Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Thursday, 16 January 2025 at 2.00 pm – 4.00 pm

The Garden Suite, Best Western Thurrock Hotel, Ship Lane, Aveley, Purfleet-on-Thames, Purfleet RM19 1YN

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 14 November 2024 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	9
5.	2.13 pm	Review of Action Log	Note	Attached	Prof. M Thorne	21
		Items for Decision / Non-Standing Items				
6.	2.15 pm	Specialised Commissioning: Further delegation of services	Approve	Attached	Dr M Sweeting	22
7.	2.25 pm	Stewardship	Note	Attached	Dr M Sweeting	25
8.	2.40 pm	Contract Awards for NHS General & Acute Services and ISP Acute Contracts 2025/26	Approve	Attached	J Kearton	46
		Standing Items				
9.	2.50 pm	Chief Executive's Report	Note	Attached	T Abell	52
10.	3.00 pm	Quality Report	Note	Attached	Dr G Thorpe	60
11.	3.15 pm	Finance & Performance Report	Note	Attached	J Kearton	70
12.	3.30 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis A Mecan	81
13.	3.45 pm	General Governance: 13.1 Board Assurance Framework	Note	Attached	T Abell	103

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		13.2 New and Revised Policies	Note	Attached	Prof. M Thorne	120
		13.3 Approved Committee minutes	Note	Attached	Prof. M Thorne	122
14.	3.55 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
15.	4.00 pm	Date and time of next Part I Board meeting: Thursday, 13 March 2025 at 2.00 pm, Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend On Sea, SS2 6ER.	Note	Verbal	Prof. M Thorne	-

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer	Aidsmap, a HIV information service charity			x	Direct	Chair of Trustees	Jan 2020	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Tom	Abell	Chief Executive Officer	Community First Responder			x	Direct	Community First Responder (voluntary)	Nov 2023	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
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, decision making, procurement or financial authorisation involving the Colne Valley PCN.
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	Ongoing	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x			Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
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 appropriate 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	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
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.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
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.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
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.
Joanne	Cripps	System Recovery Director	Lime Academy Trust (education)			x	Indirect		June 2023	Ongoing	No conflict is anticipated.
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	Nil								
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 immediate 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 discussed with my Line Manager

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	x			Direct	Potential Financial/Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	2021	Ongoing	Company currently dormant; if any changes occur those will be discussed with my Line Manager
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.
Shahina	Pardhan	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 - employed by Anglia Ruskin University	31/03/23	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Lead for Grant to Anglia Ruskin University to improve eye health, prevent eye disease and reduce eye health inequality in mid and south Essex	01/05/23	01/04/27	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various Universities	x				PhD Examiner	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various grant awarding bodies UK and overseas		x		Direct	Grant reviewer	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Visionary (Charity)		x		Direct	Trustee	20/04/22	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Cambridge Local Optical Committee	x			Indirect	Member			Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various optometry practices	x			Indirect	Optometrist	10/09/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Indirect	Research Optometrist	10/01/09	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Lucy	Wightman	Chief Executive, Provide Health	Health Council Reform (Health Think Tank)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The International Advisory Panel for Academic Health Solutions (Health Advisory Enterprise)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Lucy	Wightman	Chief Executive, Provide Health	Faculty of Public Health		x		Indirect	Fellow		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	UK Public Health Register (UKPHR)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Nursing and Midwifery Council		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide CIC	x			Direct	CEO Provide Health and Chief Nurse	02/04/24	Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Wellbeing	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Care Solutions	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	React Homecare Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The Provide Group Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangements can be implemented.

Minutes of the Part I ICB Board Meeting

Held on Thursday, 14 November 2024 at 2.00pm – 4.00pm

Basildon Sporting Village, Gloucester Park, Cranes Farm Road, Basildon, Essex, SS14 3GR

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tom Abell (TA), Chief Executive, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB, up to item 16.
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Mark Harvey (MHar), Partner Member, Southend City Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), 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.
- 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.
- Robert Persey (RP), Partner Member Designate, Thurrock Council.
- Ashley King (AK), Director of Finance and Estates, representing Jennifer Kearton, Chief Finance Officer, MSE ICB.
- Mike Thompson (MTh), Associate Director System Programme, MSE ICB, for item 6.
- Simon Griffiths (SG), Director of Adult Social Care, Essex County Council, representing Peter Fairley, Partner Member.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.

- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT)
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Peter Fairley (PF), Partner Member, Essex County Council.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.

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

MT welcomed everyone to the meeting and reminded members of the public that this was a Board meeting held in public to enable transparent decision making, not a public meeting, and therefore members of the public would be unable to interact with the Board during discussions. The meeting was livestreamed to accommodate members of the public who were unable to attend the meeting.

MT introduced Robert Persey, Partner Member designate, Thurrock Council, and a round table of introductions were given. MT thanked Ian Wake, outgoing Partner Member for Thurrock Council, for his contribution to the work of the ICB.

Apologies were noted 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 members and other attendees were in the Register of Interests within the meeting papers.

Note: The ICB Board register of interests is also available on the ICB's website.

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

MT advised that questions had been submitted by members of the public, as set out below, which would be answered during the meeting. However, two questions submitted were of a personal nature and not related to the items on the agenda and was therefore referred to the Patient Experience Team to provide a response after the Board meeting.

Peter Blackman noted the importance of the Communications and Engagement Strategy Refresh which appeared not to reference the need for Alliances to be supported, along with Primary Care Networks (PCNs) and Integrated Neighbourhood Teams (INTs), to engage effectively with local and common interest communities. Trusted community voices were key to the ICBs effective communication and engagement. CH appreciated the supportive comments and felt that the strategy emphasised the importance of Alliances and partnership networks, including PCNs and INTs in effectively engaging with local communities. This approach was essential to the strategy which aimed to build more collaborative relationships with trusted community voices. To strengthen these Alliances, support would be provided to partners with resources, training, and shared channels, to ensure effective communication and engagement. To provide further support, a 'Readers Panel' was established which had been invaluable in refining communications content and approach. The group provided direct

feedback on proposed materials, allowing messages to be tailored to align with the needs and preferences of communities in mid and south Essex. The OASIS planning model (a series of steps that help bring order and clarity to planning campaigns) was used, which enabled targeted research and audience analysis prior to individual campaign planning. Gathering insights enabled communication assets to be accurate, accessible, and meaningful for each target audience, which avoided a one-size fits all approach where possible. The ICB was committed to enhancing this model, ensuring communications were informed by diverse voices and reflected the varied needs across service areas, as demonstrated by the recent work on developing primary care access communications.

Chris Gasper asked about the livestreaming of ICB and Integrated Care Partnership (ICP) meetings**.** MT confirmed that the ICB livestream was accessible on the ICB website. The livestreaming of the ICP meetings was being considered.

4. Minutes of the ICB Board Meeting held 12 September 2024 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 12 September 2024 and asked members if they had any comments or questions.

One amendment was noted by Karen Samuel-Smith, Chief Officer of Community Pharmacy Essex. In the Primary Care and Alliance section the minutes should read the Pharmacy First service treats 7 minor ailments, not 10 as stated.

Resolved: The Board approved the minutes of the ICB Board meeting held on 12 September 2024, as an accurate record, subject to the amendment noted above.

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

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

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

6. Lampard Inquiry Update (presented by M Thompson and Dr M Sweeting)

MS read the opening statement from the ICBs involved with the inquiry, as follows:

‘Once again as an ICB, we would like to express our deepest sympathy to all those who have lost loved ones and those who have been and remain affected by the matters that this Inquiry is examining. It is hoped that the Inquiry’s robust investigation will provide the answers that many have been waiting for. The ICB would like to recognise the courage of those engaging with this process, despite their loss and suffering.’

MT explained that the report provided an update on three key areas, opening hearing and statements; Rule 9 request received, and the response provided; and the arrangements with other ICBs to provide a response to the inquiry.

The next hearings were scheduled at the end of November to hear the commemorative statements from affected patients and families and more formal hearings would take place in April 2025.

Resolved: The Board noted the Lampard Inquiry Update report and the progress in developing the cross ICB approach to responding to the Inquiry.

7. Equality, Diversity, and Inclusion (EDI) High Impact actions (presented by Dr K Bonney)

The ICB Board committed to monitor progress of the six high impact actions which were a national directive. KB noted that the data set was incomplete because both data from the North East London NHS Foundation Trust (NELFT), Provide Community Interest Company and Essex County Council was missing, however, progress had been made in collecting the data in terms of national and local benchmarking, and the additional data would be included in the 2025/26 dataset.

In response to a query from MT, KB provided assurance there was no issue with data provision from Provide, but rather ensuring consistency in data collection and presentation.

NIB requested assurance that the data received by the trusts was accurate. KB advised that the data was extracted from regionally and nationally recognised existing sources (Model Hospital). A data sharing agreement had been signed with EPUT and MSEFT which allowed access to data.

In response to a query from SP, KB advised that the staff survey response rate from MSEFT and EPUT was approximately 30% and the system engagement group was committed to improve that response rate.

GO asked what actions were in place to tackle ethnic discrimination in relation to career progression across all three NHS organisations. KB explained that the architecture of EDI, both as a system and the ICB was described within the EDI strategy. Three subgroups reported directly into People Board, one group reviewed the capacity and expansion programme, one group reviewed colleague engagement and retention and the final group were responsible for delivery of the high impact actions. There was also an internal Inclusion and Belonging Steering Group which was chaired by the ICB Executive Chief Nursing Officer. JF commented that there appeared to be a number of siloed views and all of the work should be connected and aligned for maximum impact.

TA agreed with JF comments and suggested further discussion on the joined-up approach and that the Board should receive regular reports from People Board to provide assurance that the actions were being delivered.

RJ highlighted the high impact action where one provider showed as red in relation to international staff being more likely to experience bullying and harassment, and whether a review of how international staff were recruited should be completed as a system, to benefit from learning from other organisations.

Resolved: The Board noted the Equality, Diversity and Inclusion High Impact Actions Update report.

Action: TA to discuss further the joined-up EDI approach and KB to provide an assurance report from People Board on the progress of the high impact actions to a future meeting.

8. Equality, Diversity, Inclusion and Belonging Strategy (presented by Dr K Bonney and E Hough)

KB and EH presented the Equality, Diversity, Inclusion and Belonging (EDIB) Strategy explaining that it presented the ICBs approach to EDIB from both a commissioner perspective in terms of the services it commissions to address the health inequalities within the system

and as an employer in terms of addressing inequities experienced by staff. The latter would also address the delivery of the high impact actions, the anti-racism agenda, data collection to understand any inequity and the initiatives in place to develop and grow staff networks and become an employer of choice, as set out within the People Strategy.

GO asked whether the resource allocation for EDIB and health inequalities should be included in the medium-term plan to ensure sustainability and also if the anti-racism strategy was available for circulation. EH advised that it was critical for EDIB to be embedded into everyone's role and responsibility, and therefore is integral to how we commission services to maximise the resources, rather than having a limited, but specific budget. The health inequality investment would continue to be supported, along with financial commitments to support workforce initiatives. KB advised that the anti-racism strategy was part of the deliverables of the system EDI group. The implementation of the strategy recommendations would be the next focus for the group, which would be reported up through the People Board.

Responding to SP, EH advised that the measures of success were set out in the objectives of the strategy which would be reviewed to monitor progress in their delivery.

BF suggested that the metrics partners were working to, to support EDIB, should be ascertained to ensure consistency of reporting and monitoring of progress across the system.

RP asked whether the wider partnership (e.g. social care and the voluntary community sector) should be engaged to raise awareness and ensure consistency. KB advised that the ambition for People Board was to be fully representative across the system. Representation from the voluntary sector and Essex County Council was in place. EH confirmed that health inequalities data and progress with achieving objectives was presented to the Population Health Improvement Board and the ICP, and the health inequalities work included the local authority public health teams. JF (as Chair of the People Board) noted that further work was required to align partners to provide consistency and common thinking.

Resolved: The Board approved the Equality, Diversity, Inclusion and Belonging Strategy.

9. Winter Plan 2024/25 (presented by E Hough)

EH advised on the approach taken collaboratively across the system for the strategic and operational management of the winter plan for 2024/25. This included strategic planning and coordination, tactical oversight of key areas of challenge (e.g. discharge, flow, prevention, and the day-to-day operational management). Input had been provided by primary care, the community collaborative and acute provider, as well as social care. The plan included support to adults and children services and reflected national guidance.

The risks and mitigating collaborative initiatives associated with managing winter activity / capacity were detailed within the report. The Executive Team would be key to balance the quality of services and performance against the financial pressures within the system.

JF suggested the need to consider the financial implications of the bed model if the mitigations were not successful. TA advised that there was a significant financial risk for the system which would be managed through protocols to ensure safety and quality.

In response to AD, EH confirmed that virtual wards would support admission avoidance. PG advised that the Transfer of Care Hubs would be critical infrastructure where the community and INTs could escalate activity and work with social care to support admission avoidance.

NIB raised concern that the plan could put pressure on community resources, e.g. pharmacies. PG advised of the 100% use of Pharmacy First, with good engagement from pharmacy colleagues who were providing support to develop the strategy for the future.

EH advised that the communications campaign through winter helped patients understand how services could be accessed, which was demonstrated by the success of the vaccine uptake programme. It also supported the broader primary care team and pharmacists.

Resolved: The Board approved the 2024/25 winter planning approach and noted the associated risks and mitigations.

10. Communications and Engagement Strategy (presented by E Hough and C Hankey)

CH advised that the refreshed communications and engagement strategy provided a framework to align to the ICBs strategic objectives and addressed capacity challenges.

Insight was gathered from a range of audiences to help inform the development of the strategy, which had a strong focus on responsiveness, inclusivity and data driven practices and was built around three core areas: supporting system wide priorities, managing business as usual (particularly with primary care audiences), supporting organisational development, and the prioritisation of work, recognising resource constraints within the organisation.

MT suggested including a sentence to acknowledge that the strategy considered that of providers who had their own strategies and engagement with their communities.

MHar asked how communications were accessible for people with learning disabilities. CH explained that the communications team were conscious of accessibility requirements and previous communications were developed with learning disability advocates and service users. There was a good network across communications professionals in Essex and a group from Healthwatch Essex who provided early input to communications. MT referred to the low numbers of health checks being completed for people with learning disabilities; as a vulnerable group, early intervention would be beneficial and so requested a review.

JF commended the strategy, particularly the candid approach to resource constraints noting that the strategy provided good guidance and clarity on responsibilities.

Resolved: The Board approved the Communications and Engagement Strategy for 2025-2027.

11. Emergency Preparedness, Resilience and Response (EPRR) Core Standards 2024/25 (presented by E Hough)

EH advised that the report sought Board endorsement of the ICBs EPRR approach and annual core standards self-assessment which remained at a substantial level of compliance.

A validation conversation had been held with NHS England regional colleagues who supported the internal recommendations. The following assurance was provided on the areas of partial compliance:

- There was a focus on joint working across the system to alleviate capacity, however the large number of EPRR incidents or reports continued across the system.
- The duty to maintain plans relied on external input around national guidance relating to

pandemics and counter measures.

- Throughout this year, the ICB participated in mass casualty exercises and was updating their Essex mass casualty framework.
- Work was ongoing with colleagues across the whole supply chain, particularly primary care regarding their own business continuity and how that linked to the EPRR work.
- A cyber security deep dive was completed and the EPRR team were working with IT and digital team on all the elements identified.

An EPRR action plan was developed, reviewed and approved by Audit Committee and validated by the NHS England regional team.

GW advised that there was a 120-page document that underpinned the report and full compliance was achieved with 42 out of 47 standards. The Audit Committee reviewed the document regularly and were satisfied with the assessment.

Resolved: The Board endorsed the MSE ICB EPRR Annual Core Standards self-assessment of 'Substantial Compliance' as approved by the MSE ICB Audit Committee and validated by the NHS England regional team.

12. Anchor Charter (presented by E Hough)

EH advised of the actions taken and those planned for next year, noting that the five pillars of the anchor charter would be embedded into everyday business across the ICB, and therefore contributed to how the organisation was run. Resources would be used to best support the people of MSE more broadly alongside delivering good health outcomes.

Several colleagues across the ICP had signed the anchor charter and an update would be taken to the ICP meeting before the end of the financial year to confirm all partner signatures.

Resolved: The Board supported the ICB being a signatory of the MSE Anchor Charter for 2024-2027 and committed the ICB to work to apply the anchor principles into everyday business.

