Meeting of the Mid and South Essex Integrated Care Board

Thursday, 16 March 2023 at 3.00 pm – 4.30 pm

Committee Room 1, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER

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	Review of Register of Interests and Declarations of Interest	Note	Attached	Professor M Thorne	3
3.	3.02 pm	Questions from the Public	Note	Verbal	Professor M Thorne	-
4.	3.03 pm	Minutes of ICB Board meeting held 9 February 2023 and matters arising.	Approve	Attached	Professor M Thorne	6
5.	3.04 pm	Review of Action Log	Note	Attached	Professor M Thorne	11
		Items for Decision				
6.	3.05 pm	Operational and Strategic Planning 2023/24 Update	Approve	Attached	J Cripps J Kearton	12
7.	3.10 pm	MSE Integrated Care Strategy	Approve	Attached	J Cripps J Banks	17
		Items For Noting				
8.	3.20 pm	Stewardship Stocktake and White paper response	Endorse	Attached	R Fenton P Scolding	63
9.	3.30 pm	Quality Report	Note	Attached	F Bolger	115
10.	3.40 pm	Performance Report	Note	Attached	T Hemming	120
11.	3.50 pm	Fuller Stocktake Update	Note	Verbal	Dr A Davey	126
12.	4.00 pm	Finance Report Month 10	Note	Attached	J Kearton	132
13.	4.10 pm	General Governance:				
		13.1 Delegated Commissioning:Pharmacy, Optometry and Dental)	Approve	Attached	R Fenton	138
		13.2 Thurrock Alliance Terms of Reference	Approve	Attached	A Mecan / L Billingham	146

No	Time	Title	Action	Papers	Lead	Page No
		13.3 Annual amendments to Committee Terms of Reference	Approve	Attached	Professor M Thorne	160
		13.4 Delegation of approval of Annual Report and Accounts to Audit Committee	Approve	Attached	Professor M Thorne	165
		13.5 Approved Committee minutes: • Audit Committee • Finance & Investment Committee • Quality Committee • System Oversight and Assurance Committee • Primary Care Commissioning Committee • Clinical and Multi-Professional Congress	Note	Attached	Professor M Thorne	167
		13.6 Adoption of ICB Policies	Ratify	Attached	Professor M Thorne	213
		13.7 Board Assurance Framework	Note	Attached	Professor M Thorne	215
14.	4.29 pm	Any Other Business	Note	Verbal	Professor M Thorne	-
15.	4.30 pm	Date and time of next Part I Board meeting: Thursday, 18 May 2023 at 3.00 pm, Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, Essex, CM1 1JE.	Note	Verbal	Professor M Thorne	-

Mid and South Essex Integrated Care Board
Register of Interests for Board Members

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared: Financial	Type of Interest Declared: Non-Financial Professional Interest	Type of Interest Declared: Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	Date of Interest: From	Date of Interest: To	Actions taken to mitigate risk
Les	Billingham	Local Authority Partner Member for Thurrock Council	Thurrock Council	x			Direct	Interim Director of Adult Social Care	Nov 22	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 the Colne Valley PCN.
Anna	Davey	GP Partner Member	Essex Cares	x			Indirect	Close relative is employed	06/12/21	On-going	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x	x		Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Peter	Fairley	ICB Partner Member (Essex County Council)	Suffolk and North East Essex (SNEE) Integrated Care Partnership	x	x		Direct	ECC representative	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.

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				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x	x		Direct	Employed as Consultant Anaesthetist	20/06/05	Ongoing	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x			Indirect	My wife is employed by MSEFT as a Consultant Anesthetist.	24/06/05	Ongoing	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Springfield Hospital/Ramsay Healthcare	x			Direct	I carryout Private Medical Services at Springfield Hospital	20/06/05	Ongoing	I will declare my interest if at any time issues relevant to Springfield Hospital or Private anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Springfield Hospital/Ramsay Healthcare	x			Indirect	My wife carries out private medical services at Springfield hospital	26/06/05	Ongoing	I will declare my interest if at any time issues relevant to Springfield Hospital or Private anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Fentons Limited	x			Direct	I ama a registered officer of "Fentons Ltd" which is a company which offer general and specialist medical services	22/06/05	Ongoing	I will declare my interest if at any time issues relevant to this company or private 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 (Board Member)	01/01/19	Ongoing	As above.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England and Improvement	x			Indirect	Close family member employed as senior strategy manager	Jan 2023	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	QTH often works with local volunteer sector including Healthwatch, social care sector for various community based iniaitives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	No direct action required.
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
Benedict	Leigh	ICB Partner Board Member	Sense		x		Direct	Trustee	01/07/22	Ongoing	Will recuse myself from any procurement or
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.

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Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	MACS et al Ltd	x			Direct	Director of wholly owned company through which I contract with the NHS for interim and other services.	02/03/20	On-going	As of 3/10/2020 I am employed and paid through NHS payroll for my role in Mid and South Essex. However, I will declare my interest in MACS et al Ltd if and where required so that appropriate arrangements can be implemented.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Royal Society of Medicine (RSM)		x		Direct	Fellow	02/03/20	On-going	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Faculty of Medical Leadership & Management (FMLM)		x		Direct	Fellow	02/03/20	On-going	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	NHS IMAS' Strategic Advisory Board - Board Member		x		Direct	Board Member	01/03/23	Ongoing	No immediate action required. Any potential conflict will be managed in consultation with Chair as and when the ICB's business concerns IMAS.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	UCL Partners Limited - Board Member		x		Direct	Board Member	01/03/23	Ongoing	No immediate action required. Any potential conflict will be managed in consultation with Chair as and when the ICB's business concerns UCL Partners.
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 9 February 2023 at 3.00 pm – 4.00 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), Director of Resources, MSE ICB.
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Dr 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.
- Dr Anna Davey (AD), Primary Care Board Member.
- Hannah Coffey (HC), Partner Member, Mid and South Essex NHS Foundation Trust.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust.
- Peter Fairley (PF), Partner Member, Essex County Council.

Other attendees

- Jo Cripps (JC), Executive Director of Strategy and Partnerships.
- Dr Tiffany Hemming (SH), Interim Executive Director of Oversight and Delivery, MSE ICB.
- Ruth Hallett (RH), Alliance Director, South East Essex, MSE ICB.
- Dr Pete Scolding (PSc), Assistant Medical Director, MSE Integrated Care System
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB
- Mike Thompson (MTh), Chief of Staff, MSE ICB.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.
- Sara O'Connor (SO), Head of Governance and Risk (minute taker).

Apologies

- Les Billingham (LB), Partner Member, Thurrock Council.
- Benedict Leigh (BL), Partner Member, Southend City Council.
- Pam Green (PG), Alliance Director (Basildon & Brentwood) MSE ICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid and South Essex) MSE ICB.

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

MT welcomed everyone to the meeting and noted apologies as listed above.

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

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

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

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

MT advised that two questions had been received from members of the public. Due to the personal nature of the issues raised, the questions would not be read out or answered directly during the meeting and written responses would be provided.

MT explained that, as well as their personal stories, the underlying issue raised by both individuals was that the In-vitro Ferilisation (IVF) policies of the former five MSE Clinical Commissioning Groups differed. The ICB was now proposing to harmonise the provision of IVF treatment across MSE, along with five other commissioning policies.

MT mentioned that in order to address health inequalities, it was sometimes necessary to focus service provision in particular areas where there was a greater need, for example respiratory health assistance.

Action: NA to arrange for a written response to be provided to questions raised by two members of the public.

4. Minutes of the ICB Board Meeting held 19 Januay 2023 and matters arising (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 19 January 2023 and asked members if they had any comments or questions. No comments were submitted.

There were no matters arising.

Resolved: The Board approved the minutes of the ICB Board meeting held on 29 January 2023 as an accurate record.

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

The updates provided on the action log were noted and no queries were raised.

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

6. Harmonisation of Commissioning Policies (Presented by Dr R Fenton, Dr P Scolding and C Hankey)

RF advised that the Board had previously been briefed on two occasions regarding the process being undertaken to ensure the ICB met its legal responsibility to address local variations in relation to the following six commissioning policies:

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

RF explained and provided examples of the terms ‘group prior approval’ and ‘individual prior approval’ referred to throughout the report.

The proposals were developed in response to a national requirement and had undergone a rigorous process, including review by the Clinical and Multi-Professional Congress, scrutiny of the financial implications by finance colleagues and a public consultation to enable the MSE population to comment upon the proposals.

CH advised that the public consultation ran between 31 October 2022 and 19 December 2022. A range of communication methods were used including: online surveys promoted by local partner organisations and libraries; social media; face to face meetings; engagement with focus groups; and provision of the consultation document in several formats. The consultation did not elicit a huge response, but this was not unexpected due to the fact that the proposals were not hugely contraversial.

To avoid bias when analysing and reporting on feedback received, an independent organisation, STAND, was engaged to provide a report, as set out in Appendix 4.

CH summarised the outcome of feedback relating to each of the six services, including the generally high level of support for the proposals, as set out on the slides available on the ICB’s website. CH also provided examples of feedback received.

CH confirmed that any patients who had already commenced treatment or would start treatment under the former CCG policies could continue with their treatment, with the harmonised ICB policies effective for new referrals from 1 April 2023.

PSc explained that he would comment on themes identified during the consultation and the way in which draft proposals were reviewed and adjusted to take account of these.

Body Mass Index (BMI) was used as a criteria in four policies. Queries were raised as to whether it was a valid measure to use during the threshold assessment process. The relevant policies were reviewed individually against the available evidence base, including national guidance, and it was clear that BMI was the only validated tool widely used for the particular policies under review. For example, the criteria for fertility services was a BMI of

19-30 as there was good evidence that a BMI above 30 had an adverse impact on the clinical effectiveness of these treatments.

For female sterilisation, an expert panel advised it was standard practice that surgery was unlikely to proceed for individuals with a BMI of 35 or above and their recommendation was that this should be a threshold criteria at referral stage. However, national guidance from the Faculty of Sexual Reproductive Health, did not include this as a recommended criteria. Consequently, the proposal was updated to include guidance to referrers that BMI would be looked at during surgical assessment, with weight management support a potential option prior to treatment.

The requirement to be a non-smoker for tertiary fertility services, breast reduction and breast asymmetry was a threshold criteria based on evidence that smoking adversely affected both male and fertility fertility and wound healing following surgery. Consequently, the recommendation to the Board was that non-smoking should remain as a threshold criteria for these three policies.

The role of counselling prior to female sterilisation was included to ensure the full range of contraceptive options (male and female) were considered before patients decided to undergo a surgical procedure under general anaesthetic, which had associated risks. Concerns were raised that this might act as a barrier for those seeking female sterilisation, noting it was not originally a requirement for male sterilisation. Following an evidence review, counselling was included for both female and male sterilisation.

PSc advised that it had been queried why Gynecomastia had not been covered within the policies for breast reduction or asymmetry and explained that this condition related to a particular cohort of patients covered within an existing harmonised policy.

In relation to inter-uterine insemination (IUI) for unexplained infertility two issues were considered, being treatment and diagnoses.

In terms of treatment it was known that for cases of unexplained infertility, IUI was no more clinically effective than a male and female having sexual intercourse. The expert panel had therefore recommended the ICB’s available resources should focus on the provision of IVF.

In terms of diagnosis, to access treatment all couples first had to demonstrate unexplained infertility. Male/female couples could evidence this by at least two years of trying but not becoming pregnant. However, female same sex couples could not demonstrate this in the same way. Therefore, six cycles of IUI, either funded by the NHS or self-funded, was applied as the standard for these individuals.

If the ICB decided to only fund same sex diagnosis, concerns might be raised by people seeking IUI as a treatment option; for example, those who for religious reasons might not want to pursue IVF.

The affordability of providing IUI for both treatment and diagnosis had been quantified within the business case as circa £150,000 per annum. If the recommendation within the report not to fund IUI was agreed, sex couples would need to self-fund the six rounds of IUI in order to demonstrate unexplained infertility for diagnosis purposes.

The equality and health inequalities impact assessment considered same sex couples and assessed there should be an overall positive impact for this cohort of patients for three

reasons being: expanded access MSE; provision of the same benefits for both female/male and same sex couples; and a full review of the language used within the policies to include trans and non-binary individuals.

PSc summarised the criteria and approval categories for each commissioning policy as set out in the report and advised that the new policies, if approved, would become effective from 1 April 2023.

MT confirmed that Board members had been full appraised of the process applied to harmonise the policies and he was assured that all appropriate steps had been undertaken to consider relevant evidence, the views of clinicians and the local population, and the financial impact of the proposals.

MT asked members if they supported the recommendations made for each of the six policies. All members signalled their support for all recommendations made.

Resolved: The Board:

- **Approved the service harmonisation business case pertaining to harmonisation of six service area policies, listed below:**

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

- **Approved the transitional arrangements necessary for specific populations affected, to be effective from 1 April 2023.**

7. Any Other Business

There was no other business discussed.

8. Date and Time of Next Part I Board meeting:

Thursday, 16 March 2023 at 3.00 pm to 5.00 pm in Committee Room 1, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER.

ICB Board Action Log

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
2	01/07/2022 and 17/01/2023	7 6	**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.	L Billingham / A Mecan	31/08/2022	Draft Terms of Reference on agenda of ICB Board meeting, 16 March 2023.	Complete
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
9	13/10/2022	8	**Digital Strategy and Investment Priorities** Secure investment requirements over future years.	System Leaders Finance Group/ J Kearton	Ongoing	Deep dive on EPR completed, next steps to schedule additional time with digital and finance leads to confirm understanding around remaining items. Will form part of planning next steps.	In progress
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	Mental Health services included in latest iteration of BAF.	Complete
19	19/01/2023	10	**Fuller Stocktake** Provide information regarding access to primary care services relating to each Alliance in future reports.	A Davey E Cox	18/05/2023	Actioned.	Complete
20	09/02/2022	6	**Harmonisation of Commissioning Policies:** Arrange for a written response to be provided to questions raised by two members of the public.	N Adams	16/03/2023	Actioned.	Complete

Integrated Care Board Meeting of 16 March 2023

Agenda Number: 6

Operational & Strategic Planning – Update

Summary Report

1. Purpose of Report

The paper describes the approach being taken to develop our operational plans for 2023/24 and the NHS Joint Forward Plan (JFP).

The paper proposes sign-off mechanisms to meet the required submission dates.

2. Executive Leads:

Finance; Jen Kearton, Executive Director of Resources.

Operational: Tiffany Hemming, Interim Director of Oversight, Assurance & Delivery.

Workforce: Dr Ruth Jackson, Executive Chief People Officer.

JFP: Jo Cripps, Executive Director, Strategy & Partnerships.

3. Report Author

Jo Cripps, Executive Director, Strategy & Partnerships.

Jen Kearton, Executive Director of Resources.

4. Responsible Committees

The Finance & Investment Committee has oversight of the financial plans for the system.

The NHS Chief Executive Officer (CEO) Forum plays a key role in overseeing the development of operational plans and the Joint Forward Plan.

5. Link to the ICB's Strategic Objectives

The new Integrated Care Strategy for Mid and South Essex is on the agenda for ICB approval on 16 March.

Operational plans have clear regard to the requirements set out by NHS England.

The JFP will have clear regard to the integrated care strategy and the joint local health and wellbeing strategies of our upper tier local authority partners.

6. Impact Assessments

Individual impact assessments relating to services or specific aspects of the operational plan and/or JFP will be undertaken as required.

7. Financial Implications

Nil

8. Details of patient or public engagement or consultation

Engagement with patients and the public will be undertaken in the normal course of work.

9. Conflicts of Interest

None identified.

10. Recommendation/s

The Board is asked to:

1. Note the process of development for the operational plan 2023/24.
2. Note the requirements of the Joint Forward Plan as per guidance from NHS England.
3. Note our approach and progress on completing operational plans.
4. Note our approach to developing the JFP with partners.
5. Approve the arrangements for:
    a. Submission of the operational plan to NHS England
    b. Submission of the draft JFP to NHS England (31 March)
    c. Plans for engagement with partners on the JFP, to take place during May/early June to observe the local election period.
    d. Publication of the JFP by all NHS partners (30 June).

Operational & Strategic Planning – Update

1. Introduction

This paper outlines the process for completing operational plan submissions and the process we are undertaking to develop the NHS Joint Forward Plan, a new requirement for NHS organisations.

It asks the Board to approve mechanisms for sign-off and submission of these plans.

2. Background

Operational Planning

The operational plan for 2023/24 is set by NHS England. The focus is on three key tasks:

- Recovery of core services and productivity.
- Progress in delivering key ambitions in the NHS Long Term Plan.
- Continuing to transform the NHS for the future.

Clear parameters and metrics are set for improvements in:

- Ambulance response times.
- A&E waiting times.
- Elective care waiting times.
- Cancer waiting times.
- Diagnostic waiting times.
- Community services.
- Access to primary care.
- Maternity services.
- Mental health services.

In addition, our operational plans will need to outline:

- Our financial plan (including improving our financial position).
- Provider activity plans.
- Workforce plans.
- Resulting performance in the key areas described above.

We will need to triangulate these aspects to ensure we are clear on the conditions for delivering our recovery plan.

ICB and provider colleagues have been working together to prepare the operational plan response. There have been several delays in the release of guidance and national templates. A draft submission was made on 27 February 2023.

Joint Forward Plan:

Following the formation of Integrated Care Boards (ICBs) as statutory bodies, NHS England (NHSE) has issued guidance on the new duty for ICBs and their NHS partner trusts to develop a plan over 5 years – known as the Joint Forward Plan (JFP) – and to update this plan annually in line with national operational planning requirements.

Each year, NHS England releases the annual operational planning requirements for the NHS. In turn, the ICB and its NHS partners are required to devise plans (relating to finance, activity, workforce and performance) to discharge the planning requirements. Operational plans for 2023/24 will effectively be the detailed plan for 'year 1' of the JFP.

The JFP must, as a minimum, describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet our population's physical and mental health needs, including the delivery of universal NHS commitments. The JFP must also address the four core purposes of the Integrated Care System, and meet relevant legal obligations. Crucially, the JFP must support the delivery of the new integrated care strategy (developed by the ICP) and the local health and wellbeing strategies of our upper tier local authority partners.

Ordinarily, the JFP would need to be completed by the start of the financial year – 1 April. However, for this first year, and in recognition of the ongoing development of guidance for integrated care systems, NHSE has specified that the date for publishing and sharing the final plan with NHS England, our integrated care partnership (ICP) and our three local Health and Well-being Boards (HWBs), will be 30 June 2023. A draft must be submitted to NHSE by 31 March, in line with operational planning submissions for the year 2023/24.

Guidance states that ICBs and their partner trusts must consult with 'those for whom the ICB has core responsibility and anyone else they consider appropriate'. This should include the Integrated Care Partnership (ICP) and NHS England (with respect to the commissioning functions that will be delegated to ICBs). Of course, the development of our integrated care strategy involved wide-ranging engagement with partners and the public, and the development of the JFP will use and build upon the insight gained during this engagement.

The ICB and our partner trusts must agree a process for finalising and approving the JFP and the final version must be published by all partners. JFPs must be reviewed and updated before the start of each financial year (in line with annual operational plans).

The guidance states that ICBs and their partner trusts 'must involve relevant HWBs in preparing or revising the JFP'. This will include sharing a draft with our HWBs, and consulting members on whether the JFP takes proper account of each joint local health and wellbeing strategy. Local elections will mean that our health and wellbeing boards will likely be disbanded in mid-March and reconstituted from mid-May. Therefore, engagement with HWBs will need to take place during May/early June.

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

3. Our Approach

Operational Plans:

Finance colleagues in EPUT, MSEFT and the ICB have been working to develop first cut financial plans, which have been consolidated and are now being reviewed for triangulation and assurance across the system.

Operational teams have been meeting weekly to work on plan development, looking specifically at activity, performance and workforce.

The next step will be for a triangulation exercise to take place to ensure that available finances and workforce can deliver the required activity to deliver our performance improvement plans.

A draft submission was made on 27 February 2023. The CEO Forum has overseen the progress of operational plan development and will be receiving a further draft at its meeting on 10 March. Importantly, we must as a system submit plans that are realistic and deliverable in the current context. We will exit this financial year in a deficit position and as such financial stability needs to be at the forefront of planning and delivery in the new financial year. Final plans must be submitted on 31 March 2023.

Joint Forward Plan:

Systems have been given significant flexibility to determine the scope and development of their JFP. Locally, we have decided that our JFP will be in two parts:

Part 1: will set the strategic ambition of NHS partners over the 5-year period. This will be a short document, setting out our key ambitions. We will engage with partners on this element of the JFP once the local elections are over and our local HWBs are reconstituted.

Part 2: will set out the five-year plan for NHS statutory duties and NHS Long-Term Plan commitments (recognising that the 23/24 operational planning round effectively creates ‘year 1’ of the 5-year plan).

The CEO Forum has oversight of the development of the JFP.

4. Recommendations

Operational Plan:

1. As work continues the operational plan, and the submission date is 31 March 2023, ICB members are asked to delegate responsibility for approving and submitting the plan returns to the ICB CEO. The Board will receive a full update on the plans submitted at its April meeting.

Joint Forward Plan:

As work is on-going on both parts of the JFP, it is recommended that:

1. The Board delegates responsibility for endorsing the draft JFP (for submission to NHSE by 31 March, alongside the operational planning submission) to the CEO, Anthony McKeever, working with CEOs from NHS partner organisations.

2. During May (post local elections) we undertake a period of engagement on the JFP, building on that undertaken during the development of our integrated care strategy, with our Health and Wellbeing Boards, wider partners and further groups we have established.

3. Feedback from this engagement and NHS England’s review of our JFP is collated and the final document is prepared for the Integrated Care Board and provider Board approvals in early June to enable the plan to be published by 30 June 2023.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 7

Mid and South Essex Integrated Care Strategy

Summary Report

1. Purpose of Report

The purpose of this report is to present the Draft Mid and South Essex Integrated Care Strategy, at **Appendix 1**, produced by the Integrated Care Partnership.

The Health and Care Act 2022 requires that:

"… integrated care boards must, in exercising any functions, have regard to the following so far as relevant -

[…]

(b)any integrated care strategy prepared under section 116ZB in relation to an area that coincides with or includes the whole or part of the responsible local authority's area".

2. Executive Lead

Jo Cripps, Executive Director Strategy and Partnerships.

3. Report Author

Jeff Banks, Director of Strategic Partnerships

4. Responsible Committees

Mid & South Essex Integrated Care Partnership.

The Strategy was also presented to the Health & Wellbeing Boards of the Upper Tier Local Authorities as follows:

- Essex Health and Wellbeing Board (25.01.23).
- Thurrock Health and Wellbeing Board (10.02.23).
- Southend Health and Wellbeing Board (06.03.23).

All three Health and Wellbeing Boards have formally approved the Strategy.

The Strategy will be tabled for approved by the Integrated Care Partnership at its meeting on 20 March 2023 (with partners having been instrumental in its development).

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

Section 8.6 identifies that partners will *“identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set”.* This will be addressed by partners in due course.

Section 7.4 identifies how the Integrated Care Partnership will seek to influence Partners’ use of resources across the wider Integrated Care System.

7. Details of patient or public engagement or consultation

The following work was undertaken in the preparation of this Strategy:

1. **Review of Partner Strategies and JSNAs:** 27 publicly available strategies and plans from partner organisations within the MSE ICP as well as the relevant Joint Strategic Needs Assessments (JSNAs). Each strategy covered a three-to-five-year period between 2018 and 2026.
2. **Health inequality data analysis:** Partners reviewed the evidence of need from the analyses of Population Health Management health inequality data packs and JSNAs.
3. **Engagement:** eight workshops based in community venues, collectively engaging over 170 people. Partners used the ‘Essex is United – Your Questions Answered’ Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question. On publication of a Concept Paper, a further 20+ one-to-one and small group engagement sessions were held with Partners.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is required to:

- Approve the Integrated Care Strategy at **Appendix 1.**
- Have regard to the Strategy in exercising its functions.
- Ensure it sets out steps for delivering the Strategy in the Joint Forward Plan.

Mid and South Essex ICS

Integrated Care Strategy

2022-2033

December 2022

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Priorities for the Mid and South Essex Health and Care Partnership

1. Context

1.1. The health and care system

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area.

Following several years of locally led development, recommendations from NHS England and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1st July 2022. The ICS is made up of two main committees:

- ***Integrated Care Board (ICB):*** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the Integrated Care System area. The establishment of ICBs resulted in Clinical Commissioning Groups being closed.
- ***Integrated Care Partnership (ICP):*** A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICSs area (councils with responsibility for children's and adult social care and public health). The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy on how to meet the health and wellbeing needs of the population in the Integrated Care System area.

In Mid and South Essex, our ICS is made up of a wide range of partners, supporting our population of 1.2m people. We operate at several levels, ensuring we always organise our work and deliver services at the most local appropriate level and closest to the residents we serve:

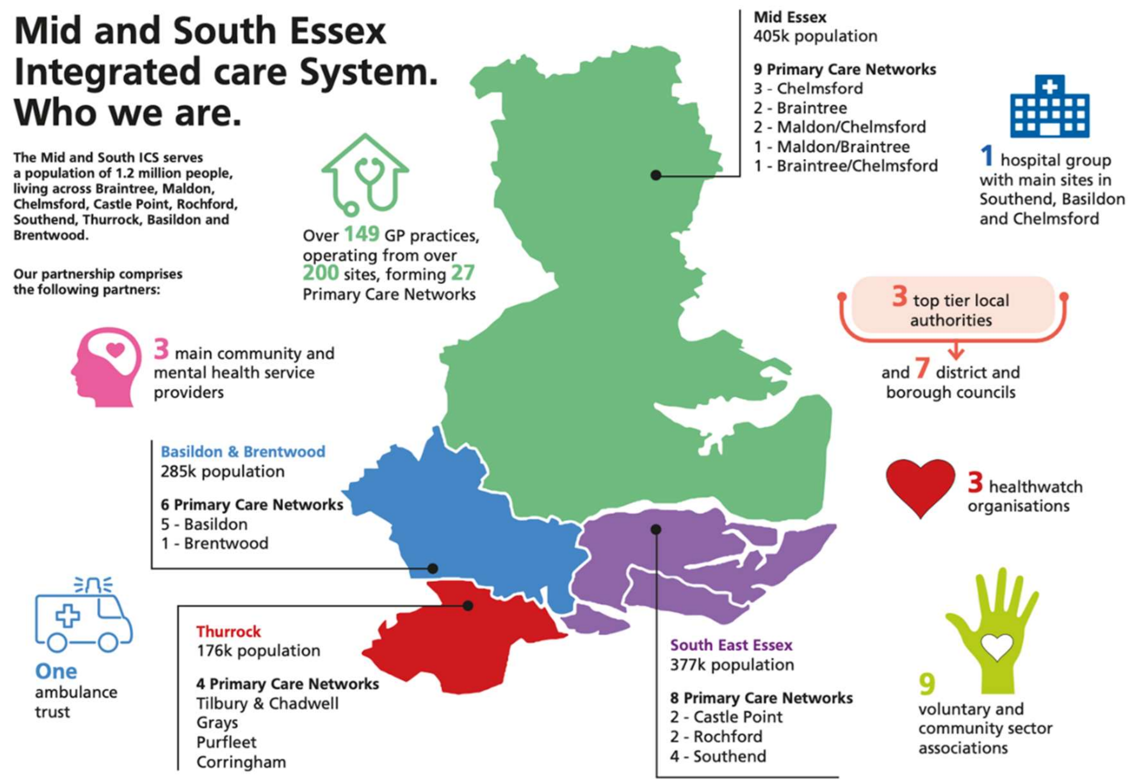
- ***Neighbourhoods:*** The areas covered by our 27 Primary Care Networks, and local neighbourhood teams, etc.
- ***Places:*** The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.
- ***System:*** The whole of Mid and South Essex.

Our Partnership includes;

- ***Three upper tier local authorities:*** Essex County Council, Southend-on-Sea City Council (unitary), and Thurrock Council (unitary).
- ***Seven district councils:*** Basildon Borough Council, Braintree District Council, Brentwood Borough Council, Castle Point Borough Council, Chelmsford City Council, Maldon District Council, Rochford District Council.
- ***One acute hospital provider:*** Mid and South Essex NHS Foundation Trust (MSEFT).
- ***Mid and South Essex Community Collaborative:*** *Bringing together NHS community services in mid and south Essex* - Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT) and Provide CIC.
- ***One ambulance service provider:*** East of England Ambulance Service NHS Foundation Trust (EEAST).
- ***Primary care:*** 27 Primary Care Networks (PCN) covering 180 GP Practices.

- ***Three local independent watchdog bodies:*** Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock.
- ***Nine community and voluntary sector associations:*** Basildon, Billericay and Wickford CVS, Brentwood CVS, Castle Point Association of Voluntary Services (CAVS), Chelmsford CVS, Community 360 (covering the Braintree District), Maldon and District CVS, Rayleigh, Rochford and District Association for Voluntary Service (RRAVS (RRAVS), Southend Association of Voluntary Services (SAVS) and Thurrock CVS.
- ***Other partners:*** Essex Police, Essex County Fire and Rescue Service, parish and town councils, the Local Medical Committee, local universities and colleges, and community and faith organisations.

The diagram below shows the shape of our Partnership:



1.2. Our successes

In Mid and South Essex we are building on firm foundations. The organisations and agencies working to improve health and social care outcomes for our residents have been working together positively for several years, starting with the formation of a Sustainability and Transformation Partnership in 2017, leading to the establishment of the Mid and South Essex Health and Care Partnership. In 2020 we agreed a Memorandum of Understanding, committing us to work together on a set of nine priorities:

1. Prevention.
2. Partnership.
3. Whole Systems Thinking.
4. Strengths and Asset Based Approach.
5. Subsidiarity.
6. Empowering Front-Line Staff to do the Right Thing.
7. Pragmatic Pluralism.
8. Health Intelligence and the Evidence Base.
9. Innovation.

Appendix Three describes how the Mid and South Essex Health and Care Partnership described these priorities/principles.

A draft strategy was produced, which, along with our practical experience of working together, has substantially informed our thinking. Although our previous strategy could not be formalised due to us having to prioritise our response to the COVID-19 pandemic, now our Integrated Care System has been given legal standing under the Health and Care Act (2022), we will build on our excellent track record of partnership working to take this work forward over the next decade through this Integrated Care Strategy.

1.3. Our challenges

Our health and care systems are stretched beyond capacity. What have been typically regarded as 'winter pressures' are now evident year-round. Demand for health and social care services has increased exponentially, outpacing funding provided from central government to both the NHS and local authorities.

The impact of the COVID-19 pandemic and workforce pressures have created unprecedented waiting lists. In many areas, such as consultant-led referrals and cancer diagnosis and treatment, this has caused significant backlogs and consequential impacts on quality of life for individuals. Pressure on primary care, children's and adult social care, and urgent and emergency services is extreme.

At a system and community level, we recognise a mismatch between:

Demand	Capacity
Where we are best supported	Where we seek support
Our desire to invest in early intervention and prevention	The requirement to prioritise urgent and emergency care and support
Our willingness as citizens to be involved	Opportunities to become involved
Our desire to trust systems and services	Our experiences and messages we receive
Our desire to give equal value to all system players	The dominance of key system players such as the NHS or adult social care

Most of our resources are invested in dealing with the consequences of long-term conditions, such as obesity, diabetes and mental ill-health and leaving much less available for helping people to maintain or improve their own health and wellbeing and finding effective support within their communities.

Changing this dynamic is a major social challenge of our time. This will require a significant reset, with action required by all partners, including those in the voluntary, community, faith, and social enterprise sectors. This change will necessitate a mindset-shift about the future role of residents and community organisations, moving them to a position where both are seen and treated as full and equal value partners in creating better health and care outcomes. Our future health and social care system cannot simply be about providers or services 'getting it right' for the public; it must involve a new covenant with residents and community organisations, that asks them directly to partner with services to help our residents stay healthy and well.

"It is not enough to do things differently; we need to be prepared to do different things."

To achieve this shift, our Strategy includes a shared public statement of ambition, bringing together residents and services in a single *'Common Endeavour'*. This ambition is informed by evidence and experience, supported by clarity about what must happen to deliver our objectives, what actions we will pursue to get there and underpinned by the measures to know that we are successful.

To support our Strategy, we are also establishing clear mechanism for our Partnership to receiving and consider regular updates on system performance, alongside providing space to explore emerging challenges and opportunities.

1.4. How we have developed this strategy

"Whether sitting as committee members or on advisory panels, we expect the people and communities of every system to be fully involved in all aspects of the development of the Integrated Care Partnership's Integrated Care Strategy. We expect Integrated Care Partnerships to set out how it has involved, engaged, and listened to local people and explained how they have acted in response to these views. This is a minimum requirement. We expect Integrated Care Partnerships to develop proposals for engagement with people in their areas which ensure that their plans and strategies deliver what people need and expect."

Integrated Care Partnership: engagement summary

Our overall approach to developing this Strategy was agreed by the Chair and the three Vice Chairs of the ICP, with support from the three local Healthwatch organisations and confirmed in the Partnership's first meeting in September 2022. We knew it was essential that the building-blocks of our strategy were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in the NHS, plus our local authorities. Accordingly, we have undertaken:

- ***A Review of Partner Strategies and Joint Strategic Needs Assessments:*** We reviewed 27 publicly available strategies and plans from partner organisations within the Mid and South Essex ICP as well as the relevant Joint Strategic Needs Assessments. Each strategy covered a three-to-five-year period between 2018 and 2026.
- ***A Health inequality data analysis:*** We reviewed the evidence of need as identified in the Joint Strategic Needs Assessments published by our three upper tier local authorities (Southend, Essex and Thurrock) and from our own Population Health Management team's health inequality data packs.
- ***Engagement:*** We held eight workshops based in community venues, collectively engaging over 170 people from all parts of our system, including elected councillors, system leaders, staff and, most importantly, members of our community. We also used the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question.

In terms of our approach, we did not start with a firm proposal and test this with partners and stakeholders, rather, we adopted an *'appreciative enquiry'* approach (focusing on what is working well and how we can do more of this), developing the proposals into an initial 'Concept Paper' which we then presented back to the colleagues, partners and community members who had contributed. We then held a further 25+ one-to-one and small group meetings with partner organisations and agencies.

Feedback has been extremely positive, and we are proud of the engagement work we have undertaken as part of this process. However, we know there is more work to do, especially in gathering the views and experiences of residents and a broader section of staff who work in our health and care system. We also want to undertake more work with residents who come

from more marginalised groups who are less often heard, often referred to as *'Inclusion Health Groups'*. This will become an ongoing feature of the work of the ICP as it moves forward. Engagement will not be a one-off event, it will be an ongoing, permanent feature of how we will work together as a Partnership.

All our conversations and analysis have reinforced the message that things need to change. There is a common understanding that improving the health and care of residents in Mid and South Essex depends on every part of the ICP playing a part in a rebalancing of our health and social care system towards prevention, early intervention, and anticipatory care, learning from partners who do this well and promoting and sharing best practice.

1.5. Review of partner strategies

Our review of 27 partner strategies identified many overarching themes, including:

- ***Persistent inequalities***: These lead to lower quality of life and shorter life expectancy for many, particularly for residents in parts of Basildon, Thurrock and Southend. Partners agree that eradicating these differences starts by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention and early intervention. This must also involve a real focus on babies, children, and young people, where many future health problems are seeded.
- ***Growing and ageing population***: With this comes a wide array of conditions including dementia, cardiovascular disease, cancer, diabetes, and chronic obstructive pulmonary disease, as well as the wider challenges of frailty and increased social isolation. It is vital that solutions better meet the increasing volume and complexity of need in a sustainable way, including the provision of care closer to home. This is a ticking time-bomb in terms of future pressure on Integrated Care System partners across health and care services if we do not act now.
- ***Mental health conditions:*** These are increasing in both adults and children and in some areas suicide rates are increasing at a worrying pace. Supporting people to feel comfortable talking about mental health, reducing stigma, and encouraging communities to work together are highlighted as key to improving mental health and wellbeing. Community partners have a particularly important role to play in the here and now, well before people present to mental health services for children and adults.

1.6. Our communities - evidence of need

We have undertaken an in-depth review of health inequality data, gathered from the Joint Strategic Needs Assessment published by our three upper tier local authorities (Southend, Essex, and Thurrock) and the ICP's Population Health Management team. This has generated a strong foundation for our work together as partners. **Appendix One** provides a snapshot of the challenges we face together.

In particular, there is evidence that:

- The significant majority of Mid and South Essex's most economically deprived population live in Basildon (where 17% population are part of the 20% most deprived nationally), Southend (15% population) and Thurrock (11% population).
- Premature mortality caused by cardio-vascular disease, cancer, and chronic obstructive pulmonary disease is particularly high amongst disadvantaged groups, driven by inequalities attributable to a range of socio-economic factors.
- Smoking prevalence amongst adults is particularly high in Basildon and Thurrock.
- The proportion of adults identified as overweight or obese is particularly high in Thurrock.

However, it is recognised that, as the Office of National Statistics states in the notes to the English Indices of Deprivation, *"Not everyone living in a deprived neighbourhood is deprived, and many deprived people live in non-deprived areas".*

In Mid and South Essex, we have invested as individual partners, and as a system, in developing our data and business intelligence capability and capacity. We have an established Population Health Management team, reporting to a Population Health Improvement Board.

"Stories are data with soul"

Brené Brown

We will continue to develop this capability to support our Partnership's work, using the very best available evidence, both in terms of quantitative and qualitative data. Quantitative data tells us about need and outcomes in terms of numbers or metrics - qualitative data tells us about needs and outcomes from the stories of those we are, and wish to be, supporting. We acknowledge there is more work to do on this.

1.7. Engagement findings

We have actively sought involvement of a wide range of statutory and non-statutory organisations and community groups who are involved in the provision of health and social care services.

Although some experiences varied, the engagement workshops confirmed that improved relationships between partner organisations and increased collaboration, particularly at a local Alliance level, was evident and that conversations are more evidence-based, with an increased focus on shared outcomes rather than inputs and activities. However, they also identified several key challenges:

System	***Community***
• Lack of clarity about the respective roles of the ICP, ICB, Health & Wellbeing Boards and Alliances. • Financial restrictions and 'red tape' mean funding does not flow around the system easily enough. Budgets are often not aligned, let alone pooled. • Difficult to prioritise and fund prevention and early intervention and meet urgent demands (this should not be a 'get out clause'). • Duplication and friction across patient pathways due to operational silos and lack of shared records. • Workforce recruitment, development and retention issues lead to staff shortages and risk of burnout.	• We encourage people to go to services for issues that they could address themselves, or within their community. • Top-down approach does not reflect the priorities or needs of residents and local communities. There is also insufficient service user engagement. • Services are difficult to access. There are not enough appointments and long delays. • Individuals are sometimes concerned about asking for help, because they don't believe they will be seen or listened to or will be adding pressure on services. • Individuals were frustrated that some people used the wrong services, which could block access for those with genuine need.
Communication and engagement	***Partnerships***
• Communication with residents, patients and service users is too complex and one-directional, making it difficult for people to understand choices, leading to default use of A&E or GPs and feeling uninvolved and disenfranchised.	• Concern amongst voluntary and community sector partners around equality of access to the most important conversations and decision making, with a desire to move to a more equal partnership.

1.8. This strategy

"The integrated care strategy should set the direction of the system […] setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care [it is] an opportunity to do things differently to before […] reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services."

Guidance on the preparation of integrated care strategies - July 2022

Following the engagement work undertaken, a 'Concept Paper' was produced, proposing how the ICP could articulate a single Integrated Care Strategy and outlining the priorities on which partners all agreed. This was presented to the ICP in November 2022 and, following agreement on this, this initial Strategy was developed and agreed by Partners in December 2022.

In recognition of the scale of the task and the need to change fundamentally the relationship between systems, services and our relationship with residents, the Strategy is presented as a ten-year plan, with reviews to take place annually to take into account progress made as well as new challenges and opportunities that arise. There will be a major review at the midway point in five years' time, commencing in the 2026/7 financial year.

There is a requirement that, on completion, we present our Strategy to the NHS ICB and the Health and Wellbeing Boards of our upper tier local authorities. The Strategy must be refreshed every time the upper tier local authorities publish a revised Joint Strategic Needs Assessment and/or a revised local Health and Wellbeing Strategy. In turn, the upper tier local authorities are required to consider the Integrated Care Strategy as they develop their own local plans. In addition, the ICB must have regard to the Integrated Care Strategy in how it exercises its statutory functions as the unitary authority for the NHS in Mid and South Essex.

It should be noted that the ICP will never seek to diminish or weaken the sovereignty of our partner organisations and agencies or our powerful local Alliances, nor will our Strategy replace or replicate their strategies and operational plans. It is simply intended to identify those shared priorities on which we will all work together and describe how we will do so.

In preparing this Strategy, we have had regard for the regulatory and statutory requirements, particularly the four key aims established for ICS:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

We have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, which requires them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by themselves and other relevant bodies.

For each of the key priorities outlined in this Strategy, there are ***'I statements'*** describing the change that residents should expect to see as a result of partners implementing this Strategy.

There are also ***'We statements'*** confirming in broad terms the commitments the Partnership makes and how these will be measured. We number these (e.g., *I7*, *W3*) and include a date by which we will expect to have made progress (in the format, month/year). The detailed measures and milestones we will use to identify how we are performing will be developed further in the early stages of implementing our Strategy.

The Strategy will be published on the Mid and South Essex Integrated Care System website, in an accessible and engaging format, and will be regularly updated as work progresses, and changes are agreed by the Partnership as a result of new challenges and opportunities. The website will include examples of good practice, and the experiences of our staff, partners, and residents, all regularly updated. We have and will always ensure material related to this strategy is accessible to those with limited access to the internet.

1.9. The language we use

We recognise that it is natural that any group of people working together in a specific field or sector will create short-hand language and use acronyms and abbreviations to help them manage their work more efficiently. However, we will always seek to use accessible language and plain English, particularly when we are communicating with those new to our system or members of the public.

The Kings Fund provides a helpful glossary of commonly used health terms which can be found at this link: https://www.kingsfund.org.uk/health-care-explained/jargon-buster.

The 'Think Local Act Personal' glossary also includes terms related to social care and can be viewed at this link:
https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/.

It is, however, important that we have agreement on what we mean when using terms and phrases in this Strategy. When we use the word **'Residents'** we refer to all members of the community living and working in Mid and South Essex, including those who receive services from our partners. These might elsewhere be referred to as 'members of the public', 'citizens', 'service users', 'patients', 'clients' or 'beneficiaries'.

When we refer to **'services'** we mean the support provided now or in the future by our partners, including by local health and social care agencies in the statutory sector (the NHS and local authorities) and those working as part of the voluntary, community, faith, or social enterprise sectors.

We use the word **'health'** to refer to the mental or physical health of residents, and **'health services'** when describing the services provided by our partners to support mental or physical health conditions as and when they arise.

We use the phrase **'social care'** when referring to the non-health-related needs of residents, such as personal or home care, residential or day care, and the wider assistance residents may need to live their lives as comfortably and independently as possible. Care needs may arise as a result of age, illness, disability, or concerns regarding the safety of children or vulnerable adults. When we say **'social care services'** we refer to the services provided by our partners which support social care outcomes. Very often, residents will need support from both health and social care services.

When we refer collectively to **'health and social care services'** we include the broad range of health and wellbeing offers. For pregnant women and children, we include health visiting services, school nurses and a range of children and young people's health and wellbeing services. We also acknowledge the valuable services our partners provide in formal and informal education, leisure, managing and caring for outdoor spaces and the environment,

travel, highways, housing, planning and the work of our local schools, colleges, and universities, plus police, fire, and coastguard services, which all play a crucial role in keeping us safe and well. All of these are considered central to helping our Partnership achieve its objectives and we hold these with equal value.

We use the phrase **‘primary care’** to describe the services residents often use as the first point of contact with services for their health needs, usually provided by professionals such as GPs, pharmacists, dentists, and optometrists. We also include **‘social prescribing’** in this definition, which is where professionals refer residents to support in the community to improve their health and wellbeing, and the services which make this happen.

The phrase **‘urgent and emergency care’** is often used to refer to emergency health services, provided by accident and emergency departments at our three hospitals. However, in this Strategy, we are equally concerned about urgent social care services, such as those which respond when a child or vulnerable adult is in danger or requires immediate support to ensure their wellbeing is protected or when residents experience acute mental health crises.

When we say ‘**public health’** we refer to the statutory services which work to reduce the causes of ill-health and improve residents’ health and wellbeing through, for example, health protection - action for clean air, water and food, infectious disease control, protection against environmental health hazards, chemical incidents, and other emergency responses.

Overall, it is our intention to use inclusive language. As such, when we present this Strategy to different audiences, we will ensure that the language we use and the way we present the Strategy is accessible to the people we are addressing.

1.10. Risk, safeguarding and equality

Our Partnership recognises we all have responsibility to safeguard children and vulnerable adults and to promote equality and inclusion for all our residents. We will ensure that we meet our statutory responsibilities and champion the highest standards in all that we do, ensuring joint accountability when they fall short of our expectations. We will meet the Public Sector Equality Duty, but seek to go further, with our health and care system being an exemplar; setting a high standard for our Partners, our system, and our communities.

We will support the development of shared approaches and tools, including health equality impact assessment approaches.

We acknowledge that risk thrives in gaps - the space between services and at transition points. It also occurs when our work goes unchecked and poor practice goes unchallenged. By working better together as Partners and with our residents and by having the space and opportunity to deal swiftly with challenges and to build on opportunities, plus by ensuring our collective services and supports are of the highest quality and well connected, we will reduce risk.

1.11. Sustainability and the environment

Similarly, our Partnership recognises we all have a part to play in meeting sustainability goals and tackling the climate crisis. We recognise that the impact of not doing so will have significant detrimental impact on our residents and in particular those experience greater disadvantage. To support health and wellbeing of our residents, we must play our part in protecting our local and global environment and ecosystems, conserving natural resources, and supporting sustainable, thriving communities. This will remain a key cross-cutting theme in the work of our individual Partners, and for our ICP more broadly, particularly through our support of partnership initiatives through the Anchor Network.

2. Our Common Endeavour

2.1. Reducing inequalities together

Central to our vision is our desire to see residents united with health and social care services around the single ***'Common Endeavour'*** of reducing inequalities together.

The Common Endeavour will express our desire to work to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations, and agencies, focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

This cannot be achieved by statutory partners alone. We must invite voluntary, community, faith and social enterprise organisations, residents, and others to join us in our Common Endeavour. Together we will work to significantly increase our focus on individual and community engagement, wider determinants, early intervention, and prevention, with a transformed role for communities in relation to health and social care and with residents helping themselves and each other.

To achieve this will necessitate an alignment of our efforts, with the ICP acting as the fulcrum for engagement and community mobilisation, working alongside statutory and voluntary services and involving a 're-setting' of our partnership with residents.

We will develop a simple, accessible, and inclusive campaign model, in which residents and services agree on a 'shared social mission of purpose', through which we will harness the full potential of all contributors.

The 'ask' of us as residents is that we do everything we can to maintain our own health and wellbeing and that of our families, neighbours, and communities, keeping health and care services 'in reserve' for when we need them most.

The corresponding 'ask' of the ICS will be: first, to support people to manage their own health by helping 'upstream' in a cost-effective manner before problems become serious, expensive, and irretrievable 'downstream'; and second, to integrate services around the individual once they need formal services.

We recognise this working together on this Common Endeavour will require, **commitment**, **courage**, and most importantly, **trust**. Working together positively to build these will be central theme for our Partnership.

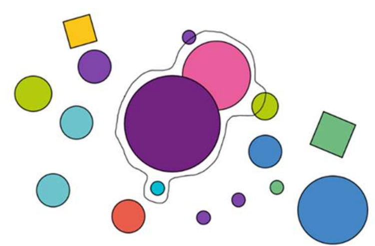
W1	***We** will work together with our communities to develop a simple and accessible campaign which unites residents and services around a Common Endeavour, which will be owned by residents and the widest possible range of partners and stakeholders. (W1 - 09/23)*
I1	***I** will understand what the ICS is and how I can contribute to improving health and social care outcomes for myself, my family, and my neighbourhood. (I1 - 03/24 and ongoing)*

2.2. A new model partnership

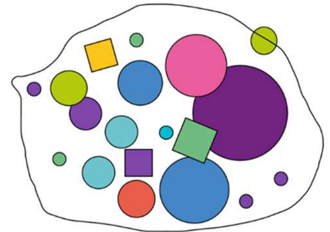
Working to this Common Endeavour will require a new model of partnership. Alongside continued influence from the statutory boards and forums which feed into the ICP, we will need to become much broader and more inclusive, ensuring engagement of a more diverse range of contributors, feeding into the formal ICP meetings themselves.

Non-statutory partners are keen to have a prominent voice in our Partnership and to see their role reflected in its strategy. We believe an 'equal value partnership', where the contributions of all partners, large and small, are equally valued and fed through into the partnership, will enable us to achieve better outcomes for the residents of Mid and South Essex.

A New Model of Participation



Integrated Care System Conceptual Model - Present State



Integrated Care System Conceptual Model - Future State

(Lines delineates elements we consider to be inside 'the system'.)

Currently, several potentially powerful partners and allies (e.g., private adult social care providers, community pharmacy, schools, colleges and early years providers and users of services) feel peripheral in terms of voice and influence and insufficiently co-opted into the system for supporting health and care outcomes.

As such, we propose to engage a more diverse set of organisations and individuals than have previously been able to contribute to the development of health and care strategies. To achieve this, our Partnership will bring together the following initial standing groups to support and influence the work of our Partnership:

- A Community Assembly.
- An Independent and Private Providers' Network.
- A Community Voices Network.

The Community Assembly will provide an opportunity for us to connect around universal and societal challenges. Distinctive in its diversity of voluntary, community, faith and social enterprise sector actors, the co-production of an Assembly model will support the amplification of best practice approaches that embrace human learning systems, drive better community representation, increase creativity in problem solving and insight gathering with communities of place, purpose, and interest. If we are to act purposefully and learn together as a whole system, the Assembly model is critical in creating the foundations of resilient, resident-led communities that can level up equitably.

The Independent and Private Providers network will meet the guidance that the ICP engage positively with adult social care providers and bring together the diverse experiences of partners operating commercially to provide health and care services including for adults and children. The Partnership is keen to ensure there is positive engagement, so we hear and are able to addressing the challenges and opportunities with our independent and private providers, to support market maturity, market development and build capacity.

