Mid and South Essex Integrated Care System

Meeting of the Mid and South Essex Integrated Care Board

NHS Mid and South Essex Integrated Care Board

Thursday, 11 July 2024 at 2.00 pm – 3.30 pm

Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER

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 9 May 2024 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	6
5.	2.13 pm	Review of Action Log	Note	Attached	Prof. M Thorne	14
		Items for Decision / Non-Standing Items				
6.	2.14 pm	Proposed changes to services at local community hospitals: draft consultation outcome reports.	Note	Attached	E Hough P Parsons	15
7.	2.35 pm	MSE ICB Annual Assessment 2024/25	Note	Verbal	Prof. M Thorne T Dowling	-
8.	2.38 pm	Annual Report and Accounts 2023/24	Note	See separate document	Prof. M Thorne	21
9.	2.40 pm	Joint Forward Plan	Approve	Attached	E Hough	22
		Standing Items				
10.	2.45 pm	Chief Executive's Report	Note	Attached	T Dowling	155
11.	2.50 pm	Quality Report	Note	Attached	Dr G Thorpe	166
12.	3.00 pm	Finance & Performance Report	Note	Attached	J Kearton	171
13.	3.10 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty A Mecan R Jarvis	185
14.	3.20 pm	General Governance: 14.1 Board Assurance Framework	Note	Attached	T Dowling	203

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		14.2 Revised Committee Terms of Reference	Approve	Attached	Prof. M Thorne.	220
		14.3 New/Revised Policies	Note	Attached	Prof. M Thorne	244
		14.4 Approved Committee minutes	Note	Attached	Prof. M Thorne	247
		14.5 ICB Corporate Objectives	Ratify	Attached	Prof. M Thorne	315
15.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
16.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 12 September 2024 at 2.00 pm, Spring Lodge Community Centre, Powers Hall End, Witham, Essex, CM8 2HE.	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - July 2024

MID AND SOUTH ESSEX INTEGRATED CARE BOARD MEMBERS (VOTING)											
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	
Kathy	Bonney	Interim 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,
Anna	Davey	ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	On-going	I will declare my interest if at any time issues relevant 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.
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 of Company - provides individual coaching in the NHS, predominantly at NELFT and St Barts	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	Partner is NELFT's Interim Executive Director of Operations for North East London (Board Member).	01/03/19	Ongoing	I will declare my interest as necessary to ensure appropriate arrangements are implemented.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England	x			Indirect	Son (Alfred) employed as Head of Efficiency.	Jan 2023	Ongoing	No conflict of interest is anticipated but will declare my interest as necessary to ensure appropriate arrangements are implemented.
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.
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	Chief Finance Officer	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	Executive Medical Director	Nil								
Mike	Thorne	ICB Chair	Nil								

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - July 2024

MID AND SOUTH ESSEX INTEGRATED CARE BOARD MEMBERS (VOTING)										
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	
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
July 2024

ASSOCIATE NON-EXECUTIVE MEMBERS / ALLIANCE DIRECTORS / EXECUTIVE DIRECTORS AND REGULAR ATTENDEES (NON-VOTING)

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 Foundation 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.
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 Partnerships	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.
Rebecca	Jarvis	Alliance Director (South East Essex)	Nil								
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
Neill	Moloney	Executive Director of System Recovery	Suffolk and North East Essex Integrated Care Board (SNEE ICB)			x	Indirect	Wife is Deputy Director of Strategic Change	Jul-22	Ongoing	Will exclude himself from any discussions regarding SNEE ICB that could benefit his wife.
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	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 9 May 2024 at 2.00 pm – 3.30 pm

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

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tracy Dowling (TD), Interim Chief Executive, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSEICB
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Ian Wake (IW), Partner Member, Thurrock Council.
- Peter Fairley (PF), Partner Member, Essex County Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Neill Moloney (NM), Executive Director of System Recovery, MSE ICB and Mid and South Essex NHS Foundation Trust (MSEFT).
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Philip Richards (PR), Group Finance Officer, deputising for Lucy Wightman, Provide Health.
- Keith Ellis (KR), Deputy Director of Financial Performance, Analytics and Reporting, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.

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

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

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

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

Declarations made by the Integrated Care Board (ICB) Board and committee members were listed in the Register of Interests available on the ICB website and included within the papers for the meeting.

3. Acknowledgement of Petition (presented by Prof. M. Thorne).

MT advised that a petition had been received on behalf of Save Maldon's Medical Services. A named member of the public had started the petition on 7 October 2023, following the introduction of the temporary changes to the midwife led birthing unit and community rehabilitation beds at St Peters Hospital in Maldon.

On behalf of the Board, MT formally acknowledged the receipt of the petition to 'Prevent the closure of St Peter's or ensure investment in a new Maldon medical facility', which consisted of over 7,200 signatures at the time of the meeting.

MT advised that the effort and concern demonstrated by the community was greatly appreciated and recognised, and assurance was provided that the petition, received on Wednesday, 3 April 2024, would be reviewed and incorporated into the ongoing consultation analysis to ensure the voices of the local population would, alongside other evidence, form part of the decision-making business case.

4. 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.

- **Ms X** (name redated to protect confidentiality) – MT advised that due to the personal nature of the question, it had been referred to the Patient Experience Team to provide a private response.

- **Mr Peter Blackman** asked whether it was an oversight that any improvements to mental health services were not included in the Chief Executives Report. TD advised that the

mental health data was unavailable at the time of writing the paper due to the collation and validation process. The performance of our Improving Access to Psychological Therapies (IAPT) Services was generally good, however there was unwarranted variation between the different IAP providers, and the procurement for Talking Therapies should improve consistency and provide better value.

- **Mr John Wallace** asked when the cow's milk protein allergy service would commence. GT gave assurance that interim arrangements for stable babies cared for under the cow's milk allergy pathway had been operating since April 2024 after an existing contract ended. The recruitment of dieticians had been challenging. This meant there would be a phased implementation of the new pathway which should be fully operational by Autumn 2024. Any personal concerns in the interim should be directed to the patient's GP.

5. Minutes of the ICB Board Meeting held 21 March 2024 and matters arising (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 21 March 2024 and asked members if they had any comments or questions.

The minutes had a minor error under agenda item 3 (Questions from the Public), as below:

"TD advised that the system would be extremely challenged with addressing immediate delivery concerns in the next year and that future strategies needing development would be considered through ***2024/25***."

There were no matters arising.

Resolved: The Board approved the minutes of the ICB Board meeting held on 21 March 2024, as an accurate record, subject to the amendment noted above.

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

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

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

7. People Management Strategy (presented by Dr K Bonney)

KB advised that the People Management Strategy was developed in the context of two significant organisational restructures. The NHS Staff Survey results (November 2023) showed that morale and engagement was low in the organisation. However, the results from the recent quarterly People Pulse Survey had showed a slight improvement.

Consequently, the Strategy aimed to improve staff morale, management behaviours, lower sickness rates and encourage a culture of openness, making the ICB a place where our staff would recommend others to work. KB noted that the Strategy had been supported by the Executive Committee and Remuneration Committee.

EH noted that the pay reward and recognition element was pay focused and suggested the inclusion of other non-pay rewards for recognition.

TD was pleased to see the approach to Talent Management.

JF supported the comments made and was pleased with the inclusion of the promotion of excellent people management.

GO suggested that there could be more focus on retention.

Resolved: The Board approved the People Management Strategy, subject to the comments made above.

8. Chief Executive's Report (presented by T Dowling)

TD advised that the report provided an update on key issues, progress and priorities since the Board meeting held on 21 March 2024 and detailed the decisions taken at the weekly Executive Committee meetings. The following key updates were noted:

The Executive Chief Nurse, Mid Essex Alliance Director and Chief Executive visited the Wethersfield asylum accommodation centre, with a focus on health and wellbeing support, and were impressed with the efforts taken to support reasonable adjustments and how flexible the staff were to support the health and wellbeing of people seeking asylum.

TD had attended the Spring Stewardship Summit meeting and paid tribute to the work of the clinically led stewardship groups, to deliver better outcomes for patients.

The community services consultation closed on 11 April 2024, with over 5,000 responses received, including those via Members of Parliament (MPs) and a petition, received at the Board. Responses were being analysed and considered. The Decision-Making Business Case (DMBC) would then be drafted on the three areas consulted upon. The DMBC was planned for submission to the July Board meeting, however, due to the breadth of responses received, the date could be extended to enable meaningful analysis of the feedback. There was also a requirement to ensure that the assessment and costings of the options were up-to-date and complete.

The results from the staff survey had been analysed and a six-month organisational development plan had been drafted, alongside the People Management Strategy.

Performance improvements were noted, and tribute was paid to clinical and managerial staff who had addressed the backlogs following the impact of COVID, however work was ongoing to make access equitable and reduce the number of people waiting for care.

PF asked that the Health Oversight and Scrutiny Committees were kept updated and engaged on information relating to the community services consultation and asked for the stewardship presentation to be shared with the ICB Board and the Essex Health and Wellbeing Board.

MT was pleased that there were slight improvements following the People Pulse Survey and confirmed the ICB must ensure people were supported throughout their career.

Resolved: The Board noted the Chief Executives Report.

Action: MS to share the Stewardship presentation with the ICB Board and the Essex Health and Wellbeing Board.

9. Quality Report (presented by Dr G Thorpe)

GT presented the quality report and highlighted the following key patient safety and quality issues:

The System Quality Group had an ongoing focus on neonatal mortality via the Local Maternity and Neonatal Safety Board (LMNSB). A deeper understanding of different ethnic and cultural groups' impressions of accessing maternity services was required and work was underway with the Maternity and Neonatal Voices Partnership to engage with these communities.

A general practice which was undergoing enhanced scrutiny had been de-escalated to standard oversight following a joint visit by the Care Quality Commission (CQC) and the ICB Quality team who had raised no immediate safety concerns.

A business case for a specialist eating disorder service was being submitted to the East of England Provider Collaborative to develop virtual centres and day centres for children and young people (CYP) to minimise admissions into hospital.

Quality Committee undertook a deep dive on catheter care in primary, secondary and specialist services and focused on actions required to promote continence and reduce use of urinary catheters, which was shared with other ICBs by the regional team.

A local memorandum of understanding was being considered across the Safeguarding Partnership Boards and within health providers to address the impact of 'Right Care Right Person' guidance. This would address the concerns regarding the impact on CYP.

As a result of the new 'Working Together' guidance statutory responsibilities as lead safeguarding partners sits with ICB Chief Executive Officers, local authorities, and the Chief Constable. Work was underway to enact the recommendations of the guidance across the three local authority areas.

A direction had been received from the Regional Quality Group for systems to have clear oversight of the Special Educational Needs and Disabilities agenda. Within mid and south Essex (MSE), the Southend inspection had concluded with an associated action plan in place. Both Essex and Thurrock are in preparation for future inspections.

In relation to Medicines Management, significant conversations were being held on the reduction of opioid medication use which had the potential for addiction. Alliance Directors would support progression of this, along with third sector partners, to enable people to stop using opioids in the long term.

The Quality Committee considered a report from EPUT on the findings of an Independent Review into the care and treatment provided by Greater Manchester NHS Foundation Trust. Several factors had enabled poor care and consideration was being given to the findings to identify any lessons to be learnt across the MSE system.
GT advised that EPUT undertook an analysis and benchmarked themselves against the key findings. The system Quality Together meeting focused on independent reviews, CQC findings and recommendations. A further update would be provided in a future quality report. TD suggested that North East London NHS Foundation Trust (NELFT) should also be included.

JF sought clarification on capacity to undertake domestic homicide reviews (DHRs). GT advised that the quality assurance process of DHR reports was changing, placing a greater level of responsibility on ICBs, particularly safeguarding teams. A second designated nurse was required to undertake an independent review of health-related recommendations, which

would increase input from the teams. Chief Nurses across the East of England had met with the national safeguarding team and assurance had been provided that the operational impact and capacity issues were recognised and would be escalated to the Home Office, if required. TD raised a concern regarding continence services and queried whether there was sufficient innovation. GT advised conversations were being held with providers on how catheter care could be considered, in the wider context, as harm free care. Clinicians would focus on early removal of catheters and support continence, which would be an area of focus for the system's Harm Free Group. AD advised that a care home had trialled the provision of decaffeinated drinks for their residents which had reduced the number of patient falls due to less urgency to visit the toilet.

In response to queries from GO, GT confirmed that resources in maternity and neonatal services was a national priority, and the system was working closely with MSEFT to ensure that quality was maximised where possible. There were two community ethnic minority leads on the Maternity and Neonatal Voices partnership, who were actively reaching out to smaller communities, to ensure a greater understanding of issues and barriers. MH advised that the MSEFT Board were focused on improving maternity services across the three sites, with service users' experience being a priority.

Resolved: The Board noted the Quality Report.

Action: GT to include an update on the benchmarking analysis for the Greater Manchester review for EPUT and NELFT in a future Quality Report to Board.

10. Primary Care and Alliance Report (presented by P Green, D Doherty, R Jarvis, A Mecan)

PG advised that the report was on behalf of the four Alliances and the Primary Care team. The following key points were highlighted:

Significant progress had been made with the development of Integrated Neighbourhood Teams (INTs), with a further six being mobilised. There had been no further pharmacy closures and the dentistry programme continued to improve with increased units of dental activity.

For GPs, significant work had been undertaken following the introduction of the modern general practice model and several practices had moved onto the triage programme as part of that implementation.

Better Care Fund (BCF) guidance had been published and good practice would be shared across all geographies. A review of the guidance was being held with regard to future applications of the BCF.

RJ advised that the four Alliances were beginning to think about how financial recovery and performance could be strengthened.

AM advised that the Thurrock Alliance had rolled out the Early Years Oral Health programme and supported improvements in dementia and Learning Disability Health Check rates.

AD advised that the Primary Care Collaborative was being progressed in partnership with the Local Medical Committees with support from over 80% of PCNs. The collaborative was seeking learning from similar groups across the country.

JF asked if all GP practices would be signed up to Cloud Computing and if there was any resolution on the British Medical Association (BMA) contract dispute. AD advised that there was no resolution yet, however there had been no indication to date of industrial action as most GPs would prefer to negotiate. However, there would be a struggle in general practice to meet the pay awards required. Several staff were on minimum wage, which had been significantly uplifted, and impacted on practices costs.

BF confirmed that there had been good uptake of the Cloud Computing programme which was on track for 50-55 practices, with half of those signed up, and would continue to be rolled out.

GO referred to the INTs and the Local Enhanced Service (LES) for cardiovascular disease (CVD) and asked what determined the distribution of activities. RJ advised that patients already engaged in general practice through the LES approach was optimised and it was equally important to work with local authorities regarding preventative measures, such as weight and smoking. EH confirmed that the service was funded from health inequalities funding and PCNs with the greatest deprivation were initially approached, followed by other PCNs depending on deprivation levels. Digital tools were being utilised with GPs to understand which patients needed support from identification of CVD and how support could be provided through the secondary prevention approach. MS confirmed that the Cardiovascular Programme Board was being resumed and would be reviewing the whole programme, focusing on secondary prevention. The latest figures for diagnosis rates showed that MSE was the most improved in the East of England and was supported by stewardship and local delivery.

Resolved: The Board noted the Primary Care and Alliance Report.

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

11.1 ICB Board Risk Appetite

MT referred members to the ICB Board Risk Appetite for approval, following Board interaction at a recent seminar.

No questions or comments were raised.

Resolved: The Board:

- **Approved the ICB's Risk Appetite Statement and noted that the statement would be incorporated within the ICBs Risk Management Policy.**
- **Noted the intention to review the Risk Appetite statement at least every six months, or sooner should the environment in which the ICB operates neccessitate this.**

11.2 Amendments to ICB Constitution

MT advised that the proposed changes to the ICB Constitution were required to mirror the requirements of NHSE and did not alter the fundamental principles of ICB Governance.

No questions or comments were raised.

Resolved: The Board approved the amendments to its constitution for submission to NHS England.

11.3 Board Assurance Framework

MT referred members to the Board Assurance Framework, noting that it highlighted the strategic risks of the ICB that had largely been discussed throughout the meeting.

No questions or comments were raised.

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

11.4 Revised Policies

The Board noted the following revised policies that had been approved by the relevant Committees:

- Stress Management Policy
- Maternity Adoption and Paternity Policy
- Special Leave Policy
- Organisational Change Policy
- Social Media Policy
- Lone Working Policy
- Information Governance Management and Framework Policy
- Absence Management Policy
- Flexible Working Policy
- Shared Parental Leave Policy
- Media Policy
- Standards of Business Conduct Policy
- Healty & Safety Policy

Resolved: The Board noted and adopted the set of revised policies and the additional revised Information Governance Management and Framework Policy (Ref 010).

11.5 Approved Committee Minutes.

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

- Audit Committee (AC), 16 January 2024.
- Clinical and Multi-professional Congress (CliMPC), 28 February 2024.
- Finance and Investment Committee (FIC), 21 February 2024, 14 March 2024 and 11 April 2024.
- Primary Care Commissioning Committee (PCCC), 29 February 2024.
- Quality Committee (QC), 23 February 2024.

Resolved: The Board noted the latest approved committee minutes.

12. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

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

Thursday, 11 July 2024 at 2.00 pm, in Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER.

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	30/08/2024	Verbal update to be provided at July Board meeting.	In progress
45	18/01/2024	12.3	**Board Assurance Framework:** Revisit the Cyber Security Risk to decide whether to include in future iteration of Board Assurance Framework.	N Adams S O'Connor	30/07/2024	A revised risk hierarchy and associated criteria is being developed and will be shared with Executives and the wider Board shortly, following which a decision will be made on which risks will be included within the Board Assurance Framework.	In progress
46	21/03/2024	10	**Quality Report:** Provide a report to a future Board meeting on a SEND deep dive which would initially be presented to Quality Committee	G Thorpe	11/07/2024	A SEND deep dive took place at Quality Committee on 28/06/24.	Complete
47	21/03/2024	12	**Primary Care and Alliance Report** A report on primary care estate to be presented to Board outlining estates issues that need to be addressed.	P Green	30/08/2024	Deferred to September Board meeting.	In progress
48	09/05/2024	8	**Chief Executives Report** Share the Stewardship workshop presentation with the ICB Board and Essex HWB	M Sweeting	11/07/2024	05/06: Stewardship presentation has been shared.	Complete
49	09/05/2024	9	**Quality Report** Provide an update on the benchmarking analysis for the Greater Manchester Review for EPUT and NELFT in a future Quality Report to Board.	G Thorpe	12/09/2024	Completion not yet due - scheduled for September Board meeting.	In progress

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 6

Community hospital proposals: draft public consultation outcome reports

Summary Report

1. Purpose of Report

To provide the Board with an overview of the draft consultation outcome reports, developed and presented by Stand, the organisation that supported the consultation process and completed the independent analysis of responses.

2. Executive Lead

Emily Hough, Executive Director of Strategy and Corporate Services

3. Report Author

Claire Hankey, Director of Communications and Partnerships

4. Responsible Committees

The draft Consultation Response Report and the Consultation Hearing Report are also being shared with the Community Capacity Programme Board for considering in developing the final Business Cases for any service reconfigurations.

5. Impact Assessments

An Integrated Impact Assessment (IIA) of the potential changes was developed as part of the Pre-Consultation Business Case. The IIA will be reviewed and updated as part of decision-making business case development, this process will take account of the insights contained within the Consultation Response Reports.

6. Financial Implications

Not applicable to this report

7. Details of patient or public engagement or consultation

A formal consultation process on the potential changes was carried out with patients, family members, carers, user groups, voluntary sector representatives, and public representatives between January 2024 and April 2024.

8. Conflicts of Interest

None identified

9. Recommendation(s)

The Board is asked to:

1. Receive the draft outcome of consultation report and review its findings.
2. Receive the draft consultation hearing report and review its findings.
3. Acknowledge that members of public who took part in the consultation process have until 31 July 2024 to feedback to Stand on the contents of the outcome report.
4. Ensure conscientious consideration is given to the insight and evidence captured in both reports in the development and refinement of options for future decision-making.

Community hospital proposals: draft public consultation outcome reports

1. Introduction

Formal consultation is intended to help NHS organisations make decisions to secure the best possible services that meet the needs of local patients and represent the best possible value for money. The consultation on potential changes to community hospital services, including intermediate care and stroke rehabilitation services, the permanent location of the midwife-led birthing unit, and the relocation of services from St Peter's Hospital, Maldon, was initiated to gather insights from stakeholders, patients and the public on options developed and set out in a pre-consultation business case. The consultation took place between January 2024 and April 2024.

The consultation feedback report, written by Stand an expert independent consultation agency, analyses feedback received via the consultation process. A factual report on the consultation hearing held on 19 March 2024 in Maldon has also been compiled independently by Stand. Both will be made available on the MSE Virtual Views engagement website from 10 July 2024.

The draft reports provide the Board with a clear analysis of the feedback given by a range of stakeholders throughout the consultation process. The Board is expected to consider these responses in the development of the decision-making business case.

Consultation Scope:

- Changes to community hospital intermediate care and stroke rehabilitation services.
- Proposal to make Braintree the permanent location of the midwife-led birthing unit.
- Potential relocation of services from St Peter's Hospital to other locations in and around the Maldon district.

Consultation Process

The consultation ran from 25 January 2024 to 11 April 2024 and involved a variety of resources published to inform and engage the public, including consultation documents, videos, and Frequently Asked Questions (FAQs). Engagement methods included public meetings, surveys, focus groups and written submissions. Materials were widely distributed and made available in multiple formats to ensure accessibility.

Reach and Response

The consultation received 5,544 survey responses, numerous public event attendances and significant social media engagement. This included extensive publicity and promotion efforts, with social media posts seen by users 122,000 times and over 1,000 engagements. Information on the consultation website was viewed more than 20,000 times.

2. Main content of the report

The public consultation ran from 25 January 2024 to 11 April 2024. Draft reports on the outcome of the consultation were due to be published early in June. However, following the announcement of the general election and the start of the pre-election period, the ICB, as an NHS body, is restricted in its ability to publish the report until a new government has been formed. The draft report will be available on the MSE Virtual Views engagement website from 10 July 2024.

Local people will have until Wednesday, 31 July 2024 to provide comments on the draft feedback via Stand using the email NHSConsultation@WeAreStand.co.uk. This opportunity to comment on the accuracy of the report is to ensure that the report captures all feedback received during the consultation.

Published alongside the full consultation feedback report is the draft report of the public consultation hearing. The public consultation hearing was a special event where groups or individuals presented directly to NHS leaders on the issues they thought were important.

This presents the first opportunity for the Board to consider the findings in both reports.

3. Findings/Conclusion

Summary of findings

The opportunity to discuss the issues and challenges facing the heath and care system in mid and south Essex is welcomed, as is the willingness of the community to seek greater understanding and become more informed in the development of options for the future configuration of services. The draft report sets out in detail the responses and feedback received via the consultation process.

A summary is provided below on the main themes emerging from each of the three service areas:

Stroke Rehabilitation and Intermediate Care Services

Proposals: Two options were presented for arranging intermediate care and stroke rehabilitation beds at community hospitals:

Option A: A single 50-bed stroke rehabilitation unit at Brentwood Community Hospital, with 22 intermediate care beds at Cumberlege Intermediate Care Centre in Rochford.

Option B: A 25-bed stroke rehabilitation unit and 25 intermediate care beds at Brentwood Community Hospital, and a 22-bed stroke rehabilitation unit at Cumberlege Intermediate Care Centre.

Feedback from consultation responses: Significant objection to both options, with concerns about increased travel and the loss of local services. The majority

rated both options poorly, however, there was a preference for Option B among respondents, particularly from Brentwood and Southend-on-Sea.

1. **Midwife-led Birthing Unit**

   Proposal: To make the William Julien Courtauld Unit in Braintree the permanent home for the midwife-led birthing unit.

   Feedback from consultation responses: High objection rates, particularly from Maldon, Chelmsford, and Braintree, due concerns around increased travel, access difficulties and the burden on existing hospital services at Broomfield.

2. **Principle of relocating other services at St Peter's Hospital**

   Proposal: Relocation of services from St Peter's Hospital to other locations in and around the Maldon area, with suggestions sought for potential sites.

   Feedback from consultation responses: Strong opposition to moving services from St Peter's Hospital, with concerns about the impact on local access and service provision.

   Concerns: Major concerns from those who responded were travel, access, and the impact on vulnerable populations.

   Preferences: There was a strong preference from those who responded for retaining and investing in local services in the district.

   Suggestions: Stakeholders suggested alternative solutions, including the refurbishment or rebuilding of St Peter's Hospital, utilising office and retail premises in the town.

Conclusion:

The outcome of the public consultation is an important factor in decision-making that needs to be fully considered. It is, however, one of several important factors which will guide the final decision. The Board will need to fully review the findings of the outcome report as part of its decision-making process alongside evidence and reports that review clinical, financial and practical considerations in reaching its final decision.

4. Recommendations

1. Receive the draft outcome of consultation report and review its findings.
2. Receive the draft consultation hearing report and review its findings.
3. Acknowledge that members of the public who took part in the consultation process. have until 31 July 2024 to give feedback to Stand on the contents of the outcome report.
4. Ensure conscientious consideration is given to the insight and evidence captured in both reports in the development and refinement of options for future decision-making.

5. Appendices

Appendix A – Draft outcome of consultation report

Appendix B – Draft consultation hearing report

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 8

Mid and South Essex Integrated Care Board Annual Report and Accounts 2023/24

Summary Report

1. Purpose of Report

To provide the Board with a copy of the final version of the ICB's Annual Report and Accounts 2023/24, which received a clean audit opinion and were approved by the Audit Committee prior to submission to NHS England. The Annual Report and Accounts will be formally submitted to the ICB's Annual General Meeting on 12 September 2024.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director Corporate Services

4. Responsible Committees

Audit Committee approved the Annual Report and Accounts prior to submission to NHS England in accordance with authority delegated to the committee.

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

As set out in the Annual Report and Accounts 2023/24.

7. Details of patient or public engagement or consultation

The Annual Report includes information regarding public engagement or consultation undertaken during 2023/24.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to note the final version of the ICB's Annual Report and Accounts 2023/24, which is provided as a separate document and is available on the ICB's website.

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 9

Updated MSE Joint Forward Plan for 2024-2029

Summary Report

1. Purpose of Report

To seek Board approval for the publication of the updated version of the Mid and South Essex Integrated Care Board Joint Forward Plan (JFP) for 2024-2029. The Board approved publication of sections one and two of the Joint Forward Plan in March 2024. These sections have been updated following feedback from NHS England (Appendix 1). An additional Section three (Appendix 2) has also been added to provide more detail of how MSE ICB will deliver on the commitment in the JFP in 2024/25 and beyond.

2. Executive Lead

Emily Hough, Executive Director, Strategy and Corporate Services

3. Report Author

Emily Hough, Executive Director, Strategy and Corporate Services

4. Responsible Committees

The full JFP was shared with and supported by the Executive Committee, 25 June 2024.

5. Impact Assessments

No specific impact assessment has been completed on the JFP. However, individual projects and programmes within the JFP are expected to complete relevant impact assessments as they are implemented.

6. Financial Implications

There are no financial implications to note in relation to the JFP. The JFP aligns with the operational plan for 2024/25.

7. Details of patient or public engagement or consultation

This JFP is an update of the 2023-2028 JFP, which was developed in partnership with system partners. Section three of the JFP highlights areas where we have continued to engage patients and the public against each key are of delivery.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to note the updated MSE JFP for 2024-2029 and support publication of this version on the ICB's website.

Mid and South Essex Integrated Care System

NHS Mid and South Essex

Appendix 1

NHS Mid and South Essex

Joint Forward Plan Refresh 2024-2029

Contents

About this Document

This document provides a refresh of Mid and South Essex Integrated Care Board's (MSE ICB) Joint Forward Plan for 2024-29. It recommits the NHS system in MSE to the strategic ambitions set out in the 2023-28 Joint Forward Plan, which were developed in partnership with local stakeholders and approved by the Essex, Southend and Thurrock Health and Wellbeing Boards in June 2023 and by the ICB Board in May 2023.

MSE ICB is a system that is currently facing significant financial challenges. During 2023/24 the system planned to deliver a £40m deficit. Having faced significant financial challenges in year driven by workforce, performance and quality challenges the system revised its forecast in year having been unable to meet the planned figures. The final position for MSE at the end of 24/25 was a £57m deficit. This financial challenge is continuing into 2024/25 and beyond.

The ICB's immediate focus is on recovering a sustainable financial position, delivering on national operational requirements and maintaining a focus on addressing health inequalities as we do those. The details of how this will be delivered in 2024/25 have been developed through the system's Operational Plan, with information on our 2024/25 provided in an updated section of this Joint Forward Plan.

The final 2024-29 Joint Forward Plan for MSE ICB includes:

1. A reminder of the strategic ambitions the system has committed to
2. A summary of some of the commitments the ICB delivered on in 2023/24
3. A summary of what the ICB will deliver in 2024/25 and beyond

Foreword from our Chair

I am delighted to present the Mid and South Essex Integrated Care System Joint Forward Plan for 2024-2029. This refreshed Joint Forward Plan reiterates the ICB's commitment to the strategic ambitions developed in collaboration with our partner organisations last year. These ambitions are the foundations for how we will continue to develop and improve our services to better meet the needs of our population and communities. We can only do this successfully by building on our existing joint work with local government and by listening to staff, residents and communities to deliver change.

As is the case for many Integrated Care Systems, we face several significant challenges. The Covid pandemic exacerbated health inequalities in our population and our primary care services are under extreme pressure. Demands on our mental health, urgent and emergency services are significant, there are long waits for planned treatments, and national standards for cancer care are not being met. Our provider organisations have significant staff vacancies and are over-reliant on bank and agency staff to fill rotas. Consequently, the quality of care offered can sometimes be adversely affected.

MSE is a system with high ambitions to improve the health and wellbeing of its residents. During 2023/24 we have delivered a range of impressive and long-lasting improvements.

In addition to recommitting to our strategic ambitions, this revised plan highlights the progress made in 2023/24, for example the Anchor Programme, virtual hospital, Stewardship and innovations such as Teledermatology, and the Happy Hubs and wellbeing cafes that provide one-stop wellness venues within our community.

In December 2023, primary care delivered over 7% more consultations than in the same period the year before. This is being supported by new roles, technology and self-referral pathways to help residents access the best care to meet their needs.

The ICB is committed to working in partnership across health, local government and our communities to do all that it can to improve access to services and outcomes for our population. Our system's strategic ambitions and plans for this year are set out in this Joint Forward Plan.

Professor Michael Thorne CBE

Chair
NHS Mid and South Essex Integrated Care Board

Section 1: Strategic Ambitions

Introduction

Mid and South Essex Integrated Care Board (MSE ICB) oversees the NHS budget for the 1.2 million people that live and work in mid and south Essex. In 2024/25 that budget is £2.7 billion. The ICB is responsible for developing a plan for how to invest and spend this money to deliver care and support services that will help improve people's health, deliver high quality care that meets their needs and that offers value for money.

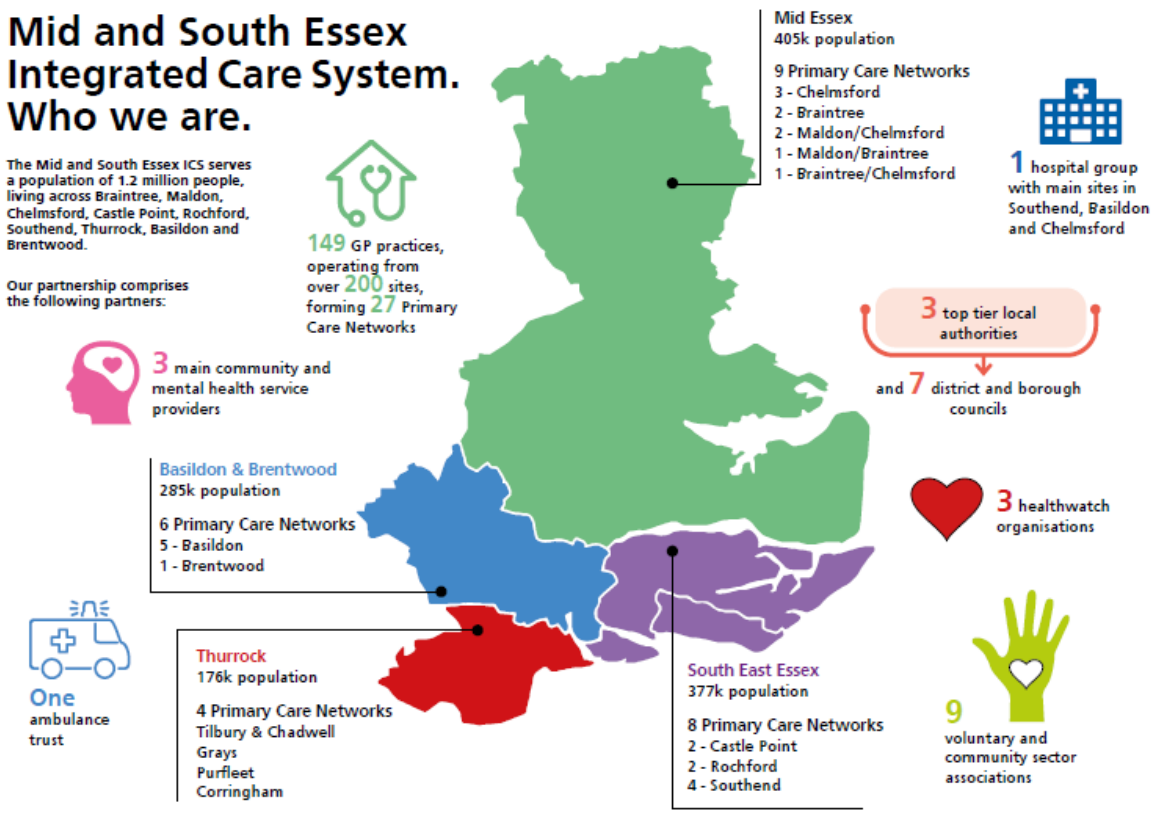
Figure 1 shows the shape of our partnership across MSE, which includes 142 GP practices working across 27 Primary Care Networks, three community and mental health providers, one acute hospital trust working across three large hospitals, one ambulance trust, three upper tier local authorities and seven district and borough councils, three Healthwatch organisations and many community, voluntary, faith and social enterprise sector organisations.

Throughout 2023/24 the financial and operational context across the NHS in MSE has remained challenging, with the system facing increasing financial challenges as it aims to deliver sustainable services that meet the needs of local residents. At the end of 2023/24 MSE reported a system-wide deficit of £57 million and is currently working within a 'triple' lock, with any unplanned expenditure or requests over £25,000 being scrutinised by NHS England, as well as the ICB.

Despite this, the ICB remains committed to being a health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident supported to make informed choices in a strengthened health and care system. We want people to live longer, healthy lives, to be able to access the best of care and to experience the best clinical outcomes, and for us to be able to attract good people to work with us, recognising we offer meaningful careers.

This Joint Forward Plan recommits the ICB to the strategic ambitions that were developed by the system in 2023 to align with the Mid and South Essex Integrated Care Partnership (ICP) Strategy. These ambitions are supported by the delivery plans set out in section 3 of the Joint Forward Plan, which outline how we will deliver on our ambitions in 2024/25 and beyond.

Figure 1: Mid and South Essex Integrated Care Partnership



Our Strategic Ambitions

In 2023, the ICB committed to twelve strategic ambitions for our health and care system. These strategic ambitions inform the system's operational planning and delivery, ensuring that the ICB can deliver on its statutory duties and maintains a focus on the Triple aim of improving the health of our local population, improving the quality of services we provide and improving the efficiency and sustainability of local services. The ambitions also support the four key aims of Integrated Care Systems to:

- Improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience and access;
- Enhance productivity and value for money; and
- Supporting broader social and economic development.

For the 2024-2029 Joint Forward Plan, the ICB's strategic ambitions have been grouped under three headings that reflect areas of focus across the ICB:

1. **Partnership:** These ambitions focus on how we work together to develop and deliver our plans and provide collective assurance on the quality and value that services offer to local residents.
2. **Delivery:** These ambitions focus on operational delivery to drive improved quality of care for patients, adjusting how we deliver to address health inequalities and look at upstream delivery to improve the health outcomes across our populations.
3. **Enablers:** These ambitions focus on the critical enablers in our system that are needed to support successful delivery and effective partnership working to improve care outcomes. Those include our workforce, data, digital and technology, financial sustainability and research and innovation.

Partnership	Delivery	Enablers
Let staff lead	Improve quality (access, experience and outcomes)	Supporting our workforce
Mobilising and supporting communities	Reduce health inequalities	Data, digital, technology
Further developing our system	Population health improvement	Financial sustainability
Improve oversight framework rating	Operational delivery	Research and Innovation

In May 2024 the ICB Board agreed a set of Strategic Priorities that provide focus for how the ICB will deliver on the Strategic Ambitions. These Corporate Objectives are:

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
3. To improve standards of operational delivery, supported by collaborative system working to deliver patient centred care in the right place that the right time and at the right cost to the NHS.
4. To develop and support our workforce through compassionate leadership and inclusion, achieving significant improved by March 2026.
5. To develop effective oversight and assurance of healthcare service delivery across mid and south Essex, ensuing compliance with statutory and regulatory requirements.
6. To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
7. To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

Central to these priorities is the need to recover our financial position. The development of a system-wide recovery programme has been a key priority for 2024/25. This work, led by the Director of System Recovery, provides a structured approach to overseeing both organisational and system level recovery projects and programmes. The governance that oversees this work, and how it feeds into the ICB's overall governance, are set out at the start of Section 3 of the Joint Forward Plan.

Looking more broadly across mid and south Essex, in March 2024 the Integrated Care Partnership agreed a set of joint priorities to focus on in 2024. These priorities focus on wider determinants of health and focus on areas where there is value in partners coming together to improve services for the local population. Between January and March 2024 an initial set of priorities was identified by drawing on priorities in the three local Health and Wellbeing Strategies and local health priorities. This initial 'long list' was tested with community partners through the Community Assembly, with an updated list proposed back to the ICP Delivery Group that was overseeing the work. This led to an agreed set of five priorities for a 'Healthy MSE' were developed across the partnership through a Steering Group which drew on priorities identified from the three local Health and Wellbeing Strategies, as well as the local health priorities.

The five priorities for a Healthy MSE, which are reporting into the Integrated Care Partnership, are:

- Developing a system-wide strategy to support those born and living in MSE to have the **best start in life** with access to education, housing and health
- System-wide approach to supporting people to **live healthy lives** through diet and physical activity, with support and treatment available where needed
- Working together to support people living in MSE to have healthy hearts, including support for **adults living with a CVD as a Long Term Condition,** so that we have the best outcomes in the East of England
- System wide support for **people living with mental health conditions**, providing the right care at the right time, so they can live healthy, productive lives
- Partnership working to understand and address housing and homelessness issues across MSE to help people **live healthy lives**

Partnership

1. Let Staff Lead

Our workforce are our biggest investment and our greatest asset. An engaged and empowered workforce is more likely to deliver high quality care and support the transformation that is needed in our system.

The 'Stewardship' programme in MSE is putting clinical and operational leaders at the centre of work to drive the transformational change that is needed in our system. Stewardship offers staff the chance to receive training and development that will help them engage with data, information and evidence to help them identify and address challenges in the services they are working in. Our stewards also ensure that we have access to the expert advice that we need to inform the development of clinical and operational pathways to support the ongoing improvement of care.

We are supporting our Stewards to lead clinical change through regular leadership and development opportunities, including our Summits. As the programme evolves, we will be bringing the Stewards closer to our overall Financial Recovery programme and considering how they can help us drive improved productivity alongside improved outcomes and experience for patients.

Alongside our Stewardship programme, we are reviewing our System Clinical Leadership to ensure resource efficiency, system value and a focus on quality improvement. This work is being supported by the Clinical Leadership and Innovation Directorate and is underpinned by the national principles that will see clinical leaders better connected, developed and supported in our system. Our clinical leadership development programme 'Leading Better Together' will support those stepping up to lead in our system.

Staff are often best placed to identify opportunities to improve our services. The ICB is committed to developing a model for Quality Improvement that will help equip and support staff to speak up and step up in suggesting ways that they can improve the quality and value of care offered to patients. As the ICB has re-ignited its Greener NHS programme, we have sought Green Champions within our organisation to join those who have already come forward in other organisations. These champions are invited to join others across the system in the MSE Sustainability Forum to share ideas and insights and help lead action to support the system to deliver on its Net Zero ambitions.

2. Mobilising and supporting our communities

It is important to acknowledge the breadth of assets that exist across our communities in MSE. We recognise that there is more that we can do to work with communities to acknowledge, draw on and support those assets to support local residents. This is central to the work we are undertaking in our Alliances, including the development of local Integrated Neighbourhood Teams.

We are committed to continuing to listen to and work with individuals, groups and communities to ensure that we both understand local challenges and develop asset-based responses to local need. MSE Virtual Views has been established as an online community for local people to share their views, experiences and ideals about local health and care services. In addition, we will continue to develop our approach for engaging our people and communities through our placed-based Alliances and the development of our Community Assembly.

3. Further developing our system

The ICB is continuing to develop as both as organisation and as a system. Investing in our collective development and partnership working is critical to enabling our success as an integrated care system. As we continue to mature as a system, we will continue to support and develop our leaders as individuals and our teams so that they are equipped to help lead effective decision making and delivery across our system.

We are continuing to strengthen our partnership working with local authorities across mid and south Essex at all levels, including our district and borough councils. We recognise the importance of collaborating in how we plan and deliver health and care services for the benefit of local residents, and the ICB and ICP continue to align with and support the priorities identified by the three upper tier Health and Wellbeing Boards and our local placed-based partnerships, our Alliances.

A core part of our system development is our place-based Alliances. We will continue to develop and mature these partnerships so that they can better understand the needs of local communities and support delivery of integrated services that support improve population health outcomes, quality of care, experience and value. Alliances will develop delivery plans around shared local outcomes that contribute to our priorities as an ICB and ICP. They will use an asset-based approach to community development to drive transformation and focus on the wider determinants of health to improve health outcomes, particularly through the vehicle of integrated neighbourhood working. As Alliances continue to mature and develop, they will look for opportunities to make best use of the collective resource to deliver sustainable change.

The ICB is now responsible for commissioning all primary care services, including community pharmacy, optometry and dental services. This provides us with a further opportunity to strengthen primary care services in our system and consider new ways of delivering care and treatment to meet local need. MSE is one of the first systems in the country to receive delegated responsibility for commissioning specialised services. We are excited about the opportunity this provides us to review how we commission services to best meet the needs of our local population.

The ICB is also supporting the development with providers and provider collaboratives across our system, including:

- The **Primary Care Collaborative** for mid and south Essex, including a focus on supporting the sustainability of general practice and implementing the recommendations from the Fuller review.
- The **Community Collaborative**, which brings together Essex Partnership NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NEFLT) and Provide Community Interest Company (CIC).
- The **NHS Specialist Mental Health, Learning Disability and Autism Provider Collaborative** across East of England.
- **Mid and South Essex NHS Foundation Trust** (MSEFT) to reduce variation and increase the quality and value of care offered across its acute and community hospitals.

The NHS in MSE remains committed to being an anchor in our community. With a budget of over £2 billion and a workforce of over 23,000 we are a huge contributor to our local economy. Through the MSE Anchor programme the ICB continues to explore ways that we can contribute to wider social and economic development through:

- **Our workforce:** helping local people to gain jobs in the NHS through the Anchor Ambition programme, anchor youth programme, apprenticeships and then ongoing career development. We will also continue to focus on the wellbeing of our workforce and their families as potential users of our health and care services.
- **Our purchasing:** the NHS is committed to ensuring social value remains an important consideration in our procurements. This includes including requirements around ethical and labour standards, including net zero and modern slavery requirements, in all our procurements and contracts.
- **Our buildings and spaces:** we are currently developing our infrastructure strategy, which will consider how we can make better use of the buildings, spaces and assets we have across MSE to better serve our patients and the wider community.
- **Our environmental impact:** MSE has established and new Greener NHS Programme Board to oversee system progress in supporting our Net Zero ambitions. This Board will support the refresh of the MSE Greener NHS plan for the system to ensure that we are taking appropriate action to reduce NHS emissions, including reducing carbon and air pollutants. The plan will also consider what adaptations health and care services will need to take to respond to the challenges climate change is presenting today and in the future.
- **Our partnerships:** we remain committed to working with and learning from others, both in our communities and beyond. We want to be a learning

system, working to make best use of the assets and resource that we have access to so that we can best serve the people living in MSE.

4. **Improving our NHS oversight framework rating**

The NHS oversight framework looks at how local NHS partners are aligning with wider system partners and aims to identify areas where systems might require additional support.

MSE ICB remains committed to improving its oversight framework ratings, recognising that this is a system facing significant financial and quality challenges and is currently failing to recover care in line with the national targets.

To support the system in its financial recovery, an Executive Director of System Recovery has started working across ICB and MSEFT.

Delivery

5. Improve quality

Whilst the NHS in MSE been working hard to address known quality issues, several challenges remain in the system, including the delivery of sustained improvements in mental health, perinatal/maternity care, and supporting our children and young people with Special Educational Needs and Disabilities (SEND). These are evident from current CQC ratings and Ofsted Inspection findings, as well as patient experience indicators and inquiries into local services, specifically in mental health provision. We are working in partnership across the system to continue to address these issues and improve the quality of services available to residents.

The system's response to the recent Ofsted and CQC visit to Thurrock is an example of how system partners are collaborating effectively to both understand opportunities for improvement and working together to drive improvements. The ICB is committed to supporting all providers to improve the quality of care they provide, including working across the system to deliver the CQC 'should do' and 'must do' recommendations, and Ofsted Inspection recommendations, through evidence assurance and triangulation of improvements across the system. This work will be overseen by the Quality Committee, which is a formal sub-committee of the ICB Board, which remains a focus on ensuring it continues to listen to patient voices around areas of concern, improving patient experience and outcomes.

Work is further supported by quality groups and forums such as the MSE System Quality Group, the Harm Free Care forum and a system Learning from Deaths group. The system also remains committed to participating in national work streams, including the national Maternity and Neonatal Safety Improvement Programme and will be looking at mental health pathway reconfiguration in line with the wider Essex All Age Mental Health Strategy and national standards.

This work will be supported through the development of an updated ICB Quality Strategy for 2024/27 which will align with the National Quality Board principles. This new ICB quality strategy will build on a review of the previous 2021/23 Quality Strategy and Implementation plan. It will contain a set of quality objectives which will use quality information and data to provide a clear understanding that reflects our local system intelligence. The ICB will develop robust system quality dashboards which will align quality metrics on processes and patient outcomes. This will evidence ongoing sustainable and equitable improvement. The ICB Quality strategy will articulate our quality priorities and will go beyond performance metrics and include outcomes and preventing ill-health and use the Core20PLUS5 approach to ensure inequalities are considered.

The ICB maintains its statutory functions relating to safeguarding, forming partnerships with local authority and police partners in order to ensure that the system safeguards children and adults at risk of abuse as part of its collective responsibility. Safeguarding responsibilities are led by the ICB's Executive Chief

Nursing Officer, supported by clinical leads to ensure that the partnerships focus on prevention of abuse. The ICB Safeguarding Team will be working with system partners to ensure that the updated Working Together to Safeguard Children (2023) guidance will be implemented across the system.

During 2024/25 the ICB will be focussed on ensuring that quality data is synthesised and delivered in a way that is consistent, and in line with Data for Improvement. Data dashboards which focus on key clinical quality improvement priorities are being designed at the current time to enhance an understanding of variation in outcomes across populations, in order to focus resources on addressing where greatest need is identified.

Furthermore, the ICB team will consider how it can link with the NHS IMPACT (Improving Patient Care Together) team in order to support organisations maximise quality improvement opportunities. NHS IMPACT is a single improvement approach to support organisations, systems and providers to shape their strategy underpinning this with continuous improvement, and to share best practice and learn from one another.

6. Reduce health inequalities

Reducing health inequalities for the population who live and work in mid and south Essex is the Common Endeavour that sits at the centre of the system's Integrated Care Strategy. We know that existing health inequalities have been exacerbated by Covid and we must continue to listen to the experience of individuals and communities regarding their experiences, and work with them to help us design support, together. On average, deprivation in MSE is lower than the national average.

However, an estimated 133,000 people, or 10.5% of the population of MSE live in the 20% most deprived areas nationally. Figure 2 shows the number of people across each Alliance living in the 20% most deprived area nationally.

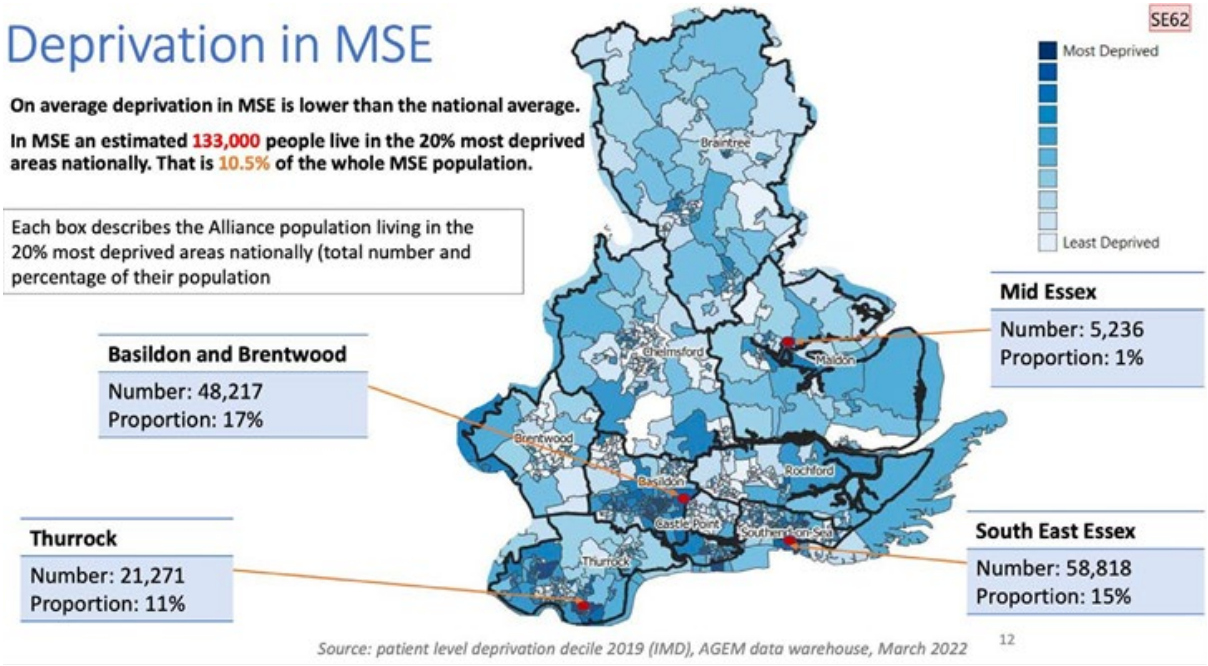


Figure 2: Deprivation in MSE

Looking across MSE, there is variation in life expectancy at birth. Those living in Essex generally have a higher life expectancy than the English average, men living in Southend have a higher life expectancy than English males, but women in Southend and all those living in Thurrock have a lower life expectancy than the English average (see figure 3).

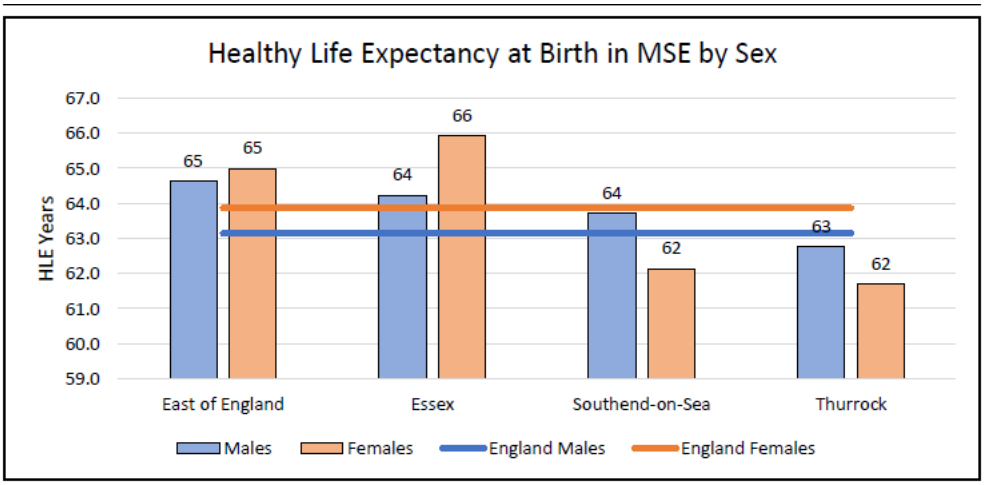
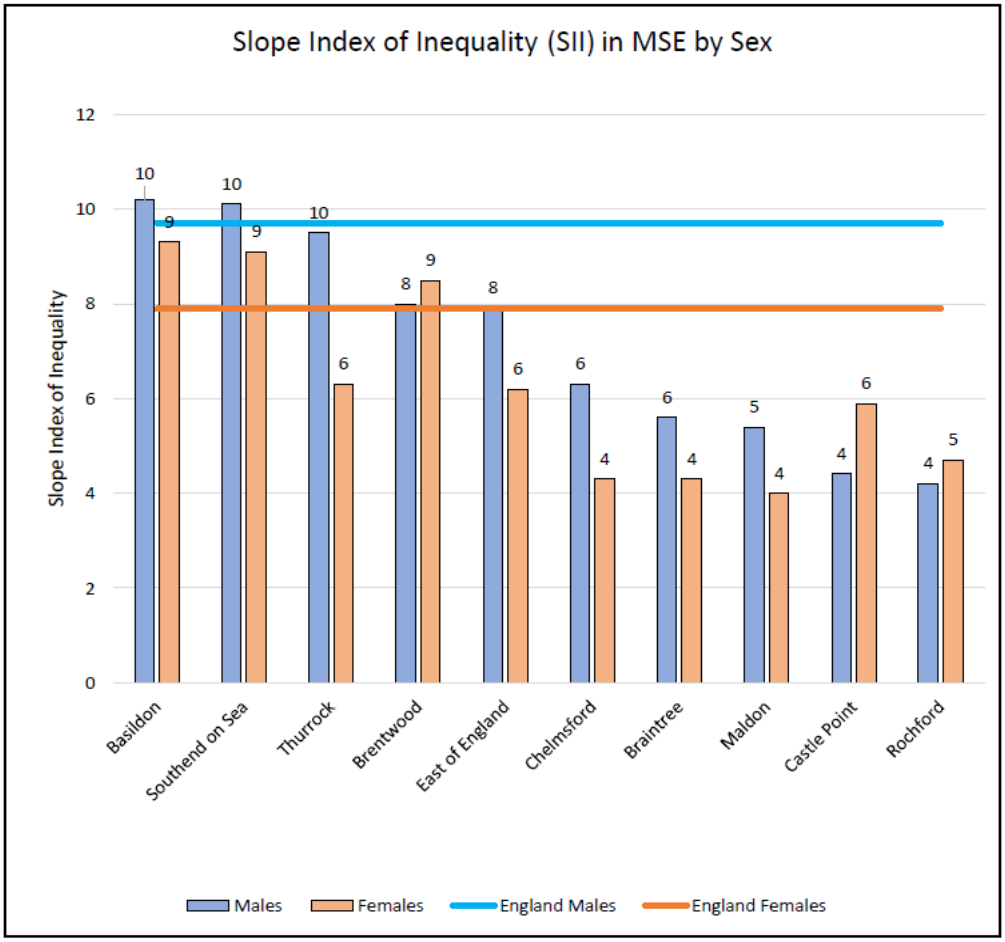


Figure 3: Life Expectancy at Birth in MSE

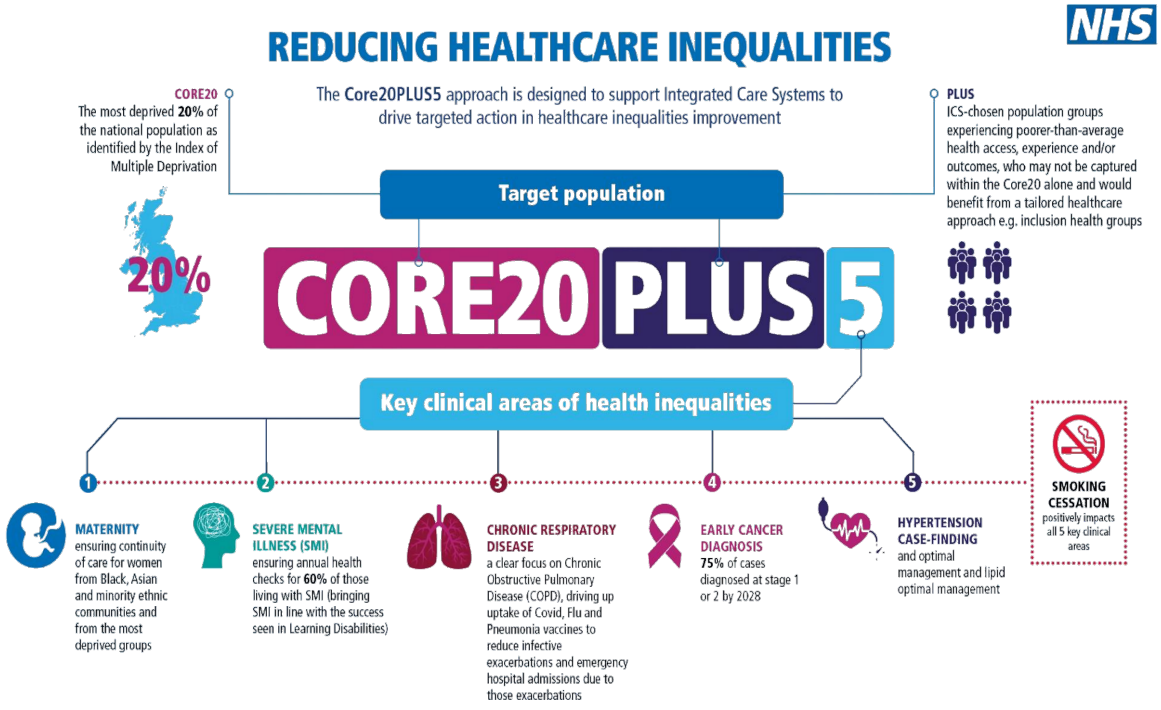
The areas that have a lower life expectancy overall, also tend to have greater inequality of life expectancy within their populations. The inequality gaps are greatest across Basildon, Southend and Thurrock, with the inequality gap across Chelmsford, Braintree, Maldon, Castle Point and Rochford being significantly lower, and lower than the national average (see figure 4).



Source: ONS data from fingertips 2020

Figure 4: Slope Index of Inequality in MSE

Using data, both quantitative and qualitative, to better understand the specific drivers of health inequalities experienced by local residents is key to developing our services and to overcoming potential barriers to access, outcomes or experience. MSE is committed to using the 'core20PLUS5' frameworks developed by NHS England to help us understand and address health inequalities in our communities. This includes both the 'core20PLUS5' for adults and for children (See figure 5).



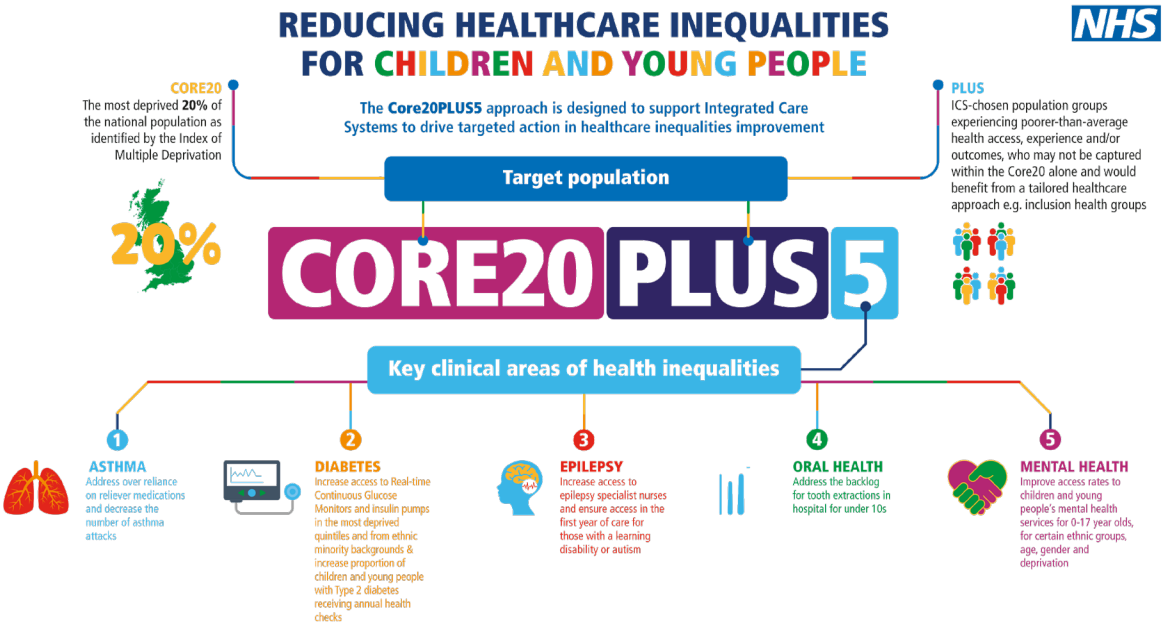


Figure 5: Core20PLUS5 frameworks

In addition to focusing on the needs of the communities that live in our most deprived areas, we have identified a number of local 'PLUS' groups for adults and children who live and work in mid and south Essex and are committed to working with partners and communities to develop plans for how we can address the barriers they experience in engaging with health and care services. The adult groups that have been identified as being at risk of experiencing poorer health outcomes in MSE are:

- Black and Minority Ethnic groups
- Carers
- People with Learning Disabilities
- People experiencing Homelessness
- Gypsy, Roma, and Traveller communities.
- Veterans

The groups of children and young people that have been identified as being at risk of experiencing poorer health outcomes in MSE are:

- Young Carers,
- Ethnic minorities
- Roma, Gypsy, Travellers,
- Looked After Children, Care Givers
- Learning Disability
- Special Educational Needs and Disabilities (SEND),
- Neurodiversity (ASD and ADHD, Tics and Tourette's)
- Young people in the criminal justice system
- Families in Temporary Accommodation,
- Emotionally Based School Avoidance (EBSA),
- Unaccompanied asylum seekers, migrants
- CYP affected by Domestic Abuse

We remain committed to progressing this work through Alliance-level health inequalities funding and targeted system supporting priority areas.

As a Core20PLUS5 accelerator, with clinical, financial and programme ambassadors, we remain committed to embedding a focus on addressing health in equalities in all that the ICB does. This will include having a focus on ensuring that any recovery plans take account of the need to identify and address health inequalities alongside our drive to improve financial sustainability.

7. Improve population health

Traditionally the NHS has focused on treatment and curative activities. While we have, more recently concentrated on early identification and intervention, we recognise that we must play a full part, with our public health teams and wider partners, on prevention. As we seek to do this, we must recognise the importance of supporting more personalised care that responds to an individual's needs and situation. Empowering patients to make informed choices and enabling a more personalised approach to managing their health and any treatment they may need should be embedded in how we offer care across mid and south Essex.

The importance of focusing on improving health overall was reinforced through engagement with our Community Assembly in February 2024. When considering

the components of the Integrated Care Strategy's 'Plan on a Page', those who were in the discussion highlighted prevention and early intervention as being the things they considered to be most important for the system to focus on.

Delivering on these ambitions is a core focus of MSE's Population Health Improvement Board (PHIB). PHIB brings together stakeholders from across health, public health, local governance, alliances and community and voluntary partners to identify, develop and oversee delivery of plans to improve overall population health, prevention and reducing health inequalities. The PHIB is committed to focusing on joint prevention priorities relating to smoking cessation, supporting healthy weight, addressing wider determinants of health such as employment; and to using population health management approaches to support targeted programmes to improve health outcomes and tackle health inequalities. This PHIB will also support the five priorities for a Healthy MSE that have been identified by the ICP, working to support collaborative progress in prevention and action to tackle the wider determinants of health.

Improving the health of our populations is also a core focus of our place-based alliances which bring together and integrate services across a wide range of local partners in health, care and beyond. Central to this is the development of our Integrated Neighbourhood Teams and the development of our Primary Care Networks. This local approach supports delivery of personalised care, supporting patients to more involved in the decisions about their own care and their right to choose. Alliances are also lead local decision making on the best use of the Better Care Fund to support patients to access the care and support that they need as close to home as possible.

8. Operational delivery

The NHS in MSE needs to do more to ensure that patients can access high quality care at the right time, first time. The ICB remains committed to improving access to and experience of care for local patients and ensuring that patients can exercise their rights to choose which provider they receive consultant-led care from

The NHS is working to continuously improve how we offer care to our patients across all settings of care. In MSE we still have a long way to go to recover care in line with national targets in areas including: urgent and emergency care, planned care and cancer. We remain focused on using data, insights and benchmarking in relation to our activity, outcomes and experience to understand the areas where we are doing well, and the areas where we are falling short. Through our alliances and provider collaboratives we want to share learning and best practice and ensure a targeted focus on improving care for those who find care hard to access or are having a poor experience, specifically those who have identified health inequalities.