13. Benchmarking Analysis of Greater Manchester Review (presented by Dr G Thorpe and P Scott)

GT advised that there was an action for the Board to seek assurance from EPUT and NELFT regarding the gap analysis report against the 11 recommendations made following the Edenfield Centre in Manchester report, which was subsequently reviewed by Oliver Stanley.

The Quality Committee had thoroughly reviewed the progress against recommendations, noting EPUTs programme on fundamentals of care and the culture in care programme that NHS England held nationally and NELFTs work against those recommendations. Quality Committee endorsed and were satisfied with the progress being made.

Resolved: The Board noted the verbal update on the Benchmarking Analysis of Greater Manchester Review.

14. Digital Achievements (presented by B Frostick)

BF highlighted progress on the digital and data strategy and provided an overview of partners

achievements outside of the strategy in their own local organisation.

The report was supported by the Digital Data and Technology (DDaT) Board; which recognised that all achievements had not been reflected (such as primary care). The provision of an annual report was suggested to support traction and evidence the impact of the strategy.

GW referred to the potential opportunity for earlier realisation of benefits due to digitalisation and suggested the reduction in operating costs or staffing. BF advised that the Chief Finance Officer of Provide had responsibility for the efficiency element of the programme. Following the implementation of the Shared Care Record (SCR), partner organisations should take ownership to drive cost reduction and efficiencies. It was noted that the potential savings had increased to £2.1 million rather than the £1.7 million stated in the report.

NIB asked how people not engaged with the system were being encouraged. BF advised that discussions were held with MSEFT, who were the biggest users of the SCR system, to understand how implementation could be effective, similar conversations would be held with other partner organisations. Essex County Council had access to SCR previously and were engaged in the proactive conversation to drive utilisation.

Responding to GO, BF confirmed that there would be continual implementation using Agile to link the SCR with Primary Care Networks. AD advised that the SCR was not being used fully in Primary Care, as SystmOne tended to be used mostly, so further work was required.

SP asked if there were any barriers to importing images used for the management of certain conditions. BF advised that images for radiology, pathology, diagnostic information was on the road map for implementation. No issues had been reported.

Resolved: The Board:

- **Noted the content of the MSE ICS Strategic Digital Benefits and Achievements pack.**
- **Considered the content and improvements to future reports moving forwards.**
- **Supported promotion of these achievements within partner organisations, regional and national teams.**

15. Chief Executive's Report (presented by T Abell)

TA highlighted key areas of the report noting the risk around winter was significant and would require active management and the system financial position was significantly challenged. There were early indications of improvement however, but concerns that the ability of the system to achieve the plan remained.

TA raised significant concerns regarding the access standards in MSE for cancer performance, which were shown as one of the worst in the country. The faster diagnosis standard and the outcome measures were not as expected. TA and MHop met with respective teams and assurance was received in some areas, such as colorectal and skin, but other areas required additional focus to ensure that the right capacity was in place and existing processes and pathways were being streamlined and would be closely monitored.

GW raised concern with meeting the target of 70% by March 2025 for cancer performance during the winter period.

JF noted that cancer performance was included in the letter received following regional review

and the fact that performance was static would not be tolerated and consequently a plan to show improvement would be required.

Resolved: The Board noted the Chief Executives Report.

Action: TA and MT to send communication to MSEFT regarding cancer performance.

16. Quality Report (presented by Dr G Thorpe)

Mental Health, Learning Disability and Autism Quality Inpatient Transformation
The quality report provided an update in relation to realigning inpatient services, harnessing the potential of people and communities and improving the culture of care and supporting staff within the organisations. Further work was underway, led by the ICB mental health and learning disability teams focusing on purposeful admissions, therapeutic inpatient care, and proactive discharge planning. Clear commitments were outlined in the three-year plan to transform the quality and experience of care, and oversight would be delivered through the ICB Quality Committee.

Intensive Assertive Outreach
The other area of focus followed the sad deaths of Ian Coates, Grace O'Malley–Kumar and Barnaby Webber in Nottingham. All ICBs were actioned to undertake a maturity index review against intensive and assertive outreach service models for mental health patients who presented with psychosis. It was noted that whilst these teams were in place some years ago, decisions had been made that they would be integrated into community mental health teams. An appendix within the report showed the progress and findings to date.

There were examples of good relationships and joint working across organisations and agencies for both health and social care services and criminal justice partners, substance use services and voluntary, community faith and social enterprise (VCFSE) partners across MSE, however gaps in service provision had been identified and were detailed in the report.

GT outlined the Patient and Carer Race Equality Framework (PCREF) was in place and further work would be considered, led by EPUT. There were some resource implications and work would continue with the regional and national teams following this review.

Resolved: The Board noted the Quality Report.

17. Finance and Performance Report (presented by A King)

AK highlighted the following key points:

At month 6, the system received its deficit allocation funding of £96 million (which would need to be repaid in future years). The system year-to-date position remained off plan with a combined deficit of £28.6 million and reflected ongoing cost pressures. The system continued to forecast delivery of its plan, although this was challenging and required significant improvement from month 8, subject to the earlier discussion on winter plans.

JF, TA and AK discussed in detail the assumptions and potential outcomes based on worst- and best-case scenarios.

In response to a query from GW, AK confirmed that the dates for the 2025/26 budget had not yet been published and internal planning would begin in December.

MT requested a view of the current position of the three organisations included within the system financial control total.

TA advised that the ICB position was principally driven by All Age Continuing Care (AACC) and was a combination of increased demand and increased per patient costs. There was a specific focus on the operation of the discharge to access pathway which delivered poor outcomes for patients and was expensive. A pilot of a new model was being implemented to concentrate discharge to assess patients in a smaller number of homes and repurpose the rehabilitation services organised by a Continuing Health Care (CHC) case manager. The aim was to ensure the best prices for the package of care provided, ensuring patients were receiving the necessary therapy and input to help re-enablement. This should reduce length of stay and get patients home successfully. Consideration was being given to join up the brokerage functions between AACC and local authority partners.

The primary factor affecting the EPUT position was the cost of temporary staffing. A recruitment campaign was ongoing, but some associated premium costs would remain until the new model of care was fully implemented. The second issue was the significant increase in the number of out of area placements which was driven by demand and increased length of stay in mental health inpatient accommodation. There was an increased risk aversion to discharge decision making (following the Inquiry). A multiagency discharge event (MADE) was undertaken to review the inpatient bed base and understand the actions needed. EPUT had expressed confidence that they would revert to the plan position.

MSEFT had challenges in both pay and non-pay spend. There had been several actions taken in the last three months, including support from the ICB and NHS England establishing a turnaround director and team, and ensuring wards and clinical areas were safely staffed, with an appropriate use of temporary staff. The impact of these changes was expected in month 8. The reduction in bank rates for doctors and other clinical staff was being implemented. There was also a reduction in non-clinical, non-patient facing staff, and the initiative for staff to be given a day off for their birthday had ceased. A proposal was received by the ICB for additional capacity within the procurement team to ensure that the national procurement frameworks were being utilised, there was standardisation across all three sites and items were procured at a lower cost.

JC warned that progress could be hampered by the impact of winter, cancer, and referral to treatment (RTT) activity.

AK advised Urgent and Emergency Care performance continued to be below the standard required for ambulance response times and Emergency Department (ED) waiting times, and several actions were in place via the winter plan. Elective care performance also remained below the targeted national standard for diagnostics, cancer waiting times and RTT times. The standards for mental health (improving access, psychological therapies, and early intervention of psychosis) targets were sustainably met.

A discussion took place regarding cancer performance.

Resolved: The Board noted the Finance and Performance Report.

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

PG presented highlights from the report noting there had been a significant rollout of increased digital tools in primary care that supported the total triage approach, there had been

areas of development with prescribing pathways, positive outcomes had been delivered in dentistry from the care home pilots, an area of Section 106 funding had been unlocked to enable some redesign and development work with estates in general practice and another Integrated Neighbourhood Team (INT) had 'gone live' with one remaining to be delivered.

Work continued with local authority colleagues in relation to the Better Care Fund (BCF).

RJ advised that the Alliances would be reviewing how to build relationships with the hospital trust, local authorities and the wider system community partners to accelerate service delivery and discharges, such as virtual wards and same day emergency care (SDEC).

AD advised that the GP provider collaborative was developing and met monthly. Individual alliances had their own subgroups and a governance working group met fortnightly. External support had also been utilised to develop the structure of the collaborative and its terms of reference. There had been encouraging progress with the engagement of GPs, however, engaging over 140 practices was a challenge. The collaborative worked closely with the Local Medical Council (LMC).

PG advised that the performance dashboard for the alliance level data was being developed.

Following a question from GO, RJ advised that there was good engagement across alliances with the PCNs.

PG advised that an internal audit on alliances had been completed and presented to the Audit Committee and Alliance Committees.

SG advised that the Essex County Council social work teams were closely aligned with the INTs.

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

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

19.1 ICB Constitution

MT refered members to the changes made in the ICB Constitutuion. There was a national requirement to have a Senior Independent Director (SID) on the ICB Board and this had now been written into the Constitution.

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

19.2 Board Assurance Framework

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

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

19.3 Terms of Reference

MT referred members to the updated Terms of Reference for the People Board and Digital Data and Technology Board (DDaT) and the Scheme of Reservation and Delegation (SoRD) which had been amended to reflect the minor structural changes and finanical limits. No questions were raised.

Resolved: The Board approved:

- **The Digital, Data and Technology Board as a sub-committee of the ICB Board.**
- **The updated Digital, Data and Technology Board terms of reference.**
- **The amended Scheme of Reservation and Delegation.**
- **The People Board terms of reference.**

19.4 New/Revised Policies

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

- 032 Equality and Health Inequalities Impact Assessment Policy
- 063 Safeguarding Adults and Children Policy
- 073 Mental Capacity Act 2005 Policy

Resolved: The Board noted and adopted the set of revised policies.

19.5 Approved Committee Minutes

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

- Audit Committee (AC), 23 July 2024.
- Finance and Performance Committee (F&P), 3 September 2024
- Primary Care Commissioning Committee (PCCC), 14 August 2024
- Quality Committee (QC), 30 August 2024.

Resolved: The Board noted the latest approved committee minutes.

19.6 Urgent Decisions taken since last Board meeting

MT advised that a decision had been made outside of the Board meeting to provide a letter of support for the MSEFT Pathology procurement full business case to meet NHSE requirements.

Resolved: The Board ratified the urgent decisions taken since the last Board meeting.

20. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

21. Date and Time of Next Board meeting:

Thursday, 16 January 2025 at 2.00 pm, The Garden Suite, Best Western Thurrock Hotel, Ship Lane, Aveley, Purfleet-on-Thames, Purfleet, RM19 1YN.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
54	14/11/2024	7	**EDI High Impact Actions** TA and MT to discuss the joined-up EDI approach and KB to provide a regular assurance report from People Board on the progress of the high impact actions.	T Abell M Thorne K Bonney	30/04/2025	Report to be prepared for May 2025 Board meeting. Reporting built into 2025/26 Board workplan.	**In progress**
55	14/11/2024	15	**Chief Executives Report** TA and MT to draft communication to MSEFT regarding cancer performance	T Abell M Thorne	30/11/2024	The Chair and Chief Executive of the ICB have met with the Chair and Chief Executive of MSEFT. Further meetings are planned to develop and agree the recovery plan for cancer performance.	**Complete**

Part I ICB Board Meeting, 16 January 2025

Agenda Number: 6

Specialised Commissioning Board Update Report

Summary Report

1. Purpose of Report

To provide the Board with an update on the proposal to further delegate 11 specialised services to the ICB from April 2025 and seek delegation from the Board for the Chief Executive Officer to approve the governance arrangements being established on its behalf.

2. Executive Lead

Matt Sweeting, Executive Chief Medical Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Audit Committee was responsible for reviewing the establishment of governance arrangements for specialised commissioning, prior to approval by the ICB Board.

The Executive Committee oversees commissioning arrangements.

The Board retains authority for the approval of delegated commissioning arrangements to the ICB but can delegate authority for the Chief Executive Officer to discharge those responsibilities on its behalf.

5. Impact Assessments

N/A, the services being delegated are not changing.

6. Financial Implications / engagement or consultation

Not applicable to this report.

7. Conflicts of Interest

None identified.

8. Recommendation(s)

The Board are asked to agree (and therefore delegate) that the Chief Executive Officer can sign the revised delegation and collaboration agreements on behalf of the ICB once finalised.

Specialised Commissioning Board Update Report

1. Introduction

Specialised Services support people with a range of complex conditions, they often relate to care given to people with rare cancers, genetic disorders or complex medical or surgical situations. They are provided by a small number of hospitals to a small number of patients. The Roadmap for integrating specialised services within integrated care systems (2022) set out a change to the commissioning of prescribed specialised services which allows systems to operate a more integrated approach to enable the provision of high-quality equitable care. Legislative changes in 2022 to the Health and Social Care Act permits ICBs to take on delegated responsibility for some specialised services. Moving to ICB-led commissioning supports a focus on population health management across whole pathways of care, improving the quality of services, tackling health inequalities, and ensuring best value.

At the NHS England (NHSE) Board meeting on the 7 December 2023 it was agreed that the delegation of specialised commissioning (spec comm) to ICBs in England would be supported. In March 2024, all six east of England (EoE) ICB Boards ratified the Delegation and Collaboration Agreements paving the way for delegation of commissioning responsibilities for 59 specialised services to ICBs with governance and oversight through the Joint Commissioning Consortium (JCC) and the regional Specialised Commissioning function (across the six ICBs and NHS England), hosted by Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB).
A further 11 specialised services will be delegated from April 2025.

Although the specialised commissioning team remain employed by NHS England until the planned transfer of the team to BLMK in July 2025, the Specialised Commissioning function is now managed by BLMK ICB. Lynelle Hales was appointed as Managing Director to undertake leadership of the hosted delegated service, started in May 2024.

The specialised commissioning team (SCT) which currently sits within NHS England (EoE), from 1 April 2024, work on behalf of the six ICBs and NHS England for both the retained and delegated specialised services. From 1 July 2025 the SCT will be hosted (employed) by BLMK ICB and will continue to work for the six ICBs and NHS England reporting through the JCC and its subcommittees

2. Main content of Report

The governance work required to expand the Specialised Services that are delegated to ICBs from April 2025 is underway. This includes amending the delegation and collaboration agreements, developing an East of England specialised commissioning strategy and a commissioning framework. The governance and oversight will continue to be through the JCC with the regional and specialised commissioning function hosted by BLMK ICB.

The revised Agreements need to be signed by each of the member organisations to the EoE JCC. That is the six ICBs and NHS England by the 21 March 2025.

The NHS England Board meeting on 5 December 2024 approved the paper on delegation of Specialised Services. They agreed to:

a) Consider and reaffirm the ambition, intent and opportunities offered by the delegation of commissioning responsibility for suitable and ready specialised services to integrated care boards (ICBs).
b) Note that the list of services suitable and ready for delegation to ICBs has now been finalised with 70 services in scope.
c) Approve the delegation of commissioning responsibility for these 70 specialised services to all ICBs in the North East and Yorkshire, London, South East and South West regions from April 2025 (and the additional 11 services to those ICBs in the Midlands, North West and East of England regions that took on full delegated commissioning responsibilities this financial year).
d) Approve the template delegation agreement for signature ahead of 2025/26.
e) Give delegated authority to regional directors to sign the final delegation agreements on behalf of NHS England

A EoE ICB Governance subgroup has been established to review the revised Delegation Agreement and consider any amendments to the current Collaboration Agreement and governance arrangements. The commissioning guidance for 2025/26, once released, will be reviewed in relation to the future governance requirements.

3. Findings/Conclusion

Given the short timeframe to finalise the agreements by 21 March 2025, the process agreed is to:

1. Establish drop-in sessions in February for EoE ICB Board members to attend for a briefing on the updated governance and delegation arrangements from April 2025 and any amendments to the delegation and collaboration agreements.
2. Take the finalised versions to the JCC for agreement, and
3. Signed by all parties.

It is recognised that not all Boards will meet in the short timeframe between documents being finalised in February and signed in March. As such, it is recommended that each Board give delegated authority to sign the Agreement on behalf of the ICB.

4. Recommendation(s)

The Board are asked to agree (and therefore delegate) that the Chief Executive Officer can sign the revised delegation and collaboration agreements on behalf of the ICB once finalised.