The Community Voices Network will focus and share the community engagement work being undertaken across our system and at a local Alliance level, and by our Healthwatch partners.

Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of our Partnership. There will be a range of debates, talks, and workshops throughout the year, feeding into and from an annual symposium or conference.

These will be open to all contributors, not just those organisations and individuals who attend the statutory Partnership meetings.

There will be a clear agreement defining how partners give and receive support to each other as part of our Partnership. This will include the new proposed forums, as well as existing forums and networks. This will assist the development of trust and respect for contributions from voluntary, community, faith and social enterprise sector partners, independent and private providers, education partners and residents.

The Partnership will not just be a 'talking shop', it will set specific tasks and require tools and resources to complete these. Initially, a small, agile infrastructure will support the work of the Partnership, but this will grow over time as we demonstrate the impact of this way of working and as we identify additional opportunities. All Partners will be expected to contribute time, skills, and expertise as part of the ongoing work of the ICP.

The Partnership must work differently if the population's confidence in the system is to be regained and maintained and our long-term health and care challenges met. The Partnership needs to be agile and purposeful, bring together the resources needed to do the job and have a clear focus on the 'destination' (i.e., what we want to achieve) and the 'journey' (i.e., how we will work together to achieve it).

2.3. Working together locally

As a Partnership, we firmly believe that we act best, when we act locally. This is often described as the 'subsidiarity' principle, which asserts that any central authority should have a subsidiary, or secondary role performing only those tasks which cannot be performed at a more local level. As such, we will always do work where work is best done. This will include the following:

- ***Neighbourhoods:*** The areas covered by our 27 Primary Care Networks (PCNs) and local neighbourhood teams, etc.
- ***Places:*** The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.
- ***System:*** The whole of Mid and South Essex.

We have set up the Integrated Care System to work at a system, place, and neighbourhood level, because needs, challenges and opportunities differ at each level of our operation. What might be good for Tilbury, for example, may not be right for the Dengie; what works for Braintree, may not be right for Basildon.

The strength of work at a local level is demonstrated by the partnerships formed by our powerful local Alliances, Councils and Health and Wellbeing Boards, alongside Primary Care Networks and Healthwatch organisations, and our community and voluntary sector associations. Examples of this work include integrated neighbourhood teams, including Local Area Coordinator services, PCN Aligned Community Teams (PACT), and our developing Social Prescribing offers.

"Co-production is when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered".

The Care Act 2014 - Care and Support Statutory Guidance

We will also work together, championing co-production as the foundation of successful action across our system.

We are also committed to supporting personalised care, so residents have choice and control over the way their care is planned and delivered. Based on 'what matters' to us as residents, and our individual strengths and needs, we will support the six principles of personalised care:

1. Shared decision making.
2. Personalised care and support planning.
3. Enabling choice, including legal rights to choice.
4. Social prescribing and community-based support.
5. Supported self-management.
6. Personal health budgets and integrated personal budgets.

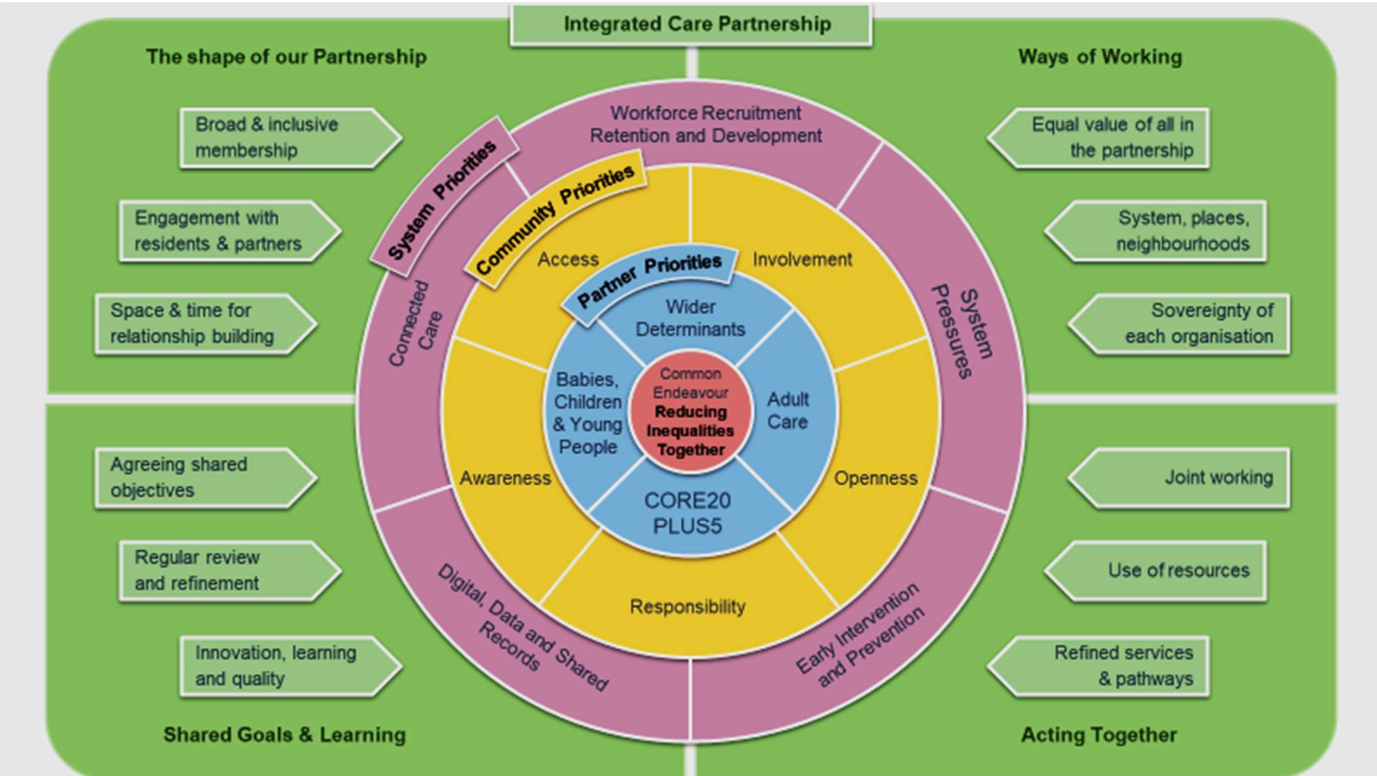
Our commitment to working together, locally, recognises that we can only achieve the change we wished to see, by harnessing all the talents, building personal and community resilience and mobilising communities effectively around our Common Endeavour.

W2	***We** will develop and maintain a map of the statutory boards and forums which feed into the work of the ICP and ensure that there are clear mechanisms for communicating to and from these forums. (W2 - 10/23 and ongoing)*
W3	***We** will ensure that our non-statutory partners are equally valued within our Partnership are demonstrably able to influence and contribute to achieving our shared objectives. (W3 - 03/24 and ongoing)*
W4	***We** will engage with partners who do not currently attend our ICP and ensure that they are able to influence and contribute to achieving our shared objectives. (W4 - 09/23)*
W5	***We** will establish a Community Assembly, an Independent and Private Providers Network, and a Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives. (W5 - 09/23)*
W6	***We** will develop an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our ICP. (W6 - 04/23 and ongoing)*
W7	***We** will always seek to work at the most appropriate local level, supporting our Alliances and local partnerships. (W7 - 09/23 and ongoing)*
I2	***I** will recognise the ICS and the ICP as a force for change, and value and respect the contributions being made to improve health and care outcomes at a local level and together. (I2 - 03/24 and ongoing)*
I3	***I** will experience health and care services as being both locally and individually responsive to my needs and those of my neighbourhood. (I3 - 09/23 and ongoing)*

3.Our shared objectives and priorities

3.1. Defining our reviewing our shared priorities

The first task for us has been to develop a clear model which articulates our Common Endeavour, alongside our Partner Priorities, Community Priorities, and key System Priorities, on which we will work together to help us meet our objectives. This is, in effect, a 'plan on a page' which helps focus our thinking as a Partnership and as a System.



This Strategy indicates in general terms our shared priorities and the direction that we wish to move in together. However, one of our first tasks will be to develop and agree a *'Theory of Change'* followed by an accompanying *'Logic Model'*, a detailed description and illustration of how and why we feel our desired changes will happen at a system and community level, along with a graphical depiction of the chain of causes and effects and contributing factors which we anticipate will contribute to us achieving our desired outcomes.

With this, we will develop a set of outcomes and measures, building on those we have already established as a Partnership and as individual Partners, which we will use to review our progress. We will undertake this work with independent support and challenge from our university partners, ensuring we are developing our approach based on the latest research evidence of what has been shown to work in health, social care, and community development.

The ICP will review progress on our agreed outcomes and measures, publishing an annual report on our progress.

W8	***We*** *will work together with the support of our university partners to develop an overarching Theory of Change/Logic Model, and a detailed set of outcome measures. (W8 - 04/23 and ongoing)*
W9	***We*** *will review our progress regularly and produce an annual report demonstrating the difference we are making. (W9 - 03/24 and ongoing)*
I4	***I*** *will be confident that the health and care system in Mid and South Essex is working purposefully and with clear aims and objectives, reporting regularly on progress and holding the wider system to account. (I4 - 03/24 and ongoing)*

4. Partner Priorities

The ICP agrees there are four key areas where our Partner's priorities align, referred to as the north, south, east, and west of our Integrated Care Strategy.

4.1. Determinants of health

At the ***'north'*** of our Strategy is our recognition that having access to high quality health and social care services only plays a part in ensuring we have good health and wellbeing. Much more important are a range of other factors which have nothing to do with hospitals, doctors, nurses, or social workers. Some of these we cannot control that much, but others we can - and should - try to influence. Moving forward, the role of our Partnership will be increasingly about working together to tackle the wider determinants of health (sometimes referred to as 'social determinants of health').

The model below, based upon the work of the Robert Wood Johnson Foundation, demonstrates the areas where we can have an impact on health and care outcomes for our communities.

With its broad and inclusive membership, the ICP is uniquely placed to lead work to address the wider determinants of health working closely with our local Alliances and health and Wellbeing Boards and other partnerships. The coming together of our NHS services, children's and adult social care and public health, with our partners in district, borough, and city councils, the voluntary, community, faith, and social enterprise sector, plus our experience as leading 'anchor institutions', gives us the opportunity to ensure we are using all of the tools available to us to create circumstances in which our communities can have good health and wellbeing. Moreover, as we develop our partnership with communities themselves, we can ensure they are able to mobilise, at an individual, family and community level, to be part of the change they wish to see.

We will promote key cross-sectoral developments, such as 'Health in All Policies' and 'Health Inequality Impact Assessments' which seek to reinforce our commitment to tackling the wider determinants of health together.

W10	***We** will work together across our Partnership to address the wider determinants of health which impact on health and care outcomes for our communities and promote cross-sectoral developments which reinforce this approach. (W10 - 03/24 and ongoing)*
I5	***I** will see progress in tackling wider determinants of health, including socio-economic factors, healthy behaviours, and the built environment. (I5 - 03/24 and ongoing)*

4.2. Core20PLUS5 - health priorities for all ages

To the ***'south'*** of our Strategy, is the Core20PLUS5 framework developed by Government with engagement from a wide range of partners and stakeholders. This recognises the groups, across all ages, who experience the greatest health inequalities and the specific conditions where outcomes are poorest. The framework provides a powerful starting point for our actions to address inequalities. The frameworks include the following:

For adults

- ***Core20:*** The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

- ***PLUS:*** Population groups identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups, coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence). Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants including refugees and asylum seekers, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

  In Mid and South Essex, we have identified Gypsy, Roma and Traveller communities, Black, Asian, and Minoritised Ethnic communities, Carers, Adults with Learning Disabilities and Autism, Homeless People, Veterans, Armed Forces Communities and their families, Care Leavers, and Victims of Domestic Abuse and Domestic Violence.

  As a Partnership, we will work to better understand the needs of these groups and engage proactively with communities to do so. We will encourage our Partners to work closely with these communities in the planning and delivery of services.

- ***Five:*** There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

  1. ***Maternity:*** Ensuring continuity of care for women from Black, Asian and minoritised ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

  2. ***Severe mental illness (SMI):*** Ensuring annual health checks for at least 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. ***Chronic respiratory disease:*** A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up the uptake of COVID-19, flu, and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. ***Early cancer diagnosis:*** 75% of cases diagnosed at stage 1 or 2 by 2028.

5. ***Hypertension case-finding and optimal management and lipid optimal management:*** Interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

   In addition, we recognise smoking cessation is a cross cutting priority because smoking tobacco has an impact on all of these five health conditions. Locally, we would add to this list tackling rates of obesity.

The NHS Core20PLUS5 model for adults can be viewed at the following link:
https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

For babies, children, and young people

- ***Core20:*** The most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. For children and young people wider sources of data may also be helpful including the national child mortality database and data available on the Fingertips platform.

- ***PLUS:*** Population groups including ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. There should be specific inclusion of young carers, looked after children/care leavers and those in contact with the justice system. Inclusion health groups focus on children and young people where their families include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

- ***Five:*** The final part sets out five clinical areas of focus. The five areas of focus are part of wider actions for ICB and ICPs to achieve system change and improve care for children and young people. Governance for these five focus areas sits with national programmes, whilst national and regional teams coordinate local systems to achieve these aims.

  1. ***Asthma:*** Address over reliance on reliever medications and decrease the number of asthma attacks.

  2. ***Diabetes:*** Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

  3. ***Epilepsy:*** Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

  4. ***Oral health:*** Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.

5. ***Mental health:*** Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender, and deprivation.

The NHS Core20PLUS5 model for babies, children and young people can be viewed at the following link:
https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

As a Partnership, we also recognise the impact of 'co-morbidity' (where a resident has two or more diseases or medical conditions). Residents frequently have several conditions and if we can connect services provided by different partners across health and social care and wider community support, we will more effectively address the underlying lifestyle and behaviour issues which may be causing ill health.

We also recognise that 'intersectionality' (the interconnected nature of social categorisations such as race, class, and gender disability) can apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

"Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking"

Professor Kimberlé Crenshaw

For both children and adults, this framework establishes very specific national targets for improving health outcomes, but through the 'Plus' groups, we are encouraged to respond to local needs and the unique characteristics of our population in Mid and South Essex. The ICP will regularly review local data and evidence identifying the local characteristics which identify priority groups in our area.

W11	***We*** *will work together across our Partnership to address the priorities identified in the Core20PLUS5 frameworks. (W11 - 09/23 and ongoing)*
W12	***We*** *will work together to define our local Core20PLUS5 targets and measures and review progress annually. (W12 - 09/23 and ongoing)*
W13	***We*** *will work with our local Alliances to regularly review and update those local characteristics which form our priority PLUS groups. (W13 - 09/23 and annually)*
I6	***I*** *will see progress in tackling long standing health inequalities for all ages. (I6 - 03/24 and ongoing)*
I7	***I*** *will see improvement in outcomes in the specific clinical areas. (I7 - 03/24 and ongoing)*

4.3. Adult Care

To the ***'east'*** of our Strategy, is our recognition that our Partnership must act together on the challenges which our partners and communities face, in offering and receiving support for broader adult health and social care needs. We will work to support Partners meeting the needs of adults in health and social care and support the development and delivery of their own strategic priorities and operational plans. In particular, we will focus on the following areas:

The ageing population

We have an ageing population with increasing demands for support from those living with dementia, increased frailty, and the range of health conditions which are related to old age and their carers. The demands for domiciliary or home care and residential care for those unable to live independently, is and will continue to cause significant pressure on our systems and services. Enabling older people to remain at home, for as long as possible, is both a practical and moral imperative. We recognise a number of health conditions impact on quality of life, including those related to mobility, chronic pain, cataracts and glaucoma, etc.

Mental health and suicide prevention

Providing support for those experiencing mental ill health, including treatment for serious mental illness and suicide prevention is a key challenge. Services are stretched to their limits and in some cases are failing residents. Partners are committed to working upstream, harnessing the reach of our wider Partnership to prevent mild to moderate mental health problems leading to serious mental illness and to deal with mental health needs effectively as a Partnership. We will work to ensure we have high quality, safe inpatient care, including psychiatric intensive care, where required, and that inpatient stays are as short and as close to home as possible.

Learning disabilities and autism

Partners agree that adults with learning disabilities and autism should be a particular focus of attention, recognising outcomes are significantly worse across a range of measures for this group. Partners are committed to improving access to and take-up of preventative services, including regular health checks and screening, developing sustainable personal assistant support, mentoring and outreach services. We wish to see a reduction in the need for inpatient accommodation and prompt discharge to community care. In Mid and South Essex, we have strong and vibrant voluntary sector organisations, including user-led organisations, who we will work with to build the effectiveness of our support for adults with learning disabilities and autism and to engage residents with lived experiences in the design and delivery of services.

High-intensity users of services including alcohol and substance misuse

In Mid and South Essex, we have undertaken successful pilot projects tackling high intensity users of multiple services, including alcohol and substance misuse. We recognise that these users, often with multiple health and social care needs, place extreme demands on our primary and urgent and emergency care, our adult social care services, and for our partners working in housing, policing and community safety. They challenge the communities in which they live. In many cases, these residents have extremely poor quality of life and health outcomes. We will build on our experiences to develop and refine multi-agency interventions, alongside our communities, to prevent residents from becoming high-intensity users, and to manage support better in the community.

Adult end of life and palliative care

We have some outstanding services in adult end of life and palliative care, particularly through our local hospice services. As a partnership, we are well placed to meet and exceed the guidance for services, including addressing inequity of access to services, strengthening, and aligning commissioning, and building community capabilities.

Loneliness and isolation

For adults of all ages, loneliness and isolation are known to worsen health outcomes, reduce healthy life expectancy, and quality of life, adding pressure on services. We have heard a clear message from residents that they want to address loneliness and isolation, in both our rural and urban communities, and our partnerships with primary care networks, social prescribing and the voluntary, community, faith and social enterprise sector, will support this work.

W14	***We*** *will work together to define our local targets and measures for Adult Health and Social Care and review progress annually. (W14 - 09/23 and ongoing)*
I8	***I*** *will see significant improvement in adult health and wellbeing outcomes (I8 - 03/24 and ongoing)*

4.4. Babies, children and young people

To the ***'west'*** of our Strategy is our recognition that we must get things right for babies, children, and young people because they deserve the very best start in life, but also because this can lead to long-term improvement in outcomes of adults. We have excellent examples of partnership working in this area and strong service offers. We will continue to focus our efforts on:

Maternity and early years health and care

Maternity and early years health and care is an area served by a wide variety of service providers in a wide range of locations across Mid and South Essex. We will support our Partners by sharing learning and offering support with connecting services and offers, to ensure consistency of approach and improvement in outcomes. In particular, we will support the work undertaken by our health visiting and school nursing services and wider children and family wellbeing services, including in our excellent family hubs and children's centres, recognising the unique role these services can offer to ensuring families are strong and resilient and able to gain access to support when and where they need it. We recognise that there is inequality in outcome within maternity services, and system performance challenges. We will work together to tackle these and to ensure all maternity and early years health and care services are connected and aligned.

Children and adolescent mental health

We recognise that there is a growing problem with children and adolescent mental health, and, in many cases, demand is outpacing capacity. As with adults, our Partnership is uniquely placed to work upstream, tackling the causes of mental health issues for children and young people, including adverse childhood experiences, supporting families, and building children

and young people's resilience and access to support for mild or moderate mental health issues. We will work to ensure we have high quality, safe child and adolescent mental health services, and high-quality local inpatient care where needed, and that any interventions or treatments are as effective as possible and connected to long-term support within the community and in our schools and colleges.

Special educational needs and disabilities

Providing effective support for children and young people with special educational needs and disabilities is an area where most of our Partners, including those in health, education, and social care, have a statutory duty, and where close partnership working is essential to ensure needs are met. This is an area where our partners have experienced challenge, and are working proactively with parents and carers to build more effective local offers. In Mid and South Essex, we have strong and effective Parent Carer Forums, keen to support the evolution of services for children with special educational needs and disabilities, and we will work with them closely to ensure early identification of needs, prompt and effective referral to specialist support, and in the design and delivery of service offers.

Prevention of adult health conditions

We recognise that many long-term adult health conditions are seeded in childhood, including conditions related to healthy weight, poor diet and nutrition, limited access to healthy lifestyles and exercise, mental health, and speech and language development. Early action by Partners, to tackle early concerns about the health and wellbeing of children, ensuring families are supported to make healthy lifestyle choices and children are forming good habits, will stave off many long-term issues.

Maternal and children's healthy weight

Our partnership is particularly concerned to see joined-up action on childhood obesity and maternal and children's healthy weight, which we recognise as one of the key factors contributing to longer-term health conditions.

Education including the healthy schools' programmes

We recognise that our colleagues in education play an important role in supporting the health and wellbeing of children and young people, often without due recognition of support. Developing our support for early years settings and schools will have a significant impact in improving population health outcomes. Education is also recognised as one of the wider determinants of health. Children and young people, who do well at school and move into secure employment and housing, have better outcomes across a range of measures.

We also recognise the unique challenges and opportunities that arise within our special education and alternative provision settings, and where children are home-schooled (elective home educated children). Our Partnership will strengthen relationships with our education colleagues, ensuring they are supported and can effectively offer support with improving health and social care outcomes for children and young people.

Health inequalities experienced by looked after children and care leavers

Our partnership recognises that looked after children experience significant health inequality, and we will work closely with our children's social care partners to ensure they receive access to excellent healthcare services, which are co-designed to address the unique barriers they experience.

Children's end of life and palliative care

As with adults, our ambition is to meet and exceed the guidance for children's end of life and palliative care, including addressing inequity of access to services, strengthening, and aligning commissioning and building community capabilities.

W15	***We** will work together to define our local targets and measures for Children's Health and Social Care and review progress annually. (W15 - 09/23 and ongoing)*
I9	***I** will see significant improvement in health, care and wellbeing outcomes for babies, children, and young people (I9 - 03/24 and ongoing)*

4.5. The first 5,000 households

Partners agree that, in addition to identifying specific thematic priorities, we will also work together to identify a specific cohort of residents that we will prioritise and work and alongside as part of our work. Our starting point will be a focus on a group of priority families and individuals experiencing the worst health and care outcomes.

This targeted, practical approach will allow us to innovate and learn about how the partnership can work in a highly collaborative way across organisational boundaries to better understand and support the needs of these households. This will include a major focus on prevention and early intervention across the wider determinants of health.

These 'First 5,000' households will be the initial focus of our Common Endeavour. We will work together as a partnership to define who is in this group, understand their needs, and develop and deliver a plan of collective action. We will agree on clear workstreams (e.g., data sharing and common referral mechanisms), timings, measures of success and accountabilities to track progress. The work of our Population Health Management team will be central in developing this work.

W16	***We** will identify a specific cohort of c.5,000 households experiencing poor health and care outcomes and develop and deliver a plan to better understand and support their needs. (W16 - 09/23 and ongoing)*
I10	***I** will see real progress in tackling the needs of the most vulnerable members of my community. (I10 - 03/24 and ongoing)*

5. Community Priorities

5.1. Access

Our communities are particularly concerned about having good access to primary care and ensuring residents use the full range of primary care services available, including community pharmacy, social prescribing, etc. They are also concerned about pressures on urgent and emergency care (NHS and Social Care) and ambulances. They want to see care brought closer to home and a greater emphasis on personalised care solutions and choices.

5.2. Openness

For many of our residents, the health and social care system looks like a closed book, something that keeps its conversations to itself. This leads to both a lack of trust and a feeling of disengagement. At its most extreme, the system is seen to close ranks when things go wrong, rather than being open and honest.

For our health and care system to flourish in Mid and South Essex, we need to embrace an openness that has not yet been achieved in many places in the UK. For our Partnership with residents to mean anything at all, we must be honest about what is and is not going well and what we can all do to make things better, together. This kind of dialogue already happens in small pockets - including our three Healthwatch organisations - but these are quite small conversations. We need much bigger conversations that take place from a starting point of openness and trust in our residents. We need to talk with residents about what they can expect from services, including primary care, urgent and emergency care, and children's and adult social care.

5.3. Involvement

It is important that we work together to build trust – both in and from services and accept when things have gone wrong and learn fast from feedback and criticism. To do so, we must create more, and more varied, opportunities for residents to become involved in the work of our Partnership.

We are keen to define our communities as much by their capabilities, talents, and strengths, as by their perceived deficits - illness, deprivation, needs, etc. If our vision of a Common Endeavour is to flourish, we need to be able to build on these strengths as well as what might be missing in communities. It's a shift of mindset, certainly on the part of statutory bodies and even some voluntary and community sector organisations: a shift from doing 'to' towards doing 'with'.

All of this points to our Partnership having much stronger, active engagement of residents than is the case now. Historically, these residents have been marginal to the overall health and social care agenda including in terms of resources. Funding for voluntary and community sector and community development and mobilisation has been fixed-term and finite - the first to be cut back when system pressures arise. This will need to change if we are to build the community cohesion, resilience, and mutual support necessary to shift the dial in terms of helping residents to do more to maintain their own health and that of their families and communities.

Our Partnership is committed to developing co-productive practice, expanding engagement and mobilising communities, voluntary, community, faith, and social enterprise sectors and

local businesses and employees, so they can become part of the change they wish to see. Our local Alliances will be front and centre in this work, feeding through to the ICP directly and via the Community Assembly and Community Voices Network. We will use all the tools available to us, including digital enragement and social media, but, recognising the impact of the 'digital divide', we will always offer different way for people to become involved.

5.4. Awareness

Some of our residents describe the heath and care system as a 'mystery' and, potentially, a 'minefield'. For our future health and social care system to work, the system must be better at explaining how it works, what services are available and where, and what can and cannot be done. A big part of this is about creating one 'front door' for support. Where this has been tried, it has been successful. This involves abolishing many of the distinctions in the health and social care services that mean everything to professionals, but next to nothing to residents. One front door, both digitally and in real world services. We will work across our Partnership, particularly with our Healthwatch partners who have been promoting this agenda for some time.

5.5. Responsibility

The best way we can improve our health and wellbeing is by seeing ourselves as part of a team. Even a tiny decision we, as residents, make about the health and wellbeing of ourselves, a family member, or someone in our community might help cut waiting times, ease pressure at A&E, or even save a life by helping an ambulance be ready to respond to an emergency. We should think of health and social care like a 'chain' of events. Every time we do something - however big or small - we change something further along the 'chain'.

For example, by getting daily exercise (even a walk in the park) we improve our health, and we may only see our GP four times in a year, not nine. By sharing our experience of parenthood with a new mum and directing her to trusted sources of information and advice, we might eliminate an unnecessary visit to an overcrowded A&E.

If we need help, the health and social care system is always there, but we should think about using it like climbing up a ladder: always start on the lowest step - like asking friends or family for advice. If that will not do, we can visit our local pharmacy, before going to our GP. What's important is that we do not put pressure on the same bits of the system when there are lots of other options.

The biggest thing we can do to help is to look after ourselves. Every GP appointment or hospital visit that does not happen releases pressure on the system. Stopping smoking, being more active, and looking after our mental health will make a massive difference up the 'chain' if enough of us do it. Everyone in our community is part of making things better. However, we must not be discouraged from seeking early help when needed and in accessing urgent and emergency care at times of crisis.

Our aim is to build strong and resilient communities, where people are able to support themselves, their families, neighbourhoods, and the wider communities. We will grow a spirit of purposeful 'volunteerism' at the heart of our system.

W17	*We will create 'one front door' for residents to access the vast majority of health and care services. (W17 - 04/23 and ongoing)*
W18	*We will work together to define our local targets for community resilience, mobilisation and transformation, and review progress annually. (W18 - 09/23 and ongoing)*
W19	*We will be open and honest about what is and isn't going well, why, and what we can all do to make things better. (W19 - 04/23 and ongoing)*
I11	*I will feel my care is closer to home and more personalised. (I11 - 03/24 and ongoing)*
I12	*I will feel that everyone in our community is part of making health and care better and understand my part in that team effort. (I12 - 03/24 and ongoing)*

6. System Priorities

6.1. System pressures

We are all aware of the pressure on our systems at both primary care, urgent and emergency care, ambulances, waiting lists for treatment including elective surgery, challenges with safe discharge from hospital and pressure on children and adult social care.

Our Partnership will work together to tackle acute system pressure and bottlenecks, managing resources effectively and engaging a wider range of partners and communities in supporting the improvements we wish to see.

We will plan ahead, developing protocols for mobilising wider support for the times when we know the system will be under pressure and to support us with unexpected challenges.

6.2. Workforce recruitment, retention, and development

We are facing unprecedented challenges in recruitment and retention across the health, social care, and community sectors. Some of this is beyond the control of our ICP and will take time to put right.

We will develop a 'one workforce' approach, that aligns people strategies across our system, and will seek to make Mid and South Essex a place that values and develops the talents of our people. We will recognise the importance of 'skills' as opposed to focusing on traditional 'roles' when determining who we need to undertake specific pieces of work. We will also utilise the talents of a wider range of people including, for example, practice nurses, community pharmacists, social prescribers, and voluntary sector staff. We will recognise and support initiatives which develop our allied health professionals, who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings. We will have equal interest in those providing services in our large institutions, and those working in the community and in residents' homes (including the public, private and voluntary sector).

Our employed staff will be supported by a growing body of well-trained volunteers, working to ensure the precious time of our clinical and social work professionals are put to best use.

Whilst we recognise the work is often challenging, we will prioritise safe working and a good work life balance, and ensure that we do not place our clinical, ancillary and support staff, social work professionals and voluntary sector workforce under undue pressure. We will work to ensure staff are supported and protected from harm, and can work flexibly, where they have caring responsibilities themselves, or to maintain their own health and wellbeing. We will work closely with our employed and voluntary colleagues, to ensure they are supported and supportive of our Common Endeavour.

We will work with our Anchor Network of larger institutions, to grow and develop workforce development initiatives and engage closely with our partners in secondary, further, and higher education, to develop the pipeline for our future workforce in both health and care settings, in the public, private and voluntary sector.

6.3. Early intervention and prevention

The evidence on the effectiveness of early intervention and prevention is overwhelming. It saves not only millions of pounds but also untold levels of human illness and suffering.

This starts with our ‘First 5,000 households’, working with those people who, without early support, will experience poor outcomes and become a much bigger weight on the health and care system. We will support them now so that they need fewer health and care services down the line. We will use all the tools and talents available to us, including those in all our communities, and will invest in new models of care and support that we know will save us money ‘downstream’ – and make for happier healthier lives for our residents.

We will develop a unified population health improvement approach, building on the best available population health management evidence, and create space for innovation, in health and social care and public health, and within our voluntary, community, faith, and social enterprise sector and local businesses. We recognise that ‘non-medicalised’ community-based support is often best placed to achieve the change we wish to see, and will explore new models of investment, seeking to resolve the challenge of unlocking resources for preventative work now, when the benefits will not be experienced, in some cases, for many years to come.

6.4. Connecting care

In the engagement work for this Strategy, one of the biggest concerns of residents concerned the disconnected nature of health and care services. We will work to ensure better connection between services, refinement of pathways and ensure effective joint commissioning and accountability. From a resident’s perspective, we want people to experience health and care as one seamless, integrated offer of support.

6.5. Digital, data and shared records

We will develop strong shared data and digital systems to provide insight and enable evidence-based decision making with the aim of improving the health and wellbeing of the local population, reducing inequalities, and addressing current and future needs.

At the same time any newly developed digital solutions will be more resident-centric in their approach and design, empowering residents to take greater control of their digital presence within our system. We will also use digital tools to communicate and engage with our residents and help them join us in our Common Endeavour, whilst remaining aware of the need to address the ‘digital divide’ supporting those who do not have access to digital technologies.

This will drive economies of scale, standardisation of technologies as well as supporting the delivery of more coordinated care and enabling our health and care professionals to do their jobs more efficiently.

We will support our Population Health Management team, in developing consistent, reliable evidence about the needs of our residents and the approaches evidence demonstrates will have best impact (i.e., ‘actionable insights’).

W20	***We*** *will work together to define our local targets for dealing with system priorities, challenges and opportunities and review progress annually. (W20 - 09/23 and ongoing)*
W21	***We*** *will significantly improve the recruitment and retention of staff across the health and care system by adopting a 'one workforce' approach, making people feel more valued, empowered, developed, and respected. (W21 - 03/24 and ongoing)*
W22	***We*** *will increasingly invest in prevention and early. (W22 - 03/24 and ongoing)*
W23	***We*** *will develop shared data and digital systems across the Partnership to provide greater insight and enable evidence-based decision making. (W23 - 03/24 and ongoing)*
I13	***I*** *will feel that health and care services are much more 'joined up' and I only need to tell my story once. (I13 - 03/24 and ongoing)*
I14	***I*** *will feel that my health and care needs were identified and supported early enough to reduce the need for higher-level services and increase my chances of living independently. (I14 - 03/24 and ongoing)*

7. How we will work together

7.1. Shape of the partnership

Broad and Inclusive membership

To work as it should, the ICP will draw upon the skills and experience of partners beyond the NHS and Councils and will reach deep into our community and voluntary organisations.

Through the actions identified previously, we will ensure all potential contributors are able to engage in our work, and join us in our Common Endeavour, and will regularly review and develop our approach to engaging with wider partners, including local business, leisure, schools, colleges, environmental protection, etc.

We will proactively seek the involvement of minoritised communities, many of whom experience worse health outcomes. The idea of the ICP is to bring the voices and influence of the community into the conversation so that this helps shape the way resources are allocated.

We will always engage with and involve specialist bodies, including local safeguarding partnerships, to ensure we are working with the best available advice and support.

Engagement with residents and partners

Engagement is not a one-off event; it will be a continuing conversation. The ICP will become the focus for engagement work, as a collecting point for a range of views and perspectives from Partners and the many forums that seek insight from residents. The Community Assembly, Independent and Private Providers' Network and Community Voices Network, will be central to this objective and the ICP will conduct continuing outreach as part of its work so that residents and diverse partners, have clear routes for influencing and contributing to the work of the ICP. We will champion the benefits of co-production, support Partners by sharing experiences, promote training and continuing professional development, and explore the creation of co-production toolkits.

Space and time for relationship building

The ICP is not just a collection of voices, it is also a place to curate relationships between different parts of our health and care system. This takes time and effort, particularly with those parts of the system where there is little history of working together, or when previous efforts have not been successful. Experience tells us that 'change happens at the speed of trust' and stronger relationships are key to making health and social care work better. We see the ICP as a focus for making these relationships as productive as possible.

7.2. Ways of working

Equal value partnership

The principle that all the participants in the ICP are of equal value is one that is central to its success. We will always value the role of our NHS Partners, local authorities, and wider contributors equally.

For a long time, many of the organisations involved in health and care, particularly at community level, have felt like second-class players in the conversation about the kind of health and care services we need. This has meant that many have slowly become disengaged or frustrated. The ICP is about resetting this and underlining the fundamental role of the wider community in the way health and care is planned and delivered.

System, place, neighbourhoods

We are organising much of our efforts in the ICP the most appropriate local level. This should mean that we have as much decision-making as possible coming from the places and people affected by these decisions. So, the principle of subsidiarity, distributed leadership and working at place will be at the core of all that we do.

We are also building good relationships with our neighbouring systems:

- *Hertfordshire and West Essex Integrated Care System.*
- *Suffolk and North East Essex Integrated Care System.*
- *North East London Integrated Care System.*

Where it is appropriate and adds value, we will work with our neighbours, particularly across the whole Essex footprint, where there is learning that can be shared or innovation which can be jointly developed, but also to ensure consistency of experience and outcomes for our residents.

We will tell the story of our progress and our successes nationally and internationally, particularly through our work with university partners, recognising that building our reputation will lead to greater opportunity for investment in our local work.

Sovereignty of member organisations

Our Integrated Care System is an attempt to bring together many independent organisations and agencies, rather than create a single organisational entity. The Partnership is designed to be the glue holding this together and maximising cooperation and collaboration between its constituent parts.

While we will want to ensure that residents benefit, where needed, from ‘one front door’ when dealing with the health and care system, this support will, in reality, come from a wide range of different ‘sovereign’ organisations.

We have a number of proactive and powerful boards, partnerships and forums and a well-established Anchor Network, and will ensure that they are supported and have the opportunity to share their work through the ICP. In turn, we ask that they knowledge, support and contribute towards the shared objectives articulated in this Strategy.

7.3. Shared goals and learning

Agreeing shared objectives

A key task of the ICP is to achieve an alignment between all the organisations involved in health and care in Mid and South Essex, our acute hospitals through to neighbourhood level voluntary groups supporting people to stay healthy and well.

Part of our work in developing this Strategy was to review the strategic and operational plans of our members and pull together shared objectives. When we did this, we found a very high

level of congruity around priorities: prevention and early intervention, reducing inequalities in health outcomes and delivering more health and care closer to communities. There is remarkable alignment here and this is a solid basis for the ICP's work in the 2020s and beyond. We will, however, continually review strategies and operational plans of our partners as they develop and change over time, taking these into consideration in the evolution of our shared Integrated Care Strategy.

Regular review and refinement

The ICP is new and will develop over time. Our shared objectives will evolve, and corresponding outcome measures, which will be established during the early part of 2023, will continue to develop as our partnership matures. We will regularly review performance, publishing an annual report on our progress.

Innovation, learning and quality improvement

The work of the Partnership will be based upon the best available evidence and research. We will commit to rapid test and learn, and longer-term pilot projects, which explore new, innovative approaches, backed up by solid research and evaluation. Working with our university partners, we will share the findings openly, at a local, regional, and national level, building our reputation as a centre of learning and development in the health and care sector.

We will regularly consider and review how we can best meet assessed needs and work to secure a continuous and sustainable improvement in care quality and outcomes, including with reference to the National Quality Board guidance and other frameworks which support quality improvement.

7.4. Acting together

Joint working

In line with our commitment to develop effective partnership working to better meet the needs of residents, we will regularly review opportunities for joint commissioning and closer partnership working. We will consider when and how our residents' needs could be better met through an arrangement, such as the pooling of budgets, under Section 75 of the NHS Act (2006). Section 75 can be a key tool to enable integration and our Partnerships has considered the benefits of Section 75 agreements as part of preparing this Strategy. Whilst acknowledging that the Partnership is not a commissioner of services - that remains the responsibility of our partner organisations and agencies - we will always promote and encourage and expect joint commissioning to take place, where it better meets the needs of our residents.

Use of resources

Our Partnership sees the use of our system's physical, financial, and human resources, and the deployment of our data digital and intellectual property assets, as being key to the success of our work together as a system.

Together, we will set targets and expectations around the effective use of financial resources, particularly in relation to our objective of seeing increasing investment in early intervention and prevention. It follows that we will aim to flex resources between different care and service areas over time. We will have the courage to do things differently and do different things, but will also expect our partners to stop or change things which are not working.

As partnership working develops and it becomes easier to provide more care in or closer to people's homes, we will expect to see the proportion of spend in acute and crisis interventions in health and care reduce significantly, as investment in primary care and early intervention and prevention goes up.

Partners are already working collaboratively (e.g., through our multi-agency 'Stewardship' groups, refining and developing our approach to key care areas) to establish how resources can be best used, to best meet the needs of our residents and to ensure maximum efficiency and benefit. Where joint opportunities arise, for example, the Better Care Fund, or the Adult Social Care Discharge Fund, we will expect partners to work together in a spirit of cooperation and mutual agreement to determine how and where these funds are re-allocated.

Refinement of services and pathways

Our Partnership will play a key role, through our engagement work and commitment innovation and learning and quality improvement, and in our assessment of risk, in ensuring that pathways are refined and improved to better meet the needs of residents. In particular, we will ensure that pathways actively include more diverse contributors, including those services and supports provided by our voluntary, community, faith and social enterprise sector and local businesses.

W24	***We*** *will work together to define our working practices as a partnership, and review progress annually. (W24 - 09/23 and ongoing)*
W25	***We*** *will ensure partner organisations are aligned on common goals and share plans and resources wherever effective. (W25 - 03/24 and ongoing)*
I16	***I*** *will see the ICP as a powerful advocate for health and care, working positively to effect change at a neighbourhood, place, and system level. (I16 - 03/24 and ongoing)*

8. Governance and operation

8.1. Our board

Our ICP is chaired by an Independent Chair, with three Vice Chairs - being the Chairs of the Health and Wellbeing Boards of our upper tier local authorities.

Our formal Partnership meetings will always be held in public, and there will be ample opportunity for engagement with a wider range of partners and stakeholders through an ongoing series of debates, talks and workshops throughout the year, feeding to and from an annual symposium or conference.

The business of the meetings will be conducted professionally, with decisions clearly recorded and communicated. A standard meeting Agenda and Annual Business Cycle will be developed, giving clarity about expectations, to ensuring no statutory or regulatory requirements fall off the agenda. However, in addition to attending to business, every meeting will provide opportunities for networking and relationship building, with a focus on discussion, debate, and shared learning. We will explore opportunities for teambuilding and improving our working relationships.

8.2. Inputs and outputs

Our Partnership will work together with our three local authority Health and Wellbeing Boards and our local Alliance Boards/Committees. A representative from the Partnership will attend these boards, ensuring there is a consistent exchange of ideas and influence.

In addition to establishing a new Community Assembly, Independent and Private Providers Network, and Community Voices Network which will feed directly into the work of the Partnership, we will map all boards, groups and forums convened by our partners responding to their own local, sectoral, or thematic areas of work. We will ensure that there are clear routes for receiving and sharing information from these boards and forums, and in turn sharing the work of the Partnership.

8.3. Membership

The membership of our ICP is well established but will be kept under regular review. Residents, partners, and stakeholders not currently attending the formal Partnership meetings should feel able to influence and inform the work of the Partnership. As our engagement work matures, we will consider whether an alternative, representative membership model may be appropriate, to formalise arrangements allowing established forums and committees to nominate representatives who may attend the formal Partnership meetings.

8.4. Terms of reference and values

The Terms of Reference, format and structure of our meetings will be regularly reviewed, in line with good governance standards. Partners have an agreed set of values, developed as part of the formation of our predecessor body, the Mid and South Essex Health and Care Partnership. This will be reviewed and updated as and when required.

8.5. Regulatory and statutory requirements

As a statutory committee, we will continually monitor how we are meeting statutory and regulatory requirements as they exist now and in the future. **Appendix Two** addresses the requirements for the formation of the ICP and the development of this Integrated Care Strategy.

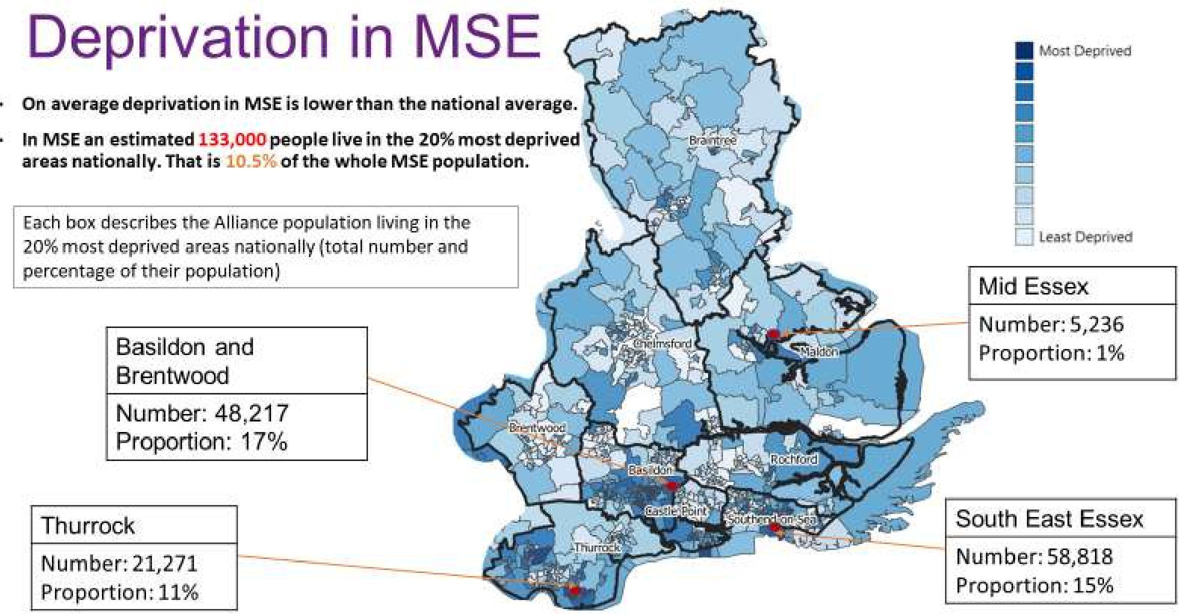
8.6. Resources

We will identify the resources needed to ensure our Partnership is able to manage its work effectively. Initially, a small, agile infrastructure will support the work of the Partnership, but this will grow over time as we demonstrate the impact of this way of working and as we identify additional opportunities. All partners will be expected to contribute time, skills and expertise as part of the ongoing work of our Partnership.

W26	***We*** *will identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set. (W26 - 04/23 and ongoing)*
I17	***I*** *will feel able to engage and contribute to the ongoing work of the Partnership. (I17 - 03/24 and ongoing)*

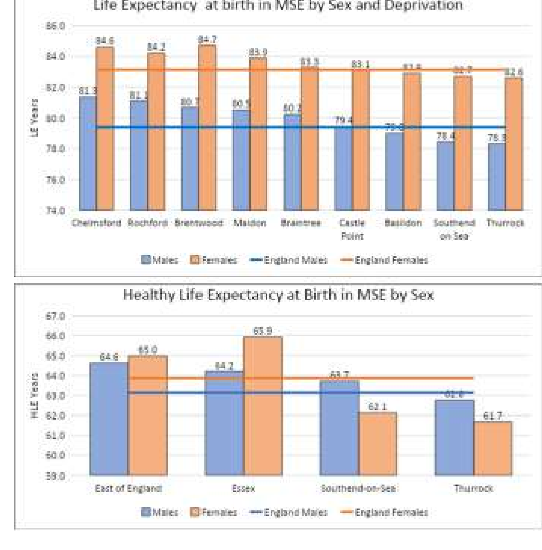
Appendix One

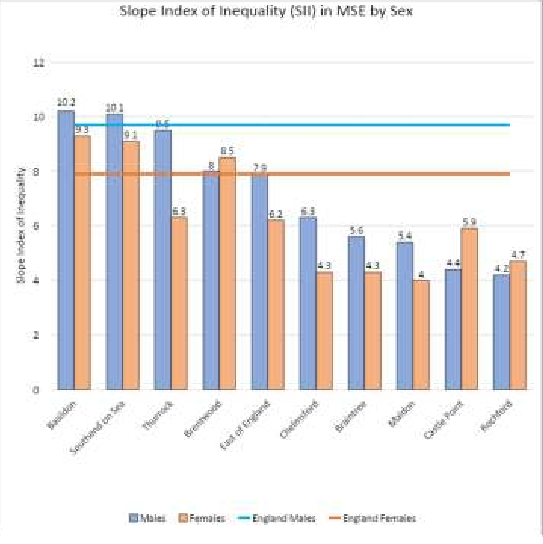
Population health data - snapshot



Source: patient level deprivation decile 2019 (IMD), AGEM data warehouse, March 2022

Consequences of Inequalities - Life Expectancy



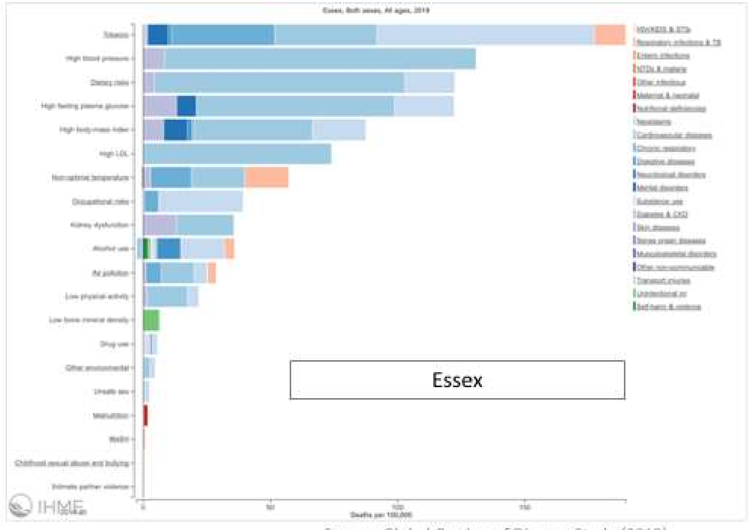


Risk Factors for Premature Mortality

Global Burden of Disease Study identifies key cross-cutting risk factors. In MSE, the 3 with the greatest impact are:

- Tobacco
- Blood Pressure
- Dietary Risks

These are the risk factors that will have the greatest impact on population health and health inequalities

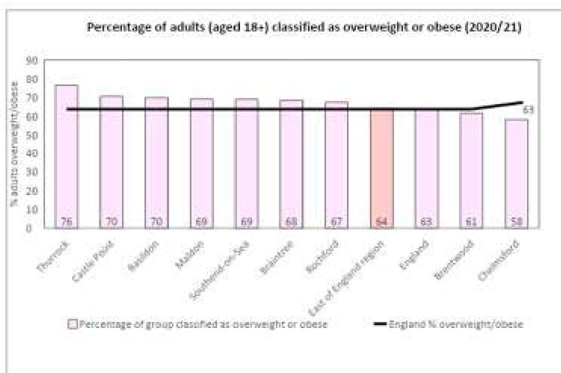


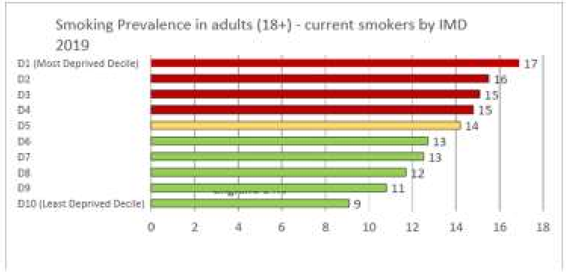
Source: Global Burden of Disease Study (2019)

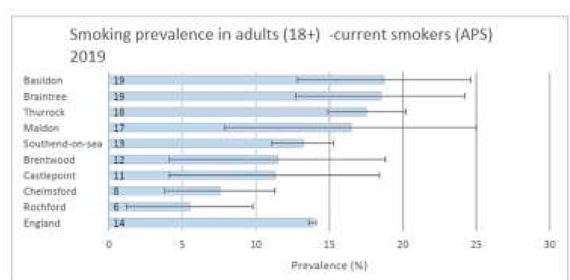
Inequality & Behavioural Risk Factors

Global Burden of Disease Study - Cross-cutting risks

- Tobacco
- Blood Pressure
- Dietary Risks







Appendix Two

Regulatory and statutory requirements

In forming our ICP and developing this Strategy, we have met the regulatory requirements set out by the Department for Health and Social Care, which can be summarised as follows:

> *“Integrated care partnerships (ICPs) will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. ICPs will include representatives from the ICB, the local authorities within their area and other partners such as NHS providers, public health, social care, housing services, and voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met. This should be informed by any relevant joint strategic needs assessments. In developing its integrated care strategy, the ICP must involve the local Healthwatch, the VCSE sector, and people and communities living in the area. ICPs will not directly commission services"*
>
> *The Kings Fund*

We have had regard for the guidance released including guidance on:

- The preparation of integrated care strategies by integrated care partnerships
- Health and wellbeing boards and how they will work with and within integrated care systems
- Principles for integrated care partnership engagement with adult social care providers
- Principles for integrated care partnership engagement with health overview and scrutiny committees.

