, including ICBs. Nationally rates are currently at the highest levels for thirteen years. MSEFT and consequently the ICB, are outliers on this metric.

2.2 NHS England and the ICB oversee Infection Prevention and Control (IPC) management via outbreak meetings. Following an ICB IPC team visit on 4 November 2022, the team are assured that correct IPC measures have been undertaken to prevent spread. Although MSEFT has seen declining CDI rates over the last month (see table below) they remain above the trajectory set. The ICB continues to monitor closely.



Ongoing monitoring of the CDI rates will continue via the Quality Committee, with an update to the ICB Board in May 2023 when the current 2022/23 threshold has closed. A revised threshold will be agreed for 2023/24.

3. Maternity Nitrous Oxide Incident on Basildon Hospital Site, Mid and South Essex NHS Foundation Trust

3.1 The ICB Board has been made aware of a maternity incident which was declared on 14 October 2022. In June 2021, during routine environmental sampling, it was identified 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). Regular and long-term exposure to nitrous oxide can cause vitamin B12 deficiency and associated nerve damage, and possible infertility. There is no risk to women and their families as potential harm to health is caused by prolonged long-term exposure.

3.2 Although appropriate short term remedial actions had been undertaken, the nitrous oxide levels remained above acceptable levels. Therefore, it was necessary to temporarily cease Entonox usage from the beginning of December 2022 until 20 December 2022. During this time, an alternative analgesia pathway was available to women, with 12 women choosing to deliver in an alternative location. There was no evidence of increased epidural usage or instrumental deliveries during this period.

3.3 Close monitoring of the current situation is through weekly incident management meetings chaired by the Trust's Medical Director. Actions include regular environmental sampling of nitrous oxide levels.

3.4 NHS England, the Care Quality Commission (CQC) and the Health & Safety Executive (HSE) were informed. In December 2022 the HSE informed the Trust that it had commenced an investigation into the incident.

3.5 An external investigation was commissioned by one of the Trust's non-executive directors. A summary of the report findings and the outcome of the HSE investigation will be brought back to ICB Board once completed.

4. Dispatches Programme 10 October 2022 - Essex Partnership University NHS Foundation Trust

4.1 The ICB Board has been made aware of the recent adverse media attention and the subsequent CQC inspection at Essex Partnership University NHS Foundation Trust. The Channel 4 'Dispatches' documentary featured the trust in their recent programme regarding care within mental health wards. An investigation, commissioned by the Trust Chief Executive Officer, is nearing completion.

4.2 Since the programme, the CQC commenced a full inspection of six core services with the well-led inspection held on 17-19 January 2023. A Section 29A warning notice was issued following an unannounced inspection in October 2022 following concerns around safe staffing, observation of patients and access to ligature cutters.

4.3 On 14 December 2022, the three ICBs (Mid & South Essex, Herts & West Essex, and Suffolk & North East Essex) held a Rapid Quality Review meeting with representation from the Trust, NHS England, CQC, General Medical Council and Nursing & Midwifery Council. The remit of the meeting was to gain assurance that appropriate actions and mitigations had been undertaken by the Trust to ensure safe care following findings identified by the Dispatches programme and the CQC, including agreeing any additional support that may be required.

4.4 A follow-up Rapid Quality Review meeting has been organised for 2 February 2023.

4.5 The findings of the Trust investigation and the CQC inspection will be brought back to the ICB Board once reports are received by the ICB.

4.6 Abuse of staff was a theme identified during the CQC inspection and in the NHS Staff Survey for the Trust. The 2022 National NHS Staff Survey closed on 25 November 2022. Once the results are published nationally (expected by March 2023), a summary of the results for all the trusts in Mid and South Essex will be brought back to the ICB Board.

5. CQC Findings - Mid and South Essex NHS Foundation Trust

5.1 The CQC undertook an unannounced focussed inspection of MSEFT core services between 18 August to 21 September 2022 and a 'well led' inspection on 11 and 12 October 2022. The following services were inspected:

- Diagnostic imaging services at Southend University Hospital.
- Maternity services across all three sites.
- A Well-led inspection of the Trust.

The CQC report was published in December 2022. The overall rating of 'Requirements Improvement' remains unchanged from the previous inspection, as set out below:

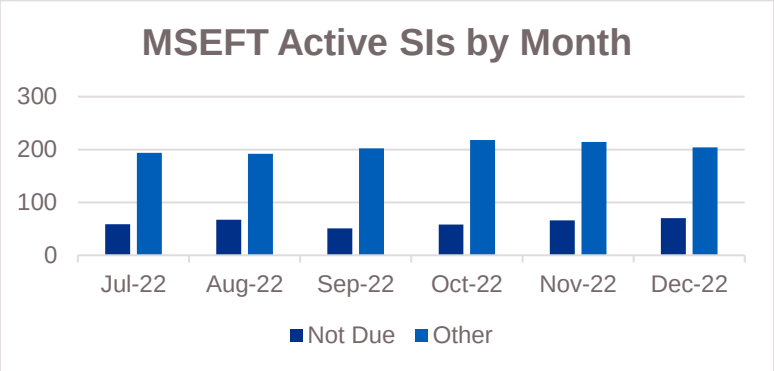
5.2 Areas identified as requiring improvement included mandatory training compliance, staff appraisal, safe staffing levels, management of SIs including duty of candour and learning from incidents. The CQC actions will be incorporated into the current overarching improvement plan.

5.3 Progress against the plan is monitored via the MSEFT CQC Programme Group, the Quality Improvement Board and the Maternity Assurance Committee.

5.4 The Trust's undertakings, which set out specific improvements required by NHS England (NHSE) are being reviewed to reflect the CQC findings. Once all parties have agreed the undertakings, an update will be brought back to ICB Board. The ICB System Oversight and Assurance Committee, which is co-chaired by NHSE, has specific provision to review and monitor the Trust's undertakings.

6. Serious Incidents at Mid and South Essex NHS Foundation Trust

6.1 As highlighted in the recent CQC report, Mid and South Essex NHS Foundation Trust had 280 open serious incidents (SIs) as of 30 November 2022, of which 214 were overdue, making the Trust an outlier in the East of England.



6.2 A contributing factor for the backlog of SIs is that, as of 31 December 2020, in response to unprecedented pressures of the pandemic, NHS England allowed organisations to delay the completion of SI investigations. The changes have not been reverted to previous processes due to implementation of the new national investigation framework. Organisations are expected to transition to the new Patient Safety Incident Response Framework (PSIRF), published in August 2022, by Autumn 2023. To enable a smooth transition, it is important to close as many of the current SIs as possible. Despite actions undertaken by the Trust to reduce the number of open SI investigations, the Trust has had limited success to date meeting their trajectory to close incidents.

6.3 The ICB participates in the Trust Executive Review Group, where potential SIs that have occurred are discussed. Immediate learning and action is undertaken and decisions are made as to whether the incident requires further investigation.

6.4 On 2 December 2022, a deep dive was undertaken into the Trust's SIs to identify additional actions that could be undertaken to reduce the backlog. Based on learning from other Systems and PSIRF, the ICB agreed that a group of identified low and moderate harm investigations, such as pressure ulcers and falls, could undergo a thematic review. In addition, the Trust has implemented a concise template to support investigation and closure of incidents. Individual duty of candour must continue to be met.

6.5 The trajectory has now been reviewed and amended to May 2023. Progress against the trajectory is monitored via fortnightly SI review meetings between the ICB and Trust and a fortnightly meeting between ICB and Trust Chief Nurse.

6.6 The ICB Quality Committee will continue to monitor progress against the trajectory for the overdue SIs. The ICB Patent Safety Specialist will provide a report regarding the implementation of PSIRF to the March 2023 Board meeting.

7. Cancer Harm Review Backlog

7.1 Due to a backlog of cancer harm reviews, a proposal to change the cancer harm review process was agreed at the System Oversight & Assurance Committee (SOAC) on 10 August 2022. The temporary change to process was agreed for a three-month period, allowing teams to focus on 104+ day cancer harm reviews, where the greatest harm is likely to occur, and enabling clinical time to be released to treat patients.

7.2 Patients are reviewed weekly at the patient tracking list to mitigate the risk of harm whilst awaiting treatment. If a patient is identified at risk of harm, priority treatment is arranged. A more formal assessment process occurs when a patient reaches day 90 on a cancer pathway.

7.3 Of the patients reviewed, for 2022-2023, 95% of patients were identified as having no harm, whilst 5% were identified as having low harm, either physical or psychological. No patients were identified as having moderate or severe harm.

7.4 The Trust has made a request to extend the temporary change in process to be extended until March 2023. However, NHS England has requested evidence that clinician time has been released as a result of the process change.

7.5 The ICB will continue to seek assurance through the weekly harm review panel meetings and provide assurance to the ICB Quality Committee.

8. Conclusion

8.1 On the basis of the information supplied and analysed, the specific actions being taken to address the concerns identified, and the detailed work overseen by the Quality Committee, the Board can be assured of the measures being taken to ensure quality of services across MSE.

9 Recommendations

9.1 The Board is asked to:

- Note the key quality concerns and escalations as identified by Quality Committee.
- Receive assurance that mitigating actions are being undertaken to address concerns.
- Agree that CDI rates continue to be monitored via Quality Committee with an update after the current year which completes in March 2023. Oversight of MSEFT actions will continue via the MSEFT Infection Control Committee and ICB Antimicrobial Meeting.
- Note the recent adverse media attention received by MSEFT resulting from an incident impacting maternity services; the recent Channel 4 Dispatches programme which featured Essex Partnership NHS Trust (EPUT); the resulting potential impact on confidence in services by the public and staff; and the consequent remedial actions being undertaken by the Trusts and, where appropriate, the ICB
- Note the MSEFT CQC report publication, findings and ICB oversight processes for supporting improvement of services.
- Agree that the rates of overdue SI and cancer harm reviews backlog continue to be monitored via the Quality Committee. ICB oversight of MSEFT actions will continue via the formal meetings held with the Trust.

Part I ICB Board meeting, 19 January 2023

Agenda Number: 9

Performance and Assurance Report

Summary Report

1. Purpose of Report

This paper is intended to provide members with an overview of the current position (where available) against the NHS constitutional standards and to outline 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 paper has been developed using information shared within the ICB assurance cycle meetings. The performance outlined in this paper is within the assurance and planning papers submitted to the System Oversight and Assurance Committee (SOAC).

5. Conflicts of Interest

None identified for this paper.

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

2.1 Urgent and Emergency Care (UEC)

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

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

Ambulance Response Times

Standards:

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

The ambulance response times remain below the NHS constitutional standards.

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

Metric			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Category 1 Calls - Standard: 90th Centile <= 15min Mean <= 7min	90th Centile	Min	00:16:08	00:16:07	00:15:01	00:17:05	00:15:07	00:15:41	00:17:29	00:14:27				
		Max	00:19:15	00:19:37	00:19:31	00:21:42	00:19:33	00:22:22	00:22:04	00:20:15				
	Mean	Min	00:08:31	00:08:22	00:08:09	00:09:09	00:07:54	00:08:36	00:09:05	00:08:15				
		Max	00:11:27	00:11:16	00:11:15	00:11:58	00:11:03	00:12:38	00:12:30	00:12:01				
Category 2 Calls - Standard: 90th Centile <= 40min Mean <= 18min	90th Centile	Min	02:22:34	01:49:36	02:06:14	02:49:56	02:18:00	03:16:52	04:02:27	02:33:00				
		Max	03:29:59	02:37:31	02:32:43	03:09:12	02:53:07	04:22:03	05:25:31	03:25:26				
	Mean	Min	01:09:44	00:54:28	01:02:36	01:18:10	01:04:14	01:24:39	01:45:49	01:14:50				
		Max	01:28:11	01:12:23	01:09:52	01:24:19	01:14:30	01:46:59	02:04:18	01:27:57				

[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 the following table.