5. Appendices

Appendix A – List of agreed delegated specialised services for delegation.

Part I ICB Board Meeting, 16 January 2025

Agenda Number: 7

Stewardship Programme

Summary Report

1. Purpose of Report

To provide the Board with an overview of the stewardship programme over 2021-2024 and outline plans for taking stewardship to the next step within Mid and South Essex Integrated Care System (MSE ICS).

2. Executive Lead

Dr Matt Sweeting, Executive Medical Director, MSE ICB

3. Report Author

Dr Peter Scolding, Clinical Director of Stewardship, MSE ICB

4. Responsible Committees

Stewardship Programme Board, MSE ICB Executive Team

5. **Impact Assessments**

Not applicable to this report

6. Financial Implications

Not applicable to this report**.**

7. Details of patient or public engagement or consultation

Not applicable to this report**.**

8. Conflicts of Interest

None identified.

9. Recommendation(s)

1. Endorse the overall progression of our MSE Stewardship approach, from the '*stewardship hot house*' phase, to a '*whole system stewardship*' phase.
2. Support the development of key '*Mission'* or '*Priority'* boards as detailed in this paper.
3. Support the development approach for these boards and for wider ICS health and care staff in principles of stewardship.

Stewardship Programme

1. Introduction

This report outlines intentions for further adoption of the Stewardship approach in MSE ICS over 2025.

This will see a move from our '*hot house*' phase (2021-24), with its focus on developing frontline leadership groups, to a '*whole system stewardship'* phase, where some of our frontline leadership groups will join experienced commissioning, alliance and provider colleagues in '*Mission'* or '*Priority'* boards aligned to key priority areas.

These boards will be empowered to deliver specific objectives, as defined in our system Medium Term Plan, as well as an overall mission to improve population health and resource stewardship in that area. They will be founded on key stewardship principles (based on Elinor Ostrom's Nobel Prize-winning work), including having clearly defined resource scope, a long-term time horizon, strong participation from across pathways of care, and appropriate autonomy.

2. Main content of Report

2.1 'Hot house phase' - 10 Stewardship Groups

The Stewardship Programme has delivered ten stewardship teams, bringing together frontline clinical and managerial staff from across the whole pathway of care in 10 care areas:

1. Ageing Well/ Frailty
2. Babies, Children and Young People
3. Cancer
4. Dermatology
5. Diabetes
6. Eyes
7. Mental Health
8. Musculoskeletal care
9. Stroke
10. Urgent and Emergency Care

These ten groups are at different stages of maturity along their crawl, walk, run pathway towards acting as high-performing, effective stewardship teams, able to provide leadership and direction to our ICS on the allocation and improved use of health and care resource.

Stewardship teams have developed portfolios of successful work. However, overall, groups are not always well integrated into system decision-making, delivery and monitoring processes.

2.2 Towards a whole system approach

Discussions over the last two months involving Mid and South Essex Integrated Care Board (MSE ICB), Foundation Trust (FT) and Community Collaborative executive and senior leaders have all supported intent to move towards stronger models of collaborative working. These should focus on shared system priority areas, involve established stewardship teams where these exist, and be based upon stewardship principles overall.

2.3 Shared System Priority areas

These will be aligned with Medium Term Plan (MTP) priority areas and are also likely to align with our most mature stewardship teams, for example Cancer, Frailty, Urgent and Emergency Care, and Cardiometabolic disease (N.B. currently there are stewardship groups for Stroke and for Diabetes, but not for Cardiovascular disease).

2.4 Proposal for 'Mission'/ 'Priority' Board model

The next step in our stewardship journey as a system will be to convene 'Mission' or 'Priority' boards. These will forge together frontline leadership from established stewards, commissioning expertise from the ICB and delivery experience from Mid and South Essex NHS Foundation Trust (MSEFT), the Community Collaborative, and Alliance staff.

These boards will be responsible and accountable for taking forward agreed priorities, such as our MTP priorities. They will differ from previous arrangements in the way that they build on Ostrom's core stewardship principles, delivering the MTP priorities using stewardship mindset.

2.5 Stewardship principles

Stewardship principles are drawn directly from Elinor Ostrom's Nobel Prize-winning work (see table 1 below). These include involving trusted leaders from across the system, defining clear boundaries in terms of relevant population size and resources, shared system aims and population outcomes, and a long-term time horizon.

The 'Mission' or 'Priority' boards will develop an approach based on these fundamentals which focuses on delivering agreed priorities, whilst consciously building towards longer term sustainability through regular review of available intelligence.

2.6 Development approach

We will provide specific support for the boards leading on the MTP priorities to (i) form where new people, including from our stewardship teams, are coming together and (ii) adopt key stewardship principles in their work e.g. shared definitions of the resource set, the service activity, and outcomes it must produce, and the population who depend on it over the long term.

We will also seek to develop broader learning and development opportunities for any staff member, from apprentice to executive levels, so that they can learn more about stewardship and how it may be relevant to their work. We intend to draw on existing system expertise in developing this approach, which may bring together a package of new and available learning materials e.g. video, slides, published articles, available online or via individual learning modules and/or scheduled training sessions.

Table 1: Stewardship principles in MSE (Adapted from McGuiness 2013)[1]

	Ostrom Stewardship principles	Application in MSE ICS
Leading the commons	**Trusted leaders** - Commons need trusted leaders with moral authority	Bring together established Stewards with Commissioning and Delivery Leads from MSE ICB and Provider organisations in Mission/ Priority Boards for key priority areas.
Defining the commons	**Clear boundaries** - commons need clear boundaries	Define clear scope for each mission board, including population size, burden of disease, resources, activity and outcomes. These should aim to cover whole pathways of care.
	Clear aims - commons need a long-term horizon with clear aims	Define clear aims, with a long-term horizon. These will likely align with our system Medium Term plan, as well as the Triple Aim for ISCs.[2]
Organising the commons	**Wide participation** - all resource users should be involved in decision-making.	Mission/ Priority Boards must forge together frontline leadership from stewards, commissioning expertise from the ICB and Delivery experience from Providers into teams.
	Recognised autonomy – commons need to have the right to self-organise	We will work together to define scope to act for each board, aiming to maximise autonomy, with accountability overall to the Commissioning Board.
	Nested enterprises – commons often work by devolving responsibility through tiered networks.	The Mission/ Priority Boards will consider delegating responsibility to particular system partners, working groups etc. in the course of their work.

[1] McGuiness M. 2013. Caring for the Health Commons: What It Is and Who's Responsible for It? Rethink Health. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2221413

[2] Health and Care Act 2022: Triple Aim. *"…must have regard to all likely effects of the decision in relation to a) the health and well-being of the people … b) the quality of services provided… c) efficiency and sustainability in relation to the use of resources..."* Available at www.legislation.gov.uk/ukpga/2022/31/enacted

	Ostrom Stewardship principles	Application in MSE ICS
Managing the commons	**Congruence** – resource rules should match local context	Each Mission/ Priority Board must have reference to national and local mandates and recommendations in their decision-making and delivery – with particular note of local resource rules.
	Responsible monitoring - the use of resources and adherence to rules should be monitored	Population health outcomes and resource use will be monitored at the care area level, to ensure long term resource stewardship - alongside effective, quality service delivery. The stewardship groups' value frameworks will support this monitoring.
	Graduated sanctions - failure to meet the rules leads to graduated sanctions	We will develop transparency and sanction mechanisms as appropriate, for individuals, teams or organisations, to ensure adherence to agreed resource rules. These should include clear signals to rule breakers that misbehaviour has been observed, with sanction options including social e.g. awareness, and structural e.g. limiting influence over or access to resource decision-making.
	Dispute resolution - conflicts need an easy means of resolution	We will develop appropriate dispute resolution mechanisms, aiming to resolve at the simplest level possible.

3. Findings/Conclusion

This paper outlines intentions to move from our '*stewardship hot house'* phase to a '*whole system stewardship'* phase. This will see some of our frontline leadership groups join experienced commissioning and provider colleagues in '*Mission'* or '*Priority'* boards aligned to key priority areas.

These boards will be empowered to deliver specific aims, as defined in our system Medium Term Plan, as well as an overall mission to improve population health and resource stewardship in that area. They will be founded on key stewardship principles (based on Elinor Ostrom's Nobel Prize-winning work), including having clearly defined resource scope, a long-term time horizon, strong participation from across pathways of care, and appropriate autonomy.

Stewardship OD approaches will be developed, including for the boards themselves, as well as a broader approach for all staff in our health and care system.

4. Recommendation(s)

1. Endorse the overall progression of our MSE Stewardship approach, from the '*stewardship hot house*' phase, to a '*whole system stewardship*' phase.
2. Support the development of '*Mission'* or '*Priority'* boards as detailed in this paper.
3. Support the development of OD approaches for these boards and for wider ICS health and care staff.

5. Appendices

Appendix A – Stewardship Paper III.

Appendix A

Stewardship Paper III

December 2024

I am a big fan of the approach the system is taking.[1]

Matthew Taylor, CEO, NHS Confederation

You're lucky in Mid and South Essex to have Stewards.

Prof Tim Briggs, Chair of GIRFT

Stewardship awards 23-24

HSJ Award 2023 ***Data- driven Transformation Award***

Healthcare Financial Management Association (HFMA) Awards - **Costing Award**

[1] *Taylor*, M (2024) *Why is change in the health service so difficult?* NHS Confed. Available at *www.nhsconfed.org/articles/why-change-health-service-so-difficult*

1. Executive Summary. Oct 24

MSE ICS's Stewardship Programme is now established as an award-winning, nationally recognised exemplar, with a track record of delivering value improvement in Mid and South Essex ICS. In 2024-25, our stewards must continue leading and supporting system work to deliver on the Triple Aim, particularly financial sustainability.[2]

Based on Elinor Ostrom's Noble Prize winning work on stewardship, we have now brought frontline staff from across our system together into Stewardship groups in 10 out of 25 care areas to lead and support our system in stewarding resources better, delivering on the Triple Aim.

This paper outlines progress over the last year, including an overview of delivery on the objectives set by the ICB Board in 2023, as well as four case studies of specific projects delivered by stewardship groups over the last year.

It goes on to outline six priorities as the way in which stewardship groups and the programme team will support our system to meet its major challenges over 2024-25 – financial recovery and the changes to our system operating model after organisational restructure. These include:

1. **Value improvement process -** identify, analyse, execute.

Effect: to deliver projects supporting financial recovery, stewardship groups will work through a process to identify, analyse and collaboratively execute opportunities over the next 12-24 months - contributing the breadth of their frontline experience, knowledge and relationships to this work.

2. **Underpin commissioning decision-making**

Effect: to strengthen commissioning decision-making towards financial recovery, stewardship teams should work with our commissioning and decision-making committees and processes across ICB and Provider organisations.

3. **Adjust programme trajectory for 2024-25**

Effect: We will pause development of new stewardship groups in this financial year to release non-recurrent funds. Groups will produce progress reports by early 2025 identifying updated priorities.

4. **Re-orientate**

Effect: re-orientate as new people, processes, and priorities emerge in the context of organisational change and financial recovery. Stewardship groups and the programme team will aim to have the right relationships, routes and presence across the system to get things done.

5. **Consolidate**

Effect: work to make existing elements of the stewardship programme more effective and resilient, including our current group model and approach to engagement. All organisations and staff groups in MSE should have awareness of the programme and of opportunities to engage further.

6. **Innovate and Improve**

Effect: we will lead work to shift towards a model of whole system stewardship, supporting the forging of 'Mission' or 'Priority' board arrangements. We will also explore ways to align stewards' efforts with national policy trends, including intentions for 'left shift' and greater adoption of digital and data tools available.

[2] Health and Care Act 2022: *Triple Aim*[2]*. "…an ICB must have regard to all likely effects of the decision in relation to a) the health and well-being of the people … b) the quality of services provided… c) efficiency and sustainability in relation to the use of resources..."* Available at www.legislation.gov.uk/ukpga/2022/31/enacted

Case study 1: Ageing Well Stewards. HSJ Data-driven Innovation Award 2023 - Frailty improvement

Problem: In Frailty services across MSE had problems with incorrect data and limited staff tools available to ensure that patients were receiving best practice care.
Intervention: The Ageing Well Stewards co-designed a Frailty, End of Life and Dementia Assessment tool (FrEDA) to deliver and capture best practice, focusing on the use of seven high impact pro-active personalised actions. This was used within a new electronic Frailty Care Co-ordination system (e-FraCCS), used across Primary Care Networks, community teams, hospices, dementia teams and virtual wards.
Results:

- 12,000 new people with frailty, dementia or end of life needs were identified in the 1st year.
- 50% reduction in older people with >3 unplanned hospital admissions in their last 90 days of life
- 5% reduction in 30-day hospital readmission rates and 70% reduction in Integrated Neighbourhood Teams with highest FrEDA usage.

Feedback:

- Patient: "*Thank you for just listening to what I want and making that happen*"
- Patient family member: "*It was awful before. This was so much better for my gran*".
- Paramedic Single Point of Access staff: "*It's so easy to use FrEDA to connect to other teams in seconds to help me support a patient at home".*
- GP: "*This has halved the time it used to take on care home ward rounds*"
- Consultant in Virtual Hospital: "*FrEDa helps me make better quality more accurate clinical decisions, and quicker too*".
- Ageing Well Steward: "*uniting colleagues under a whole-person culture, using integrated tools so partners seamlessly collaborate for better patient outcomes, as opposed to siloed organisational practice. The real-time access to the same data, no matter what team you're in or who you work for, is driving new ideas too. What a boost to morale*!"

Case study 2: Urgent and Emergency Care Stewards - Unscheduled Care Co-ordination Hub (UCCH). March 24

Problem: Emergency departments in MSE were failing to meet national waiting time standards and an opportunity to reduce the number of ambulance arrivals was identified.
Background: The UEC stewards developed the UCCH model which encouraged all ambulance crews to contact the UCCH prior to conveying a patient to ED. The UCCH MDT consists of ED Consultant, Urgent Community Response Team (UCRT) nurses, East of England Ambulance Service Trust (EEAST) clinicians and administrative support. This team would speak to the ambulance crew and together they would decide whether there was a more suitable option than ED for the patient.
Results: 50% of patients were not conveyed to ED following a discussion with UCCH – with an estimated 140 ambulance conveyances per month avoided. UCCH coincided with a 50% increase in referrals to UCRT.
Next steps: the team plan to move into a phase 2 and 3 model deployment across MSE inviting other partners, including General Practices, Care Homes and Mental Health to utilise the UCCH.

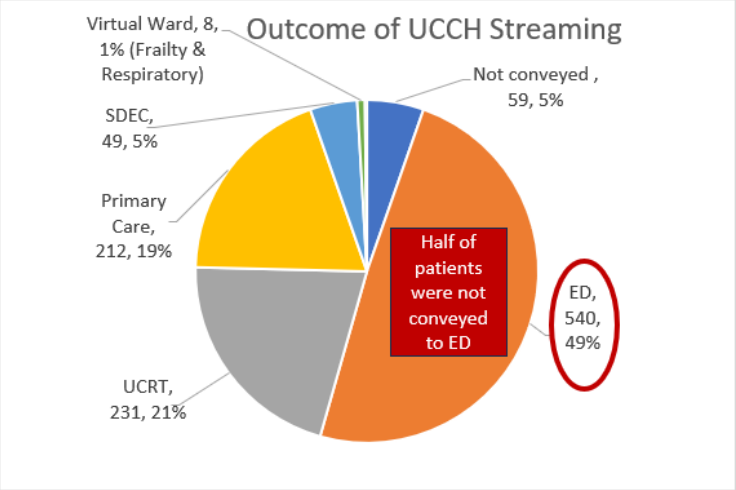


Figure 1: Outcomes of Urgent Care Coordination Hub streaming

Case study 3: Stroke Stewards - Rightsizing Stroke Community Rehab Beds. March 24

Problem: The Stroke Stewardship team have supported the 'rightsizing' of the number of Stroke Community Rehab beds across MSE as part of the Community Capacity programme. The team identified several opportunities to improve rehabilitation care, including increasing community stroke rehab bed provision, and reviewing the staffing and care models so that people can receive the right care in right place.
Background: Stroke stewards reviewed demand and capacity data, including a two-month audit of >100 acute stroke beds during 2023. This identified many patients were awaiting referral, care or assessment. Two options were developed for the reconfiguration of Stroke Community Rehab beds, increasing the number of community rehab beds overall, and bringing them together in 1 or 2 sites.
Intervention: These options were put to our local population as part of a public consultation, to understand their views and what works best for people in MSE. A number of public events took place, as well as media stories and social media campaigns, which the Stroke Stewardship Team supported.
Results: The results of public consultation are due to be published via an independent report. This will inform the development of a decision-making business case (DMBC) to support system decision-making.
Next steps: The stroke stewards are now working hard to prepare materials for the next phase, including different options for staffing and clinical models which can be adapted as needed in the final DMBC.