We have met the requirements identified including:

Statutory requirements	Further detail
The integrated care strategy must set out how the ‘assessed needs’ from the joint strategic needs assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	We have reviewed the needs including the Joint Strategic Needs Assessments and our Population health Management data. We have identified how we will continue to review and refresh our shared objectives as needs change and new opportunities arise. We have identified shared outcomes; considered quality improvement, joint working and section 75 of the NHS Act 2006; personalised care; disparities in health and social care; population health and prevention; health protection; babies, children, young people, and their families, and health ageing; workforce; research and innovation; ‘health-related services’; data and information sharing. See Section 1.5 through to 1.7
In preparing the integrated care strategy, the integrated care partnership must, in particular, consider whether the needs could be more effectively met with an	We have considered joint working and identified when and how we will expect Partners to enter into joint commissioning arrangements under Section 75 of the NHS Act 2006’ in this document for further detail on this requirement. See Section 7.4

arrangement under section 75 of the NHS Act 2006.	
The integrated care partnership may include a statement on better integration of health or social care services with ‘health-related’ services in the integrated care strategy.	We have included a statement to this effect. See Section 7
The integrated care partnership must have regard to the NHS mandate in preparing the integrated care strategy.	We have had regard for the NHS Mandate See Section 1.8
The integrated care partnership must involve in the preparation of the integrated care strategy: local Healthwatch organisations whose areas coincide with, or fall wholly or partly within the integrated care partnership’s area; and people who live and work in the area.	We have engaged widely and indicated how/when we will undertake further ongoing engagement with people who live and work in the area. See Section 1.4
The integrated care partnership must publish the integrated care strategy and give a copy to each partner local authority and each integrated care board that is a partner to one of those local authorities.	The Integrated care Strategy has been published and copies given to each partner local authority and each integrated care board. The Partnership has identified how it will disseminate the Strategy with the wider community and engage them in our work moving forwards.
Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.	The Partnership has identified how/when it will review its objectives on receipt of updated joint strategic needs assessments. See Section 1.8

The Integrated Care Partnership will regularly review new guidance and changes in requirements, including, but not limited to, setting, and reviewing common objectives, inspection, audit, financial regulations, safeguarding and equal opportunities.

Appendix Three

Priorities for the Mid and South Essex Health and Care Partnership

1. **Prevention.** We will transform services from ones that react to health and care needs, to ones that play a proactive part in keeping our residents as healthy and independent for as long as possible. We will intervene earlier to help people remain well. We recognise that this approach is both good for our population's health and wellbeing, and saves money in the longer term.

2. **Partnership.** *Progress occurs at the speed of trust.* We will ensure that future transformation and integration builds upon the strong relationships and partnerships at System, Place and Locality/PCN level and seek to protect and nurture these relationships. We will ensure that future partnership arrangements include the widest possible range of stakeholders. As partners, at every level we will act for the benefit of the population we serve, and not for organisational self-interest. We will ensure that our residents are engaged as equal partners in decision making on future transformation activity at the most appropriate level.

3. **Whole Systems Thinking.** We recognise the value of coordinated action across all providers at each level of the system, as the best way to address the health and wellbeing challenges that our residents face. We have developed a single outcomes framework that operates across System, Place and Locality footprints. We seek to define population outcomes based contracts that coordinate action across multiple providers to ensure our system becomes sustainable over the long term.

4. **Strengths and Asset Based Approach.** We believe in a 'strengths and solutions' based approach. We see the individual as a whole person with differing needs and wants, not a passive recipient of "top down" services. We will harness and empower individuals to solve their own problems, with service providers support to 'fill the gaps'. We will leverage existing community and third sector assets in care delivery, connecting individuals with support outside of traditional NHS or Social Care interventions. This strengths based approach to delivering care will generate positive and varied solutions tailored to the wider wellbeing needs of each resident, not a 'one size fits all' option.

5. **Subsidiarity.** We believe in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities. We recognise that PCNs and localities are the building blocks around which integration best occurs. We will devolve planning and delivery down to the lowest possible level where it makes sense to do so. Our starting point for service delivery, transformation and integration will be locality/sub locality level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

6. **Empowering front line staff to do the right thing.** We believe in 'distributed leadership'; harnessing the creativity and energy of staff. We will move from a transactional model of commissioning to an approach that focuses on outcomes.

7. **Pragmatic Pluralism**. We recognise that across the system and our places there is a considerable heterogeneity of need between populations. We recognise that there are some actions that it makes sense to do once at system level, whilst others that need to be done

differently in different places and localities. We will respect this diversity and develop pragmatic solutions that respond to it.

8. **Health Intelligence and the evidence base.** We recognise the importance of health intelligence and published evidence to fully understand and then best respond to ensure a high quality of care. We will use our JSNA programmes to understand the needs of our residents and improve their outcomes. We will look for opportunities for joint working between the three Public Health teams on shared health intelligence products. We know that different population groups have different care needs and we will use Population Health Management techniques like risk stratification and predictive modelling developed from our integrated health and care record system to identify and segment ‘at risk’ cohorts in our population and design targeted, tailored and proactive evidence based interventions to keep people well.

9. **Innovation.** Transforming the way we work means trying new and innovative approaches. To make progress we will try and test new approaches, evaluating as we go, keeping the best and not admonishing ourselves where we fail and not being afraid to stop things that have not worked.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 8

Stewardship: Stocktake Report and ICB 'White Paper' II Plans for the next 18 months.

Summary Report

1. **Purpose of Report**

   To provide the Board with an update on the Stewardship programme, and overview of intended actions and progress over the next 18 months.

2. **Executive Lead**

   Dr Ronan Fenton, Medical Director, MSE ICS.

3. **Report Author**

   Dr Peter Scolding, Assistant Medical Director, MSE ICB.

4. **Responsible Committees**

   Interim findings from Stewardship Stocktake reviewed and endorsed at Clinical and Multi-professional Congress, 23 February 2023, and Stewardship Programme Board, 2 March 2023.

5. **Impact Assessments**

   Not applicable to this report.

6. **Financial Implications**

   Not applicable to this report.

7. **Details of patient or public engagement or consultation**

   Not applicable to this report.

8. **Conflicts of Interest**

   None identified'

9. **Recommendation(s)**

   The Board is asked to note and endorse the content of the NHS Arden and Greater East Midlands Commissioning Support Unit (AGEM) stocktake on Stewardship **(Appendix 1)** and the ICB's 'White Paper' responses **(Appendix 2)** outlining actions to be taken.

Title of Report

1. Introduction

Stewardship is our vehicle for achieving the triple aim in Mid and South Essex (MSE): improving the health and wellbeing of our population, improving the quality of our services, and using our resources efficiently and sustainably, whilst addressing existing inequalities within each of these.

The programme is based upon the work of Nobel Prize winner Elinor Ostrom, who studied the sustainable, equitable management of shared resources by the resource users. It applies her ground-breaking work to our health and care settings.

Stewardship in MSE: *bringing 'resource-users' (frontline and back-office staff and residents) together within care areas to act as stewards – delivering the greatest value for residents from our pooled resources.*

After almost two years of the stewardship programme in MSE, with six groups established and induction for six more underway, we have commissioned a stocktake report to review all aspects of the programme thus far.

This second ICB stewardship 'white paper' provides a brief overview of activity over the past year (for further detail see AGEM Stocktake Report), and then builds on the findings of the Stocktake Report and system progress over the last two years to outline major areas of focus and action for the next 12-18 months.

2. Main content of Report

Over the past two years we have developed significant, unique capacity via our cohort 1 stewardship groups (Ageing Well, Cancer, Cardiac care, Respiratory, Stroke and Urgent and Emergency Care). These groups have now begun to provide important leadership within their care areas, resulting in both tangible and intangible changes and improvements, as described in the separate AGEM Stocktake Report and White Paper below.

The stocktake findings outline some key achievements, areas for development and opportunities. These are summarised here, with full findings available in the separate Stocktake report.

Achievements:

Vision: A remarkable degree of buy-in from those associated with the programme, along with passion and belief in the transformative potential of the stewardship approach.

Capacity: We have created six groups, with frontline and 'back office' capabilities, who have grown into their role as care area leaders. They have developed value frameworks and are working on the stewardship dashboards to track personal, population and resource outcomes.

Cultural shift: It has started to 'feel' different in those care areas, through growing genuinely collaborative relationships, and a shared whole-pathway, whole-population mindset.

Selected highlights: concrete changes resulting from stewardship groups' work.

Cancer: With active support and encouragement from the Cancer Stewards, a new day zero Patient Tracker List (PTL) approach was launched in November 2022. At that point there were around 1,000 patients waiting 62 days for a diagnosis after a GP referral. This has subsequently been reduced to 595 and is expected to be under 100 by March 2023. The day zero PTL is a real game changer. The action-oriented strategy ensures patients who don't have cancer are appropriately and speedily informed and taken off cancer pathways, meaning those with cancer are quickly and appropriately directed to the correct service. The team's next focus is on prostate cancer pathways.

Ageing Well: Through the guidance and efforts of the Ageing Well Stewards, the MSE electronic frailty care coordination system (efraccs) register was designed, built and launched in April 2022. It now has more than 8,000 people with frailty and dementia added. This resource enables prioritisation and increased visibility of residents with frailty and complex needs for more seamless, proactive and effective care coordination between providers. The team have also championed the Frailty Consultant hotline, which now takes over 350 calls/ month, and is associated with admission avoidance rates at 80%.

Challenges and areas for development

Role: Different groups have engaged in different mixes of strategic and operational work, influenced by group membership and care area needs. This has led overall to some uncertainty about what is the 'right', or intended, role for a stewardship group. Awareness of stewardship and the groups is not currently widespread across the system at all levels, and so it can be seen as 'cliquey'.

Relationships: Tensions have occurred over relationships with existing transformational capacity, or where such capacity is lacking.

Resources: Whilst stewardship teams have been developed at a care area level, care area budgets remain unclear and accountability for resource management remains distributed by organisation. This has restricted stewards' opportunities, leading to a focus on service improvement within existing siloed budgets, rather than being able to meaningfully steward and help flex resources across settings for greater population benefit within their care area.

Opportunities:

Stewardship positioned as a key enabler to achieve the triple aim, with hosting of whole care areas necessary to unlock further potential.

System-wide communication of the vision of stewardship for whole system transformation rather than incremental improvement.

Empowerment of stewardship groups to influence long term plans.

Next steps: (further details in Stewardship White Paper II)

Over the next 18 months, we will deliver a streamlined programme of training and induction for our cohort 2 stewardship groups (e.g. Children and Young People, Dermatology, Diabetes, Eyes, Mental Health, Musculoskeletal care), building on testing and learning from the last 2 years. This will ensure that future cohorts form, mature and will be ready to provide care area stewardship much more quickly and effectively.

We also aim to implement, test and iteratively improve hosting arrangements, using stroke as a pilot care area. This will enable the development of system-wide accountability, scrutiny and resourcing arrangements, relating to the hosting of a whole care area and the enacting of resource-shifting stewardship proposals. This must also involve the flow of resource data within care areas.

Other cohort 1 groups, such as Ageing Well, Cancer and UEC, will increasingly be brought into BAU processes, so that they can support and influence significant choices, decisions and actions taken within those care areas, before following a pathway towards partnership with a host organisation.

Finally, we will take steps to further improve and streamline the process of group formation, and will develop a more concerted approach to communication and engagement across the system, so that colleagues at all levels are aware and engaged appropriately.

3. Findings/Conclusion

Stewardship should remain a hallmark of MSE. Our system Chief Executive Officers remain united in their support for this. If we are successful in achieving these actions as a health and care system, we will be well on the way towards establishing key elements of the paradigm shift needed in order to deliver on the triple aim, improving the health and wellbeing of our population, the quality of our services, sustainability of resource use and addressing inequalities within each of these.

4. Recommendation(s)

The Board is asked to note and endorse the content of the AGEM stocktake on Stewardship and White Paper responses outlining actions to be taken.

5. Appendices

Appendix 1 - AGEM Stewardship Stocktake Report.

Appendix 2 - Stewardship White paper II

Arden&GEM
Health and social care systems support

NHS
Arden and Greater East Midlands
Commissioning Support Unit

Agenda item 8 - Appendix 1

Mid-South Essex Stewardship Stocktake 22/23

Final report for Integrated Care Board on 16 Mar 2023

Alison Hawley, Programme Manager & Deputy SRO, Leadership & Organisation Development (L&OD)
Margaret Joyce, Senior Consultant, L&OD

This stocktake was undertaken through AGEM stewardship Investment Fund

Conflict of Interest statement: AGEM delivered part of the stewardship training and has used investment funds to undertake this stocktake, however, neither Alison nor Margaret were involved in the original work and have been mindful and committed to taking an objective perspective. AGEM colleagues involved in the MSE stewardship programme were interviewed as part of this process and committed to impartial responses to interview questions.

Purpose & Contents

The purpose of this paper is to provide a final report on the stewardship stocktake that Arden & Greater East Midlands Commissioning Support Unit's (AGEM CSU) L&OD unit, commissioned by the MSE stewardship Programme, conducted between Nov 2022 to March 2023.

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Note: the findings and recommendations have been socialised with the MSE FT, SLT, system CEO Forum, Clinical and Multi-Professions Congress and MSE Stewardship Programme Board meetings.

Acknowledgements: AGEM would like to acknowledge all the stocktake participants for their valuable insights and commitment to this process and thank the MSE Programme staff for all their superb collaboration and support.

Stewardship Stocktake - Executive Summary

This section provides the executive summary of the stocktake. More details for each section are contained in the main report with further reading on some elements in the appendices.

Stocktake background

In Oct 2022, AGEM were commissioned to conduct a stocktake of MSE's stewardship work to date: what works, what to improve, what next and how to scale. This stocktake was conducted using Key Lines of Enquiry (KLOE) across the following six areas:

Main elements:

(1) Provide stewardship groups with appropriate training/support: experience of/gaps in training.
(2) Six stewardship groups: effective groups, appropriate membership, right support.
(3) stewardship groups to take responsibility for defined care area: clarity of role, appropriate skills.

Also questions on emergent/new elements:

(4) Host organisations: the model for planning and delivering care, including governance at all levels.
(5) Structured engagement with citizens, (including patient representation); awareness, co-production.
(6) stewardship culture and leadership.

The stocktake was conducted through a series of over thirty one-to-one interviews, mainly with those already involved in stewardship, including with the stewardship groups themselves, (as well as observation of stewardship groups where timing allowed), several key executive team leaders, MSE stewardship Programme Board, Staff College and AGEM colleagues.

Findings

The findings are organised using the KLOE above and this summary highlights the main elements.

Overall, given the intentionally light touch approach, initiated post the COVID-19 pandemic, there has been good progress so far and this has set the groundwork to build and expand stewardship as part of MSE's approach to achieving the Triple Aim (Health & Care Act, 2022). Due to pressures, there was no capacity to interview Urgent & Emergency Care and the U&EC stewardship group or any acute trust colleagues.

The good news headlines:

- **Significant support and commitment for stewardship as a concept and its potentiality (where it is known):** there was positive talk of "what it could do for us" but "with proper support, including protected time" and "needs to be shared" more widely.
- **Good outcomes: relationship building across wider system(s) – a key enabler for work and culture:** good working relationships, improved system working and early collaboration in some stewardship groups. There was an understanding of some of the characteristics of good stewardship as well as the scope of the work involved. Some clinicians were energised by the vision of what stewardship could achieve for patients.
- **stewardship training was valued and seen as valuable at personal, team and wider levels:** the Staff College training was very well received and the Oxford Value and Stewardship Programme, in partnership with AGEM, although complex, was valued. The data work began to build insights into current pathway resources.

Challenges and areas for development:

Findings by stewardship groups:

1. Training, Data & Roles: Two key training elements were delivered separately and this now needs to be integrated for a better participant experience, including clearer connections between system thinking, stewardship and leadership. One of the facilitators said that “we should have painted a more exciting picture of how the system could look and feel five years from now.” Participants also highlighted that there was a lot of content to digest, especially pre-reading and completing the online modules. Data packs were intended to be produced for each of the groups ahead of stewardship training, however, this needed clearer specification, more time and resource as data was coming from several sources with no clear line of accountability. Capacity: there is a need for protected time (clinicians) as well as managerial and operational support. Additionally, some participants were not given protected time to attend the stewardship training workshops, while others were.

2. Stewardship groups - effective, membership and support: initial group selection was not transparent, some groups were not representative of all relevant stakeholders. There were some drop-offs over time. The intention was to have a flat structure to give everyone an equal voice. Some groups struggled to get support, said they “got too operational” and that they “need more formal management support.” Due to a lack of Business Intelligence (BI) resource, tracking dashboards for all in the first cohort have not yet been finished, impacting effectiveness. At the moment the infrastructure to access public health data is being built, due for completion end 2023. From a public health perspective, it was said that once there is system wide access to the integrated data set it will be much easier for stewards to identify at-risk groups. Reflecting on the characteristics of successful stewardship groups one person said that the mature groups displayed altruism where benefits to patients were put ahead of personal clinical interests. Additionally, these groups demonstrated a high level of mutual respect with no deference shown to individuals and all having an equal voice.

Having the time to give to stewardship was another theme and this seemed to vary, for example, one chair had a day a week funded to the role, while other stewards may have the equivalent of two days a month either as secondment, backfill or direct payment to a GP practice.

3. Stewardship groups taking responsibility for defined care areas: the groups have made variable progress in identifying priority areas due to time taken to identify the scope of the care area, the time it takes to develop a comprehensive profile of activity in the area and the lack of a defined budget across the system. Even where budgets exist, individual organisations have not always shared them. Roles: Some were unclear about their role as stewards at the start of the programme and felt they would have benefitted from greater clarity. Some tensions were experienced where transformation boards were in place and stewardship started.

4. Infrastructure and being embedded in a host organisation: there is a need to understand how to operationalise, empower and enable decision-making. Stewardship is not widely understood (yet). Individual organisations still take priority over the system.

5. Citizen engagement: Some groups have involved patients to get an individual perspective on care. Also there was some engagement with the wider population to understand priorities through the use of the STAR tool in Stroke and via the online platform ‘This is Essex’, used by the Cancer and Ageing Well groups.

6. Culture: In almost every interview, the need to emphasise and address the role of cultural change and system leadership came up as a critical success factor to support the delivery of stewardship.

Opportunities and leveraging progress to date:

There is a significant opportunity and need to strategically position stewardship with a real commitment to make this work across the whole system. This will require communicating the vision and wider engagement across and throughout the system with a clear cascade process. Potentially, stewardship can be positioned as a vehicle to enable whole system transformation and working together, beyond what is currently held with a relatively small group of colleagues.

To enable and leverage stewardship fully, the stewardship groups need to be skilled and empowered for their strategic role to influence resource allocation as well as long term plans, including the Joint Forward Plan. Underpinning this work will require system infrastructure and dedicated support, including the processes of accountability and governance and actively share learning to achieve outcomes and measure impact.

There is both an opportunity now and a need to set this up for success, to empower stewards, to provide the specialist functional expertise and support to "do it properly," as one stocktake participant said.

Literature and current good practice search

As part of the stocktake and to support the second MSE stewardship whitepaper, a search of current literature and good practice was undertaken. Not much has been published under the term stewardship so far, therefore the scope of this search was widened to include clinically led or multi-disciplinary resource allocation, devolved budget decision-making and related population health work. Approaches varied and at this stage, processes rather than outcomes were described. A full copy of the literature search is attached in the Appendices.

The headline findings were to engage the right people from all levels and different specialities, commit resources to the work and attend to the relational and cultural factors to facilitate a fundamental shift to a culture of stewardship.

The key messages were as follows:

- Engaging and getting all the right system stakeholders together, including service users was crucial. Multiple case studies detailed that they "got there by working together and having the right people in the room."
- To pay attention to relationships and culture in the context of the system and ensure buy-in at all levels by involving, engaging, and empowering clinical and other staff. Leaders taking ownership of outcomes was important factor.
- Committing resources meant that clinicians' time could be freed up to engage effectively with the work.
- The need to look at people with similar needs, outcomes that matter to people and outcomes that would improve the financial sustainability of the system.
- Having established procedures for regularly sharing information was key. Additionally, integrated and cross functional solutions allowed for processes and pathways to be based upon population health management.

Additionally, in some cases, using an independent facilitator meant that sensitive issues could be addressed constructively and productively whilst colleagues could also be challenged on their progress.

Overall, multiple case studies detail that the engagement of clinicians, other members of staff and patients are a key enabler for developing a model of stewardship. Additionally, there is a need to undertake a population health approach, whether it be to identify specific population groups and care areas for 'stewardship' type groups to focus on, or to identify outcomes that matter to the population and identify ways to make these sustainable and achievable.

Recommendations: The recommendations are to build the stewardship programme over three cumulative phases of development during the next three years, with learning from each phase informing the following one but not waiting for each phase to be completed before the next phase begins. There is a strong recommendation to strategically position and communicate stewardship as a key vehicle to achieve the Triple Aim.

The headlines of these phases, with indicative phase titles and timeframes, are as follows:

- **Phase 1**, **Incremental Improvements, during 2023**, focuses on improvements at every level of the current approach, based on stewardship cohort one, to build momentum.
- **Phase 2**, **Unify to Mainstream, late 2023 through 2024, proposes structuring and underpinning the stewardship programme to build and scale it**, creating critical mass in order to achieve a tipping point.
- **Phase 3, System Shift, likely during 2025, will need to elevate and expand the programme**, in order to achieve system shift, based on the decisions and progress made during phase 2.

Strategic positioning and communication of stewardship: overall, in order to leverage the valuable work-in-progress and to ensure stewardship engages all colleagues across the system, there is a need to communicate how stewardship will drive the strategic vision and priorities for the ICS. In practice, this means a comprehensive engagement and communications programme that explains the system level vision, strategy and how that will be operationalised. System leaders need to be committed to this vision and it is imperative that consistent messages are shared through all system organisations at all levels for a fully inclusive, involved programme and for optimum impact. This recommendation is located in the intermediate section of phase 1 and the expectation is that this will evolve as stewardship does and will need refreshing and reinforcing regularly.

An additional key recommendation is focused on leveraging Stewardship and Transformation as a partnership of equals with different roles for optimum results. This recommendation is outlined after Phase 1.

Recommendations by phases:

PHASE 1, titled Incremental Improvements, has two elements: immediate and intermediate improvements.

The immediate improvements, focus directly on early findings from the stocktake, **and are already being implemented for stewardship cohort two**. This includes steward selection for equitable participant opportunity as well as system representation, integrated end-to-end training experience for participants and improvement in the preparation and early provision of data packs and dashboards through early cohort data calls, including supporting data requests from stewardship groups. On-going, the recommendation regarding data dashboards is that one person is designated the 'accountable officer' for stewardship and that there is defined role clarity where there are shared responsibilities for supporting this accountable data lead. Immediate improvements also need to focus on reviewing capacity and aligning support across the system.

The next stage Stroke pilot, agreed at the system CEO Forum on 10 Feb 2023, will also provide key learning and insights as it progresses. The recommendation is to expand that pilot to include two other areas, potentially sub-sections of the Ageing Well and Cancer care areas, for triangulation and variety of learning.

Additionally, as cohort improvements progress, it will be necessary to run 'refresh and renew' training for early stewardship groups, both to support everyone to be at the same level as well as to on-board new members, including building a standardised succession process when there are steward changes.

The intermediate improvements mainly build on the immediate work, taking them to the next level of development. It is essential to develop a clear engagement and communications pack and programme, both with and for the wider system, from citizen engagement and patient representation, through to full scale all levels of internal communication. A standardised process for applying and accounting for protected time and operational support is necessary now, including, ensuring that these opportunities are available to all system organisations. There is a need for stewardship specific learning events (one already planned for summer 2023 to bring cohorts one and two together) to share emergent learning, build good practice and expand training beyond induction.

At this stage, it will be useful to build in-house MSE stewardship specific training delivery capability and capacity, potentially by inviting and involving transformation, organisation development, learning et al., colleagues across all system organisations to support, co-deliver and evolve stewardship. Those involved in this delivery

ideally would co-create a competence framework and maturity model to guide stewardship, with a longitudinal implementation, accountability, and impact focus.

stewardship and Transformation: leveraging a partnership of equals with different roles for optimum results: Before getting into the details of Phase 2 actions, the next recommendation is to ensure that the right support and infrastructure is in place as readiness to enable and mainstream stewardship. This focus is about **setting stewardship up for success and mainstreaming it by leveraging as many key enabling services as possible** (rather than building separate functions or borrowing support). The proposal is to leverage stewardship and transformation as partners. The enabling options are either to **align and combine stewardship and transformation or divide and deliver – do one or the other in any care area at a time.**
Align & combine means unifying stewardship and transformation as a partnership with different and equally important roles with role clarity essential. stewardship to provide clinically led strategic direction and data informed decision-making regarding resources allocation and transformation (or operational leadership), will implement the stewardship informed strategy through systematic delivery.
Divide & deliver means either lead with stewardship or transformation in any care area at any one time. In some cases, this would continue how work is currently structured and where transformation boards work well and towards the Triple Aim, leave them as is. Clarity of roles could prevent tensions that have happened where stewardship and transformation have overlapped.
The recommendation is to Align and combine, with clear roles, responsibilities, and accountabilities.

PHASE 2, titled Unify to Mainstream, proposes amalgamating stewardship and transformation activities and programmes, both to build critical mass and scale stewardship and for optimum value, progress and impact.

This phase has two main elements of work, **Accelerator implementation and System stewardship development** which are outlined below. Accelerator implementation has a greater focus on what needs to be done, while system stewardship development emphasises how this can be achieved. Both are of equal value and importance with both system working and systematic delivery paired for optimum outcomes and impact. The recommendation is to work at both these levels simultaneously, in a whole system inclusive, collaborative, participative process, inviting system leaders to sponsor each element of the work, with representation from all parts of the system.

Accelerator implementation means taking what has been achieved in the intermediate improvements work of Phase 1 and advancing it with a focus on implementation. The recommendations are to expand stewardship group work through allocation of resources, shadow budgets (including finance and analytics support and oversight), hosting (including accountability, risk, governance etc). Note: hosting means enabling the whole service, including the budget (slightly akin to a Lead Provider model). Where hosting is located would need to be defined and agreed by care area with a whole pathway perspective.

System and stewardship development means building the system level conditions, capability and capacity, creating a 'movement' and aligning all system organisations for culture coherence, congruence and impact. This work element is detailed under three sub-sections which are interconnected and interdependent:
System leadership development, a programme for executive and all system leadership levels (beyond organisation), building in-house system level capability and capacity, including distributed leadership.
System-wide and stewardship innovation and learning labs to build and test conditions and factors for success, from requirements (must do), success factors (should do) and set up for success (for best results).
System and stewardship culture, sustainability and legacy to co-create a system stewardship specific culture with all system organisations through participative processes including wider levels of engagement for public participation and by place. Building a sustainability and legacy focus at this stage, will ensure stewardship fulfils its potential, both internally and externally through publishing articles, conference speaking etc to share and inspire.
End of Executive Summary.

Findings from the Key Lines of Enquiry

Did the training provide participants with the appropriate support?

In 2021, following the launch of MSE's stewardship programme, stewards were given four days of management development and leadership training run by The Staff College. This was well received by everyone we spoke to; for some it was the first time they had received this sort of input and it felt relevant and dynamic.

Several months later, a series of three half day workshops were delivered by the Oxford Value and stewardship programme in partnership with AGEM CSU to introduce the concepts of clinicians as stewards.

The two training programmes were delivered independently with no links to, or references from one to another. In retrospect, participants thought more integration between the two would have been valuable. For example, ''an understanding about how leadership training can make you a better steward.''

The intention was that ahead of the stewardship training, data packs would be produced for each of the groups. This proved challenging with data coming from several sources and without clarity about who was ultimately responsible for pulling it together. Some, who had participated in data collection, felt that not enough time and resource had been identified for this. Lack of timely data meant time was lost focusing on the issues.

Some participants were not given protected time to attend the stewardship workshops, while others were. Some were unclear about their role as stewards at the start.

While the stewardship programme was well received some participants thought it ''conceptual,'' a bit ''hypothetical'' and difficult to link to the reality of everyday practice. stewards came away from the training and were asking questions that their peers could not connect with. One of the facilitators said that ''we should have painted a more exciting picture of how the system could look and feel five years from now.''

Some said that more time was needed to reflect on the course content – that there was a lot to digest and it was difficult to find the time to do pre-work reading and completing the online modules. The need for ongoing support to understand and apply the principles of stewardship was raised. There were also several comments about the training needing to emphasise the importance of cultural change to support the delivery of stewardship.

Were the stewardship groups effective, with the appropriate membership and support?

Several interviewees felt that the groups were not representative of all the stakeholders delivering care in their area, for different reasons. Some groups started with people who then dropped out over time. For example, social care was initially represented at the Ageing Well group but then the participant was told that it was not a priority to attend. Interviewees reported that primary care was missing from some groups and others said that there was too much of an acute bias. One person thought that ICB pathway managers, who had previously been a commissioner for a care area covered by a stewardship group, should be a member. Another would have preferred to have more than one clinician from each discipline at the meetings.

The relatively informal way in which people were identified for the groups, initially meant that others who had not been approached could feel left out, even alienated. It was felt that there should be a more transparent

selection process for the next cohort. ''Some stewards are thought leaders in their fields and have the respect of their peers.'' Others described themselves as ''treading on eggshells,'' wary of asserting themselves for fear of alienating their clinical colleagues.

Interviewees, particularly clinicians, would have valued more support in terms of dedicated protected time for administering and running the groups. Some groups started out with support from MSE Partners, but reorganisation of resources has meant that support has been stretched and groups have had to look for alternatives. For example the Ageing Well group identified a source of funding for programme support. Other groups have struggled and some clinicians have felt that organising meetings and keeping track of actions is not the best use of their skills and have said that they ''need more formal management support.''

Having agreed their value propositions and measures for success, groups have been told that they will have dashboards to help them track progress. Dashboards for all in the first cohort have not yet been completed. The aim is to achieve this by the end of March '23, but this coincides with the production of data packs for cohort two. At present the infrastructure to access public health data is being built and is due to be completed at the end of this year. From a public health perspective, it was said that once there is system wide access to an integrated data set it will be much easier for stewards to identify at risk groups.

Reflecting on the characteristics of successful stewardship groups one person said that the mature groups displayed altruism with benefits to patients being put ahead of personal clinical interests. Additionally, these groups demonstrated a high level of mutual respect with no deference shown to individuals and all having an equal voice.

It was felt that stewards need to be figure heads who have earned respect. ''People who others are happy to follow because of their commitment.''

The stewardship model for delivery was not detailed at the start and has been evolving. The idea was to have a deliberately flat structure to give everyone an equal voice, consultant and physio alike. One facilitator felt that there needs to be a core leadership team of up to about six people who then link to connectors (experts in their field) and influencers who are the wider stakeholder group that can help prioritise. Ageing Well have followed this model and have agreed a chair. It was said that each group has now been asked to nominate a lead steward but at the time of interview this had not happened. Cardiology for example does not have a lead.

Having the time to give to stewardship was another theme and this seems to vary, with one chair having a day a week funded to the role. Other stewards may have the equivalent of two days a month either as secondment, backfill or direct payment to a GP practice.

Have stewardship groups taken responsibility for defined care areas?

Observation of some of the stewardship groups demonstrated tremendous commitment and desire for change. The groups have made variable progress in identifying priority areas due to the time taken to identify the scope of the care area, the time it takes to develop a comprehensive profile of activity in the area and the lack of a defined budget across the system because individual organisations have not always been prepared to share information.

Stroke has identified areas for resource allocation involving a number of stakeholders using *the Socio-Technical Allocation of Resource* (STAR) tool. Cancer and Ageing Well have been building good relationships across the system and have identified a number of areas to work on. In the absence of a defined budget for Ageing Well, the group have decided to prioritise initiatives that they think they should influence because, for example, they focus on prevention.

The Respiratory group has been paused as work is being enabled through a Transformation Board. Urgent and Emergency Care were not available to take part in the stocktake due to pressures of work.

Cardiology has chosen to focus on atrial fibrillation on the basis that this is where significant resource is spent and public health data suggests an unmet need. However, a lack of comprehensive data has made it difficult to determine whether a diagnosis of atrial fibrillation was made in the acute trust or in primary care.

Some stewards have struggled to understand their role. One said ''The expectation of what it means to be a steward is vague" and another asked "Is it our role to implement our ideas or contribute to strategy?''

Clinicians were recruited to the groups with the incentive that this would be an opportunity to improve care for patients; how to achieve this has been interpreted differently. The Cancer group became involved in operational delivery which initially caused friction with the service manager.

One interviewee told us that members of the Cardiology group do not feel empowered to make decisions on behalf of the specialty as there are consultants more senior to those who sit on the group who expect to be deferred to. Also, it was felt that there were other fora/forums, separate from the stewardship group, where cardiology issues are being progressed. Several managers said that there is a tension between programme boards or service transformation groups and the stewardship groups, with the former feeling that for all the resource and time put into stewardship groups, there has been little to show in terms of demonstrable improvement. A paper presented to the clinical forum in February, after interviews had been completed, highlights that this is not the case. It cites the creation of a new day zero patient tracker list by the Cancer group and the development of the electronic frailty care coordination register led by the Ageing Well group, but these benefits are not yet widely known. One steward said that stewardship was a good vehicle for engaging a large number of clinicians compared with a programme board where clinical involvement felt ''more token.''

One of the key proponents said stewardship ''isn't about service improvement, it should focus on optimising resources and thinking about prevention.'' However even where groups are thinking about the strategic picture for their service area it is still not clear to them how ideas can be implemented. One person said ''are the governance processes in place to allow a change of direction and expenditure, probably not.'' Another said ''I don't think people are behind the practical implementation. Staff want to deliver better outcomes for our population, we want to have more patient engagement but we're struggling with the hard yards of implementation because it means different things to different people.''

The STAR workshop for the Stroke group helped identify some areas for disinvestment/investment but ''the extent of devolved decision making is unclear.'' What are group members responsible for? The view was expressed that if stewards do not hold the budget for a particular area ''then their authority is diluted.'' Nevertheless, several stewards expressed concern, fear even, about the idea of having responsibility for a budget. One manager said ''I'm not sure the stewardship groups would know what to do if they had full budget accountability and responsibility for the whole system.'' The view was expressed that stewardship groups could ''pivot'' to give them a strong clinical advisory role.

Two people expressed concern about progressing with the next cohort of stewardship training while the issues of role and how to translate strategic ambition into reality were still unclear.

Are stewardship groups embedded in a host organisation?

The concept of a stewardship group being hosted, for reasons of budget responsibility, governance and accountability, in an organisation that is part of the integrated care system in Mid and South Essex was outlined in a white paper about stewardship that came to the ICB. Most people interviewed felt that hosting was a good idea but that it wasn't yet developed as a concept. Few could articulate opinions on what it would look like in reality. Some had attended stewardship development meetings where the concept had been discussed with system leaders, for example with the Essex Partnership University Trust, EPUT. Questions remain, ''if EPUT is the host, where does responsibility for financial governance and quality sit, at provider or ICB level.''

An interviewee said that discussions were focused on how to choose the host organisation. Some perceive it should be the locus of care, but this is not always easy to agree. While interventions incurring the most cost may take place in the acute trust, for example for stroke patients, the majority of time may be spent on rehabilitation in the community. Also, the need to consider wellness and promoting healthy lifestyle points to other services being hosted away from the acute setting. It was also said that it was difficult to understand when services focused on health promotion, for example healthy eating, smoking cessation and managing obesity, which impact across several stewardship groups, should be coordinated by the Mid-Essex Alliance.

Has there been structured engagement with the citizens of MSE?

An interviewee said that there were four ways to engage with citizens: Individuals could be part of the core stewardship group or part of the wider stakeholder forum, stewardship groups could engage with the local population about outcomes and also account for value, producing information about how the budget for a particular care area has been spent.

Some groups have involved individual patients as part of their initial discussions and found that this gave a useful perspective. Nevertheless, there was acknowledgement that the views of one or two patients cannot be used as the basis for making decisions about priorities.

Stroke used a wider group of stakeholders to work through priorities using the STAR tool. Ageing Well and Cancer have also consulted widely about priorities using 'This is Essex' virtual platforms run by the community engagement team. This has meant that messages have been received by tens of thousands of people and been targeted at a wide range of population groups both demographically and by interest.

Is the culture of stewardship embedded across MSE?

Many stewards expressed the view that more needs to be done to embed the concept of stewardship across MSE. One person said that stewardship ''needs to be owned and driven by leaders at the top'' questioning whether there was a consistent narrative across the system. Several people said that there needed to be a lot more work at middle and upper management levels and that if they were to ask fellow clinicians from their team/discipline what stewardship was about the majority would not know.

Several people expressed concern that unless the issues relating to decision making and governance, allowing resources to be reallocated, were addressed, momentum would be lost and the enthusiasm and commitment of clinicians would drain away. One person acknowledged that stewardship has created good momentum with clinical leaders but that the fundamental principles are very ambitious. ''I don't think there's buy-in from the system at the moment. I think there's a bit of emperor's new clothes around… stewardship is a very big bet in the system and if we want to take it further, we will need to talk about cultural change.

Stewardship Stocktake - Literature search and current good practice

As part of the stocktake and to support the second MSE stewardship whitepaper, a search of current literature and good practice was conducted. Not much has been published under the term stewardship so far, therefore the scope of this search was widened to identify any case studies or examples in which clinicians and/or managers (as well as other front-line members of staff) engaged in multi-disciplinary decision-making, either to inform or directly identify services or pathways to fund via a devolved budget. Subject matter experts on stewardship were consulted and provided case examples and other resources such as The King's Fund, NHS Leadership Academy and UK government websites were searched.

Approaches varied and at this stage, processes rather than outcomes were described. A full copy of the literature search is attached in the Appendices.

The headline findings were to engage the right people from all levels and different specialities, commit resources to the work and attend to the relational and cultural factors to facilitate a fundamental shift to a culture of stewardship.

The key messages were as follows:

- Engaging and getting all the right system stakeholders together, including service users was crucial. Multiple case studies detailed that they "got there by working together and having the right people in the room."
- To pay attention to relationships and culture in the context of the system and ensure buy-in at all levels by involving, engaging, and empowering clinical and other staff. Leaders taking ownership of outcomes was important factor.
- Committing resources meant that clinicians' time could be freed up to engage effectively with the work.
- The need to look at people with similar needs, outcomes that matter to people and outcomes that would improve financial sustainability of the system.
- Having established procedures for regularly sharing information was key. Additionally, integrated and cross functional IT solutions allowed for processes and pathways to be based upon population health management.

Additionally, working with an independent expert facilitator allowed multi-disciplinary groups to "broach sensitive issues, challenge each other on progress to date, share aspirations for future ways of working and learn from what has worked well elsewhere."

The following UK examples highlight the key findings and where they came from, as well as timeframes.

Leeds Office of West Yorkshire ICB: Leeds aimed to improve long term outcomes and reduce health inequalities via the embedding of a Population Health Planning (PHP) approach that ensures available resources are directed towards evidence-based interventions. Population and Care Boards (for different care areas) were set-up to make decisions and direct the work that was required. Children was one of population health groups and may be of interest to the Children and Young People cohort. This work was recently undertaken as part of the statutory formation of ICSs and ICBs in July 2022 and so there is no published learning or outcomes as of yet.

Cambridgeshire & Peterborough ICS: C&P ICS shifted their operation to a strong clinical and care professional empowerment culture. This shift enabled different outcomes, such as the ICS being able to develop a proactive population health management approach - with citizens at its heart and to direct resources to those with greatest need to reduce inequalities. Based on historic challenges within the ICS, some cynicism of the approach was originally voiced. A pro-clinical and care professional system development position now exists and the ICS detailed that paying attention to relational, cultural and architectural factors was important to this fundamental shift.

Stockport Together Vanguard: This vanguard adopted an outcome-based commissioning model and in turn, set up four broad population groups. They aimed to move away from using Key Performance Indicators (KPIs) to instead measuring patient outcomes whilst also linking funding to desired patient outcomes via a capitation contract. The vanguard moved away from individual organisations working in silos and looking at pathways as separate, to looking at people with similar needs. Stockport Together focused on outcomes that mattered to people, Patient Reported Outcome Measures (PROMs) around health and wellbeing as well as clinical and system outcomes that would improve the financial sustainability of the system.

Highland and Perth & Kinross Health and Social Care Partnerships: Two Health & Social Care Partnerships in Scotland engaged in a pilot to outline the principles of Programme Budgeting and Marginal Analysis (PBMA) and set-up multidisciplinary advisory groups to make decisions on investment and disinvestment for resources within the local health & social care system. The case study mentioned that there is a need to ensure clinicians and managers' time is protected to allow participation in stewardship groups.

Gloucestershire Health and Care NHS FT: This Foundation Trust undertook sessions between multi-disciplinary teams made up of clinicians, operational managers and finance & informatic colleagues in order to improve their understanding of Patient Level Information and Costing Systems (PLICS) data. A key output of these multidisciplinary sessions included colleagues identifying areas and interventions to explore in further detail for diabetic patients. The aim was to understand the diabetic patient's journey whilst also using PLICS intelligence to plan and deliver services. This may be of interest to the Diabetes stewardship group in cohort 2. The case study detailed that colleague "got there by working together and having the right people in the room."

Searching beyond the UK, the following examples of practice with elements encompassed in stewardship were found and while health and care system vary hugely, it may be useful to understand where other similar work approaches are in progress.

Grand Junction Colorado (USA): This community's leadership group took ownership of specific care programmes, as well as the regional system in its entirety, whilst ensuring they defended their autonomy from external threats. Local leaders routinely engaged in a consultative and collaborative approach to identify programmes of particular importance and value to the community whilst also locating any additional funding sources to make these programmes more sustainable. A critical factor for success was leaders frequently interacting with each other in both formal and informal settings in a way that built mutual trust and respect whilst also establishing procedures for regularly sharing information.

Riberia Salud (Valencia, Spain): A healthcare provider based in Valencia developed their management model for a more integrated healthcare approach. The healthcare group aimed to focus on patients' present and future needs whilst holding themselves, as a healthcare provider, responsible for the cost of services and outcomes. In terms of learning, an agreement on shared vision, shared goals, and incentives, whilst putting synergies and economies of scale in place is a key factor as well as the use of integrated and cross functional solutions that facilitate a population health management approach.

Canterbury Clinical Network (New Zealand): The Canterbury Clinical Network (CCN) was established in 2009 and aimed to have the health and wellbeing of the patient as a primary goal. The CCN consists of workstreams that focus on a particular target population (segment) or area of work, as well as Service Level Alliances (SLA), that lead on the transformation and implementation of services. The network aimed to support clinicians so that they were enabled "to do the right thing, the right way." It was mentioned that one of the principal achievements of the CCN was the buy-in at all levels to a more co-operative way of working and the re-empowering and re-engagement of staff.

Overall, the commonality between multiple case studies, both from within the UK and abroad, seems to identify engagement from clinicians, other members of staff and patients as a key enabler for developing a model of stewardship and enabling it to flourish. Most case studies also detailed the need for a population health approach, whether it be to identify specific population groups and care areas for 'stewardship' type groups to focus on, or to identify outcomes that matter to the population and identify ways to make these sustainable and achievable. Next steps consist of engaging clinicians and other members of staff from disparate organisations to buy into the stewardship journey whilst also dedicating resources to ensure clinicians' time is protected to take part in this work. Additionally, agreeing shared visions, goals and incentives, as well as disseminating this across organisations would help bolster wider colleagues' awareness of this work and aid the culture of stewardship to be embedded and to flourish across MSE.

Recommendations

The recommendations are to build the stewardship programme over three cumulative phases of development during the next three years, with learning from each phase informing the following one but not waiting for each phase to be completed before the next phases begins. There is also a strong recommendation to strategically position stewardship as a key vehicle to achieve Triple Aim.

The headlines of these phases, with indicative phase titles and timeframes, are as follows:

- **Phase 1**, **Incremental Improvements, 2023**, focuses on improvements at every level of the current approach, based on stewardship cohort 1, to build momentum.
- **Phase 2**, **Unify to Mainstream, late 2023-24, proposes structuring and underpinning the stewardship programme to build and scale it**, creating critical mass to achieve tipping point.
- **Phase 3, System Shift, likely during 2024, will need to elevate and expand the programme**, to achieve system shift, based on the decisions and progress made during phase 2.

Strategic positioning, engagement, and communication of stewardship: Overall, in order to leverage the valuable work already in progress and to ensure stewardship is engaged by the many across the system, there is a need to communicate how stewardship fits into the strategic vision and priorities for the ICS in its journey to achieve Triple Aim. This means having a full engagement and communications package and programme that articulates and shares the narrative of the system level vision, strategy and how that is and will be operationalised.

System leaders need to be actively, explicitly and visibly committed to this vision and it will be imperative that the messages are shared, both across all parts of the system and cascaded down through system organisations, for a fully inclusive, involved, and empowered commitment and to optimise participation and impact. The first level of this recommendation is included in the intermediate section of phase 1 and the expectation is that this will evolve as stewardship does and will need regular refreshing and reinforcing.

Detailed recommendations by phases:

PHASE 1, titled Incremental Improvements, has two elements: immediate and intermediate improvements.

Immediate improvements: (and some already in progress). These focus directly on early findings from the stocktake.

1. **Improve all elements for next cohort of stewardship groups:** This includes steward selection for equitable participant opportunity as well as system representation, an integrated end-to-end training experience for cohort participants, strategic messaging (i.e. leaders all giving consistent clear messages and more leaders involved in sharing those messages) and a key improvement in the preparation and early provision of data packs and dashboards through early cohort data calls, including supporting data requests from stewardship groups. All this is already in progress for cohort 2, start 28.02.23.
2. **One person to be accountable for the data needed to support stewardship and clarity about any shared responsibilities that would support that accountable data lead.** Dedicated time and resources given to consistent, specified data packs and dashboards and for supporting data requests from stewardship groups.
3. **Review capacity & align support across the system**: protected time is essential and this needs to be fair across the system. In the short term this is being done individually as required but will be useful to review fully at intermediate level and get systematic. Data and analytics support and capacity needs to be improved and implementation support clearer.

4. **Build in-house capability for stewardship**: develop in-house training and delivery capability, ideally aligned with existing MSE wide training and development/transformation programmes.
5. **Stroke as a pilot in 2023** to *"develop proposals around accountability, scrutiny process and transformation resource", agreed at the system CEO Forum, 10.02.23.* Ensure the pilot is supported properly and that the learning and insights from this pilot are shared actively as it progresses through peer learning, including during the pilot for dynamic on-going learning. The recommendation is to expand that pilot to include two other areas, potentially sub-sections of the Ageing Well and Cancer care areas for triangulation and variety of learning.
6. **Cohort 1 refresh & renew:** Update development for cohort 1, and later other following cohorts, to ensure all stewards keep pace at same level of development and build a 'playbook' to ensure new participants to cohorts are onboarded as well as building a success process for when there are steward changes.

The intermediate improvements build on the immediate work, taking them to the next level of development as follows:

1. **Account for protected time & operational support**: clarify what is required for each stewardship group – this may vary depending on scale of Care Area. Ensure that these opportunities are open to all system organisations for equity of opportunity.
2. **Share stewardship specific learning actively:** run stewardship specific learning events (one already in planning for summer 2023 to bring cohorts 1 and 2 together) to share success stories and emergent learning, build good practice and expand training beyond induction.
3. **Engage and communicate with/in the wider system**: develop a clear engagement and communication strategy including virtual training packages; potentially a stewardship Hub, a one-stop-virtual space where everything stewardship can be found and success stories shared, both with and for the wider system from citizen engagement, patient representation through to full scale all levels of internal communication.
4. **Build internal stewardship training delivery capability:** build in-house full delivery bench, both for stewardship programmes as well as data/insights sharing, ideally underpinned by a stewardship competence framework, potentially through inviting and involving transformation, organisation development and learning and development colleagues across all system organisations to support, co-deliver relevant elements of and evolve stewardship. Those involved in this delivery ideally would co-create a competence framework to guide stewardship, with a longitudinal implementation, accountability, and impact focus.
5. **Develop a stewardship maturity model**: develop an MSE specific model for next phases of stewardship development with an implementation and impact focus, potentially aligned with the Joint Forward Plan.
6. **Population health:** with equity of access as a compass to guide the work overall, ensuring that public health management principles inform all dashboards will provide valuable underpinning for Triple Aim requirements.

Stewardship and Transformation: leveraging a partnership of equals with different roles for optimum results:

Before getting into the details of Phase 2 actions, the next recommendation is to ensure that the right support is in place in readiness to enable and mainstream stewardship. The focus here is setting stewardship up for success and mainstreaming it by leveraging as many key enabling services as possible (rather than building separate functions or borrowing support).

The proposal is to leverage stewardship and transformation as partners. The enabling options are either to align and combine stewardship and transformation or divide and deliver – do one or the other in any care area at a time.