Metric		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Emergency Department - 4 hour standard - type 1 (Standard: >=95%)	*Total*	*28,175*	*31,117*	*29,872*	*29,832*	*27,586*	*27,695*	*29,894*	*29,641*	*30,921*			
	Breaches	*9,881*	*10,342*	*10,009*	*10,605*	*10,077*	*10,754*	*11,852*	*12,148*	*14,665*			
	Performance	64.9%	66.8%	66.5%	64.5%	63.5%	61.2%	60.4%	59.0%	52.6%			

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

Test		Oct-22				
		13+ Weeks		6+ Weeks		Total WL size
		No.	%	No.	%	
Imaging	Magnetic Resonance Imaging	408	6%	2,102	32%	6,504
	Non-Obstetric Ultrasound	1,511	15%	3,513	35%	10,013
	Computed Tomography	908	19%	1,921	40%	4,797
	Barium Enema	0		0		0
	DEXA Scan	79	5%	494	30%	1,625
Endoscopy	Colonoscopy	114	9%	362	29%	1,241
	Cystoscopy	112	40%	140	50%	282
	Flexi Sigmoidoscopy	47	11%	140	33%	422
	Gastroscopy	90	9%	214	22%	968
Physiological Measurement	Audiology - Audiology Assessments	498	24%	943	45%	2,111
	Cardiology - Echocardiography	313	9%	1,156	35%	3,338
	Cardiology - Electrophysiology	0		0		0
	Neurophysiology	134	34%	178	45%	392
	Respiratory Physiology - Sleep Studies	41	14%	126	42%	301
	Urodynamics - Pressures & Flows	1	3%	4	13%	30
Total Diagnostic Tests		4,256	13%	11,293	35%	32,024

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 (November 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%)	
51.1%	30.2%	55.2%	80.9%	91.6%	82.7%	67.8%	40.2%	55.7%	57.6%

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

Action undertaken includes:

- Day Zero Patient Tracking List (PTL) – Skin and Lower GI.
- Insourcing and outsourcing continues.
- 5 key pathways (skin, gynae, breast, prostate, lower GI) are our transformation areas, working towards best practice pathways including improving the front end of the pathway to confirm or rule out a cancer diagnosis.
- 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.
- Working through the recovery improvement plan submitted to NHS England and Improvement (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 November 2022, there were 2 patients waiting 104+ weeks, 680 patients waiting 78+ weeks and 12,207 patients waiting 52+ weeks on an RTT pathway at MSEFT.

The Elective Board oversees RTT assurance.

Actions undertaken include:

- Gooroo (a waiting list management tool) 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 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 of ‘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 obtain 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.

2.3 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 (latest position: October 2022).

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 (latest position: June 2022 - data not published at ICB level yet from July 2022).

3. Findings/Conclusion

The main areas to note are: workforce pressures with vacancies remaining a key area of concern across all partners; 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.

4. Recommendation(s)

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

Part I ICB Board meeting, 19 January 2023

Agenda Number: 10

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 Board meeting 13 October 2022 where our action plan was first presented.

2. Executive Lead

Dr Ronan Fenton, Medical Director.
Dr 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 Commissioning Committee.

5. Conflicts of Interest

None Identified for this report.

6. Recommendations

The Board is asked to note and discuss the Fuller Stocktake and Our Plan for Patients Update.

Fuller Stocktake and Our Plan for Patients 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 PCN Clinical Strategy Development

We have continued to oversee the development of clinical strategies for each of our 27 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. The strategies will be underpinned by population health management (PHM) and aligned with the Fuller Stocktake, to help develop new models of urgent and episodic, complex and preventative care. We are continuing to work to a March 2023 deadline.

2.2 New care model development

The creation of integrated neighbourhood teams (INTs) continues to be widely welcomed across the 27 mid and south Essex (MSE) PCNs, where progress by PCNs such as Benfleet and SS9 has been recently showcased. Although in their infancy and at present largely health-focused, we are confident that with continued support, the wider integration of health, care and local assets will continue.

We continue to work with the ICB Digital team to identify digital platforms that can facilitate and support integration as it evolves. The use of a digital platform (Pando) was crucial to the PCN Aligned Care Team (PACT) model in Benfleet / SS9, and we would like to explore system-wide solutions wherever possible.

We are encouraging PCNs to work with established patient participation groups (PPGs) to champion the creation of a ‘lived experience team’ and resident networks in all PCNs. Across the MSE, there are currently four fully established and an additional seven that have agreed to adopt the approach. We are confident that we will reach the target of six established by March 2023.

Notable progress at each place includes:

- **Mid Essex**: The Alliance has recruited three people jointly employed by NHS, Essex County Council (ECC) and Provide to lead the development of integrated neighbourhood teams. Strategy workshops will take place across January and February to support the development of PCN clinical strategies. Specific work is underway to develop new models of personalised care for complex patients in Aegros, Dengie and South Woodham and Chelmsford West PCNs.
- **Basildon and Brentwood**: Brentwood PCN has developed a local model for care of frail patients with complex needs called ‘IMPACT’. Central Basildon recently undertook an away-day to develop relationships across the broader PCN and agreed to align care coordinators with wider partners drawing on third-sector assets to support this. West Basildon has also focused on creating an integrated neighbourhood team for people with complex mental health needs, focusuing on addressing the wider determinants of health in doing so.

- **Thurrock**: Lesley Roberts, Programme Director, has been overseeing the development of all four PCNs in Thurrock, with strategy days for each taking place recently with the involvement of broader system partners (e.g. social care). Models of care are in development, such as the patient access centre (for people with complex needs) and new preventative services for people with cardiovascular disease and obesity.
- **South East Essex**: The focus in south east Essex continues to be on the spread of the PACT model for the management of frailty and people with complex needs. In addition to continuing to evolve the model in Benfleet and SS9, other PCNs have expressed interest in taking up the model, including West Central PCN, where Additional Roles Reimbursement Scheme (ARRS) staff are being refocused to support its delivery.

2.3 Prevention & PHM

We have been working with the PHM team to identify a process to take a number of PCNs through PHM cycles against five key areas: blood pressure recording, hypertension detection & management, diabetes and blood pressure control, Serious Mental Illness (SMI) health checks and vaccinations for individuals with Chronic Obstructive Pulmonary Disease (COPD). This aims address the prevention and PHM element of the Fuller Stocktake.

2.4 Funding and Incentivisation

Work continues on the changes to our contracting approaches in line with the Working Together Scheme and methodology.

PCNs have been given clarity on the approach to the commissioning of services in the early part of 2023/24. This will enable them to retain invaluable work force whilst still working with the ICB on new approaches to commissioning primary care services.

The Local Winter Access Fund has been rolled out to secure additional longer consultations for complex comorbity/copharmacology patients. This has been widely well received by primary care providers.

We are currently working with all parties on how to further support primary care colleagues and the patients they serve during the current winter pressures.

2.5 Progress/Achievements

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

Overall numbers of consultations have continued to rise. The table below shows comparative activity for the period April – November across the last four years. Overall consultations are 7% in 2022/23 compared to the pre-pandemic 2019/20 position. This equates to 283k additional consultations. There has also been a year on year increase in comparison to the 2021/22 activity levels with an additional 75k consultations compared to last year.

In addition, there has been a significant increase in the proportion of activity undertaken via face to face consultation. Whilst this is still below pre pandemic levels, there has been a 15% year on year increase in the number of face to face consultations undertaken in comparison to the same period last year.

Consultation Method	2019/20	20/21	21/22	22/23	Change on pre pandemic (19/20)	Change on 2021/22
Face-to-Face	3,275,633	1,935,798	2,609,081	3,006,960	-8%	15%
Home Visit	8,417	4,089	6,377	12,295	46%	93%
Telephone	373,512	1,341,968	1,259,392	875,754	134%	-30%
Video Conference/Online	102,074	49,278	49,881	80,823	-21%	62%
Unknown	108,062	95,155	150,964	174,888	62%	16%
Total	3,867,698	3,426,288	4,075,695	4,150,720	7%	2%

Within the national “Plan for Patients”, there is an ambition for patients to be seen within two weeks of contacting primary care. The table below shows the proportion of patients seen within key time periods (for April – November 2022/23);

Period	MSE ICS	National
Same Day	41.2%	42.9%
Within 1 Day (cumulative)	49.2%	51.1%
Within 14 days (cumulative)	82.8%	83.6%

From a digital perspective:

- 105/148 practices have gone live with their ICB provided Online/Video Consultation solution (some practices are sourcing their provision independently).
- The remaining practices have confirmed their preferred solution, this is currently being rolled out.
- 141/148 practices have the ability to book/cancel appointments online. Usage increased from 31k in August to 40k in September.
- 143/148 practices are enabling repeat prescriptions online. There were 146k usages of this in September 2022. 64 of our practices are above the England average for usage
- 556k people are now registered to use the NHS App (53% of all patients above the age of 13), all MSE Alliances, with the exception of Thurrock, have greater engagement with the App than the England average.

3. Findings/Conclusion

Substantial progress continues to be 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 and spread innovation relating to the three models of care set out in the Fuller Stocktake.

4. Recommendation(s)

The Board is asked to note the Fuller Stocktake and Our Plan for Patients Update.

Board Meeting of 19 January 2023

Agenda Number: 11

Month 8 Finance Report

Summary Report

1. Purpose of Report

To report on financial performance for the ICB at Month 8 and offer a broader perspective on outturn across partners in the Mid & South Essex system (period ending 30 November 2022).

2. Executive Lead

Jennifer Kearton, Executive Director of Resources

3. Report Author

Resources Team

4. Committee involvement

Due to the timing of Committees, the position at M8 was circulated virtually to the ICB Finance & Investment Committee on 12 January 2023.

(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. Financial Implications

The report describes the current financial position.

6. Conflicts of Interest

None identified.

7. Recommendation

The Board is asked to receive this report for information.

Month 8 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 (MSE) System alongside our NHS Partners, Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust (EPUT).

Our wider Health and Social Care position including Essex County Council (ECC), 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 8 ICB Financial Performance

The forecast expenditure for the ICB is £1,811.3m and this is contained within its total attributable allocation at month 8 (M8). The ICB is therefore forecast to breakeven at the end of the financial year. Table 1 below summarises the M8 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 of 2022/23[1]. The second reflects two reimbursement programmes which are in operation this year, namely 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	Plan £m	Actual £m	Variance £m
Acute Services	537.4	539.7	(2.3)	958.2	960.3	(2.1)
Mental Health Services	95.8	97.0	(1.1)	171.9	178.5	(6.6)
Community Health Services	94.5	98.3	(3.8)	169.9	176.6	(6.8)
Continuing Care Services	44.7	51.2	(6.5)	80.5	91.3	(10.7)
Prescribing	83.9	86.2	(2.3)	151.1	154.0	(2.9)
Primary Care	92.1	96.0	3.9	175.6	181.4	5.9
Other Commissioned Services	8.4	7.4	0.9	15.8	14.8	1.0
Other Programme Services	3.5	28.8	(25.3)	23.3	35.8	(12.5)
ICB Running Costs	9.6	10.1	(0.5)	17.4	18.6	(1.2)
Total ICB Net Expenditure	970.0	1,014.7	(44.7)	1763.7	1811.3	(47.6)
Retrospective Allocation Adjustment		(44.7)	44.7		(44.7)	44.7
ARRS and Covid Reimbursement		0.0	0.0		(2.9)	2.9
Final Month 8 Position		970.0	0.0		1,763.7	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 M8, presenting the changes since the last report to the Board at month 6. All additional allocations received are accounted for within our expenditure position.

Table 2

Allocation	Recurrent £m	Non-Recurrent £m	Total £m
Allocation at Month 6	1626.3	169.4	1795.7
Pay award and Employers NI Adjustments	0.2	(0.2)	0.0
Cancer Alliance		6.4	6.4
Primary Care Transformation		1.0	1.0
Discharge Funding Tranche 1		1.3	1.3
Clinical Staffing Funding		0.7	0.7
COVID Therapeutics Tranche 1		0.8	0.8
Direct Action Oral Anticoagulants Rebates		0.6	0.6
Other Service Development Funding and Adjustments		1.9	1.9
Allocation at Month 8	1626.5	181.9	1808.4
Anticipated ARRS and Covid Reimbursement			2.9
Total Allocation at month 8	**1626.5**	**181.9**	**1811.3**

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 might 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. There has been no change to the risks and mitigations for the ICB since the previous report to the Board. 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 meeting on 19 January 2023.

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	Plan £m	Actual £m	Variance £m
Contract Changes	1.7	1.7	0.0	2.6	2.6	0.0
Prescribing	5.6	5.6	0.0	8.4	8.4	0.0
Continuing Care	2.3	2.3	0.0	3.3	3.3	0.0
Running Cost Review	0.3	0.3	0.0	0.5	0.5	0.0
Other	0.5	0.5	0.0	0.8	0.8	0.0
Total	**10.4**	**10.4**	**0.0**	**15.6**	**15.6**	**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. The level of risk in the position has remained unchanged. Any increased demand for continuing healthcare and prescribing over the winter months will be seen in the quarter 4 figures and the risk position will be adjusted accordingly. 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.

The ICB position includes an in-year System Risk Reserve. Negotiations and agreement on a stretch forecast outturn for the System have been finalised and the ICB will move its forecast outturn accordingly at month 9 (M9). The ICB has a duty to co-operate with other System partners within the financial control total. Consequently, the ICB will release the risk reserve to support the overall System position. This will be seen as an improvement in the ICB financial position for 2022/23. This improvement will partially compensate the system challenge, however, it is not sufficient to mitigate it entirely.

2.5 Overall System Finances at M8

At the end of M8 the overall health system position is a deficit of £55.7m which is a slight improvement against the run rate position otherwise anticipated. MSEFT accounts for £53.8m of the overall deficit and is £47.0m adverse to their year-to-date plan. The balance of the system deficit, £1.9m, is in EPUT and is £0.3m adverse to their planned position at M8.

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.

