Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Thursday, 18 January 2024 at 2.00 pm – 3.30 pm

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

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of Minutes of previous Part I meeting held 16 November 2023 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	6
5.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	17
		Items for Decision / Non-Standing Items				
6.	2.15 pm	Community Beds Pre-Consultation Business Case	Ratify	Attached **(also see PCBC and appendices on ICB website)**	E Hough	19
7.	2.35 pm	Rapid Reset and Recommit Update	Note	Verbal	J Kearton	-
		Standing Items				
8.	2.40 pm	Chief Executive's Report	To support	Attached	T Dowling	27
9.	2.45 pm	Quality Report	Note	Attached	Dr G Thorpe	30
10.	2.55 pm	Finance and Performance Report	Note	Attached	J Kearton	35
11.	3.05 pm	Primary Care Report	Note	Attached	P Green	49

No	Time	Title	Action	Papers	Lead / Presenter	Page No
12.	3.15 pm	General Governance:				
		12.1 Updated Governance Documents and Committee Terms of Reference.	Approve	Attached	Prof. M Thorne	54
		12.2 Adoption of new Policies	Approve	Attached	Prof. M Thorne	64
		12.3 Board Assurance Framework	Note	Attached	T Dowling	67
		12.4 Approved Committee minutes	Note	Attached	Prof. M Thorne	83
		12.5 Decisions Between Meetings	Ratify	Attached	Prof. M Thorne	154
13.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
14.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 21 March 2024 at 3.00 pm, in Function Room 1, Barleylands, Barleylands Road, Billericay, CM11 2UD.	Note	Verbal	Prof. M Thorne	-

ICB Board Register of Interests January 2024

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Lisa	Adams	Interim Executive Chief People Officer	Nil								
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	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	ICB Partner Member Primary Care)	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, [illegible]
Anna	Davey	ICB Partner Member (Primary Care)	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
Tracy	Dowling	Interim Chief Executive Officer	Health Innovation East - Company limited by guarantee supporting the adoption and spread of innovation in healthcare in the East of England	x	x		Direct	Chair of the Board since April 2022. Non-Executive Director from January 2020 until March 2022.	01/01/20	Ongoing	Mid and South Essex is not in the geography of Health Innovation East - but if a situation arose where there was a conflict I would remove myself from the discussion and decision making.
Tracy	Dowling	Interim Chief Executive Officer	West Suffolk NHS Foundation Trust	x			Direct	Non-Executive Director	01/11/22	Until Interim CEO role commences	Will cease Non-Executive Director role on commencement of Interim CEO role.
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	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)	Essex Cares Limited (ECL) ECL is a company 100% owned by Essex County Council. ECL provide care services, including reablement, equipment services (until 30 June 23), sensory services and day services, as well as inclusive employment	x			Direct	Interim CEO	03/04/23	Ongoing	Interest declared to MSE ICB and ECC. Be excluded from discussions/deicsions of the ICB that relate to ECL services or where ECL may be a bidder or potential bidder for such services. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
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)	01/03/19	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.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
Matthew	Hopkins	ICB Board Partner Member (MSE FT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive	01/08/23	Ongoing	Interest to be declared, if and when necessary, so that appopriate arrangements can be made to manage any conflict of interest.

ICB Board Register of Interests January 2024

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
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 initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Jennifer	Kearton	Executive Director of Resources	Nil								
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	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.
Matthew	Sweeting	Interim Medical Director	Nil								
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Borough Council	x			Direct	Employed as Corporate Director of Adults, Housing and Health.	01/03/21	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Joint Health and Wellbeing Board		x		Direct	Voting member	01/06/15	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Dartmouth Residential Ltd	x			Direct	99% Shareholder and in receipt of income.	01/10/15	Ongoing	Interest to be declared if and when any matters relevant to this company are discussed so that appropriate arrangements can be implemented.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

MID AND SOUTH ESSEX INTEGRATED CARE BOARD - REGISTER OF INTERESTS - JANUARY 2024

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional	Non-Financial Personal Interest			From	To	
Mark	Bailham	Associate Non-Executive Member	Enterprise Investment Schemes in non-listed companies in tech world, including medical devices/initiatives	x			Direct	Shareholder - non-voting interest	01/07/20	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Mark	Bailham	Associate Non-Executive Member	Mid and South Essex Fountaion Trust	x			Direct	Council of Governors - Appointed Member	01/10/23	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	Provide	x			Direct	Chief Executive	01/05/22	Ongoing	Any interests to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	Provide Group Ltd	x			Direct	Director	01/06/21	Ongoing	Any Interest to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	Provide Wellbeing Ltd	x			Direct	Director	01/03/22	Ongoing	Any interest to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	Provide Care Solutions Ltd	x			Direct	Director	01/04/23	Ongoing	Any interest to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	React Homecare Ltd	x			Direct	Director	01/05/22	Ongoing	Any interest to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Stephanie	Dawe	MSE ICB Partner Member (Chief Executive - Provide)	MSE Community Collaborative	x			Direct	Member	01/09/20	Ongoing	Any interest to be declared if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Daniel	Doherty	Alliance Director (Mid Essex)	North East London Foundation Trust	x			Indirect	Spouse is a Community Physiotherapist at North East London Foundation Trust		Ongoing	There is a potential that this organisation could bid for work with the CCG, at which point I would declare my interest so that appropriate arrangements can be implemented
Daniel	Doherty	Primary Care ICB Partnership Board Member	Active Essex		x		Direct	Board member	25/03/21	Ongoing	Agreed with Line Manager that it is unlikely that this interest is relevant to my current position, but I will declare my interest where relevant so that appropriate action can be taken.
Barry	Frostick	Chief Digital and Information Officer	Nil								
Pamela	Green	Alliance Director, Basildon and Brentwood	Kirby Le Soken School, Tendring, Essex.			x	Direct	School Governor (voluntary arrangement).	September 2019	Ongoing	No action required as a conflict of interest is unlikely to occur.
Claire	Hankey	Director of Communications and Engagement	Legra Academy Trust		x		Indirect	Trustee of Academy Board	Jul-17	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Emily	Hough	Executive Director of Strategy & Corporate Services	Brown University		x		Direct	Holds an affiliate position as a Senior Research Associate	01/09/23	Ongoing	No immedicate action required.
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company - Mecando Limited	x			Direct	Potential Financial/Director of own Limited Company Mecando Ltd	2016	Ongoing	Company ceased activity due to Covid-19 pandemic currently dormant; if any changes occur those will be
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	x			Direct	Potential Financial/Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	2021	Ongoing	Company currently dormant; if any changes occur those will be discussed with my Line Manager
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.
Shahina	Pardhan	ICB Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Professor and Director of the Vision and Eye Research Institute (Research and improvements in ophthalmology pathways and reducing eye related health inequality	31/03/23	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.

Minutes of the Part I ICB Board Meeting

Held on 16 November 2023 at 3.00 pm – 4.30 pm

Gold Room, Orsett Hall, Prince Charles Avenue, Grays, RM16 3HS

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 Matt Sweeting (MS), Interim Medical Director, MSE ICB.
- Lisa Adams (LA), Interim Chief People Officer, MSE ICB.
- Jennifer Kearton (JK), Director of Resources, MSE ICB.
- Joe Fielder (JF), Non-Executive Member.
- George Wood (GW), Non-Executive Member.
- Dr Neha Issar-Brown (NIB), Non-Executive Member.
- Dr Anna Davey (AD), Primary Care Board Member.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT)
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Ian Wake (IW), Partner Member, Thurrock Council.

Other attendees

- Tracy Dowling (TD), Interim Chief Executive Designate, MSEICB.
- Geoffrey Ocen (GO), Associate Non-Executive Member.
- Mark Bailham (MB), Associate Non-Executive Member.
- Professor Shahina Pardham (SP), Associate Non-Executive Member.
- Dan Doherty (DD), Alliance Director (Mid and South Essex), MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood), MSE ICB.
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSEICB.
- Stephen Mayo (SM), Director of Nursing for Patient Experience, representing Dr Giles Thorpe, Executive Chief Nursing Officer, MSEICB.
- Nicola Adams (NA), Deputy Director of Governance and Risk, MSE ICB.
- Helen Chasney (HC), Governance Officer, MSE ICB (minutes).

Apologies

- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Peter Fairley (PF), Partner Member, Essex County Council.
- Stephanie Dawe (SD), Chief Executive Officer, Provide Health.

- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.

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

MT welcomed everyone to the meeting and thanked AMcK for all his work and support and wished him well for the future. MT introduced Tracy Dowling, Interim Chief Executive Designate.

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 were listed in the Register of Interests available on the ICB website**.**

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

MT advised that several questions had been submitted by members of the public, as set out below, which would be answered during the meeting. However, some questions were not submitted within the requested timeframe and would be responded to in writing.

- **Alison Thorpe** queried why the Essex Implementation Policy for Personal Health Budgets (PHB) was not implemented in Essex. SM advised that Mid and South Essex (MSE) Integrated Care Board (ICB) was committed to ensuring that the principles of personalisation were embedded into health and care services. The system's PHB Implementation Policy outlined how PHBs were delivered across services. All Age Continuing Care were one of many services that offered PHBs to residents and staff were responsible for the delivery of PHBs in accordance with this policy, which was embedded within practice.

- **Rob Woolley** sought clarity on dementia services for people living in Southend as carers had suggested that services provided were not good and asked what the ICB would do to improve them. MS advised that Southend was the third highest performer in terms of dementia diagnostic rates in England. The dementia wrap around model, launched on 1 April 2020, integrated services in the pre, peri and post diagnostic phases of the dementia journey and brought health and social care workers together. The model supported the health needs of the individual and carer, and adopted the successful intensive case management model, providing diagnosis, annual review and ongoing support.

- **Andrew Porter** referred to multiple patient surveys and asked if consideration could be given to organisations collaborating on surveys to avoid duplication. EH acknowledged the challenge of engaging with a diverse population of 1.2 million in the face of numerous programmes and projects with simultaneous timelines in the health and care system. The system was increasing collaboration with partners to involve and engage residents in different ways. To further support a more joined up approach, an MSE virtual views initiative was launched on 6 November, an online community platform for residents to access information, identify topics of interest and engage in targeted

discussions. Details on how to register could be found on the ICS website. The goal was to offer better choices and an understanding of how the system worked collectively with communities. The platform provided a streamlined method of participation for those who preferred to use it. Other engagement methods would also be maintained to ensure accessibility, inclusivity, and diversity of thought which remained as guiding principles to the system's approach.

- **Vic (surname unknown)** queried the locations used to hold ICB Board meetings as some were difficult for residents residing in mid Essex to attend. EH advised that the ICB endeavoured to hold Board meetings across its geographical area to ensure that residents were able to attend. Since the ICB was established in July 2022 until March 2024, five meetings were held in Chelmsford, two in Billericay, three in Grays, one in Southend and one in Braintree.

- **Peter Blackman** raised questions regarding pharmacy opening times in South Woodham Ferrers; the steps being taken to identify and support carers; having patient stories from Primary Care and a specific report from the Chief Executive Officer (CEO)/Chair at Board meetings.

  MS advised that the Govani pharmacy operated under the contractual framework and was open Monday to Friday from 9 am to 6 pm, and Saturdays from 9 am to 5 pm. On Christmas Day 2023, they were commissioned to open from 10 am to 12 noon. Pharmaceutical needs were assessed by the Heath and Wellbeing Board. The assessment was published at Pharmaceutical Needs Assessment (PNA) 2022-2025 | Essex Open Data and gave details of opening hours and services provided by pharmacies across Essex.

  With respect to carers, each Alliance had schemes underway to improve the identification of carers, which included working with local authorities and primary care. The Carers Maturity Matrix reported an increase in registered carers in mid Essex, with ongoing efforts to improve identification and support. The Mid Essex Alliance was implementing an Outcomes Framework to jointly track and improve outcomes, including those for carers, across all partners.

  Patient stories were presented to the Quality Committee led by the MSE ICB Chief Nurse and included representation from across the system to ensure that learning was embedded in practice.

  The suggestion of a CEO/Chair report would be considered as part of the ongoing corporate review taking place and the arrival of a new interim CEO.

Action: NA to arrange for written responses to be provided to questions raised by members of the public that were not addressed during the meeting.

4. Minutes of the ICB Board Meeting held 28 September 2023 and ICB Annual General Meeting (AGM) held 12 September 2023 (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 28 September 2023 and the draft minutes of the ICB AGM held on 12 September 2023. The following amendments were noted:

- List of Attendees: Amend Dr Shahina Pardhan to Professor Shahina Pardhan in both sets of minutes.
- Part I Board minutes, 16 November 2023: JF asked that the beginning of paragraph 8 of item 13, Finance Report, was amended to "In response to a question, JF warned that the deficit could exceed £80 million".

Resolved: The Board approved the minutes of the ICB Board meeting held on 28 September 2023 and the ICB AGM on 12 September 2023 as an accurate record, subject to the amendments noted above.

5. Matters Arising (presented by Prof. M Thorne)

There were no matters arising.

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

The updates provided on the action log were noted, along with the following update:

- **Action 4** – The role of the ICB Deputy Chair would be rotated between Dr Neha Issar-Brown and Joe Fielder. George Wood was not eligible to be included in the rotation due to him undertaking the role of chairing the Audit Committee.

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

7. Primary Care Access and Recovery Plan Update (presented by P Green)

PG reported that there had been a shift in the model of delivery of primary care General Practitioners (GP) services, outlined by several essential government documents, to address the '8 am rush' experienced in most practices.

The Primary Care Strategy focused on the linkage between primary care and the wider system to enable a different approach to addressing such a surge a demand for GP services at that specific time. There was a requirement for better technological systems to fulfil the strategy, however the system would be unable to force the models onto primary care but would provide leadership and technical support to enable the required change. The system would encourage and build confidence that there were other methods for people to engage with primary care and that professionals other than GPs were available to provide care.

A national campaign relating to the diversity of roles within primary care that supported GPs was imminent. The model would be an integrated approach across the whole system and would support Integrated Neighbourhood Teams (INTs).

The plan was being developed with NHS England (NHSE), to ensure implementation of the Fuller Stocktake report recommendations that supported the different budgets and increased demand within the system.

MT asked if the deadline for all practices to be operating a Cloud-based telephony system by March 2025 was sufficiently ambitious. PG advised that the timeframe linked into the national procurement framework. BF advised that along with new technology a shift in culture would also occur with call centre environments resolving some current challenges.

AD explained that improved access would not increase capacity within primary care. The rationale for the '8 am strategy' was to manage the overwhelming demand, so until capacity

increased, the problem would not be completely resolved. There were other ways to improve access such as e-consultations or digital interfaces, which would improve patient experience in the longer term.

JF asked when targets for improvement would be indicated. PG advised that the model would include data which would go to NHSE initially and then be presented to Board at a later date for endorsement.

GW and AD noted that calls to practices could be for pharmacy and health professionals other than GPs and suggested future telephony data should reflect this if possible.

SP asked why the total number of GP consultations had fallen from 54% in 2019/20 to 46% in 2022/23. AD explained that there could be fewer GPs and GPs were also supervising other roles, such as the Advanced Paramedic Practitioner, who discussed each case with the GP.

In response to a query from NIB, AD advised that the number of consultations overall had increased significantly, but fewer people were seeing GPs due to the positive changes as a result of the Additional Roles Reimbursement Scheme improving the skill mix within the primary care workforce.

Resolved: The Board endorsed the Mid and South Essex Access Recovery Plan.

8. Integrated Neighbourhood Teams (presented by P Green)

PG advised that the Integrated Neighbourhood Teams (INTs) were a 'wraparound' of all services for better integration between the systems statutory partners, voluntary sector and communities.

PG noted that 30% of patients entering GP practices were there for non-medical related issues and a review was required of how other determinants of health, such as isolation, economic stability and housing would be identified. The fundamental reason for creating INTs was to create a broader team anchored into a neighbourhood, for early intervention, prevention, and to build trust. The maturity process for 9 INTs had begun, with good support from partners.

References were made to the national strategy, the Fuller Stocktake and the segmentation of work to ensure people received the correct intervention first time. It would be a cultural change alongside the alignment of strategies and would change service delivery, connection between organisations and the trust within clinical and non-clinical groups. Ideally, teams would work on connection rather than referral.

MH advised that converations were held with Alliances to build closer relationships with primary and secondary care and the involvement of the acute and mental health sectors were important.

MT asked if any funding would be received for INTs. PG suggested that the finance team could provide support to identify any additional funding should it be available.

AD explained that INTs were an existing workforce, working differently and were important for the prevention of illnesses and simplyfying care for patients with complex illness to prevent deterioation.

Resolved: The Board noted the update on Integrated Neighbourhood Teams.

9. Health Inequalities (presented by E Hough)

EH thanked the team (and individuals specifically) for all their work and support and noted that reducing health inequalities was everyone's responsibility. An estimated 133,000 people in MSE lived in the 20% most deprived areas.

The top 3 contributors to premature mortality attributable to socio-economic inequality were cancer, cardiovascular disease and respiratory disease which sat alongside the risk factors of tobacco, blood pressure and dietary risks. The Core20PLUS5 frameworks for Adults and Children focussed on the areas of inequality to address these factors.

The Population Health Improvement Board brought together system partners to focus on addressing inequalities. Several adults 'PLUS' groups had been identified and work was ongoing to provide support to them. The ICB had committed to financial investment of £1.2 million and endorsed the approach of Alliance 'Trusted Partner' contracts to support the process. The report contained details of the many projects being implemented.

MT asked if there was yet evidence of improvements arising from the investments being made. DD advised that it was too soon to acknowledge whether any benefits had been realised, although encouragement for engagement in the process was a step forward.

SP asked how success and model evaluation would be measured. EH advised that the system commissioned University of Essex to provide an interim evaluation report in February 2024 which could be brought back to Board. There needed to be a balance between effective evaluation and the cost of each project. This also required an understanding from the Alliances regarding metrics used for evaluation and would be picked up with the team.

DD advised that in mid Essex, a framework had been created with the county council and all 3 local authorities to assess the language meaningful to the NHS and local government which had galvanised people to work together.

MS commented that the stewardship programmes were using clinical leaders to drive outcomes for the population to make a difference which was being tracked on dashboards, so should see traction in the future.

PG advised that within Basildon and Brentwood, the University of Essex supported the community based physical activity agenda. The Wellby model was being utilised, which monitored and evaluated wellbeing.

Resolved: The Board noted the approach outlined to tackle and reduce Health Inequalities.

Action: SOC to add Health Inequalities interim evaluation report to the Board agenda for March 2024.

10. MSE ICB Emergency Preparedness, Resilience and Response (EPRR) Core Standards (presented by E Hough)

EH advised that there was a requirement for the ICB to undertake a review of the Emergency Preparedness, Resilience and Response (EPRR) core standards as set out by NHSE. The position summary which had moved to substantial compliance for 2023/24 and was an improvement on the previous position, was approved by the Audit Committee and required ICB Board endorsement.

The areas that required further work were detailed in the report.

Resolved: The Board endorsed Audit Committee's approval of the MSE ICB EPRR Core Standards move to substantial compliance for 2023/24.

11. Quality Report (presented by S Mayo on behalf of Dr. G Thorpe)

SM provided the following key highlights from the Quality Report:

There were recent quality concerns relating to Endoscopy services in Mid and South Essex Foundation Trust (MSEFT) and the private sector, which were raised following recent inspections and planned quality visits. One of the private sector providers had been given a suspension order, which had since been lifted. Funding was secured for system level development of endoscopy services and the governance processes relating to oversight had been strengthened. The situation would continue to be monitored.

External reviews had been commissioned regarding paediatric sepsis at MSEFT and the ICB quality team had scheduled visits to the 3 emergency departments to gain assurance on the management of the deteriorating patient and paediatric sepsis. There had been recent national media reports concerning the Paediatric Early Warning Score (PEWS) and the Secretary of State's intention to roll out 'Martha's rule'. [A new way for patients and their families to trigger an urgent clinical review from a different team if they are in hospital, are deteriorating rapidly and feel they are not getting the care they need.]

In response to Essex Partnership University NHS Foundation Trust's (EPUT) CQC action plan, an Evidence Assurance Group had been established to be chaired by the ICB Executive Chief Nurse. The first meeting had been held and positive assurance was received on actions completed.

Several complaints had been received relating to the diagnostic times of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) for children and young people and the system would be providing support to address the issues identified from the complaints.

There were some issues with Paediatric Audiology and the team would be working closely with providers, as a collaborative system, to reduce the backlog of waiting times. Assurance was provided that responses to requests from the national team had been submitted.

Following the ICB taking over responsibility for primary care complaints from NHSE, there had been a significant increase in the number of complaints being processed by the ICB, which were being worked through, with new methods of complaint triage and response processes being rolled out to support with reducing the backlog.

MH advised that there would be a refresh of the whole approach to quality and care in the Trust.

PS advised that the CQC action plan would be receiving extensive scrutiny through the ICB, EPUT and the System Oversight and Assurance Committee (SOAC) in the new year.

AM advised that the acute and mental health trusts had shared their responses to the CQC inspections with stakeholders and were focused on providing confidence that the recommendations would be acted upon. SM provided assurance that mortality statistics and Structured Judgement Reviews continued to be monitored at Quality Committee meetings.

In response to a query from GO regarding health inequalities in maternity, PG advised that inequalities within maternity services and maternal deaths were a focus for the Local Maternity and Neonatal Safety Board (LMNSB) with specific groups focussed on equity and equality across perinatal care. An update report would be provided at a future meeting on the groups that were already set up. MT reflected on whether the Board was being appropriately probing on this agenda.

Resolved: The Board noted the Quality Report.

Action: PG to provide an update report at a future meeting on the cultural perinatal groups that had been set up.

12. Finance and Performance Report (presented by J Kearton)

JK advised that the report for month 6 combined finance and performance, and the intention was for future reports to include quality to provide triangulation of overall performance.

For month 6, the system reported a £45 million deficit year to date, which made a stretch plan at the end of the financial year of a £40 million deficit, previously agreed by the Board, difficult to achieve. As a result, a mid-year review had commenced to determine whether a change would be required to the system forecast outturn, which would need to be agreed by the national team.

A national announcement had been made regarding funding which was being worked through and would be brought to Board in due course.

JK advised that the team were working on month 7 reports and noted that independent sector provider performance had increased significantly. Independent Sector activity was 20% higher than the anticipated activity when budgets were set at the beginning of 2023/24. The Trusts had worked well to manage pressures due to industrial action, however use of agency staff and other workforce issues continued to be a challenge. EPUT were facing additional pressures which were unknown at the planning stage.

MT asked JK to explain, for the record, how money was distributed amongst organisations nationally. JK explained the national formula drove the annual allocation and uplifts and that our system has historically received funding which was in excess of its national formulaic allocation. Consequently, a 'convergence factor' was now being applied to its annual allocation so as to eventually bring funding into line with its correct (lower) national allocation. We aligned part of our system allocation to the hospital that reflected the national guidance for Elective and Non Elective Care.

MT asked, given the current financial position, where the system might be financially against the original deficit. JK advised that the direct run rate was in the region of eighty to ninety million, however, that would not account for all actions being put in place that had slightly improved the run rate in months 5 and 6. There had been a slight contraction in the run rate nationally. There were also further options regarding the refresh and reset flexibilities that would be explored.

MH confirmed that the size and scale of the deficit that affected the acute trust and the system, was of the magnitude that would likely take more than 1 year to resolve. Taking into account the convergence factor the system should be working on a 2-3 year plan to reach a financially sustainable position.

GW advised that the system needed breathing space to develop a clear plan that would take longer from which progress could be built and accelerated.

MB asked what the consequences for the system would be if it took 1-2 years to reach the £40 million deficit. JK advised that the system already operated in a double lock arrangement with controls in place for spend and workforce, and that the triple lock would be invoked, if the system deviates off that plan for a year, which would involve regional colleagues in decision making. It was a balance between the risk of short-term delivery and sustainability.

With regards to performance, JK reported that there had been no significant changes from the last report. The report outlined performance against NHS constitutional standards and a below plan position had been reported in some areas. However, there was a slight improvement in other areas and sustainable delivery against some mental health standards.

AM requested that the figures for 4 hour waits in the Emergency Department and handover times were highlighted in future reports as they would be key indicators during the winter period. The trust had agreed a stretch target of 80% for the 4 hour waits with NHSE, which was in the process of providing an underpinning trajectory for mapping into future reports.

MH advised that there had been a 41% increase in September and October 2023 in ambulance conveyances across the 3 hospital sites, compared to last year, which was an unsustainable position. Discussions were being held with the ambulance service to understand the demand and data would be provided regarding patients brought into hospital and then discharged without treatment.

MT asked when the Community Diagnostic Centre would be functional. AD advised that the date would December 2024 at the earliest, however interim measures were being put into place, such as transfer of the mobile CT scanner from Broomfield to Braintree.

Resolved: The Board noted the Performance and Assurance report.

13. Primary Care Report (presented by P Green)

PG advised of the intention to develop a revised primary care report to the Board with pharmacy, optometry, and dentistry (POD) included. The ICB had responsibility for maintaining oversight of approximately 600 providers across MSE. The report would include escalations from the ICB's Primary Care Commissioning Committee.

GO welcomed the combined reporting, which would highlight discussions relating to other organisations in PCNs such as community pharmacies.

In response to a suggestion from SP, PG confirmed that additional support functions that linked into services would be included in future reports.

AD reported that there was some innovative work occurring for Dental Services in MSEFT, which included a Care Home Dentistry Pilot and Dental Access Hubs, with the latter treating patients more efficiently than previous arrangements. With the development of INTs, patient needs could be reviewed to ensure referral to the right provider (community pharmacy, GP, dentistry, optometry) at the first point of access.

PG reported good progress had been made on oral health prevention work and confirmed the Board would be kept updated.

Resolved: The Board endorsed the approach to present a standing board agenda item on Primary Care.

Action: PG to include additional support functions in the Primary Care report.

14. General Governance (presented by Prof. M Thorne)

14.1 Adoption of new Patient Safety Incident Response Framework Policy

MT advised that the policy had been through the appropriate governance processes and invited further questions from the Board. No questions were raised.

Resolved: The Board approved the Patient Safety Incident Response Framework Policy.

14.2 Approval of Committee Terms of Reference

MT advised that minor changes had been made to the Terms of Reference of the System Oversight and Assurance Committee and Quality Committee and invited comments from the Board. No queries were raised.

Resolved: The Board approved the revised Terms of Reference for the System Oversight and Assurance Committee and Quality Committee.

14.3 Board Assurance Framework

MT outlined the Board Assurance Framework (BAF) paper presenting the key risks to the ICB, noting that the key risks outlined in the BAF had been discussed throughout the meeting, and invited further questions from the Board. No further questions were raised.

Resolved: The Board noted the latest iteration of the Board Assurance Framework.

14.4 Approved Committee Minutes.

The Board received the summary report and copies of approved minutes of the following main committees:

- Audit Committee, 8 August 2023.
- Finance and Investment Committee, 14 September 2023.
- Primary Care Commissioning Committee, 6 September 2023 and 4 October 2023.
- Quality Committee, 18 August 2023.
- System Oversight and Assurance Committee, 9 August 2023.

Resolved: The Board noted the latest approved minutes of the Audit Committee, Finance and Investment Committee, Primary Care Commissioning Committee, Quality Committee, and System Oversight and Assurance Committee.

15. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

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

Thursday, 18 January 2024 at 3.00 pm, in The Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, CM1 1JE.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
32	28/09/2023	8	**Transfer of Care Hubs (TOCH) Development** Provide a report tracking performance measures before and after the development of the TOCHs.	P Green	21/03/2024	Added to March 2024 Board agenda. A system wide performance and reporting sub group of the TOCH steering group are devising a set of reporting metrics.	In progress
34	28/09/2023	9	**Letby Report** Work with system partners to reinforce the FTSU message on screensavers on laptops.	B Frostick	18/01/2024	**Update on closed action.** Further to the update provided at the ICB Board meeting on 16 November 2023, given the current financial situation the ICB will not be pursuing the purchase of screen saver capabilities at this point in time. However, if this is deemed a priority investment area, we will look to include as part of the 24/25 budget baselines. It is anticipated that the implementation of a solution would have a lead time of approximately 2-3mths.	Complete
35	28/09/2023	11	**Quality Report** Caring for residents with Learning Disabilities to be added to the agenda of a Board meeting.	S O'Connor	31/10/2023	The December Board Seminar session will include Learning Disabilities.	Complete
37	16/11/2023	3	**Questions from the Public:** Arrange for written responses to be provided to questions raised by members of the public that were not addressed during the meeting.	N Adams	18/01/2023	All questions have been responded to.	Complete
38	16/11/2023	9	**Health Inequalities** Add Health Inequalities interim evaluation report to the Board agenda for March 2024.	S O'Connor	18/01/2023	Added to agenda for 21 March Board meeting. Health Inequalities Lead has been made aware of request.	Complete

Mid and South Essex Integrated Care System

Agenda Item 5 - ICB Board Action Log (January 2024)

NHS Mid and South Essex

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
39	16/11/2023	12	**Quality Report** Provide an update report at a future meeting on the cultural perinatal groups that had been set up.	P Green	18/01/2023	Provisionally scheduled for March Board primary care update.	In progress
40	16/11/2023	13	**Primary Care Report** Include additional support functions in the Primary Care report.	P Green	18/01/2023	Please refer to latest primary care report.	Complete
41	29/11/2023	3	**Heavy Menstrual Bleeding Service Restriction Policy (Myomectomy):** Clarify the number of woman who wished to opt for myomectomy.	Dr M Sweeting	18/01/2023	It has been clarified that 23 women might wish to opt for Myojectomy.	Complete
42	29/11/2023	3	**Heavy Menstrual Bleeding Service Restriction Policy (Myomectomy):** Discuss future arrangements for approval of changes to Service Restriction Policies with Nicola Adams.	T Dowling	18/01/2023	This has been covered within the new SRP policy presented to the Board for approval in the January meeting.	Complete

MSE ICB Board Meeting of 18 January 2024

Agenda Number: 6

Community Capacity Pre-Consultation Business Case

Summary Report

1. Purpose of Report

To present the Pre-Consultation Business Case (PCBC) that has resulted from the work of the system-wide Community Capacity Task Force (CCTF) and outline proposals for a public consultation on the future of community inpatient beds across MSE, freestanding midwife-led birthing capacity in MSE and ambulatory care services provided on the St Peter's Hospital site in Maldon.

2. Executive Lead

Emily Hough, Executive Director of Strategy and Corporate Services.

3. Report Authors

Emily Hough, Executive Director of Strategy and Corporate Services.

Claire Hankey, Director of Communications and Partnerships.

4. Responsible Committees

This paper was reviewed and supported by the System Oversight and Assurance Committee (SOAC) in December 2023.

Prior to discussion at the ICB Board meeting, the PCBC is also being considered by the Mid and South Essex NHS Foundation Trust (MSEFT) Board on 16 January 2024 and the MSE Community Collaborative [Executive] on 17 January 2024.

5. Link to the ICB's Strategic Objectives

The proposals set out in the PCBC support the ICB objectives to:

- Improve outcomes in population health and healthcare
- Tackle Inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

6. Impact Assessments

A full Integrated Impact Assessment (IIA) has been completed as part of the PCBC.

A summary of the findings from the IIA can be found in section 12 of the PCBC with the full IIA provided in **Appendix 4** to the PCBC.

7. Financial Implications

Proposals within the PCBC have been developed with consideration for the system's financial position to ensure that proposals are affordable and do not contribute further to the system's financial challenges. The capital and revenue implications of the proposal are set out in section 11 of the PCBC, with a detailed financial overview provided in **Appendix 5.**

8. Details of patient or public engagement or consultation

Public, patients and staff have been engaged in the development of the proposals set out in the PCBC since the initial development of care models in 2022. The themes of this engagement are set out in section 14 of the PCBC and in the pre-consultation engagement report provided in **Appendix 9** of the PCBC.

9. Conflicts of Interest

None identified.

10. Recommendation/s

The Board is asked to:

- Review and **approve** the PCBC and

- Subject to NHS England's assurance, **approve** the decision to, undertake a single public consultation in accordance with the s.14Z45 NHS Health and Care Act 2022- Public involvement and consultation by ICBs, consultation with the relevant local authorities under s.244 of the Act and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

  Specifically, this should seek views on:

  - The options for reconfiguration of intermediate care and stroke rehabilitation services in community hospitals.

  - The proposal to locate the freestanding midwife-led birthing unit at the William Julien Courtauld (WJC) Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital.

  - The proposal to relocate ambulatory services currently provided at St Peter's Hospital Maldon.

Community Capacity Pre-Consultation Business Case

1. Introduction

In summer 2023, Mid and South Essex (MSE) Integrated Care Board (ICB) established a multi-agency Community Capacity Taskforce (CCTF) to review the care model and future demand for community beds in the system. The initial focus of this work was to look at the demand and care model requirements for both intermediate (IMC) and stroke rehabilitation beds in community based inpatient settings. This built on urgent changes made during the COVID pandemic and further temporary changes to support winter service provision for 2023/24. The CCTF has also looked at the residual services provided from St Peter's hospital, mindful of the poor quality of the estate and the challenges associated with ensuring access to high quality clinical care on that site.

In doing so, the CCTF has developed the attached PCBC that proposes a public consultation on the following:

- Two options for the reconfiguration of IMC and stroke rehabilitation beds in community hospitals.
- Relocating the freestanding midwife-led birthing unit for MSE at the William Julien Courtauld (WJC) Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital.
- Relocating ambulatory services currently provided at St Peter's Hospital in Maldon.

2. Main content of Report

Community inpatient bed capacity in MSE has been under consideration for several years. In 2022 the East of England Clinical Senate was asked to consider proposals relating to the provision of intermediate care (IMC), stroke rehabilitation and frailty bedded care across the MSE system. More recently in Summer 2023, the CCTF developed proposals for community inpatient bed capacity and use, as well as proposals for freestanding midwife-led birthing and other ambulatory care services provided at St Peter's Hospital.

Community Beds

Work to review future community inpatient bed demand for the population of MSE has considered the best clinical model for providing both intermediate care and stroke rehabilitation in the community, looking at best practice pathways that support people to receive care where it is most appropriate, but also return to their place of residence as quickly as possible. Alongside this, the CCTF has looked at future demand for beds based on population growth, length of stay, bed occupancy, hospital discharges and use of local authority IMC capacity. Based on these assessments it is estimated that MSE requires between 77-87 IMC beds and 48-50 stroke rehabilitation beds.

The clinical subgroup of the CCTF developed 13 options for the distribution of community inpatient beds across the current estate available in MSE, recognising that given the current financial position there isn't sufficient capital available to develop any

new capacity. The thirteen options were reduced down to two preferred options that are proposed for public consultation set out in Table 1 below.

Table 1: preferred options for community inpatient beds

	IMC / Stroke rehab	**IMC/Stroke rehab**	**IMC/Stroke rehab**
St Peter's	0/16	0	0
Mountessing Court	22/0	22/0	22/0
Cumberlege Intermediate Care Centre (CICC)	14/8	22/0	0/22
Halstead	20/0	20/0	20/0
Mayfield	24/0	24/0	24/0
Brentwood	25/0	0/50	25/25
Total IMC/Str	105/24	88/50	91/47
Grand Total	**129**	**138**	**138**

Freestanding midwife-led birthing

Options for a midwife-led birthing unit (MLBU) are much more limited. In the absence of St Peter's as an option, the remaining freestanding MLBU in MSE is the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital. Maintaining the alternative inpatient capacity at this site provides a more resilient service less prone to closure due to staff shortages.

Options concerning the future arrangements for maternity outpatients are discussed in Section 5 - Options for Change, but the PCBC proposes that maternity outpatient services for Maldon, which include consultant and midwife clinics post-natal care, parenting and ultrasound scanning be provided locally in a maternity 'hub'. Therefore, the option to locate the MLBU at Braintree, whilst retaining a maternity outpatient service in Maldon, is preferred, given co-location with primary care services is desirable but not yet available.

Ambulatory care services

The preferred option for ambulatory services, based upon the advice of the system's Clinical and Multi-professional Congress, is to provide accommodation in Maldon where it does not need to be co-located with other services for clinical reasons. Patients who come from further away, such as Braintree and Chelmsford should also, where possible, be offered access closer to their place of residence.

Until such time as purpose-built health facilities linked to primary care are available, a number of locations in central Maldon will need to be used for NHS services. Options are being explored across currently vacant buildings within the Maldon area.