The longer-term ambitions for primary care in MSE will be updated through the primary care strategy, due for publication later in 2024/25. This will be the first

integrated primary care strategy covering primary medical services, community pharmacy, optometry and dental services that has been produced by the local system. This will build upon “The Fuller Stocktake” (the development of Integrated Neighbourhood Teams), the local response to the Primary Care Access Recovery Plan and the Dental Plan. This strategy will be developed in dialogue with provider representation and wider stakeholders. The ICB recognises the importance of good access to primary care services as, for most people, this is where the majority of NHS provision is delivered. Sustainable and effective primary care will have a stabilising effect across the wider health and care system.

Whilst the strategy will provide a long-term direction of travel, the ICB will maintain momentum with the transformation of primary care services. We will continue to make changes in line with our Primary Care Access Recovery Plan. By the end of June 2024, all practices in MSE will have access to a cloud-based telephony solution. We will expand the number of self-referral pathways that our patients can utilise and promote these through social media, practice websites and other outlets.

We will promote access into community pharmacy, optometry and dental services who are best placed to support patients with a range of issues that currently present to general practice. We will support practices to use digital tools and new triage approaches to ensure that patient need is consistently assessed and managed in the most appropriate way and avoid the current 8am rush on phones where despite best efforts, need is often managed on a first come first served basis rather than being based on clinical need. We will work with dental providers to better support our population through increasing capacity in contracts, piloting innovative approaches to address specific needs and encouraging retention through career development linked to new services. We will improve collaboration between general practice and community pharmacy to support both providers with their long-term sustainability.

MSE is working closely with its Community Collaborative to explore ways that we can support more patients to receive care in the community where it is appropriate to do so. The introduction of Virtual Wards has supported more patients to receive more care at home, avoiding time in hospitals that can lead to greater deconditioning and greater cost to the system. Use of these digital solutions can also help reduce health system emissions and contribute to net zero ambitions. A review of Discharge to Assess pathways is underway to support more patients to return to their primary place of residence as fast as possible. Cross-system working throughout 2024 will support a shift to more ‘home first’ approaches that will improve outcomes for patients and help reduce demand on acute beds.

Further shifts from acute hospitals into the community will be supported by the development of Community Diagnostic Centres (CDC) in MSE. In January 2024 demolition work started to support the development of the Thurrock CDC, which will create new capacity in Thurrock to enable people to access diagnostic testing in the community. Further centres area also planned for Pitsea and Southend.

Figure 6: Artist impression of Thurrock CDC

To support improvements in Mental Health across our system we have developed a Southend, Essex and Thurrock All Age Mental Health Strategy in partnerships with our providers, local government colleagues, partnering ICPs and Essex Police. The vision that underpins this strategy is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well. Our work to improve mental health services must cover all ages, recognising the increased pressure facing today's Children and Young People and the associated impact that is have on demand for services.

Working in partnership with education and the voluntary sector, we will be looking to find ways to increase support through prevention and early intervention initiatives that also address the health inequalities facing children support people of all ages with Learning Disabilities, Autism and others with neurodiversity in our community. We will review our support and develop a more sustainable model of provision for patients across Southend, Essex and Thurrock, with the aim of improving access and experience of support to all people who need it. This will also include a focus on ensuring that the ICB responds to the expected assent of the Downs Syndrome Act. This work will be overseen by the Southend, Essex and Thurrock Strategic Implementation Group, who will also ensure that activities support the broader ICP priority 'Healthy Minds'.

MSE's Growing Well Programme Board is being refreshed and will look to develop a strategy to improve care and support available to babies, children and young people in our system. This work, which considers both physical and mental health needs, will build on existing plans to improve care for children in areas such as: special educational needs and disabilities (SEND), asthma, diabetes, epilepsy, urgent and emergency care, oral health and end of life care. This work will support the ICP's 'Healthy Start' priority.

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically effective and cost-effective. MSE is working to reduce overprescribing to make patient care better and safer, support the NHS, and reduce carbon emissions. Work to reduce medicines waste, unnecessary prescribing and shift to lower-carbon inhalers will deliver both financial and carbon savings that can

contribute to the NHS' Net Zero ambitions. We are maintaining a focus on achieving antimicrobial resistance prescribing metrics and reducing risk of medicines-related harm from high-risk drugs through improved monitoring. Central to this is embedding shared decision making when prescribing and making better use of clinical decision support tools to reduce variation across MSE. Community pharmacists support patient care through delivery of a number of clinical services including New Medicines, Discharge Medicines, Blood Pressure Check and Oral Contraceptive Services, and most recently 'Pharmacy First' which launched in January 2024. Digital integration of community pharmacies with general practice and PCN Community Pharmacy Lead roles will support implementation of these initiatives.

Over the period of this Joint Forward Plan, the Integrated Care System will increase its focus on improving productivity across all parts of the system. We need to ensure that we are maximising the use of the resources that we have to ensure that people are being seen as quickly as possible in the setting that best suits their needs. We will continue to innovate and test new ways of supporting people to access care in the best way for their current needs, whether that is an urgent or planned care need.

To support the delivery of these operational objectives, we are continuing to review and strengthen how we govern our system through partnership working, but also effective oversight and assurance. Following the restructure of the ICB, completed in January 2024, we have undertaken a Corporate Review which has supported strengthened approaches across our Operating Model, Decision Making and Organisational Development, all of which are enabling our approach to Recovery. Through this work we have strengthened our risk management, with the introduction of Datix and a review of the Board's risk appetite, agreed new strategic objectives, refreshed our governance following the annual committee effectiveness reviews and developed an Organisational Development programme that specifically responds to the challenges identified through our staff survey results.

Enablers

9. Supporting our workforce

We want people to see the NHS in mid and south Essex as a place they want to work and build a career in. We want to attract a diverse workforce and support people from mid and south Essex to work and progress in our system. We want to train and maintain the best clinical and non-clinical talent and are aware that to do that, we need to create environments and opportunities that will appeal to all.

Developing our workforce to be able to deliver the care models of the future requires effective planning. Training clinical staff takes years, so we need to get better at mapping out our long-term workforce needs and supporting people through training and placements in our system. We want to keep building on exciting developments in medical and nursing training through local university partnership with Anglia Ruskin University and the University of Essex to create life-long careers for both those leaving school and those looking to retrain. We will also continue to develop our 'One Workforce' initiative to attract, train and maintain Healthcare Support Workers to the MSE NHS Workforce.

The NHS is one of the largest employers in mid and south Essex. Recognising this role as an 'anchor' in our community, MSE's Anchor Ambitions programme continues to provide support for people looking for employment opportunities in the NHS and beyond.

People who work in the NHS in MSE have demonstrated, through their staff survey results, that we have work to do to improve our organisations, with less than 50% of staff working in either the acute trust or the ICB recommending our organisations as good places to work. We must take the time to understand the issues in our organisations and work to address them to attract and retain our talent, creating a culture and environment that people want to and feel safe and supported to work in. This is particularly true in the acute hospital, where high vacancy rates continue to drive use of more expensive temporary staffing which can also impact on the quality of care offered to patients.

We have made significant strides in our work to provide recruitment, retention and development support to our Primary Care workforce. The MSE Training Hub, supported by the ICB People Directorate and led by a team of Clinical Leads and Ambassadors, is highly regarded across the region for its best practice work in supporting primary care transformation and developing the current and new workforce required to deliver world-class patient care. The hub supports our PCNs with their breadth of workforce planning, including the embedding of new roles through the Additional Roles Reimbursement Scheme (ARRS). It develops, delivers and procures education and training for GPs and primary care teams. It supports educational placements in PCNs and practices and career support to staff from new to practice, mid and late career. The hub delivers clinical practice specialty and refresher training,

development for clinical supervisors and educators, CPD and training in management and administration.

The ICB is fully committed to the implementation of the comprehensive NHS Equality Diversity and Inclusion Action Plan with its six high priority actions:

1. Measurable objectives on Equality Diversity and Inclusion for Chairs Chief Executives and Board members.
2. Overhaul recruitment processes and embed talent management processes.
3. Eliminate total pay gaps with respect to race, disability and gender.
4. Address Health Inequalities within their workforce
5. Comprehensive Induction and onboarding programme for International recruited staff.
6. Eliminate conditions and environment in which bullying, harassment and physical harassment exist

This plan provides specific actions that we know from evidence and data will make a real difference to our ambition to be a highly inclusive organisation but the plan always shows how we can learn and respond to lived experiences.

Our recently established Mid and South Essex People Board is leading the development and oversight of the systemwide plans to support all this work and help us ensure that we attract, train and retain staff to help us deliver high quality and high value care to our patients. Below are some of the initiatives we will be implementing over the next 12 months, to meet our NHS workforce challenges in Mid and South Essex:

Train

- Identifying hot spots where targeted recruitment and retention is critical and highlighting where enduring unfilled vacancies can be addressed with new skill mixes and new ways of working.
- Build on recent success through a ‘grow our own’ approach in hard to fill roles e.g., developing and retaining Clinical Assistant Psychologists (CAPs) and converting long term agency staff to permanent contracts.
- In primary care, strengthening the multi-disciplinary approach and ongoing utilisation of ARRS funding. Targeted action to recruit and retain key primary care roles, including GPs, nurses, community pharmacists, NHS dentists, and dental nurses. Leveraging MSE’s exemplar Primary Care Training Hub and associated Clinical Ambassador roles, to address capability gaps and build peer support and learning networks.
- Develop programmes through the Health and Care Academy that respond to areas of short supply.
- Work with Higher Education Institutions to support clinical expansion linked to long term workforce plan and trajectories to 2037.

- Realistic mapping of potential workforce supply based on current performance, undergraduate trajectories, local demographics, and turnover.
- Healthcare Assistant Academy model to support induction & retention of Health Care Assistants (HCAs) and promote a joined-up approach to recruitment, retention & training/on-boarding.
- HCA academy led centralised induction programme to increase training capacity and quality of induction.
- Increased engagement with HCAs and educational settings providing the Health and Care Certificate to expand outreach.
- Expansion of College Enrichment Programme to engage with and develop Health and Social Care Further Education Students, providing a clear understanding of the Healthcare Support Workers role and an early recruitment pathway into health and social care careers.
- Ongoing development of pre-employments programmes and wrap around provision to aide retention and widen participation, attracting job seekers into careers in health care.
- Exploring innovative recruitment processes (candidate apps, voice activated application forms etc.).
- Expand Apprenticeship offer.
- In MSEFT, establishment of a new leadership faculty to co-create capacity and upskill leaders across the trust.
- Development and implementation of student engagement programmes for nursing students to bolster Registered General Nurse and Registered Mental Health Nurse pipelines and reduce reliance on market-driven supply.
- Analysis of newly qualified nurse's experience (placements, induction, preceptorship training and first 12 months of employment) to inform improvements.
- Implementation of a new Central Placements Platform across MSE to increase the quality and variety of placements and the efficiency with which they are scheduled. The platform will also improve visibility of and access to undergraduate student numbers and allow for early engagement and proactive recruitment.
- Further develop our system wide clinical capacity and expansion group to meet the demand for an increase in the workforce numbers across all disciplines in the next 9 years.

Retain

- Developing system-wide legacy practitioner vision. Building awareness and understanding of the value of this role in supporting the recruitment and ongoing workplace support (and therefore retention) for Nursing Associates, newly qualified practitioners, Trainee Nurse Associates, and other students.

Increasing the number of legacy practitioners will be key, as critical mass will help establish and embed the role.

- A similar advocacy/sponsorship approach will be taken to healthcare assistant champions, Physician Associate leads and Advanced Clinical Practitioner Leads across organisations (and recognising those roles in permanent Establishments).
- Ambition in MSE continues to be a workforce strategy that is clinically led, and work will continue in 2024 to secure the sponsorship of clinical leaders to the adoption of new roles and increase their receptiveness to new skill mixes.
- Driving the take-up of internal apprenticeship pathways to bolster staff development and enhance clinical skills.
- Ongoing commitment to the expansion of flexible working policies.
- Focused work on the retention of undergraduates (including those out of area).
- Ensuring a systematic and high-touch approach to the offering of employment to nursing graduates within the system at the beginning of their final year of placement.
- HCA Academy focus on retention of new to care HCAs with a particular focus on the first 12 months.
- Fully embedding the six high impact actions in the NHS Equality, Diversity and Inclusion Improvement Plan into recruitment, onboarding, talent management and Learning and Development initiatives across MSE.
- Further develop the system Wellbeing and Retention Group.
- Implementation of the ICB's Organisational Development Strategy that responds to challenges from recent restructures and poor staff survey results through:
    a. launching of new core values, prioritisation, and the development of a clear narrative and delivery plan
    b. Focusing on talent management and development, with a particular emphasis on building capabilities and capacity in change, innovation and transformation
    c. Leadership and line manager commitment to developing a compelling vision and roadmap for the future that will encourage staff to stay
    d. Ongoing implementation of Freedom to Speak Up policies, ensure that people feel able to speak up and contribute ideas to improving patient experience and service delivery.
- Implementation of MSEFT's 2-year improvement programme that responds to its People Survey of 2022 and recently reviewed in light of 2023 survey results. Its 'Valuing Our People' programme focuses on 7 areas of improvement: 1. Embedding Zero Tolerance to Bullying, Harassment and Discrimination. 2.Reducing pay errors and Inequity. 3.Improving your Working Environment. 4.Prioritising your Wellbeing and Development. 5.Improving Communication and Engagement. 6.Increasing Recognition and Organisational Pride. 7.Improving Leadership Visibility.

Reform

Given significant financial deficits relating to workforce, financial improvement plans are in place to support urgent reduction in temporary staffing. In the Acute, the cost drivers are urgent and emergency care, elective care and cancer care. In the Mental Health Trust they are increased acuity, observation and engagement.

Essex Partnership University NHS Foundation Trust:

- Eliminating long term agency placements, tightening rostering practice, increasing Direct Engagement uptake for medics and AHPs; potential transfer to NHS Professionals Secondary Bank and re-negotiating rates with preferred suppliers.
- Targeted work on staff groups with high temporary staffing spend (especially Community nursing), while maintaining Time to Care safe staffing levels.
- Establishment Control panels in place for all care units and corporate services.
- Recruitment strategy for consultant posts.
- Active establishment controls.

Mid and South Essex NHS Foundation Trust:

- Nursing, Medical and Corporate Assurance - senior leader approvals on resourcing.
- Improved rostering processes in train (now need to be scaled, including all medics onto e roster)
- Regular audit of most costly locums, alongside clear recruitment plans to fill posts. Maternity and paediatrics areas of particular challenge, due to sickness levels and vacancy gaps.
- Improved accuracy of staffing categories – specifically ‘unique post identifiers’
- Upskilling and training for off framework and booking approach.
- Review of doctor’s bank booking platform with view to more robust controls
- Push to move staff from temporary to substantive.
- Active establishment controls.

10. Data, digital and technology

We know that healthcare is lagging behind many sectors when it comes to making best use of both its data and the potential that technology has to offer. The ICB is committed to working collectively to improve both the data and intelligence that we have and use in our system, and the use of digital and technology solutions that will

improve the staff experience of delivering care and the patient experience of receiving it.

MSE is the first system in the country to commit to implementing a Unified Electronic Patient Record (UEPR) across our local providers. Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust have jointly procured a technology partner that will see them have the same Electronic Patient Record system in place. The trusts are targeting quarter two of 2026, which is subject to investment case approvals and contractual agreements. This joint approach will allow for more integrated care pathways across our acute, mental health and community pathways, offering a better experience for patients and staff.

In implementing the UEPR it is expected to deliver significant cash releasing and non-cash releasing benefits. Detailed benefits scoping has identified opportunities around reduced agency, local and temporary staffing costs. A reduced need for managing paper and consumables. From a clinical and operational perspective, the UEPR will drive standardised care pathways reducing unwarranted clinical variation. It will enable the trusts to optimise care services improving productivity across the organisation. Using new technology the UEPR will also improve system compliance and resilience for cyber security.

Across our Health and Care partners we are working to implement a Shared Care Record. This will enable information to be shared across health and care partners and provide capabilities that can support joint ways of working, helping to underpin the transformation needed to deliver on our operational and clinical priorities.

Across MSEFT and EPUT work continues to implement our digital patient interface with appointments and diagnostic information being shared electronically to patients across both organisations by Oct 2024.

The success of Virtual Wards in MSE demonstrates how effective use of technology can transform how we deliver care and deliver broad benefits across the health system, such as reducing emissions. We must continue to build on these successes to implement proven technologies that will allow us to transform and improve how we deliver care at all stages of the pathway. As we do this, we will continue to support our staff, partners and patients to receive the training needed to help them improve their digital literacy and use of emerging tools. An example of this is our primary care ‘tiger teams’ that are working to help local practices maximise the use of new technologies and data that is available to them.

As we improve our ability to collect data and integrate our data, we must continue to work on our supporting data and digital infrastructure so that we can generate and use insights to inform improvements in planning and operational delivery. Alongside the technical platform that will allow greater integration and data reporting, we will continue to train and develop our staff to draw out and use the insights that such solutions provide. As part of this work the ICB and its partners are exploring how best to utilise the opportunities of the nationally provided Federated Data Platform.

Engaging patients and communities in how we are developing our data, digital and technologies across the NHS is key. It is important that we ensure that digital solutions enable the provision of care, and don't increase digital exclusion or become a barrier to access. We must recognise the differential needs of our population and ensure that we are listening to where technology can help, as well as being transparent in our plans to use data to improve how and what care we provide.

11. Financial sustainability

MSE ICB remains committed to delivering high quality care that offers value to the taxpayer. As the system enters another year facing a significant financial deficit, there is a significant challenge ahead to develop and deliver plans that will allow us to live within our means and meet the needs of residents.

As the financial challenges in the system increase, the financial scrutiny and oversight also increases. In April 2024, MSEFT was placed in segment 4 of the NHS Oversight Framework, meaning that the Trust will now be receiving additional recovery support and additional scrutiny from NHS England. In addition, the whole system has entered 'triple lock', with more financial decisions being reviewed by both the ICB and NHS England. Collectively, this is increasing the focus on how we are managing all components of our financial plans. This includes the significant pay costs across our NHS providers, which still includes a high volume of temporary staffing, as well as non-pay and non-healthcare service costs.

Alongside this review of spend, it is important that we consider where we have made investments that have not added value. In a system that supports innovation and improvement it is important that we continue to test ways to improve our services. However, it is equally important that we evaluate those investments and review the impact that they have had. If things are not delivering the expected impact, we must commit to stopping them and considering alternative uses for that investment.

To further support our commitment to achieving financial sustainability, the system has committed to a review of corporate functions and areas which might drive efficiency and savings by consolidating our 'back office' functions across multiple system partners. A system-wide NHS infrastructure strategy is also being developed to explore opportunities to make better use of the physical assets we have to support patient care and improve the health of our local communities.

Through the newly appointed Executive Director of System Recovery, the system will continue to interrogate its costs and activities to identify opportunities for efficiency and productivity in how we work. In addition to using available tools, to benchmark opportunities for improvement, the system will continue to look at how it can transform care to offer better outcomes for better value.

We are embarking on the development of a medium term plan during the summer of 2024 with the expectation that by early Autumn we will have a system wide medium term financial plan which sets out the key changes across the system, and within Mid

and South Essex NHS Foundation Trust that will result in both the Trust and the wider integrated care system achieving financial, operational and clinical sustainability. This plan will set out the key actions and timelines for delivery.

12. Research and innovation

Research and innovation are integral parts of the NHS constitution and key enablers in driving improvements in clinical care. They can help attract additional investment into the local system and broader economy, can provide greater opportunities for staff to expand their experience and career opportunities and offer benefit to patients and the public through opportunities both participation and improved outcomes. As our ICB continues to mature, we will develop our strategies for both research and innovation.

Research:

MSE aims to publish an updated research strategy later in 2024/25 that will draw on organisational strategies and plans that are already in place across MSEFT, EPUT and our university partners. The strategy will ensure that we are supporting research across all settings of care, increasing our focus on research in primary and community care and the wider determinants of health. This will be aligned with the work of the newly established Greater Essex Health Determinants Research Collaboration (HDRC). The strategy will help increase the system's overall awareness of the value research offers in relation to improving patient care, partnership working between organisations and with patients and the public and funding opportunities. The research strategy will also be informed by the work we are currently undertaken through our Research Engagement Network project, which is looking to increase engagement from groups that are traditionally under-represented in research.

Innovation:

In developing an innovation strategy, MSE will continue to build on its established track record of innovation, including its local Innovation Fellowship programme for staff working in our health and care system, hosted by MSEFT, who also host a number of national innovation schemes. These schemes demonstrate the value we place on supporting our staff to innovate, test and learn.

Our innovation strategy will draw on the organisational strategies that already exist across the system, such as the EPUT Innovation Strategy for 2023-2026 which focuses on opportunities to optimise physical infrastructure and digitally connected things, quality improvement and innovation in working practice and digital and technology innovation. As we do this, we will explore options to expand our innovation programmes and not only test new ideas, but also focus on scaling proven innovations that can improve outcomes and value in our system. We will remain open to new and evolving technology innovations, including the potential AI has to transform not only care delivery, but also efficiency and effectiveness in clinical and corporate support services.

MSE is part of the University College London Partners (UCLP) Academic Health and Science Network, which reaches into North East and North Central London. We will continue to work with UCLP in implementing proven innovations and practices that will help us improve the health of our local population. We will focus our adoption of innovation in areas of strategic and operational clinical priority such as cardiovascular disease, frailty and cancer care.

Alongside these strategies, we will continue to evaluate and report on the impact investment in research and innovation is having in our system and our broader economy. It will be important to recognise that not all research and innovations will deliver the expected benefits, but reporting on and learning from work that doesn't succeed is as important as continuing to invest and scale what works so that we remain a learning system.

Section 2: Delivery in 2023/24

This section of the Joint Forward Plan (JFP) sets out some of the things that Mid and South Essex Integrated Care Board (MSE ICB) has delivered in 2023/24 against the strategic ambitions that we set for our system.

Partnership

1. Let Staff Lead

MSE's Stewardship programme has continued to bring together clinical and operational leaders to focus on how we can best 'steward' our resources to improve the care we provide to patients in MSE.

Our Stewardship Expo events, held in October 2023 and April 2024, demonstrated the progress made by our Stewardship groups, including:

- **Urgent and Emergency Care (UEC)**: Our UEC stewards have established and trialled a new Unscheduled Care Co-ordination Hub (UCCH) to test a new way of supporting patients with an urgent need to access the most suitable pathway to meet their needs through a central co-ordinating multi-disciplinary team (MDT). The trial has demonstrated that a coordination hub of this kind is effective in directly people to the pathway most suitable to them, which can reduce pressure on Emergency Departments and reduce Ambulance waiting times. Over 44 active days in 2023/24 the UCCH saw over 1100 patients, with over 560 (51%) of referrals being referred to an alternative urgent care pathway, therefore avoiding an attendance at the Emergency Department.
- **Cancer:** Our multi-disciplinary group of cancer leads are using a new cancer dashboard to better understand where the challenges are across our cancer care pathways and are working to introduce projects that improve patient case finding and offer more personalised care to our patients.
- **Ageing Well**: Our ageing well stewards have focused on how they can support people in MSE to age better through more empowered choices and control over their health and wellbeing, whist offering more efficient care. Through new assessment and reporting tools (FrEDA) and improved use of electronic registers and data they have develop an Ageing Well Dashboard that captures and measures the things that really matter and make a difference for patients. This has allowed them to identify 12,000 new people with frailty, dementia or end of life needs since April 2022. This work has supported a 5% reduction in 30 day hospital readmission rates, a 50% reduction in rates of older people with more than three unplanned hospital admissions in their last 90 days of life, around 10,000 hospital bed days saved through the Frailty consultant hotline that is helping avoid emergency attendances and over 3,000 people supported through Frailty Virtual Wards.

- **Stroke:** Our stroke stewards have supported improved stroke education across our ICS, expanded Level One psychological care for stroke and increased access to rehabilitation assistants in community settings. This has supported an improved Acute Sentinel Stroke National Audit Programme rating to an 'A'. Stroke Stewards have also supported work on the development of the community rehabilitation stroke pathway, including recommendations on increasing the number of stroke rehabilitation beds across MSE, which is currently was consulted on between January and April 2024.
- **Diabetes:** our diabetes stewards have worked to increase referrals into the NHS Type 2 Diabetes Path to Remission Programme which can help support patients lose weight, improve their blood sugar levels and reduce diabetes-related medication. Their focused approach used digital tools to identify patients eligible for the programme, increasing awareness with both clinicians and patients to increase referrals by over 100 a month since the programme started in November 2023, enabling MSE to deliver the highest referrals in the East of England.

In addition to the Stewardship Programme, we continue to support the development of our clinical leads through our Leading Better Together programme, which has supported over 40 people in 2023/24. Our broader Lunch and Learn sessions, open to all MSE staff who have expressed an interested in developing as a clinical leader, had 160 people undertake leadership development during 2023/24. We also saw 120 aspiring, emergent and established clinical and care leaders (from primary, community, third sector and social care stakeholder organisations) come together at our MSE Leading Better Together 2023 conference with keynote speech by Prof Claire Fuller, NHSE National Medical Director for Primary Care, to underpin and share learning about PCNs, INTs, and the Fuller Stocktake, combined with wellbeing coaching for leaders.

2. Mobilising and supporting communities

Work with our community, voluntary, faith and social enterprise sector partners has progressed through our Alliance partnerships and our system-wide Community Assembly. The Community Assembly was established in 2022 but continues to be a work-in-progress as we work with the sector to consider how we can best partner with them to support our local communities through the collective power of our assets.

Our work to engage and involve public and patients has been strengthened through our new Virtual Views platform, launched in November 2023, which provides an online community where people can share their views, experiences and ideas about local health and care services. Virtual Views is supporting conversations across the system, within our Alliances and on specific projects and issues, including women's

health services, our Research Engagement Network and proposed changes to local community hospitals.

In November 2023, four Transfer of Care Hubs (TOCHs) were established across MSE, one per Alliance footprint. Each TOCH facilitates “pulling” patients from the acute hospital into the community pathways including the emerging Integrated Neighbourhood Teams (INTs). NHS Alliance Directors are working in collaboration with community health services, emerging INTs and Local Authorities to effectively build on the existing infrastructure. A multi-disciplinary working approach supported by wider partners including housing and Voluntary, Community or Social Enterprise sector (VCSE) enables a targeted focus on enhancing flow, reducing length of stay and improving the experience and outcome for residents.

In 2023/24 nine initial Integrated Neighbourhood Teams (INTs) were established across MSE and have undergone assessment against an agreed framework. The assessment indicates that all INTs are anchored in neighbourhoods acknowledged by the community. Core providers are positioned at the heart of the INT, and incremental transformation is grounded in shared learning and collaborative efforts. To support this, South East Essex Alliance have established a Strategic Integrated Neighbourhood Group (SING) that brings together key voluntary and statutory partners from all eight neighbourhoods to oversee the development of local INTs.

Examples of community initiatives that have been delivered in 2023/24 include;

- **The Langdon Hills Estate Residents Association (LHERA)** created the Duvet Project aiming to distribute duvets to vulnerable residents, to provide warmth due to the escalated cost of the estates uncapped District Heating unit price, which had increased by 201% alongside the impact of the rise on the cost-of-living. In total of 65 duvet sets and duvets, six pillows and six baby blankets were delivered supporting over 80 residents on the estate including: 18 single residents, 21 couples and 13 families with 28 children.
- **Sound and Vision (Sensory) CIC** supports deaf, blind and sensory impaired people to access their community, take part in leisure activities, enjoy positive mental health activities and much more. Through their support, deaf, blind and sensory impaired people are able to access activities they would like to experience to improve their well-being. They have received funds through the MSE ICB Inequalities Microgrant Programme, to introduce new activities into deaf blind people’s lives by providing specialised support at no cost to them.
- During 2023/24 **Neurodivergent Safe Space – Southend** received funding from the Inequalities Microgrants Programme to provide free community mental health support group. The service provides support for neurodivergent (ND), autistic, PDA, attention deficit hyperactivity disorder (ADHD) teens and young adults, between the ages of 13-20 years who are experiencing mental health difficulties.

3. Further Developing our System

During 2023/24 we have continued to support the development of our collaboratives across the system, including:

- Continued development of our local place-based Alliances as local partnerships focused on identifying and addressing the needs of our local communities.
- Launch of the new Primary Care Collaborative in February 2024 as a place for us to bring together stakeholders working across the breadth of primary care to discuss how we can continue to develop services to best serve local patients.
- Consolidating our Community Collaborative across Essex Partnership NHS Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company. The Collaborative has supported the development of a staff 'passport' to allow more flexible working across the Collaborative and is focused on identifying and removing variation in service provision to improve the quality of and access to care across the whole system.
- The development of the Southend, Essex and Thurrock Mental Health Strategy has set a vision, supported by a set of actions that will see improve health and care outcomes for local people.

4. Improve Oversight Framework Rating

In 2023/24 the NHS across MSE has demonstrated improvements in a number of areas, including:

- Quality improvements at MSEFT that led to an improved Care Quality Committee (CQC) rating from 'inadequate' to 'requires improvement'
- East of England Ambulance Service NHS Trust (EEAST) coming out of special measures in two areas, with the CQC lifting two additional conditions on its licence

During 2023/24, MSE continued to face significant financial challenges across the system, with both of the providers within our control total ending the year with financial deficits. Given this, the system has been working under a 'triple lock' arrangement since February 2024, with all expenditure requests for over £25,000 facing additional assurance from both the ICB and NHS England. Through this process we are starting to realise benefits of collaborative system working through better forward planning in both delivery and procurement.

Delivery

5. Improve Quality

In 2023/24 the ICB has focused on improving its governance and assurance around the quality of care provided for our residents. This has included implementing the Patient Safety Strategy and Patient Safety Incident Framework; establishing the Quality Committee and the System Quality Group; implementing a revised safeguarding structure across the system and reviewing our approach to managing complaints. A key component of each Quality Committee meeting is a deep dive review and the presentation of patient voices around a particular area of concern. This has been particularly successful and impactful and driven real quality improvement in areas such as eating disorder and maternity services. Going forward the Quality Committee aim is to strengthen this process therefore improving patient experience outcomes.

Through the leadership of the Nursing and Quality Team, all providers have had their Patient Safety Incident Response Frameworks and Plans approved, formally ratified by the Executive Chief Nursing Officer in line with national Patient Safety Framework. Through the delegation of oversight to ICB, the Patient Experience team are now overseeing concerns and complaints relating to primary care, pharmacy, optometry, and dental services. The analysis of complaints and concerns will help support identification of emerging risks to service provision across the system and enable the primary care quality team to engage with providers to ensure standards of care delivery and access are sustained and improved across the system.

The Primary Care Quality Team has worked both proactively and reactively with general practices to improve the quality of care we can offered to our patients. The team has supported a number practices who have received poor Care Quality Commission reports to systematically address the issues identified by the CQC. On re-inspection, the majority of practices subsequently achieved good outcomes. Proactively, the team reach out to practices to pre-empt issues and provide guidance and support to avoid deterioration.

6. Reduce health inequalities

Each Alliance has a local health inequalities programme which oversees the investment of its health inequalities funding, in partnership with a designated ‘Trusted Partner’. Local activities and investments vary, based on the needs of the community, but examples of successes include:

- Improved Health Check performance across Basildon and Brentwood, with more people with Learning Disabilities having a check in 2024 (61%) compared with 2023 (56.5%) and over 60% of people with serious mental illness having a check.

- Health and wellbeing cafes introduced across Basildon and Brentwood Primary Care Networks to increase engagement with local residents and provide information on key topics, such as winter readiness. The hubs have also supported people attending homeless shelters to register with local GP Practices so they can receive the support they need.

Case study: Mobilising communities – Central Basildon INT

643 patients with high attendances in primary care and A&E amassed 12,000 GP appointments. The approach reduced attendances by 48%. 6,000 GP appointments freed up, with patients being supported through care co-ordination, with a 30% reduction in A&E attendances for this cohort.

Health & Wellbeing Café - Participants noticed positive changes since attending the cafe and talked about feeling happier, calmer, and more centred. There was evidence that feelings of wellbeing were not just during the cafe session, they also seemed to have a positive impact on life beyond the cafe and small healthy lifestyle changes were mentioned with a sense of pride.

- Achieve Thrive Flourish (ATF) is a strategic partnership for local delivery of a Sport England pilot focused on supporting wellbeing in Basildon. One of our PCNs in Basildon is working in partnership with Active Essex to support the West Basildon Wellbeing café, which is hosting one of the PCN social prescribers. This work is supporting social prescribers to support the local population, including attending homeless shelters to support individuals not yet registered with a local GP practice to register and access the ongoing support they need.
- PCNs in Southend have worked with the Innovations in Healthcare Inequalities Programme (InHIP), delivered through University College London, to use an outreach vehicle to deliver services to communities at high risk of CVD in the heart of Southend.
- MSE ICS teamed up with Ford and local community health leaders to identify and assess the effects of ‘long covid’ by offering a mobile clinic specialising in spirometry, BP and ECG testing in the Ford Transit Van. The Transit houses the equipment, allowing NHS clinicians and health workers to offer a ‘one-stop-shop-service’ to assist residents in the county that may have mobility issues, language barriers or live in more rural areas of the town. Due to the success of this programme of work plans are in place to enhance this model further during 2024/25.
- Thurrock PCNs and Thurrock Public Health designed a new holistic approach to care, setting up and designing their own multiple morbidity clinics and interventions focused on cardio-vascular diseases, supporting the

management of existing conditions and lifestyle support services. The clinics are overseen by an advanced nurse practitioner and include social prescribers, community pharmacy, as well as Thurrock Healthy Lifestyle Service for smoking cessation, and weight management.

- A new innovative project called Greening Southend Queensway in working to improve the outdoor green spaces on the Queensway estate and support the improvement of the communities' health and care. The project, delivered by mental health and wellbeing charity Trust Links and funded by the SEE Alliance Health Inequalities grant funding from 2022/23, will give people living in the Victoria Ward access to green spaces and get them involved in physical activities outside to improve their own communities, while improving residents' mental and physical health, as well as decreasing social isolation. This is particularly important as population health data about the residents highlights that they often have multi health conditions including, severe mental illness and chronic obstructive pulmonary disease (COPD). It's also been highlighted as a coastal community with pockets of deprivation hidden amongst relative affluence. In addition, it's in the top 10% most disadvantaged areas in England according to the Indices of Multiple Deprivation (IMD) 2019 and is therefore a target area for the NHS under the Core20PLUS5 inequalities framework.

Case study: Population health improvement – greening Southend

Greening Southend Queensway has been launched to improve outdoor green spaces and support the improvement of the community's health and care. The project, delivered by mental health and wellbeing charity Trust Links and funded by the SEE Alliance Health Inequalities grant funding gives people living in the Victoria Ward access to green spaces. As a coastal community it has been identified as having pockets of deprivation hidden amongst relative affluence and data shows residents have multiple health conditions such as severe mental illness and chronic obstructive pulmonary disease.
The project gets residents involved in physical activities outside to improve their own communities, while improving residents' mental and physical health, as well as decreasing social isolation.

Case study: Health inequalities – mental health joint response vehicle

"Since March 2023, I have been working for the local ambulance service… My role is to help introduce new and better ways of working, to improve access and outcomes for patients suffering with their mental health. I am also helping to upskill ambulance clinicians and strengthen pathways so that the patients using the 999 system can gain access to the right mental health support early without the need for attendance to an emergency department…. This now brings mental health care and support to the patient, and in most cases, the patients' own homes. The service is now covering mid and south Essex, 7 days a week 13.00hrs to 01.00hrs when we know we usually see the greatest number of people needing help."

Claire Fuller, Mental Health Nurse

The system's CVD prevention programme been supported by £80,000 of funding from NHS England, allowing additional focus on health inequalities. The programme has enabled 2,000 monitors to be sent out to 19 PCNs and distributed to 80 practices in areas of high deprivation and has seen an additional 15 PCNs in areas with the greatest CVD needs in areas of greater deprivation of with higher black or Asian ethnic minority groups to sign up to the CVD Locally Enhanced Scheme.

Lung health checks taking place across MSE have helped diagnose 100 new lung cancers in residents.

Case study: targeted lung health checks, improving patient care.

Since 2020, people living in Southend and Thurrock (aged between 55 and 75), were invited to have a free NHS lung health check, which identified people at risk of developing lung cancer. Those at higher risk were offered a scan, then referred for treatment if needed.
More than 100 local people have now had previously undiscovered lung cancer found and treated.
Over 17,000 checks (Feb 2024) have been completed. In addition, nearly 10,000 CT scans and 561 referrals to follow up care, linked to cardio-vascular disease, gallbladder, respiratory, breast, gastro, urology, liver and renal findings.

7. Population health improvement

Work to improve the identification and management of cardiovascular disease (CVD) of those living in our community has been a priority for our system in 2023/24. We have continued to roll out the BP@Home programme, with nearly 98,000 people having participated in the scheme since March 2021 and improved GP practice information and patient guides that respond to patient feedback which highlighted, they have a lack of awareness and information on how to monitor their blood pressure at home as part of the scheme. The MSE Lipid QOF Enhanced Service has been introduced across 27 practices with a high percentage of CVD patient and low treatment to threshold performance rates.

Over the last year we have established in-house smoking cessation service for acute inpatients for behavioural support, nicotine replacement therapy or pharmacotherapy. This is supported with follow-up post discharge and referral to community stop smoking services. We have also improved support for individuals who are pregnant, offering smoking cessation support at their first contact with the pregnancy booking line and carbon monoxide monitoring at ante-natal appointments, which offers the opportunity for very brief advice and referral to in-house services.

During 2023/24, MSE has worked towards implementing the principles of a whole system approach to addressing obesity prevalence and supporting residents access to weight management services. To support this, the ICB has developed a weight Management dashboard which will inform future transformation work and has identified potential unmet need of 35,572, adults whose BMI is equal or above 30 or 27.5 for Black or Asian ethnicities and have diabetes or hypertension without a recorded referral into weight management services. We have also worked with local authorities to develop an integrated weight management service pathway and roadmap, commenced an outcomes focused evaluation framework which will continue into 2024/25 and inform Tier 3 re-procurement of specialist weight management services. This work is critical as demand for Tier 3 services continues to rise, with significant waiting lists in place across the system and the potential for new drugs to further drive up demand.

8. Operational delivery

In 2023/24, the ICB has continued its upward trajectory on the number of consultations being undertaken in primary care. As of December 2023, primary care in MSE had undertaken 7.1% more consultations than the equivalent period in 2022/23. The Primary Care Access Recovery Programme is supporting the roll out of Cloud Based Telephony to all practices, introduced a ‘total triage’ model across a number of practices and established 11 self-referral pathways into musculoskeletal services, weight management services, community podiatry and wheelchair services.

Case Study: total triage – reducing the 8am rush

Staff said "the quality of contacts has dramatically improved, we are seeing the right patient first time, rather than patients having multiple contacts".

Patients said: "The communication between the administrative staff & me was great. They explained the process clearly via the messaging system and sent me a booking link that morning with appointments at my local surgery.".

"I used to dread being on hold for 40 minutes… [it] takes 30 seconds to use - I had to book to have stitches out and had an appointment within 10 minutes of my request and had to book 2 appointments for my son and he was seen an hour later. Really lovely nurse and doctor in both cases".

By working in partnership with PCNs, the ICB has made significant progress on the recruitment of the additional roles reimbursement scheme (ARRS). As of Month 9, we are forecasting an 87% utilisation of resource (£24m of £27.5m). This represents a £7.7m increase on 22/23. Whilst the overall satisfaction in general practice reported in the national GP patient survey remains below the national average, MSE's results have plateaued in 2023/24, despite a national downward trend.

In the first year of delegation, the ICB has taken forward a number of initiatives to improve access to dental services and support the recovery of Units of Dental Activity (UDAs) to pre Covid pandemic levels. The ICB has established an urgent access pilot, care home pilot, allowed a number of contactors to deliver in excess of their contracted activity and recommissioned UDAs from contract hand backs.

Integrated Neighbourhood Teams (INT) have started to demonstrate positive results for patients and the system, with early results from the Central Basildon INT showing that their model has saved around 6,000 GP appointments across 650 patients, as well as reducing A&E attendances within the cohort by 30% and reporting improved staff satisfaction.

MSE has seen an improvement in delivery of Talking Therapy 90 day waiting targets. This will be further supported by a review of opportunities to harmonise services across MSE to both offer improved patient outcomes and value in the services that we commission. MSE has focused on improving delivery of annual health checks for people with severe mental health and the ongoing community care support they receive. We have also been reviewing our model of care for adults with eating disorders to offer an expanded model of care.

MSE is continuing to work to address the backlog of patients waiting to receive planned care treatment across the system. Currently there are still over 2,000 patients that have been waiting over 65 weeks for treatment. The system is also still not meeting the national cancer standards, with only around 62% of people getting a

diagnosis or having cancer ruled out within 28 days of referral and only 38% of people having their first definitive treatment within 62 days of receipt of an urgent referral. Over 23% of patients are waiting more than six weeks for a diagnostic test.

The ICB has successfully reduced the rolling 12m antibacterial items /STARPU from 1.143 in April 2023 to 1.108 in December 2023 (latest data available) whilst maintaining proportion of co-amoxiclav, cephalosporins and quinolone items below 10% (8.53% in Dec 2023). It has also reduced overprescribing. In Oct 2022 there were 111,458 (10.87% c.f. 10.79% national average) people taking 8 or more unique medications (range across alliances 8.33% to 11.04%) and the average number of unique medicines prescribed for all patients in MSE was 3.66 compared with 3.53 nationally. In December 2023 figures had reduced to 37,690 (9.30% c.f. 11.15% nationally) and 3.37 compared with 3.58 nationally.

Enablers

9. Supporting our workforce

Understanding our current workforce and planning for the future has been a key focus in 2023/24. The NHS Long Term Workforce Plan released in 2023 is the most comprehensive workforce plan in NHS history and provides a blueprint that can be tailored to the needs of our system. Its ambitious strategy includes three priorities of 'Recruit, Retain and Reform' which means retaining existing talent, making the best use of new technology and the biggest drive on recruitment in health service history.

To support this, MSE has been working towards a system-wide approach to workforce planning that is closely aligned to finance and activity planning so that workforce enduring vacancy information is shared across the system and a joint approach established to work to reduce vacancies and bank and agency utilisation. Workforce stratification is being used to understand workforce hotspots by specialty to support focussed intervention on recruitment. Retention, transformation and staff wellbeing.

Throughout the year, we have also been working in partnership across the system to support the introduction of new roles within each organisation which include Training Nurse Associates, Advanced clinical Practitioners Physician Associate, Enhanced Healthcare Support Worker roles and apprenticeships. We have also launched the Healthcare Support Worker academy launched as a 'one workforce' initiative.

As part of our 'One Workforce' strategy, we have launched a Healthcare Support Worker Academy to ensure a strong pipeline of Healthcare Support Assistants (HSAs). System-wide, the 'Our People Your Future' programme is in place, with its ambition to attract those who will 'Be the future of health and care in Essex', providing online courses, apprenticeship guidance, careers advice and job opportunities.

Looking forward to future generations of the workforce, Basildon Hospital is working as the pilot site for 'Generation Medics in Essex' is an Anchor Programme that connects the NHS in MSE with the local community to provide more opportunities for young people, reduce their environmental impact and create volunteering opportunities. The Programme brings together partners from across the healthcare system to understand how the Trust can be a real force for good and provide high-quality local employment, support staff in their professional development, and reach out to local partners to help them succeed.

Case study: Anchor Programme – supporting our workforce

In partnership with health and care (local councils) and the education sector in mid and south Essex, MSEFT (as one of the largest employers in the region) aims to provide more opportunities for young people, reduce their environmental impact and create volunteering opportunities, through the Anchor programme.
The programme brings high-quality local employment, supports staff in their professional development, and reaches out to local partners to help them succeed. Basildon Hospital is the pilot site, with the programme set to expand to include all three hospital sites and communities across mid and south Essex later this year.

10. Data, digital and technology

MSE ICS has implemented Athena its strategic data platform. This platform provides self-service business capability across population health, primary care performance, mental health and UEC. It provides the insight which underpins our stewardship programmes and teams redesign care pathways and interventions. Moving forward the teams are reviewing how the Federated Data Platform can further complement and enhance our capabilities as a system.

Partners across MSE are on track to implement the first release of our Shared Care Record initiative by July 2024. The Shared Care Record will be accessible to our health and care partners across MSE. Future releases will take a clinical use case approach to ensure the Shared Care Record supports a patient centred approach to care provision across our partners.

MSE ICS continue the delivery of their digital patient interface solutions. We are live with demographic information across MSEFT and EPUT. With further releases providing appointment and diagnostic information being phased over July to October 2024. Both trusts are working with their services to support service specific transformation and implementation requirements.

Work to implement a unified Electronic Patient Record (EPR) across MSE, specifically across the two major NHS Trusts (MSEFT and EPUT) has also progressed in 2023/24. A preferred provider has been identified and planning for implementation, which will start post full business case approval and contract signature has begun. The Full Business Case is currently undergoing its national review. Our teams are working towards an approval date at the end of July 2024. The trusts are planning to go live in 2026 where they will aim to realise significant productivity, patient experience and clinical benefits.

The virtual hospital programme continued to progress during 2023/24 with the equivalent of an Emergency Department: the Urgent Community Response Team (UCRT) and at this stage three virtual wards, one for frailty, one for respiratory

patients and one for heart failure, in addition to the acute led Hospital@Home service. As at February 2024, virtual wards have been at 100% occupancy with the exception of respiratory. Patient and staff surveys have been undertaken to assess ease of use and overcome any challenges faced. Analysis showed that 60% of patients entering the frailty virtual ward with some level of social care input achieved complete independence at discharge from the frailty virtual ward, requiring no package of care. Avoiding admissions to a physical hospital not only alleviates system bed pressures, it also reduces infection risks on physical hospital wards during a time of high occupancy and has the opportunity to reduce carbon emissions.

Case study: virtual hospital – digital, data and technology

- As of February 2024, virtual wards have been at 100% occupancy with the exception of respiratory.
- Avoiding admissions to a physical hospital not only alleviates system bed pressures but reduces infection risks on physical hospital wards during a time of high occupancy.
- The UCRT operates across MSE, with a single point of access offering a two-hour response time. It supports patients in their own homes (including nursing and residential care comes) for up to 48 hours, with others transferred to the virtual wards where clinically appropriate for up to 14 days.
- The virtual wards are multidisciplinary with medical oversight and leadership. The team includes registered nurses, physiotherapists, occupational therapists, rehabilitation assistants and health and care support workers.

The UCRT operates across MSE, with a single point of access offering a two-hour response time. It supports patients in their own homes (including nursing and residential care comes) for up to 48 hours, with others transferred to the virtual wards where clinically appropriate for up to 14 days.

11. Financial sustainability

Throughout 2023/24 MSE has continued to have a system-wide financial sustainability programme in place. Within the ICB this has included:

- A significant restructure during 2023/24, reducing running costs by 30% and is on track to reduce to £17.2m by April 2025.
- Closure of historic clinical commissioning group headquarters estates, except for Phoenix Court which remains as the ICB headquarters.
- Leading a system-wide programme to review options for corporate function consolidation and further collaboration, to offer best value to our population.

- Recruiting a new Health Economist to help us better evaluate the impact and value we gain from services to inform future planning and contracting. They have started working on a review of Talking Therapies service provision, Tier three weight management services and intermediate care provision.
- Initiated an NHS system-wide infrastructure strategy, to be completed in 2024 to help us understand our current estate and broader infrastructure, as well as opportunities for improving use and value across the system.
- Work with our procurement provider, Attain, to update internal processes to ensure the ICB is compliant with the new Provider Selection Regime (PSR).
- Appointing a new Executive Director of System Recovery working across the ICB and MSEFT.

Across the system, we have had confirmation of £110 million of capital, to support MSEFT to increase the number of beds, improve capacity in all three emergency departments, improve cancer and planned care by upgrading and expanding surgical theatres.

12. Research and innovation

Research:

During 2023/24, MSE has continued to draw investment in research and innovation, into the system. As part of that, MSE has secured funding from NHS England to develop a Research Engagement Network (REN) which is being developed in partnership with our main hospitals and members of our Community Assembly. The REN aims to help researchers in MSE provide a better service for groups that have traditionally been under-represented in research.

MSE has been undertaking research across the whole system, including studies in community and primary care such as:

- LISTEN: Long COVID personalised self-management support evaluation where nurses and our CRPs were trained to deliver a coaching-style intervention to those suffering from diverse symptoms of long COVID. We delivered 6 one-hour sessions to each participant, and it was hugely successful. We received positive feedback from our participants and as this was also a community study, not just primary care, we reached a wider population and helped those who were in isolated locations too.
- Chelsea 2: A cluster randomised trial of clinically assisted hydration in patients in the last days of life. We helped a research-naive hospice set up and run this study. Farleigh hospice was randomised to the intervention arm; therefore we evaluated the effects of receiving fluids during EOL. Our nurses and CRPs go over to the hospice to transcribe comprehensive data of the last 2 weeks of life for each participant.

- E-Plays: Enhancing pragmatic language skills for young children with social communication impairment. Evaluation of a computerised intervention to promote communicative development and collaborative skills in children. Many of our Luton schools have participated and the study is one of the biggest research trials on children's language development ever to take place, which has given schools the opportunity to access a brand-new language programme free of charge.
- Small Business Research Initiative for Healthcare (SBRI): Recognising the unique challenges encountered by LD patients, particularly in healthcare settings, MSEFT collaborated with oVRcome to initiate an innovative project focused on addressing phobias and social anxiety in the comfort of patients' homes. oVRcome, a clinically proven smartphone app utilising virtual reality (VR) and exposure therapy, was tailored to meet the specific needs of LD and autism cohorts, empowering users to acclimatise to hospital environments at their own pace, alleviating associated anxiety and phobias. With funding from SBRI, we have successfully completed phase 1 of this research project which involved a pilot, developing scenarios familiarising patients with our different hospital sites, scenarios with needles and a few other busy environments. Following the success of phase 1, MSEFT applied and won SBRI funding for Phase 2 of the project, and we have committed to focussing on scenarios to tackle needle phobia, primary care environments (annual health checks etc) and diagnostics. So far, co-production sessions have taken place to establish the specific content to be covered, and we will be piloting these with LD participants in Autumn this year.

Across EPUT, work has progressed to provide more capacity to support research within the organisation and strengthen the relationships with academic networks within and beyond Essex. This capacity has supported the Trust to increase the number of clinicians able to act as Principal Investigators, created a forum to support nursing and AHP Masters students in their research, helped increase the volume and participation in trials and increase internal awareness of support for research within the organisation.

Innovation:

MSE has strong track record of support innovators and adoption of innovations, both locally and nationally. This is demonstrated through the MSE Innovation Fellowship, which supported 18 innovators within MSE in 2023/24. MSE also has a number of anchor innovation programmes, including:

- **Social Spark** – a Basildon Healthcare social innovation incubator that is exploring innovative ways to tackle healthcare inequality through social and economic solutions by supporting those in and around the Basildon area with great ideas to improve healthcare.
- **Accident and emergency youth project** – which is building on an existing model of youth worker presence in Basildon Hospital A&E between 3pm –

8pm, 5 to 7 days a week to provide a safe space for young people to explore their identity, experience decision-making, increase their confidence, develop inter-personal skills and think through the consequences of their actions.

- **Essex Pedal Power** – which provides free bikes for local NHS staff working at bands 2-4 at Basildon Hospital. The scheme recognises that there are a range of barriers to cycling that go beyond simply having access to a bike. As such, the Essex Pedal Power team will offer free cycle training in a safe environment with trained professionals and support you to maintain your bike. They will also help to create informal cycle groups to create a community of people who all benefit from cycling. Bikes are initially given to recipients as part of a six-month loan. If successful applicants are enjoying having a bike and using it regularly, at the end of the six months they can keep the bike for free. They will also receive a bike helmet, lights, pump, and a D lock free of charge.

Building on their success in supporting the national Clinical Entrepreneur Programme (CEP), in 2023, MSEFT co-developed the NHS CEP InSites Programme as a system capacity-building pilot programme to evaluate innovations supported by NHS England whilst also developing organisational capability and infrastructure in local systems.

www.midandsouthessex.ics.nhs.uk

Mid and South Essex

NHS Mid and South Essex Joint Forward Plan 2024-29

(Section 3 - Delivery)

Final Draft for Approval

We are collaborative

We are innovative

We are compassionate

We are living well

MSE JFP 2024-29: Operational Delivery

Mid and South Essex

Mid and South Essex Integrated Care Board (MSE ICB) have refreshed our Joint Forward Plan (JFP) for the next five years, 2024-2029. The JFP recommits the NHS system in MSE to the strategic ambitions set out in the 2023/28 Joint Forward Plan. Given MSE's financial challenges, the immediate focus is on recovering a sustainable financial position, delivering on national operational requirements and maintaining a focus on addressing health inequalities as we do that.

This section (3) of our JFP provides more detail on the operational activities that we will undertake to deliver against our ambitions. It takes account of our statutory requirements, the national requirements set out in the Operational Planning Guidance and the priorities agreed through the local Recovery Programme focused on improving our system's financial position. Wherever possible, we have set out longer term ambitions for improving care. These ambitions will be used to inform the Medium-Term Financial Plan that MSE will be developing in 2024, which may – in turn – lead to updates in future iterations of the JFP.

In March 2024 we published an updated JFP summary that sets our recommitment to our Strategic Ambitions and progress to date. This section of the JFP takes into consideration and builds upon our plans for system financial recovery, 24/25 operational planning commitments and any additional salutatory duties not covered by these.

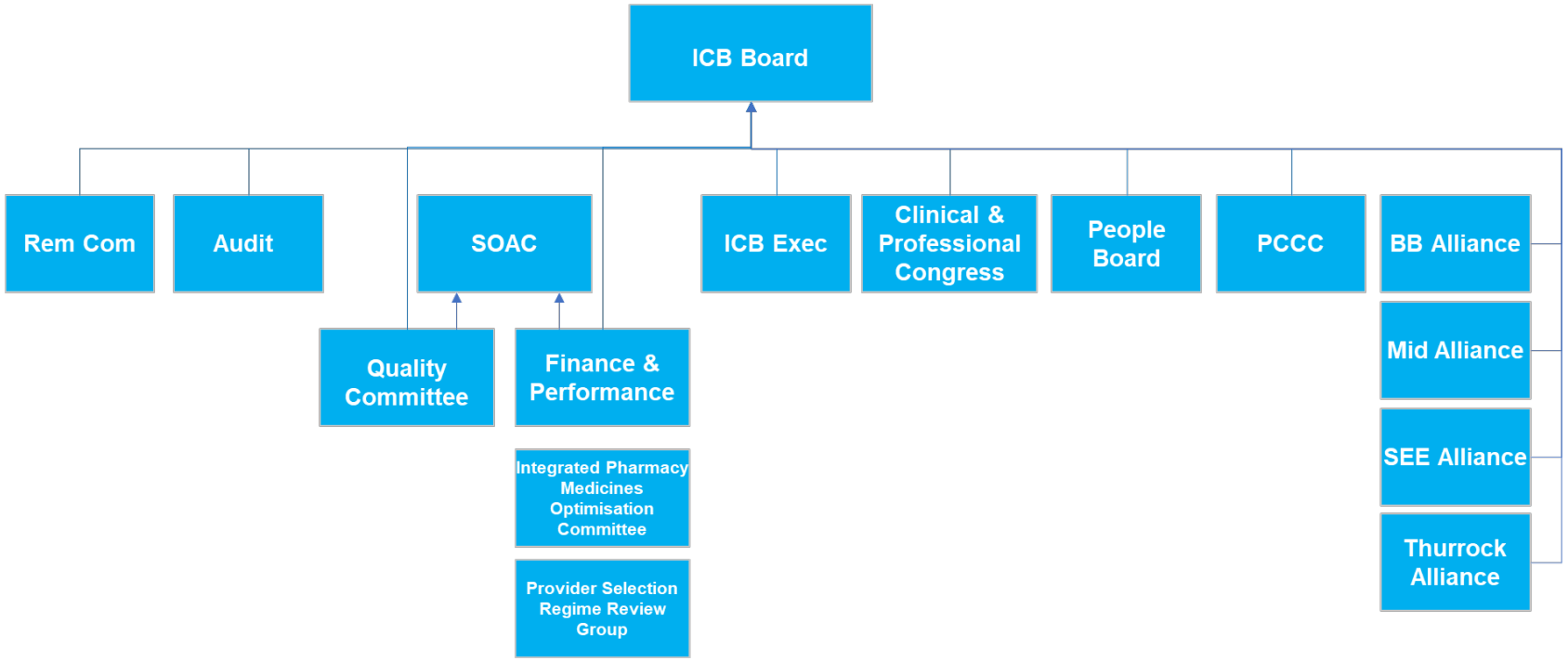
To align with the strategic priorities set out in Section 1 of our JFP, we have grouped programmes to align with the three areas of focus across the ICB:

Partnering	These programmes and initiatives focus on how we work together to develop and deliver our plans and provide collective assurance on the quality and value that services offer to local residents.
Delivering	These programmes and initiatives focus on operational delivery to drive improved quality of care for patients, adjusting how we deliver to address health inequalities and look at upstream delivery to improve the health outcomes across our populations. This includes the programmes that fall within the current System Financial Recovery Programme.
Enabling	These programmes and initiatives focus on the critical enablers in our system that are needed to support successful delivery and effective partnership working to improve care outcomes. Those include our workforce, data, digital and technology, financial sustainability and research and innovation.

Governance to support delivery

Mid and South Essex

The ICB's formal governance arrangements provide a clear route for oversight of performance across the system, including performance on quality and finance.

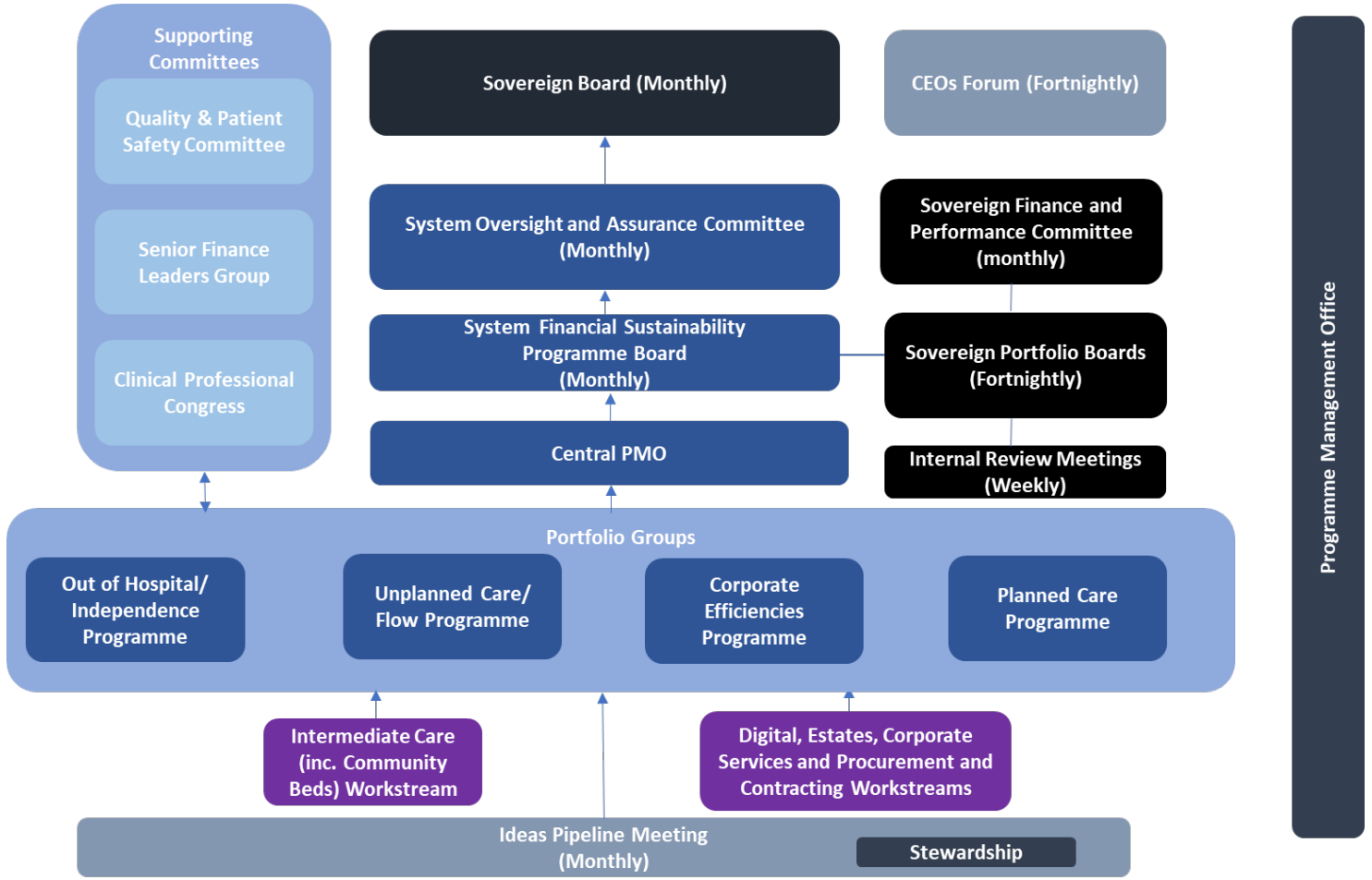


- The ICB Executive facilitates swift decision making within the organisation, within its delegated authority. That includes weekly financial considerations through the system's 'Triple Lock' process for financial approval and oversight of recruitment decision.
- Core Programmes report into the Finance and Investment Committee and Quality Committee on progress, including highlighting key risks and associated mitigations.
- Escalations are made to the System Oversight and Assurance Committee (SOAC). SOAC is co-chaired by a representative from NHS England's East of England Regional Team, ensuring there is alignment in their oversight of the system.

System Financial Recovery Programme

NHS
Mid and South Essex

The System Financial Recovery Programme governance structures provide a clear accountability route for work that is providing a significant contribution to MSE's financial recovery in 2024/25.



- The system will be held to account for collective delivery against the agreed recovery plan through the System Financial Sustainability Programme Board (SFSPB), chaired by the Director for System Recovery.
- Each Organisation within the system has established its own Recovery Portfolio Board, responsible for overseeing implementation of its individual initiatives. These will report into the SFSPB.
- Four core portfolio groups bring the system together to ensure alignment across individual projects and programmes that are collectively delivering improvements for the system in key areas:
  - Out of Hospital Care (independence)
  - Unplanned Care / Flow
  - Corporate Efficiencies
  - Planned Care

Partnering

Mid and South Essex

These programmes and initiatives focus on how we work together to develop and deliver our plans and provide collective assurance on the quality and value that services offer to local residents.

Strategic ambitions identified in the Joint Forward Plan include:

- Letting Staff Lead
- Mobilising and Supporting Communities
- Further Developing our system
- Improving our oversight framework rating

Stewardship

Mid and South Essex

Where are we now	How are we engaging our population
Stewardship is an innovative approach to health and care services that we have developed across the Mid and South Essex Integrated Care System. The purpose of Stewardship is to bring together teams of health and care professionals within a care area, to get the best value from our shared health and care resources by applying the principles of the NHS Triple Aim. We have 10 active stewardship groups – Ageing Well; Babies, Children and Young People; Cancer; Dermatology; Diabetes; Eyes; Mental Health; Musculoskeletal; Stroke; Urgent and Emergency Care. Our Stewardship Spring Summit was a success and featured in Matthew Taylor's recent blog regards the culture of change: https://nhsconfed.org/articles/why-change-health-service-so-difficult	Ageing Well and Stroke stewards are contributing to the current Community Capacity public consultation as well as public and staff engagement events. Musculoskeletal and Ageing Well stewards are working with patient engagement groups to develop aspects of Fracture Liaison Service.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to increase the number of stewardship groups across the system each year. In doing this, we will continue to develop the stewardship programme so that it contributes to the financial recovery of the system through data driven decision making, application of the value improvement process, involvement in investment and disinvestment discussions and embedding the principles of personalised care	We are currently developing our white paper for the year ahead. This will include our intended approach, in particular how stewards will support system financial recovery, and how the stewardship programme team will work to orientate following the ICB re-structure, consolidate on existing work and work to develop and deliver on longer term goals including broader system engagement, culture change and to spread the stewardship approach and value improvement capabilities further.