The System continues to engage fully in financial improvement actions with Chief Executive oversight. MSE System has been meeting regularly with regional and national finance colleagues to negotiate a change to its forecast outturn position. It is clear our planned breakeven ambition will not be achieved. As the NHS forms part of the consolidated national account, agreement must be made with the national team before a change to the agreed plan can be made. After rigorous review, both internal and external the system will move its position for M9 reporting to a deficit of circa £50 million. 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 £20.3m. Essex County Council £5.2m, Southend City Council £8.7m and Thurrock Council £6.4m. All our upper tier authorities are experiencing pressure across both Children's and Adult Social Care Services.

2.6 System Risk Position

The system is currently reporting a net risk position of £72.7m (£75.4m at month 7). There are two significant risks in the system position, both impacting on MSEFT's ongoing deficit. The under delivery of system efficiencies (£40.3m) and the costs to manage delivery (£44.3m).

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	(40.3)	0.0	(40.3)
Elective Recovery - additional costs	(4.6)	0.0	(4.6)
System pressures to manage delivery	(44.3)	0.0	(44.3)
Net lost trading income	(6.9)	0.3	(6.6)
Cost of capital support	0.0	2.6	2.6
Additional cancer services costs	(5.2)	4.0	(1.2)
Service Reviews	0.0	11.3	11.3
Technical Adjustments	0.0	12.8	12.8
Inflationary Pressures	(5.1)	0.0	(5.1)
Market Pressures (CHC)	(4.3)	0.0	(4.3)
Out of Area Pressures	(0.4)	0.4	0.0
Pathway Harmonisation	(0.5)	0.0	(0.5)
Costs of Improvement	(2.7)	0.0	(2.7)
Contract challenges	(0.1)	0.1	0.0
Non Recurrent Mitigations	0.0	9.9	9.9
Other	(0.2)	0.5	0.3
Total	(114.6)	41.9	(72.7)

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% unchanged from month 7).

The MSE FSP is targeted to deliver £49.7m. At M8 forecast delivery is £14.0m (28%). A further £24.9m has been identified, however, plans are not at a mature enough stage to provide confidence of in-year delivery.

Currently, the total likely delivery against the efficiency target of £84m is £46m (55%).

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. Prioritisation and planning are underway for 2023/24, which will include focus on year 2 of our FSP and actions to remedy slippage from 2022/23.

2.7 System Capital Position

The System has a local capital allocation of £65.1m (£63.1m Provider and £2.0m Primary Care). We also have £27m of nationally allocated funding for specific projects, bringing our total capital plan £92m for 2022/23.

All systems were asked to reforecast their capital plans during quarter 3. MSE is now slightly head of its reprofiled plan with a year-to-date overspend of £3.2m (MSEFT £2.7m and EPUT £0.5m). Good progress and acceleration in areas are driving the in-year position, however all plans are largely expected to be in line with forecast for the end of the year.

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. Regional and national escalation discussions have concluded and the System will change its planned forecast outturn position for 2022/23 during M9.

The development of our system financial improvement plan is progressing with all reasonable measures being taken to mitigate the in-year financial position. Our planning for 2023/24 is well underway and it is recognised that sustainable transformation is essential to enable our system to deliver its wider ambitions.

3. Recommendation

The Board is asked to note this report.

Mid and South Essex Integrated Care Board, 19 January 2023

Agenda Number: 12

Approach to Operational Planning 2023/24

Summary Report

1. Purpose of Report

This report is to outline to process that the System is using to ensure that it meets the 2023/24 NHS Planning Round asks and develops the Joint Forward Plan (JFP) in accordance with guidance. The paper outlines the following:

- Central process to ensure each component of the NHS plan is coordinated and completed in line with nationally mandated timeline – noting this is subject to change with regional oversight.
- Process for completing triangulation work across finance, workforce, performance (activity), in readiness for key lines of enquiry.
- Provide key metrics and asks from the guidance.
- Assurance that members will receive draft and finalised submission ahead of the 31 March 2023 submission date for sign off.

2. Executive Lead

Jennifer Kearton, Executive Chief Finance Officer.
Jo Cripps, Executive Director Strategy and Partnerships.

3. Report Author

Karen Wesson, Director of Assurance and Planning.

4. Responsible Committees

System Oversight and Assurance Committee.

Other Groups/Forums:

Chief Executive Forum
System Finance Leads Group
Deputy Finance Leads
System Delivery Planning and Performance Group

5. Financial Implications

The report includes the necessary financial planning requirements for 2023/24.

6. Conflicts of Interest

None identified for this report.

7. Recommendation/s

Members are asked to:

- Note the process and timeline in place to ensure completion and triangulation of the 2023/24 NHS Planning round in line with the parameters and instruction set out in the NHS planning guidance.
- Note the process to develop the Joint Forward Plan (JFP).
- Note that the monitoring of the 2023/24 NHS Planning round asks and JFP will be through the System Oversight and Assurance Committee and Finance and Investment Committee.
- Note the asks outlined within this paper and the 2023/24 Priorities and Operational Planning Guidance.

2023/24 Planning Round

1. Introduction

Background:

On 23 December 2022 NHS England (NHSE) published the 2023/24 Planning Guidance along with guidance on completing the Joint Forward Plan (JFP) covering a five year timescale. The planning guidance details the asks and requirements from Systems for the coming financial year, noting that 2023/24 plans form the first year of the Joint Forward Plan.

Planning Guidance 2023/24

This year's planning requirements, as set out in 2023/24 Priorities and Operational Planning Guidance, have been streamlined considerably in recognition of the severe pressures being experienced across systems.

The process is led by the Director of Planning and Assurance and coordinated via the System Delivery, Planning and Performance Group, which holds meetings weekly to ensure tracking and delivery of the required narrative, activity, finance and workforce information to complete the MSE ICB submission.

Joint Forward Plan

The JFP is a new requirement placed upon ICBs and their partner NHS Trusts. The JFP covers a five year period (of which year one is the operational plan described above).

The ICB and its partner Trusts have a statutory duty to prepare a first JFP before the start of each financial year. For this first year, however, NHSE has specified that the date for publishing and sharing the final plan with NHSE, the integrated care partnership (ICP) and our three upper tier local authority Health and Well-being Boards (HWBs) is 30 June 2023.

There is significant flexibility in how the system decides to create its JFP – ours will build upon our previous Health and Care Partnership five year strategy and take forward our plans to deliver the newly developed integrated care strategy. As a minimum, the JFP must describe how the ICB and its partner Trusts intend to arrange NHS services to meet the needs of the population and deliver against the requirements of the NHS Long Term Plan. This must include the delivery of universal NHS commitments and address the four core purposes of the integrated care system (ICS).

Alongside the annual planning requirements, we have commenced the process of developing the JFP, linking with strategy and operational leads from across the NHS.

Guidance on Joint Forward Plan development can be found at https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf.

Process for completion of operational planning requirements and JFP:

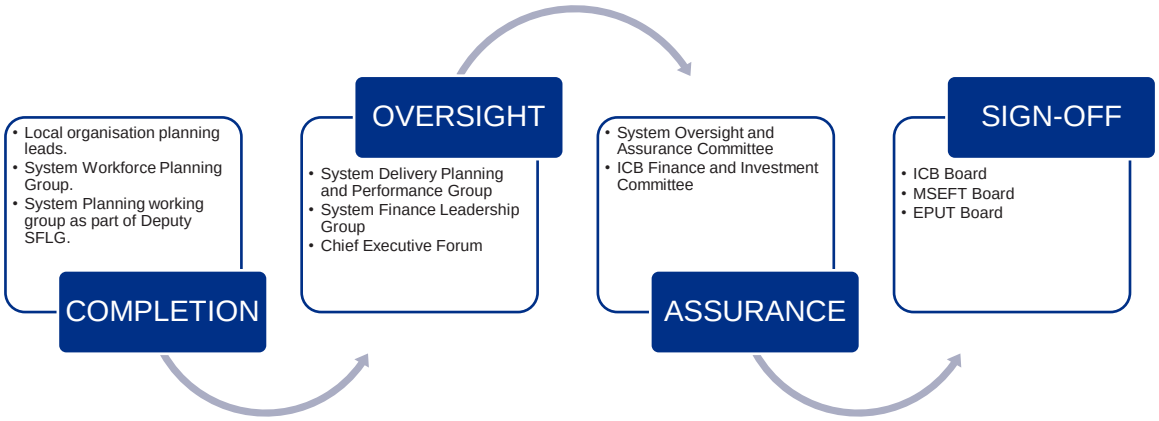
In previous years, NHSE have released operational planning templates for completion and submission for the ICB/S to complete. At the time of writing no templates have been made available, however, they are anticipated along with published allocations the week beginning 9 January 2023. Current leads are, with their colleagues, completing narrative and locally designed model templates for the delivery of the 2023/24 asks so that on receipt of the template these can be transposed. Leads have also been identified to develop the narrative for the JFP.

In this coming year, it will be vital that the system can clearly articulate its plans to deliver against requirements set out in the guidance. Key to this will be the need to triangulate activity, workforce and finance and understand the impact on performance.

The Deputy System Finance Leadership Group began work on our System medium term financial plan (MTFP) in October 2022. The bi-weekly meeting of the working group now includes representation from workforce, activity and performance colleagues to ensure triangulation of assumptions and escalation of issues to the oversight groups as identified below.

A priority will be to ensure key lines of enquiry are drafted and responded to, documenting decisions in order to provide assurance and create a solid baseline by which to measure our 2023/24 delivery.

NHS Plan Governance



Timeline, subject to NHSE East of England updates

Date	What/Where	Comment
23 December 2022	2023/24 Planning Guidance and Guidance of the Joint Forward Plan published.	
25 December 2022	Guidance and email identifying leads sent to leads for each element of planning Leads for each element of the Joint Forward Plan identified and narrative template distributed.	
5 January 2023	System Delivery Planning and Performance meeting reinstated for 2023/24.	Meetings held weekly. Guidance and further information and detail shared with members.
12 January 2023	Chief Executive Officer (CEO) Forum: • Share ICB paper outlining plan & timelines. • Discuss 'ground rules' to support planning process.	Receive MSE ICB Board Paper that outlines the process.
19 January 2023	MSE ICB Board meeting • Board Paper outlining plan & timelines.	
23 January 2023	CEO Forum: • Progress and exception report. • Finalise 'ground rules'.	
1 February 2023	Draft paper for SOAC/Board (ICB).	
8 February 2023	SOAC meeting: • Paper updating on progress, gaps and any escalations.	
9 February 2023	MSE ICB Board: • Paper updating on progress, gaps and any escalations.	
10 February 2023	CEO Forum: • Draft of both planning return and JFP / progress report.	
20 February 2023	CEO Forum: • Draft of both JFP and Planning return. • Highlight decisions to be made /discussions required by CEOs (eg strategic matters around capital, transformation plans, etc)	
23 February 2023	Indicative Regional draft submission date.	To be confirmed by Region.

Date	What/Where	Comment
1 March 2023	Draft paper for SOAC/Board (ICB)	
8 March 2023	SOAC meeting: Paper updating on progress, gaps and any escalations.	
10 March 2023	CEO Forum: Final draft for sign off with any caveats that remain ahead of submission.	(NB: MSEFT sign off 17 March 2023)
16 March 2023	MSE ICB Board: • Final draft for sign off with any caveats that remain ahead of submission. • Agree delegation to ICB Chief Executive to approve any amendments required pre-submission.	Ensure that contractual requirements of the plans submitted are completed.
24 March 2023	CEO Forum: Final review by Chief Executives ahead of submission.	
25-30 March 2023	MSE ICB Chief Executive hold for any final review/amendments pre-submission.	
31 March 2023	Submission of the 2023/24 Plan for MSE System.	

There will be ongoing alignment and triangulation of contract values throughout the plan development, both within system and outside system.

Key Operational Planning requirements:

Below outlines the key planning requirements that the System is required to achieve. Note not all have timelines for achievement at present – this is taken from the national planning document appendix one of this paper.