Case Study 4: Diabetes Stewards – Path to Remission. March 24.

Problem: MSE had a low referral rate (<30/ month) of people with Type II diabetes (T2DM) and obesity to the national Path to Remission Programme, which provides 12 weeks of support via a low calorie diet.
Background: This national programme helps people to lose >10kg on average, improves blood sugar levels, reduces diabetes medication use and, in almost 50% of participants, puts T2DM into remission. The stewards identified several barriers to referrals including lack of awareness of the programme, workload, workforce capability and change in providers.
Intervention: The stewards worked to increase referrals through engagement with patients, providers, and Diabetes UK. They used digital tools to put prompts onto the clinical systems that flagged patients who would be eligible for the programme, and organised training for staff.
Results: Referrals have now increased to over 100 per month (peaking at >200 in November 23). MSE ICS now has the highest referrals in the region, and the second highest nationally.

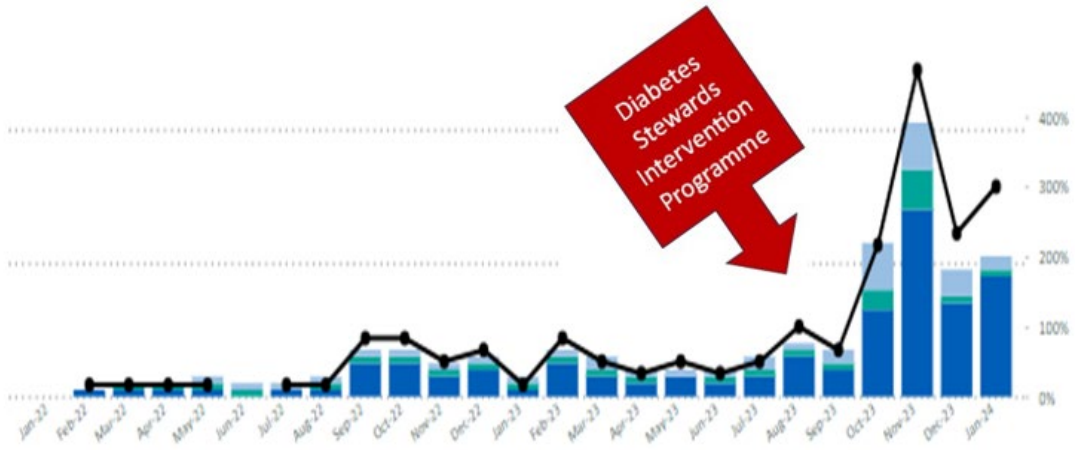


Figure 2: MSE Referrals to Type II Path to Remission Programme

2. Look back: Stewardship programme impact 2023-24

Recognition: 2023-24 saw recognition for the impact of our stewardship programme in Mid and South Essex. Matthew Taylor, Chief Executive of NHS Confederation visited the system twice, once virtually in Oct 2023 for our Stewardship Expo, and then again in person in March 2024 for a Spring Summit, summarising his impressions in a blog for NHS Confederation www.nhsconfed.org/articles/why-change-health-service-so-difficult.

Work from the Ageing Well Stewardship team won the HSJ Award for Data-based Transformation [*Case Study 1 box*], whilst our system costing hub won the HFMA Costing Award for their work with Stewardship teams.

Work from the programme was also presented nationally at the NHS Confederation Expo in 2023 and at the Leaders in Healthcare Conference in 2024 (overviews of the programme overall), and again at the NHS Confederation Expo in 2024 (focusing on the work of Ageing Well and UEC stewards (see Case study boxes 1 and 2).

Impact: As the case study boxes illustrate, stewardship teams undertook a range of initiatives, including:

- Developing NHS-leading new models of care (*Case Study 2 – UEC Stewards*).
- Addressing significant waiting lists and backlogs e.g. our Cancer Stewards work improving the Faster Diagnostic Standard for receiving a diagnosis within 29 days when referred as possible skin cancer from 25% to 69%, and reduced 62 day waits from 1240 people waiting in August 2022 to just 109 in Feb 2024.
- Supporting system priorities such as the Community Capacity programme (*Case study 3 – Stroke*)
- Improving the value our population receives from existing resource, for example increasing referrals to the National Type II Path to Remission programme (*see Case Study 4 – Diabetes*)
- Implementing fundamental change to a care area for short and long term population benefit e.g. increasing frailty literacy through an extensive training programme, alongside developing and rolling out a new Frailty assessment tool (*Case Study 1*).

Programme overview 2023-24:

Over the last year, the programme has continued to expand with the development of a second cohort of stewardship groups, including Babies, Children and Young People, Dermatology, Diabetes, Eyes, Mental Health and Musculoskeletal Care.

The ICB re-structure also saw the establishment of a dedicated stewardship programme team for the first time, with ICB staff supporting the mandate approved by the Board in 2023. This mandate was based on last year's White Paper II and the independently commissioned programme stock-take, and set a number of challenges for the programme during 2023-24. These included establishing norms for how stewardship teams worked within our system, including with commissioners and providers, and to develop 'Care Area accountability' within our ICS, as well as stronger accountability for each team within its care area. They also included continued expansion of the programme towards the goal the ICB Board had set of ~25 groups, and establishing relevant support and enablers to stewardship teams, and finally to promote greater awareness and engagement of the programme's impact.

The rest of this section (below) outlines in greater detail how we met these challenges.

Table 1: Review of mandate set in White Paper II in March 2023

Question	Summary	Full Update
System Level		
1. What is the 'right' role for stewardship groups, and how should they relate to existing organisational structures and hierarchies? Context: different groups have operated differently since 2021. They have adopted varying mixes of short, medium and long term activities and approaches at different times.	**Stewardship groups are the agile leadership network alongside our health and care hierarchies**. They provide disruptive leadership within our system, based on the Triple Aim for ICSs and applying core stewardship principles within their care area. They must maintain strong connection and support across MSE.	Stewardship groups are the agile network alongside our traditional health and care hierarchies[3]. They are there to provide agile, principled, distributed leadership within a care area, able to quickly identify and seize opportunities and rise to challenges, as well as to provide expert support, advice and leadership. They are there to operate in an entrepreneurial, disruptive manner within our health and care system. Stewardship groups must however maintain strong connection, alignment and support overall with regards to existing hierarchies and organisational structures. Groups must indeed consist of people working within our existing hierarchies, in order to maintain relevant organisational knowledge, credibility, and relationships. Groups are all aligned to the same guiding vision of the Triple Aim for Integrated Care Systems (refined within their specific care area via their Value Framework), and work according to Ostrom's stewardship principles applied to health and care i.e. stewarding the whole set of resources for a whole population across whole health and care pathways. Therefore a stewardship group, working in concert with partners and senior leaders in existing hierarchies, may identify and address opportunities and challenges with both short to medium term horizons (e.g. exploring poor outcomes in a particular geography or population sub-group, tackling a specific waiting list, capitalising on a new funding stream) or a longer term timeframe (e.g. increasing awareness and use of a frailty approach).

[3] Kotter J. 2014. Accelerate. Harvard Business Review Press. Boston, Massachusetts.

Question	Summary	Full Update
2. How far has 'care area accountability' been realised? Context: care area budgets have been notional over the past 3 years. Responsibility for the resources underpinning pathways (e.g. a stroke pathway) has remained split between relevant organisations (e.g. MSE ICB, MSE FT, MSE CC).	**Work began in 2023 to develop a pilot of 'care area accountability' in Stroke via a Joint Committee**	Workshops in the Summer of 2022 explored dimensions of responsibility involved in bringing all care area resources under a single responsible entity – with a focus on a lead provider model used for discussion. This was further explored through discussion at MSE CEO Forum in April and September 2023. It was agreed to progress a pilot of a Joint Committee taking accountability on behalf of MSE ICS for stroke resources. In 2024, early work took place to develop terms of reference and agreeing membership from Stroke stewards, Community Collaborative, MSE FT and MSE ICB. The aim of the Joint Committee would be to take collective responsibility for the stroke care area, enabling joint decision-making and risk-sharing approaches, including to financial management and pooled funds. This work was paused whilst a focus on system financial recovery was established. A system resource reporting working group has initially focussed on stroke to develop an aligned, cross-organisational approach to resource reporting along care area lines to develop a true understanding of resource by care area.
Stewardship group-level		
3. How have groups taken accountability for their work? Context: stewardship groups interact regularly with the programme team and with senior leaders for their care area. Broader visibility of, and accountability for their contribution to their care area is crucial for sustaining opportunity and success.	**Cohort 1 groups produced annual reports, outlining different projects and dimensions of their work. All 10 will do in 24-25.** Ongoing visibility and support are maintained via the Stewardship Programme board and regular check-ins between groups and programme team.	For the first time within the programme, we developed a stewardship annual report template to enable each group to highlight efforts and impact across different domains. Annual reports for all cohort 1 groups (i.e. Ageing Well, Cancer, Stroke and Urgent and Emergency Care) were completed in time for our Stewardship Expo in October 2023. Key achievements were further highlighted in a Stewardship Impact Report released at this time (see appendices). These focused on qualitative reporting and identifying future priorities. They included sections on the team itself, its ability to function, membership etc, and on integrated partnership working, pathway improvement, strategic contribution, governance, dashboard development and other project work. The capacity to deliver and the model for a stronger quantitative dimension to these annual reports will be further scoped in 2024. Groups meet regularly with the Stewardship programme team to support ongoing, aligned, purposeful action. Groups must also maintain strong relationships with relevant senior leaders, contribute at key meetings or events and have access to relevant information. Groups' capability to function and to perform their role as stewards is monitored by the Programme team under the Stewardship Programme Board, with supporting actions taken as necessary. Two groups within Cohort 1 (Cardiovascular and Respiratory health) were paused as part of this work. Greater accountability at the care area level is also in development via the Joint Committee arrangements described above in row 2.

Question	Summary	Full Update
4. How have we equipped our stewardship groups with relevant data and connections? Context: stewards bring 'soft intelligence' via their organisational knowledge, relationships and experience. They also need 'hard intelligence' via data flows.	**Most cohort 1 groups have now developed Stewardship dashboards, based on their value frameworks of key personal and population outcomes.**	We committed to develop stewardship dashboards for each cohort 1 group. These are based on their value framework, and therefore should include metrics relating to personal, population and resource outcomes. The dashboards are intended to enable identification of problems and outlying metrics, to support benchmarking and decision-making, and to track changes over time. The personal and population sections have been completed for both Cancer and Ageing Well, with ongoing maintenance. Development of the stroke stewardship dashboard initially focused on developing a specification for resource data which could be used for all care areas. This has been taken on further by a cross-system resources working group. Stroke dashboard development then switched to focus on personal and population outcome data, and is now developing using SSNAP data. UEC have focused data-work on developing the MSE SHREWD platform, which provides real-time health and social care data on demand and capacity across all elements of the UEC system, enabling focussing of support to improve flow. Stewards must maintain their 'soft intelligence' via their individual and team relationships across our system and beyond. Ageing Well also developed the '*Essex is Ageing Well*' Facebook community to support interaction with residents. This has now ended due to ICB re-structuring.
5. How have we continued to support development of our stewardship groups? Context: Cohort 1 groups have been operating since April 2021, with some flux in membership. Cohort 2 groups formed in 2023	**We initiated a second cohort of 6 groups, who completed their 'Crawl' phase of training and development in 2023.** We also supported a refresh of Cohort 1 membership.	Cohort 1 groups have all maintained a solid core membership, with ongoing principles of a flat hierarchy overall and a 'lead steward' for each group acting as the main liaison point. A number of original group members have left for a variety of reasons (retirement, role change etc), and, via the Programme Board, we have promoted new stewards to add their own energies and experience. In the summer of 2023, we ran an accelerated development day for all new Cohort 1 group members. Cohort 2 groups began their condensed training and development programme in March 2023. This included content on team and leadership development (delivered by the Staff College), and value improvement (delivered by AGEM), and supported six cohort 2 teams to start forming as teams, and to produce some of their core value improvement tools (i.e. population and resource scopes, value framework). This material was delivered across 8.5 days over 6 months (previously 12-18 months for Cohort 1 groups). As we develop greater experience and clarity regarding the way in which Stewards work, and the skills and competencies they need as individuals and teams, we have started development of maturity matrix to underpin progression through the crawl-walk-run phases of group development. Finally, the programme has also enabled the emergence of many talented individuals who have used the platform and mission provided by Stewardship within system leadership roles, either as Stewards themselves (such as our Cancer Stewards) or through taking on additional leadership roles, including ICB Medical Director, Alliance Clinical Directors and Clinical Leads, and Provider Organisation Clinical Leads.
Programme team-level		

Question	Summary	Full Update
6. How have we promoted awareness of and engagement with our stewardship groups? Context: It is crucial that stewardship groups are not siloed, and in fact operate in close concert with organisational hierarchies. Broad awareness, alignment and support across leaders and staff is necessary.	**Our 'Stewardship Expo' brought together >100 people to hear about work over the last year. Our monthly Wool Street Journal started in early 2024.** Groups routinely engage with key care area stakeholders. We have also begun to share and discuss the model nationally through award ceremonies, conferences and publications.	We have sought to ensure that key stakeholders across the ICS have remained sighted on the key decisions, activities and successes. At a programme level, we organised the Stewardship Expo in October 2023, with a keynote speech from Matthew Taylor, CEO of the NHS Confederation and updates from the MSE ICB's CEO, former Medical Director, Stewardship Lead and all four Cohort 1 groups. This was attended by over 100 people, including senior leaders from across health and care sectors in MSE. Groups' Annual Reports, as well as a programme-level Stewardship Impact Report was also made widely available at this time. Videos of all keynote speeches were created and are available online (https://www.midandsouthessex.ics.nhs.uk/work/stewardship/). Matthew Taylor and a team from NHS Confed joined in person for our Spring Summit in March 2024, resulting in a national blog. More routinely, groups work closely with senior leaders relevant to their care area, both internal and external (e.g. Cancer Alliance, NHS England, political representatives), and work directly with colleagues across the system on specific projects. Nationally, the programme will be featured in the Leading Improvement in Health and Care podcast this autumn, hosted by NHS Confed and the Health Foundation. We also presented our stewardship approach and progress at a session with senior health and care leaders at the NHS Confederation Expo in June 2023, and the FMLM Conference in 2024. We have also presented and shared details with a number of other organisations and conferences nationally.
7. What capacity will underpin stewardship activity going forwards? Context: we made a commitment that Stewardship is how we do things in MSE. This was maintained as MSE ICB underwent its latest restructure in 2023.	**Our stewards' desire to lead is critical.** **System leaders' support for the stewardship programme as a platform for agile leadership remains vital.** Key enablers are in place to support continued impact.	The vital resources underpinning success to date have been our stewards' sense of purpose, their desire and energy to make a difference, and their ability to lead and influence. They lead in our system as Stewards because they want to, not because they 'have to'. The wellspring sustaining these resources consists of the culture and purpose based on Elinor Ostrom's work, the genuine platform to work differently which the programme has provided to date, and the ongoing capability to remove barriers to change, and to generate and celebrate wins, large and small. As a result of the ICB re-structure in 2023, a number of specific arrangements are now in place to continue replenishing that 'wellspring'. Backfill funding remains in place to facilitate a 'genuine opportunity' to participate. This is available where it would be necessary to bring in staff to cover clinical duties and release frontline stewards for up to one session per week (or two sessions for lead stewards). In the context of financial recovery, we must ensure this resource continues to be used effectively. At our Expo in October 2023, senior organisational leaders re-affirmed their support for staff to use time in this way. A small stewardship programme team is now in place to provide support and structure to the network of stewardship groups, particularly in relation to tackling barriers to change, recognising, capturing and communicating success (more on future plans below). Other significant assets are available across MSE ICS after the ICB re-structure including our system Costing Hub, behavioural intelligence and resources teams, and quality improvement and innovation teams. We will look to collaborate on planned and ad hoc work as appropriate.