In order to get to mainstream stewardship and as a pre-emptive approach where transformation programmes or activities are already in place in any care area or pathway, the options are to either (a) Align and Combine stewardship and transformation or (b) Divide and Deliver – do one or the other in any care area at a time. Each is described in outline below:

(a) **Align & combine:** unify stewardship and transformation as a partnership with different and equally important roles. **Role clarity essential**.
- stewardship, clinically led strategic direction and data informed decision making regarding (dis)investment/re-allocation of resources, based on outcome measures, across whole care path.
- Transformation (or operational leadership), implement the stewardship informed strategy (landing stewardship through systematic delivery).

OR

(b) **Divide & deliver:** Either do stewardship **or** transformation in any care area:
- this would continue how work is currently structured – where transformation boards work well and towards Triple Aim, leave as is.
- would likely prevent tensions that happened where stewardship and transformation were overlapping.

The recommendation is to Align and combine, with clear roles, responsibilities and accountabilities.

The final set of recommendations below are to enable scaling up the stewardship programme and how to embed a culture of stewardship across the system

PHASE 2, titled Unify to Mainstream, proposes aligning stewardship and transformation activities and programmes, both to build critical mass and scale stewardship and for optimum value, progress and impact. This phase has two main elements of work, **Accelerator implementation and System stewardship development** which are detailed below.

Accelerator implementation has a greater focus on what needs to be done, while system stewardship development emphasises how this can be achieved. Both are of equal value and importance with both system working and systematic delivery paired for optimum outcomes and impact. The recommendations are to work at both these levels simultaneously, in a whole system inclusive, collaborative, participative process, inviting system leaders to sponsor each element of the work, with representation from all parts of the system.

Accelerator implementation means elevating what has been achieved in the intermediate improvements work of Phase 1 and developing a focus on implementation. This looks at several elements of work, which would need to be led and have oversight by functional professional experts including finance and analytics, such as:

1. Allocation of resources/(Dis)investment: Accountability; Population & Place; & build on learning from Stroke pilot, as well as any other pilot undertaken.
2. Shadow budgets: Finance and Analytics test shadow budgets, run parallel budgets and implement when testing satisfies agreed accountability factors.
3. Hosting, including accountability, risk and governance: enabling and operationally managing the whole service, including the budgets, in a model similar to how Lead Providers function. The location of hosting can be located at any part of the care pathway but does need to have a whole pathway allocative perspective.

Critical question for consideration: for hosting effectiveness, is there a step before hosting to understand envelope/budgets/breakdowns for pathways etc?

Three options for Hosting as a key enabler for stewardship implementation are outlined below:

(1) Pathway based: this could mean that for any care area, the hosting organisation is based somewhere within that care pathway, and ideally where the best resource allocation decisions can be made, such as prevention, community etc (rather than necessarily highest care cost);
   a. Advantages: agile; potentially leaner; even if locally based, could draw on central/system expertise/functions etc; go where the energy, focus and work is in the system;

   b. Disadvantages: could miss economies of scale, wider learning.

(2) System based: this could mean one core hub/organisational team, ideally co-located but not essential, from which all stewardship and transformation work is led. Suggest could include key finance, analytics/data experts.
   a. Advantages: economies of scale; expertise on hand; cross fertilisation of ideas; sharing learning.
   b. Disadvantages: may/could require some re-allocation of colleagues from existing programmes of work into one bigger team.

(3) Blended/hybrid model: potentially a small core hub, with a rotation of colleagues across a core set of support services/roles/functions which would include finance, analytics/data.

System and stewardship development means building the conditions, capability and capacity for delivering Triple Aim, creating a 'movement' and aligning all system organisations for culture coherence, congruence and impact. This work element is detailed under three sub-sections, which are both interconnected and interdependent:

1. System leadership development: build the system leadership capability through a development programme for executive and all system leadership levels (beyond organisation only levels). This will be essential for all system leaders across the whole ICS, including executive development at ICB, all executive teams and distributed leadership as well as stewards, building in-house system level capability and capacity, ideally in collaboration with all system organisation OD. Additionally, build expert system and stewardship facilitation, potentially sourced from the above system leadership development groups, to be able to address and work through any challenges, tensions etc constructively to achieve commitment to solution.
2. System-wide and stewardship innovation and learning labs: build a forum for stewards, as well as other innovation leaders and practitioners, to bring and test thinking, ideas, conditions and factors for success, from requirements (must do), success factors (should do) and set up for success (for best results). These can also be energising ways to share success stories, learning and get system level co-consulting from and with colleagues as part of building the next level of stewardship.
3. System and stewardship culture, sustainability and legacy: co-create a system stewardship specific culture with all system organisations through participative processes including wider levels of engagement for public participation and by place. Sustainability: define what is required to ensure stewardship is fully inclusive, supported, and supportive. This is also an opportunity to build system integration for all parts of the system, particularly aligning any parts where there have been organisation mergers. Legacy: ensure all systems and system colleagues are aware, engaged and involved through on-going sharing of success stories, both internally and externally through publishing articles, conference speaking etc.

Phase 3, System Shift, likely during 2025, is about building towards a paradigm shift which will require courageous all system collaboration. Design of this phase to be based on outcomes, innovations and learning from Phase 2 to achieve a system wide stewardship culture.

Conclusion

As MSE have already started and made some good progress on the systemic longitudinal journey of stewardship, the only way is forward. The key questions, pinched with pride from observing a stewardship group are:

Are you up for this? Is the system up for this? If so, do it properly.

Appendix A: Key lines of Enquiry – Mid and South Essex stewardship Programme

Name & Role of Interviewee:

	Programme Objectives	Themes Calibration Scale – out of 10, with 1 =low; 10 = high. Also, ok not to have a view or say too early to tell.	Potential questions for Interviewees	Responses/Notes – add any comments EXPAND FOR NOTES
1	Provide stewardship groups with appropriate training and support	An explanation of stewardship Experience of training Gaps in training Ongoing support **On a scale of 1-10 how effective was the training?**	a) What does it mean to you to be a steward? b) Before you started the AGEM training did you feel you understood all that being a steward would entail? What were the gaps in your knowledge/understanding? c) How has any of your training helped you address these gaps and to develop as a steward? d) In the context of the next cohort of stewards and the train the trainer workshops can you reflect on the content of the training – what was done well? Where were the gaps? Should there have been more/less emphasis on specific aspects e) Thinking of future masterclasses, what ongoing training do you think would help your stewardship group be more effective?	
2	Establish 6 stewardship groups	Effective groups with appropriate membership and support **On a scale of 1-10 how well established are the groups?**	a) Do you think membership of your group is appropriate – are there gaps? b) Are members fully engaged and supported by their organisations? How often do you meet? c) Describe any other support needed to help you deliver your plans?	
. 3	stewardship groups to take responsibility for defined care areas	Clarity of role Appropriate skills **On a scale of 1-10 how effective are the groups in taking responsibility for each care area?**	a) What are the group's priorities for the next 12 months? b) Do you have a devolved budget for your care area and the authority to make decisions about where to invest and where to disinvest? c) How to you compare outcomes from other similar systems to benchmark the performance across MSE? d) What process have you been through to agree these?	

	Programme Objectives	Themes **Calibration Scale – out of 10, with 1 =low; 10 = high. Also, ok not to have a view or say too early to tell.**	Potential questions for Interviewees	Responses/Notes – add any comments EXPAND FOR NOTES
		Cancer, Ageing well, Stroke, Cardiac, Respiratory and U&EC.	e) What lessons have you learnt from this?	
4	stewardship group embedded in a host organisation	The model for planning and delivering care **Governance** at all levels of the organisation **On a scale of 1-10 how effective have the groups been in embedding in host organisations?**	a) Has your stewardship group identified a host organisation; if so, is there an agreement in place about how it will operate? b) Is an appropriate governance structure in place to ensure that decisions are ratified across all stakeholders? If no what have been the blocks? If yes, what were the enablers? c) What have been the lessons from this process? d) Describe how you measure success and report it to the host organisation e) How is the group held to account for progress against the plan?	
5	Structured engagement with the citizens of MSE	Raising awareness/co- production with the local population **On a scale of 1-10 how effective have groups been in engaging local people**	a) Is there a vision for how the stewardship group would like to engage with the local population/patient cohort? b) What, if any engagement has there been so far? c) What would help your group achieve the level of engagement you would like?	
6	The culture of stewardship is embedded across MSE	Cultural change Leadership **On a scale of 1-10 how effective has MSE been at embracing and embedding stewardship?** **Overall –**	a) What actions have/should leaders be taking to embed cultural change in their organisations? b) What support will they need to do this? (Behaviour/ Values/ Language) c) How is stewardship acting to integrate work programmes across BI, finance, and service redesign, rather than being seen as a separate work programme of its own? **For leaders not directly involved in the stewardship programme:** d) What does stewardship mean to your organisation? e) Has your organisation had any discussions about 'hosting' a stewardship group?	

	Programme Objectives	Themes **Calibration Scale – out of 10, with 1 =low; 10 = high. Also, ok not to have a view or say too early to tell.**	Potential questions for Interviewees	Responses/Notes – add any comments EXPAND FOR NOTES
			f) What governance arrangements will need to be in place across the system at all levels to support stewardship? g) Does your organisation see stewardship groups as 'system integrators'; working to coordinate the system, stewarding resources to deliver the best value possible for the population? h) If not, why do you think this is? i) What do you perceive to be the barriers to stewardship? j) What will motivate stakeholders to be excited by and engaged with this approach	

Appendix B: KLOE – Main Findings through the lens of Key Lines of Enquiry

KLOE areas of questions below	Main Findings – through the lens of Key Lines of Enquiry **Overall Comments: important work; good opportunity; lot potential to be valuable vehicle for Triple Aim; Items 1, 2 & 3 – progress; Items 4, 5 & 6 – in darker blue boxes – just starting;**
1. Training, gaps & support	Overall, useful and relevant training; Some said "I did not fully understand what I was getting into at start of stewardship"; need to improve context, expectations, commitment messaging etc; Team and leadership training, delivered by Staff College in 2020 very positive, both at individual development, leadership skills and team building levels as stewardship groups; Triple Value training good but complex; some repetition; lack of time; not enough on-going support for what was seen initially as 'conceptual'; data packs need simplifying and timely, coordinated preparation; The training opened minds and helped for different stages of collaboration and co-production, both of which were built on over time and continue to be developed; **Data collection not well coordinated or resourced leading to delay in production of data packs.** Support: useful programme support, not enough operational support to run the groups or implement change;
2. Six Stewardship Groups: Stroke; Cancer; Ageing Well; Cardiology; Respiratory; Urgent & Emergency Care	Participant selection is not system wide/representative enough; great passion and commitment; improve selection transparency for better representation as well as equity of opportunity; Overall: variable progress: Not clear if the scope/range of a Care Area affected the success. All groups at different stages of development (inevitably); Success factors: good relationships, built through shared passion, mutual respect; diverse voices & perspectives; all members have an equal voice; perception that the more 'successful' groups had one clear lead; Stroke; Cancer; Ageing Well: Building and developing good working relationships in MSE system and beyond; expanding and beginning to work towards what is required. Cardiology: lot of proactive improvement; Respiratory: stewardship paused as work being enabled via transformation board; Urgent and Emergency Care – understandably not available for stocktake. **Note: Stroke has been approved for next level work: at CEO Forum on 10 Feb**
3. Responsibility for Care Areas, Role; Skills;	Positive appetite and ambition to do this; those involved in stewardship passionate; not everyone/enough representation involved; not clear enough about roles and responsibility, especially where Transformation Board in place; groups said they found they got "too operational"; Resources: Disinvest/invest: groups do not have capability/skills/ assurance to get to a position to influence key allocations (yet);

4. Embedded in Host org.	Very early days; many considered hosting an excellent idea, as long as roles, accountability and governance/risk clear and managed;
5. Structured engagement with citizens; Patient representation	Citizens: Cancer, Ageing Well and Respiratory groups have all linked with the 'Essex is United' programme to build inclusive virtual interest groups with extensive reach which will be used in participative decision-making; Patient representation: in some Groups; valuable insights especially into "how to navigate the system as a patient"; recognition that individual patients are not representative of pathway/system;
6. Culture of stewardship & Cultural Change Leadership Reported Note: "culture change takes a long time; we are just starting this"; this is not a 'one and done';	
6. (a) directly involved	Embracing stewardship – still very early days; Leaders need to be aligned, vocal and visible on this; stewardship groups reported it was still early in their development and will take time to deliver results; expectations management is important – but share learning; several people said that if we were to ask members of their clinical teams about stewardship, they wouldn't know anything about it.
6. (b) not directly involved	"If you missed the original message and unless you are involved, you are unlikely to know much about this (stewardship)"; not heard about outcomes or progress yet, "seems a bit quiet"; Has the potential to be valuable; "now we need to do it right";

Appendix C: Literature Search and Review of Best Practice Examples of Stewardship

Context and Introduction:

stewardship as a principle seems synonymous with a variety of work that aims to bring together professionals, across all disciplines, to collaboratively work together across organisational boundaries. Coupled with the principle of resource (whether it be time, funding and workforce) being finite, the idea of stewardship, along with sovereignty over a budget, can facilitate collaborative conversations to identify areas of investment and dis-investment whilst allowing the 'stewards' (and akin) of these resources to be accountable for the outcomes they achieve.

Elinor Ostrom used the language of stewardship in relation to 'a commons;' resources available to whole populations that are not privately managed (Williams, 2018). Wilson et al., (2020) used the example of the commons in relation to universal health systems where resources, organisational priorities and physical infrastructure can also be finite. Wilson et al., (2020) also detailed the need to prevent the 'Tragedy of the Common' and a depletion of common resources that would negatively impact a population. One recommendation for preventing the tragedy was by implementing a culture of stewardship that facilitated the reinvestment from wasted resources to higher value interventions. This culture would be underpinned by Ostrom's principles for managing 'a commons' but also by local leaders bringing together professionals from various backgrounds and signing them up to a common purpose.

With regards to a working definition, stewardship can be defined as the sustainable and efficient use of resources to gain the best outcomes for patients and achieve the Triple Aim. It is achieved when front-line clinical staff and managers, across a whole health and care system (all agencies), collaboratively determine the best use of resources for the population they serve, based on the best data available (see Figure 1 below).

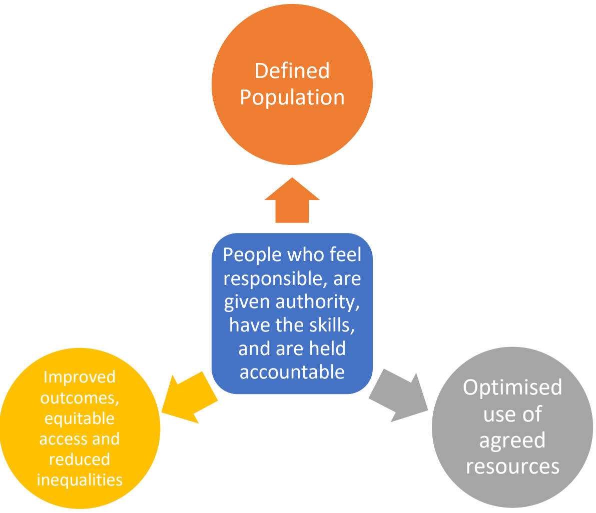


Figure 1: A diagram to show the principles of stewardship type goups. stewards and stewardship groups are at the centre of the diagram.

Mid-South Essex (MSE) Health and Care Partnership are aiming to deliver on the Triple Aim of improved population health, improved quality of care and better, more equitable and sustainable use of resources. MSE aim to action this by engendering a culture of stewardship that aims to "bring together the people responsible for delivering the Triple Aim, the resources at their disposal and the insights to inform the decisions they collectively make." For the purposes of this paper, MSE's definition of stewardship culture will be used.

MSE's stewardship approach, as listed in their 'Stewardship White Paper' (2022) aims to support seven functions:

- Aid understanding of current practice and value.
- Provide a platform for bringing people and expertise together.
- Prioritise choices regarding the deployment of resources.
- Facilitate the flexing of resources.
- Benchmark against other places.
- Know if we've made an improvement and to enable accountability for results.
- Create the conditions for a culture of stewardship to flourish.

MSE have formed six stewardship groups across care areas that broadly reflect the service-line budgeting approach outlined in the ICS's financial strategy. These care areas are cancer, urgent and emergency care, ageing well, stroke, respiratory and cardiology.

As part of a 'stocktake' to review current performance of these stewardship groups and, in addition to any themes arising from a range of interviews with key colleagues from MSE, this document will aim to outline any areas of 'best practice' of stewardship occurring elsewhere in the UK.

When referencing best practice case studies of stewardship, the particular elements that we aimed to identify were around multi-professional teams coming together in order to make decisions about use of resources and staff, a focus on populations and not individual organisations or pathways, a focus on prioritising high value interventions as opposed to low value interventions and a focus on outcomes that matter to people.

In order to identify best practice, the scope of this review was widened to identify any case studies or examples in which NHS clinicians and/or managers (as well as other front-line members of staff) engaged in multi-disciplinary decision making to either inform or directly identify services/pathways to fund via a devolved budget. The rationale for this was to identify areas of best practice that may not be labelled directly as 'stewardship.' SMEs on the topic of stewardship were consulted and provided case examples. Additionally, other resources such as The Kings Fund, NHS Leadership Academy and Government websites were used. It is noteworthy that overall, there were not many written examples of clinicians and managers directing resources to services via a devolved budget.

Best Practice Examples Within the UK:

Cambridgeshire and Peterborough Integrated Care System (C&P ICS) - Creating a Care Professional and Clinical culture to underpin the delivery of Integrated Care (E.of E. Leadership Academy, 2022).

In order to achieve the ICS quadruple aim of better health, better care, better value for every pound spent and reduced health inequalities, C&P ICS decided to shift their operation to a strong clinical and care professional empowerment culture (See Figure 2). This shift enabled different outcomes however, the outcomes related to stewardship were to:

- Develop a proactive population health management approach, with citizens at its heart.
- Direct resources to those with greatest need to reduce inequalities.
- Assess, understand and where clear, apply evidence-based approaches to reduce unwarranted clinical and professional variability.

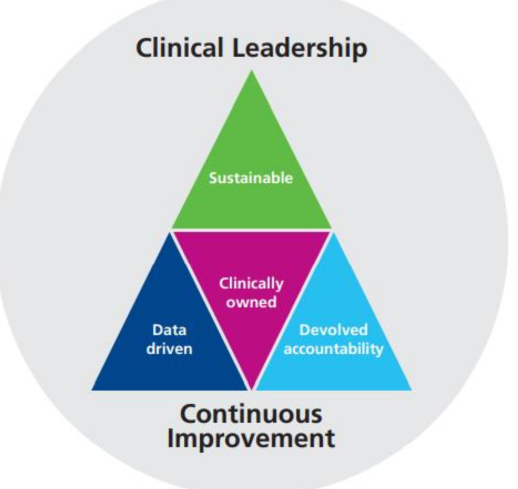


Figure 2: Cambridgeshire and Peterborough Integrated Care System's underpinning principles to deliver integrated care (E.of E. Leadership Academy, 2022).

This work culminated in a set of ten recommendations for the C&P ICS Board however, there was also a commitment from clinical and professional staff involved to equally own, with managerial and all other colleagues, the challenges that the ICS faces, notably the financial challenge of the health system and taking joint responsibility for the difficult decisions that the system has to make – this seems to link to the devolved responsibility that underpins the principle of stewardship.

Immediate next steps for this piece of work (at the time of publishing) were around widening clinical and professional input by embedding representation of GPs and primary care non-GP staff on the Professional and Clinical Leadership Assembly.

With regards to stewardship, C&P ICS seem to have a wider, system-level focus of stewardship as opposed to stewardship with a specific population segment / care area focus. Whilst the method may not fully align to MSE's deployment of stewardship groups, the underlining principles seem to align to MSE's functions of "*prioritise choices regarding the deployment of* resources, know *if we've made an improvement and to enable accountability for results and provide a platform for bringing people and expertise together."*

In terms of any learning, the following points were detailed:

- Based on historic challenges within the ICS, some cynicism of the approach was originally voiced. A pro-clinical and care professional system development position now exists. The ICS detailed that **paying attention to relational, cultural and architectural factors was important to this fundamental shift**.
- Working with **an independent expert facilitator** enabled C&P ICS to "broach sensitive issues, challenge ourselves on progress to date and shared aspirations for future ways of working and learn from what has worked well elsewhere."

The Leeds Office of the NHS West Yorkshire Integrated Care Board (ICB in Leeds) – A relentless focus on improving outcomes via population and care boards (Leeds Health and Care Partnership, 2022).

The Leeds Office of the NHS West Yorkshire ICB (the ICB in Leeds) is part of the West Yorkshire Integrated Care Board and wider West Yorkshire Integrated Care System (WYICS). They aimed to achieve their ambition of improving long term outcomes and reduce health inequalities in Leeds, via the embedding of a Population Health Planning (PHP) approach that ensures available resources are directed towards evidence-based interventions that will have the biggest impact on the health outcomes of their populations. As part of this work, population and care boards were set-up to make decisions and direct the work required to improve outcomes and value for people in Leeds (see Figure 3).

This **illustration** exemplifies how experts from a number of Business Units (from the ICB in Leeds), working alongside other core teams, will work as one of many matrix teams to support (and respond to) priorities identified by providers and partners on a Population Board.

The focus of the matrix team's work will be directed by the Population Boards' priorities and work programme.

Matrix teams will usually be led by a Portfolio Holder. Portfolio Holder roles are senior leaders responsible for establishing and leading change and improvement in response to agreed priorities, through matrix teams.

At any one time Population and Care Boards may be supported by multiple matrix teams which will vary in size and longevity. Some matrix teams may span all Boards and Sub-committees (particularly those developing and delivering cross cutting infrastructure eg Governance and Information Governance).

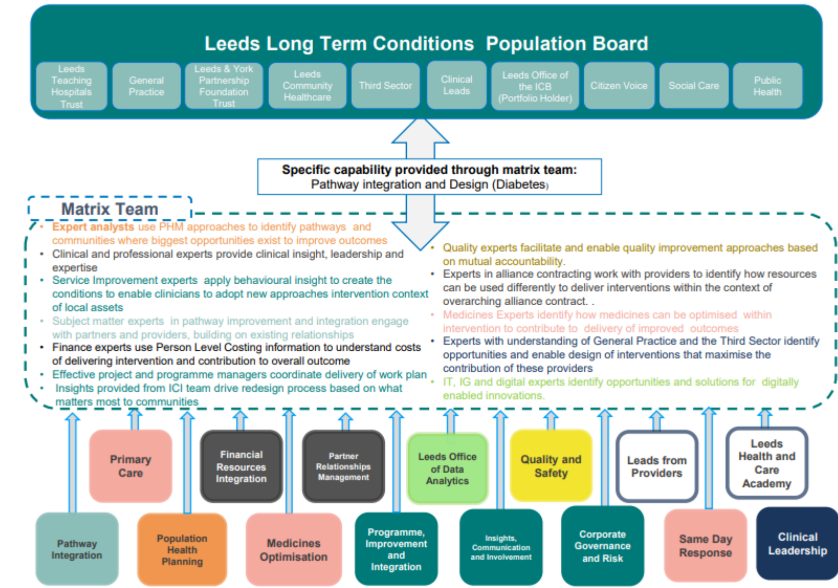


Figure 3: A diagram to show how the Integrated Care Board in Leeds are providing capabilities to their Population and Care Boards (Leeds Health and Care Partnership, 2022).

The population and care boards focus on different population segments e.g. mostly healthy, children and end of life, as well as different care areas e.g. people with learning disabilities & autistic people, cancer and same day emergency response.

When reviewing this approach in terms of stewardship, it is noteworthy that overall approach and principles align with that of MSE's stewardship approach, specifically MSE's functions of *"provide a platform for bringing people and expertise together, prioritise choices regarding the deployment of resources, know if we've made an improvement and to enable accountability for results and create the conditions for a culture of stewardship to flourish."* Additionally, whilst there was no specific mention of a devolved budget, there was mention of directing resources via the use of their PHP approach.

This work was recently undertaken as part of the statutory formation of ICSs and ICBs in July 2022 and so there is no published learning.

Gloucestershire Health and Care NHS Foundation Trust - Patient-level information and costing systems (PLICS) to deliver higher value services to diabetes patients (One NHS Finance, 2020).

As part of an Engagement Value Outcome (EVO) pilot, Gloucestershire Health and Care NHS FT undertook sessions between multi-disciplinary teams made up of clinicians, operational managers and finance & informatic colleagues in order to improve their understanding of Patient Level Information and Costing Systems (PLICS) data. These sessions were led by a trained facilitator and the aim of the sessions were to understand the diabetic patient's journey whilst also using PLICS intelligence to plan and deliver services.

PLICS data collection records activity and cost information for acute, mental health and ambulance services in England. When used in conjunction with other data sources, PLICS data can provide clinicians with information to aid their understanding of their patients and services.

As part of these multi-disciplinary discussions, key points arising included:

- An emergent, shared view that exploring PLICS data may provide opportunities to deliver higher value services to diabetes patients.
- An opportunity to quantify the 'health gain' from a particular intervention with diabetes patients.

A key output of these multidisciplinary sessions included colleagues identifying areas and interventions to explore in further detail e.g. specialist diabetes nurses highlighting that providing structured education for patients with diabetes could allow these patients to better manage and control their diabetes and, in turn, be less dependent on clinical interventions and services. As a result of this, finance colleagues subsequently shared data which indicated that patients who had attended diabetes education programmes in 2016/17 had a significantly lower need for healthcare services in 2018/19 than those who had not. The data indicated the value of education programmes on patient outcomes in preventing ill health, and thereby reducing the 'service dependency factor' associated with diabetes.

While the findings were interesting, it has been detailed that more may need to be done to account for other variables and ensure they are all considered. In terms of subsequent outcomes, it was detailed that:

- Patients in all aged bands that received education were found to have used tissue services much less than those who had not.
- The dependency of patients aged 45-64 on podiatry services was far less for those who had undertaken the diabetes education programme.

From the lens of stewardship, it was relevant that this multidisciplinary group were able to come together and use evidence to greater prioritise an intervention for a certain care area. Aligned to this. the group concluded that '**We got there by working together and having the right people in the room.**' This seems to align to MSE's functions of "*aid understanding of current practice and value, provide a platform for bringing people and expertise together and prioritise choices regarding the deployment of resources.*"

Health & Social Care Partnerships (Highland and Perth & Kinross) - redirecting resources to priority areas (Audit Scotland, 2016).

Two Health & Social Care Partnerships (partnerships between NHS Trusts and Local Authorities) in Scotland engaged in a pilot to outline the principles of Programme Budgeting and Marginal Analysis (PBMA) and set-up multidisciplinary advisory groups to better make decisions on investment and disinvestment for resources within the local health & social care system.

PBMA is a generic economic framework that offers an analytical approach for assessing the costs and benefits of alternative courses of action, which could assist with identification of the effects of resource shifts and areas for disinvestment among programmes it considers:

- How current available resources are used.
- If more resources should be directed to certain services or groups of people.
- Where care could be provided more efficiently, and more resources redirected to priority areas.
- Areas of care where fewer resources should be allocated as they could be used more effectively in priority areas.

Workshops outlining the economic principles and theory of PBMA were held in both localities and from this, multidisciplinary advisory groups were formed to lead the process in each site.

The pilot test sites were very positive about the approach taken and allowed them to progress with a decision-making process while changing the thinking of those involved as to how decisions are made and how resources can be (re)allocated within health and social care.

Similarly to MSE's approach, the two health and social care partnerships aimed to enable the functions of *"provide a platform for bringing people and expertise together, prioritise choices regarding the deployment of resources, facilitate the flexing of resources and create the conditions for a culture of stewardship to flourish."* However, the approach seemed universal in terms of its application to health and social care services used within

the health and care partnership's locality as opposed to resources being granularly reallocated based on population segments and care areas.

In terms of learning and insights, it was mentioned that a particular strength was the role and composition of the advisory groups - the benefit of **including other stakeholders, such as service users, carers and service providers, alongside statutory providers in a co-production approach** was evident. Additionally, there was acknowledgement that going forward, **clinicians' time will need to be protected** to allow participation in these multidisciplinary advisory groups.

Stockport Together – a focus on prevention & empowerment, reducing inequalities and moving care from hospitals to communities.

As part of the 5-year forward view, Stockport Together (see Figure 4) was a first wave vanguard that aimed to uses funding to move away from using KPIs by designing an outcome-based commissioning model that instead measured Patient Reported Outcome Measures (PROMs) whilst also linking funding to desired patient outcomes (via a capitation contract). The vanguard's rationale for this was around obtaining a picture of 'what good looks like' for the people of Stockport, to focus on outcomes that mattered to people by formalising these within contracts and to gain the freedom to be innovative by not being restricted to specific activities or financial incentives when deciding treatments.

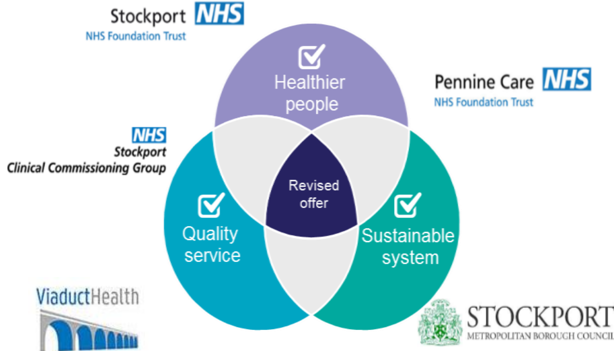


Figure 4: A diagram to show Stockport Together's integrated model of care.

The vanguard set up 4 Expert Reference Groups (ERGs) that worked to develop Clinical and Social Outcomes (CSOMs) and select appropriate PROMs according to the needs of different population groups. These ERGs (see Figure 5) were comprised of multiple professionals including clinicians, staff, patient/service user representatives, commissioners and providers. Following selection of appropriate CSOMs and PROMs, an integrated contract, using a lead provider framework, was used that **incentivised providers based on these outcomes**, with **payments (to providers) being contingent on delivering the aforementioned outcomes over a 2 to 10-year period.**

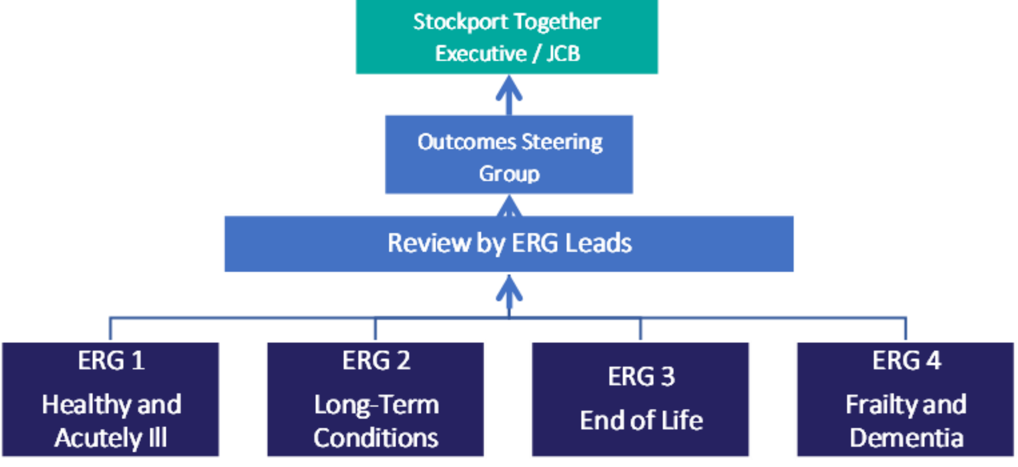


Figure 5: A diagram to show Stockport Together's governance pathway for the Expert Reference Groups.

These population groups arose from Stockport's 'Bridges to Health model' research - a segmentation model with 8 main segments, 7 of which were Stockport's initial focus as they were relevant to people aged over 65-years-old:

- Healthy
- Maternal and infant health (not relevant to those aged > 65-years-old)
- Acutely Ill
- Long-term Conditions, generally stable
- Serious Disability, generally stable
- Dying with short period of decline
- Limited reserve and serious exacerbations
- Frailty and/or Dementia (long course of decline)

In terms of any learning, Stockport Together wanted a **discrete budget linked to an outcomes** framework that was **underpinned by a population-based approach**. The vanguard moved away from individual organisations working as separate silos and looking at pathways as separate, to **looking at people with similar needs.** In terms of outcomes, Stockport Together focused on **outcomes that mattered to people**, **PROMs** around health and wellbeing as well as **clinical and system outcomes that would improve the financial sustainability of the system.** This vanguard was, at the time, one of the few places in the country that delved deep into their journey to achieve outcome-based commissioning.

Whilst this initiative occurred at place level as opposed to system level, a few similarities and learning can be drawn between Stockport's approach and MSE's approach. Stockport's population-based approach, use of ERGs and integrated contact which incentivised providers based on outcomes seem to align to MSE's functions of "*provide a platform for bringing people and expertise together, prioritise choices regarding the deployment of resources, facilitate the flexing of resources, and create the conditions for a culture of stewardship to flourish.*" Whilst the vanguard may have not progressed (due to relationship breakdown), there is still learning that is useful and applicable.

Best Practice Examples Outside of the UK:

Canterbury Clinical Network - Integrated Care in New Zealand (Centre for Policy on Ageing, 2016; Timmins and Ham, 2013).

Within New Zealand, District Health Boards (DHBs) are responsible for most public hospital (secondary care) services and social care services whilst primary health care services are provided by a number of Primary Health Organisations (PHOs) funded by the DHBs.

Figure 6: A diagram to show Canterbury Clinical Network's integrated model of health and social care (Centre for Policy on Ageing, 2016).

In order to bring together health and social care systems, the Canterbury Clinical Network (CCN) was established in 2009 and aimed to have the health and wellbeing of the patient as a primary goal. This integrated approach (see Figure 6) aimed to achieve the aforementioned goal by avoiding the constraints and conflicts dictated by the processes of the individual and separate care systems. The CCN provides a platform for clinical leadership and demonstrates the principles of an alliance whilst also leading on the development of services across the sector where innovation and transformational change is required.

The CCN consists of workstreams (see Figure 7), that focus on a particular target population (segment) or area of work, as well as Service Level Alliances' (SLA), that lead on the transformation and implementation of services. The network aimed to support clinicians so that they were enabled "to do the right thing, the right way," whilst the workstreams had a focus on strong clinical leadership.

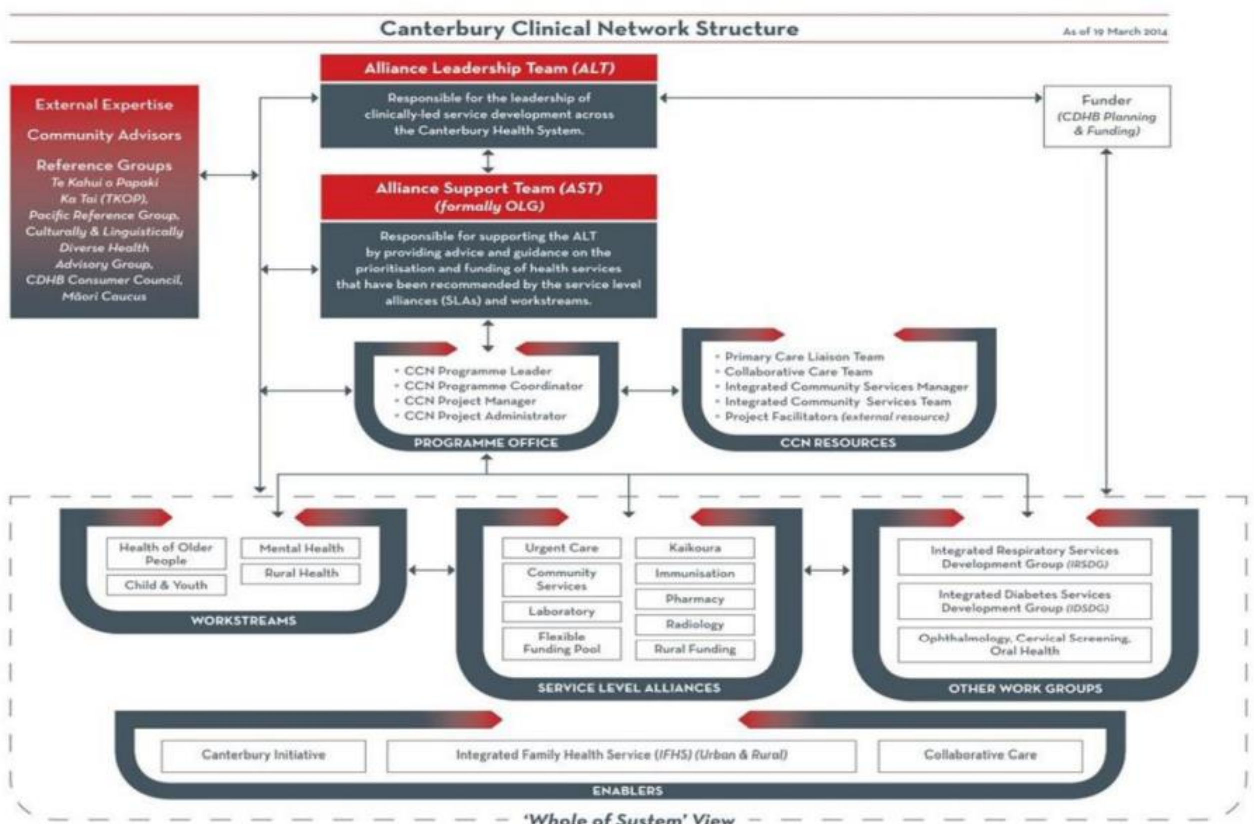


Figure 7: A diagram to show the structure of the Canterbury Clinical Network (Centre for Policy on Ageing, 2016).

With regards to insights, it was mentioned that one of the principal achievements of the CCN was the **buy-in at all levels to a more co-operative way of working and the re-empowering and re-engagement of clinicians and other staff.** There was also a note that organisational integration (presumably in the most literal sense) was not necessary to deliver integrated care.

Considering the differences arising due to the approaches occurring in different healthcare systems and whilst this approach seemed more focus on integrated care as opposed to stewardship of resources, there seems to be some overlap between this approach and MSE's approach with specific reference to working groups based on specific population segments and care areas and the overall integrated care approach. Outputs by the CCN seem to uphold MSE's functions of "*provide a platform for bringing people and expertise together and create the conditions for a culture of stewardship to flourish.*" However, there was no mention of devolving funding responsibilities to front-line staff (a key component of stewardship).

Grand Junction Colorado – An informal but effective model of stewardship (McGinnis, 2013; Thorson et al., 2010).

The municipality of Grand Junction Colorado has delivered effective and efficient care via a series of self-governing organisations that believe healthcare as being a resource for the community. As such, Grand Junction Colorado has outperformed most other communities in the United States of America (USA) in terms of patient outcomes exemplified by fewer and shorter hospitalisations, and lower mortality rates following hospitalisation compared to other areas within the USA.

The community's leadership group took ownership of not just specific care programmes, but also of the regional system in its entirety. Overtime, this change caused the programme to become more sustainable in terms of improved outcomes and lower cost. Via this initiative, Grand Junction Colorado have demonstrated that

undergoing transformational change by incremental steps is possible, as long as the service transformation occurs in a strategic manner. A key step in the efficacy of this new care model was the self-identification of a team of leaders and their ability to work effectively as a team - this required the creation and maintenance of trust between these leaders which facilitated frequent open and frank discussions while ensuring that all points of view were aired and that any fairness concerns were honestly evaluated. The topics of these collaborative discussions were on meaningful tasks that can only be accomplished through joint action.

This particular case study details the minimal requirements for effective stewardship of a regional health commons. Local leaders routinely engaged in a consultative and collaborative approach which enabled them to identify programmes of particular importance and value to the community with leaders subsequently locating any additional funding sources for these high-priority programmes to make them sustainable over the long haul. The leaders' discussions also undertook gap analyses to and in turn, began the process of devising and implementing programmes that might fill those gaps.

A critical factor to the success of Grand Junction was the way in which **leaders frequently interacted with each other in both formal and informal settings** in a way that **built mutual trust and respect.** These informal social networks were critical in sustaining a sense of community however, it was more than frequent communication that led to Grand Junction Colorado's success; collectively, **community leaders took ownership of their regional system**'s healthcare delivery and **defended their autonomy against threats from outside the region**. Additionally, they have established **procedures for regularly sharing information** and rewarding those physicians who perform best, according to the standards they have jointly set.

When aligning this case study to that of MSE's stewardship approach, there is clear alignment with MSE's functions of "*provide a platform for bringing people and expertise together, prioritise choices regarding the deployment of resources, facilitate the flexing of resources and create the conditions for a culture of stewardship to flourish.*" Whilst the example of Grand Junction Colorado occurred at place level compared to MSE's system wide approach (with Grand Junction's population being ~5.5 % of MSE's), their focus on prioritising the sustainability (including financial sustainability) of programmes of care that were important and valuable to the local community absolutely aligns to the principles of stewardship.

Riberia Salud – Delivering integrated and preventative care within Spain (de Rosa, 2017; Riberia Salud Grupo 2016; Riberia Salud Grupo, 2016).

Riberia Salud, a healthcare provider based in Valencia (Spain), developed their management model (see Figure 8) for a more integrated healthcare approach. The model is based on service networks that offer coordinated attention and care for the patients and caregivers in a specific geographical area. The healthcare group aim to focus on patients' present and future needs whilst holding themselves, as a healthcare provider, responsible for the cost of services and outcomes.

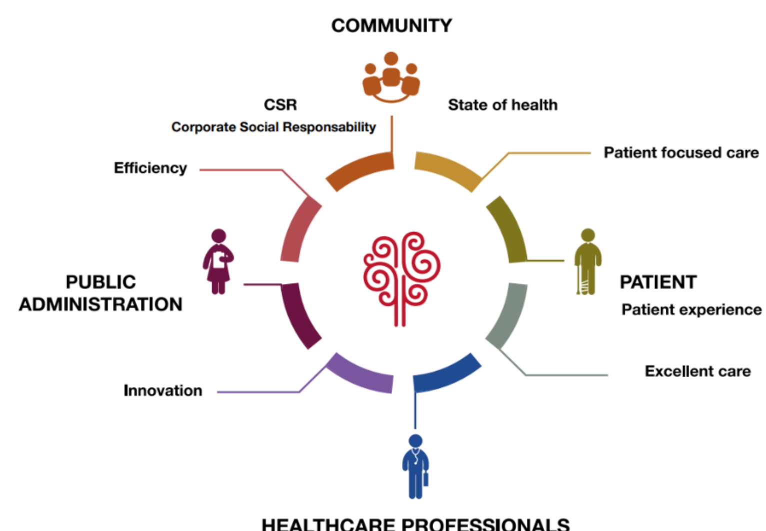
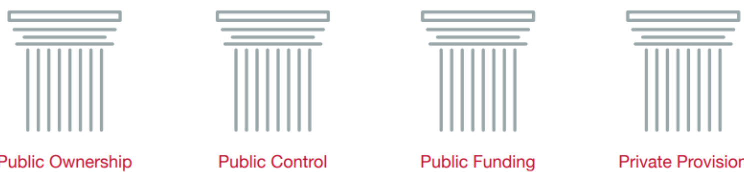


Figure 8: A diagram to show Riberia Salud's healthcare management model (Riberia Salud Grupo, 2016).

The healthcare model's value is based on the "5 Ps," in that medicine should be: Personalised, Preventative, Predictive, Population-based and Participatory. Additionally, the model is based on four fundamental principles (see

Figure 9) which detail that the financing, ownership and control of the healthcare model are public, with only the provision of services being private. This ensures that the quality of health are remains guaranteed and the administration does not lose control of the service provided.



Public Funding. The payment is based on a capitation payment system. The Administration pays the concessionaire company an annual fixed and pre-established amount for each of the inhabitants ascribed to it.

Public Ownership. The public nature of the health service is guaranteed at all times. The health center remains a public hospital, built on public ground and belongs to the network of public hospitals.

Public Control. The concessionaire company has to comply with the clauses set out in the bid specifications. The Administration has the power to control and inspect it, as well as regulatory and sanction authority.

Private Provision. The provision of health care service is allotted, for a pre-established period of time, to a concessionaire company that is committed to the successful operating and management of the public service.

Figure 9: A diagram to show the principles underpinning Riberia Salud's healthcare management model (Riberia Salud Grupo, 2016).

The healthcare provider comprehensively manages the health of their patients in a transparent and results-oriented manner. Their model pursues the most effective use of resources to ensure they achieve the best possible outcomes. The group places a special emphasis on preventive health and have developed protocols for chronic health conditions. Cross-functional teams work collaboratively to provide the best health care for all patients while managing costs; the group specifically use the 'cost per member of the population' as their measure of efficiency. Since Riberia Salud's integrated care journey began, they saw improvements in both the number of emergency hospital visits and waiting lists.

When referencing any learning, Riberia Salud's Chief Executive mentioned that:

- Healthcare integration, facilitated by **modern, integrated and cross functional IT solutions**, was a critical factor as it allowed for processes and pathways to be based upon **population health management.**
- **A single budget** and capitation allowed for **a focus on financial healthcare and not solely activity** which helps to keep citizens as healthy as possible for as long as possible.
- An agreement on **shared vision, shared goals**, and incentives, whilst putting synergies and **economies of scale** in place was also a key factor.

Riberia Salud's approach focuses on integrated care however, it also showcases principles of stewardship in their Public-Private Partnership (PPP) model. Overlap between this approach and MSE's approach seem to uphold MSE's functions of "p*rovide a platform for bringing people and expertise together, prioritise choices regarding the deployment of resources, benchmark against other places and create the conditions for a culture of stewardship to flourish.*"

Conclusion and Next Steps:

Overall, the commonality between multiple case studies, both from within the UK and abroad, seems to identify engagement from clinicians, other members of staff and patients as a key enabler for developing a model of stewardship and enabling it to flourish. Most case studies also detailed the need for a population health approach, whether it be to identify specific population groups and care areas for 'stewardship' type groups to focus on, or to identify outcomes that matter to the population and identify ways to make these sustainable and achievable. Next steps consist of engaging clinicians and other members of staff from disparate organisations to buy into the stewardship journey whilst also dedicating resources to ensure clinicians' time is protected to take part in this work. Additionally, agreeing shared visions, goals and incentives, as well as disseminating this across organisations would help bolster wider colleagues' awareness of this work and aid the culture of stewardship to be embedded and to flourish across MSE.

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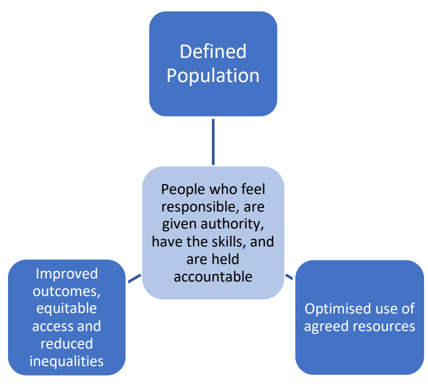
Appendix D: Background to stewardship & MSE stewardship (shared with Clinical and Multi Professions Congress, Feb 2023)

Stewardship: a working definition: stewardship is the sustainable and efficient use of resources to gain the best outcomes. It means clinical and other professions, front line and beyond, across whole health and care system (all agencies), coming together to determine best use of resources for the population they serve, based on the best data available. stewards will advise and enable disinvestment/different investment decisions for optimum health, including preventing health inequalities, for the purpose of achieving the Triple Aim.

Stewardship as a concept for healthcare and at MSE was in part inspired by the "Tragedy of the Commons" paper (RSM, Wilson et al, 2020) regarding the collective management of shared finite resources and what can happen when those resources are not allocated and managed for the good of all.

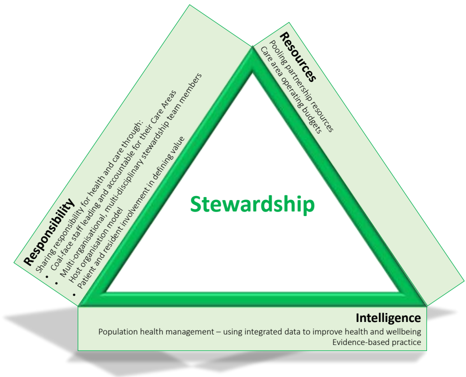
Stewardship model in use and stewardship group (sometimes called population stewardship groups):



Stewardship Group structures are ideally intended to have an enabling set up, as follows:
stewardship Lead: facilitator or convenor, chairing meetings.
stewardship Team – the core stewards involved, who meet regularly (usually monthly so far) to move the thinking and work forward; this critical team are ideally fully representative of the whole system.
stewardship Group – the wider system membership who are involved to help consult widely, build ideas, test and inform decision-making.

MSE Stewardship: The Mid and South Essex Integrated Care System has committed to its statutory duty on delivering the Triple Aim and is positioning stewardship as a key enabler for that. The Integrated Care Board supports stewardship as a route to achieve the Triple Aim. NHS England is also supporting pilots in various ICS/ICBs to build a model of stewardship as a route to achieving Triple Aim.
"The Mid and South Essex ICS promises to 'work together for better lives'. This means delivering the Triple Aim: improved population health, improved quality of care and better, more equitable and sustainable use of resources. To deliver this we are aiming to engender a culture of stewardship and we have developed a programme to support this, which has been underway since April 2021." Source: MSE Whitepaper on stewardship, Feb 2022.

MSE Stewardship Model & Outline Plan, as set out in MSE stewardship White Paper, Feb 2022:



MSE stewardship Outline Plan:

1. 25 X 25 = 25 Care Areas have stewardship Groups by 2025
2. Criteria clear for selecting and prioritising new care areas
3. Gateway assurance process for all stewardship groups
4. Host organisation to 'sponsor' each stewardship group
5. Structured engagement with citizens, including a focus on digital campaigns
6. An annual report by each stewardship group for the population segment they serve

Appendix E: MSE Stewardship to date: Background & Timeline: to end 2022

1. Stewardship was initially inspired by concept of 'the commons' and by some of the innovative practices that rapidly occurred during the pandemic in MSE.
2. MSE's approach so far has been intentionally light touch to test, build and refine the approach, rather than the more standard transformational systematic programmatic approach.
3. Stewardship groups were selected from MSE's existing care area (service lines) structure. The first cohort of six stewardship groups, were agreed and inducted through a team development and leadership programme, experienced over four days, delivered by the Staff College, during 2020/21.
4. Triple Aim/Value training, including system leadership, system stewardship thinking and data work, for the stewardship groups first cohort, was delivered by a collaboration of the Oxford Value and stewardship Programme and Arden & GEM SMEs over three half-day workshop, during 2021/22.
5. MSE ran several workshops for the stewardship groups to develop understanding; Each group has created a value framework outlining the outcomes that they want to focus on; Dashboards are being designed based on the care pathway and financial data available to measure the outcomes. stewardship groups will use the dashboards to monitor the impact of any service changes made. The intention is that stewardship groups will inform/become decision-making forums for optimal resources allocation.
6. Stewardship Groups have been active to varying degrees since their set-up; are mainly self-directed and meet monthly; senior leaders sometimes sit in and observe without directing to build their understanding of how stewardship is developing.