The determination of the configuration of ambulatory services needs to be co-produced with representatives of the local community ensuring that key services remain local. In the case of the Cherry Trees Unit similar co-production work with service users and staff will be required to identify suitable alternative accommodation.

Meeting NHS England's Five Tests

The PCBC and its appendices provide assurance that the proposed service changes have been developed in line with the five tests set out by NHS England:

1) **Strong Public and Patient Involvement:** demonstrated by the pre-consultation engagement described in section 14 of the PCBC. The proposed public consultation, which would run for eight weeks from 25 January to 21 March 2024 provides further opportunity for patients, the public and staff to formally respond to the specific proposals in the PCBC.

2) **Patient Choice:** the proposals continue to offer patients choice in where they access services, where it is clinically appropriate to do so, and aim to support patients to access care as close to home as possible. For example, the freestanding midwife-led unit at WJC provides choice to mothers with low-risk births, and maintaining ambulatory care services within Maldon supports patients wishing to receive outpatient care close to home.

3) **Clinical evidence:** Proposals were developed by the CCTF's clinical subgroup, based on the latest clinical evidence for community stroke rehabilitation, intermediate care and midwifery-led services. Proposals were also reviewed and endorsed by clinicians at the system's Clinical and Multi-Professional Congress on 29 November 2023, by the East of England Clinical Senate on 5 December 2023 and by the Chief Midwifery Officer for the East of England.

4) **Commissioner support:** Proposals were reviewed by the ICB's System Oversight and Assurance Committee on 13 December 2023. The full PCBC is also being considered by the Boards of MSEFT (16 January 2024) and the Community Collaborative (17 January 2024) prior to being considered by the ICB Board on 18 January 2024.

5) **Bed numbers:** the proposals set out in the PCBC aim to ensure that the population of MSE has access to sufficient community inpatient beds to support their intermediate care and stroke rehabilitation needs. To ensure patients can access the care and support they need, the care model will continue to be

developed to support patients to receive care where they need it most and to return home as quickly as possible. Whilst the distribution of beds in the preferred options for community beds in the PCBC differ in the distribution of intermediate care and stroke rehabilitation beds, both propose to increase community bed capacity from 129 beds prior to the temporary changes that were enacted in October 2023, to 138 beds, an increase of nine community inpatient beds on what was previously commissioned.

Given MSE's significant financial challenges and the [triple] lock on the system, we have worked to ensure the proposals in the PCBC would not have a negative financial impact on the local health economy. Their impact on the system's revenue position is minimal, with options either costing around £200,000 (option 11) or saving the system £1m (option 12) a year. There are some capital costs associated with delivering the proposals, particularly the ambulatory care services. Currently these are estimated to be around £3m, which would be covered by the sale of the St Peter's site, estimated to generate around £6.2m. Capital costs will need to be finalised prior to the Decision Making Business Case, given the need to further co-develop the ambulatory care proposals. The system is committed to working together to ensure that funding will be redistributed to support the delivery of proposals and ensure value for the system.

3. Proposed Consultation Process

Subject to relevant approvals the consultation would commence on 25 January 2024 and will run for eight weeks to 21 March 2024. A current consultation plan is contained at **Appendix 8** of the PCBC and will iterate over the process.

During this time there will be a number of ways for people to get involved including:

1) Survey

A survey about the proposals will be available on our involvement website. The survey is in four sections, so people can share views about the services that matter most to them.

2) Face-to-face discussion sessions

There will be 5 face-to-face discussions in different locations:

- Burnham
- Thurrock
- Southend
- Chelmsford
- Basildon

These locations have been chosen as the proposals could affect people living in these areas and the services that they use. We also want to ensure we hear from a range of people who are likely to have different experiences of the services proposed to change.

3) Online discussion sessions

There will be five online sessions using Microsoft Teams. One session for each element of the proposal, and one general session:

- Stroke rehabilitation
- Intermediate care beds

- Midwife-led birth hub
- Outpatient services
- General session about the proposals as a whole

Recordings and transcriptions of the online sessions will be available during the consultation period.

4) Consultation Hearing

Public hearings give people who have specific views or would like to present a different point of view to provide evidence to the decision makers who can ask questions about the evidence presented.

The Consultation Hearing will involve a panel of experts from the ICB. Participants will be asked to register their interest in presenting information to the panel.

The Panel will listen to people's evidence and ask and answer questions. Everything put to the Panel will form part of the consultation exercise.

There will be one Consultation Hearing event held in Maldon town.

5) Voluntary and Community Sector Organisation (VCSO)-led discussions

There will be 10 of these discussions held in total. VCSOs will be targeted to ensure we are hearing from a diverse group of people as those identified in the equality impact analysis.

During the consultation period, engagement will be overseen by a consultation reference group.This will include patient representatives, voluntary sector organisations, clinicians and Healthwatch to guide the process. The group will help to ensure we are listening to a range of people and organisations.

A report of the analysis of the feedback will be independently compiled and will be shared and published on the Mid and South Essex ICB website. This should happen within three months of the end of the consultation period.

4. Recommendations

The Board is asked to formally review and **approve** the PCBC and, subject to NHS England's assurance, **approve** the decision to undertake a single public consultation in accordance with the s.14Z45 NHS Health and Care Act 2022-Public involvement and consultation by ICBs, consultation with the relevant local authorities under s.244 of the Act and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Specifically, this should seek views on:

- The options for reconfiguration of intermediate care and stroke rehabilitation services in community hospitals.

- The proposal to locate the freestanding midwife-led birthing unit at the WJC Unit at St Michael's Health Centre, adjacent to the Braintree Community Hospital.

- The proposal to relocate ambulatory services currently provided at St Peter's Hospital Maldon.

5. Appendices

Pre-Consultation Business Case and supporting appendices, as listed below.

1. List of Organisations / Acronyms / Abbreviations
2. MSE Context and Reconfigurations of Community Beds since 2020
3. Options Appraisal
4. Integrated Impact Assessment
5. Financial Overview
6. Clinical Senate Report and Recommendations
7. Travel Analysis
8. Communications and Engagement plan
9. Pre-Consultation Engagement report
10. Stroke and IMC Audit
11. Roadmap of IMC across MSE
12. Bed Calculations
13. UK Levels of Neuro-rehabilitation
14. Feedback from Clinical Congress, Clinical Senate and Regional Chief Midwife
15. References

These documents are available on the ICB Website.

Part I ICB Board meeting, 18 January 2024

Agenda Number: 8

Chief Executive's Report

Summary Report

1. Purpose of Report

To provide the Board with an update from the Interim Chief Executive on key issues, progress and priorities.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer.

3. Report Author

Tracy Dowling, Interim Chief Executive Officer.

4. Responsible Committees

Not applicable

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 the current position regarding the update from the Interim Chief Executive and to support the priorities set out in Section 3 of the report.

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Interim Chief Executive covering key issues, progress and priorities that have marked her first six weeks in post.

2. Overview of First Six Weeks

Over my first six weeks in the Mid and South Essex (MSE) Integrated Care System (ICS) I have begun to familiarise myself with some of the excellent and integrated work that is being done to improve the health of our people, and the quality of the services they receive.

I have had the pleasure of receiving a warm welcome, with introductory meetings with key partners from across our ICS including the three upper tier local authorities, the Chief Executive of the Local Medical Committee (LMC) and leads from our NHS partner organisations. I have visited the Basildon Hospital site, Essex Partnership University Hospitals Trust (EPUT) headquarters and secure unit, and a number of community hospital sites. I look forward to visiting sites in Thurrock and Southend in the coming weeks, and to attending all three Health and Wellbeing Boards.

I have been especially impressed by the clinically led Stewardship programmes involving primary and secondary care clinicians working together; by the leadership and delivery of urgent and emergency care services especially over the festive period and during industrial action; and by the development of 'collaboratives' of providers working together to improve the impact and value of their work. The development of integrated care is apparent, with some excellent outcomes that can only be delivered through effective system wide partnership work.

However, I have also experienced how challenged our health and care system is and it is clear that there is a need to improve planning and delivery functions such that the MSE ICS can get onto a clinically and financially sustainable footing.

For 2023-24 we are projecting a £57m deficit position, which is £17m worse than the agreed deficit plan.

I have attended two meetings with members of the NHS England (NHSE) national executive team as a result of the inability of the MSE ICS to deliver services within the financial budgets agreed with us. This requires addressing with urgency and rigour over the remainder of 2023-4 and into 2024-5 where the challenge is even greater. This must be our priority as it is our statutory duty to live within our means, and to deliver the care standards that patients expect from their NHS.

We need to do this within the context of the MSE Integrated Care Strategy and the Joint Forward Plan (JFP). Both of these documents describe the needs of our population, our vision and our ambitions. They do not describe how we will achieve these ambitions, but state that collectively we need to 'up our game'. It is clear that we now need to accelerate the detail of how, within the resources available to us, we will deliver the commitments defined in these strategies, including addressing variation and fragmentation.

3. Priorities for the ICS

There are some elements from this first six weeks that are reflected in my personal objectives and are consistent with the JFP. I would like to share these with the Board as priorities for action.

a) To develop the maturity of the Integrated Care Board following the organisational restructure, the recent recruitment of a number of new executive directors, and the need to ensure that our people are aligned to delivering our strategic and operational priorities, in partnership with our communities.

b) To ensure an ICS wide coordinated and evidence-based response to the planning guidance for 2024-25. The financial position is such that we will need to develop and deliver a programme of action to achieve sustainable recovery of both finance and performance standards; whilst continuing to deliver safe standards of care. This must be the top priority and will mean setting realistic expectations about growth and service development.

   The priorities will be to ensure high levels of productivity, low use of temporary staffing and review of all expenditure both within our providers and across commissioned service levels with a clear plan to bring this back to within budget.

   This recovery plan needs to be clear on workforce levels; productivity; service delivery and redesign; and activity with all elements aligned to financial delivery within the context of the ICS strategy.

c) To ensure that the ICS delivers the improvements to urgent care, cancer, elective care and mental health services in line with improvement trajectories set by NHSE.

d) To develop ICS wide systems of assurance, delivery, partnership and risk management to enable the ICB to undertake its role as system convenor and ultimate accountable NHS organisation. The emphasis will be on seeking evidence to assure that required outcomes are delivered and risks are managed.

e) To ensure that the MSE Alliances, working with partners in primary care and in our communities, continue to address health inequalities and impact positively on the health of their populations. This includes working with partner organisations, patient and public forums to co-produce services that meet local needs, within the context of the challenges set out above.

4. Findings/Conclusion

It is clear from the priorities above that there is much to do if we are to deliver the standards of service and improvements in health that our patients expect, within the resources available to us. The recovery programme will take time to develop and to deliver, but returning to a clinically sustainable financial and operational position must be our first priority.

5. Recommendations

The Board is asked to note the current position regarding the update from the Interim Chief Executive and to support the priorities set out in section 3 of the report.

Part I ICB Board Meeting, 18 January 2024

Agenda Number: 9

Quality Report

Summary Report

1. **Purpose of Report**

   The purpose of this report is to provide the Board with a summary of the key quality and patient safety issues, risks, escalations, and actions being taken for assurance. The report also includes key escalations from the ICB's Quality Committee.

2. **Executive Lead and Report Author**

   Dr Giles Thorpe, Executive Chief Nursing Officer.

3. **Responsible Committees**

   ICB Quality Committee.
   ICB System Quality Group.

4. **Impact Assessments**

   Not required for this report.

5. **Financial Implications**

   Not required for this report.

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

   Not required for this report.

7. **Conflicts of Interest**

   None identified.

8. **Recommendations**

   The Board is asked to note the contents of the Quality report and key actions being undertaken.

Quality Report

1. Introduction

This report provides the Board with a summary of the key quality and patient safety issues, risks, escalations, and subsequent actions taken in response, to provide assurance of oversight on all aspects of quality within the Mid and South Essex (MSE) Integrated Care System (ICS). The Quality Committee last met on 15 December 2023.

2. System Quality Group Escalations (SQG)

A workshop led by NHS England took place during November 2023 with system partners to review the form and function of the System Quality Group (SQG). In line with the National Quality Board recommendations for the development of System Quality Groups, an outline agreement was reached determining the form and function of SQG moving forward.

An email has since been sent to all key stakeholders and partners who are expected to attend SQG in 2024, with updated Terms of Reference and Workplans. The Terms of Reference will be agreed at the first meeting of SQG which is tabled for 7 February 2024.

The current outline of quality risks held by the ICB has also been shared with stakeholders as an initial review to determine that all relevant system-level risks have been identified, as these will help direct the focus of deep dives moving forward.

The Quality Committee will receive an update from System Quality Group and ratification of final Terms of Reference on 23 February 2024.

3. Quality Committee Escalations

3.1 Eating Disorder Service

The committee invited colleagues to present a patient experience video and organisational presentation from EPUT's Eating Disorder Services, highlighting the considerable investment made over the past three years which has enabled positive changes to service provision.

The development of the East of England Adult Eating Disorder Provider Collaborative has shown how people are now being treated nearer to home, with a reduction in the need or length of admission into hospital, in line with the ICB's priorities.

The development of Medical Emergencies in Eating Disorders (MEED) guidance supports a multi-disciplinary team which comprises of a consultant psychiatrist, general practitioners, and a dietitian who is able to interpret results, blood tests and electrocardiographs (ECGs) to enable earlier identification and treatment of physical problems. In-house prescribing also allows for the timely delivery of emergency interventions.

From a psychological perspective, the addition of Assistant Psychologists, has allowed for greater support for individual patients and an extension of available therapies.

In addition, work has been developed to support people transitioning from children to adults eating disorder service, and from inpatient to outpatient services.

In relation to people with a diagnosis of autism, a pathway is currently under development to support this population group with specific needs, and it was noted that the commissioning of the Autism Outreach Service would be another channel to offer support.

Finally, in relation to health inequalities and protected characteristics, training provided to healthcare professionals included recognition of other groups including men, LGBTQIA+ population, and ethnic minority groups who may also suffer with eating disorders, so that all groups were appropriately supported and identified.

3.2 Emerging Safety Concerns/National Update

The Committee received an update regarding the National Children's and Young People's (CYP) Board. Key areas discussed included the update national paediatric early warning score, and the recognition of marginalisation of CYP with epilepsy, noting this formed one of the key areas of focus within the CORE20PLUS5 approach for Children. The Committee sought assurance that CYP in MSE were receiving appropriate access to specialist support from epilepsy nurses by speaking with the BCYP oversight team.

3.3 System Oversight and Assurance Committee (SOAC) referral regarding Quality Concerns

SOAC requested that the Quality Committee seek assurance in relation to some quality concerns raised there, which included:

Aseptic Drug Preparation capacity – the committee was provided with information that within MSE outsourcing capacity had been increased to meet demand whilst the unit at Southend was being refurbished. A business case had been developed to increase production and capacity across all three sites. It was noted that this issue was being considered by NHSE regional team in terms of overarching demand and capacity modelling, and the Quality Committee wished to receive further assurance about the long-term feasibility of the plans in place. Quality Committee requested a further update from Mid and South Essex NHS Foundation Trust (MSEFT) within the next six months.

Head and Neck Cancer – Restorative Dental Surgery capacity– it was noted that whilst restorative dental surgery is not currently performed within MSEFT due to low numbers of patients, patients were appropriately referred into other providers with relevant capacity and service provision.

Diagnostic Waiting List Backlog – the committee was provided with assurance that the diagnostic backlog in radiology and endoscopy had stabilised and improved in recent months but noted the ongoing risk with industrial action impacting on delivery. Assurance was also provided that all urgent or cancer referrals were automatically prioritised and closely monitored. However, routine referrals were reviewed to ensure they were appropriately classified so all were routed to the correct pathway.

3.4 Safeguarding Quarterly update

The committee received the quarterly report from the Safeguarding Team and noted that the national consultation on 'Working Together to Safeguard Children' had been completed. The final document was due to be published which would have implications on future working arrangements with partner agencies. It was noted that the team would work closely with all Safeguarding Boards across MSE to ensure plans for any working changes would be supported and delivered against.

The management of non-accidental injuries working group had been developed, with engagement from across the system, and would focus on aligning clinical pathways across the 3 acute sites and community provider organisations.

The Right Care, Right Person initiative developed by police colleagues to ensure that the most appropriate service responded to the correct situation was currently being implemented across Essex. Assurance was required from health providers that policies and procedures were revised in relation to missing persons to minimise inappropriate escalations to the police.

3.5 Learning Disabilities and Autism (LDA) – Update

The committee received a presentation focussing on how people with LDA were being supported in MSE, in order to avoid inappropriate admission to specialist inpatient beds.

People not previously known to the LDA team in Essex County Council (ECC) had been offered support, including a case worker to co-ordinate support, care and treatment review and the ability to access other services. Sadly, the number of children in inpatient mental health beds had increased, with a small cohort unable to return home due to complex presentation, requiring specific accommodation needs.

Positively, the committee were informed that the LDA team were now owners of the dynamic support register, which brought together the separate Children, Young People and Adults registers into one, thereby offering more robust oversight of how people were being supported and allowing for earlier and more targeted preventative work. Quality Committee welcomed the update and looked forward to receiving a further update in line with the Committee's work plan (within six months).

3.6 Babies, Children and Young People - Update

The Committee were informed about 'Martha's Rule' which allowed parents to raise concerns for an independent review should they have concerns about their child's care. 'Martha's Rule' has stemmed from the death of Martha Mills, and a campaign led by her parents to ensure that the voices of children and their parents are heard, and action is taken. The key recommendations are that: any referral must go to an independent team; the referral point must be reliable, such as a critical care outreach team; there must be good communication between the family and the team and accessibility and the opportunity for junior members of staff to raise concerns if support is not being provided from their seniors.

A call for concern programme is in place at MSEFT which is being reviewed by the MSEFT Chief Nurse to ensure the principles of 'Martha's Rule' are implemented. A further update will be provided in future acute care reports to the Quality Committee.

4. Recommendation

The Board is asked to note the contents of the report and the key actions being undertaken to address escalated concerns to improve the quality of services provided to residents in Mid and South Essex.

Part I Board Meeting,

Agenda Number: 10

Month 8 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the financial performance of the ICB to date and offer a broader perspective on outturn across partners in the Mid & South Essex (MSE) system (period ending 30 November 2023).

The paper also presents our current position against our NHS constitutional standards.

As we develop our operating plan for 2024/25, workforce will be a key component of integrated planning which will enable us to triangulate and report effectively against our system plan ambitions.

2. Executive Lead

Jennifer Kearton, Executive Chief Finance Officer.

3. Report Author

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

4. Committee involvement

The most recent finance position was reviewed by the ICB Finance and Investment Committee (FIC) during November and December 2023.

Our latest Performance Report was reviewed by the System Oversight and Assurance Committee (SOAC) during November and December 2023.

5. Conflicts of Interest

None identified.

6. Recommendation

The Board is asked to receive this report for information.

Finance & Performance Report

1. Introduction

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

The System has a nationally negotiated and agreed plan position for 2023/24 of £40m (million) deficit, a £6m improvement on the outturn position for 2022/23. This plan was considered very challenging at the time of agreement and has been under sustained pressure this financial year.

During November 2023 all systems were required to recommit to their financial plans alongside delivery of Urgent & Emergency and Cancer Standards. During a Board Seminar on 21 November 2023 the Board signed off a resubmission which confirmed that MSE System was unable to meet its agreed deficit and wished to reforecast to £57m deficit. The System will be moving its reported position during month 9 (m9). The System is working closely with NHS England (NHSE) Regional colleagues to ensure the next steps in the forecast outturn change protocol are embedded, including additional expenditure controls.

This report reflects month 8 (m8) and therefore continues to present a forecast to plan position, as this was before national agreement for the adjustment.

2. Key Points

2.1 Month 8 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB has increased by £34m since last reported at m6. The single largest allocation is the nationally announced support as a result of Industrial Action and additional pressures across the NHS, £12.6M was received in m8.

Table 1 – Allocation movements between month 4 and month 6

	Recurrent £m	Non Recurrent £m	Total £m
Allocation at month 6	2,456	111	2,568
Movements:			
Primary Care Inflation Uplift	3		3
Other Pay Inflation Impact	2	0	2
Central Support for ongoing IA and Pressures		13	13
Elective Recovery Funding		4	4
Removal of held back elements		7	7
Diagnostic Revenue Support		3	3
Charge Exempt Overseas Visitors		(2)	(2)
Other Adjustments and SDF	0	5	4
Current Allocation at month 8	2,461	141	2,602

The ICB continues to forecast its agreed outturn position of £10m surplus. The risks across our variable spend areas continue into the last quarter of the year. Deep dive work is supporting a complete understanding of the Continuing Health Care (CHC) challenge and we continue to work with nationally produced numbers and benchmarking to report our potential pressure across Prescribing. The latest forecasts below present the most recent estimates.

Adjustments to the elective recovery threshold should enable the ICB to largely mitigate the unprecedented growth in our independent sector.

All areas are working hard to mitigate in-year pressure which has surpassed expectations at planning stage.

Table 2 – summary of the position against the revenue resource limit for month 6.

Expenditure	Year to Date			Forecast Outturn		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Revenue Resource Limit	(1,723)			(2,602)		
Acute Services	903	908	(5)	1,364	1,371	(7)
Mental Health Services	171	170	1	257	257	1
Community Health Services	149	149	(0)	230	230	(0)
Continuing Care Services	84	88	(4)	125	131	(6)
Prescribing	158	166	(8)	235	249	(14)
Primary Care	218	215	3	335	328	7
Other Commissioned Services	11	10	1	17	15	2
Other Programme Services	8	(5)	13	6	(10)	16
ICB Running Costs	15	15	0	24	22	2
Total ICB Net Expenditure	1,716	1,716	(0)	2,593	2,593	0

2.2 ICB Finance Report Conclusion

At m8 the ICB is forecasting to deliver its agreed plan. This is a particularly challenging position given the level of inflationary and activity demand, currently being managed. The ICB is part of the wider system reforecast work, however the intention is to continue to hold the surplus position for 2023/24.

2.3 Month 8 System Financial Performance

At m8 the overall health system position is a deficit of £60m, (m7 £52m, m6, £45m, m5 £39). This position is off plan by £31m. The year-to-date (YTD) position largely reflects the current shortfall in efficiency programme delivery which was set to mitigate the impact of rising risk. However, workforce pressures continue to drive high levels of spend within our provider sector.

The system forecast outturn is currently in line with plan. However, as noted above this will change at m9 as a result of the reset exercise which took place during November 2023.

The System currently meets monthly with regional colleagues and regularly with our national team to review the financial performance in-year and discuss actions.

Our system deficit is manifest in our Provider Sector, with a YTD deficit of £57m in MSEFT and £9.5m in EPUT. Both organisations have implemented grip and control actions and continue to work collectively with the ICB to reduce the run rate together.

2.4 System Efficiency Position

The System has been working collectively to validate and assure the target efficiencies of £119m, required to deliver the agreed deficit plan. The Central Programme Management Office (PMO) is established with a programme of governance across our core efficiency pillars: workforce, system flow, independence, and corporate efficiencies. The system is building on the financial improvement works 2022/23 to drive delivery during 2023/24.

There is still a gap against the required position and the Central PMO continues to focus on the identification of schemes, overseeing delivery and ensuring sustainability through continuous review of opportunities.

At m6 a total of £96m, (69% recurrent and 31% non-recurrent) has been identified, leaving a gap of £23m against our required target.

Non delivery of efficiency has reduced our ability to close our financial gap as well as mitigate new pressures.

2.5 System Capital Position

The system has been working closely with regional colleagues during m8 to confirm spend profiles against both local schemes and externally funded programmes of work. All efforts are being made to accelerate work with external contractors and manage multi-year projects.

The working group for capital investment continues to monitor and report on the delivery bi-weekly and is meeting regularly with System Finance Leaders Group and regional leads to ensure the system can maximise the opportunities against local and nationally funded projects.

Table 4 – Capital Spend Summary

Capital Spend Summary	Full Year 2023/24			YTD - November 2023		
	Plan £'000	FOT £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Mid and South Essex NHSFT	115,043	101,957	13,086	58,227	46,134	12,093
Essex Partnership University NHSFT	21,806	24,472	(2,666)	8,525	7,997	528
ICB	1,987	1,987	-	233	60	173
Total System Capital	**138,836**	**128,416**	**10,420**	**66,985**	**54,191**	**12,793**
YTD Spend as a % of YTD Plan					81%	

System Finance Report Conclusion

At month 8 (m8) the System continues to be behind its planned YTD performance. Recovery actions are in place and the system has prepared a re-forecast position for m9.

The System is under regular review with both regional and national NHS England colleagues and continues to operate under strengthened internal governance and financial control.

2.6 Urgent and Emergency Care (UEC) Performance

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.

The MSE System Winter Plan has been submitted detailing the improvement programmes and schemes behind the plan to deliver the planning round trajectories. These will be overseen by the System UEC Board.

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 and have not recovered to pre-pandemic levels.

East of England Ambulance Service

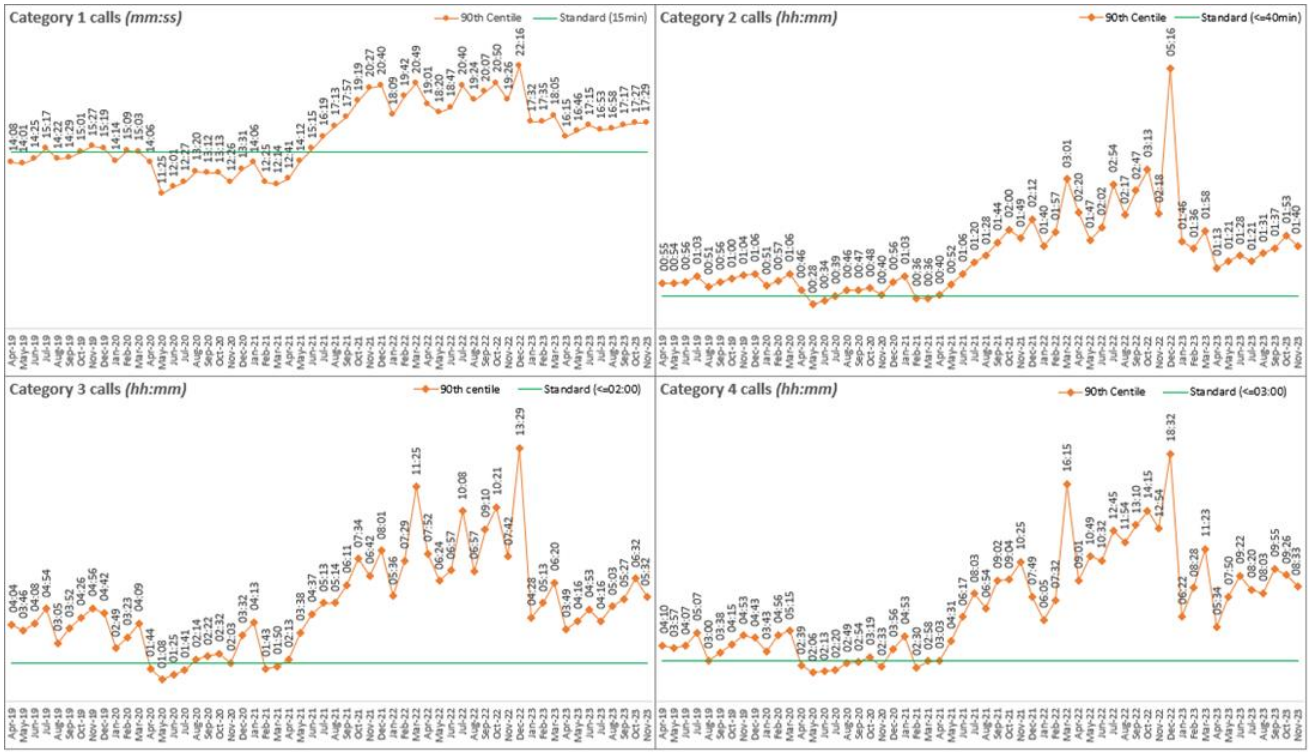
90th Centile Response Time by call category 2023/24 compared to pre-pandemic 2019/20

Please note: response times:

- Green where meeting standard
- Amber where not meeting standard but <= pre-pandemic 2019/20
- red where not meeting standard and > pre-pandemic 2019/20

Call Category	Standard	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Category 1 Calls MM:SS	<= 15min	2019/20	14:08	14:01	14:25	15:17	14:22	14:29	15:01	15:27	15:19	14:14	15:09	15:03
		2023/24	16:15	16:46	17:15	16:53	16:58	17:17	17:27	17:29				
Category 2 Calls HH:MM	<= 40min	2019/20	00:55	00:54	00:56	01:03	00:51	00:56	01:00	01:04	01:06	00:51	00:57	01:06
		2023/24	01:13	01:21	01:28	01:21	01:31	01:37	01:53	01:40				
Category 3 Calls HH:MM	<= 02:00:00	2019/20	04:04	03:46	04:08	04:54	03:05	03:52	04:26	04:56	04:42	02:49	03:23	04:09
		2023/24	03:49	04:16	04:53	04:16	05:03	05:27	06:32	05:32				
Category 4 Calls HH:MM	<= 03:00:00	2019/20	04:10	03:57	04:07	05:07	03:00	03:38	04:15	04:53	04:43	03:43	04:56	05:15
		2023/24	05:34	07:50	09:22	08:20	08:03	09:55	09:26	08:33				

The following graphs show the 90th centile response times for EEAST for each of the four categories of calls against their respective standards.



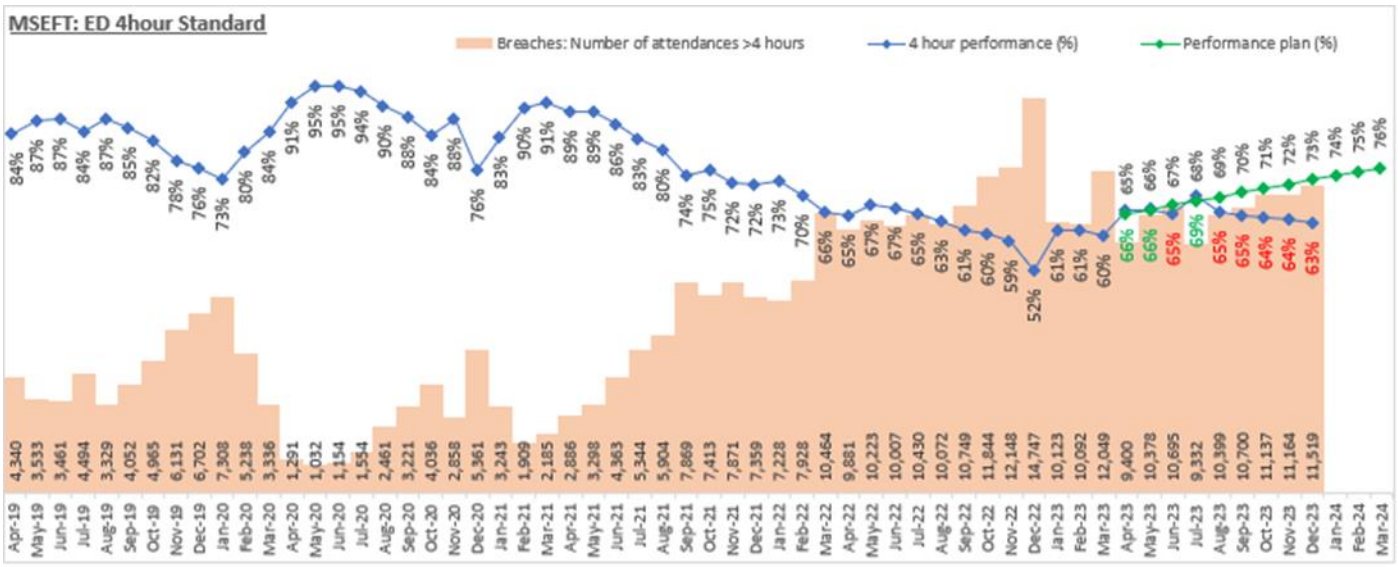
Our Winter Plan includes system actions to support recovery of ambulance response times and arrival to handover and is overseen by the System Urgent and Emergency Care (UEC) Board. Escalations are made to the SOAC.

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 graph. December 2023 performance is below the 2023/24 plan. The plan has the ambition to increase performance to 76% by March 2024, shown as the green line.



2.7 Elective Care

The Elective Programme Board manages the delivery of elective targets across the system. A key focus for the Board is waiting time performance for Diagnostics, Cancer and Referral to Treatment (RTT). Our performance in these areas is currently below the national standard.

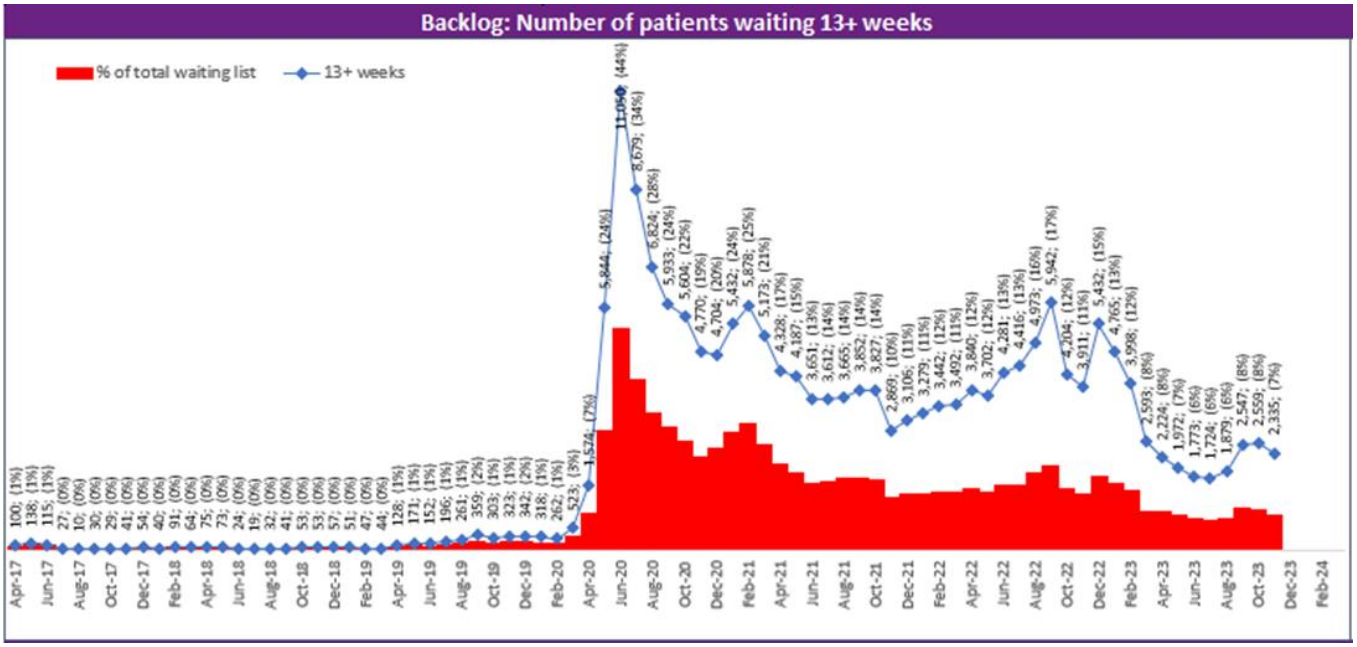
Diagnostics Waiting Times

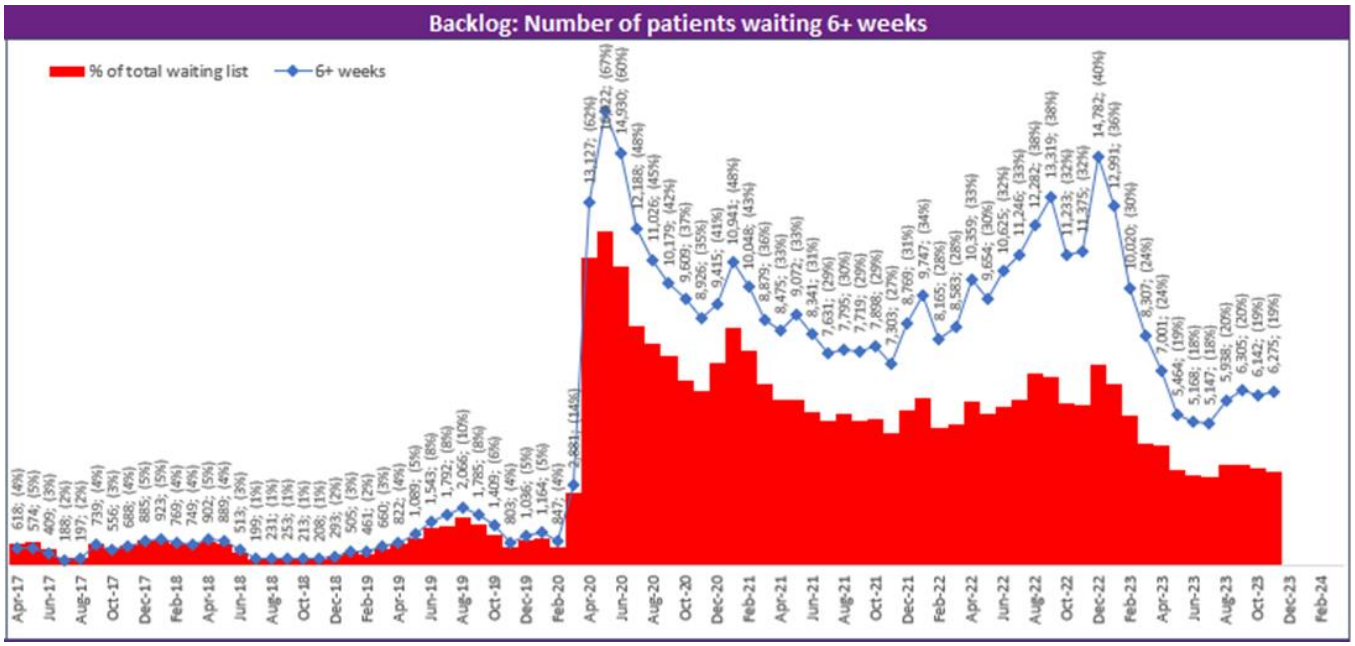
The System Diagnostic Board oversees performance and planning for diagnostics across MSE supported by sub-groups including assurance.