Area	Objective	Standard	Target	Timeframe
Urgent Emergency Care (UEC)	Improve A&E Waiting Times - in year 4hr standard delivery with further improvement in 2024-25.	4hrs in ED	76%	Mar-24
	Improve Category 2 ambulance response in year and work towards pre-pandemic levels in 2024-25.	Cat 2 ambulance response time	30 mins	Mar-24
	Reduce general and acute (G&A) bed occupancy equal to or below the optimum %.	Bed Occupancy %	92%	TBC
Community Health Services	Routinely meet or exceed the 2hr UCR standard	2hr UCR response time	70%	TBC

Area	Objective	Standard	Target	Timeframe
	Reduce unnecessary GP appointments and improve patient experience via streamlined direct access & referrals	Community Direct Access	TBC	TBC
Primary Care	100% of patients needing routine appointments to be seen within 2weeks	GP appointment access within 14 days	100%	TBC
	Urgent GP contacts assessed same or next day depending on need	GP Urgent assessment within 48hrs	100%	TBC
	Meet trajectory to deliver 50m more GP appointments by end of 2023-24	Increased GP Capacity	TBC	Mar-24
	Deliver ambition to recruit 26k additional roles reimbursement scheme (ARRS) by end of 2023-24	Number of ARRS roles	TBC	Mar-24
	Recover dental activity to pre pandemic levels	Units of Dental Activity (UDAs)	TBC	TBC
Elective Care	Zero waits over 65weeks by end of year excluding patient choice and/or specific specialities.	RTT 65 week waits	Zero >65w	Mar-24
	Deliver agreed activity plans as per operational plan.	Activity Units	TBC	Mar-24
Cancer	Reduce number of over 62ww patients.	↓62ww Breaches	TBC	TBC
	Meet faster diagnostics within 28 days standard for all 2ww suspected cancer cases to rule it in or out.	2ww referral diagnostics within 28d	75%	Mar-24
	Increase % of stage 1 & 2 cancer cases being diagnosed as per 75% faster diagnosis ambition by 2028.	% of stage 1 & 2 cancers diagnosed	75%	Mar-28
Diagnostics	Improve DM01 diagnostics within 6 weeks performance working towards 95% by March 2025.	% of diagnostic tests (DM01) within 6 weeks	95%	Mar-25
	Deliver agreed diagnostic activity levels to support elective and cancer backlog reductions and DM01.	Activity Units	TBC	Mar-24
Maternity	Improve performance by reducing stillbirths, neonatal & maternal mortality and serious intrapartum brain injury.	Maternity standard targets	TBC	TBC
	Increase workforce fill rates against funded establishments.	Vacancy/fill Rates	TBC	TBC

Area	Objective	Standard	Target	Timeframe
Use of Resources	Deliver balanced net system financial position in year.	Net Financial Balance	TBC	TBC
Workforce	Improve retention and attendance rates.	Retention and absence rates	TBC	TBC
Mental Health (MH)	Increase access for children and young people (CYP) - national ambition for 345k more 0-25 year olds accessing services.	Activity Units	TBC	TBC
	Increasing Access to Psychological Therapies (IAPT) - Increase number of older people accessing treatment.	Activity Units	TBC	TBC
	5% growth in number of adults and older people supported by community MH services.	Activity Units	TBC	TBC
	Work towards eliminating adult acute out of area placements.	Activity Units	TBC	TBC
	Recover dementia diagnosis rate to 66.7%.	% of dementia cases	66.70%	TBC
	Improve access to perinatal MH services	Activity Units	TBC	TBC
Learning Disability (LD) & Autisim	75% of over 14 year olds on GP LD registers have an annual health check and action plan by end of the year	% of >14yr olds on LD Register with health check and action plan	75%	Mar-24
	<30 adults with LD and Autism per million and =/<12 - 15 under 18s are inpatients in a designated facility at the end of the year	Headcount per population	<30 adults =/<12 - 15 under 18s	Mar-24
Prevention & Health Inequalities	77% of patients with hypertension treated to NICE guidance by the end of the year	% of hypertensive patients treated as per NICE NG136	77%	Mar-24
	Achieve 60% of 25 - 84 year olds with a cardiovascular disease (CVD) risk score of >20% being on lipid lowering therapies.	% of eligible patients on lipid lowering therapy	60%	TBC
	Address health inequalities by delivering the Core20PLUS5 approach.	Delivery against the 5 core areas	TBC	TBC

2. Recommendation(s)

Members are asked to:

- Note the process and timeline in place to ensure completion and triangulation of the 2023/24 NHS Planning round in line with the parameters and instruction set out in the NHS planning guidance.
- Note the process to develop the Joint Forward Plan (JFP).
- Note that the monitoring of the 2023/24 NHS Planning round asks and JFP will be through the System Oversight and Assurance Committee and Finance and Investment Committee.
- Note the asks outlined within this paper and the 2023/24 Priorities and Operational Planning Guidance.

Part I ICB Board meeting, 19 January 2023

Agenda Number: 13.1

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:

- Quality Committee, 30 September 2022.
- System Oversight and Assurance Committee (SOAC), 14 December 2022.
- Primary Care Commissioning Committee (PCCC), 16 November 2022.

2. Chair of each Committee

- Dr Neha Issar-Brown, Chair of Quality Committee
- Anthony McKeever, Co-Chair of SOAC.
- Sanjiv 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 Part I Quality Committee Meeting

Held on 30 September 2022 at 10.00 am – 12.00 noon

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member and Committee Chair.
- Dr Ronan Fenton (RF), Medical Director.

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience.
- Viv Barker (VB), Director of Nursing for Patient Safety.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Gemma Hickford (GH), Consultant Midwife.
- Greer Phillips (GP), Patient Safety & Quality Manager.
- Jackie Barrett (JB), Interim Head of Nursing.
- Eleanor Carrington, (EC), Quality Assurance Nurse.
- Linda Moncur (LM), Interim Director of Safeguarding.
- Eleanor Sherwen (ES), Interim Head of Nursing.
- John Swanson (JS), Infection Prevention & Control Specialist.
- Karen Flitton (KF), Patient Safety Specialist.
- Vicky Cline (VC), Head of Nursing – Primary Care.
- Yvonne Anarfi (YA), Deputy Director for Safeguarding.
- Peter Scolding (PS), Assistant Medical Director.
- Gemma Stacey (GS), Designated Clinical Officer for Special Educational Needs and Disabilities.
- Marie McEntee (MMcE), Children and Young People Transformation Manager.
- Sara O'Connor (SO), Head of Corporate Governance.
- Alix McMahon (AMcM), Complaints Manager.
- Eleanor Carrington (EC), Deputy Head of Nursing, Primary Care Quality.

Apologies

- Frances Bolger (FB), Interim Chief Nursing Officer.
- Helen Farmer (HF), Interim Director for Children and Young People and Learning Disability.
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care.

1. Welcome and Apologies

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

2. Declarations of Interest

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

NIB declared an interest under agenda item 8. There were no other declarations of interest made.

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

3. Minutes

The minutes of the last Quality Committee meeting held on 13 July 2022 were reviewed and approved, subject to apologies from VB being added.

Resolved: The minutes of the Quality Committee meeting held on 13 July 2022 were approved subject to a minor amendment as noted above.

4. Matters Arising

There were no matters arising.

5. Action log

The action log was reviewed and updates noted: NIB confirmed that Action No 2 would be discussed under agenda item 6 below.

6. Quality Committee Governance

NIB advised that partner organisations were being asked to nominate representatives to sit on the Quality Committee. Once membership had been finalised, a Vice-Chair would be appointed.

SM advised that clarification on the process to nominate providers' representatives had been received. SM would meet with quality team colleagues the following week to agree who should be approached, following which a letter prepared by SO would be sent to formally request nominations.

NIB advised that the committee workplan had been developed and reviewed by herself, RF and quality team colleagues, but might be subject to change as the work of the committee evolved.

Resolved: The Quality Committee noted the update on Committee membership and approved the committee workplan.

7. Lived Experience Story – Opiates

The committee were shown a video of a patient with experience of being prescribed opioids, explaining how her confidence in her ability to reduce her dependence upon opiates was gradually improved by health professionals supporting her.

A second video featuring Dr Caroline Dollery, a local GP, was shared with committee members in the 'chat' function.

SM advised that the video highlighted the importance of a trusting relationship between patients and clinicians who cared for them.

Resolved: The Committee noted the Lived Experience Stories and agreed that future topics should be derived from the suggestions made by the members.

8. Deep Dive – Opiates

PW advised that MSE was one of the highest prescribing ICBs for patients on high oral morphine equivalent dosage. As of August 2022, 1,256 patients within MSE were taking the equivalent of 120mg morphine on a daily basis, which was of concern. However, in terms of the number of individuals prescribed opiates per 1,000 patients, MSE was currently in the lower range of ICBs (11.86 compared with the ICB average of 15.85). This indicated that the message that it was not good to commence patients on opioids was being followed.

Further work to address the high number of people receiving high doses of opioids as part of a wider NHS opioid safety programme (accessible via the QR code within the slides) would take place. The programme took a whole systems approach to high-risk opioid prescribing and included provision of support to patients suffering chronic pain.

PW highlighted the importance of bringing MSE clinicians together to embed how patients with chronic pain should be managed within primary care without commencing opioids and to reduce the number of patients on high dosages. The approach being taken was based on National Institute for Health and Care Excellence (NICE) guidance which advised how to manage primary and secondary chronic pain and set out pain management options which included exercise programmes, psychological therapy, and acupuncture. Pharmacological management was listed last.

PW noted that MSE currently had a service restriction policy on acupuncture and therefore did not support direct referrals for this, but it could be accessed via a physiotherapist if considered appropriate. In addition, historically therapies provided by Osteopaths had not been commissioned, but it was now necessary to consider this. PW had discussed with Maggie Pacini, Clinical Lead for Service Restriction, the need to be open minded about how evidence regarding efficacy should be reviewed as we moved towards no longer using just opioids.

MSE had already implemented its pain formulary which 'blacklisted' the use of opiates by asking clinicians not to commence prescribing opioids for patients with chronic pain. It was however recognised that there was a need for opioids in the acute stage of a condition, but this would be managed within a maximum of twelve weeks. Patients would then be moved to an alternative programme introducing exercise and alternative therapies sooner, which could prevent them moving into the chronic stage. Personalised care, effective engagement with shared decision making to increase 'buy-in' from patients was vital for this approach to be successful. Early indications were that patients were keen to reduce their dependency on opioids.

PW explained that her report set out current services available to support patients with chronic pain and conversations were being held with partners to identify how services might be improved. Some services could be accessed by patients self-referring. There were also a series of on-line support resources, although face-to-face support was available for those who preferred this.

PW advised that there were a number of drivers available to primary care to make changes happen via the Primary Care Network (PCN) Direct Enhanced Scheme and the Innovation and Impact Fund. PW confirmed that there were ongoing conversations being held with pain consultants regarding the need to use alternative therapies, but the definition of what people perceived as primary or secondary chronic pain remained a grey area. In addition, patients often had long waits for a pain clinic appointment, only to be told there was nothing that could be done for them apart from opioids. PW understood that Laura Harding, Chair of Medicines Optimisation Committee, had written to RF and Anthony McKeever, asking what the system could do to support patients with chronic pain other than medication.

RF commented that one of the potential problems was gaining the acceptance of the NICE guidelines by doctors who valued their personal autonomy. However, RF was happy to support PW to implement a cultural change.

NIB referred to those patients on high oral morphine equivalent dosage and suggested it appeared that alternative methods of pain management were not discussed at initial consultations, there was a lack of alternative therapies available across the system, or patients sought or received help at a late stage. NIB advised that she understood the number of patients who sought over the counter (OTC) drugs who then progressed gradually to stronger pain relief was quite high and asked what was being done to ensure pharmacists had an awareness of the NICE guidelines. NIB also commented that individuals known to her who lived with chronic pain were not aware of the resources available, including ‘Escape Pain’ (NIB declared an interest in this regard as she was connected to the work of this organisation via her position with Versus Arthritis). NIB highlighted the importance of promoting resources but suggested the ICB should work with relevant partners to evaluate the effectiveness and impact of these services, including those not often used.

PW advised that reasons why patients were on high dosages were often historical, for example, there were some patients who were addicted to immediate release Fentanyl lozenges. PW noted that Thurrock had some of the lowest numbers due to a de-prescribing service having been in place for some time and this was the approach that would be taken forward. Further communications and engagement with patients on this issue would occur in January 2023 and funding was being requested to support a ‘Painkillers Don’t Work’ public facing campaign across the East of England. Other work was being undertaken to upskill clinicians, as well as ongoing patient support.

AMcM advised that based on research undertaken within other systems, the MSK getUBetter app, had demonstrated a positive impact as it delayed initial contacts, promoted exercise, and was personal to individuals. The app had also helped to identify which services should be focussed upon to make improvements. Research on the Whizan tele-health system had also highlighted positive benefits upon a range of specialties. AMcM therefore suggested that any communication and engagement campaign should also promote self-help support available for a wider range of conditions.

PW advised that she had previously suggested that community pharmacies should be the 'go to' place for patients to access digital support when they attended for initial pain relief, so the ICB should consider how it could support pharmacies to recommend and follow-up on this, to enable patients to be supported at an earlier stage of their disease/condition.

RF agreed that patients would only benefit if they knew about services and were part of the solution. This went to the heart of the concept of neighbourhoods of circa 40,000 people, with each neighbourhood having resident participation in their own health and care, with involvement from primary and community care and the voluntary sector.

NIB asked if PW could liaise with AMcM to discuss the issues raised by her. NIB noted the benefits realised by the Thurrock de-prescribing service despite other socio-economic challenges in that area and suggested that de-prescribing could be focussed upon in a future report to the committee.

Resolved: The Committee noted the discussion following a Deep Dive on Opiates.

- **Action:** PW to liaise with AMcM to discuss promotion of on-line self-help.

- **Action:** PW to include further information on the de-prescribing service in a future medicines optimisation report to the committee.