What action will we take	What impact will this have	When will this action be completed
Development and approval of Stewardship White Paper 24/25	Clear plan for stewardship programme	September 2024
Ongoing training and support programme for all stewards	Enhance the skills and confidence of stewards	Ongoing
Sustained and improved use of data sources to drive decision making	Robust data sets that enable identification of financial and quality improvement opportunities	April 2025
Embed the Stewardship Value Improvement Process as a framework for decision making	Support navigation of complex decision-making processes through a structured, and pragmatic manner	April 2025

Working with People & Communities (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have established a wider network of community relationships, especially within the underserved groups and those affected by health inequalities. The development of our Research Engagement Network this year has underpinned our progress with the creation of 18 community champions and closer and more cohesive working with partners through Alliances. We continue to develop a range of training modules for staff to support embedding involvement and engagement principles across the ICB and wider partnership. There is also guidance for staff to understand the need to engage and what tools and resources are available to them. A work plan and timeline has been developed to support the development of the 'Working with People and Communities Strategy', however, delivery of this is dependent on securing substantive resource.	1. Virtual Views – our online engagement platform, has supported our engagement, especially for the community beds consultation. This platform is now very popular for the public and our staff for sharing surveys, gathering feedback via forums and focus groups. These have been both virtual and face to face. 2. Engage News – is our regular newsletter to share all engagement activity and opportunities. We also offer our partners across the ICS the opportunity to share information this way. 3. REN – The development of the Research Engagement Network is an important way to reach underserved communities and link with local research opportunities. 4. Insight Bank – is a repository for sharing reports and insight from across the ICS and further afield. The information continues to grow. 5. Readers Panel – we have a strong readers panel who support our work before it is published. Working with our three Heathwatches and key VCSE organisations to target key demographics will continue as business as usual.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to increase the number of groups we work with and support to reach into communities, especially those who are affected by health inequalities. We will continue and build on our system working with our ICS partners to ensure joined-up engagement. We will drive shared use of Virtual Views across our health partners and redevelop our Community Assembly to be more inclusive and embed the VSCE sector more fully.	Behaviour change across the system to support a more joined-up approach as resources have been reduced centrally. We can share more and reduce duplication. The Virtual Views platform is starting to support this approach. We will review opportunities to secure substantive resource to support the ICB to deliver its statutory responsibilities in regard to involvement activities.

Working with People & Communities (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Continue to develop the REN community champions network i.e. target GRT and LGBTQ+ groups to become champions	By improving the trust we have with underserved groups it will improve even further our reach into these groups	Ongoing but will be subject to bidding for and winning future bids through the REN project
Development and further awareness raising of Virtual Views, Including the expansion of the platform into primary care.	increase numbers signed up to the platform, allowing us to target our engagement more appropriately	Pilot launched in 2024 with one PCNs with nine GP surgeries, prior to to extending all
Readers Panel – increase numbers of younger panel members, along with those where English is not their first language.	Improve our communications with a wider cohort of the public which would be much easier to understand.	During 2024
Work with Community Assembly leadership group to develop a refreshed operating model	Successfully embed the sector in the work of the ICB/ICS at strategic level	Over the next year and regularly reviewed

Developing our Community Services (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have consolidated our community health services under a single contract to provide us with a platform to improve, integrate and innovate our community services aligned to the 3 pillars of community services – 1) Urgent & Episodic Care, 2) Complex & Chronic Care, 3) Preventative Care. Our virtual wards and urgent community response teams continue to consistently perform above the national standards for responsiveness and occupation. We retain focus on the reduction of the number of people awaiting first appointments and the number people waiting a long time for an appointment in line with the national target of zero waits over 52 weeks by April 2025. There has been a temporary reconfiguration of community inpatient beds for intermediate care (IMC) and stroke rehabilitation. An 11week public consultation took place between January and April 2024 to gather views on the future, long term configuration of these beds.	We have undertaken a public consultation to inform the location and configuration of the community health service bed base. We have had a significant response to the consultation, and we are awaiting the outcome report of this consultation. The Decision-Making Business Case will be presented to the ICB Board in September.

What are our ambitions	What needs to change to achieve our ambitions
We have set an ambitious plan for 2024/25 focussing on these priority areas: 1. Reduce unwarranted variation. 2. Focus on healthy lives and disease prevention through earlier intervention. 3. Supporting the triple aim – value to person, system and value for money 4. Provide care closer to home 5. Supporting the reduction in 4-hour ambulance handover times, acute demand and length of stay improvements	We have identified several changes to support our ambition: 1. Development of our community workforce 2. Standardisation of services across the community collaborative 3. Increased patient and public engagement to facilitate more co-creation 4. Continued service improvement programmes 5. Development of the community collaborative 6. Increased and improved community service to bring care closer to home wherever possible

Developing our Community Services (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Increased virtualisation	More people receive support and treatment at home	March 2025
Optimised IMC and stroke rehabilitation	Optimise recovery after periods of ill health	March 2025
Optimised estate	Increased investment in community services	March 2025
Cardiovascular disease prevention	People receive early diagnosis	March 2025
CYP service optimisation for complex children	Better management of long-term conditions Improved experience	March 2025
Integrated neighbourhood teams and Transfer of Care Hubs	Wrap around, joined up support, for people to stay healthy in their communities	March 2025

Anchor Programme (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
System Annual Impact reports have recently been presented to respective boards including plans for a refresh of the 'MSE Charter 2023-27', that may feature a Greater Essex Anchors variation. The programme has series of (Pillars) work strands; Employment, Social Value , Land and Buildings , Sustainability and Leadership and Partnership with activity taking place in each pillar. The work programme has an established stakeholder base, that includes national recognition and participation. Key priorities for 2024/25 focus on the implementation a refreshed Mid and South Essex and Greater Essex Anchor Charter(s), delivering its values and outcomes work equalising its deployment across all five of its pillars.	1. Dedicated webpages, published reports, and webinars 2. Continuing the regular and periodic virtual and in person engagement opportunities that in 23/24 saw 455 system leaders attending 16 sessions that helped to support their knowledge and experience of anchor, including the Acute Trust Annual General Meeting, How Strong is your Anchor? and Future Anchor events. 3. We have engaged circa 1,500 individuals (residents) participation in demonstrators i.e. Anchor Ambition, Supported Internship, Work Experience and Youth Work in Hospitals. As well as through public facing activity that we facilitate in health settings i.e. Basildon Women's Safety Charter awareness raising and Armed Forces Community

What are our ambitions	What needs to change to achieve our ambitions
To provide a series of demonstrators that enable the public sector in Mid and South Essex and beyond to develop and implement their Anchor work and ensure it has support at all levels of an organisation Supporting activity that collocates multi-sector activities making the best use of MSE land and buildings and harnesses opportunities to increase people's access to high-quality work. To develop a sequence of sustainability demonstrators, that, including active travel help to improve air quality, reduce costs for all and improve physical and mental health	1. Agreement, commitment and implementation of an Anchor Charter by its signatories 2. Additional system wide/ led investment in Anchor Ambition 3. The effective management and use of social value offers derived from procurement processes that are local and /or clearly benefit the residents of Mid and South Essex 4. An agreed approach to co-financing projects (community transformation fund) that can prove positive outcomes and reduce the pressure on acute and primary health demand

Anchor Programme (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Refreshing the Mid and South Essex Charter and extending its reach, supporting and enabling signatories to report and evidence their progress	Supports the delivery Objective 4 for Mid and South Essex Integrated care System	October 2024
Values and Outcomes: work to identify opportunities (and their value) to work with Voluntary, Community, Faith and Social Enterprise organisations to reduce attendance, admissions, readmission and expedite discharge	Provide insight, and evidence of potential savings and invest to avoid further system costs	March 2025
The development and continuation of Anchor Ambition and Social Spark demonstrators and their contribution (using social value) to help the NHS support broader social and economic development	Better use of resource (social value) and widening of individual and community participation in wealth creation	October 2024 and ongoing
To develop further an NHS iteration of Essex Pedal Power (Active Travel) pursue opportunities that help to develop and sustain climate activism and changing practice in health settings	MSE's health workforce becomes a key contributor to climate led behavioural change	March 2025 and ongoing

Delivering

NHS
Mid and South Essex

These programmes and initiatives focus on operational delivery to drive improved quality of care for patients, adjusting how we deliver to address health inequalities and look at upstream delivery to improve the health outcomes across our populations. This includes the clinical service programmes that fall within the current System Financial Recovery Programme.

Strategic ambitions identified in the Joint Forward Plan include:

- Improve Quality (access, experience and outcomes)
- Reduce Health Inequalities
- Population Health Improvement
- Operational Delivery

Delivery through our place-based Alliances

NHS
Mid and South Essex

Across our system it is recognised that delivery of our plans will be achieved locally through Alliance teams and close partnership working.

The 4 Alliances across MSE have undertaken a prioritisation exercise linked to financial recovery. In order to support system priorities, the aim is to have clarity on which areas Alliances will lead on (key areas will include Integrated Neighbourhood Teams and Transfer of Care Hubs) and areas that Alliances will actively deliver in conjunction with other teams, including:

- Medicines Optimisation
- Mental Health
- Children and Young People

By 30th June 2024 further clarity on specific areas that each Alliance will lead. Currently Thurrock will lead on Mental Health, Basildon and Brentwood to lead on Primary care, Mid Essex to lead on Community Collaborative and South East Essex to lead on Flow and Discharge. Other areas to be clarified.

The following slides highlight the importance that Integrated Neighbourhood Teams will play in local delivery, and Alliances are working together to ensure consistency, share learning and to agree shared priorities and promote integration across health, social care, local Council and Voluntary sector. Monthly reporting will be in place from July 2024 to measure progress.

Other key areas for Alliances include reducing Health Inequalities and promoting further integration by developing and strengthening local delivery plans with partners. Health Inequality funding has been devolved to individual Alliances and plans already in place for 2024-25. Progress on spend and delivery will be monitored quarterly through the MSE Health Inequalities Investment Group.

Each Alliance area has a strategy, co-designed with partners and supported with data, to improve the health and wellbeing of the local population. Delivery plans will be monitored via each Alliance Committee.

Basildon and Brentwood Alliance

NHS
Mid and South Essex

Where are we now	How are we engaging our population
2 out of planned 6 Integrated Neighbourhood Teams (INTs) are now operational with positive impacts being seen in terms of capacity and outcomes. Specific focus on Mental Health and High Intensity Users. In conjunction with PCNs and local provider changes to pathways with involving mental health practitioners have led to reduced waiting times. Through our health inequality panel our plans are supporting a diverse range of projects in our most deprived areas, children and young people and Black, Asian, Minority Ethnic communities. Our Live Well strategy continues to develop with different partner organisations taking a lead on each domain.	Each of our 6 PCNs have established wellbeing cafes to engage local residents and provide key information and receive feedback. Achieve, Thrive and Flourish have been commissioned to work with us and grow the strengths in our local communities. They also provide Social Prescribing on behalf of 1 Primary Care Network and using their reach into communities to provide more personalised care. Asset mapping was commissioned in 2023 to engage with our local communities and provided valuable insights into local service provision and will be used as part of our ongoing delivery plan.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is for all 6 INTs to become operational during 24/25 with clear priorities agreed with partners. We intend to publish a clear health inequality plan across our Alliance supported by baseline data and stretch targets for improvement. We aim to have 90% of GP Practices to be accredited as Active Practices. Through our Live Well Strategy, we will publish clear outcomes and metrics with ongoing monitoring by our Alliance Committee.	Clarity on estates plans as there is a significant cost pressure that will prevent any primary care development. Creation of communities of practice focusing on Additional Roles Reimbursement Schemes (AARS roles). Supporting the local third sector, maximising health inequality funding ensuring alignment to local strategies. With the extension of Find Your Active funding, linking INTs to build upon current successes with physical activity.

What action will we take	What impact will this have	When will this action be completed
Implement plans to establish 6 INTs during 2024-25 ensuring Councils, voluntary sector, health partners and emergency services engaged	Improve capacity, improve outcomes, avoid duplication	December 2024
Publish Health Inequality plan that includes PCN level data with clear priority areas	Reduce inequality (screening/traveller community)	October 2024
Publish Live Well Strategy and associated delivery plan	Clarity for all Alliance partners on locally agreed priorities and pooling of resources	August 2024
Support our GP practices to become accredited Active Practices (aiming for 90%)	Focus on staff and patient health and wellbeing, not just through clinical care	March 2025

South East Essex Alliance (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
6 Integrated Neighbourhood Teams (INTs) are maturing with a consistent focus on frailty using Aligned Community Teams (PACT) models. Across our neighbourhoods, condition specific health and wellbeing events (incl. diabetes & CVD) are improving access to assessment, intervention and health literacy. The 2024/26 Alliance Delivery Plan is aligned to the strategic ambitions of the MSE System Financial Recovery Plan, uniting system and local priority areas with a single outcome of 'Healthy Neighbourhoods', underpinned by 4 local targeted areas; Healthy Start, Healthy Minds, Healthy Living and Healthy Ageing.	Our 'In Conversation With ....' programme proactively seeks out the public where they are, in their own communities to listen to what matters to them in their neighbourhood. The data and insights gathered will be shared with Alliance partners to help focus future priorities and shape plans for positive change. We are hearing to be healthier people need: Access to GPs, Better roads and Pavements, Cleaner Environments, Less Crime and Better Transport.

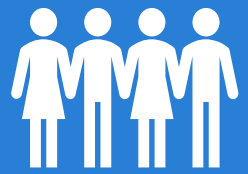
What are our ambitions	What needs to change to achieve our ambitions
Aiming to narrow the gap in health inequalities, improve population outcomes and experiences and ensure best value for money. Empowering communities to be active participants in their own health and care by delivering a total of 8 INTs by March 2025, embedding agile approaches to build strong partnership networks and provide proactive, preventative and anticipatory care. Through the lens of recovery, we will target system priorities, focussing on active and impactful contributions with all partners and building on the strong foundations already in place. Creative and innovative mobilisation of health inequality funding will target populations with greatest need, improving access, outcomes and healthy life expectancy.	The 2024/26 Alliance Plan highlights the need to be agile and create opportunities to co-design and deliver collaborative ways of working, this approach will enable us to eliminate duplication and identify where Alliance partners can add maximum value. Narrowing the gap in inequality will be a golden thread throughout all programmes of work and this will be driven by a data and insight led approach to focus action and deliver meaningful and sustainable impact.

South East Essex Alliance (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Deliver 8 operational INTs, embedding new collaborative ways of working and connecting communities, focus on increasing early identification of frailty by embedding FrEDa (see next slide for information) within INTs and multi-agency partners.	Create united shared capacity, focussed interventions to reduce duplication and improve outcomes. Reducing avoidable attendances, admissions and improving lived experience for residents, families and carers	March 2025
Evaluate the Trusted Partner approved Health Inequality initiatives, selected based on criteria aligned to system financial recovery	Improved access for targeted populations to meet needs and drive preventative approaches	January 2025
Targeted approach to CVD risk stratification and champion optimisation of system and local led initiatives including Sport England funded initiatives in Canvey Island	Increase CVD registers in primary care. Focussed approach to preventative measures, improved adherence to medication and reduced incidence of hypertension and ED attendances	March 2025
Review, redesign and right-size the Southend Enhanced Discharge (SEDs) model	Residents will be placed on optimum discharge pathway, reducing dependency, readmissions and streamline acute flow	October 2024
Develop a dashboard that brings together insight, need, quality and performance into a single view	Accessible view of local level data including hotspots, trends, need and achievement of local/national targets	October 2024

4 reasons why Fr E D A can be a system wide game changer



Fit for purpose Population Health Management (PHM) delivering and measuring the metrics that matter most, that we never could comprehensively deliver and capture before

Ensuring Frailty/Dementia/EOLC is Everyone's business

Uniting our collaborative efforts together

Organic cultural change at scale to achieve a positive paradigm shift

OUR PEOPLE YOUR FUTURE

Be the future of health and care in Essex

Practical system wide deployment of Personalised Proactive Care

Mid Essex Alliance

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Six INTs have been developed using a combination of data, relationships, the Core20Plus5 framework and Wider Determinants of Health. Integrated leadership forums and locality-based meetings have been established to identify patient level solutions and design wider strategic priorities for each neighbourhood. Projects are in place to support the reduction of health inequalities in areas such as homelessness and Serious Mental Illness. More broadly, Alliance partners worked collaboratively to produce a bespoke, Mid Essex version of the Thriving Places Index (TPI), clearly setting out opportunities for improvement of health inequalities within each of our three districts.	Healthwatch Essex are key stakeholders providing strong patient perspective and insight. Quarterly engagement groups are held with the public, as well as several events (i.e. Community in a Cup') in the Maldon locality. Integrated Neighbourhood Team (INT) membership from a broad range of partners ensures a 'voice' from across our community, which we anticipate will further develop as INTs continue to mature. Previous asset mapping continues to shape understanding and opportunities for targeted support, building on existing strengths.

What are our ambitions	What needs to change to achieve our ambitions
We will develop a plan to address Health Inequalities by routinely incorporating TPI into shaping priority, policy and funding decisions. We will also focus on two 'demonstration projects' (respiratory and economic development) over the next 12 months to evidence how the theory translates to actual change. We will expand MSE-wide health inequality schemes to reduce variation. We will develop a strong interface between the Mid Essex Transfer of Care Hub (TOCH) and INTs, ensuring a smooth transition for patients throughout their care pathway. With partners, we will refresh our Alliance Strategy in 24/25, maximising the opportunity for impact by streamlining priorities.	Incorporation of TPI into the decision-making mechanisms across all partners aligned to a commitment to focus resources on recommendations emerging from TPI, in particular for the two demonstration projects. Ongoing 'promotion' of the purpose and benefits of INTs across all levels of staff and communities, and a mechanism for stakeholders to contribute to vision and priorities. A strategic approach to estates that cuts across Alliance partners, recognising financial and operational benefits of co-locating clinical and non-clinical services.

What action will we take	What impact will this have	When will this action be completed
Finalise INT strategic priorities and outline delivery plans	Clarity of purpose and benefit realisation through an integrated approach.	Dec 2024
Refresh and publish Mid Essex Alliance strategy	Clarity across partners on locally agreed priorities / pooling of resources.	August 2024
Incorporate TPI into decision making across all partners, devise district-based priorities and outline delivery plans	Greater positive impact on health inequalities through targeted, multi-agency solutions that better understand and address issues.	September 2024
Local expansion of MSE-wide schemes to address defined health inequality priorities	Consistent improvement across the Alliance and targeted utilisation of funding	October 2024

Thurrock Alliance

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have 4 PCN areas in Thurrock, of which 3 have successfully launched their INT and the 4th launched on 12th June 2024. The 3 established INTs are fully operational with fortnightly meetings of frontline staff to case manage complex cases. This has resulted in new ways of working and reduced 'hand offs' and referrals across the system, thereby speeding up the assessment of the needs of residents and improving response times for care and support. Additionally, we now have a well-developed Transfer of Care Hub arrangement in Thurrock which links not only statutory services but also third sector agencies supporting hospital discharge.	Healthwatch Thurrock was commissioned by the Alliance team, to provide an in-depth evaluation of the experience of patients within the hospital discharge process. Early evidence suggests that most were aware that they were going to be discharged, but in the main, had less than 24hrs notice. Half said they did not feel confident that everyone who needed to know they were being discharged was aware. Discharge with medication/equipment etc, showed mixed results. This evaluation also engaged professionals (24) of varying disciplines. Similarly, most of the professionals stated they were not always aware that a patient was being discharged. We have regular community events being held at the 4 PCN areas and we link primary care, community health, adult social care and voluntary centre in with those, these events are approximately every 2 months.

What are our ambitions	What needs to change to achieve our ambitions
In Thurrock we have an integrated Delivery Plan which is aligned to the ICP strategy and Health and Wellbeing strategy and the Joint Forward Plan. The ambition for Thurrock is to collectively deliver on the plan, improving access. We also have an ambition to move towards integrated commissioning and we will be using the Better Care Fund to drive this forward. We aim to draw in the functions of the TOCH into the INTs over the next 18 months.	Increased support to local third sector is vital to moving plans on at pace and scale, aligned to this would be releasing additional funding from the ICB's BCF and discharge funds, to allow local priorities to be progressed more quickly. Workforce development and opportunities are now under discussion in order to build new/blended roles and to ensure that these focus on reducing health inequalities across high deprivation areas that sit within the borough.

What action will we take	What impact will this have	When will this action be completed
We will conduct a line-by-line review of the Better Care Fund to ensure alignment with strategic priorities	Better sight of current expenditure and decisions on which services remain relevant and to allow innovation in new service design	August 2024
We will progress the Integrated Commissioning Executive to provide clear governance, aligning the Better Care Fund to strategic priorities.	Improved oversight, value for money and commissioning clarity to deliver against agreed metrics and milestones.	October 2024
Establish localised funding boards.	Funding released to localised boards directly supporting co-design whilst linking these opportunities to the wider issues and priorities	March 2025

Patient Safety and Quality

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have implemented the Patient Safety Strategy and the Patient Safety Incident Framework in December 2023, across applicable commissioned services The Quality Committee, System Quality Group have been established, as noted requirement in NQB Guidance along with the establishment of a revised safeguarding structure across the Integrated Care System that provides safeguarding expertise at a Strategic, Place and Provider level. Our Quality Strategy is being refreshed in line with the ICB priorities for 24/25. Our 2023 Internal Core Quality Control Audit found 2 minor recommendations, enhancing the patient voice and building of a quality dashboard.	• Through feedback from the 4-place based alliance's • Use of patient stories within the ICB Quality Committee • Introducing patient stories and voice into SQG though our Healthwatch partners • To commence Quality Assurance visits to commissioned services that will include outpatient safety partners to understand the patient experience

What are our ambitions	What needs to change to achieve our ambitions
1. Ensuring CQC 'Should do' and 'Must do' recommendations are delivered and sustained. 2. More effective use of data to allow triangulation of information to support early identification of emerging concerns – development of system level quality dashboard 3. Development of oversight triangulation with contracting and operations to ensure all contracts have sufficient scrutiny to ensure quality of service provision, in partnership with provider teams.	• Promoting providers operate within a collaborative framework, with shared learning and approach to safety mechanisms are in place. • Strengthening relationship with Alliance's Teams to ensure local needs are understood. • Comprehensive understanding of CQC assessment frameworks for providers, but also our responsibilities in relation to becoming a regulated organisation • Continued team development to ensure the requisite skills to deliver against the ICB priorities • Continued promotion and implementation of the Pt Safety Strategy across the system.

What action will we take	What impact will this have	When will this action be completed
Series of education and learning events held to promote what good looks like	CQC Rating Improvements	March 2026
To build trust and confidence in the system quality space to enable shared learning	Learning culture	March 2026
Work with Business Intelligence teams to deliver an ICB quality dashboard	Timely and accurate understanding of system quality issues	March 2025

Serious Violence (Including Violence Against Women and Girls)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The ICB is a member of the Southend Essex Thurrock wide Strategic Violence & Vulnerability Partnerships (VVP), which work across Southend, Essex, and Thurrock (SET) to provide a co-ordinated approach to address particular violence issues, partnership include the: Violence and Vulnerability (VVU) Operational Board and Round Table, Southend Essex and Thurrock Domestic Abuse Board and Violence Against Women and Girls meetings.	Serious Violence Strategic Needs Assessment (SNA) - Gathering this intelligence on violence into one place ensures a multi-agency lens approach which allows the VVP to better understand the levels of violence in the community across Essex. This insight feeds into the 2024/25 plan, allowing strategic and operational activity to be targeted towards the key drivers of serious violence within the county, as part of a preventative approach to reducing serious violence. The insight within the SNA endorses the current approach of the VVP – that the Partnership is on the right course, delivering interventions which are having an impact and making a difference to communities.

What are our ambitions	What needs to change to achieve our ambitions
1. The partnership will promote multi-agency working and drive system change 2. The partnership will commission evidence-based interventions 3. The partnership will engage and communicate with a range of voices, including communities most affected by serious violence; service users; and young people 4. The partnership will support a learning environment	The SET VVP is meeting and delivering the requirement within the Duty of a Strategic Needs Assessment (SNA) through a SET wide SNA (produced in January 2023). All partners including the ICB have a role to play in reducing and preventing serious violence, especially since the commencement of the Serious Violence Duty (SVD) - this statutory responsibility is an opportunity for all partnerships to review their approach. Specified organisations named within the Duty have a range of duties, including to share data, intelligence and knowledge to generate evidence-based analysis of local problems and solutions and to commit to creating environments that nurture the protective factors that are evidenced as helping to prevent violence.

What action will we take	What impact will this have	When will this action be completed
1. Continue to receive and share learning with the system to drive change and awareness. 2. MSE ICB has offered their share of the SVD funding to the partnership multiagency work. This work has included joint commissioning projects and programmes.	As set out in the monitoring and evaluation framework, the VVP ultimately is working to reduce the three key success measures: 1. Reduce hospital admissions for assaults with a knife or sharp object and especially among those victims aged under 25 2. Reduce knife-enabled serious violence and especially among those victims aged under 25 3. Reduce all non-domestic homicides and especially among those victims aged under 25 involving knives	Ongoing Target to 2030

Tackling Health Inequalities (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The gap in life expectancy across MSE is as much as 10 years between some of the wealthiest and most deprived neighbourhoods. To address this, MSE has committed dedicated funding to address health inequalities. In 23/24 MSE funded over 50 projects focused on reducing health inequalities by supporting community development, improving access to health services in the most deprived areas or underrepresented groups and providing training and support for staff. Health inequalities is embedded in all programmes, including alliance place-based strategies. MSE's Population Health Management team are supporting increased use of data and insights through the population segmentation tool and 'disproportionate care' modelling. This is further supported by the Health Inequalities Dashboard, which is currently being developed. System wide governance has been established through the Population Health Improvement Board, which includes memberships from key system partners. More information on progress can be found in MSE's 'Narrowing the Gap' report and Health Inequalities Information Statement.	Alliances have appointed 'Trusted partners' which for 3 out of the 4 Alliances are Community Voluntary Sector partners and Thurrock Council. All Alliances have engaged with our communities to understand their needs and prioritise health inequalities spending to reduce inequities in access, experience or outcomes.

What are our ambitions	What needs to change to achieve our ambitions
Fully embed health inequalities, prevention and personalised care principles across the ICB organisation and throughout stewardship groups and other priority programmes. Shifting to a greater emphasis on early detection and prevention of ill health as well as further integration of services. Greater utilisation of data and insights to inform intentional commissioning to tackle health inequalities across all settings of care. Continue to invest in action to reduce health inequalities across MSE, in 24/25 that includes taking a more targeted approach to investing in system priorities including CVD and Cancer.	Embedding health inequalities and prevention across the ICB including within the Stewardship groups and priority programmes of work with support transformation and integration of services. Continued improvement in collection and use of health inequalities data, including finalising Health Inequalities Dashboard. Continued roll out of the digital ImpactEQ Equality and Health Inequalities Impact Assessment. Continued commitment to Health Inequalities funding within the ICB.

Tackling Health Inequalities (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Phased launch of new health inequalities dashboard.	Increase access to HI data across ICB/ICS	March 25
Implement Equity and Inclusion Panel utilising 'ImpactEQ'.	All business cases have completed EHIIA	December 24
Utilise the health inequalities annual report analysis and the data from the health inequalities dashboard to establish priorities and quantify ambitions for improving access to health and wellbeing services for underrepresented groups.	Priorities established with clear ambitions	March 25
Improve data completeness regarding ethnicity and inclusion characteristics to support health inequalities analysis and action.	Increase % data completeness	March 25
Demonstrate progress in delivering on Core20plus5 frameworks (adults and children) and the five planning priorities.	Improved outcomes	March 25

Healthy Weight / Weight Management Services

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The system is implementing a whole system approach to address obesity prevalence and supporting residents access weight management services. Overweight and obesity prevalence in MSE (65.3%) is higher than England (63.8%). We have potential unmet need of 35,572 adults whose BMI is 30+ or 27.5+ for Black or Asian ethnicities and have diabetes or hypertension without a recorded referral into weight management services. We have developed an integrated weight management pathway and roadmap and undertaken an outcome review which will inform Tier 3 re-procurement of specialist weight management services. We continue to support development and implementation of the Essex Healthy Weight work.	Weight management services survey completed April 2024 with 370 responses and further engagement has been undertaken as part of implementation of additional access criteria for Tier 3 weight management services. Local authorities in Essex and Thurrock are also inviting public view on weight management services.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to meet the requirements of the NHS Long Term Plan and increasing access to weight management services in particularly through the NHS Digital Weight Management Programme (DWMP).	To support delivery of our ambitions we need to deliver a 5-year transformation plan moving towards an integrated weight management pathway across MSE. Re-procurement of Tier 3 to deliver equitable service with improved outcomes is a key element. The Healthy Weight Steering Group is being refreshed across the ICP to support the delivery of actions to improve access, outcomes and experience for all weight management services, including Tier 2 and Tier 3 services.

What action will we take	What impact will this have	When will this action be completed
Implement revised access criteria for Tier 3 specialist weight management services, subject to board approval	Reduce waiting times	April 2025
Working with Alliances and Primary Care to fully utilise Digital Weight Management Programme (DWMP) capacity.	Increase uptake	March 2025
Re-procure Tier 3 specialist weight management services with one MSE provider in place from April 2025.	Improved outcomes	April 2025
Implementation of delivery plan via Healthy Weight Steering Group	Increase uptake	March 2025

Smoking Cessation and Tobacco Control

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Our Acute Provider have launched their acute inpatient and maternity pathways at all 3 sites and our community provider (EPUT) plans to launch the Mental Health pathway over the coming months. The ICB is working with Local Authority partners to deliver in house face to face NHS staff stop smoking support.	The new Maternity pathway communications will be put to a resident panel for consideration.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to meet the requirements of the NHS Long Term Plan that by 2024, NHS funded tobacco treatment services will be offered to: 1. Anyone admitted overnight to hospital who smokes will be offered bedside behavioural change support and access to NRT/Vape 2. Pregnant women and members of their household offered behavioural therapy and access to NRT/Vape 3. Long term users of specialist mental health services offered behaviour change therapy and access to NRT/Vape The ICB will work with partners to achieve smokefree 2030 ambitions for reduction in smoking prevalence to less than 5% within local populations with a particular focus on areas of deprivation or high user groups.	Additional investment to be identified to enable a 7 day a week service and a new community pathway to be established. The vaping policy across our sites needs to be reviewed to consider policy decisions for vaping on site for patients and staff. All wards with patient admitting staff are to consider establishing smoking status of both patients and ward staff to undertake suitable targeted advice and guidance.

What action will we take	What impact will this have	When will this action be completed
Analyse data from the Trust's in-house stop smoking services to determine impact	Demonstrate impact and return of investment of service	March 25
EPUT – Support EPUT with launch of their Mental Health inpatient pathway	Stop smoking support offered	October 24
Staff Stop Smoking offer – pilot in Basildon. Collaborate with Local Authority and Trusts to deliver a staff stop smoking service to all NHS staff across all sites.	Reduce number of staff smoking and support NHS staff to live healthier lives	March 25
Stop smoking support offered within community mental health settings and talking therapies – Pilot a stop smoking provision within IAPT	Support people accessing talking therapies to stop smoking as part of their pathway.	June 25
Support the Trust's to amend their vaping policies to permit vaping on site	Vaping is less harmful than smoking and an effective smoking cessation tool	October 24

Primary Care – Integrated Neighbourhood Teams

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Over the next three years, we will continue the implementation of the Integrated Neighbourhood Team model across Mid and South Essex. This will incorporate all three facets of the Fuller Stocktake (Episodic Care, Complex Care and Preventative Care). INTs have begun to flourish where the focus of developments have been identified at a local level e.g. Central Basildon who have focussed on adults with mental health issues, the PACT model in South East Essex. We have started to integrate dental services and community pharmacy into the INT model. We have piloted a very successful care home dental project (focussing on Complex Care cohort) and the Pharmacy First model has been widely rolled out (focussing on Episodic Care)	Engagement on the development and role of Integrated Neighbourhood Teams is best undertaken at a local level and is therefore being led through Alliances. Engagement includes a broad range of stakeholders from statutory and non-statutory sectors as well as local residents.

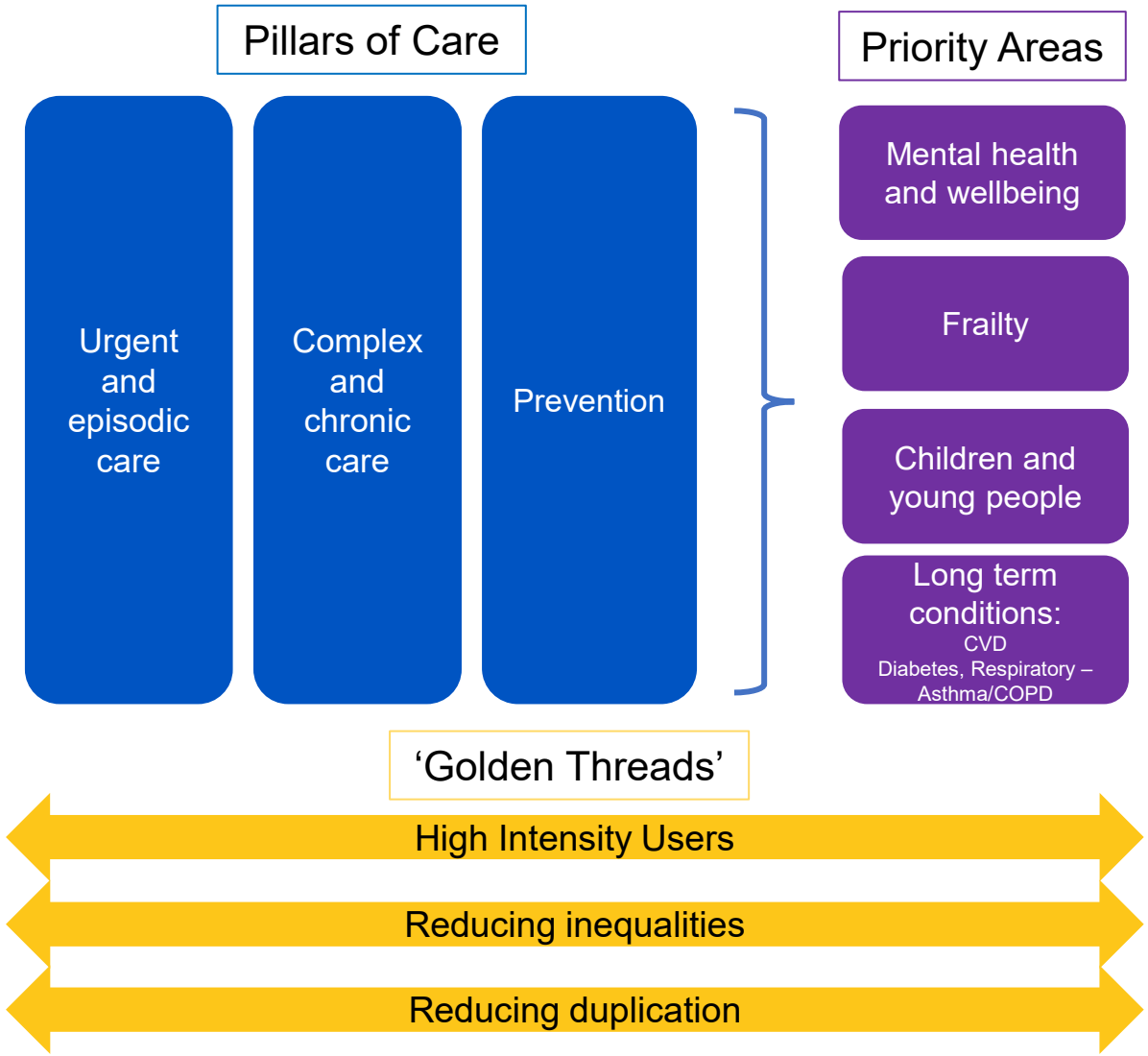
What are our ambitions	What needs to change to achieve our ambitions
Our longer-term ambitions (3 years) will be determined through the updating of our primary care strategy. This will be published by end of Q3 24/25. As part of a national programme, we will pilot a hypertension identification pathway in local dental practices (Preventative Model) and will seek to enhance the role of community pharmacy within the INT model, ensuring utilisation of national initiatives as well as identifying local opportunities.	As part of our strategy refresh, we will need to ensure that our discretionary resources are targeted at the delivery of the INT model across primary care. This includes financial resources alongside other enablers such as estate, digital solutions and communication support. We need to leverage our wider commissioning arrangements to ensure that all providers structure service provision in a model that supports the INT approach.

What action will we take	What impact will this have	When will this action be completed
Pilot Hypertension identification model in dental practices	Improved approached to prevention, enhanced role of dentistry in INT model	June 24
Develop PCN link pharmacist model in MSE	Improved role of community pharmacy in INT model	October 24
Use local INT Maturity Matrix to support the develop models across MSE	Support the development of INTs	March 25

Integrated Neighbourhood Teams (INTs)

Mid and South Essex

Integrated Neighbourhood Teams are fundamental to our plans to improve access and outcomes across health and social care, providing more proactive, joined up care and reducing health inequalities.



- This INT graphic, developed in partnership by the 4 Alliances, is based upon ICB and ICP priorities to focus INT development
- An INT maturity matrix will be finalised by July 2024 and will be supported by a peer review process to provide a unified position on progress
- From a position of 9 INTs on 1st April 2024, we will move to the planned 24 operational INTs across Mid and South Essex by March 2025
- Metrics are currently being developed and agreed (to include areas such as reduction in General Practice appointments by high intensity users, reduction in A&E attendance). Finalised by 26th July 2024
- Each Alliance has strong partnership models in place with health, social care, local Councils and Voluntary sectors, plans will continue to evolve to promote further integration and avoid duplication (examples in Alliance specific slides)
- Oversight of INT development is provided through the Primary Care Commissioning Committee

Primary Care – Primary Care Access Recovery Programme

NHS Mid and South Essex

Where are we now	How are we engaging our population
The ICB's Board endorsed our local response to the Primary Care Access Recovery programme in November 23. This plan will be implemented over the next two years and centres on our Connected Pathways Team – a resource dedicated to supporting the implementation of the Modern General Practice model and embedding new approaches across primary medical, pharmacy, optometry and dental services within Mid and South Essex. We have many early successes in the implementation of our model; an increase in the number of consultation in general practice of nearly 8% year on year, successful roll out of Cloud Based Telephony across a number of practices, an urgent access dental pilot which has improved access to services in the evenings and at weekends, broad take up of Pharmacy First, a number of practices implement a "total triage model" and the implementation of over 10 self-referral pathways across Mid and South Essex.	Despite plateauing the national GP Survey shows overall satisfaction locally remains below the national average. During 23/24, the ICB received several concerns regarding access to community pharmacy. With the publication of the national dental access plan, public and stakeholder interest in dental access has increased. We continue working with and through our Alliances to ensure continuous engagement and continuous improvement locally.

What are our ambitions	What needs to change to achieve our ambitions
We will continue to build upon our Connected Pathways approach, embedding new ways of working across all primary care services and ensuring the interface with other health services operates in way that aligns with this approach. We are keen to ensure all practices implement the aspects of Modern General Practice that work for their population We will expand the role of (Pharmacy, Optometry, Dental (POD) services within the access model by piloting improved access to dental services for children, increasing the usage of minor eye conditions and other optometry led pathways, expand utilisation of pharmacy first and testing other pharmacy opportunities.	The refresh of our primary care strategy will ensure that we take long term decisions that support our response to primary care access recovery including resource utilisation. We will need to strengthen our approach to ensuring continuity of care for complex/comorbidity patients and differential diagnosis within our strategy refresh. This is likely to be GP led. To support this aim, we will strengthen our approaches to retaining experienced GPs within the local workforce. We will utilise flexibilities within dental contracts to pilot and embed new approaches to improve access to services.

What action will we take	What impact will this have	When will this action be completed
Implement cloud-based telephony across all GP practices	Improved patient experience, improved workflow within practices	September 24
Support practices to implement the ‘Modern General Practice’ Model	Improved workflow and workload – supports the delivery of INTs	March 25
Implement pilot to improve access to dental services for children	Improved access to dental service for school children	Start Autumn 24

Primary Care – Primary/Secondary Interface

NHS
Mid and South Essex

Where are we now	How are we engaging our stakeholders
The primary/secondary care interface places significant additional demand on general practice. Long waiting times for secondary care services result in between 20% - 30% of patient queries relating to patients on waiting lists. Lack of agreed approaches to pathway development and delivery mean unnecessary work is generated for both primary and secondary services. There is significant opportunity to bring together clinically led solutions accompanied by the right digital solutions to make the interface more efficient and effective. There is a willingness from both primary and secondary care to make this happen. It is a priority of the newly established primary care collaborative to improve this interface.	A local strategy has been developed for the improvement of the primary/secondary interface. This was developed through engagement with stakeholders across various parts of the NHS in Mid and South Essex.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to improve the effectiveness and efficiency of the primary/secondary interface so as not to place unnecessary bureaucratic burdens on either party, and to ensure pathways are collectively developed so as to be embraced and adhered to more broadly across primary care, and to support the outpatient transformation programme	We need to build on the early success of the GP Primary Care Collaborative to strengthen the primary care voice across these development and ensure communication is improved to make it clearer what is to be done, by whom and how.

What action will we take	What impact will this have	When will this action be completed
Agree an approach to improve communication regarding service developments	Improve adherence to pathway changes and agreed standards	September 24
Develop interprofessional guidance across the interface	Improve professionalism and reduce unnecessary bureaucracy	September 24
Utilise the 'Tiger Team' to support the use of digital tools to reduce unnecessary workload currently placed on general practice	Reduced demand on general practice	March 25

Mental Health (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The Strategy Implementation Group (SIG) has been formed and mandated to act as a decision recommending body for our mental health strategy which is all age with a greater focus on integration. The 24/25 delivery programme has been reviewed and priorities set which aligns to the Integrated Care Strategy. Key focus areas based on subdivision of three major workstream for adult mental health are: 1. Urgent and Emergency Care (flow across the System, Inpatient quality and culture of care) 2. Mental Health Community Transformation and Older Adults (developing models of care and aligning to frailty) 3. Focus for Children and Young Persons (CYP) improved and timely access with expansion of the mental health in schools' team.	Engagement with key stakeholders through ensuring that service users are part of the transformation steering groups and a service user network for eating disorder and personality disorder has informed our views and plans. Further engagement is planned throughout 24/25 as part of service redesign and procurement of Talking Therapies and community mental health service procurement and through the SIG priority programme of work.

What are our ambitions	What needs to change to achieve our ambitions
The ambition is to have a reset and focus on recovery of the LTP (Year 6) in line with the Long-Term Plan (LTP) in reforming and reviewing our all-age mental health approach with the ambition to bring historic individual transformation workstreams together into a more streamlined and connected approach. This aligns with the integrated approach to new ways of working with our localities whilst acknowledging the subsidiarity of the four alliances to support place-based delivery.	Several service changes are required and will be the focus of our transformation programme, including: 1. Working pan Essex to reduce Talking Therapies waiting times. 2. Expand mental health accommodation, street triage, crisis response, urgent care pathways including discharge arrangements. 3. Alignment of community and primary care MH provision as essential with clear governance and assurance framework to be developed to support moving to a zero approach for out of area placement. 4. Build robustness of engagement with other directorates/teams/alliances to be clear on the interdependencies of our collective work programmes. 5. Ensuring improved access to CYP mental health services, with a focus on early intervention and prevention support.

Mental Health (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Using data and Business Intelligence, to monitor, measure and evidence delivery of long-term plan; and work with colleagues, providers and partners to recover and reset services	Clear understanding of mental health demand and capacity across the system	August 2024
Building a new integrated community mental health, social care and Voluntary, Community and Social Enterprise (VCSE) capability wrapped around primary care networks and integrated neighbourhood teams	Aligning to residents' needs with resources, manpower and activity to specific parameters and expectations	April 2025
Talking Therapies, Psychological Therapies-serious mental health redesign and harmonisation including redesign of physical health checks for serious mental illness	Ensure performance against ICB plans to understand local needs, track delivery, and drive continuous improvement	April 2025
Audit and Review of Liaison Service in line with core 24/7 standards.	Will ensure there is a consistent and equitable service offer and improved patient experience across the ICB.	September 2024
Development of accommodation pathway including rehab offer redesign	Support reduction of Zero ambition for Out of Area placements	October 2024

Mental Health 2024/25 Opportunities

NHS
Mid and South Essex

Harmonise services across the ICB footprint and review the links and connectivity across the Emotional Wellbeing Service and Talking Therapies through contract reduction

Streamline programmes of work and look at options for increased efficiency through collaborative approach with wider system partners reducing the number of overall contracts within the system

Support **Time to Care** business case with EPUT in order to reduce Out of Area Placements for Adults and CYP requiring inpatient services

Key element of improving safety of in-patient care

Enhance oversight and assurance of mental health services through operational governance group (in development now) to feed into SOAC with clear workplan and deliverables

Neurodiversity

NHS
Mid and South Essex

Where are we now	How are we engaging our population
In 2023/2024 the Integrated Care Board completed an all-age review of the current provision of services across Mid and South Essex, identifying the current pathway, provision and any gaps in provision. In 2024, the ICB with system partners including the Children and Young Persons (CYP) Community Collaborative will develop new partnership models for delivery of the Neurodiversity programmes.	Parent and Carer feedback has been included in the demand and capacity review for Neurodiversity and the findings will be used to shape future models of service provision during 24/25.

What are our ambitions	What needs to change to achieve our ambitions
In 2024, the CYP Community Collaborative will remodel service provision to address inequalities and improve access and early intervention. Adult mental health services will also be remodelled and aligned to the CYP models of care. To ensure an integrated care model we will align workstreams with existing strategies, any previous service mapping and ensure alignment with local and National Guidance, Best Practice, avoiding overlap and duplication within agreed Governance and oversight In 2025, the review of CYP and Adult Neurodiversity will lead to a re-procurement and commissioning of fit for purpose, evidence based modern models of care for Neurodiversity. The ICB is committed to developing new partnership models for service delivery that address the current challenges with a focus on place-based provision with timely early interventions that will lead to better long-term outcomes. Opportunity to develop fully integrated systems and pathways within local communities, improve Co-Production approaches, utilising the expertise, experience of experts by experience and families to re-design and shape improved models of provision.	Development of new partnership models for delivery of the Neurodiversity programmes which aligns to the babies, children and young people programme and is in line with the Integrated Care Strategy.

What action will we take	What impact will this have	When will this action be completed
The Growing Well Programme Board will provide the required oversight and assurance on the CYP workstream aligned to the Adult Neurodiversity workstream.	Improved outcomes for patients	2025/2026

Cardiovascular Disease (CVD)

NHS Mid and South Essex

Where are we now	How are we engaging our population
CVD is the leading cause of death worldwide, accounting for 17.9 million deaths each year, 31% of all global deaths. The Mid and South Essex CVD Programme Board has been re-established, chaired by ICB Medical Director. Agreeing focus on core priorities for 24/25, including prevention ('Healthy Hearts'); standardising and improving Arterial Fibrillation (AF) pathway; cardiac rehabilitation and addressing challenges with Echocardiogram capacity.	In 2023, we carried out a Patient survey as part of our BP@home evaluation. This highlighted a lack of patient awareness and information provision to patients when being asked to monitor their blood pressure from home as part of the scheme. We have since updated our GP Practice information and developed Patient guides in response to patient feedback.

What are our ambitions	What needs to change to achieve our ambitions
1. Bring Mid and South Essex Lipids treatment to threshold performance rates in line with the national average = 35% (28.3% as of December 2023, CVD PREVENT). 2. Increase levels of treatment to target for hypertension in line with the national objective of 80% by March 2025% (currently at 62.9% as of December 2023, CVD PREVENT). 3. Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025 (currently at 58.4% as of December 2023, CVD Prevent)	Focus on blood pressure and lipids, through developing a stronger partnership approach across the ICS as part of ICP delivery plan for 'Healthy Hearts' and through the Stewardship approach. Increasing cross-system engagement in key cardiac pathways allowing a whole-system approach to improvement.

What action will we take	What impact will this have	When will this action be completed
Monitor performance against local and national CVD Prevention targets to improve detection and treatment of the high-risk conditions of AF, hypertension (high BP) and high cholesterol: BP@home, BP in the community, CVD LES, Lipid QOF Extension and Lipid Pharmacy Pilot	National ambition to prevent 150,000 strokes, heart attacks and dementia cases over the next 10 years	2030
Standardisation of Atrial Fibrillation pathways, including build on Direct oral anticoagulants (DOACs) prescribing success. Anticoagulation is an effective therapy for managing people with AF who are at risk of stroke and can reduce the risk of stroke by up to 66%.	Baseline to be established	March 2025
Cardiac rehabilitation - pathway redesign to maximise the prevention of disease progression	Baseline to be established	March 2025
Complete demand and capacity modelling for Echocardiogram to inform development of recovery programme	Baseline to be established	March 2025

Maternity (1)

Mid and South Essex

Where are we now	How are we engaging our population
The Local Maternity and Neonatal System (LMNS) is committed to making care safer, more personalised and more equitable by prioritising the implementation of the NHS Three-year delivery plan for maternity and neonatal services (2023). **Workforce**: Local maternity services have successfully reduced midwife vacancy rate to 10% compared with 16.1% for the same period last year (April 2024) whilst increasing their retention of midwifery staff. **Listening to women and families with compassion:** Personalised Care and Support Plans have been coproduced with service users and are now available for all receiving maternity care. **Developing and sustaining a culture of safety:** Local services have implemented the Patient Safety Incident Response Framework (PSIRF) and leaders have participated in the Perinatal culture and leadership programme. **Meeting and improving standards and structures that underpin the national ambition:** Implementation of the Saving Babies Lives Care Bundle Version 3 is underway. Implementation of Maternity Early Warning Scores (MEWS) and Neonatal Early Warning Trigger and Track (NEWTT-2) on one of its site.	The Mid and South Essex Maternity and Neonatal Voices Partnership (MNVP) are a core member of the LMNS. They are strategic partners in our services and play an important role in co-production and service development by sharing the views of local communities. They are an important voice for communities who may be at risk of health inequalities and have developed Ethnic Community roles that are representing global majority communities within both maternity and neonatal services. The annual Care Quality Commission (CQC) Maternity survey reflects the experiences of respondents using maternity services. Mid and South Essex were identified as one of five trusts that were categorised as 'worse than expected' in 2023 (Mid and South Essex NHS Foundation Trust - Care Quality Commission (cqc.org.uk)). In response to these results an action plan has been developed to make improvements in the areas identified. The Maternity and Neonatal Independent Senior Advocate service is being piloted in response to the Ockenden report. Advocates help ensure that the voices of women and families are listened to, heard, and acted upon by their care providers when they have experienced an adverse outcome during their maternity and/or neonatal care.

What are our ambitions	What needs to change to achieve our ambitions
The LMNS is supporting progress towards the national ambition of a 50% reduction in stillbirths, maternal and neonatal mortality, and serious brain injury by 2025. MBRRACE reporting shows how rates of stillbirth and neonatal death have changed in Mid and South Essex since 2019 (Perinatal mortality data viewer | MBRRACE-UK (le.ac.uk)). There has been a reduction in the perinatal mortality rate between 2019-2022, these figures represent both neonatal death and stillbirths, mortality rates are 5-15% lower than comparative organisations in 2022 (current reporting period in June 2024). Our ambition is to have 6% or less who smoke during pregnancy.	In response to safety concerns identified by the Care Quality Commission at Basildon hospital's maternity services, a Maternity Improvement Plan was developed. This plan identifies 'Must' and 'Should' actions identified by the CQC, as well as the Section 31 and associated legal undertakings that accompany it. The plan will respond to improvements identified once the CQC report and ratings have been shared. Currently the service is rated as 'Requiring Improvement' and seeks to improve on this. Maternity services are currently placed on the NHS England Maternity Safety Support Programme in response to regulatory concerns. The system is working hard to make the improvements to exit this programme.

Maternity (2)

NHS
Mid and South Essex

	What action will we take	What impact will this have	When will this action be completed
Year 1	Ensure the NHS England Perinatal Quality Surveillance Model is used to identify, address and escalate where needed, quality concerns within maternity and neonatal services.	Effective system escalation	Annual review
	Deliver Acute Maternity Improvement Plan and Care Quality Commission (CQC) actions resulting from regulatory inspections of local services and support improvement of CQC Rating.	Improved CQC rating	December 2024
	Embed smoke-free pregnancy pathways, to reduce the numbers of babies born to smokers.	smoking to 6% or less	December 2024
	Improve access to specialist care (including perinatal mental health / pelvic health services).	Equitable access	December 2024
	Participate in the NHS England Maternity and Neonatal Independent Senior Advocate (MNISA) pilot.	Ensuring service users are listened to and concerns acted upon	March 2025
	Implementation of the Saving Babies Lives Care bundle (Version 3) and support rollout of national MEWS and NEWTT-2 tools.	Improved safety and reduced perinatal mortality	March 2025
	Reduce the incidence of preterm birth in line with the national ambition.	Preterm birth to 6% or less	March 2025
	Ensure Maternity and Neonatal Voice Partnerships (MNVPs) are appropriately commissioned.	Service user engagement	Annually
Year 3	Roll out electronic patient records to enable women to access their records.	Informed decision making	Awaiting confirmation
	Improve the culture of maternity and neonatal services. This will include ensuring staff are supported by clear and structured routes for the escalation of clinical concerns.	Improved safety, learning and support	Dec 2026
	Achieve the accreditation standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding.	UNICEF accreditation	March 2027
	Deliver Equity and Equality action plan to reduce inequalities in experience and outcomes for women, people, babies and staff.	Reduced health inequalities	March 2027
Year 5	Local maternity and neonatal services will have an established workforce, with plans to address vacancies and achieve fill rates. The ICB will agree staffing levels with services utilising national guidance.	Clear workforce planning and recruitment trajectory	March 2028

Babies Children and Young People (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Specialist Education Needs and Disability (SEND) – The ICB and system partners continue working collaboratively using a coproduction approach to deliver the SEND strategy and utilise CQC, Ofsted findings to drive improvements in delivery. **Transformation of Community Services** – The CYP Community Collaborative is working together to address variation, equality and access to outcomes, we are aiming to address variation and inequality in access and outcomes, reduce duplication and share resources, improve wellbeing and staff retention and recruitment. **Urgent and Emergency pathways** – Youth Workers in A&E expansion / pilot has now been mobilised and is operating in two of our three hospital sites with additional support for long-term condition clinics in the acute setting. **Long-term conditions** – Established programmes of transformation, led by clinical leads, has been established for asthma, epilepsy and diabetes. Key areas of focus have been agreed for each long-term condition including prevention of future deaths, transition, clear pathways, workforce and technologies. **Governance** – The Growing Well Programme Board provides oversight and assurance on delivery of the CYP portfolio of services.	The MSE has strong engagement with Parent and Carer Forums and direct engagement with children and young people to deliver and improve on the SEND requirements. This includes forums across Southend, Essex and Thurrock (SET) and our ambition is to further strengthen coproduction and engagement via the Growing Well Programme Board.

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to work cross system to deliver a number of priority areas of work with associated programmes. These include: Children and Young People Mental health, Special Education Needs and Disability, Neurodiversity, Palliative and End of Life - ambition to deliver 24/7 care, Transformation of Community Services - continue to address inequalities, access and outcomes, Urgent and Emergency pathways – ambition to reduce the numbers of children and young people attending A&E, Long Term Conditions – ambition to improve the care and quality of life of CYP with long-term conditions, Health Inequalities – ambition to utilise health inequalities data to develop and deliver interventions to reduce health inequalities There is an opportunity with existing partnerships to secure development resources to form a new integrated Babies, Children and Young People approach, starting with early years health and care and then extending into all Children and Young People.	Key Priorities for 2024 include transformational changes through a collaborative approach across systems to improve the uniformity and requires service oversight and assurance on strategic and operational delivery. There are significant interdependencies on achieving the desired outcomes and impact for children. ➢ Develop a Physical Health Care Strategy for Children ➢ Having a clear long-term vision developed with children, young people and families ➢ Maintain quality of service provision ensuring transparency and resource allocation ➢ Transforming the commissioning of Children's services ➢ Strengthen the oversight and assurance functions system wide ➢ Establishing CYP elective care sub committee ➢ Continued service redesign through the community collaborative

Babies Children and Young People (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Mental Health: Implementation of the SET Mental Health Strategy (2024 – 2028) for children and young people	Key impacts include:- • Improving access to mental health via CAMHS (Children & Adolescent MH Services) & Primary Care • Increase access and choice of support and treatment options for Young People • Supporting children to stay with their families whilst receiving services so that less children with mental health needs entering the care system	March 2026
Mental Health: Strengthening early intervention, support and education for schools and colleges through an all school/college approach (MHSTs)	• Delivering evidence-based interventions for mild-to-moderate issues across 126 education settings (13 operational teams + 2 further teams in training) • Giving timely advice and work alongside school/college staff and with external specialist service to help CYP get the right support • Reducing health inequalities in areas with high level of need and most at risk of poor outcomes • Education Mental Health Practitioners successfully trained and added to the wider workforce to support our local population	March 2026
Asthma: Targeted work with primary care to improve asthma reviews and risk stratification of at risk children, including ensuring delivery against the Asthma Bundle of care	• Early identification of at-risk children to prevent asthma exacerbations and avoid hospital admissions. • Improved care of children within primary care to prevent development of uncontrolled asthma	September 2025
Diabetes: Agreed improvement plan to be developed to include key areas of focus including pathways, access to technologies and transition	• Improving access to technology and therefore better controlled diabetes • Reducing health inequalities across MSE	March 2025

Babies Children and Young People (3)

Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Epilepsy: Self-assessment against the new Epilepsy National Bundle of Care, with a resulting action plan for delivery.	• Improved access to key diagnostics in the epilepsy pathway • Improved access to services for CYP with LD/ Autism and Epilepsy	December 2025
Urgent & Emergency Care: Expansion of the youth worker roles to Southend and Broomfield Hospitals as well as trialling youth workers in long-term condition clinics	• Better support for CYP who attend emergency departments with mental health challenges and long-term conditions	December 2025
SEND: Work in partnership with health providers to understand their responsibilities in relation to SEND and ensure effective joint working with Local Authority teams to capture the needs of CYP	• Improved timeliness and effectiveness of responses to requests • High quality advice provided by health professionals • Health needs and the provisions required to meet those needs are accurately reflected in the EHCP • CYPs health needs are more consistently understood and met by education, health and social care	March 2025
Oral Health: Delivery of place based oral health improvements	• Improved oral health of children from birth to primary school aged (interventions include supervised toothbrushing, healthy diet advice and upskilling local professionals)	March 2025

Stroke (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The Sentinel Stroke National Audit Programme (SSNAP) action plan includes overarching workstreams focused on improving care in all 10 SSNAP domains. Each acute site has areas of excellence and focus, we have seen significant improvements in door to needle time across all 3 sites. Artificial Intelligence AI) software is now implemented at all 3 sites assisting clinical decision making and compliance with National optimal Stroke Imaging Pathway (NOSIP). NOSIP is an ongoing workstream with a CT prefusion (CTP) pilot ongoing at Southend and being discussed for Basildon. Occupational therapy and Physiotherapy vacancies continue to be a barrier in achieving A grade ratings in therapy domains. The development of the model and business case for provision of stroke rehabilitation is ongoing, with the stroke stewardship team reviewing the end-to-end pathway to ensure that all elements are delivered in line with the National Stroke Service Model and the Integrated Community Stroke Service (ICSS). Work is also ongoing on three Catalyst projects and four Stroke Quality Improvement for Rehab (SQuIRe) projects with regional funding, including: • Catalyst 1 - Growing our own stroke Multi-Disciplinary Team (MDT) workforce • Catalyst 2 - Supporting and expanding level one psychological care for stroke within the Integrated Community Stroke Service (ICSS) • Catalyst 2 - Specialist aphasia service to augment MSE ICS Teams • (SQuIRe) workstreams: workforce, 7 Day MDT Working, stroke-specific training, improving 6 month reviews. In terms of long-term improvements stroke stewards will undertake a review of longer-term strategic goals for stroke in the Autumn 2024. Previously, a review of Quality Adjusted Life Years (QALY) data demonstrated that MSE should invest less into acute services and more into community services and Thrombectomy to provide better outcomes for stroke survivors.	Public consultation undertaken during early stages of 24/25 on proposals for community stroke rehabilitation beds.

Stroke (2)

NHS
Mid and South Essex

What are our ambitions	What needs to change to achieve our ambitions
Our ambition is to improve to 'A' rating in the Sentinel Stroke National Audit Programme (SSNAP). To achieve this our system action plan focuses on improving the stroke rating across MSE in all 10 domains. We also aim to deliver the national model of Integrated Community Stroke Service (ICSS) in MSE, including an expanded community stroke rehab bed base and develop a strategic approach towards delivering longer term improvements in stroke population health outcomes, service quality and resource sustainability.	To support our ambition, we need to Implement acute-focused plans (28/29) including the development and implementation of the acute hub model within MSE, based on plans approved as part of our acute merger, updated to reflect changes in national guidance. The reconfiguration of community stroke beds (24/25) including implementation of updated aligned model of care delivered across all stroke rehab community beds in MSE. The Integrated Community Stroke Service deliver in (26/27) will be supported by further work over the next 2 years on the home-based pathway component.

What action will we take	What impact will this have	When will this action be completed
Complete implementation of Catalyst and SQuIRe projects	Delivery on features of ICSS model	During 2025/26
Complete reconfiguration of Stroke Rehab community beds	Delivery on features of ICSS model	During 2025
Implement SSNAP action plans	Improve SSNAP rating domains	During 2025

Respiratory (1)

Mid and South Essex

Where are we now	How are we engaging our population
Mid and South Essex currently have a well-established integrated respiratory services across all providers with teams covering five key respiratory services, Respiratory Diagnostics, Home Oxygen Service, Pulmonary Rehabilitation, Long Covid and Respiratory Virtual Wards. We currently have a waiting list for respiratory diagnostics of approx. 2,733 patients. In addition, there are 773 waiting to start Pulmonary Rehabilitation. The waiting list size is attributable to the Covid 19 pandemic and ageing population. Long Covid there are no waiting lists and manageable case-load and MSE Respiratory Virtual ward has approx. 30% occupancy level. A Respiratory workshop is in place for August 2024 and the System Respiratory Programme Board is being re-established August 2024.	A patient and public voice participation group specifically to support the development and aspirations within the Respiratory Programme Plan. We are committed to ensuring MSE patient voices are heard, being at the centre of shaping new developments. To ensure we reach all the MSE population, we will work with voluntary, community, faith and social enterprise sector (VCFSE) to promote and advocate partnership working for better health and living well with respiratory disease.

What are our ambitions	What needs to change to achieve our ambitions
Our core ambitions for Respiratory: 1. Decrease waiting lists for Respiratory diagnostics 2. Set up a Centralised Virtual Respiratory Hub across MSECC for Triage and interpretation of spirometry. 3. Achieve completion of Association for Respiratory Technology & Physiology (ARTP) Accreditation across MSECC Respiratory Clinicians. 4. Implementation of Pulmonary Rehabilitation Information Hub for MSE patients to be able to access to support Living Well with respiratory disease. 5. Increase Pneumococcal Vaccination Uptake – Prevention better than cure awareness Campaign. 6. ILD and Bronchiectasis Primary Care Alerts and Pathway programme 7. Additional Respiratory Community Diagnostic Centres increased across MSE 8. Increase Respiratory Virtual Ward Occupancy aligned to the national aspirational target of 80%	To be successful in: 1. Achieving additional funding from NHSE to support implementation of agreed plan – FY24/25 2. Achieving additional funding from NHSE to support Digital innovation FY24/25 3. Respiratory teams have been working towards accreditation throughout FY22/23 with the aim to upload and complete FY24/25 – All planning in place with continuation of support from NHSE EoE Respiratory Network. 4. Respiratory Teams have been working with NHSE EoE respiratory Network and have received funding to support delivery -– launch Sept 2024 5. SystmOne alert in Primary Care alongside a promotion and awareness campaign and partnership working with Public Health and VCFSE. 6. Build pathway and alerts supporting Primary Care and Patient engagement. 7. Close working relationships with MSEFT in planning respiratory diagnostic pathways. 8. Awareness campaign for all professional groups across MSE and monitoring of staffing levels to enable flex.

Respiratory (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Provide additional respiratory diagnostics (Spirometry & FeNO) to decrease the current number through agreement in place with staff to increase working hours and by utilising the HI mobile van for Respiratory services up to 7 days a week, the van is equipped with two clinic rooms to enable Spirometry to be undertaken, (pending funding approval)	A decrease of approx. 25%-30% from the current waiting list	March 2025
Provide additional triage and respiratory interpretation workforce to reduce current waits by implementation of a Respiratory Centralised Virtual Hub (pending funding approval)	A decrease of approx. 25%-30% from the current waiting list	March 2025
Support the Workforce Education and Training Programme with NHS EoE Respiratory Network for all staff currently undertaking ARTP Accreditation	Respiratory clinicians across MSE will be compliant with National recommendations	March 2025
Implementation of a MSE Pulmonary Rehabilitation Information Hub	To enable patients to access key information and exercises.	September 2024
Engagement and implementation of Pneumococcal vaccination Uptake Campaign and apply an alert to SystmOne across MSE Primary Care.	Increase in Uptake on Pneumococcal vaccination in eligible cohort.	March 2025
Build an Education package to support Interstitial Lung Disease (ILD) and Bronchiectasis in Primary Care with SystmOne alerts	Partnership working with Secondary care –supporting management of patients on specific pathways	September 2025
Build and Implement additional capacity for respiratory diagnostics through Community Diagnostic Hubs x 4 across MSE	Additional capacity created for approx. 5,324 new cases full-year effect.	December 2025
Build awareness across MSE with all clinical partners on availability of Virtual Respiratory Ward and criteria.	Reduction in hospital admissions and increase in RVW occupancy.	March 2025

Diabetes

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Currently there is a disjointed model of diabetes care across the MSE system. There are several key opportunities for change that we now need to implement to create more integrated offer for diabetes care. The current issues include: the foot pathway being disjointed, leading to sub-optimal recognition and treatment of diabetic foot complications; uptake of structured education is low; MSE is an outlier as a low performer in the delivery of the three care processes for diabetes.	We understand that our residents want care closer to home with a joined-up approach to delivery of services. The work undertaken with the integrated diabetes model will be led by our service users feedback to shape and develop the future service model. We have actively engaged with Diabetes UK to look to schedule engagement events for our residents to understand the areas that are working well and the challenges they face, especially with regards to podiatry and the diabetic foot.