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 do not meet the NHS constitutional standards as per following graphs showing the total number of patients waiting 13+ and 6+ weeks across all providers for patients registered to MSE Integrated Care System (ICS) to November 2023.





As of November 2023, 2,335 waits were 13+ weeks (standard: zero) and 19% of waits were 6+ weeks (standard: <=5%).

The following table compares the MSE diagnostic position in terms of number of 13+ week diagnostic waits compared against pre-pandemic 2019/20. Except for colonoscopy and flexi-sigmoidoscopy, the number of 13+ week waits are greater than the 2019/20 pre-pandemic position.

All providers position for Mid and South Essex System

Number of patients on a diagnostic six week wait pathway, waiting 13+ weeks by test 2023/24 compared to pre-pandemic 2019/20

Please note: response times:

- Green where meeting standard of zero patients waiting 13+ weeks
- Amber where not meeting standard but <= pre-pandemic 2019/20
- red where not meeting standard and > pre-pandemic 2019/20

Test		Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Imaging	Magnetic Resonance Imaging	2019/20	11	6	4	5	5	10	7	7	2	2	7	15
		2023/24	89	56	36	32	71	179	94	94				
	Non-Obstetric Ultrasound	2019/20	7	4	3	0	3	2	0	0	0	0	1	9
		2023/24	1,020	697	587	643	562	674	662	494				
	Computed Tomography	2019/20	0	0	1	0	2	1	1	1	0	1	0	7
		2023/24	34	28	46	35	79	173	134	30				
	Barium Enema	2019/20	0	1	0	0	0	0	0	0	0	0	0	0
		2023/24	0	0	0	0	0	4	0	1				
	DEXA Scan	2019/20	0	0	0	0	0	0	0	1	0	0	1	1
		2023/24	58	42	58	30	48	50	36	14				
Endoscopy	Colonoscopy	2019/20	68	76	62	76	123	156	141	154	181	166	124	173
		2023/24	19	27	24	18	44	49	37	48				
	Cystoscopy	2019/20	8	6	5	4	5	7	5	3	2	7	10	48
		2023/24	85	77	83	69	65	67	80	69				
	Flexi Sigmoidoscopy	2019/20	8	33	26	46	55	72	77	84	90	84	80	87
		2023/24	1	1	4	4	12	10	21	28				
	Gastroscopy	2019/20	24	42	45	54	60	102	67	60	61	46	32	66
		2023/24	60	56	56	52	82	95	72	79				
Physiological Measurement	Audiology - Audiology Assessments	2019/20	0	0	0	0	0	0	0	1	0	0	0	33
		2023/24	457	234	118	126	15	139	65	30				
	Cardiology - Echocardiography	2019/20	1	0	3	2	1	1	2	4	2	3	4	73
		2023/24	139	404	483	427	602	862	1,072	1,144				
	Cardiology - Electrophysiology	2019/20	0	0	0	0	0	0	0	0	0	0	0	0
		2023/24	0	0	0	0	0	0	0	0				
	Neurophysiology	2019/20	0	0	0	0	0	0	2	1	0	0	0	1
		2023/24	171	210	126	162	200	154	208	237				
	Respiratory Physiology - Sleep Studies	2019/20	0	0	0	0	0	0	0	0	0	0	0	8
		2023/24	80	134	143	121	88	89	72	59				
	Urodynamics - Pressures & Flows	2019/20	1	3	3	9	7	8	1	7	4	9	3	2
		2023/24	11	6	9	5	11	2	6	8				
Total Diagnostic Tests		2019/20	128	171	152	196	261	359	303	323	342	318	262	523
		2023/24	2,224	1,972	1,773	1,724	1,879	2,547	2,559	2,335				

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

Cancer Waiting Times

Standards: For people with suspected cancer:

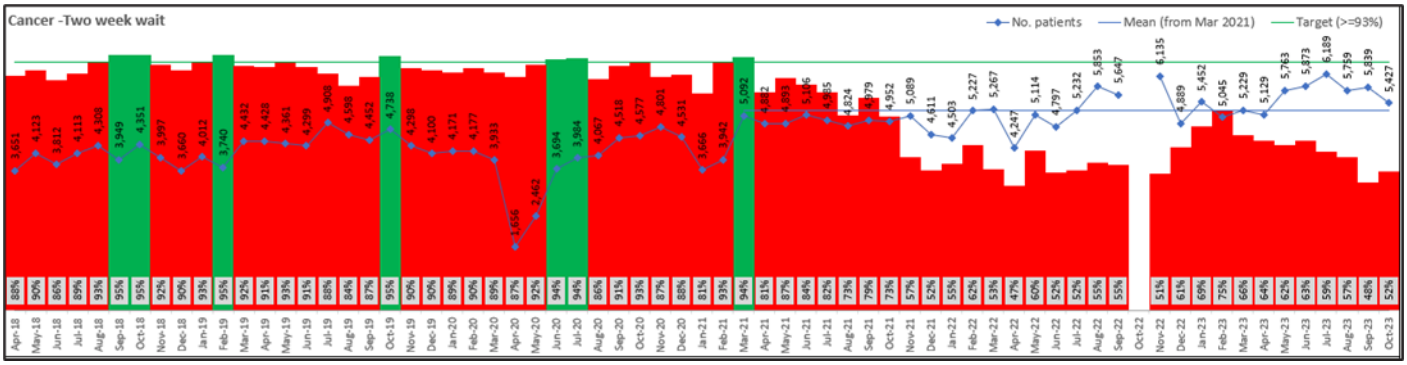
- To see a specialist within 14 days of being urgently referred by their GP or a screening programme.
- To not wait more than 28 days from referral to getting a cancer diagnosis or having cancer ruled out.
- To receive first definitive treatment within 31 days from decision to treat.
- To start drug,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

Waiting times for patients on a cancer pathway remain below NHS constitutional standards.

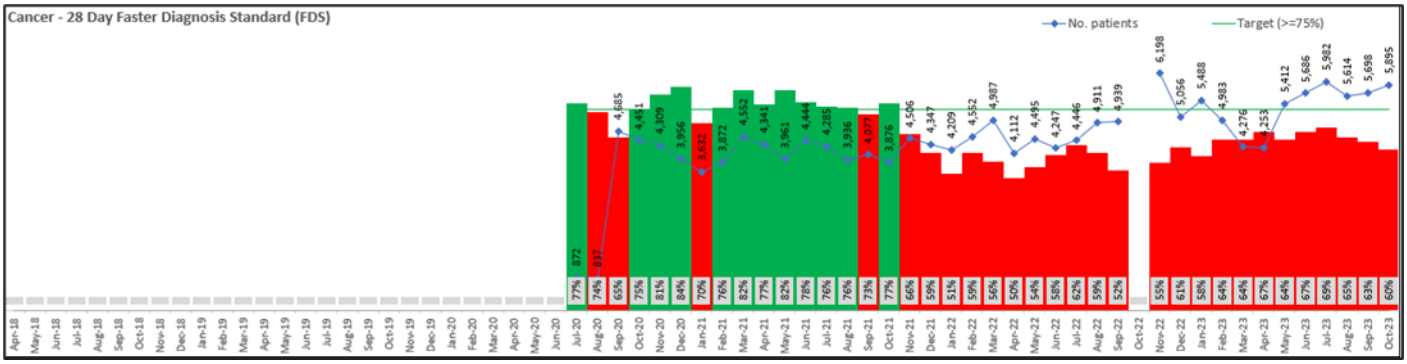
The following table shows the latest MSEFT position (October 2023) for each of the waiting time standards.

Tumour Site	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%)	
Total	52.1%	32.6%	60.3%	72.9%	92.4%	86.6%	58.2%	38.7%	50.0%	58.7%
Acute leukaemia										
Brain/Central Nervous System	88.9%		57.1%							100.0%
Breast	20.8%	32.6%	68.4%	78.3%				42.4%	56.5%	0.0%
Children's	28.6%		75.0%							
Exhibited (non-cancer) breast symptoms - cancer not initially suspected			85.4%							
Gynaecological	75.3%		56.0%	11.1%				0.0%		
Haematological	83.0%		46.2%	57.1%				25.0%		100.0%
Head & Neck	56.4%		61.6%	66.7%				0.0%		
Lower Gastrointestinal	95.5%		48.1%	76.7%				33.3%	28.6%	100.0%
Lung	95.3%		84.3%	88.6%				30.8%		52.6%
Other	100.0%		25.0%	80.0%				0.0%		100.0%
Sarcoma				100.0%				42.9%		
Skin	2.9%		61.4%	73.9%				54.3%		71.4%
Testicular	95.0%		61.1%					100.0%		
Upper Gastrointestinal	91.7%		60.5%	66.7%				0.0%		0.0%
Urological	89.8%		51.2%	27.8%				10.0%		0.0%

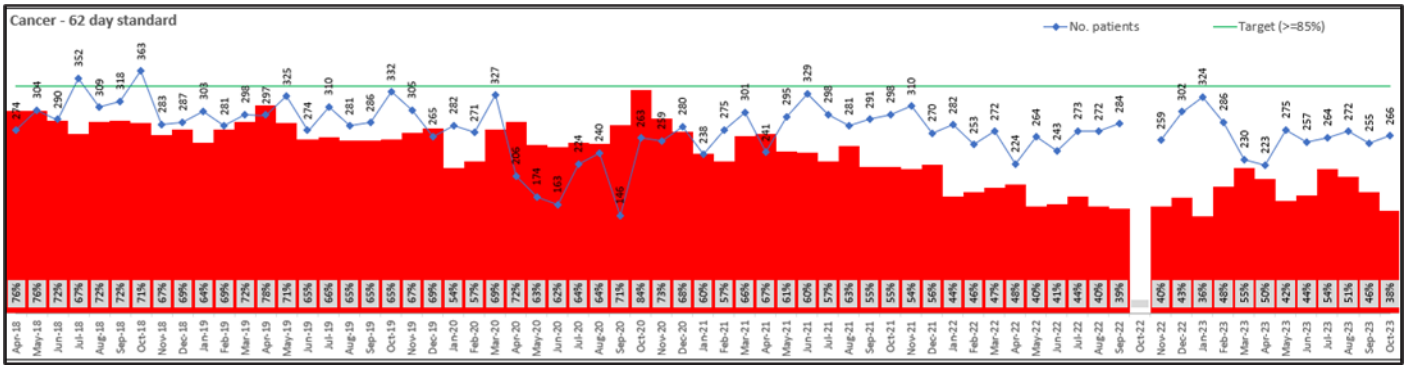
The following graph shows the performance together with the number of referrals on a two-week pathway above pre-covid levels. For October 2023 the performance was 52% (standard: >=93%).



The following graph shows the 28-day Faster Diagnosis Standard. The October 2023 performance was 60% (standard: >=75%). The 2023/24 plan is to increase performance to achieve the 75% standard by March 2024. Mitigating actions to recover to plan are in place and forecast to achieve 75% by March 2024.



The following graph shows the 62-day standard performance. The October 2023 performance was 38.7% (standard: >=85%).



The following table compares the MSEFT cancer waiting time position for each of the standards to pre-pandemic 2019/20. The performance does not meet the constitutional standards and is below pre-pandemic 2019/20.

Mid and South Essex Foundation Trust

Cancer Performance by Standard 2023/24 compared to pre-pandemic 2019/20

Please note: response times:

- Green where meeting standard
- Amber where not meeting standard but >= pre-pandemic 2019/20
- red where not meeting standard and < pre-pandemic 2019/20

Standard	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Two Week Wait - Target: 93%	2019/20	90.8%	92.7%	91.0%	88.4%	84.2%	87.4%	94.8%	90.5%	89.7%	88.9%	90.4%	88.7%
	2023/24	63.6%	61.9%	63.3%	59.3%	57.2%	47.7%	52.1%					
Breast Symptom Two Week Wait - Target: 93%	2019/20	70.6%	86.1%	86.0%	95.7%	98.7%	97.2%	94.8%	79.5%	67.7%	75.1%	73.0%	79.1%
	2023/24	25.3%	30.6%	54.0%	61.8%	53.6%	19.7%	32.6%					
28-Day Faster Diagnosis Standard (FDS) - Target: 75%	2019/20												
	2023/24	66.9%	63.9%	66.8%	68.5%	64.7%	63.0%	60.3%					
31 Day First Treatment - Target: 96%	2019/20	91.6%	89.1%	89.8%	90.3%	88.7%	89.2%	91.0%	91.6%	90.4%	83.3%	88.8%	94.2%
	2023/24	79.6%	81.9%	80.9%	85.2%	84.2%	76.1%	80.1%					
31 Day Subsequent Treatment - Surgery - Target: 94%	2019/20	63.9%	65.7%	80.0%	82.5%	80.9%	80.4%	79.2%	77.0%	70.1%	63.0%	71.3%	78.2%
	2023/24	61.9%	53.8%	57.1%	64.5%	71.4%	71.4%	58.2%					
31 Day Subsequent Treatment - Drug - Target: 98%	2019/20	87.8%	96.7%	95.7%	95.5%	95.8%	95.7%	94.6%	95.7%	95.5%	79.2%	86.1%	88.9%
	2023/24	94.6%	89.0%	90.0%	87.9%	92.8%	91.7%	92.4%					
31 Day Subsequent Treatment - Radiotherapy - Target: 94%	2019/20	98.6%	95.9%	97.8%	97.8%	99.2%	96.7%	94.0%	98.5%	96.7%	94.1%	97.5%	97.8%
	2023/24	86.8%	77.0%	89.5%	91.1%	87.8%	86.7%	86.6%					
62 Day Standard - Target: 85%	2019/20	77.7%	71.2%	65.1%	65.9%	64.5%	64.6%	65.0%	67.5%	69.4%	54.4%	56.9%	68.6%
	2023/24	50.3%	42.2%	44.4%	53.9%	51.1%	45.6%	38.2%					
62 Day Screening - Target: 90%	2019/20	73.5%	73.0%	76.3%	91.2%	70.4%	80.4%	77.8%	85.0%	82.1%	73.3%	71.9%	80.5%
	2023/24	47.8%	43.2%	54.1%	50.8%	48.6%	46.7%	48.4%					

The MSE Cancer Transformation and Improvement 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.

As reported in the Tier 1 national meeting, MSEFT trajectories show recovery of the variance to plan.

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 65+ weeks on an RTT pathway to zero by March 2024.
- Reduce the number of patients waiting 52+ weeks on an RTT pathway to zero by March 2025.

The following table summarises the latest MSEFT RTT position (October 2023) by specialty. As of October 2023, there was the following number of patients on an RTT pathway at MSEFT:

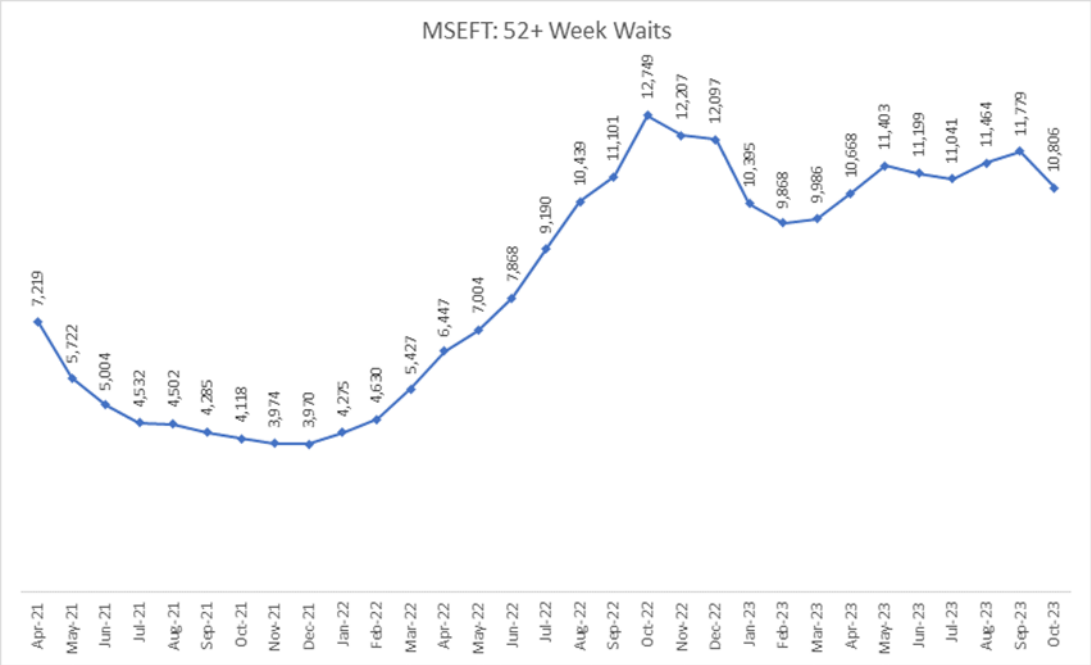
232 patients waiting 78+ weeks.

2,867 patients waiting 65+ weeks

10,806 patients waiting 52+ weeks

Specialty	Total waiting list size	Average (median) waiting time in weeks	92nd percentile waiting time in weeks	Total number of patients waiting 52 plus weeks	Total number of patients waiting 65 plus weeks	Total number of patients waiting 78 plus weeks
Total	**166,411**	**16**	**49**	**10,806**	**2,867**	**232**
General Surgery	10,848	17	42	452	92	4
Urology	9,168	16	49	558	158	21
Trauma and Orthopaedic	15,357	20	58	1,880	539	18
Ear Nose and Throat	12,210	19	52	1,003	259	49
Ophthalmology	16,365	18	51	1,170	308	4
Oral Surgery	5,768	27	60	889	265	9
Neurosurgical	87	20	58	7	2	0
Plastic Surgery	5,378	17	60	652	300	53
Cardiothoracic Surgery	428	12	42	14	5	0
General Internal Medicine	1,756	11	30	11	3	1
Gastroenterology	8,514	15	49	514	118	1
Cardiology	11,031	13	34	121	17	0
Dermatology	12,474	15	49	758	49	2
Respiratory Medicine	4,527	14	36	107	25	2
Neurology	5,132	15	42	236	75	1
Rheumatology	3,148	14	33	51	7	1
Elderly Medicine	804	9	28	1	1	0
Gynaecology	12,282	17	47	640	140	7
Other - Medical Services	17,145	15	45	835	222	32
Other - Mental Health Services	0	-	-	0	0	0
Other - Paediatric Services	3,709	21	56	371	125	13
Other - Surgical Services	7,256	14	48	442	140	13
Other - Other Services	3,024	5	37	94	17	1

The following graph shows the number of patients waiting 52+ weeks since April 2021.



The Elective Board oversees RTT assurance for MSEFT, Independent Sector, Community (RTT services) and Tier 2.

2.8 Mental Health

Our Mental Health Partnership Board oversees all aspects of mental health performance. The key challenge for the work programme relates to workforce capacity.

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.

This standard is being sustainably achieved across MSE (latest position: October 2023).

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 MSE (latest position: July 2023).

3. System Performance Report Conclusion

The System has an arrangement of oversight groups whose core concern is the delivery of the constitutional targets. Actions are regularly reviewed, and progress monitored with escalation to SOAC where there is a variance to plan.

It is important to note that the majority of urgent and emergency care for the system continues to be funded via a block payment arrangement. However, a payment for activity approach has been reinstated for Elective Care, meaning the system will distribute its allocation according to the activity delivered for the population.

The System must adhere to the Mental Health Investment Standard which requires us to increase Mental Health spend at a level higher than our annual growth in overall allocations. MSE ICB is currently meeting its obligations under the standard.

4. Recommendation

The Board is asked to note the performance across both finance and the constitutional standards of delivery.

Part I ICB Board meeting, 18 January 2024

Agenda Number: 11

Primary Care Report

Summary Report

1. Purpose of Report

To brief the Board on the development of Primary Care Services across Mid and South Essex (MSE).

2. Executive Lead

Pam Green, Alliance Director, Basildon and Brentwood and Primary Care Executive Lead for Mid and South Essex ICB

3. Report Author

William Guy, Director of Primary Care, Mid and South Essex ICB

4. Responsible Committees

The developments outlined in this paper are regularly considered by the Primary Care Commissioning Committee

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

Dr Anna Davey, Primary Care Partner Member of the ICB Board, is a partner of The Coggeshall Surgery, but there is no conflict identified within the contents of this report.

9. Recommendation(s)

The Board is asked to note the contents of this report.

Primary Care Update

1. Introduction

At the November Part I ICB Board meeting, Pam Green presented a paper to the Board seeking agreement to provide a regular update of developments across primary medical, pharmacy, optometry and dental services in Mid and South Essex (MSE). This report is the first iteration of what will be a regular update. The content and format of the report will evolve over time.

2. Main content of Report

Primary Care Access Recovery Plan

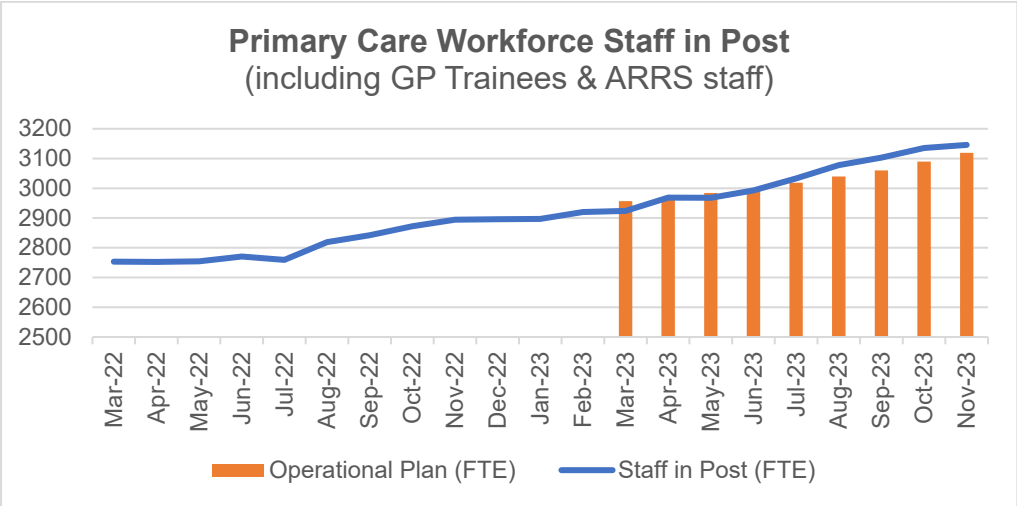
- Following the approval of the local response to the Access Recovery Programme by the ICB Board in November 2023, a number of key initiatives have been progressed.
- Phase 1 of the Cloud Based Telephony roll out has now been completed (subject to delivery of new solutions by service providers). All 57 practices identified as being on analogue systems have committed to new Cloud Based Telephony systems. 50 of these have been through a process supported by the ICB.
- Phase 2 of the Cloud Based Telephony roll out is now underway. 14 practices to-date have been identified as having a Cloud Based Telephony solution which is not compliant with core requirements for the Modern General Practice model. The ICB is likely to support these 14 practices transition onto a compliant solution.
- A number of appointments have been made to the ICB's 'Connected Pathways' team. This team will lead the local response to the Access Recovery Plan working with partners to support the implementation of the Modern General Practice model.
- A number of self-referral pathways are now up and running across MSE. This will empower patients to go directly to other service providers (where appropriate) rather than having to be triaged/seen within general practice.

Integrated Neighbourhood Teams and Fuller Stocktake Review

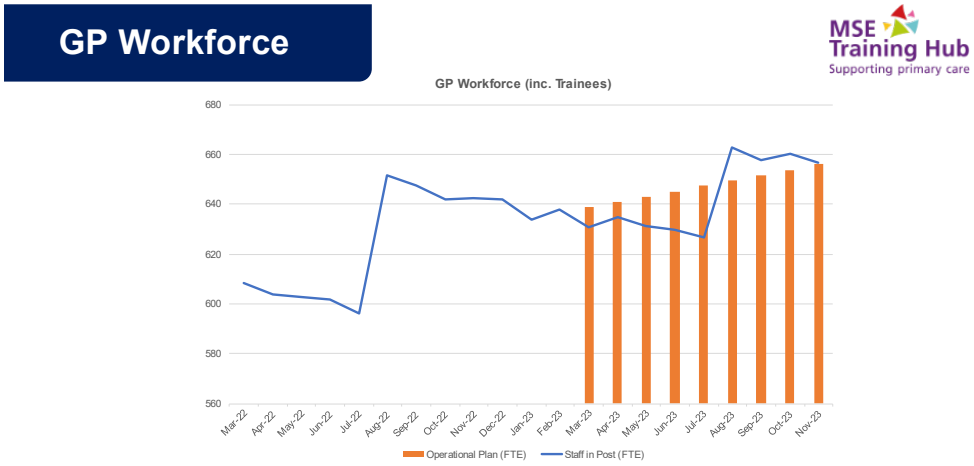
- At December's Primary Care Commissioning Committee (PCCC), Dr Anna Davey and Katherine Cornish (Fuller Implementation Lead) presented an update on the implementation of Integrated Neighbourhood Teams (INTs) across MSE.
- Through working with stakeholders, a Framework tool has been developed to enable INTs to objectively assess the maturity of their INTs. An initial review of all INTs has been undertaken and is currently being refined to ensure consistency across the system.
- There are nine INTs established across the MSE system currently, with this number expected to significantly increase across 2024/2025.
- The INT Incentive Scheme has been used during 2023/2024 to support development of INT/Fuller work across all Primary Care Networks (PCNs) in MSE.
- Provision of estates has been identified as a key risk by stakeholders. A mechanism is already in place to allow PCNs to utilise 'void space' in NHS Property Services buildings across MSE. However, this risk is likely to remain. Consideration is being given to how this may be addressed working across system partners.

Primary Care Workforce Hub and Additional Roles Reimbursement Scheme (ARRS)

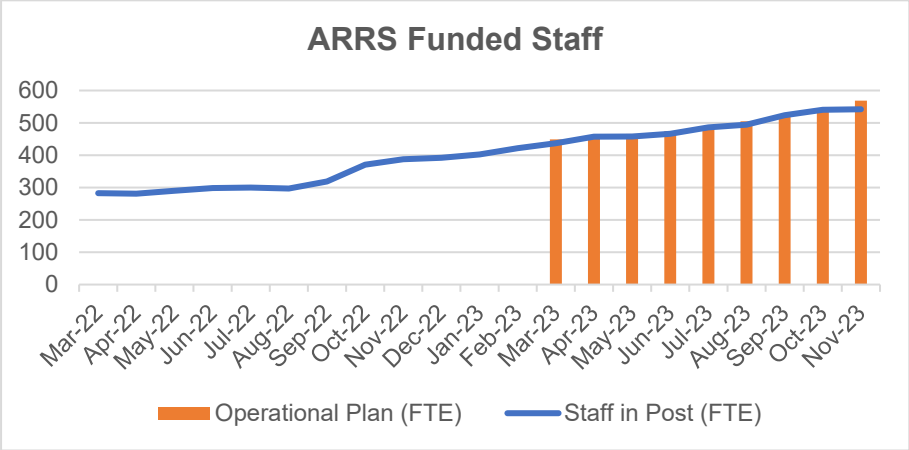
- Through a broad range of initiatives across both clinical and non-clinical roles, the Primary Care Workforce Hub has seen continued increase in overall numbers of staff in primary care across MSE.



- This includes an overall increase in the number of GPs (including trainees)



- As of November 23, there are 550 ARRS staff in post across MSE. This is an increase in over 100 posts since March 2023. Plans are in place within PCNs to fully recruit to ARRS complements by the end of March 2024.



Pharmacy Developments

- At the December PCCC meeting, a number of developments across community pharmacy services were noted.
- As of 1 December 2023, there are 203 Community Pharmacies operational in MSE. This is a reduction on the 212 Pharmacies in place at the time of the last Pharmaceutical Needs Assessment in October 2022. Work is being undertaken to consider opportunities for addressing need in areas where pharmacies have left the marketplace.
- A number of national developments are now being implemented at a local level. This includes amendments to the provision of Blood Pressure Checks, Contraception Services and the introduction of 'Pharmacy First' services. Pharmacy First services will see community pharmacy operate as a first point of call for patients presenting with common ailments such as sinusitis, earache, and infected insect bites. This service is due to go live nationally at the end of January 2024. 83% of local community pharmacies have signed up to this 'Advanced Service'.

Optometry Developments

- Emma Spofforth, Secretary of the Local Optometry Committee (LOC), presented an overview of Optometry Services to the December PCCC. The committee welcomed this discussion and have identified opportunities for working with the LOC and its members on the development of 'Connected Pathways' and Integrated Neighbourhood Teams.

Dentistry Developments

- The Access Pilot continues to be well utilised across MSE. 10 dental practices are participating in this development. These practices provide additional 30-minute appointment slots outside of normal working hours (i.e. in the evenings, weekends and bank holidays). The pilot commenced in September 2023. As of the end of December 2023, 3,932 additional patients were seen through the pilot. The pilot will run until 31/03/25. It is expected that 40,000 additional appointments will be provided during the pilot.
- The Dental Care Home Pilot has commenced. This scheme seeks to provide care homes with linked dental care professionals to support care home staff to assess oral health and create an oral health plan for residents. Those patients requiring

further dental care will then be either seen in the linked dental practice or via a domiciliary service. Within the first phase of the pilot, we have secured provision for 6,224 care home beds out of a total of 8,298 beds in MSE. This represents 75% coverage, against an initial plan of between 33%-50%.

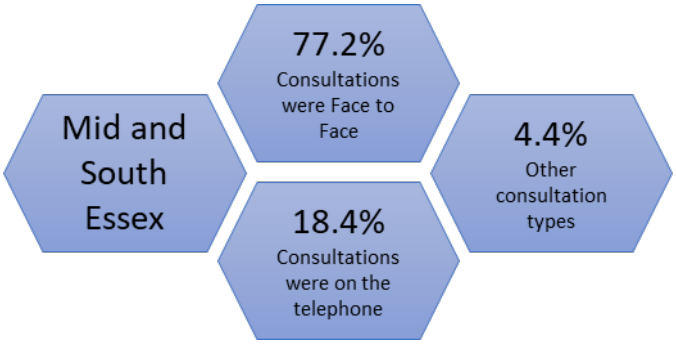
- A number of contractual decisions have been approved by the PCCC to maintain total Units of Dental Activity (UDA) across MSE. This has included negotiations with existing providers and reprovision of UDAs where contractors have served notice on provision.

Primary Care Performance

- The Primary Care Team is working with stakeholders to develop a standard dashboard of indicators across primary care provision (medical, pharmacy, optometry and dental services). This is being overseen by the PCCC.

- Total consultations in Primary Care:

	April – Oct 22/23	**Apr – Oct 23/24**	**Net change**
Mid and South Essex	3.573m consultations	3.882m consultations	+ 0.31m consultations



Primary Care Engagement

- Dr Anna Davey has updated the PCCC on work she is undertaking with the Local Medical Committee to understand the opportunities for establishing a 'Primary Care Collaborative' locally. Similar models are in place across the country and seek to improve the ability of independent contracts to work together on solutions such as the provision of services or influencing decisions.

3. Recommendation

The Board is asked to note the contents of the Primary Care Report.

ICB Board Meeting of 18 January 2024

Agenda Number: 12.1

Updated Governance Documents

Summary Report

1. Purpose of Report

To present changes to the ICB Scheme of Reservation and Delegation (SORD) and other governance documents, that have resulted primarily from the introduction of the Provider Selection Regime (PSR), but also take account of changes resulting from the ICB restructure, the corporate review and those required for delegation of Specialised Services from NHS England.

2. Executive Leads

Emily Hough Director of Strategy & Corporate Services.
Jennifer Kearton, Chief Finance Officer.

3. Report Author

Nicola Adams, Associate Director of Corporate Services.

4. Responsible Committees

The Audit Committee is required to oversee and endorse any changes to the govenance of the ICB for final approval by the ICB Board. All documents will be presented to the Audit Committee on 16 January 2024.

The Finance and Investment Committee (FIC) oversee financial policies and in some cases approve business cases that lead to procurements and thus ensure we comply with procurement legislation. The FIC have considered and supported all recommendations outlined in section 10 below, subject to some amendments outlined herein.

The Board retains overall responsibility for approval of changes to ICB governance.

5. Link to the ICB's Strategic Objectives

This is an enabler function and links to all strategic objectives.

6. Impact Assessments

None required, main changes are as a result of statutory guidance.

7. Financial Implications

There are proposed changes to financial thresholds within the Scheme of Reservation and Delegation as follows:

Committee	Existing Threshold	Proposed change
Executive Committee	None	£250k to £5m (in budget) <£100k (with no budget)
Chief Executive Officer / Chief Finance Officer	£250k - £1m (in budget) £100k - £250k (with no budget)	No authority, other than an Executive Director
Finance and Investment Committee	£1m - £5m (in budget) £250k - £2.5m (with no budget)	£5m - £10m (in budget) £100k - £2.5m (with no budget)
Board	>£5m (in budget) >£250k (with no budget)	>£10m (in budget) >£250k (with no budget)

8. Details of patient or public engagement or consultation

None required.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board are asked to:

- **Approve** the revised Scheme of Reservation and Delegation.
- **Approve** the establishment of and terms of reference for the PSR Review Group as a sub-committee of the Finance & Investment Committee.
- **Support** the principle of collaborative working under a Memorandum of Understanding (MoU) (to be developed) with the East of England (EoE) ICBs to provide independent members for the PSR Review Group.
- **Approve** the establishment of and terms of reference for the Executive Team Committee as a formal sub-committee of the ICB Board.
- **Approve** the revised terms of reference of the Finance & Investment Committee.
- **Approve** the revised Procurement and Contracting Policy.
- **Approve** the revised Standing Financial Instructions.

Updated Governance Documents

1. Introduction

The NHS Long Term Plan set out the need to transform health and care services to meet increasing demand, deliver better care and outcomes and ensure the health and care system is financially sustainable.

To meet these goals, as well as recover service delivery following the COVID-19 pandemic, the health and care landscape in England is changing. NHS bodies, local authorities and their partner organisations are increasingly working together to plan and deliver more integrated care and improve health outcomes for local people and communities.

The Health and Care Act 2022 (the 2022 Act) amended the National Health Service Act 2006 (the 2006 Act) to put in place legislative changes that support this, including the creation of integrated care systems. The legislation sets an expectation that all those involved in planning, purchasing, and delivering health and care services work together to agree and address shared objectives, and makes it easier for them to do so.