3. Look forward – six priorities for Stewardship in 2024-25

What are the key strategic challenges at this time, and what does this mean for the programme?

Challenge 1: Financial Recovery

Context: MSE ICS has an ongoing financial sustainability challenge. The challenge for all staff is to support recovery to a position of system sustainability.

What does this mean for Stewardship? Stewardship is based upon the Triple Aim. The challenge of financial recovery requires a major focus on the third aim – improving the sustainability of resource use. There are three main ways in which stewardship teams and value improvement approaches can support this focus.

1. Value improvement - identify, analyse, execute.

Effect: to identify, analyse and collaboratively execute opportunities to improve value delivered from our resources in the context of financial recovery. We will lead a systematic approach to this, including steps to:

- **Identify** opportunities for value improvement e.g. where existing resources and activity yield limited individual or population value. Potential opportunities might be identified by stewardship groups pooling frontline perspectives, as well as review of resource use, activity, outcome and benchmarking data from stewardship dashboards, Model Health System etc to find and explore variation.[4,5,6,7]
- **Analyse** opportunities in order to confirm realistic potential for value improvement in context of financial recovery. Options will be weighed using criteria including size of opportunity, feasibility and fit with stewardship value framework. Solutions might include pathway re-design or improvement, increasing the use of data and technology to target resource use, staff training and development, changes in commissioning approach, flexing resource use between settings, and reducing resources deployed towards low impact services. This step could involve input from specialist teams and individuals from across MSE including our stewardship teams, system costing hub, health economist and quality improvement teams, as well as commissioning and delivery experts as appropriate.
  We will share regular updates for visibility and consideration with relevant ICB and Provider financial recovery committees.
- **Execute** value improvement opportunities, involving collaboration across stewardship teams, provider and delivery leads.

2. Underpin commissioning decision-making.

Effect: to strengthen decision-making towards financial recovery, stewardship teams should work with our commissioning and decision-making committees across the ICB and Providers.

In the context of financial recovery, system decision-making (i.e. considering options to increase or reduce the resources used for different services) will depend on understanding and weighing the value and impact of different proposals e.g. to stop, start, reduce or increase particular services. This may be reviewing existing contracts when they are due for review, as well as considering proposals for new or altered activity. Our stewardship groups have already started to contribute by reviewing proposals relevant to their care area.

This process should combine local data, national evidence and 'soft intelligence' (i.e. stewardship teams' knowledge of each care area), underpinned by use of their value frameworks[8] (e.g. individual and population outcomes), to assess and advise on proposals for investment or disinvestment.

3. Adjust programme trajectory for 2024-25.

Effect: We will slow development of new stewardship groups to release non-recurrent funds. This will mean shifting from the ambition to achieve 25 groups by 2025 in our system Joint Forward Plan, with no new groups in 2024-25. This will mean there will be a maximum of 10 groups by 2025.
Proposals had been discussed at Stewardship Programme Board for a full Cohort 3 of six groups, (including CVD, Respiratory, Women's Health, Renal, Gastro and Neurology/ Neurosurgery), a reduced Cohort 3 of three groups (CVD, Respiratory, Women's Health) or having no new groups in 2024-25. The programme will adopt the final option, with no new groups in the coming financial year, with a one-off reduction in training and development investment this year.
The existing 10 groups will produce progress updates by early 2025, highlighting key achievements over the past year, and identifying priorities for their care area to signal intent and support system planning.

---

[4] Appleby J., Ham C., Imison C., Jennings M. (2010) Improving NHS Productivity. Kings Fund.
[5] Alderwick H., Roberston R., Appleby J., Dunn P., Maguire D. (2015) Better Value in the NHS. Kings Fund
[6] Jabbal J., Lewis M. (2018) Approaches to Better Value in the NHS. Kings Fund
[7] NHS RightCare. Methodology. Available at https://www.england.nhs.uk/rightcare/rightcare-methodology/
[8] Each value framework is tailored by a stewardship group to their own care area. The framework is based on considering individual impact (e.g. on quality of life, personalisation of care and experience of services), and population impact (e.g. equity of access, equity of outcomes, burden of disease and burden of treatment).

Challenge 2: Building beyond re-structure

Context: During 2023, MSE ICB re-structured in line with national requirements to reduce running costs by 30%, whilst in 2024, the requirements of financial recovery have taken shape, including changes to Provider organisation structures. This has led to new teams, portfolios and relationships forming across the ICS.

What does this mean for Stewardship?
We will contribute towards developing the new system operating model, so that our frontline staff continue to play a key role in delivering the triple aim.
We will also work to make best use of the talents and resources across the system.

1. Re-orientate:
Effect: stewardship groups and the programme team have the right relationships, routes and presence across the system to get things done, with enough time to do their work, and an understanding of current priorities.

After the ICB re-structure, the new ICB stewardship programme team is in place to support stewardship teams to continue maturing in effectiveness and impact.
Part of this will be working with the groups to update and ensure appropriate relationships and governance links, as the ICB re-structure and requirements of financial recovery have resulted in a lot of change in personnel and processes across the system.
Specific actions will include working to update backfill guidance and processes for stewards with a clinical role, refreshing our Programme Board terms of reference, membership and reporting lines. We will also work to update planning timelines for stewardship dashboard development and wider BI and data support.

2. Consolidate:
Effect: work to make existing elements of stewardship programme will be more effective and resilient, including our current groups and our approach to engagement. All organisations and staff groups in MSE should have awareness of the programme and of opportunities for them engage further.

We will support our six cohort 2 groups (Children and Young People, Dermatology, Diabetes, Eyes, Mental Health and Musculoskeletal) to continue developing in line with our crawl, walk, run framework. This means support and challenge to form the key relationships, team practices and confidence, whilst delivering change and improvement for our population and system.

The AGEM Stewardship Stocktake report (presented to ICB Board March 2023), as well as discussions at the ICS Stewardship Expo (October 2023), highlighted that many people remained unaware of the impact of stewards' work. We will work to strengthen our approach to sharing successes and ongoing work across our ICS and beyond via our new monthly newsletter (*Wool Street Journal*), exploring options for webpage development, and updating programme reporting formats to be shared across organisations and staff groups in MSE ICS. We will also continue to run monthly Community of Interest sessions, open to all stewards to join with others leading work with system-wide implications. Finally, we will explore further options to share materials and stories nationally.

3. **Innovate and Improve**:
Effect: we will support further work on a model of whole system stewardship, updating proposals for Joint Committee arrangements and health and care resource alignment in Stroke Care (or another area e.g. Frailty) which were paused to enable ICB re-structure and immediate focus on financial recovery. We will also explore ways to align stewards' efforts with national policy trends, including intentions for 'left shift' and greater adoption of the wealth of digital and data tools now available.

Towards a whole system stewardship approach: Discussions towards the end of 2024, involving MSE ICB, FT and Community Collaborative executive and senior leaders, have all supported intent to move towards stronger models of collaborative working. These should focus on shared system priority areas, involve established stewardship teams where these exist, and be based upon stewardship principles overall.

Shared System Priority areas: These will be aligned with Medium Term Plan priority areas, and are also likely to align with our most mature stewardship teams, for example Cancer, Frailty, Urgent and Emergency Care, and Cardiometabolic disease (N.B. currently there are stewardship groups for Stroke and for Diabetes, but not for Cardiovascular disease).

Proposal for 'Mission'/ 'Priority' Board model: The next step in our stewardship journey as a system will be to convene 'Mission' or 'Priority' boards. These will forge together frontline leadership from stewards, commissioning expertise from the ICB and delivery experience from MSE FT and the Community Collaborative into teams. These teams will take on responsibility for key priority areas, differing from previous arrangements in the way that they build on Ostrom's core stewardship principles.

Stewardship principles: These stewardship principles are drawn directly from Elinor Ostrom's Nobel Prize-winning work (see table 2 below).

Organisational Development (OD) approach: We will develop an OD approach for these 'Mission' or 'Priority' Boards, based on what has worked well in forging effective teams from scratch over the past 4 years, and giving them a secure foundation in stewardship principles. We will also seek to develop OD opportunities relevant to any staff member, to support broader cultural change across the health and care system.

We will also continue, via the Stewardship Programme Board, to explore application of stewardship principles beyond the care area model, for example to staff groups such as Allied Healthcare Professionals and to locality settings.

Support emerging local and national policy:
We will explore ways to align stewardship group efforts with emerging national policy, such as that signalled in the Darzi Report and forthcoming updated national 10 year plan. This will likely include shifting care and resources from acute to community settings, from a treatment to prevention focus, and from analogue to digital.
New models of care such as the Fracture Liaison Service, MSK Community Assessment Day and CVD Hypertension outreach work signal a way ahead.

Digital and Data:
We already have some award-winning digital and data exemplars within MSE, including the electronic Frailty Care Coordination System (eFraCCS) and our system Costing Hub.
Across MSE ICS, there is a wealth of data and analytical capability, including BI analysis, our system costing hub and PHM team. The past three years have shown how important these can in delivering change – including the presentation and analysis of activity and outcome data, the use of costing techniques such as Patient Level Information and Costing System (PLICS) and the Socio-technical Allocation of Resources (STAR), population health management approaches and the stewards' own value frameworks.

We will develop a more robust approach data use within the Stewardship programme. This should provide appropriate tools and techniques (e.g. system dashboards and additional focused data sets) to support stewards in reviewing trends, identifying problems and priorities, developing solutions, and monitoring impact. It will also enable clear communication of successes, and learning from failure, for example through inclusion in stewardship annual reports.
We will also explore ways to better support and embed digital innovation, including how the Shared Care Record and Patients Know Best app can add value to existing pathways.

Table 2: Stewardship principles in MSE (Adapted from McGuiness 2013)[9]

	Ostrom Stewardship principles	Application in MSE ICS
Leading the commons	**Trusted leaders** - Commons need trusted leaders with moral authority	Bring together established Stewards with Commissioning and Delivery Leads from MSE ICB and Provider organisations in Mission/ Priority Boards for key priority areas.
Defining the commons	**Clear boundaries** - commons need clear boundaries **Clear aims** - commons need a long-term horizon with clear aims	Define clear scope for each mission board, including population size, burden of disease, resources, activity and outcomes. These should aim to cover whole pathways of care. Define clear aims, with a long-term horizon. These will likely align with our system Medium Term plan, as well as the Triple Aim for ISCs.[10]
Organising the commons	**Wide participation** - all resource users should be involved in decision-making. **Recognised autonomy** – commons need to have the right to self-organise **Nested enterprises** – commons often work by devolving responsibility through tiered networks.	Mission/ Priority Boards must forge together frontline leadership from stewards, commissioning expertise from the ICB and Delivery experience from Providers into teams. We will work together to define scope to act for each board, aiming to maximise autonomy, with accountability overall to the Commissioning Board. The Mission/ Priority Boards will consider delegating responsibility to particular system partners, working groups etc. in the course of their work.
Managing the commons	**Congruence** – resource rules should match local context **Responsible monitoring** - the use of resources and adherence to rules should be monitored **Graduated sanctions** - failure to meet the rules leads to graduated sanctions	Each Mission/ Priority Board must have reference to national and local mandates and recommendations in their decision-making and delivery – with particular note of local resource rules. Population health outcomes and resource use will be monitored at the care area level, to ensure long term resource stewardship - alongside effective, quality service delivery. The stewardship groups' value frameworks will support this monitoring. We will develop transparency and sanction mechanisms as appropriate, for individuals, teams or organisations, to ensure adherence to agreed resource rules. These should include clear signals to

[9] McGuiness M. 2013. Caring for the Health Commons: What It Is and Who's Responsible for It? Rethink Health. Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2221413

[10] Health and Care Act 2022: Triple Aim. *"…must have regard to all likely effects of the decision in relation to a) the health and well-being of the people … b) the quality of services provided… c) efficiency and sustainability in relation to the use of resources..."* Available at www.legislation.gov.uk/ukpga/2022/31/enacted

	Ostrom Stewardship principles	Application in MSE ICS
		rule breakers that misbehaviour has been observed, with sanction options including social e.g. awareness, and structural e.g. limiting influence over or access to resource decision-making.
	Dispute resolution - conflicts need an easy means of resolution	We will develop appropriate dispute resolution mechanisms, aiming to resolve at the simplest level possible.

Part I ICB Board Meeting, 16 January 2025

Agenda Number: 8

Contract Awards for NHS General & Acute Services and ISP Acute Contracts 2025/26

Summary Report

1. Purpose of Report

To provide the Board with the information required to agree to the award of contracts to NHS providers of General & Acute Services, and Independent Sector Acute Services in Mid and South Essex from 1 April 2025.

2. Executive Lead

Jennifer Kearton, Executive Chief Finance Officer

3. Report Author

Janette Joshi, Deputy Director of Contracting

4. Responsible Committees

NHS General & Acute Services

The recommendations within the paper were supported by the ICB Operational Group on 16 December 2024, and supported by the ICB Executive Committee at the meeting on 17 December 2024. The recommendations in the paper were also supported by the ICB Finance and Performance Committee on 7 January 2025.

Independent Sector Acute Services

The recommendations within the paper were supported by the ICB Operational Group and supported by the ICB Executive Committee at the meeting on 5 November 2024. The recommendations in the paper were also supported by the ICB Finance and Performance Committee on 5 November 2024.

5. Impact Assessments

Not applicable to this report

6. Financial Implications

The contracts identified in this paper have existing recurrent budgets, and therefore the paper is not requesting new investment decisions. Financial values quoted relate to 2024/25, and are therefore indicative, subject to the publication of operational planning guidance and the NHS Payment Scheme for 2025/26.

7. Details of patient or public engagement or consultation

The recommendations made in this paper do not require patient or public consultation.

8. Conflicts of Interest

Conflicts of interest are managed in accordance with the ICB policy, conflicted members are excluded from decision making.

Given this is not a commercially sensitive procurement, it does not relate to a selection process and is a decision on the rolling over of contracts, conflicted colleagues may remain in the meeting, but will be excluded from decision making. Should the Chair consider at any point that a confidential discussion is required, conflicted members may be asked to temporarily leave the meeting. This principle also applies where it becomes apparent to a conflicted colleague that they should in fact recuse themselves from the discussion to avoid any perception that the conflict is not being managed appropriately or open discussion is potentially hindered.

9. Recommendation/s

The Board is asked to:

- agree to award a 3-year contract to Mid & South Essex Foundation Trust for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.
- agree to award 1-year contracts to the NHS Acute Providers specified in this paper (Appendix A), for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.
- approve the proposal to undertake a 'Self Declaration' Accreditation process for the existing contracted Independent Sector Providers of Acute Elective Services (Appendix B) with the intention of awarding a contract for a three-year term under Provider Selection Regime Direct Award Process B.
- note that contract values for 2025/26 will be calculated in line with national guidance and using the ICBs planning principles.

Contract Awards for NHS General & Acute Services and ISP Acute Contracts 2025/26

1. Introduction

There are 4 contracts with NHS Providers of General & Acute services (with a contract value in excess of £10m) that are due to expire on 31 March 2025. The contracts are for healthcare services which are in scope of the Provider Selection Regime (PSR), and therefore must be re-procured under the most appropriate process.

In addition, there are 4 contracts with Independent Sector Provider of Acute Services (with proposed contract values in excess of £10m). The services are healthcare services in scope of patient choice and therefore must be re-procured under the most appropriate process.

2. Contracting arrangements for NHS Providers of General & Acute Services

Procurement and Contracting Considerations

The NHS Payment Scheme Requires contracts to be in place with NHS Providers, where the relationship is not covered by Nationally determined Low Value Associate (LVA) arrangements.

The ICB currently has 4 contracts with NHS Providers of General and Acute Services (with a contract value in excess of £10m, see Appendix A). The ICB currently contracts directly with Mid & South Essex NHS Foundation Trust, and Barking, Havering & Redbridge NHS Trust, while the other NHS Providers are contracted for on an Associate basis.

The contracts are for healthcare services which are in scope of the Provider Selection Regime (PSR), and therefore must be re-procured under the most appropriate process.

Direct award process A must be used when all of the following apply:

- there is an existing provider of the health care services to which the proposed contracting arrangements relate
- the relevant authority is satisfied that the health care services to which the proposed contracting arrangements relate can only be provided by the existing provider (or group of providers) due to the nature of the health care services.