What are our ambitions	What needs to change to achieve our ambitions
A key ambition of ours is for increased awareness of diabetes along with further uptake of structured education and use of digital tools. We aim to reduce complications of the diabetic foot by optimising diabetic care foot care pathway and medicine management, including implementing Hybrid Closed Loop, insulin safety work recommendations and optimising prescribing across MSE. We aim to deliver our ambition by increasing uptake of 8 care process, planning and implementing a new service model (including Colne Valley).	• Potential requirement for invest to save funding, as part of setting up new diabetes model of care. • Releasing clinical time from patient care to deliver changes. • Inclusion of ambassador participation into the transformation programme. • Integrated working across all providers to develop end to end pathways

What action will we take	What impact will this have	When will this action be completed
Develop an end-to-end integrated pathway for feet inclusive of the diabetic foot	Reduction in below knee amputations	March 2025
Increase uptake of the 8 care process in primary care	% increase in completion of all 8 care processes.	March 2025
Implementation of Hybrid Closed Loop Pumps as per NHSE implementation plan	Reduce unscheduled admissions due to unstable blood chemistry	March 2025 (dependant on NICE reimbursement scheme)
Mapping and optimise use of available technology to increase awareness of diabetes and increase structured education	Increase structured education uptake	March 2025

Urgent and Emergency Care Services (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
MSEFT adult general and acute (G&A) bed base will be retained at 1,700, and 75 beds for paediatric G&A beds, equating to a total of 1,775. To enable delivery of the required operational performance, length of stay reductions across the three MSEFT sites are required. Each site has an ambition to reduce their length of stay to contribute towards the closure of escalation beds by 30th April, and further reduce core beds by 67 from May 2024 onwards: • Basildon have a 0.26 length of stay reduction and improvement from May 2024. • Broomfield have a 0.50 length of stay reduction and improvement from June 2024 • Southend have a 0.50 length of stay reduction and improvement from May 2024. All of these improvements are associated with each hospital site and system improvement plans, which are reflected in the MSEFT bed model (version 4) for monthly tracking delivery against plan. We Continue to work in partnership across the EoE region to improve ambulance response times.	There are patient groups that support the patient pathway changes and associated work that takes place throughout the year System partners regularly review friends and family feedback, complaints and incidents. This insight is used to review service provision and redesign services to meet the needs of our population.

What are our ambitions	What needs to change to achieve our ambitions
• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025. • The Community Collaborative will deliver 180 Virtual Ward Beds across Mid and South Essex in the specialities of Frailty, Respiratory, Older Adult Mental Health and Hospital at Home. • Discharge to Assess will continue, with the ambition to reduce the number of current care home bed utilisation (circa 350) supporting this pathway. • Mental Health Joint Referral Car is allocated to mental health calls by EEAST following a call via 999 will continue. • Mental Health Urgent Care Department – Basildon site MSEFT plans to further increase the service utilisation in 2024/25 to maximise the utilisation of direct access patient pathways into the department. This will support a reduction of mental health presentations to the Emergency Departments.	• Urgent Community Response Team service Plans in place to expanding beyond the nine clinical conditions including falls. • Mobilise phase two and three deployment of the Unscheduled Care Co-ordination Hub model will be activated in 2024/25. • Same Day Emergency Care (SDEC) across the three MSEFT sites have been used during 2023/24 for escalation capacity, the System recognise that these facilities need to be in place to reduce admissions and support turnaround within the UEC pathway. • Upgrading of PAS data collection and training of staff to support Emergency Care Data Set (ECDS) recording.

Urgent and Emergency Care Services (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Variation of Same Day Emergency Care (SDEC) services across MSEFT with standardised referral criteria and direct access from partners.	ED Performance & Ambulance handovers	December 2024
Evolve the Unscheduled Care Co-ordination Hubs beyond direct access from EEAST to incorporate direct referrals from Primary Care, Care Homes, Hospices and the Community.	ED Performance & Ambulance handovers	December 2024
LOS reduction: Standardised GP model/service provision in MSEFT hospitals with streaming and referral criteria enabling urgent care to be seen, treated and discharged, releasing emergency capacity for type 1/emergency patients.	ED Performance & Ambulance handovers	November 2024
LOS reduction: Reset SAFER and Red to Green principles on the wards, with pro-planning of patient discharges, bringing discharges earlier in the day to enable patient flow for the non-admitted pathway.	ED Performance & Ambulance handovers	October 2024
Capital programme at Southend Hospital to improve the emergency village allowing for UEC pathway improvement with the patient being seen and treated in the right pathway the first time and maximising all SDEC and assessment pathways to admission avoid where appropriate.	ED Performance & Ambulance handovers LOS reduction	March 2025

Elective Care - Including Outpatients (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
ICB Elective number of people waiting over 65 week from referral to treatment 1,491 as at 31st March 2024, 1,438 of which are waiting at Mid and South Essex NHS Foundation Trust. Patient Initiated Follow Up (PIFU) actual performance is 5.3% against a plan of 5%. Theatre productivity work is ongoing as part of the Get it Right First Time (GIRFT) work.	There are patient groups that support the patient pathway changes and associated work that takes place throughout the year. Communications via the ICB and/or ICS website to ensure patient Choice, promotion of 'MyPlannedCare' to support decision making and provide advice and guidance for people prior to surgery. Ensuring patient engagement with any patient pathway or service change (e.g. MSK and Dermatology)

What are our ambitions	What needs to change to achieve our ambitions
May 2024 and Beyond: • Zero 78 week waiting patients by end of June 2024 • Zero 65 week waiting patients by end of September 2024 • DNA rate 6% by March 2025 • PIFU increased from 5% current delivery level • eTriage - 100% roll out by March 2025 • Advice and Guidance - improved turnaround time for each specialty to support referral management • Ophthalmology pathway changes to reduce delays for new and planned patients to improve patient outcomes and experience • Optimise activity via the Surgical Hub at Braintree • Focus on Children and Young People elective activity • Ensure equal focus on non-acute planned services to ensure oversight of waits and delivery	1. Greater focus on validation of patient tracking list, the MSEFT Access Team have a recruitment plan to support patient tracking both for elective and cancer to reduce pathway delays 2. Continued focus on Further Faster expectations to deliver improvements across elective pathways 3. Continued engagement and participation in the Get it Right First Time (GIRFT) programme to improve performance across elective pathways and theatre productivity 4. Greater focus on improving referral pathways, working with Primary Care, Community and Acute providers 5. Changes planned to Dermatology and MSK through System procurements these will be led via the Integrated Care Board and have been shaped through engagement with the clinical leads and Stewards.

Elective Care - Including Outpatients (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Progress patient booking to achieve zero 78 weeks by end of June 2024	Zero 78 week waiting patients	June 2024
Progress patient booking to achieve zero 65 weeks by end of September 2024	Zero 65 week waiting patients	September 2024
Ensure robust process in place across MSEFT to achieve 6% DNA rate	Support performance and optimise capacity	March 2025
MSEFT 100% eTriage implementation	Support capacity and recovery	March 2025
Ensure PIFU plans achieve the minimum 5% performance	Enables release of capacity to support performance recovery	March 2025
Continued focus on improving referral pathways (primary care, community and acute)	Support Choice, optimise pathways and services	Ongoing
Procurement of Community MSK and Pain service (new model of care)	Improved service model and pathway to improve experience and outcomes	31st March 2025
Procurement of Community Dermatology including Teledermatology service (new model of care)	Improved service model and pathway to improve experience and outcomes	31st March 2025
Children and Young People Planned (Elective) Care oversight, ensuring delivery of key metrics to support young people's care and outcomes	Ensure focus on waits and outcomes	Ongoing
Focus on Planned Care services to ensure delays are managed to reduce risk and ensure outcomes for people	Ensure focus on waits and outcomes	Ongoing
Independent Sector capacity to support Choice and outsourcing pathways/activity to support performance recovery, including application of Patient Choice Provider Accreditation Policy.	Support capacity and recovery	Ongoing

Diagnostics (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
• The number of people waiting over thirteen weeks at the end of April 2024 was 1,121 across all providers. • For Mid and South Essex Integrated Care Board the referral to test within six weeks was 75% national standard is 95% by March 2025. • Community Diagnostic Centre's are seeing patients for tests • £1.5m additional funding has been identified via ME8 Pathology Network supporting focus on digital storage and digital out-sourcing capability. • MSEFT are a vanguard site piloting use of volunteers to reduce non-attended appointments (DNAs) in radiology imaging by contacting patients.	There are patient groups that support the patient pathway changes and associated work that takes place throughout the year. Communications via the ICB and/or ICS website to ensure patient Choice, promotion of MyPlannedCare to support decision making and provide advice and guidance for people prior to surgery.

What are our ambitions	What needs to change to achieve our ambitions
May 2024 and Beyond: • Achieve the 95% referral to test within six weeks as per the operational plan • Achieve all urgent histology turnaround times within ten days to support early diagnosis • Deliver the planned activity levels across Mid and South Essex NHS Foundation Trust and all providers • Achieve the Community Diagnostic Centre development plan with opening of centres within agreed timeframes • Ensure equipment replacement/repair plan is in place to manage ageing equipment at Mid and South Essex NHS Foundation Trust • Continue to work with Tier Two (non acute) providers to provider diagnostic capacity closer to home	ImageEast network focus on MSE roll-out of Behold AI for high confidence normal reporting in chest x-ray. Histopathology improvement plans focussed on a consistent approach to reporting underpinned by tumour site specific benchmarking Workforce plans and opportunities are progressed across modalities to "grow their own" workforce in particularly challenged specialties across Mid and South Essex NHS Foundation Trust.

Diagnostics (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Community Diagnostic Centres (CDC): Braintree and Thurrock phased opening	Greater activity to meet demand closer to home	December 2024
Southend Independent Sector CDC specification is currently being prepared to go out to market via Mid and South Essex NHS Foundation Trust	Greater activity to meet demand closer to home	April 2024
Pitsea CDC phased opening	Greater activity to meet demand closer to home	September 2025
Equal access to diagnostic tests across the Mid and South Essex (MSE) Primary Care footprint.	Greater activity to meet demand closer to home	March 2025
Roll-out of Royal College of Radiologist's "iREFER" clinical decision support tool across MSE System has commenced, where implemented in other trusts this has demonstrated a 6% demand reduction from primary care. Early data under review to understand scaling of demand reduction.	Supporting clinical decision making and optimising referral pathways	September 2024
Radiology and Endoscopy workforce plan is contingent upon recruiting roles into the CDC programme; recruitment is progressing against plan. CDC Radiology – 68wte being recruited by October 2024 for Thurrock and Braintree; Pitsea CDC recruitment is phased to commence October 2024 to Autumn 2026. Endoscopy recruitment is on target. The Thurrock and Braintree centres have recruited to medical AHP roles via the CDC international recruitment national programme and the pipeline of student apprentices as well as having trainee positions in place for cardiology testing.	Increased workforce to support safe service delivery, improved retention of staff and deliver care closer to home	Commences October 2024 completes October2026
Echocardiography workforce is more challenged by a national shortage of roles; additional investment being explored internally within MSEFT. CDC trainee posts in place to support additional CDC activity in Thurrock and Braintree centres.	Increased workforce to support safe service delivery, improved retention of staff and deliver care closer to home	December 2024

Cancer (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
• MSEFT Faster Diagnosis Standard (FDS) validated data for April 2024: 65.97% against a plan of 71.4% • April 2024 Cancer 62 day performance: 51.06% against national standard of 70% • CAN 02 performance at April 2024: 69.5%	There are patient groups that support the patient pathway changes and associated work that takes place throughout the year. Cancer Patient Experience Survey (CPES) results are reviewed, and Mid and South Essex NHS Foundation Trust develop, with patients', action plans to make changes to any areas where the survey flags or identifies that improvements are required.

What are our ambitions	What needs to change to achieve our ambitions
May 2024 and beyond: • The 2024/25 trajectory will see delivery against 70% national expectation for 28 day (FDS) by December 2024, with March 2025 position of 73%. • That the backlog of patients waiting for their definitive treatment for their cancer will reduce as performance improves throughout 2024/25 to deliver the 70% 62 day standard. • Histology turnaround times for urgent suspected cancer will consistently meet a 10 day turnaround. • Improve CAN02 performance in line with the Operational Plan commitment to achieve 80% by January 2025.	• Breast: Triage, clinic templates, workforce & estates identified as areas to improve. • Lower GI: Continue to improve secondary care pathways. • The implementation of the FIT<10 urgent pathway will support continued FDS improvement to 80% and the reduction of USC referrals without FIT result (per pathway indications only). MSEFT will continue to monitor Lower GI urgent suspected cancer referrals accompanied by FIT and colonoscopies performed on a USC referral pathway for Lower GI. • Skin: Interim tele-dermatology went live in Mid and South Essex (MSE) in 2023/24. This will continue in 2024/25. • Urology: Complete the baseline pathway analyser by end of Quarter one, investigate, and identify challenges, and agree plan with Cancer Alliance. • Engagement with the Cancer Alliance Faster Diagnosis projects and working with other providers to share learning and best practice.

Cancer (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Intensive Support Team (IST) Pathway analyser tool used in conjunction with internal pathway profile tool on Healthcare Analytics dashboard. Pathway analyser baselines (prostate, bladder, breast, skin and gynae) will be completed in 2024/25 Quarter One as per the cancer programme planning guidance.	This will enable demand and capacity planning	End of Quarter One 2024/25
Utilise Cancer Alliance funding for Quarter one and Quarter two in Breast, Skin, Radiology and Histopathology to support further improvements in FDS performance.	Support recovery of performance	End of Quarter One/Two 2024/25
Use of Histology by MSEFT hospital site and Radiology Cancer Diagnostic turnaround times by tumour site will be used for monitoring activity trends, request to reporting times and enable required actions to be developed when activity is outside of set target days.	Support recovery of performance	End of Quarter Two 2024/25
Increase the number of people referred to the pre-hab programme. The programme has been supported by Cancer Alliance SDF funding in 2024/25 with an evaluation planned for Quarter Three 2024/25. Nationally there is a drive for prehabilitation and rehabilitation to be incorporated into routine cancer care. It enables people to prepare for treatment through promoting healthy behaviours and improving functional ability through needs-based prescribing of exercise, nutrition, and psychological interventions.	Maximise patients wellness to support them before, during and after their cancer treatment	End of Quarter Three 2024/25
Oncology: Develop central cancer hub for single point of access via one telephone number and increase in Specialty Doctor capacity.	Improve communication with oncology patients	End of Quarter Four 2024/25
Urology RDS – take learning from the lower GI work and develop a Rapid Diagnostic Service for urology patients	Improve performance and reduce patient waiting times	End of Quarter Four 2024/25
Skin Teledermatology – continue with the implementation and optimisation of the Teledermatology service	Improve performance and reduce patient waiting times	End of Quarter Four 2024/25

Palliative and End of Life Care (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Recently, moved to an all-age Palliative and End of Life programme to ensure continuity across both areas. Funding received from Macmillan for a Programme Lead. Electronic Palliative Care Coordinating Systems (EPaCCS) now in place across the Mid and South Essex System (for adults) which provides data for monitoring the effectiveness of service delivery. As of April 2024, 0.49% of the 1% EoL expected population has been identified and added to EPaCCS. 71.23% of the 0.49% had received anticipatory medications in the last week of life. There are >400 additions per month, however 31.8% of those were added in their last 30 days of life. April's data is incomplete for Mid Essex as EPaCCS new. 10.05% of all deaths in hospital has 3 or more emergency admissions within the last 90 days of death as of April 2024. Discussions are starting with Babies Children and Young People (BCYP) steering group to look at what an equivalent would look like for BCYP to ensure that we are gathering the right data and be able to inform how we support BCYP and our workforce going forward. Rapid Access Service to enable adults who have a rapidly deteriorating condition regardless of diagnosis to receive care coordinated by the Hospice Specialist team. Work ongoing within BCYP to standardise and streamline documentation to be utilised in delivering PEoLC – this includes an agreement to implement the evidence based national CYP Advanced Care Plan.	Compassionate Communities Campaign Steering Group has achieved through community groups, a Life & Legacy Café held in John Lewis; a conference in partnership with ARU on Person Centred Holistic Approaches to EoL Care and an Art Exhibition running from 1st Sep. to 3rd Nov. 2024 to celebrate living, caring and dying. Healthwatch work completed during 2022/23, the outputs of this are shared via the System Palliative Care Groups and wider System programme to ensure that patients, carers, relatives and health professionals views are part of the Palliative and End of Life service offer. The Children and Young People's programme, working with partners including the local Children's Hospice has an ambition to commence engagement with children, young people and their families and carers. Launch of HPAL MSE website from August 2024 this will empower both patients/carers/public and clinicians through sharing of information, services and evidence-based guidelines. This has been developed in direct response to the lived experience survey which suggested that our public did not know how to access information or services.

Palliative and End of Life Care (2)

NHS
Mid and South Essex

What are our ambitions	What needs to change to achieve our ambitions
Ensuring reduction in variation of palliative and end of life care offer for our population by reducing health inequalities. Increasing the number of people on our end of life register and enabling more people to receive care and die in their preferred place. Ensuring anticipatory care and plans are in place to support outcomes and experience for all with a life limiting condition. There is a national ambition for all Palliative and End of Life care (PEoLC) support to be available 24/7 to reduce the number of admissions to hospital and improve the end-of-life experience for our MSE population.	To provide equitable access for all MSE population a model of care needs to be defined which reflects the variation of service offer and aligns resources to reduce variation and improve outcomes.

What action will we take	What impact will this have	When will this action be completed
Recruit the Macmillan Transformation post	Support plan and ability to report transparently on services/outcomes	July 2024
Utilise data to inform and address variation working across primary, community and secondary care ensuring the interdependency with social care is reflected	Transparency of outcomes and services to support change	Ongoing
Compassionate Communities work – ensuring infrastructure is in place to build on the work to date	Ensure outcomes and impact	September 2024
Implementation of the Children and Young Peoples Advanced Care Plan	Improved patient journey for BCYP and their families Ensure patient choice and decisions are implemented	March 2025
Scoping the current children and young peoples 24/7 service provision across MSE and understand the implication of the gap, this will include improved data collection	Understanding the gap that needs to be filled.	December 2024
Produce Business case to support new 24/7 model of care.	Defining the reduction in non -elective admissions and A&E attendances for people in the last 3 months of life.	October 2024

Women's Health Hubs

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The development of a women's health hub within each primary care network will deliver the core specification services outlined by the Department of Health as a clear ambition for each Integrated Care System to have in place by the end of 2024. The aim of the hubs is to improve women's access and experiences of care by better integration of services and support throughout their life course. Phase One is currently mobilising and will see and treat women who have a pelvic organ prolapse and would benefit from a vaginal ring pessary insertion and women requiring an Intrauterine Device for the management of menorrhagia, Hormone Replacement Therapy (HRT), or other non-contraceptive uses.	A survey seeking views on what women's services are important to our residents was released earlier this year. Results showed key areas for development; Menopause, pelvic health, breast screening and gynaecological problems. Our first women's health resident forum will meet on the 20th June 2024.

What are our ambitions	What needs to change to achieve our ambitions
• Delivery of the Department of Health ambition of two core services in a hub delivery model ahead of 31st July 2024. • Reduction in secondary care referrals for ring pessary services and long-acting reversible contraception for gynaecological purposes once the women's health hub model is fully functional. • Development of plans to further integrate six further core services into the hub delivery model by December 2024 (Phase Two) The aims and objectives of the Hubs include: • Reduced health inequalities across Mid and South Essex by creating access to services closer to home. • Improved patient experience and outcomes through reducing waiting times for assessment and treatment and streamlined pathways • Improved waiting list management, by creating capacity within secondary care to focus on 2WW and RTT patients requiring acute care. • Optimised use of workforce capacity, delivering care in the right place at the right time.	Development of robust delivery models to deliver the Department of Health core services specified in the women's health strategy

What action will we take	What impact will this have	When will this action be completed
Procure local enhanced services for ring pessary services and IUD for gynaecology purposes (Phase One)	Improved access, experience and outcomes	1st July 2024
Address any training needs to deliver Phase One	Upskilling within primary care	1st December 2024
Implementation of Phase Two: integrating six further core services	Improved access, experience and outcomes	31st December 2024

Dermatology

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Challenges driving dermatology pressures include a shortage of consultant dermatologists and an ageing workforce, variation in diagnosis and management in primary care due to a lack of dermatological training for General Practitioners; limited or fragmented use of available technology; inadequate triage in both primary and secondary care, limited and inconsistent coding of outpatient activity. Local pressures resemble the national picture for Dermatology with increased patient waiting lists: dermatology is one of three priority areas due to significantly increasing demand for Dermatology services.	The Dermatology patient survey in February 2023 found that: 1. 59% of respondents had accessed care from their General Practitioner for their skin condition with 62% of patients regularly managing their skin conditions at home. Only 23% had a tele dermatology assessment. 2. 44% of respondents had accessed skin treatment via a community or hospital service with mixed outcomes, the common trend being the clinical care received by hospitals was good but often experienced long waiting times and thought the service was not patient focussed. 3. 45% stated that their skin condition has impacted their mental health and wellbeing with common themes being skin conditions leading to lack of sleep, increased anxiety of visual appearance.

What are our ambitions	What needs to change to achieve our ambitions
The ambitions of the service include: • Supporting delivery of faster diagnosis standards through early detection of skin cancer, and a reduction in cancer backlog and waiting times • Provide a single point of access, utilising teledermatology, to triage service users to the most appropriate pathway • Deliver initial assessment and management providing a one stop model of care, where appropriate. • Support waiting lists ensuring that service users are only referred to secondary care following agreed criteria	The Dermatology Programme Board alongside Dermatology Stewards have committed to implementing a single Community Dermatology Service across the Integrated Care System to support improvement in Dermatology services, reducing health inequalities, improving patient experience and patient outcomes, communication, and waiting times for patients.

What action will we take	What impact will this have	When will this action be completed
Undertake formal procurement process to commission the new model of care	Deliver new model of care and expected outcomes across MSE	31st March 2025

Eye Care Services (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Whilst there have been significant improvements in eye care services over the last year they continue to be significantly challenged as a result of year-on-year growth in demand and the added impact of the COVID-19 pandemic. There have been some notable successes with regards the number of people waiting for appointments (for example the number of people waiting 52+ weeks has halved from over 1500 to 743 in 12 months and is continuing to drop) however this remains a priority focus area. This is particularly important for those with developing or chronic conditions as this has an impact on the avoidable deterioration of vision and long-term outcomes for our population.	The common theme in feedback from residents is that the quality of care given during attendances is good, however the waiting time for appointments (particularly follow up care), delays for surgery and telephone access to the service require improvement. Care closer to home and easier to access is well received, this is supported by Friends and Family Test responses that are more positive for satellite/community locations than for attendances at the large Trust sites.

What are our ambitions	What needs to change to achieve our ambitions
The aim of the Mid and South Essex Eyecare Transformation Programme is to 'improve and preserve the vision of our residents now and in the future by achieving a system-wide sustainable and integrated eye care service across mid and south Essex. We intend to continue to reduce the non-admitted waiting list and improve Referral to Treatment performance, significantly reduce the overdue follow up waiting list and improve patient outcomes, particularly relating to avoidable deterioration of vision whilst waiting for treatment.	1. Developing new pathways and increasing capacity and efficiency of services to meet growing demand 2. Reducing waiting times for care 3. Maximising the clinical capabilities of the ophthalmic workforce and developing new roles 4. Improving estates and digital infrastructure to support the future delivery model

Eye Care Services (2)

Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Introduction of diagnostic hubs. Nurse or technician led rapid diagnostic tests in a 45 minute appointment. Results reviewed virtually by a Consultant and follow up plan developed.	More effective use of clinical time will impact on waiting lists	Orsett Hub opened April 2024. Second site opens August 2024
Alignment with best practice (GIRFT) recommendations for Cataract provision and introduction of Cataract one stop assessment clinics - includes pre-assessment, investigations and clinical examination in single appointment	The right patients on the waiting lists. Increased number of patients per theatre session. Reduced number of appointments per patient	Being embedded through 2024
Introduction of AMD Nurse Injector clinics - Upskilling nurses to lead AMD injector clinics to enable Consultants to focus on more complex patients	Reduce waits for AMD treatment	September 2024
Review and development of current referral and triage pathways	Early and effective decision-making regards treatment options to ensure patients on correct pathways	September 2024

Musculoskeletal and Pain Services

NHS
Mid and South Essex

Where are we now	How are we engaging our population
There are currently several challenges including differential access to services across the system in community and secondary care, waiting list and workforce pressures. A Musculoskeletal (MSK) Delivery Group with speciality specific task and finish groups has developed a new model of care and service specification for Community MSK and Pain services including a single point of access and triage, for across mid and south Essex.	As part of the development of the new service model, a survey was undertaken in 2023, 108 people responded in total with 46 expressing an interest in being involved in future discussions. An online event was held 11th May 2023 targeting the people who responded to the survey. Further engagement will be undertaken during the commissioning process, for example to support mobilisation of the new service.

What are our ambitions	What needs to change to achieve our ambitions
Implement a system wide community Musculoskeletal and pain service achieving 80% conversion rate to surgery, <20% discharged at first appointment and support waiting list reduction. To deliver a new service delivering high quality, patient focussed care that is innovative, improves outcomes and reduces health inequalities for patients.	Delivering a population health approach focused on optimising outcomes, including reducing health inequalities. Implementing a service that delivers equitable outcomes and experience. Improving life-long best Musculoskeletal health for the population of mid and south Essex using preventative and anticipatory care approaches. Delivering a seamless integrated pathway. Adherence to Referral to Treatment standards and more efficient recovery of waiting lists.

What action will we take	What impact will this have	When will this action be completed
Undertake formal procurement process to commission the new model of care	Deliver new model of care and expected outcomes across MSE	31st March 2025

Fracture Liaison Service

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Fracture Liaison Services (FLS), are the gold standard for fracture care, and play an important role in identifying, assessing and treating osteoporosis in people over the age of 50 with a fracture. In August 2023 a business case was approved to provide one year funding to mobilise a MSE wide FLS. The Mid and South Essex service is now in place with staff recruited, digital solution procured to maximise information sharing across all partners, prescribing guidance revised, evaluation framework approved and significant patient engagement as we continue to roll out this first of its kind ICB wide service. The project is receiving significant local and national press interest.	Members of the local Royal Osteoporosis Society patient group sit on our weekly FLS operational group and are involved in decisions regards development of the model and pathways Patient feedback is one of the key elements of our evaluation framework FLS is a high priority local project with significant local and national interest and MSE ICB is often cited as a first of its kind system wide service in the press:

What are our ambitions	What needs to change to achieve our ambitions
There is a national commitment from all main political parties to support provision of FLS in every ICB in England by 2030. This has been driven by support from the Royal Osteoporosis Society, our local MP and the Health Secretary, Victoria Atkins, who cited the work of the ICB in Prime Ministers Questions on 23rd May 2024. Our ambition is to demonstrate the benefits of this service in order to secure a sustainable future for FLS in MSE.	Strong evaluation framework that demonstrates impacts Ongoing patient engagement to develop services that meet the needs of the population Stakeholder buy-in to recognise the benefits of the service

What action will we take	What impact will this have	When will this action be completed
Ongoing roll out of service across MSE	Deliver consistent service across MSE to those at risk of repeat fracture	September 2024
Six month and one-year evaluation	Monitor impact of service to inform future planning decisions	September 2024 and March 2025

All Age Continuing Care (AACC)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The All Age Continuing Care team have been embedding new ways of working to ensure we deliver consistent high-quality outcomes for the people we support. We have a high number of referrals that require additional support to complete and to support delivery we have established a regular performance meeting to look at demand and how we can ensure assessments are completed within the NHS England 28-day target.	We continue to work open & transparently with our residents, partners & our providers to deliver an integrated, innovative & valuable service. We provide a personalisation and personal Health budget offer.

What are our ambitions	What needs to change to achieve our ambitions
We want to ensure we put people at the heart of what we do. We're passionate and dedicated to getting people the right care, in the right place, at the right time and by the right person. We work open & transparently with our partners & our providers to deliver an integrated, innovative & valuable service to deliver the national care standards for All Age Continuing Care.	Ensure we have robust processes in place. Data to back up the activity and delivery targets. Improve partnership working with Local Authorities and Community Partners. Market management and aligning of shared knowledge of placements and providers

What action will we take	What impact will this have	When will this action be completed
Processes – ensure that we have standardisation across the teams to reduce duplication and improve efficiency	Timely assessment. Improved patient experience	December 24
Workforce – to ensure we have an effective team to deliver timely assessments and outcomes	Ensuring that resident are on the correct pathway	December 24
Market Management – working in partnership with LA and system to align brokerage and commissioning.	Efficiency saving on cost of package and placements	March 25

Pharmacy and Medicines Optimisation

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have reduced: • the rolling 12m antibacterial items /STARPU from 1.143 in April 2023 to 1.108 in December 2023 whilst maintaining proportion of co-amoxiclav, cephalosporins and quinolone items below 10% (8.53% in Dec 2023). • the number of patients prescribed 120mg or more equivalent morphine daily from over 1000 to around 988. We are experiencing: • Continued prescribing cost pressures arising from increasing demand for medication and implementation of NICE Technologies, increasing prices due to shortages, price inflation and Department of Health price concessions. • Annual growth in cost of medicines prescribed in primary care of +10.1%* (Jan 23– Dec 23 compared to Jan22 – Dec22). We have increased: • Community Pharmacy Consultation Service referrals from our GP practices to community pharmacies by 3690 compared with same period the previous year, but with large variation between practices. Pharmacy First was launched on 31st January 2024 with 98% of MSE community pharmacies signing up to deliver this, and as a result in February 2024 avoided over 3,000 GP appointments. • Community Pharmacy activity in the Discharge Medicines, Blood Pressure Check and Oral Contraceptive Services.	Social media campaign to raise awareness of risk of opioids Pain Killers Don't Exist.-May until September ICS website advice on managing UTIs and use of antibiotics Public communications launch of Pharmacy First and information on ICS website

What are our ambitions	What needs to change to achieve our ambitions
1. Achieve the antimicrobial prescribing metrics year on year by implementation of National Institute for Health and Care Excellence guidance and cross-sector guidance on common infections. 2. Reduce the risk of medicines-related harm from high-risk e.g. Valproate Prescribing and deliver against other Patient Safety Incident Response Framework priorities. 3. Continually improve the value and sustainability of prescribed medicines, including reducing over-prescribing, over-supply and the carbon burden of medication. 4. Integrate nationally commissioned clinical services delivered by community pharmacists and pharmacy technicians into ICB pathways; supporting the community pharmacy workforce to work to the top of their license.	1. Improved prescribing behaviours 2. Improved access to future-ready pharmacy workforce. 3. Digital integration of community pharmacies with general practice to improve referrals and communications 4. Greater integration of community pharmacy clinical services into primary care pathways and improved joint working between primary medical services and community pharmacies.

Pharmacy and Medicines Optimisation (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Work with system partners to develop an ICS Medicines Optimisation Strategy	Collective vision and goals to improve value and sustainability of prescribed medicines	June 2025
Identify and offer through various forums education and training on improving prescribing behaviours	Improve safety, value and sustainability of prescribed medicines	On-going
Work with system partners to develop an ICS Pharmacy Workforce Strategy	Increase access to future ready workforce	June 2025
Establish PCN Community Pharmacy Engagement Lead roles for all PCNs to support integration of community pharmacy teams into PCNs and Integrated Neighbourhood teams.	Improved access to primary care through integrated working.	October 2024
Support existing pharmacist workforce to become independent prescribers by identifying and supporting Designated Prescribing Practitioners and Designated Prescribing Supervisors. All newly qualified pharmacists will be independent prescribers from 2026.	Increase access to future ready workforce	August 2026
Workforce-improve access to training places for Foundation Pharmacists and pharmacy technicians and improve access to clinical placements for M. Pharm students.	Increase access to future ready workforce	On-going
Establish agreement for ICB Training Hub to support education and training for community pharmacy workforce with calendar of multisector events.	Integration of community pharmacy workforce with wider primary care	March 2025

Specialised Commissioning

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Mid & South Essex (MSE) ICB is part of the East of England Region which is in the first wave of delegation of NHS England Specialised Commissioning Services to ICBs. On 1st April we took delegated responsibility for 59 services from NHS England. The services continue to be overseen and assured by the Specialised Commissioning team on our behalf. The team is hosted by Bedford, Luton & Milton Keynes ICB. ICB officers have joined three key committees: Joint Commissioning Committee, an Operational Group and a Strategy & Planning Group.	Delegation gives us the opportunity to better meet the needs of our population. We will work with the Specialised Commissioning team to analyse current performance and access data to identify areas where our population is not currently gaining access to specialised services. We will then engage with communities to identify how to overcome barriers to access or move services closer to patients.

What are our ambitions	What needs to change to achieve our ambitions
We will work with our regional partners to develop the regional commissioning strategy, planning, and prioritisation framework for specialised services for 2025 onward as part of the Strategy and Planning Workstream. This will include a review of strategic networks and Operational Development Networks (ODNs) to ensure alignment with future strategy and the preparation of specific plans for leveraging changes for the benefit of under-served MSE populations. Priority areas for this work will be agreed by end Sept 2024. From 1st April 2025 we expect a further 29 Amber services to be delegated, with most remaining services likely to be retained permanently by NHS England.	We require a greater focus on integration between specialised and non-specialised services required with work programmes targeting end to end pathway transformation. Key aspects of this will be considered during the next 12 months. We need to explore ways to open access to specialised services to more of our population as we approach a fair shares allocation over the next 7 years. This may include improving pathways into services outside our region (especially London and Cambridge) or repatriating part or all of a pathway into MSE.

What action will we take	What impact will this have	When will this action be completed
Agree priority areas in regional strategy	Ensure resources are targeted most effectively in line with MSE priorities	September 2024
Analyse inequities of access	Understand where we need to improve health inequalities	December 2024
Scoping exercise to identify optimal areas for integrating specialised and other pathways	Improve patient experience and increased efficiency	March 2025

Enabling

NHS
Mid and South Essex

- These programmes and initiatives focus on the critical enablers in our system that are needed to support successful delivery and effective partnership working to improve care outcomes. Those include our workforce, data, digital and technology, financial sustainability and research and innovation.

- Strategic ambitions identified in the JFP include:

    - Supporting our workforce
    - Data, Digital and technology
    - Financial sustainability
    - Research and innovation

Workforce (1)

Mid and South Essex

Where are we now	How are we engaging our population
The ICB is planning to: 1. Reduce Staff in Post (SIP) – 5.5% across providers (MSEFT & EPUT). 2. 30% reduction in WTE in the ICB. 3. Significant reduction in use of temporary workforce 4. Bank by 58% & Agency by 55%. 5. Clearer alignment of workforce plans to clinical and operational priorities. 6. Clear understanding of the national clinical expansion ask. The ICB's NHS leaver rate is at 8.3% currently, the second highest among the six East of England ICBs. We have a new System Workforce delivery model in place- to facilitate delivery of key ICB ambitions.	• The Health & Care Academy is working with schools and colleges. e.g.: Anchor /Halo programmes/Cadets/Princes Trust/Department of Work and Pensions/College Enrichment programme. • 'Level Up Your Potential' – care leavers programme. • Health Care Assistant Academy- centralised recruitment and retention hub for HCAs across the system- Induction programme aimed to improve retention, offer career conversations and expanding opportunities for local people • Careers website 'Our People Your Future' • Working closely with HEI- developing career opportunities for local people.

What are our ambitions	What needs to change to achieve our ambitions
REFORM: • Reduce reliance on bank and agency staff: • Work with key stakeholders to include Care Group Managers to understand what is required to consider different staffing models. RETAIN: • Improve staff retention and development: System-wide legacy practitioner vision. Commitment to the expansion of flexible working policies. Fully embedding the six high impact actions in the NHS EDI Improvement Plan. Deliver on People Promise • Embed Clinical Learning Strategy- innovation in education & launch of placements platform. RECRUIT: • Improve recruitment processes, time to hire, innovative recruitment • Drive the take-up of internal apprenticeship pathways. • Offer of employment to all our nursing/midwives/AHP graduates on placement. SUPPORT TO LEFT SHIFT: • Primary Care long term workforce planning.	• Review of Electronic Staff Record coding of staff and workforce /skill mix requirements. • Consider new roles for Acute and Community alongside the Additional Role Reimbursement Scheme • Optimisation and ways of working- Advanced Clinical Practice/Physician Associates/Nursing Associates and rotational posts • Expand Community Diagnostic Centre workforce opportunities. • Move staff from temporary to substantive roles. • Review of doctors' bank booking platform/improve rostering process- include medics • Expansion of apprenticeships for clinical and non- clinical staff and increase the offer to external recruits • More accurate short, and longer- term workforce planning. • An effective Primary Care People Strategy

Workforce (2)

Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Triple Lock controls are in place, including a recruitment freeze for non-clinical roles, across the system	Scrutiny of spend and reduction in bank and agency Less reliance on bank and agency staff more sustainable staffing model, fewer vacancies Improved pipelines for recruitment and increased retention.	30th June 2024
Launch system wide staff experience, wellbeing group and retention group		31st July 2024
Launch system wide Clinical Capacity and Expansion group.		31st July 2024
Launch system wide Equality Diversity and Inclusion Group.		31st July 2024
Close the Health Care Assistant vacancy gap as close to zero and increase the retention rates of candidates in post.		31st March 2025
Focus on career development		31st March 2025
Develop and Deliver the Primary Care People Strategy,.		30th September 2024
Procure a Student Placement Platform		30th September 2024

Clinical and Care Professional Leadership (CCPL)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The Mid and South Essex Clinical and Care Professional Framework strategy sets out to achieve and align with the national guidance 'Building strong integrated care systems everywhere' which consists of Integrated Care System (ICS) implementation guidance on effective clinical and care professional leadership. This also clearly sets out the structure and rationale for CCPL across Mid and South Essex system.	The CCPL engagement event titled Leading Better Together, has had strong positive feedback from attendees. Securing inspirational keynote speakers, such as Prof Claire Fuller – National Medical Director for Primary Care, drew in attendees from every core provider organisation in MSE and some PCNs/general practices.

What are our ambitions	What needs to change to achieve our ambitions
Via the CCPL Council system stakeholders have a shared ambition to develop and deliver the MSE CCPL framework. Working with special interest groups targets will be set for years 1-5. Plans will be based on national principles including: Communication, Learning from Practice, Support, Development and the identification and recruitment of leaders.	The CCPL ambition is to become more connected to, and more aware of, the residents we serve and the staff we employ to be more responsive and agile to the system-wide circumstances, workforce, and feedback.

What action will we take	What impact will this have	When will this action be completed
Clinical Leadership Review (roles, structure, governance and renumeration).	Right resources to deliver clinical priorities areas, protected time, support and infrastructure available to carry out leadership roles.	July 2024
CCPLs are represented at every level and within every decision-making forum, from Neighbourhood, to Place to System.	Clinical leaders at all levels of the ICS with a voice and mechanism to influence decisions made.	During 2024-25
CCPLs to collaborate and innovate with a wide range of partners, including patients and local communities.	Leadership that focuses on subsidiary as a key principle. Diverse CCPLs with a clear, local identify, capable and eager to lead	Throughout 2024-25
Clearly defined and visible support for CCPLs	Development of the leadership and skills required to work effectively across organisational and professional boundaries	March 2025
Identify, recruit, and develop a pipeline of CCPLs	Mechanisms to identify and develop future leaders earlier in their career. Leadership that geographically reflects the communities it serves. Transparent recruitment systems.	March 2025

Shared Care Record - ShCR (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
In June 23 awarded contract ensuring full interoperability and flow of information across the MSE system. MSE Primary Care Hub page launched with information governance framework embedded. Front line staff engaged through phase 1 to map use cases and determine data sets. Centralised intelligent client function developed managing relationships across system stakeholders and with the supplier. Connectivity in place and testing underway with Operational Go Live scheduled for 15 July. Various training completed and training materials created.	There have been a wide range of public facing activities, including workshops and surveys to raise awareness. In December 2023, a survey was undertaken, using Virtual Views, an interactive online platform for engaging with mid and south Essex residents about health and social care initiatives to help to understand the public's perception of a ShCR and shape how we implement, and communicate details about the shared care record to best service the local health and care needs.

What are our ambitions	What needs to change to achieve our ambitions
Year 1 – Ensure ready access and reporting and analytics capability align to Data Platform strategy. Enabling service usage patterns. Support strategic integration across ICS boundaries. Year 1-2 support frailty work with bi-directional integration to provide an enhanced patient centred approach to cross organisational care needs between all partners. Create a holistic ShCR by extending into other care settings including hospices, pharmacies, dentists and optometrists. Further integration and explore creation of individualised care plans. Year 2-3 – Progress other bi-directional integration and delivering a fully connected (interoperable) shared care record with sharing capabilities across health and care systems.	System transformation, ongoing communication and promotion of the benefits of a ShCR will be required. Each organisation will have access and will need to promote the value of using it to support patient care. Benefits realisation will be critical to its success for the committed system investment and local resource prioritisation. Continued engagement with partners and ensuring strategies, created to support delivery, remain iterative for the lifecycle of the programme.

Shared Care Record - ShCR (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
MVS Go Live across MSE ICS (healthcare partners) including data sets to support Frail, Complex Adults	Improved and more timely decision making at the point of contact	July 2024
Phase 1 Go Live across MSE ICS (LA partners) including additional data sets to including MSEFT encounters/pathology/radiology and LA data to support Frail, Complex Adults	Improved and more timely decision making at the point of contact especially for healthcare partners who currently have no access to LA data	October 2024
Work with system partners to agree the inclusion of additional organisations and new data flows and the options of further integration	Support the integration and strategic direction of utilising the roles of the wider primary care organisations (Pharmacy/Dental/Optom) and the third sector organisation to support patient access and care.	April 2025
Inclusion of Children's data into the ShCR	Provide a fully holistic ShCR and support	October 2025

Electronic Patient Record - EPR (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The Mid and South Essex ICS completed Outline Business Cases and conducted an extensive procurement process that deeply engaged clinical staff. A multi-disciplinary team of 201 staff members across the two trusts participated, ensuring alignment with the procurement requirements. A unified Full Business Case has now been drafted and is progressing through national approval reviews scheduled for the EPR Investment Board on July 3rd and the Joint Investment Committee by late July. Concurrently, a draft contract is under review with the likely supplier, Oracle Health. Joint program governance has been established with a UEPR Programme Board overseeing workstreams like Technical, Data & Analytics, Finance & Procurement, and Digital Change & Engagement. Further clinical engagement and wider collaborative efforts with ICS partners, primary care, neighbourhood teams, staff or other stakeholders are underway.	We are in the process of standing up a People Participation Group. This group will be brought and will dove tail with existing PPGs across the Trusts. They will be engaged on the ambitions of delivering better care. Further details are still to be worked up.

What are our ambitions	What needs to change to achieve our ambitions
A single Unified Electronic Patient Record (EPR) across Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Trust (EPUT). This would cover acute, community and mental health services for our ICS as well as neighbouring Hertfordshire and West Essex and Suffolk and Northeast Essex.	Achieving the unified EPR ambitions requires clear ownership and leadership driving supporting strategies. The Change Strategy has been completed under assigned business and clinical leads. The Communications Strategy is final with designated leads. Remaining strategies are progressing with committed owners: Technical and Data Strategy pending board approval with technical leadership identified, People and Culture Plan with HR/OD and clinical leads, and Patient, Carers and Residents Strategy with patient experience and clinical leads assigned. Providing specific business and clinical role owners for each sub-strategy is critical for aligning the ICS around program goals. This shared leadership model, unifying strategic execution efforts across the EPR lifecycle, is pivotal for realising the digitalisation ambition of improving patient care.

Electronic Patient Record - EPR (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Complete discovery and part way through project initiation - Full Business Case completion and Contract Signature.	Increased awareness of need for change and UEPR benefits	During 2024/25
Complete project initiation, EPR design and commence EPR development	Broader engagement of clinicians, ops and IT staff	During 2025/26
Complete EPR development and deliver EPR deployment and Go Live	High degree of organisational focus	During 2026/27
Complete Go Live with focus on post go live (optimisation/benefits realisation)	Increased data and analytics capabilities to support clinical, operational and financial decisions	August 2026

Strategic Data Platform - SDP

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The SDP has been live for over a year and is built from the recommendations outlined in the 2021 BI Strategy and Roadmap. There are currently over 130 users from across our ICS partners, accessing 55 dashboards, as well as an underlying database. This platform is key in both the delivery of our PHM and Stewardship programmes, and means our staff and partners spend "less time sourcing data and more time to apply impactful interventions that can change lives".	In 2024, we advertised a patient representative role to be involved in making decisions on how health and social care data is used in MSE. We received an impressive number of applications, reflecting a shared enthusiasm for enhancing health and social care through responsible data use. Three successful representatives have been offered the role with plans for onboarding them in April 2024.

What are our ambitions	What needs to change to achieve our ambitions
To extend the reach and use of the SDP across all our partners, to improve integration and a movement to a single data platform.. To create areas on the SDP for both Finance and Workforce, then transfer their existing reporting on to the platform. Work in conjunction with the regional FDP team, to take advantage of any use cases that maybe advantageous to the ICB. Work with our regional SDE team, to supply data from our platform to support their research projects.	The Strategic Data Platform supports the Stewardship Programme which is set out to achieve MSE triple aim: (1) Improve health & wellbeing of everyone (2) Improve quality of services (3) Ensure sustainability and efficient use of NHS resources. 25 speciality dashboards identified for delivery between 2023-2026, with the following dashboards live on Athena: Stroke, Ageing Well, Cancer, Diabetes – Partial, Serious Mental Illness

What action will we take	What impact will this have	When will this action be completed
Target remaining GP practices to include data in Athena	Dashboards reflect our whole population	During 2024/25
Create data quality framework including assessments, education and metrics	Improved data quality and support the EPR project	During 2024/25
Creation of single virtual (or physical) data and analytics team	Shared resources, streamline reporting, improve DQ	During 2024/25
Inclusion of additional data flows to Athena, including workforce, finance, plus housing, education	Supports analysis not previously achieved. Also creates a triangulated view	During 2024/25

Patient Knows Best - PKB (1)

NHS
Mid and South Essex

Where are we now	How are we engaging our population
Over 1.2 records have been created in PKB, c. 235k records by EPUT and nearly 800k in MSEFT. 12% of patients with records in PKB are currently registered to use the system. Patients and service users are able to view their demographics within PKB and there is technical development and testing underway to launch appointments and discharge letters for MSEFT, and, appointments and appointment letters for EPUT by the end of July 2024. Phase 2 will bring the alignment of the basic offerings across each organisation with the addition of radiology and pathology results being published for patients to view. Each organisation is working on their phased plans to tailor and enhance offerings from PKB in line with the clinical transformation plans, speciality by specialty. Additional functionality such as care plans, questionnaires and asynchronous messaging are some of the enhanced features that PKB offer	The Phase 1 communications plan will begin to provide continued engagement with our population from June. This plan was created with a lens that supports clear messaging of the benefits and intended use of PKB as well as how PKB fits into the bigger picture alongside our other large strategic programmes of work (EPR, SCR). The communications will utilise a variety of methods to engage with our population from trust websites, social media, print materials throughout the trusts, promotion through partners (i.e. HealthWatch), news and press release.

What are our ambitions	What needs to change to achieve our ambitions
To provide the population of Mid and South Essex with greater access to their health information and improve the way they engage with their providers of healthcare. Answering the question of how do we turn PKB into a mechanism to provide community support for patients, allowing patients to help patients. Providing those with long term conditions or difficult diagnosis with an alternative support method aside from NHS professionals. MSEFT will use PKB to empower our patients with interactive tools and knowledge to proactively manage their health. Simultaneously equipping our services with localised configuration to deliver a cohesive and intuitive tool which will enhance patient cohort management, creating seamless communication and information flow between our services and patients to improve outcomes, reduce risk, increase productivity, and ultimately support our elective recovery. Over the next year there will be at least 6 clinical service using PKB alongside patients receiving appointment information, letters, pathology and radiology results.	Significant service transformation and business change is required to bring clinical services onboard with PKB. It will require changes in practice as patients can use functionality such as questionnaires and symptom tracking to provide information that can support care outside of the hospital helping to keep patients well.

Patient Knows Best - PKB (2)

NHS
Mid and South Essex

What action will we take	What impact will this have	When will this action be completed
Appointment information provided to patients via PKB	Patients can see when appointment information digitally and much quicker than paper methods which could reduce DNAs.	31st July 2024
Appointment letters provided to patients via PKB	Patients will receive appointment letters digitally creating the opportunity to not send paper letters and save money	MSEFT 2025 EPUT 31st July 2024
Inpatient Discharge Summaries provided to patients via PKB	Patients can see their inpatient discharge summaries digitally increasing patient satisfaction and reducing queries.	MSEFT 31st July 2024 EPUT Autumn 2024
Pathology and Radiology results provided to patients via PKB	Patients can see their test results digitally increasing patient satisfaction and reducing queries.	During 2025
Transformation work with 6 clinical services to provide patients with service specific functionality such as a health library, questionnaires or care plans.	Services will be able to provide patients access to a space on PKB specific to their service which can reduce queries and support patients to stay well.	During 2025

Digitising Social Care Records

NHS
Mid and South Essex

Where are we now	How are we engaging our population
We have received 135 applications, meeting our target of 105 applications by the end of March 2024, and are well ahead on our target of 135 applications by the end of March 2025. We have paid 115 applications to date, exceeding our end of year 2 target of 105. MSE is at an adoption rate of 82% , up from the baseline start point of 28% at the outset of the project and ahead of the national benchmark of 80%. We have allocated £601,836.67 worth of funding to MSE based providers. As we have hit the relevant targets, we can transfer funding to other care technology schemes. At present, the ICB is transferring funding to ECC to deliver the project throughout Essex.	Throughout the previous year we have held provider engagement events in Chelmsford and Thurrock. We have a further event to be held on 4th July 2024 at Chelmsford racecourse which will promote DSCR and Care Technology and aim to reach 85% adoption in the short project time remaining. Our team regularly engage the market through targeted calls and emails, as well as regular bulletins on our weekly ECC newsletter for care providers.

What are our ambitions	What needs to change to achieve our ambitions
Having met the NHSE 80% target locally for ASC providers using a DSCR system by March 2025, MSE have allocated funds to aid the reduction in falls by promoting and installing falls care technology. Procurement of an appropriate technology will be completed by August 2024. By deploying falls care technology in MSE, health of residents locally will be significantly improved - in addition to cost prevention for the NHS due to reduced admissions.	We have met our applications, payments and digitised percentage targets up until year two. We will need to process a further 20 payments by 31st March 2025 to meet our year 3 target. We will collate and feedback cost and time savings via benefit analysis along with increased data accuracy, to feed the continuous improvement drive of the project.

What action will we take	What impact will this have	When will this action be completed
Deliver individual target of 105 applicants	This will allow us to move funding to care technology, allowing us to place technology in homes without a need for match funding.	June 2024
Complete tender exercise and scale the falls technology scheme.	This will allow us to support 375 adults with falls technology.	March 2025

Finance

Mid and South Essex

Where are we now	How are we engaging our population
MSE is a system that is facing significant financial challenges. Having delivered a deficit plan in 2023/24 the challenge continues into 2024/25 with the system planning to post a £96m deficit in year. The ICB's immediate focus is on the system delivering the in-year efficiency requirement of £168m and moving towards a sustainable financial position over the next 2-3 years.	Should any engagement with the wider population be required as a result of the financial challenges we face the ICBs and system partners service change policies will be fully complied with to ensure all those affected have an opportunity to engage fully in any decisions.

What are our ambitions	What needs to change to achieve our ambitions
System ambitions for 2024/25 include: 1. Delivering the agreed financial sustainability programme to achieve the planned deficit position 2. Making improvements in the underlying spend position 3. Develop an agreed Medium Term Financial Plan that see's the system move back towards a sustainable financial position 4. To review corporate functions and identify areas where financial opportunity exists through consolidating 'back office' functions	We require a greater focus on sustainable models of care addressing the priority needs of our population, using population health management techniques to target our limited resource where it delivers greatest benefit.

What action will we take	What impact will this have	When will this action be completed
Delivery of the Financial Sustainability Programme	Delivery of efficiency requirement underpinning the £96m deficit plan	March 2025
Develop Medium Term Financial Plan	Provide a route map for the system back to balance	During 2024/25
Corporate Services Review	Identify opportunities and actions for delivering 'back off' efficiencies	During 2025/26

Estates

NHS
Mid and South Essex

Where are we now	How are we engaging our population
There is an overall deficit in the capacity of primary care estates compared to both current registered list sizes and projected housing growth. The extent of this deficit varies by locality. Our estates programme is limited by both capital and revenue availability. The infrastructure strategy will support the prioritisation of the use of capital and revenue monies and look at wider approaches to mitigating the current gap.	The infrastructure strategy is being engaged upon with a wide range of stakeholders. More thorough engagement is undertaken with local stakeholders on a development by development basis.

What are our ambitions	What needs to change to achieve our ambitions
Our ambitions will be formally articulated through the publication of our infrastructure strategy. We seek to ensure that available capital and revenue resources are prioritised into delivering fit for purpose buildings in the areas of greatest need. Through review of local plans, consideration is being given to housing growth and how the needs generated from this growth are best met.	Publication of the infrastructure strategy and a shared ownership of delivering upon this. Increased availability of capital and revenue to support premises developments.

What action will we take	What impact will this have	When will this action be completed
Publication of the Infrastructure Strategy	Strategic plan for the use of Estates and Infrastructure across the Mid and South Essex system.	During 2024/25
Review of the “void space” initiative that has provided Primary Care Networks with access to void space	Enable continued use of void space to maximum effect.	December 24

Contract Review

NHS
Mid and South Essex

Where are we now	How are we engaging our population
The ICB's priority has been to strengthen contractual oversight, and ensure contracts are delivering value for money as part of the 2024/25 contract planning round. Robust procurement pipeline in place for key strategic services which will deliver in-year System efficiencies. Increased controls and measures implemented.	This is an internal process with engagement across NHS commissioned services.

What are our ambitions	What needs to change to achieve our ambitions
• Ensure contracts deliver value for money, maximising opportunities for efficiencies to be realised • Greater collaboration with peers to minimise duplicated effort • Ongoing development of analytic capabilities to enable strategic and operational commercial insight • Maximising use of technology, such as Atamis, to improve transparency, accountability and establish the foundation for commercial intelligence and insight	• Leverage unique influence and scale to develop and shape new markets, unlocking benefits from innovation • Use data as a strategic asset to enable it to be used to delivery greatest value • Maximise use of limited resource to deliver maximum benefit

What action will we take	What impact will this have	When will this action be completed
Contract Reviews – ongoing review of activity and value for identification of further opportunity	Support the delivery of the efficiency requirement	September 2024
Procurement Planning – proactive review of contracts to inform Commissioning Intentions and support 2025/26 planning	Ensure pro-active decision making regarding procurement decisions	December 2024
System wide adoption of Atamis (National eCommercial Platform) and ongoing development plan in place	Facilitate transparency and enable proactive contract reviews and procurement planning across System Partners	December 2024

Sustainability and Net Zero

NHS Mid and South Essex

Where are we now	How are we engaging our population
MSE's first Greener NHS plan was published in March 2022. Each provider within the system has also published its own Green Plan. MSE Exec Director of Strategy and Corporate Services taking system-level ownership of the agenda to ensure increased focus on actions to reduce emissions and environmental impact. Current progress includes embedding social value in procurements, action to reducing air pollution (in partnership with ECC) and increase active travel through initiatives such as 'Essex Pedal Power', greening theatres campaigns, Gloves Off Campaign, shift from plastic cutlery, re-use of equipment (walking aids and office based). In Q1 2024/25 the MSE Greener NHS Programme Board has been established to bring together all Exec level leads for Greener NHS.	ICS Sustainability Forum provides an opportunity to bring together all those working in the system with an interest in reducing environmental impact. MSE Anchor work also highlights local sustainability work across system partnerships.

What are our ambitions	What needs to change to achieve our ambitions
System ambitions for 2024/25 include: 1. Developing an organisational level Green Plan for the ICB 2. Sharing and scaling best practice, proven interventions across MSE 3. Increasing overall awareness and leadership support for the Greener NHS agenda 4. Coordinating approaches to energy efficiency and purchasing across MSE 5. Embedding climate risk planning into EPRR across MSE 6. Increasing primary care engagement in Greener NHS ambitions	• Consideration for sustainability and Greener NHS impacts in all projects, programmes and decisions • Increased overall awareness of need to act to reduce emissions and impact climate change is having on health • Guidance from NHSE for Greener NHS plan refresh • Management of tensions between Greener NHS ambitions and others, e.g. finance or workforce priorities.

What action will we take	What impact will this have	When will this action be completed
Development of the MSE Greener NHS Programme Board	Increased partnership working and joint ownership of agenda across MSE	March 2025
Expanding access to Executive Level Sustainability Training (16 places available in 24/25)	Increased sustainability awareness	March 2025
Maximise opportunities to apply for additional funding for Greener NHS improvements	Targeted funding for Greener NHS initiatives	Ongoing
Update provider and system Greener NHS plans in line with national guidance	Clarity on priorities for coming years	During 2025

Research

Mid and South Essex

Where are we now	How are we engaging our population
Within MSE we have excellent clinical research assets: Essex CTC, Broomfield Burns Unit as well as some independent researchers but most research is conducted led by institutions outside MSE There is a growing network of Primary Care research-active practices supported by LEH CRN based in Chelmsford, supported by ICB with significant research activity in MSEFT. Community providers EPUT, Provide and NELFT are conducting third party research in community and inpatient settings, with support from ICB.	1. Research engagement network developed over 2023-4 with community-based groups representing groups traditionally under-represented in research including BAME, Disability and LGBTQ+ groups 2. Developed better understanding of barriers and motivators 3. Outreach facilities for researchers using research vehicle that can access anywhere with a road

What are our ambitions	What needs to change to achieve our ambitions
1. Develop our People to be able to develop and conduct more “home-grown” research through Fellowships and academic training 2. Further develop our engagement with our Population in research studies making use of specific local characteristics such as deprived coastal 3. Create centres of excellence in MSE: Centre for Integrated Healthcare Research at ARU, Greater Essex Health Determinants Research Collaboration (HDRC) 4. Deliver research into Real World problems that can be implemented locally	1. Refresh our ICS Research Strategy in 2024 2. Work in partnership with MSEFT, EPUT and other providers, ARU and UoE to establish strong collaborative links and research infrastructure

What action will we take	What impact will this have	When will this action be completed
Work with MSEFT to finalise ICS Research Strategy	Create overall vision and plan	December 2024
Work with ARU to finalise Community & Primary Care research strategy	Establish our ambitions	December 2024
Develop and strengthen links with ARU and UoE to explore areas for mutual collaboration	Essential groundwork to support future strategy	Ongoing

Innovation

NHS
Mid and South Essex

Where are we now	How are we engaging our population
MSE ICB is a leading force among ICBs for Innovation across England. Anglia Ruskin University hosts the NHS Clinical Entrepreneur Programme whilst MSEFT hosts the Fellowship training programme open to anyone in MSE. MSEFT also acts as the coordination hub for 18 innovation sites across England in a peer-peer learning network. MSE ICS Innovation Advisory Group is long-established with a record of supporting numerous innovations.	Successful innovation must help empower the population to improve their health and should have real world evidence to show benefits. As part of our innovation strategy we will develop a plan to engage with our population to ensure they are able to benefit from innovations implemented in MSE. We will consider how to overcome the barriers to uptake of innovations that may be faced by disadvantaged population groups within MSE.

What are our ambitions	What needs to change to achieve our ambitions
1. Develop a culture of innovation across the ICS 2. Raise profile of opportunities throughout local NHS workforce 3. Provide framework of support to innovators including advice, practice support and senior leadership 4. Focus on key priorities such as Integrated care, workforce pressures, efficiency and quality improvements	1. Engage with senior leadership across all partners to raise status of innovation and establish a culture of innovation in all our organisations 2. Provide a clear support offer for innovators, and ensure opportunities are clear 3. Ensure investment is available where innovation can improve outcomes and efficiency

What action will we take	What impact will this have	When will this action be completed
Develop an innovation strategy describing how we will create and maintain a culture of Innovation	Provide a shared vision and ambition	March 2025
Continue to support successful initiatives to develop and grow our innovation work	Innovations will increase what we can do with limited resources and demonstrate commitment	Ongoing

Part I ICB Board meeting, 11 July 2024

Agenda Number: 10

Chief Executive's Report

Summary Report

1. Purpose of Report

To provide the Board with an update from the Interim Chief Executive of 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 / Impact Assessments / Financial Implications / Engagement

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

The Board is asked to note the current position regarding the update from the Interim Chief Executive and to note the work undertaken and decisions made by the Executive Committee.

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 since the last update received on 9 May 2024. The report also provides information regarding decisions taken at the weekly executive committee meetings.

2. Main content of Report

2.0 Key activities and issues over the last two months:

Over the last two months I have continued to lead progress across the ICB and to work with partners across Mid and South Essex and the East of England region in order to improve and develop services in line with the core responsibilities of an Integrated Care Board. Since the announcement of the General Election the ICB has been conducting its business in accordance with the requirements relating to the pre-election period. This has therefore impacted on some meetings such as the Integrated Care Partnership, and other meetings with political representatives.

2.1 Annual Accountability Review

On 24 June 2024 the Board met with colleagues from the NHS England East regional team. We focussed on partnership working and had three excellent presentations from partners working with us to improve health, improve services and reduce health inequalities.

The first presentation was titled, 'Creating conditions to hard-wire physical activity – What does Co-Ownership look like?' presented by Jason Fergus, Active Essex; Lyndsey Barrett, Sport for Confidence and Stuart Long from ATF (Active, Thrive, Flourish).

The second was called 'Fr E D A Frailty End of Life Dementia Assessment with e-Fra CCS electronic Frailty Care Coordination System register; An ICS wide tertiary prevention example aimed at our highest needs population segments'. This was presented by Dr Sarah Zaidi, GP and Ageing Well Steward, Sarah Little, Ageing Well Steward, Nadia Halley and Ryan Walker, SS9 PCN INT clinicians, and Dr Aggarwal, Consultant Geriatrician in the MSE Frailty Virtual Hospital.

The third presentation was about developing our workforce and showcased the ICS Health and Care Academy and the work being delivered with schools and colleges, universities, and our staff across the ICS to ensure that we develop the workforce of the future with the skills they need to deliver leading edge care, in roles that enhance skills and retain the best staff in MSE. This was delivered by Dr Sharon McDonald, Head of System Workforce; Kate Merritt, Health & Care Academy Manager; Rachel Sestak, Head of System Workforce; Kara Stoker, Curriculum Manager, Health, Social Care & Early Years at USP College; Kirsten Dangerfield, Senior Head of Advanced Practice Directorate and Dr Sue Truman, NHS Primary Care Advisor and Dr Eva Lew, Farleigh Hospice.

The meeting is an opportunity for the regional team and the ICB to consider progress and development opportunities for the ICB. As an organisation which has only been established for two years, the focus was on how we build on the strong partnerships we have developed to now accelerate the pace of improvement and delivery in the quality of services people receive, our use of resources and making Mid and South Essex the place people choose to come and work.

The formal outcome of the annual assessment will be published once the process is completed across England.

2.2 Leading Better Together – 22 May 2024 – Writtle College

The ICB Medical Director hosted a system wide leadership event for colleagues across the system. The keynote address was given by Clare Panniker, Regional Director, NHS England (East of England), who shared her leadership journey in the NHS. This annual event was held at Writtle College, and we would like to thank the College for hosting us. The event was attended by clinical and managerial leaders from across the health sector in Mid and South Essex.

2.3 Planning and financial recovery

On 23 May, accompanied by the Chief Executive Officers of Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust, and supported by the Chief Finance Officer and System Recovery Director, the ICB met with the regional and national executive team members of NHS England to review our planning position. We have not yet been formally notified of the outcome of this meeting but are clear about the progress we need to continue to make to deliver the best financial outturn possible in 2024-5, and to begin the medium-term strategic planning for 2025-26.

We anticipate a further meeting in July to confirm progress, and again in September to review the medium-term plan with an expectation that this outlines how and when the system will return to a sustainable financial position.

Mid and South Essex NHS Foundation Trust is in National Oversight Framework (NOF) level 4 for finance. This is the level where there is national support and oversight arrangements for financial recovery, and clear criteria to demonstrate that progress is being made. It is expected that these criteria will be based on delivery of the 24-5 financial recovery plan and the development and delivery of the medium-term strategic plan to return the Trust and the system overall to a position of recurrent balance.

2.4 Community Services Consultation:

The community services consultation closed on 11 April 2024 after running for eleven weeks. We are considering the consultation analysis at the Board meeting today. Following this, work will continue to consider the responses and develop the decision making business case.

As anticipated in my report to the May Board, it has taken longer than expected to complete the analysis of the consultation responses, and the pre-election period has prevented sharing responses or engaging with the public on the future options for service delivery over this period.

Following the Board meeting today, we will continue to engage and to work on the decision making business case, taking into account the consultation responses.

2.5 Infrastructure strategy and primary care estate development

The ICS has undertaken work with NHS Property Services to review our capital infrastructure. As an integrated care system we need clear oversight of the totality of NHS estate and infrastructure, and to work with partners in the NHS and in our local authorities to ensure that we secure best value from any investments.