9. Patient Safety and Quality Risks

NIB advised that she understood work was being progressed to develop the ICB's Board Assurance Framework (BAF) and risk management processes, including remapping risks against the new organisational and committee structure. A Board seminar on risk management would also take place.

SM advised that some of the risks were inter-related with services within the wider context of other ICB teams such as commissioning and transformation teams which impacted upon the safety and quality of services.

SM confirmed that the existing BAF/risk register would continue to be updated until the new risk management arrangements were in place.

VB confirmed that in relation to the serious incidents (SI) risk, significant work was being undertaken with MSEFT in preparation for implementation of the Patient Safety Incident Response Framework (PSIRF).

VC advised that the Primary Care Commissioning Committee was reviewing risks relating to general practice and primary care services and she wished to highlight the need to ensure that work in this regard was not duplicated. SM advised that he would liaise with VC and SO in this regard following the meeting.

- **Action:** SM to liaise with VC and SO regarding review of general practice and primary care risks and with SO regarding review of safety and quality risks generally.

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

10. Quality Strategy Implementation Update

SM advised that the ICB was working with an independent company, L&L, to review how to embed quality reporting structures and processes across the ICB and the support required to develop reports that accurately reflected new ways of working across the ICB, whilst considering the expectations of partner organisations. An internal workshop was held with relevant staff and another would be held with wider system partners to ensure meaningful quality metrics were available.

This work would be framed around the six quality priorities identified in the Quality Strategy and implementation plan. An incremental approach would be taken to develop a new quality dashboard, with infection prevention and control (IP&C) and maternity services being considered first as there was a considerable amount of existing data on these services that could be used. It was anticipated that a first draft of the dashboard containing this data would be submitted to the November committee meeting.

There was interest in MSE's approach from regional colleagues as other systems were also in the early stages of developing more meaningful data and reporting. However, MSE would also review best practice in other areas when developing its own arrangements.

JS advised that he had met with Laura Marshall from L&L to discuss IP&C and he anticipated that the new dashboard would be an improvement on existing reports.

NIB advised that the new dashboard would include qualitative and quantitative data and colleagues' continued input into this work was important.

Resolved: The update on the implementation of the Quality Strategy was noted.

11. Patient Safety Specialist Updates:

11.1 Patient Safety Framework Update

KF advised that the report confirmed she had been appointed as the ICB's full time Patient Safety Specialist (PSS) which was fundamental to the whole system working effectively. The PSS Network meeting had been strengthened and terms of reference were being finalised.

Work was being undertaken in conjunction with Human Resources colleagues regarding rollout of the patient safety training syllabus.

Arrangements to implement PSIRF were also progressing to ensure learning identified was put at the heart of everything. There were six phases to the process, with phase one currently being worked through. A workshop to be attended by system partners would be held on 18 October 2022.

The World Patient Safety Day (WPSD) had been deferred due to the period of national mourning and would take place the following week, to be launched by Henrietta Hughes, the Patient Safety Commissioner.

11.2 Appointment of Patient Safety Partners

KF advised that the report introduced the concept of Patient Safety Partners (PSPs) which was one of the strategy's objectives and was fundamental to the agenda. Each

organisation should have a minimum number of two PSPs by September 2022 and MSE was therefore behind schedule.

The PSS Network had concluded that the best way forward was to take a system approach in line with other ICBs within the region. The report set out two options in relation to the recruitment of PSPs, with option 2 being recommended.

VB advised that she agreed with the recommendation that a single pool of PSPs should be taken forward and understood that KF's plan was to rotate PSPs through different providers to increase their experience. NIB agreed with this suggestion and requested that this was made clear in the final paper for these posts.

PW highlighted that organisations should also have Medication Safety Officers in post. PW offered to meet with KF to provide an update on the work of a regional group and other medicines safety initiatives if required. PW also advised that pharmacists would be speaking alongside nurses on medication safety issues as part of WPSD and noted her thanks to Zafiat Quadry (ZQ), quality and safety lead pharmacist, for her input in this regard. KF confirmed she had been in contact with ZQ and would be meeting with her shortly.

KF advised that due to WPSD being delayed, two of the speakers, including one from HM prison service, had been lost. KF advised that in relation to PSPs, she would draft a paper outlining the finer details. With regard to PSIRF and primary care, this was being addressed nationally but KF was being kept aware of developments.

Resolved: The Committee noted the Patient Safety Specialist update and endorsed the recommendation to proceed with Option 2 as set out in the report to progress recruitment of Patient Safety Partners.

- **Action:** KF to include the proposal to rotate Patient Safety Specialists through different providers to increase their experience in the final paper for these posts.

12. NHS Patient Safety Updates

The committee received the NHS Patient Safety updates dated 26 July 2022 and 30 August 2022.

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

13. Acute Care

JB advised that the report focussed predominantly on escalations and current mitigating action and highlighted the following three key areas.

Cancer waits of 104+ days continued on an upward trajectory. The National Cancer team were working with MSEFT as part of the new integrated oversight and support process.

There were also a high number of cancer harm reviews outstanding. A plan had been presented to the System Oversight and Assurance Committee (SOAC) to pause the 62 day reviews to enable clinicians and administrative staff to redirect resources to address waiting lists. Progress reports would be presented to the November SOAC meeting.

The backlog of SIs would be reviewed at fortnightly meetings with the ICB Quality Team and the Associate Director of Patient Safety and monthly SI review meetings continued. It was anticipated that work being undertaken by KF in the lead up to implementation of PSIRF would assist in this regard.

In response to a query from NIB, JB advised that harm reviews had not identified a significant number of cases of 'moderate' harm, so the decision to pause 62 day reviews was taken in light of this data to allow staff to focus on addressing wait times.

VB explained that the number of staff that would be released as a result of this decision, which was supported by NHS England and Improvement, was quite significant, equating to 1.4 whole time equivalent (WTE) clinicians and 2 WTE administrators monthly during the relevant period. VB also advised that more prospective harm reviews would be undertaken for certain categories, e.g. those awaiting cardiology intervention and cholecystectomies, as retrospective harm reviews had identified these were areas where harm was likely to occur.

JB noted that 90 day clinical reviews remained in place and the ICB was seeking regular updates on the 9 cases of moderate harm identified to-date.

KF explained that there had been many changes to pathways and it was felt important to focus on learning identified during the past three months to ascertain whether the new pathways were effective.

Resolved: The Committee noted the Acute Care update.

14. Infection Prevention and Control

JS advised there had been 11 Methicillin-resistant *Staphylococcus aureus* MRSA bacteraemias during the year to-date. Affected patients reported in the previous period were severely complex patients.

In relation to *Clostridioides difficile* infection (CDI), both Basildon and Thurrock had breached their annual thresholds. This was linked directly to the surgery cases associated with a recent outbreak at Basildon hospital. Across MSEFT, there were 29 more cases than this time last year, also directly linked to the outbreak and cluster at Basildon.

A Healthcare Associated Infection (HCAI) Summit was attended earlier in the week with East of England colleagues and it was noted that regionally and nationally CDI numbers were much higher than they had been. This was believed to be linked to antibiotic usage throughout the COVID-19 pandemic as a result of people not being able to access health and other forms of treatment during that period.

A local HCAI summit was also held to discuss with peers how increasing cases should be addressed. Challenges had been escalated to the senior management team regarding the treatment of individuals in the community with CDI and difficulties accessing Vancomycin which was now the first line treatment. PW and her pharmacy colleagues had provided support to ensure patients received the necessary treatment.

NIB noted that a general decrease in peoples' immunity had also been an impact of the pandemic.

Resolved: The Committee noted the Infection Prevention and Control update.

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

GH highlighted progress against the Care Quality Care (CQC) action plan, noting it was important to recognise there had been a significant reorganisation of the maternity improvement plan which contained outstanding CQC actions and the Ockenden immediate and essential actions. This was a positive step with ongoing oversight of progress maintained within the Trust and by the Local Maternity and Neonatal System (LMNS).

With regard to retention of the maternity workforce, 47 WTE newly qualified midwives starting in-post across the three hospital sites in September 2022 and being supported through an established preceptorship twelve-month programme. There was also a focus on looking at retention roles for midwives currently in place and health and wellbeing support for staff to ensure they worked in a supportive environment.

NIB advised that it was anticipated that maternity services would be the subject of a future committee deep dive.

VB advised that the work being undertaken by GH and colleagues was considerable. Each of the hospitals had received a CQC unannounced maternity visit in the last few weeks leading up to the Trust's well-led inspections and there were some positive aspects identified regarding culture, the approachability of staff and them knowing who to escalate issues to. However, a few concerns were identified on one site and formal feedback was awaited.

PW highlighted the positive work being undertaken by GH and colleagues within maternity services supporting women to stop smoking by linking them into community pharmacies for follow-up.

Resolved: The Committee noted the update on maternity services.

16. Mental Health

SM advised that since the last report to committee, there had been one in-patient death in one of the wards in the South East area which was being investigated through the new PSIRF process.

An inquest into the death of a 19 year old male who fell from a bridge should have been concluded by 30 September 2022, but the Coroner had extended the hearing until the following week after seeking additional evidence. The outcome of the Inquest might not be known until January 2023.

There were difficulties within the south west in relation to meeting dementia diagnosis rates and the team was working with the relevant Trust to identify the longest waiters. A harms review process was being considered as long waits could affect the psychosocial wellbeing of patients and their families.

Mental health workforce challenges remained both regionally and nationally, but EPUT were working hard to fill vacancies, particularly within the Crisis Resolution Service, where there were currently 26 Band 6 vacancies which adversely impacted upon service delivery.

Resolved: The Committee noted the Mental Health update.

17. Community Care

ES advised that workforce remained a significant challenge for community providers and whilst the rollout of the Community Nursing Safer Staffing Tool should help, NELFT were undergoing a pay review of their staff based on competencies including considering whether some Band 6s should be B7 as part of a plan to improve recruitment and retention. The acuity of patients of patients at home had increased significantly and it was therefore important to understand the pressures faced by community teams.

Despite the challenges, relationships and system working within organisations and teams were improving.

Speech and Language Therapy services remained challenged regionally and nationally. The community collaborative was working hard to address this as set out in the report. A single Clinical Leadership Team was taking a stewardship approach to address service and funding issues.

Resolved: The Committee noted the Community Care Update report.

18. Alliance Primary Care Quality Report

EC advised that MSE currently had one practice with a CQC rating of 'inadequate'. Meetings were being held with the practice and an action plan was in place.

Three practices were rated as 'requires improvement'. All had action plans in place which were being reviewed weekly by the Primary Care Quality Team.

A total of 12 practices were currently rated red by the ICB, 28 practices rated amber and 108 rated green.

A large number of practices rated red/amber were single practitioners which meant that service provision was at greater risk should something happen to the relevant GP. These ratings enabled the PCQT to focus support where it was needed most.

EC highlighted that greater interaction with practices was being experienced in relation to preparation for CQC inspections and the SI process which was welcomed.

VB advised that the increased levels of inspection by the CQC could potentially mean that some practices previously rated 'adequate' or 'good' might not achieve these ratings in future. However, the PCQT would provide ongoing support to reduce the risk of this occurring.

PW advised that in relation to medicines management, all practices could access Eclipse, which held CQC indicators, to see how they were currently performing. A pre-inspection checklist was also available to help practices prepare for inspection.

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

19. Adults and Children Safeguarding System Report

NIB advised that, having recently met with Safeguarding Chairs, it was clear that although challenges remained, some excellent work was being undertaken to improve safeguarding.

LM confirmed that the ICB had recruited to all Safeguarding Team posts, including the Liberty Protection Safeguarding (LPS) Lead, except one which had been shortlisted. The risk level remained high due to lead-in times for new staff, but the situation would improve around December 2022.

LM explained that the request to step-down the liberty protection risk was because the LPS legislation being consulted upon nationally was due to be implemented in April 2024 and no guidance was currently available to measure risks against. A major concern was that the ICB would take on responsibility for some patients, particularly continuing health care (CHC) patients. There was currently a backlog of 3,150 patients within social care, but the ICB had not yet been advised how many it might inherit and could not therefore plan mitigating action until this was known.

LM advised that work that Deborah Stuart-Angus, Independent Chair of Essex Safeguarding Adults Board had agreed with David Archibald, Independent Chair of the Essex Safeguarding Children's Board, to take the lead on mapping suicide prevention initiatives for children and adults.

LM informed members that five Police Officers from different Boards had raised concerns that acute providers were not always correctly escalating to the police when children presented with non-accidental injuries (NAIs). The Southend, Essex and Thurrock Policy stated that if a child had suffered an NAI it must be escalated to social care to decide whether to escalate to the Police or not. This had caused delays, but there was also evidence that escalation did not always occur, and children were returning home without appropriate investigation. Five relevant SI reports remained outstanding and LM was working with acute providers to obtain a response on these and to ensure processes were followed correctly in future. LM confirmed these issues were also escalated via the System Quality Group. A meeting with all key partners would take place in October and an update to committee would be provided in November.