The contracts NHS Providers of General and Acute Services satisfy the above requirements, and therefore Direct Award Process A (DAP A) must be followed.

The contract form must be the NHS Standard Contract (Full Length).

It is proposed that the contractual arrangement for Barking Havering & Redbridge NHS Trust move to an Associate basis in 2025/26, to align the contracting arrangements for both delegated specialised services and ICB commissioned services.

Financial Implications

The NHS Payment Scheme (NHSPS) requires that the Aligned Payment and Incentive (API) payment mechanism is applied to all NHS Provider relationships for acute services not covered by LVA arrangements.

The two components of API arrangements are:

- a fixed element, based on funding an agreed level of activity
- a variable element, which increases or reduces payment based on the actual activity and quality of care delivered

API is designed to support the delivery of system plans and encourage providers and commissioners to collaborate to agree the best way to use the resources available to systems and to remain in financial balance. It provides a consistent approach to paying for acute secondary healthcare services.

The contracts identified in this paper have existing budgets within the current financial year, and therefore the paper is not requesting new investment decisions.

Financial values specified relate to 2024/25, and are therefore indicative, subject to the publication of operational planning guidance and the NHS Payment Scheme for 2025/26. The current 2024/25 annual contract values are included in Appendix A.

Contract values for 2025/26 will be calculated in line with national guidance and using the ICBs planning principles regarding inflationary uplifts, efficiency requirements, convergence and growth, and known service changes.

3. Contracting arrangements for Independent Sector Acute Services

Procurement and Contracting Considerations

The ICB currently holds four contracts with Independent Sector Providers (ISPs) for acute elective care services where the annual forecast exceeds £5m (see Appendix B). All contracts are cost and volume, based on national tariff (referred to as Payment by Results or PbR) and expire on 31st March 2025. There are no quality concerns with the current services at any of the ISPs.

In adherence with Patient Choice and PSR requirements, it is proposed that following a 'Self Declaration' Accreditation process, contracts are awarded for a three-year term to the existing ISPs under PSR DAP B.

For any new ISP requesting accreditation and award of contract, the process outlined in the ICB Patient Choice Provider Accreditation Policy is applied. For existing ISPs with which the ICB already holds contracts and undertakes routine quality assurance, it is

proposed that a 'Self Declaration' Accreditation process is followed, by which an application is completed by each contracted ISP and that this is assessed before renewing (awarding) the contract. The Self Declaration Accreditation would be a 'light' version of the DAP B Process and would include CQC status, information governance (IG) compliance, Governance, and other mandated requirements.

PSR regulations are not specific on contract term and therefore the recommendation, given that these are cost and volume contracts, is to award a contract for a three-year term for those expiring on 31st March 2025. The longer contract term will reduce the future impact on commissioning and contractual resource.

Financial Implications

The NHS Payment Scheme (NHSPS) requires that the activity-based payment mechanism is applied to activity delivered by non-NHS Providers for services where there are NHSPS unit prices.

The contracts identified in this paper have existing budgets within the current financial year, and therefore the paper is not requesting new investment decisions.

The proposed contract values for the three-year term are shown in Appendix B. It should be noted that these are the estimated values based on 24/25 forecast outturn as at month six, and are therefore indicative, subject to the publication of operational planning guidance and the NHS Payment Scheme for 2025/26.

Contract values for 2025/26 will be calculated in line with national guidance and using the ICBs planning principles regarding inflationary uplifts, efficiency requirements, convergence and growth, and known service changes.

4. Recommendation(s)

For NHS General & Acute Services, the ICB must contract with NHS Providers of General and Acute Services (not covered by LVA arrangements). The contracts satisfy the requirements of Provider Selection Regime Direct Award Process A, and therefore this process must be followed.

For Independent Sector Acute Services, the services are in scope of patient choice and therefore Direct Award Process B must be followed.

The Board is asked to:

- agree to award a 3-year contract to Mid & South Essex Foundation Trust for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.
- agree to award 1-year contracts to the NHS Acute Providers specified in this paper (Appendix A), for General & Acute Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.
- approve the proposal to undertake a 'Self Declaration' Accreditation process for the existing contracted Independent Sector Providers of Acute Elective Services

(Appendix B) with the intention of awarding a contract for a three-year term under Provider Selection Regime Direct Award Process B.

- note that contract values for 2025/26 will be calculated in line with national guidance and using the ICBs planning principles.

5. Appendices

Appendix A – NHS General & Acute Services (>£10m Aggregate)

Provider	24/25 Annual Contract Value Post CUF Uplift	Recommendation	Indicative Aggregate Contract Value
MID AND SOUTH ESSEX NHS FOUNDATION TRUST	£1,103,229,229	3 year contract award under PSR DAP A	£3,309,687,687
BARKING, HAVERING AND REDBRIDGE UNIVERSITY	£43,411,734	1 year contract award under PSR DAP A	£43,411,734
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION	£34,215,961	1 year contract award under PSR DAP A	£34,215,961
BARTS HEALTH NHS TRUST	£22,133,467	1 year contract award under PSR DAP A	£22,133,467

Appendix B – ISP Acute Services (>£10m Aggregate)

Independent Sector Provision	24/25 Contract Value	24/25 Forecast Outturn	Proposal	Proposed Aggregate Contract Value
Ramsay Health Care - Springield	£22,362,068	£22,725,955	3 year term, Cost & Volume	£68,177,865
Spire Healthcare - Wellesley, Hartswood, London East	£17,074,843	£18,867,467	3 year term, Cost & Volume	£56,602,401
SpaMedica	£15,191,893	£16,030,519	3 year term, Cost & Volume	£48,091,557
Nuffield Health - Brentwood	£6,945,680	£5,561,324	3 year term, Cost & Volume	£16,683,972

Part I ICB Board meeting, 16 January 2025

Agenda Number: 9

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, 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 Chief Executive, including the work undertaken and decisions made by the Executive Committee, and
- Note the three-month update from the Community Consultation Working Group at **Appendix B**.

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Chief Executive covering key issues, progress and priorities since the last update. The report also provides information regarding decisions taken at the weekly Executive Committee meetings.

2. Main content of Report

2.0 Key activities since the last Board meeting

Since the last meeting of the Board in November 2024, I have been involved in several events and activities including:

- Attending a Personality Disorder Group meeting organised by Mid and North Essex Mind in Braintree.

- Speaking at the Southend Association for Voluntary Services (SAVS) Annual General Meeting.

- Participating in the Thurrock People Overview and Scrutiny Committee to discuss General Practice resourcing and estates as well as the Essex Health and Wellbeing Board.

- Attending two research related events, firstly a Cancer Research Networking Event and the Research Engagement Network (REN) Learning Event.

- Various other meetings with stakeholders and partners from across mid and south Essex.

2.1 Prioritisation and Medium-Term Planning

Since the last Board meeting the ICB has continued to work to agree its areas of focus for the remainder of the financial year. These priorities are set out in **Appendix A** to my report for information. This work is intended to better focus the resource of the ICB for the remainder of the year on activities which will underpin future sustainability and improved outcomes. Progress will be monitored via a new monthly reporting and accountability cycle reporting through to the Executive Committee.

Alongside this we have commenced work on the development of the Medium Term Plan (MTP) for the system with the specific aim of addressing the sustainability challenge faced by health and care services over the next three to five years, which will succeed the prioritisation work once agreed. Extensive engagement is currently underway with the work reporting through to the CEO Forum. We are aiming for the initial draft of the plan to be ready by the end of January 2025 to help inform financial, operational and service planning for 2025/26.

At the time of writing the national guidance on planning for 2025/26 was not available, although we anticipate that, given our planned deficit position and current performance across a range of standards, this will be challenging for the system and will require substantial change to deliver the improvements that our communities expect.

2.2 ICB development and staff survey

Board members will note that one of the priority areas for the ICB is the development of the Organisational Development Plan which I identified as a priority in my last report.

To help inform this we have seen a good uptake of the NHS Staff Survey, which was 79%. This was above average for ICBs in England and a significant improvement on last year (62%). The full analysis of this, once available, will help us understand opportunities for improvement.

2.3 Community Services Consultation

The Working Group on the Community Services Consultation has continued to meet monthly, with a variety of sub-groups to focus on specific areas of interest.

I attached in **Appendix B** the three-month report from the chair of the working group, which sets out the emerging findings of the group and its work for the next period of time before it makes its recommendations to the Board to be considered as part of the outcome of the consultation.

2.4 Winter

As expected, we are experiencing pressures within the urgent and emergency care system associated with winter. The system is working well together to help mitigate these pressures, whilst recognising that we are still seeing some days where access and experience are not as good as we would wish.

I particularly want to highlight the excellent work undertaken by the Discharge Cell which I covered in my last report. Early numbers show that as a result of focused partnership work we are seeing the lowest number of medically optimised and delayed patients in hospital across mid and South Essex (MSE) since formal recording commenced in December 2021.

This will be complemented by the co-location of the Unscheduled Care Coordination Centre with the Discharge Cell at Phoenix House in January 2025, and the commencement of the trial of providing access to Care Homes and GP Practices in-month. This is intended to help support greater admission avoidance and redirection of patients to alternative services from hospital where clinically appropriate.

We have also launched our new model Discharge to Assess pathway since the last Board report. This is intended to provide greater therapeutical and case management support to patients who are discharged from hospital via this route, so their health is optimised, and their ongoing care needs identified and met faster.

In common with all areas across England, we are seeing an increase in the number of patients with flu or COVID in our hospitals and are therefore continuing to push vaccine uptake across MSE. At the time of writing, overall vaccine uptake is slightly down on last year (as is the case across England), although the MSE system is performing above the national average, with particular focus on Southend, Thurrock and Castle Point as the areas of lowest uptake.

2.4 General Practice Estate

One of the issues which has been raised with me repeatedly since commencing at the ICB is the quality and availability of general practice estate as a key rate limiting factor in facilitating 'left shift' and the expansion of service capacity.

Whilst we await news on whether there will be additional NHS capital funding available in 2025/26 for general practice estate, we do have the opportunity with the recent changes in regulations to begin to deploy Section 106 (S106) development contributions held by local authorities to improve healthcare facilities. We are currently prioritising this work on tactical schemes to improve the quality and availability of general practice estate with the following schemes already having been approved in the last few months:

- Sidney House & The Laurels Doctor's Surgery, Chelmsford
  - Funding to support additional clinical workforce.
  - Funding for reconfiguration and adaptation of existing space creating additional clinical space.

- Church Lane Surgery, Braintree
  - Funding to support refurbishment of practice first floor, allowing additional room for clinical consultation rooms.

- Chelmer Medical Partnership & Rivermead Gate Medical Centre, Chelmsford
  - Funding split across both practices to support refurbishment of existing space, to create additional clinical consultation rooms, and administrative support.

- Coggeshall Surgery, Coggeshall
  - Funding to support creation of new rooms to support clinical consultations.

3. Executive Committee

Since the last report, there have been seven weekly meetings (from 5 November 2024 to 17 December 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 ICB Executive Committee:

- Review of Memorandum of Understanding with NHS England for Medicines Optimisation of Controlled Drugs.
- Review of multiple Service Restriction Policies (SRPs) including revision of existing policies.
- Agreement to build on an existing dental pilot across care homes within MSE creating a fully commissioned service.
- Review of contractual management approach across the ICB's clinical contracts, including new governance arrangements and oversight.
- Approved commissioning intentions for Elective Tier II and Independent Sector Providers.
- Review of multiple operational business cases across the ICB.
- Approved contract award for Stroke Services.

- Review of Attention Deficit Hyperactivity Disorder (ADHD) service provision within primary care.
- Approved Terms of Reference for the ICB's internal Learning and Development Steering Group which reports into Executive Committee.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability across the system and organisation.

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'.

4. Recommendations

The Board is asked to:

- Note the current position regarding the update from the Chief Executive, including the work undertaken and decisions made by the Executive Committee, and
- Note the three-month update from the Community Consultation Working Group at Appendix B.

5. Appendices

Appendix A – ICB Priorities

Appendix B – Three-month report from the Chair of the Community Services Consultation Working Group

Appendix A - Priorities – December 2024 - April 2025

Alliances

- **FrEDA** (Frailty, End of Life, Dementia Review a… Assessment) roll out, including end of life and dementia diagnosis.
- **Serious Mental Illness (SMI)** and **Learning Disability (LD)** health checks.
- **Hypertension** identification.

Delivery

- **Musculo-Skeletal (MSK)** and Pain Service re-procurement
- **Dermatology** and **eye care** pathway improvements
- **Clinical Diagnostic Centre (CDC)** programme delivery.
- **Cancer** pathway improvements
- Service reviews of community **gynaecology** and **urology**

Primary care commissioning

- Service continuity in adult **Attention Deficit Hyperactivity Disorder (ADHD) prescribing and Electrocardiograms (ECGs).**
- Piloting solutions for **GP prescribing** on behalf of acute and community services.
- **Vaccination** programme delivery.
- **Connected pathways** implementation.
- Dental Access Programme and **Care Home** schemes
- Mobilising **children** and **young people** dental scheme.
- Ensuring delivery of **dental access**.

Community commissioning

- Improving data availability for community services.
- Identifying **levelling up/out** opportunities.
- **Virtual ward** optimisation
- **Intermediate Care (IMC) bed** utilisation
- **Community Consultation** working group

End of Life Care

- Development of **single end of life model** across mid and south Essex with aim of establishing 24/7 service access aligned with Unscheduled Care Co-ordination Hub (UCCH).

Urgent and emergency care

- **Winter resilience** and response, deployment of discharge cell and co-location of UCCH.
- Strengthening **UCCH** operations and access.
- Developing a **whole system** bed model, including for mental health (MH) services (with MH LD team).

Mental health

- **Talking therapies**, primary care mental health services and recovery college re-procurement.
- **Mental health bed** model development.
- **SMI Health Checks**
- **Out of area** placement reduction.

Learning disabilities

- **LD Health checks**
- Facilitating and progressing **s.75** and other collaborative arrangements within the ELDP partnership.
- Reviewing and developing a new **LD/ASD (Autism Spectrum Disorder)** care pathway to reduce inappropriate admissions.

Babies, children and young people

- Establish a LD programme for **Children and Young People (CYP).**
- Implement the pan-Essex **neurodiversity** action plan.
- Establish a provider framework for **ASD/ADHD** right to choose framework.
- Develop an outcomes data dashboard for **Special Educational Needs and Disabilities (SEND)** and embed a balanced therapies model.

Estates

- **Section 106** utilisation and deployment.

All age continuing care

- Pillar 1 – **efficiency** and **productivity** programme.
- Pillar 2 – pilot new **Discharge to Assess (D2A) model** and develop proposed model for 25/26
- Pillar 3 – Explore options for **integrated brokerage** with local authorities.

Appendix B

Three month update from the Chair of the Community Consultation Working Group

Introduction and background

The Working Group into the services hosted at St Peter's Hospital in Maldon, the wider pathway and wider impacted areas in Mid and South Essex was set up by the ICB Board following a lengthy consultation process which focused around 3 core elements with the following rationale;

1. Disposal of the St Peters estate given it was too large and dilapidated, and the corresponding rehousing of all ambulatory services within Maldon District.

2. Two options regarding the relocation of stroke beds where they would move away from St Peters to consolidate them in larger sites which were easier to staff with wrap around expertise, as well as the "home first" policy of care.

3. The removal of the birthing unit from St Peters on the basis that the ad-hoc and stretched staffing was becoming both too complex and unsafe.

It was broadly felt by Working Group members that, despite a lot of good work being done, the consultation had left a number of issues unresolved, not fully thought-out, and needing additional work. The entire Working Group welcomed the pause put in place by the ICB Board.

Purpose of the group

Following my appointment, I have hosted over 20 one on one meetings, four full commission meetings, and three site visits. The first working group meeting culminated in the unanimous passage of the mission statement which set out that;

- A – The group must suggest a long-term solution, rather than a temporary solution at the end of the groups' 6-month mandate. The only temporary solutions being transitional arrangements from the current site to the new. To fail to finish this work in 6 months risks a knee-jerk decision that no one will be happy with.

- B – While we want to work with local government and wider partners to co-design a solution, the solution cannot be so complex and with so many moving parts that the scheme is too mired in risk to be delivered. We are talking about the current package of services and connected issues, not the entire gambit of healthcare provision in general.