The outcomes of this work will inform decision making in the medium-term plan referred to above in section 2.3.

In May 2024 new NHS Premises Costs Directions were published replacing Directions from 2013. These define how ICBs fund primary care premises costs. A key change was removal of the requirement for GP contractors to contribute to premises developments/improvements. This change opens the opportunity to utilise Section 106 funding, provided by developers to support a proportion of the cost of new public sector infrastructure associated with housing developments, previously constrained through the requirement for GP contractor contribution. This will enable use of available funding, especially for relatively small-scale practice extensions or enhancements which can be funded in their entirety by Section 106 monies.

There remains a major barrier to large scale, new build, primary care infrastructure investments which needs the consideration of the Board. It is a requirement that Primary Care investment business cases demonstrate value through the rental reimbursement paid to the GP contractor. This should be in line with District Valuer assessment. With current construction costs, the revenue rental reimbursements required by developers significantly exceed this value. The implication is that new Primary Care premises business cases will not be approved by NHS England. This issue is affecting many ICBs across the country, and in Mid and South Essex this is going to stall several priority developments that are vital to meet the populations needs for primary care provision.

It is recommended that the Board undertake some work in seminar format to understand the implications of this and whether there are any options to make progress.

3. Priorities for the ICS:

The purpose of this section is to update the Board on progress made with the objectives set at the beginning of my interim period of tenure.

3.1 To develop the maturity of the Integrated Care Board:

The ICB Board has continued to have development seminars including recently, ‘Approach to the Lampard Inquiry’ and ‘Improving population health and reducing health inequalities’. Future seminars are arranged for estate planning, and equality, diversity and inclusion.

The executive team has also prioritised their development having an away day with the incoming Chief executive Officer on 21 June 2024.

Following the annual staff survey results from November 2023, the Board agreed that we would commence quarterly staff ‘Pulse’ surveys. The first staff Pulse survey has concluded, and it was clear that there has been significant improvement in many areas since the November 2023 staff survey. There is more to do still, and priorities to address include increasing survey response rates, and seeking to understand and then address areas such as staff experiencing discrimination. The results of the first Pulse survey are included in Appendix 1.

3.2 To ensure an ICS wide coordinated and evidence-based response to the planning guidance for 2024-25:

As referenced above in section 2, the planning process is concluding and the focus now is on delivery of the plan. The system architecture for oversight of delivery is in place and developing in content. The delivery plan requires a step change in efficiency delivery and expenditure control in comparison to previous years, and the risks regarding delivery are understood, with NOF 4 support aimed to mitigate these risks in the acute Trust.

The planning process for 2025-26 is commencing with support to develop the medium-term system strategy and delivery plan to achieve a sustainable financial position.

3.3 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 NHS England:

There is a need to deliver the performance outcomes indicated in the NHS operating framework. The current position is as follows:

Urgent and Emergency Care

- The national standard for A&E 4 hour wait time is improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March. In May 2024 71.2% were seen within 4 hours in Mid and South Essex ICB. There is a portfolio board in place to oversee urgent and emergency care performance and transformation, including pre and post hospital pathways of care. During 2024-25 this board will oversee improvement to achieve the expected March 2025 position.
- 10% of ambulance handovers were over 30 mins in May 2024 which was half the number of breaches in 2022-23. This is an area where Mid and South Essex perform among the best in the region.

Elective Care

- Elective waiting list performance at the end of April 2024 was as follows:
    - The number of patients waiting over 65 weeks was 1,056. The national expectation is that this will reduce to zero by September 2025. There is a recovery plan in place at the Trust to achieve this.
    - The current size of the overall elective waiting list (@ 9/6/24) is 166,479. This is over 12,000 less patients than were waiting at the end of June in 2023.

Cancer

- Performance in the cancer Faster Diagnosis Standard for April 2024 was 66%, requiring improvement to achieve a minimum of 77% by March 2025.
- Performance in the 62 day referral to treatment target was 51.06% at the end of April, compared to an expected position of 70% by March 2025.
- The Trust is in Tier 1 for cancer performance and has fortnightly oversight meetings with the NHS England national team. The ICB Cancer Oversight and Assurance Committee is ensuring that the service developments needed to deliver sustainable

cancer performance are put into practice. The Cancer Alliance has been asked to support this work.

Mental Health

- 15,340 people accessed Mental Health Talking Therapies services (2+ treatment appointments) across Mid and South Essex during 2023-24, similar access rate to 2022/23. Circa 98% received their first treatment within 6 weeks.
- The number of people registered with Dementia on GP practice registers increased to 66% of the estimated number (April 2024), a 6% increase from 2022-23.
- 69.3% of people with SMI (Severe Mental Illness) received their full physical health check and follow up interventions (May 2024) a circa 10% improvement from 2023.
- To date (April to May-2024), 464 people with Learning Disability received their health checks, circa 200 people more than 2023 on track to achieve minimum of 75% over 2024-25.
- The number of inappropriate adult acute mental health out of areas placements (OAPs) has halved over 2023/24 to 20 people.

The ICB approach to securing performance improvement in parallel with financial recovery and improving quality will be reviewed in Q2 as there is a need to embed best practice pathways of care which consistently deliver the required standards of care.

3.4 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 terms of reference and Chair arrangements for the System Oversight and Assurance Committee have been revised to enable performance improvement in parallel with financial recovery and improving quality. The method of escalating system issues has been clarified and membership has been streamlined to ensure accountability.

Risk management processes and practices continue to develop now that the Datix system is being implemented, with improved clarity and accountability of Board sub-committees for managing risk.

3.5 To ensure that the Mid and South Essex 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:

As stated above, an impressive set of presentations showcasing how the partnerships across the ICS have developed with real impact at the place level of our four alliances was the centre point of our annual assurance review.

We also continue to develop our partnerships with both Anglia Ruskin University and the University of Essex. The launch of the Centre for Healthcare Science which I attended on 20 June at the University of Essex was a great example of how together we are seeking to meet the demand for the breadth of healthcare roles across our system; whilst also supporting research and innovation and creating fantastic employment opportunities for the people of Essex.

4. Executive Committee

Since the last report, there have been eight weekly meetings (from 30 April 2024 to 18 June 2024)

Aside from noting the recommendations from the internal recruitment panel and investment decisions through the triple lock arrangements, the following decisions were approved by the Executive Committee:

- Contract award for Neurological Rehabilitation Services (level 2b inpatients) across the ICB.
- ICB Risk Appetite Statement and Corporate Objectives
- A review of the ICB's Discharge to Assess processes and arrangements.
- Introduction of an Enhanced Monitoring/Shared Care Local Enhanced Service for ADHD medication, approved subject to review of funding sources across NHSE funding.
- A revised process to strength the arrangements for Practice Branch Surgery closures, including enhanced ICB Board oversight.
- Reduction of internal media monitoring tools as part of the financial recovery programme.
- Inclusion and Belonging Group Terms of Reference, which has been formed as a sub-group of the Executive Committee
- Individual Funding Request (IFR) escalation for a patient which required Neurological Rehabilitation Services and exceeded existing funding limits.
- To ratify the decision made by the ICB's Operational Group (IOG) to cease work on the first '5k households' programme, as there was not committed funding associated with the work.
- Approval of Health and Care Academy programme scope for the next 12 months, including ringfenced budget.
- Review of Organisational Development Plan for the ICB, including proposed actions for next 6 months.
- Approval of revised principles within a new ICB DBS Policy, including requirement for Board members.
- For review of System Development Funds (SDF) to be undertaken across the ICB, which will aim to review non-committed funds. All existing contractual obligations to remain in place.
- Short term contract extension for the North East Essex Diabetes Service (NEEDs) to allow a safe transition of care to a new provider, funds within existing budget.
- To approve recommendations following an internal consultation for on-call arrangements across the ICB.
- To undertake a procurement for clinical waste services across MSE ICB, aligned to a procurement across all ICBs within East of England.
- To undertake a procurement for a digital consultation tool across all GP practices within Mid and South Essex, utilising national primary care digital first funding.
- To adopt a new proposed framework for utilising development contributions across Primary Care, in line with revised central legislation.
- Approval of the three local authority submissions to NHSE regarding Better Care Funds (BCF) across Mid and South Essex.

- Approval of business case and procurement plan for Tier 3 Weight Management Services (WMS) across MSE, with onward recommendation to Finance and Investment Committee (FIC) in line with delegated authority for the committee.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability, development & review of the ICB annual report and worked together in preparation for the NHS England annual review that took place on 24 June 2024.

All decisions and work undertaken by the Executive Committee continues to be regularly communicated to staff within a weekly summary as part of the ICB's communication channel 'connect'.

5. Conclusion

This is my final report to the Board as Interim Chief Executive. I note significant progress over the eight months I have led the ICB; and despite some significant challenges, there is vision, energy and optimism for the future of health and care services working with the communities in Mid and South Essex. I am proud of the work our teams have delivered and of their ambition to progress out of financial recovery and into a place of delivering really high quality care and improving the populations health.

6. Recommendation(s)

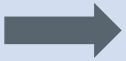
The Board is asked to note the current position regarding the update from the Interim Chief Executive and to note the work undertaken and decisions made by the Executive Committee.

Appendix 1 – Quarterly Pulse Survey Results (May 2024)

What has taken place since the last staff survey results*? (November 2023)*

- Created a collective ICB Mission and Vision.
- Revised and implemented the core values co-produced with staff. (They are now part of our recruitment process).
- We have regular all-staff briefings.
- Published a new People Management Strategy for the ICB.
- Revamped induction and onboarding to make it more welcoming and inclusive.
- Created a Learning Network to bring together our Community of Managers.
- Launched new 1:1 paperwork that prompts Health and Wellbeing; flexible working and career conversations and gives the opportunity for two - way feedback.
- Internal staff development events & managers learning networks have a focus on psychological safety, building trust and handling difficult conversations.
- Organised internal staff development events & managers learning networks which have a focus on psychological safety, building trust and handling difficult conversations.
- Encouraged staff and managers to access national and regional community of practice offers and learning webinars.
- Reviewed our Recruitment processes to ensure it is inclusive.
- Implemented the first phase of National EDI Implementation Plan (Board EDI objectives).
- Refreshed Staff Networks (LQBTQ+, Diversity, Women, Positive Ways to Wellness). Setting up a new neurodiversity network.
- Refreshed Staff Champion roles (Staff Engagement, Wellbeing; and Freedom to Speak up, Mental Health First Aiders).
- Created an ICB Inclusion and Belonging Steering Group.
- Ran our first Quarterly Pulse Survey

Question	Nov 2023 Result	May 2024 Result	Direction of Travel
My colleagues show appreciation of each other	60%	69%	
You feel safe to speak up about anything that concerns you	46%	58%	
If you had concerns the ICB would address these	31%	40%	
Have you experienced discrimination from managers team leaders or other colleagues in the last 6 months	8%	12%	
Have you experienced discrimination from patients their relatives or members of the public in the last 6 months	4%	6%	
My organisation is proactively supporting my health and wellbeing	44%	48.50%	
Time passes quickly when I am working	60%	71.70%	
I look forward to going to work	35%	42.50%	
I am able to make suggestions to improve the work of my team/department	72%	82%	
There are frequent opportunities for me to show initiative in my role	63%	73.50%	
I am able to make improvements happen in my area of work	51%	63.70%	
Care of patients and services users is my organisations top priority	52%	52%	

Question	Nov 2023 Result	May 2024 Result	Direction of Travel
I would recommend the organisation as a place to work	28%	36%	
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	31%	30%	
I feel informed about changes taking place in my organisation	No comparison	53.80%	
I found the health and wellbeing conversation supportive	no comparison	69.70%	
In my team we support each other	no comparison	81.80%	
Positive mood at the time of survey	no comparison	53.20%	
I have had a conversation about my health and wellbeing in the last 3 months.	no comparison	78.80%	

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 11

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.

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**

   No impact assessments were discussed at either Committee or Group.

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

1.1 The purpose of this report is to provide 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 Integrated Care System.

1.2 To note there are no escalations from the System Quality Group which met on 5 June 2024, and since the last Board the Quality Committee has not yet met, and will be meeting on 28 June 2024, post submission of this report. Therefore, the Quality Report for the Board this month will provide an update and information on guidance published regarding expected quality oversight and assurance.

2. National Update for the Board – Quality Functions in Integrated Care Systems

2.1 Updated guidance has been shared with to clarify some of the key statutory duties, accountabilities, and responsibilities that providers, Integrated Care Boards (ICBs) and NHS England hold for quality. These include:

- Strategic
- Operational Management
- Patient Safety
- Experience
- Effectiveness
- Safeguarding
- LeDeR (Learning Disability Mortality Review)
- STOMP (STopping Over Medication of people with learning disability, autism, or both with Psychotropic medicines)
- STAMP (Supporting Treatment and Appropriate Medication in Paediatrics)
- SEND (Special Educational Needs and Disabilities)
- Mental Health

Background

2.2 Integrated Care Boards ICBs were legally established on 1 July 2022, replacing clinical commissioning groups (or CCGs), taking on the NHS planning functions previously held by CCGs (as well as absorbing some planning roles from NHS England).

2.3 The statutory requirements for ICSs/ICBs have created greater consistency in governance arrangements and responsibilities, but still leave significant flexibility for systems to determine their own arrangements. However, the National Quality Board and NHS England continue to provide information on how ICBs are expected to discharge their statutory duties related to oversight, assurance relating to financial control, performance and quality of service provision.

2.4 Responsibility for delivering these functions sits in different teams across providers, ICBs and NHS England, and should not solely be the responsibility of a quality team or executive clinical quality lead (such as an ICB Chief Nursing Officer). The structures, systems, and processes in place to manage these functions must:

- Provide a clear line of sight on quality.
- Support effective intelligence-sharing and triangulation.
- Enable proactive improvement and risk management, as set out in the NQB guidance.

2.5 Furthermore, the commitment was given to Parliament, during consideration of the Health and Care Act 2022, that every integrated care board (ICB) would identify members of its board – i.e., any member with voting rights at meetings of the board of the ICB – which would have explicit responsibility for the population groups and functions, including:

- Children and young people (aged 0 to 25).
- Children and young people with special educational needs and disabilities (SEND).
- Safeguarding (all-age), including looked after children.
- Learning disabilities and autism (all-age).
- Down syndrome (all-age).

2.6 Within Mid and South Essex ICB that responsibility sits with the Executive Chief Nursing Officer. National guidance on the expectations of the lead role(s) can be found here - NHS England » Executive lead roles within integrated care boards

Current position

2.7 A recent update on the expected requirements of ICBs to discharge their responsibilities relating to quality oversight and assurance has been shared with the Executive Team. Currently the Nursing and Quality Directorate Senior Leadership Team are completing a gap analysis which better outlines those responsibilities already overseen within the ICB and being delivered against. Those areas which require further focus are being highlighted and will be shared across directorates.

2.8 Cross-directorate working has been agreed by the Executive Team to ensure that responsibilities for the oversight and assurance of quality are addressed by those teams with the relevant knowledge, skills and experience, and will be co-ordinated through the Nursing and Quality team.

2.9 Once this work has been concluded, a full update will be shared with the Board for their assurance and with key recommendations outlining how the Board will discharge its duty of collective responsibility for quality oversight, assurance and improvement. This work will align with current developments nationally on the expectation that Integrated Care Systems should develop a new model of strategic risk management, through the development of dynamic system-level risk registers, which consider key system risks to the delivery of high quality, efficient and effective health and care services across all system partners.

2.10 The National Quality Board has developed draft guidance on the use of dynamic risk registers, and Mid and South Essex Integrated Care Board are meeting with the national team on 10 July 2024 to determine how this can be implemented within this system.

3. Rapid Quality Review Meeting – Maternity Services Broomfield

3.1 As part of the statutory function of an Integrated Care Board, Rapid Quality Review (RQR) Meetings are multi-stakeholder meetings set up to facilitate rapid diagnosis of quality concerns/ issues and to agree next steps, including action/ improvement plans. Guidance for Rapid Quality Reviews are provided by the National Quality Board.

3.2 The purpose of an RQR Meeting is to:

- Give specific and focused consideration to quality concerns/risks raised, sharing intelligence, including with providers where quality risks have been identified.
- Facilitate rapid, collective judgements to be taken about quality within the provider / sector/ pathway in question.
- Identify actions needed as a result of the risk(s) identified, summarised in an Action/ Improvement Plan, which may be taken forward by a Quality Improvement Group.

3.3 Following a Section 31 Warning Notice being raised against maternity services at Broomfield Hospital by the Care Quality Commission (CQC), a RQR meeting was convened and held on 25 June 2024, chaired by the ICB Executive Chief Nursing Officer. Key stakeholders attended the RQR, including NHS England Maternity and Quality Teams, National Maternity Improvement Advisory Team, Care Quality Commission, Maternity and Neonatal Voices Partnership, Healthwatch Essex and Executive and Senior Leadership from Mid and South Essex NHS Foundation Trust (MSEFT).

3.4 MSEFT presented an update in relation to work underway to address the concerns raised by CQC colleagues following their inspection, with an opportunity to stakeholders to feedback on progress and further areas of focus.

3.5 At the RQR it was agreed that ongoing oversight and assurance would be undertaken through a revised and strengthened Maternity Improvement Group, which would report both into an updated Trust-level Perinatal Assurance Committee within the Trust. External stakeholders would attend these meetings to ensure an objective scrutiny of sustained improvement would be in place. The Local Maternity and Neonatal System Board (LMNSB) would receive updated Terms of Reference to scrutinise and approve, with updates being provided into the Board.

3.6 It was also agreed that should there be any evidence of ongoing concern, and/or issues which required immediate action a further RQR would be convened. The ICB would be assured through pre-arranged reporting into the Quality Committee as per the workplan and reports from the LMNSB and the Trust respectively.

4. Recommendations

4.1 The Board is recommended to:

- Note the updated guidance on the Board's responsibilities for quality oversight within the portfolios of work of the Executive Team, and the work underway to highlight and address any gaps.
- Support development work so the Board utilises system-level risk management processes across system partners to better gain assurance of mitigating actions against primary risks to the delivery of high-quality health and care services.
- Request that the Executive Team and Quality Committee receive the findings of the gap analysis and consider key recommendations that will enhance oversight and assurance within MSE ICB for its statutory quality functions.
- Note the undertaking of a Rapid Quality Review Meeting for maternity services, following receipt of the Section 31 Warning Notice for Broomfield Hospital maternity services, and the agreed actions to further strengthen assurance and oversight of sustained quality improvements.

Part I Board Meeting,

Agenda Number: 12

Month 2 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 across partners in the Mid & South Essex system (period ending 31 May 2024).

The paper also presents our current position against our NHS constitutional standards, we recognise there are additional operational standards we are working to deliver during 2024/25 and we will continue to develop this report in that respect.

2. Executive Lead

Jennifer Kearton – Chief Finance Officer,

Report Author

Jennifer Kearton – Chief Finance Officer
Ashley King – Director of Finance – Primary Care, Financial Services & Infrastructure
Karen Wesson, Director of Assurance and Planning.
James Buschor, Head of Assurance and Analytics.
Resources Team.

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance Committee on 2 July 2024.

4. Conflicts of Interest

None identified.

5. 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 Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT).

The System has a nationally negotiated and agreed plan position for 2024/25 of £96m (million) deficit. Our plan is considered very stretching for 2024/25, however it is imperative we deliver so we can a strong foundation for financial recovery over the medium term.

During June all systems were required to resubmit their financial and operating plans. The financial plan resubmission aligned with that presented at the Board Seminar in April and at Finance & Investment Committee.

2. Key Points

2.1 Month 2 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB remains in line with the opening allocation.

Table 1 – Allocation movements between month 1 and month 2

Allocation	Current Month £m	Previous Month £m	M1 to M2 Change £m
⊟ Recurrent			
Programme	2,217.0	2,217.0	0.0
Delegated - Specialised	279.9	279.9	0.0
Co-Comm	220.2	220.2	0.0
Delegated - DOP	104.5	104.5	0.0
Running Costs	19.9	19.9	0.0
Total	**2,841.5**	**2,841.5**	**0.0**
⊟ Non-Recurrent			
Programme	66.8	66.8	0.0
Delegated - DOP	1.7	1.7	0.0
Delegated - Specialised	(53.2)	(53.2)	0.0
Total	**15.3**	**15.3**	**0.0**
Total	**2,856.8**	**2,856.8**	**0.0**

The ICB is forecasting the agreed outturn position of breakeven. The pressures across our variable spend areas experienced during 2023/24 are expected to continue into this financial year. Continuing Health Care and Discharge to Assess pressures are a core focus for the ICB and we are working with the system Discharge Executive on the actions required to deliver the efficiencies within the programme.

The rate of increase in prescribing expenditure began to reduce towards the end of 2023/24. As data begins to flow in July, we will be able to understand if this is a continuing trend. Our Medicines Management team has a plan to deliver efficiencies across the opportunities in the National Medicines Optimisations work and continues to engage fully with regional efficiencies, benchmarks and opportunities.

Within the ICB our 2 key efficiencies programmes are Continuing Care and Medicines Management. Delivery across these areas is key to supporting the overall financial delivery of the ICB in 2024/25.

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

Expenditure	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m
Allocation	(478.3)	(478.5)	(0.2)	(2,856.8)	(2,856.8)	0.0
Acute	229.3	229.5	0.2	1,354.2	1,354.2	0.0
Community Health Services	38.1	38.1	0.0	228.2	228.2	0.0
Continuing Care	26.5	26.9	0.4	158.8	158.8	0.0
Mental Health	44.2	44.2	0.0	269.1	269.1	0.0
Other Commissioned Services	0.7	0.0	(0.7)	4.4	4.4	0.0
Other Programme Services	3.1	3.2	0.1	18.6	18.6	0.0
Primary Care	96.3	96.3	(0.0)	577.7	577.7	0.0
Programme Reserve & Contingency	(0.0)	0.0	0.0	(0.2)	(0.2)	0.0
Specialised Commissioning	36.9	37.1	0.2	226.7	226.7	0.0
Corporate	3.2	3.2	0.0	19.0	19.0	0.0
Hosted Services Admin	0.1	0.1	(0.0)	0.4	0.4	0.0
Total	**0.0**	**0.0**	**0.0**	**(0.0)**	**(0.0)**	**0.0**

2.2 ICB Finance Report Conclusion

At month 2 the ICB is forecasting to deliver its agreed plan. This is a stretching position for the ICB and our focus is on evaluation, delivery and ensuring that every pound into our system faces the same oversight and scrutiny.

2.3 Month 2 System Financial Performance

At month 2 the overall health system position is a deficit of £25.7m. This position is off plan by £8.8m. A revised profile of the plan was submitted on 12 June 2024 which will be reflected in the M3 position. The revised profile would have the current position as off plan by £0.3m due to a more accurate reflection of the expected achievement of efficiencies delivery throughout the year.

The year-to-date position against the current profile 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 £96m this is in line with national expectation and our opening system plan.

Our system deficit is manifest in our Provider Sector, with a forecast deficit of £85m in MSEFT and £11m in EPUT. Both organisations implemented grip and control actions during 2023/24 and continue to work collectively with the ICB to reduce the run rate during 2024/25. The whole system continues to operate in Triple Lock with regional oversight of expenditure items greater than £25k.

2.4 System Efficiency Position

At month 2 the system has delivered £11.2m of efficiencies against a year-to-date plan of £14.2m reflecting the revised planning submission made to NHS England in June 2024. The system is still forecasting delivery of the full requirement of £167.8m.

Our system focus is on the recurrent delivery of efficiencies to enable us to bring a strong foundation to our medium-term planning.

2.5 System Capital Position

The forecast capital spend for the system is £142m in line with its plan. Our actual spend year to date is £7.93m against a planned position of £8.13m. This, level of slippage is not considered a concern at this point in the year.

Table 4 – Capital Spend Summary

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
Internally						
Essex Partnership University	1.31	1.31	0.00	9.92	9.92	0.00
ICB	0.20	0.00	0.20	1.99	1.99	0.00
Mid and South Essex NHSFT	3.25	3.25	0.00	42.73	42.73	0.00
Total	**4.76**	**4.56**	**0.20**	**54.64**	**54.64**	**0.00**
Externally						
Essex Partnership University	1.14	1.14	0.00	14.46	14.46	0.00
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Mid and South Essex NHSFT	2.23	2.23	0.00	72.85	72.85	0.00
Total	**3.37**	**3.37**	**0.00**	**87.30**	**87.30**	**0.00**
Total	**8.13**	**7.93**	**0.20**	**141.94**	**141.94**	**0.00**
ICB - Potential new IFRS 16 leases	0.00	0.00	0.00	20.00	20.00	0.00

2.6 System Finance Report Conclusion

At month 2 the System is working toward its agreed planned year end position of a £96m deficit.

The system is focused on delivering its Operating Plan for 2024/25, with a focus on system recovery whilst mitigating any potential risks to the plan in year.

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.

2.7 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 2024/25 Operational Plan has been submitted with the commitment to achieve >=78% of patients having a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

The plan incorporates the wider system improvement programmes and schemes overseen by the System UEC Board.

Key issues for the UEC programme include the following where performance is below the constitutional 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.

East of England Ambulance Service

90th Centile Response Time by call category for rolling 12 months

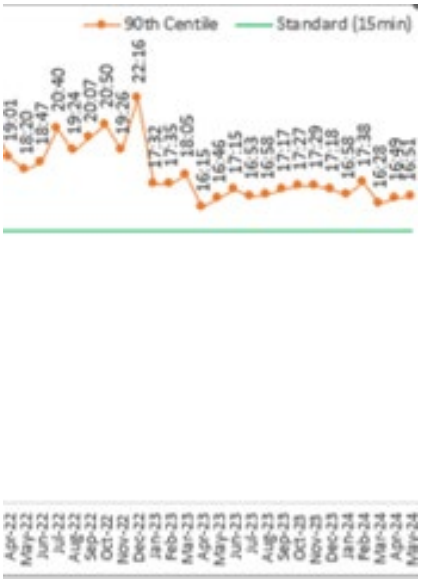
Please note: response times:

- Green where meeting standard
- Red where not meeting standard

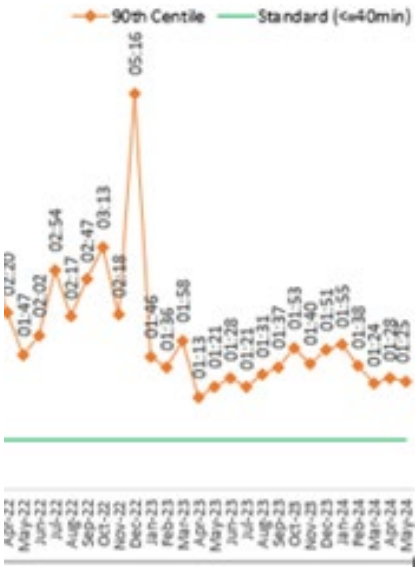
Call Category	Standard	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Category 1 Calls MM:SS	<= 15min	17:15	16:53	16:58	17:17	17:27	17:29	17:18	16:58	17:38	16:28	16:49	16:51
Category 2 Calls HH:MM	<= 40min	01:28	01:21	01:31	01:37	01:53	01:40	01:51	01:55	01:38	01:24	01:28	01:25
Category 3 Calls HH:MM	<= 02:00:00	04:53	04:16	05:03	05:27	06:32	05:32	05:53	05:57	05:09	04:32	04:56	05:40
Category 4 Calls HH:MM	<= 03:00:00	09:22	08:20	08:03	09:55	09:26	08:33	10:45	11:06	09:52	07:24	07:56	08:31

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

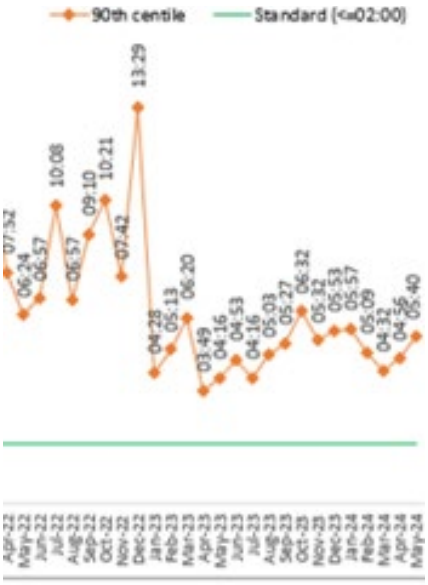
Category 1



Category 2



Category 3



Category 4

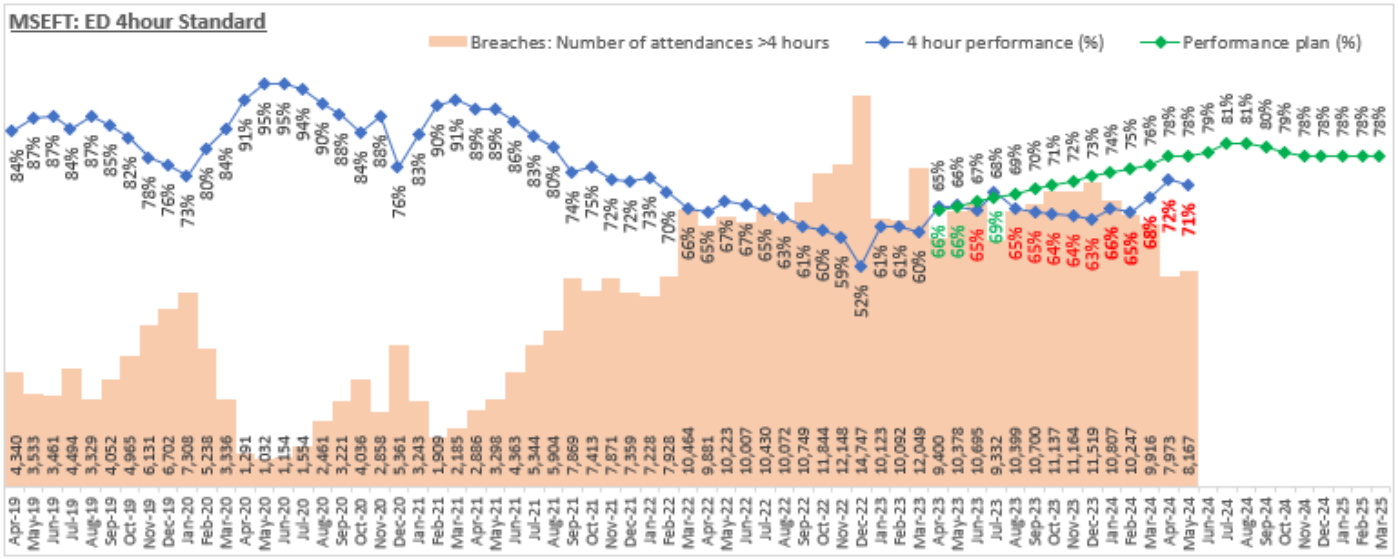
The system actions to support recovery of ambulance response times from arrival to handover is overseen by the System Urgent and Emergency Care (UEC) Board. Escalations and presented to Finance Committee with specific escalations to the System wide oversight and assurance committee.

Emergency Department – waiting times.

2024/25 priorities and operational planning guidance ask*:*

- >=78% of patients having a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

The MSEFT A&E (Type 1) performance to date for April and May 2024 increased to circa 70% but below the 2024/25 plan as per the following graph. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

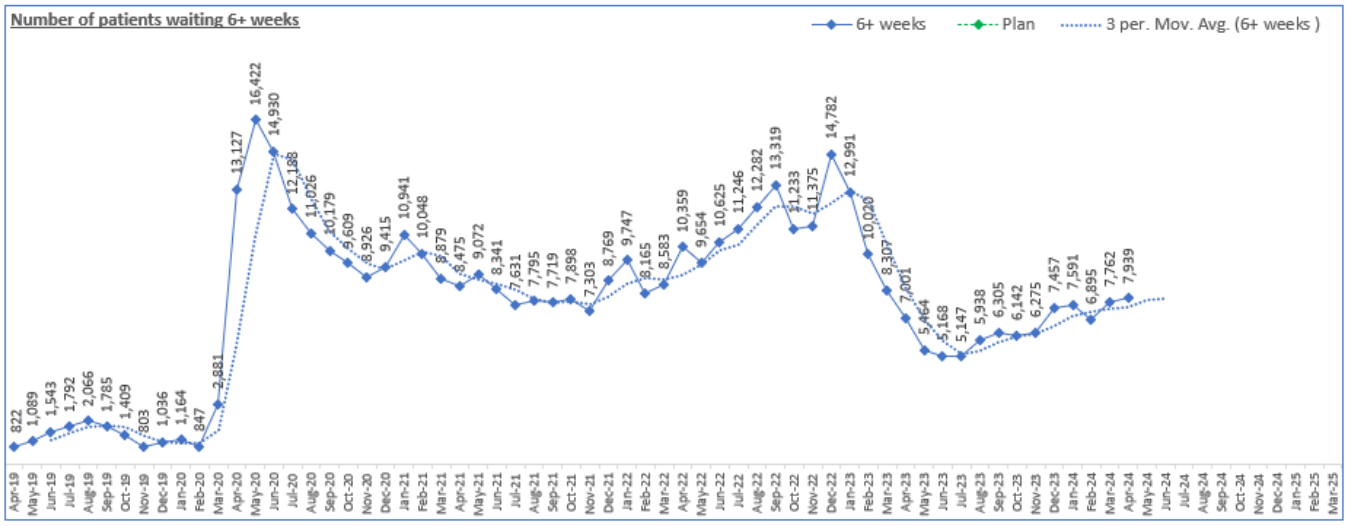
The Elective Board manages the delivery of elective targets across the system. A key focus for the Board is waiting time performance for Diagnostics, Cancer and RTT (Referral to Treatment). Performance in these areas is currently below the national standard.

Diagnostics Waiting Times

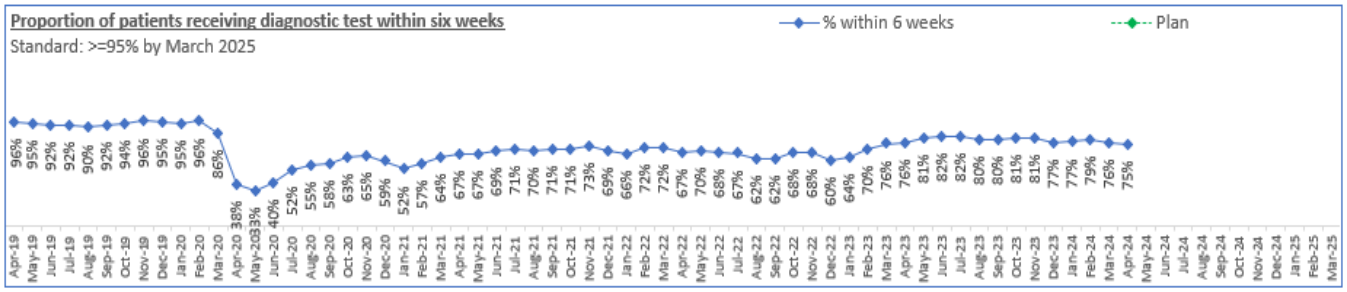
2024/25 priorities and operational planning guidance ask*:*

- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

The waiting times for diagnostic tests do not currently meet the NHS constitutional standards.



The graph below shows current performance for proportion of patients waits within 6 weeks of their referrals for their diagnostic test.



As at April 2024, 2,851 waits were 13+ weeks (standard: zero) and 75% of waits were within six weeks (standard: >=95%).

The following table shows the number of 13+ week diagnostic waits by modality with risks in all three areas as follows:

- Imaging: Non-obstetric Ultrasound and MRIs
- Physiological measurements: Echocardiology and Neurophysiology
- Endoscopy: Colonoscopy and Gastroscopy.

Mid and South Essex: Diagnostic DM01 waiting list summary for Apr-24		
Diagnostics		Number of patients waiting 13+ weeks Standard: 0
Test		Total
Imaging	Barium Enema	0
	CT	32
	DEXA Scan	41
	MRI	129
	Non-Obstetric Ultrasound	1,121
Physiological Measurement	Audiology Assessments	21
	Cardiology Echocardiography	755
	Peripheral Neurophysiology	228
	Respiratory Physiology Sleep Studies	36
	Urodynamics - Pressures & Flows	7
Endoscopy	Colonoscopy	189
	Cystoscopy	60
	Flexi sigmoidoscopy	60
	Gastroscopy	172

The following table shows the proportion of diagnostic tests withing six weeks with risk in the modalities outlined above.

Mid and South Essex: Diagnostic DM01 waiting list summary for Apr-24		
Diagnostics		Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%
Test		Total
Imaging	Barium Enema	100% (0)
	CT	93.3% (213)
	DEXA Scan	88.7% (102)
	MRI	85.4% (704)
	Non-Obstetric Ultrasound	78.2% (2,716)
Physiological Measurement	Audiology Assessments	81.7% (204)
	Cardiology Echocardiography	40.8% (2,548)
	Peripheral Neurophysiology	48% (272)
	Respiratory Physiology Sleep Studies	67.2% (157)
	Urodynamics - Pressures & Flows	75.9% (19)
Endoscopy	Colonoscopy	78% (366)
	Cystoscopy	55.4% (164)
	Flexi sigmoidoscopy	73.5% (120)
	Gastroscopy	76.8% (354)

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

The waiting times for patients on a cancer pathway remain below the NHS constitutional standards. The section below reflects constitution and 2024/25 operational planning requirements.

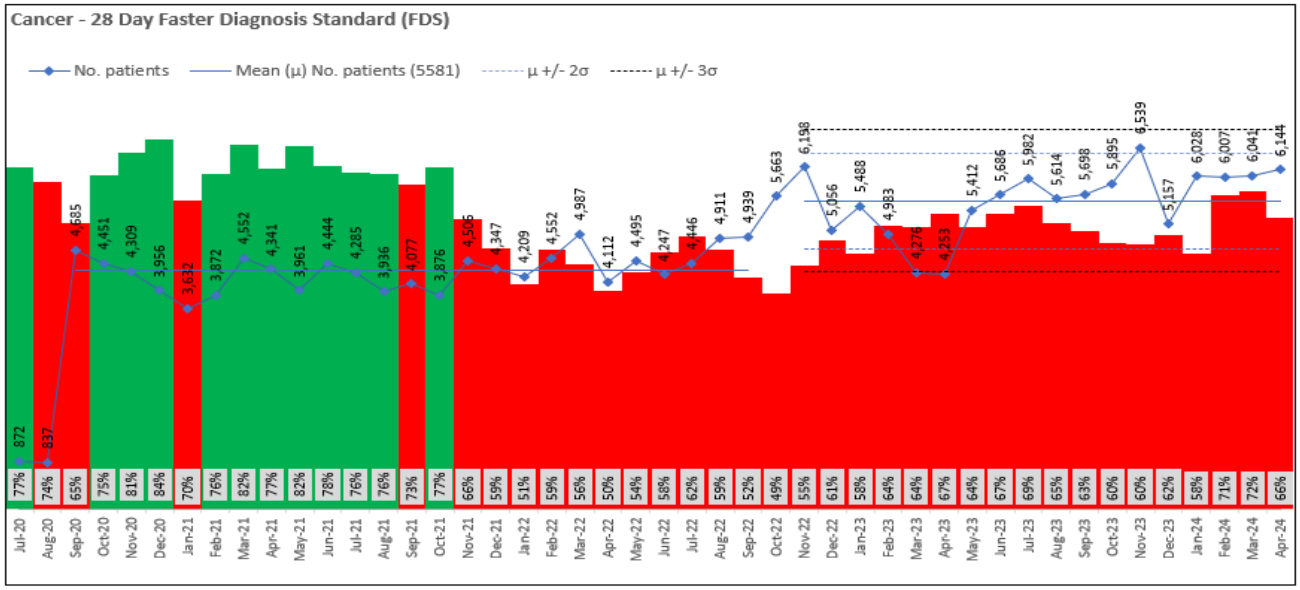
The following table shows the latest MSEFT position (April 2024) for each of the waiting time standards by specialty.

Tumour Site	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 (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=90%)	
Total	**66.0%**	**82.4%**	**85.8%**	**60.4%**	**58.4%**	**44.9%**	**51.9%**	**67.4%**
Acute leukaemia		100.0%						0.0%
Brain/Central Nervous System	64.3%							100.0%
Breast	59.2%	84.4%				55.4%	56.5%	60.0%
Children's	66.7%							100.0%
Exhibited (non-cancer) breast symptoms	87.5%							
Gynaecological	58.8%	72.2%				31.0%	100.0%	66.7%
Haematological	46.4%	93.3%				53.3%		83.3%
Head & Neck	58.3%	85.2%				32.4%		69.2%
Lower Gastrointestinal	53.2%	78.9%				29.0%	0.0%	76.0%
Lung	82.6%	88.5%				48.3%		56.3%
Other	0.0%	77.8%				100.0%		100.0%
Sarcoma	0.0%	100.0%				50.0%		
Skin	86.6%	74.7%				56.7%		33.3%
Testicular	63.2%	100.0%				100.0%		
Upper Gastrointestinal	61.5%	89.5%				73.7%		88.2%
Urological	46.5%	80.8%				33.3%		60.4%

The following table benchmarks the performance to all trusts nationally.

Pathway	Standard	Metric	Mar-24	Apr-24
28 Day Faster Diagnosis Standard	>=75%	Performance	72.0%	66.0%
		Rank (1= highest)	*121*	*130*
		No. of Trusts	*141*	*144*
31 day first treatment	>=96%	Performance	80.3%	82.4%
		Rank (1= highest)	*136*	*125*
		No. of Trusts	*139*	*139*
31 day subsequent treatment Drug Treatments	>=98%	Performance	94.9%	85.8%
		Rank (1= highest)	*105*	*119*
		No. of Trusts	*122*	*121*
31 day subsequent treatment Radiotherapy Treatments	>=94%	Performance	57.3%	60.4%
		Rank (1= highest)	*58*	*58*
		No. of Trusts	*60*	*66*
31 day subsequent treatment Surgery	>=94%	Performance	45.1%	58.4%
		Rank (1= highest)	*131*	*120*
		No. of Trusts	*133*	*133*
62 day standard	>=85%	Performance	40.2%	44.9%
		Rank (1= highest)	*130*	*124*
		No. of Trusts	*138*	*139*
62 day standard (Screening)	>=90%	Performance	82.4%	51.9%
		Rank (1= highest)	*46*	*94*
		No. of Trusts	*125*	*122*
62 day standard (Upgrade)	N/A	Performance	66.7%	67.4%
		Rank (1= highest)	*124*	*117*
		No. of Trusts	*142*	*145*

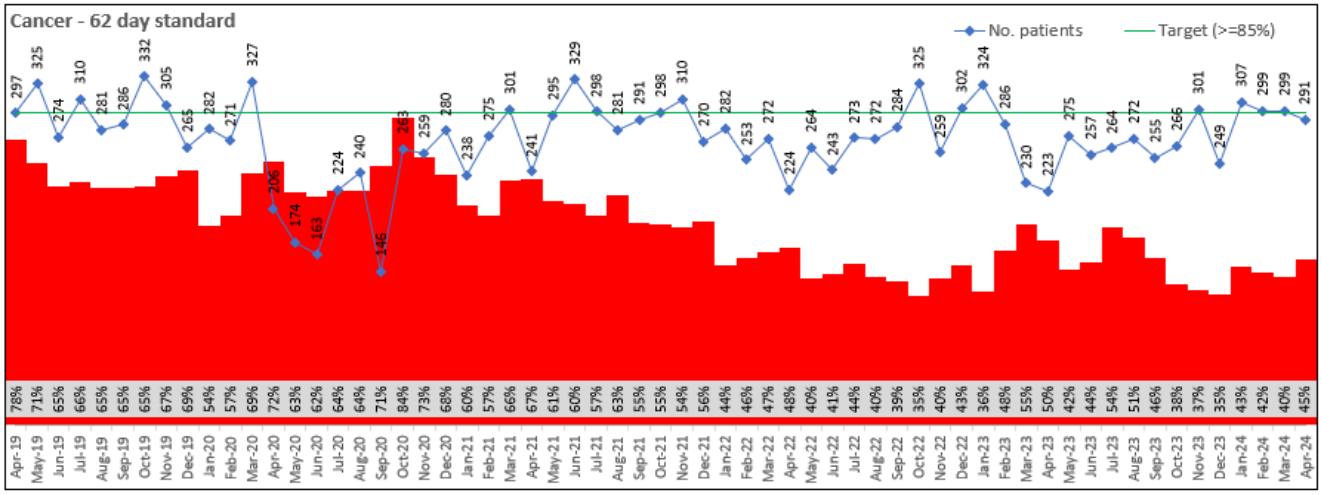
The following graph shows the monthly performance for the 28-day Faster Diagnosis Standard together with the number of patients. The April 2024 performance was 66%. The 2024/25 priorities and operational planning guidance ask is to improve performance to 77% by March 2025. MSEFT plan is to increase performance to achieve the 77% from September 2024.



The following graph shows the 62-day standard performance. The April 2024 performance was 45%. MSEFT plan to meet the 2024/25 priorities and operational planning guidance ask to improve performance to >= 70% by March 2025.

The reporting of this standard changed to include Urgent Suspected Cancer, Breast

Symptomatic, Screening and Consultant Upgrade as reported at the Tier 1 meeting MSEFT achieved 51.06% in April 2024. Future paper will reflect this change in reporting.



The MSE Cancer Oversight and Assurance Committee oversees cancer assurance and transformation.

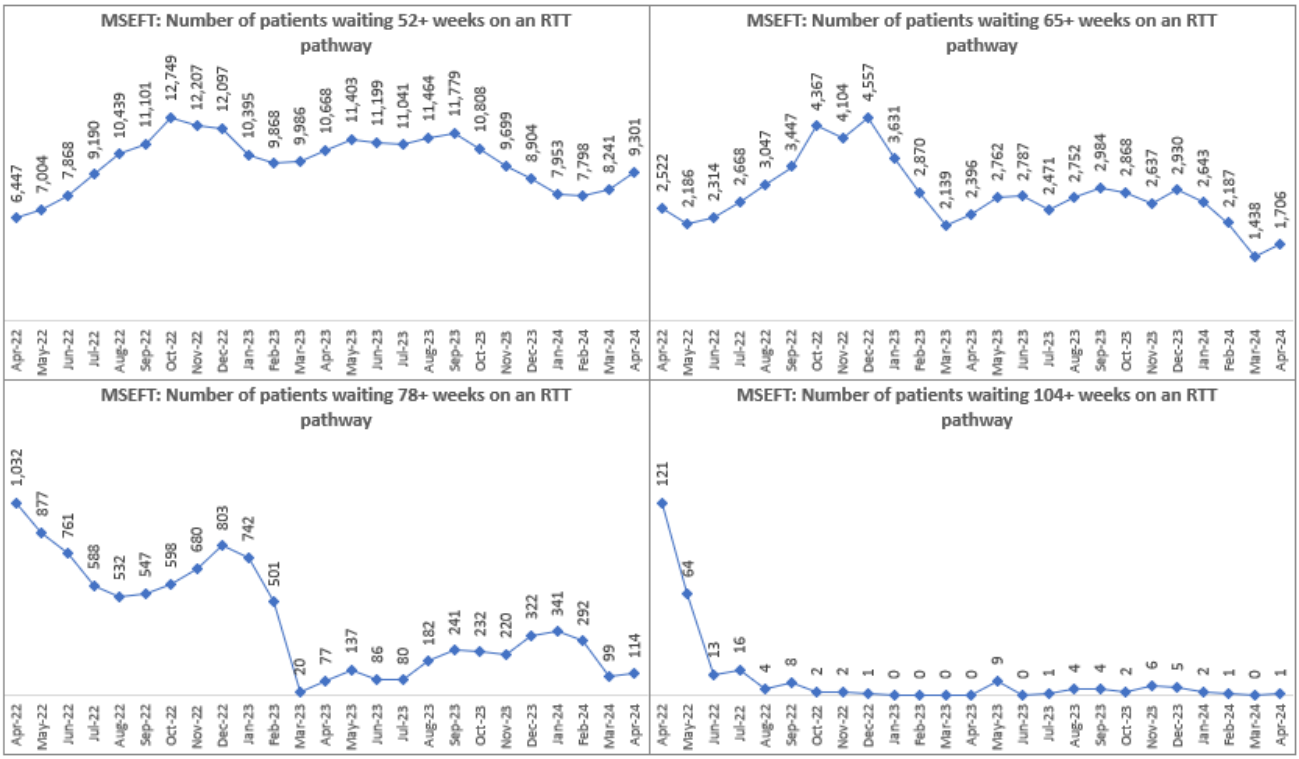
Referral to Treatment (RTT) Waiting Times

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 eliminate waits of over 65 weeks by September 2024 as outlined in the 2024/25 priorities and operational guidance.

The following graphs show the number of patients waiting 52+, 65+, 78+ and 104+ weeks on an RTT pathway at MSEFT. As at April 2024, there was the following number of patients on an RTT pathway at MSEFT:

- 1 patient waiting 104+ weeks.
- 114 patients waiting 78+ weeks.
- 1,706 patients waiting 65+ weeks.
- 9,301 patients waiting 52+ weeks.



The system plan is to meet the 2024/25 priorities and operational guidance of zero patients waiting 65+ weeks by September 2024.

The following table summarises the latest MSEFT RTT position (April 2024) by specialty.

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	**164,302**	**17**	**48**	**9,301**	**1,706**	**114**
General Surgery	8,795	21	47	388	36	1
Urology	9,553	16	46	478	98	4
Trauma and Orthopaedic	15,730	21	54	1,451	337	6
Ear Nose and Throat	13,845	22	55	1,392	211	20
Ophthalmology	13,766	17	50	859	40	1
Oral Surgery	5,302	31	61	902	296	32
Neurosurgical	96	13	44	3	0	0
Plastic Surgery	5,209	16	54	465	155	29
Cardiothoracic Surgery	17	-	-	3	0	0
General Internal Medicine	1,590	11	31	2	0	0
Gastroenterology	9,380	16	46	485	118	4
Cardiology	12,202	13	39	249	45	1
Dermatology	10,395	19	44	166	1	0
Respiratory Medicine	4,601	12	33	27	0	0
Neurology	5,558	18	45	257	16	0
Rheumatology	2,559	14	40	19	3	0
Elderly Medicine	734	10	32	10	0	0
Gynaecology	12,217	16	44	444	64	2
Other - Medical Services	16,594	13	43	548	151	8
Other - Mental Health Services	0	-	-	0	0	0
Other - Paediatric Services	4,301	23	56	510	60	2
Other - Surgical Services	7,570	15	49	498	65	1
Other - Other Services	4,288	10	42	145	10	3

The system Elective Board oversees RTT assurance for MSEFT, Independent Sector,

Community (RTT services) and Tier 2.

2.9 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 Mid and South Essex (latest position: January 2024).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across Mid and South Essex (latest position: December 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 reporting to the Finance Committee and specific escalations to the system wide oversight and assurance committee.

4. Recommendation

The Finance and Investment Committee is asked to note the performance across both finance and the constitutional standards and 2024/25 Operational Planning Commitments.

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 13

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

The purpose of this report is to update Board members of the development of services by the Alliance teams including the Primary Care Team.

2. Executive Lead

Dan Doherty, Alliance Director – Mid Essex
Aleks Mecan, Alliance Director – Thurrock
Rebecca Jarvis, Alliance Director – South East Essex
Pam Green, Alliance Director – Thurrock

3. Report Author

Kate Butcher, Deputy Alliance Director – Mid Essex
Margaret Allan, Deputy Alliance Director – Thurrock
Caroline McCarron, Deputy Alliance Director – South East Essex
Simon Williams, Deputy Alliance Director – Mid Essex
Paula Wilkinson, Director of Pharmacy and Medicines Optimisation
William Guy, Director of Primary Care

4. Responsible Committees

The Primary Care elements of this report are overseen by Primary Care Commissioning Committee

5. Impact Assessments

Not applicable

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. Recommendations

The Board is asked to note this update.

Primary Care and Alliance Report

1. Main content of Report

Primary Care – General Practice

Full year workforce data has been published. Overall, Mid and South Essex has seen an increase in primary care workforce in post to a level ahead of the planned trajectory. GP numbers have increased in part due to the success of the fellowship scheme.

Work has commenced on the refresh of the primary care strategy. This will be the first local strategy to full cover primary medical, pharmacy, optometry and dental services. The refresh commenced with a review of the delivery of the previous strategy.

The ICB is continuing to make preparations for potential industrial action by GPs. The British Medical Association (BMA) are currently balloting members on this issue.

The ICB is working closely with the newly formed GP Provider Collaborative. The ICB has agreed to invest some seed resource to support the development of the collaborative and for the collaborative to support the delivery of a number of key shared priorities.

The Connected Pathways Team continue to make good progress on the delivery of our Primary Care Access Recovery Programme. In particular, the roll out of Cloud Based Telephony, use of digital tools to support total triage and self-referral pathways. Practices are making steady progress in the implementation of the “modern general practice” model, 47 practices have now submitted applications for the use of transitional funding to support their implementation of this model. This is an increase from 20 practices since the previous Board report.

Primary Care – Pharmacy

Pharmacy First is now fully implemented in Mid and South Essex. GP Practices are the main source of referral to these pathways with pharmacies seeing patients for clinical pathways consultations, minor illness referrals and urgent medication supply.

Primary Care – Dentistry

Provisional out turn data for 23/24 shows an increase in overall utilisation of contracted activity across Mid and South Essex with both an increase in total units of dental activity (UDAs) delivered and an increase in number of contracts delivering over 90% of contracted levels.

The ICB has been successful in securing national funding for a hypertension case finding programme within dental practices. This is likely to commence in autumn 2024.

The ICBs in East of England have agreed to collaborate on the transformation of secondary care dental pathways. A number of pathway reviews will be taken forward through this approach.

Focus of Alliance Teams

The focus of the alliance teams has shifted in the last three months to ensure greater alignment to the Financial Recovery Programme. Across our system it is recognised that delivery of our plans will be achieved locally through Alliance teams and close partnership working with local stakeholders.

The 4 Alliances across Mid and South Essex have led a system wide prioritisation exercise linked to financial recovery. In order to support system priorities, the aim is to have clarity on which areas Alliances will lead on (key areas will include Integrated Neighbourhood Teams and Transfer of Care Hubs) and which areas Alliances will support other teams to deliver locally (includes Medicines Optimisation, Mental Health, Children and Young People) by 30 June 2024.

By 30 June there will be further clarity on specific areas that each Alliance will lead on. Currently Thurrock will lead on Mental Health, Basildon and Brentwood to lead on Primary care, Mid Essex to lead on Community Collaborative and South East Essex to lead on Flow and Discharge. Further areas to be clarified.

In particular, the Alliances have been strengthening their approach to the development of Integrated Neighbourhood Teams (INTs). A plan has been developed that will see the ICB move from 9 INTs as of the end of March 2024 to 24 INTs as of March 2025. This will be supported by metrics that are currently under development. An overview of which INTs are currently established is available on page nine of the attached report.

Better Care Fund

All three Better Care Fund templates for 2024/25 are being signed off by their respective committees in June. The BCF is being strengthened through the development of a Demand and Capacity plan. This includes target levels of unplanned admissions for ambulatory sensitive conditions, admissions due to falls, discharge to the usual place of residence and admissions into long term care.

Transfer of Care Hubs

The evaluation of the first three months of Transfer of Care Hubs has been presented to the system leadership group. Phase 2 planning is now underway. The leadership group will now be chaired by James Wilson from the Community Collaborative.

2. Recommendation(s)

The Board is asked to note this update.

3. Appendices

MSE ICB – Primary Care and Alliances Highlight Report July 2024

Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight Report

July 2024

www.midandsouthessex.ics.nhs.uk

Primary Care - General Practice

Reporting Month	July 2024	Executive Lead	Pam Green	SRO	William Guy/Jenni Speller	RAG	Amber

Overall Summary

- *The outturn 23/24 workforce data is now published. Across Mid and South Essex, there were just under 3,200 Full Time Equivalent (FTE) staff in post. This was 38 FTE staff ahead of our trajectory. GP numbers increased by 19 FTE between Q1 and Q4, Additional Roles Reimbursement Scheme (ARRS) by over 60 FTE. The fellowship scheme has supported GP recruitment with 30 GPs*
- *GP Partner numbers has remained roughly consistent over 23/24 at 339 FTE in March 24 compared to 338 the previous year.*
- *Nursing Staff numbers have marginally increased with a 3% increase in FTE numbers across 23/24.*

- *The Primary Care Team has commenced the refreshing of the primary care strategy. For the first time, this strategy will cover primary medical, pharmacy, optometry and dental services. This started with a review of the breadth of delivery of the previous primary care strategy. It was noted that significant progress had been made on a number of areas but the primary/secondary interface and translation of our strategic intent into our local commissioning areas could be strengthened. A number of engagement sessions have been commenced with various stakeholders. This work will continue throughout the summer.*

- *The British Medical Association (BMA) have commenced a vote with their members on proposed Industrial Action. ICBs have been advised that this is likely to involve limiting the number of patients seen on any given day to the BMA's safe level of care (circa 25 appointments per day). In addition, not undertaking activities deemed to be outside of the scope of GMS/PMS contracts.*
- *The ICB has established a forum led by the Emergency Preparedness, Resilience and Response (EPRR) team to better forecast potential impact of this and work with partners to try and mitigate impact on the wider system.*
- *The ICB is in discussion with the Local Medical Committee on this issue.*

- *The ICB is working closely with the emerging GP Provider Collaborative (GP PC). In June, the ICB confirmed to the GP PC that the ICB is investing £50k in the development of the GP PC and in their engagement with a number of key work programmes which the ICB is leading on.*

- *The primary care team are leading on a number of Financial Recovery Programmes including reviewing APMS contracts, reviewing local primary care schemes, NHS Property Services review and optimising referrals*

Primary Care – Access Recovery Programme/Connected Pathways

Reporting Month	July 2024	Executive Lead	Pam Green	SRO	William Guy/Jenni Speller	RAG	Amber

Overall Summary

Significant progress has been made on a number of deliverables within the Primary Care Access Recovery Programme

Development	Progress	Status
Cloud Based Telephony - "we will establish Cloud Based Telephony across 45 practices identified as critical"	Phase 1 – 55 practices included in scope. All contracts signed with new providers. 51 practices implemented and gone live (+6 on previous month). All remaining practices scheduled for installation between writing and publishing this report. Phase 2 – 37 further practices identified for improvements (+7 on previous month). 24 contracts signed (+8 on previous report). 16 practices completed upgrade (up from 4 previous month).	On Track
Communication of Modern General Practice and various aspects of the Recovery Plan to stakeholders	Comms plan for public and key stakeholders defined and agreed. Dedicated area within the MSE ICB Primary Care Hub page for Access Recovery Programme now live and promoted to practices via Alliance Practice Manager meetings. Connected Pathways teams visiting various stakeholders to promote programme	On Track
Digital Tools – supporting implementation of Modern General Practice through digital tools	Work continues to promote NHS App and ensure practices with low uptake are promoting this to their patients. Utilisation currently exceeding 24/25 targets. Frontline -funding approved for 2024/25 through triple lock process. Contract with provider has been sent for signature. NHS App use continues to exceed targets with a steady increase showing each month.	Delayed
Pharmacy/Dental/Optom - strengthen the role of other primary care services to help manage patient need	Vast majority of community pharmacies now delivering Pharmacy First. Community Optometry Services being further promoted to practices/PCNs including self referral pathways. Dental access pilot now fully integrated into 111	On Track
Self Referral Pathways – By March 24 we will establish at least 10 self referral pathways	11 Self Referral pathways are now available to all patients across MSE. Further opportunities being scoped.	Completed
Total Triage – By March 24 5 practices will have implemented a total triage model in line with Modern General Practice	47 Applications for Transitional Funding reviewed (up from 20 in previous report). Further support being provided by Connected Pathways team where not approved. Total Triage lunch and learn taking place on 4th July.	On Track

Primary Care – Community Pharmacy

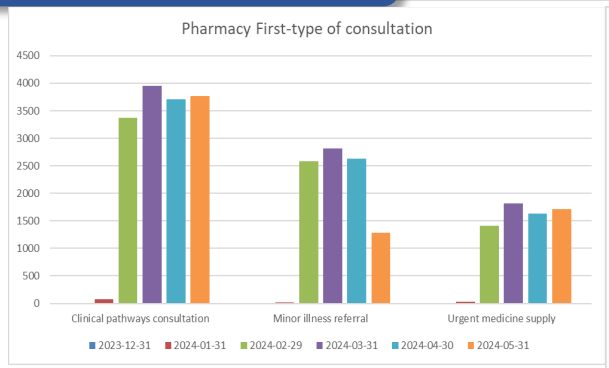
Reporting Month	July 2024	Executive Lead	Pam Green	SRO	William Guy/Paula Wilkinson	RAG	Amber

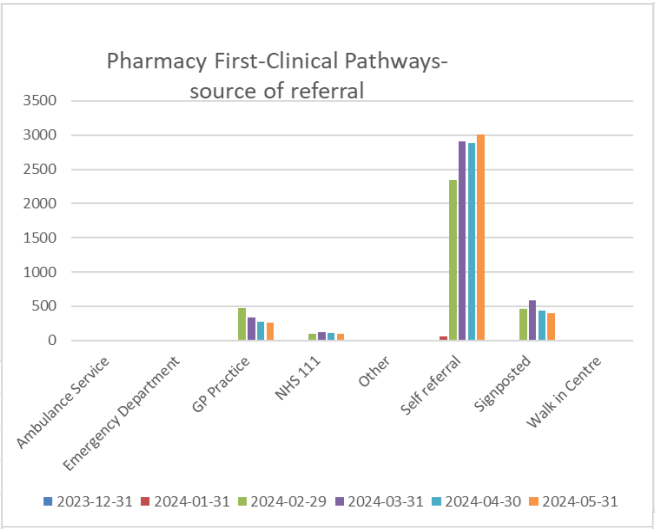
Community Pharmacy -Focus on Pharmacy First

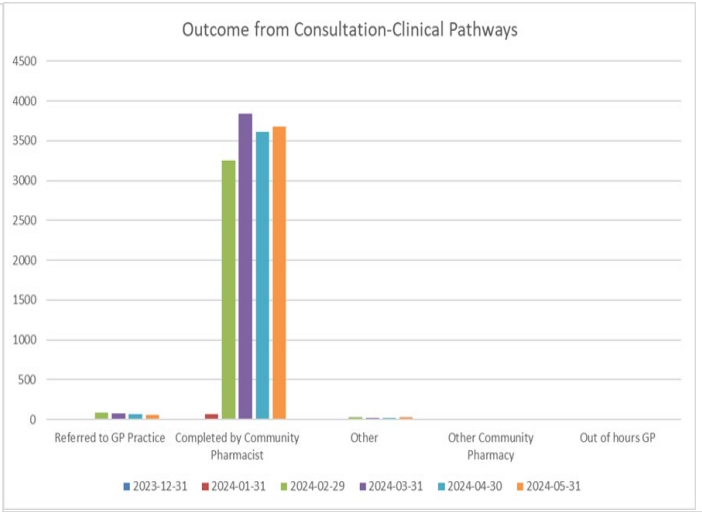
The Pharmacy First service is now fully implemented and has been well received by patients. This data is based on payment claims by community pharmacies and is subject to change following verification.

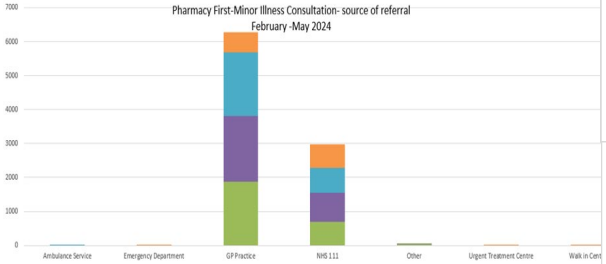
Minor illness consultations are only claimable following a referral from a GP practice or NHS 111 or other urgent care providers. A large proportion of minor illness consultations only require advice, with a smaller number also resulting the sale of an over-the-counter medicine. Others requiring treatment not available at the pharmacy may be referred to the GP practice/Out of Hours provider for a routine or urgent appointment or sent to A&E or Urgent Care Centre. Pharmacies in MSE will receive referrals from patients living outside our area and refer into services outside MSE for follow up.

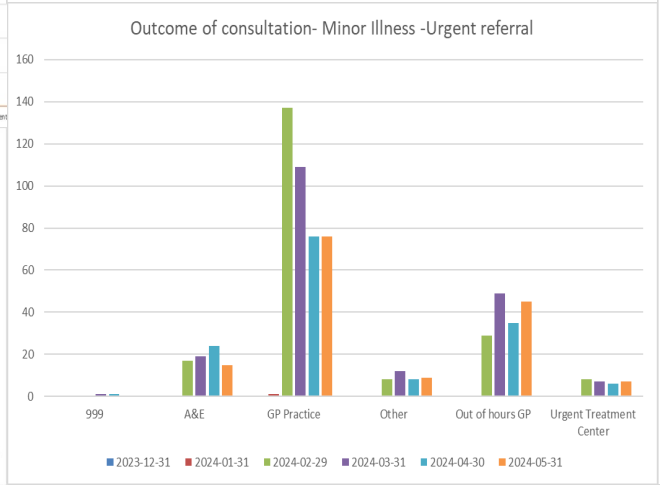
Seven common conditions can now be managed in community pharmacies under Pharmacy First. A high proportion of patients self- refer (walk-in) and a smaller number are referred by GP practices. Consultations for walk-in patients who meet the threshold for treatment under Pharmacy First Clinical Pathways are claimable; but where the threshold is not met no fee is payable. Consultations for minor illness for walk-in patients is funded as part of essential services. The vast majority of consultations are resolved by the pharmacy and need no onward referral. Across MSE over 3,500 GP consultations per month are now being avoided as a result of this service.