PW advised that the Medicines Optimisation Team for care homes, covering Castle Point and Rochford, Basildon and Brentwood and mid Essex areas, also provided safeguarding support funded via the Better Care Fund. However, Southend and Thurrock had declined to fund this. This was currently under discussion due to the inequitable support offer across MSE. LM advised that she would liaise with PW with a view to escalating the funding issue to the Southend and Thurrock Safeguarding Partner Boards.

Resolved: The Committee

1. **Acknowledged the improved resource provision across the team and the development of work programmes in line with statutory responsibilities as well as the requirements to work collaboratively with statutory partners.**
2. **Agreed step down of the liberty protection risk given that there are no identifiable and measurable risks to the system at this time.**
3. **Noted work being led by the ESAB Chair to map services currently available and the strategic direction in commissioning services across the ICP.**
4. **Noted action being taken to address concerns regarding the escalation to the police of NAI to children.**

- **Action:** LM and PW to discuss funding of Medicines Optimisation Team safeguarding support for care homes with a view to escalating to Southend/Thurrock Safeguarding Partnership Boards.

20. Medicines Optimisation

NIB advised that she and PW had agreed that due to the deep dive on opioids (agenda item 8) the medicines optimisation report would be considered 'as read' due to time constraints. NIB confirmed her support for the recommendations made and asked other committee members to confirm their support.

Resolved: The Committee:

1. **Noted the current performance of the ICS on antimicrobial stewardship.**
2. **Recognised the on-going work towards the strategic goals of ensuring antimicrobial stewardship and reducing the prescribing of dependence forming medicines.**
3. **Noted the current performance in relation to prescribing of dependence forming medicines, Low Clinical Value (LCV) and Over the Counter (OTC) prescribing and eclipse alerts.**

21. Learning Disabilities (LD)

ES advised that the report had been written jointly with Rebecca Bailey, the LD Health Commissioner from Essex County Council. ES explained that LD had recently been added to her remit, but system working was progressing well and nursing support had been welcomed.

The LD workforce was significantly underfunded with staffing gaps across MSE. Mid Essex was the only area well resourced and funded. Rebecca Bailey was writing a report on this and the process for progressing a business case for additional resources was being clarified.

ES advised that the number of inpatient children was higher than the expected target. The procurement of the key worker project, driven by the local authority and supported by Attain, the ICB's procurement specialists, had moved at pace and the contract had been awarded, which should help to keep individuals at home.

A scoping exercise to understand what was required to increase the number of LD annual healthchecks had been undertaken with one of the PCNs in Southend and had already identified some interesting data that would be used to support improvements.

PW advised that the Medicines Team had been working on 'stopping over medication of people with LD/Autism' (STOMP). EPUT had been funded for a part-time pharmacist to lead on this, but were experiencing recruitment difficulties. Therefore, whilst PCN pharmacists supported STOMP, a lead specialist pharmacist was not yet available.

NIB advised she would liaise with ES regarding some queries she had on the data referred to within the report.

Resolved: The Committee noted the Learning Disabilities update.

- **Action:** NIB to liaise with ES regarding data referred to within the learning disability report.

22. Impact Assessments – Harmonisation of Commissioning Policies

PS provided an overview of the service harmonisation process covering six policies which were different across the former five MSE CCG areas, with the aim of developing one single way of providing those interventions equally across the whole ICB. The relevant services were:

- Bariatric surgery
- Vasectomy
- Fermale sterilisation
- Breast reduction
- Breast asymmetry
- Tertiary fertility services including in-vitro fertilisation (IVF)

The process was underpinned by clinical and frontline voices; the views of residents which would be gathered via a consultation process; and value and affordability considerations.

PS outlined the work undertaken so far and advised that the next major phase was engagement and consultation with residents to inform the development of the business case and implementation and adjustment of services.

Equality and Health Inequalities Impact Assessments (EHIIA) were undertaken at an early stage with clinical input and would be updated and adjusted depending on the outcome of the consultation. PS advised that it was anticipated that 'levelling-up' of services would occur thereby increasing access to these services.

PW advised that it was her view that the bariatric surgery should be referred to as 'Tertiary or Specialist Obesity Services' because cases should be considered by a multi-disciplinary team (MDT) as options were available for either medical or surgical intervention, although the criteria to access these pathways was the same. RF confirmed that following discussions with clinical colleagues, a recommendation was made to ensure that weight loss management programmes were prioritised within the relevant policy.

VC asked if a pre-prepared response could be prepared for use by GPs during the consultation period as primary care could be the first point that patients contacted to seek clarification on the proposed changes, and such a response could reduce pressure on practices.

In response to a query from NIB relating to how equity of patient views across MSE would be achieved, PS advised he would discuss this with communications and engagement team colleagues.

PW referred to the affordability of service harmonisation and mentioned that the ICB could currently not afford to fully implement NICE guidance on full time glucose monitoring and should it decide to increase access to the relevant six service areas, it would be necessary to explain why these services were being prioritised over other competing demands.
RF advised that the primary reason for this work was that the six services had not yet been

harmonised across MSE, but residents would be able to raise affordability and priority concerns during the consultation.

Resolved: The Committee noted the update on Impact Assessments undertaken in relation to the harmonisation of commissioning policies.

- **Action:** PS to liaise with VC and communications and engagement colleagues regarding development of a pre-prepared response (i.e. Frequently Asked Questions) that GPs could use to deal with queries raised by patients regarding service harmonisation.

- **Action:** PS to liaise with communications and engagement team to discuss how equity of patient views across MSE would be achieved.

23. Special Educational Needs and Disabilities (SEND) Update

GS advised that the report focused on local area inspections. Both Essex and Thurrock had previously received Written Statements of Action (WSoA) following previous inspections. Subsequently revisits had identified good progress in all areas and the WSoA had therefore been removed for both areas.

Southend had made sufficient progress in three out of four areas of weakness, with one remaining area to be addressed via an accelerated progress plan. GS and her a colleague would undertake focussed work with Southend to improve joint commissioning.

There was a proposal for a new SEND inspection framework which was expected to be launched in early 2023 which would require significant preparation work. It was envisaged that the focus would move from whether organisations were meeting statutory requirements to what the impact and outcome for children was.

Resolved: The Committee noted the SEND update report.

24. Little Havens

MMcE advised that Little Havens remained closed to inpatients for end of life care for children and young people due to workforce issues, although hospice at home, respite care and some support to community paediatric teams was still being delivered.

A recovery plan jointly developed by the ICB and Little Havens was in place, with the key action to recruit to vacant posts. Little Havens had been encouraged by the interest in these roles, but it was not yet clear when full services would resume.

Two alternative hospices had been approached to deliver in-patient end of life care where the child or young person's family deemed the hospice was their preferred place of care. To-date, two children had been referred to alternative hospice provision. These providers were unfortunately outside of the MSE area but were happy to provide support.

In response to a query from NIB, MMcE advised there were currently four children requiring end of life care, two of which had chosen hospice care and the other two had requested hospital / home care. McME confirmed that this situation was regularly monitored.

Resolved: The Committee noted the Little Havens update report.

25. Any Other Business / Reporting to ICB Board

25.1 Future Deep Dives

NIB asked those present if they had any suggestions for future deep dives, other than maternity services and safeguarding which were already being considered. NIB asked that any suggestions were notified to SM so that arrangements to film lived experience stories and write in-depth reports could be put in place.

VB advised that efforts were being made to increase virtual ward capacity to avoid people having to go to hospital and suggested that Tiffany Hemming or one of her colleagues could be invited to talk about future plans.

LM agreed that a deep dive of both safeguarding and virtual wards would be welcomed, with a focus on domiciliary care providers who supported virtual wards as they were under significant pressure.

PW advised that end of life (EoL) care should also be considered as there were a number of gaps that had led to poor patient experience. PW had a friend who might be willing to speak about her mother's experience of EoL care.

- **Action:** SM to liaise with Tiffany Hemming regarding a future deep dive on virtual wards and consider other suggestions made for future deep dives (maternity, safeguarding, end-of-life care).

26. Date of Next Meeting

Friday, 25 November 2022 at 10 am to 12 noon via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 14 December 2022 at 1.00 pm – 2.30 pm via Teams

Attendees

Members (Voting)

- Anthony McKeever (AMcK), Chief Executive Officer and Joint Chair of Committee, MSE Integrated Care Board (ICB).
- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England and Joint Chair of Committee
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England.
- Hannah Coffey (HC), Interim Chief Executive of Mid and South Essex NHS Hospitals Trust (MSEFT).
- Jo Cripps (JC), Executive Director of Strategy & Partnerships.
- Barry Frostick (BF), Chief Digital and Information Officer (Items 1 to 6).
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Ruth Jackson (RJ), Executive Chief People Officer, MSE ICB (Items 1 to 5 only).
- 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 (Items 1 to 8).
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Alan Whitehead (AW), Head of Operations, East of England Ambulance NHS Trust (EEAST) (Items 1 to 8).

Other attendees

- David Walker (DW), Chief Medical Officer, MSEFT.
- Viv Barker (VB), Director of Nursing (Patient Safety), MSEICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSEICB.
- Lynnbritt Gale (LG), Director of Community Delivery, EPUT.
- Ruth Hallett (RH), Alliance Director (South East Essex), MSEICB.
- Catherine O'Doherty (CO), Medical Director for Cancer, MSEFT.
- Marcus Riddell (MR), Senior Director for Organisational Development and Deputy Executive Director for People and Culture, EPUT.
- Diane Sarkar (DS), Chief Nursing Officer, MSEFT.
- Mike Thompson (MT), Chief of Staff, MSE ICB.
- Danny Hariram (DH), Chief People & Organisational Development Officer, MSE NHS Foundation Trust.
- James Wilson (JW), Transformation Director, Mid and South Essex Community Collaborative.
- Annette Thomas-Gregory (ATG), Director of Education EPUT and MSE ICB (present as an observer for Items 1-6).
- Nicola Adams (NA), Deputy Director of Governance and Risk, MSE ICB (minute taker).

Apologies Received

- Stephanie Dawe (SD), Chief Executive Officer, Provide Health (Provide Community Interest Company)

1. Welcome and Apologies (presented by Anthony McKeever)

AMcK welcomed everyone to the meeting and noted apologies listed above.

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 9 November 2022 were reviewed and approved with no amendments.

Outcome: The minutes of the meeting held on 9 November 2022 were approved.

4. Action log (presented by Mike Thompson)

MT confirmed that actions were either complete or were issues discussed on the agenda.

5. Quality

5.1 Harm Review Update

CO presented the cancer harm review report noting the requirement for undertaking harm reviews for patients breaching the 62-day target for referral to first treatment in addition to those waiting longer than 104 days. CO explained the clear process for undertaking reviews outlined in the report, but highlighted the difficulties which presented from January 2022 because of more referrals, resulting in breaches of the harm review target and the impact upon operational performance. Consequently, from April 2022 the Trust were given authority by NHS England to focus on the 104-day target. CO asked SOAC to consider a temporary extension to this moratorium into the new financial year.

Members had a detailed discussion on performance and the consequence of supporting such an extension.

In response to AMcK and SW, CO confirmed that the reviews completed to-date identified very little by way of harm (15 cases during December to March 2022, from 1600 reviews), but there was a significant operational impact from the team (who also provided clinical care); each review took 2.5 to 3 hours away from direct patient care. SW noted that SOAC was not responsible for authorising the extension, but asked that this request was escalated to NHSE. The Trust would need to clarify the balance to minimise the overall risk when presenting to NHS England. AM

summarised and noted that the purpose of any extension was to sustain additional treatment capacity for a further quarter.

ACTION 96: FB to request an extension of the moratorium for the 62-day cancer harm target from NHS England, quantifying the time saved/released and the number of patients to be seen and copy SW to ensure it is escalated.

Outcome:

- The Committee **SUPPORTED** the current MSE approach of undertaking harm reviews for patients whose treatment has taken place more than 103 days (i.e. 104+ days) from urgent cancer referral to allow continued release of resource to focus on operational recovery and minimise further delays in treatment while still allowing investigation of, and learning from, pathways that result in delayed cancer treatments.
- The Committee **AGREED** that approval of this approach be sought from NHS England for all treatments delivered from April 2022 to March 2023, to align with the Trust's cancer waiting times recovery trajectory, after which the Trust would move back to undertaking harm reviews on cancer treatments occurring more than 62 days after urgent referral.

5.2 Quality key risks/concerns

Nitrous Oxide Serious Incident Update

FB presented escalations from the quality team and provided an update regarding the Nitrous Oxide Incident at Basildon Hospital. It was noted that, following the establishment of an incident management team and investigation, the department continued to operate providing a good service with no major concerns; advice from the Health and Safety Executive regarding the environment had been followed and was monitored daily, but levels remained unacceptable and so the use of Entonox had ceased, pending an estates solution, which would be completed by Friday; occupational health were working with staff to provide appropriate support (although it was noted there was little evidence of the effects of long-term exposure) which included B12 testing, webinars and advice, and expedited clinical support if required; communications had been maintained with stakeholders and regulators. It was noted that other instances had been identified at other hospitals suggesting that the annual testing regime may not be sufficient.