- C – That the meetings will remain a private and free exchange of ideas, leading to my recommendation in April 2025, but with time and space for any dissenting views to be added.

Emerging findings

Thus far, a near consensus has emerged on the following points;

1. It is not broadly disputed that St Peter's is too large and too outdated to remain or to be financially viable to refurbish totally. The original basis for a change is sound.

2. With regards to the plan for a new health hub for ambulatory services, the original consultation lacked clear thinking for the community, staff and patients on a definitive future. Work is now underway to drill down on options from a land list, following unviable options being removed. At the moment, the bulk of this work is being focused on utilising a portion of the current St Peter's site given all the transport logistics are currently focused on it. Shortly, community representatives will be invited to consider some details concerning the art of the possible in an estates working group.

3. A new home for the ambulatory services should host all services together, and not separate them unless there is a compelling reason not to.

4. The original consultation did not consider what options there are to bring additional services into Maldon. This is now being rectified by formally inviting expressions of interest to partners.

5. The original consultation did not consider the primary care needs of the area and how this process could address these. This is now being rectified by the calculation of the GP clinical space deficit in the district and how this could be addressed in a new outpatients build, being led by the Alliance Director.

6. The current position on bed sufficiency saw some data which was too out of date / inaccurate to form a final opinion. A working group has been set up to consider a refreshed data set. The clinical leadership remains that a policy of home first is the correct way forward, as is consolidating bed location to ensure stability of a wrap around workforce.

Next steps

In terms of the future, the final 3 months of this commission will focus on:

- A – Fleshing out the exact scope and viability of the new site, matching the cost per square footage with financial resources.

- B – Taking a formal view on if option A or B for the reprovision of beds is correct based on refreshed data, and being satisfied that the home first and bed entry criteria is being referred to the correct bodies based

- C – Taking the evidence on the birthing unit to consider its future.

I would like to express thanks to the community groups such as SMMS, all the NHS staff, provider groups, local government and elected members, both MPs and to the staff supporting the commission, such as Teg, for their hard work.

James Halden
Chair
December 2024

Part I ICB Board meeting, 16 January 2025

Agenda Number: 10

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response. This Quality Report provides a focus on escalations from the Quality Committee relating to sodium valproate and opioid use; NHS Insightful Board guidance; the current position in relation to regulatory oversight by the Care Quality Commission; implementation of the Assessment and Management of Risk in line with national guidance'; and implementation of the RASCI (Responsible, Accountable, Support, Consulted and Informed) Tool in line with national guidance.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Dr Giles Thorpe, Executive Chief Nursing Officer.

4. Responsible Committees

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 develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

None required for this report.

7. Financial Implications

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is asked to:

- Note the points of escalation from the Trust's Quality Committee relating to Sodium Valproate and Opioid usage.
- Note the national update shared with the Trust's Quality Committee.
- Support the implementation of NHS Insightful Board guidance, in line with NHS England recommendations.
- Note the current position in relation to regulatory oversight by the Care Quality Commission
- Support the implementation of the Assessment and Management of Risk in line with the national guidance.
- Support the implementation of the RASCI Tool in line with national guidance.

Mid and South Essex Quality Report

1. Introduction

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

1.2 The report for this Board provides an update from the ICB's Quality Committee with any key points of escalation. Furthermore, the Quality Report for this month's Board will also provide an initial update on the development relating to Quality Improvement data, and the refresh of the System Quality Group.

2. Quality Committee Update and Escalations

Sodium Valproate Patient Safety Alert

2.1 The Quality Committee received an update in relation to an ongoing national alert regarding the use of Sodium Valproate. Not all actions within the alert have been fully evidenced across all providers and so the committee has requested a further detailed report to be provided in February 2025.

2.2 It is expected that full assurance that pathways within the hospital are changed to ensure patients seen under the pregnancy prevention programme are routinely monitored will be sought through the Pharmacy Optimisation and Maternity teams. All new patients being placed on sodium valproate are now required to have the use of sodium valproate signed off by two specialists.

Medicines Management – Opioid Overuse

2.3 The Quality Committee received information regarding opioid use. It was positive to note that the Mid and South Essex (MSE) system was at the lower end of the spectrum in relation to patients taking opioids overall compared with other Integrated Care Systems. MSE I will continue to focus on ensuring long-term use is minimised as much as possible, given ongoing variation at place level. Findings from the Southend Essex and Thurrock Suicide Prevention Group were also shared which evidenced from police real-time suicide surveillance data a high correlation between suicide and long-term opioid prescriptions. This was flagged by partners as a standout issue.

2.4 Key performance indicators (KPIs) within hospital settings are being monitored to ensure a stop date is defined when prescribing opioids for post-operative pain relief for those patients being discharged.

2.5 Committee members were informed of an ongoing challenge with practices not receiving formal deprescribing support for patients on high doses of morphine as this is not a commissioned service. However, as the community Musculo-skeletal (MSK) pathway is commissioned, this provides an opportunity for GPs to refer these specific patients in pain on high dose opioids for management, which includes deprescribing, but this is a limited offer.

2.6 The KPIs for general practice focus on deprescribing and refraining from starting discharged patients on opioids unless absolutely necessary. If prescribing is required, patients will have an 'opioid contract' as a strategy to avoid long-term use of opioids.

2.7 The Committee will seek to receive further information on the success of these strategies in a future report.

National Update – Chief Nursing Officers Conference

2.8 The Committee was informed that at the Chief Nursing Officers conference held in October the new Chief Nursing Officer for England, Duncan Burton, spoke about the development of the new national nursing and quality strategies, which would be aligned to the 10-year plan. A focus on 'Kindness to Professionals' and 'Sexual Safety' initiatives and aligning the 10-year plan with central government missions formed part of the ongoing development works, alongside widespread national engagement focussed on the new 10-year plan.

The Insightful Board

2.9 Amanda Pritchard, Chief Executive of the NHS, also shared the development of new guidance for Boards, both at provider and ICB-level – The Insightful Board.

2.10 This guide helps integrated care boards (ICBs) to assess the effectiveness of the information they collect and use. Using information insightfully – supported by robust corporate governance arrangements – enables the ICB board to:

- be assured the organisation is meeting its statutory duties
- spot early warning signs of quality, performance or financial issues across the system
- ensure that care provided across the system is continuously improving and services meet the population's current and future needs
- stand back and consider whether the ICB's leadership, culture, systems and processes are getting the right results.

2.11 This guide is built around the 6 functional areas which underpin how ICBs deliver their purpose. It suggests, within each functional area, a range of indicators, information and lines of enquiry to help ICBs – it does not mean that ICBs need to structure their Board reporting in this way. It is not a checklist of data and behaviours; it is a starting point that ICB Boards can adapt and develop in line with their needs, reflecting the scale and complexity of their systems. This similar guidance is for boards of NHS providers.

2.12 This guide is structured as follows:

- chapter 1: expectations of ICB boards, and ICBs' core purpose and functions
- chapter 2: high level principles which underpin the effective use of information
- chapter 3: suggested information sets to support the delivery of each function
- chapter 4: considerations for processes and practices.

2.13 Guidance has now been published, with the Corporate Governance and Quality teams reviewing the contents, in readiness for preparation for its implementation in line with national expectation. A Board seminar will be developed to support how this will be operationally enacted within MSE ICB, aligned to the ICB's operating model moving forward.

3. Regulatory Updates

3.1 The Care Quality Commission have undertaken a number of inspections since the last Board meeting held in November. An update in relation to expected reports is also provided below:

3.1.1 MSEFT Paediatric Services across all three sites focussing on Urgent and Emergency Care Pathways were inspected – no immediate safety concerns identified.

3.1.2 Urgent and Emergency Care Pathways and Core Medical Services at Basildon Hospital site were inspected as part of a wider system pressures inspection schedule.

3.1.3 Maternity Reports from 2024 published by CQC – Broomfield rated as 'Inadequate' although a secondary inspection report is expected by the Trust for factual accuracy which will show improvements.

3.1.4 EPUT inspection into adult inpatient wards and Psychiatric Intensive Care Units inspected across North and South Essex – no immediate safety concerns raised – report awaited.

3.1.5 EPUT inspection into forensic services still awaiting publication of report.

3.2 Board will be sighted on reports as they are published and assurance will be sought through the ICB's Quality Committee and learning through the System Quality Group.

4. National Quality Board (NQB) Principles for Assessing and Managing Risks Across Integrated Care Systems

4.1 Whilst existing risk management processes and frameworks are fundamental to managing quality, including safety, traditionally they are only focused on single organisations and do not recognise the importance of approaching and mitigating risk collaboratively and in a balanced way across systems. This systems approach is particularly needed in fast-changing and multi-factorial situations, such as service closures or pressured emergency departments, where collaborative solutions are required.

4.2 There are few resources available to support collaborative, system approaches to risk management. The principles have been developed to provide a first step to support those working in Integrated Care Systems.

4.3 These principles should be for use only in fast-changing, multi-factorial scenarios where collaborative responses are required. Existing risk management processes and accountabilities remain unchanged for sovereign organisations including ICBs, and this process will supplement existing practice.

4.4 NHS England is encouraging systems to use the principles to inform collaborative system risk discussions, in alignment with the previous guidance issued by the NQB, however they will not be mandatory.

4.5 The principles are designed as a multi-agency approach, to ensure that the views of those working in local authorities, the voluntary, community and social enterprise (VCSE) sector, public health and wider services are considered and inform risk assessment and management.

4.6 The document has been developed to align with the previous NQB guidance; however, the approach also draws on Emergency Preparedness, Resilience and Response (EPRR) principles and can be used to support decision makers to fulfil their statutory responsibilities in planning for and responding to incidents (e.g. disruptions to supplies or provider failures).

4.7 NHS England will be testing the principles further with selected systems to gather more detailed learning on how to deploy. This is intended in 2025 and it is expected that Mid and South Essex ICB will be one of the test systems. The Corporate Governance and Quality teams will be working together to develop this in partnership with the NHS England Team.

5. Responsible, Accountable, Support, Consulted and Informed (RASCI) Tool

Rationale – the need for the RASCI tool

5.1 The operational and commissioning landscape in health and care has changed significantly in recent years with the establishment of Integrated Care Systems (ICSs) and provider collaboratives, delegation of functions and services and increased joint working.

5.2 To ensure the care delivered is good quality, it is essential that the different health and care teams and partners are clear on what responsibilities and accountabilities they hold.

5.3 This is one of the most common recommendations of independent inquiries and reviews, from Mid Staffordshire to recent reviews.

Introducing RASCI

5.4 RASCI stands for Responsible, Accountable, Support, Consulted and Informed. It is a tool that has long been used in project management and IT industries to help determine what different people, teams and organisations should be doing, and what authority they have to make what decisions.

5.5 This tool is designed to support NHS England and system colleagues where there is a need for clarity on responsibilities and accountabilities. This includes those working in Integrated Care Boards (ICBs), local authorities, acute, primary and community care.

5.6 It is not comprehensive nor exhaustive but provides a framework that can be used across different scenarios and services, including the delivery of care to individuals, or across teams, services, organisations or pathways.

Why use the RASCI Tool?

5.7 The value of using RASCI in health and care is wide-ranging, including:

- Informing new operating models and oversight arrangements for key functions/ services.
- Clarifying what role different organisations, including NHS England, must play when concerns/ risks have been identified and improvement is needed.

5.8 Using RASCI also helps to:

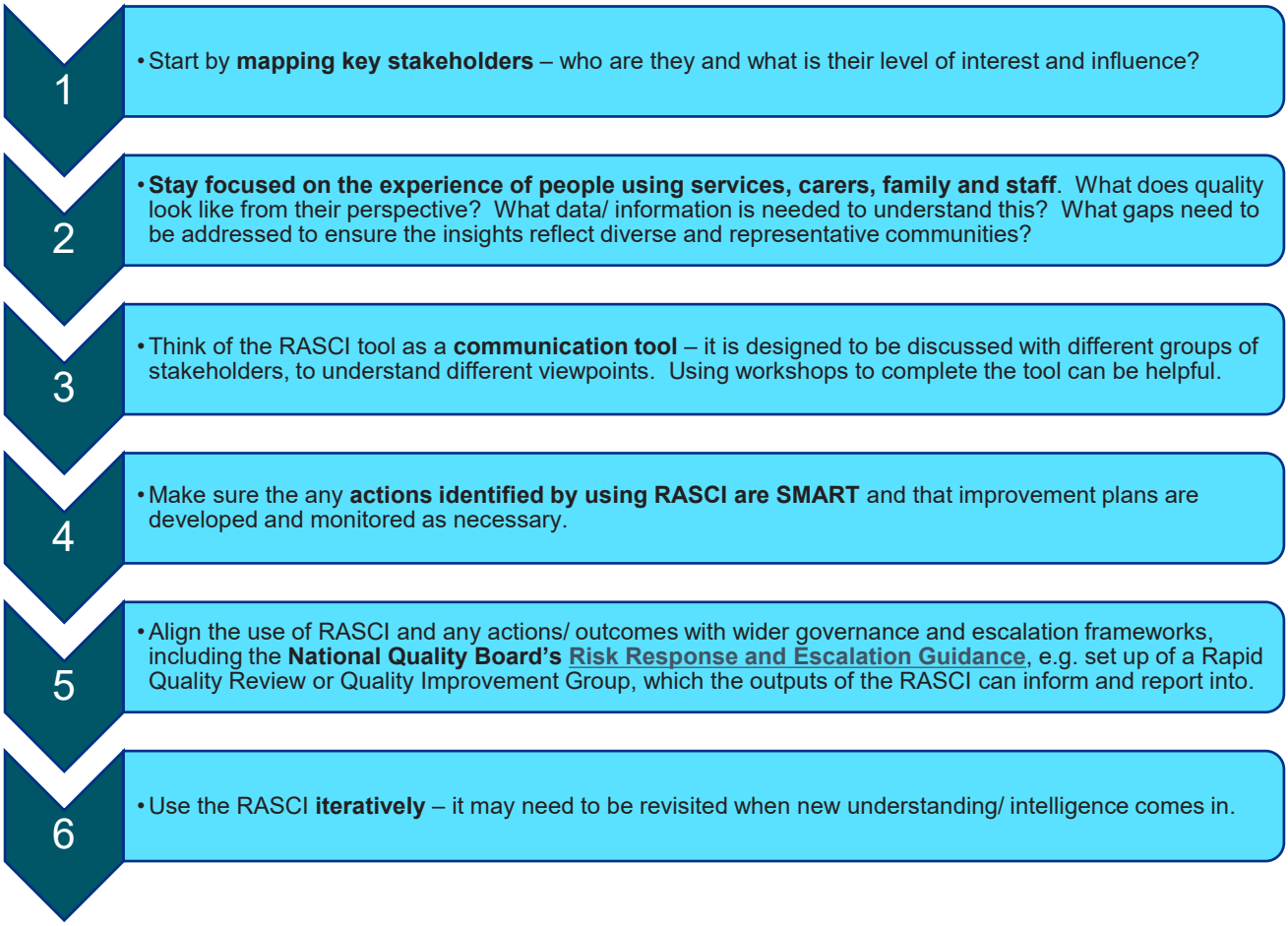
- Resolve conflicts/ confusion across organisations and system partners.
- Manage quality improvement projects effectively.
- Document responsibility distribution and improvement planning.
- Make sure no person/ system partner is overburdened with work.
- Clearly define the organisational hierarchy.

5.9 RASCI is particularly helpful to use in complex scenarios, where they may be multiple teams or organisations involved in the delivery of care.

5.10 Using RASCI also helps to:

- Improving the quality care to an individual using multiple services
- Addressing quality concerns about a multi-site provider or a provider commissioned by multiple organisations (e.g. independent sector provider commissioned by several Integrated Care Boards).

Good Practice when using the RASCI Tool



5.11 This guidance is currently being reviewed by the Corporate Governance and Quality teams to ensure that this tool is deployed appropriately within the ICB to aid in decision-making and clarity of responsibilities within its commissioning and quality oversight functions.

5.12 An example of the use of a RASCI Tool is supplied at **Appendix A**.

6. Recommendations

The Board is recommended to:

- Note the points of escalation from the Trust's Quality Committee relating to Sodium Valproate and Opioid usage.
- Note the national update shared with the Trust's Quality Committee.
- Support the implementation of NHS Insightful Board guidance, in line with NHS England recommendations.
- Note the current position in relation to regulatory oversight by the Care Quality Commission
- Support the implementation of the Assessment and Management of Risk in line with the national guidance.
- Support the implementation of the RASCI Tool in line with national guidance.