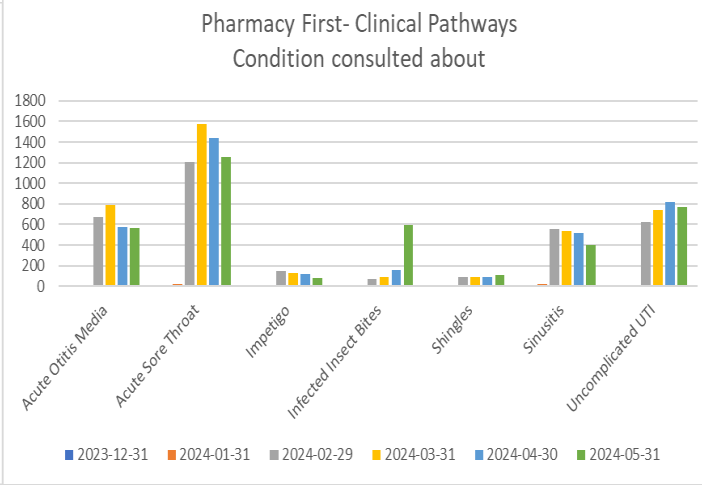


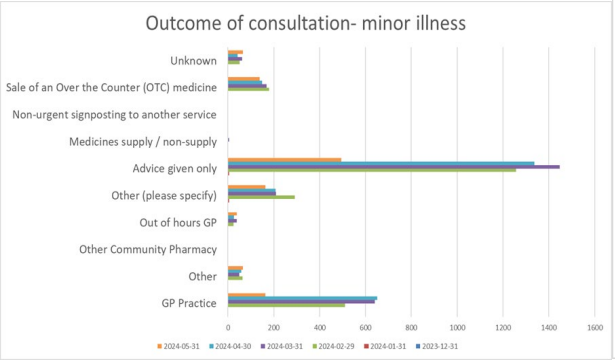












Primary Care – Dentistry

Reporting Month	July 2024	Executive Lead	Pam Green	SRO	William Guy	RAG	Amber

Dentistry

- A large number of providers in Mid and South Essex performed 110% of agreed contract value in 23/24 - final detail to be confirmed in July/August (due to data reporting lag).
- Our urgent access pilot continues to be successful. This aims to improve access to dental services by utilising capacity in the evenings and at weekends. Recently developments have included a software integration with 111 which allows for the direct booking of patients into available slots.
- The care home pilot now covers all eligible care home beds in Mid and South Essex. Work is being undertaken to ensure that the final few care homes engage with this pilot. Academic support has been secured to support the review of this service. Very positive case studies have been identified from a large number of care homes. A peer support/development network is in place to try and ensure there is a consistent standard of input into all care homes. A review of this service will report back to the Primary Care Commissioning Committee in July/August 24.
- A new pilot service for cardio vascular disease went live in May 24. This will support the early treatment of cardio vascular disease to ensure patients are orally fit for surgery.
- All ICBs in East of England have committed to collaborating on the transformation of secondary care dental services. Through a number of pathway reviews, this programme of work aims to improve access for patients requiring secondary care and ensure that those who can be managed effectively in primary care can be.
- The review of Children's and Young Peoples provision continues. We are aiming to develop a model of care that improves access to NHS dental services for children and young people.
- We have been successful in our bid to secure national funding to support a hypertension case finding programme in dental practices. We are aiming to launch this pilot in autumn 2024.

Delivery through our place-based Alliances

Across our system it is recognised that delivery of our plans will be achieved locally through Alliance teams and close partnership working.

- The 4 Alliances across MSE have led a system wide prioritisation exercise linked to financial recovery.
- In order to support system priorities, the aim is to have clarity on which areas Alliances will lead on (key areas will include Integrated Neighbourhood Teams and Transfer of Care Hubs) and which areas Alliances will support other teams to deliver locally (includes Medicines Optimisation, Mental Health, Children and Young People) by 30th June 2024.
- By 30th June further clarity on specific areas that each Alliance will lead. Currently Thurrock will lead on Mental Health, Basildon and Brentwood to lead on Primary care, Mid Essex to lead on Community Collaborative and South East Essex to lead on Flow and Discharge. Other areas to be clarified.
- Integrated Neighbourhood Teams remain as a high priority and progress continues to be made with more sites going live this month, a refreshed maturity matrix being tested together across the 4 Alliances and strategic planning going ahead with other key partners such as the Community Collaborative and Councils.

Prioritisation of Work Areas

We have collated the priorities to support the ICB work plan in the following 4 areas

Level 1

- Financial recovery - cash releasing
- Statutory responsibilities related to primary care delegations
- Integrated Neighbourhood team development and maturity
- Delivery of efficiency and improved sustainability schemes

Level 2

- Delivery of the ICB operational plan
- Partnership statutory responsibilities (Better Care Fund, joint commissioning)
- The Alliance directorate will focus on delivery of key metrics in areas identified as requiring input from the alliance with local partners and in particular Primary Care

Level 3

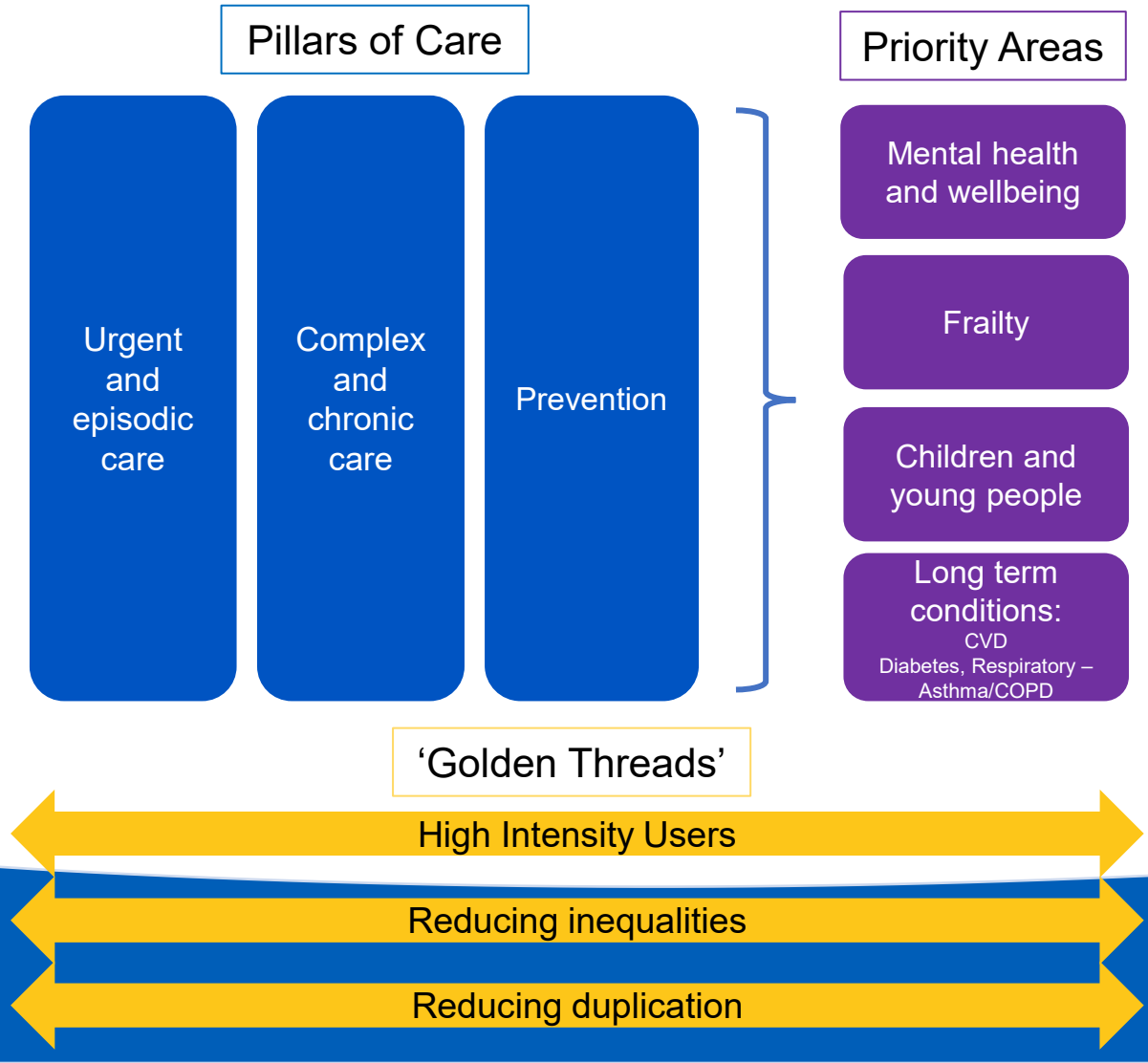
- Delivery of the ICP priorities
- There are several areas that overlap with Level 1 and Level 2 priorities
- There are several other workstreams that still need to be developed further for delivery

Level 4

- Other areas Alliances are required to deliver
- This will have less focus from the Alliance directorate but still require some input
- Some areas of work may be slowed or stopped depending on available resource

Integrated Neighbourhood Teams (INTs)

Integrated Neighbourhood Teams are fundamental to our plans to improve access and outcomes across health and social care, providing more proactive, joined up care and reducing health inequalities



- This INT graphic, developed in partnership by the 4 Alliances, is based upon ICB and ICP priorities to focus INT development
- An INT maturity matrix will be finalised by July 2024 and will be supported by a peer review process to provide a unified position on progress
- From a position of 9 INTs on 1st April 2024, we will move to the planned 24 operational INTs across MSE by March 2025
- Metrics are currently being developed and agreed (to include areas such as reduction in GP appointments by high intensity users, reduction in A&E attendance). Finalised by 26th July 2024
- Each Alliance has strong partnership models in place with health, social care, local Councils and Voluntary sectors, plans will continue to evolve to promote further integration and avoid duplication (examples in Alliance specific slides)
- Oversight of INT development is provided through the Primary Care Commissioning Committee

Integrated Neighbourhood Team (INT) development

Reporting Month	July 2024	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Overall Summary

The current INT position:

Basildon and Brentwood - Central Basildon, West Basildon and Brentwood are all live. Billericay will go live during July 2024. Wickford will be live by October 2024. East Basildon will be live by December 2024.
Mid Essex - All 6 live, Braintree North (INT 1), Braintree South (INT2), Maldon North, Chelmsford East & Witham (INT 3), Chelmsford Outer (INT 4), Chelmsford Central (INT 5), Maldon Central, Dengie & Woodham (INT 6)
South East Essex - SS9, Southend West Central, Southend East, Benfleet, Rayleigh and Canvey Island are all live. Rochford and Southend Victoria have emerging plans with aspirations to be live by Autumn 2024.
Thurrock - All 4 now live

Planned activities

- Completion of INT maturity position - cross Alliance check and challenge
- Broader discussion with strategic leaders from Community Collaborative and Councils regarding aligned priorities
- Agreement on INT metrics and reporting

Alliances

Reporting Month	July 2024	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Thurrock

Thurrock Alliance plan, will be presented at the June meeting of the Alliance Committee for approval and sign off. The plan brings together the requirements of the FRP, the Updated JFP and the Thurrock Strategy.
All 4 PCNs in Thurrock have now launched their INTs. Further work is now planned to increase the maturity of the INTs, via a stock take (agreed with the Alliance Clinical Director), and the development of a shared outcomes framework for INT partners to agree.

TOCH development is being supported by a commissioned evaluation of patient experience of hospital discharge. This work has been carried out by Healthwatch Thurrock and will be presented to the Alliance Committee in July.

•The Alliance Primary Care Account Manager (PCAM) is working closely with the Clinical Leads and the voluntary sector to improve the take up and quality of Learning Disability health checks in the borough. This work will continue throughout the remainder of this financial year and a quality framework is planned which will be shared across all 4 Alliances in 2025/26. Currently, the Delivery & Engagement Officer is devising a methodology for improving the performance against targets for screening (CVD, cancer, hypertension, and SMI/LD health checks and 40+ health checks), which will be used to improve the performance level across MSE.

Plans for the new Community Diagnostic Centre in Grays are underway, with the building work already started. The Alliance Director is the Exec SRO for diagnostics and is working closely with primary care and the acute trust to ensure robust roll out of the diagnostics provision in the borough

Basildon and Brentwood

The May Alliance Committee was used to highlight the financial position across the Mid and South Essex system , the actions being taken across the ICB, EPUT and the Acute Trust, how as an Alliance we need to prioritise work to support financial recovery and the impact on partnerships. There was a report from the Essex Wellbeing Service that focused on weight management, smoking cessation, sexual health and supporting health in the workplace. There is positive progress in all of these areas but there are still challenges, particularly in areas of Basildon where smoking prevalence is at 19% compared to the national average of approximately 13%. Vaping was highlighted. The Committee received a detailed report from Trusted Partners regarding the health Inequality Fund. This confirmed spending against budget and highlighted the diverse range of projects that have been funded across the Alliance with many focussed on our areas of highest deprivation as well as Children and Young People and our BAME community.
Members were also asked to feedback on Committee effectiveness which would be used to shape future working.
After the meeting it was agreed virtually that the Alliance Committee would sign up to the Essex Faith Covenant and that an independent Chair for the Alliance Committee would be sought.
At the June informal Alliance Committee meeting, following a presentation regarding Anchor Institutions and Social Sparks, it was agreed that this work would become part of the Alliance formal governance.

On Thursday, 18th June Sport for Confidence hosted 'The Big Health Day' to improve the accessibility of health and care services for individuals with a Learning Disability and / or autism. All the Basildon and Brentwood Primary Care Networks were represented, emphasising the understanding that health inequalities for these individuals needs to be addressed.

Alliances (1)

Reporting Month	July 2024	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Mid Essex

The focus of the Alliance Committee in May was the Southend, Essex and Thurrock (SET) Mental Health Strategy. This was presented to the Committee, and it was agreed that a workshop would be held at a future committee to agree how the Alliance partnership can support the implementation of the strategy, in particular the work around prevention and early intervention. This session is planned for July. There was also an introduction to the MSE Compassionate Communities work, the aim of which is to strengthen communities facing death and loss and introduced the film which has been created on the 'Impact of Covid on Dying Death & Bereavement' by South Woodham Ferrers Health and Social Care Group. The Children's Partnership Board also gave an update on their workplans and priority subgroups and it was agreed they would come back to present in more detail as a future committee (see below).

The Alliance Committee agreed future topics for discussion over the next 12 months and agreed that bimonthly meetings would be held as workshops focusing on one topic pertinent to the partnership. Topics agreed include mental health and wellbeing, housing challenges, an overview from each of our district councils, communications, engagement and co-production and babies, children and young people. The committee also agreed to develop a directory of everyone in the partnership with information about who each other are and our roles and responsibilities to support collaborative working and strengthening relationships and knowledge about each other.

This month has seen the continuation of the INT Leadership Groups across all 6 INTs, giving those that wish to lead the work in these areas the opportunity to come together to discuss and agree focus areas for collaborative working, focusing on person centred, proactive care that removes duplication in the system.

South East Essex

The approach to the 2024/26 SEE Alliance Delivery plan has been reviewed and agreed by the Committee and Partnership, shaped around a single outcome of Healthy Neighbourhoods with a targeted focus on delivery in four key areas including, Healthy Start, Healthy Living, Healthy Minds and Healthy Ageing. The plan highlights the need to be agile and create opportunities to co-design and deliver collaborative ways of working, enabling us to eliminate duplication and identify where Alliance partners can add maximum value. To support effective delivery of the 2024/26 Alliance Delivery Plan, a new governance model has been proposed and agreed, aiming to embed a robust approach to delivery and monitoring of meaningful impact.

The Alliance Partnership heard from partners in June month about key developments in place based working, focusing on sustainable partnership approaches to improve overall health and wellbeing of our local residents. Southend City Council outlined their ambition to create a 'Southend City Vision', initially focussing on engagement with the local population who live, work, study and visit Southend, aiming to influence the shape of Southend in the future. Castle Point District Council shared an update on progress of the Sport England/Active Essex Place Partnership expansion in Castle Point, this programme focussed on Canvey Island will bring innovation and investment to improve health and wellbeing initiatives including a partnership response to improve CVD outcomes.

The ongoing development of Integrated Neighbourhood Teams (INTs) in SEE continues to build momentum, 6 of 8 integrated neighbourhood teams are actively working in a multi-agency way to support better outcomes for local residents. A broad range of partners came together in June to attend an Outcomes Workshop, designed to co-produce effective measures that will enable easy identification of progress and impact from INT working, both quantitative and qualitative measures were discussed and outputs from the workshop will be shared with the wider system.

Alliances (2)

Reporting Month	July 2024	Executive Lead	Alliance Deputy Directors	SRO	Alliance Directors	RAG	Amber

Overall Summary

Area of work	Commentary	Current RAG
Dementia Diagnosis	Alliance teams are supporting the completion of the new dementia self-assessment toolkit that is currently being tested with our ICS. This project is being funded centrally by the Department of Health and Social Care as part of a national pilot. The toolkit is designed to be completed by each “place”, or Alliance, within Mid and South Essex ICS and is not directed at any particular provider. This is a unique opportunity to showcase what is happening across our ICS and raise areas we would like support in to a national level. Whilst Thurrock, Southend, and Castle Point & Rochford are all meeting the target, Mid Essex and Basildon and Brentwood are still below target, however significant improvement has been made during 23/24.	
Learning Disability Health checks	Joint working with Southend Essex Thurrock (SET) LD Forum. Regular training/promotion of work needed at Time to Learn session with primary care. Monthly Impact and Investment Funds (IIF) dashboards including LD Annual Health Check performance are circulated to PCNs. Follow-up discussions at PCN level are held by Alliance clinical leads where required. Regularly review and initiate action on LD health check performance at local Health Inequalities Groups. For 2023-34 73,2% of LD Health checks were completed for those registered (target of 75%)	
Cardiovascular Disease (CVD) Prevention	The Alliance teams are supporting the health inequalities team in the implementation of the CVD Local Enhanced Service (LES), promoting and encouraging PCNs to sign up to the LES. The LES aims to improve CVD outcomes and in the longer-term reduce emergency admissions and prevent the escalation of risk. It asks PCNs to collaborate and provide holistic care through **multimorbidity clinics** with clinical interventions determined within the PCN, by utilising the wider PCN network and workforce in delivering care. 14 of the 14 identified PCNs are now signed up to this LES.	
Seriously mentally Ill (SMI) Healthchecks	Regular training/promotion of work needed at Time to Learn session with primary care. Monthly performance circulated to PCNs. Follow-up discussions at PCN level are held by Alliance clinical leads where required. Regularly review and initiate action on SMI health check performance at local Health Inequalities Groups. Supporting the MSE accelerator site project for SMIs by working closely with PCNs and the central team to help embed processes and learning.	

Better Care Fund/Discharge Fund

Reporting Month	July 2024	Executive Lead	Deputy Directors	SRO	Alliance Directors	RAG	Green

BCF and Discharge fund

BCF - All 4 Alliances maintained partnership BCF governance groups with Local Authority (LA) partners.
MSE wide refresh of the BCF templates have been completed for submission to NHSE these templates will have formal sign off at the Health and Wellbeing boards in June across all three LA areas.
To support our submission within the ICB our Head of Assurance and Analytics developed a new comprehensive demand and capacity model for this revised BCF submission, building on the core modelling used last year as the functionality of Anaplan is not yet matured to be able to use this as a planning tool at this time. This C&D model will evolve as we develop it further as it requires us to use several assumptions that will be tested as the analytics team plot actuals against the predicted demand over the next 12 months.
Metrics within the BCF submission have been updated as below for regular reporting to the BCF groups

BCF Metric Targets – 2024/25	Unplanned admissions for ambulatory sensitive chronic conditions per 100,000 population	Emergency hospital admissions due to falls in people over 65 per 100,000 population	Discharges to the usual place of residence	Admissions to long-term residential care for people over 65 per 100,000
ECC	171	1960**	93.5%	420*
SCC	246.3	2700***	95.2%	391.7
Thurrock	190	1258	94.9%	597.7****

Financial Position
The financial modelling within the NHSE submission files follows central BCF guidance for both the Core BCF (NHS minimum contributions) and ICB Discharge funding, both of which are supported via ICB allocations.
National guidance dictated that the Minimum NHS contribution from in 2024/25 should increase by 5.66%, which takes the total ICB BCF commitment to £102.9m.

ECC have adjusted the target for admissions to long-term residential care for people over 65 to 420 per 100,000 since the discussion at the health and wellbeing board due to updated data on our Q4 performance. A target of between 430-450 per 100,000 was initially suggested however the latest data for Q4 suggests an improved target of 420.
**The Falls target is now shown as the figure for the year this means the target is presented in the plan as 1960 per 100,000 rather than the average of 490 per quarter.
***Southend have adjusted the target for emergency admissions due to falls for over 65's from 2,100 to 2,700 (per 100,000). The incidence of falls rose significantly in 2022/23 to a rate of 3829 per 100,000 population, successfully decreasing to 3,274 per 100,000 population in 2023/24. A stretch target of 2,700 per 100,000 population will be in place for 2024/25.
***Thurrock's ambition has been set at the level achieved in 2023/24. It is believed that maintaining the current level of admissions is a stretching target for the following reasons: The indicator is demand-driven, and individuals are only admitted to residential care following effective screening and assessment. Thurrock has an increasing number of LA funded placements counted in this metric (48% in 23/24 compared to 44% in 22/23 and 39% in 21/22), which inflates our rates

Transfer of Care Hubs (TOCH)

Reporting Month	July 2024	Executive Lead	Deputy Directors	SRO	Alliance Directors	RAG	Green

Transfer of Care Hubs

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- The Evaluation of the first 3 months running has been completed and presented to the leadership group for review and agreement of actions
- A digital workshop occurred in June to support the digital integration agenda, Shared Care record going live in June remains part of the solution for Digital integration, a workstream meeting is now being set up to support ongoing developments in the digital arena
- The voluntary sector support model for the TOCHs is being reviewed across the Alliance to build into Phase 2 planning, this case is being prepared for further sharing with partners to agree the next steps, it will require to be taken through triple lock for agreement.
- The chair of the leadership group has been taken over by James Wilson from the community collaborative from July to reflect the leadership role of the collaborative in the TOCH development.
- Operational metrics collected by each TOCH is the focus of phase 2, outline circulated for review by operational leads for feedback
- A Communication lead is now working in each TOCH delivery group to support

- Operational Performance remains focused on the discharge from Hospital metrics to ensure flow is supported by TOCH developments – it is still early in the TOCH development to show significant sustained changes in this data currently. Improvements prior to TOCH go live are due to the internal improvement works undertaken within the acute flow portfolio, ahead of TOCH rollout and are process related.

NHS
Mid and South Essex

Alliance Directors

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Aleksandra MECAN
Rebecca JARVIS

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Key for project updates

G	On track, no intervention required
A	Project remains on track. However, there are a number of risks/issues that should be noted and monitored carefully
R	Off track, Diagnostic Implementation Working Group and/or Diagnostic Programme Board intervention required

Part I ICB Board meeting, 11 July 2024

Agenda Number: 14.1

Board Assurance Framework

Summary Report

1. Purpose of Report

To provide assurance to the Board regarding the management of strategic risks via the latest version of the Board Assurance Framework (BAF).

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, Senior Corporate Services Manager

4. Responsible Committees

Each sub-committee of the Board is responsible for their own areas of risk and receives risk reports to review on a bi-monthly basis.

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. The ICB's main committees also receive excerpts from the BAF in relation to risks within their remit.

2. Risks currently on the Board Assurance Framework

The current BAF, provided at **Appendix 1**, includes the following strategic risks, all of which are rated red (scored between 15 and 25) with the exception of Health Inequalities which is scored 12 (Amber).

- 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

The BAF also includes an updated summary of Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust's red risks.

3. Review of ICB Risk Management Arrangements

The ICB continues to implement the RLDatix DCiQ database (Datix) which includes a module to manage risks and, in due course, the Board Assurance Framework (BAF).

User accounts and permissions for risk leads have been set up and training delivered. Ongoing support is available via the Senior Manager Corporate Services and Datix Administrator. Improved reporting and dashboards are also being developed.

A revised risk hierarchy is under development and will be submitted to the Executive Team for consideration prior to approval by Board members. The revised hierarchy will take account of a national quality board proposal to introduce 'dynamic/complex risk assessments' to assess complex system risks, and will set out the process for escalating risks through directorate and corporate risk registers and to the Board. A Board seminar on the revised risk management arrangements is planned as part of the implementation and development process.

It is proposed that future Board agendas will be mapped to ICB Strategic Risks providing assurance that those risks are discussed during the Board and provide the opportunity for the Board to receive assurances over how those risks are being managed, in addition to the assurances provided on the BAF document itself.

4. Recommendation

The Board is asked to consider the latest iteration of the BAF and seek any further assurances required.

5. Appendices

Appendix 1 - Board Assurance Framework, July 2024.

Mid and South Essex Integrated Care System

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Mid and South Essex

Board Assurance Framework

July 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	K Bonney	• 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 4 = 16** ↓
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	J Kearton	• Oversight via System Investment Group reporting to ICB Finance Committee. • Delivery of system infrastructure 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.	**4 x 4 = 16** ↓
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 = 20** ↔
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	J Kearton	• Preparation of plan position for Board, Regional and National Sign-off. • Development of financial insights through Medium Term Financial Plan. • Overseen by the ICB Finance Committee and the Chief Executives Forum, also discussed at SLFG and Exec Committee. • 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 3 = 12** ↔
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 4 = 20 (all associated risks on Datix are rated 20)**
Risk Owner/Dependent:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	Associated Risks on Datix:	ID Nos 4, 53, 54, 55 and 56.

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against target of 11.55%, vacancies have been improving month on month for 6 months down to 8.9% in February 2024 (from high of 15.6% in July 22), May vacancy rate is 9.8%. Nursing and midwifery vacancies down to 9.1% (from significant high of 19.1% for nurses & 24.6% for midwives July 22). Medical & dental vacancies down to 8.0% in May 2024 against target of 11.5%. **EPUT:** overall vacancy rate now at 11.1% against 12% target. EPUT on plan for substantive staffing.
TURNOVER: **MSEFT:** Continued downward trend from a peak of 15.6% in August 2022 to 11.1% in February 2024, May 2024 turnover 10.8% against 12% target. Nursing turnover down to 8.4%, midwifery 7.6% (19.1% in July 2022). Medical and dental less improvement - 11.7% against target of 12% (17.5% in July 2022 **). EPUT:** Staff Turnover down to 9.2% in February 2024, May 2024 turnover 9.4% against 12% target
BANK & AGENCY: EPUT agency spend in February 2024 is £2.3m lower than Feb 2023, but 7% of the total pay bill so still above the required 3.5%. EPUT are still operating significantly over establishment, currently using unbudgeted temporary workforce to support observation and engagement. Awaiting figures for MSEFT. No update on actual spend but both EPUT and MSEFT are on a downward trajectory.

How is it being addressed? (Current Controls)

With vacancies and turnover in an improved position, focused work continues across Finance, Workforce/People, Operations and Clinical leadership to see these benefits reflected in lower use of temporary staffing. The following stronger workforce controls have been put in place to facilitate this change:

❑ EPUT: Commitment from operational and clinical leads to bring staffing levels back to Establishment:
- Bank & agency reduction plan through sustainable measures (eliminating long term agency placements; tightening rostering practice, increasing Direct Engagement uptake for medics and AHPs; potential transfer to NHS Professionals Secondary Bank and re-negotiating rates with preferred suppliers).
- Targeted work on cost reduction for staff groups with high temporary staffing spend, while maintaining Time to Care safe staffing levels, with a focus on rostering
- Establishment Control panels in for all care units and corporate services, including Medical. review medical vacancies and agency assignments, alongside a recruitment strategy for Consultant posts.

❑ MSEFFT: Greater triangulation between nursing, finance and HR with continued sprint on 'Improving Value'.
- Bank and agency controls implemented (including those imposed by Triple Lock).
- Nursing, Medical and Corporate Assurance groups set up for senior leaders to approve resourcing requests and a 6-week forward look.
- Recruitment freeze for non-clinical roles.
- Improved rostering processes in train (though needs to be scaled including moving all medics onto e roster)
- Regular audit of most costly locums alongside clear recruitment plans to fill posts
- Improved accuracy of staffing categories – specifically 'unique post identifiers'
- Upskilling and training for off framework and booking approach for temp staffing
- Review of doctor's bank booking platform with more robust controls
- Push to move staff from temporary to substantive

Barriers (Gaps)

- Compliance and controls will make a difference and is the right discipline.
- However, sustainable change will require significant decisions around size, shape and skill mix of future workforce aligned to priorities. The current operational planning is an opportunity to achieve that.

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

- Reduction of percentage of workforce that is over –Establishment and unfunded.
- Reduction in temporary staffing spend.
- Evidence of better value for money where temporary staffing continues to be needed.

Next Steps: (Actions)

1. Ongoing compliance and control tracking.
2. 2024/5 operational planning to agree affordable staffing levels and commitment to manage to that workforce 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 4 = 16 (reduced from 20)**
Risk Owner:	Pam Green – Basildon & Brentwood Alliance, Exec Lead for Primary Care William Guy, Director of Primary Care.	Directorate: Board Committee:	Basildon and Brentwood Alliance Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, ARRS, Hospital performance, reputational damage.	Associated Risks on Datix:	ID Nos 3, 21

Current Performance v's Target and Trajectory

Workforce:

- Additional Roles Re-imbursement Scheme (ARRS): Good progress has been made on the recruitment of ARRS staff: 600 FTEs in place as of March 2024.
- Fellowship scheme: 30 GPs have now been recruited to the MSE system with support of the fellowship scheme.
- Overall primary care workforce increased ahead of trajectory in 23/24.

Demand/Capacity:

- Patient Experience National Survey: Poor performance locally in terms of access.
- Available Appointments: 7.8% increase in primary care consultations in 23/24 vs 22/23.

Barriers (Gaps)

- National workforce challenges (recruitment and retention).
- Resource for investment in infrastructure (including estate, digital, telephony).
- Increase in overall demand on primary care services.
- Overall funding of primary care – potential Industrial Action by general practice (ballot currently underway).

How is it being addressed? (Current Controls)

- Access Recovery Plan – 10 Self-referral pathways established, roll out of Cloud Based Telephony ahead of trajectory. Second wave added to support practices move to optimal systems.
- Workforce development e.g. Additional Roles Reimbursement Scheme (ARRS) optimisation.
- Additional investment in Digital solutions planned for 24/25 – new scheme currently being finalised.
- Initiatives for new GPs / Partners and to support other roles in Practice Teams.
- Refreshing the Mid and South Essex Primary Care Strategy
- Development of services in other primary care disciplines (i.e. Pharmacy First, minor eye condition pathways, dental access pathway)

How will we know it's working? (Internal Groups & Independent Assurance)

- Patient Survey Results (due July 2024).
- Workforce retention rates (monthly data). Latest data indicates marginal improvement in GP retention rates.
- Improved Patient to GP Ratio (quarterly data).
- Consultation data (volume, speed of access), digital tool data (engagement and usage), monthly data currently showing upward trends.

Next Steps (Actions)

- Integrated Neighbourhood Teams – all INTs expected to go live by end of March 2025.
- New digital tools scheme to be confirmed across Mid and South Essex by July 2024.
- Transitional funding for practices – scheme in place, all practices expected to apply by end of September 2024 (40 practices have submitted requests to date).
- BMA Contract Dispute – continue engagement with Essex Local Medical Committee to understand impact of dispute on local primary care provision (ongoing – timeline outside of local control).

Risk Narrative:	**CAPITAL:** Insufficient capital to support all system needs, necessitates prioritisation and reduces our ability to invest in new opportunities, for transformational impact.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer. Ashley King, Director of Finance Primary Care, Financial Services & Infrastructure	Directorate: Board Committee:	System Resources Finance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	Associated Risks on Datix:	ID 58

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.
- Accounting rules relating to the capitalising of Leases has resulted in greater affordability risk.
- Impact of system financial position ('triple lock' and reduction of CDEL).

How is it being addressed? (Current Controls)

- Developing Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance 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 benefits associated with the sustainability and transformation plan capital.
- Prioritisation framework for Primary Care Capital now established and under regular review.
- Prioritised list of investments informed submission of the 2024/25 capital plan (submitted May 2024) and development of capital requirements as part of Infrastructure Strategy.

How will we know it's working? (Assurance)

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

Next Steps: (Actions)

- Infrastructure Strategy (indicative July 2024).
- Primary Care Projects Review on-going.
- Training for Board members & executives (senior managers) on capital funding framework (post approval of Infrastructure Strategy).

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)**	**4 x 4 = 16 (reduced from 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.	Datix Risks:	ID Nos 19, 26, 32

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 delivery 78% 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 Workforce Risk slide).

How is it being addressed? (Current Controls)

- The UEC & Flow Improvement programme for 2024/25 is a pillar within the MSE Transformation & Improvement Programme reporting into the Executive Discharge Meeting, which is designed to align efforts across the System to optimise both acute and community hospital capacity, increase the provision of alternative care outside the hospital setting, contribute to financial sustainability and improve patient flow. The aim will be to sustain the closure of escalation beds and support the reduction of beds.
- The well-established MSEFT bed model will be the tool that is utilised for incorporating all hospital and system transformational schemes, to translate the delivery into length of stay reductions and positively deliver the closure of escalation capacity by 30 April 2024 and bed reductions per hospital for 2024/25. The overall transformation programme will be overseen by the MSE Discharge & Flow Executive group with workstreams led by SRO's accountable for delivery.
- Close escalation capacity circa 41 beds, by the 30 April 2024
- Reduce Beds occupancy to 92% and reduction in General & Acute core beds.
- Maximise attendance to Emergency Department, and admission avoidance with all alternative urgent care pathways.
- Delivery of UEC & Ambulance handover targets.

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 continuing health care teams via situational awareness 10am system call.

Next Steps

- The UEC & Flow Improvement programme for 2024/25 is a pillar within the MSE Transformation & Improvement Programme reporting into the Executive Discharge Meeting, which is designed to align efforts across the System to optimise both acute and community hospital capacity, increase the provision of alternative care outside the hospital setting, contribute to financial sustainability and improve patient flow. The aim will be to sustain the closure of escalation beds and support the reduction of beds
- Expected outputs from the UEC & Flow schemes to triangulate into the MSEFT bed model, equating to length of stay or admission avoidance reduction to demonstrate overall reduction in bed occupancy – Ongoing: bed model regularly reviewed, updated to capture progress/slippage.
- Establish funding source for the continuation of the Unscheduled Care Co-ordination Hub and further deployment of model to maximise alternative pathway direct referrals / attendance/admission avoidance. Evaluation from 2023/24 demonstrated alterative urgent car pathways utilised and reduction in ambulance conveyances. Big submitted from EoE NHSE to the National NHSE to support finding all UCCH's across the region – Outcome expected July 2024.
- Demand and capacity modelling continues with the System Co-ordination Centre undergoing training.
- MSEFT escalation capacity circa 41 beds, by the end of April 2024 - Escalation beds closed at Broomfield & Southend
- Reduce Beds occupancy to 92% and reduction in General & Acute core beds July 2024 - G&A bed reduction at Black and completed at Broomfield & Southend.

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score:** (impact x likelihood)	**5 x 4 = 20**
Risk Owner/ Dependent:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation (Cancer) Aleks Mecan, Alliance Director Thurrock (Diagnostics) Karen Wesson, Director Oversight Assurance (Elective)	Directorate: Committee:	Clinical Leadership and Innovation, Thurrock Alliance, Resources Cancer Assurance Committee, Diagnostic Board Elective/Planned Care Group
Impacted Strategic Objectives:	Delivery of Operational Planning commitments/Recovery of constitutional standards for diagnostics, cancer and Referral to Treatment (RTT).	Associated Risks on Datix:	ID Nos 1, 2 and 13.

Current Performance v's Target and Trajectory

Diagnostics: Current plans on track to deliver operational planning commitment
Cancer: Waiting times continue not to meet NHS constitutional standards. Cancer Plan on track to meet operational planning commitment for 2024/25
Referral to Treatment:

- 65+ week wait: MSEFT updated trajectory to achieve operational plan commitment

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – SDF funding approved, MSEFT recruiting to the posts to support pathway delivery
- **Diagnostic Capacity –** capacity across diagnostics is impacting 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.
- **Elective –** Delivery of capacity and optimisation of the Surgical Hub

How is it being addressed? (Current Controls)

Diagnostics:

- MSEFT have recovery plans for all modalities and trajectories these are now incorporated into the 2024/25 operational plan.
- Working with Trust to ensure clinical prioritisation and chronological booking – initial assigned risk code remaining in clinical system.

Cancer:

- Daily review of PTL and next steps with all tracking focused on trajectory compliance. Weekly "huddle" in place and oversight via the National Tier 1 meetings.

Referral to Treatment (RTT):

- MSEFT sites working to maximise capacity utilisation for long waits through optimal clinical prioritisation and chronological booking. Oversight via the National Tier 1 meetings.

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

- ICB maintains oversight of performance against all NHS Constitutional Standards/Operational Plan asks**.**
- **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. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions)

RTT and Cancer:

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

Operational Planning 2024/25:
System oversight of delivery vs operational plan for 2024/25

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** MSE is a system that is facing significant financial challenges. Having delivered a deficit plan in 2023/24 the challenge continues into 2024/25 with the system planning to post a £96m deficit in year. Failure to deliver the financial plan will place increased pressures across the whole system, impacting on our ability to deliver our intended outcomes.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer	Directorate: Committee:	System Resources Finance Committee
Impacted Strategic Objectives:	Financial sustainability	Associated Risks on Datix	ID Nos 7, 10, 14, 42.

Current Performance v's Target and Trajectory	Barriers (Gaps)
The System has agreed its plan for 2024/25 submitting a revised profile in June 2024. The planned position has the ICB breaking even with both MSEFT and EPUT in deficit. Performance against trajectory will be known as we move into Month 2 reporting.	- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery. - System pressures to manage delivery (capacity). - Capacity due to vacancy freeze.

How is it being addressed? (Controls)

- 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.
- Continued oversight and by Chief Executive Officers, Finance Committees and Executive Committees 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.
- Additional spend controls – triple lock arrangements.
- Appointment of Executive Director System Recovery and enhanced project management arrangements.

How will we know controls are working? (Internal Groups & Independent Assurance)	Next Steps: (Actions)
• Delivery of the agreed position in-year and at year-end. • Improved delivery throughout the medium term (5 years) to system breakeven. • Being overseen by the Finance Committees and the Chief Executives Forum. • Internal and External Audits planned.	- Finalise on-going monitoring arrangements. - Delivery of system efficiencies programme/financial sustainability programme for 2024/25. - Medium Term Financial Plan developed, to inform future planning.

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 3 = 12 (unchanged)**
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	**Associated Risks on Datix.**	ID Nos 18 and 45

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 developed by the PHM team and will be shared with the Growing Well Board.
- PLUS group insights provided by PHM team outlining opportunities for reducing health inequalities.
- Population Health Improvement Board will be establishing MSE system priorities. Key metrics and a dashboard in Phase 1 development.

Barriers (Gaps)

- Capacity and resources to support Prevention and health inequalities programmes when ICB focused on financial recovery
- Availability of Business Intelligence/Population Health Management 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 health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project including those part of financial recovery programme. Internal ICB resource identified to support implementation of Digital EHIIA tool but not immediately available.
- Equality Delivery System (EDS) annual reviews undertaken with 2023/24 report published on ICB website and areas for review in 2024/25 identified.
- Health inequalities information statement for the 2023/24 annual report approved by Audit Committee.
- Health inequalities funding of £3.5m pa reviewed and reprioritised allowing for one off contribution towards deficit of £1.3m in 2024/25. Alliances funding via trusted partners will be more targeted on specific health inequalities priorities and schemes yet contractually committed will be subject to additional scrutiny and triple lock process.
- University of Essex evaluation report of health inequalities schemes shared with Alliances to review opportunities for spread and scale and to inform future system wide approach.
- Bi-annual reporting to ICB Board on health inequalities activities.

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 2025)

- Launch of digital EHIIA tool (Sept 2024)
- Health inequalities dashboard Phase 1 launch (Aug 2024).
- Establishment of 'Equity & Diversity Impact Assessment Panel' to review EHIIA as part of formal governance under Board approved EDI Strategy (Sept 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	Risks on Datix:	ID Nos 5, 8, 22 and 23.

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.
- The Lampard Inquiry (Essex Mental Health Statutory Inquiry) Terms of Reference were published on 10th April with a wider scope and increased timeline, MSE ICB Have been granted core participant status (June 2024).
- 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)

- System Oversight and Assurance Committee (SOAC) monitor performance and quality of services with provider reports now taken to Quality Committee.
- Evidence Assurance Group, chaired by MSE ICB, attended by MSE ICB and EPUT.
- Monthly 'Quality Together' meeting attended by NHSE, EPUT and ICB senior staff, alongside EPUT and ICB 'Safety huddles' held on a weekly basis.
- Quality Assurance Compliance Visits with EPUT compliance colleagues.
- Multi-agency delayed transfer of care meetings to ensure good flow and capacity, held weekly on Fridays with system partners.
- Essex ICBs quality team continued joint working.
- Implementation of a Unified Electronic Patient Record will resolve the multiple IT systems within EPUT, but is a long-term project (due to complete by April 2026).
- Implementation of a Shared Care Record solution will provide the opportunity to integrate information into a single source, due to commence July 2024.
- Identified data quality concerns will be managed by Task and Finish Group reporting to relevant forum.

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.
- EPUT Reporting to MSE ICB Quality Committee
- 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.
- Accountability review with focus on performance.

Next Steps (Actions):

- Implementation of recommendations from England Rapid Review into Inpatient Services published June 2023 with focus on recommendations which state twelve months, currently delayed whilst awaiting NHSE guidance (October 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)
- Lampard Inquiry – MSE ICB have been granted core participant status.
- Implementation of the mental health learning disability autism (MHLDA) inpatient quality transformation with final plan to be submitted 28th June 2024(March 2025)

Partner Organisation Self Identified Red Risks (and scores)

MSEFT - 11 Red Risks (as of June 2024).

- 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)
- Integrated care system working (16)

Partner Organisation Self Identified Risks

EPUT red risks, as of March 2024*

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

1 Red Corporate Risk (scored 20)

- Observation and Engagement

(NB: The June EPUT Board meeting did not receive a BAF report and at the time of writing, the July EPUT Board papers were not available).

Mid and South Essex Integrated Care System

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Part I ICB Board Meeting, 11 July 2024

Agenda Number: 14.2

Committee Terms of Reference

Summary Report

1. Purpose of Report

To seek approval of revised Board sub-committee terms of reference (TOR) following annual effectiveness reviews.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

Each committee has considered its terms of reference and approved any changes recommending approval by the Board.

The Audit Committee maintains oversight of governance and considers the effectiveness of Board sub-committees as part of its terms of reference.

The Board retains responsibility for approving changes to committee terms of reference prior to them becoming effective.

5. Impact Assessments / Financial Implications / Patient or public engagement

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to consider and approve the committee terms of reference (subject to inclusion for oversight of Individual Funding Requests within a committee TOR) for the:

- Audit Committee
- Remuneration committee
- Primary Care Commissioning Committee
- Finance and Performance Committee
- System Oversight and Assurance Committee

- Quality Committee
- Clinical and Multi-professional Congress and
- Executive Committee.

Committee Terms of Reference

1. Introduction

Each sub-committee of the Board is required to undertake an annual self-assessment of its effectiveness to determine whether it has met its objectives as set out within its terms of reference (TOR). This process includes a desktop review, a questionnaire sent to its members and a review of its TOR to ensure it is current and appropriate.

2. Main content of Report

The outcomes of the committee self-assessments and proposed changes to TORs have been presented to and approved by each respective committee.

In summary, committees concluded that they had met their objectives, according to their TOR. However, the Finance and Investment Committee (FIC), and System Oversight and Assurance Committee (SOAC), both concluded that significant changes to their remit were required moving forward.

The FIC noted that whilst robust decision making was in place, the committee needed to be mindful of the wider context in which the ICB was performing, and that understanding performance would ensure that decisions were properly informed. Furthermore, that in having oversight of and scrutinising the financial stability of the ICB and the wider system, the committee could be much more effective by understanding performance and how the financial situation can drive performance or vice versa.

The SOAC concluded that there had been duplication of its role with other sub-committees and consequently there could be confusion as to whether papers should be presented to SOAC or another committee. The committee also lacked purpose as a result attendance at the committee was fluid in the past year. A review of the TOR has therefore proposed significant changes to rectify these issues going forward.

The table below highlights the key changes to committee TORs for approval of the Board.

Board sub-committee	**Summary of changes to terms of reference**
Audit Committee	• Minor changes to reflect new job titles, post re-structure and correct any misspellings. • Removal of the additional Associate Non-Executive Member from a system partner that had remained vacant all year. • Formalising the Health & Safety Committee as a sub-committee of the Audit Committee. • Removal of the requirement to comment on the robustness of the quality accounts process, which is undertaken by the Quality Committee

Board sub-committee	Summary of changes to terms of reference
Remuneration Committee	• Minor changes to reflect new job titles, post re-structure. Removal of the Director of Resources (now known as the Chief Finance Officer) from the list of attendees. • Confirming meetings as bi-monthly.
Primary Care Commissioning Committee	• Minor changes to reflect new job titles, post re-structure and correct any misspellings etc. • Clarifying that whilst meetings are monthly, transacting operational and strategic business will alternate months. • Clarifying the wording of committee responsibilities, but adding assurances or escalations being received from the People Board regarding the primary care workforce.
Finance & Performance Committee (formerly Finance & Investment Committee)	• Change of scope to include all aspects of scrutinising performance. • Change of name to Finance and Performance Committee. • Minor changes to reflect new job titles, post re-structure and correct any misspellings. • Amending membership to have clinical representation by including the System Medical Director and including the Executive Director of System Recovery as a member. • Including quarterly deep-dive sessions where the Executive Chief Finance Officers from MSEFT and EPUT will attend regarding financial sustainability and performance.
System Oversight and Assurance Committee	• Removal of general oversight of performance. • Revised purpose as primarily an executive escalations committee. • Inclusion of the recovery support programme from NHS England, incorporating the National Oversight Framework 4 (NOF4) requirements of MSEFT as a Part II section of the SOAC meeting. This will also include MSEFT undertakings reviews by NHS England. • Clarifying the Chairing arrangements of both the Part I and Part II meeting. • Revised membership to reflect the new remit of the committee and the Part II review of NOF4.

Board sub-committee	Summary of changes to terms of reference
	• Revised frequency of Part I meetings from monthly to bi-monthly, but Part II NOF4 meetings to still be held monthly as required. • Strengthening of quoracy to include NHS England and representation from each provider Trust. • Re-written TOR in accordance with ICB template to reflect the revised remit of SOAC.
Quality Committee	• Minor changes to reflect new job titles, post re-structure and correct any misspellings. • Removal of oversight of compliance with the principles of the Individual Funding Request (IFR) policy and monitoring the effectiveness of the policy by receiving updates from the IFR Team.
Clinical and Multi-professional Congress	• Minor changes to reflect new job titles, post re-structure and correct any misspellings.
Executive Committee	• Minor changes to reflect new job titles, post re-structure and correct any misspellings. • Including the Executive Director of System Recovery in the membership. • Establishing the Inclusion and Belonging group as a sub-group of the Executive Committee. • Including the equality, diversity, inclusion and belonging agenda as a responsibility of the committee, as well as ownership of the corporate risk register. • Revising the frequency of meetings to weekly, with robust decision and action logs maintained in lieu of detailed minutes.

3. Findings/Conclusion

Committee TORs have been updated to ensure that they are current and reflect the work of the committee. Changes to most TORs were minor, except for the FIC and SOAC where more significant changes in the scope of the committees were proposed, as detailed in the table above.

With the Quality Committee removing oversight of the IFR policy from its TOR, there is a potential gap within our governance oversight arrangements. Consequently, consideration is being given to the most appropriate committee to undertake this role.

Approval of the revised TORs will enable each committee to develop further in the coming year and provide more robust assurance to the Board that the ICB is meeting

its objectives and adequately managing associated risks and issues. Once approved, the TORs will be published within the governance handbook on the ICB website.

4. Recommendation(s)

The Board is asked to consider and approve the committee terms of reference (subject to inclusion for oversight of Individual Funding Requests within a committee TOR) for the:

- Audit Committee
- Remuneration committee
- Primary Care Commissioning Committee
- Finance and Performance Committee
- System Oversight and Assurance Committee
- Quality Committee
- Clinical and Multi-professional Congress and
- Executive Committee.

5. Appendices

Appendix A – Finance and Performance Committee Terms of Reference

Appendix B – System Oversight and Assurance Committee Terms of Reference

Appendix A

Mid and South Essex Integrated Care Board

Finance and Performance Committee

Terms of Reference

1. Constitution

1.1 The Mid and South Essex Integrated Care Board (MSE ICB) Finance and Performance Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) and is a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The Finance and Performance Committee is a formal committee of the MSE ICB, which has delegated authority from the MSE ICB details of which are set out in the Scheme of Reservation and Delegation (SoRD). The Committee holds only those powers as delegated in these Terms of Reference as determined by the Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the MSE ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members, to support the discharge of their duties. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and SoRD but may not delegate any decisions to such groups.
- Establish sub-committees to support the discharge of relevant or related ICB functions.

2.3 At the point of review of these terms of reference (June 2024) the Finance and

Performance Committee has the following sub-committees:

1) Integrated Pharmacy Medicines Optimisation Committee (IPMOC) - this group will report quarterly to the Committee unless there is a need to escalate between times.
2) Provider Selection Regime (PSR) Review Group – this group will only report as required to the Committee as it only meets if there is representation from Providers on a decision that has been made.

2.4 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

3.1 To oversee the performance of MSE ICB in delivering its finance and performance national targets and objectives, ensuring the effective and efficient use of resources, whilst working towards/delivering financial balance.

3.2 The Committee will contribute to the overall delivery of the ICB objectives and Integrated Care Partnership (ICP) strategy through the oversight and assurance of:

1. Annual system and ICB finance and performance planning, including appropriate scrutiny of provider partner plans to the extent that they form part of the overall system finance and performance plan. Monthly finance and performance monitoring, including quarterly system deep dives.
2. Medium-term financial and performance planning including the development and performance against the System Financial Recovery Plan.
3. Providing regular assurance updates to the ICB Board via the Chair's finance and performance report and minutes of the committee.
4. The committee may be requested by the Board, or Chief Executive, to undertake specific oversight and assurance, related to their role within the overall ICB and system governance structure.

3.4 The duties of the Committee will be driven by the ICB's objectives and the associated system risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

4. Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than 7 members of the Committee, including at least one independent Non-Executive Member of the Board/external Chair, based on their specific knowledge, skills, and experience. Other members of the Committee need not be members of the Board.

4.3 The Chair of the Committee may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

4.4 Membership will comprise:

- Non-Executive Member of the Board (Chair) or External Chair
- Two Associate Non-Executive Members or Chairs of Finance Committees from intra-system NHS Foundation Trusts
- A third independent Associate Non-Executive Member
- Chief Executive, MSE ICB
- Executive Chief Finance Officer, MSE ICB
- Executive Director of Strategy & Corporate Services, MSE ICB
- System Medical Director, MSE ICB
- Executive Director of System Recovery
- Local Authority Partner Member

4.5 On a quarterly basis the Executive Chief Finance Officers from MSEFT and EPUT will attend for 'deep dive' sessions on system financial sustainability and performance.

Chair and vice chair

4.6 The Committee will be chaired by a Non-Executive Member of the Board with the relevant skills and experience to chair the Finance and Performance Committee, appointed by the Chair of the ICB.

4.7 The Committee may appoint a Vice Chair of the Committee from amongst its members.

4.8 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

4.10 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended by the following individuals who are not members of the Committee by invitation:

- Executive Chief Finance Officer, MSEFT (or nominated Deputy)
- Executive Chief Finance Officer, EPUT (or nominated Deputy)
- ICB Executive Directors, including the Chief Digital Information Officer
- Local Authority Partner Member Finance Officers
- MSE ICB Director of Oversight & Assurance
- MSE ICB Director of Commercial
- MSE ICB Director of Finance
- MSE ICB Deputy Director of Finance – Analytics and Performance
- Director of Pharmacy and Medicines Optimisation (ref: IPMOC)
- Deputy Director of Contracting (ref: PSE Review Group)

4.11 The NHSE Regional Chief Finance Officer (or nominated deputy) may attend meetings periodically when the System is in escalation owing to its financial performance.

4.12 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

4.13 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any matter including representatives from health partners.

Attendance

4.14 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may vote on behalf of the absent Committee member.

4.15 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings Quoracy and Decisions

5.1 The Finance and Performance Committee is not a meeting held in public. The Committee will meet at least 8 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 4 Members of the Committee are required, including the Chair or Vice Chair of the Committee and the Executive Chief Finance Officer or their representative.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis by telephone, email, or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually, via video conference facilities. Where this is not possible decisions should be achieved through email to all members of the committee to capture a transparent audit trail.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers known as 'Chairs Action' shall be reported to the next formal meeting of the Committee for ratification.

6. Responsibilities of the Committee

6.1 The Committee's duties can be categorised as follows:

6.1.1 System Oversight Framework

- To receive assurance regarding the arrangements for discharging and implications of the ICBs responsibilities in respect of the following themes under the NHS System Oversight Framework (SOF):
  - Finance – including use of resources.
  - Performance – including access and outcomes.
  - Local – strategic priorities.

6.1.2 System financial management framework:

- To oversee the joint obligation to achieve financial balance/agreed financial plan in line with published guidance and collaborative in whole system balance.
- To oversee and monitor delivery of the financial performance of the ICB and providers partners, through regular reporting on all aspects of the ICB and system financial performance.
- To ensure financial information systems and processes are established to make recommendations to the Board on financial planning in line with the strategy and national guidance.
- To ensure health and social inequalities are considered in financial decision-making and that all impact assessments have been appropriately completed and considered.

6.1.3 Resource allocations (revenue)

- To agree the approach for distribution of the resource allocation via agreement of the ICB Budgets on an annual basis.
- To receive regular reports and planning updates regarding the deployment of system-wide transformation funding and one-off resource provided to the ICB on behalf of the system.
- The committee can seek the advice of the Senior Finance Leadership Group (SFLG) on any matters it feels necessary.

6.1.4 National framework:

- To advise the ICB on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICB can be best used within the system to achieve the best outcomes for the local population.
- To oversee national ICB level financial submissions.
- To receive assurance that the required preparatory work is scheduled to meet national planning timelines.

6.1.5 Financial monitoring information

- To agree a reporting framework for the ICB as a statutory body, using the chart of accounts devised by NHSE and the integrated single financial environment (ISFE) and the ICB as a system of bodies.
- To work with ICS partners to identify and agree common approaches across the system such as financial reporting, estimates and judgements.
- To work with ICS partners to seek assurance over the financial reports from system bodies and provide feedback to them (being clear on how this role interacts with that of the audit committee).
- To oversee the development of financial and activity modelling to support the ICB priority areas.
- To recommend to the ICB Board a medium and long-term financial plan which demonstrates ongoing value and recovery.
- To develop an understanding of where costs sit across a system, system cost drivers and the impacts of service change on costs.
- To ensure the appropriate information is available to manage financial issues, risks, and opportunities across the ICB.
- To review financial and associated risks against the system financial target and the ICBs own financial targets and made recommendations to address risks that are not tolerable to the ICB and wider system.
- To agree key outcomes to assess delivery of the ICBs financial strategy (including financial recovery programme).
- To monitor and report to the Board overall financial performance against national and local metrics, highlighting areas of concern.
- To monitor and report to the Board key service performance which should be considered when assessing the financial position.

6.1.6 Performance:

- To receive regular contract performance reports (covering contract management, activity, cost, and quality) for each of the ICB's' main areas of commissioning expenditure.
- To review assurance on performance against the delivery of the relevant core ICB's Strategies and Operational Plan through regular reporting on delivery and the ICB Board Assurance Framework, providing recommendations to SOAC where rectifying actions are required.
- To review assurance on progress and achievement against key national, regional, and local targets for service improvement, with a particular focus on

delivery of the annual planning requirements.

- To make recommendations to the Board on developments to the System Performance Assurance Framework.
- To receive and review in year monitoring reports covering all national constitutional standards, any additional national or regional performance requirements as specified by NHSE, local priorities targets, patient outcome measures and inequality performance.
- To provide assurance on system performance improvement plans and recovery trajectories, making recommendations to SOAC in-year on corrective actions, and oversee progress on performance against such plans on a regular basis, seeking SOAC escalation to the Board in relation to any serious concerns or deviation from plan.
- To review assurance on progress and achievement against outcomes and targets agreed with partner organisations.
- To oversee the management of the system financial target and the ICB's own financial targets (as set out above).
- To agree key outcomes to assess delivery of the ICB financial strategy.
- To monitor and report to the Board overall financial performance against national and local metrics, highlighting areas of concern.
- To monitor and report to the Board key service performance which should be considered when assessing the financial position.

6.1.7 System efficiencies:

Given the governance arrangements for financial recovery, the following items will be managed through separate governance and reported through to the committee:

- To ensure system efficiencies are identified and monitored across the ICB, in particular opportunities at system level where the scale of the ICB partners together and the ability to work across organisations can be leveraged.
- To ensure financial resources are used in an efficient way to deliver the objectives of the ICB and achieve financial sustainability.
- Agreeing strategies to reduce variation and improvement outcomes by maximizing efficient and effective use of non-financial and financial resources.
- To review exception reports on any material breaches of the delivery of agreed efficiency improvement plan including the adequacy of proposed remedial action plans.

6.1.8 Capital:

- To ensure that the system estates & digital strategies and plans properly balance clinical, strategic and affordability drivers.
- To gain assurance that these plans are built into system financial plans.
- To monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used.
- To ensure effective oversight of future prioritisation and capital funding bids.

- To scrutinse and support capital business cases to ensure alignment with system objectives, efficiency expectations and affordability of on-going revenue consequences.

6.1.9 Board Assurance Framework:

- Review and monitor those risks on the BAF and Corporate Risk Register which relate to finance and performance and ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- To co-ordinate system financial BAF risk reporting and liaise with system partners to ensure consistency in articulation and mitigation of financial risk.

6.1.10 Investment & Procurement:

- To oversee procurement and contracting activity (business cases / service proposals) of the ICB, providing assurance to the Board that these activities have been conducted in a manner that meets the legal, statutory, regulator and other obligations of the ICB whilst also delivering best value for patients and taxpayers.
- The committee will approve investments and procurements within its delegated financial limits.
- To review procurement outcomes and approve the award of contracts and/or make recommendations to the ICB, in accordance with the Scheme of Reservation and Delegation.
- To review and monitor the procurement programme and pipeline in line with the ICB Commissioning Intentions.
- To review lessons learned from procurements and recommend changes to practice and procedures where necessary.

6.2 The Committee has delegated authority via the Scheme of Reservation and Delegation to make decisions in respect of the following:

- Approving on behalf of the ICB Board or endorsing new and/or significant amendments for the Board, of policies and procedures within its remit.
- Approving business cases / financial spend up to the limits specified in the detailed delegated financial limits within the Scheme of Reservation and Delegation.
- Approving updated policies for which the Committee is a sponsor.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives, the Nolan Principles and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to and are responsible for declaring interests relevant to agenda items as soon as they are aware of an actual or potential conflict. Committee members must consequently comply with the Committee Chair's decision on the necessary action to manage the interest in accordance with the ICBs Conflict of Interest Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

Policies and procedures

7.7 The policies and procedures approved as the sponsoring committee for those associated with its remit of work, shall be reported to the Board.

8 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Committee will escalate issues of continued non-compliance or non-delivery of expected plans to the SOAC or Board as necessary.

8.3 The Committee will advise the Audit Committee on the adequacy of assurance available and contribute to the Annual Governance Statement.

8.4 Regular reports on the delivery of plans will be submitted to the ICB for assurance.

8.5 The Chair of the committee may be invited to attend the ICB Board as requested by the Chair of the ICB.

8.6 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.7 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary, and submitted to the Board in accordance with the Standing Orders. It is noted that commercially sensitive or other confidential / sensitive information may be noted in the meeting that cannot be reflected in minutes

that are available to the public (i.e., submitted to the public Board meetings). Where this is the case, those items will be minuted 'confidentially', and a note made within the minutes of this fact. Confidential minutes are then reported to the Part II confidential meeting of the ICB Board.

8.8 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.9 The Integrated Pharmacy Medicines Optimisation Committee and Provider Selection Review Group shall report and be accountable to the Finance and Performance Committee.

9 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval:

Date of review:

Appendix B

Mid & South Essex Integrated Care Board

System Oversight and Assurance Committee

Terms of Reference

1 Constitution and Context

1.1 The System Oversight and Assurance Committee (SOAC) is established by the Integrated Care Board (the Board or ICB) and is a committee of the Board in accordance with its constitution.

1.2 These terms of reference (TOR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board.

1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

1.4 These Terms of Reference describe the scope, function, and ways of working for the SOAC. They should be read in conjunction with the Memorandum of Understanding (MoU) and Compacts of the ICS, and the MoU with NHS England (NHSE).

1.5 The partnership approach to system oversight will be geared towards overall performance improvement and development (this includes finance, quality, performance, and workforce, hereafter referred to as overall performance). It will include an oversight of progress towards delivery of the MSEFT NOF4 exit criteria. It will be data-driven, evidence-based, and rigorous.

1.6 The SOAC will therefore be pivotal to effecting change resulting from escalations from the ICB or partners that impacts on overall performance as a system.

1.7 NHS England (NHSE) has adopted a relationship with NHS system Partners in Mid and South Essex, enacting streamlined oversight arrangements under which:

- NHS system partners will take the collective lead on oversight of providers, commissioners, and Alliances in accordance with the terms of the Partnership MoU.
- NHSE will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, outcomes, and quality.
- The intention of SOAC is to support an embedded assurance approach. It remains an ICB committee and as such it is expected that region (NHSE) will work with and through the ICB to support issues raised in the committee where appropriate.

1.8 In line with principles and functions set out in the Memorandum of Understanding between NHSE and MSE, NHSE may, where appropriate, enact certain regulatory and system oversight functions through the committee. Where appropriate NHSE will utilise its role as Co-Chair to fulfil this function. This may be conducted in a Part 2 meeting where the nature of the business requires.

2 Authority

2.1 The Committee is a formal committee of the ICB Board, which has delegated authority from the ICB details of which are set out in the Scheme of Reservation and Delegation. The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB or within the wider system (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's Constitution, Standing Orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.
- Establish sub-committees to support the discharge of relevant or related ICB functions.

3 Purpose

3.1 The role of the Committee is to bring partners together for mutual accountability of system overall performance according to the requirements of relevant legislation, the NHS Constitution and NHS England (assessed through the NHSE Oversight Framework).

3.2 The committee will not duplicate the role of other ICB Board sub-committees but will receive escalation of items that are not being resolved through those sub-committees.

3.3 Partners in attendance at the committee will then take the appropriate steps required to facilitate a response to the issues identified.

3.4 The Committee will thereby ensure that system risks are being managed and mitigated appropriately.

3.5 It supports the joint accountability function for and on behalf of the partners and provides a mechanism of providing additional assurance or escalation to the ICB Board, individual Boards and Governing Bodies and committees established across statutory organisations that monitor performance.

4 Membership

4.1 The membership of the SOAC (core business) will include representation from each sector of the Partnership. 4.5 below reflects the role of NHSE in the National Oversight Framework (NOF) and details the membership of the Part II meeting for NOF 4.

4.2 The membership will comprise:

- ICB Chief Executive (Co-Chair)
- Lead Director NHSE (Co-Chair)
- Lead Recovery Support Programme (RSP) Director, NHSE (Co-Chair for the RSP part of the meeting)
- Chief Executive, Mid and South Essex NHS Foundation Trust (MSEFT)
- Chief Executive, Essex Partnership University NHS Foundation Trust (EPUT) (also a member representing the Mid and South Essex Community Collaborative.
- Executive Chief Nurse, MSE ICB
- Nominated Director, East of England Ambulance Service NHS Trust (EEAST)
- Alliance Director Representative, MSE ICB
- Executive Chief Finance Officer, MSE ICB
- Executive Director of Strategy and Corporate Services, MSE ICB
- Directors of Oversight and Assurance (link to NHSE Multi-Disciplinary Team (MDT)), MSE ICB and/or Trust
- Executive Chief People Officer, MSE ICB
- Upper Tier Local Authority Partner Representative

4.3 If a member is unable to attend a SOAC meeting, they will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered, to represent their organisation.