AM recorded his thanks to those involved in managing the situation and the communications team for their swift response and confirmed with FB that service users' needs were being met regarding communications and transfers. FB stated that 12 patients had been transferred.

ACTION 97: FB to present the outcome of the independent review for the Nitrous Oxide incident to SOAC.

[following the meeting, it was noted that the Health and Safety Executive would be undertaking an investigation into the concerns raised regarding the Nitrous Oxide report, which could result in enforcement action]

FB provided assurance over 12 never events at MSEFT noting that the team were reviewing themes and lessons and undertaking observational audits. FB noted that MSEFT had received a draft CQC report. Details of follow up action required would be brought back to SOAC in due course.

Essex Partnership University Hospital NHS FT (EPUT)

FB reminded Members of the CQC unannounced visit at EPUT following the Dispatches programme and that a rapid quality review had been convened on 14 December so that stakeholders could begin to oversee and support the development of a reponse, which would be finalised at a further meeting to be held in the new year.

AMcK invited questions, none were raised.

Outcome: The Committee **NOTED** the quality key risks/concerns.

6. Workforce: Progress against agreed trajectories / KPIs and Key Risks (presented by Ruth Jackson)

RJ presented the workforce data, explaining the monthly performance and the actions being taken to manage any associated risks, noting that the last SOAC meeting agreed a revised trajectory for MSEFT and EPUT and that the data showed a stabilising position.

Members discussed in detail the data presented and the actions being taken to address workforce concerns.

In response to discussion regarding data quality concerns and performance AMcK requested that only data confirmed as accurate be presented to the Committee and asked for assurance regarding the progress within EPUT in filling nursing vacancies. MR stated that issues relating to physical infrastructure had affected getting the nurses onto the wards, but that two major programmes had been established to fill vacancies in 2023 and provide assurance over the actions being taken. RH insisted that data anomalies should be remedied prior to the next planning round.

A discussion took place regarding community data and the merits of a combined or separate organisational data set. AMcK expressed concerns over the extra work to create a combined dataset for the Collaborative but was reassured that separate data would be available to track the position in each stakeholder organisation.

ACTION 98: RJ to present to a future SOAC, a dataset for community, ensuring that data is clear, accurate and useful.

Members noted that Primary Care data would be included on the report next month and that there was a hotspot in the additional roles reimbursement scheme and GP recruitment.

AMcK concluded that the presentation was useful in showing service pressures and the changing shape of the workforce, but in relation to bank and agency ratios there needed to be a better and shared understanding of the actions required to achieve different and improved outcomes.

ACTION 99: MR to provide narrative (as an audit trail) of the workforce data in relation to bank and agency to vacancy ratios.

In response to SW questioning the management controls in place for spend in relation to workforce and whether this was a driver of the Trust deficit, HC described the series of senior oversight mechanisms in place to provide a robust control framework limiting ad hoc decisions.

ACTION 100: HC to share deficit drivers with SW.

Outcome: The Committee **NOTED** the Workforce Update Report.

7. Key Risks – Performance and Assurance Report (Presented by Dr Tiffany Hemming)

TH presented the performance and assurance report noting that there had been little change, summarising that only two of the 17 system promises were being met, though delivery plans were supposed to be in place and being followed up. Poor performance at odds with agreed trajectories was noted in 104 week waits, UEC and most elective targets. There had been increasing paediatric presentations, driven by a rise in Strep A; the underlying 62 day cancer target was on trajectory; additional activity in the dermatology pathway was going out to tender, with patient transfer protocols in development.

Members discussed the performance report and HC highlighted the risk that dermatology might not meet the required trajectory and consequently the 78ww position might not be achieved and additional outsourcing may be required to address the position. Further discussion concluded by EM outlining that the 'at risk' cohort was reducing and should resolve.

ACTION 101: HC/TH and EM to clarify the position regarding dermatology performance and whether the trajectory can be achieved.

Outcome: The Committee **NOTED** the Performance and Assurance Report.

8. System Finance Update (presented by Jennifer Kearton)

8.1 Key Risks – System Finance and Use of Resources Update (Month 7)

JK presented the key risks and overview of the month 7 financial position noting that it would be changed in the next few months with a net risk of £73m; the outturn position was being agreed with NHS England, a full briefing would be provided to the January meeting. It was noted that there had been escalation to the System Finance Leaders group on capital and a deep forensic review was scheduled.

AMcK pointed out that there had been intensive discussions about recovery plans between FDs and CEOs and national, regional and local level. He invited specific questions on local particulars, but none were forthcoming .

Outcome: The Committee **NOTED** the Month 7 System Financial position.

9. System Partner Assurance Paper (presented by Anthony McKeever)

AMcK introduced the system partner assurance paper, outlining the role of the Committee and its partners. JC outlined the purpose of the paper was to strengthen the development of SOAC ensuring that there was adequate challenge and scrutiny prior to papers being presented to SOAC. Future SOAC agendas would be focussed on System Oversight Framework (SOF) data and escalations with assurance obtained beforehand through the committee structure outlined in the report and from the individuals accountable for delivering performance and escalating risks.

Members considered the actions outlined in the report and how it would shape the functioning of the Committee.

AMcK noted the proposals regarding managing waiting times and targets and the need to prioritise and manage according to the quality framework, expanding focus on poor performing areas where appropriate.

JH and JW highlighted pressures relating to non-constitutional standards and the need to develop escalations through SOAC.

ACTION 102: Members to consider how assurance regarding their areas of responsibility can best be achieved through relevant committees with shortfalls escalated to SOAC. Feedback to be provided to JC on areas not currently covered by the existing reporting arrangements.

In response to JW, AMcK confirmed that Primary Care assurances were via the Primary Care Commissioning Committee, but that JC and BF were reviewing the link with local Alliances.

ACTION 103: BF / JC to consider with DD/PG how work with the Alliances should feed into SOAC escalations and assurances.

Outcome:

- The Committee **NOTED** the System Partner Assurance Paper detailing how assurance processes would support SOAC's work.
- The Committee Members **AGREED** to ensure that where their organisation reported to a sub-group (defined in Appendix 1 of the report), the requirement for papers, updates, preparation and engagement was understood by those attending.
- The Committee **APPROVED** a more equitable approach to managing waiting times across RTT and non-RTT services (where formalised standards weren't in place).
- The Committee **AGREED** actions to clarify how Alliancess would feed into SOAC, particularly with regard to local delivery in primary care.

10. MSEFT Undertakings Update (presented by Frances Bolger and Elizabeth McEwan)

Members noted that EM and FB had met with NHS England (following the RSG and MSEFT meetings) in November to review undertakings.

There had been a request to remove the governance undertaking and harm review, but that the undertakings in relation to cancer and RTT would be retained. Progress to date was deemed satisfactory and the request would be considered after the CQC report had been issued whereby no change or an improvement would result in the lifting of the governance undertaking. New metrics for RTT and the cancer 62-day backlog were agreed and there would be a follow-up meeting in January.

AMcK invited further questions, none were raised.

Outcome: The Committee **NOTED** the MSEFT Undertakings Update.

11. Any other business (presented by Anthony McKeever).

There was no other business discussed.

12. Papers shared for information only.

There were no papers shared for information only.

13. Date of Next Meeting

11 January 2023 – 1.00 pm to 3.00 pm via MS Teams.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 16 November 2022 at 9.30 am

Via MS Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Associate Non-Executive Member – Chair.
- William Guy (WG), Director of Primary Care.
- Pam Green (PG), NHS Alliance Director for Basildon Brentwood.
- Dan Doherty (DD), NHS Alliance Director for Mid Essex.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Caroline McCarron (CMc), Deputy Alliance Director South East Essex (Deputising for Ruth Hallett).
- Margaret Allen (MA), Deputy Alliance Director Thurrock (Deputising for Stephen Porter).

Other attendees

- Kirsten Dangerfield (KD), Advance Practitioner Lead for MSE.
- Dr Sarah Crane (SCr), workforce team, presenting item 11 on behalf of Kathryn Perry.
- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes.
- Alison Birch (AB), Head of Primary Care Oversight & Assurance.
- Simon Williams (SW), Deputy Alliance Director Basildon & Brentwood.
- Vicky Cline (VC), Head of Nursing, Primary Care Quality.
- Sarah Cansell (SCa), Contract and Support Manager, NHS England.
- Eleanor Carrington (Observer), Deputy Head of Nursing, Primary Care Quality.
- Debbie Crisp (Observer), Primary Care Account Manager, Thurrock.
- Nicola Adams (NA), Deputy Director of Governance and Risk (minute taker).

Apologies

- Ronan Fenton (RF), Medical Director.
- Elaine Roe (ER), Contracts Manager (Primary Care), NHS England.

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

No declarations were raised.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 19 October 2022 were received.

Outcome: The minutes of the ICB PCCC meeting on 19 October 2022 were approved.

4. Action log

The action log was reviewed and noted that one outstanding action remained from the predecessor CCGs which was expected to be completed by December 2022.

Action 7 noted that the Alliance Directors for Mid Essex and Basildon & Brentwood were leading an exercise to prioritise estates and an update would be provided at the December meeting. This action to be closed.

Actions 9 and 10 could also be closed.

5. Procurement of Special Allocation Scheme

AB presented the report providing the background to the special allocation scheme (SAS) procurement and requested approval to extend the current contract by 12 months to allow the team sufficient time to re-procure the service.

AB explained that the ICB is required to commission SAS for patients who are violent and aggressive, so they continue to receive services. Commisceo Primary Care Solutions (APMS contract) are currently providing the services which cover Basildon, Chelmsford, Grays, Rochford, and Southend. There were no issues raised with the service being provided and the list size remained within contractual allowance and was reducing. The contract was due to expire in March 2023 and contract terms allowed for a further 12-month extension.

SA asked for questions from Members, none were raised.

Outcome: The Committee APPROVED the extension of the special allocation scheme contract with Primary Care Solutions for 12 months to allow for a full procurement process to be undertaken.

6. Commercial Framework

WG apologised that the presentation slide deck had only been circulated just prior to the meeting but noted that the commercial framework (called the 'Working Together Scheme') for primary care had been developed over last 12-18 months with a view to making services sustainable and extend the breadth of the primary care offer. It therefore Identified local priorities to be delivered by primary care.

WG explained the key components of the scheme as set out within the presentation, noting that it aligned to the ICB strategies and improvement plan and was compliant with the delegation agreement; incentivising Primary Care Networks (PCNs) and giving them flexibility in how it is delivered, particularly given current pressures on primary care.

SA invited questions and comments from Members.

PG was supportive of the framework but sought assurance that the scheme aligned with current Alliance initiatives. AD confirmed that it did. PG asked to make it clear to PCNs that the two dovetailed to deliver the Fuller Recommendations.

VC asked to strengthen the framework to make clear the focus on quality and improvement through shared learning. AD noted that RF was clear that PCN Patient Participation Groups play a part in evaluation and what PCNs are developing to feedback on quality. Concern was raised that some PCNs still need to develop PPGs and SA noted a concern surrounding the workload on PCNs.

DD asked what the leverage was to address poor performance. WG confirmed the scheme was staggered and so needs to be delivered to receive the funding, noting that the following year would be more comprehensive and demanding, additional feedback from Clinical Directors emphasised the fragility of primary care.

In response to CM regarding the funding of clinical auditors, AK confirmed that funding for two schemes is new uncommitted funding and is affordable.

In response to SA's anxieties regarding capacity within Primary Care to deliver the framework, WG confirmed the appointment of a digital transformation role, clinical capacity to support and progress ideas and work within the alliances to progress existing programmes around integration.

ACTION: WG to reflect within the commercial framework, the support that would be available to allow Primary Care to engage fully and effectively.

WG presented an assessment of funding sources and phasing of the framework for 23/24, including Primary Care transformation sources and new models of care, which will be led locally rather than prescribing how the framework will be delivered.

AK noted it was an ambitious timescale; a long-term piece of work; therefore, the team need to agree the outcomes.

In response to SA, WG confirmed that much of the funding was ringfenced to Primary Medical services; pharmacy has similar ringfencing, but not dental. There is opportunity to look at integrated working within the scheme and how this was extended for maximum change.

SA asked for clarity over the views of the professions and the unions. WG confirmed the team were engaging with the LMC who were broadly supportive of the transformation agenda, but they will review as the detail emerges. The next step was to broaden engagement with Clinical Directors, who were supportive at this stage, but wanted to understand the detail.

Outcome: The Committee SUPPORTED the Commercial Framework, noting that further iterations of the scheme will be presented at future meetings.

7. Dickens Place Reprovision

WG presented an overview of a contract hand back from Dickens Place practice and the intentions to ensure reprovision of primary medical services for the population presently served by this practice. This would involve an options appraisal process with alternative provision required from 1 April 2023.

WG drew the attention of the committee to the success criteria set for review and endorsement by the committee.