Stocktake, Nov 2022-Mar 2023

a) In Oct 2022, Arden & GEM (funded through AGEM's stewardship investment) were commissioned to conduct a stocktake of the stewardship work to date: what works, what to improve, what next.
b) This stocktake was conducted using Key Lines of Enquiry across the following six areas:

    Main elements

    (7) Provide stewardship groups with appropriate training/support: experience of/gaps in training.
    (8) Six stewardship groups: effective groups, appropriate membership, right support.
    (9) stewardship groups to take responsibility for defined care area: clarity of role, appropriate skills.

    Also questions on emergent/new elements

    (10)Host organisations: the model for planning and delivering care, incl. governance at all levels.
    (11)Structured engagement with citizens, (incl. patient representation); awareness, co-production.
    (12) stewardship culture and leadership.
c) The stocktake was conducted through a series of **over thirty 1-2-1 interviews**, mainly with those already involved in stewardship, including with the stewardship groups themselves, (as well as observation of stewardship groups where timing allowed), several key executive team leaders, MSE stewardship Programme and AGEM Programme colleagues.
d) The early collation of high-level Findings and Recommendations are set out below, including some notes on findings of Cohort 1 stewardship groups.
e) The findings and recommendations of this stocktake will support the following:

    -Improvements to the training for the next cohort of stewards, starting end Feb 2023.
    -Recommendations, in outline, for what will be required to mainstream stewardship.
    -As AGEM investment, this will also inform stewardship work and models, including other pilot work and collaborations with NHS England.

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Agenda item 8 – Appendix 2

Stewardship White Paper II

March 2023

1. Executive Summary:

Stewardship should remain a hallmark of Mid and South Essex. Our system CEOs remain united in their support for this.

Over the past two years we have developed significant, unique capacity via our cohort 1 stewardship groups (Ageing Well, Cancer, Cardiac care, Respiratory, Stroke and Urgent and Emergency Care). These groups have now begun to provide important leadership within their care areas, resulting in both tangible and intangible changes and improvements, as described in the separate AGEM Stocktake Report and White Paper below.

Over the next 18 months, we will deliver a streamlined programme of training and induction for our cohort 2 stewardship groups (e.g. Children and Young People, Dermatology, Diabetes, Eyes, Mental Health, Musculoskeletal care), building on testing and learning from the last 2 years. This will ensure that future cohorts form, mature and will be ready to provide care area stewardship much more quickly and effectively.

We also aim to implement, test and iteratively improve hosting arrangements, using stroke as a pilot care area. This will enable the development of system-wide accountability, scrutiny and resourcing arrangements, relating to the hosting of a whole care area and the enacting of resource-shifting stewardship proposals. This must also involve the flow of resource data within care areas.

Other cohort 1 groups, such as Ageing Well, Cancer and UEC, will increasingly be brought into BAU processes, so that they can support and influence significant choices, decisions and actions taken within those care areas, before following a pathway towards partnership with a host organisation.

If we are successful in achieving these actions as a health and care system, we will be well on the way towards establishing key elements of the paradigm shift needed in order to deliver on the triple aim, improving the health and wellbeing of our population, the quality of our services, sustainability of resource use and addressing inequalities within each of these.

2. Introduction:

Stewardship is our vehicle for achieving the triple aim in Mid and South Essex: improving the health and wellbeing of our population, improving the quality of our services, and using our resources efficiently and sustainably, whilst addressing existing inequalities within each of these.

The programme is based upon the work of Nobel Prize winner Elinor Ostrom, who studied the sustainable, equitable management of shared resources by the resource users. It applies her ground-breaking work to our health and care settings.

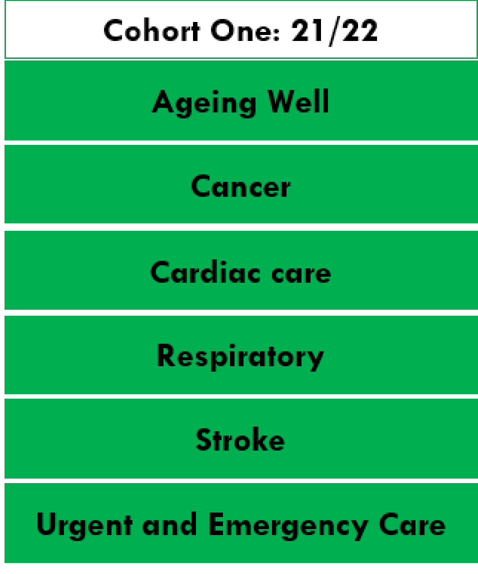
> **Stewardship in MSE**: *bringing 'resource-users' (frontline and back-office staff and residents) together within care areas to act as stewards – delivering the greatest value for residents from our pooled resources.*

Our first Stewardship white paper in Feb 2022, laid out seven functions for the stewardship programme to deliver. These continue to apply now, and are to:

1. Aid understanding of current practice and value.
2. Provide a platform for bringing people and expertise together.
3. Prioritise choices regarding the deployment of resources.
4. Facilitate the flexing of resources.
5. Benchmark against other places.
6. Know if we've made an improvement and to enable accountability for results.
7. Create the conditions for a culture of stewardship to flourish.

After almost two years of the stewardship programme in Mid and South Essex, with six groups established and induction for six more underway, we have commissioned a stocktake report to review all aspects of the programme thus far.

This second stewardship white paper provides a brief overview of activity over the past year (for further detail see AGEM Stocktake Report), and then builds on the findings of the Stocktake Report and system progress over the last 2 years to outline major areas of focus and action for the next 12-18 months.



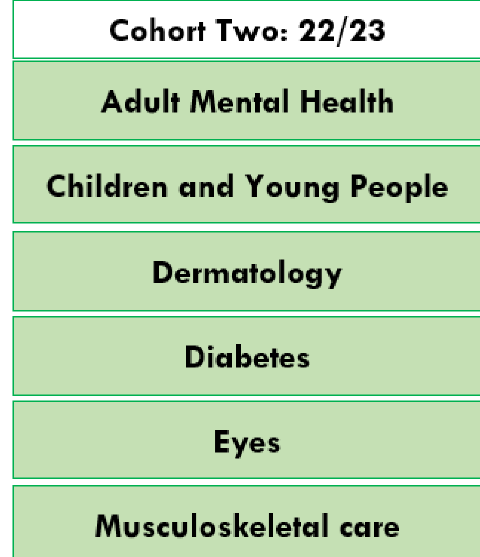


Figure 1: Stewardship groups in cohorts 1 & 2

3. Activity update:

Since the previous Stewardship white paper in February 2022, cohort 1 groups (Ageing Well, Cancer, Cardiac Care, Respiratory, Stroke and Urgent and Emergency Care) have undergone a series of training and development workshops, led by Prof Sir Muir Gray and Dr Tim Wilson with AGEM. These focused on the practical, technical and cultural aspects of stewardship and value improvement, including an introduction to the Socio-technical Allocation of Resources (STAR) process. It included support and facilitation to develop care area value frameworks.

All cohort 1 groups came together again in September 2022 to share progress updates, peer-to-peer learning, and for discussions on the next steps for the programme. These next steps included the development of stewardship dashboards, with Ageing Well, Cancer and Stroke leading development of different aspects. All groups also continued to contribute and provide leadership in different ways within their care areas (selected examples in highlights box below). This white paper will not review individual activity group by group – in future this should be reflected within groups' annual reports (see section 5.2).

In Autumn 2022, the Respiratory stewardship group was paused, with plans to review as part of a future cohort. Frontline leadership continues to be provided via System Clinical Leads for Respiratory and for COVID, who were both Respiratory group members.

Formation of cohort 2 groups (Children and Young People, Dermatology, Diabetes, Eyes, Mental Health and Musculoskeletal Care) also began in the Autumn, with initial introductory discussions in November 2022, and an updated, condensed training and development programme commencing, after the winter activity peak, in February 2023.

Selected highlights: concrete changes resulting from stewardship groups' work.

Cancer: With active support and encouragement from the Cancer Stewards, a new day zero Patient Tracker List (PTL) approach was launched in November 2022. At that point there were around 1,000 patients waiting 62 days for a diagnosis after a GP referral. This has subsequently been reduced to 595 and is expected to be under 100 by March 2023. The Day zero PTL is a real game changer. The action-oriented strategy ensures patients who don't have cancer are appropriately and speedily informed and taken off cancer pathways, meaning those with cancer are quickly and appropriately directed to the correct service. The team's next focus is on prostate cancer pathways.

Ageing Well: Through the guidance and efforts of the Ageing Well Stewards, the MSE electronic frailty care coordination system (efraccs) register was designed, built and launched in April 2022. It now has more than 8,000 people with frailty and dementia added. This resource enables prioritisation and increased visibility of residents with frailty and complex needs for more seamless, proactive and effective care coordination between providers. The team have also championed the Frailty Consultant hotline, which now takes over 350 calls/ month, and is associated with admission avoidance rates at 80%.

4. AGEM stocktake:

The stocktake findings outline some key achievements, areas for development and opportunities. These are summarised here, with full findings available in the separate Stocktake report.

4.1 Achievements:

Vision: a remarkable degree of buy-in from those associated with the programme, along with passion and belief in the transformative potential of the stewardship approach.

Capacity: We have created six groups, with frontline and 'back office' capabilities, who have grown into their role as care area leaders. They have developed value frameworks and are working on the stewardship dashboards to track personal, population and resource outcomes.

Cultural shift: It has started to 'feel' different in those care areas, through growing genuinely collaborative relationships, and a shared whole-pathway, whole-population mindset.

4.2 Challenges and areas for development

Role: different groups have engaged in different mixes of strategic and operational work, influenced by group membership and care area needs. This has led overall to some uncertainty about what is the 'right', or intended, role for a stewardship group. Awareness of stewardship and the groups is not currently widespread across the system at all levels, and so it can be seen as 'cliquey'.

Relationships: tensions have occurred over relationships with existing transformational capacity, or where such capacity is lacking.

Resources: Whilst stewardship teams have been developed at a care area level, care area budgets remain unclear and accountability for resource management remains distributed by organisation. This has restricted stewards' opportunities, leading to a focus on service improvement within existing siloed budgets, rather than being able to meaningfully steward and help flex resources across settings for greater population benefit within their care area.

4.3 Opportunities:

- Stewardship positioned as a key enabler to achieve the triple aim, with hosting of a whole care area necessary to unlock further potential.
- System-wide communication of the vision of stewardship for whole system transformation rather than incremental improvement.
- Empowerment of stewardship groups to influence long term plans.

5. Programme-level improvements:

This section describes actions we have already taken, or intend to take, at cohort and programme levels. These build upon the stocktake findings and recommendations, and outline how we will continue to take action to deliver upon the seven functions outlined in the introduction.

5.1 Cohort 2, and future cohorts: by October 2023

- **Selection**: we have reviewed and improved the process for joining a new stewardship group, increasing transparency and visibility. There is now an Expression of Interest process, shared via communication channels across the system and open to all staff members. A group discussion session, as with cohort 1, is used to bring potential candidates together and provides an opportunity for applicants and programme team to consider the make-up of the group. This process aims to ensure that groups contain staff with experience from across all parts of a care area pathway.
- **Training and development**: we have streamlined the programme of training and development stewards go through, learning from the most important elements for the Cohort 1 groups. Cohort 2 stewards will have an integrated programme over 6 months of individual and team-focused leadership development, as well as stewardship and value-improvement training. Within these sessions they will develop key artefacts necessary for their work including:

  - Care area specification: population, burden of disease, resources, service activity and outcomes.
  - Value framework which articulates the key personal, population and resource outcomes for the care area. This should include identification of priority metrics showing progress on those outcomes which will form the basis of their stewardship dashboard.

  As a result of this focused programme, we anticipate that cohort 2 groups will be ready to play a leading role within their care area much more quickly.
- **Relationship with transformation groups**: we will support cohort 2 groups to engage and develop constructive, collaborative relationships with existing transformation groups, programme boards etc as relevant. The remit of the stewardship groups is to steward resources at care area level, improving care area decision-making through their pooled experience, evidence and aligned strategic and information assets (e.g. stewardship value frameworks and dashboards). They may work with transformation groups to operationalise existing transformation priorities in the next short to medium term, or future stewardship proposals in the longer term. Where there are no relevant transformation groups or programme boards, it may be appropriate for stewards to support operational decision-making, or to play a role in creating and supporting this capability. The Cardiac care Stewards for example have now convened a system Cardiovascular care programme board.

5.2 Cohort 1: by October 2023

- **Annual reports:** we will develop a template to support all active cohort 1 groups to create their first care area annual report by October 2023. This will contain a narrative section outlining their activity, projects and achievements over the last year. A more quantitative section, based on their dashboard, will focus on measured progress against their value framework. Finally, they should state specific priorities and plans for the coming year based on these two sections.
- **Mainstream into BAU processes**: see section 6 below.
- **Stewardship tools**: all groups will complete full stewardship dashboards – with personal, population, resources outcome metrics. We will work with organisational finance and resource teams to ensure access to resources data in order to complete the resources sections – access to resource data is a critical dependency.
- **Group renewal**: following two years of activity, all cohort 1 groups will be encouraged to review their group membership, particularly where there has been flux with members leaving or arriving. It will be important that there is a pathway and opportunities for people to join existing stewardship groups, ensuring that stewardship group performance can be maintained despite inevitable turnover over time.
- **Refresher training:** we will aim to work with cohort 1 groups to develop a short form stewardship "refresher" or "catch-up" training for new members joining cohort 1 groups or any who may benefit from an update.
- **Resident engagement:** groups go further to support development of and continued interaction with communities of purpose associated with different care areas within MSE via the "Essex is United" social media model, along with work with Health Watch organisations and our system Communications teams as appropriate.

5.3 Programme team: next 6-12 months

- **System-wide engagement:** we will work with system colleagues, including Communications and Engagement teams, to develop a more concerted approach to promoting awareness, interest and support for stewardship across our ICS.
  This may include considering different staff group perspectives and opportunities, promoting visibility and accessibility of existing stewardship groups and their work. It may also entail

developing accessible, appealing central resources to promote key concepts and contacts, along with a platform for regular updates, for example via a community of interest newsletter.

- **Consolidate programme capacity:** we will review and articulate the enabling requirements likely to be needed to support progress over the next 12-18 months, e.g. elements of BI, HR, resource-management, change management, communications and administrative support – some of which is already in place. We will develop proposals for ensuring appropriate capacity, which will likely involve matrix-working with existing colleagues across the system.
- **Develop training capability:** we will work with People and OD teams to consider what may be needed in terms of developing training capacity, to enable future cohorts to receive more of their training and development via suitable in-house processes. A range of training options might be developed, including offers for core stewardship group members, as well as for other frontline clinical and care staff interested in joining or working closely with them, for operational and management staff, executive and senior leaders and others. Such training capability could become a strong system asset.
- **Group maturity matrix**: we intend to develop a stewardship group maturity matrix, in-line with the learning from cohort 1 on necessary capabilities, capacity and functioning. This will be used to support the development and progression of all groups. Where needs are identified, support and development opportunities can be sourced where appropriate options exist, or can be constructed where there are no ready-made solutions.
- **Group progression framework**: we will work to refine the existing crawl, walk, run gateway process, building on learning over the past two years. This should align with the group maturity matrix above, along with other potentially critical factors such as system-readiness and identification of an appropriate host organisation.
- **Stewardship community of practice:** we will support peer learning and cross-fertilisation through convening sessions, at least annually, bringing all active groups together, with a first event after the completion of cohort 2 training, in October 2023. We will also continue to convene the monthly community of practice meetings, which provide a platform for discussion of different system programmes and sharing of stewardship work.
- **Protected time**: we will continue to proactively support stewardship group members to contribute up to 4 sessions per month to stewardship work, identifying and addressing any issues together with stewards as they arise.
- **Connection with Alliances:** this may be based upon stewardship groups supporting upstream approaches which are rooted in integrated neighbourhood teams. We will also work with Alliance teams to further consider how stewardship ethos and artefacts may support place-based work.
- **Connection with Community and Voluntary Sector**: this large, active and important sector plays an important role within health and care pathways. We will work to scope opportunity for greater alignment and involvement with the stewardship model.

6. System change:

There are number of aspects of system change which will be needed in order to unlock further progression over the next 12-18 months. These relate particularly to operationalising resource management at the level of whole care areas, and to mainstreaming the influence of existing stewardship groups.

- **Resources**: we will work to secure and accelerate commitment to care area budgets by turning on flow of resource data within the system. Once established, we will work with stewards, colleagues within Resources teams, and the system Costing Hub to develop greater understanding of resource use at care area level.

- **Host organisation:** we will work with our system's senior leaders to develop a pilot for a host organisation model, likely focusing on the stroke care area as the first option. This will enable testing and adoption of arrangements for
    - Taking budgetary responsibility
    - A host organisation's role in working with a stewardship group to determine resource allocation and consumption (e.g. financial and human resources)
    - Accountability for outcomes

  We will also support work to explore the necessary delegation and contractual mechanisms, assurance process and governance framework.
- **Scrutiny**: we will articulate the process and requirements for developing, reviewing and approving stewardship proposals, including routes involving existing organisational and/ or system governance depending on whether different thresholds are involved. This is likely to be further developed iteratively as we accrue system experience of hosting care areas.
- **Programme resource:** we will support work by potential host organisations to identify staff capacity requirements needed in order to operationalise care area hosting and to enact specific stewardship proposals. This may involve finance, BI and analytical, community engagement, service transformation and other disciplined methodologies. We will also explore possible configurations of this 'virtual team' involving existing staff at host organisation and system levels. Our approach is again likely to be iterative, ensuring that we test and learn as a system.
- **Mainstreaming:** we will work to bring cohort 1 stewardship groups (including Ageing Well, Cancer and Urgent and Emergency Care groups) more closely into current BAU decision-making processes, so that they are meaningfully engaged and involved in any significant decision-making within their care area.

  Recognising their demonstrable ability to add value to such decision-making processes, stewards should support and actively contribute to decision-making, particularly involving choices over significant levels of health and care resources. To do so, they will need access to timely information, active presence in key decision-making groups and the strong, mutually supportive relationships with senior leaders.

  This will also be further enabled by system engagement work (see 5.3) to promote widespread awareness of stewards' identity, purpose and impact.

7. Where do we want to be in five years' time?

In the first Stewardship White paper in February 22, we outlined 3-5 year aims. These have now been updated and included in this paper.

7.1 For the system:

- A culture of stewardship is a hallmark of the ICS and underpins everything that it does.
- Stewardship has buy-in from every part of the ICS as the best available mechanism for promoting the triple aim of improved population health and wellbeing, improving service provision and outcomes, and sustainably managing the use of resources.
- A 'hosting model' has created the conditions enabling collaboration with clear lines of accountability across the supply chain, and every stewardship group is hosted.
- Population outcomes that matter to people locally are being tracked and improvements have been measured and recognised.
- Twenty-five care areas in place, managed through the stewardship approach.

7.2 For stewardship groups

- Stewardship groups, working in partnership with host organisations, are the custodians of resources for the population, and resources have begun to shift from higher to lower acuity settings.
- They have access to expertise and knowledge from across all sections of care pathways.
- They are visionary and focus on “big, hairy, audacious, goals”.
- They have a clear and evolving blueprint for their care area, based on both national best practice and ‘leading edge’ practice across the world, their pooled experience and expertise, resident voice, and their value framework. Based on these sources of information, they should articulate how they see the care area working optimally and where resources should be channelled, updating this via annual care area reports.
- They specify and promote common clinical standards and policies across the system.
- Evidence, for example via stewardship dashboards, is used routinely to understand variation in resource use, burden of disease, service activity and outcomes within their population, benchmarking against populations in other systems.
- They have a close relationship with their host organisation and wider care area community, which provides them with a route for implementing their blueprint.
- Groups routinely engage with their population to design and resource services according to the outcomes they value.
- Groups produce regular annual reports on service value and performance, including narrative, quantitative review and priority-setting.
- Stewardship groups work with the existing groups and functions within the care area to review the deployment of resources, including staff, estate and resources.
- Each group has a team, a team leader and programme manager, with access to finance, PHM analytical and community engagement support when they need it. They will draw on the disciplined methodologies, such as ethnography, ideation, and service transformation.
- Groups have close working relationships, meet regularly and challenge each other.
- Groups aiming to improve health and wellbeing overall, and adopting an emphasis on shifting system activity upstream, towards preventative approaches promoting health behaviours and environments.
- Groups work with cross- care area functions (e.g., alliances) on models for prevention and management of multi-morbidity.

7.3 For citizens

- Citizens are active participants in the partnership between the ICS and the 1.2 million people in Mid and South Essex
- They are empowered to improve their own health and wellbeing, due to the commitment of stewardship groups to moving resources upstream, enabling greater resource flow towards tackling the wider determinants of health.
- They are ever more present within health and care service planning due to the use of linked data sets and a population segmentation approach, which better represent individual and group care needs, in prioritising resource use.
- They are routinely engaged in redefining the concepts of value which health and care services seek to deliver (for instance, in balancing improved health at a population level and personalised care at an individual level)

Part I ICB Board meeting, 16 March 2023

Agenda Number: 9

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

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not 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.
- Note the recent Care Quality Commission (CQC) inspection and findings, and the ICB oversight processes for supporting improvement of services.
- Note the recent findings in the CQC Maternity Survey and the Local Maternity and Neonatal Board oversight processes for supporting improvement in maternity care.
- Note the planned CQC and Ofsted Inspection of Southend Special Educational Needs and Disabilities (SEND) services.

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. CQC Findings - Mid and South Essex NHS Foundation Trust

2.1 The ICB Board has been made aware of the recent CQC inspection at Mid and South Essex NHS Foundation Trust (MSEFT). Following an unannounced focussed CQC inspection of MSEFT core services between 18 August to 21 September 2022 and a 'well led' inspection on 11 and 12 October 2022, the Trust was rated as 'Requires Improvement'.

2.2 Subsequently, the CQC undertook an unannounced inspection of medical care across all three sites at the Trust on 24 and 25 January 2023.

2.3 On 26 January 2023, the CQC requested that the Trust undertook urgent action to improve the care provided to those patients with mental health concerns, and the nutrition and hydration of patients. Immediate action was undertaken by the Trust and an action plan was submitted to CQC on 27 January 2023.

2.4 A follow-up unannounced CQC inspection to all three sites was undertaken on 7 February 2023, which focussed on the areas of concern identified at the previous inspection on 24 and 25 January 2023. Subsequently, a Section 29A notice was issued on 24 February 2023 requiring improvements to be made by 15 May 2023, in the following areas:

- Documentation of risk assessments including assessment of mental capacity and the management of Deprivation of Liberty.
- Nutrition and hydration of patients.
- Ensuring the environment and equipment is suitable for the patients being cared for – CQC identified ligature points i.e. coat hooks, and equipment such as hoists that required servicing.
- Governance - actions relating to poor compliance with audit and training.

2.5 The ICB Quality Team have commenced a series of quality assurance visits focused on the key themes identified by CQC, to gain assurance that improvements are being made and embedded in practice.

2.6 A Rapid Quality Review meeting has been organised for 27 March 2023 with representation from the Trust, NHS England (NHSE), CQC, General Medical Council, Nursing & Midwifery Council, Local Authorities and HealthWatch. The remit of the meeting is to gain assurance that appropriate actions and mitigations have been undertaken by the Trust to ensure safe care, following findings identified by CQC, and to identify additional support the Trust may require.

2.7 Progress against the CQC action plan will be monitored via the MSEFT CQC Programme Group, the Quality Improvement Board and the Maternity Assurance

Committee. A newly set up meeting, Quality Together, will allow the Trust, ICB and NHSE to have a deeper discussion about quality concerns and progress of improvements against trajectories set.

2.8 The Trust's undertakings, which set out specific improvements required by NHSE, are being reviewed on 27 March 2023 to reflect the findings found in the maternity element of the CQC inspection. 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.

3. CQC Maternity Survey 2022 (MSEFT)

3.1 The ICB Board has been made aware of the recent CQC Maternity Survey results. The ICB Quality Committee received a deep dive into maternity services at its meeting on 27 January 2023 and included detailed analysis of the survey results.

3.2 Nationally, women and other pregnant people who gave birth between 1 and 28 February 2022 were invited to take part in the survey. The recent national survey results have demonstrated that the experience of those using the services has deteriorated over the last five years.

3.3 Last year, MSEFT's maternity service was rated in the bottom eight trusts nationally. However, in the 2022 CQC Maternity Survey, the Trust saw an improvement in the survey results when compared to their peers nationally and are no longer rated as being amongst the bottom eight trusts. However, although it is acknowledged improvements have been made, more work is required to improve the experience of women and other pregnant people and their families accessing maternity care at the Trust.

3.4 MSEFT maternity services, when compared to other trusts:

- scored the same in all but one domain, which scored worse than expected.
- three scores have shown a statistically significant increase
- there was no deterioration of scores.

3.5 Areas identified for improvement were:

- Involving women in the decision to be induced.
- Partners or family being allowed to stay with the mother whilst in hospital.
- Having an opportunity to ask questions about their labour or birth in the postnatal period.

The Trust has now employed a Patient Experience Midwife who will be instrumental for developing and driving improvements in care.

3.6 The survey results and an improvement plan are being developed by the Trust maternity team and will be shared with the Local Maternity and Neonatal Steering Board (LMNSB) on 30 March 2023. The LMNSB will continue to monitor progress against the actions through regular reporting against actions at the LMNSB meeting.

4. Southend SEND CQC Inspection

4.1 The ICB Board has been made aware of the planned CQC and Ofsted inspection of Special Educational Needs and Disabilities (SEND) services provided at Southend. The inspection is due to take place between 2 to 10 March 2023. It will be the first inspection within the East of England using the new SEND Inspection Framework 2, recently launched in January 2023.

4.3 All of the three Local Areas were last inspected under the previous SEND Framework 1. The most recent inspections to Essex County Council (May 2022) and Thurrock (Dec 2021) demonstrated improvements had been made.

4.4 Southend was last visited in 2021. Although sufficient progress in 2 of the 3 areas, they remained under an Accelerated Improvement Plan.

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

5. Conclusion

5.1 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.

6. Recommendations

6.1 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.
- Note the recent Care Quality Commission (CQC) inspection and findings, and the ICB oversight processes for supporting improvement of services.
- Note the recent findings in the CQC Maternity Survey and the Local Maternity and Neonatal Board oversight processes for supporting improvement in maternity care.
- Note the planned CQC and Ofsted Inspection of Southern SEND services.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 10

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

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 90th centile and mean response times for the East of England Ambulance Service for each of the four categories of calls and respective standards for January 2023.

East of England Ambulance Service
Mean and 90th centile response times for January 2023

Category		Mean	90th centile
Category 1 mm:ss	Standard	<= 7min	<= 15min
	Actual	9:13	17:32
Category 2	Standard	<= 18min	<= 40min
	Actual	49:03	01:46:15
Category 3 hh:mm:ss	Standard		<= 02:00:00
	Actual		04:28:28
Category 4 hh:mm:ss	Standard		<= 03:00:00
	Actual		06:22:10

[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	26,212		
	Breaches	9,881	10,342	10,009	10,605	10,077	10,754	11,852	12,148	14,665	10,123		
	Performance	64.9%	66.8%	66.5%	64.5%	63.5%	61.2%	60.4%	59.0%	52.6%	61.4%		

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

Diagnostic Test Name	Total Waiting List	6+ Weeks	13+ Weeks	% waiting 6+ weeks	% waiting 13+ weeks
Magnetic Resonance Imaging	6,227	2,605	503	41.8%	8.1%
Computed Tomography	6,259	2,801	1,239	44.8%	19.8%
Non-obstetric Ultrasound	11,650	5,394	2,238	46.3%	19.2%
DEXA Scan	1,199	529	113	44.1%	9.4%
Audiology - Audiology Assessments	2,145	1,146	679	53.4%	31.7%
Cardiology - Echocardiography	2,916	1,071	76	36.7%	2.6%
Neurophysiology - Peripheral Neurophysio	453	266	239	58.7%	52.8%
Respiratory physiology - Sleep Studies	474	187	91	39.5%	19.2%
Urodynamics - Pressures & Flows	39	4	0	10.3%	0.0%
Colonoscopy	1,061	259	48	24.4%	4.5%
Flexi Sigmoidoscopy	335	98	19	29.3%	5.7%
Cystoscopy	187	103	74	55.1%	39.6%
Gastroscopy	911	215	79	23.6%	8.7%
Total	33,856	14,678	5,398	43.4%	15.9%

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 (December 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%)	
60.9%	45.5%	60.9%	85.5%	92.6%	92.4%	63.6%	43.4%	73.3%	51.0%

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 at December 2022, there was 1 patient waiting 104+ weeks, 803 patients waiting 78+ weeks and 12,097 patients waiting 52+ weeks on an RTT pathway at MSEFT.

The Elective Board oversees RTT assurance.

Actions undertaken include:

- Gooroo and Patient Plus data management systems to be fully implemented across MSEFT sites to support through automation strict operational scheduling and booking of patients by priority and then chronological. This is an essential process to recover backlogs.
- Daily PTL meeting in place with each specialty including:
  - 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 outlining 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 published November 2022 at 100%.

3. Findings/Conclusion

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

4. Recommendation(s)

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

Part I ICB Board meeting, 16 March 2023

Agenda Number: 11

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

William Guy, Director of Primary Care.
Jack Short, Interim cover for Ed Cox (Director of Clinical Policy)

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 Primary Care Network (PCN) Clinical Strategy Development

PCN clinical strategies on track for completion by the end of March 2023. Through our Alliances these will align our GP element of primary care with the overall vision at set out within the Fuller Stocktake and provide clarity of local priorities as we mature towards future Integrated Neighbourhood Teams (INTs).

The strategy to fully integrate at a neighbourhood level is one that there is consistent alignment with. However, there are varying levels of understanding around what the "integration" looks like within our neighbourhood. The next section sets out an approach to work through each element systematically to deliver our goal.

2.2 Evolution towards Integrated Neighbourhood Teams

The Fuller Stocktake review clearly sets out the ambition for all out-of-hospital health services to be delivered by a single neighbourhood team. Although we have many great examples of teams working together the work required to move towards "fully integrated" is relatively early on in its journey. 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.

Our approach, informed by the review of our transformation requirements by the Porthmeor Group (January 2023) will focus on creating a framework that can be used to build a team from teams focussing on the needs of their local populations. This framework will be co-developed with the Alliances and this phase will establish:

- A methodology to enable the change needed locally based on leadership and team development and co-production.
- The evolution of existing team working.
- The population health data and data sharing to ensure priorities are focused on need.
- The membership of integrated neighbourhood teams for the NHS and other partners.
- The outcome measures.
- The future options on organisational and employment structure.

In addition, this framework will agree areas of design where there needs to be local freedoms. These will include:

- How teams work together, expansion of roles, use of Additional Roles Reimbursement Scheme (ARRS).
- Priority areas of focus based on local needs.
- Co-production methodologies with local people.
- Work with local VCSE.

- Leadership structure.
- Employment and organisational structure chosen from ICB framework options.

Once the framework has been approved the detailed evolution will be led by the Alliances and developed bottom-up with their Neighbourhood partners.

2.3 Oversight and Governance of the delivery of Fuller/INTs

The scale of this transformation is huge and plans to push integration further than previous models. Therefore there is a need to ensure that we collate and formalise the current transformation strategies, delivery and oversight governance to effectively manage the programme. This is currently in development and will utilise existing structures such as the Primary Care Network Delivery and Development group with the plan to continue to report into the Primary Care Commissioning Committee.

The accountability of the overall programme will need to remain with the ICB, and the Alliances will oversee local delivery through the individual neighbourhoods. To assist the oversight a new 8c role has been created to help lead the Fuller advocacy, engagement and delivery across Mid and South Essex.

2.4 Local Progress

Key enablers such as Digital, Estates, Information Governance and Workforce will be critical to delivering a timely delivery of the Fuller Stocktake objectives. Building on the strategy work underway within PCNs and wider system wide approach is central to the future transformation efforts.

PCNs continue the establish and implement patient participation groups (PPGs).

Notable progress at each place includes:

- **Mid Essex**: The new roles jointly employed by NHS, Essex County Council (ECC) and Provide have started to take up their positions and will lead the development of integrated neighbourhood teams. Work continues in Aegros, Dengie and South Woodham and Chelmsford West PCNs to develop new models of personalised care for complex patients.
- **Basildon and Brentwood**: At a place level developing asset based approach to deliver on neighbourhood needs taking advantage of community connectors to facilitate. Activating teams around PCNs for example the Brentwood PCNs "IMPACT scheme" for frail patients with complex needs. Many other pieces of work in the pipeline include a focus on mental health needs in West Basildon.
- **Thurrock**: Continue to develop their models of care which will improve access for patients with complex needs and improve management and prevention of obesity and cardiovascular disease (CVD). Widespread engagement underway with other partners to jointly build a strategy that is meaningful to the people of Thurrock. The Programme Director role has been extended for an additional 3 months to drive forward changes locally.
- **South East Essex**: The PACT model for frailty and complex needs patients continues to evolve in Benfleet and SS9, providing the basis for further implementation in other areas. West Central PCN are exploring and plan to refocus ARRS staff to support its delivery Alignment of wider workforce and neighbourhood to deliver Fuller completely in some areas.

2.5 Funding and Incentivisation

The Working Together scheme is to be reframed under the INT programme banner in order for all conversations to be aligned toward delivery of a mutual ambition.

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.

Access to the remaining 2022/23 PCN funds are to be dependent on PCNs' commitment and ability to demonstrate a plan to deliver impactful developments across the three Fuller pillars (Complex Care, Urgent and Episodic and Prevention) as well as engagement in the wider development of INTs. The Primary Care team are working with the Alliances and PCNs to formalise this with proposals returning to Board for sign off.

The Local Winter Access Fund has been rolled out to secure additional longer consultations for complex comorbidity/pharmacology patients. This has been well received by primary care providers. We are on track to deliver an additional 13k consultations as a result of this initiative.

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.

2.6 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 – January across the last four years. Overall consultations are 7% in 2022/23 compared to the pre-pandemic 2019/20 position. This equates to 347k additional consultations. There has also been a year-on-year increase in comparison to the 2021/22 activity levels with an additional 145k consultations compared to last year.

Consultation Method	April - Jan 19/20	April - Jan 20/21	April - Jan 21/22	April - Jan 22/23
Face-to-Face	4,089,120	2,497,229	3,260,239	3,794,565
Home Visit	10,672	4,923	7,975	15,797
Telephone	472,309	1,670,553	1,525,841	1,065,528
Video Conference/Online	131,659	59,422	58,453	102,822
Unknown	133,841	121,663	187,059	206,748
Total	**4,837,601**	**4,353,790**	**5,039,567**	**5,185,460**

Consultations by Alliance

Alliance	Consultation Method	April - Jan 19/20	April - Jan 20/21	April - Jan 21/22	April - Jan 22/23		
Basildon and Brentwood	Face-to-Face	878,225	532,900	789,972	958,598		
	Home Visit	135	2	1,384	2,999		
	Telephone	92,296	366,430	307,272	218,332	Net Change on Pre Pandemic	Net change on 21/22
	Video Conference/Online	32,371	23,320	9,563	12,083		
	Unknown	41,311	26,592	38,235	37,394		
	Total	**1,044,338**	**949,244**	**1,146,426**	**1,229,406**	**185,068**	**82,980**
Castle Point and Rochford	Face-to-Face	592,902	423,906	533,224	590,608		
	Home Visit	-	-	192	743		
	Telephone	27,747	162,778	168,203	118,753	Net Change on Pre Pandemic	Net change on 21/22
	Video Conference/Online	34,967	1,937	4,936	11,209		
	Unknown	12,500	11,637	16,594	16,497		
	Total	**668,116**	**600,258**	**723,149**	**737,810**	**69,694**	**14,661**
Mid Essex	Face-to-Face	1,427,901	867,011	1,039,313	1,199,555		
	Home Visit	4,610	3,167	3,073	8,686		
	Telephone	158,868	573,802	537,231	377,379	Net Change on Pre Pandemic	Net change on 21/22
	Video Conference/Online	27,914	15,433	28,673	47,944		
	Unknown	42,866	43,927	60,754	75,618		
	Total	**1,662,159**	**1,503,340**	**1,669,044**	**1,709,182**	**47,023**	**40,138**
Southend	Face-to-Face	590,071	317,355	453,107	507,323		
	Home Visit	2,406	1,446	3,098	3,272		
	Telephone	55,141	261,071	231,426	145,174	Net Change on Pre Pandemic	Net change on 21/22
	Video Conference/Online	25,627	16,225	11,816	25,416		
	Unknown	13,165	13,772	18,239	13,977		
	Total	**686,410**	**609,869**	**717,686**	**695,162**	**8,752**	**- 22,524**
Thurrock	Face-to-Face	600,021	356,057	444,623	538,481		
	Home Visit	3,521	308	228	97		
	Telephone	138,257	306,472	281,709	205,890	Net Change on Pre Pandemic	Net change on 21/22
	Video Conference/Online	10,780	2,507	3,465	6,170		
	Unknown	23,999	25,735	53,237	63,262		
	Total	**776,578**	**691,079**	**783,262**	**813,900**	**37,322**	**30,638**

We have continued to see an increase in face-to-face rates. In January 2023, 77% of all consultations were face to face.

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 – January 2022/23);

Period	MSE ICS	National
Same Day	42% (increase on previous period)	43.7%
Within 1 Day (cumulative)	50.1% (increase on previous period)	51.9%
Within 14 days (cumulative)	83.5% (increase on previous period)	84%

2.7 Workforce

Comparative data from January 2022 to January 2023 shows a small growth in the total number of whole time equivalent (WTE) staff in primary care, rising from 2,469 to 2495. Increases have been seen in both GPs other non-admin (e.g receptionists). MSE has 8

more salaried GPs than this time last year and 22 GP training grades but numbers of fully qualified GPs have increased by only 1 WTE. There has been a small decrease in the number locums as a result. Nursing has seen small decrease in the number of both Advanced Nurse practitioners (-3) and Practice Nurse (-5).

Direct Patient Care staff (Therapists, Phlebotomy, Healthcare Assistants etc) have also seen an overall drop in number. It should be noted that the data for this group was incomplete in both years.

Rises in non-admin staff driven by an increase in the numbers of support staff such as receptionists despite there being a decrease of 6 in the number of Managers.

A summary is provided below

General Practice Workforce	FTE		Variance
	2022	2023	
All GPs	611	634	23
All Nurses	300	292	-8
Direct Patient Care	269	256	-13
Non-Admin	1289	1313	24
Total	**2,469**	**2,495**	**26**

3. Findings/Conclusion

We continue to make significant progress towards the ambitions set out in the Fuller stocktake. The next quarter is critical in defining the INT landscape across Mid and South Essex and identifying the transformative requirements in each of our Neighbourhoods.

4. Recommendation(s)

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

Part I ICB Board Meeting, 16 March 2023

Agenda Number: 12

Month 10 Finance Report

Summary Report

1. Purpose of Report

To report on financial performance for the ICB at Month 10 (M10) and offer a broader perspective on outturn across partners in the Mid & South Essex system (period ending 31 January 2022).

2. Executive Lead

Jennifer Kearton, Director of Resources.

3. Report Author

Resources Team.

4. Committee involvement

The M10 ICB position was reviewed by the Finance and Investment Committee on 8 March 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. Conflicts of Interest

None identified.

6. Recommendation

The Board is asked to note the Finance report.

Month 10 Finance Report

1. Introduction

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

Our wider Health and Social Care position including Essex County Council, Southend City Council and Thurrock Council, is brought together for information and discussion within the MSE System.

This paper provides the Board with detail of the Financial Performance of the MSE ICB and information on the overall MSE System.

During January the Board received the M8 Finance Report. The report presented a year-to-date deficit of £55.7m as result of sustained system pressures manifest in our Acute sector.

The report noted that the M8 deficit position made it increasingly difficult to assert breakeven by the year end. The report confirmed that regional and national escalation discussions had concluded, and the system was planning to adjust its forecast outturn position during M9.

A negotiated stretch forecast outturn position of £46.4m deficit was reported at M9, (£16.8m surplus ICB, £63.2m deficit MSEFT and EPUT breakeven). Management actions have been identified and agreed through relevant organisations' governance, with system oversight from the Chief Executive Forum. The Board reviewed the position during seminar sessions in December 2022 and February 2023.

Officers within the system continue to work with regional colleagues to respond to the conditions set out nationally in respect of changes to revenue forecasts in year.

The following paper provides the Board with the latest financial position at M10.

2. Key Points

2.1 Month 10 ICB financial performance

Table 1 below summarises the month 10, financial position for the ICB.

After adjustment for the two reimbursement programmes still in operation during 2022/23, the ICB is anticipated to deliver its agreed improved forecast outturn position of £16.8m (no change from M9, £16.8m improvement on M8). The majority of the ICB improvement is driven by the release of the system risk reserve, this reserve has been held throughout the year on behalf of the system.

Table 2 below summarises the changes to the revenue allocation between M8 (the last position reported to the board) and M10. All additional allocations (22.4m) in the period have been non-recurrent in nature.

Table 1

Expenditure	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Outturn Plan £m	Forecast Outturn Actual £m	Forecast Outturn Variance £m
Revenue Resource Limit	(1,413.9)			(1,830.8)		
Acute Services	750.1	752.0	(1.9)	963.2	968.1	(4.9)
Mental Health Services	133.1	134.9	(1.8)	173.1	176.2	(3.1)
Community Health Services	134.2	143.8	(9.7)	173.6	180.5	(6.9)
Continuing Care Services	62.6	74.3	(11.7)	80.5	93.6	(13.0)
Prescribing	118.0	124.0	(6.0)	151.7	159.3	(7.6)
Primary Care	136.5	133.0	3.5	184.6	184.6	0.0
Other Commissioned Services	12.2	9.9	2.3	15.9	14.5	1.5
Other Programme Services	8.2	13.7	(5.5)	25.2	21.9	3.3
ICB Running Costs	14.4	15.3	(0.9)	18.3	19.5	(1.2)
Total ICB Net Expenditure	1,369.2	1,400.9	(31.7)	1,786.1	1,818.1	(32.0)
ARRS and Discharge Funding Reibursement		(1.0)			(4.1)	4.1
ICB Surplus	(44.7)	(13.0)	(31.7)	1,786.1	(16.8)	(27.9)
M1-3 CCG Combined Revenue Resource Limit	(509.1)			(509.1)		
M1-3 CCG Combined Expenditure	553.8	509.1	44.7	553.8	509.1	44.7
M1-3 CCG (combined) Surplus/(Deficit)	44.7	0.0	(44.7)	44.7	0.0	(44.7)
TOTAL ICS Revenue Resource Limit (ICB + CCG)	(1,922.9)			(2,339.9)		
TOTAL ICS Net Expenditure	1,922.9	1909.9	13.1	2,339.9	2,323.1	16.8
TOTAL ICS Surplus/(Deficit)	1,922.9	1,909.9	13.1	0.0	2,323.1	16.8

Table 2

Revenue Allocation	**Recurrent £m**	**Non - Recurrent £m**	**Total £m**
Allocation at Month 8	1626.5	181.9	1808.4
Primary Care Transformation and Other		10.3	
Discharge Funding		2.2	
Clinical Diagnostic Centre Funding		3.9	
Digital adjustments		1.5	
Cancer		0.9	
Pensions Adjustments		0.9	
Other Service Development and Specific adjustments		2.7	
Total Allocation at month 10	**1626.5**	**204.3**	**1830.8**

2.2 ICB Risk

Various risks to the financial position emerge and are managed throughout the financial year. Table 2 below presents our three key risks and the best, likely and worst-case impact on the ICB financial position at M10. Risks have been mitigated in year. In the worst-case scenario, we may experience additional inflationary pressures specifically across continuing health care (CHC) and prescribing that will outstrip our ability to mitigate. In the best-case scenario, the pressure will be lower, and our mitigations will continue to be available therefore improving the ICB financial position. There has been no change to the risk position since M9.

Table 2

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 planned 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. Overall budgets are delivering in line with plans and the ICB is reported as delivering both its year to date and forecast outturn efficiency challenge.

Table 3

Area of Efficiences	Year to Date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Contract Changes	2.2	2.2	0.0	2.6	2.6	0.0
Prescribing	7.0	7.0	0.0	8.4	8.4	0.0
Continuing Care	2.8	2.8	0.0	3.3	3.3	0.0
Running Cost Review	0.4	0.4	0.0	0.5	0.5	0.0
Other	0.7	0.7	0.0	0.8	0.8	0.0
Total	**13.0**	**13.0**	**0.0**	**15.6**	**15.6**	**0.0**

2.4 ICB Finance Report Conclusion

The ICB is forecasting to deliver a surplus position of £16.8m and is on track to deliver this. Whilst there are some risks to the position, mainly driven by inflationary pressures in our CHC market, the ICB is managing and mitigating. Efficiencies continue to deliver on plan.

2.5 Month 10 System Financial Performance

At M10 the overall health system position is a deficit of £45.9m. The system has a 3-month average run rate of £3.2m deficit and is anticipating central funding of £6m in month 12 which will support the delivery of the forecast deficit of £46.4m.

Our Local Authority Partners are reporting a forecast deficit of £17.7m, a £2.0m improvement from the position reported last month. Essex County Council £2.9m, Southend City Council £9.0m and Thurrock Council £5.7m (Thurrock Council's position is as at month 9, Southend and Essex at M10). Councils are experiencing pressure across children's services because of higher demand for placements. Adult Social Care budgets also continue to experience high and rising costs for social care packages.

2.6 System Risk Position

As previously reported, whilst the system was forecast to breakeven a significant amount of unmitigated risk was being reported. With the movement to a system deficit this risk has been realised into the position and therefore the system is currently reporting a balanced net risk position. Table 4 presents the latest System risks and mitigations position.

Table 4

Area of Risk	Risks £m	Mitigations £m	Net Risk Position £m
Net lost trading income	(0.3)	0.3	0.0
Additional cancer services costs	(4.0)	4.0	0.0
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)
Contract challenges	(0.1)	0.1	0.0
Non Recurrent Mitigations	0.0	9.9	9.9
Other	(0.2)	0.2	0.0
Total	(14.9)	14.9	0.0
2022/23 Plan	(143.4)	57.7	(85.7)
Movement	128.5	42.8	85.7

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 £29.3m (85% a 3% increase on the previous reported position).

The MSE FSP, is targeted to deliver £49.7m. At month 10 forecast delivery is £14.1m (28%) a further £26.7m has been identified, however, plans are not at a mature enough stage to provide confidence of in year delivery.

At month 10 the total forecast outturn delivery against the efficiency target of £84m is £44.2m (53%).

2.7 System Capital Position

The forecast capital investment for providers for 2022/23 increases by £11.5m to £103.5m this month following additional funding, an increase from the £90m (including Primary Care £2m) submitted at planning stage.

At the request of NHSE Systems reprofiled their capital plans during quarter 3. The system is now showing an overspend of £11.4m, year to date, due to accelerating some programmes. The profile of spend in respect of capital projects is anticipated to deliver largely to plan by the end of the financial year.

2.8 System Report Conclusion

After a thorough review of the forecast outturn position including external support and Chief Executive oversight, the System has agreed and negotiated a change to its forecast outturn position to a stretching target of £46.4m deficit. Our M10 position is on track to deliver this outturn position by 31 March 2023.

The system is now mobilising its response to the forecast change protocol and efforts continue to ensure our financial plan position for 2023/24 is fully triangulated with activity and workforce plans so the system has a complete understanding of how we move forward together to deliver financial stability.

3. Recommendation(s)

The Board is asked to note the Finance report.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.1

Pharmacy, Optometry and Dental (POD) Delegation

Summary Report

1. Purpose of Report

To provide the Board with an overview of the proposed Delegation of Pharmacy, Optometry and Dental (POD) Services from NHS England (NHSE) to Integrated Care Boards (ICBs) from 1 April 2023, to summarise the arrangements for the management of these functions, and to seek the Board's approval for Delegation.

2. Executive Lead

Dr Ronan Fenton, Medical Director.

3. Report Author

William Guy, Director of Primary Care

4. Responsible Committees

Oversight of the Delegation of POD Services has been undertaken by:

- Primary Care Commissioning Committee.
- Executive Committee.
- Delegation Board.
- Audit Committee.

5. Impact Assessments

Not applicable to this report

6. Financial Implications

The budgets for the Delegated Functions will be transferred to the ICB from NHS England. The final provisions are being confirmed.

7. Details of patient or public engagement or consultation

Not applicable to this report

8. Conflicts of Interest

None Identified

9. Recommendation(s)

The Board is asked to note the proposed Delegation of Pharmacy, Optometry and Dental Services from NHSE to ICBs and approve the MSE ICB receiving this delegation.

Pharmacy, Optometry and Dental Services Delegation

1. Introduction

In December 2022, NHS England confirmed that subject to final due diligence, Pharmacy, Optometry and Dental (POD) services would be delegated to Integrated Care Boards (ICBs) from 1 April 2023.

This arrangement will be underpinned by a National Delegation Agreement which sets out the roles and responsibilities of the Integrated Care Board and NHS England under the Delegated Arrangement. The latest draft of this is available to Board members upon request.

This follows the previous delegation of Primary Medical Services to the former Clinical Commissioning Groups and is likely to be proceeded by further delegation of other functions undertaken by NHS England such as Specialised Commissioning and Immunisation & Screening services.

The six ICBs in the East of England are taking a collective approach to the undertaking of POD commissioning functions. Under this arrangement day-to-day Pharmacy and Optometry Commissioning will be hosted by Herts and West Essex ICB on behalf of all six ICBs. Each ICB will take direct responsibility for day-to-day Dental commissioning.