A key component of the changes introduced by the 2022 Act – and strongly supported by stakeholders across the NHS and local government – is the new Provider Selection Regime (the PSR, or the regime), which is set out in the Health Care Services (Provider Selection Regime) Regulations 2023 (the Regulations), to replace the existing procurement rules for NHS and local authority funded health care services.

With the introduction of the Provider Selection Regime (PSR) from 1 January 2024 the ICB is required to develop several changes to policies and procedures.

In addition, the ICB has undergone a restructure that requires changes to its governance framework, namely the Scheme of Reservation and Delegation (SoRD) to ensure it is reflective of recent changes. Alongside this, the ICB is preparing to receive delegation of Specialised Commissioning from NHS England in April 2024.

2. Main content of Report

Provider Selection Regime

Background

The PSR replaces the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (the PPCCR) and, alongside its introduction, removes the procurement of health care services, when procured by relevant authorities under the PSR, from the scope of the Public Contracts Regulations 2015 (the PCR). The PCR and the PPCCR had set the expectation that competitive tendering is used to award contracts for health care services. The PSR has been designed to give the relevant authorities to which it applies more flexibility in selecting providers for health care services. Under the regime, competitive tendering will be one tool for organisations to use when it is of benefit, alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of integrated care. The regime still requires relevant authorities to

consider value for money as an important criterion, and to be transparent, fair, and proportionate in their decision-making.

The PSR has been designed to introduce:

- a flexible and proportionate process for selecting providers of health care services (so that all decisions can be made with a view to securing the needs of the people who use the services, improving the quality of the services, and improving the efficiency in the provision of the services).
- the capability for greater integration and collaboration across the system, while ensuring that all decisions about how health care is arranged are made transparently.
- opportunities to reduce bureaucracy and cost associated with the current rules.

The PSR will apply to the arrangement of health care and public health services arranged by relevant authorities and irrespective of who the provider is (i.e., whether the service is provided by NHS providers, other public sector bodies, local authorities, or providers within the voluntary, community, social enterprise (VCSE) and independent sectors). The PSR will not apply to goods and non-health care services (such as medicines, medical equipment, cleaning, catering, business consultancy services and social care), unless arranged as part of mixed procurement. What constitutes mixed procurement is set out in the Regulations and is explained further in this guidance.

Relevant authorities can follow three different provider selection processes to award contracts for health care services under the PSR:

1. direct award processes (direct award process A, direct award process B and direct award process C).
2. most suitable provider process.
3. competitive process.

Annual summary

The ICB will need to develop processes to support the mandatory requirements of production of an annual summary (The annual summary requirements are set out in Regulation 25 of the Act)

Relevant authorities must publish a summary of their application of the PSR annually online (e.g., via the relevant authority's annual reports or annual governance statement). We expect the first annual summary to relate to contracts awarded using the PSR between 1 January 2024 – 31 March 2025, and we expect this to be published no later than six months following the end of 2024/2025 financial year.

Following the first annual summary, all other annual summaries must be published no later than six months following the end of the financial year it relates to.

This must include, in the year to which the summary relates, the:

- number of contracts directly awarded under direct award processes A, B or C
- number of contracts awarded under the most suitable provider process.
- number of contracts awarded under the competitive process.
- number of framework agreements concluded.
- number of contracts awarded based on a framework agreement.

- number of urgent contracts awarded and urgent modifications (in line with the urgent awards or contract modifications section)
- number of new providers awarded contracts.
- number of providers who ceased to hold any contracts with the relevant authority.
- details of representations received, including:
- the number of representations received in writing and during the standstill period in accordance with Regulation 12(3).
- summary of the outcome of all representations received and of the nature and impact of those representations.

In addition, relevant authorities are expected to publish:

- total number of providers the relevant authority is currently contracted with.
- details of any PSR review panel reviews:
  - number of requests for consideration received by the PSR review panel.
  - number of requests accepted and rejected by the PSR review panel for consideration.
  - number of times where the PSR review panel advised the relevant authority to re-run or go back to an earlier step in a provider selection process under the PSR, and the number of times the advice was followed.

Provider Representation

Within the context of PSR, providers can make representation to the ICB if they are in disagreement with a decision they have made. Consequently, the ICB must development governance arrangements to independently review representations, thus, a PSR Review Group is proposed that would be a sub-committee of the Finance & Investment Committee.

Further to this, the ICBs within the East of England will work together setting up similar groups so that where any ICB struggles with independence or there is a particularly complex or contentious procurement ICBs can either interchange Members or refer to Groups outside of their own ICB for support with the independent review process.

Membership of the Group, whilst guided by the terms of reference shall remain fluid depending on the contract award to which the representations relate. This will ensure that members of the group are independent of any associated decision making.

Where Providers remain unsatisfied with the review, there will be recourse to an NHS England PSR Review Panel that is being established.

PSR Governance

As a result of PSR, the ICB has reviewed and update relevant governance documents that guide its procurement processes to ensure that they reflect the new PSR Regulations. This included the SORD, Standing Financial Instructions, Procurement and Contracting Policy, supporting contract governance documents (that do not require formal committee approval) and the business case template (that does not require formal committee approval).

Organisational Restructure

Following the organisational restructure a number of Directorates and posts have changed rendering key terms of reference, policies and most importantly the Scheme of Reservation and Delegation (SORD) out of date. The Governance Team are working on updating all relevant documentation, but have prioritised the SORD to ensure that its delegation arrangements and therefore decision making governance is sound.

Other documents updated as part of the corporate review or introduced as part of the corporate review (described below) have incorporate changes resulting from the re-structure as a matter of course. For example policies and terms of reference presented as part of this paper.

Corporate Review

A review of ICB governance arrangements is currently being undertaken and includes many different facets of how the ICB operates. A full report outlining the outcome of the review and changes that may be required will be provided in due course. However, given the importance of robust decision making the following key changes are being implemented:

Introducing the Executive Team as a formal sub-committee of the Board.

To enable robust and agile decision making, it is proposed that the Executive Team be a formal sub-committee of the Board with delegated authority to approve financial spend. Consequently, increasing the value of cases presented to the Finance and Investment Committee and the Board. The following table summarises the proposed changes to thresholds:

Committee	Existing Threshold	Proposed change
Executive Committee	None	£250k to £5m (in budget) <£100k (with no budget)
Chief Executive Officer / Chief Finance Officer	£250k - £1m (in budget) £100k - £250k (with no budget)	No authority, other than an Executive Director
Finance and Investment Committee	£1m - £5m (in budget) £250k - £2.5m (with no budget)	£5m - £10m (in budget) £100k - £2.5m (with no budget)
Board	>£5m (in budget) >£250k (with no budget)	>£10m (in budget) >£250k (with no budget)

3. Findings/Conclusion

The Board reserves authority to approve the ICB governance framework which includes the SORD, Standing Financial Instructions and committee Terms of Reference. These have been presented to and supported by the Finance and Investment Committee and are being presented to the Audit Committee on 16 January 2024. The following outlines the key changes to these documents that have been shared separately with Board Members and will be published on the ICB website following any Board approval.

Scheme of Reservation and Delegation

As a result of the corporate review it is proposed that the Executive Team be formally constituted as a sub-committee of the Board with delegated authority to approve up to £5m (within an existing budget) or £100k (with no existing budget). The Team have been included as a separate committee and the detailed delegated financial limits have been updated accordingly.

Extracts of the SORD have been provided below to show the proposed changes compared to the existing thresholds.

<u>Proposed thresholds</u>

		Provision	Board	Committee	CEO or CFO	Executive Team	Executive Director	Budget Holders (note 1)	Specified Individual
2. Approval limits for committing expenditure and service contracts, including variation of contracts, but excluding staff pay costs (see notes 2 & 3).									
		Business Cases to be presented in accordance with the Decision Making Policy.							
a		Within existing agreed budgets:							
	i	<£100,000 (and within budget holder limits)						X	
	ii	< £250,000					X		
	iii	£250,000 - £5,000,000				X			
	iv	£5,000,001 - £10,000,000		F&IC					
	v	> £10,000,001	X						
b		In-year proposals with no budgetary provision:							
	i	< £100,000				X			
	ii	£100,001 - £2,500,000		F&IC					
	iii	> £2,500,000	X						
c		Approval of invoices within approved contract values:							
	i	< £1,000,001						X	
	ii	£1,000,001 - £10,000,000					X		
	iii	£10,000,001 - £25,000,000			CFO				DDoF
	iv	> £25,000,000 to NHS providers within M&SE system			CFO				DDoF
	v	> £25,000,000 with other providers			CFO				
d		Approval of expenditure greater than tender price/business case. Subject to remaining within approval and tender limits identified above.	Follow the same limits as per contracts section 3. above						
	i	< 10% of approved tender.			X				
	ii	> 10% of approved tender or business case would require review of need and affordability in accordance with the business case process defined above.	Follow the same limits as per business case section 2. above						

Current thresholds

Provision	Board	Committee	CEO or DoR	Executive Directors	Budget Holders (note 1)	Specified Individual
2. Approval of Business Cases (and limits for committing programme expenditure), including variation of contracts.						
In accordance with System Service Change / Business Case Policy.						
a Within existing agreed budgets:						
i < £250,000				X		
ii £250,001 - £1,000,000			X			
iii £1,000,001 - £5,000,000		F&IC				
iv > £5,000,001	X					
b In-year proposals with no budgetary provision:						
i < £100,000				X		
ii £100,001 - £250,000			X			
iii £250,001 - £2,500,000		F&IC				
iv > £2,500,000	X					

As a result of the re-organisation names of posts and their duties have been updated to reflect the latest ICB organisational structure.

Updates to clarify existing arrangements have also been included i.e. explicit mention that the audit committee oversees and approves governance arrangements and is notified of urgent decisions made by the Board (as per standing orders); mention of the sub-committees of the Finance and Investment Committee; inclusion of the People Board as an ICB Board sub-committee; specifying delegated arrangements for neighbouring ICBs leading on Specialised Commissioning, Individual Placement Teams, Home Oxygen and the East of England Ambulance Service.

More formal delegation of accountability for the management of the Better Care Fund (BCF) to Alliances has been clarified.

Minor updates have been included to reflect the coming delegation of Specialised Commissioning from NHS England and the new Provider Selection Regime.

There has been some consolidation of how the detailed delegated financial limits are presented and some clarity over the governance around committing expenditure and signing contracts and some aspects of delegated functions performed by individuals such as the specific statutory roles overseen by the Chief Nurse that must be more explicitly documented.

Standing Financial Instructions

Very minor changes have been made to the Standing Financial Instructions to reflect change in job titles following the re-organisation, inclusion of reference to the Provider Selection Regime and to transfer them into the ICB standard policy template.

Executive Team Terms of Reference

As a new committee, the terms of reference set out the purpose of the committee being to provide oversight and assurance to the Board regarding the operational management of the ICB and delivery of its strategic objectives. The responsibilities of the committee are to ensure appropriate multi-professional diligence, scrutiny, and strategic alignment over the operation of the ICB and the delivery of its objectives:

- To ensure our people our empowered to deliver the projects and programmes that support the achievement of objectives.
- To support and contribute to financial sustainability through robust decision

making as delegated through the SORD.

- To ensure consistent message across the ICB in relation to its strategic direction and the delivery of financial turnaround.
- Review and collective ownership of finance, quality, performance, and operations ahead of formal scrutiny by Board sub-committees.
- To provide advice, guidance and clear decision making to the Senior Leadership team
- To support the Board and other sub committees of the board to discharge their responsibilities effectively.
- To set the standard and example for matrix working across the ICB
- To oversee the response to regulatory review (e.g., NHSE, CQC).
- To approve non-complex/controversial changes to the Service Restriction Policy for which the financial impact remains within the financial authority of the Executive Team as set out within the SORD.

Provider Selection Regime Review Group Terms of Reference

As a new sub-group of the Finance and Investment Committee, the terms of reference set out the purpose of the Group being to provide local independent scrutiny for representations made against specific intention to award notices under the 'most suitable provider' procurement process. The responsibilities of the Group reflect those described in the new Provider Selection Regime regulations.

Neighbouring ICBs are setting up mirroring groups to support with a pool of independent colleagues who can be co-opted onto the ICB Group to ensure independent review as required by the regulations.

Finance and Investment Committee Terms of Reference

There have been very minor changes to the terms of reference to acknowledge the creation of the PSR Review Group, to correct minor formatting and to update job titles that changed as a result of the re-organisation.

Procurement and Contracting Policy

The Policy includes new sections to describe the Provider Selection Regime process and has been drafted by the ICB procurement advisors, Attain. Further updates have been included to reflect the re-organisations e.g. changing job titles.

The policy has been approved by the Finance and Investment Committee.

4. Recommendation(s)

The Board are asked to:

- **Approve** the revised Scheme of Reservation and Delegation.
- **Approve** the establishment of and terms of reference for the PSR Review Group as a sub-committee of the Finance & Investment Committee.
- **Support** the principle of collaborative working under a Memorandum of Understanding (MoU) (to be developed) with the East of England (EoE) ICBs to provide independent members for the PSR Review Group.
- **Approve** the establishment of and terms of reference for the Executive Team Committee as a formal sub-committee of the ICB Board.

- **Approve** the revised terms of reference of the Finance & Investment Committee.
- **Approve** the revised Procurement and Contracting Policy.
- **Approve** the revised Standing Financial Instructions.

5. Appendices

The following appendices have been provided separately to Board members and if approved will be published on the ICB website shortly after the Board meeting.

1. Scheme of Reservation and Delegation.
2. PSR Review Group Terms of Reference.
3. Executive Team Committee Terms of Reference.
4. Revised Finance & Investment Committee Terms of Reference.
5. Standing Financial Instructions.
6. Procurement and Contracting Policy

Part I ICB Board Meeting, 18 January 2024

Agenda Number: 12.2

Revised / New Policies

Summary Report

1. Purpose of Report

To update the Board on the development and approval of new policies, namely the Provider Accreditation Policy and the Commissioning Policy (Service Restriction).

2. Executive Lead

Matt Sweeting – Interim Executive Medical Director

3. Report Author

Nicola Adams – Associate Director of Corporate Services

4. Responsible Committees

The Provider Accreditation Policy has been supported by the Executive Team and approved by the Audit Committee.

The Commissioning Policy (Service Restriction) has been supported by the Executive Team and is presented to the Audit Committee on 16 January for approval.

5. Link to the ICB's Strategic Objectives:

To maintain compliance with statutory functions.

6. Impact Assessments

The Equality Impact Assessments have been undertaken, with no issues identified.

7. Conflicts of Interest

None identified.

8. Recommendation

The Board is asked to approve the new Provider Accreditation Policy and Commissioning Policy (Service Restriction).

Revised / New Policies

1. Introduction

To update the Board on the development and approval of new policies, namely the Provider Accreditation Policy and the Commissioning Policy (Service Restriction).

Integrated Care Boards (ICBs) are mandated by NHS England to accredit new Providers for services where the legal rights to choice apply under the Procurement Patient Choice and Competition Regulations (PPCCRs). This predominantly relates to elective, consultant led services within the population catchment area. ICBs are required to accredit providers 'without any due delay'.

There is no national/NHSE accreditation process. Each ICB is required to develop their own process based on local commissioning arrangements e.g., specific service requirements.

The Mid and South Essex Integrated Care Board (ICB), as part of the Integrated Care System (ICS) receives a fixed budget from NHS England to enable it to fulfil its statutory functions, duties and the health aspect of the Integrated Care Strategy set by the Integrated Care Partnership (ICP). The ICB has a statutory responsibility to maintain financial balance and, as part of discharging this obligation, must decide how and where finite local resources are allocated.

The need for health care is always greater than the resources available to a society to meet demand. Therefore, it is evident that it will not be possible for the ICB to commission all the health care that is needed or wanted by the population it serves and, as a result, it will need to prioritise its commissioning intentions based on the needs of the local population and clinical evidence that supports the effectiveness of treatment.

The ICB has established a 'decision making policy' that governs how it makes commissioning decisions, and this commissioning policy to define the basis upon which it restricts the services it delivers.

2. Main content of Report

Provider Accreditation

MSE ICB has opted to implement a three-part accreditation (qualification) process. The process will include a standard set of general requirements (part one), followed by service, specialty, or pathway ('service') specific requirements (part two). Part three being references and declarations (standard).

Through patient choice and the accreditation of new providers it is expected that the number of contracted providers (predominantly independent sector) will increase, particularly in high volume low risk specialties such as Ophthalmology.

The financial implication of this on the ICB will be dependent upon the funding model in place with existing NHS and Independent Sector providers of the services.

If activity is currently funded on a variable basis (cost per case / PbR (payment by results)) then the funding would 'follow the patient' to the provider of their choice.

However, even with variable arrangements it is likely that the total quantum of activity will increase in the short to medium term as waiting lists are recovered.

If activity is currently funded on a block basis, any activity undertaken at a newly accredited provider would be a direct cost pressure and would be managed accordingly by the ICB.

The Audit Committee has approved the Provider Accreditation Policy and recommend it for approval by the Board.

Commissioning Policy (Service Restriction)

The purpose of this Commissioning policy is to ensure that the Mid and South Essex Integrated Care Board (ICB) fund treatment only for clinically effective interventions delivered to the right patients.

It sets out the overarching framework and governance process to support commissioning decisions and identification of treatments deemed to be of insufficient priority to justify funding from the available budget.

For several commissioned treatments, the ICB has specific policy statements setting out restrictions on access, based on clinical evidence of effectiveness or relative priority for funding. These are known as Service Restriction Policies. The restriction policies themselves will be updated and published in accordance with the Commissioning Policy and will be published on the ICB website.

This policy also sets out the governance of how the ICB revisits decisions to restrict services.

The Policy is presented to the Audit Committee on 16 January for approval.

3. Findings/Conclusion

The ICB must maintain appropriate governance regarding the Accreditation of new Providers and the way in which it commissions and where appropriate restricts the commissioning of services. The Policies presented ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities.

Policies have been provided to Board Members under separate cover and where approved will be published on the ICB website in due course.

4. Recommendation

The Board is asked to approve the new Provider Accreditation Policy and Commissioning Policy (Service Restriction).

Part I ICB Board meeting, 24 January 2024

Agenda Number: 12.3

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

Tracy Dowling, Interim Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

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 (BAF) by the Audit Committee which reviews the BAF at each committee meeting.

2. Risks currently on the Board Assurance Framework

The current BAF, provided at **Appendix 1**, includes the following strategic risks:

- Workforce
- Primary Care
- Capital
- Urgent Emergency Care (UEC) and System Co-ordination
- Diagnostics, Elective Care and Cancer Performance
- System Financial Performance
- Inequalities
- Mental Health Services

Members are asked to note the description of the UEC and System Co-ordination risk (formerly referred to as 'unblocking the hospital' has been updated.

The BAF also includes an updated summary of Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trusts' red risks (as set out in the latest Board reports available on their websites).

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 January 2024.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

January 2024

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	L Adams	• Regular Workforce reporting to System Oversight and Assurance Committee (SOAC) and People Board • Regional Provider Workforce Return (PWR). • Reduction in unfilled vacancies and Improved attrition and turnover rates. • Reduction in bank and agency usage leading to positive impact on patient safety/quality. • Improved resilience of workforce.	**4 x 5 = 20** ⟷
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	P Green	• Patient Survey Results. • Workforce Retention. • Improved Patient to GP Ratio. • Better patient access, experience and outcomes • Consultation data (volume, speed of access), digital tool data (engagement and usage)	**4 x 5 = 20** ⟷
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	J Kearton	• Throughput of business cases to FIC. • Delivery of Estates Strategy. • Progress reporting on investment pipeline. • Monthly reporting of capital expenditure as an ICS to NHSE.	**4 x 4 = 16** ⟷
4.	**UEC AND SYSTEM CO-ORDINATION ('Unblocking the Hospital)** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	E Hough	• Monthly MSE UEC Board monthly oversees programme and reports into SOAC and ICB Board. • MSE Executive Discharge Group oversee patient flow. • Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness 10am system call.	**5 x 4 = 20** ⟷
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Dr M Sweeting	• 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.	**5 x 4 = 25** ⟷
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	J Kearton	• Delivery of the agreed position at year end. Forecast is £40.3m in line with plan and agreed additional funding. • Improved delivery throughout the medium term (5 years) to system breakeven. • Overseen by Finance & Investment Committee and the Chief Executives Forum, also discussed at SLFG and SOAC. • Internal and External Audits planned.	**5 x 4 = 20** ⟷
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	E Hough	• 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.	**4 x 4 = 16** ⟷
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Dr G Thorpe	• CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR. • Reporting to Clinical Quality Review Group. • Outcome of Quality Assurance visits. • Improved flow and capacity, reduction in OOA placements and reduced length of stay. • Mental Health Partnership Board & Whole System Transformation Group (WSTG). • Reports to SOAC to identify key quality/performance risks and action being taken. • Internal Audit of Oversight of MH Services - Reasonable Assurance (Dec 22). • Accountability review with focus on performance.	**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 a reliable pipeline of staff to fill future vacancies.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Lisa Adams, Interim 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

Slight improvement in terms of lower turnover and recruitment success . However, these developments are not flowing through to reducing over-spend on workforce, particularly Bank and Agency usage and MSEFT and EPUT are operating significantly over their Establishments.

How is it being addressed? (Current Controls)

1. **Short-term** (Jan – end of March):

- MSEFFT & EPUT are implementing agreed controls (recruitment freeze for non-clinical roles and more rigorous sign-off of temporary staffing (bank and agency)).
- Establishment of a Workforce Task Force ('War Room') for MSEFT & EPUT to increase grip around workforce planning and spend (as stipulated by SOAC) and strengthen performance around recruitment, retention and workforce reform. Three workstreams reporting through Tracy Dowling to Chief Executive Group: I. Finance II. Operations & Clinical Leadership and III. People
- (Potentially with a phase 2 to take a similar approach with other partners).

2. **Medium-term** (The 2024/2025 financial plan)**:**

- With better grip secured via the short-term actions, lay the groundwork for what good looks like – i.e. A funded establishment, with budget holders living within the funding envelope and a ledger that reports on that plan, alongside a workforce less reliant on temporary staff.

Barriers (Gaps)

- Historical position of insufficient triangulation between financial plans and workforce plans. Consequent lack of confidence that the Establishment is correct and affordable.

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

- Reduction in bank and agency usage and spend linked to increase in substantive posts.
- Shorter recruitment and onboarding timeframes.

Next Steps:

1. Workforce Task Force.
2. Triangulate 2024/2025 workforce plan with financial plan.

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:	Pam Green – Basildon & Brentwood Alliance 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:	CPLPC02

Current Performance v's Target and Trajectory

Workforce:

- Additional Roles Re-imbursement Scheme (ARRS): Good progress has been made on the recruitment of Additional Roles Reimbursement Scheme staff: 120 FTEs recruited in 22/23. 87% of planned recruitment successfully delivered.
- Fellowship scheme: New scheme now in place and first fellows have commenced roles.
- Patient to GP Ratio: BB/Thurrock in top 10 worst ratio in country.

Demand/Capacity:

- Patient Experience National Survey: Poor performance locally in terms of access.
- Available Appointments: 185k more consultations in 22/23 than in 21/22.
- Impact should be noticeable in the 23/24 (published July 24) survey.

Barriers (Gaps)

- National workforce challenges (recruitment and retention).
- Resource for investment in infrastructure (estate, digital, telephony etc).
- Increase in overall demand on primary care services.
- Overall funding of primary care.

How is it being addressed? (Current Controls)

- Access Recovery Plan - presented to Board in November 2023.
- 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.
- Primary Care Network (PCN) Development.

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

- Patient Survey Results.
- Workforce Retention.
- Improved Patient to GP Ratio.
- Resulting in better patient experience and access.
- Consultation data (volume, speed of access), digital tool data (engagement and usage)

Next Steps (and date):

- Cloud Based Telephony (CBT) – Phase 1 now complete. Phase 2 commenced (additional practices being supported to transfer to comprehensive CBT services). (March 2024).
- Integrated Neighbourhood Team Scheme – submissions approved – PCNs delivering.
- Access Recovery Plan endorsed by Board in Nov. Presented to Southend Health Oversight and Scrutiny Committee (HOSC) in Dec, to be presented to Thurrock HOSC & Essex HOSC – Jan 24.
- Connected Pathways – Team commenced Jan 24. Focus on Pharmacy and Optometry Pathways.

Risk Narrative:	**CAPITAL:** Insufficient capital to support all Primary Care needs, necessitates prioritisation against the agreed matrix. This could result in delays to improvements impacting on access to and quality / performance of services. System wide capital is also constrained and delays in projects could impact on delivery within year.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Executive Director of Finance & Estates Ashley King, Director of Finance Primary Care, Financial Services & Infrastructure	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:	SREST02

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)

- Medium Term prioritisation framework to guide investment,
- Expectations of Stakeholders outstrip the current available capital.
- 'New' accounting rules relating to the capitalising of Leases has resulted in greater affordability risk.
- Impact of financial position (potential 'triple lock').

How is it being addressed? (Controls & Actions)

- Developing medium term prioritisation framework for pipeline of investments.
- Oversight by Finance & Investment Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- System Investment Group sighted on 'whole system' capital and potential opportunities to work collaboratively.
- Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.
- Prioritisation framework for Primary Care Capital now established.
- Prioritised list of investments developed that informed the submission of the 2023/24 capital plan (submitted first week of May 2023) as part of overall financial plan.
- Current years plan within capital envelope.
- Work to commence on 2024/25 Capital Plan and ICS Infrastructure Strategy

How will we know its working? (Assurance)

- Throughput of business cases to FIC.
- Delivery of Capital/Estates Plans.
- Progress reporting on investment pipeline.
- Monthly reporting of capital expenditure as an ICS to NHSE.

Next Steps:

- Training for Board & Exec (senior managers) on capital funding framework (Q4 23/24).
- Primary Care Projects Review on-going (Q3 & Q4 23/24).
- Infrastructure Strategy (indicative Mar 2024 but subject to national guidance).
- 2024/25 Capital Plan Development & Submission (Jan – Mar 2024 and subject to national guidance)

Risk Narrative:	**UEC and System coordination (formerly 'unblocking the hospital'):** Risk that ICB and providers organisations are unable to effectively manage / coordinate the capacity across the system and the inability to deliver effective care to patients.	**Risk Score:** **(impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Emily Hough, Director of Strategy and Corporate Affairs Samantha Goldberg, Urgent Emergency Care System Director	Directorate: Committee:	Oversight, Assurance and Delivery. MSE Strategic UEC Board and System Oversight and Assurance Committee (SOAC).
Impacted Strategic Objectives:	Improving and transforming our services.	BAF Ref:	PLAC04

Current Performance v's Target and Trajectory

Emergency Department performance below constitutional standard, as are ambulance response times, although improvement in reducing ambulance delays 30+ minutes delays across MSEFT. Ambulance demand reverted to pre-pandemic levels. Targets for Q4 to deliver 76% ED Performance and 90% 30 minute ambulance performance.

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)

- 2022/23 Winter capacity physical/virtual beds at acute ended 30 June 2023, Hospices (Post FIC approval) ending 31 July 2023 and Community continue under review completed.
- MSEFT 'UEC Improvement Programme' launched 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, 30 minutes category 2 ambulance handovers and 92% bed occupancy.
- Trajectories for delivery of the 76% A&E (all-type) performance against the four-hour standard compiled by hospital site, feeding into one aggregated MSEFT trajectory.
- Increased focus on discharging pathway zero patients, and 21+ LOS patients.
- Community and Voluntary Sector (CVS) engagement in progress to support admission avoidance and discharge.
- Alliance plans for Transfer of Care Hubs continues (report submitted to Part I Board, 28 September 2023).
- SHREWD Resilience now fully operational and embedded into daily practice and seeking further opportunities to provide data to support operational and strategic planning.
- System Co-ordination Centres now operational and core function of the ICB overseeing Surge and proactively working 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)

- Monthly MSE UEC Board monthly oversees programme and reports into SOAC and ICB Board.
- MSE Executive Discharge Group oversee patient flow.
- Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness 10am system call.

Next Steps

- MSE UEC Recovery Programme from national UEC Recovery Plan in place with provider trajectories. Oversight and responsibility with UEC System Director to track progression of action delivery with ICS partners at the monthly 'UEC Transformation & Improvement Board'.
- Unscheduled Care Co-ordination Hub to maximise alternative pathway direct referrals / attendance/admission avoidance. Soft launch week undertaken in September with evaluation for completed. Scheme to be implemented from 16 November – 31 March 2024.
- Introduction of Pathway Light in IC24 (Completed) and recruitment campaign for 2023/24. Call and Clinical Assessment handlers onboarded since July 2023, which has significantly improved the call answering and reduced the call abandonments rate. Performance has seen IC24 ranked in the top 5 providers in the country.
- Introduction of the Transfer of Care Hubs (TOCH) from December 2023.
- MSE system with AGEM creating and adopting bed/capacity & demand planning model. Pilot commenced in September and ICB Executive approved progression of platform build for one year from November 2023-November 2024. Currently in the procurement process for provider.
- Winter plan submitted. Triggers required for opening up acute beds as per winter plan approved by Health CEOs and monitored weekly.
- System Co-ordination Centre physical room setup with screens displaying data support real-time decision making for operational patient flow.

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score: (impact x likelihood)**	**5 x 5 = 25**
Risk Owner/Dependent:	Matt Sweeting, Interim Director of Clinical Leadership and Innovation (Cancer) Aleks Mecan, Alliance Director Thurrock (Diagnostics) Karen Wesson, Director Oversight Assurance (Elective)	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), achievement of Operational Planning commitments.	BAF Ref(s):	PLAC01, PLAC02 and CANC01.

Current Performance v's Target and Trajectory

Diagnostics: Increased backlog for 13+ weeks to 2,559 as at October 2023.
Cancer: Waiting times continue not to meet NHS constitutional standards. MSEFT recovering the variance from the 23/24 plan submission in the number of people waiting over 62 days.
Referral to Treatment:

- 65+ week wait: MSEFT updated trajectory to reduce by March 2024 to meet national expectation. As at October 2023 there were 2,868 patients.
- 52+ week waits: 2023/24 plan submission to reduce. Required in order to meet the national expectation position of zero people by March 2025. As at October 2023 position at 10,808 patients.

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – programme refresh to enable this work to happen – supported by Stewards. Quarter 1 to 3 review being undertaken in January 2024.
- **Workforce - Cancer -** 2023/24 plan will incorporate sustainability for fixed term posts and includes CNS review and alternate workforce/skill mix – MSEFT reviewing substantive workforce and how can reduce reliance on Cancer SDF funding.
- **Diagnostic Capacity –** capacity across diagnostics is impacting of delivery of the Faster Diagnostic Standard, this is being reported and overseen in terms of actions taken via the Diagnostic Performance Sub-Group of the MSE System Diagnostic Board and the Tier 1 Cancer meeting

How is it being addressed? (Current Controls)

Diagnostics:

- MSEFT developed recovery plans for all modalities and trajectories working through.
- Working with Trust to ensure clinical prioritisation and chronological booking – initial assigned risk code remaining in clinical system.

Cancer:

- Day Zero Patient Tracking List (PTL) – focus across specific specialities. Daily review of PTL and next steps with all tracking focused on trajectory compliance.

Referral to Treatment (RTT):

- MSEFT sites working to maximise capacity utilisation for long waits through optimal clinical prioritisation and chronological booking.

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 is a significant risk overseen via elective board. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions to be implemented and ongoing)

RTT and Cancer:

- Fortnightly Tier 1 meetings continue with the national and regional team with oversight of actions and performance position.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** The System is financially challenged with an original deficit plan for 2023/24 of £40.3m. The system faces new and increasing challenges in-year across all areas which has frustrated our attempts to deliver the deficit position for 2023/24. Our deficit plan is being amended following the rapid reset and recommit exercise. Financial recovery plans must deliver in order to provide sustainable services for our population.	**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:	SRFO01 and SRFO03

Current Performance v's Target and Trajectory

The System had initially agreed a deficit plan of £40.3m deficit (MSEFT £50m deficit, EPUT breakeven, ICB £9.7m surplus).
The system is currently in the process of changing this deficit plan in agreement with NHSE.

It should be noted that the system monthly position has continued to diverge from plan, and is at M8 £31m worse than plan at £60.0m deficit.

Barriers (Gaps)

- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery.
- System pressures to manage delivery (capacity).
- Team capacity, due to Industrial Action Impact, Essex Mental Health Statutory Inquiry resourcing and ICB Restructure

How is it being addressed? (Controls & Actions)

- Escalation meetings with Regional Colleagues and regular review with national team.
- Central PMO focus on efficiency delivery and new ideas for continued momentum across the medium-term planning period.
- Organisational bottom-up service and division review and improvement plans in plans
- Continued oversight and by Chief Executive Officers, System Oversight and Assurance Committee (SOAC) and Finance and Investment Committee (FIC) across organisations and ICB.
- Control Total Delivery Group of System Chief Finance Officers established
- Engagement across the system with all disciplines to escalate the importance of financial control, value for money and improving value.
- Additional workforce controls – please see workforce slide.

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

- Delivery of the agreed position at year end.
- Improved delivery throughout the medium term (5 years) to system breakeven.
- Being overseen by the Finance & Investment Committee and the Chief Executives Forum, also discussed at System Leaders Finance Group (SFLG) and SOAC.
- Internal and External Audits planned.

Next Steps:

- Medium Term Financial Plan developed, to inform 2024/25 planning.
- Agree trajectory for financial delivery, including consideration of enacting the forecast change protocol in conjunction with NHS England currently in-train
- Delivery of system efficiencies programme for 2023/24.
- Refresh risk and narrative following reset of system financial forecast Q4.

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 4 = 16**
Risk Owner:	Emily Hough, Executive Director of Strategy and Corporate Affairs Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Partnerships Population Health Improvement Board.
Impacted Strategic Objectives:	Reduction of Health Inequalities	**BAF Ref:**	GOSD17

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 (PHIB) provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with the Alliances will provide oversight and direct priorities for the £3.4m p.a health inequalities funding.
- Health inequalities stocktake (Q2) provided to NHS England against the 2023/24 planning requirements and delivery against the Core 20 plus 5 framework, reported to Health Inequalities Delivery Group. MSE suggested maturity matrix status had improved from Foundation to Developing in areas of Prevention, Leadership and Hypertension case finding
- Health inequalities funding of £3.4m pa, ~80 projects commissioned in 22/23 in implementation with evaluation being supported by University of Essex. Alliances have appointed trusted partners for 3 year period from 1 Sept. 23 to support with management of Health Inequalities funding and PHIB approved 12 MSE system wide at scale schemes covering priority areas.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project. Development of digital EHIIA tool progressing well to embed common approach across the system.
- Developing a culture and system capability for addressing health inequalities progressing through comms and engagement regarding Core20plus5 frameworks, Tackling Health Inequalities workshop in partnership with RCGP, community collaborators programme and roll out of four questions to promote shared decision making

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 March 2024)

- Launch of digital EHIIA tool (March 2024)
- Creation of a health inequalities dashboard (March 2024)
- Improvement in identification of groups at greatest risk anticipated by (March 2023)
- Delivery of Alliance plans to reduce Health Inequalities (March 2024)
- Establishment of 'Equity & Diversity Impact Assessment Panel' to review EHIIA as part of formal governance (June 2024)

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:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient Experience, Workforce, Reputational Damage	Risk Ref(s):	GOSD15, MHLD01 & 02, MENH04, 11 & 12 (also related to PO1/ Workforce slide)

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators, lack of formal contractual oversight for escalation.
- Demand, capacity and flow issues resulting in long length of stay and continued out of area (OOA) placements of patients above the Long Term Plan (LTP) expectation.
- Significant external scrutiny from media, Care Quality Commission (CQC) / Regulators.
- Confirmation that the Lampard Inquiry (Essex Mental Health Statutory Inquiry) Terms of Reference were reviewed and put to public consultation in November 2023, published ToR are awaited.
- Ongoing HM Coroners cases with possibility of Regulation 28 Prevention of Future Deaths Reports (PFDR).
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder (ASD) and wider neuro divergent pathway (NDD).

Barriers (Gaps)

- Strategic approach to all age Mental Health service, however lack of 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).
- Flow through inpatient services.