Members discussed the case presented. SA invited questions from members, there were none.

Outcome: The Committee APPROVED to approach to procurement for the provision of services to those currently served by Dickens Place and ENDORSED the proposed criteria for the options appraisal.

8. Valkyrie Boundary Change

AB presented a request to reduce practice boundary of the Valkyrie Surgery confirming that the Practice proposal to reduce the boundary would not significantly affect patient choice on where to register because there were various alternative options for provision of local services. Furthermore, that other local Practices (four in addition to Queensway) were happy to increase their list size and consequently their boundaries, resulting in the equality impact assessment remaining neutral.

SA invited questions from Members. Members discussed the case presented.

VC commented that patients already registered that will then be outside of the boundary will stay with the practice and that this would facilitate improved quality of services because of the boundary change.

In response to AD, AB confirmed that the Practice had discussed with other Practices.

PG wondered if this would set a precedent and confirmed there would need to be a consistent assessment to ensure patients are not disadvantaged.

Outcome: The Committee APPROVED the boundary reduction for the Valkyrie Surgery.

9. South Green Surgery

SCa presented a request from the South Green Surgery to change status from a single-handed practitioner to that of a partnership. SCa confirmed that there were no general circumstances identified that this shouldn't be agreed but noted that the GPs do hold other contracts in the area. SCa stated that this would not affect the delivery of services at any site, patient choice would be maintained, and it could pre-empt merger.

SA invited questions from members. Members discussed the case proposed.

VC noted that there would need to be a change in registration at the CQC and there would need to be a plan for clinical leadership as per CQC requirements.

PG and SA highlighted that the clinical lead at the Alliance should be involved in the conversations regarding this.

ACTION: WG to work with Alliance Directors to develop a process to bring an Alliance view into future decisions, via the clinical director, subject to managing any conflicts of interest. The process to be brought back to a future meeting for noting.

Outcome: The Committee APPROVED the change of status of the South Green Surgery to that of a Partnership.

10. APMS Procurement conflict of interest management

WG noted that the paper presented in the meeting pack was incorrect and asked members to disregard the paper and a further paper would be circulated after the meeting.

WG stated that the paper highlighted several apparent conflicts of interest in the APMS procurement process now that bidders were known. The paper (to be circulated) sets out the associated risks are and how they were being managed and mitigated to enable the procurement to continue.

SA noted that limited discussion could be held in the absence of the paper, but that discussion could be held outside of the meeting, to note the actions virtually once the paper had been distributed.

Outcome: The Committee NOTED the advice from WG regarding conflicts of interest management for the APMS procurement and that a further paper would be circulated outside of the meeting.

[post meeting note: WG circulated the APMS Conflicts of Interest management paper, no comments were received, and the paper was therefore taken as ENDORSED by the Members]

11. Primary Care Workforce

SCr (workforce team) presented the report on behalf of Kathryn Perry who was unable to join the meeting. The report outlined the planned and ongoing interventions to create a sustainable workforce for the future.

SCr highlighted the primary workforce risks given that a third of GPs were forecast to retire in the next five years. Members discussed the workforce data.

SCr highlighted the strategies around GP retention and recruitment, training, active support for succession planning for those retiring over next 5-10 years, and the provision of peer support. SCr concluded that the team continues to work closely with PCNs to recruit and retain staff ensuring access to a wide range of resources and support.

SA invited questions from members.

AD asked whether the students graduating next summer from Anglia Ruskin University (ARU) were going to be placed in hospitals in Essex. SA noted he was responding not as Chair of the committee, but in his role within ARU therefore noting his external interest; that ARU were working with Health Education England and the UK Foundation programme to develop a pilot for graduates to stay local where appropriate.

KD reflected upon whether there was an opportunity for non-clinical staff to be a partner in the GP Practices. AD noted that it was possible, but there must be a GP within the partnership.

Outcome: The Committee NOTED the assurances provided from the Primary Care Workforce update.

12. Primary Care Risk Management

WG noted that the risks discussed at the previous meeting remained the same, but that the Primary Care risk register would be provided to the next meeting.

SA invited questions, there were none.

13. Guidance for advance Practitioners

KD presented ‘MSE ICS Guidance for the Organisational Governance of Advanced Practitioner and Consultant Practitioner Roles. Primary and Community Care’ noting it accords to Health Education England (HEE) guidance, proposing it be approved by the committee. KD noted that a funded post was in place to support the roll out of the guidance.

SA invited questions from members.

VC sought further information regarding how this would be rolled out in primary care and who would be responsible for clinical supervision. KD assured members that it would be rolled out working with relevant line managers, noting that HEE bringing in regulation for Advanced Practitioners so this might form part of registration in the future.

SA asked what engagement had been undertaken with Primary Care employers. KD noted that there would be engagement, but that the policy was brought for approval prior to that happening. In addition, the Advance Practitioner faculty group and the training hub leads were supportive. SA praised the document, but noted it needs engagement with providers and training hubs, involving the Clinical Directors in the Alliances for it to be successful.

Outcome: The Committee SUPPORTED the guidance subject to careful ongoing engagement with Primary Care and training hubs.

ACTION: KD to connect with Clinical Directors within Alliances and with training hubs (WG/AD and Alliance Directors to help facilitate).

14. Primary Care Quality & Safety

VC presented the Primary Care Quality and Safety report noting that the paper provided the committee with oversight on the reporting and quality assurance needed to ensure that primary care clinical services were providing safe, effective, and quality care to the patients across mid and south Essex.

VC highlighted the key risks to the attention of the committee, namely that CQC ratings issued since the last report rated Wakering Medical Centre as inadequate; a rapid review has been undertaken and GPs were engaged in making changes required. Dickens Place had been rated as good. However, Southend Road Surgery was rated as requires improvement with plans in place to address concerns raised.

Monthly Alliance-based risk meetings were being held from December. This would enable practice risks to be aligned to the quality agenda assessment as mild, moderate, high and the team were looking at how this would fit with the ICB risk management processes.

VC informed members that the quality and safety programme risk register / issues log was being developed for Practices.

VC summarised that 9 incidents remained open but were reducing.

SA invited questions. Members discussed the merits of a Part II confidential meeting. NA noted that the meetings were not held in public, but that there could be confidential matters that were contained within the minutes that would be a matter of public record as they would be shared with the ICB Board. NA suggested that separate notes of confidential matters could be maintained.

ACTION: NA/WG to consider how to address confidential discussions and bring back to next meeting under matters arising.

Outcome: The Committee NOTED the update and assurances from the Primary Care Quality and Safety Report.

15. Escalations

The funding aspect of Commercial Framework is to be presented to the Finance & Investment Committee for information.

16. Any other Business

Chairs action was required on an issue that had arisen in Southend. WG noted that alongside social care colleagues, the ICB commission across the system several beds that were between nursing home and an intermediate care setting for short stays to support hospital flow. In Southend there was a unit developed to take on higher complex patients. The GP who supports the unit had flagged that this cannot be sustained under existing GMS contract arrangements and consequently there is a proposed short-term enhanced service to support (through that practice). This follows a precedent and would be reviewed. From a patient quality and safety perspective this is necessary, and approval is therefore sought from the committee.

SA invited comments and questions from members, there were none.

Outcome: The Committee APPROVED the short-term enhanced service to the GP contract for support to the Southend Unit assisting hospital flow.

17. Date of Next Meeting

21 December 2022 - 9.30–11.30 am via MS Teams.

Part I ICB Board meeting, 19 January 2023

Agenda Number: 13.2

Approvals made in between meetings.

Summary Report

1. Purpose of Report

To notify the Board of decisions made under the constitutional provision for making decisions outside of scheduled Board meetings.

2. Executive Lead

Anthony McKeever, Chief Executive Officer.

3. Report Author

Mike Thompson, Chief of Staff.

4. Responsible Committees

As per the requirements of the Constitution, the Audit Committee will receive a note of formal decisions taken under the provisions for decisions outside of meetings as ratified by the Board.

5. Conflicts of Interest

None identified for this report.

6. Recommendation/s

The Board is asked to ratify the decisions taken to approve the following business cases made in between Board meetings:

- Alternative Provider Medical Service (APMS) Procurement.
- Business Intelligence (BI) Procurement.
- Independent Sector Contracts for additional elective capacity.

Approvals Made Between Board Meetings

1. Introduction

The ICB Constitution sets out provision for circumstances where decisions need to be made that cannot wait until the date of the next Board meeting such as where procurement timetables dictate an urgent decision.

2. Main content of Report

Since the last Board meeting held on 17 November 2022, three business cases were presented that required a decision before the January meeting of the Board and were approved through the constitutional provisions for making decisions as follows:

Alternative Provider Medical Service (APMS) Procurement

The APMS procurement programme was running to a schedule determined by local process and statutorily defined timelines. As a result of this, the window between completion of the evaluation process and seeking approval of the Preferred Bidders fell between 8 and 23 December.

Reports had been provided to the Primary Care Commissioning Committee who had responsibility for overseeing the procurement and ensuring that due process had been completed. Advice was also sought from the ICB Executive and System Finance Leaders Group.

BI Procurement

The Arden and Greater East Midlands (AGEM) Commissioning Support Unit (CSU) contract for Business Intelligence Services was novated from the five CCGs to the ICB on 1July 2022. This contract was awarded to AGEM in July 2018 for a three-year term and has been extended twice under valid extension provisions within the contract, a procurement process must therefore be undertaken.

The Finance and Investment Committee supported a recommendation to use the Consult18 framework to make a direct award to AGEM CSU for business intelligence services with an updated service specification for an initial contract term of two years (expendable by a further two periods of one year). This would allow plans to in-house the service to be further advanced and to determine if in-housing would provide the best service fit for the ICB.

Independent Sector Contracts

Several services commissioned from the independent sector via the national Increasing Capacity Framework were due to expire in March 2023 to support the delivery and recovery of elective care services across mid and south Essex and to support the Referral To Treatment and Diagnostic waiting time standards.

The Finance and Investment committee supported the recommendation to re-procure the services with the Independent Sector through the framework.

3. Findings/Conclusion

The decisions made under Constitution provisions for making decisions between meetings were discharged as required by the Chair, Chief Executive and a Non-Executive Member of the ICB. These decisions are to be ratified by the ICB Board and noted at the next Audit Committee meeting.

4. Recommendation(s)

The Board is asked to ratify the decisions taken to approve the following business cases made in between Board meetings:

- Alternative Provider Medical Service (APMS) Procurement.
- Business Intelligence (BI) Procurement.
- Independent Sector Contracts for additional elective capacity.

Part I ICB Board meeting, 19 January 2023

Agenda Number: 13.3

Integrated Care Board Policies

Summary Report

1. Purpose of Report

To ask the Board to ratify three newly adopted ICB Board policies which have received approval by the relevant Committees, as set out in Section 2 of the report.

2. Executive Leads

- Jennifer Kearton, Director of Resources.
- Dr Ronan Fenton, Medical Director.
- Dr Ruth Jackson, Chief People Officer.

3. Report Author

Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

As set out in Section 2 of the report below.

5. Impact Assessments

Each policy includes an Equality Impact Assessment at Appendix A of each policy.

6. Financial Implications

Policies set out any financial implications or processes that must be applied.

7. Details of patient or public engagement or consultation

Policies confirm stakeholders who have reviewed and commented upon draft policies.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to ratify the following new ICB Policies:

- MSEICB 003 - Procurement and Contracting Policy.
- MSEICB 076 - Individual Funding Request Policy.
- MSEICB 078 - Reimbursement of Staff Expenses Policy.

Integrated Care Board Policies

1. Introduction

Prior to the establishment of the ICB, a suite of policies was agreed and developed to support the ICB to deliver its duties. The majority were 'Day 1' priority policies and were adopted by the ICB Board at its inaugural Board meeting on 1 July 2022.

Three further policies have since been developed, reviewed and approved by the relevant committee, as set out in Section 2 below.

Several other policies are under development and will be submitted to the relevant committees for approval prior to their ratification by the Board.

2. New Policies for Adoption by the Board

Policy No and Title	Purpose	Responsible Committee	Approval Date
003: Procurement and Contracting Policy	This policy sets out the framework within which the ICB will work to procure and contract for services within national and regulatory requirements.	Finance & Investment	09/11/2022
076: Individual Funding Request Policy	This policy will be used to consider Individual Funding Requests where a service, intervention or treatment falls outside existing service agreements.	Clinical and Multi-professional Congress	27/10/2022
078: Reimbursement of Staff Expenses Policy	This policy sets out the ICB's arrangements for reimbursement of employees for travel, subsistence and other expenses (as covered by NHS Terms and Conditions of Service Handbook) incurred during ICB employment.	Remuneration	09/11/2022

Once ratified by the Board, the above policies will be posted on the ICB's website.

3. Recommendation(s)

The Board is asked to ratify the following new ICB policies:

- MSEICB 003 - Procurement and Contracting Policy.
- MSEICB 076 - Individual Funding Request Policy.
- MSEICB 078 - Reimbursement of Staff Expenses Policy.