NB. Whilst Herts and West Essex will host Pharmacy and Optometry commissioning, the accountability for these functions is delegated to each ICB. We have therefore made necessary changes to our governance arrangements to ensure relevant committees receive necessary assurance from Herts and West Essex ICB and can make decisions where recommendations are made that require ICB approval.

In preparation for delegation, a due diligence process has continued throughout 2022/23. This process has involved national and regional NHSE alongside all ICBs. The due diligence process has covered four key workstreams;

- Transformation and Quality.
- Governance and Leadership.
- Finance.
- Workforce Capability and Capacity.

This paper provides an overview of this approach and the arrangements made to enable Mid and South Essex ICB to undertake delegated functions with a focus on the governance arrangements being put in place.

2. Main content of Report

Delegation brings significant opportunity to improve outcomes and access to services for our population. However, our approach to preparation for delegation is to safely embed functions and stabilise before developing a local strategy that aligns to our ICB ambitions and then ultimately implementing that strategy. We are therefore taking the following approach;

- Safely embed, stabilise and ensure critical functions can be effectively undertaken from Day 1 of Delegation (i.e. 01/04/23) and be in a position to provide assurance to the ICB of these arrangements.
- Ensure all key known risks identified by our ICB, fellow ICBs or the Region are documented with suitable assurance/acknowledgement ahead of delegation.
- Through organisation development and partnership working use the first six months of delegation to strengthen our capability to undertake responsibilities.
- Through Q3 and Q4, develop strategies to transform services in line with our local transformation programme. This would include developing our functionality as a commissioner, quality assurance, clinical leadership.

Take delegation and ensure business critical functions are undertaken	Embed	Strategy Development	Ratify Strategy	Delivery Strategy			
Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25

Quality

Initially, the ICB will largely adopt the current approaches to Quality Assurance as in place within the NHSE regional team.

NB. Performer management (i.e. individual clinicians) across primary medical, dental, optometry and pharmacy services remains the responsibility of NHSE.

The ICB will evolve to a more proactive approach to quality assurance during 2023/24 and this will be commensurate with the intentions set out within our local strategies.

Quality assurance will be provided to the Quality and Safety Committee and Primary Care Commissioning Committee. The Terms of Reference for the Primary Care Commissioning Committee have proposed amendments that will be signed off in March.

There is no additional quality resource being transferred from NHSE to the ICB to support this process. However, we are in the process of recruiting an expanded Primary Care Quality Team to support these additional responsibilities.

The NHSE Complaints function for delegated services will transfer to ICBs on 1 July 2023. A focussed workstream is overseeing this process.

Governance and Leadership

Corporate Governance

The governance arrangements for undertaking POD responsibilities have been reviewed and required changes to governance documents for 01/04/23 have been identified. Please see **Appendix 1** for a summary of these changes.

Proposed primary care governance structure is set out at **Appendix 2.**

Proposed amendments to the Primary Care Commissioning Committee's Terms of Reference to reflect the broader range of responsibilities have been discussed and a proposed set of changes was presented to the February committee meeting.

Information Governance and Digital

Nationally and regionally, there is still a significant level of due diligence required to enable full business functionality in a safe and compliant approach.

The national and regional teams are looking at workaround solutions in the first instance, but this remains a high risk.

Finance

The ICB has been notified of an opening recurrent allocation, after growth and convergence, of £98,154k in relation to the 'to be' delegated services. The indicative provisions for each of the service groups is as follows:

	Total Indicative Allocation
Primary Dental	47,991,450
Community Dental	1,760,409
Secondary Dental	9,188,006
Pharmacy	22,977,075
Optom	11,439,972
	93,356,913

NHSE are leading on the budget setting and planning arrangements for 2023/24 with the ICB is yet to receive the detail for inclusion in our plans.

The headline risk to MSE ICB (as it is to all ICBs) is the cost pressure on Pharmacy budgets. Historically, this was offset through dental underspends. However, Dental budgets have subsequently been ring fenced for dental service and therefore this offset is no longer an option.

This issue has been collectively escalated to the region by the six ICBs and is being worked through with the national team.

Workforce Capability and Capacity

From 1 April 2023, a number of staff from the dental contracting team, residual staff from the primary medical services contracting team and finance team will 'TUPE' over to MSE ICB to support the undertaking of these functions.

On the 1 July 2023, the ICB will receive staff under TUPE arrangements from the Complaints service (at the same time responsibility for managing complaints moves to the ICB) and an underdetermined complement of Primary Care Transformation resources.

In addition to staff transferring from NHSE, MSE ICB has commenced the recruitment of 3x Band 5 WTE nurses to support the primary care quality assurance function (across POD and general medical services).

The ICB has received written confirmation from NHS England that identified POD staff transferring on 1 April 2023 will be added to ICB Running Cost allocations.

The TUPE over of a full complement of dental contractual staff will enable day to day contract management and oversight, continuity of relationships for providers and manage risk.

Whilst there has been a regionally led process of knowledge sharing and development of staff being 'TUPE'd', the previous structure for dental commissioning had subject matter experts on aspects of the commissioning programme. There will need to be continued collaboration across the ICBs to ensure that any gaps in knowledge and experience can be mitigated going forward. The ICBs are committed to working in this approach.

Key Risks

Financial Risk – There is a significant cost pressure on pharmacy budgets. This can no longer be offset by Dental underspends due to new ring-fencing arrangements. This issue has been escalated to the national team for resolution (this is a common risk to all ICBs).

Financial Risk – There is still work required for establishing a process for all transactional elements of POD to be effectively undertaken from 1 April 2023. Work around solutions are being considered but these need to be finalised (this is a common risk to all ICBs).

Information Governance (IG) and Digital – there is a significant amount of further due diligence required by NHSE IT/IG (supported by ICB Digital & IG staff) to ensure that all necessary IG arrangements and contractual arrangements can be put in place to allow TUPE'd staff to continue to access all necessary systems, data and files. There is a dedicated working group seeking to address this and the national team are supporting workaround solution development (this is a common risk to all ICBs).

Quality – The ICBs will be adopting approaches to quality assurance that are significantly different to those applied to other areas of our portfolio. As part of the development of strategies for POD, we will develop quality assurance processes commensurate to the service requirements.

3. Findings/Conclusion

Through due diligence processes, Mid and South Essex ICB has made a significant number of preparations for the forthcoming delegation of Pharmacy, Optometry and Dental services. These have largely been focussed on a controlled approach that initially focusses on embedding and stabilising these functions before undertaking strategy development to then maximise the opportunities that taking delegation presents. There remain several risks that continue to be mitigated.

4. Recommendation(s)

The Board is asked to note the proposed delegation of Pharmacy, Optometry and Dental Services from NHSE England to ICBs and approve MSE ICB receiving this delegation.

5. Appendices

Appendix 1 - Summary of required governance changes to undertake delegation.

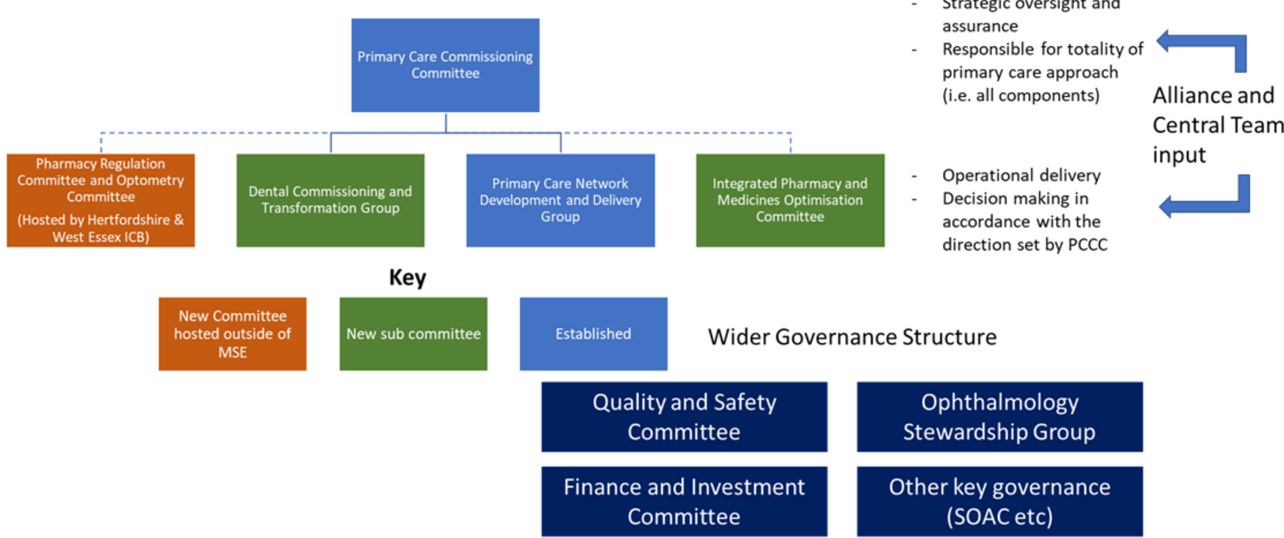
Appendix 2 – Proposed Primary Care governance structure

Appendix 1

Summary of required governance changes to undertake delegation and progress against this:

Requirement	Update	Tracker RAG rating
Constitution	No changes are required to our Constitution	
SORD	Minor changes – in progress	
Standing Financial Instructions	No changes required	
Committee Structures & TORs	In progress. Provisional discussions held, TORs being amended/developed - Changes required to PCCC - 1 new sub committee of PCCC "Dental Commissioning + Transformation Group" being established - 1 new committee reporting to PCCC and other committees "Integrated Pharmacy and Medicines Optimisation Committee".	
MOU with Herts and West Essex for Pharmacy and Optometry functions	Draft agreement agreed between ICBs and NHSE	
Delegation Agreement with NHS England	Current version shared by NHSE on 01/02/23 – being reviewed	
Governance Handbook	To be updated with changes outlined in this table	
Conflict of Interest Policy	No changes required. Any new Committee members will need to complete declarations.	
DPIA/Data Sharing Arrangements and Records	In progress – awaiting NHSE to complete first draft & finalise due diligence exercise	

Appendix 2



Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.2

Thurrock Alliance Terms of Reference

Summary Report

1. Purpose of Report

To seek the Board's approval of draft Terms of Reference for Thurrock Alliance.

2. Executive Lead

Aleksandra Mecan, Alliance Director, Thurrock
Les Billingham, Partner Member, Thurrock Council

3. Report Author

Aleksandra Mecan, Alliance Director, Thurrock.

4. Responsible Committees

The draft Terms of Reference were endorsed by Thurrock Integrated Care Alliance Board on 23 February 2023.

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to approve the draft Thurrock Alliance Terms of Reference.

Mid & South Essex Integrated Care Board (ICB) Thurrock Integrated Care Alliance (TICA) Committee Terms of Reference

1. Introduction

The key aim of the Alliance Committees is to bring key partners together 'at place' to create opportunities for people to live well. They will act as the interface between the ICB, ICP, Health & Wellbeing Boards, district and borough forums, PCNs and other bodies and take actions which improve health and wellbeing outcomes and reduce inequalities across their geography.

Thurrock specific Terms of Reference are presented for approval, which have been developed at a local level within each locality. Any substantial changes will be proposed by the Alliance and brought back to the Board for further approval.

As part of this process, the Chair for the Thurrock Alliance Committee will also be proposed to the ICB Chair.

2. Main content of Report

Within Thurrock Integrated Care Alliance Terms of Reference, we have set out, as a MSE ICS guiding principle, subsidiarity; that the starting point for planning, transforming, and delivering services should be at the most geographically local level practicable.

The work within Thurrock Alliance will reflect local priorities and relationships, and provide a greater focus on population health, integration of services around individuals' needs, and a focus on care and support provided in primary and community settings. The ICB recognises the Alliance as the primary planning footprint for both delivery of population health and integration of NHS, adult and children's social care services and community and voluntary sector services. This means that subsidiarity will require the delivery of locally developed integrated care models, programmes and policies, locally developed place strategy including the Thurrock Joint Health and Wellbeing Strategy 2022-2066, Better Care Together Thurrock – The Case for Further Change, Thurrock's Brighter Futures Strategy.

The Thurrock Alliance will also need to ensure delivery of agreed system standards, outcomes and common clinical policies for the people we serve.

It is important that Alliances continue to have local opportunity and flexibility to meet and continue with their agreed plans to meet the needs of the local population. For example, the formal Alliance Committee may meet only quarterly to transact any decisions and to provide assurance to the ICB on delivery of their responsibilities, but they may also choose to meet as they see fit at any point or frequency, through extended membership, or establish relevant groups, to focus on local priorities and on place-based development.

Unlike other places in MSE, Thurrock has had a strong Thurrock Integrated Care Alliance since 2018. It is agreed that this will act as the ICB's Alliance committee (or "place board") for Thurrock.

In order to comply with the agreement (at system level and within Thurrock) the Integrated Care Alliance Committee will initially work as a committee of the ICB (one of 5 permitted governance models for the Integrated Care System).

The draft TOR focus on the remit, responsibilities and operation of Part A of the TICA. It includes the need to support the current TICA transaction of ICB responsibilities, the business of TICA will be conducted through Part A and Part B sections of TICA meetings, with Part A limited to ICB specific business and appropriate voting rights assigned to committee members to support existing NHS governance rules. Part A of committee meetings are not designed to constrain work within the Alliance, but to license it to operate flexibly to deliver benefits within the framework of the ICB.

3. Recommendation(s)

The Board is asked to approve the draft Thurrock Integrated Care Alliance Committee Terms of Reference.

4. Appendices

Appendix 1 – Draft Thurrock Integrated Care Alliance Committee Terms of Reference

Mid & South Essex Integrated Care Board (ICB)

Thurrock Integrated Care Alliance Committee

Part A

Terms of Reference

We have set out, as a MSE ICS guiding principle, *subsidiarity;* that the starting point for planning, transforming, and delivering services should be at the most geographically local level practicable.

The work within each Alliance will reflect local priorities and relationships, and provide a greater focus on population health, integration of services around the individual's needs, and a focus on care and support provided in primary and community settings. The ICB recognises the Alliance as the primary planning footprint for both delivery of population health and integration of NHS, adult and children's social care services and community and voluntary sector services. This means that subsidiarity will require the delivery of locally developed integrated care models, programmes and policies, locally developed place strategy including *The Thurrock Joint Health and Wellbeing Strategy 2022-2066, Better Care Together Thurrock – The Case for Further Change, Thurrock's Brighter Futures Strategy.*

The Alliance will also need to ensure delivery of agreed system standards, outcomes and common clinical policies for the people we serve.

It is important that Alliances continue to have local opportunity and flexibility to meet and continue with their agreed plans to meet the needs of the local population. For example, the formal Alliance Committee may meet only quarterly to transact any decisions and to provide assurance to the ICB on delivery of their responsibilities, but they may also choose to meet as they see fit at any point or frequency, through extended membership, or establish relevant groups, to focus on local priorities and on place-based development.

Unlike other places in MSE, Thurrock has had a strong Thurrock Integrated Care Alliance since 2018. It is agreed that this will act as the ICB's Alliance committee (or "place board") for Thurrock.

In order to comply with the agreement (at system level and within Thurrock) that the Integrated Care Alliance Committee will initially work as a committee of the ICB (one of 5 permitted governance models for the Integrated Care System)[1]

This TOR focusses on the remit, responsibilities and operation of Part A of the TICA. IT includes the need to support the current TICA transaction of ICB responsibilities, the business of TICA will be conducted through Part A and Part B sections of TICA meetings, with Part A limited to ICB specific business and appropriate voting rights assigned to committee members to support existing NHS governance rules. Part A of committee meetings are not designed to constrain or the work within Alliances, but to license them to operate flexibly to deliver benefits within the framework of the ICB.

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[1] As described in "Thriving Places" NHS England 2021.

1. Constitution

This TOR focusses on the remit responsibilities and operation of Part A of the TICA. Part A meetings of the Thurrock Integrated Care Alliance will be established a Thurrock Alliance Committee (the 'Alliance' by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the ICB (Part A) and Thurrock Joint Health and Wellbeing Board (Part B). NHS bodies are not currently accountable to council committees and vice versa and hence Part A and Part B of the Thurrock Integrated Care Alliance will have different accountabilities and governance arrangements. These are described in more detail on pages 3 and 4.

The Committee members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB for Part A of committee meetings and Part A of the Committee is accountable to the ICB.

2. Authority

Part A of meetings of the Thurrock Integrated Care Alliance is authorised by the ICB to:

- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.

For the avoidance of doubt, the Committee shall comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD. The Committee will oversee matters arising from core purpose and functions of ICB that will be delegated from NHS England.

Part A will be aligned with Part B in considering how best to utilise resources made available through the Better Care Fund, described further in section 3, purpose of TICA

3. Purpose

The purpose of Parts A and B of the Thurrock Integrated Care Alliance is to contribute to the overall delivery of the ICB's and Health and Wellbeing Board's objectives to create opportunities for the benefit of local residents, to support health and wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board and Health and Wellbeing Board on the following:

- The aim of the Thurrock Integrated Care Alliance is to bring key partners together to provide the localism needed within the Mid & South Essex system to create opportunities for people to live well in Thurrock.

- This extends beyond the traditional boundaries of health and social care and incorporates wider system partners to tackle the social determinants of poor health and wellbeing with levelling-up in terms of outcomes and reduced disparities in conjunction with the Thurrock Joint Health and Wellbeing Board

- The key function of the Alliance is strategic oversight of the development, agreement and implementation of successful collective plans to transform, improve and integrate health, care, housing and third sector services to improve wellbeing outcomes for Thurrock residents, strengthening and further embedding existing collaborative arrangements.

- There is a recognition by all partners in the system that the social determinants of poor health and wellbeing need to be tackled by everyone levelled-up in terms of outcomes and reduced disparities. Developing this local partnership will support this.

- Where resources and funding have been aligned to the Thurrock Integrated Care Alliance by partner organisations, the Thurrock Integrated Care Alliance will recommend the best allocation of those resources and funding based on agreed priorities and ensuring appropriate good stewardship. Where possible, incentivised budgets will prioritise upstream preventative interventions that improve population health and address health inequalities. Where future governance allows, the Alliance will also seek to integrate funding historically separated by organisational budgets into single pooled funds.

- The work of the Thurrock Integrated Care Alliance will embody the principle of subsidiarity, that is, devolving power, decision making, and resources the lowest geographical level possible unless there is a clear need or benefit to commissioning and delivery of services over a wider geographical footprint.

- The Thurrock Integrated Care Alliance will act as the interface between the ICP, Health & Wellbeing Boards , PCNs, Thurrock CVS/ third sector and Healthwatch as well as communities in translating strategy and outcomes for the benefit of residents within the Alliance, PCNs and local communities. It will be driven forward by decisive leadership that holds itself to account, co-designs and co-produces new models of care in conjunction with residents and has clear accountability for delivery.

- Figure 1 below shows how the Thurrock Integrated Care Alliance governance operates in the context of the ICB

Figure 1 – Part A Governance

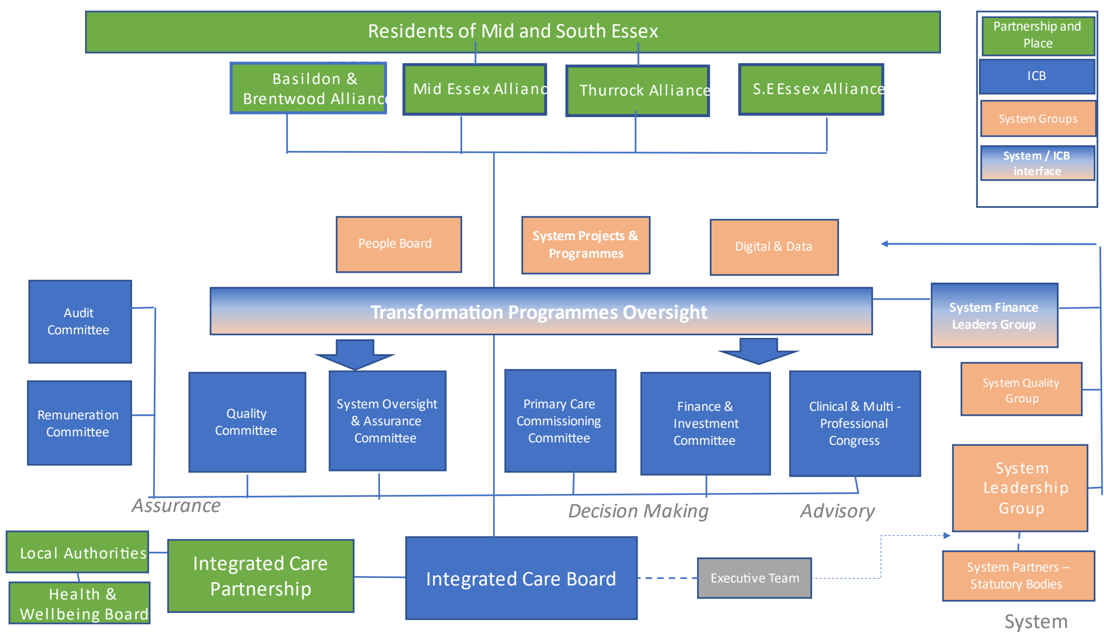
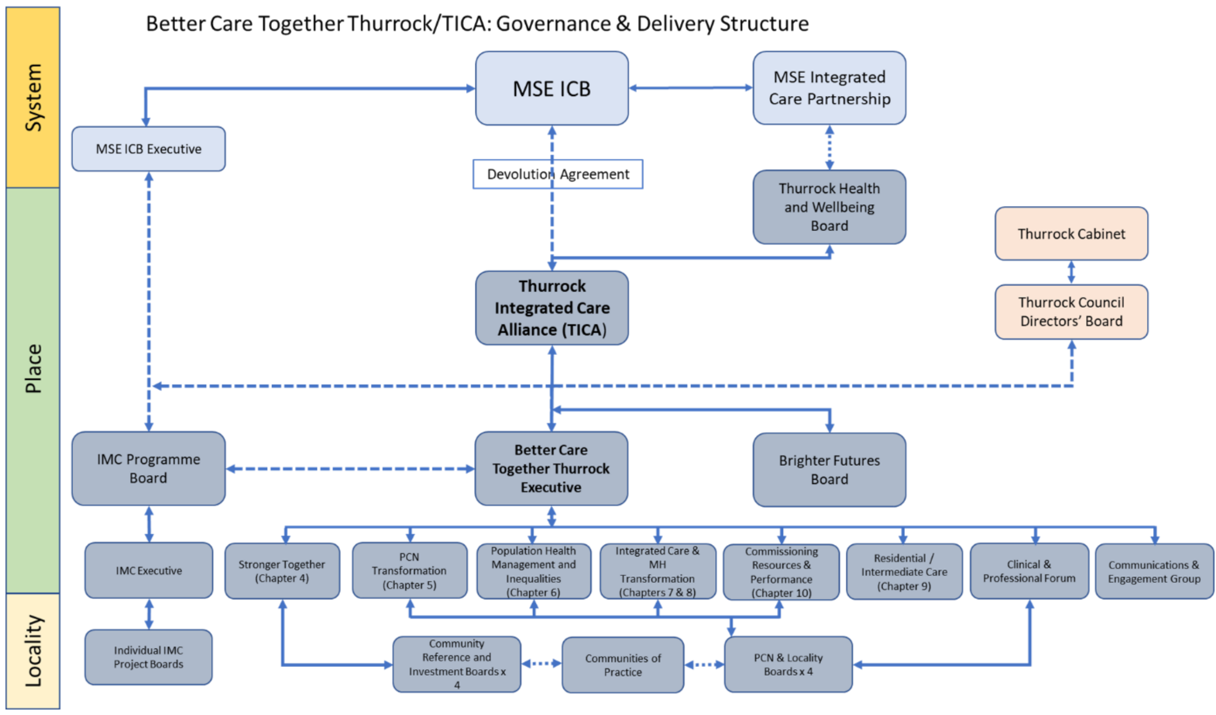


Figure 2 shows how the Thurrock Integrated Care Alliance operates in the context of wider governance and delivery mechanisms for locally developed existing strategy, including the Part B elements of the Alliance meetings.

Figure 2 – Part B Governance



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- The Thurrock Alliance will also provide the interface for advising those bodies of the vision for the Alliance, the priorities and how the Alliance will oversee delivery.
- The Thurrock Alliance will, using data and intelligence including resident engagement, stories and lived experience actions which improve health and wellbeing outcomes and reduce inequalities across its geography.

3.1 Duties

- The duties of the Alliance will be driven by
    - The integrated care strategy of the Integrated Care Partnership (ICP), the associated strategy and delivery plans of the ICB and the associated risks.
    - Locally developed strategy including the *Thurrock Health and Wellbeing Strategy 2022 to 2026*, *Better Care Together – The Case for Further Change, Thurrock Brighter Futures Strategy, Thurrock Housing Strategy 2022 to 2026*
    - Continuous resident engagement, co-design and co-production approaches

- An annual programme of business for both Parts will be agreed with the ICB and Health and Wellbeing Board before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

4. Membership and attendance

4.1 Membership

The Committee members able to act and vote in Part A of the meeting shall be appointed by the MSE ICB in accordance with the ICB Constitution. The Board will appoint no fewer than seven members of the Committee based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the ICB Board, but they may be.

The membership will comprise the following or, if they are unable to attend, their nominated representative: to be specific

Part A

- Primary care providers represented by PCN clinical directors or other relevant primary care leaders
- Appointed Alliance clinical leaders
- Local authorities senior and chief officers
- Providers of acute, community and mental health services, including representatives of Provider collaboratives where appropriate
- Representatives of people who use care and support services including Healthwatch
- Adult and children's social care professionals
- The voluntary, community and social enterprise sector (VCSE)
- The ICB e.g. relevant Director / nominated Senior Manager

4.2 Chair and vice chair

The Chair of the ICB in agreement with the Chair of the Thurrock Health and Wellbeing Board will appoint a Chair for both Part A and Part B of the Thurrock Alliance Committee who has the specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

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

4.3 Attendees

Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended by the following individuals who are not members of the Committee:

- ICB Executive Directors
- Council Directors and Assistant Directors
- Other health, care and third sector representatives where the Committee feels attendance is necessary to discharge the work and functions of the Alliance

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

Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from the Health and Wellbeing Boards, District and Borough Councils, Secondary and Community Providers and community and voluntary organisations.

4.4 Attendance

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

5. Meetings Quoracy and Decisions

The Thurrock Alliance Committee Part A will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned quarterly/bi-monthly/monthly subject to there being necessary business to transact. Additional meetings may take place as required.

- The ICB Board, Chair or Chief Executive and the Chair of the Health and Wellbeing Board may ask the Thurrock Integrated Care Alliance Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- In accordance with the ICB Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

5.1 Quorum

- For a meeting to be quorate a minimum of 50% of total members of the Committee are required, including the Chair or Vice Chair of the Committee.
- If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.
- If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

5.2 Decision making and voting

- The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.3 Urgent Decisions

- In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.
- Where this is not possible, an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).
- The exercise of such powers shall be reported to the next formal meeting of the Committee for formal ratification.

6. Responsibilities of the Committee

The Committee's duties can be categorised as follows:

6.1 Delivery of Alliance plans:

Part A:

- Propose Alliance plans, and secure agreement by ICB, in response to the place-based elements of the ICP strategy and ICB plan,
- Ensure relevant risks (including clinical and financial) are managed and mitigated as per the ICBs Risk Management Policy Framework.

6.2 Projects to support delivery of Alliance-based plans:

- Prepare and secure approval of business cases as per the delegation set out in the SORD and SFIs setting out the requirements and case for transformation projects in support of Alliance plans.
- Propose to the ICB business cases in excess of the committee's delegation as set out in the SORD and SFIs, and to Thurrock Council's Directors Board, Cabinet and Health and Wellbeing where local authority investment is required in excess of existing budgetary delegation as set out in the Council's constitution, setting out the requirements and case for transformation projects to support delivery of Alliance plans and the overarching priorities and plans of the ICB and Health and Wellbeing Board
- Monitor the delivery of agreed project objectives associated with transformation funds and undertake recovery actions where required.

Part B:

With the agreement of the Thurrock Health and Wellbeing Board, progress locally developed existing strategies that deliver on the Health and Wellbeing Strategy objectives

Parts A and B:

- Secure progress against the Alliance plan and provide assurance to the ICB and Health and Wellbeing Board that the plan is on target for delivery.
- Ensure operational delivery of the plan with all relevant partners.

6.3 Develop and agree a devolution framework between Thurrock and the ICB that clearly specifies what will be devolved and delivered from 'system' to 'place', what outcomes will be achieved, and associated decision making powers and resources to achieve those outcomes.

6.4 Ensure the development of integrated multi-disciplinary care as per agreed Alliance plans. This will include;

- Enabling people to access their shared digital care record to support joined-up, informed decisions around an individual's care

- Securing plans that are delivered by a capable, confident workforce which is planned in a way that allows services to wrap around individuals, their families, and carers.

6.5 Ensure strategic oversight of a new infrastructure to have ongoing conversations with residents and devolved decision making to neighbourhood level to ensure strategy reflects and responds to resident needs, and to provide assurance to ICB and Health and Wellbeing Board on outcomes

6.6 Deliver an agreed programme of activity that improves population health outcomes, intervenes at the earliest possible opportunity, prevents ill health and addresses health inequalities

6.7 Embed clinical and multi-professional engagement throughout the Alliance and across Alliances in support of the delivery of local plans and wider system priorities e.g., Stewardship and Population Health Management activities.

6.8 Better Care Fund / S75:

- Agreement and delivery of relevant s75 or joint funded initiatives within the scope of the SORD.

6.9 Driving Performance:

- Drive and oversee the delivery of the Alliance accountable ICB standards, outcomes, and common clinical policies set out in the agreed Alliance-ICB devolution agreement and Alliance plan.
- Drive and oversee the delivery of locally agreed population health outcomes related to locally developed strategies.
- Monitoring of resource utilisation at place, identifying recovery actions where required and participating in projects to realign resources in line with ICB and Thurrock Council programmes (e.g. PHM, stewardship).
- Provide assurance to the Board that management actions are in place and succeeding to reduce inappropriate clinical variation.

6.10 In accordance with the strategy and prioritisation framework for the ICB, propose and coordinate delivery of local elements of the estate strategy.

6.11 Ensure insight gained from local residents is used to shape the strategy and policy of both the Alliance, ICB and the ICS more generally with a focus on co-design and co-production of transformed services with residents and clinicians

7. Behaviours and Conduct

7.1 Values

Members will be expected to conduct business in line with the ICB and Thurrock Council values, objectives and Code of Conduct set out including the East of England Leadership Compact and council policy.

Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy and Thurrock Council's constitution and policy framework.

7.2 Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB and Thurrock Council.

7.3 Conflicts of Interest

Members of the Committee will be required to declare any relevant interests to the ICB and Thurrock Council in accordance with the ICB's and council's Conflicts of Interest Policies..

A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

7.4 Confidentiality

Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8. Accountability and reporting

During Part A of committee meetings:

- The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- The Committee will undertake the agreed accountability review and assurance processes with the ICB.
- Regular reports on the delivery of place-based plans will be submitted to the ICB for assurance.
- The Chair of the Committee may be invited to attend the ICB as requested by the Chair of the ICB and the Chair of the ICB will be invited to attend the committee at least annually.
- The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

- The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

- The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

9. Secretariat and Administration

The Committee shall be supported with a secretariat function provided by MSE which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Where relevant records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.
- Clear links are made between Part A and Part B of the Alliance and reporting arrangements established.
- A forward planner will be established and maintained to support links being made between parts A and B

10. Review

The Committee will review its effectiveness at least annually.

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

Date of approval: Commitment for approval made at ICB Board on 19/01/2023

Date of review:19/01/2023

Date of approval by Mid & South Essex Integrated Care Board (ICB)

Thurrock Integrated Care Alliance Committee:……………

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.3

Governance changes required for POD and Specialised Commissioning Delegation

Summary Report

1. Purpose of Report

To seek approval from the Board to change aspects of ICB governance required to achieve delegation for Pharmacy, Optometry and Dental Services; namely to the ICB Scheme of Reservation and Delegation and the Primary Care Commissioning Committee Terms of Reference.

In addition to seek approval for minor changes to the Finance & Investment Committee Terms of Reference.

2. Executive Lead

Mike Thompson, Chief of Staff

3. Report Author

Nicola Adams, Deputy Director of Governance and Risk

4. Responsible Committees

It is the responsibility of the Board to approve changes to ICB governance.

The proposed changes were presented to and approved by the relevant committees as detailed below,

- Audit Committee on 7 March 2023.
- Primary Care Commissioning Committee on 15 February 2023.
- Finance & Investment Committee on 8 March 2023.

The changes are now recommended to the Board for approval.

5. Impact Assessments

Impact assessments are not applicable to this change.

6. Financial Implications

There are no financial implications.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to:

- Approve the revisions to the Scheme of Reservation and Delegation.
- Approve the revisions to the Primary Care Commissioning Committee Terms of Reference.
- Approve the ICBs membership of the regional Specialised Services Joint Commissioning Committee for 2023/24 (SSJCC) and agree that the joint working arrangements can be signed by the Chief Executive Officer.
- Approve the minor changes to the membership of the Finance & Investment Committee.

Governance Changes Required for POD and Specialist Commissioning Delegation

1. Introduction

The Primary Care Team have been working with and alongside NHS England to enable the delegation of Pharmacy, Optometry and Dental Services to the ICB from 1 April 2023 and for the delegation of Specialist Commissioning Services from 1 April 2024, with shadow arrangements in place from 1 April 2023. A separate report has been provided to update the Board on progress with POD delegation (please see agenda item 13.1).

2. Main content of Report

Pharmacy, Optometry and Dentistry Delegation

Governance arrangements to fully enable POD delegation include amendment of the ICB Scheme of Reservation and Delegation (SORD), the establishment of a Primary Care Delegation Agreement with NHS England, the updating of the Primary Care Commissioning Committee (PCCC) Terms of Reference and the establishment of sub-committees to discharge primary care commissioning functions, which has been approved by the PCCC and recommended to the Board by the Audit Committee.

The SORD has therefore been expanded to:

- Include Pharmacy, Optometry and Dentistry to the existing sections regarding Primary Medical Services.
- Include specific delegation to Hertfordshire and West Essex Integrated Care Board for the contract management of Pharmacy and Optometry Services as well as the commissioning function for Children and Young People Mental Health Services.

In addition to the delegation of POD Services, the following amendments have also been made to the SORD:

- Clear articulation of the ability of committees to approve policies for which they are sponsor.
- Amendment to System Leadership/Partner Groups to reflect current groups.
- Clarity over continuity arrangements for the role of the Director of Resources.
- Clarity over the role of budget holders and their ability to sign contracts on behalf of the ICB (at Director level and above).

Governance arrangements to fully enable POD delegation include the establishment of a Primary Care Delegation Agreement with NHS England, the updating of the Primary Care Commissioning Committee (PCCC) Terms of Reference and the establishment of sub-committees to discharge primary care commissioning functions, which has been approved by the PCCC, presented to the audit committee for information and recommended to the ICB Board for final approval.

Specialised Commissioning

Delegation of specialist services to ICBs has been deferred until April 2024, and so commissioning and financial responsibility will transfer to ICBs for their respective populations from April 24. In the meantime, the East of England Specialised Services

Joint Commissioning Committee (SSJCC) will operate for 2023/24 and be a regional joint committee of all six ICBs and NHSE-EoE operating as a shadow committee to that which may be operating from 24/25.

The SSJCC will have responsibility for:

- making decisions about the commissioning of services within the specialised services portfolio.
- agreeing the work programmes.
- financial risk sharing on specialised services with ICB services where integration of pathways may be required.
- representation on Partnership Boards or Commissioning Committees that have oversight of patients flows to Providers outside the East of England region.
- representation at the national Delegated Commissioning Group, which is the national group that has oversight of national service specifications and clinical policy.
- oversight of commissioned providers with respect to quality of service, performance, and service transformation.
- oversight of commissioned specialised operational delivery and specialised clinical networks, with respect to agreeing their work programmes, reporting of progress and signing off annual reports and as a point of escalation; and
- oversight of the East of England Provider Collaborative (Mental Health).

The arrangements for the SSJCC are set out within a Joint Working Agreement and including terms of reference of the committee which reflects the responsibilities set out above. All regional ICBs are asked to establish and approve these arrangements. The Chief Executive will ensure that the governance arrangements for Specialised Commissioning are robust and appropriate, and the Interim Executive Director of Oversight, Assurance and Delivery will represent the ICB as the lead Executive Director. Locally, the lead Executive Director will ensure the CEO, Chair or Board are engaged and notified as necessary regarding any significant issues, decision or risks prior to the Joint Committee meetings to ensure the views and position of MSE ICB is reflected.

MSE ICB has established a local Delegation Programme Board which includes wider system representation including providers. This forum will receive reports on the progress with delegation, oversee the preparation for full delegation and highlight risks and issues to the appropriate forum e.g. executive team, committee etc.

Over the year, and in readiness for full delegation from 24/25, specialised commissioning performance and development will be considered for inclusion in the scope of the System Oversight and Assurance, Quality and Finance & Investment Committees' scope.

The Joint Working Agreement, draft regional Terms of reference and the setting up of the Joint Commissioning Committee were presented to the Finance & Investment Committee on 8 March 23 which has in turn, reviewed and scrutinised the proposed arrangements and recommended their approval to the ICB Board. The F&IC also recommended that the ICB Board should agree to the Chief Executive Officer signing the Joint Working Agreement on their behalf.

Finance & Investment Committee Terms of Reference

To manage conflicts of interest and potential issues with quoracy of decision making within the Finance & Investment Committee, the Committee recommend increasing the membership to include an Associate Non-Executive Member.

The committee also requested that the membership section was updated to say that where systems are in financial deficit the NHSE Regional Chief Finance Officer will attend committee meetings.

3. Findings/Conclusion

The governance arrangements of the ICB have enabled joint working and delegations of Primary Care Medical delegation, but some tweaks to those governance arrangements are required to enable delegation of POD, which are recommended to ensure that POD delegation can take place from 1 April 2023.

4. Recommendation(s)

The Board is asked to:

- Approve the revisions to the Scheme of Reservation and Delegation.
- Approve the revisions to the Primary Care Commissioning Committee Terms of Reference.
- Approve the ICBs membership of the regional Specialised Services Joint Commissioning Committee for 2023/24 (SSJCC) and agree that the arrangements can be signed by the Chief Executive Officer.
- Approve the minor change to the membership of the Finance & Investment Committee.

5. Appendices

None - the updated versions of the following documents are available to members upon request:

- Scheme of Reservation and Delegation.
- Committee Terms of Reference.
- Joint Working Agreement.
- SSJCC Terms of Reference.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.4

Delegating the approval of the Annual Report and Accounts to the Audit Committee

Summary Report

1. Purpose of Report

To seek approval from the ICB Board for delegation to the Audit Committee of approval of the Annual Report and Accounts.

The Scheme of Reservation and Delegation (SORD) reserved Annual Report and Accounts approval to the Board, on the recommendation of the Audit Committee. However, the timetable for production of the annual report and accounts does not align with Board meeting dates and there is a very short turn around time from the end of the reporting period, the external audit review and submission deadline for the accounts element of the report.

It is therefore proposed that the Board delegate authority to approve both the draft and final accounts submissions (due on 27 April and 20 June respectively) to the Audit Committee. This approach is common across NHS organisations for these reasons. The Board will be presented with the draft Annual Report and Accounts at the May meeting, at which there will be opportunity to comment on the report. Additionally, pre-final draft versions will also be shared with members and the Executive Team for their views and input.

2. Executive Lead

Anthony McKeever, Chief Executive Officer.

3. Report Author

Nicola Adams, Deputy Director of Governance and Risk.

4. Responsible Committees

The ICB Scheme of Reservation and Delegation sets out that the approval of the annual report and accounts is reserved to the Board.

5. Impact Assessments

Impact assessments are not applicable to this change.

6. Financial Implications

There are no financial implications.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to delegate authority to the Audit Committee to approve the annual report and accounts.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.5

Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee (AC), 17 January 2023.
- Clinical and Multi-Professional Congress (CliMPC), 26 January 2023.
- Finance and Investment Committee (FIC), 1 February 2023.
- Primary Care Commissioning Committee (PCCC), 18 February 2023.
- Quality Committee (QC), 25 November 2022.
- System Oversight and Assurance Committee (SOAC), 8 February 2022.

2. Chair of each Committee

- George Wood, Chair of AC.
- Dr Ronan Fenton, Chair of CliMPC.
- Joe Fielder, Chair of FIC.
- Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.
- Anthony McKeever, Co-Chair of SOAC.

3. Report Author

Sara O’Connor, Head of Governance and Risk.

4. Responsible Committees

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

5. Conflicts of Interest

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

6. Recommendation/s

The Board is asked to note the content of the approved minutes of the above committee meetings.

Minutes of the Audit Committee Meeting

Held on 17 January 2023, 9.00–11.30 am

Via MS Teams

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Attendees

Members

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

Other attendees

- Jennifer Kearton (JK), Director of Resources and Director of Finance Operations & Delivery, MSE ICB.
- Mike Thompson (MT), Chief of Staff, MSE ICB.
- Nicola Adams (NA), Deputy Director of Governance & Risk, MSE ICB.
- Tendai Mnangagwa (TM), Deputy Director of Finance for Financial Services & Management, MSE ICB.
- Jane King (JKi), Governance Lead (Minute Taker), MSE ICB.
- Colin Larby (CL), Deputy Head of Audit and Assurance, WMAS.
- Eleni Gill (EG), Lead Counter Fraud Manager, WMAS.
- Emma Larcombe (EL), Director, KPMG LLP.
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare (For Item 7 only).
- Barry Frostick (BF), Chief Digital and Information Officer (For Item 8 only).
- Viv Clements (VC), EPRR Lead (For Item 9 only).
- Iain Gear (IGe), Head of Information Governance, MSE ICB.

Apologies

- None received.

1. Welcome and Apologies

GW welcomed everyone to the meeting. There were no apologies.

The meeting was quorate.

2. Declarations of Interest

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

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

There were no declarations raised.

3. Minutes and Action Log

The minutes of the last meeting of the ICB Audit Committee on 25 October 2023 were received. JKi confirmed the highlighting and duplication of words 'Health Financial' on pg 8 of the minutes would be removed and amended respectively.

Outcome: The minutes of the meeting held on 25 October 2023 were approved as an accurate record, subject to the changes required.

The Action Log was reviewed and the Committee noted the one outstanding action due for completion by March 2023.

4. Board Assurance Framework

NA shared the latest iteration of the Board Assurance Framework (BAF) which was presented to the ICB Board on 17 November 2022 and well received. The Board requested that mental health risks should be incorporated into the next BAF iteration to be presented at the Part I Board meeting on 8 March 2023. NA reminded the committee that full risk registers for each directorate fed into the overarching BAF which provided details of the seven key ICB risks.

The ICB had agreed with NHSE on the areas of focused improvements (aligned to the priorities outlined in the 2023/24 Operational Planning Guidance) to maintain its current System Oversight Framework (SOF) rating at SOF3. To assist with the monitoring of delivery, a new, high-level performance dashboard was discussed at the System Oversight and Assurance Committee (SOAC) on 11 January 2023 and work undertaken to review and revise the SOAC work programme and key risks across ICS.

Existing BAF risks would be reviewed with the relevant senior responsible officers and updated prior to the next meeting in March when the Audit Committee would receive the latest iteration, as well as and copies of risk registers (which were presented to the relevant committees of the Board and periodically to the Audit Committee for assurance).

NA confirmed the ICB were considering the use of a risk management system in the new financial year which would would provide depth to risk reporting and financial framework. To support system working, governance leads at partner organisations had received copies of the ICB's BAF and Risk Management Policy.

GW suggested that it would be helpful to include information on community beds, staff capacity etc within the 'Unblocking the Hospital' risk. Additionally, it would be useful to understand how virtual wards were progressing and whether there were any potential risks to be aware of. GW recommended stronger links between workforce and finance risks.

Outcome: The Committee Noted the Board Assurance Framework update.

5. Annual Report and Acccounts Timetable and Month 9 Governance Statement

DRAFT

NA advised that, although financial accounting and reporting details for 2022/23 were not yet issued, there was a draft timetable in place and a final Annual Report and Accounts deadline of 20 June 2023 was agreed with the auditors. The Scheme of Reservation and Delegation (SORD) reserved Annual Report and Accounts approval to the Board, therefore it would be necessary to ask the Chair and Chief Executive Officer if they would agree to delegate approval to the Audit Committee to support this deadline. The final timetable would be brought to the next Audit Committee and the Board would be updated accordingly. NA was progressing an annual report project plan and was linked in with the teams providing input to ensure deadlines would be met. The Committee noted that draft Annual Report and Accounts would not be available for the meeting on 7 March 2023.

MT stressed that the annual report plan and narrative must be in line with the Chair and CEO's agreed approach. GW concurred and recommended that the Communications Team worked with the Chair and CEO on the approach.

EL advised that KPMG were happy to look at early drafts of the Annual Report and Accounts but stressed that the published version must be the version signed off by auditors.

Outcome: The Committee NOTED the update on the timetable and governance for the ICB Annual Report and Accounts.

6. Scheme of Reservation and Delegation Update

NA explained that from April 2023, Pharmacy, Optometry and Dentistry services would be delegated to the ICB, therefore changes to the Scheme of Reservation and Delegation (SORD) would be required and an updated document would be presented in full at the March Audit Committee meeting. JK added that adjustments to the SORD were also required for outsourced contracts and hosted arrangements needed to be mapped to avoid duplication.

MT queried whether there would be capacity for the Internal Auditers to support work on the SORD in an advisory role and to provide assurance on the changes required.

Outcome: The Committee NOTED the update on the forthcoming changes to the ICB's Scheme of Reservation and Delegation.

7. Contract Governance Update Report and Register of Procurement Decisions

JJ provided an update on the contract governance work undertaken to date to ensure the ICB had a robust procurement process in place. A more detailed paper would be brought to the next Audit Committee in March 2023.

The Committee noted the Register of Procurement Decisions and the progress in relation to contract governance following transition from the 5 CCGs into the ICB. This remained an ongoing programme of work and would be closely aligned to the implementation of the new Provider Selection Regime during 2023/24. JK explained that the introduction of the Provider Selection Regime had been delayed and was not expected to be operational until the next financial year. However, key preparation work was underway which would offer opportunity to strengthen already improved processes.

DRAFT

PF would welcome a Board presentation on the Provider Selection Regime once detail was known.

ACTION: MT to arrange a presentation to Board on the Provider Selection Regime once detail has been finalised.

Outcome: The Committee NOTED the Contract Governance Review update and the Register of Procurement Decisions.

8. Business Intelligence Strategy

BF presented the ICB's Business Intelligence (BI) Strategy and Roadmap to the Committee. A 'Data Summit' meeting was due to take place with partner organisations which would drive joint BI work and support integrated working. The technical BI recommendations made by PwC were incorporated into the new Strategic Data Platform (SDP) and the first version of the platform was due to go live imminently. BF confirmed that information governance activity was in line with National Data Guardian and DPA requirements.

PF highlighted that Essex County Council worked across three Integrated Care Systems therefore needed to find a system aligned to all three.

Outcome: The Committee NOTED the Business Intelligence Strategy.

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

VC provided a summary of the work undertaken by the Emergency Planning Team (EPT) during the last quarter. As part of the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Framework, NHS providers and commissioners must undertake an annual assurance process to demonstrate they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. ICBs were responsible for monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and their applicable core standards. The ICBs were responsible for the submission of a consolidated report providing assurance for their System. MSE ICB reported as 'partially compliant' with the Core Standards for 2022/23, an action plan was in place to ensure the standards were met by March 2023.

On-call training was ongoing and had included ICB specific 'Principles in Health Command' and media training sessions. The EPT continued to work with the Essex Resilience Forum (ERF) to ensure key business as usual work was undertaken, including ensuring Essex could respond to a concurrent incident.

GW invited questions or comments from Members. There were none.

Outcome: The Audit Committee NOTED EPRR Quarterly Update

10. Information Governance (IG) Quarterly Report

IGe provided a summary of the work undertaken by the IG Team during the last quarter. The Committee noted there had been significant information governance work undertaken on the development of the Strategic Data Platform.

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The 2022/23 Data Security & Protection Toolkit audit was due to commence and was split into two parts. The first would look at the action plan identifying responsibilities and gaps in evidence for the toolkit assertions and the structures in place to manage IG. The second part will be an audit of a selection of assertions, the evidence and supporting information around them, as selected by NHS Digital and will be carried out in April / May 2023.

The IG Team were also working with a number of practices on GP IT Fair Processing following a review of the action plans put in place as a result of the DPO Audit where it was highlighted that a large number of practices were not compliant with Fair Processing requirements.

Following the announcement that Pharmacy, Optometry and Dentistry (POD) services would be delegated to the ICB, the IG Team were exploring the information governance implications.

GW took the opportunity to enquire whether there would be a Board session on POD. MT advised that POD and Specialised Commissioning services would be absorbed into the ICB's management and governance structure, MT was assured that plans were in place. The Board would be advised of place, quality, information governance, finance and governance arrangements etc.

In response to GW's query around whether the ICB would be responsible for POD negligence liabilities, JK highlighted that POD services would be delivered by indepedent providers and did not expect the ICB's liability premiums to increase. POD staff would transfer to the ICB bringing skills and expertise in their respective fields. The delivery of POD services would receive oversight through respective committees and the Board fully sighted on degrees of control and flexibility.

ACTION: MT to bring a summary to March Audit Committee meeting setting out POD arrangements which can also be shared with Board. GW requested that the current status of dentistry in MSE be included.

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

11. Internal Audit Progress Report

CL presented the Internal Audit Progress Report and advised that delivery of the plan was on track. Due to a delay in NHSE assessment guidance being issued, a request was received to delay the Digital Strategy/Levelling Up audit to Q1 2023/24. A further request was received from the executive lead for the Population Health Management audit to delay the start to Q1 as the outcome of regional population health management work being undertaken would be beneficial to the audit and may avoid duplication of work.

Three reports were finalised since the last Audit Committee meeting: the Financial Sustainability Review (advisory report); the Quality of Mental Health Services (received 'Reasonable Assurance'); and the Oversight of Implementation of Ockendon Review Recommendations (received 'Reasonable Assurance').