How is it being addressed? (Controls / Ongoing Actions)

- System Oversight and Assurance Committee (SOAC) monitor performance and quality of services with provider reports now taken to Quality Committee.
- Evidence Assurance Group.
- 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 with EPUT compliance colleagues.
- Multi-agency delayed transfer of care (DTOC) meetings to ensure good flow and capacity, held weekly on Fridays with system partners.
- Essex ICBs quality team continued joint working.

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

- CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR.
- Reporting to Clinical Quality Review Group.
- Outcome of Quality Assurance visits.
- Improved flow and capacity, reduction in OOA placements and reduced length of stay.
- Mental Health Partnership Board & Whole System Transformation Group (WSTG).
- Reports to SOAC to identify key quality/performance risks and action being taken.
- Internal Audit of Oversight of MH Services - Reasonable Assurance (Dec 22).
- Accountability review with focus on performance.

Next Steps:

- Implementation of recommendations from England Rapid Review into Inpatient Services published June 2023 with focus on recommendations which state twelve months (June 2024).
- ICBs working collaboratively across Essex to review the financial risk share agreement on inpatient acute mental health provision to include out of area expenditure (Sept 2024)
- Essex ICBs/EPUT establishing regular contract governance and oversight meetings (to be developed)
- Implementation of the mental health learning disability autism (MHLDA) inpatient quality transformation (March 2025).

Partner Organisation Self Identified Key Risks (and scores)

MSEFT - 11 Red Risks at 4 January 2024, as per Trust Board review Sept 23 (next review Jan 24). Risk scores remain as per previous report

- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (16)
- Capacity and Patient Flow Impacting on Quality and Safety (16)
- Estate Infrastructure (20)
- Planned Care and Cancer Capacity (16)
- Delivery of Clinical and Operational Systems to Support delivery of business objectives (16)
- Cyber security (15)
- Health and Wellbeing Resources* (16)
- Organisational culture and engagement*(16)
- Cyber Security (15)
- Integrated care system working (12)

*risk title updated to reflect the additional aspects of culture and wellbeing

Partner Organisation Self Identified Risks

EPUT as of November 2023

5 Red Strategic Risks (all scored 20)

- People (National challenge for recruitment and retention)
- Statutory Public Inquiry into Mental Health Services in Essex (Lampard Inquiry)
- Capital resource for essential works and transformation programmes.
- Use of Resources (control total target / statutory financial duty)
- Demand and Capacity

2 Red Corporate Risks (both scored 20)

- Engagement and supportive observation
- Pharmacy Resource

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

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Part I ICB Board meeting, 18 January 2024

Agenda Number: 12.4

Committee Minutes

Summary Report

1. Purpose of Report

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

- Finance and Investment Committee (FIC), 25 October and 22 November 2023.
- Primary Care Commissioning Committee (PCCC), 1 November 2023.
- Quality Committee (QC), 27 October 2023.
- System Oversight and Assurance Committee (SOAC), 11 October, 8 November and 13 December 2023.
- Clinical and Multi-professional Congress (CliMPC), 27 October 2023.

2. Chair of each Committee

- Joe Fielder, Chair of FIC.
- Sanjiv Ahluwalia, Chair of PCCC.
- Neha Issar-Brown, Chair of QC and Dr Shahina Pardham, Interim Chair of QC during October.
- George Wood, Co-Chair of SOAC.
- Dr Matt Sweeting, Chair of CliMPC.

3. Report Authors

Nicola Adams, Associate Director of Corporate Services
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 approved minutes of the meetings of the above committees.

Committee Minutes

1. Introduction

Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of the meetings held (once approved by the committee) are therefore presented to the Board to provide assurance and feedback on the functions and decisions delivered on their behalf.

2. Main content of Report

The following summarises the key items that were discussed / decisions made by committees as recorded in the minutes approved since the last Board meeting.

Finance & Investment Committee, 25 October 2023

- The month 6 Finance Report highlighted a year-to-date (YTD) system deficit of £45 million which exceeded the anticipated year-end position.
- The use of ring-fenced non-recurrent dental underspends to commission additional orthodontic activity to support a waiting list reduction was approved.
- All Age Autism Outreach Service - the committee supported the recommendation that an open procurement process under the 'Light Touch Regime' was preferred and that the LDHE team (formally transforming care) holds the contract on behalf of all parties. This should proceed to the Board for consideration.
- The committee received an update on the Medium-Term Financial Plan and were advised that, according to the convergence factor, the system was considered to be overfunded, which might result in a £30 million reduction in the system allocation for 2024/25.
- An update on the Efficiency Programme noted that a further £32 million of opportunities had been identified and were being taken through the portfolio groups, although it was unlikely they would to impact upon this financial year.

Finance & Investment Committee, 22 November 2023

- The Fresenius Kabi Home Enteral Feed and Equipment Contract was extended within the existing contract provisions, with some caveats regarding the second year of extension.
- The committee (under the provisions for double-lock approval) endorsed a recommendation for MSEFT to enter into a 5-year lease, with a break clause at 2 years, for the Fairfield (Unit 5) lease extension.
- The committee (under the provisions for double-lock approval) endorsed a report for MSEFT to invest in international recruitment in order to reduce bank and agency premium within the theatres' workforce.
- An update on the system forecast outturn review was provided.
- The month 7 Finance and Efficiency update highlighted a year to date system deficit of £52.5 million.
- The committee received an update on financial risks.

Primary Care Commissioning Committee, 1 November 2023

- The Primary Medical Services Contracts report highlighted that details of the 2024/25 GP contract were still awaited from NHS England (NHSE), which was creating uncertainty and operational challenges for GP practices.
- The Primary Care Quality report noted that during Q2 of 2023/24 there was a 483% increase in the number of concerns and complaints raised (314), when compared to Q2 in 2022/23 (54). Consequently, a temporary extension of

acknowledgement and response timescales had been introduced and new triage of complaints implemented.
- The committee received an update on primary care workforce initiatives, a copy of the draft Access Recovery Plan, a community pharmacy stocktake report and minutes of the Dental Commissioning and Transformation Group (13 September 2023).

Quality Committee, 27 October 2023

- A lived experience story focussed on challenges faced by Lesbian, Gay, Bi, Trans, Queer, Questioning, Intersex or Asexual (LGBTQIA+) when accessing fertility services.
- An update on escalations from the Safety Quality Group, emerging safety concerns and issues escalated via SOAC was provided by the Executive Chief Nurse.
- Quality updates were provided by representatives from MSEFT, EPUT and the Community Collaborative.
- The Local Maternity and Neonatal System update was received and the committee approved the MSE Perinatal Quality Surveillance Standard Operating Procedure.
- The committee considered the 'Inbetweeners' report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) which is an independent report containing several recommendations at national, regional and local level relating to transition between children's and adult services for chronic long term health conditions.
- The committee reviewed safety and quality risks within its remit. The committee also approved the Patient Safety Incident Response Framework Policy, revised Quality Committee Terms of Reference and associated Workplan for 2023/24.

System Oversight and Assurance Committee, 11 October, 8 November & 13 December 2023

This committee receives regular updates on Workforce, Quality, Finance, Performance, and the Financial Recovery Plan at each meeting. In addition, the following additional key issues were discussed at the meetings held on the dates set out below:

11 October 2023:

- An update on the good progress made against completing recommendations in a national letter regarding paediatric hearing services was noted.
- Members received a presentation on the MSEFT Care Quality Commission Matrix which provided an overview of the Trust's performance against quality indicators.
- The committee received a report on recovering access to primary care and on risks within the remit of the committee.

8 November 2023: No additional agenda items.

13 December 2023:

- An update on the cancer harm review process in place at MSEFT was received.
- The committee reviewed risks within the remit of the committee.

Clinical and Multi-Professional Congress, 31 August 2023

- Members considered actions required to support the financial recovery plan.

3. Recommendation(s)

The Board is asked to note the approved minutes of the committee meetings listed above.

Minutes of ICB Finance & Investment Committee Meeting

Held on 25 October 2023 at 15.00

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee **Chair,** MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Emily Hough (EH) Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Director of Resources, MSE ICB
- Elena Lokteva (EL) Non-Executive Director, EPUT (attending on behalf of Loy Lobo)
- Anthony McKeever (AMcK) Chief Executive Officer, MSE ICB
- Julie Parker (JP) Finance and Performance Committee Chair, MSEFT
- Karen Wesson (KW) Acting Director of Assurance and Planning, MSE ICB

Other attendees

- Nicola Adams (NA) Deputy Director of Governance and Risk, MSE ICB
- Rebekah Bailie (RB) Associate Director - SET Transforming Care/Learning Disability and Autism Health Equalities Programme, Essex County Council (for agenda item 7 - All Age Autism Outreach Service)
- David Barter (DB) Head of Commissioning MSE ICB (until and for agenda item 6 - Primary Care Dental Contracts - Orthodontics waiting list clearance)
- Maria Crowley (MC) Interim Director Children, Mental Health & Neurodiversity, MSE ICB (for agenda item 7 - All Age Autism Outreach Service)
- George Martin (GM) Learning Disability/Autism Health Equalities Commissioner, Essex County Council (for agenda item 7 - All Age Autism Outreach Service)
- Nina van-Markwijk (Nv-M) Finance Director, MSEFT (from agenda item 9 - Month 6 Finance update)
- Emma Seabrook (ES) Resources Business Manager, MSE ICB (minutes)

1. Welcome and Apologies

The Chair welcomed everyone to the meeting in particular Elena Lokteva who was attending the meeting on behalf of Loy Lobo.

Introductions were conducted; apologies were received from Loy Lobo, EPUT Finance and Performance Committee Chair.

The Committee were confirmed 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.

EL had submitted her declarations and confirmed she had nothing to declare in relation to the agenda items.

3. Minutes of the previous meeting

The minutes of the meeting held 14 September 2023 were received.

Outcome: The minutes of the meeting held on 14 September 2023 were approved as an accurate record.

4. Action log/ Matters arising

The action log was discussed and updated accordingly.

JP asked if guidance had been issued from NHS England (NHSE) around enacting the forecast outturn change protocol. JK explained guidance was due however, it was not anticipated the timetable would be released until during Q3. JK explained the system would likely be discouraged from submitting a formal application until national discussions had concluded.

JP highlighted the difficulty in planning meetings with system partners and suggested time was allocated in next year's planning to accommodate such meetings. NA confirmed the team were looking at the cycle of business for 24/25 and would consider this during planning. ICB Board meeting dates were being scheduled to ensure they did not clash with the Trust Boards.

5. Reflection on Month 5 Finance Report

The Chair referred the Committee to the Month 5 Finance Report circulated post the October meeting and highlighted a year-to-date system deficit of £39m (off plan by £20m). He highlighted the significant challenge within the Medium-Term Financial Plan (MTFP) to deliver £150m of efficiencies per year to bring the system back to balance in year 5 of the plan.

The Committee were informed the movement from Month 5 to Month 6 was a smaller deficit than previous months. JK reported a significant challenge around elective recovery and the contract payment of 104% with the main acute provider. Activity was highlighted at circa 90%; a deep dive around productivity would take place at the System Finance Leaders Group (SFLG).

EL highlighted the underlying system deficit of £156m and asked how well the drivers of the deficit were understood to recover the position. JK advised the underlying position was an improvement compared to previous years.

It was flagged the underlying position was likely to worsen due to the utilisation of non-recurrent monies to support the position in the financial year. JK suggested a fuller discussion took place when system CFOs were present to explain the pressures the Trusts were facing. It was agreed this was added to the forward planner to bring back to a future meeting.

There was a wider discussion around difficult choices and what conversations were taking place. JK highlighted work was taking place within the ICB to take a detailed look at the contract register. The ICB had made the decision in conjunction with system Chief Executive Officers (CEOs) restricting service investment in order to support the additional capacity MSEFT required over winter.

Outcome: The Committee noted the update.

ACTION: *Fuller discussion to take place on the underlying financial position (when system CFOs are present) to explain the pressures Trusts were facing be added to the forward planner for a future meeting.*

Business Cases for approval

6. Primary Care Dental Contracts - Orthodontics waiting list clearance

DB presented the paper to request approval to utilise non-recurrent dental under-committed funds to undertake additional orthodontic activity to support waiting list reduction.

Funds would be utilised to undertake additional activity from November 2023 to March 2024 to support approx. 1,900 children. The recommendation had been supported by the Primary Care Commissioning Committee.

JP asked if the additional activity would accrue a premium rate and queried if part of the funding might be channelled into prevention. DB confirmed this would be funded at the standard rate and advised this related to children who had been referred for specialist intervention by their dentist because of malocclusion. DB highlighted a small case of children (3-4%) that could benefit from early orthodontic intervention, but the majority had to wait for the growth phase to finish.

Following a query from EL regarding the confidence to deliver the additional activity, DB advised specialists had confirmed there was the capacity to treat 1,900-2,000 children within the 5-month period.

In response to JF, DB explained the contract was activity based, providers would only be remunerated for the activity undertaken.

JP asked if there was merit to ask NHSE to not ringfence monies in future years. JK highlighted this was a challenge and advised conversations were taking place.

MB queried the ongoing costs post this financial year should treatment go beyond the 5 months. DB explained due to the construct of the national contract the whole course of treatment was paid at the point the wires are applied no matter the length of treatment time. JK raised the importance to not set expectation around the baseline into 24/25.

Outcome: The Committee approved the use of ring-fenced non-recurrent dental underspends to commission additional orthodontic activity to support a waiting list reduction.

DB left the meeting.

7. All Age Autism Outreach Service

GM presented the paper and referred the Committee to Appendix F which addressed the

points raised at the September meeting.

It was queried at the September meeting, why MSE were providing contract, procurement, and finance support, despite delegating responsibility to the LDHE team at Essex County Council (ECC). It was explained as part of the original collaborative agreement, the former Castlepoint and Rochford held the role as Lead CCG, this had been inherited by MSE ICB. GM added as a local authority ECC were unable to contract health services.

JK informed the Committee of a commitment from Attain to support MSE more broadly and within its current financial envelope to ensure the ICB restructure did not create any associated risk.

The Chair suggested a session take place with Attain and colleagues to understand the scope of the procurement approach and how this delivered best value for money for the population. JP added a session in light of the new Provider Selection Regime being introduced in 2024 might also be helpful.

JK provided some context to the proposal to weight price at 0% and quality at 100% for assessment criteria in the procurement. It was explained the approach allowed best value by awarding the contract to the provider who offered the highest quality bid across several award criteria. There would still be a set envelope and financial standings reviewed.

Outcome: The Committee approved the recommendation identified by Attain that an open Procurement process under the "Light Touch Regime" was preferred, noting the options and risks presented within the paper. The Committee approved the case to proceed to undertake the procurement process and award of this service.

The Committee approved the recommendation that the LDHE team (formally transforming care) holds the contract on behalf of all parties, utilising the Section 75 and/or Collaborative Agreement to which all partners are signatories.

8. This agenda item was minuted confidentially.

Items for Assurance

9. Month 6 Finance update

JK provided a verbal update on Month 6 reporting which highlighted a YTD system deficit of £45m, this had exceeded the position anticipated to be at year-end. JK explained the construct of the deficit was a minor surplus within the ICB, deficit of £44m for MSEFT and a deficit of £6m for EPUT. JK highlighted the surplus within the ICB was held as part of national monies safeguarded to support the system position and were unable to be distributed.

Nv-M present

The Committee were informed of an increased pace against capital spend and advised the net risk remained unchanged at £60m. It was explained whilst the net risk remained unchanged there was a focus to assess what was risk and what was reality. JK highlighted the System Investment Group was undertaking a mid-year review around capital spend and took an action to bring back the outputs from the meeting to the Committee. JK confirmed discussions were taking place around the prioritisation of capital schemes to address any slippage.

ACTION: *Outputs from the capital spend mid-year review at the System Investment Group to be brought back to a future meeting.*

Outcome: The Committee noted the Month 6 finance update.

10. Medium Term Financial Plan

JK provided a verbal update on the Medium-Term Financial Plan (MTFP) which detailed each of the organisations required investment, must do, and challenges. As part of a regional led exercise MSE had submitted its approach to NHSE to enable some benchmarking to be undertaken. JK highlighted the November MSE Review meeting with regional colleagues had been extended to look at the MTFP and forecast outturn. The meeting would enable insight to assumptions around pay inflation and the efficiency challenge in other systems.

JK highlighted the Financial Recovery Plan had been overlayed into the MTFP to ensure triangulation. Following a query from EL, it was clarified the ask was to deliver 5-6% of efficiencies against the overall annual income. JK explained unlocking of productivity would be key to enable MSE to make good traction, this also formed part of the national direction. The challenge was recognised as significant and there were further discussions around what was achievable and realistic.

JK highlighted the impact of national policy being modelled into the plan and explained according to the convergence factor, as a system MSE was considered to be overfunded. This might see a £30m reduction in the system allocation for 2024/25. The challenge next year was further compounded by the requirement to repay the deficit accrued to date (1.5% of overall allocation). The shortage of cash was added as a further pressure.

Outcome: The Committee noted the update.

11. Efficiency Programme

Nv-M presented the report as read and outlined the key highlights as at Month 6:

- The pipeline of schemes had been increased by £4.5m.
- Planning ahead for 24/25 was a focus within the team.
- £64m of plans were in delivery (an increase from £51m as per the last report).
- 50% of the target achieved was recurrent into 24/25.
- A further £32m of opportunities identified were being taken through the portfolio groups and although unlikely to impact this financial year, it placed MSE in good stead for 24/25.
- MSEFT hosted an improving values conference 20 October with clinical and operational workforce.
- A follow up session with System colleagues was anticipated to take place in March 2024

MB left the meeting.

EL felt the connection and transformative component of the efficiency programme to the strategic plan was not visible. The Chair highlighted the need to not lose sight of the basics, including benchmarking and model hospital. JP added this was touched upon at a recent Finance and Investment Committee seminar within MSEFT.

Outcome: The Committee noted the contents of the efficiency report and the actions being taken to develop plans against the full efficiency target for each organisation.

Financial Governance

12. Approach to forecast outturn change protocol

It was confirmed this had been covered in early agenda items.

Outcome: The Committee noted the update.

13. Finance Risk Register

The risks associated to finance were presented for information. It was highlighted although the risks presented had been covered in earlier agenda items, due to time constraints a fuller discussion would take place at the next meeting.

14. Feedback from System Groups

The minutes of the System Finance Leaders Group, System Transformation Improvement Group and System Investment Group were presented for information; there were no comments.

15. Any other Business

The Chair thanked EL for her input into the meeting.

16. Items for Escalation

To the ICB Board:

- Autism Outreach Service

17. Date of Next Meeting

Thursday 9 November 2023,
2.30-5pm
MS Teams meeting

Minutes of ICB Finance & Investment Committee Meeting

Held on 22 November 2023 at 13.30

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee **Chair,** MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Tracy Dowling (TD) Chief Executive Officer, MSE ICB (from agenda item 7 - Primary Medical Services: Beaulieu Park)
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Executive Director of Finance and Estates, MSE ICB
- Loy Lobo (LL) EPUT Finance and Performance Committee Chair

Other attendees

- Nicola Adams (NA) Deputy Director of Governance and Risk, MSE ICB
- Angela Bell (AB) Senior Pharmacist Medicines Optimisation, Quality & Safety MSE ICB (for agenda item 6)
- Dawn Scrafield (DS) Chief Finance Officer, MSEFT (for part of agenda item 10)
- Trevor Smith (TS) Chief Finance Officer, EPUT (until agenda item 10)
- James Thirgood (JT) Finance Director, MSEFT (for agenda item 9)
- Nina van-Markwijk (Nv-M) Finance Director, MSEFT
- Emma Seabrook (ES) Resources Business Manager, MSE ICB (minutes)

1. Welcome and Apologies

The Chair welcomed everyone to the meeting.

Introductions were conducted; apologies were received from Julie Parker, Finance and Performance Committee Chair, MSEFT.

The Committee were confirmed 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.

LL had notified the ICB of a new indirect interest for Juul Labs Inc, a vaping technology company participating in the Swap to Stop programme for Smoking Cessation.

MB outlined the register did not correlate to the Board register of interests and his declaration as an appointed member of the Council of Governors for MSEFT.

NA explained this was likely due to the register for the meeting being produced before it was updated to reflect the declaration.

ACTION: *NA to ensure that the register of interest for the FIC is fully updated.*

3. Minutes of the previous meeting

The minutes of the meeting held 25 October 2023 were received.

Outcome: The minutes of the meeting held on 25 October 2023 were approved as an accurate record.

4. Action log/ Matters arising

The action log was discussed and updated accordingly.

5. Reflection on Month 6

The Committee were in receipt of and noted the Month 6 report.

Following the verbal update provided at the October meeting and subsequent circulated report it was agreed in light of the recent national announcement and associated funding a fuller discussion would take place later in the agenda.

Outcome: The Committee noted the update.

Business Cases for approval

6. Fresenius Kabi Home Enteral Feed and Equipment Contract Extension

AB presented the paper with a request to extend the current contract by 2 years from April 2024 as per the option to extend within the original contract duration (5 years plus 2 years).

AB outlined an annual cost increase of £512,190 for the first year of the contract extension and an indication that the Provider wanted to revisit the price review at the end of year 1. This presented an unknown potential cost pressure for the second year of the contract extension.

AB highlighted the risk to patient care should the service not be extended; patients would have to access hospital care for feeds and equipment. There was also a financial pressure on the cost of prescriptions as products were secured at a reduced cost.

AB highlighted the price of the contract had remained unchanged for 5 years. The Committee were informed the provider had the option to carry out a price review at year 3 however this had not been enacted by the provider.

MB asked if the cost pressure had been captured within the recent financial national submission or if it presented an additional cost pressure. JK confirmed this was not accounted for and the price increase would take effect from April 2024.

Following a query from the Chair around the current market availability, AB advised there were only 3 providers nationally who provided the service and reported little interest from them during the previous procurement. There was a wider discussion following concerns of creating a monopolistic supplier and uncompetitive market. LL suggested a feasibility study could be undertaken to assess insourcing options.

JK spoke of the need to re-negotiate inflationary uplifts should inflation rates reduce, to ensure the ICB is not fixed into a higher rate. JK offered support from herself and the contracts team to aid AB with discussions with the provider.

Outcome: The Committee approved the extension of the contract with Fresenius Kabi, as per the original contract provision to extend for 2 years (5 years plus 2 years) but with the caveat the ICB reserves the right to not proceed with year 2 of the extension should costs for year 2 not be negotiated by 1st April 2024.

7. This agenda item was minuted confidentially.

Double Lock Ratification

8. Fairfield (Unit 5) Lease Extension Approval

Nv-M presented the paper and advised that MSEFT commenced the lease for the property at the start of the Covid pandemic as per a requirement to move services out of the acute setting. The lease holder was requesting the lease moves to a commercial footing, which presented an annual cost pressure of £100k for the Trust (previously peppercorn rent).

Nv-M referred the Committee to the business case that stated the options that had been explored and set out the rationale for discounts.

The case had been supported by the MSEFT Investment Group and the System Investment Group and was presented to this Committee for endorsement as per the 'double lock' arrangements (in place as MSEFT is a provider in deficit).

TS highlighted that clarification was sought from the System Investment Group around the break clause and lease/rent costs being covered within current plans and was recommended to the Finance and Investment Committee on that basis.

LL queried why maternity and phlebotomy had to be co-located and why the option to restructure had not been explored. Nv-M explained the break clause would facilitate potential locations to relocate services to be explored.

Outcome: The Committee endorsed the report, allowing MSEFT to enter into the 5-year lease with a break clause at 2 years for the Fairfield lease.

9. Operating Department Practitioners (ODPs) – international recruitment

JT presented the paper to seek endorsement from the Committee as per the double lock arrangements to recruit ODPs internationally over three years within MSEFT.

JT reported a combined approach of international recruitment (utilising the process in place for registered nurses) and adoption of the 'grow your own' method. It was clarified the run rate would be unaffected.

Following a query from MB around the savings per post, JT clarified the 3-year investment (£321k) related to the international recruitment of 30 ODPs due to high national band and agency rates.
MB asked if there was some further flex the Trust could explore to encourage staff to move from agency to NHS contracts. JT highlighted a national shortage of ODP roles and the need for a mix of international recruitment and adoption of the grow your own method to increase the workforce.

JK referred to the comment in the paper as to what non-statutory services could be stopped to fund this service and queried what had taken place. JT advised there would not be a pressure on the bottom line/net cost. Figures within the paper were there as a baseline for future international recruitment and reflected the true cost of the process.

LL queried the impact on the recruitment of registered nurses if the recruitment were paused whilst ODP recruitment took place. JT reported an improved position on internal retention within the Trust for nursing roles and highlighted progressing with the recruitment of 30 ODP roles would not create a material impact.

JK queried how the savings posed were captured within efficiencies and asked if there were further discussions around sustainability beyond the 3-year time period.
JT advised the efficiencies would reduce the run rate in surgical areas and total costs around bank and agency. The combined approach would allow a short-term plan whilst longer-term recruitment/grow your own was realised.

LL queried why an earlier timeline than 3 years was not recommended. JT highlighted the need to proceed with a realistic number as there was some uncertainty as to how successful the recruitment might be. There was a risk that the workforce might disperse out of area once trained.

Following a further discussion, it was agreed the case be reviewed in 6-months' time to assess the impact of the initiative. TD highlighted the need for a solid workforce plan to grow the workforce and to monitor the effectiveness which could show a reduction in bank and agency costs.

Outcome: The Committee endorsed the report, allowing MSEFT to invest in international recruitment in order to reduce bank and agency premium within the theatre's workforce.

Action: A review on the impact of international recruitment for Operating Department Practitioners take place in 6 months' time and is reported to the System Oversight and Assurance Committee as well as the Finance and Investment Committee.

Assurance

10. System Forecast Outturn Review

JK highlighted the 'rapid, reset and recommit' system return was submitted to NHS England (NHSE) the morning of the Finance and Investment Committee meeting. Feedback was not anticipated before the national meeting scheduled for 29 November 2023.

JK confirmed MSE had stipulated they were unable to deliver the planned deficit of £40m. MSE were forecasting to deliver a system deficit of £57m. The construct of the deficit was a £9m deficit within EPUT, £9m surplus within the ICB and a deficit of £69.5m within MSEFT. The position was offset by £12.6m national support (share of £800m nationally) to support pressures specifically around industrial action. The money was being held within the ICB bottom line.

MSE had recommitted to deliver the 4-hour performance standards to protect patient safety and urgent and emergency care over the winter period.

TS advised the Committee the £9m deficit within EPUT was driven by the shortfall of the national pay award, impact of industrial action, the cost of capital and PFI inflationary pressures not met through the tariff uplift. The second component related to patient demand, acuity and capacity within the inpatient mental health service and impact on security, staffing and recruitment.

Discussion was taking place with national colleagues around the ability to underwrite costs associated to the inquiry.

JK confirmed that although work had commenced around the forecast outturn and best, worst and likely case scenarios in light of recent national funding, and the resubmission, further guidance as to the consequence of sending an 'off plan submission' was awaited.

LL asked if a review had been undertaken of what services needed to stop to support the financial position. JK advised the ICB Senior Leadership Team (SLT) had met to review the contracts register including contracts inherited by the 5 predecessor CCGs. Evaluation coaching had taken place to provide staff with the tools to aid decisions.

JK had requested an example pack of what was taking place around 'model hospital', what had been shared with the divisions and would be shared once received.

TS left the meeting.

DS explained the challenges within the Trust particularly around the impact of industrial action earlier in the financial year and discussed early actions that were enacted such as a pause in investments and the elective recovery plan to support the position. Escalation beds were highlighted as one of the largest variances to delivery.

DS explained despite a reduction in the use of agency staff, numbers remain high, this remained a focus within the Trust. The fragmentation of information points was flagged as a challenge across the system. DS highlighted the EPR programme in time would significantly improve common reporting. The Trust was working hard to increase standardisation across sites and continued to push the outpatient programme and the opportunities it presented around productivity.

LL highlighted a number of interventions to provide savings. There was a further discussion around the need to see a cash benefit and not push the cost around the system.

Outcome: The Committee noted the update on the system forecast outturn review.

11. Month 7 Finance and Efficiency update

JK provided a verbal update on Month 7 reporting which highlighted a YTD system deficit of £52.5m. The construct of the deficit was a surplus of £5.7m within the ICB, a deficit of £50.5m for MSEFT and a deficit of £7.6m for EPUT. JK highlighted a slight improvement within the run rate.

The resubmission to deliver a forecast outturn of a system deficit of £57m, would require EPUT to breakeven, the ICB to continue to consume the pressures it had been around Continuing Healthcare (CHC) and prescribing, and for MSEFT to improve its run rate by £2m per month. JK highlighted half of the improvement within the run rate was technical with the remaining half around agency costs and grip and control.

JK reported a slight improvement to £43m in Capital spend (against the £54m plan), however this was slightly behind the anticipated plan at the current point in the financial year.

Nv-M outlined the key highlights as at Month 7 for efficiencies:

- £96.2m identified (an increase from £90m as reported at Month 6) £4.4m was of non-recurrent release. £1.8m was new schemes.
- The in-year delivery continued on the same trajectory of £56.2m of the YTD plan of £66.8 (£1.5m was non-recurrent release).
- There continued to be a push for schemes that would have a benefit in 2023/24.
- Planning ahead for 24/25 was a focus within the team particularly around the large schemes, looking at how productivity would deliver a cash return.
- An update on the planning process would be brought to a future meeting.

LL highlighted the need to focus on recurrent benefits which seemed to benchmark around 70% in other areas. Nv-M explained as part of initial discussions with the national team at the beginning of the financial year it was agreed MSE would have to use an element of non-recurrent release to support the position due to the low number of schemes. Services continued to be challenged to pose non-recurrent schemes into recurrent.

JK advised efficiencies alone would not deliver the required position. MSE would also be required to repay the deficit in future years.

Outcome: The Committee noted the Month 7 Finance and Efficiency update.

Financial Governance

12. Deep Dive on Financial Risks – Continuing Healthcare

Item deferred to the December meeting.

13. Finance Risk Register

The risks associated to finance were presented for information. It was highlighted a number of the risks had been discussed within the earlier agenda items.

NA confirmed risks were being reviewed by Risk Owners.

It was noted deep dives would take place at the December meeting around risk SRPH01-CHC Market Pressures and SRPH02 – Prescribing costs.

JK confirmed that work was taking place to reflect the rapid reset and recommit within the risk position of the ICB, in particular to the risks associated with the independent sector. JK raised the Control Total Delivery Group as a potential vehicle to hold system risks and report into the Committee.

NA advised the Committee of the introduction of Datix to enhance risk reporting within the ICB, which was welcomed by TD.

Outcome: The Committee noted the update on ICB risks.

14. Feedback from System Groups

The minutes of the System Finance Leaders Group and System Investment Group were presented for information; there were no comments.

JK advised of an update from local authority around reablement pressures at a recent System Finance Leaders Group and an invitation to explore further with system colleagues.

Outcome: The minutes of system groups were noted.

15. Any other Business

High Cost IPT Case
To be brought to the December meeting.

16. Items for Escalation

To the ICB Board:

- Primary Medical Services: Beaulieu Park

17. Date of Next Meeting

Wednesday 20 December 2023,
10.00am - 12.30pm
Boardroom, Phoenix Court, Christopher Martin Road, Basildon SS14 3HG.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 1 November 2023, 9.30–11.30am

Via MS Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- James Hickling (JH), Deputy Medical Director (Nominated deputy for Dr Matt Sweeting).
- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes (Nominated deputy for Jennifer Kearton).
- Simon Williams (SW), Deputy Alliance Director Basildon Brentwood (Nominated deputy for Pam Green).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Jackie Barrett (JB), Deputy Director of Nursing (Nominated deputy for Viv Barker).
- Michelle Cleary (MC), Transformation & Engagement Lead South East Essex (Nominated deputy for Caroline McCarron).

Other attendees

- Jennifer Speller (JS), Deputy Director of Primary Care.
- Sarah Cansell (SC), Contracting Support Manager.
- Nicola Adams (NA), Deputy Director of Governance and Risk.
- Jane King (JKi), Governance Lead (minute taker).
- Daniel Brindle (DBr), Primary Care Estates Officer.
- Ali Birch (AB), Head of Primary Care Oversight and Assurance.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock.
- Ellie Carrington (EC), Deputy Head of Nursing for Primary Care Quality.
- Kathryn Perry (KP), Head of Primary Care Workforce.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.
- Natalie Beard (NB), Contracts Support Officer (Observer).

Apologies

- Pam Green (PG), Alliance Director for Basildon Brentwood.
- Viv Barker (VB), Director of Nursing for Patient Safety.
- David Barter (DBa), Head of Commissioning.
- Caroline McCarron (CMc), Deputy Alliance Director for South East Essex.
- Dr Matt Sweeting (MS), Interim Medical Director.
- Jennifer Kearton (JKe), Director of Resources.
- Vicky Cline (VC), Head of Nursing, Primary Care Quality.
- Les Sweetman (LS), Deputy Director of Programme Delivery.

1. Welcome and Apologies

SA welcomed everyone to the meeting.

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.

Members noted the register of interests.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 4 October 2023 were received.

Outcome: The minutes of the ICB PCCC meeting on 4 October 2023 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that the outstanding actions (30, 46, 59, 64, 67 & 68) were all within timescales for completion.

5. Primary Medical Services Contracts Report

JS provided an update on key activities and issues in relation to Primary Care Medical Services contracts since the last report was presented to the October Committee meeting.

It was highlighted that details of the 2024/25 GP contract were still awaited from NHS England (NHSE) and this was creating uncertainty and operational challenges for GP practices. The ICB was investigating if there were actions that could be undertaken locally regarding future commissioning intentions to provide some security to practices.

WG commented that there may be a delay to the national settlement of long-term GP contracts for a number of reasons, including a general election within the next 12 to 14 months and a potential change in government. There were a number of practices experiencing financial and sustainability difficulties and, whilst the independent contractor

model was effective, delays to the settlement of contracts might lead to an increasing number of practices questioning their sustainability.

AD added that uncertainty around the 2024/25 GP contract was also a factor for GPs considering retirement.

JH said there was opportunity for the ICB to build upon the good foundations of the PCNs to encourage new ideas, opportunities, and relationships amongst practices. JH stressed that failure in primary care would affect the whole system, therefore there was an argument to lobby for additional development funds given the difficulties that primary care was facing.

AK responded that the ICB was working in a very fragile financial environment and did not have full autonomy on how some of the funding was used. WG and AK would however consider what financial support, within the gift of the ICB, could be given to practices in the absence of a national settlement of 2024/25 GP contracts.

ACTION: WG and AK to discuss what additional support could be given to GP practices in the absence of a national settlement of 2024/25 GP contracts.

SA suggested that it may be useful for the ICB to communicate to NHSE the consequences and potential operational issues that the absence of the national settlement of GP contracts could cause and asked AD to consider an appropriate way to do that. Consideration would also be given to how the national settlement delay was reflected on the ICB risk register.

ACTION: AD to consider an appropriate way to communicate to NHSE the consequences and potential operational issues that the absence of national settlement of GP contracts could cause.

ACTION: WG & JS to consider how to reflect the national GP Contract settlement delay on the ICB risk register.

SA felt that the primary care voice needed to be strengthened. AD explained that the Primary Care Provider Collaborative was intended to strengthen the primary care voice at ICB level.

ACTION: Consider how to strengthen the voice of primary care and how the ICB can manage through a period of uncertainty with the delay in settlement of GP Contracts.

JS advised that a number of MSE GP practices faced challenges with their building leases and that a paper would be brought to a future Committee meeting setting out the issues and how the ICB could offer support.

BB commented that problems with building leases was a national issue and agreed to work with JS to explore what could be done to offer support to practices in MSE.

ACTION: JS and BB to explore potential solutions or support for practices facing challenges with their building leases. A paper setting out the issues and how the ICB could offer support to be presented to future Committee.

Outcome: The Committee NOTED the Primary Care Medical Services update.

6. This item was minuted confidentially.

7. Primary Care Quality – General Practice

EC presented the quality update and provided assurance over the quality oversight and reporting that the primary care clinical services were safe, effective and quality care to the patients across mid & south Essex.

Of the 146 MSE GP Practices, 3 were rated as 'inadequate' and 5 rated as 'requires improvement' by the Care Quality Commission (CQC). Active support was provided to the practices and regular meetings held with the CQC to ensure the assurance required as part of the review process was received. New CQC Inspection Reports were shared for Kelvedon & Feering, The Island Surgery and Eastwood Group who were all rated 'Good'. The Aegis Medical Centre rating changed from 'inadequate' to 'requires improvement'.