4.4 Additional attendees may include (dependent on agenda items):

- Executive Director of System Recovery
- Executive Medical Director, MSE ICB
- Executive Chief Digital Information Officer, MSE ICB
- Senior Responsible Officers (SROs) for identified areas such as workforce, quality, finance, and performance
- SROs and programme leads for transformation programmes
- Director of Communications and Engagement, MSE ICB

4.5 Membership of the NOF4 Part II meeting include:

- Lead Recovery Support Programme (RSP) Director, NHSE (Co-Chair for the RSP/NOF4 part of the meeting)
- ICB Chief Executive
- Lead Director, NHSE
- Senior Workforce Lead, NHSE
- Chief Executive, Mid and South Essex NHS Foundation Trust (MSEFT)

- Chief Executive, Essex Partnership University NHS Foundation Trust (EPUT)
- Executive Chief Finance Officer, MSE ICB
- Executive Chief Finance Officer, MSEFT

4.6 Additional attendees for the NOF4 Part II meeting may include by invitation:

- Executive Director of System Recovery
- Executive Chief Finance Officer, EPUT
- Executive Chief Nurse, MSE ICB
- Executive Director of Strategy and Corporate Services, MSE ICB
- Executive Chief People Officers, MSE ICB, MSEFT, EPUT

Chair and vice chair

4.7 The Chair of the ICB will appoint a Member of the Board, with the relevant skills and experience, to co-chair the Committee alongside the representative from NHS England. With the Lead RSP Director from NHSE Chairing the NOF4 Part II meeting.

4.8 In the absence of both Co-Chairs, the remaining members present shall elect one of their number to Chair the meeting.

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

5 Meeting Quoracy and Decisions

5.1 The SOAC does not have formal delegated functions from the ICB Board other than in relation to its function as an oversight committee as outlined in section 6 below and has no authority for the approval of financial commitment. The Committee will operate based on joint accountability and consensus and through the delegation to individual members.

5.2 The full SOAC meeting will normally occur bi-monthly, with a minimum of six meetings held per financial year. However, *NOF4* and *undertakings* discussions initially be established monthly, with frequency to be adjusted on the recommendation of the NOF4 Chair from NHS England. Arrangements and notice for calling meetings are set out in the Standing Orders.

5.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of five working days' notice will be given when calling an extraordinary meeting.

5.4 In accordance with the Standing Orders, the committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.5 For a meeting to be quorate a minimum of 6 Members of the Committee are required, including:

- At least one Co-Chair/nominated Chair

- 2 x ICB Executives
- Representation from both Provider Executives (MSEFT and EPUT)
- NHSE representative

5.6 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.7 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision Making and Voting

5.8 Where a recommendation or decision is made this will be through consensus. When this is not possible the Chair may call a vote. Under exceptional circumstances any substantive difference of views among members will be reported to the Integrated Care Board.

5.9 Only members of the Committee or their nominated deputy may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.10 Where there is a split vote, with no clear majority, the Chair will hold the casting vote.

5.11 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis using telephone, email, or other electronic communication.

Urgent Decisions

5.12 If an urgent decision is required, every attempt will be made for the Committee to meet virtually, via video conference facilities. Where this is not possible decisions should be achieved through email to all members of the committee to capture a transparent audit trail.

5.13 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead ICB Executive director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.14 The exercise of such powers shall be reported to the next formal meeting of the Committee for ratification.

6 Responsibilities of the Committee

6.1 To ensure that appropriate escalations are received and where appropriate acted upon to address the realisation of risks or performance issues affecting the system (i.e., issues that affect more than one organisation within the partnership). Appropriate escalations are defined as matters referred to SOAC by sub-committees of the ICB Board where risks or issues are not being addressed sufficiently or in a timely manner. Matters relating to individual partner organisations will be escalated through sovereign organization governance. Matters relating to system working across the partnership will be escalated through appropriate system forum governance or ICB sub-committees as appropriate.

Only once other governance routes have been exhausted and SOAC escalation deemed appropriate, will it be addressed by the Committee.

6.2 To ensure that the system partners are working together to deliver required standards of overall performance and where this is not the case, govern how issues are resolved or escalated accordingly.

6.3 Be the forum under which preparations are made for NHS England quarterly and annual assurance review meetings, and where accountability sits for delivery of actions arising from those meetings.

6.4 To decide on issues that need to form part of the workplan of SOAC for a period of time where traction and progress is stalled and is posing an increased risk to the system in delivering its statutory responsibilities and functions.

6.5 To receive requests from assurance committees to take enhanced oversight for delivery, where cross-provider/cross-system risks are identified and are unable to be managed within the sovereign organisations' governance arrangements, or where the committees are not assured of the mitigations of said risks.

6.6 To bring together the triangulation of activity, finance, quality, and workforce data where issues exceed the remit of individual committees.

6.7 To provide feedback to the ICB Board and where appropriate the Chief Executive's Forum.

6.8 To have oversight that the partners in the system are supporting the delivery of the Joint Forward Plan.

6.9 To maintain oversight of progress towards the delivery of the agreed MSEFT NOF4 exit criteria.

6.10 To maintain oversight of progress towards delivering the undertakings requirements placed on MSEFT.

7 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8 Accountability and Reporting

8.1 The committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.3 The Chair of the committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary, and submitted to the Board in accordance with the Standing Orders.

8.5 The SOAC will formally report and provide assurance, through the Chair, to the Integrated Care Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board of require action. It will make recommendations, where appropriate to the ICB Board, the Chief Executive Forum (Health) and partner organisations as required.

9 Secretariat and Administration

9.1 The secretariat function for the SOAC will be provided by the ICB. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair. They will ensure:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary.

- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10 Review

10.1 These terms of reference and the membership of the SOAC will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the ICS. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

10.2 The Committee will review its effectiveness at least annually.

Date of approval by ICB Board: XX XXX 2024

Date for review: July 2025

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 14,3

Revised Policies

Summary Report

1. Purpose of Report

To update the Board on policies that have been revised and approved by sub-committees of the Board.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

Kathy Bonney, Interim Chief People Officer.

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Remuneration Committee and Quality Committee

5. Link to the ICB's Strategic Objectives:

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

The Board is asked to note the revised policies set out in this report.

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on revised policies which have been approved by the relevant committees since the last Board meeting.

2. Revised Policies

The following policies have been revised and approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Remuneration Committee 5 June 2024.	The committee approved amendments to the following policies: • 035 Job Matching and Evaluation Policy • 036 Disclosure and Barring Policy • 037 Nurse Revalidation Policy • 038 Professional Registration Policy • 040 Stress Management Policy • 047 Annual Leave Policy The committee also extended the review dates of the following policies until 31 August 2024: • Probation Policy (039) • Parental Leave Policy (050) • Fostering Policy (052) • Learning and Development Policy (053) • Close Personal Relationships at Work Policy (060) • Domestic Violence and Abuse Policy (061)
Quality Committee 28 June 2024.	The committee approved amendments to the following policy: • 072 Quality Assurance Policy The committee also extended the review dates of the following policies: • 032 Equality and Health Inequalities Impact Assessment Policy – extended to 31 October 2024. • 068 All Age Continuing Care Policy - extended until 31 August 2024.

Committee / date of approval	Policy Ref No and Name
	• 063 Safeguarding Adults and Children Policy - extended until 31 October 2024. • 065 Management of Allegations Against Staff, Volunteers and People in Positions of Trust who work with adults and children Policy – extended until 31 October 2024. • 070 Management of Perplexing Presentations and Fabricated or Induced Illness in Children Policy- extended until 31 October 2024. • 073 Mental Capacity Act 2005 and Deprivation of Liberty Policy – extended until 31 October 2024.

3. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The above policies will be published on the ICB's website.

4. Recommendation

The Board is asked to note the revised policies set out in this report.

Part I ICB Board meeting, 11 July 2024

Agenda Number: 14.4

Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee (AC): 16 April 2024 and 22 April 2024.
- Clinical and Multi-professional Congress (CliMPC): 24 April 2024
- Finance and Investment Committee (FIC): 1 May 2024 and 4 June 2024.
- Primary Care Commissioning Committee (PCCC): 10 April and 7 May 2024.
- Quality Committee (QC): 26 April 2024.

2. Chair of each Committee

- George Wood, Chair of AC.
- Dr Matt Sweeting, Chair of CliMPC.
- Joe Fielder, Chair of FIC.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Neha Issar-Brown, Chair of QC.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

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 presented to the Board to provide assurance and feedback on the functions and decisions delivered on its 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.

Audit Committee, 16 April 2024

The committee considered reports on the following:

- Board Assurance Framework and Corporate Risk Register.
- Mandatory Training compliance.
- Information Governance Quarterly report.
- Emergency Preparedness Resilience and Response.
- Health & Safety.
- Contract Governance and Procurement Register.
- Waivers.
- The process for undertaking reviews of ICB committee effectiveness 2023/24.
- Internal Audit update, including the Head of Internal Audit Opinion which gave 'reasonable assurance' for 2023/24 and the Counter Fraud annual report.
- External audit update on progress with end of year work which was on track for completion by the end of May 2024.
- Minutes of the ICB's other main committees.

The committee also approved the following:

- The latest iteration of the draft ICB Annual Report 2023/24.
- Revised Policies: Media Policy; Social Media Policy; Conflicts of Interest Policy; Standards of Conduct Policy; Health & Safety Policy; and Lone Working Policy. The committee also agreed to extend the review date of the Legal Services Policy to 30 September 2023.

Extraordinary Audit Committee, 22 April 2024

The committee received and approved for submission, the following reports:

- Update on the draft ICB Annual Report 2023/24 which had been amended since the previous meeting following feedback from the Chief Executive and Executive Committee.
- Draft annual accounts 2023/24.

Clinical and Multi-Professional Congress, 24 April 2024

The committee received the following reports:

- Update on the process for undertaking the review of committee effectiveness 2023/24.
- Annual review of committee terms of reference and committee workplan for 2024/25.
- Horizon scanning – a discussion was held on several recent developments and the potential impact of these.

Finance & Investment Committee, 1 May 2024

The Committee considered reports on the following:

- Portfolio of Social Care Discharge Schemes.
- Month 11 Finance Report and a verbal update on the Month 12 position.
- Capital update.
- Review of committee effectiveness, committee terms of reference and workplan for 2024/25.
- 2024/25 Planning.
- Triple Lock ratification process, which was under review with the regional NHS England team.
- Minutes of the System Finance Leaders Group meeting held on 4 March 2024 and System Investment Group meeting held on 19 February 2024.

The Committee took the following decisions:

- Ratification of ICB Financial budgets.
- Approved the 2 May 2024 Planning Submission, subject to there being no substantial changes.

Finance & Investment Committee, 4 June 2024

The Committee considered reports on the following:

- Progress on implementing the Mid and South Essex Infrastructure Strategy to ensure that the estate was being used effectively to support improved patient pathways.
- System Financial Recovery.
- An update regarding Month 2 finance reporting arrangements.
- The outcome of the review of FIC's effectiveness 2023/24 which included a recommendation that the committee should revise its scope to consider performance reporting in future (to be known as the Finance & Performance Committee). The committee approved the revised Terms of Reference (submitted to the ICB Board Part I meeting on 11 July 2024 for approval) and its workplan for 2024/25.
- Specialised commissioning opening allocations, which confirmed the ICB had received £6.4 million less than anticipated.
- The committee were advised that there had been a reduction of £5.4 million in the system's capital allocation for 2024/25 and that a more detailed update on this issue would be provided at the July meeting.

Primary Care Commissioning Committee, 10 April 2024

The committee receive reports on:

- Primary Medical Services Contracts.

- General Practice Estates – Rent and Rates Review Function, detailing the position regarding GPs operating from leased buildings and some key associated risks and issues.
- Medicines Optimisation Local Enhances Services scheme for 2024/25 which would support delivery of the medicines optimisation and prescribing efficiencies.
- Estates prioritisation.
- Delegated Primary Care Functions – the annual self-declaration of the ICB's compliance with a range of assurance requirements across delegated primary care functions, which was supported by the committee.
- An update on the development of the primary care performance report.
- Risks within the remit of the committee.
- An update on the arrangements to review the effectiveness of the committee during 2023/24.
- The minutes of the Dental Commissioning and Transformation Group meetings held on 14 February 2024 and 13 March 2024.

Primary Care Commissioning Committee, 7 May 2024

The committee receive reports on:

- Alternative Provider Medical Services future provision.
- The Phase One business case to commission a new Women's Health Hub for each Primary Care Network.
- The proposed process to be followed when considering 'branch' surgery closure applications from practices.
- The Babies Children and Young People Asthma Transformation Programme.
- An overview of progress in establishing Integrated Neighbourhood Teams within Mid Essex Alliance.
- An update on the Burnham Surgery estate.
- Progress with the review of the committee's effectiveness 2023/24.
- A discussion occurred on the refresh of the Primary Care Strategy and how best to progress this.
- Details of the decisions taken by the Pharmaceutical Services Regulation Committee (PSCR) during Q4 2023/24.

The committee made the following decisions:

- Approved the development of two locally enhanced services for the provision of ring pessaries and Long-Acting Reversible Contraceptives (LARC), subject to triple lock approval.

Quality Committee, 26 April 2024

The committee received reports / presentations on the following:

- Lived experience story / deep dive into catheter care.
- Work undertaken by the Safety Quality Group.
- Emerging safety concerns, including an update on Regulation 9A which gave rights to visitors to visit their relative in hospitals, care homes and hospices; and Working Together (2023) guidance in relation to safeguarding children.
- EPUT Mental Health update.
- Local Maternity and Neonatal Safety Board Update.
- Safeguarding Quarterly Report – Adults.

- Medicines Management.
- Palliative and End of Life Care / Hospices.
- Greater Manchester Oliver Shanley Review – the committee were provided with an overview of the findings of the report.
- Patient Safety and Quality risks.
- Patient Safety Update which showed progress made with each of the eight priorities of the Patient Safety Framework.
- Arrangements for the review of the committee's effectiveness 2023/24 and workplan for 2024/25.

The committee also approved:

- Terms of Reference of the Patient Safety Collaborative Group and the Patient Safety Incident Response Framework Peer Review Group

3. Recommendation

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

Minutes of the Audit Committee Meeting

Held on 16 April 2024 at 1.00pm

Via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

Other attendees

- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Senior Financial Control Manager, MSE ICB.
- Jane King (JKi), Corporate Services and Governance Support Manager (minute taker), MSE ICB.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB (for Item 4).
- Rachel Stinson (RS), HR Manager, MSE ICB (for Item 7).
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB (for Items 9 & 10).
- Barry Frostick (BF), Chief Digital & Information Officer, MSE ICB (for Item 10).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (for Items 11 and 14).
- Emma Larcombe (EL), Director, KPMG LLP.
- Nathan Ackroyd (NAc), Senior Manager, KPMG LLP.
- Michael Townsend (MT), Managing Director, Barts Assurance (representing WMAS).
- Zoe Picken (ZP), Head of Internal Audit, WMAS.
- Clarence Mpofu (CM), Director – Healthcare Sector, TIAA.
- Melanie Alflatt (MA), Director – Operations, TIAA.
- Jonathan Gladwin (JG), Director of Anti-Crime Services, TIAA.
- Hannah Wenlock (HW), Senior Anti-Crime Specialist, TIAA.

Apologies

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Eleni Gill (EG), Lead Counter Fraud Manager, WMAS.

1. Welcome and Apologies

GW welcomed everyone to the meeting and extended a warm welcome to the incoming auditors. Apologies were noted, as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the last meeting of the ICB Audit Committee on 16 February 2024 were received.

Outcome: The minutes of the meeting held on 16 February 2024 were approved as an accurate record.

The action log was reviewed, it was noted all actions were complete except for action ref 44 Wethersfield Register.

Under Matters Arising, the Committee noted that virtual decisions were taken in between meetings on the delegation of Specialised Commissioning and the Information Governance Framework and Policy and ratified the decisions.

Outcome: The decisions relation to the delegation of Specialised Commissioning and the Information Governance Framework and Policy were ratified.

4. Board Assurance Framework & Corporate Risk Register

SOC presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 21 March 2024. The updated BAF would also be submitted to the next Part I ICB Board meeting on 9 May 2024. There were 8 ICB red rated risks outlined in the BAF.

The format/content of the BAF would be reviewed following implementation of RLDatix DCiQ (a database to manage risks) and as part of an ongoing review of the ICB's risk management arrangements.

A copy of the Corporate Risk Register was also presented to the Committee, which detailed fifty-one risks. At the time of writing, updates for nine risks remained outstanding.

SOC advised that two risks had been closed since the last committee meeting relating to the ICB organisational change (Ref PO2) and capital resource to cover leases for the new Integrated Medical Centres (SREST02). There was one new risk added in relation to the capacity of the Complaints Team.

SOC advised that an ICB Board Seminar session was held on 11 April 2024 to review the ICB's risk appetite.

GW enquired whether there were any themes arising from the complaints received. NA advised that the reporting route for complaints was via the Quality Committee but would check whether any were non-quality complaints received.

ACTION: NA to check whether non-quality complaints received were reported to the Quality Committee.

Outcome: The Committee NOTED the Board Assurance Framework and Corporate Risk Register update.

5. Draft Annual Report

NA explained that following the two iterations of the draft Annual Report circulated to the Audit Committee for review, the draft Annual Report had also been considered by the Executive Team and CEO. Following their review, substantial changes were suggested to restructure the report, therefore it was agreed not to review the version circulated to the Committee. NA invited members to feedback any comments they may have on specific sections outside of meeting.

A further iteration of the draft Annual Report would be circulated to the Committee on 22 April 2024 which incorporated the changes suggested by the Executive Team with comments to be provided back to NA by COB Tuesday. The draft Annual Report must be submitted to NHS England and the external auditors by 25 April 2024.

Outcome: The Committee NOTED draft Annual Report update.

6. Policy Approval

NA presented the policies below for Audit Committee approval. The policies had been revised to reflect changes to job titles, roles, and responsibilities as a result of the recent ICB organisational change process and any changes to legislation or guidance.

- Media Policy

The Committee noted that the Media Policy had been strengthened to uphold privacy rights of ICB staff members and advise that a media training video resource was available on the intranet.

GW enquired how the ICB would co-ordinate with EPUT around patient safety incidents. NA confirmed that patient safety was managed under Quality Committee and a new Patient Safety Incident Response Framework (PSIRF) used for reporting incidents. Any media requests would be dealt with by the Communications team, as set out in the ICB's Communications Strategy.

- Social Media Policy

The Social Media Policy included updated guidance on staff use of social media internal guidance for monitoring social comments.

- Conflicts of interest

The updated Conflicts of Interest policy reflected the new mandatory conflicts of interest training requirements for all ICB staff.

- Standards of Business Conduct Policy

Minor changes were made to the Standards of Business Conduct Policy,

HW commented that she was happy to approve the policy, subject to providing feedback to SOC following the meeting on fraud and bribery.

- Legal Services Policy

The paper requested for the review date of the Legal Services policy to be extended to 30 September 2024 because of a potential review of legal services provision across mid and south Essex NHS organisations, and the implementation of the RLDatix DCiQ legal services module within MSE ICB.

The Committee noted that two additional health and safety policies (Lone Worker Policy and Health and Safety Policy) would be presented under Item 10, Health & Safety Report.

Outcome: The Committee APPROVED:

- 001 Media Policy
- 002 Social Media Policy
- 018 Conflicts of Interest Policy
- 019 Standards of Business Conduct Policy
- The extension of the review date of the Legal Services Policy (Ref 022) to 30 September 2024.

7. Training Compliance

RS presented the latest training report which provided a summary of mandatory training compliance as at year end 31 March 2024. The Human Resources team had continued to update course requirements in the Electronic Staff Record (ESR) to ensure staff's competency requirements were reflected accurately on their ESR portal. However, there was still some work to be undertaken following the recent restructure.

Work was completed to ensure secondees, contractors and agency temporary workers had been added to ESR to enable them to complete their training via this route.

Information had been shared via Connect to remind staff and managers to ensure their mandatory training was up to date, further communications would be sent out over the next few months to try and increase the compliance rates.

HR were also considering providing Business Managers with proxy access to ESR which would enable them to pull training reports on behalf of their director to enable them to manage compliance rates at a local level.

MH was concerned that the clinical staffing percentage was low for Safeguarding Level 2 training and queried whether this was because few staff fell into this category. RS advised that the Human Resources team were undertaking a data quality exercise and were collaborating with the Safeguarding team to ensure correct staff were included on the Level 2 training module. RS was aware from the Safeguarding Board that some safeguarding training had taken place and was awaiting data. RS recognised that more needed to be done to increase compliance levels for Safeguarding Adults Level 2 training.

GW said it was unacceptable for staff to not be adequately trained and asked for some wording to be provided to the CEO to raise at the staff briefing the following day. Concerns around Safeguarding training compliance should also be raised with the Executive Committee.

GO hoped that that risk management training compliance would increase following the recent risk discussions. NA advised that additional risk management training would be provided as the new DatixIQ risk management module was rolled out. Also, once the annual appraisal process was complete should see an increase in compliance.

ACTION: Communications to be raised at the all staff briefing regarding mandatory training compliance.

Outcome: The Committee NOTED the training compliance update.

8. Information Governance Quarterly Report

IGe provided the committee with an overview of the work undertaken towards the Data Security Protection Toolkit (DSPT) submission, the associated DSPT audit, and wider IG related work across the ICB and ICS. The Committee noted that action plans were in place to address the three remaining recommendations arising from last year's DSPT audit which also form part of this year's mandatory DSPT audit.

In 2023/24 there had been a significant increase in Freedom of Information (FOI) requests. Additionally, there had also been a number of challenges to FOI responses provided, however this had not resulted in an increase of requests being raised with the Information Commissioner's Office which remained the same as previous year at 1. In 2023/24 the FOI response time was breached on four occasions which equated to an overall rate of 0.78%. The Committee was supportive of the new FOI process outlined which would make better use of Information Asset Owners (IAOs), digital tools and improvements to the ICB's FOI publication scheme.

The committee noted that the Medical Director had been appointed as an additional Deputy Caldicott Guardian, and Chief Digital Information Officer has been appointed as an additional Deputy Senior Information Risk Owner (SIRO).

Following a question from GW, IGe advised there had been a lot of requests in relation to the Community Beds consultation and that a large number of mental health queries had been received from one individual, who was now being treated as vexatious.

GO enquired whether there was a link between the increased rise in complaints and increased volume of FOI requests. IGe said he would link in with the complaints manager and include data in the next report.

ACTION: IGe to work with the complaints manager to identify whether there was a link between the increased rise in complaints and increased volume of FOI requests.

Outcome: The Committee NOTED the Information Governance update.

9. Emergency Preparedness Resilience & Response

JC presented the update on Emergency Preparedness Resilience & Response (EPRR) and the System Co-ordination Centre (SCC).

As a Category 1 responder, the ICB must demonstrate it can deal with a wide range of incidents and emergencies that could affect health or patient care whilst maintaining services through its compliance with the NHS Core Standards for EPRR and be ready to coordinate the local NHS response to an incident. The Committee noted the ICB was in a strong position to maintain 'substantial' compliance for the coming year and that partnership working was taking place across the system to build strengthen compliance with EPRR standards.

GW enquired what the contingency plan was to relocate patients should there be a fire at a hospital. JC explained that the ICB control and command operation would be stood up which would trigger a regional response. Providers were also required to have their own plans for emergency situations. JC gave assurance that the EPRR plans in place were tested regularly.

Outcome: The Committee NOTED the EPRR update.

10. Health & Safety update

BF presented the Health and Safety (H&S) report to the Audit Committee following the establishment of the Health & Safety Working Group (HSWG) in early 2024. The HSWG's initial focus was on the revision of existing policies and on progressing risk assessment items with the responsible directorates across the organisation.

The following policies had been updated:

- Health & Safety Policy

The H&S Policy was a legal requirement under the H&S at Work Act (1974) and set out the ICB's general approach to health and safety detailing the Statement of Intent, responsibilities, and arrangements for H&S. Minor amendments were made to the policy following the ICB restructure and establishment of the HWSG.

- Lone Working Policy

The Lone Working Policy was updated with minor amendments to provide clarity regarding guidance for on-call staff responding to an incident.

GW enquired how lone worker staff were supported with appropriate training and what methods of communication were provided to lone workers. BF explained the Lone Working Policy was a comprehensive guidance document containing all the tools to support lone workers, including risk-assessments and checklists, and was accessible to staff online. As well as guidance for staff visiting people outside of the workplace, there was guidance on lone working in office premises. Staff would be made aware of the updated policy at the staff briefing. Lone working will be a standing agenda item for the HSWG to monitor any new issues and incidents.

GW enquired whether details of aggressive or violent patients could be built into shared care records. BF said a tool to manage this information was being considered for a future update and would require appropriate staff training on where to look and where to record this information on the system.

JG asked whether the Violence Prevention & Reduction Standards (VPRS) framework was used at the ICB. NA advised there was a Violence and Reduction policy in place but would discuss further with JG for the new internal auditors to pick up.

NA added that Health and Safety came under the remit of the Audit Committee, therefore the HSWG would be a sub-group of the Audit Committee.

BF stressed the importance of creating a positive health and safety culture within the ICB.

Outcome: The Committee APPROVED:

- Lone Worker Policy
- Health and Safety Policy

11. Contract Governance & Procurement Register

JJ presented the Register of Procurement Decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. It was highlighted that the Register contained six, not sixteen contract decisions, as indicated in the cover paper. Attain, the ICB's procurement specialists, would be taking over the responsibility of maintaining and producing the Register of Procurement Decisions from 1 April 2024. The ICB's Register of Grants and Other Arrangements was also shared with the Committee.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

GO asked for clarification on what decisions need to be published on the Register. JJ confirmed contract awards over £25k needed to be published.

Outcome: The Committee NOTED the Contract Governance update.

12. Waiver Report

JJ presented the Waiver Report. There were forty-six new waivers authorised during the period 16 December 2023 to 31 March 2024, totalling £31,154,849.

In response to GW, JJ confirmed that the waivers for ultrasound services detailed in the Waiver Summary were for independent providers and it expected that these would reduce as the Community Diagnostic centres progressed. JJ further explained the new routes to selecting providers was outlined in Provider Selection Regime guidance, however contracts could still be awarded directly under certain circumstances, but the ICB must be clear on why a direct award decision was taken.

Outcome: The Committee NOTED the Waiver Report.

13. Losses and Special Payments

There were no losses or special payments to report.

Outcome: The Committee NOTED there were no Losses and Special Payments.

14. Committee Effectiveness

NA outlined the Committee Effectiveness review process, explaining that each formal sub-committee of the ICB Board was required to undertake an annual review of its effectiveness to assess how the Committee had performed over the last year in accordance with the objectives set within its terms of reference and how effective it had been in discharging those responsibilities.

The committee effectiveness review would be conducted in three parts, an initial desktop assessment, undertaken by the Committee administrator, a committee members/attendees survey followed by an overall committee review which would be shared with the committee for comment. The findings of the review would help inform any changes required to the Committee terms of reference and workplan for 2024/25.

The findings of the reviews of effectiveness for all sub-committees of the Board would be collated and a summary document presented to the Audit Committee and recommended to Board.

Outcome: The Committee NOTED the Committee Effectiveness update.

15. Internal Audit

MT presented the final Internal Audit update from West Midlands Ambulance Service (WMAS), the outgoing internal auditors. MT confirmed the draft report was finalised and there were no changes to report. The Committee noted all finalised audit reports provided positive 'Reasonable' or 'Substantial' opinions. Any recommendations that had been made had been accepted by management and many had been completed. There was a total of fifteen recommendations to hand over to the new incoming internal auditors which were included in the report.

Head of Internal Audit Opinion

The 2023/24 Annual Head of Internal Audit Opinion (HoIAO) for the ICB gave 'Reasonable' assurance.

GW appreciated the excellent work undertaken by WMAS and expressed his thanks to the team. NA and GO echoed GW comments.

GW welcomed the incoming auditors, TIAA, and invited CM to present the combined Strategic and Annual Plans for Internal Audit, Counter Fraud and Security Management services.

CM thanked WMAS for the comprehensive handover to TIAA and advised that the outstanding recommendations would be uploaded to TIAA's online portal. The draft Combined Strategic and Annual plan for 2024/24 was linked to the ICB's key strategic risks and incorporated comments received from the ICB Executive team. The plan was flexible to be able to respond to any emerging risks and reflected audit standards.

MT queried whether the timing of the Fit and Proper Persons Test person test audit could be pushed to year 3 given this audit had been undertaken Q4 2023/24.

Counter Fraud Annual Report

ZP advised there were no issues to highlight in the final Counter Fraud Annual Report and advised that the Counter Fraud Functional Standard return would be handed over to TIAA to submit in May.

GW extended his thanks to EG for her hard work and support.

Outcome: The Audit Committee NOTED the Internal Audit and Counter Fraud updates.

16. External Audit

EL explained the external audit work was on track to be completed by the end of May 2024.

In relation to the Mental Health Investment Standard audit, KPMG had concluded that there would not be sufficient evidence to confirm mental health expenditure and had struggled to obtain necessary information, which had resulted from the closure of the predecessor Clinical Commissioning Groups and establishment of the ICB, and furthermore that organisational memory had been lost during the ICB's organisational restructure. To mitigate this, a technical disclaimer would be required. GW enquired whether this situation was unique to MSE ICB. EL had not previously encountered the issue but there could be other ICB's in the same position. If an adjustment to the statement was required, EL would work with JKe on this.

EL summarised the Final Audit Plan, changes to materiality and the accruals position, noting that the Value for Money audit would focus on financial sustainability.

GW enquired whether the work on the Remuneration Report was on track and whether any issues had been identified. DM confirmed work was on track and no issues identified.

GW stressed the need to resolve the issues with the Mental Health Investment Standard evidence.

Outcome: The Committee NOTED the external audit update.

17. Minutes of other ICB Committees

The following minutes were presented to the Committee

- Finance & Investment Committee - 20 Dec 23, 11 Jan 24, 23 Jan 24
- Quality Committee - 15 Dec 23
- Primary Care Commissioning Committee - 6 Dec 23, 10 Jan 24
- Clinical & Multi Professional Congress - 31 Aug 23, 29 Nov 23, 31 Jan 24
- System Oversight & Assurance Committee - 8 Nov 23, 13 Dec 23, 10 Jan 24

Outcome: The Committee NOTED the minutes of other ICB Committees.

18. Any Other Business

There was no other business.

19. Items to Escalate

The low training compliance figures would be escalated to the Executive Committee.

20. Any other Business

No matters of any other business were raised.

21. Date of Next Meeting

GW asked for the August meeting to be brought forward to July to avoid holiday season.

Minutes of the Audit Committee Meeting

Held on 22 April 2023 at 1.00pm

via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.

Other attendees

- Joe Fielder (JF), ICB Finance & Investment Committee Chair, MSE ICB.
- Mark Bailham (MB), Associate Non-Executive Member & ICB Finance & Investment Committee Member, MSE ICB.
- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Senior Financial Control Manager, MSE ICB.

Apologies

- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

1. Welcome and Apologies

GW welcomed everyone to the meeting and explained that the focus of the meeting was to review the draft ICB annual accounts and receive an update on the draft ICB annual report, hence the auditors were not required to attend.

Apologies were noted as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Draft ICB Annual Report 2023/24

Following feedback received from the Chief Executive Officer and Executive Committee on the initial iteration of the annual report, significant changes had been made to the document. NA advised that a further iteration of the draft annual report would be sent to the Audit Committee following the Extraordinary meeting and Audit Committee members were asked to provide their comments to NA by 3.00pm the following day. The deadline to submit the draft annual report to NHS England was 9.00am Wednesday 24 April 2024.

Outcome: The Committee NOTED the draft annual report update and agreed to provide any high level comments to NA by the deadline requested.

4. Draft ICB Annual Accounts 2023/24

JKe clarified that it was the Executive Chief Finance Officer's responsibility to approve the draft annual accounts for submission to NHS England (NHSE) The draft accounts were presented to the Audit Committee for review only.

NB advised that the ICB was on track to submit draft annual accounts by NHSE's deadline.

DM highlighted that last year's accounts were for a 9 month period, this year's accounts were for the full 12 month period and that the income for 2023/24 had increased from the previous year, primarily due to the Pharmacy, Optometry and Dentistry (POD) related income streams. Additional income was also due to how Better Care Funds were distributed.

MB suggested it would be useful for the reader to include a headline statement to explain the 9 month vs 12 months comparison and the material changes from the previous year, e.g. POD.

JKe agreed with MB's comment and confirmed that explanations would be included in the notes that accompanied the annual accounts.

In response to GW's query regarding the underspend in Dentistry, JKe advised that dental funding was an allocation. NB added that the dental underspend related to Units of Dental Activity (UDAs) against the allocation.

GO noted that income was received the previous year for education, however no funding was received for 2023/24. DM explained that the ICB did not typically receive training funds (which was usually allocated directly to the Trust), however the funding received for 2022/23 was a one-off funding grant received from Health Education England.

DM explained it was key to note, for the Statement of Financial Position, that overall liabilities creditors had reduced, therefore there was a reduced audit risk. JKe added that provisions had not been increased, but a previous CHC provision had been released. KPMG were aware of the rationale for this and it was discussed previously at the Audit Committee.

DM advised that he was required to confirm the ICB would not be making changes to accounting policies.

GW had expected the average number of people employed by the ICB to be lower given the recent organisational restructure and subsequent reduction in staff. DM explained that a large number of staff left the organisation at the end of 2023/24, therefore he would expect to see next year's staff number to drop significantly. JKe asked DM to provide the current average staff number at the next meeting to approve the final accounts.

ACTION: DM to provide average staff number at the next meeting to approve the final accounts.

It was noted that the formatting of the notes would be reviewed before submission to NHSE to ensure all notes were visible.

In response to MB's query on whether all references included in the related parties' section were relevant, JKe advised she would take a steer from KPMG on the appropriate levels of disclosure.

ACTION: DM will take steer from KPMG on appropriate level of disclosure for related parties.

GW enquired whether Partner Members were aware their remuneration details were included in the Remuneration Report. JKi confirmed that consent to disclose details of remuneration had been sought from all ICB Board Members.

NA enquired whether the provisional date for the Extraordinary Audit Committee on 13 June 2024 was in line with KPMG's timescales. NB advised she was waiting for KPMG to confirm if the date worked and would confirm once notified by KPMG.

ACTION: Meeting invitation to be sent for the Extraordinary Audit Committee on 13 June once confirmation received from KPMG.

Outcome: The Committee NOTED the draft ICB Annual Accounts.

10.37am Meeting Close

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 24 April 2024 at 09.30 am – 10.30 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Olugbenga Odutola (OO), Primary Care.
- Gerdalize Du Toit (GDT), Community Care.
- Babafemi Salako (BS), Primary Care
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Krishna Ramkhelawon (KR), Public Health.
- Feena Sebastian (FS), Mental Health.
- Rachael Marchant (RM), Primary Care
- Sarah Zaidi (SZ), Primary Care.
- Gavin Tucker (GT), Senior Clinical Fellow. MSE ICB.
- Donald McGeachy (DM), Urgent and Emergency Care.

Attendees

- Helen Chasney, Corporate Services & Governance Support Officer, MSE ICB (Minutes).

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Christopher Westall (CW), Acute Care.
- Fatemah Leedham (FL), Pharmacy.

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. It was confirmed that the meeting was quorate.

2. Declarations of Interest

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

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

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress meeting held on 28 February 2024 were approved.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 28 February 2024 were approved.

4. Matters Arising

This item has been minuted confidentially.

5. Review of Committee Effectiveness & Reporting Schedule

HM advised that the desktop review had been undertaken to ensure that the committee operated in line with governance processes, ensuring adherence to the committee Terms of Reference (ToR). The main changes within the ToR related to reducing the quoracy from eight to six and changing the frequency of meetings from monthly to bi-monthly and would be covered under Item 6.

HC advised that following approval of the desktop review, a survey would be sent to all Congress members with ten questions relevant to the effectiveness of the committee. On receipt of the responses, a report would be drafted and shared with Audit Committee and the Board.

GDT commented that in light of the recovery plan, Congress might be required to make more decisions, so would changing the frequency or length of meetings work.

SZ asked how the current situation and the possible requirement for Congress to review more items, applying a recovery lens to it, be drawn together with other check and challenge groups, such as stewardship. MS advised that PS was keen to design a programme that stewardship supported the recovery programme, but Congress would still need to take a general view of that as one of the opinions.

MS asked Congress if the meeting frequency should be changed to bi-monthly but increase the length of the meeting.

Due to the discussion held on the meeting frequency which was dependent on the work of Congress, it was agreed that Item 7 would be presented next.

6. Review of Committee Terms of Reference

HM advised that discussions had already been held on the amendments on the ToR under Item 7. There were some further changes to wording. Congress were asked to comment on the following items:

- Paragraph 5.1 – Meeting frequency to be changed back to monthly and make clear in the ToR that the meetings could be cancelled, if there were no business to transact.
- Paragraph 5.4 - Quorum to be reduced from eight to six.

RM explained that initially the quorum was ten which gave the correct breadth of experience as the group should be multi-disciplinary and multi-professional. If quorum was decreased to

6, there may need to be stipulation on who those members should be and the area that was represented.

KR suggested that quorum should remain as eight as the minimum.

SZ advised that membership should be reviewed following members resignation from the group, representatives have been lost from the acute trust. It may be beneficial to review the breadth of perspectives in terms of membership as balanced membership seemed an issue. Consideration could be given for Advanced Healthcare Practitioners to become members.

GDT commented that Congress had also lost the social care representative which was a crucial that the group required.

DM commented that the group was not multi-professional in the current set up and felt that the ToR were too wordy. RM suggested removing the decision-making items as was not the function of the group and would make the role of the group clearer as an advisory group.

SZ advised that there might be some qualified resident patient voices in stewardship groups.

KR advised that urgent decisions should remain to ensure that complex items were not deferred to the Chair. A community representative is key to the group for a voice in the third sector. MS commented that might be a challenge as the group makes difficult clinical decisions, but clearly the voice of the resident is also paramount. The group helps when difficult decisions are required, particularly when regional cabinet was involved and avoided duplication. KR suggested that it could be a public health member.

GDT advised recruiting a member from the Voluntary, Community, Faith and Social Enterprise sector organisations.

RM commented that some groups were overrepresented, so membership required review.

MS summarised the key outputs which were:

- Quorum to remain at eight.
- To remain a monthly meeting, and include in the ToR that the meetings could be cancelled, if there were no business to transact.
- To review membership and for AHP, nursing, Healthwatch and community representatives to be considered, working with stewardship for some cross over. The purpose of the group and members involvement required clarification to avoid duplication in the system.

Action: MS to review the Terms of Reference, with particular consideration to the group membership, the purpose of the group and members involvement.

7. Congress Workplan 2024-25

GT advised that the report provided a programme of incoming work for the next year that may require input from Congress. Congress members were asked to note the programme of works and consider how the work would be approached, alongside other groups, such as stewardship.

The ICBs expectation in the financial recovery programme would be that Congress was a supporting committee to system recovery and would not be one of the central decision making committees. The role of Congress would be as an advisory group to the wider process.

In terms of topics, there would be two main challenges in the context of financial recovery, the set of NICE technology appraisals (TAs) which would be published within the next year and a review of the ICBs service restriction policies (SRPs), and whether changes were required to the criteria or whether there were any clinical areas not currently covered.

In relation to the NICE Technology Appraisals (TAs) the following challenges were noted.

The current SRP for hair loss was written when there were no drugs available for alopecia and states that the ICB would not fund hair transplantation or other hair systems. Unlike other NICE guidance, ICBs are legally obliged to make funding available to patients who meet the criteria set out in the TAs within 90 days of publication date unless the Secretary of State states otherwise. The compatibility of the wording for that SRP would need to be reviewed now that a drug was legally mandated to be funded according to legislation.

Tirzepatide was a weight loss drug that proposed for use in primary care settings. The TA is yet to be published and NICE might decide to restrict use to specialist WMS , so could be potential implications on the systems approach.

A drug for treating macular oedema was already in use for wet age-related macular degeneration and NHSE are investigating whether the drug should be given earlier in the treatment pathway, which could lead to fewer injections overall. The ICB would need to consider how this drug fits in with the treatment pathways, given the availability of other biosimilar medicines, which might be better value.

New NICE guidance is due to be published for episodic and chronic migraines. NICE had raised an issue with the oral migraine drug approved a few months ago, that it was for acute migraine and there was no stopping rule in the guidance, so could present challenges if a significant number of several patients trying the drug. were prescribed the drug.

There would be a large population who would be eligible for the dementia drugs which NICE were currently appraising for treating mild cognitive impairment, and there could be a huge demand on diagnostics to identify the cohort that may benefit. The ICB would need to consider the service impact and implications.

The financial recovery group have identified that service pathway redesign was a key strand of savings opportunities, so congress may be asked to review those that currently exist or propose new ones for clinical areas where there isn't currently an SRP.

The area for discussion would be the quantity of work this required and how frequently the group should meet. Consideration would also be required for Congress' process in dealing with these programmes of work and how it would link with other groups, such as stewardship, who could offer advice, as these could be items that required a quick decision.

MS suggested the addition of the consultation business case for the service reconfiguration for Stroke and Intermediate Care and Community Services in Maldon, where over 5,000 responses were being reviewed, and would need to return to Congress for the recommendations to be ratified and a review of the financial costings.

DM asked what the legal requirement was to implement TAs and what would be the ratification. The SRPs were brought together for the five CCGs for unity and if the systems started intervening, what would be the responses be from other systems in the country and would inequalities gradually be built. GT advised that NICE were being asked the same questions from other ICBs and with regards to the WMS, MSE ICB were the first ICB to have approached NICE requesting guidance. The legal requirement for TAs was to have the drug available in the formulary and part of your service pathways, and to keep the requirement if there was more than one drug. The only way to legitimately restrict would be to give to patients based on clinical priority. The approach that Congress had taken to weight management should form the approach to TAs more generally going forward. The SRPs need to be considered by Congress with the potential to introduce new inequalities if there were interventions. MS advised that Medical Directors were having conversations with regards to the regional and national response of ICBs to TAs. If the SRP changed there would need to be a consultation which would require a significant amount of work.

KR commented that if the system remained in triple lock, and if difficult decisions were required, conversations regarding health inequalities funding should be held. There could be a potential to create a postcode lottery if TAs must be applied, so how could resources be deployed differently, to enable Public Health to better support the system with making those decisions locally. MS suggested that the way synergy worked across the system and gaining an understanding of the different pots of money, particularly with triple lock, should be picked up offline.

RM reflected that the NICE TAs considered the cost, benefit and risks, so would put the system in a difficult position if they are not adopted. The cost would be outweighed by the benefit, which would be partly due to saving money in other areas. GT explained that NICE evaluated cost effectiveness which would be different from the ultimate cost. Alongside each guidance, a resource impact report would be included the recommendations made could impact other services. The vast majority of NICE guidelines increase costs in the long term, as there would be an increase in activity. It would be cost effectiveness in terms of patient benefit but an extreme level of NICE guidance were cash or capacity releasing. MS advised that the issue for the ICB would be the cash releasing ability of some projects versus the long term benefits of drugs.

MS reiterated DMs advice regarding the regional and national approach, as the system does not want to be seen as restrictive.

BS suggested holding these discussions with engagement from the public and the system could be open to challenge, which could result in judicial review. MS commented that financial recovery could mean restriction with budgets and that difficult choices would need to be made. SZ commented that assumptions that the NICE TAs analysis was 100% robust was not always correct as research has not evolved with the segmentation of population health management (PHM). Many cardiovascular disease networks had challenged against some NICE TA's. Work was ongoing in the Confederation, particularly in relation to the prevention agenda. The systems approach to analysis was outdated and no longer fit for purpose in many areas. GT advised that NICE were developing its approach to incorporating real world evidence from NHS partners into its guidance and had published a framework for groups to show best practice standards of collecting and analysing real world evidence, which should support the PHM segmentation.

RM advised that initially Congress had a fixed two-hour meeting, which was well attended. If meetings were fixed in the diary, it would promote agility if quick decisions were required. HC explained the arrangements for Remuneration Committee, where every other meeting was optional, so could be cancelled if there was no business to be transacted.

The Congress approved to keep the meetings as monthly, with every other meeting to be optional.

GT asked if there was any need to review when in the month the meeting was held. HC confirmed that the meeting was moved from Thursday to Wednesday to allow MS to attend.

Action: MS to meet with KR to discuss the working synergy across the system and to gain an understanding of the different pots of money, particularly with triple lock.

8. Horizon Scanning

MS provided an update on the system financial position and advised that MSEFT have gone into National Operating Framework (NOF) 4 because of financial deficit and would be given extra support from region and national colleagues. The system was not in complete NOF 4 however, would need to act like it was. Conversations were being held with EPUT and ICB to reduce services, taking into account the ongoing Inquiry at EPUT, and difficult decisions were being made on closing wards, freezing staff, including clinical staff and reviewing the back-office function etc. The MSE ICB were the most challenged in the region for financial turnaround. Therefore, the next two years would be focused on recovery, but should not lose the clinical voice, but also need to support the financial recovery of the system. A projected deficit needs to be delivered which would be acceptable to the national team.

9. Any other Business

There were no items of any other business raised.

10. Date of Next Meeting

Wednesday 29 May 2024 at 9.30am – 11.30am via MS Teams.

Minutes of the ICB Finance & Investment Committee Meeting

Held on 1 May 2024 at 1.30pm

Boardroom, ICB headquarters

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee MSE ICB, **Chair**
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB (Via MS Teams)
- Jennifer Kearton (JK) Chief Finance Officer, MSE ICB
- Loy Lobo (LL) EPUT Finance and Performance Committee Chair (Via MS Teams)
- Julie Parker (JP) Finance and Performance Committee Chair, MSEFT

Other attendees

- Jenny Davis (JD) (Via MS Teams) for agenda item 7 Capital update
- Vicki Decroo (VD) (Via MS Teams) for agenda item 5 Portfolio of Social Care Discharge Fund Schemes
- Ashley King (AK) (Via MS Teams)
- Neill Moloney (NM) Executive Director of System Recovery
- Karen Wesson (KW) Director Oversight and Assurance, MSE ICB
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB (Via MS Teams)
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

The Chair welcomed everyone to the meeting and confirmed the Committee quorate.
Apologies were received from Tracy Dowling (TD) Chief Executive Officer, MSE ICB

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.

The Chair had a technical amendment to his declaration of interest and would send to the Governance team when complete, which was not pertinent to any items on the agenda for the meeting. LL advised the Governance team of a new declaration and confirmed this did not have any impact on today's agenda items. The Register of Interests would be updated for the June meeting.

ACTION: Finance & Investment Committee register of interests to be updated for the June meeting.

3. Minutes of previous meetings

The minutes of 14 March 2024 were agreed as an accurate record.

Minutes of the Extraordinary meeting of 14 April 2024 were agreed as an accurate record subject to the following amendments:

- Title of the minutes to reflect it was an extraordinary meeting
- Sentence added to state the purpose of the meeting was to sign off the ICB budgets with only ICB members invited to attend.

Outcome: The minutes of the meeting on 14 March 2024 were approved. The minutes of the extraordinary meeting of 14 April 2024 were approved with the amendments above.

4. Action Log / Matters arising

JK referred to action 56 (consideration of future reporting to reflect the direct correlation between the progress of PIDs (Project Initiation Documents) through to implementation, and the subsequent impact on the 'run rate') and explained work was underway in the ICB, MSEFT and EPUT to understand the 'normalised' picture of what the run rate was for 2023/24. JK spoke of the challenge to overlay efficiencies due to PIDs within MSEFT not being profiled until they reach Gateway 3.

NM explained the rationale of profiling efficiencies over 12 months and spoke of the risk that sits within the plan. The Portfolio Board would articulate the delivered actions but there was a need to measure outputs. LL recommended the use of Smartsheet, a Project Initiation tool to aid grip, traction, and transparency.

There was an aspiration to report on the run rate this financial year, which was being followed up by JK/NM. JK queried if the run rate was being requested by EPUT and MSEFT Finance Committees. JP/LL took an action to raise with their retrospective organisations as until PIDs materialised it was difficult to assess whether the System was on track to deliver what was required in 2024/25.

The Chair stressed that this action does need to be discharged and understanding the run rate position is essential to recovery.

ACTION: JP/LL to query the reporting of run rate with their retrospective organisations.

Assurance

5. Portfolio of Social Care Discharge Fund Schemes

In February 2024, the Committee were provided with an overview of the Discharge Fund for 2024/25. When the paper was discussed, the Committee requested to have sight of the evaluation summary.

Since the February meeting, and considering the current financial position the team had undertaken a reprioritisation of schemes. Several schemes would be closed at the end of Quarter one, earlier than planned where they had not delivered the desired outcome.

Although the financial plan was largely on plan and spend had decreased, there remained an over-subscription against the available resource of £183k (1.84% of the total available). VD confirmed mitigation was in place to bring the plan back within budget.

Following a query from JP on the intentions for 2025/26, VD explained confirmation of future funding was awaited, as was updated guidance to support planning. The evaluation process would provide opportunity to review whether schemes had delivered the required outcomes and work was underway to identify and develop new schemes.

JK thanked VD for her negotiations with local authority and welcomed further improvement to reduce the remaining bridging arrangements that had been enacted in response to COVID-19.

Following a query from the Chair, it was clarified the System did not benefit from additional funding for additional activity however the Discharge fund had benefited from an uplift of circa £2m.

The Chair requested spend was brought back within budget for 24/25.

Outcome: The Committee: noted the evaluation undertaken and agreed the revised Financial Plan.

6. Month 11 Finance Report and verbal update on Month 12

JK presented the Month 11 position and reported the 2023/24-year end accounts were being finalised and reviewed by Auditors.
MB referred to the Workforce slide and queried the plan versus spend for EPUT as the graphs did not correlate. JK explained the data had been extracted from planning submissions and flagged a potential triangulation issue with data reported through Finance and that reported by Workforce. JK took an action to clarify the data with EPUT colleagues.

LL queried the scale of the impact on the financial position if the System had additional activity. NM advised work was taking place with services not generating the greatest benefits to improve productivity and spoke of a real focus to identify what services within the Trust would provide a greater return on investment. The Committee was advised a new style report was in development and would report on productivity.

JP stated the planning submission did not assume industrial action and the consequent impact on finance, performance, and loss of productivity.

Outcome: The Committee noted the Finance Report.

ACTION: JK to clarify the data within the Workforce slide for plan versus spend with EPUT colleagues.

7. Capital update

The report provided an update from the System Investment Group and the System Capital position as at Month 11. JD provided a verbal update on the Month 12 position and clarified the overall system capital spend for Month 12 was £153m. Of the total spend, £126m was spent within MSEFT, £24m within EPUT and £2m within the ICB.

In addition, local provider spend totalled £64.6m (£38k short of the total allocation).

The Committee was advised the Electronic Patient Record (EPR) Business Case had progressed for full regional review. Due to the size of the case, EPR dominated 57% of the Provider Capital Allocation in 2026/27.

The Chair highlighted the requirement of spend well exceeded the system capital allocation and asked if there had been a collaborative approach to prioritise schemes. It was confirmed both Trusts undertook a risk-based approach to prioritisation. JD spoke of the opportunity to standardise the risk approach across the organisations for future years and an ambition for a system prioritisation approach.

The Chair highlighted the substantial costs associated to the EPR Business Case and queried the confidence that EPR would provide true interoperability across the System. MB queried the second phase to enable greater connectivity in wider settings such as Primary Care and welcomed an update on the progression of the case at a future meeting.

NM would consider how benefits associated to the EPR Business Case were captured within the financial recovery programme.

As co-Chair of the EPR Joint Oversight Committee, LL offered to provide periodic reports to the Finance and Investment Committee alongside the Accountable Senior Responsible Officer to provide assurance the EPR Business Case was progressing as planned.

LL referred to minutes of the System Investment Group and the Capital cost pressures emerging around Community Diagnostic Centres (CDCs). JD reported the Trust had seen emerging cost pressures across some of the larger cases.

EH advised there was an MSE wide Greener NHS Programme Board that could be reflected within the governance of the joint capital resource use plan 2024/25. EH would liaise with JD outside of the meeting.

Outcome: The Committee noted the update on Capital and welcomed quarterly updates to the Finance and Investment Committee.

ACTION: Update on EPR to come to an upcoming Finance and Investment Committee.

8. Business Cases

None for this meeting.

Financial Governance

9. Committee Effectiveness, Terms of Reference and Workplan 2024/25

The desktop review had been undertaken by the Committee administrator to assess if the Committee had met its key objectives and had worked effectively the past year. In addition, an anonymous questionnaire had been circulated to obtain views from members of the Committee; NA encouraged all members to complete the questionnaire.

A final report of the findings would be shared at the next committee meeting along with an action plan to strengthen the operation of the committee. The findings would be presented to the Audit Committee who had oversight of ICB governance and feed into the Board effectiveness to ensure the Board had discharged its own responsibilities and duties through its sub-committees.

LL highlighted the need for sight of performance data to make informed decisions.

JK agreed and spoke of the ambition to interact with System Finance Committees to streamline reporting. There was a discussion on the benefit of members of the Finance and Investment Committee observing Finance Committees in the wider system.

The Chair reflected on time spent on larger business cases compared to granular investments. It was noted the change to the Scheme of Reservation and Delegation to increase the expenditure threshold for the Executive Committee would ensure Business Cases below the value of £5m would be approved by the Executive Committee, thereby reducing the workload of the Finance and Investment Committee.

EH queried if membership of the Committee could be widened to include Clinical Executives.

MB felt the Committee were presented with a high number of contract extensions which would likely impact service transformation. He highlighted the need to support the system to become sustainable.

The Committee agreed the membership of the Committee should include representation from Local Authority but that the role requirement was broadened and not specific to recruiting a Partner Member s151 Officer.

The Chair stressed and the Committee agreed the value of the Recovery Director attending future meetings whether this be as a member or in attendance. NM would discuss with TD.

Outcome: The Committee

- **Noted that a short anonymous questionnaire was required to be completed by members of the Finance and Investment Committee, the results of which would be included in the final report on committee effectiveness.**
- **Reviewed and approved the draft Finance and Investment Committee Work Plan for 2024/25.**
- **Noted an updated terms of reference would be considered at a future meeting.**

10. ICB Financial Budgets

The Board delegated authority to the Finance and Investment Committee to sign off the draft cost centre level budgets which it undertook on the 11 April 2024 at the Extraordinary Finance and Investment Committee.

The ICB received an initial allocation of £2.646bn, however, this was subsequently revised to a final allocation of £2.665bn. AK presented the final summary level budgets and reported the key changes:

- Additional expenditure in line with additional allocation (Service Development Funds (SDF) and Depreciation).
- Realignment of internal support from discharge and capacity funding between Acute and Community Care.
- Inclusion of deficit repayment in Total Acute Service (no longer a variance between allocation and budget).
- Increased liability for Shared Care Record.
- Reduction in plan for Mental Health following review of previous submission offset by other adjustments.

The ICB net risk position had increased from £13.9m to £15.2m mainly due to the readjustment of the efficiency delivery assumptions. Following a query from the Chair, it was clarified the £15.2m ICB risk was included in the reported £79m System net risk.

Outcome: The Committee ratified the setting of the final budgets as presented (with an allocation of £2.665bn, with a net risk position of £15.2m), in line with the plan submission on 2 May 2024.

ACTION: AK to share the ICB Financial Budgets paper with members of the Finance and Investment Committee.

11. 2024/25 Planning

Since the first planning submission on 29 February, the System had improved its deficit position by £52m (£148m deficit to £96m deficit) by increasing the efficiency target and committing to an Elective Recovery Stretch target. The System had also received additional funding for depreciation costs.

The 2nd of May 2024 final plan (pending National sign off) outlined a:

- £96m System deficit (3.6% of allocation)
- £168m efficiency requirement (6.4% of allocation)
- £79m net risk (3% of allocation)

The risk position had remained broadly static across the submissions however, all organisations were finalising their risk view ahead of final submission on the 2 May.

It was clarified the plan did not account for industrial action. JP highlighted MSEFT had quantified

such impact.

EPUT had been notified the scope of the independent statutory Lampard Inquiry had been extended, this presented a negative movement of £11.8m bringing the System draft reported outturn to £29.1m deficit.

JK noted that as a system Mid and south Essex was considered to be overfunded, consequently a convergence factor had been introduced to rebase allocations accordingly. JK explained this resulted in a reduction in the system allocation of £25.9m for 2024/25. The System was also required to repay the deficit of £10.9m accrued in 2022/23. The Committee were made aware of a £9.5m Clinical Negligence Scheme for Trusts (CNST) pressure in the Trusts and additional pressures relating to quality and safety improvements in our mental health partners.

The System was in receipt of £40m cash support funding for 2023/24. This resulted in a reported improvement in the year-end position. It was a one-off adjustment made to protect the cash position only and did not impact the deficit; the System would be required to pay it back in 2025/26 apportioned over 3 years.

JK reported a move in the balance sheet position of £159m between 2022/23 and 2023/24. JK explained an independent review of the balance sheets was underway and would be shared at a future meeting.

KW informed the Committee except for diagnostics, the System planned to deliver all remaining Constitutional standards.

NM provided an overview of the enhanced governance arrangements in place to manage System Recovery. It was explained the focus was to review plans and ensure traction of project initiation documents (PIDs) into delivery.

NM spoke of the intention for Sovereign Portfolio Boards to capture programme benefits and flagged outputs of the System Financial Sustainability Programme Board would be reported to the Finance and Investment Committee.

Outcome: The Committee approved the 2 May Planning Submission subject to there being no substantial changes.

Action: Independent review of balance sheets would be shared when available.

Triple Lock Ratification

JK advised the System were reviewing the Triple Lock process with the regional NHS England Team.

Outcome: The Committee noted the update on Triple Lock.

12. Feedback from system groups

The minutes of the System Finance Leaders Group held on 4 March 2024 and System Investment Group on 19 February 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

13. Any other Business

There were no items of any other business.

14. Items for Escalation

No items required escalation.

15. Date of Next Meeting

Tuesday 4 June 2024
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the ICB Finance & Investment Committee Meeting

Held on 4 June 2024 at 2.00pm

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee MSE ICB, **Chair**
- Tracy Dowling (TD) Chief Executive Officer, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Loy Lobo (LL) EPUT Finance and Performance Committee Chair
- Alan Tobias (AT) MSEFT Non-Executive Director and Trust Vice Chair (attending on behalf of Julie Parker)

Other attendees

- Ashley King (AK) Director of Finance - Primary Care, Financial Services & Infrastructure, MSE ICB
- Keith Ellis (KE) Deputy Director Financial Performance, Analytics & Reporting, MSE ICB
- Vicky Sawtell (VS) Director of Commercial, MSE ICB
- Simon Taylor (ST) NHS Property Services (for agenda item 5 – Infrastructure Strategy)
- Andrew Evans (AE) NHS Property Services (for agenda item 5 – Infrastructure Strategy)
- Neill Moloney (NM) Executive Director of System Recovery (for agenda item 6 – System Recovery Report).
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

The Chair (JF) welcomed everyone to the meeting and conducted introductions. The Committee was confirmed quorate. Apologies were received from:

- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Julie Parker (JP) Finance and Performance Committee Chair, MSEFT

2. Declarations of interest

The Chair (JF) 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.

The Chair (JF) provided the Governance team with a new declaration and a technical amendment to a current declaration of interest. It was clarified the new declaration was not pertinent to any items on the agenda for the meeting.

LL provided the Governance team with an updated form closing two of his declarations and updating a further. It was clarified the changes were not pertinent to any items on the agenda for the meeting.

As the amendments were received after meeting papers had been issued, updates would be reflected in the Register of Interests presented at the July meeting.

ACTION: Finance & Investment Committee register of interests to be updated for the July meeting.

3. Minutes of previous meetings

The minutes of 1 May 2024 were agreed as an accurate record, there were no matters arising.

Outcome: The minutes of the meeting on 1 May 2024 were approved.

4. Action Log / Matters arising

The action log was discussed and updated accordingly, there were no matters arising.

Assurance

5. Infrastructure Strategy (update)

NHS Property Services had been working collaboratively with the ICB and stakeholders to develop the mid and south Essex (MSE) Integrated Care System (ICS) Infrastructure Strategy to deliver the objectives set out by NHS England. An update on progress was provided to the Committee.

The aim of the strategy was for an integrated and collaborative approach to infrastructure decision making, creating a strategy that was owned and supported by system stakeholders to make best use of the core estate. Two System workshops had taken place alongside individual dialogue sessions to obtain feedback.

LL queried the role of digital infrastructure to shape services in coming years. ST confirmed digital was a key enabler to ensure smarter buildings and improving patient pathways.

In relation to the utilisation of estate, the Chair (JF) asked if there was a sense of the areas that would deliver both quick benefits plus longer-term opportunities. ST outlined the complexities to measure the utilisation of estate and advised of internal discussions to develop a census to do this. Work was required with stakeholders to triangulate how buildings were being utilised. TD spoke of the need to move to a tactical delivery plan to recognise the quick and longer-term financial gains along with the best use of facilities for our patients.

There was a wider discussion on optimising service delivery, it was noted the majority of estate was not utilised by the acute trust and in light of the current financial position (and the need to be an efficient organisation) there would be a need to reduce the total quantum of public sector estate. LL spoke of an aim to secure best use of space for community services ensuring services were more accessible to the population of mid and south Essex.

A final draft of the Infrastructure Strategy would be submitted to NHS England by the end of July 2024.

Outcome: The Committee noted the update on the development of the Infrastructure Strategy.

6. System Recovery Report

NM presented the System Recovery Report and highlighted progress in some areas albeit noting that pace had been slow. The ICB was working with system partners to mitigate the risks associated to the All Age Continuing Care (AACC) and discharge to assess programme.

Due to plans being profiled in twelfths, Mid and South Essex NHS Foundation Trust (MSEFT) was reporting a £7m deficit in Month 1. Work was taking place to reprofile plans to reflect when they are

likely to be achieved (noting that there would not be consistent delivery each month for the year e.g., the first quarter was unlikely to see significant achievement) and to understand areas lacking traction. It was noted there had been good progress on the outpatient theatres procurement and workforce schemes.

Essex Partnership University NHS Foundation Trust (EPUT) had seen a slow start to the delivery of efficiencies in Month 1, however there was a real emphasis to strengthen plans to aid delivery. Corporate Services was flagged as an area of significant focus.

Following a query from LL on the approach within MSEFT on long Length-of-Stay (LOS), NM advised the implementation of the new staffing approach would enable a reduction in the LOS in Mental health beds and out of area placements. There was a separate approach to make better use of capacity within community hospital to improve patient care and reduce cost of provision.

JK explained a tracker was being implemented to monitor traction against delivery month on month. This was flagged as vital to understand the planning gap verses the delivery gap as a significant number of efficiencies had been included in the position which was skewing reporting. Budgets were extremely tight, and delivery was imperative with further work required to identify the full £168m of efficiencies.

There was a further and full discussion on the need to accelerate areas that would deliver the highest impact. EH spoke of the need to increase visibility to understand the wider opportunities and where information was being held, reported, and escalated to ensure accountability and avoid duplication of effort.

It was agreed that the committee would have oversight of the financial planning and performance elements being prepared for the July Review meeting with NHS England.

LL welcomed a more detailed breakdown in future reports to show what was listed within the portfolio, its current stage and the value assigned. JK noted that sight of the vital actions assigned to each of the big programmes would be beneficial this would enable the committee to monitor the requirements for schemes to deliver.

Outcome: The Committee noted the System Recovery Report.

Assurance

7. System Finance Report.

Month 2 reporting requirements for the system were awaited from NHS England in recognition of a number of conflicting deadlines including the resubmission of 2024/25 plans due on 12th June 2024. It was anticipated Month 2 reporting would be light touch and as such not all data was available within the reporting pack.

KE presented a draft reporting pack that included the high-level financial position, performance metrics as well as key areas of influential information such as workforce.

Where data signalled an organisation was off track, the Chair (JF) encouraged the recovery actions required to bring the position back in line with plan were captured within the reporting pack.

Following a query from the Chair (JF) on the availability of viewing real time data, it was explained although accessible for performance data, it was not possible for financial spend. The reporting pack would report on the previous months close down position.

The risk position was flagged as a vital area of focus as the position on risk did not reduce throughout 2023/24. JK spoke of the need for the system to generate its own mitigations to reduce risk.

The Chair (JF) suggested an additional column to the Headline slide showing the '2025/26 forecast'.

KE spoke of the ability to filter data by organisation to provide a more interactive capacity within the reporting.

Outcome: The Committee: noted the 2024/25 reporting pack.

8. Business Cases

There were no business cases requiring consideration for the June meeting.

Financial Governance

9. Committee Effectiveness, Terms of Reference and Workplan 2024/25

NA presented the outcome of the committee effectiveness review following discussion of the survey and desktop review at the May Finance and Investment Committee meeting. The committee were presented with the associated action plan, the updated Terms of Reference (TOR) and the associated committee work plan for 2024/25.

The findings of the effectiveness assessment concluded that the committee had generally delivered the objectives set out within its TOR however, it was noted that decisions had sometimes been made in isolation of performance data. As such, it was recommended the committee moved to a Finance and Performance Committee, reflecting a subsequent shift in focus, moving performance out of the remit of the System Oversight and Assurance Committee.

The Chair (JF) spoke of the need for triangulation of Board Committees work to provide assurance and confidence that work was comprehensive and there were no gaps. It was therefore proposed that a separate session was scheduled in between Board meetings with the ICB Chairman and Board Committee Chairs. This would provide a space for discussion and understanding of the wider context, opportunity to raise concerns and would provide a better overview of Board effectiveness.

The Chair (JF) stressed the value of the Recovery Director being a Member of the Finance and Performance Committee. MB had stepped into the role of Vice Chair, the Chair (JF) requested this be ratified at the July meeting, given MB was not in attendance.