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The Committee noted the Quality of Mental Health Services report referred to limited intelligence relating to mental health complaints. NA explained this was in regard to mental health complaints reported to directly to the ICB. MT advised that work would be undertaken by the Quality team on capturing and categorising complaints but was assured there were no gaps in reporting of mental health data to the appropriate committees.

The Ockendon audit report highlighted that Mid and South Essex NHS Foundation Trust (MSE FT) continued to address its compliance against the Immediate and Essential Actions (IEAs) contained in the first Ockendon Report (published in December 2020) and that significant progress had been made. JK advised that the recent East Kent Maternity Report would impact on some of the same areas of the Ockenden review. MT would discuss assurance and oversight of MSE FT Maternity Services with the Executive Director of Nursing and Quality to ensure the Audit Committee were kept informed of progress on the action plan, which GW and PF welcomed. GW was concerned that the response rate for MSE FT maternity service users was low but noted the actions to increase response rates to help ensure underperformance in all areas was identified and could be addressed.

JK confirmed that lessons had been identified following the Financial Sustainability review. Noting that the ICB had only been in existence for a very short period; in future, auditors would be involved at the start of the financial sustainability process to ensure consistency and the Audit Committee would be involved at an early stage. JK advised that MSE FT had undertaken a financial sustainability audit and the outcome had been received, the recommendations would form part of the System Improvement Plan.

NA advised that the final reports for the Ockendon Recommendations and Quality of Mental Health Service audits would be shared with ICB Quality Committee. CL remarked that he was open to agreeing a protocol for sharing of information and reports across the system.

ACTION: Share Ockendon Review and Quality of Mental Health Services reports with the ICB Quality Committee.

Outcome: The Committee NOTED Internal Audit Progress Report and Follow-up of Audit Recommendations.

12. Counter Fraud Progress Report

EG provided an update on the counter fraud work undertaken during the last quarter. One new referral had been received since the last Committee meeting which related to a patient potentially submitting travel claims for appointments they did not attend. A data protection request had been submitted to the relevant hospital for formal confirmation of attendance or non-attendance of the patient on the specific dates and times under investigation. The investigation was in progress and an update was expected for next meeting.

Following advise that the NHSCFA were notified of numerous fraudulent attempts for payment of office supplies/consumables, the Director of Resources and lead finance staff were asked to identify any attempts, concerns or questions. Online mandate fraud and invoice fraud training relating to the Finance Team would be scheduled. EG confirmed that Mandatory Fraud & Bribery training formed part of the bi-monthly corporate induction for new starters and Board training was scheduled.

GW suggested it would be useful to look at mandatory training requirements across the organisation. NA confirmed that the HR team were currently reviewing training requirements and an update would be brought to the Committee. NA would check the Terms of Reference for the appropriate committee to receive training data.

ACTION: NA to confirm where compliance with mandatory training is reported for assurance.

Outcome: The Committee Noted the Counter Fraud Progress Report

13. External Audit Update

EL advised that since the last Committee meeting, audit plans for the five predecessor CCGs (for Q1 2022) were complete and testing would commence. ICB audit planning discussions had commenced and details would be available at the March meeting.

The risk assessment process was ongoing, areas of the audit subject to higher risk for the CCGs were likely to include the management of controls, errors risk on accruals and the continuing health care provision risk for Basildon and Brentwood CCG. The Remuneration Report was also likely to be an area of risk for the CCGs and the ICB.

In response to PF's request for further detail on the Remuneration Report risk, EL explained the Remuneration Report was a complex document and historically there had been challenges with this area of audit. Additionally, there was a specific risk given there were two accounting periods but a single set of pension data.

JK agreed that the Remuneration Report was a very complex area, however this year a single person would be leading this workstream. In terms of the CHC provision risk, JK advised that discussions with legal teams and a review of the taskforce was underway and an update on CHC provision would be shared with the Committee at the March meeting.

MT suggested it would be useful, at the appropriate time, to brief the Chair and CEO if any risks were identified.

Outcome: The Committee Noted the External Audit Update.

14. Waiver Report

JK presented the Waiver Report which, in line with the MSE ICB Scheme of Reservation and Delegation, set out the waiving of quotations and tenders which must be reported to the Audit Committee. The report included details of the financial value and reason for the waiver.

The Committee noted there were 21 new waivers to report since the last Audit Committee which totalled almost £2m. Many were legacy waivers which formed retrospective work undertaken by Procurement Team. There were also nine waivers in relation to the winter pressures programme.

PF welcomed the comprehensive and transparent report and suggested it would be useful to add trend data. JK agreed and advised that work on waivers now included exit planning.

GW noted that three of the waivers were in relation to discharge and suggested it would be helpful to know the long term strategy to get patients into the right setting at right time for

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best cost evaluation and enquired who this would sit with. JK agreed on the need to be proactive and suggested this exercise could be undertaken at year-end.

ACTION: JK to arrange a paper outlining the long-term strategy for discharge planning at a future Audit Committee meeting.

Outcome: The Committee Noted the Waiver Report.

15. Losses and Special Payments

JK advised there were no losses or special payments to report to the Committee.

16. Urgent Decisions – Approvals Made Between Board Meetings

Since the date of the last Board meeting, 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 urgent decisions as follows:

- APMS Procurement
- Business Intelligence Procurement
- Independent Sector Contracts

The Chair invited comments and questions from Members. No questions were raised.

Outcome: The Committee NOTED the decisions taken to approve the business cases made in between Board meetings.

17. Conflicts of Interest Self-Assessment

NA explained that NHS England had requested all ICBs to complete a self-assessment outlining the arrangements in place to manage conflicts of interest. The Committee were provided with the full response outlining the key actions undertaken by the ICB. The self-assessment concluded that the ICB had appropriate arrangements in place for the management of conflicts of interest and work was on-going to ensure the register of declared interests was fully up to date and that all relevant staff have completed their conflicts of interest training.

The Chair invited comments and questions from Members. No questions were raised.

Outcome: The Committee NOTED the ICB's Conflict of Interests Self-Assessment report.

18. Gifts and Hospitality Register

NA presented the Gifts and Hospitality Register which detailed a record of declarations made by staff in relation to gifts and/or hospitality whether accepted or declined. A copy of the latest Gifts and Hospitality Register would be made available on the ICB website.

The Chair invited comments and questions from Members. No questions were raised.

Outcome: The Committee NOTED the Gifts and Hospitality Register

19. ICB Data Compliance

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Following a request received from the National Data Guardian regarding Data Sharing for Secondary Uses, IGe shared the ICB's response which demonstrated the ICB's compliance with the four activities outlined in the request.

Outcome: The Committee NOTED the response to the National Data Guardian.

20. Items for Information

The following items were included for information:

- Minutes of Finance & Investment Committee Meeting 5 October 2022
- Minutes of Quality Committee Meeting 30 September 2022
- Minutes of Primary Care Commissioning Committee 16 November 2022
- Minutes of System Oversight & Assurance Committee 14 December 2022

Outcome: The Committee Noted the Minutes presented.

21. Audit Committee Terms of Reference v1.1

The Audit Committee were presented with the Terms of Reference for noting.

22. Any other Business

The timing of future audit committee meetings was discussed, noting the corporate calendar for 2023/24 was being drafted. NA explained that the Annual Report and Accounts guidance was awaited to be able to schedule the Audit Committee appropriately to accommodate the Annual Report and Accounts timetable.

JK flagged that from March 2023 the Audit Committee meetings would move to Tuesday afternoons as the ICB Executive meetings had moved to Tuesday mornings. There were no objections from the Committee.

23. Items to Escalate

To the Quality Committee – Share final audit reports 'Quality of Mental Health Services' and 'Oversight of Implementation of Ockendon Review Recommendations'

24. Date of Next Meeting

Tuesday, 7 March 2023

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

26th January 2023

9:00 - 11:00 am

Via MS Teams

Attendees

Ronan Fenton (RF), Sarah Zaidi (SZ), Babafemi Salako (BS), Peter Scolding (PS), Rachael Marchant (RM), Krishna Ramkhelawon (KrR); Gbola Otun (GO); Olubenga Odutola (OO), Gerdi De Toit (GDT), Stuart Harris (StH), Donald McGeachy (DM), Anna Ramsay (AR), Edward Cox (EC), Kelly Robinson (KeR) – left at 10:00, Jose Garcia (JG), Kirsty O'Callaghan (KO), Scott Baker (SB), Radha Sehgal (RaS), Robert Spackman (RoS)

Guest presenters:

Way Wong (WW) – *Consultant Rheumatologist, Acting Consultant Orthogeriatrician, Southend University Hospital, MSEFT*

Kassim Javaid (KJ) – *Associate Professor in Metabolic Bone Disease, University of Oxford Honorary Consultant Rheumatologist, Oxford University Hospitals NHS Trust Clinical Lead for HQIP Fracture Liaison Service Database Audit for England and Wales*

Apologies

Russell White (AR as deputy)

Meeting Summary

Item No	
1.	**Welcome**
	RF welcomed colleagues to meeting. Fourteen members of the CliMPC were present therefore the meeting was quorate as per the ToR. Conflicts of interest were declared by: - Kassim Javaid: In last three years received honoraria, unrestricted research grants, travel and/or subsistence expenses from Amgen Ltd, Kyowa Kirin, UCB, Abbvie, Besin Healthcare, Sanofi, Abbvie, Theramex. Has not received any direct or indirect funding for this work. The minutes from the previous meeting were taken as accurate. RF gave an overview of the group's three main purposes: - To develop ideas - To provide structured advice to the board - To review cases of transformational change RF explained that the group would look at one transformational improvement idea over the course of two sessions.

2.	**Fracture Liaison Service (FLS) – Presentation and Q&A**
	RF welcomed speakers WW and KJ to the group who were invited to present and congress members to consider the FLS business case. WW presented an overview of FLS to the group – a multidisciplinary healthcare delivery model for secondary fracture prevention. He explained that the aims of the service would be to identify, investigate and initiate treatment and refer appropriately those who have suffered a fragility fracture. There is currently no FLS service in MSE. WW outlined areas that were not in the scope of FLS such as primary prevention. WW presented the data on the expected impact of the FLS scheme across MSE, including estimated savings and the opportunities it provides for primary/secondary care and the system. StH – Highlighted our ageing population in MSE and vocalised his support for the FLS initiative in relation to this RM – Posed the question how do we integrate this with primary care and avoid duplication? WW – Was in agreement with integrated to primary care. Expressed opinions regarding the disjointed nature of primary care, for example, some practices initiating and managing osteoporosis medication long-term where others will not. Provision of osteoporosis care is patchy across MSE. Some GPs may be more comfortable managing osteoporosis than others. Osteoporosis does not score as highly as other conditions on QOF, so this may be a disincentive. Need to work together to address this. KJ – Shared similar experiences in Oxford where a positive outcome achieved by upskilling clinicians and via primary care champions. This provided an opportunity for harmonisation of care. WW – Shared his uncertainty about the long-term plans for Denosumab across MSE and posed the question who is the current lead for MSK? KJ – Emphasised his confidence in the strong governance structure shown in slide 14 of the business case. RM – Expressed the need to ensure primary care is acknowledged in the business case to ensure care is equal across all practices. Suggests the FLS model is more joined up and the need to reflect this in the business case. KJ – Stated the view that the phased element of the model may address some of these issues. KrR – Highlighted the persistent nature of health inequalities and the need to consider them in all aspects of service development. SZ – Stated the ongoing need for a fully integrated model which addresses falls and frailty. Also one which is personalised and tailored to patient needs. Some patients which fragility fractures are younger by national average in MSE due to high levels of economic deprivation. Also emphased need to think more broadly than primary care and consider neighbourhood models. WW – Explained that it was not within the remit of FLS to address all of the wide ranging issues facing MSE however the focus on falls and frailty should help address some of the concerns. JG – Noted that slide 7 states primary care should provide continuing long term care. PS – Suggested the need to link with alliances and place based services. JG – Asked whether consultant time been factored into the service? WW – In answer stated that currently there is no consultant time allocated. However a bid has been submitted for three PAs per week to lead FLS across the trust. Agreed that dedicated consultant time is needed.

	BS – Highlighted the lack of wider services and need to address this with the local authority. For example, many services have become virtual which may lead patients to not engage or may exclude elderly patients. Also raised the issue of missed fractures in A&E and whether systems need to change to address this. KJ – Acknowledged that A&E is a challenging place to identify fractures. Part of the work of the group is to map where fractures are happening through the use of data. GDT – Asked what are the role of therapists and other allied healthcare professionals (AHPs)? This needs to be incorporated into planning to prevent inequalities being exacerbated. Can job descriptions be broader than nursing staff? WW – Shared feedback from a session with AHPs in Southend who supported the proposals and where keen to be involved. Explained how they are often the first practitioner to identify a fracture patient and have a pivotal role in the service. OO – Asked the group to recall the importance of primary prevention. KJ – Explained how clinical evidence shows that secondary prevention is more effective given the increased rate of further fracture after first fracture and offered to share the evidence to the group.
3.	**To discuss: Fracture Liaison Service business case**
	Congress members discussed the format used to discuss these cases (agile vs senate model) and their views on the FLS business case, in a private session. DM – Offered straight forward agreement with the FLS proposals and the opinion that there was no need for congress to debate this proposal in a further session. KrR – Similarly was in agreement with the proposals. RM – Whilst broadly supporting the proposals placed emphasis on the need for alternative solutions to be presented in outline form in order to build the model. JG – Offered agreement that it is critical to look at other options. Focusing on acute pathways creates the risk of a bottleneck in services. SZ – Emphasised the need to robust and effective evaluation. GDT – Was broadly supportive of the proposals and it's phased approach. AR – Highlighted the need for integration with care homes, whose population is at highest risk of falls. RoS – Emphasised the importance of clinical leadership in this proposal and the opportunity to harness the momentum of a motivated clinician driving a positive project that is FLS. KO – Reinforced the need to focus on community involvement including volunteers and community groups and other partners KrR – Remined the group of previous services pathways which may have benefitted from more ongoing evaluation. Suggested reviewing impact and benefits at 5 year mark. PS – Summarised that part of the role of congress could be to help 'filling out' the rest of the pathway to involve the community and improve the model. OO – Expressed the opinion of that congress should think critically as to how proposals like this will benefit the system? Where does this rank in ICS priorities and its road map for change? SZ – Warned against a 'one size fits all approach' to a problem and asked the groups to consider independently how the proposal could be improved to make it more holistic. BS – Praised the level of discussion in over the proposals and made the case for further integrated system level consideration. He asked the group to consider what is different now that we are in an ICB landscape compared with two years ago? He

	drew attention to existing specific problems such as AHPS not being able to request imaging. RM – Was in support of FLS however broadly but placed emphasis on the need for robust evaluation and continued model development to work at a system level. In Summary RF thanked the group for their contributions and offered applause regarding the richness of the debate. - Acknowledged that discussing this over two sessions may not be the correct approach, reminding congress that this is an evolving learning process. - Collectively the position appears to be broadly clinically supportive of FLS however Congress has put forward clear challenges. - There have been previous experiences where transformational work did not deliver because it lacked integration, not taking into account primary care for example. - The pathway is good but not complete and will may risk not realising the benefit to the whole population. We therefore pose to the ICB that we are in support of FLS but it shouldn't be started unless there is commitment to whole pathway development. - There should be a recommendation for a stewardship link RF asked the group what the next steps should be. SZ – Asked the question of how does the new MSK stewardship group play in? How do we cross link stewardship groups? GO – Highlighted that currently only FLS and status quo are the available options. Asked the group to closely consider the challenge of how closer integration can be achieved for the FLS. RM – Suggested Congress recommendations could be to taken to the MSK stewardship group who have more of a system view of the matter rather than an acute led one. He highlighted the need for a system pathway not just an acute pathway. PS - Clarified that funding is not yet settled. JG – Asked the group what our ambition should be in 2 years (referencing slide 23).
4.	**Service Harmonisation Update**
	PS provided an oral update. The business case is complete, with material from the packs having been incorporated. This will go to the finance committee next week and the ICB board the week following. The public consultation closed before Christmas, with much of the feedback based on threshold criteria. PS can share the business case and consultation report for information. Implementation will be in April 2023. RF thanked the group for their contribution to this.
	AOB
	Next meeting is 23rd Feb – the agenda is TBC but part of the session will be used to discuss recommendations around FLS. PS and RF will circulate this for approval.

Minutes of ICB Finance & Investment Committee Meeting

Held on 1 February 2023 at 09.30

Via Microsoft Teams

Attendees

Members

- Joe Fielder (JF), Non-Executive Member, Committee **Chair,** MSE ICB
- Loy Lobo (LL), Finance and Performance Committee Chair, EPUT
- Julie Parker (JP), Finance Committee Chair, MSEFT
- Anthony McKeever (AMcK), Chief Executive Officer, MSE ICB
- Jennifer Kearton (JK), Director of Resources, MSE ICB
- Jo Cripps, (JC), Executive Director, Strategy & Partnerships, MSE ICB
- Dr Tiffany Hemming (TH), Interim Executive Director of Oversight, Assurance and Delivery, MSE ICB

Other attendees

- Mike Thompson (MT), Chief of Staff, MSE ICB
- Barry Frostick (BF) (item 4 - GP IT VOIP), Chief Digital and Information Officer, MSE ICB
- Alfie Bandakpara-Taylor (AB-T) (part) , Deputy Director for Adult Mental Health, MSE ICB
- Peter Scolding (PS), Assistant Medical Director, MSE ICB
- Nicola Adams (NA), Deputy Director of Governance and Risk, MSE ICB
- Neha Issar-Brown (NI-B), Non-Executive Member, Quality Committee Chair, MSE ICB (**part Chair**)
- Catherine Hamilton (CH) (item 5c), Alliance Lead and Medicines Strategy & Analytics Lead, MSE ICB
- Paula Wilkinson (PW) (item 5c) Director of Pharmacy and Medicines Optimisation, MSE ICB
- Nina van Markwijk (NV-M) (part)Finance Director – Efficiency and Care Group 4, MSEFT
- Jason Skinner (JS) (part), Director of Finance System Planning & Reporting, MSE ICB
- Zoe Pietrzak (ZP) (item 5h & 6), Regional Director of Finance, NHS England
- Emma Seabrook (ES), Resources Business Manager, MSE ICB

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and in particular Neha Issar-Brown who due to conflicts will chair the meeting for three business cases on the agenda items 5e) Interim Community Teledermatology Service, 5f) Integrated Community Dermatology Service and 5g) Mental Health Services.

ES who will provide the administration support going forward was welcomed to the meeting. Jane King was thanked for all of her support so far.

The Chair conducted introductions, there were no apologies.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and outlined the process today to manage the conflicts of interests which had been raised in advance of the meeting.

The Chair declared an indirect interest in agenda items 5e-5g.

JP declared an interest in agenda items 5e, 5f, 5g and 5h as in the role as NEM for MSEFT.

LL also declared an interest in agenda items 5e-5g as in the role of NEM for EPUT.

It was clarified JF, JP and LL would remove themselves from the discussion, they had also received a separate agenda pack excluding those papers. The remaining members would move into a breakout room to discuss papers 5e-5g and return back to the meeting following discussions.

3. Minutes of meeting

The minutes of the last meeting of the ICB Finance & Investment Committee on 9 November 2022 were received. The following points of accuracy were highlighted:

- Pg 1 – LL title to read 'Finance and Performance Committee Chair – EPUT'
- Pg 5 – 'waitlist' to be amended to 'waiting list'

Outcome: The minutes of the meeting held on 9 November 2022 were approved as an accurate record subject to the amendments above.

4. Action log/ Matters arising

The Committee were provided with an update on the Lighthouse handover following a report of data issues that arose from the transfer from MSEFT to EPUT. The Committee were advise the Digital team are supporting and AMcK will brief other organsiations over the course of the next week.

The Action Log was noted and updated accordingly.

GP IT VOIP (Telephony)

The Committtee were advised following presentation of the paper at a previous meeting, upon working with the supplier it has been identified there were some hidden costs. Those costs are outside of the envelope approved by the Committee. Work is taking place to revisit the framework and dsicussions taking place with wider aprtners around options to support the telephony solution for GPs moving forward. **It was agreed an update will be provided for the March meeting.**

Following a question around future learning to reduce the risk of it occurring in future it was confirmed work around lessons learned is underway.

It was asked if there is any consideration around unified comms to widen the scope and other options to obtain better value for money? It was confirmed discussions are underway with partners.

Virtual Decisions Learning

The Committee were informed of a change to the business case process to ensure a more natural flow of decisions to the Committee. This will enable the majority of decisions to be brought to the Committee in good time and provide good governance allowing members sufficient time to discuss papers.

It was recognised there may be occasions a decision is required in between meetings and there was a suggestion of a two stage review prior to the circulation of papers to ensure the appropriate content and with regards to commercial sensitiviites and possible conflicts.

5. Business Case Approvals

a. Service Harmonisation

The business case sets out a proposal to harmonise service restriction policies for six services, from five sets of legacy policies. The six services are: Bariatric Surgery, Breast asymmetry, Breast reduction, Female Sterilisation, Vasectomy (male sterilisation) and Tertiary Fertility. By harmosiing policies this will enhance equality geographically and ensure consistency.

The process has been through multi-professional clinical, professional advice and through engagement and consultation with residents which has generated the recommendations.

The cost to harmonise the service restriction policies presents an annual cost pressure of up to £1.076m. Following policy implementation it is expected there is likely to be an initial spike in activity up to circa £1.614m. A further pressure of £150K is anticipated for non-recurrent transitional costs for those patients currently on a pathway who are no longer eligible.

There was suggestion of a portfolio for further services to be harmonised to enable forward thinking. The undertaking of preminlary health impact assessments was suggested to enable services to be priortised. It was clarified this review process is underway. It was asked if rather than excluding smokers from some services a benefit might be to offer support around smoking cessation.

It was clarified the requirement to harmonise services was also to meet national responsibilities and core ICB purposes, including addressing inequalities.

TF highlighted breast reduction excludes surgery for gynacomastica is not explicit within the policy and will discuss outside of the meeting.

The Committee were informed there is a Service Harmonisation Group in train that include both finance and clinical representation.

Outcome: The Committee approved the financial case within the service harmonisation business case, pertaining to harmonisation of 6 service area policies and the transitional arrangements necessary for specific populations affected.

b. CYP Counselling

The Committee were advised the service for the counselling service will be extended by 12 months via a waiver to enable some further work to take place to ensure it dovevails into the community and voluntary sector commissioned services. By extending the service also provides the opportunity to undertake some pilots to understand what will be a better service offering to consider in the reporcurement.

It was suggested to run a market wide competition to ask people to come forward to suggest ideas for innotitaive services prior to the development of a pilot.

In summary it was confirmed the ICB will:

- adopt option c pausing, the procurement process.
- roll the existing contracts forward for 12 months, giving existing providers plenty of notice that the specification is changing.
- work towards harmonising (i.e. levelling up) provision across different geographies before a formalising a single contract.

The ICB will ask the Growing Well Programme Board to produce a plan for true integration to allow a holistic and integrated approach.

Outcome: The Committee noted the approach to CYP Counselling.

c. Continuous Glucose Monitoring

The Committee were asked to approve the implementation of an amended Continuous Glucose Monitoring (CGM) policy statement, a decision pathway and preferred treatment choices that has been developed with input from local diabetes specialists. This is in response to changes to national diabetes guidelines produced by NICE.

Through the national audit of existing patients being implemented on CGM showed a significant reduction in ambulance call outs and hospitalisation for DKA. NICE consider this as a cost effecitive implementation and there are wider improvements around determinents of health, patient empowerment and the ability to provide care remotely.

It was highlighted although the request is for a £1.4m additional investment it is anticipated this will provide a reduction on activity. It was noted this is a 1% cost pressure on the prescribing budget and whilst we would look to ensure this is within budget, there will be a requirement to stretch the prescribing efficiencies to support the ask.

It was suggested the offer of CGM is extended to patients who are first diagnosed with diabetes for behaviour change as evidence shows this supports the reduction of long term diabetes. There was a wider discussion around benefits realisaiton and the educational pieice which will form part of the implementation.

HF added this will help identify young people with diabetes who develop an eating disorder much earlier and will support a cost saving. This will also support savings in further years with better management of diabetes in terms of conditions that come with badly amanged blood levels.

Outcome: The Committee <u>approved</u> funding for the implementation of the CGM policy of £1.421m as per the NICE clinical guidance as recommended by the MSE Medicines Optimisation Committee.

PW & CH left the meeting.

d. <u>System Cancer Workforce Monies</u>

The Cancer Alliance annually allocate on a per capita basis an amount of monies that is used by the System for cancer transformation programmes.

This paper proposes to go at risk in order to support the recruitment of staff until the cancer alliance funds are released for the next financial year. Once funds are announced they will be prioritiesd to cover the essential posts with any balance used to support innovation. In response to a question from the Chair around when funds are likely to be announced it was flagged this was not yet known but due to the nature of the funding the risk of funds not being released was extremely low.

It was fagged this will provide some stability and allow focus to transform and enhance the service to support the reduction of backlogs by supporting the recruitment of these critical posts

Outcome: The Committtee

- **<u>supported</u> the approach of making substantive the clinical nurse specialists and other post holders (to be determined by the employer whether posts are substantive/fixed term).**
- **<u>supported and agreed</u> this approach up to £2.5m in 2023/24 full year cost, at risk. This risk will be mitigated, subject to receipt of equivalent Cancer Alliance funding. The proposal is that any such funding will be used to fund these posts prior to any wider commitments or asks being made of the 2023/24 monies.**

Due to conflicts of interest for the next 3 business cases NI-B took over as Chair (agenda items 5e, 5f and 5g). JF, JP and LL were removed from the discussion and voting process. Members were asked to refrain from using the chat facility.

e. Interim Community Teledermatology Service

Minutes retracted for confidentiality and in response to managing conflicts of interest.

f. Integrated Community Dermatology Service

Minutes retracted for confidentiality and in response to managing conflicts of interest.

g. Mental Health Services

Minutes retracted for confidentiality and in response to managing conflicts of interest.

AB-T left the meeting.

Members reconvened and the chairing was passed back to JF.

h. Tier II (two services omitted from previous business case)

JP declared an interest in this item as NEM for MSE FT and removed herself from the meeting.

The purpose of this paper is to seek approval to extend the current commissioning arrangements for community MSK in Thurrock and Community Dermatology in southeast Essex in order to align with delivery of transformation programmes. It was noted the services were omitted from the previous business case.

The Committee were asked to approve a direct award (via a waiver) to Thurrock Health Hubs for the provision of Community MSK, services to the value of £1,056k. This will ensure continuation of service provision until the new model for MSK is implemented.

Following a question from the Chair around timescales there was confidence work will be complete within the extension period.

Outcome: The Committe

- **approved a direct award (subject to waiver) to Thurrock Health Hubs for seven months with an option to extend for a further five months for the provision of Community MSK, services to the value of £1,056k**

- **approved a direct award (subject to waiver) a contract to Mid and South Essex NHS Foundation Trust (MSEFT) for six months with an option to extend for a further six months for the provision of Community Dermatology services to the value of £1,050k**

JS, NV-M and ZP joined the meeting.

Farleigh Hospice

The Committee were advised this is a new/additional investment.
In January 2020, a transfer from the Mid Essex CCG CHC Team to Farleigh Hospice took place giving the responsibility to Farleigh to source and/or provide care packages to patients who have a 'rapidly deteriorating condition which may be entering a terminal phase'. It was raised without this arrangement we would see this cost pressure within our own budgets.
The Hospice has flagged a £500k cost pressure driven by both price and volume (overall contract value is £4.3m).

The Committee were advised of a risk that the Hospice return the service. It was clarified the ask is for this financial year and work is taking place around the uniformity across the hospices in the patch to level up the amount of grip applied and bring separate CCGs policies into one. The request was flagged as late in the financial year and recognised in line with the contract should have indicated much earlier.

The Chair raised the the tracking of volume against cost to ensure value for money was not clear within the paper. **It was agreed sensible the paper is brought back to the March Committee to provide assurance the value for money cirtiera has been embedded**.

KP raised the investment this year is significant and highlighted the review to unify processes forms part of the strategy under the financial recovery plan.

Outcome: The Commiittee approved the increase to the Farleigh Hospice budget for 2022/23 of £500k, noted the change of commissioning approach from multiple teams to a core team and supported the work programme for reducing the variation in contracting for fast-track care across the three hospices, ensuring value for money and equity, quality and safety of service.

Items for Assurance

6. 2022-23 Forecast Outturn and Change Protocol

The Committee were presented with a summarised position to date in respect of System financial improvement action, adherence to the Forecast Outturn Change Protocol and the forecast of moving our financial position . It was reported since the end of Q1 the in year financial plan divereged from plan. Earlier in the year the Committee were made aware of the extent of the risk and the pressure the delay in converting efficiencies into cash releasing efficiencies was having on our overall System.

The System has agreed and negotitated a stretch target which has been approved by Board and agreed by regional and national colleagues. The stretch ambition has been set at £52.4m deficit (1.8% of turnover).
The system has received one-off central funding of £6m, which has moved the forecast deficit to £46.4m.

The construct of the System meant that all system players have a responsibility to breakeven as a System. EPUT were expected to provide a breakeven position, the ICB would move to a forecast surplus of £16.8m and MSEFT was declaring a deficit which was mainly reflective of a considerable amount of escalation capacity and significant agency costs. There was a suggestion that wording was factored into contracts to support organisations overcome the issue where staff being trained leave and come back into the workplace via an agency. It was noted the price variance was not unique to MSE but would be explored.

JK took an action to speak to Ruth Jackson, Executive Chief People Officer around the contracting element and report directly back to LL.

The in-year system improvement plan report will be shared with the Committee following discussion at the CEO Forum and ICB Board.

JP highlighted the implications for 23/24 and flagged how we ensure grip and are realistic is key. The Committee were informed the Forecast Outturn and Change Protocol is a nationally mandated document. It was noted with operational pressures and competing priorities in the NHS this needs to be least ownerous and as practictable as possible. Part of the requirement within the protocol is to have an agreed and peer challenged financial recovery plan. MSE are meeting with Julian Kelly, Deputy Chief Executive and Chief Financial Officer – NHSE next week to start the process and understand the trajectory; this will provide the assurance throughout planning period.

The Committee were advised the process for double lock where any revenue investments >£50k will require sign off by the provider and ICB for providers who change their forecast.
Triple lock for Systems changing their forecast will require NHSE final approval of any additional investments in year (£100k threshold).

Following a question around the run rate for MSEFT it was confirmed this has seen a reduction from £7m to £5m each month and put us on trajectory to deliver what has been agreed.
The Committee were advised a management action plan is in place and owned by individuals and the CEO forum.

It was clarified MSE is an outlier. There are several Systems within the south east, Midlands and north east who have undertaken a deep dive processes from the national team.

The team are working through the guidance in terms of planning and what the allocations look like. Check and challange sessions are taking place to look at integrated plans and work is taking place regarding a longer term plan.

The Committee noted the conditions as set out in appendix 1.

Outcome: The Committee noted the paper.

ZP left the meeting.

7. Finance Update – Month 9 Financial Performance Update

The Committee were presented with the month 9 report. It was reported the risk position remains static. Financial effiiciences within the ICB continue to be on track however this is not the case for the rest of the System.

The System was set a stretch target by NHSE and at month 9 is now forecasting £46.4m deficit, (MSEFT deficit of £63.2m, off-set by an ICB surplus £16.8m). Our year-to-date position at month 9 is £38.1m deficit which is in line with our new forecast outturn position.
The position for local authority is presenting a £13.6 defiict year to date, £19.7m deficit against the original plan.
The overall system risk is reporting at £14.9m of which is fully mitigated.

The forecast capital investment for providers for 2022/23 remains at £92m this month, an increase from £90m (including Primary Care £2m) submitted at planning stage to £92m. At the request of NHSE Systems reprofiled their capital plans during quarter 3. The system is now showing a small overspend, £0.3m, year to date. Capital projects are anticipated to deliver largely to plan by the end of the financial year.

JP highlighted the CDC programme and lack of opportunity to redirect capital funding. It was clarified this had been fed back in the Hewitt review.

It was clariifed the heading for 2.5 should read month 9 System Financial Performance.

Following a query around the System cash position it was clarified the there were no concerns. **JS took an action to look at including the System position on cash in future reporting to the Committee**.

Outcome: The Committee noted the paper and appendix 1.

8. Efficiency Programme Update Report

It was reported the System currently has £68.8m of identified schemes (full year effect £83.9m), of which: £30.5m are cash releasing (£32.3m full year effect) – the majority of schemes are sitting within the ICB and EPUT.

MSEFT is launching a new “Improving Value” approach to efficiency delivery which has been received well. Check and challanage sessions are taking place as part of the planning process, the foundation of efficiency delivery is being factored into plans. Benchmarking data has been shared with divisions to look at opportunities to delivery in 23/24.

The majority of the efficiecny delivery expectation has been delivered from the local schemes. The financial sustainability element target has not been delivered and would have mittgated some of the cost pressures.
It was confirmed there is a view to planning effieciences over a longer period.
Outcome: The Committee noted the content of the report and the actions being taken to improve the delivery of efficiency.

9. 23/24 Planning

Following the receipt of planning guidance issued just prior to Christmas work has been taking place to understand and map out the allocations; the first draft submission is 23 February.

It was suggested a one hour FIC seminar is arranged to allow members to be briefed on the submission. It was agreed this is scheduled between 20-22 February. Draft plan will be circulated in due course.

Outcome: The Committee noted the update.

10. Use of Funding Reviews

Adult Social Care Discharge Fund

The Committee were provided with an overview of the Adult Social Care Discharge Fund received in 2022/23 and how monies have been allocated. It was clarified this does not include the recententlyaccounced additional funding of £200m.

The £500m Adult Social Care Discharge Fund allocation consisted of £200m distributed to local authorities and £300m distributed to ICBs to areas experiencing the greatest discharge delays. The allocation is based on a fair shares basis. It was noted there was a slight adjustment to what was received in our footprint due to a data issue which meant MSE lost out on funding circ.£1m – the metric is being worked through with digital and regional colleagues.

There is a set of strict criteria as to how funding is utilised and funding will be withdrawn where not utilised to support additional capacity and virtual and physical beds. It was a condition that funding was pooled into the Better Care Fund to be used on interventions.
Plans have been submitted, and work progressed; waivers to support the plans have been through the ICB Audit Committee.

The alliances have been working closely with the local authority to ensure the funding is discharged and reporting is in place.
JP raised the purchasing of beds is not always right for the patient. The Committee were assured of a home first approach and the ward led reablement to maximise patient outcomes.

Outcome: The Committee received the report.

Winter Funding Pressures 2022/23
The paper provided an overview of the Demand and Capacity funding received in 2022/23 and the plans for managing the expenditure incurred against it.

The ICB was issued with a specific allocation of £7.9m, with the utilisation of the resource being very clearly defined, in that it must increase the capacity of both physical and virtual beds. Funding is on a drawed down approach and will be clawed back should it not used how it is intended.
Plans were discussed at the Urgent and Emergency Care Task Force (and subsequently the Winter Capacity Schemes meeting). Capacity has been utilised within MSEFT, virtual ward and the Hospice.

The Committee were informed of an over-commitment over winter. The current over-commitments against the Demand and Capacity resource are proposed to be managed via corresponding reductions in the forecast spend on Virtual wards to offset the pressure.
The latest forecast is showing spend of £4.6m. A further release of virtual ward funding is anticipated in 2024-25, this does not present any siginicant risk. Funding has enabled the voluntary sector to see if we can mobilise other areas of the system and exit plans are in place.

LL flagged the benefit of running physical capacity at 80% utilisation and to flex virtual ward capacity to enable patients to be allocated a physical bed should they deteriorate. It was suggested this links into the evaluation process to enable improvements for next year. LL welcomed to work with TH and team with regards to the approach.

There was a further discussion around the turnaround needed to support NHSE requests and the need through evaluatuons to reflect on approporiate use of funding. It was advised this had been fed back into the Hewitt review.

The Committee were informed of improved performance in several areas despite significant pressures over winter including an improvement in EEAST category 1 response times. It was flagged our System continues to pull more cases from the ambulance stack then any other System.

Outcome: The Committee received the report and noted that a detailed paper will be presented at the March 2023 Committee, outlining the next steps on schemes from 1 April 2023.

11. Approval of Finance Policies

Allocations and Systems Reporting Policy

Following a query on page 7 of the policy with regards to the capital allocation It was highlighted there is no capital for the ICB, elements relating to primary care are within the delegation of NHSE. It was confirmed although 5.4.1 states Directors are responsible for ensuring that expenditure is managed within the allocated budgets this is a responsibility for all.

Outcome: The Committee approved the Allocations and Systems Reporting Policy.

12. Feedback from System Groups

The Committee noted the minutes of the System Finance Leaders Group, System Efficiency Programme Board and System Investment Group; there were no comments.

13. Items to Escalate

To the ICB Board:

- Service Harmonisation
- Integrated Community Dermatology Service
- Mental Health Services
- 2022-23 Forecast Outturn and Change Protocol

14. Any other Business

The Chair highlighted the need to look for an Associate Non-Executive Member and Vice Chair which will assist with the management of any future conflicts of interest.

15. Date of Next Meeting

10.00-12.00, 8 March 2023 via MS Teams.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 18 January 2023 at 9.30 am

Via MS Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Associate Non-Executive Member – Chair.
- William Guy (WG), Director of Primary Care.
- Dan Doherty (DD), NHS Alliance Director for Mid Essex.
- Aleksandra Mecan (AM), NHS Alliance Director for Thurrock.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Caroline McCarron (CMc), Deputy Alliance Director South East Essex (Deputising for Ruth Hallett).
- Simon Williams (SW), Deputy Alliance Director Basildon Brentwood (Deputising for Pam Green).
- James Hickling (JH), Associate Medical Director (Deputising for Ronan Fenton).

Other attendees

- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes.
- Alison Birch (AB), Head of Primary Care Oversight & Assurance.
- Viv Barker (VB), Director of Nursing.
- Sarah Cansell (SCa), Contract and Support Manager, NHS England.
- Vicky Cline (VC), Head of Nursing, Primary Care Quality
- Jennifer Speller, Deputy Director of Primary Care.
- Jane King (JKi), Governance Lead (minute taker).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.

Apologies

- Ronan Fenton (RF), Medical Director.
- Nicola Adams (NA), Deputy Director of Governance and Risk.
- Pam Green (PG), NHS Alliance Director for Basildon Brentwood.
- Jennifer Kearton (JK), Director of Resources.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and a round of introductions took place. Apologies were noted as listed above.

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.

Under Agenda Item 7, it was noted that Dr Anna Davey was a partner of The Coggelshall Surgery, providing primary medical services under a GMS contract, managed by the ICB. AD is therefore party to decisions made by the ICB that affect GP Practices generally. Item 7 did not require any specific action to manage the noted conflict.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 21 December 2022 were received and approved as an accurate record.

Outcome: The minutes of the ICB PCCC meeting on 21 December 2022 were approved.

4. Action log and Matters Arising

The action log was reviewed and updated accordingly.

Under Matters Arising, WG provided clarification in relation to Service Harmonisation and Tertiary Fertility Services offer in Thurrock (Action 23 - Service Harmonisation, 21/12/2022). It was confirmed that final service harmonisation proposals would depend on the outcomes from public consultation (due at the end January 2023) and review, alongside finance and clinical advice.

5. Boundary Changes

Stock Surgery

AB presented the boundary change request from Stock Surgery which was made following an influx of new registrations from parts of Billericay and Galleywood which were included within the Practice’s boundary. Stock Surgery initially sought advice from the Primary Care Team on closing their patient list to new registrations. However, to keep registrations open to people living in Stock village, the Practice agreed that a change to their boundary would maintain a safe service to their registered population and enable new residents to the village to be registered at the surgery.

Due to a good number of alternative practices nearby, no significant impact was identified and the proposal to reduce the boundary was not considered to significantly affect patient choice. It was noted that Stock Surgery had the lowest ratio of patients to GPs in the area, SA suggested it would be useful to know ratio detail for future boundary change requests from practices.

In response to JH, AB confirmed that the practice had advised the ICB of their intention to close registration, pending the boundary change decision by the committee. JS explained that informal list closures did not require permission from the ICB.

JH asked how 'a last practice standing' situation could be avoided with list closure decisions. AB explained that list closure decisions were part of a collaborative discussion and, in this case, the practices in the surrounding area of Billericay were supportive of the request.

Outcome: The Committee **APPROVED** the recommendation that Stock Surgery's boundary be reduced to avoid the practice closing their list to maintain safe service provision.

Palacin Surgery

AB presented the proposed boundary change to Palacin Surgery following concerns raised by the Surgery that they were reaching capacity within the practice and the impact of the recent planning approval granted to build approx. 250 homes in 2023, adjacent to the Health Centre.

Due to a good number of alternative practices nearby, including one within the same building, no significant impact was identified around patient choice. Alternative practices were all partnerships and relatively stable, although it was noted that North Shoebury Surgery was part of the APMS procurement and there was the potential for the provider of services from this site to change in April 2023.

VC highlighted that the only alternative option for the Wakering area was limited to a practice with a poor CQC rating, therefore limited patient choice. Although the Care Quality Commission and Primary Care Team were working with the Practice to improve service, VC voiced concerns the impact of taking on additional patients would have on the practice.

SA acknowledged the concerns raised and commented that the Committee's decision should be made with the caveat that the impact the boundary change may have on surrounding Practices would be monitored.

Outcome: The Committee **APPROVED** the recommendation that Dr Palacin's boundary be reduced, with the caveat that the impact on surrounding Practices would be monitored.

6. Contract Hand back

Dickens Place

Following the Partners of Dickens Place Surgery, Chelmsford, serving notice on their GMS Contract in September 2022, the Primary Care Commissioning Committee, at the meeting on 21 December 2022, supported the recommendation for an open patient list dispersal.

WG advised that Dickens Place Surgery had agreed to extend their GMS contract notice period on 3 month rolling basis to ensure continuity of services for the population currently registered with Dickens Place Surgery.

Outcome: The Committee NOTED the update on Dickens Place contract hand back.

7. Contractual Changes to support Winter Response

At the Primary Care Commissioning Committee held in December 2022, the Director of Primary Care briefly updated the Committee that several ICSs, including Mid and South

Essex, were reviewing what arrangements may be taken to support primary care providers respond to the winter pressures.

WG updated that following discussions with the ICB's Executive Team, it was agreed that the ICB would make provisions to ensure that no practice would suffer a detrimental financial impact as a result of having to utilise their capacity to manage urgent and episodic demand rather than undertake more proactive work associated with QOF. In broad terms;

- We have communicated with practices that we recognise that winter pressures are impacting on their ability to manage all demands.
- That in line with the national position, we have reiterated that QOF and IIF still stand and our expectation is that practices and PCNs should be delivering QOF and IIF as far as possible.
- That where QOF and IIF achievement is impacted by "quantified actions" that the practices and PCNs are currently taking to reprioritise clinical resources then we would ensure that this work is funded. This will need to be demonstrated.
- For key elements of QOF, where achievement is below our expectation for our population, we expect recovery in Q1 2023/24 (i.e. over a 15 month time period rather than the 12 month QOF year).

This development was taken forward with the LMC and the full implementation of it would continue to be in dialogue with the LMC.

SA invited comments and questions and from Members.

AD acknowledged that the ICB's primary care support arrangements must be seen in context; that winter pressures were a system wide problem, and that Primary Care were being asked to meet 'on the day' demand to support the pressure on the overall system.

JH stressed that PCNs and Practices should be encouraged to use professional judgement appropriately and allowed autonomy to direct resources where needed.

JS advised that practices and PCNs wishing to take up the winter response proposals had been supported to submit simple report based on their agreed Urgent and Emergency Care (UEC) plans. AD hoped the plans would provide an insight into practice thinking, planning and innovation.

The committee discussed the issues of access vs continuity and agreed that when access for urgent and episodic care was right, e.g., using pharmacists, it can help protect those clinicians providing continuity. PW advised that utilisation of the Community Pharmacist Consultation Service was generally very low.

The ICB would continue to work with practices, PCNs and the LMC to ensure the effectiveness of the Winter Response arrangements.

Outcome: The Committee **ENDORSED** the actions undertaken to enable Primary Care to respond to winter pressures as part of the ICB's wider system response.

8. Primary Care Delegation

WG provided an update on Primary Care Delegation following NHS England's decision in December 2022 to approve the proposed delegation of Pharmacy, Optometry and Dentistry

(POD) commissioning to ICBs. Subject to final local approval, Mid and South Essex ICB would take responsibility for the commissioning of these services from 1 April 2023. Whilst these would be delegated to each ICB, the ICBs in East of England would collaborate on the day to day commissioning and contract management of Pharmacy and Optometry Services. Subject to final approval, these functions would be hosted by Hertfordshire and West Essex, underpinned by a Memorandum of Understanding (MoU) on behalf of all six ICBs in East of England. The current MoU was shared with the Committee which set out the core principles, responsibilities and standard operating procedure.

WG explained the existing governance infrastructure would be adapted to support POD delegation and that a proposed Primary Care governance structure would be presented to the committee in February. The governance structure would allow the Primary Care Commissioning Committee to provide the ICB with appropriate assurance that the optimal provision of primary care services was being delivered. WG clarified that Primary Care would refer to Medical, Dental, Optometry and Pharmacy Services.

SA invited comments and questions from members.

The Committee agreed that any new arrangements must have input from the Alliances and practicalities to ensure people are involved and empowered in decision making needed to be worked through. To ensure the committee can focus on key strategic issues, operational decisions e.g., GP contract changes would need to be done outside the committee, but this remit was yet to be decided.

In response to SW's query around whether adequate resource was available to support POD delegation, WG advised that initially POD services would be embedded into the ICB structure and allow for a period of stabilisation, only then would transformation work commence. There may be potential gaps, however contract management would not be affected. WG confirmed that dental staff would transfer across to the ICB.

The committee agreed that clear communication to staff around what POD delegation meant for the ICB was essential. SA suggested that an education piece on POD would be valuable to the Primary Care Commissioning Committee, and it was agreed that a seminar session was the best approach. WG offered to involve external experts to support committee learning.

ACTION: WG to arrange seminar training session covering Pharmacy, Optometry and Dentistry for Primary Care Commissioning Committee Members.

The Committee discussed whether it was worthwhile reaching out to dentists and optometrists to start to create relationships and gather transformation thoughts. WG explained there was minimal opportunity for transformation within dentistry due to current national contracts. The committee noted that dental services regularly attracted media attention therefore a common understanding of issues and good communications support would be essential.

WG said there was potential for transformation of community pharmacy services and that the Primary Care team were looking at how pharmacists could be part of Alliance level conversations. PW highlighted that Primary Care Networks were already linked in to community pharmacies. The committee noted that optometry services had a good pathway currently.

CMc said that the expectations for the Alliances needed to be clear, whilst local and strategic relationships need to be formed it must be recognised that there was also limited capacity within the Alliance teams.

AD explained that her role as Primary Care Board Member represented all areas of primary care, therefore the Alliances would be critical to ensure the primary care voice was heard across the board.

JS suggested working through opportunities and proposals with Deputy Alliance Directors to form a plan to sustain and develop relationships before reaching out. SA agreed with JS and stressed the need for careful consideration on how to progress with relationships.

In terms of contract numbers, PW advised there were currently 212 community pharmacies across the patch PW and agreed that lots of work was needed to build relationships. SC reported approximately 155 dental contracts. SA stressed the importance of having a full understanding of the scale and business inherited, because of POD delegation.

ACTION: WG to prepare a paper for future Committee meeting outlining what POD delegation means for ICB.

VC proposed that the Primary Care Quality team would mirror the steps taken with general practice to support service improvements for any POD hotspots. VC stressed the importance of local quality issues being taken through the MSE ICB Clinical Quality Review Group.

PW requested that Easter Commissioning arrangements for pharmacies were put in place as a priority to allow pharmacies adequate notice to open and to ensure adequate coverage. Although pharmacies would be under the ICB by Easter, commissioning decisions were currently with NHS England.

ACTION: PW and WG to liaise with NHS England around Easter Commissioning requirements.

Given there were many different delivery modules within the newly delegated services and a large increase in relationships to maintain, the committee agreed that relationship management and building needed a strategic approach.

WG agreed and would bring a proposal for a relationship management and timeline to a future committee.

ACTION: WG to bring a proposal for a relationship management and timeline to a future PCCC meeting.

VC advised there would be a separate delegated services complaints workstream moving across to the ICB, but this would be after April 2023.

SA thanked the Committee for the robust discussion around Primary Care delegation and reiterated the importance of looking at how the relationship between commissioning, provider workforce and finance can come together to work effectively.

Outcome: The Committee NOTED the update on Primary Care Delegation.

9. Primary Care Planning Guidance

WG explained that NHS England Annual Planning Guidance for 2023/34 had been issued which outlined specified deliverables for Primary Care for the coming year. The focus was on access and capacity. Additionally, a General Practice "Access Recovery Plan" was due to be published by NHS England.

The Committee agreed that the aim of the ICB was for the right person to see right patient and deliver quality care at right time. A self-refer approach where patients can decide who they need to see and when they are seen, would not be appropriate for vulnerable cohorts of patients.

SA said the real challenge was in maintaining continuity of care between different parts of the system and that a strategy would be required to support an integrated communication service to improve continuity. SA said it was also important to ensure an evaluation of interventions was undertaken to support the restructure of services at local level. SA requested consideration be given to how an evaluation piece could be undertaken.

WG advised that updates on delivery would be presented to the committee throughout 2023/24.

Outcome: The Committee NOTED the Primary Care Planning Guidance update.

10. Escalations

- To NHSE – Easter coverage to NSHE

11. Any other Business

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

12. Date of Next Meeting

15 February 2023 - 9.30–11.30am via MS Teams.

Minutes of Part I Quality Committee Meeting

Held on 25 November 2022 at 10.00 am – 12.00 noon

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member and Committee Chair.

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.
- Jackie Barrett (JB), Interim Head of Nursing.
- Linda Moncur (LM), Interim Director of Safeguarding.
- Vicky Cline (VC), Head of Nursing – Primary Care.
- Sara O'Connor (SO), Head of Corporate Governance.
- Alix McMahon (AMcM), Complaints Manager.
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care.
- Laura Marshall (LMar), L&L Consulting.
- Kathy Ramsay (KR), Senior Infection Prevention and Control Nurse.
- Angela Harding (AH), Quality Improvement Nurse.
- Ross Cracknell (RC), Senior Quality Manager Mental Health.
- Michelle Angell (MA), Portfolio Director, Mid and South Essex Partners (Items 1 - 6).
- Stevie Attree (SA), Personalised Care Lead (item 20).