The Safeguarding update set out the Primary Care Safeguarding Development Offer for 2023/24 which included Safeguarding Forums and Time to Learn sessions, Safeguarding Audit and workshops.

In Q2 2023/24, 315 new concerns and complaints were received for Primary Care, an increase of 483% from Q2 2022/23 where only 54 Primary Care complaints were received.

In response to the high number of complaints received, a temporary extension of acknowledgement and response timescales had been introduced as well as new methods of complaint triage. The top 4 areas of complaint were in relation to Clinical Care/ Treatment, Access to GP appointments and registration issues, Administration (including attitude of staff) and Prescribing/GP Medication issues (including access to medication).

JS highlighted that since 1 July 2023 the ICB had taken over responsibility from NHSE to manage all Primary Care complaints which had led to a greater number of primary care complaints being processed by the ICB.

The change in process had also caused confusion for some practices who had listed the ICB as the first point of contact for GP Practice complaints. The quality team were working with practices to ensure they were aware of the correct complaints procedure and were looking how GP practices could be supported with responding to complaints.

PW advised that medication shortages had contributed to the rise in access to medication complaints and causing additional pressures on GP practices and community pharmacies as a result of requests to change prescriptions.

JB suggested that a more detailed breakdown of complaints would provide the Committee with a better understanding of the issues raised. AD agreed a detailed breakdown would provide an early indicator of stress factors in the system.

SC advised that where specific issues had been identified e.g. around registration, clarification on the correct process and the practice's responsibility was provided. KSS added that it would be useful to identify 'Upheld' and 'Not Upheld' outcomes and that learning from compliments and positive reviews was as important as learning from complaints.

NA urged the quality team to work with the complaints team to ensure it was clearly communicated to practices and complainants that NHS Complaint Regulations state that only one organisation was responsible for investigating a formal complaint. If a practice

records an enquiry or concern as a complaint, and if unsatisfactorily resolved, it would need to be escalated to the Parliamentary and Health Service Ombudsman, not the ICB.

SA agreed that wherever possible the provider should be the first point of contact for complaints, however patient choice needed to be respected if it was preferred to approach the ICB.

SA enquired how population groups struggling to access healthcare could share their experiences or concerns. WG advised that advocacy services were available to residents at Wethersfield and refugees in identified hotel accommodation. It was difficult, however, to identify those who had been placed at other accommodations.

JH advised he had recently visited Wethersfield and was assured that the primary care provider was providing equivalent medical care in community to local populations. It had been necessary for the primary care team to manage expectations in terms of waitlists etc. of this cohort of patients.

SA requested that the quality team consider promoting access to the NHS complaints process for excluded communities.

ACTION: Breakdown of complaints, upheld and not upheld as well as trends to be incorporated into the next quality report and consideration be given to promoting access to the NHS complaints process for excluded communities.

Outcome: The Committee NOTED the Primary Care Quality Update.

8. Primary Care Workforce Update

KP presented the Primary Care Workforce paper which provided an update on the workforce, including performance against operational planning targets, recruitment to Additional Roles Reimbursement Scheme (ARRS) roles and the planning and implementation of recruitment and retention initiatives.

As of August 2023, there were 3,078 FTE staff (over 4,000 individual staff) working in primary care which included staff funded via the ARRS.

There were initiatives and planned developments available to support all areas of the primary care workforce to help with staff retention and career development. KP advised the challenge was in getting offer details out to the workforce. KP highlighted that the Training Hub was a great source of support and resource to practices and urged colleagues to signpost practices to the Training Hub. The Training Hub would continue to work closely with PCNs, primary care staff and workforce colleagues across the ICB to maximise workforce initiatives and opportunities available to staff in primary care.

In response to PW, KP advised that Training Hub funding was often ringfenced to general practice, however, to ensure other groups, including community pharmacy, were not excluded from training opportunities there was an option to draw on other funds. KP agreed to work with PW and KSS to identify training support needs or gaps. WG acknowledged the ICB needed to consider how to put additional resource to support Pharmacy, Optometry and Dental services workforce training. KSS suggested that ringfenced courses not at capacity could be offered to other primary care groups.

ACTION: Pharmacy training support needs or gaps to be identified.

SA enquired whether analysis on demand for care and workforce supply had been undertaken and whether the ICB was in a position to match demand and supply or close the gap between the two elements. KP said that further work was required on demand and supply and welcomed the outcome of the ARRS optimisation work.

SA also enquired whether innovation in traditional clinical sectors, e.g. general practice had been considered. KP explained that the clinical leads, innovation & GP training and GP educator expansion leads all worked closely with medical schools and universities to shape GP training.

SA requested assurance that the ICB had an adequate primary care workforce, it was important to understand if workforce would be a barrier to the ICB undertaking transformation activities in the future.

ACTION: KP to provide assurance to the committee that the ICB had an adequate primary care workforce to understand if workforce would be a barrier to the ICB undertaking transformation activities in the future.

Outcome: The Committee NOTED the Primary Care Workforce Update.

9. Access Recovery Update

WG presented the latest iteration of the draft Access Recovery Plan, explaining it would be an iterative document and would build on successes. To differentiate the demand placed upon primary care services and deliver services most appropriately, a “total triage” approach was required to move away from the 8am rush to an approach that made optimal use of digital tools, alternative care pathways, increased capacity and an INT approach.

The Access Recovery plan was proposing four key programmes of work which covered a total triage delivered through ‘Connected Pathways’; improving Primary/Secondary care interface; optimisation of the workforce and INTs.

WG explained that staff satisfaction would be a key metric used to monitor progress and success of the Access Recovery Plan. The Workforce team were establishing baseline data and activities to monitor and improve staff satisfaction. Implementation and progress reports on the Access Recovery Plan would be brought back to the Committee on a regular basis.

ACTION: Access Recovery Plan progress and updates on a regular basis to be added to Work plan.

SA enquired what patient engagement had taken place in respect of the Access Recovery Plan. WG advised that patient view had been informed through the national patient survey, national plan requirements and local patient experience data. There was not a patient representative working group but engagement with Healthwatch was part of the communications plan.

DD suggested it would be useful to provide a basic narrative on any changes with local councillors, MPs and groups to support and strengthen ICB communications. SA requested that Alliance colleagues were involved in discussions.

The Committee agreed that patient education around changes to access were critical to the Access Recovery Plan's success. AD suggested that Patient Participation Groups could be involved in the communications plan. WG confirmed that dedicated communications support was included in the connected pathways work.

SA commented that it was important to talk to the other primary care provider groups, as well as GP practices, as improved access would require a whole system approach. WG confirmed that there had been engagement with pharmacy, optometry and dental providers, community collaborative and the Mid and South Essex NHS Foundation Trust (MSEFT) but it was an ongoing approach. SA enquired what measures were planned for intended and unintended consequences of the plan. WG explained there would be a feedback forum to understand what was happening and suggested that negative impact might be felt quite quickly.

ACTION: WG to consider an overall primary care patient engagement proposal, particularly in respect of Access Recovery work, and a feedback approach to understand the intended and unintended consequences of the Access Recovery work.

SA suggested the Training Hub would be crucial to transition to 'total triage' to support the workforce.

Outcome: The Committee NOTED the draft Access Recovery Plan for mid and south Essex.

10. Community Pharmacy Stocktake

KSS presented the Community Pharmacy stocktake which provided an overview of Community Pharmacy services in MSE and the issues faced by the service.

In MSE there were 205 community pharmacies (working under the national Community Pharmacy Contractual Framework (CPCF)), a reduction of two since the paper was written. There was a reduction of 5 premises in the last calendar year due to closures by Lloyds in Sainsbury's stores and some Boots branches. The causes behind the level of closures were both complex and multifactorial, including financial, commercial, labour market and contractual factors.

A Community Pharmacy review was planned to identify gaps in the market. Pharmacy regulations provided opportunity for the ICB to direct pharmacies to open, if required.

Community Pharmacy was funded largely through the Pharmacy Global Sum, which was negotiated as part of a 5-year framework deal in 2019 at a fixed flat rate of £2.59 billion per annum. The funding covered dispensing fees and service fees for essential and advanced services. Medicine costs were paid by the originating ICB. The flat funding was a key factor in some of the challenges the sector was facing, and the funding model was impacting on delivery of new services which were funded by the same global sum.

Interoperability between Community Pharmacy IT and other digital systems remained a challenge to service integration.

Despite the challenges faced, there were opportunities for the service, including opportunity to address health inequalities in deprived neighbourhoods by ensuring Community

Pharmacies were fully integrated into local primary care systems. Community Pharmacy could be used as part of the 'total triage' pathway.

JH enquired whether there was a pharmacy strategy group. PW advised that the Integrated Pharmacy and Medicines Optimisation Committee (IPMOC) allowed for wider discussion across MSE and governance routes linked IPMOC discussion into the PCCC.

SA enquired whether there was a proposal to bring strategic integration of pharmacy services to PCCC. PW advised there had been conversations with WG to update the Primary Care Strategy and include Community Pharmacy into the wider primary care system.

WG agreed that the Primary Care Strategy needed to include Pharmacy, Optometry and Dental services. WG had been in discussion with PW and KSS regarding capacity to take forward developments and although some capacity would be picked up via the Connected Pathways development, if the ICB intended to undertake the agenda proposed, more operational capacity would be required.

SA commented that the changes proposed to primary care access would not succeed without a robust community pharmacy provision and a well-developed strategic approach to pharmacy integration was required.

KSS highlighted that the MSE ICB was the only ICB in the region that didn't employ a community pharmacy clinical lead for the past 2 years.

Outcome: The Committee NOTED the Community Pharmacy Stocktake report.

11. Minutes from Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 13 September 2023 were received.

Outcome: The Committee NOTED the minutes from the Dental Commissioning and Transformation Group.

12. Items to Escalate

Recommended to the Finance and Investment Committee for approval –

- Beaulieu Park Scheme

13. Any Other Business

WG raised on behalf of PG that discussions were underway with the Executive Team and Board regarding the presentation of a regular paper to Board to ensure the Board was fully updated on Primary Care matters. PG would work with Governance colleagues on how to proceed and intended this to be taken forward in the new year.

BH took the opportunity to advise the Committee that the Parliamentary and Health Service Ombudsman had recently outlined to the Government Select Committee the ICB's role in terms of dentistry and suggested he meet with WG and DB to discuss further.

ACTION: WG and DB to meet with BH as part of the Dental Strategy development, particularly regarding PHSO outlining the ICB role in terms of dentistry.

13. Date of Next Meeting

9.30am, Wednesday 6 December 2023 via Microsoft Teams

Minutes of Part I Quality Committee Meeting

Held on 27 October 2023 at 9.30am – 12.30pm

Via MS Teams

Members

- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, deputising for Neha Issar-Brown, Non-Executive Member & Chair of Committee.
- Dr Giles Thorpe (GT), Executive Chief Nurse.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.
- Joanne Foley (JF), Patient Safety Partner.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Frances Bolger (FB), Interim Chief Nurse, EPUT.
- Mathew Fry (MF), Head of Maternity Clinical Network & Nursing Programmes, NHS England.
- Aleksandra Mecan (AM), Alliance Director, Thurrock.
- Bridgette Beal (BB), Director of Nursing & Allied Health Professionals, Provide (from item 7).

Attendees

- Viv Barker (VB), Director of Nursing for Patient Safety.
- Jackie Barrett (JB), Deputy Director of Nursing for Patient Safety.
- Emma Everitt (EE), Business Manager, Nursing and Quality.
- Karen Flitton (KF), Patient Safety Specialist.
- Matt Gillam (MG), Deputy Director of Nursing.
- Stephen Mayo (SM), Director of Nursing for Patient Experience.
- Alix McMahon (AMcM), Complaints Manager.
- John Swanson (JS), Head of Infection Prevention & Control.
- Eleanor Sherwen (ES), Head of Nursing, Quality.
- Maria Crowley (MC), Director of Children, Mental Health and Neurodiversity (from item 10).
- Sara O'Connor (SOC), Head of Governance and Risk.
- Helen Chasney (HC), Governance Officer (minute taker).

Apologies

- Neha Issar-Brown (NIH), Non-Executive Member.
- Wendy Dodds (WD), Healthwatch Southend.
- Ross Cracknell (RC), Senior Quality Manager - Mental Health.
- Gemma Hickford (GH), Consultant Midwife.
- Matt Sweeting (MS), Interim Medical Director.
- Alison Clark (AC), Head of Safeguarding Adults & Mental Capacity, Essex County Council.

- Linda Moncur (LM), Director of Safeguarding.
- Vicky Cline (VC), Head of Nursing – Primary Care.
- Peter Devlin (PD), Director of Adult Social Care Mental Health, Essex County Council.
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care.
- Amba Murdamootoo (AM), Deputy Director of Clinical Quality and Patient Safety, NHS England.

1. Welcome and Apologies

SP welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate.

SP noted that the Quality Committee agenda, meeting arrangements and papers had been reviewed and updated to ensure robustness and consistency.

2. Declarations of Interest

SP 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 were listed in the Register of Interests available on the ICB website**.**

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 18 August 2023 were reviewed and approved, subject to the following amendment.

- Section 12 (Medicines Optimisation) – sentence should read 'PW advised that the MSK service was *being* commissioned.'

Resolved: The minutes of the Quality Committee meeting held on 18 August 2023 were approved, subject to the amendment being made.

4. Action log

The action log was reviewed and the following updates were noted.

- **Action 42** – The Safeguarding Assurance Framework would be included in the next cycle of the Safeguarding Report.
- **Action 44** – The Palliative and End of Life Care (PEoLC) strategy would be presented to the ICB Executives meeting and other relevant groups prior to presentation to Quality Committee. ES advised that following discussions the PEoLC strategy might become the Palliative and End of Life Care Strategic Delivery Plan. An update would be provided following the Programme Board meeting.

Resolved: The Committee noted the Action Log.

5. Lived Experience Story

GT advised that one of the Quality Committee's key responsibilities was to hear people's experiences in our system and to understand challenges faced by people with one or more protected characteristics. The lived experience video story focused on challenges faced by Lesbian, Gay, Bi, Trans, Queer, Questioning, Intersex or Asexual (LGBTQIA+) when accessing fertility services.

GT thanked Healthwatch for sharing the story and noted that the couple were fortunate to be able to access private services for the opportunity to build a family, and highlighted recent media attention on NHS services where non-heterosexual couples were unable to gain that level of access.

In response to queries from DS and SP, PW confirmed the ICB's policy on Invitro-Fertilisation (IVF) included a statement about the system's approach to same sex couples whereby they had to demonstrate the same criteria as heterosexual couples, which might involve self-funding of cycles. GT explained that the proof which couples needed to show was inconsistent nationally and there was discrepancy with the number of cycles offered dependent on sexual orientation and marital status. FB advised that considerable engagement work was completed to align the mid and south Essex (MSE) offer.

SP highlighted the importance of receiving assurance that the system was not discriminating. PW advised that data would be available through the Individual Funding Team on the number of applications received, although this would not evidence people's awareness of treatment availability. SO confirmed that an Equality and Health Inequalities Impact Assessment was undertaken on the aligned Policy approved by the ICB Board in February 2023.

SP requested that an update on access to IVF treatment for the LGBTQIA+ community was provided in 6 months' time.

Resolved: The committee noted the lived experience story relating to the LGBTQIA+ community.

Action 45**:** SO to add access to treatment for **LGBTQIA+** community to the Quality Committee workplan for meeting in February 2024.

6. Safety Quality Group - Escalations

GT provided a verbal update on the following key points:

There was recognition for work undertaken by Essex Partnership University Trust (EPUT) and Mid and South Essex Foundation Trust (MSEFT) on their action plans following their Care Quality Commission (CQC) inspection reports.

A national shortage of medications was reported for people with Attention Deficit Hyperactivity Disorder (ADHD), however the situation was improving.

There were potential radiology issues at MSEFT relating to aging equipment, but assurance was provided that there was no harm to patients or staff. Mitigations were in place, including equipment upgrade plans.

The national bed shortages within Child and Adolescent Mental Health Services (CAMHS) and local demand for Tier 4 beds which was a perennial challenge in the system.

There were quality concerns regarding endoscopy services within NHS settings and private providers. Oversight of these services would be achieved via a new ICB Endoscopy Group reporting to the Diagnostic Board.

The next Safety Quality Group (SQG) meeting would be a reset workshop with NHS England (NHSE) regional team to review the function of SQG in line with National Quality Board (NQB) recommendations.

FB noted the shortage of ADHD medications had impacted upon primary care which led to an increase in referrals to EPUT. PW advised that there were regular communications between primary care and the medicines optimisation team to minimise the pressure on primary care colleagues.

GT reported that Essex Family Carers had highlighted concerns from parents regarding the management of the medication. Advice was available on the system website, including a request to not stockpile medication.

PW mentioned that ongoing shortages of a range of medications was increasing pressure on primary care.

Resolved: The committee noted the verbal update on the Safety Quality Group escalations.

7. Emerging Safety Concerns/National Update

GT highlighted the following key issues:

GT advised that the Secretary of State for Health (SoS) had invited all Executive Leads with responsibility for people with Downs Syndrome to a meeting on 20 November 2023, to discuss the system's compliance with the Down Syndrome Act 2022. The outcome would be reported back to Quality Committee.

A national information request had been received regarding management of Section 75 contracts and related to pooled budgets. The system would contribute to a response which would inform how pooled budgets would enable the system to discharge their statutory duties in relation to learning disabilities (LD) and autism regulations.

PW explained that GP systems had an alert if patients were coded to have a LD or autism, which enabled the inclusion of additional information on referrals.

SP asked if there had been good engagement from local councils and other partners. GT advised that good work had been undertaken with the formation of a Learning Disabilities and Autism Health Inequalities Board. Section 75 contracts required review to reflect the ICB's statutory responsibilities as host commissioner. In addition, assurance was required that Care and Treatment Reviews (CTRs) and Care Education and Treatment Reviews (CETRs) were being undertaken and that the views of people with learning disabilities and autism were considered. Essex County Council (ECC) colleagues would be invited to a future Quality Committee to provide an update.

GT provided assurance that CTR and Dynamic Support Register (DSR) panels were set up and would be attended by himself and the ICB's Medical Director.

SM advised that a quality assurance framework would be drafted and confirmed that routine checks were undertaken.

Resolved: The Committee noted the verbal update on the national agenda items.

Action 46: GT to provide feedback on the meeting with the Secretary of State regarding the system response to the Down Syndrome Act 2022.

8. ICB Board/SOAC concerns and actions

GT explained that concerns had been raised relating to key quality issues at MSEFT which were reported at the System Oversight and Assurance (SOAC) meeting.

Abdominal Aortic Aneurysm Repairs

The incident management team continued to meet weekly and appropriate checks and challenge were in place for patients, with oversight from MSEFT's Chief Executive. An external review was being undertaken by the Royal College of Surgeons. Assurance had been provided that appropriate pre-assessment and planning for surgeries were being undertaken.

Mortality/Structure Judgement Reviews (SJRs)

An enhanced rate of completion of SJRs was noted but issues continued with coding and the quantitative aspect of Summary Hospital -level Mortality Indicator (SHMI). Dr James Hickling provided positive assurance that the backlog was decreasing, with no concerns of significant practice or quality issues. The system would be working with MSEFT in readiness for the statutory function of medical examiners within community settings next financial year.

Paediatric Sepsis

GT noted that the Royal College of Paediatricians and Capsticks Solicitors, would be undertaking a review across all 3 acute hospital sites, and an agreed quality assurance visit into the paediatric emergency departments on all 3 sites, focusing on the management of a deteriorating child and sepsis. There would be continued close scrutiny, recognising recent media attention regarding a national issue of early diagnosis, treatment and management of people with sepsis in all areas of care.

SP advised that the issues were discussed at the last ICB Board meeting and a meeting was held with the CEO of MSEFT where assurance was provided regarding action being taken.

SP requested a progress update in 6 months' time to provide assurance plans were sustainable. GT confirmed mortality was a key focus for the SQG and suggested sepsis was a deep dive item at a future meeting, although feedback could be provided following the quality assurance visits. The abdominal aortic aneurysm (AAA) repair issues would be picked up through the Quality Together mechanism.

Resolved: The Committee noted the report escalating concerns raised from the System Oversight and Assurance Committee.

Action 47: SO to schedule a sepsis deep dive for 6 months' time.

Action 48: VB to update the Committee following the quality assurance visits.

9. Deep Dive – Eating Disorders

This item was deferred until the next meeting.

10. Mid and South Essex Foundation Trust – Quality Update

DS advised that the CQC report had been published following the 'inadequate' rating and warning notice in January 2023. The warning notice had been lifted and medical core services were now rated as 'requires improvement'. Teamwork and boosted morale amongst staff were recognised.

In terms of quality, work was being undertaken on risk management, ensuring that quality was driven by risks to enable improvements. The Board and Executive teams had been working on their Board Assurance Framework, which included 6 risks that were exceeding Trust tolerance levels. These related to financial sustainability, capital funding, delivery of clinical and operational systems, cyber security, health and wellbeing and knowledge and understanding.

DS advised that industrial action had significantly impacted on the delivery of care for patients and staff morale, which could lead to poor patient experience and an increase in complaints. The Serious Incident's (SIs) and complaints backlogs were reducing and were monitored weekly. Due to industrial action, a limited number of people were available to conduct investigations and write reports, including for an increased number of HM Coroner inquests.

DS advised that a further never event was reported for the dermatology service. There were robust action plans in place for the service and following a round table event, no further improvements could be identified.

A Safeguarding and Preventing Future Deaths report identified concerns with food and nutrition and care assessments, and a response had been provided to the Coroner who had suggested 24/7 dietetic cover. However, due to the limited utilisation of the service, the Trust considered it would be an unsuitable use of resources and therefore suggested a robust mutli-disciplinary team approach.

There were significant challenges with the paediatric department's culture. A review of SIs and deaths had been undertaken, along with an external review of leadership and culture. A royal college review of clinical issues was also requested. Weekly executive oversight meetings were being held. The biggest challenge for the Trust was strengthening nurse leadership.

There was an ongoing challenge with patients with mental health needs not being in the right place at the right time which was incurring additional costs. Additional staff training had been held. A monthly vulnerable people group meeting was held, with good engagement from the ICB Medical Director and EPUT.

DS thanked ICS colleagues for their support with the internal compliance reviews.

SP congratulated the Trust on the improved CQC rating and thanked DS for her honest and transparent update. Assurance was requested on plans to address risks in dermatology. GT advised that the strength of dermatology clinical leadership was impressive and as soon as issues were raised, decisive action was taken to not use the outsourcing company for surgical procedures. A technical solution was in place to support the increase in demand. All patients involved in the never events had their correct procedures and were being supported. DS advised that the Trust was not an outlier and the issues identified should be seen in the context of the total number of dermatology procedures completed.

JB advised that discussions were held in the Quality Governance Committee that the reduction in the number of SIs during industrial action, was to be commended. DS advised that on each industrial action day, incidents and SIs were monitored and no episodes of harm were reported.

SP asked if the System Quality Group monitored SIs. GT advised that progress was tracked by the Quality Together meeting. The backlog should be completed prior to the imminent implementation of the Patient Safety Incident Response Framework (PSIRF).

DS expressed confidence in the Trust's internal systems and confirmed a PSIRF implementation plan was in place and would be closely monitored. VB confirmed the Trust's governance team worked closely with the ICB quality team.

In response to a query from MF, DS agreed that the paediatric review scope would include neonatal as care was delivered by the same service. MF advised that a regional conversation was being held relating to the Neonatal Critical Care Review (NCCR), particularly relating to capacity. DS advised that the scope did not include reviewing capacity and flow, however, there would be a requirement for congruence between them.

In a response to a query from SP, DS confirmed that maternity was not reinspected. A Section 31 notice remained in place for maternity at Basildon, however discussions were being held with regards to full or partial exit. There had been a successful recruitment campaign for newly qualified midwives recently.

Resolved: The Committee noted the MSEFT Quality Update Report.

11. Essex Partnership University Trust – Quality Update

FB advised that the full published CQC well led report confirmed the Trust rating had deteriorated from 'good' to 'requires improvement', with 45 'must do' and 26 'should do' actions.

The report highlighted steps taken to embed and sustain improvements. The governance structure had been reviewed and weekly CQC action leads meetings were being held. The CQC action plans, developed with KPMG, would be owned at service level. The actions and evidence would be presented to the Evidence Assurance Group, commencing 6 November 2023 and chaired by GT.

Assurance and auditing processes were also being reviewed and a meeting would be held with ICB colleagues and service user groups to review development of peer assessments to ensure sustainable provision of quality services.

Five must do actions, which included 160 sub-actions, had been completed. Outstanding action deadlines would not be amended to ensure focus.

FB advised that the Statutory Inquiry into Essex mental health services would review deaths from 2000 to 2020. The new Inquiry Chair Baroness Kate Lampard, would commence reviewing the Terms of Reference in November.

FB highlighted that several people had been absent without leave (AWOL) from mental health units and a thematic review was therefore undertaken. One patient had still not returned and the police were therefore involved.

GT advised that greater partnership working with EPUT provided assurance to the collective regulators that the system was well led.

GT queried in relation to 'right care, right person guidance', if EPUT were confident that all necessary steps were taken before involving the police. FB advised that a Rapid Quality Review meeting held with multiple partners, was assured with the action plan in place. In relation to AWOL, a care group lead would liaise with the police. If a patient did not return to the unit by their specified time, an escalation process was commenced. However, the communications process needed to be more robust. Cambridgeshire and Peterborough NHS Foundation Trust had taken a different approach to managing risk and a visit there might be beneficial.

In response to a query from MF, FB confirmed a general increase in mental health referrals and data would require review to provide information on perinatal mental health referrals specifically. GT advised that this information would be reported through the Local Maternity and Neonatal System (LMNS) Board. There was a new mental health mother and baby unit in Chelmsford, which NHSE visited. GT advised that quality assurance visits to the unit would be undertaken by the system to ensure alignment between perinatal and mental health needs. MF suggested that the geographical footprint of services from MSE and Suffolk and North East Essex (SNEE) could be a complicating factor.

In response to a query from SP regarding timeframes, FB confirmed due dates were included on the action plan and if, following review, any actions reverted back to red, a recovery plan would be developed, although some actions were out of EPUT's control, e.g. publication of guidance from the Royal College of Psychiatrists. FB advised actions would be completed in approximately 12 to 18 months.

SP queried the impact of the Statutory Inquiry on staff. FB explained that a team would receive requests from the inquiry. There would be a significant impact on staff, particularly if evidence was provided in a court setting. Other organisations would also be included in the inquiry so this would potentially be a system wide pressure. FB provided assurance that staff support mechanisms were in place and would be closely monitored.

GT confirmed that Matt Sweeting had been confirmed as the system Senior Responsible Officer for the inquiry. The system team had been agreed and it was recognised that other commissioning organisations were involved previously and other providers not involved with mental health would also be asked to give evidence. People who no longer worked in the NHS might be called, and would require support, as would the families involved.

SP asked for assurance regarding the patient who had not yet returned following leave. FB explained the circumstances and acknowledged the impact these types of incidents had on

colleagues within the Police.

Resolved: The Committee noted the EPUT Quality Update Report.

12. Community Collaborative – Quality Update

BB noted that the update was from a Provide perspective and confirmed that the Community Collaborative consisted of EPUT, NELFT and Provide. A discussion was held with the Collaborative Steering Board to ensure that a joined-up report could be provided for future meetings.

BB highlighted the significant risks for Provide which included: the deterioration of St Peters Hospital site, legionella risk at Bayman Ward, Brentwood Hospital; referral to treatment and waiting times with paediatric services, including Autism Spectrum Disorder (ASD) assessments and community therapy services; podiatry; community cardiac service, integrated care team staffing; and respiratory protective equipment (RPE) face fitting.

BB highlighted that Health Education England (HEE) withdrew professional development funding due to Provide being a social enterprise organisation. This was a significant risk as people would be unable to develop their non-medical prescribing, consultation and diagnostic skills which in the longer term would impact upon patient attendance at and discharge from hospitals.

In response to a query from MG, BB advised that the request for collaborative support with training via the NHS could be requested as part of the single contract.

MC confirmed that a task and finish group had been established to complete a comprehensive demand and capacity review of neurodiversity. Demand was high and compounded by the national safety alert regarding ADHD medications. System leads were meeting with providers to understand the impact to develop a recovery plan. The complexity of children discharged from hospital was a key challenge.

GT advised that discussions regarding Continued Professional Development (CPD) were held. It was recognised that CPD funding from NHSE Education and Workforce Directorate, and should then be distributed to all organisations. The risk needed to be reported to People Board to ensure a commitment was made that education and training was available to all.

GT referred to the podiatry service and the risk of lower limb loss and asked if there were any incidents that required referral due to deterioration and if the lower limb service could support the management of capacity. BB advised that the tissue viability nurse specialist managed both lower limb and podiatry services. The podiatry service was provided in acute hospitals, so could review for increased referrals. There had been an increase in complaints regarding access to the podiatry service, however, there had been no adverse incidents. GT asked if Provide felt supported in developing the pipeline of podiatrists. BB confirmed that they were closely linked with the relevant societies to obtain training.

SP asked if health literacy programmes were in place for people at risk of foot ulcers. BB advised that regular patients had access and a community diabetic service provided advice on foot care. SP confirmed that details for patients under primary care would be sourced from the diabetic lead in the ICS.

In response to a query from FB, BB confirmed that Provide ceased the nail cutting service as this service was provided by other organisations.

In response to a query from SP, GT advised that there was significant dilapidation on the St Peters Hospital site and services had therefore been moved temporarily from a health and safety perspective. The long-term solution would require full consultation.

JB referred to the intensity of community visits being undertaken and that from her experience, it was a challenge to stay within service criteria. BB confirmed work was ongoing regarding the service specification, with a focus on keeping people out of hospital, rapid discharge and the staffing profile.

VB thanked BB for the service provided despite the current constraints.

Resolved: The Committee noted the Community Collaborative Quality Update Report.

13. Local Maternity and Neonatal System (LMNS) Board – Quality Update

GT highlighted key issues discussed at the Local Maternity and Neonatal System Board:

Recent Office of National Statistics (ONS) data showed an increase in the rate of stillbirths in the East of England region. MSEFT was not an outlier and strict monitoring would continue. The increase in midwifery vacancies was recognised, however, this has improved with the recent student appointments.

The system was supporting the Trust regarding the exit strategy of the Section 31 notice. One key area was ensuring the Clinical Negligence Scheme for Trusts (CNST) year 5 was signed off, specifically regarding training due to the impact of industrial action. The compliance rate was reduced to 80% with an action plan of how 95% compliance would be reached.

GT requested the committee's approval of the updated Perinatal Surveillance Model Standard Operating Procedure (SOP). The main changes were the reference to escalation points which was now SQG and the ICB rather than former CCG governance structures, and the SOP was now in line with the statutory responsibilities of the ICB in relation to CNST.

MF referred to the thematic review of stillbirths and the actions and recommendations being shared through the LMNS Board and highlighted the opportunity to share learning through regional Board. GT provided assurance that following completion of the actions, the learning would be fed back through the LMNS and then to region.

FB commented that the biggest challenge for the system was workforce and it was crucial a constant focus on recruitment was maintained. The declining stillbirth rate demonstrated work done to improve care, noting some people came from complex backgrounds, and reflected work undertaken to reduce health inequalities.

SP asked if data indicated ethnic groups were more susceptible to stillbirth. FB advised that each LMNS was tasked with developing an equity plan to address health inequalities.

The committee approved the MSE Perinatal Quality Surveillance SOP.

Resolved: The committee:

- **Noted the LMNS Board Quality Update report**
- **Approved the MSE Perinatal Quality Surveillance SOP.**

14. NCEPOD Report "The Inbetweeners"

MM advised that the Inbetweeners report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) was an independent report containing several recommendations at national, regional and local level relating to transition between children's and adult services for chronic long term health conditions. The Growing Well Programme Board considered the report on 11 October 2023.

The report's conclusion suggested that children and adult providers audit their transition process against the recommendations, alongside the National Institute for Health and Care Excellence (NICE), gather examples of transition cases across mid and south Essex (MSE) demonstrating good processes and areas of improvement for review, and consider the recommendations from an Integrated Care System perspective.

GT welcomed the report and advised the system should support providers to ensure they were able to deliver collective support to children, young people and their families during transition into adult services.

SP requested an update report at a future meeting and asked if this could be supported through a stewardship programme. MM highlighted that there was already a children's and young people stewardship group which had discussed linkages with the mental health stewardship group. It has been agreed that the CYP stewardship group will consider transitioning children as part of the work programme moving forward.

MC advised that work was ongoing in mental health. The mental health strategy was for all ages and all partners were fully engaged. The area of focus would be the transition of physical health care for children, due to the increase of concerns raised. There would be a requirement to include transitioning in the specification when the contract was refreshed.

Resolved: The committee noted the NCEPOD report.

15. Patient Safety and Quality Risks

SOC advised that there were 15 risks currently within the remit of Quality Committee. Of those, 10 were rated amber and 5 rated red. The red risks related to health inequalities, mental health and acute provider quality assurance, quality assurance of Autistic Spectrum Disorder (ASD) services and maternity services.

SO highlighted that the maternity and all age continuing care risks were amalgamated into 1 risk each and 2 risks were closed as agreed at the previous meeting. There were no further risks recommended for closure.

The 6 quality related risks on the Board Assurance Framework were appended to the report. SO advised the BAF presented to ICB Board meetings also summarised the top risks for EPUT and MSEFT, which would be included in future iterations of the risk report.

Once Datix had been implemented, the intention would be joint working with providers on system risks to ensure alignment and consistency of rating.

It was agreed consideration would be given to adding a generic risk in relation to medication shortages rather than specific medications.

Resolved: The Committee noted the patient safety and quality risks report.

16. Patient Safety and Incident Response Framework (PSIRF) Policy

KF advised that the policy had been widely circulated within the ICB, Staff Engagement Group and shared with Quality Committee members. Feedback received was considered and incorporated into the final policy as appropriate.

KF proposed to set the review date to a year, rather than the usual 2 years, due to implementation of the PSIRF and its proposed expansion into primary care in 2025. The policy would also be reviewed should any new guidance be received.

Resolved: The Committee approved the Patient Safety Incident Response Framework Policy.

17. Review of Quality Committee Terms of Reference

17.1 Quality Committee Terms of Reference

GT advised the Terms of Reference (ToR) for the Quality Committee had been reviewed and updated to ensure they fully referenced the ICB's statutory duties.

The proposed ToR ensured appropriate representation across health and care, clarity regarding areas of focus discharged to the Quality Committee on behalf of the ICB, and robust reporting back to the ICB Board and System Oversight and Assurance Committee (SOAC).

DS asked if the membership for MSEFT could be amended to Chief Nurse/Chief Medical Director.

GT confirmed that once approved, communication would go out to Directors of Public Health, Directors of Adult Social Services and Director of Childrens Social Care to request representation on the committee.

SP asked if a Health Inequalities lead should be included. GT would speak with Emily Hough for a relevant representative.

Resolved: The committee approved the amended Terms of Reference for Quality Committee, subject to the amendments noted and if any changes requested by the Chair, Neha Issar Brown.

17.2 Quality Committee Workplan 2023-24

GT noted the amended workplan which reflected a reduction in frequency of reporting, although the opportunity to escalate any immediate concerns remained.

Resolved: The committee noted the Quality Committee workplan for 2023-24.

18. Discussion, Escalations to ICB Board and agreement on next deep dive.

HC confirmed that approved minutes of Quality Committee meetings were submitted to the Part I Board ICB meetings. In addition, GT submitted a regular Quality Report to the Board highlighting issues discussed at the committee and any urgent escalations.

Escalations were noted as follows:

- The positive progress made from provider organisations with the change of rating and the exit strategy for the removal of the Section 31.
- Concerns regarding children and young people transitioning into adult services
- Mental health patients not returning from leave, recognising that work was underway.
- The Statutory Inquiry which required a whole system response and that a programme team was in place. The impact the Inquiry would have on staff and affected families, and the potential impact on service delivery.
- Recognising the patient story relating to LGBTQIA+ access to fertility support services and the committee's intention to seek further assurances discrimination was not occurring in practice in the coming year.
- Recognising the challenges for Provide in relation to acuity and activity within community services.
- Progression made on the historical quality concerns at MSEFT, however further assurance was required.
- Maternity at MSEFT was not an outlier and approval of the MSE Perinatal Quality Surveillance SOP.
- The estate issues with St Peters House and Bayman Ward at Brentwood.