NA clarified reference to an External Chair would be removed from section 4.4 of the Finance and Performance Committee Terms of Reference.

It was agreed the Finance and Performance Committee Terms of Reference would be reviewed in 6 months alongside the review of the Terms of Reference for the System Oversight Assurance Group (SOAC) and in relation to the MSEFT moving into Level 4 of the National Oversight Framework.

NA raised the value of the standing agenda item for Committees on escalation to strengthen the reporting process. NA reminded members that changes to the TOR would not be effective until approved by the Board.

Outcome: The Committee

- **Considered** the outcome of the Committee Effectiveness Review 2023/24.
- **Approved** the terms of reference of the Committee revising its scope to a Finance and Performance Committee.
- **Approved** the updated draft Finance and Performance Committee Work Plan for 2024/25.

ACTION: Role of the Finance and Performance Committee Vice Chair to be ratified at the July meeting.

10. Specialised Commissioning Opening Allocations

On the 1 April 2024 the ICB took on delegated responsibility for the commissioning of a range of specialised services previously commissioned by NHS England. The purpose of the report was to provide the Committee with an overview of the opening allocations for the Delegation of Specialised Services for 2024/25.

The Committee was advised the ICB had received an allocation of £226.686m, £6.4m less than what was expected. It was noted the majority was aligned to contractual agreements; however, the reduced allocation did mean there was little flexibility within the commissioning portfolio. There was also attached costs to the variable reserve, discussions are ongoing with NHS England.

The Chair (JF) highlighted a breakdown of services would be helpful in future reporting. AT added it was not clear if the current allocation aligned with our objectives and queried what influence the ICB would have over future commissioning arrangements.

AK explained the purpose of the report was to note the opening allocation, but that fuller detailed report was available. The Committee would receive regular reports from the hosted team. As the Consortium was not a committee of the ICB Board, any decisions taken by the Consortium would only be those that are already within the delegated authority of the ICB Medical Director, who was a member.

Outcome: The Committee received the report for assurance and information

11. Triple Lock Ratification

There were no triple lock ratification decisions for this meeting.

12. Feedback from system groups

There were no approved minutes of the System Finance Leaders Group as recent meetings had been stood down to focus on planning submissions.

An update on Capital would be provided to the Committee at a future meeting following a £5.4m reduction in the System Capital allocation for 2024/25.

ACTION: Update on Capital to be provided at the July meeting.

13. Any other Business

There were no items of any other business.

14. Items for Escalation

To the ICB Board

- Finance and Performance Terms of Reference

15. Date of Next Meeting

Tuesday 2 July 2024
2.00pm - 4.30pm
Boardroom, Phoenix Court Basildon

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 10 April 2024, 3.30–5.30pm

Via Microsoft Teams

Attendees

Members

- Dr Anna Davey (AD), ICB Primary Care Partner Member (Acting Chair on behalf of Sanjiv Ahluwalia).
- Jennifer Speller (JS), Deputy Director for Primary Care Development (Nominated deputy for William Guy).
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- 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).
- Caroline McCarron (CMc), Deputy Alliance Director for South East Essex (Nominated deputy for Rebecca Jarvis).
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood (Nominated deputy for Pam Green).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (Nominated deputy for Aleksandra Mecan).

Other attendees

- David Barter (DBa), Head of Commissioning.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality.
- Karen Hull (KH), Senior Primary Care Oversight & Assurance Manager.
- Sarah Crane (SC), Training Hub Clinical Lead.
- Les Sweetman (LS), Deputy Director of Digital Technology.
- Jane King (JKi), Corporate Services & Governance Support Manager.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.

Apologies

- Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.

Approved 7 May 2024

- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.

1. Welcome and Apologies

AD advised that she would be chairing the meeting on behalf of Sanjiv Ahluwalia who had sent his apologies. AD welcomed everyone, noting that Victoria Kramer, Karen Hull and Sarah Crane were new attendees to the meeting.

Apologies were noted as listed above. It was noted that 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. For Item 6 (Estates Prioritisation / Recommendation 1) and Item 7 (Medicines Optimisation Local Enhanced Scheme), it was noted that Dr Anna Davey was a provider of services included within the scope of the papers, therefore was excluded from the decision making process. The Local Medical Committee were the representative body for the providers of services included within the scope of the paper but were not voting members of the Committee.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 29 February 2024 were received.

PW highlighted that page 4 of the minutes should be amended to read ‘Local Enhanced Service payments would be funded from delegated funds’ instead of ‘medications would be funded from delegated funds’.

Outcome: The minutes of the ICB PCCC meeting on 29 February 2024 were approved, subject to amendment discussed.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

It was noted that the outstanding actions (84, 95, 97 and 98) were all within timescales for completion.

5. Primary Medical Services Contracts

JS provided an update on primary medical service contracts activity since the last paper was presented to the Committee in February 2024.

The ICB Contracts and Quality teams continued to work with a specific practice in South East Essex to address concerns raised regarding quality and performance issues. Two other practices (in South East Essex and Thurrock) were also being supported following overall Care Quality Commission (CQC) ratings of 'Inadequate' following inspections in 2023.

There were a number of changes in Contractor Status to note. The Eastwood Group Practice and High Road Family Doctors both changed from Individual to Partnership status on 1 April 2024 and North Avenue Surgery changed from Individual to Partnership status on 4 April 2024. JS advised that the list size for High Road Surgery was omitted from the paper but shared that it was 4,149 as at March 2024. Wyncroft & Greenwood Surgery changed from Partnership to Individual status from 1 April 2024.

The decision to merge Witham and Maldon Primary Care Network (PCN) and Phoenix PCN to form a single PCN, known as Maldon and Witham PCN from 1 April 2024 was supported by the ICB.

The Connected Pathways team, in post until December 2025, had made significant progress on supporting practices to move to a modern general practice access model and raising public awareness of the changes to general practice.

AD commented that it was important for the GP Provider Collaborative to develop strong links with the Connected Pathways team. JS agreed and suggested that, given the Connected Pathways programme was funded for a limited time only, the GP Provider Collaborative should consider where the Connected Pathways work would sit once the programme ended.

Since the paper was issued, a Memorandum of Understanding with NHS England (NHSE) was signed to introduce a national staff survey in general practice which would feed into staff satisfaction survey metrics.

NHSE had published information relating to the 2024/25 GP contract, however the full detail was awaited. A paper outlining the Primary Care Strategy was due to be presented at the May meeting where the implications of the GP contract, including the Quality and Outcomes Framework (QOF), Network Directed Enhanced Service (DES) and Enhanced Service (ES) requirements, the primary and secondary care interface and workforce would be covered.

ACTION: Paper outlining the changes to the 2024/25 GP contract, to include the Quality and Outcomes Framework (QOF), Network Directed Enhanced Service (DES), Enhanced Service (ES) requirements, primary and secondary care interface and workforce to be presented to the Committee.

Since the paper was written, confirmation had been received from NHSE that the Whitley House Outline Business Case was to move to Full Business Case, subject to the ICB confirming revenue affordability. The Hedingham Full Business Case was approved as a revenue project, therefore did not require NHSE regional or national approval. The Practice and developer had been informed.

Planning was underway for a commissioner assurance exercise on service delivery, similar to that undertaken in 2022/23. Discussions were in progress with the Quality team and Stewardship to develop a model for quality assurance for Network DES services.

It was noted that the Primary Care team continued to run with vacancies in critical roles. Capacity issues were impacting on the progress of the Alternative Provider Medical Services (APMS) review.

Outcome: The Committee NOTED the Primary Medical Services update.

6. General Practice Estates Update – Rent and Rates Review Function

JS presented an update on the Primary Care (General Practice) Estates programme of work for the current and future financial years. The report provided a detailed overview of the position with regards to GPs operating from leased buildings and some key risks and issues associated with this.

The ICB was responsible for the Rent and Rates Review function previously hosted by NHSE. As part of the ICB restructure, responsibility for managing the process transferred from the Estates team to the Primary Care team.

Under the terms of the national GP contract, the ICB was contractually obliged to reimburse practices for a number of specifically identifiable estates costs incurred by General Medical Services (GMS) and Primary Medical Services (PMS) contract holders, including rent and rates for premises used in the delivery of GMS. Within NHS England this work was managed largely as an administrative function, responsible for coordinating the process of routine rent reviews utilising the District Valuer.

There was a risk to ongoing provision of Primary Medical Services due to numerous issues associated with GP premises leases. The report set out examples of lease issues and the impact they had on the ICB. The ICB intended to move to a planned and proactive approach to estates development and recommended the same principle was applied to the management of the Rent and Rates function.

The Primary Medical Services Rent and Rates payments in Mid and South Essex equated to around £14m per annum.

BB said it would be useful to work with NHSPS on local solutions for lease issues. AK commented that if the NHSPS were willing to work with the ICB on the lease issues, the ICB would need to jointly own the programme with NHSPS and have clarification on responsibilities. AK added that future GP partners needed to be aware of lease situations before joining a practice.

AD enquired whether there was adequate capacity to undertake the work on lease solutions and the rent and rates functions. AK responded that the robustness of the team would need to be considered.

JH cautioned that, given there were limited resources, it would be important to focus on resolving the issues most likely to result in successful outcomes. JS agreed and pointed out that there were varying degrees of engagement from practices with the ICB on lease issues but hoped that by sharing success stories, this may persuade those practices to engage. AD suggested a rent and rates update brought back to a future meeting in about 3 months.

ACTION: Bring update on Rent and Rates function back to the Committee in around 3 months.

Outcome: The Committee APPROVED the following recommendations:

(1) Allocate resources to support practices to resolve all lease and debt issues with NHSPS by the end of March 2025 – this has been put forward as a Financial Recovery Scheme.

(2) Proactively seek to identify when practices are thinking about moving from owner occupied status to a commercial rent.

(3) Discuss options with the LMC for providing advice to practices on the ICBs expectations of GP practice leases and the support available via the Premises Costs Directions.

(4) Review arrangements in place to assure ourselves of quality of premises and ensure we have a clear understanding of the role of the District Valuer in this.

(5) Ensure that we have a clear process for knowing when leases are coming up for renewal and engaging with practices early in the process.

7. Medicines Optimisation Local Enhanced Scheme (MOLES)

PW presented the proposed Medicines Optimisation Local Enhanced Scheme (MOLES) for 2024/25 which would support the delivery of the Medicines Optimisation and Prescribing Efficiencies. PCNs and practices across Mid and South Essex (MSE) had engaged well in the 2023/24 scheme. Minor amendments to the 2024/25 service specification had been made based on lessons learnt from the previous year.

The 2024/25 scheme required a total budget of £2,283k, however, it was likely that there would be an annual underspend with an anticipated total pay-out of not more than £1,867k. The 2024/25 national budget uplift was yet to be advised. The total budget figure would only be required if the ICB had fully achieved or exceeded the primary care medicines optimisation efficiency target. The agreed efficiency saving was removed from the prescribing budget before it was given to the Medicines Optimisation team and allocated out to practices.

Funding for the scheme was within budgeted resources and agreed in principle with Finance colleagues. On 2 April 2024, the Executive Committee supported the recommendation to implement the 2024/25 scheme, a triple lock application for approval of spend of non-committed budget had been submitted.

Due to conflicts of interest (COI) as recorded under Item 2, JH led the discussion. JH enquired why the details of the scheme, including how finances would be managed, were not included in the papers. PW explained the detail was being finalised and would be circulated to Committee once available.

ACTION: PW to provide full details of MOLES 2024/25 to JK for circulation to members.

AK enquired whether a response was available to the query previously raised at the Executives meeting on 2 April 2024 on the scheme's ability to deliver savings. PW advised

that the predicted savings were based on previous financial reports and that details would be shared with AK when her deputy, Head of Pharmacy and Medicines Optimisation, returned from leave.

ACTION: PW to share details on MOLES ability to deliver savings with AK when her deputy, Head of Pharmacy and Medicines Optimisation returns from leave.

JS explained there would also be discussion on how the Additional Roles and Responsibility Scheme (ARRS) could connect with MOLES in respect of the financial recovery programme. AK stressed the importance of using MOLES as a lever to maximise the ARRS workforce.

It was noted that on page 5 of the MOLES paper the figure should read £1,867k.

Outcome: The Committee APPROVED the implementation of the Medicines Optimisation Local Enhanced Scheme (MOLES) for 2024/25.

8. Estates Prioritisation

AK presented an overview of the approval process for primary care estates projects. The ICB was required to consider supporting premises developments for General Practice, as defined in the Premises Costs Directions (PCD), which can be proposed at any time. Amended PCD's were due for publication in the coming months.

ICB support could take different forms and be for proposals of varying scale, from minor refurbishments through to full rebuilds. Financial support was mainly in the form of capacity contributions either from the ICB, via 'developer contributions', or on-going revenue consequences. Estates projects were 'practice' led and the ICB's responsibility was one of support. The ICB played a role in development, quality assurance and approval of project documentation that progressed through the ICB and, where required, NHSE governance channels.

A summary of the estate's prioritisation process was provided to the Committee. The length of time to progress through the process would be impacted by a variety of factors, including the complexity of the scheme and actions of parties outside of the ICB.

Current market factors were impacting on the ability to progress a number of strategically and operationally important projects as a result of the current cost to build new premises and the limitations of the financial regimes in which the ICB operates. All new builds must be considered affordable and value for money, and are, in part, evaluated by the District Valuer (DV) assessment of a fair Current Market Rental (CMR) (generally presented as £/sqm). Currently, there was a significant variation between the DV assessment and that quoted by developers.

At the end of 2022 there were 45 'legacy' Clinical Commissioning Group (CCG) estates projects. Work was undertaken to understand the comparative priority of the projects with consideration given to the limited capacity and financial resource of the ICB. A set of objective criteria, using measures such as available capacity, deprivation and future growth, was created in partnership between Alliance Directors, Estates and Finance colleagues. This enabled the schemes to be ranked in priority order.

Of the 45 schemes, 2 were agreed to be closed and a third was identified by the ICB as a priority for delivery in 2023/24 and was due for completion during 2024/25 utilising capital resource over the two years.

The remaining 42 schemes were reviewed and reclassified as:

- **in train** - where a project had commenced and work was underway to progress through the various approval stages. These varied in maturity and project status.
- **requiring a decision by either the ICB or another party** - where a project cannot be continued until a specific decision is made.
- **ceased** – where the original project proposed had either been completed or formally ceased.
- **not a project** – where either no formal proposal had been received or no progress made within the last 14 months.

The ICB, MSEFT and EPUT were working with NHSPS to develop its infrastructure strategy, a draft was due for submission to NHSE by the end of May 2024. The infrastructure strategy would support the ICB, and partner organisations, to move to a more proactive approach to estates development, whilst acknowledging the constraints under which the system operates.

JS commented that new housing developments requiring GP sites were expected in MSE over next 3-5 years and queried when these should be added to the project list. JS also voiced concerns that GP led contract requirements in deprived areas could exacerbate health inequalities as these practices may not have the means to grow the business and would also be focused on the challenge of the day, JS enquired whether these practices would be covered by the infrastructure strategy.

AK explained that the estates process map would take into consideration GP led contractual requirements and confirmed the requirement for additional sites would connect into the infrastructure strategy.

SW noted there were a number of schemes labelled as ‘not a project’ and said that clear messaging was required on how estate prioritisation was communicated to primary care. AD agreed that communication with PCNs and practices on estates was important and something for the GP Provider Collaborate to consider.

KB suggested that clarification was required on project classification and queried how projects using Section 106 funding were factored in. AK advised that where Section 106 funding was available, this should be communicated to practices, however practices were required to advise the ICB if they wished to utilise the funding.

The Committee agreed that the project approval process was a helpful step forward.

Outcome: The Committee NOTED the Estates Prioritisation update.

9. Delegated Primary Care Functions – Self-Declaration

JS explained that, as part of the delegation of services from NHS England (NHSE) to ICBs, the ICB was required to undertake an annual self-declaration review of its compliance with a range of assurance requirements across delegated primary care functions. There was

an NHSE requirement for the self-declaration to be reviewed through the ICB's internal audit process which resulted in a 'Substantial' assurance outcome.

Where the self-assessment criteria identified that the ICB was 'compliant but some risks identified', an action plan was put in place to enable future declarations to be 'fully compliant'. An update on the outstanding actions would be presented to a future Committee meeting.

ACTION: JK to schedule an update on Delegated Primary Care function self-assessment action plan for future Committee.

JS explained that much of the work required, hinged on the development and agreement of the Primary Care Strategy which the Committee would be key in developing and approving.

ES advised there were limited providers of domiciliary ophthalmology services registered within the ICB, therefore it was necessary for external domiciliary providers to provide this service to the vulnerable population in MSE. ES was concerned as an optometrist that the ICB did not have oversight of governance and processes of these providers.

AD enquired what could be done to improve governance and process oversight of external domiciliary providers. ES suggested that once the external domiciliary providers were identified, the relevant ICB could be contacted to check what oversight and assurance they have, what processes there were and whether there were any concerns with the providers.

ES advised that the General Ophthalmic Services (GOS) 2024/25 contract had received a minimal uplift from NHSE and flagged that due to cost pressures there was a potential risk of optometrists handing back their GOS contracts.

PW highlighted that for accuracy on page 64 of the binder, the Community Pharmacy Independent Prescribers (CPIP) reference should be linked to the Local Enhanced Services in the row above, not the Local Pharmaceutical Service schemes.

Outcome: The Committee SUPPORTED the outcome of the self-declaration of delegated functions, to support the internal audit review of the self-assessment and for the Committee to oversee the implementation of the actions outlined in the self-declaration.

10. Primary Care Performance Reporting Outline

JS presented the proposed approach to the development of a key Primary Care Performance Report to support the Committee to undertake its key functions and provide assurance to the ICB Board. The report would evolve over time to include a range of metrics relevant to the Committee. Whilst elements of the reporting would be available at a practice level, it was proposed that the Committee would receive reporting only at an aggregate Alliance level and ICB level.

Reporting would cover all four delegated functions (primary medical, pharmacy, optometry and dental services). Due to a variation in the data currently collected and reported across different working functions, the main focus of the reporting would initially be primary medical services. Work would be undertaken with the Alliances to include a number of metrics supporting the development of Integrated Neighbourhood Teams. The report would also include a range of metrics identified in previous work on the 'Added Value Framework'.

BB asked about the level of detail to be reported to the Committee as practice confidentiality must be maintained. JS confirmed that individual contractors' performance would not be reported to the Committee, only system level detail and alliance variations.

Outcome: The Committee NOTED the development of the Primary Care Performance Report.

11. Primary Care risk Management

JS presented an overview of primary care risks included on the ICB's risk register and Board Assurance Framework. The Committee noted there were 10 risks on the Corporate Risk Register relevant to the work of the Primary Care Commissioning Committee, two of which were red rated (in respect of primary care demand and capacity and prescribing costs) and therefore were included on the Board Assurance Framework.

Since the last risk report presented to the Committee in January 2024, risk SREST02 (regarding insufficient capital resource to cover leases for the new Integrated Medical Centres) was closed as the Thurrock IMC was not progressing.

There were no comments or questions.

Outcome: The Committee NOTED the risk updates and the closure of risk SREST02.

12. Committee Self-Assessment

JK advised that a desktop review of the MSE ICB Committee effectiveness 2023/24 was underway. The results of the Primary Care Commissioning Committee review would be brought to the next Committee meeting for discussion. A short anonymous questionnaire would be shared with members of the Committee and would be included in the final report on Committee effectiveness.

ACTION: Present results of the desktop review of the Primary Care Commissioning Committee at the next meeting.

13. Minutes from the Dental Commissioning & Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 14 February 2024 and 13 March 2024 were received.

Outcome: The Committee NOTED the Minutes of Dental Commissioning and Transformation Group.

14. Items to Escalate

To BAF - Consider adding risk around optometry contracts.

15. Any Other Business

CMc advised that during a recent meeting with Healthwatch Southend where visibility of the Primary Care Access Plan was discussed, Healthwatch commented that they were not invited to attend the ICB's Primary Care Commissioning Committee. CMc welcomed a

discussion at the next meeting on whether it was appropriate for Healthwatch to be involved in PCCC or how they could receive information from the ICB.

JS advised that the Primary Care Access Plan was approved by Board and that the Communications Team were in the process of developing a version for the public that would be shared with stakeholders, including Healthwatch.

ACTION: Discuss Healthwatch attendance at Primary Care Commissioning Committee meetings at next meeting.

JH gave advanced apologies for the next meeting.

16. Date of Next Meeting

Tuesday, 7 May 2024
2.00 pm - 4.00 pm
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Tuesday, 7 May 2024, 2.00pm–4.00pm

Via Microsoft Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services (Nominated deputy for Jennifer Kearton).
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (Nominated deputy for Aleksandra Mecan).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (Nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Caroline McCarron (CMc), Deputy Alliance Director for South East Essex.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Katherine Cornish (KC), Fuller Implementation Lead.
- Nicola Adams (NA), Associate Director of Corporate Services (Item 11 only).
- Jane King (JKi), Corporate Services & Governance Support Manager (minutes).
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Marie McEntee (MM), Babies, Children and Young People's Transformation Lead (Item 8 only).

Apologies

- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- James Hickling (JH), Deputy Medical Director.

Approved 12 June 2024

- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.

1. Welcome and Apologies

SA welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that 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 10 April 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 10 April 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

It was noted that the outstanding actions (84, 95 and 98) were all within timescales for completion.

5. APMS Future Provision

JS shared the proposal for Alternative Provider Medical Services (APMS) future provision, setting out the scope of work to secure medium to long term provision of primary care services for 12 APMS contracts held by Mid and South Essex.

The reprovision of APMS arrangements had been identified needing to be reviewed for potential efficiencies in accordance with the ICB's Financial Recovery Programme. The approach should be flexible and tailored to ensure the best outcomes for the registered population and the Integrated Care System (ICS) as a whole.

Due to the number of contracts included in the scope of the process, those that required a commissioning intention by March 2025 would be reviewed first, followed by those requiring decision by March 2026. The Mid Essex APMS contract, recently agreed in principle at the Committee meeting in November 2023, would be included in the scope of this work. An options appraisal would be undertaken for each of the APMS contracts to determine a preferred option. Checks would need to be undertaken to ensure compliance with Provider Selection Regime (PSR) requirements for all options.

Most APMS practices operated with property leases concurrent to their APMS contract. Therefore, as part of the programme of work the ICB would ensure that lease arrangements were updated to reflect arrangements for the medium/long term provision of primary medical services. Consideration would also be given to estates rationalisation as part of the process.

BB commented that quality and patient care must be taken into consideration when securing provision of primary medical services and suggested the process should include feedback from local citizens.

JS confirmed that the Primary Care Quality team were involved in the procurement selection process, providing oversight on quality assurance. The process already included engagement with local community groups and offered to include the Local Medical Council (LMC), if agreeable to BB. In response to SA, JS stressed that Equality Impact Assessments (EQIA) would be undertaken as part of the options appraisal for each contract to ensure that under-privileged communities would not be affected by any decisions taken.

Outcome: The Committee NOTED the proposed approach to securing primary care provision for APMS contracts held by the ICB. Contract specific recommendations will be set out in future Primary Medical Services updates.

6. Women's Health Hubs

WG presented the Phase One business case to commission a Women's Health Hub (WHH) for each Primary Care Network (PCN) across mid and south Essex. The Hubs would be established in existing estates, likely within GP practices (depending on the PCN estate availability). The development of the Hubs would be split into two phases. Phase One would include the set-up of two services and associated pathways; Management of pelvic organ prolapse through the fitting of a vaginal ring pessary and the fitting of an Intrauterine Device for the management of menorrhagia, hormone replacement therapy (HRT), or other non-contraceptive uses. Phase Two would focus on the co-location and co-ordination of existing women's health services. The proposal would deliver the 2024/25 Operational Planning requirements for all ICBs to have operational women's health hub provision by December 2024. The EQIA's undertaken did not highlight any concerns.

NHS England (NHSE) had allocated £595k to each ICB to support the development of a women's health hub. NHSE highlighted the need and benefit to move Long-Acting Reversible Contraception (LARC) for gynaecological purposes out of secondary care and into a primary or community setting and assumed that a transfer of 50% of activity was achievable. The overall efficiency of Phase One was expected to generate around £75k saving per year.

The Executive Team approved the proposal on 23 April 2024 but was subject to full Triple Lock approval.

The ICB's procurement advisor advised that the service could be added to the existing Local Enhanced Service (LES) contractual arrangements under Provider Selection Regime Regulations (Direct Award, Process C).

SA agreed with PG's suggestion for a paper to be presented at a future committee meeting providing an evaluation and sustainability review on the LES provision of ring pessaries and Long-Acting Reversible Contraceptives (LARC).

ACTION: Paper to be presented at future Committee meeting providing an evaluation and sustainability review on the LES provision of ring pessaries and Long-Acting Reversible Contraceptives (LARC).

Outcome: The Committee APPROVED the development of two locally enhanced services for the provision of ring pessaries and Long-Acting Reversible Contraceptives (LARC), subject to triple lock approval.

7. Branch Surgery Closure - Process

WG presented the proposed process to be followed when considering 'branch' surgery closure applications from practices within Mid and South Essex ICB. Under the GMS, PMS and some APMS contracts, closure of a 'branch' surgery might need to be considered as a result of an application made by the contractor to the Commissioner (MSE ICB) or due to the Commissioner instigating the closure following full consideration of the impact of such a closure. The Committee was responsible for the oversight of the process and to endorse any recommended actions following the receipt of a closure request. The Committee had considered a number of such requests.

The Policy and Guidance Manual (PGM) provided guidance on the application of the provisions of primary care contracts and set out roles and responsibilities of the Commissioner and Contractor in regard to issues such as 'branch' closures. A key element of this process was the engagement with affected patients.

Under changes introduced in the Health and Care Act ("the Act") 2022 on 31 January 2024, the Secretary of State had the power to intervene in NHS reconfigurations. Whilst most reconfiguration would continue to be managed at a local level and not require ministerial intervention, as good practice the ICB must ensure that the process followed in relation to branch closures demonstrated full compliance with Section 13Q of the NHS Act.

In view of experience and changes to the Act, it was proposed to enhance the existing process by providing a standardised toolkit for practices to strengthen their engagement processes. This would include guiding the practice to undertake a Quality and Equality Impact Assessment to enable them to identify the cohorts of their population most impacted by the change and how the impact could be mitigated. This information would help guide how their consultation could be undertaken. In addition, the toolkit would support the identification of key stakeholders (including statutory partners) who should be included within any engagement exercise.

The process would also strengthen the approach for assessing the two key factors for consideration when reviewing applications. i.e., whether sufficient engagement had been undertaken and considered, and whether, on balance, the ICB supported the proposed closure.

This paragraph has been minuted confidentially.

In response to BB, WG confirmed the ICB would support the practices in completing impact assessments, however the assessment would need to be owned by the practice. Equality Impact Assessments would ensure a robust decision-making process.

SA felt there was a significant shift towards bureaucratising the decision-making process and enquired what this meant for the ICB in terms of staff and support. WG agreed there would be an additional workload on practices and the ICB, but a proactive, transparent and evidenced based approach was needed. WG confirmed the process was currently for general practice only.

Outcome: The Committee APPROVED the proposed process for considering branch surgery closures. ***This part of the outcome has been minuted confidentially.***

8. Childhood Asthma & Primary Care

MM, Transformation Lead for Babies, Children and Young People's (BCYP) Services was welcomed to the meeting to present the paper detailing the BCYP Asthma Transformation Programme.

Asthma was the most common long-term condition among children and young people and continued to be among the top 10 causes of emergency hospital admission for children and young people in the UK. Emergency admissions and deaths related to asthma were preventable with improved management and early intervention. The National Review of Asthma Deaths (NRAD) (2014) found that 46% of the children who died from asthma had received an inadequate standard of asthma care. In mid and south Essex there were 5 asthma deaths in childhood between 30/01/2019 and 26/05/2022, all were known to health services.

MM explained that the BCYP Asthma Transformation Programme aimed to support primary care to manage BCYP with asthma, provide education and training on asthma, guidance in diagnosing asthma and support with asthma care plans and annual reviews.

The project, led by the Public Health Medicine Register, focused on using a medication-based risk stratification tool, designed to help identify patients who were likely to be put at risk of harm from their medication, to identify high-risk CYP (5–18-year-olds) Asthma patients in three GP practices within the Mid and South Essex who met specific required criteria.

It was proposed to establish a small primary care working group as part of the clinical network which would require nominations from primary care to join the group, e.g., GP, practice nurse, clinical pharmacists. The group would be supported by the BCYP System Clinical Lead and BCYP Asthma Clinical Lead and Consultant Paediatrician.

KSS stressed the importance of involving community pharmacy in the working group. MM agreed to invite community pharmacy representatives to attend the working group.

SA queried whether the criteria included accident and emergency (A&E) attendance rates. MM said the data was considered; however, it was found that hospital admissions data was more accurate than A&E attendances. Work was taking place with Digital colleagues on how to improve data.

SA commented that reliever inhaler prescriptions was a reliable data set. MM confirmed there were lots of data parameters available, including the use of salbutamol and prednisolone.

SA enquired whether patient engagement and involvement would be built into the working group. MM recognised there was a need to improve in this area to ensure appropriate engagement with children and young people was undertaken.

SA requested that WG worked with MM to consider how relevant primary care clinicians could be involved in the BCYP Asthma Programme working group.

ACTION: WG to work with MM to consider how relevant primary care clinicians could be involved in the BCYP Asthma Programme working group.

Outcome: The Committee NOTED the BCYP Asthma Transformation Programme paper.

9. Integrated Neighbourhood Teams – Mid Alliance

KB presented an overview on the progress of the Mid Essex Integrated Neighbourhood Teams (INTs) development, explaining that initial workshops took place in Summer 2023 to develop the mission, values and principles for INTs in Mid Essex, ensuring this was developed in collaboration with partners. An evidence based; data led approach was taken to designing the INT footprints. Feasibility criteria was considered to ensure the plan met the needs of the local population and were equitable.

There were 6 Integrated Neighbourhood Teams in mid Essex. INT Formation Workshops (3 for each INT) took place across the mid Essex Alliance area between November 2023 and January 2024 to bring together over 160 partners from 37 different organisations. An initial framework was created to identify partners' key challenges and what partners wanted from INTs. A key outcome of the workshops was to co-produce with partners our 'Ways of Working' initiatives.

These initiatives included weekly online neighbourhood drop-in sessions, facilitated by the Neighbourhood Officer for each of the INTs, providing opportunity for informal networking, real time problem solving and knowledge sharing. Neighbourhood Forums were launched in March 2024 with 3 forums formed to date with over 80 participants. Face-to-face sessions were held every other month enabling relationship building, networking and learning through focused presentations and talks.

Additionally, a 'Neighbourhoods Handbook' was created. The Handbook included links to the Drop-in sessions and Forums, as well as links to other system support and Neighbourhood contacts lists. Neighbourhood Leadership Groups (NLGs) were established in April 2024 to allow local leaders to stay connected. The NLGs created a strong local voice in the wider system and empowered local systems to find solutions to the challenges faced. All these initiatives were ongoing, building strong foundations for INTs to develop.

SA commended the Mid Essex team for the INT work undertaken and acknowledged the importance of creating space for people to come together at different levels which helped to build trust.

KB advised there was good representation across the system at the various INT groups, but momentum needed to be maintained.

In response to SA, KB explained the priority areas for mid Essex were – Frailty, Children & Young People, Long Term Conditions (e.g., COPD, diabetes), Mental Health and Wellbeing with golden threads throughout each focus areas to identify high intensity users, reduce duplication and reduce inequalities.

Outcome: The Committee NOTED the Mid Essex Integrated Neighbourhood Teams update

10. The Burnham Surgery – Estates Update

KB provided an update on The Burnham Surgery Estate. The previous report to the Committee, presented at the meeting in December 2023, explained the challenges pertaining to The Burnham Surgery estates, specifically, the public perception that a decision had been taken by MSE ICB to relocate The Burnham Surgery to a new development called Burnham Waters, which was not the case.

KB stressed the ICB's position remained unchanged. The Mid Essex Alliance had maintained ongoing communication with the GP partners/Business Manager, Landlords, local Parish and District Councils and the local "Save Our Surgery" public/patient group but there remained a great deal of public interest.

The landlords of the premises and current partners were collaborating to explore estates improvement opportunities available on the current site and within realistic financial parameters. Information would be shared with local Parish and District Councils and the local "Save Our Surgery" public/patient group, as well as the wider public/patients once available and the ICB was in a position to share and engage.

Outcome: The Committee NOTED The Burnham Surgery Estates update.

11. Committee Effectiveness, Terms of Reference and Workplan 2024/25

NA confirmed that the initial desktop review of committee effectiveness (undertaken by the Committee administrator and included information on the Committee's key achievements, whether its objectives were met, the number of meetings held, whether meetings were quorate etc.) had been shared with the Chair. The desktop review would be shared with committee members after the meeting and would be asked to complete a short anonymous questionnaire providing their own views on the work of the committee. The information would be collated and brought to a subsequent meeting with a firmed-up proposal for changes to the review, terms of reference and workplan.

SA commented that it was important to evaluate the Committee's work and stressed the value of colleague's engagement with this exercise.

JKi reminded the Committee of the request made at the last meeting to discuss the involvement of Healthwatch at Primary Care Commissioning Committee (PCCC) meetings. PG highlighted that there were three Healthwatch organisations across the mid and south Essex area.

The Committee agreed that the ICB would need to be clear on its ask if Healthwatch were invited to attend PCCC meetings, whether it was for the purpose of public engagement, their expertise or geographic representation.

RJ supported Healthwatch attending the PCCC meetings as it would bring the voice of the local population to the Committee.

SA agreed that Healthwatch's involvement would bring patient voice into conversations, but consideration must be given on how to ensure their attendance was constructive and helpful to both Healthwatch and the Committee's decision-making process and requested that WG and PG give this consideration.

ACTION: WG to discuss with PG a way to involve Healthwatch with the Primary Care Commissioning Committee (PCCC) and bring proposal on what would work for PCCC as a committee. PG suggested a meeting with Chairs of Healthwatch groups to discuss what the offer could be.

Outcome: The Committee NOTED the verbal update on the Committee Effectiveness Review.

12. Primary Care Strategy

WG explained the purpose of this item was to have a scoping discussion around a refreshed Primary Care Strategy and understand the best way to progress. The refreshed Strategy would be the first Primary Care Strategy encompassing all primary care contractor groups with the ICB as Commissioner.

The Committee recognised that there was already a defined primary care model for medical services in place incorporating the work being undertaken on the 3 elements of the Fuller Stocktake. Work on the Access Recovery model was ongoing and would also need to be incorporated. Although the Strategy was geared to general practice, there was a key role for all primary care contractors who should be encouraged to play a proactive role in primary care.

The Committee agreed the System's financial position must be considered, there was important work taking place in primary care, but the ICB was operating within a challenged financial system. There were also known performance challenges affecting primary care services, e.g., waiting lists for secondary care which were impacting primary care. Market development would also need to be considered to ensure a sustainable local primary care service for the future. WG advised that engagement on the new strategy would be undertaken.

SW sought clarity over timescales to complete the strategy, WG noted the aim to get a final version of the document approved by the ICB Board at either the September or November 2024 meeting.

Following questions from SA and KSS, PG agreed that social care could be incorporated within the strategy under the wider social care work undertaken as part of Integrated Neighbourhood Teams, that it was important that the strategy incorporated more than just primary medical care services and agreed with the need to be linked in with other stakeholders, e.g., in Basildon social workers were involved in local INT discussions and

welcomed any guidance. SA said the strategy was moving in the right direction of travel but needed to be pragmatic and deliverable.

WG explained provisional strategy conversations had taken place with the GP Collaborative and similar conversations would be held with the Local Medical Committee (LMC).

PCCC would be used as a forum to report back on progress of the strategy and allow for live discussion.

ACTION: Updates on development of the Primary Care Strategy be scheduled at future PCCC meetings.

Outcome: The Committee NOTED the update on Primary Care Strategy.

13. Pharmaceutical Services Regulation Committee (PSRC)

The Pharmaceutical Services Regulation Committee (PSRC) was hosted and chaired by NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) working on behalf of the 6 ICBs in the East of England. The Committee received details of the decisions taken by the Pharmaceutical Services Regulation Committee (PSCR) during Q4 2023/24.

Outcome: The Committee NOTED the decisions taken by the Pharmaceutical Services Regulation Committee in Q4 2023/24.

14. Items to Escalate

There were no items to escalate.

15. Any Other Business

There was no other business.

16. Date of Next Meeting

9.30-11.30am, Wednesday 12 June 2024
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 26 April 2024 at 10.00 am – 1.00 pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member & Chair of Committee.
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Dan Doherty (DD), Alliance Director, Mid Essex.
- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.
- Geraldine Rodgers (GR), Director of Nursing, Leadership and Quality, NHS England.

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience.
- Viv Barker (VB), Director of Nursing for Patient Safety.
- Sara O'Connor (SOC), Senior Corporate Services Manager.
- Yvonne Anarfi (YA), Deputy Director of Nursing for Safeguarding.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Gemma Hickford (GH), Consultant Midwife.
- Sarah Lamb (SL), representing Jo Foley, Patient Safety Partner.
- Frances Bolger (FB), Senior Nurse, EPUT, representing Ann Sheridan, Executive Nurse, EPUT.
- Eleanor Sherwen (ES), Deputy Director of Nursing.
- Jenny Louden (JL), East of England Community Nurse Fellow (left meeting after Item 6).
- Emma Everitt (EE), Business Manager, Nursing and Quality.
- Helen Chasney (HC), Corporate Services and Governance Support Officer (minute taker).

Apologies

- Ann Sheridan, Executive Nurse, EPUT.
- Joanne Foley (JF), Patient Safety Partner.
- Wendy Dodds (WD), Healthwatch Southend.
- Victoria Kramer (KD), Senior Nurse for Primary Care Quality.

1. Welcome and Apologies

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

NIB asked committee members to feedback generally on the performance of the committee. SOC advised that all committee members would shortly be asked to complete a short questionnaire on the effectiveness of the committee.

2. Declarations of Interest

NIB noted the committee 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.

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 23 February 2024 were reviewed and approved.

SP asked if a group had been created to scrutinise the reporting of performance metrics for mental health. GT advised that discussions were held with EPUT colleagues to organise a governance oversight meeting to focus on key areas of performance and quality and would include the Director of Children Services in NELFT to ensure oversight of all age mental health. The group would report into the Strategic Implementation Group and System Oversight and Assurance Committee (SOAC) as part of performance reporting.

Resolved: The minutes of the Quality Committee meeting held on 23 February 2024 were approved.

4. Action log

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

- Action 52: GT advised that quarter level datasets would not be the best for benchmarking and that safety data and the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) data should be reviewed for the next Local Maternity and Neonatal System (LMNS) Board update which would show improvement over time. GH advised that the NHS Resolution data was taken over a rolling 10-year view so recent changes would potentially not show. Action to be reviewed and amended with a deadline date to correspond with the next LMNS Board update.

Resolved: The Committee noted the Action Log.

5/6. Lived Experience Story & Deep Dive – Catheter Care

ES advised that a patient lived experience story on catheter care was unable to be obtained within the system due to the sensitivity of the issue, however, a lived experience story from within the east of England was obtained from NHS England. The story was told from a carer's perspective who cared for a patient receiving catheter care and the difficulties and

concerns they experienced.

JL gave a description of the catheter and the rationale for catheter use. Approximately 20% of hospitalised patients and 10.8% receiving district nursing care had catheters and the incidence of inappropriate catheterisation ranged from 20 to 35%.

The HOUDINI framework was developed to assess the necessity of urine catheterisation and promote appropriate catheter use. Several risks and complications arose as a result of catheters. The HOUDINI framework would evaluate clinical need and could potentially eradicate harm for a large number of people.

A catheter care practice audit had been completed and a visit had been undertaken on several wards/departments at Broomfield Hospital. The findings were detailed within the slide presentation and there was a similar picture nationally.

The majority of first catheter insertions occurred in hospital settings and was where prevention should begin. There were different methods and products which could be used as alternatives to catheterisation and implementation of a daily reminder for catheter necessity was being considered. reviewed.

The key messages were that urinary catheters posed a significant risk to patient health and wellbeing. Quality improvement should focus on abstaining from catheter insertion or removing as soon as possible, and ongoing discharge management.

PW commented that the formulary for catheters had been agreed to ensure that the most cost-effective products were used. During 2023, 7,067 patients were prescribed a catheter in the community and on average around 2000 patients per month were prescribed a catheter.

MS commented that patients could experience bacteraemia build up with long term catheterisation, resulting in overtreatment and an increase in urinary infections. There was a continual issue with recording when a catheter had been inserted, particularly in the acute setting, and joined up digital enablers would enable this to be tracked through the system. NIB commented that earlier discussions on catheter care should occur when the patient was discharged from hospital.

GT suggested that appropriate utilisation of continence products should be considered and support incontinence. Catheters should be removed earlier; appropriate continence products utilised and support provided to people to improve mobilisation.

SP raised concerns that reasons for catheter insertion were not always documented and asked what information was provided to patients with catheters in case of complications. JL advised that the catheter passport included patient and clinical sections. However, concerns had been raised that this was not the most appropriate tool as it was paper documentation and not widely used.

In response to a question from SOC regarding the risk of latex allergies, JL confirmed that this had not been reviewed during the audit but should be looked at in more detail.

GT raised concern regarding the catheterisation of young children receiving end-of-life care. JL confirmed that some nurses might not have the competency as was not a common activity. GT advised that it should be an area of focus.

The committee thanked JL for the interesting and informative presentation.

In response to question from NIB, GT suggested that catheterisation should be an area of focus for the system harm free care group that reported into the System Quality Group, and there should be system level communication to share findings with primary care.

JL commented that feedback could be provided to the Mid and South Essex (MSE) Operational Group. GR advised that feedback would also be taken to the regional catheter network.

Resolved: The committee noted the deep dive relating to Catheter Care.

7. Safety Quality Group - Escalations

GT provided a verbal update on the following key points:

The Care Quality Commission's (CQC) Operations Manager had provided an update on the single assessment framework and outlined their new ways of working. The focus would be on the quality statements which aligned to the five key domains. The relationship managers to the providers had been replaced by a multifunctional team of inspectors and assessors which were separate to the inspection team. The services inspected would be instigated by data and triangulation of evidence coming through the assessment team. The system level inspection framework pilots were ongoing, and the rollout of the Integrated Care Board (ICB) system inspection process had been delayed.

The neonatal reconfiguration was ongoing at Southend Hospital. There had been a deep dive in the neonatal deaths position and was noted that the recent MBRRACE (mother and babies national audit) data showed an improvement in the position. Consequently, MSEFT and the system were no longer an outlier.

As part of the primary care update, it was noted that one general practice had been under enhanced scrutiny. The CQC and ICB quality team undertook a joint inspection with positive verbal feedback from the CQC and the practice had since resumed normal monitoring.

The East of England Provider Collaborative had provided an update on the specialised mental health services, particularly for Children and Young People (CYP). A business case had been submitted for the development of day and virtual centres for CYP with eating disorders, which MS confirmed was now approved. The national plan was, where required, to manage admissions within the general CYP mental health bed base rather than beds in specialist eating disorder centres. There had been a reduction in length of stay and out of area placements for the system.

SP asked if the ICB system level inspections would include provider partners. GT advised that the framework was being developed and there would be specific responsibilities for the ICB, which held direct responsibility for primary care. The system level oversight from CQC would incorporate how our providers were performing and how system partners worked together. There was an expectation that interviews and conversations would occur with the triangulation of data and feedback from provider organisations.

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

8. Emerging Safety Concerns/National Update

GT highlighted the following key issues:

There was a new fundamental standard, Regulation 9A, which gave rights to visitors to visit their relative in hospitals, care homes and hospices. The CQC would visit sites to ensure enactment.

A change in police function regarding transport management of individuals, known as 'Right Care, Right Person' had caused concern nationally with regards to children. The proposals and memorandum of understanding in Essex was being closely monitored which required signoff by all part of the system before fully going live.

The Working Together (2023) guidance had been published in relation to safeguarding children and the responsibility of lead statutory partners was now the ICBs' Chief Executive Officers (CEO), local authorities and the police Chief Constable. The MSE ICB CEO was linking in with relevant CEOs in the system to ensure the MSE ICB fulfilled its responsibilities.

The Special Educational Needs and Disabilities (SEND) agenda remained a focus, both nationally and regionally. Southend's inspection had been concluded and the findings action plan was being monitored. Essex and Thurrock were in the preparation phase. There was a significant delay of the education health care plans, some of which related to the lack of education psychologists. Essex County Council had undertaken a recruitment campaign to support clearance of the backlog and the ICB was working closely with the family carer groups across the three areas.

The Babies, Children and Young People agenda required a strengthening of focus and governance in the system. The ICB Chief Nursing Officer was working closely with the Director of Babies, Children and Young People and the Children's Collaborative.

The NHS culture of care standards for inpatient care services in mental health and learning disabilities and autism were published and a review would be undertaken on how the provider organisations were meeting the standards.

GT assured committee members that the ICB was committed to the completion of quality, health and inequality, and privacy impact assessments on any decisions being made for oversight where a degree of risk was being accepted to service provision quality in order that financial responsibilities would be met.

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

9. ICB Board/SOAC concerns and actions

GT advised that there were no specific concerns raised at the System Oversight and Assurance Committee (SOAC) meeting. The April meeting had been deferred due to the planning submission.

It had been agreed with the CEO that a quality report would no longer be provided for SOAC, but GT would continue to attend the SOAC meeting should there be any items for escalation to Quality Committee. NIB advised that items were also welcome from SOAC that required further scrutiny.

SOC advised that a comprehensive review of the remit of SOAC was being undertaken and further detail would be provided following completion.

Resolved: The Committee noted the verbal update on ICB Board/SOAC concerns.

10. EPUT/Mental Health update

FB highlighted the following key items:

An unannounced inspection of Forensic Units at Brockfield House was undertaken on 6 and 7 March 2024, which focused on culture and sexual safety space. Recognition was given of the amount of work undertaken by EPUT following sign up to the Sexual Safety Charter in December 2023.

The Lampard Inquiry Terms of Reference (ToR) were published on 10 April 2024 and EPUT were preparing for any evidence requested. The main changes to the ToR were the extension of the Inquiry to the end of 2023 and included people that were three months post discharge.

EPUT was an early adopter of the Patient Safety Incident Response Framework (PSRIF) and a review had been undertaken of the PSIRF processes. The guidance had been refreshed in line with national guidance and to ensure that reports were good quality and robust learning was shared.

GT suggested including the quality data that was being focused on as an organisation and being shared with EPUT Board in the next cycle of reporting.

MS referred to the Lampard inquiry and advised that a meeting was being held with other ICBs with regards to the ICB response and how support would be provided.

Resolved: The Committee noted the EPUT/Mental Health update report.

11. Local Maternity and Neonatal Safety Board Update

GH highlighted the following key items:

A thematic review had been undertaken in maternal and neonatal deaths. In relation to maternal deaths, there were no significant concerns identified, so a regional piece of work was being completed to understand whether regionally, anything further could be extrapolated from the data. The Maternity and Newborn Safety Investigation (MNSI) have helped shape the investigations around the three direct maternal deaths that were key to ensure recognition and response to the learning identified, however there were other cases that reflected less directly related causes of death.

A further review of the neonatal deaths identified key areas of learning and reflected national themes, such as prematurity. Several of these cases reflected pregnancies which might not have progressed as they did, as there were now pre-term birth clinics which specialised in providing supportive measures to optimise the pregnancy reaching beyond 24 weeks. Opportunities to further improve the provision of care was acknowledged and would likely impact the 2023 MBRRACE data. The LMNSB would retain oversight of progress and ensure appropriate actions were being taken and tracked.

The maternity and neonatal independent senior advocate pilot service went live on 22 April

2024 and would be funded until end of March 2025. The service captured the importance of hearing the voices of parents and families and responding to their concerns when an adverse outcome had been experienced within maternity and neonatal services. The independent nature of the maternity and neonatal independent senior advocate role was key and provided knowledge and expertise and signposted support and guidance through the complaints and investigation process.

SP referred to the neonatal deaths deep dive, where many cases were linked to ethnicity and lack of access to antenatal care and asked what was being done to improve care. GH advised that the maternity and neonatal voices partnership would be key as they were service user led and included two ethnic community leads. Recent feedback received reflected experiences from Muslim women and opportunities were identified to act and respond to those experiences, such as communication with families, preparation of antenatal education and ensuring clearer communication that access to care was available to all and safety was the priority.

GH advised that the CQC had undertaken an unannounced inspection at all three maternity sites. DS explained that concerns were raised at Broomfield Hospital relating to capacity and flow, and compliance with guidance. The CQC issued a Section 31 Notice for Broomfield which was currently being reviewed for factual accuracy. System partners were thanked for the support provided.

GT advised that the ICB had been approached by the Chief Nurse's Office in Wales to understand the good work achieved in MSE on equality, diversity and inclusion in maternity and neonatal services, including promoting the voice of those from marginalised communities.

Resolved: The Committee noted the Local Maternity and Neonatal Safety Board Update report.

12. Safeguarding Quarterly Report - Adults

YA highlighted the following key points.

Four protocols were received recently from NHSE relating to Domestic Homicide Reviews (DHRs); data protection and information sharing; female genital mutilation; and safeguarding case reviews.

With regards to DHRs, the ICB was mandated to quality assure all health recommendations within DHRs which would require considerable resource to implement. The ICB was previously part of the panel process and all DHRs were signed off by the Home Office (HO) prior to publication. However, there was a significant backlog and agreement had been made with the (HO) and NHS England (NHSE). Concern had been raised with regards to the resources required because, to avoid a conflict of interest, an additional one or two people who were not part of the original panel would be required to review the report.

The Southend Essex and Thurrock (SET) Domestic Abuse Board adopted a new definition for DHRs which was 'domestic abuse related deaths' which would significantly increase the numbers.

It was noted that a safeguarding adult audit had been completed for the partnership boards and a positive response had been received about the feedback provided.

There had been two DHRs in Essex which highlighted a gap in health professionals' knowledge of firearms and shotguns. The police had developed two sets of guidance: one for general practitioners relating to information sharing with the police and another for frontline staff, to raise awareness if firearms were stored at a patient's property and how to raise any concerns identified. YA asked for the firearms information to be shared with teams to raise awareness.

PW advised that under the shotgun license, firearms and guns should be stored in approved cupboards and only the license holder should hold the keys and know their location.

In response to a query from AC regarding the DHR action plan process, YA explained that the ICB previously analysed their own and primary care recommendations, but they were not previously responsible for reviewing all recommendations made across the MSE health economy. YA provided a full description of the work now required as described in the report.

GT confirmed that the guidance document was currently in draft form. To review other systems' DHRs to identify if other health economies were undertaking actions required a level of capacity that the safeguarding team did not have. A meeting between the regional Chief Nurses and the national team would be held on 7 May 2024 to discuss the process, as the level of depth and detail expected could hinder rapid learning.

Resolved: The Committee noted the Safeguarding Quarterly report.

Action: YA to share the firearms information with teams to raise awareness.

13. Medicines Management

PW advised that data would be presented in an improved format for future reports. The following key points were highlighted:

The ICB were below national average for polypharmacy, however Thurrock Alliance had the highest number of medicines prescribed for patients, which linked with the levels of deprivation. The ICB were working with practices as part of the Medicine Optimisation Local Enhanced Scheme (MOLES) looking at structured medication reviews (SMR) for those patients at highest risk.

The number of SMRs overall was not high and there had been an increase (to 49%) in the number of patients coded as frail who received a SMR within the last 12 months.

Patients prescribed with sodium valproate were being reviewed to ensure they were being managed safely, annual checks were being carried out and pregnancy prevention plans were in place. Under the new guidance, at least two people should be involved when a new person started on sodium valproate, principally for women of childbearing age, but also evidence had emerged that men could also be at risk of passing on issues to their offspring if receiving the medication. There had been engagement with all system partners to ensure that processes were in place.

Another area of focus would be on people in the system who were on opioids, with a number in receipt of high doses. The 'Painkillers Don't Exist' campaign would begin on 14 May 2024. PCNs with a higher number of patients on opioid prescribing had been identified

to enable a focus on social media in those areas. Work was emerging from the PCNs in innovation and funding, to link with 'Open Road' and employing counsellors to support patients.

SP asked how long it would take to reach the 75% aim for antimicrobial prescribing. PW advised that a formulary was being unified across the system and once approved, would be set up on SystmOne for all practices to allow a standard duration of prescriptions. Other systems using SystmOne had reported a marked improvement. With the 'Pharmacy First' service, the Patient Group Directive (PGD) that community pharmacists worked to, was restricted to a 5-day period. SP suggested that the Integrated Care Partnership (ICP) could support with communications to inform the local population.

GT asked what the timescale was to reach the 5-day standard and commented that there could be an alignment with the ICP's five key priorities with third sector partners providing support. RJ suggested that the Alliances could also support through their local structures. PW confirmed that the formulary would be completed by June 2024 which would then enable roll out of SystmOne to the Alliances.

In response to a query from DD, PW advised that guidance was issued to GPs not to start patients on opioids, although it was recognised opioids could be used for acute pain. The ICB's guidance suggested a review was required for anyone on opioids longer than 3 months. Work had been ongoing with hospital sites to ensure anyone discharged on an opioid should have a stop date as part of their key performance indicators. However, non-pharmacological support for patients on opioids was not easily accessible for some people.

MS commented that a good understanding of actual levels was required and the datasets should therefore be shared across the system.

NIB commented that it was difficult to transition patients from pharmacological intervention to non-pharmacological intervention at later stages of their recovery. NIB requested a further update to be provided on the progress made.

Resolved: The Committee noted the Medicines Management report.

Action: PW to provide an update on the progress made with the prescribing of opioids within the next Medicines Management report.

14. Palliative and End of Life Care / Hospice

ES highlighted the following key items:

The Palliative and End of Life Care (PEoLC) strategy was amended to become a delivery plan in line with the strategic direction of the ICB, however with the current financial restraints, this was currently being reviewed.

The priority areas being worked on included increasing recognition of those in their last years of life, increasing the number of personalised support and care planning conversations, 24/7 co-ordinated care which included access to information, and having a confident and skilled workforce.

The electronic palliative care coordination system was in place across the ICB which fed into the performance dashboard and identified areas requiring enhanced focus. Access to

24/7 advice was a significant programme of work and resources were being reviewed across MSE.

Good feedback was received from the workshop on personalised care and decision making. One workshop was filmed to support development of simulation training. Funding was being secured for a platform to hold information relating to PEoLC for professionals and members of the public.

A campaign called 'Compassionate Communities' had been established and linked into the national framework for PEoLC highlighting help and support available which would be launched in May 2024.

It was noted that a lady who shared the PEoLC patient story at a previous meeting was a representative on the 24/7 access working group and was a prime example of good engagement.

GT requested confirmation of the target for increasing the recognition of the population in their last 12 months of life. ES confirmed it was 1% of the total population in line with national guidance and a dashboard was being developed. MS advised that the data was held on the Athena platform and currently reported to SOAC. The current figure was 33% of the 1%. Athena also recorded the number of advanced care reviews undertaken.

GR advised that a national dashboard had been granted funding for a further year which showed the location and cause of deaths. In MSE, 4% of deaths occurred in a hospice and 48% died in hospital, with the pre-requisite of frailty, and the remainder died at home. However, it was difficult to differentiate if people died at home with the support of the hospice, which had been challenged. A new transformation lead for Palliative Care would be starting in the ICB and funded by MacMillan.

Resolved: The Committee noted the Palliative and End of Life Care report.

15. Greater Manchester / Oliver Shanley Review

FB advised that the review would resonate with all services including maternity. The Edenfield Centre was a medium and low secure service. NHS England had commissioned an independent review of the relevant Trust following a Panorama programme broadcast.

The programme showed patients being physically and emotionally abused by staff, including inappropriate restraint for long periods. There had been a lack of scrutiny by regulators due to the COVID pandemic, the merger of three Trusts and the new Trust and local system were financially challenged.

Several contributory factors allowed poor care to occur as detailed in the report. Suicide rates for the Trust were amongst the highest in the country and there were some longstanding overdue action plans. The review highlighted several key concerns which were missed opportunities.

The key recommendations made were that the voices of patients, families and carers were listened to; strengthening of clinical leadership; a culture should be instilled that promoted quality of care and no staff should suffer racial abuse; a process put in place for when staffing fell below an acceptable level, timely escalation and data provided at the correct level; strengthening of the triangulation of data; and earlier system oversight of failing

organisations.

SM acknowledged that the review focused on a similar unit to Brockfield House, managed by EPUT, which had been recently visited by the CQC. Verbal feedback was that improvements had been made with sexual safety culture, racism and that staff were welcoming, although several areas of learning and concern were being taken forward. The only similarity with the inspections was coproduction and patient involvement, which was an ongoing challenge. A robust framework was in place which mirrored the MSEFT governance framework, together with the Evidence Assurance Group and Quality Together meetings.

NIB commented patient involvement seemed to be a key area, as was the need for better data and how it was used to inform the actions.

FB advised that it was important to consider how the system would identify a struggling organisation at an early stage to provide support, noting that the NHS Staff Survey could provide several indicators as alerts.

Resolved: The Committee noted the Greater Manchester / Oliver Shanley Review

16. Patient Safety & Quality Risks

SO advised there were currently 18 risks within the remit of Quality Committee. The ICB's Audit Committee also received a copy of the full ICB risk register and Board Assurance Framework (BAF) at each meeting and undertook deep dives into specific risks.

There were 7 risks within the remit of the committee currently rated red, these being:

1. Mental Health Provider Quality Assurance.
2. Quality Assurance of Autism Spectrum Disorder (ASD) services.
3. Compliance with Mental Capacity Act 2005.
4. All Age Continuing Care Delivery.
5. Complaints – Backlog (new risk).
6. Acute Provider Quality Assurance.
7. Maternity Services

One new risk had been added since the last committee meeting relating to the complaints team's capacity to clear the backlog of complaints. Discussions had also been held with the pharmacy team with regards to adding the sodium valproate issue to the register. PW explained that assurance was required by the ICB from providers that appropriate monitoring arrangements were in place to ensure patient safety.

There were no risks recommended for closure.

Appendix 1 provided an update on the risks.

The quality and safety related risks on the ICB's BAF as of March 2024 were set out at Appendix 2 and included a high level summary of MSEFT and EPUT's red rated risks.

All ICB risks had now been input on RLdatix DCiQ (Datix). User accounts were being set-up and training would be provided over the coming weeks to enable staff to add new risks and update and manage their own risks. The governance team would provide ongoing support.

The complaints module was now live and positive feedback had been received. The system would improve the triangulation and information across the organisation.

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

17. Patient Safety Update

VB advised that the report showed the progress made with each of the eight priorities of the patient safety framework.

A more detailed report would be presented in June 2024 and the committee was asked whether they would prefer a progress briefing on each of the eight priorities or a deep dive into a few priorities. The NHS Staff Survey feedback highlighted that the reporting of patient safety issues had not improved, so the report could include benchmarking the national picture against the system response and triangulate that information.

GT requested patient safety data to be presented on Statistical Process Control (SPC) charts, such as Learning from Patient Safety Events (LPSE) and PSIRF data on Patient Safety Incident Investigations (PSIIs) in the system. The national data available could be translated into system level and would help understand the reporting culture as a system.

NIB advised that a briefing on all eight priorities would be welcomed to identify where further discussion was required.

MS commented that the amount of data available was a good reflection of the system, although some data was held in in siloed areas, which needed to be displayed to everyone. PW suggested the distribution of a monthly summarised report that detailed any changes.

VB confirmed that a briefing would be provided on all eight priorities and the patient safety data would be presented on SPC charts.

Resolved: The Committee noted the Patient Safety Update report.

18. Terms of Reference

18.1 Patient Safety Collaborative Group

18.2 Patient Safety Incident Response Framework (PSIRF) Peer Review Forum

VB presented the Terms of Reference for the Patient Safety Collaborative Group and the Patient Safety Incident Response Framework (PSIRF) Peer Review Forum which related to the delivery phrase of the PSIRF implementation. The committee were asked for comments.

GT advised that both groups would report into the System Quality Group rather than Quality Committee.

Resolved: The Committee approved the Terms of Reference for the Patient Safety Collaborative Group and the Patient Safety Incident Response Framework (PSIRF) Peer Review Forum.

19. Review of Committee Effectiveness, including review of workplan and Terms of Reference

SOC advised that a desktop review of each committee would be undertaken by the committee administrator and initially shared with the committee chair for sign-off. The desktop review would then be shared with all committee members along with a short questionnaire. Responses would be anonymous. The outcome of the survey would be summarised in a final report, with an associated action plan (if required) to improve the effectiveness of the committee. The responses would also inform the review of the committee's Terms of Reference.

In response to a query from NIB, SOC confirmed that the review outcome would also be shared with Audit Committee and the ICB Board.

Resolved: The Committee noted the verbal update on the Review of Committee Effectiveness, including review of workplan and Terms of Reference.

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

NIB asked members for any item of escalation to the Board.

GT suggested the findings of the Manchester report should be escalated to Board.

SM asked for suggestions of areas of focus for future deep dives.

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.

Action: GT to escalate the findings of the Greater Manchester Independent Review report to be escalated to Board.

Action: Committee members and attendees to suggest to SM areas of focus for future deep dives.

21. Any Other Business

NIB noted that the paperwork, presentations and discussions had been become more robust and focused on the issues and thanked the report authors and presenters.

22. Date of Next Meeting

Friday, 28 June 2024 at 10.00 am to 1.00 pm via MS Teams.

Part I ICB Board Meeting, 11 July 2024

Agenda Number: 14.5

Corporate Objectives

Summary Report

1. Purpose of Report

To present for ratification the proposed ICB Strategic Objectives for 2024/25.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer

3. Report Author

Nicola Adams, Deputy Director of Governance and Risk

4. Responsible Committees

The ICB Board has responsibility for setting the organisations Strategic Objectives.

5. Impact Assessments / Financial Implications / Public Engagement

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to ratify the ICB Strategic Objectives for 2024/25.

Strategic Objectives

1. Introduction

As an NHS organisation, the ICB is responsible for setting out how it intends to deliver the objectives set out within the Integrated Care Strategy (ICS) (established by the Integrated Care Partnership (ICP)) alongside its duties as set out within the Health and Social Care Act.

The ICB approved the refreshed Joint Forward Plan in March 2024 that sets the strategic ambition of the ICB and details the work it intends to undertake over the next five years.

Each year the ICB will set its strategic objectives as the foundation of planning for the year ahead.

2. Main content of Report

At the Board seminar on 11 April 2024, the Board considered its strategic objectives. It was noted that the objectives would cement the priorities of the Board and enable reporting on their achievement and any challenges. The Board acknowledged that they would be used to map organisational risks, framing the Board Assurance Framework and guiding the work of sub-committees and how the Executive reports to the Board.

The Board agreed that the objectives should reflect national priorities (the core purpose of an integrated care system), locally agreed plans (set out within the ICP strategy and Joint Forward Plan) and priorities for the year ahead (set out in **Appendix 1**). In principle the objectives should be succinct and specific, limited in number and easily recognisable to staff, partners, and stakeholders.

At the Board meeting (held in private) on 9 May 2024, the Board discussed and approved the proposed strategic objectives, for further ratification at a public meeting.

3. Findings/Conclusion

The proposed strategic objectives for consideration and approval of the Board are:

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
3. To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
4. To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
5. To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. To embrace service improvement by adopting innovation, applying research, and using data to drive delivery, transformation, and strategic change.
7. To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

4. Recommendation

The Board is asked to ratify the ICB Strategic Objectives for 2024/25.

Mid and South Essex Integrated Care System

Meeting of the Mid and South Essex Integrated Care Board

NHS Mid and South Essex Integrated Care Board

Thursday, 11 July 2024 at 2.00 pm – 3.30 pm

Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER

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.	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 9 May 2024 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	
5.	2.13 pm	Review of Action Log	Note	Attached	Prof. M Thorne	
		Items for Decision / Non-Standing Items				
6.	2.14 pm	Proposed changes to services at local community hospitals: draft consultation outcome reports.	Note	Attached	E Hough P Parsons	
7.	2.35 pm	MSE ICB Annual Assessment 2024/25	Note	Verbal	Prof. M Thorne T Dowling	-
8.	2.38 pm	Annual Report and Accounts 2023/24	Note	See separate document	Prof. M Thorne	
9.	2.40 pm	Joint Forward Plan	Approve	Attached	E Hough	
		Standing Items				
10.	2.45 pm	Chief Executive's Report	Note	Attached	T Dowling	
11.	2.50 pm	Quality Report	Note	Attached	Dr G Thorpe	
12.	3.00 pm	Finance & Performance Report	Note	Attached	J Kearton	
13.	3.10 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty A Mecan R Jarvis	
14.	3.20 pm	General Governance: 14.1 Board Assurance Framework	Note	Attached	T Dowling	

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		14.2 Revised Committee Terms of Reference	Approve	Attached	Prof. M Thorne.	
		14.3 New/Revised Policies	Note	Attached	Prof. M Thorne	
		14.4 Approved Committee minutes	Note	Attached	Prof. M Thorne	
		14.5 ICB Corporate Objectives	Ratify	Attached	Prof. M Thorne	
15.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
16.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 12 September 2024 at 2.00 pm, Spring Lodge Community Centre, Powers Hall End, Witham, Essex, CM8 2HE.	Note	Verbal	Prof. M Thorne	-