Apologies

- Dr Ronan Fenton (RF), Medical Director.
- Frances Bolger (FB), Interim Chief Nursing Officer.
- Karen Flitton (KF), Patient Safety Specialist.
- Greer Phillips (GP), Patient Safety & Quality Manager.
- John Swanson (JS), Infection Prevention & Control Specialist.
- Eleanor Sherwen (ES), Interim Head of Nursing.

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.

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 30 September 2022 were reviewed and approved, subject to 'LSMS' being amended to 'LMNS' under Section 15 (Maternity Update) on page 11 of the papers.

Resolved: The minutes of the Quality Committee meeting held on 30 September 2022 were approved subject to a minor amendment as noted above.

4. Matters Arising

There were no matters arising. NH explained the order of the agenda had been amended to provide the opportunity for greater discussion on some key issues. In addition, FB was implementing arrangements to ensure that priority issues were escalated to, and focussed upon, by the committee.

5. Action log

The action log was reviewed and updates noted:

- Action 2: SO advised that she understood FB had discussed membership of the committee with Mike Thompson.
- Action 14: VB confirmed, via the 'Chat' function, that Action No 14 could be closed as all action required was in progress with interviews due to be held mid-January.

6. Lived Experience Story – Virtual Wards

Due to technical difficulties, the video could not be shown (the link to the video was therefore shared following the meeting). MA explained that the patient interviewed in the video was asked how they felt about using tele-health technology and being part of a virtual ward. The patient advised that this had enabled her to be discharged home earlier where she felt happier.

Resolved: The Committee noted the Lived Experience story relating to Virtual Wards.

7. Deep Dive – Virtual Wards

MA advised that Hospital at Home, which was an acute led ward, had recently been increased from 45 to 55 beds. There was also a respiratory and a frailty virtual ward and a business case for a children and young people's virtual ward was currently being considered by NHS England (NHSE). Plans were also being developed for a heart failure virtual ward. To-date there had been a significant amount of positive patient feedback.

Virtual wards significant reduced the risk of hospital acquired infections and deterioration whilst in an acute environment. The pathway was either step-down through the hospital wards or step-up through the UCRT. Direct referrals from GPs were being considered and the Provide team already took direct referrals from paramedics.

Not all patients received or wanted all of the technology offered, but the ‘blue box’ could support remote consultations.

MA advised that virtual wards were delivering better outcomes than traditional pathways, with reduced functional decline, greater independence and fewer readmissions.

Work was underway to optimise the use of virtual wards, including increasing staff knowledge and confidence to refer patients, to reduce delayed discharges from virtual wards, improve rota efficiency and productivity. It was estimated this could increase capacity of these wards by 65%.

SM offered the help of the Quality Team to assist MA in progressing virtual ward plans. MA advised that their help would be appreciated in assessing the quality of the service.

In response to a query from NIB, MA advised that standing operating procedures set out patient suitability criteria for virtual wards, which was also open to clinical interpretation. Links to this had been included on the primary care hub websites and would be promoted further.

PW advised that it would be important to integrate virtual wards across different services, rather than it being seen as a separate entity.

JB advised that although assisted technology was beneficial, it was important to strike a balance between the use of this and face to face visits by nursing and other clinicians to maintain the quality of care. MA advised that consideration of this was evidenced by the frailty virtual ward using less remote technology than others, with greater clinician involvement with patients, whereas the respiratory ward made greater use of technology.

Resolved: The Committee noted the Deep Dive on Virtual Wards.

8. Complaints and Lived Experience Report Quarter 2

AMcM advised that issues relating to COVID care, booster vaccinations, access to GP appointments, prescribing and medication issues, funding requests and clinician decisions formed the majority of complaints. Further work would be done to improve the categorisation of complaints once Datix had been implemented.

The complaints team was currently not yet at full capacity, affecting its ability to respond to complaints in a timely manner. In addition, from 1 April 2023, the ICB would take on responsibility for primary care complaints formerly managed by NHSE, although no further resources would be made available.

PW advised that improved liaison between the complaints team and the patient referral team might improve patient experience and reduce complaints. The Pharmacy team would also work with the complaints team to address complaints relating to community pharmacies.

In response to a query from NIB regarding how mid and south Essex compared with other ICBs regarding the management of complaints, AMcM advised that benchmarking had not yet been undertaken and was difficult due to the way complaints were currently categorised by each system.

Resolved: The Committee noted the Complaints and Lived Experience Report for Quarter 2.

9. Patient Safety and Quality Risks

SO advised that she planned to move risks on to Datix as soon as possible, as the current spreadsheet continued to be problematic.

The red risks related to Mental Health quality assurance; quality assurance of Autistic Spectrum Disorder services; and Maternity Workforce. A further red risk relating to health inequalities might transfer to the new Health Inequalities Programme Board.

SO highlighted Appendix 2 containing an excerpt from the new Board Assurance Framework (BAF) first presented to the ICB Board on 17 November, relating to safety and quality issues. The Board had asked that mental health services were included on future iterations of the BAF.

PW advised that the rising cost of electricity charges and over the counter medicines was a new risk, as people were increasingly finding it harder to self-care due to this.

SO asked for the committee's support to close risk refs PLAC06 (service provision of high risk medicines) and CYP07 (transfer of community children's services at the Lighthouse to alternative provider). No objections to closure were received.

Resolved: The committee:

- **Noted the update on patient safety and quality risks.**
- **Agreed to close Risk Refs PLAC06 (Service Provision of high risk medicines) and CYP07 (transfer of community children's services at the Lighthouse to alternative provider).**

10. Quality Strategy Implementation Update

LMar advised that the initial phase of the new quality reporting structure had completed and was now moving towards design of dashboards and interactive reporting.

A workshop held in September had been successful and there was a commitment to do things differently and more effectively.

Task and Finish groups were established to develop new reporting arrangements for Infection Prevention and Control (IP&C) and maternity. Safeguarding and the Care Sector would be focussed upon next. From January there should be an increased level of interactive data available to inform discussions, subject to confirmation of a business intelligence resource to support this work.

NIB mentioned that FB had advised that it was currently difficult to identify trends in a meaningful way and needed to be improved. LMar advised that greater use of business

intelligence and linking in with Population Health Management colleagues should achieve this.

SM advised that dates for committee meetings in 2023/24 were being identified and he was pleased with the work undertaken so far to develop the new reporting format.

Resolved: The update on the implementation of the Quality Strategy and progress with the Quality Dashboard was noted.

11. Patient Safety Specialist Updates:

11.1 Patient Safety Framework Update

VRB advised that she would take the report 'as read' and confirmed that significant work had been undertaken by KF since her appointment as Patient Safety Specialist.

11.2 Appointment of Patient Safety Partners

VRB confirmed that the recruitment pack for Patient Safety Partners had been agreed and interviews would be held in January 2023.

11.3 ME ICS Patient Safety Specialist Network Terms of Reference

VB asked those present if there were any comments on the draft Patient Safety Specialist Network Terms of Reference. In response to a query from PW, VB advised that mapping would be undertaken to develop a patient safety workplan covering all disciplines and services, including medicines, to avoid duplication.

11.4 NHS Patient Safety Updates

The committee noted the NHS Patient Safety Updates dated 27 September and 25 October 2022.

Resolved: The Committee noted the Patient Safety Specialist update and endorsed the ME ICS Patient Safety Specialist Network Terms of Reference.

12. Acute Care, including update on Never Events

JB advised that she would take the paper 'as read' and that detailed information regarding wrong site surgery Never Events was included as an appendix to the report. VB advised that a meeting with hospital colleagues was being arranged to discuss Never Events, which RF would attend, to agree action required to prevent these occurring.

JB highlighted that Mid and South Essex Hospitals NHS Foundation Trust (MSEFT) complaints response rates continued to rise. Mitigating action was being taken. The backlog of harm reviews also remained a concern.

JB advised that since the report had been written, the Cancer Quality Assurance Group (CQAG) would be discontinued and replaced by the Cancer Transformation and Improvement Board. MSEFT's Referral to Treatment (RTT) times remained challenged predominantly because of workforce challenges.

There were 253 open Serious Incidents relating to MSEFT and action was being taken to progress these to closure.

The increasing number of wrong-site surgery Never Events was of concern and East of England Ambulance Service Trust (EEAST) remained under considerable pressure.

Resolved: The Committee noted the Acute Care update.

13. Infection Prevention and Control

KR highlighted a couple of Noro-virus outbreaks in Broomfield Hospital and an ongoing scabies outbreak in a care home. KR advised she would be happy to take any questions on the information contained within the report as JS was keen to receive feedback on the new report format.

NIB advised she welcomed the new reporting format but would appreciate further information on trends and developing high risk areas.

PW highlighted that pharmacies did not stock Vancomycin used to treat C.Difficile due to its high cost. KR confirmed that she was liaising with the pharmacy team on this issue and information for clinicians on the treatment for C.Difficile was being provided.

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

14. Maternity Services

GH advised that general midwifery vacancy and turnover rates had improved slightly. However, the maternity governance structure still had vacancies which were being covered by senior interim posts, but there was concern about what would happen when these contracts ended.

Assurance had been received that open maternity incidents were being reviewed and any classed as moderate or above were actioned. However, MSEFT remained a significant outlier regionally. NHSE were aware and were monitoring this alongside the ICB. The Trust had confirmed this would be addressed, but there had been some challenges with the Datix system on one of the sites.

The Local Maternity and Neonatal System (LMNS) was privy to an updated compliance report on the Ockenden recommendations, which was positive, and there were discussions at Trust Board level regarding how to ensure reporting on progress was clear and transparent.

GH advised that the recently published East Kent investigation report recommendations had similarities to the Ockenden recommendations and had been discussed at the November ICB Board meeting. NHSE were due to publish a national action plan in early 2023.

VB advised that many of the recommendations contained within the East Kent report could be applied to other services and she therefore urged colleagues to familiarise themselves with them.

GH asked the committee to endorse the Maternity Digital Strategy, which was based on the seven pillars of practice stipulated by NHS Digital and the Maternity Transformation

Programme. The strategy had already been approved by the Digital and Data Technology Committee.

NIB noted that although digital services were necessary, the need for compassion and kindness when providing maternity care must not be overlooked as highlighted by the Ockenden and East Kent reports.

SM advised that it was anticipated that a deep dive on maternity services would take place at the January committee meeting.

Resolved: The Committee noted the update on maternity services and endorsed the Maternity Digital Strategy.

15. Mental Health

RC advised that a high profile inquest which commenced in September had been adjourned and would reconvene in early January 2023.

Quality assurance visits were ongoing across all mental health providers. The main concerns related to staffing levels, estates issues and IT systems.

Out of area placements were currently high and the ICB was working with Trusts to arrange repatriation of affected patients to local beds as soon as possible.

SM advised that the Care Quality Commission were undertaking a full inspection of Essex Partnership University NHS Foundation Trust (EPUT) services and an update on feedback would be provided to the committee as soon as possible.

Resolved: The Committee noted the Mental Health update.

16. Alliance Primary Care Quality Report

VC advised that her report had also been submitted to the Primary Care Commissioning Committee. The number of outstanding Serious Incidents had reduced from 9 to 7 and the Practice Risk Review update would look slightly different in future reports due to individual Alliance meetings having been replaced by one System meeting. The primary care quality team would also liaise with AMcM to ensure that there was no duplication regarding the management of complaints.

A rapid review of the Wakering Medical Centre had been undertaken and an action plan had been submitted to the CQC. The practice was providing evidence that it was implementing the changes required on a weekly basis and the partners were fully engaged in the process.

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

17. Care Sector Report

AH advised that the recruitment of carers and other staff within the care sector, both in care homes and domiciliary care, was extremely challenging. The ICB was working with local authorities and other agencies to address this. AH noted that although some homes had available beds, they did not have sufficient staff to provide care. Consequently, several homes had closed.

SM advised that workforce challenges in the care sector were also impacting significantly on other services.

NIB queried if further rollout of virtual wards could help. AH advised that it had been agreed that care homes could now access virtual wards following an access referral to the UCRT.

PW also advised that it was important to understand the level of pharmacy and other support required by care homes, on issues such as medicines optimisation, safeguarding and investigations.

LM agreed with PW's comments, particularly in relation to children and those with disabilities in light of issues identified in Doncaster and highlighted that it was important to focus on domiciliary care workforce challenges to enable patients to remain at home thus reducing the need for admission to care homes.

CL agreed to liaise with Matt Gillam to identify what linkage there had been between Continuing Health Care (CHC) and virtual wards.

Resolved: The Committee noted the Care Sector Report.

Action: CL to liaise with Matt Gillam regarding linkage between Continuing Health Care and virtual wards.

18. Adults and Children Safeguarding System Report

NIB advised that she had been meeting with the Chairs of the Safeguarding Boards and would liaise with them on an ongoing basis.

LM advised that an Essex wide conference, with over 400 attendees, had focussed on non-accidental injuries (NAI). LM explained that although policies were in place, the escalation process to the police once a NAI was identified was not always followed correctly. The view of the Police was that any clinician who had concerns regarding a child should be reported to them immediately. LM highlighted action being taken to address this issue.

Southend and Thurrock local authorities had submitted reports on disabled children in residential care to the national panel, with no untoward concerns identified. Essex would be doing the same. PW and her team would provide support to review medication for children in residential care.

Progress against Safeguarding Adult Reviews was also highlighted to the committee. A group had been established to progress multiple recommendations made.

LM advised that further mental health support was required to prevent people from disengaging with services and concerns had been raised about poor housing conditions which could exacerbate health conditions such as asthma.

LM also highlighted the 'Walk the Line' event held to educate children regarding child exploitation.

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

19. All Age Continuing Care (AACC)

CL advised that workforce challenges within the team continued which meant the team had not been able to deliver in several areas as highlighted within the report.

The AACC team was working with care providers to address capacity issues as highlighted within the care sector report.

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

20. Personal Health Budgets (PHB)

SA advised that the ICB was rated green in its achievement towards PHB numbers and was within the top 3 systems in the region. However, projects were in place to further mature these arrangements, including a pan-Essex initiative to implement Section 117 PHBs which were a legal requirement.

SA also advised that MSE had recently featured in a journal article 'Supporting young people who are leaving child and adolescent mental health services' (Mental Health Practice, 2022).

Resolved: The Committee noted the Personal Health Budgets update.

21. Medicines Optimisation

PW advised that additional information regarding the de-prescribing of opioids had been included within the report and advised that the next report would focus upon antibiotics.

Resolved: The Committee noted the Medicines Optimisation Report:

22. Any Other Business / Reporting to ICB Board

NIB outlined her proposals for future reporting and discussions on key issues at committee meetings and suggested that the committee should meet in person at least once during 2023/24.

23. Date of Next Meeting

Friday, 27 January 2023 at 10 am to 12 noon via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 8 February 2023 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.
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Dr Ruth Jackson (RJ), Executive Chief People Officer, MSE ICB.
- Dr Tiffany Hemming (TH), Executive Director of Oversight, Assurance and Delivery, MSE ICB.
- Claire Hankey (CH), Director of Communications & Engagement, MSE ICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Alexandra Green (AG), Chief Operating Officer, EPUT
- Ruth Hallett (RH), Alliance Director (South East Essex), MSEICB

Other attendees

- 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.
- Jason Skinner (JS), Director of Finance System Planning & Reporting.
- Annette Thomas-Gregory (ATG), Director of Education EPUT and MSE ICB.
- Paul Taylor, People Director, EPUT.
- Vickie Bennett (VB), Business Manager, People Directorate.
- Sara O'Connor (SO), Head of Governance and Risk, MSE ICB (minute taker).
- Selina Douglas (SD), Executive Director of Partnerships, North East London Foundation Trust.
- Sean Leahy (SL), Executive Director of People and Culture, EPUT.

Apologies Received

- Pam Green (PG), Alliance Director (Basildon and Brentwood), MSEICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSEICB.
- Andrew Pike, (AP), Managing Director, MSEFT.

1. Welcome and Apologies (presented by A McKeever)

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

AMcK advised that he had appraised Julian Kelly, the NHSE Director of Finance, of the ICB's financial improvement plan and had agreed the outturn financial forecast figure for 2022/23. The financial plan for 2023/24 would need to ensure that full use was made of resources within each partner organisation.

2. Declarations of Interest (presented by A McKeever)

AMcK 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 A McKeever)

The minutes of the last SOAC meeting held on 11 January 2023 were reviewed and approved, subject to inclusion of Selina Douglas in the list of those present.

Outcome: The minutes of the meeting held on 11 January 2023 were approved, subject to a minor amendment.

4. Action log and Matters Arising (presented by A McKeever)

The Action Log was noted and the following updates provided:

- **Action 79:** MT advised that RF had confirmed this action could be closed as being progressed.
- **Action 81:** To be closed.
- **Action 96:** To be closed.
- **Action 97:** Independent report awaited.
- **Action 98:** Covered under item 5 below.
- **Action 101:** To be closed.
- **Action 102:** To be closed.

There were no matters arising.

5. Workforce Priorities (presented by R Jackson)

RJ advised that the December workforce report included revised trajectories more accurately reflecting the available pipeline of staff. Vacancies rates were flattening - MSEFT showed a slight dip and EPUT had remained virtually static for three months, although 'hotspots' remained in some professional groups.

Adherence to Plan data up to October (slide 3) was based on planning round assumptions set in March 2022. MSEFT were substantially off-track but EPUT data was positive. The new trajectory (up to March 2023) showed EPUT were performing above plan and MSEFT were slightly below trajectory (0.03%).

MSEFT vacancy rates within professional groups (slide 4) showed a steady decline, including a three month reduction in nursing and midwifery (N&W) vacancies and a slight reduction in registered scientific, therapeutic and technical staff (RSTTS). Vacancies for ‘support to clinical staff’ had increased circa 17% in December 2022 and the ICB was in discussion with regional and national teams regarding this increase.

EPUT vacancy rates showed a slight reduction in N&W and RSTTS vacancies, but nursing showed an enduring 23% vacancy rate. *[AMcK subsequently requested that a detailed plan to address EPUT’s 23% vacancy rate was developed as per the action noted below].*

Slide 5 showed that whilst MSEFT had reduced vacancy rates, it remained marginally off plan both for registered N&W and RSTTS, although support to clinical staff was gradually improving. EPUT showed a significant variation on the plan in terms of registered nursing and RSTTS vacancies since the trajectory was reprofiled.

AMcK welcomed the work done to agree and deliver against new trajectories but highlighted that variances would affect the system year-end financial position.

DH advised that recent international recruitment initiatives were coming to fruition and pre-employment checks were being progressed urgently. However, retaining staff was challenging. The Trust was working with the national team to address this.

RJ advised that a Transformation Lead post was being recruited to take forward the Health Care Support Worker Academy.

HC confirmed that activity, establishment and spend was being triangulated with partner organisations to align improvement plans.

PT confirmed that despite an increase in the number of EPUT staff, the vacancy rate remained static. The ‘Time to Care’ initiative was being focussed upon to ensure appropriate skill mix during the next year. There were also medium to long term plans for apprenticeships and trainee nurse associates.

AMcK advised that although the total substantive workforce had increased by circa 3,000 since 2018/19, both in terms of head count and whole time equivalents (WTE), circa 2,000 vacancies remained. This called into question both the nature of the intended staff mix and the levels of productivity now being achieved. Both issues would need to be addressed proactively in the 23/24 plan.

In response to a query from SW, RJ advised that during December 2022 reductions in vacancies were not necessarily reflected in a corresponding reduction in bank and agency staff due to winter pressures and staff leave. The system would need to be realistic regarding the available pipeline of staff to identify vacancies that would not be filled during 2023/24. Transformative work to develop other suitable roles to fill gaps was necessary.

AMcK advised that the six fold difference in the number of vacancies and bank/agency staff in EPUT was unsustainable. Overall, the system was using twice as many bank and agency staff permitted under the national cap and organisations must not continue to distribute resources on an ad hoc basis.

RJ advised that the workforce team would model a reduction in bank/agencystaff set against the trajectory for filling vacancies to the end of March 2023. The data for the current planning round was being reviewed, following which a trajectory to reduce bank and agency use would be set.

AG advised that reducing the number of qualified vacancies would positively impact on reducing agency health care assistants being used to mitigate qualified gaps. AG also noted that improving hospital flow/discharge and identifying demand and capacity were inextricably linked to reducing bank/agency staff.

In response to a suggestion from HC regarding community workforce data, RJ explained that relying on community data had been challenging due to the way it was reported by providers. JW confirmed this had now been addressed and monthly information split by sub-geography would be provided. Community bank and agency use would also be provided in due course.

RJ confirmed there were no escalations from the People Board.

Outcome: The Committee noted the Workforce Priorities Report.

ACTION 107: MR/PT to provide a detailed plan to address EPUT's 23% nursing vacancy rate.

ACTION 108 : RJ to request workforce team to model a reduction in bank/agency staff set against the trajectory for filling vacancies to the end of March 2023.

ACTION 109 : RJ to set trajectory for reducing use of bank and agency staff during 2023/24 once planning round work has been completed.

ACTION 110 : JW to provide Holly Randall and Rochael Nicolas-Gaspard with monthly community workforce data split by sub-geography.

6. Quality Report (presented by F Bolger)

FB advised that a recent unannounced CQC inspection of older people and medicine services at MSEFT identified concerns regarding the nutrition and hydration patients and management of mental health (MH) patients. A follow-up unannounced inspection occurred on 7 February 2023. A meeting to discuss the findings would be held on the afternoon of 8 February 2023. Further evidence had been submitted and HC and DS were liaising with the CQC. A Rapid Quality Review meeting, to be chaired by AMcK, was expected to take place on 22 February 2023. DS and FB were liaising to agree arrangements and follow up action.

A meeting to review progress against MSEFT's outstanding legal undertakings, including 1 x cancer performance, 1 x referral to treatment performance and 1 x maternity services, took place on 31 January 2023. Maternity undertakings would be reviewed again on 27 March 2023.

The outcome of the CQC maternity survey had identified improvement over three domains. The Patient Experience Midwife was developing an action plan to share with the Local Maternity and Neonatal System (LMNS) Board.

FB highlighted concerns surrounding the low number of EPUT staff coming forward to provide evidence for the Independent Inquiry into mental health services. All partners were asked to encourage participation.

EPUT representatives attended Southend Health Oversight and Scrutiny Committee (HOSC) the previous week to provide reassurance regarding the quality and safety of mental health services. AG advised EPUT had also attended Thurrock HOSC at the end of January and planned to attend a future Essex HOSC meeting. AG also noted her thanks to system colleagues for the support provided to EPUT.

AMcK advised that a quality improvement plan which flowed from discussions held with EPUT was being finalised. AMcK had suggested to EPUT colleagues that, via staff briefings, the ICB could help to encourage staff (past and present) together with patients to contribute to the Independent Inquiry.

HC thanked FB and her team for the support provided to MSEFT following CQC inspections and suggested that MSEFT should mirror the approach taken by EPUT by attending HOSC meetings. MSEFT would work with EPUT colleagues to address concerns regarding the environment in which MH patients were cared for.

FB advised a request had been received for feedback from EPUT staff to triangulate what agreed high level actions were achieveing on the frony line and she would meet with Suffolk and North East Essex and Herts and West Essex colleagues to discuss later that day. FB would also meet Natalie Hammond from EPUT the following day.

EMcK advised that MSEFT had two further outstanding legal undertakings relating to governance and harm reviews which would be considered by region during March.

FB confirmed there were no issues to escalate from Clinical Quality Review Group or the LMNS Board.

Outcome: The Committee noted the Quality Report.

7. Performance Report (Presented by Dr T Hemming)

TF provided an overview on the following:

7.1 Cancer

Tier 1 meetings continued with regional/national colleagues. 62+ day waits continued to fall. Trajectory was to hit 568 by end March. Whilst there was confidence in hitting the headline number individual trajectories within it were considered to be at risk, i.e. colorectal, gynaecology and urology (a piece of urology equipment was broken, but was being mitigated including via provision of mutual aid from Colchester Hospital).

7.2 Urgent Care

December ambulance times were extremely poor reflecting historically high public demand. January data showed a slight improvement due to lower demand and significant changes at Southend Hospital including 7 additional major cubicles and new leadership. Consequently, ambulance handover units had been used less often during the past month. National winter monies would cease in March 2023. Evaluation would need to be undertaken to inform future plans. Some activities would cease and a paper regarding continuation of other activities would be presented to the ICB Finance and Investment Committee. Demand and capacity modelling was ongoing.

7.3 Discharge Funding

The ICB was currently on track to spend about a third of circa £3.9 million additional funding as it had struggled to find patients whose needs could be met within the local scheme's pathways, although MSE was understood to have done better than some other systems in this regard. A 'home first' strategy for patients was being maintained to avoid patients being placed inappropriately upon discharge from hospital. AMcK advised that an evaluation on the £3.9 million funding would be required for the Board to understand how it was used and its effect.

7.4 Longest Waiters

Currently 1 patient waiting 104+ weeks. Reduction in 78 week waits were on trajectory and expected to be met. Detailed assurance should be available propsectively – as all providers were required to evidence that all the necessary bookings and TCIs had been organised ahead of time. Concerns had been identified regarding Lighthouse data quality which was being worked through. Adult Speech and Language Therapy recovery was ahead of plan.

7.5 Escalations from Cancer Board, Strategic Urgent Care Board and Elective Care Board.

TF advised that the ambulance management action plan managed by the Urgent Care Board had been closed down. The arrival of the SHREWD system had already made a positive difference in supporting the System Control Centre and operational decision making.

HC highlighted that MSEFT booking performance was currently amongst the best in the country and the cancer patient tracking list was at its lowest since the trajectory was set. The approach taken for skin would be applied to other specialties. HC thanked Michelle Stapleton and her colleagues for their support in spending the discharge funding which had made a positive impact on discharges.

AMcK added his own thanks to those who regularly attended tactical meetings throughout each day. AMcK also noted that the average category 1 ambulance time was now around 8 mins against the 7 minute standard and the 90th percentile was 15 mins 58 seconds against 15 mins, thus edging towards normal boundaries. Category 2 response times had made similar improvements.

AG advised that for new referrals to the Lighthouse, no one was waiting over 46 weeks. A comprehensive data cleansing exercise was being undertaken on just over 500 children and young people previously cared for by MSEFT. This was approximately half way through, and had identified 4 individuals waiting over 78 weeks. Consequently, it seemed the fallout would be limited and manageable. A report on referral to treatment times would be available from April.

RJ advised that East of England Ambulance Services NHS Trust staff had just announced they would be striking. Until now, this was an area where MSE enjoyed continuity of activity. This, coupled with possible action by Junior Doctors, meant that MSE would need to develop contingency plans.

Outcome: The Committee noted the Performance Report.

8. M9 Finance Report (presented by J Skinner and J Kearton)

AMcK advised that a change to the system forecast outturn would be taken through the ICB and provider Boards by JK. PwC had assisted MSE to construct and substantiate a financial improvement plan, but Finance Directors would also be seeking an independent review as quickly as practicable. Many of the issues discussed at SOAC, such as reducing bank/agency spend, reducing length of stay and improving productivity, would need to be linked to financial plans. The national team recognised that there were risks around elective care due to the large backlog. Consequently, efforts would have to be made to provide more care within community settings where appropriate. The overriding priority was to have a realistic and reliable plan.

JS advised that the system outturn forecast was £46.4 million deficit, being the £52.4 million stretch target agreed with regional and national colleagues, plus £6 million additional funding anticipated.

The month 9 position was £38.1 million deficit, which was circa £32 million worse than the original plan. Local authorities also faced similar pressures with a deficit of £13.6 million year-to-date and forecasting £19.7 million overall imbalance for the year.

In response to a query from AMcK, JS confirmed the M9 position was consistent with the forecast outturn that the system had committed itself to.

In response to a further query from AMcK, JK advised that the run-rate had previously been circa £7 million but had curtailed to £5 - £5.5 million. This would be reflected in 2023/24 planning. A further meeting with Julian Kelly and his team was due be held in three weeks' time.

JK confirmed there were no specific escalations to report from the System Efficiencies Board. A significant amount of work was being undertaken by MSEFT to realise efficiencies and improve productivity, but further work was required by EPUT and the ICB.

Outcome: The Committee noted the Month 9 System Financial position.

9. Progress on Planning (presented by T Hemming and J Cripps)

TF advised that the system delivery and performance planning meetings had been re-established, templates had been shared and any queries/requests were being communicated to NHSE via locality leads. The draft submission was due on 23 February 2023, with the final plan due by noon on 30 March 2023.

JC advised that the Chief Executives would review the narrative and plans on 20 February 2023 prior to final submission. The Joint Forward Plan (JFP) was also under development - the Operational Plan would form Year 1 of the JFP.

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

There was no other business discussed.

11. Papers shared for information only.

There were no papers shared for information only.

12. Date of Next Meeting

8 March 2023 – 1.00 pm to 3.00 pm via MS Teams.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.6

ICB Board Policies

Summary Report

1. Purpose of Report

To ask the Board to adopt new ICB Policies which have received prior review and approval by the relevant Committees.

2. Executive Leads

Jennifer Kearton, Executive Director of Resources
Ruth Jackson, Chief People Officer

3. Report Author

Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

Finance & Investment Committee and Remuneration Committee

5. Impact Assessments

An equality impact assessment is included at Appendix A of each policy.

6. Financial Implications

Each policy outlines how any associated financial implications will be managed.

7. Details of patient or public engagement or consultation

Details of engagement with relevant stakeholders is set out in each policy

8. Conflicts of Interest

'None identified'.

9. Recommendation(s)

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

- MSEICB 009 – Allocations and System Reporting Policy
- MSEICB 086 - Under and Over Payments 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.

Since the Board meeting held on 19 January 2023, two further policies have been developed, reviewed and approved by the relevant committee, as set out in Section 2 below.

2. New Policies

Policy No and Title	Purpose	Responsible Committee	Approved by Committee
MSEICB 009 Allocations and System Reporting Policy.	This policy is part of the ICB's internal control environment and describes the key elements of the methodology and controls to fairly allocate resources within the system.	Finance & Investment	01/02/2023
MSEICB 086 Under and Over Payments Policy.	To ensure that there is a process for dealing with salary under or overpayments and that these are managed in a transparent manner.	Remuneration	01/02/2023

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

3. Recommendation

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

- MSEICB 009 - Allocations and System Reporting Policy.
- MSEICB 086 - Under and Over Payments Policy.

Part I ICB Board meeting, 16 March 2023

Agenda Number: 13.7

Board Assurance Framework

Summary Report

1. Purpose of Report

To share the latest version of the Board Assurance Framework (BAF) with the Board.

2. Executive Lead

Anthony McKeever, Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

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

4. Responsible Committees

Each committee is responsible for their own areas of risk.

5. Conflicts of Interest

None identified.

6. Recommendation/s

The Board is asked to consider and comment upon the Board Assurance Framework and seek any further assurances required.

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks. This is discharged through oversight of the Board Assurance Framework by the Audit Committee, prior to its submission to the Board.

2. Development of ICB Board Assurance Framework (BAF)

The ICB Audit Committee received an initial draft of the BAF at its meeting on 25 October 2022. Following comments received, an updated version of the BAF was presented to the ICB Board meeting held on 17 November 2022. At this meeting, the Board asked for mental health services to be included within a future iteration of the BAF, which has now been completed.

The current BAF, provided at **Appendix 1**, was reviewed by the Audit Committee on 8 March 2023 and includes the following risks:

- Workforce
- Primary Care
- Capital
- Unblocking the Hospital
- Diagnostics, Elective Care and Cancer Performance
- System Financial Performance
- Inequalities
- Mental Health Services

The BAF also includes an updated summary of MSEFT and EPUT's red risks.

3. Recommendation(s)

The Board is asked to consider the latest iteration of the Board Assurance Framework and seek any further assurances required.

4. Appendices

Appendix 1 - Board Assurance Framework.

Board Assurance Framework

March 2023

Contents

- Summary Report.
- Individual Risks - controls, barriers, assurance and actions.
- Main provider risks (MSEFT & EPUT).

BAF Risks – Summary Report

No	Risk and Key Elements	SRO(s)	Key Assurances (further information on individual risk slides)	RAG
1.	**WORKFORCE:** • Workforce Strategy • Primary Care Workforce Development (see Primary Care Risk) • Provider recruitment • Managing the care market	Ruth Jackson	• Regular Workforce reporting to System Oversight and Assurance Committee (SOAC) and People Board • Regional provider workforce return	**4 x 5 = 20** ⟺
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	Ronan Fenton	• Internal Audit Planned for 2023/24 • Patient Survey Results • Workforce Retention • Improved Patient to GP Ratio • Resulting in better patient experience and access.	**4 x 5 = 20** ⟺
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	Jennifer Kearton	• Developing prioritisation criteria for pipeline of investments. • Oversight by Finance & Investment Committee (FIC), System Finance Leaders Group (SFLG) and Executive / Senior Leadership Team. • Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.	**4 x 4 = 16** ⟺
4.	**UNBLOCKING THE HOSPITAL** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	Tiffany Hemming	• Urgent Emergency Care (UEC) Taskforce oversight and assurance • Multi-agency discharge event (MADE) audits. • MSE Strategic UEC Board (monthly) • Reports to SOAC and ICB Board. • Delayed hospital discharges monitored hourly/daily.	**5 x 4 = 20** ⟺
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Tiffany Hemming	• SOAC oversight of performance against all NHS Constitutional Standards. • Reporting to System Diagnostic Board and Diagnostic Performance Sub-Group. • MSEFT Cancer performance report: Meetings with National Team as a Tier 1 Trust. • Palliative and End of Life Care Board. • Elective Care Board: MSEFT Referral to Treatment (RTT) Long Wait Report.	**5 x 4 = 20** ⟺
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	Jennifer Kearton	• Trajectory an management actions to deliver revised forecast outturn is confirmed. • Continued system working to understand exit run rates and triangulation of delivery into new financial year. • Focus on system efficiency programme and improved delivery of financial plans. • Oversight by FIC, Chief Executives Forum, SLFG and SOAC. • Internal and External Audits planned.	**5 x 4 = 20** ⟺
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	Jo Cripps	• Reports to Population Health Improvement Board and Health Inequalities Delivery Group. • Internal Audit to review ICB systems for understanding population health needs and inequalities and the incorporation of such into operational and strategic plans (due Q3).	**4 x 5 = 20** ⟺
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Frances Bolger Tiffany Hemming	• MSE ICB inpatient rapid review outcome. • Clinical Quality Review Group / Quality Assurance visits. • Improved flow and capacity, reduction in out of area placements. • Mental Health Partnership Board & Whole System Transformation Group. • Reports to SOAC, identify key quality/performance risks and action to be taken. • Internal Audit of Oversight of Mental Health Services - Reasonable Assurance.	**4 x 4 = 16** ⟺

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

Current Performance v's Target and Trajectory

Recruitment and Retention rates remain static against recruitment trajectory.

How is it being addressed? (Current Controls)

- System Workforce Strategy in place.
- Data cleansing of Electronic Staff Records (ESR) by providers and focus on accurate data to facilitate agreement on current vacancy rates.
- System recruitment campaign launched October 2022.
- Regional funding received for further international recruitment campaign (Live in November 2022).
- Dedicated recruitment campaigns for hotspots e.g. Emergency Department, Paediatrics, Critical Care and Maternity.
- System Health Care Support Worker recruitment campaign and establishment of an Academy to support recruitment, retention and progress (funding received) to support the social care and health market.
- Volunteering and reservist function (recruitment commenced).
- System-wide retention programme to mitigate factors which cause high levels of turnover.
- Initiatives around the establishment and embedding of Physician Associates, Advanced Care Practitioners and trainee Nursing Associates.
- MSEFT Senior nursing support provided to candidates, e.g. flexibility regarding interview arrangements, as well as new appointees.
- EPUT implementing revised recruitment trajectories based on planning to support vacancy reduction in Nursing & Midwifery

The above actions should considerably reduce vacancy rates across providers and professional workforce groups as per trajectory agreed by System Oversight and Assurance Committee (SOAC) (also see Next Steps).

Barriers (Gaps)

- Accurate workforce dataset required.
- Very large volume of vacancies in a domestic market which is already challenged.
- Reliance on international recruitment and inadequate focus on establishing a local pipeline of staff.
- Reliance on bank and agency.
- Limit to current supervisory capacity to support mass recruitment initiatives.
- Insufficient emphasis on defining, developing and marketing system offer.
- Reluctance to adopt / embed new roles.

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

- Regular Workforce reporting to SOAC (monthly) and People Board (quarterly).
- Regional provider workforce return (PWR).
- Reduction in unfilled vacancies.
- Improved attrition and turnover rates.
- Reduction in bank and agency usage leading to positive impact on patient safety/quality.
- Improved resilience of workforce.

Next Steps (Actions to be implemented by March 2023)

- Planning trajectory submitted to region for review (Feb 2023)
- Review and analysis of planning submission to be undertaken (March 2023)
- Governance monitoring to be agreed through SOAC (March 2023)
- Transformation of unfilled vacancies to be confirmed (March 2023)
- System Workforce Strategy refresh (March 2023).

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

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

Nationally a lack of workforce.

How is it being addressed? (Current Controls)

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

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

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

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

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

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

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

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

How is it being addressed? (Controls & Actions)

- Developing prioritisation criteria for pipeline of investments.
- Oversight by Finance & Investment Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.
- Prioritisation framework for Primary Care Capital now established.
- Prioritised list of investments developed to inform the submission of the capital plan.

How will we know its working? (Assurance)

- Throughput of business cases to FIC.
- Delivery of Estates Strategy
- Progress reporting on investment pipeline.

Next Steps (to be implemented by June 2023):

- Training for Board & Exec (senior managers) on capital funding framework (June 2023)
- Prioritisation framework – (June 2023)
- Submission of Capital Plan (draft submitted, final March 2023)
- Infrastructure Strategy (Dec 2023)

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

Current Performance v's Target and Trajectory

Emergency Department performance below constitutional standard, as are Ambulance response times, although improvement in reducing handover long delays and 60 minutes delays (significant reductions at Southend Hospital): 71.4% long delay handover reduction throughout January 2023. Reduction in 49,569 handover minutes lost in Jan 2023.

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- Winter demand and capacity schemes implemented providing physical/virtual beds at acute and community providers until 31/03/2023. Continuation of schemes to be determined upon acknowledgement of national monies to be allocated. Submission completed on 16/02/23.
- MSEFT 'UEC Improvement Programme' launching in March 2023, focusing on improving a reduction in admissions, improving flow and discharge, and reducing length of stay. Collectively contributing towards 76% A&E (all-type) performance against the four-hour standard and ambulance handovers.
- Trajectories for delivery of the 76% A&E (all-type) performance against the four-hour standard will be compiled by hospital site, feeding into one aggregated MSEFT trajectory, and will factor in the improvement programme milestone.
- Increased focus on discharging those pathway zero patients.
- Community and Voluntary Sector (CVS) engagement in progress, in addition to work with Red Cross to support discharge.
- Alliances developing local plans.
- SHREWD Resilience implemented February 2023 to daily monitor discharges to support patient flow and early intervention where a deficit is identified.
- System Control Centres established in December 2022 to oversee UEC winter pressures and proactively work with system partners.
- MSE is an early adopter for Alternative to Emergency Departments (A-tED) - tool identifying improvement opportunities to optimise utilisation of services.

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

- MSE Strategic UEC Board (monthly) oversees programme and reports into System Oversight and Assurance Committee (SOAC) and ICB Board.
- Delayed hospital discharges monitored hourly/daily by hospitals and shared with both social care and CHC teams via situational awareness 10.00 am system call.

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

- Compile MSE UEC Recovery Programme from national UEC Recovery Plan. Oversight and responsibility with UEC System Director to track progression of action delivery with ICS partners at 'UEC Transformation & Improvement Board' (March 2023).
- Missed opportunities audits, to be linked into the UEC Recovery Programme action plan. (February 2023)
- Review of measurements, trajectories and mitigations to align to the UEC Recovery programme and ensure recovery/delivery via monthly ICB Assurance meetings pre-SOAC (April 2023).
- 'Call before Convey' to maximise alternative pathway direct referrals and attendance/admission avoidance (March 2023).
- 2023/24 MSEFT bed model under construction for acute capacity pressures and impact of mitigation (March 2023)
- Introduction of Pathway light in IC24 (April 2023)
- MSE system data and BI team working with AGEM to create and adopt a MSE system bed/capacity & demand model (April 2023).

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

Current Performance v's Target and Trajectory

Diagnostics: Recovery plans being developed by modality.
Cancer: Backlog (number of patients waiting 62+ days): on track to deliver 2022/23 plan.
Referral to Treatment:

- 104+ week waits: Any 104+ week patient is being managed on a case by case basis.
- 78+ week waits: Current MSEFT plan to reduce to zero by 31st March 2023 – on track.
- 52+ week waits: significant growing adverse position above plan.

Barriers (Gaps)

- **Cancer -** requires one registry – work now in place with programme group to introduce one Somerset cancer registry across the three MSEFT sites.
- **Cancer -** requires best practice pathways in place – programme refresh to enable this work to happen – supported by Stewards.
- **Workforce -** short term funded posts risks losing staff – FIC (Finance and Investment Committee) approved top slicing cancer SDF monies to pay for workforce to mitigate risk.
- **UEC pressures impacting on elective capacity -** with implementation of full capacity protocols across MSEFT sites. System support and oversight to expedite flow in place – see hospital flow BAF
- **Data Quality –** Group overseeing the validation work across MSEFT and EPUT before return to reporting (April-2023). Potential risk of long waiters when return to reporting happens.

How is it being addressed? (Current Controls)

Diagnostics:

- MSEFT developing recovery plans for all modalities.
- Working with Trust to ensure clinical prioritisation and chronologically booking – initial assigned risk code remaining in clinical system.

Cancer:

- Day Zero Patient Tracking List (PtL) – Skin meetings continue.
- Cancer Governance revised to ensure assurance and oversight of transformation and impact on performance.

Referral to Treatment (RTT):

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

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

RTT and Cancer:

- Fortnightly Tier 1 meetings with the national and regional team continue with oversight of actions and performance position.

Diagnostics:

- System oversight continues by the MSE Diagnostic Board.

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

SOAC maintains oversight of performance against all NHS Constitutional Standards.

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

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** Due to the level of operational pressure within the system, it has been confirmed that the system will not breakeven this financial year. It is essential to deliver financial stability to ensure transformation and service developments can be delivered.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Director of Resources	Directorate: Committee:	System Resources Finance & Investment Committee
Impacted Strategic Objectives:	Financial sustainability	Risk Ref:	FIN01

Current Performance v's Target and Trajectory

The System was set a stretch target by NHSE and at month 10 was forecasting £46.4m deficit, (MSEFT deficit of £63.2m, off-set by an ICB surplus £16.8m).

(The ICB itself had planned for breakeven and will deliver a surplus, so the risk relates to the ICB responsibility for meeting the system control total)

Barriers (Gaps)

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

How is it being addressed? (Controls & Actions)

- Forecast Outturn Protocol implemented.
- Focus on system efficiency programme and grip and control measures.
- Continued triangulation of system plans.
- Regional oversight.
- Local oversight.

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

- Delivery of the agreed position at year end.
- Improved delivery into the new financial year.
- Being overseen by the Finance & Investment Committee and the Chief Executives Forum, also discussed at SLFG and SOAC.
- Internal and External Audits planned.

Next Steps (to be implemented by December 2022):

- Submit financial plans for 2023/24 (draft submitted, final plans March 2023).
- Medium Term Financial plan being refreshed.

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

Current Performance v's Target and Trajectory

- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Core20PLUS5 (Adult) inequalities data packs are being actioned by the Alliances.
- Core20PLUS5 (Children & Young People) inequalities data packs are currently being developed by the PHM team and will be shared with the Growing Well Board.
- Population Health Improvement Board will be establishing MSE system priorities. Key metrics and a dashboard will be established over coming months in collaboration with PHM and BI teams.

Barriers (Gaps)

- Availability of BI and PHM resource.
- Quality improvement support for interventions.
- Financial resources are not yet sufficiently adjusted to reflect needs of population groups (proportionate universalism).

How is it being addressed? (Current Controls)

- Population Health Improvement Board provides system wide co-ordination and oversight for reducing health inequalities. Discussion regarding financial framework including additional £3.4m health inequalities funding for 2023/24 has commenced.
- Health inequalities stocktake (Q3) provided to NHS England against the 2022/23 planning requirements and delivery against the Core 20 plus 5 framework, reported to Health Inequalities Delivery Group.
- Integrated Care Partnership Strategy sets the common endeavour of reducing inequalities. Work has commenced to establish a theory of change / logic model that will set out the outcomes and ambitions for the next five years.
- Health inequalities funding of £3.4m (2022/23) allocated across Alliances and to support MSE wide project. South East and Thurrock Alliances projects have commenced. Basildon and Brentwood Alliance and Mid Essex Alliance due diligence complete. Successfully awarded > £90k of the £100k micro-grants scheme.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project. Development of digital EHIIA tool funded through the HI funding commenced to embed common approach across the system.

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

- Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE.
- Improvement in access and reduction of health inequalities as shown in the performance metrics, of which our priorities are currently being developed.
- Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.

Next Steps (Actions to be implemented by June 2023)

- ICP Strategic logic model with defined outcomes (April 2023)
- Establishment of work programme and agreed priorities (May 2023)
- 1 of 7 ICSs identified as a CORE20PLUS accelerator site (March 2024)
- Creation of a health inequalities dashboard (June 2023)
- Improvement in identification of groups at greatest risk anticipated by (December 2023).
- Mobilisation of HI Funded Projects with project evaluation commencing in 2023/24.

Risk Narrative:	**Mental Health Quality Assurance:** MSE Mental health (MH) services have been identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on the highest rated risk referred to below)**
Risk Owner/Dependent:	Frances Bolger, Executive Chief Nurse Tiffany Hemmings, Interim Executive Director Oversight, Assurance and Delivery	Directorate: Committee(s):	Nursing & Quality/Oversight Assurance 7 Delivery. Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient experience, Workforce, Reputational damage	Risk Ref(s):	GOSD15, PO1, MHLD01, 02, 04, & 12 and MEN11

Current Performance v's Target and Trajectory

- Poor performance against a number of quality and contract indicators.
- Demand and capacity issues resulting in eg. out of area placements of patients below standard zero.
- Significant external scrutiny from media (Dispatches C4), CQC, Essex Mental Health Independent Inquiry (EMHII).
- Multiple high profile coroners cases.
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder.
- Workforce issues.

Barriers (Gaps)

- Strategic approach to all age Mental Health service delivery pan-Essex.
- Data Quality issues and IT systems.
- Workforce challenges impacting on all services (see Workforce Risk PO1 - slide 4).
- System pressures to manage delivery (capacity).

How is it being addressed? (Controls & Actions)

- System Oversight and Assurance Committee (SOAC) monitor quality of services.
- Monthly 'Quality Together' meeting attended by NHSE, EPUT and ICB senior staff.
- EPUT and ICB 'Safety huddles' held on a weekly basis.
- Ongoing Quality Assurance Compliance Visits.
- MH workforce subgroup established and ongoing.

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

- MSE ICB inpatient rapid review outcome.
- Clinical Quality Review Group.
- Quality Assurance visits.
- Improved flow and capacity, reduction in out of area placements.
- Mental Health Partnership Board & Whole System Transformation Group.
- Reports to SOAC identify key quality/performance risks and action being taken.
- Internal Audit of Oversight of Mental Health Services - Reasonable Assurance.

Next Steps (to be implemented by DATE):

- Regular multi-agency discharge event (MADE) events to be undertaken to ensure good flow and capacity (April 2023).
- Implement recommendations from EMHII, CQC inspections, and Coroner's prevention of deaths reports (June 2023).
- Mental Health Task Force evaluation (June 2023).
- Finalise MSE Mental health strategy (March 2023).

Partner Organisation Self Identified Key Risks

MSEFT - 14 Red Risks at December 2022.

Top 7 risks (score 15 –25) are:

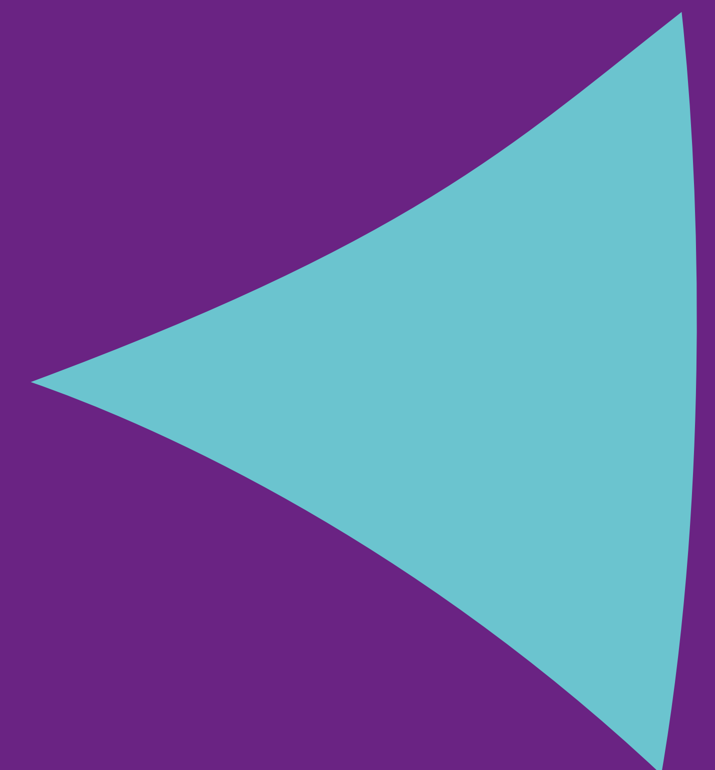
- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (20)
- Estate Infrastructure (20)
- Patient Flow and Length of Stay (20)
- Cancer Capacity (20)
- Planned Care Capacity (20)

Other red risks (x7), scored 15 or 16, relate to: Governance Structure; Trust Undertakings; Delivery of clinical and operational systems; Cyber Security; Competing Priorities; Health and Wellbeing Resources; Knowledge and Understanding.

Partner Organisation Self Identified Risks

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

- Patient Safety
- People (workforce capacity)
- Demand and Capacity (services)
- Capital resource for essential works and transformation programmes.



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