19. Any Other Business

19.1 Paediatric Hearing Services

GT provided an update on the national alert in relation to standards of paediatric audiology. All ICBs were requested to undertake a task and finish group to understand the position in relation to paediatric audiology.

The system response was submitted in line with the deadline and would be closely monitored by the Programme Board, recognising that MSEFT contributed to paediatric audiology services in MSE.

Resolved: The committee noted the update on paediatric hearing services.

19.2 Excellent inpatient care and patient engagement award

SM highlighted that Eric Watts (a retired pathologist in our system) had developed an award with other pathology physicians that would be circulated to all the Directors of Nursing. The award was for excellent inpatient care and patient engagement and the deadline for nominations was 14 January 2024.

MC highlighted to acute colleagues that progression was being made with regards to CAMHS (Children and Adolescent Mental Health Services) patients being cared for in Emergency Care departments.

20. Date of Next Meeting

Friday, 15 December 2023 at 9.30 am to 12.30 noon via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 11 October 2023 at 1.00 pm – 3.00 pm via Teams

Attendees

Members (Voting)

- Anthony McKeever (AMcK), Chief Executive Officer and Joint Chair of Committee, MSE ICB.
- George Wood (GW), Non-Executive Director of MSE ICB and Joint Chair of Committee.
- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England.
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England (items 1 to 10)
- Dr Matthew Sweeting (MS), Interim System Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Lisa Faulty (LF), East of England Ambulance Service Trust (EEAST) – on behalf of Kostas Karamountzos.
- Emily Hough (EH), Executive Director of Strategy & Corporate Services
- Matthew Hopkins, (MH), Chief Executive, MSEFT.
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Pam Green, (PG), Alliance Director (Basildon & Brentwood), MSE ICB.

Other attendees

- William Guy (WG), Director of Primary Care, MSE ICB.
- Jason Donovan (JD), Head of Finance (Assurance), NHS England
- Lynnbritt Gale (LG), Director of Community Delivery and Partnerships, South East Essex, Essex Partnership University NHS Trust (EPUT).
- Holly Randall (HR), Senior Head of Workforce Transformation, MSE ICB.
- Karen Wesson (KW), Interim Director of Oversight, Assurance and Delivery, MSE ICB.
- Lee Robson-Brown (LRB), Director of Workforce Services & Strategic Planning (on behalf of Selina Dundas).
- Phil Read (PR), Associate Director System Development, MSE ICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress.
- Susan Graham (SG), Director of Operational Performance, EPUT.
- Claire Hankey (CH), Director of Communications & Engagement, MSE ICB.
- Tracy Turner (TT), Associate Director, Risk and Compliance (on behalf of Diane Sarker)
- Susan Young (SY), Interim Chief People Officer, EPUT.
- Sara O'Connor (SO), Head of Governance and Risk, MSE ICB (minutes).

Apologies Received

- Diane Sarkar (DS), Chief Nursing Officer, MSEFT.
- Selina Dundas (SDu), Deputy Chief People Officer, MSEFT.
- Lisa Adams (LA), Interim Chief People Officer, MSE ICB.

1. Welcome and Apologies (presented by A McKeever)

AMcK welcomed everyone to the meeting and introduced George Wood (GW) who would be co-chairing the committee in future. Apologies were noted as above. It was confirmed that the meeting was quorate.

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's website**.**

There were no declarations of interest raised.

3. Minutes (presented by A McKeever)

The minutes of the last SOAC meeting held on 9 August 2023 were reviewed and approved, subject to the minor amendments listed below:

- **Item 8, Finance Report** – JK requested the following amendment: "JK advised that on day 7 in the month, there was a deficit position year to date of £29 million, with a continuing adverse ~~upward~~ trend. ~~compared to last month.~~

The notes of the SOAC papers review meeting held on 13 September 2023, which was held in lieu of the formal committee meeting cancelled due to industrial action, were also approved.

Outcome: The minutes of the committee meeting held on 9 August 2023 were approved, subject to the minor amendments noted above. The notes of the SOAC papers review held on 13 September 2023 were also approved.

4. Action log and Matters Arising (presented by A McKeever)

Members noted the action log and the following verbal updates were provided:

- **Action 97:** MS confirmed that the independent report on the Nitrous Oxide Serious Incident (SI) should be with MSEFT by December.
- **Action 109:** HR confirmed that work was ongoing to consolidate the work undertaken by Moorhouse and to ensure there was no double counting before agreeing a revised trajectory for reducing bank and agency staff, which should be available by the next SOAC meeting.
- **Action 124:** JH suggested reports relating to primary care should be submitted to the committee quarterly to six monthly depending on need. This was agreed and the action closed.
- **Action 139:** JH advised that MS would provide an update on the backlog of Structured Judgement Reviews (SJRs) under matters arising.
- **Action 149**: KW advised that SG had provided an updated report in response to the letter from GT and MS regarding out of area (OOA) placements and it proposed it was shared with members outside of the meeting and then follow-up at a later meeting to close the action.

Matters Arising:

- **EPUT NHS Oversight Framework (NOF) Rating:** SW advised that NHS England (NHSE) had reviewed the NOF rating for EPUT and believed the Trust should be moved to NOF3. Discussions were ongoing regarding the level of system support required to enable EPUT to recover their position.
- **SJRs:** MS advised that he and JH wrote and subsequently met with Dr David Walker (DW) regarding the backlog of SJRs at MSEFT, which was productive. MS explained SJRs looked at the causes of mortality to support thematic analysis. A trajectory, supported by finance, was in place to reduce the backlog by April 2024. Triangulation against SIs and mortality reviews occurring elsewhere in the system had also helped to reduce the number of SJRs. MS noted his thanks to DW, MH and colleagues for their support.

  MH advised that Medical Examiners, who reviewed care provided to patients who died in hospital, had determined that several cases should be reviewed to identify any potential omissions in care and/or learning, resulting in these cases being subject to a SJR. MH acknowledged the backlog was unacceptable and confirmed steps were being taken to prevent this in future. MH also confirmed that learning, including where the care of a patient was handled well, would be identified and implemented.

  JH confirmed that the ICB was pleased with MSEFT's formal response to the letter, including the plan to write SJRs into Consultant job plans which should make the process sustainable. The backlog had now reduced to 688, in part due to the other types of review, e.g. mortality/morbidity review, undertaken. From April 2024 it was expected that 90% of SJRs would be completed within three months and 100% within six months due to the time it sometimes takes to receive information from HM Coroner.

  AMcK acknowledged the work undertaken by colleagues to address this issue.

5. Workforce Report (presented by H Randall)

AMcK highlighted the importance of linking the number of whole time equivalent (WTE) staff to finances, particularly how this would affect the system's financial prospects for the second half of 2023/24 and asked HR to outline the work being undertaken to do this.

HR explained that linking WTE to finances was complex as financial values varied significantly between individuals. This was considered as part of work undertaken by Moorhouse and work was ongoing with Business Intelligence (BI) colleagues to attribute, as sensibly as they could, monetary value for bank/agency staff and to agree future trajectories. Both MSEFT and EPUT remained off plan regarding use of bank/agency staff but the focus remained on reducing this.

GW noted 450 people were recruited between the two Trusts in the first five months of 2023/24, with an aim to recruit another 1,600 by year end, which was a significant challenge. However, it was not clear if the rate of attrition had been considered, meaning the challenge could be even greater. Also, the total combined vacancies on slide 5 showed 2,728, but there were over 4,000 bank and agency staff, a gap of circa 1,300. GW advised he would like to understand the reasons for this gap and the associated costs.

SW noted that it appeared that MSEFT vacancies had reduced by circa 100 in August, but at same time bank/agency had increased by 300, resulting in a net increase of 400 staff which suggested something significant had occurred and/or some internal controls might not be working.

LRB advised that analysis of MSEFT's August workforce data identified a spike in annual leave,

sickness and industrial action. However, initial September data showed a significant improvement with bank/agency figures below where they should be on the trajectory.

LG advised that from September EPUT had stood up their seasonal workforce for vaccinations. HR agreed to reflect this in future reports.

AMcK noted the trajectory had been agreed when the system had identified a £40 million deficit, hence a new trajectory was now required.

MH advised that he had implemented senior leader briefings on key issues MSEFT was facing in relation to quality, workforce (including bank/agency spend versus WTE), performance and finance to ensure managers fully understood the issues and expectations placed upon them. The need to reduce the deficit with only six months left to year-end posed a significant challenge, but reassured AMcK, SW and GW that grip and control had been strengthened.

LRB noted that there had also been over 330 new starters in August before attrition.

SY noted that EPUT had identified a downward trend over the past few months which was positive. There was also a strong pipeline of newly qualified nurses which was expected at this time of year, plus another 29 internationally educated nurses were due to commence work shortly. Compared to last year, the vacancy trend was circa 9-10% lower. In addition, SY and EPUT's Chief Finance Officer had discussed implementing a greater level of scrutiny via accountability meetings.

AMcK welcomed the approach taken by MH and asked all colleagues to adopt similar arrangements. AMcK also requested that the linkage between money and WTE, an explanation of the discrepancy between substantive and temporary staff covering vacancies and clarity on the rate of attrition was provided to the committee, to determine if these numbers were material in the context of the two halves of the year.

5.2 Escalations from People Board

HR confirmed there were no escalations from People Board and mentioned that its governance structure was being reviewed.

Outcome: The Committee noted the Workforce Report.

Action 149: LA/HR - Linkage between money and WTE, an explanation of the discrepancy between substantive and temporary staff covering vacancies and clarity on the rate of attrition to be provided to the committee.

6. Quality Report (presented by V Barker)

GT highlighted the following key issues:

The Care Quality Commission (CQC) rating on all three MSEFT hospital sites for Medical Core Services had been upgraded from 'Inadequate' to 'Requires Improvement'. The related Warning Notice had therefore been lifted. A Rapid Quality Review (RQR) meeting was held with the Trust on 2 October 2023. A meeting would be held with DS and the Regional Chief Nurse to review the Trust's Quality Improvement Plan (QIP) before a final RQR meeting on 9 November 2023.

GS noted his thanks to MH, MS and colleagues for their ongoing engagement to address key quality concerns at MSEFT that sat outside of the RQR meetings, namely endoscopy service provision, paediatric services, vascular abdominal aortic aneurysm practice and neonatal

services at Southend. The ICB's Safeguarding Team was also working with the Trust's safeguarding leads to resolve over 100 outstanding safeguarding referrals which had not yet been responded to.

GT advised that work continued to gain evidence for MSEFT to exit from Section 31 Legal Undertakings by 31 March 2024.

In relation to EPUT, GT advised that a Section 29A Warning Notice had been issued to Rawreth Court which was managed through EPUT's community contracted services. The ICB had offered support in relation to ongoing monitoring and surveillance.

EPUT's CQC Action Plan would be discussed in detail at their RQR meeting on 13 October 2023. NHSE's decision to escalate EPUT's NOF rating to level 3 meant that EPUT would receive mandated regional support. OOA placements had reduced and a snapshot audit was undertaken regarding the quality and safety checks undertaken by the Trust prior and during a patient being placed OOA. The ICB would work with EPUT to further strengthen patients' experience.

AMcK added his own thanks to colleagues for addressing quality concerns and noted the wide range of action EPUT was implementing to improve quality and safety. AMcK also noted clarity was being sought regarding the agreement with NHSE for MSEFT to deviate from the standard harm review process to enable clinicians to focus on addressing the backlog.

GW noted that organisations and their staff appeared to be working collaboratively for the good of patients without a culture of blame and congratulated GT and his team on progress made to-date to ensure people felt comfortable raising concerns.

EMcE advised that changes to the normal 104-day cancer harm review process, which went through SOAC and then regional colleagues, had been agreed, but she was clarifying the position regarding harm reviews relating to referral to treatment.

GT advised that he had undertaken a review of quality governance arrangements including a review of the ICB Quality Committee Terms of Reference to ensure a systems approach, early escalation of quality issues identified and triangulation of information.

Outcome: The Committee noted the Quality Report.

- **Action 150**: EMcE to clarify position regarding harm reviews relating to referral to treatment delays.

7. Paediatric Hearing Services (presented by K Wesson)

KW advised that a national letter had been received setting out specific requests of organisations providing paediatric hearing services. The ICB had worked closely with Provide and MSEFT to complete the return and had receive assurances against the multiple requirements. The ICB Quality Team would arrange to provide an update to the ICB Quality Committee on 27 October 2023 prior to submission of the system response to the national team on 30 October 2023. AMcK commented that this report showcased the commitment of the relevant providers.

Outcome: The Committee:

- **Noted the report and provider progress against completing the recommendations.**
- **Supported that ongoing oversight of the actions was overseen via the ICB Quality Committee.**
- **Supported the sharing of the report with the Regional Quality and Screening Team.**

8. Care Quality Commission Matrix (Presented by T Turner)

TT advised that the MSEFT CQC reporting matrix was developed following a request by AMcK, and was proving very helpful by providing an overview of the Trust's performance against quality indicators. The dashboard included CQC ratings, any conditions upon the Trust's registration, 'must do' and 'should do' actions and various high-level quality metrics, some of which related to services that had not been inspected but were already reported internally. The dashboard would also become part of internal reporting processes.

AMcK was pleased the dashboard highlighted successes as well as highlighting where further improvement was required.

GT asked whether data would be tracked to show improvements over time and the impact of action taken to provide greater assurance.

TT advised that the data behind the dashboard sat within various quality improvement projects or was considered during performance reviews. Most information was available in either Statistical Process Control (SPC) or run-charts and was viewed internally that way. Although there was a trend line on the dashboard, it was developed to collate information in a concise and brief format.

GT advised the additional information would be helpful to the ICB Quality Team and advised he would contact TT to discuss outside of the meeting.

Action: 151: GT to Liaise with Tracy Turner, MSEFT, regarding providing the ICB Quality Team access to data behind the Trust's CQC dashboard.

9. Performance Report (Presented by K Wesson)

KW highlighted the following key issues and priorities:

The overall waiting list size at MSEFT was significantly higher than was sustainable and continued to grow. Discussions were ongoing with the Trust and Alliances regarding how to support the Trust whilst we manage people going through long pathways. Provision of advice and guidance (A&G) and improved communication with GPs to increase their confidence to use A&G was detailed in the report.

There had been a UCRT activity plan reporting discrepancy which had impacted on the annual plan submission 23/24. Reporting had since been amended to reflect this.

The EPUT Lighthouse service closedown report would be submitted to the November Elective Care Board and then SOAC in December. Work undertaken collectively by relevant partners provided a good level of assurance but the report needed to go through EPUT's internal governance process before sharing wider.

Chartwell, the Tier 2 endoscopy provider, had been supported by the ICB Quality Team to address several quality issues with a final meeting to be held shortly. The ICB was also working with Omnes to address data quality issues.

A Radiology Network report to Diagnostic Board highlighted significant risks to the system related to ageing diagnostic equipment. The impact of this upon patient experience was being followed up by the Quality Team (GT briefly summarised the issues) and the plans to replace equipment would be reported through the Diagnostic Board and sub-group.

There had been an overall reduction in the number of OOA placements. SG's report on this issue would recognise the associated costs and would also be picked up through the Financial Recovery workstream.

KW advised system partners, including local authorities, had engaged with Anaplan demand and capacity modelling. The ownership of data was previously a challenge, but system partners had agreed data sources and assumptions for calculations which was critical. The system checked length of stay, will support discharge and flow, and reflected out of hospital capacity for both health and local authorities to provide a system position. SHREWD was still used for day-to-day operations but Anaplan would support planning. Anaplan could also support triangulation of finance and workforce and this would be considered as part of the next phase.

The original plan for virtual wards identified circa 400 Units of Activity as opposed to current capacity of 172. The submission on 4 May had since been corrected. Regional colleagues had agreed to write a report outlining steps taken and why the changes were made for submission to regional/national teams. Services such as UCRT, stroke and complex wounds were previously grouped together, but don't meet the definition of a virtual ward, and were therefore no longer included in the 4 May submission.

SW commented that, considering current significant challenges, there were no escalations to the committee this month to ensure the right conversations occurred to drive improvements.

KW advised any escalations were included at the front of the report and that because MSEFT were already in Tier 1 escalation via regional/national processes, there was a desire not to duplicate processes.

AMcK advised that before he retired he would be putting this point to each programme board Chair to ask how they were holding people accountable to them and escalating matters where necessary, which in turn would further strengthen accountability lines between programme boards and SOAC.

MH noted that it was important to highlight issues outside of providers' control that were getting in the way of delivery, such as industrial action which was hindering elective care recovery.

EMcE noted the overall waiting list had reduced that week as a result of validation and it was important this was focussed upon to ensure services were planned on accurate data.

MH confirmed he had submitted a bid to NHSE to progress this work and was imminently submitting a proposal for the ophthalmology diagnostic hub, which would remove circa 20k patients from the list once treated. Implementation of the electronic patient record and standardisation of PAS systems was the fundamental route to reducing duplicates on the waiting list.

GW queried when a request for capital funding to replace ageing diagnostic equipment would be submitted to the appropriate ICB committee. AMcK requested JK to link with GT and colleagues MSEFT to progress this.

GW also requested an update on the risks at Southend Neonatal Intensive Care Unit (NICU). AMcK advised that NICU fell within the remit of Specialised Commissioning. KW confirmed that Gayle Murray, Specialised Commissioning Lead, was in contact with relevant people at MSEFT regarding the proposed stepdown from a NICU to a Special Care Baby Unit (SCUBU).
GT confirmed that the elective pathway for these babies was kept under review to ensure any transfers were safe. In response to comments from SW, AMcK confirmed that engagement with the relevant Health and Oversight Scrutiny Committee and/or the public was being considered.

AMcK summarised action being taken regarding the 65 week and 78 week wait (ww) position. It was originally anticipated 78 ww would be cleared by October and 65 ww booked by end-November, but a range of factors prevented this. AMcK asked KW to bring clear trajectories back to the SOAC on 8 November 2023.

KW confirmed that stretch targets agreed as part of the Winter Plan were now incorporated into the work of the UEC Board. SOAC would receive updates in due course. AMcK noted the importance of milestones and plans and requested KW to liaise with colleagues at MSEFT and EEAST in this regard.

Outcome: The committee noted the performance report.

Action 152: JK to link with GT and colleagues at MSEFT to progress request for capital funding to replace ageing diagnostic equipment.

Action 153: KW to work with Andrew Pike to provide clear trajectories for 65 week and 78 week waits by next SOAC meeting on 8 November 2023.

Action 154: KW to liaise with colleagues at MSEFT and EEAST to develop clear milestones and plans for Winter Plan stretch targets.

10. Finance Report (Presented by J Kearton)

JK advised that in relation to revenue, there was a £45 million deficit which was greater than originally envisaged. Discussions were ongoing to understand the best, worst and most likely case scenarios for the three providers which contributed to the control total. This information will then be submitted to Finance & Investment Committees and an extraordinary Chief Executive Forum the following month. Finance colleagues were also working with regional colleagues regarding the forecast outturn position.

In relation to Capital, circa £10M was committed in month 6, but the position was still slightly behind. Trevor Smith, Chief Finance Officer at EPUT was leading on the capital programme, including identifying best/worst/most likely scenarios.

The financial risk positions were being reviewed by organisations. There was nothing to escalate from the ICB or EPUT regarding cash, but MSEFT were going through the additional cash borrowing requirements via national/regional teams.

JK concluded by advising there had been movement between months 4 and 5 of £10 million and between months 5 and 6 of £6 million which represented an improvement from last month and confirmed she would add this type of information to future reports.

Outcome: The committee noted the finance report.

11. Financial Recovery Programme (Presented by P Read)

PR advised there had been a circa £3 million increase on the efficiency position since the previous meeting, which was currently just about the £90 million, with further cash releasing expected in quarter 3, which should take the position to circa £100 million. There remained reliance on non-recurrent cash releases and there were several non-recurrent schemes which the Central PMO was discussing with partners to ascertain if they could be converted to recurrent to support the financial position for 2023/24. Progress with the Chief Executive led portfolios was summarised. Recovery programme information would inform discussions regarding the forecast outturn position.

GW advised that system partners should consider how to remove structure costs, including centralising administration tasks, through use of better technology, e.g. electronic patient record, and highlighted that although there had been an increase in the workforce, productivity needed to improve.

JD asked if there was a high level of confidence that action being taken was effective. JK acknowledged there were challenges but she anticipated there would be a reduction in the exit run-rate, but whether improvements would be delivered in-year was a challenge. JK agreed with GW's comments regarding productivity and advised a Productivity and Continuous Improvement session would take place with regional colleagues the following Wednesday, and it was important to consider this issue across all care settings. Development of the Medium Term Financial Plan (MTFP) would also bring this and other factors, including investments required, into sharp focus. JK confirmed that the system had struggled to make efficiency savings during 2023/24 and it would be a huge challenge to meet targets set, but she believed partners were doing the right things to improve finances.

MH advised that one of his initial reflections since taking up post was that there needed to be greater discussion regarding finances which he had taken action to address. EPR would realise savings, but fundamentally the Trust must organise itself structurally and have a clear strategy underpinned by clear clinical and workforce input, which should lead to productivity / cost improvements. This work would commence very shortly in collaboration with partners.

Outcome: The committee noted the Financial Recovery Programme Update.

12. Recovering Access to Primary Care (presented by Dr J Hickling)

WG explained recovering access to Primary Care was a national priority, alongside elective and non-elective recovery.

Feedback gained via patient surveys was that the quality of care was often very good. However, access had been challenging for patients and primary care staff for several years, with MSE receiving some of the worst satisfaction scores across the country for access via telephone, use of websites and ability to book appointments. It was also acknowledged there was a need to differentiate how demand was managed by providing a variety of means for patients to access care depending on what their presenting need was to ensure they received care from an appropriate professional. This would then free up GPs' time to deal with more complex cases. Transfer of Care Hubs would support this work.

It was felt that the plan to recover access to Primary Care should therefore focus on the 'front-door' of primary care, in particular using digital solutions and a total triage model, which would be branded as a 'Connected Pathways' approach to provide a clear offer to patients, enable greater self-referral, and support appropriate staff to deliver care on a timely basis.

Work was ongoing with partners to formally develop the plan and the ambition was to go beyond current national requirements.

JH advised that the most important thing was the quality of service patients received. This model was not a 'one size fits all' as some practices delivered a more traditional model and still provided very high levels of access satisfaction. Therefore, the ICB would not insist everyone used the framework, although there were practices who would benefit from doing so.

GW asked whether one Alliance should implement the framework as a pilot to prove the concept. PG highlighted the potential benefits of the framework across the health and care sector and asked provider colleagues for their support in its implementation. PG confirmed there were early adopters in Southend and Mid Essex.

WG advised that feedback from practices and Primary Care Networks was that there was now a much greater desire to implement change than previously, and those that had implemented new ways of working would not revert to previous arrangements.

Outcome: The committee noted the report on Recovering Access to Primary Care.

13. ICB Board Assurance Framework and Risks within the remit of SOAC (presented by A McKeever)

AMcK advised that the Board Assurance Framework set out the risks correctly and was presented to the Board on 28 September 2023 and invited GW to comment.

GW advised that the documents reflected system risks apart from local authority partner risks, although these would also be included at some point in the future. It had been identified via the ICB Quality Committee that some issues were not being escalated appropriately and action was being taken to address this.

SO advised that she recently met with KW and colleagues to review how risks should be aligned to the ICB's new directorate structure and a report would be submitted to ICB senior leaders to agree the proposals.

Outcome: The committee noted the BAF and Risk Report.

14. Escalations (presented by A McKeever)

AMcK agreed that the following three issues would be escalated to the Chief Executive Forum and/or sovereign boards:

- **Aspects of financial challenge** in relation to capital and forecast outturn protocol. Colleagues in SLFG would ensure all capital was spent this year and would be working to generate best/worst/most likely case scenarios which would be shared with CEF prior to submission to regional/national level and sovereign boards to ensure all organisations were informed.
- **Performance targets** behind long waits and winter stretch targets once KW has obtained information from relevant programme boards, which should then go back to CEF to get absolute transparency and clarity on what they entail.
- **Workforce data** – to take issues identified back to sovereign Boards so they can receive assurance on this in relation to their own staff.

Outcome: The committee agreed the three issues for escalation to CEF and/or sovereign Boards.

15. Any Other Business

AMcK advised that SO had asked if he and GW would agree to SOAC meetings during 2024/25 being held a week later and asked if members had any objections to this. No concerns were raised and this was therefore agreed.

16. Date of Next Meeting

Wednesday, 8 November 2023 – 1.00 pm to 3.00 pm via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 8 November 2023 at 1.00 pm – 3.00 pm via Teams

Attendees

Members (Voting)

- George Wood (GW), Non-Executive Director of MSE ICB and Co-Chair of Committee.
- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England and Co-Chair of Committee.
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England (items 1 to 10)
- Dr Matthew Sweeting (MS), Interim System Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Diane Sarkar (DS), Chief Nursing Officer, MSEFT.
- Lisa Faulty (LF), East of England Ambulance Service Trust (EEAST)
- Emily Hough (EH), Executive Director of Strategy & Corporate Services
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.

Other attendees

- Jason Donovan (JD), Head of Finance (Assurance), NHS England
- Lynnbritt Gale (LG), Director of Community Delivery and Partnerships, South East Essex, Essex Partnership University NHS Trust (EPUT).
- Karen Wesson (KW), Interim Director of Oversight, Assurance and Delivery, MSE ICB.
- Phil Read (PR), Associate Director System Development, MSE ICB.
- Joanne Dickinson (JD), Regional Mental Health Team, NHS England.
- Marcus Ridell (MR), Senior Director of Organisational Development (EPUT)
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress.
- Selina Dundas (SDu), Deputy Chief People Officer, MSEFT.
- Sara O'Connor (SO), Head of Governance and Risk, MSE ICB (minutes).

Apologies Received

- Anthony McKeever (AMcK), Chief Executive Officer and Joint Chair of Committee, MSE ICB.
- Matthew Hopkins, (MH), Chief Executive, MSEFT.
- Pam Green, (PG), Alliance Director (Basildon & Brentwood), MSE ICB.
- Lisa Adams (LA), Interim Chief People Officer, MSE ICB.
- Selina Douglas (SDo), Executive Director of Partnerships, North East London NHS Foundation Trust.

1. Welcome and Apologies (presented by G Wood)

GW welcomed everyone to the meeting. It was confirmed that the meeting was quorate. Apologies were noted as above.

2. Declarations of Interest (presented by G Wood)

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 members are listed in the Register of Interests available on the ICB's website**.**

There were no declarations of interest raised.

3. Minutes (presented by G Wood)

The minutes of the last SOAC meeting held on 11 October 2023 were reviewed and approved, subject to the minor amendments listed below:

- **Item 11, Financial Recovery Plan, first paragraph:** "non-current" to be amended to "non-recurrent" in 2 places.

Outcome: The minutes of the committee meeting held on 11 October 2023 were approved, subject to the amendments noted above.

4. Action log and Matters Arising (presented by G Wood)

Members noted the action log and the following updates were provided:

- **Action 109:** Closed due to regular workforce reporting to SOAC.
- **Action 136:** Closed due to regular performance reporting to SOAC.
- **Action 153:** GW noted the Tier 1 pack with trajectories was appended to the action log.
- **Action 154:** SO advised that Sam Goldberg's report regarding winter stretch targets would be submitted to the next meeting.

There were no matters arising.

5. Forward View (presented by G Wood)

GW referred to his email dated 29 October 2023 to AMcK and reminded committee members that the financial savings required by the system would only be achieved if providers significantly reduced spend on bank and agency staff and increased recruitment of substantive staff.

6. Workforce Report (presented by J Kearton on behalf of L Adams)

6.1 Workforce data

JK advised that there had been an increase in the number of staff in post at MSEFT and EPUT. Bank usage had reduced at MSEFT following the summer leave period and industrial action but was still higher than planned. EPUT also had a continuing downward trend. Agency usage at MSEFT was still higher than expected having increased significantly in September, whereas EPUT was reducing according to plan. Attrition rates were also reducing across the system. This data would be triangulated against other data, including financial information. Although providers had implemented robust controls regarding bank/agency spend, compliance against these needed to be maintained and monitored.

In response to a query from SW, JK acknowledged the plans were ambitious, but highlighted the expected pipeline of new graduates which would help to fill vacancies.

GW asked for future reports to include greater detail linking workforce to finances, patient safety/quality, performance and staff wellbeing issues to include budgeted and actual salary costs, broken down by substantive, bank and agency to enable LA to reflect this in future reports.

6.2 Escalations from People Board

JK confirmed there were no escalations from People Board.

Outcome: The Committee noted the Workforce Report.

Action 155: LA to include greater detail linking workforce to finances, patient safety/quality, performance and staff wellbeing issues, including budgeted and actual salary costs, broken down by substantive, bank and agency within future workforce reports.

7. Quality Report (presented by G Thorpe)

GT highlighted the following key issues:

The ICB and partners fulfilled their responsibility to communicate the national Patient Safety Alert regarding short supplies of medicines used to treat Attention Deficit Hyperactivity Disorder (ADHD) to primary care, which was supplemented by close communication with families and carers. Stock supplies had since improved.

Radiology concerns at MSEFT had been investigated and addressed and the ICB was working with partners to minimise the impact of closure of Phoenix Eating Disorder Centre.

GT summarised quality issues relating to Mid and South Essex Foundation NHS Trust (MSEFT), Essex Partnership University NHS Foundation Trust (EPUT) and confirmed the ICB would work with partner organisations to ensure a co-ordinated response to information requested by the Essex Mental Health Statutory Inquiry. This would include ensuring the Inquiry was fully informed of the commissioning arrangements over the period of time under scrutiny.

Inpatient services at St Peter's Hospital had been moved to Brentwood Community Hospital due to health and safety concerns at the St Peter's site.

There had been an increase in demand for community children and young people's services, particularly relating to therapy and autism spectrum disorder services, with a consequent increase in complaints regarding delays. The Community Collaborative were increasing capacity where possible. The focus on early discharge from hospital and the acuity of patients was impacting on community services which the Quality Committee would be monitoring.

Further information had been requested by region regarding the paediatric audiology alert which would be submitted that day.

GT highlighted a significant increase in primary care complaints and concerns compared to the previous year. The ICB had negotiated a temporary extension of timeframes for acknowledgement and responses until the situation improved.

SW encouraged GT to bring more detailed information regarding issues identified via complaints to SOAC to enable it to track progress in addressing them. GW suggested that the Primary Care Commissioning Committee should firstly undertake a deep dive into complaints and advise SOAC if concerns remained, noting that there had also been a significant increase in the number of GP appointments.

In response to a query from JH, GT advised the increase was in part due to the ICB having taken on delegated responsibility for pharmacy, optometry and dentistry (POD) services from April 2023, with access to dentistry services being of particular concern. GT and JH agreed to discuss and agree arrangements for future reporting of primary care complaints to relevant committees.

DS mentioned that MSEFT had also seen an increase in complaints with access to elective surgery and cancelled outpatient appointments being the main themes.

JD advised that the Right Care, Right Person guidance included advice on mental health in-patients who go missing which would be implemented across Essex in January 2024. GT advised it was his understanding that Essex Police required assurance that organisations would do everything possible to locate missing patients prior to calling the Police.

GW referred to section 2.3 of the report and asked GT to quantify how many young people were currently awaiting placement in Tier 4 CAMHS mental health beds.

GT also suggested that EPUT's arrangements for communicating with families and the media when patients do not return to mental health units should be reviewed to ensure they were appropriate and effective. LG advised that most patients who did not return were on agreed leave and criteria had to be met before they could be counted as 'AWOL'. LG also explained that people detained under the Mental Health Act were not always cared for in a locked environment, but she would ensure that effective communications arrangements were in place.

In response to a further query from GW, GT confirmed that funding had been sourced to address flooring issues at Brentwood Community Hospital. An improved water safety flushing regime had also been implemented at this site which should not have any capital costs implications.

Outcome: The Committee noted the Quality Report.

- **Action 156**: GT and JH to agree committee reporting for GP/POD complaints (i.e. Quality Committee / Primary Care Commissioning Committee).
- **Action 157:** LG to discuss with Alexandra Green EPUT's arrangements for communicating with families/carers and the media when mental health patients are considered to be AWOL.
- **Action 158**: GT to quantify how many young people are awaiting placement in Tier 4 CAMHS mental health beds and plans to resolve this.

8. Performance Report (Presented by K Wesson)

KW advised that she would focus on escalations and highlight issues considered at the Elective Board meeting held the previous Monday, as follows:

The report provided an update on stretch targets agreed as part of the 2023/24 Winter Plan. The 4-hour A&E standard was currently significantly below the national 80% stretch target requirement at 65%, versus 71% trajectory. The average ambulance turnaround time was 36 minutes and was higher than the intention of zero ambulances waiting longer than 30 minutes. The new Unscheduled Care Co-ordination Hub (UCCH) would help to address performance against these standards. The Elective Board acknowledged that referrals to the Urgent Care Response Team (UCRT) had reduced and the service would therefore be re-promoted. Andrew Pike, Michelle Stapleton and Sam Goldberg were working to achieve improvements in flow and length of stay which would help ambulance handover times.

KW asked members to note the Royal College of Surgeons report required as part of MSEFT's legal undertakings was presented to the Cancer Board. However, the Trust had not yet met all requirements to enable the Cancer Board to recommend closure. A meeting with ICB and

NHSE England representatives to discuss the undertakings was due to take place later that afternoon.

The Cancer Board wished to highlight that the funding of the repair at Southend Aseptic Unit was delayed until April because it required a full upgrade. The Board also wished to flag the associated workforce risk as articulated within section 7.4 of the report and the potential impact upon patients.

In addition, the Cancer Board wished to highlight issues relating to restorative dentistry as set out in section 7.5 of the report. Following escalation by the Trust in August, a stakeholder event was held to discuss future requirements. A business case was under development for consideration during the next planning round. The Trust were also exploring estates options for the service.

The EPUT paediatric service (Lighthouse) close down report was due to be shared with the Elective Care Board in December which should provide transparency regarding long waits. LG apologised for the late submission of this report and confirmed that it had been escalated internally.

Palliative and End of Life care data was now included within the performance report. Funding had been identified to implement the Electronic Palliative Care Co-ordination System (EPaCCS) in mid Essex.

KW advised that the number of A&E attendances so far this year was circa 25,000 which was similar to those in 2021 (26,000 for the same period). LF asked if this information was split by ambulance conveyances and 'walk-ins'. KW confirmed she would clarify this and provide further information in the next performance report.

In response to a query from LG regarding trajectories for community paediatric services, KW advised that currently there should be zero 78-week waits, but this was not the case across the three community providers, although there were low numbers. Assurance was required that these long waits would be addressed. A zero 65-week wait position by the 31 March 2024 reported position was also required and a request had been made for an agreed trajectory against this. A zero 52-week position was required by 31 March 2025 reported position – again a trajectory had been requested LG would discuss this with community collaborative colleagues.

DD and KW outlined other work being undertaken to improve ambulance handover times. LF confirmed that EEAST were committed to providing staff for the UCCH. DD advised that he would contact Tom Abell at EEAST to follow-up on proposals to reduce ambulance handovers as discussed at a recent event.

SW suggested future performance reports should include an executive summary highlighting key issues for attention by the committee.

In response to a query from KW, GW advised primary care performance data should be included in future reports to Primary Care Commissioning Committee and highlighted the importance of setting realistic performance targets going forward.

GW expressed concern regarding the delays in upgrading the Southend Aseptic Unit, restorative dentistry and diagnostics, and asked that this issue was escalated to the board of MSEFT and Quality Committee. KW advised that the regional team leading on aseptic units would provide a detailed report prior to the next Cancer Board meeting, which could be shared with GW and MS.

In response to a query from GW regarding bed occupancy and future planning, KW outlined work to reduce length of stay including agreement of triggers for opening of escalation beds, Anaplan, work ongoing within All Age Continuing Care and to support patients within the

community. Readmissions were considered via Better Care Fund arrangements / discharge workstream. JK also outlined further work being undertaken with partner organisations and adviosed that the next planning round would enable the ICB to bring this work together.

Outcome: The committee noted the performance report.

Action 159: DD to contact Tom Abell, EEAST, regarding proposals to reduce ambulance handover times, as discussed at a recent event.

9. Finance Report (Presented by J Kearton)

JK advised that month 7 figures had not yet been received. The year-to-date position at month 6 was a £45 million deficit against a £40 million deficit plan. A set of best, worse and most likely case scenarios were being discussed with Chief Executive Officers and management actions were being implemented to reduce the deficit.

Additional national funding had just been announced and the ICB and partners would need to work through the implications of this once MSE's allocation was known. JK made it absolutely clear that this funding must not be used for additional spending and the ICB would decide how to distribute it to providers included within the system control total in order to reduce their deficits. A 2% reduction in elective recovery funding was anticipated, which would in fact be beneficial to MSEFT.

There were certain performance metrics that the system would need to recommit to and some that might be challenged assuming the £40 million deficit position was non-negotiable and, along with other systems, there was a risk that the forecast outturn protocol might need to be invoked by MSE.

In response to a query from JD, JK advised that system must consider what should be done differently to deliver within the funding envelope, requiring difficult conversations to be held alongside improvements in productivity.

LG advised that EPUT had been made aware there was no winter funding available for mental health services which could impact upon flow and length of stay. JK advised that compliance with the Mental Health Investment Standard would not be affected, but it would be helpful to understand the value of winter schemes to EPUT and would discuss this with the Trust's Chief Finance Officer.

Outcome: The committee noted the finance report.

10. Financial Recovery Programme (Presented by P Read)

PR highlighted key information contained within his report, including the work of the portfolios. PR explained that the need for the Workforce portfolio to progress at pace had been escalated and discussed with Lisa Adams.

In response to an offer by JD, JE confirmed that it would be helpful for NHSE to undertake a value for money review of the work undertaken by PWC, although it might be too early to understand the impact of work undertaken by Moorhouse.

GW asked PR to provide more detail regarding what was required to deliver schemes next year in future reports.

MS advised that the complexity of health services had increased significantly over the years. GT agreed and advised that a concomitant shift and stabilisation of workforce and maximisation of the use of health technology was required.

PR advised that Moorhouse had undertaken a significant review of the diagnostics workforce and spend which would be used to take plans forward.

Outcome: The committee noted the Financial Recovery Programme Update.

11. Escalations (presented by G Wood)

GW advised that he would be writing to the Chairs of provider organisations to ensure the relevant provider committees were addressing concerns that had been highlighted to the committee.

It was agreed the following issues would be escalated to the Chief Executive Forum and/or sovereign boards:

- Aspects of financial challenge
- Performance report: Aseptics, Restorative Dentistry and Diagnostics.
- Workforce challenges.

Outcome: The committee agreed the above issues for escalation to CEF and/or sovereign Boards.

12. Any Other Business

GW advised that AMcK would shortly be retiring from his position as Chief Executive of the ICB and thanked him for the enthusiasm, knowledge and humour he had brought to the role and for the significant work he had taken to improve services across MSE.

GW also advised that he would be happy for members to email him directly if they wished to suggest any improvements to the work of the committee.

13. Date of Next Meeting

Wednesday, 13 December 2023 – 1.00 pm to 3.00 pm via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 13 December 2023 at 1.00 pm – 3.00 pm via Teams

Attendees

Members (Voting)

- George Wood (GW), Non-Executive Director of MSE ICB and Co-Chair of Committee.
- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England and Co-Chair of Committee.
- Tracy Dowling (TD), Interim Chief Executive, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Lisa Fautley (LF), East of England Ambulance Service Trust (EEAST).
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England.
- Lisa Adams (LA), Interim Chief People Officer, MSE ICB.
- Dr Matthew Sweeting (MS), Interim System Medical Director, MSE ICB.
- Jennifer Kearton (JKe), Chief Finance Officer, MSE ICB.
- Pam Green, (PG), Alliance Director (Basildon & Brentwood), MSE ICB.
- Emily Hough (EH), Executive Director of Strategy & Corporate Services.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.

Other attendees

- Jason Donovan (JDo), Head of Finance (Assurance), NHS England.
- Lynnbritt Gale (LG), Director of Community Delivery and Partnerships, South East Essex, Essex Partnership University NHS Trust (EPUT).
- Karen Wesson (KW), Interim Director of Oversight, Assurance and Delivery, MSE ICB.
- Phil Read (PR), Associate Director System Development, MSE ICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress.
- Selina Dundas (SDu), Deputy Chief People Officer, MSEFT.
- Dr Catherine O'Doherty (CO'D), Consultant in Palliative Medicine / Oncology Lead.
- Jonathan Dunk (JDu), Chief Commercial Officer, MSEFT.
- Kate Butcher (KB), Deputy Alliance Director, Mid Essex Alliance.
- Chigozie Akinyemi (CA), Moorhouse Consulting (Item 12 only).
- Ruth Harrison (RH), Moorhouse Consulting (Item 12 only).
- Paul Taylor (PT), Essex Partnership University NHS Trust (EPUT).
- Joanne Dickinson (JDi), NHS England Regional Mental Health Team.
- James Wilson (JW), Essex Partnership University NHS Trust (EPUT).
- Jane King (JKi), Head of Governance and Risk, MSE ICB (minutes).

Apologies Received

- Sam Goldberg (SG), Urgent Emergency Care System Director, MSE ICS.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Diane Sarkar (DS), Chief Nursing Officer, MSEFT.

- Matthew Hopkins, (MH), Chief Executive, MSEFT.
- Alexandra Green (AG), Chief Operating Officer, EPUT
- Selina Douglas (SDo), Executive Director of Partnerships, North East London NHS Foundation Trust.
- Stephanie Dawe (SDa), Chief Executive, Provide.
- Sara O'Connor (SO), Head of Governance and Risk.

1. Welcome and Apologies (presented by G Wood)

GW welcomed everyone to the meeting and extended a warm welcome to Tracy Dowling, the Interim CEO for Mid and South Essex ICB. It was confirmed that the meeting was quorate. Apologies were noted as above.

2. Declarations of Interest (presented by G Wood)

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 members are listed in the Register of Interests available on the ICB's website**.**

There were no declarations of interest raised.

3. Minutes (presented by G Wood)

The minutes of the last SOAC meeting held on 8 November 2023 were reviewed and approved, subject to the minor amendments listed below:

- **Item 4, Action Log,** remove title reference to Anthony McKeever.

Outcome: The minutes of the committee meeting held on 8 November 2023 were approved, subject to the amendment noted above.

4. Action log and Matters Arising (presented by G Wood)

Members noted the action log and the following updates were provided:

- **Action 97:** On track.
- **Action 126:** Closed.
- **Action 134:** Closed.
- **Action 149:** In progress – covered under item 5.
- **Action 154:** Closed.
- **Action 155:** In progress - covered under item 5.
- **Action 156:** Closed.
- **Action 157:** Closed.
- **Action 158:** Closed.
- **Action 159:** Follow up with DD – LF (EEAST) had spoken to Tom Abell who advised he needed clarification on this action.

There were no matters arising.

5. Workforce Report (presented by L Adams)

With respect to EPUT, LA advised that vacancy and turnover rate continued to fall and was expected to be back on plan by year-end, largely due to their International Recruitment Programme. Temporary staffing levels continued to be a challenge, although agency usage had fallen, and expenditure remained high. Consequently, there had been increased executive scrutiny and additional controls introduced, including changes to agency management. Bank reforms were also being considered to improve the rate of agency to bank conversions.

LA acknowledged that despite some increased confidence from these headlines (and some similar positive trends for MSEFT) and despite increased controls and measures being taken (including forensic work in places), it was not possible to assure SOAC that these improvements would go fast enough or far enough, to remedy key workforce challenges, including cost.

In view of this, a Workforce Group, made up of mid and south Essex (MSE) Chief People Officers and the NHS Regional workforce team, was being established to look at workforce productivity and assist with the challenges faced to lay the ground work for the long term Workforce Strategy.

GW noted the EPUT data between bank, agency and actual staff exceeded authorisation levels and queried how this would be addressed, commenting he would like to understand the reason for the high number and what was required to lower the figure.

JKe commented that it would be helpful to understand what was driving costs, for example whether 'hard to recruit to' posts were contributing to the high agency costs.

SW advised that at a meeting with the NHSE National team on 12 December 2023, Julian Kelly, NHS England Finance Director, had expressed serious concerns regarding MSE's financial position, particularly high workforce expenditure.

TD advised that a further meeting with the National team was scheduled for February 2024 when the ICB was expected to have a much more robust medium term Financial Plan in place.

SD advised that there was a reduction in vacancy and turnover numbers for MSEFT, however, temporary staffing needed to correspond with this. Part of the issue was the lack of GPs causing people to seek help from acute services, increasing numbers of elderly, children and young adults presenting at A&E, and an increasing number of patients with mental health issues and/or social care/discharge challenges. JKe said that in terms of a lack of GPs and mental health pressures mentioned, it would be useful to understand what the issues were in terms of numbers, costs and pressures as there was considerable work ongoing in these areas. (TD subsequently felt that these factors would not be sufficiently material to explain the figures in a meaningful way and was no different to other trusts in terms of a general challenge).

SD explained that work was taking place across all staff groups and divisions to identify the drivers of high workforce costs. A forensic approach would identify drivers which would help to tackle issues at source. SD confirmed that a patient safety review had led to the

recruitment of 100 additional medics. TD queried how these costs had been possible - whether they were budgeted for and/or made possible by savings elsewhere.

The committee agreed that staff productivity needed to be looked into which would help reduce workforce costs. TD commented that activity levels were below planned for non-elective admissions, A&E and outpatients (apart from outpatient procedures) and less than commissioned, however workforce costs were higher.

JKe requested that MSEFT review workforce controls and undertake an analysis of growth in the workforce from pre-COVID to-date to identify whether growth was due to quality issues, patient safety or business cases. JKe highlighted that this workforce control was required to come to the ICB Board for agreement. JKe also referenced the letter sent from Claire Panniker, Regional Director at NHS England, at the beginning of 2023 regarding non-clinical and non-essential workforce vacancy control/freeze which could provide building blocks for workforce control and forensic analysis work.

SW commented that it was not the first time MSEFT was underrepresented at SOAC and suggested TD discuss this with MSEFT's CEO to ensure SOAC meetings were prioritised, particularly given the System's current financial position.

SW suggested that an urgent conversation between system Chief Executives regarding a recruitment freeze was required and that MSEFT urgently needed to revisit their Workforce Plan.

SW questioned whether the financial plan for workforce had been correct in the first place as it did not appear that it could have been. JD agreed that the plan needed to be revisited and explained that, in terms of the disconnect between money and workforce, the Workforce Plan had been submitted before the final Finance Plan was submitted and acknowledged that planning needed to be done differently in future.GW spoke of his concern that it was only coming to light at this late stage in the financial year, that the financial plan had not been triangulated with the workforce plan.

GW commented that a substantive Workforce Plan was required by February and asked LA, JKe, TD, SD and MH to consider how to get the right people together, including operational management, to progress the plan. GW suggested the meetings needed a 'war room' approach – with issues being revisited for half an hour on a daily basis over the next four to six weeks. It would be necessary to establish what we got wrong, put controls in by division and speciality, identify budget holders and original budgets, the run rate and a plan by division/speciality to get back on budget.

SOAC were not able to make a recommendation on a recruitment freeze but it was a start and signified to external colleagues that SOAC was taking the matter seriously. GW reiterated that it was disappointing that SD was the only MSEFT representative in attendance.

GT confirmed he was happy to be part of discussions and would welcome an understanding of MSEFT's workforce planning and assurance process.

GT explained that the SOAC meetings clashed with MSEFT executive accountability meetings which was affecting SOAC attendance.

LA stated it was essential that a detailed debrief of the discussion was given to the Chief Executive Officer, Chief Nursing Officer and Chief Financial Officer at MSEFT.

The Committee noted that EPUT numbers were of equal concern and that both organisations required equity of oversight and assurance in relation to workforce.

Action 160: SDu/LA to pick up outside the meeting the recruitment of an additional 100 doctors, to understand if this was included within funded establishment or was a separate agreement to spend extra and whether there would be a result drop in agency costs.

Action 161: TD to discuss with MH MSEFT executive prioritisation of SOAC meetings.

Action 162: SD to ensure MSEFT to review its Workforce Plan at speed.

Action 163: Michelle Angell to escalate to System CEOs the ask to consider recruitment freeze across organisations.

Action 164: LA to set up a War Room approach over next four to six weeks, compiling actions, ensuring correct people are attending to produce substantive Workforce Plan (to include operational management representatives) ahead of next NHSE review meeting in February 2024.

Action 165: SO to review timing of SOAC meetings to avoid clashes with MSEFT executive accountability meetings.

Action 166: Accountability for workforce expenditure to be signed off by Chief Nurse, Finance Director or Chief Executive at MSEFT/EPUT with immediate effect.

Action 167: SDu to provide detailed debrief of the workforce discussion to the Chief Executive Officer, Chief Nursing Officer and Chief Financial Officer of MSEFT.

5.2 Escalations from People Board

LA confirmed there were no escalations from People Board.

Outcome: The Committee noted the Workforce Report.

6. Quality Report (presented by G Thorpe)

GT advised the focus of the Quality Report was on Maternity Services. There was a risk to the completion of all safety actions within the Saving Babies Lives Care Bundle v3 (SBLCBv3) to fulfil the requirements of Clinical Negligence Scheme for Trusts (CNST) Safety Action Six. Following review of the evidence by the ICB (during the 2nd quarterly review in October 2023) MSEFT had achieved 63% overall compliance versus the requirement of 70%. Additional time had been allowed for MSEFT to further improve the position. The Trust was confident it would be able to submit a compliant position by 1 February 2024. A review of the remaining seven safety actions was positive.

A key risk for maternity services was around speciality roles, required under national guidance, to be fixed term contracts.

Southend Hospital Neonatal Unit was reclassified as a Special Care Baby Unit (accepting babies at 32 weeks or more gestation) until March 2024. From discussions with MSEFT no adverse outcomes or harm had come to pregnant women and people, or their babies. Ongoing conversations with the Operational Delivery Network (ODN) remain underway to ensure that appropriate transfers are occurring in good time to minimise risk.

Any further change in status of Southend Neonatal Unit would require full consultation and liaison with the ODN and GT would ensure that occurred.

The final key risk to note was in relation to the single end-to-end maternity information system across MSEFT sites which resulted in challenges to both recording and accessing information across all areas of maternity services. A new Electronic Patient Record (EPR) was being procured by MSEFT which would resolve this. Maternity staff were involved in the procurement process and were expected to participate in decision-making. Full implementation of the EPR was not expected to be fully completed until 2026. However, submission of the mandated maternity safety data set (MSDS) for the purposes of CNST submission was not compromised.

There were no questions raised.

Outcome: The Committee noted the Quality Report.

7. Performance Report (Presented by K Wesson)

KW presented the Performance Report and advised there would be some overlap with Item 8 (Winter Stretch Targets) that she would present on behalf of Sam Goldberg.

Following submission of the 22 November 2023 planning ask, the system no longer intended to deliver the 4-hour standard stretch target of 80%, returning to the 76% national ask.

The stretch target for ambulances of no more than 10% of ambulance handovers exceeding thirty minutes will remain. Average handover time in November 2023 at MSEFT was 26 minutes. In the past week, there had been higher ambulance activity and demand nationally and locally.

Cancer Faster Diagnostic Standard (FDS) standard was below the current trajectory. MSEFT and the System was committed to meet the target of 75% at the March 2024 reported position. Delivery oversight continues with the National, Regional and Cancer Alliance teams via the Tier 1 meetings to ensure delivery of this standard.

The System remained committed to the 62 day backlog recovery plan to achieve the national ask of no more than 475 waiting over 62 days at 31 March 2024. MSEFT reported at the Tier 1 meeting on 28 November 2023 that the current backlog position was 205 above plan.

Referral To Treatment (RTT) - oversight via the Tier 1 meetings continued. Following the 22 November 2023 financial planning submission, there was an ask of the System for a further submission of RTT backlog plans to the national team on 8 December 2023. The 8 December 2023 best case position for 78 week recovery was 125 people as of March 2024. The System was unable to improve this forecast, in part due to national challenge in capacity to deliver breast reconstructive surgery. The reported risk of 549 patients waiting 65+ weeks by end of March 2024 remained, with patients waiting being on the admitted pathway.

Out of Area Placements were now meeting trajectory. The key challenge for the System was to recover and reduce length of stay in mental health beds to enable patients to remain locally.

In response to a previous SOAC Chair ask, any performance metric that was reported to a different Integrated Care Board Sub-Committee has now been removed from this report to reduce duplication of reporting.

The UEC Recovery Plan was being refreshed to reflect wider actions being taken by the system.

JDi highlighted that within the Government's Autumn Statement Talking Therapies (previously referred to as Improving Access Psychological Therapies (IAPT)) there may be additional funding coming to the System. JDi advised that 'in treatment' waiting times were particularly high in the South East Essex area and would discuss with GT outside of the meeting.

TD commented that greater detail was required in the paper to explain the variance to plan, actions being taken to improve performance and the impact of the actions. TD queried whether the transformation and delivery sub-groups of SOAC received a greater level of rigour and understanding of impact and trajectory and, if so, she would like this presented at SOAC in the future.

SW commented that there continued to be limited escalations to SOAC from the sub-groups and further work should be undertaken to engage and encourage the Chair's of the sub-groups to identify and escalate issues appropriately.

EM commented that whilst a lot of oversight happened at SOAC, attendance and rigour at the sub-groups was variable and submission of sub-group papers was not always timely and sometimes lacking.

TD suggested there was a need to look at sub-group meeting structures to understand the difficulties with attendance and delay in receiving timely papers, and that it was important to do things once as a system with a consistent plan that was followed up.

KW agreed work was required on how to share downwards from National/Regional meetings and avoid duplication of meetings where oversight and escalation was happening.

GW requested a schedule of meetings was compiled to ensure SOAC received escalations and assurance on the 'what ifs', 'what next' and 'what is happening' to ensure the right people attended the right meetings to allow colleagues to be operational. GW asked KW to lead on this and to link in with EM and the ICB corporate review work being undertaken.

EM added that there remained a nervousness around fixed term Cancer staff contracts, seen as critical posts but MSEFT were not recruiting into the posts. Additionally, there were concerns that Cancer Alliance transformation money was used to continue to fund posts that should be substantive and this should be considered as part of the workforce review. KW explained that historically some of these posts were put in place to undertake transformation work but had not been evaluated as required or if evaluated as required, made substantive, so continued to draw on Cancer Alliance monies to reduce risk to the Cancer workforce. GW commented this needed to be corrected and requested this was looked into as part of the 'War Room' actions.

Action 168: KW/EM to advise if transformation and delivery sub-groups of SOAC receive a greater level of rigour and understanding of impact and trajectory, details to be shared with SOAC.

Action 169: SW, EM and TD agreed to discuss streamlining meeting structures when they meet on 15 December 2023.

Action 170: LA - Add conversion of fixed term contracts to substantive posts to 'War Room' workforce actions – see workforce section.

Action 171: KW, EM and EH to ensure that the ICB corporate review maps SOAC sub-group reporting to ensure no duplication, appropriate escalations and level of reporting to SOAC.

There were no questions regarding the Terms of Reference for the MSE System Diagnostic Transformation and Improvement Board.

Outcome: The committee noted the Performance Report and approved the Terms of Reference for the MSE System Diagnostic Transformation and Improvement Board.

8. Winter Stretch Targets (Presented by K Wesson on behalf of Sam Goldberg)

As discussed under Item 7. A detailed Winter Stretch Target plan would be brought to SOAC in January 2024.

Outcome: The committee noted the Winter Stretch Targets report.

9. Finance Report Months 7 and 8 (Presented by J Kearton)

JKe advised that SOAC had received a full month 7 (M7) finance report as was provided to the Finance & Investment Committee on 22 November 2023 which included an update on system allocations and more detailed level of risk reporting.

At month 7 the financial position was a £53 million (m) deficit, which was off plan by £27 m. It was important to note that the year-to-date position was supported by non-recurrent measures of £31.2m in the system.

At month 7 the forecast outturn remained a £40m deficit, subject to regional and national review. Delivery of this forecast was threatened by the year-to-date position and the escalating risk in the system across all organisations.

The reported risk in the system had been moved at month 7 to £62m (from £60m the previous month). While still significant and actions were being taken, this was a significant improvement, within MSEFT, from the previous position reported at the end of Q1.

JKe drew attention to the ICB risk around Independent Sector activity which had experienced a step change of 20% increase on trend in the first quarter which was not seen in the planning rounds. This was being triangulated with overall system performance and NHS acute sector activity. Risk assessed mitigations were being developed for ICB Executive Committee review. The risk would need to be monitored into the next financial year given the potential impact of provider accreditation and choice.

The key risks remained for the Trust around the efficiency programme and for EPUT around observation and capacity.

NHSE were concerned that the underlying position had deteriorated from where anticipated it would be due to the amount of non-recurrent measures across all three organisations this year to stabilise the financial position.

The Financial Recovery Plan was being finalised for formal sign-off imminently with ICS Board ahead of NHSE submission. Governance arrangements continued to be adhered to and strengthened across the system for facilitating systematic decision making.

A significant amount of the efficiency challenge would only be realised by changes in the workforce. JKe agreed to discuss with LA the need to align the workforce plan with the efficiency plan, in order to take this issue to the next Chief People Officer Forum.

–The System Investment Group was due to report to the ICB Finance & Investment Committee (FIC) on the Financial Plan which was currently behind plan.

System Partners had been developing the initial 2023/24 to 2027/28 Medium Term Financial Plan pending formal reporting requirements due from NHSE.

GW advised the ICB must ensure appropriate investment in diagnostic equipment. JKe agreed to discuss the concerns raised with Dawn Scrafield.

JDo acknowledged an improvement in the plan this month but enquired whether enough was being done at pace and if difficult decisions had been taken to affect the bottom line. JKe advised that the workforce conversations and forensic analysis work would contribute to efficiencies. There had been difficult decisions made and proposals put forward, but more was required to address the financial position.

GW suggested it would be helpful during the regional planning round for next year to consider how structural costs could be taken out.

Outcome: The committee noted the M7 Finance Report and verbal update on the M8 financial position.

Action 172: JKe/LA to liaise in order to enable aligning the Workforce and Efficiency plans to be discussed at the CPO Forum.

Action 173: JKe to discuss investment in diagnostic equipment with Dawn Scrafield, MSEFT.

10. Financial Recovery Programme (Presented by P Read)

PR highlighted that the system had submitted a revised forecast position and was currently in discussions with the national team (previously reported a £40m system deficit position). In line with this, the system was required to deliver a 2023/24 system efficiency target of £119.6m.

EPUT had revised their 2023/24 forecast to £19.2m – which left an unidentified gap of £3.6m. The ICB was forecasted to achieve its full target of £26.7m for 2023/24. MSEFT had £27m of total identified schemes to date, with the addition of nonrecurrent releases bringing the total identified to £46m. MSEFT were expected to release a total of circa £25m (£7m more in the next 5 months) of non-recurrent funds into efficiencies with a few schemes also moving to delivery status, bringing the forecast to £52m by year end.

A 12-week plan was in development with 3 stages: identify opportunities; road shows; and targeted events to understand where opportunities existed. The second phase would develop project documentation with mobilisation in the third stage. The plan would be shared with SOAC once finalised.

GW acknowledged the challenge it would be to close off 2023/24 and to plan for 2024/25 at same time, which needed to be adequately resourced and asked PR to advise him if anything was needed in this regard. It was important to communicate to staff that saving money was not about reducing care, as it could enhance patient care when invested in the right areas.

Outcome: The committee noted the Financial Recovery Programme Update.

11. Cancer Harm Review Update (Dr Catherine O'Doherty)

CO'D advised that since 2018/19 acute Trusts were required to undertake harm reviews for patients whose treatment had breached the 62 day target for referral to first treatment.

To release operational and clinical resources to support the cancer diagnostic and treatment backlog recovery, a derogation was approved to allow MSEFT to complete harm reviews only for patients who had received treatment at 104 days (in line with the levels set by NHS England in 2016/17) or after urgent cancer referral. This approach was reviewed regularly with ICS and NHSE Region Quality Leads.

There were 395 cancer harm reviews to be completed by the end of December 2023 with 295 of these overdue; 247 of the total were with the cancer team awaiting timelines and the remainder awaiting clinical review and panel sign off.

There had been 874 harm reviews completed between April 2022 – March 2023 which comprised 100% of cases where treatment was delivered at 104 days or more after urgent referral. For over 96% of patients, no harm was identified. Outcomes were awaited of 2 cases of probable severe harms.

In response to a query from JH, C'OD confirmed that harm reviews followed a national process and included assessment for psychological harm, but agreed that the trust did not know longer term outcomes would be as result of the delays. JH commented that the process would pick up pathway issues and delays and noted some were due to pathology services. C'OD advised there were vacancies within the internal consultant pathology workforce. Recruitment and conversion to digital pathology actions would help as the workforce across the sites will be able to view slides. Prioritisation work within pathology was also being undertaken.

GT confirmed he and C'OD met regularly with the regional team and supported the approach of undertaking harm reviews in patients whose treatment had taken place more than 103 days (ie 104+ days) from urgent cancer referral for treatments delivered between April 2023 and March 2024. This would allow continued release of resource to focus on operational recovery and minimise further delays in treatment while still allowing investigation of, and learning from, pathways that result in delayed cancer treatments.

TD noted the small amount of harm in very long waiting patients, and queried if cancer outcomes could be improved by not undertaking harm reviews and putting resource into accelerating treatment of patients. Given the time constraints of the meeting, TD agreed to discuss this with GT outside of the meeting.

Outcome: The committee noted the Cancer Harm Review Update and agreed with the approach outlined.

Action 174:. TD and GT to discuss Cancer Harm Reviews.

12. This agenda item has been minuted confidentially.

13. Board Assurance Framework and Risks within the remit of SOAC (presented by E Hough)

EH presented the Board Assurance Framework for information, noting that the broader review of risk management and risk registers across the ICB would form part of the Corporate review.

GW commented this would lend itself to a broader piece of work on committee effectiveness and what was being escalated to the appropriate committee and/or the Board. TD agreed that the BAF should reflect what was on each agenda for discussion.

Outcome: The committee noted the SOAC Board Assurance Framework and Risk Report.

14. Escalations (presented by G Wood)

It was agreed the following issues would be escalated to the Chief Executive Forum and/or sovereign boards:

- Lisa Adams – to lead on establishing a 'War Room' to address workforce issues.
- The need to share with SOAC before the end of the year a list of the actions being taking ahead of the NHSE February 2024 Accountability meeting.
- MSEFT (SDu) to ensure cancer staff contracts are changed to permanent.

GW stressed the urgency of addressing the system's finances and advised that assistance from SW or JDo was much appreciated. Matthew Hopkins and Paul Scott should be copied in on actions.

TD commented on the need to look at how SOAC developed, to ensure constructive and supportive challenge across the system.

Outcome: The committee agreed the above issues for escalation to CEF and/or sovereign Boards.

15. Any Other Business

There was no other business discussed.

16. Date of Next Meeting

Wednesday, 10 January 2024 – 1.00 pm to 3.00 pm via MS Teams.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 31 August 2023 at 09.00 am – 11.00 am

Via MS Teams

Members

- Ronan Fenton, Executive Medical Director (RF) (Chair)
- Peter Scolding, Assistant Medical Director (PS) (Deputy Chair)
- Donald McGeachy, Urgent and Emergency Care (DM)
- Babafemi Salako, Primary Care (BS)
- Sarah Zaidi, Primary Care (SZ)
- Fatemah Leedham, Pharmacy (FL)
- Feena Sebastian, Mental Health (FS)
- Robert Spackman, Acute Care (RS)
- Krishna Ramkhelawon, Public Health (KR)
- Rachael Marchant, Primary Care (RM)
- Radha Segal, Senior Clinical Fellow (RS)
- Odutola Olugbenga, Primary Care (OO)

Attendees

- Ruth Harrison, Moorhouse Consulting (RH)
- Helen Chasney, MSE ICB Governance Officer (Minutes)

Apologies

- Gerdalize Du Toit, Community Care (GDT)
- Kirsty O'Callaghan, Director of Community Resilience, Mobilisation and Transformation (KC)
- Matt Sweeting, Interim Medical Director Designate (MS)
- Gbola Otun, Mental Health (GO)
- Stuart Harris, Acute Care (SH)
- Christopher Westall, Acute Care (CW)
- Josė Garcia, Primary Care (JG)

1. Welcome and Apologies

RF welcomed everyone to the meeting and the apologies were noted as listed above. It was confirmed that the meeting was quorate.

2. Declarations of Interest

RF 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.

The following declarations of interest were noted in respect of the community beds item:

- RM as a Director at Havens Hospices.
- FS as the Deputy Managing Director for EPUT community health services in South East.
- SZ as an employee of EPUT.

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress meeting held on 29 June 2023 were reviewed and approved with no amendments requested.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 29 June 2023 were approved.

4. Matters Arising

Community MSK & Pain Service – Report of recommendations

There were no issues declared with regards to the content of the recommendations.

PS advised that the business case was approved, and the implementation team was being established.

RF commented that the implementation of cross system working was a common theme being highlighted recently, which was supported by Congress and the Stewardship Group.

5. Financial Recovery

RF advised that the Congress may become involved with the financial recovery plan due to reviewing and verifying the proposals being brought forward.

PS advised that the system was asked to identify efficiency savings of £120 million this year (£70 million MSEFT, £23 million EPUT and £27million ICB). Full delivery would leave a deficit of £40 million to find by the end of 2024/25. Overall, the system has had an underlying budget deficit, leading to a programme of work to tighten control on the use of resources.

MSEFT, ICB and EPUT have reviewed all the opportunities to find financial efficiencies. The PMO function would coordinate the recovery activity through to delivery and then 5 executive led portfolio groups (Flow, Independence, Workforce, Corporate Efficiencies and Elective Care) would lead the system programmes of work. Details of the process that the opportunities would go through were explained from baseline assessment to delivery and would be assessed against a set of criteria. The central PMO function would support with the development of the peers initiation document (PID). The business case would be required to go through the relevant governance approval processes. A weekly reporting tracker showed how many opportunities were being reviewed, at what stage of the process they were at and the financial element associated with successful delivery. The system PMO function would work closely with the Financial Recovery Plan Working Group. The System Transformation Improvement Group (STIG) would be involved with assessing the

transformation improvement plans and the CEO Forum would provide oversight.

The development of the new investment/disinvestment policy was currently being worked on and would ensure a formal review of each service provision or service closures for improvement in the use of resources.

PS explained that the process could generate direct requests for Congress to advise on the opportunities, however the governance process was still being reviewed and developed.

RF commented that Congress has the maturity to review issues realistically in the context of finances. The group could be asked for a view in any areas of this process and would be beneficial for Congress to consider their approach.

KR commented that the principle was to have a good framework in place as significant savings were required to make an impact on improving local services.

RM requested clarity on the decision making of which opportunities are chosen. This could be an opportunity for Congress to review the opportunities earlier which could improve efficiency.

SZ advised that Congress should be involved at the idea generation stage to spot the efficiency in the synergies or potential areas of duplication, and would ensure system working. KR commented that it would be best for Congress to remain independent and advise on best practice and mitigations.

RF commented that the power of this group could be leveraged further if involved at an earlier stage.

BS raised concern that the Congress would be used to rubber stamp the opportunities and the possibility of conflict could incur further into the process. RF commented that Congress were being asked how they would like to be involved in the process.

FL asked for clarification on the rules of engagement with regards to those who should be engaging. RF asked how Congress could leverage their strengths to optimise the outcome for patients. FL explained that everybody needs to believe and engage in the process.

KR advised that the challenge would be how Congress remained independent, with a clear view looking at our framework, on whether this is the right investment, the impact and if it is the right direction of travel for the organisation. If Congress are involved at the beginning, the independent discussion which happens later in the process could be overshadowed. There would be other opportunities for Congress to suggest alternative ideas to the proposal.

OO stated that if primary care were not involved with the process, the patients would suffer and would be frustrating for the wider system. There was a requirement to understand what was happening and the what the outcome would be. RF commented that the system were aiming to spend within budget. Congress have to execute their governance role within the ICB/ICS and use their wisdom to ensure that the best service could be provided to patients.

SZ commented that service/pathway redesign/new models should involve harnessing all providers, community assets etc. Stewardship principles should apply at every stage.

FS commented that difficult decisions would be made and feeling conflicted would be

inevitable and asked who was providing an overview of the various proposals to prevent overlap. If Congress were to have visibility of the proposals at the start of the process, it would provide a better idea of which proposal would be likely to cause the least harm to patients. RF commented that we would be able to provide a clinical perspective and influence colleagues to take part in the decisions made.

RM commented that a view of the bigger picture was required and not to review the proposals in isolation. RF advised that there should be trust in the checks and balances process in place.

PS referred to the decision making involved and commented that there should be an understanding of the whole pathway, including the impact and need to ensure that it is added into the process, with the utilisation of the stewardship group.

DM commented that was important to note that decisions made could impact on morbidity or level of harm. As clinical and health professionals, there was conflict between the financial target and the duty to stand up for what was right for patient care and safety. RF advised that the group should not be afraid to raise concerns.

SZ commented that in terms of principles, the learning from a simulation held for clinical leads, was that the group should have an intelligent approach and solve the problems that were unique to the system.

6. This item was minuted confidentially.

7. Horizon Scanning

It was noted that the previous 2 items discussed were horizon scanning.

It was noted that a change would be necessary due to finances and resources becoming scarcer and could impact on what could be achieved within the ICS. This group has the power, knowledge and influence that should be used wisely.

8. Any Other Business

PS thanked RF for leading and championing the group over the last 2 years and the group was a different model with front line leaders having an influence role.

RM noted that the groups constitution was a little doctor heavy for a multi professional congress and that the constitution would need reviewing. SZ advised that there would be advantage to have cross pollination from the Stewardship Group. Population Health Management (PHM) leads and stewards would have the mindset that would benefit Congress.

RS advised that this would be his last Congress meeting and welcomed that the group had a clear idea of what they require in the proposals and a balance between support and review is required. It was suggested that Congress could offer generic support at an early stage of the proposals.

9. Date of Next Meeting

Thursday 28th September at 9.00am – 11.00am via MS Teams.

Approved 29 November 2023

Part I ICB Board meeting, 18 January 2024

Agenda Number: 12.5

Decisions made in between meetings.

Summary Report

1. Purpose of Report

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

2. Executive Lead(s)

Tracy Dowling, Interim Chief Executive Officer.
Dr Matt Sweeting, Interim Medical Director for ICB.

3. Report Author

Sara O'Connor, Head of Governance and Risk.

4. Responsible Committees

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

5. Conflicts of Interest

None identified for this report.

6. Recommendation/s

The Board is asked to ratify the decision taken to update the Heavy Menstrual Bleeding Service Restriction Policy to include the choice of myomectomy for fibroids where a woman wishes to preserve her fertility, subject to shared decision making between the women and their specialists.

Approvals Made Between Board Meetings

1. Introduction

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

2. Details of Urgent Decision

Since the last Board meeting held on 16 November 2023, one urgent decision was made as follows:

Heavy Menstrual Bleeding Service Restriction Policy

An urgent decision meeting was held to discuss a proposal to update the Heavy Menstrual Bleeding Service Restriction Policy to include the option for women to opt for myomectomy (a surgical procedure for the treatment of fibroids) which preserved the uterus, thus maintaining their fertility. The treatment was in line with National Institute for Health and Care Excellence (NICE) Guidelines and also had potential benefits for bone health and reducing the risk of cancer.

Myomectomy was also a less expensive procedure and would therefore create potential financial savings.

The decision was deemed urgent as there were several women who indicated they might wish to opt for this procedure.

3. Outcome

Members agreed that including the option of myomectomy within the SRP was a benefit to the relevant patient cohort, with associated potential for financial savings, and the recommendation was therefore approved.

Decisions made under Constitution provisions for making decisions between meetings were discharged as required by the Chair, Interim Chief Executive and a Non-Executive Member of the ICB. This decision will also be noted at the Audit Committee meeting.

4. Recommendation

The Board is asked to ratify the decision taken to update the Heavy Menstrual Bleeding Service Restriction Policy to include the choice of myomectomy for fibroids where a woman wishes to preserve her fertility, subject to shared decision making between the women and their specialists.