7. Appendices

Appendix A - Example of complete RASCI Tool

Appendix A – Example of RASCI Tool

Case Study 1: Multi-System approach to managing quality concerns in a mental health independent provider with multiple commissioners

Background/ Context

- Concerns raised about the quality of inpatient care relating to the model being used to care for patients with eating disorders which did not fully comply with the service specification - Specialist Eating Disorders Adult.
- The provider had four sites, Northeast, Yorkshire and the Humber x1, Midlands x1 and London x2, delivering care for all-ages.
- The rationale for using the RASCI tool was the need for clarity on the roles of the different organisations for quality assurance and improvement (with assurance across multiple sites)

Diagnostic Work

- The quality assurance and oversight functions were the responsibility of the host lead provider of the respective Provider Collaborative (PC) in which the unit geographically sat or regional specialised commissioning teams. London region Director of Nursing & Quality Direct Commissioning escalated the concerns internally to regions and the National Specialised Commissioning Quality and Nursing team via the National Directors of Nursing meeting.
- A provider visit was undertaken in London by the London regional specialised commissioning quality team alongside the lead Consultant for eating disorders for the provider collaborative and the case manager. Post provider visit concerns were to the National Quality Governance Group. Regional consideration was given to a rapid quality review but due to lack of sufficient information and following discussions with national colleagues it was agreed that a peer review was required to collate adequate evidence. Peer reviews were undertaken at the four sites.
- Key lines of inquiry were agreed as the focus for the peer visits: 1) Clinical governance processes; 2) Therapeutic model of care; 3) Leadership; 4) Quality outcomes; 5) Patient and carer experience; 6) Patient safety and reporting of incidents; 7) Discharge planning; 8) Patient discharge pathways; 9) Safeguarding; 10) Staffing levels; 11) Concerns, complaints, compliments and incident processes including duty of candour.

Actions/ Improvement Planning

Action plan established following the peer reviews which included the following but not exhaustive:

1. Monthly quality oversight meeting held led by NHSE London Specialised Commissioning Director of Nursing and Quality, providing quality overview of services commissioned under the remit of NHS England, Integrated Care Boards (ICBs) and Mental Health Provider Collaboratives.
2. Provider compliance against the service specification to be reviewed.
3. Plan for diagnosis of co-morbidities.
4. Co-morbidities and primary diagnosis to be reflected in care planning and therapeutic offer.
5. Clinical decision making for nasogastric feeding to be made clear.
6. Review of the policy for nasogastric feeding and provision of staff training.
7. Review of the therapeutic offer and to link this to evidence based practice.

Ongoing oversight:

- Monthly quality oversight meeting with regions and provider organisation and a monthly contracts and quality meeting with the provider organisations executive team led by regional NHSE team.

1

Completed template: Mental Health Independent Provider

Context/scope: Concerns were raised about the quality of care relating to the model being used to care for patients with eating disorders which did not fully comply with the service specification - Specialist Eating Disorders Adult.

Task/ Function/ Duties	NHSE London Region Specialised Commissioning	Host Lead Provider (LP)	NHSE National Specialised Commissioning	Provider Collaborative (PC) (Regions with units in their footprint)	Provider	NHSE Quality and Nursing Team (QNT) Specialised Commissioning	Provider Collaborative (PC) (Patients in units out of regional footprint)
Commissioning / Subcontracting	Responsible for monitoring performance and taking contractual action	Host LP Responsible subcontractor	Consulted/asked for advice	Responsible	Responsible	Consulted on concerns raised	Responsible for subcontracting with unit or Host PC treating their patient.
Quality oversight and escalation	Responsible for quality oversight and assurance, group.	Host LP responsible for quality oversight and assurance, monthly meetings with regions and the provider organisation.	Accountable for strategic quality oversight	Responsible for quality oversight	Responsible for implementing and providing quality governance and assurance to the regional NHSE quality team.	The regional quality team consulted the National Quality and Nursing team when the concerns were first raised.	Responsible for oversight of quality of individual care for their patients.
Contracting and quality	Responsible region, as host commissioner of multi-site contract, hold routine monthly contracting and quality meetings with provider executive team and take any contractual actions.	See PC with units in their footprint	Consulted/asked for advice	Responsible for oversight as part of their subcontracting arrangements	Responsible for providing service in line with service specification and standards	National QNT kept informed of concerns	Responsible for case management for the oversight for individual patients placed in units outside of their footprint.
Initial provider visit	Regional quality team led the provider quality visit.	Responsible Quality representative as part of the initial regional visit	Accountable for strategic quality oversight	Kept informed.	Engaged with the visit when concerns were first raised.	The National QNT informed of the provider visit.	Kept informed
Peer review	Regional NHSE quality team supported NHSE Quality and Nursing team with peer review visits across sites.	See PC with units in their footprint	Accountable for strategic quality oversight	Provided a quality manager for the review panels and to develop the scope of the review.	Engaged with the peer review visits.	National Quality and Nursing team led the peer reviews across the four sites.	Supported with the peer reviews
Quality improvement	Responsible for supporting providers/ ICBs to implement guidance, gaining assurance of effective use and that other QI actions are delivered (strengthened escalation).	Responsible for quality improvement oversight and assurance, monthly meetings with regions and the provider organisation.	Accountable for strengthening existing guidance to support delivery against the service specification supported by improvement levers.	Responsible for oversight of quality improvement of individual care for their patients.	Accountable for adhering to updated guidance, sharing learning, and ensuring risk management processes are clear and followed effectively.	Supported development and sharing of new guidance, and wider learning.	Responsible for oversight of quality improvement of individual care for their patients.

Responsible	Doer
Accountable	Buck stops here
Support	Here to help
Consulted	Consulted/ asked for advice
Informed	For your information

Part I Board Meeting,16 January 2025

Agenda Number: 11

Month 8 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the financial performance of the ICB to date and offer a broader perspective across partners in the Mid & South Essex system (period ending 30 November 2024).

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

2. Executive Lead

Jennifer Kearton, Executive Chief Finance Officer.

Report Author

Jennifer Kearton – Executive Chief Finance Officer
Keith Ellis - Deputy Director of Financial Performance, Analysis and Reporting
Ashley King – Director of Finance & Estates
Karen Wesson - Director of Assurance and Planning.
James Buschor - Head of Assurance and Analytics.

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance & Performance Committee on 7 January 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 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 had 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 continue to build a strong foundation for financial recovery over the medium term.

NHS England have provided the Deficit Allocation Funding which adjusted the £96m deficit to breakeven. The system is now measured against a breakeven plan. This additional funding is repayable in future years.

2. Key Points

2.1 Month 8 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB, has increased by £8.67m of allocation.

Table 1 – Allocation movements between month 7 and month 8

Allocations	Current Month £m	Previous Month £m	Monthly Change £m
Recurrent			
Programme	2,268.61	2,269.71	-1.11
Delegated - Specialised	286.56	294.40	-7.84
Co-Comm	227.10	227.10	0.00
Delegated - DOP	104.83	104.83	0.00
Running Costs	20.55	20.55	0.00
Total	**2,907.64**	**2,916.58**	**-8.94**
Non-Recurrent			
Programme	227.79	213.64	14.15
Co-Comm	4.83	4.83	0.00
Delegated - DOP	3.00	3.00	0.00
Delegated - Specialised	-47.56	-51.03	3.46
Total	**188.05**	**170.44**	**17.61**
Total	**3,095.69**	**3,087.02**	**8.67**

The ICB has a £1.95m forecast adverse variance at month 8 relating to additional growth above plan in All Age Continuing Care offset by in-year benefits in Acute, Mental Health Services and applied mitigations.

Our year-to-date (YTD) position reflects the risks identified across continuing health care and discharge to assess, materialising and impacting our ability to stay on plan at month 8. The ICB has efficiency plans in this area and has redirected resource into supporting the mitigation of both the operational and financial impacts.

We are recognising further YTD pressures across high cost drugs, primary care, and community health services with further action required in these areas to bring them back into line with plan.

Within the ICB our two 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.

However, all areas of ICB spend remain under scrutiny of triple lock to support cross organisational financial delivery.

Table 2 – summary of the position against the revenue resource limit for month 8.

Summary of ICB Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m
Acute	1,029.37	1,021.98	7.39	5.58	1,520.72	1,519.39	1.33
Community Health Services	160.16	160.88	(0.71)	(0.02)	239.89	240.97	(1.09)
Continuing Care	106.12	119.64	(13.53)	(3.71)	159.18	180.63	(21.46)
Mental Health	192.77	191.10	1.67	0.11	291.55	287.90	3.65
Other Commissioned Services	3.37	(0.05)	3.42	(1.39)	5.07	(12.93)	18.00
Other Programme Services	13.17	12.60	0.56	0.39	19.47	18.53	0.93
Primary Care	397.48	398.81	(1.32)	0.27	596.28	598.17	(1.89)
Programme Reserve & Contingency	0.00	0.00	0.00	(0.00)	4.66	4.14	0.52
Specialised Commissioning	158.91	158.91	(0.00)	(0.00)	239.00	239.00	(0.00)
Corporate	13.13	12.54	0.59	(0.14)	19.64	19.62	0.02
Hosted Services Admin	0.27	0.29	(0.02)	0.00	0.41	0.43	(0.02)
Total	**2,074.75**	**2,076.70**	**(1.95)**	**1.09**	**3,095.84**	**3,095.84**	**(0.00)**

2.2 ICB Finance Report Conclusion

The ICB is showing improvement towards plan at month 8 and understands the drivers for the challenge and is taking deliberate steps to mitigate. The Finance and Performance Committee will continue to receive deep dive reports on progress across these areas with escalation to the System Oversight Assurance Committee and the ICB Board.

2.3 Month 8 System Financial Performance

At month 8 the overall health system position is a deficit of £31.2m against the revised plan of breakeven. This is an improvement on the M7 position which was £32.2m off plan.

Table 3 – summary of the System position against the revenue resource limit for month 8.

Organisation	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m	FY F/Cast £m	FY Variance £m
⊟ ICB						
Allocation	2,074.75	2,074.75	0.00	3,095.8	3,095.84	0.00
Expenditure	(2,074.75)	(2,076.70)	(1.95)	(3,095.8)	(3,095.84)	(0.00)
⊟ Provider						
Income	1,437.25	1,478.48	41.23	2,136.0	2,208.39	72.43
Non-OP Expenditure	(31.23)	(28.63)	2.60	(48.0)	(45.41)	2.64
Expenditure	(1,406.02)	(1,479.06)	(73.04)	(2,087.9)	(2,162.98)	(75.07)
Total	**(0.00)**	**(31.16)**	**(31.16)**	**(0.0)**	**(0.00)**	**0.00**

The YTD position against plan is reflective of ongoing cost pressures and a shortfall in system efficiency programme delivery. Our forecast outturn remains as agreed. Every effort is being made to ensure the system returns to plan as rapidly as possible.

Both our system providers have 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 8 the system has delivered £69.1m of efficiencies against a YTD plan of £94.7m 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 overall financial position is dependent on the delivery of efficiencies. The system is collectively working together to redirect resource to the areas of greatest need and return to bring the efficiency position rapidly back on track.

Table 4 – System Efficiency summary

Organisation	Plan £m	Actual £m	Variance £m	Full Year Plan £m	Forecast £m	Full Year Variance £m
ICB	28.90	28.89	(0.01)	47.6	47.62	(0.00)
EPUT	18.27	14.37	(3.90)	28.7	28.65	0.00
MSEFT	47.48	25.88	(21.59)	91.5	91.50	0.00
SYSTEM	**94.65**	**69.13**	**(25.51)**	**167.8**	**167.77**	**(0.00)**

2.5 System Capital Position

The forecast capital spend for the system is £119.4m, £18.5m below plan due to unified electronic patient record (EPR) and 23hr Surgical Unit spend being re-phased. Our actual spend YTD is £50.3m against a planned position of £72.0m. It is expected that delivery will gain pace throughout the year and prioritised capital commitments will be fulfilled.

Table 5 – 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
Externally Financed						
MSEFT	35.61	18.56	17.05	72.85	58.20	14.65
EPUT	8.66	2.56	6.10	14.46	6.53	7.93
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	**44.28**	**21.12**	**23.15**	**87.30**	**64.72**	**22.58**
Internally Financed/System CDEL						
MSEFT	21.57	23.49	(1.92)	38.73	42.73	(4.00)
EPUT	5.53	4.58	0.95	9.92	9.92	0.00
ICB	0.68	1.13	(0.45)	1.99	2.03	(0.04)
Total	**27.77**	**29.19**	**(1.42)**	**50.64**	**54.68**	**(4.04)**
Total	**72.05**	**50.32**	**21.73**	**137.94**	**119.41**	**18.54**

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
ICB - Potential new IFRS 16 leases						
ICB	0.00	0.00	0.00	10.00	0.00	10.00
Total	**0.00**	**0.00**	**0.00**	**10.00**	**0.00**	**10.00**

2.6 System Finance Report Conclusion

At month 8 the System is working toward a revised planned year end position of breakeven having received £96m in deficit funding.

The system is focused on delivering its Operating Plan for 2024/25, ensuring financial efficiencies are delivered 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 MSE 2024/25 Operational Plan is to meet the national ask of >=78% of patients will have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

Our current performance is below the standard required as outlined below:

Ambulance Response Times

Standards:

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

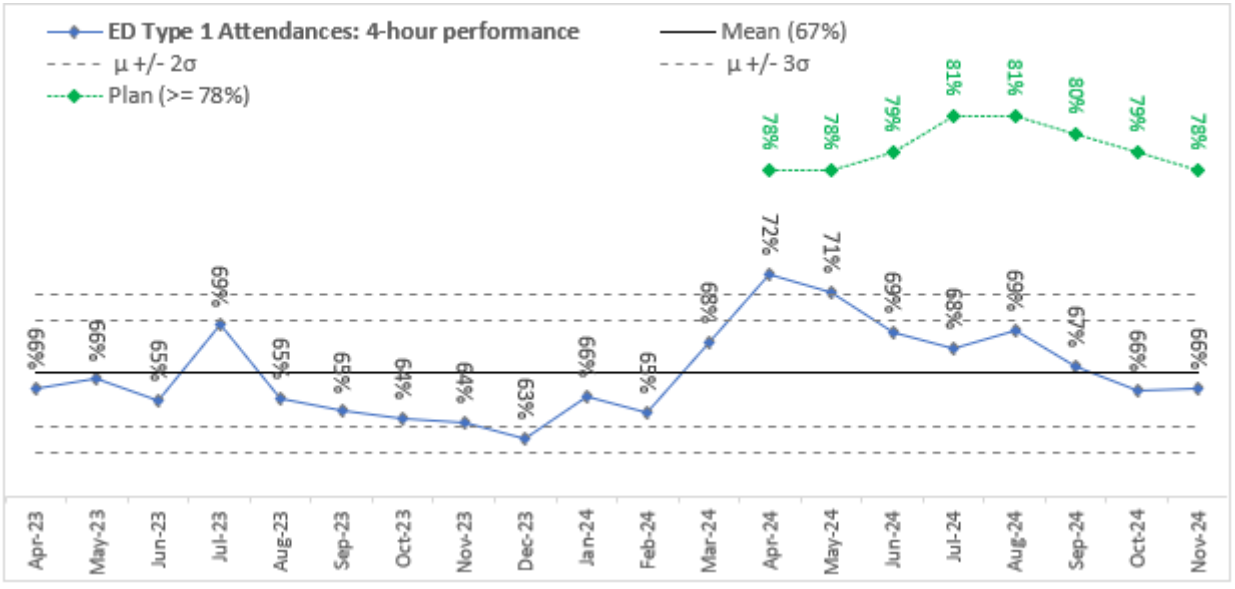
The 90th centile response times for East of England Ambulance Service for all four categories of calls do not meet their respective standards as shown in the following graphs.

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 four-hour performance has not met operational plan to achieve the 2024/25 priorities and operational planning guidance across all three MSEFT sites as per following graph. Following the significant increase at the beginning of the year for both April and May 2024, the performance has decreased to below the average for both October and November 2024. November 2024 achievement of 66% remains below the Operational Plan of 78%. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

Performance against the Operational Plan for Elective, Diagnostic and Cancer is overseen via the respective system committees.

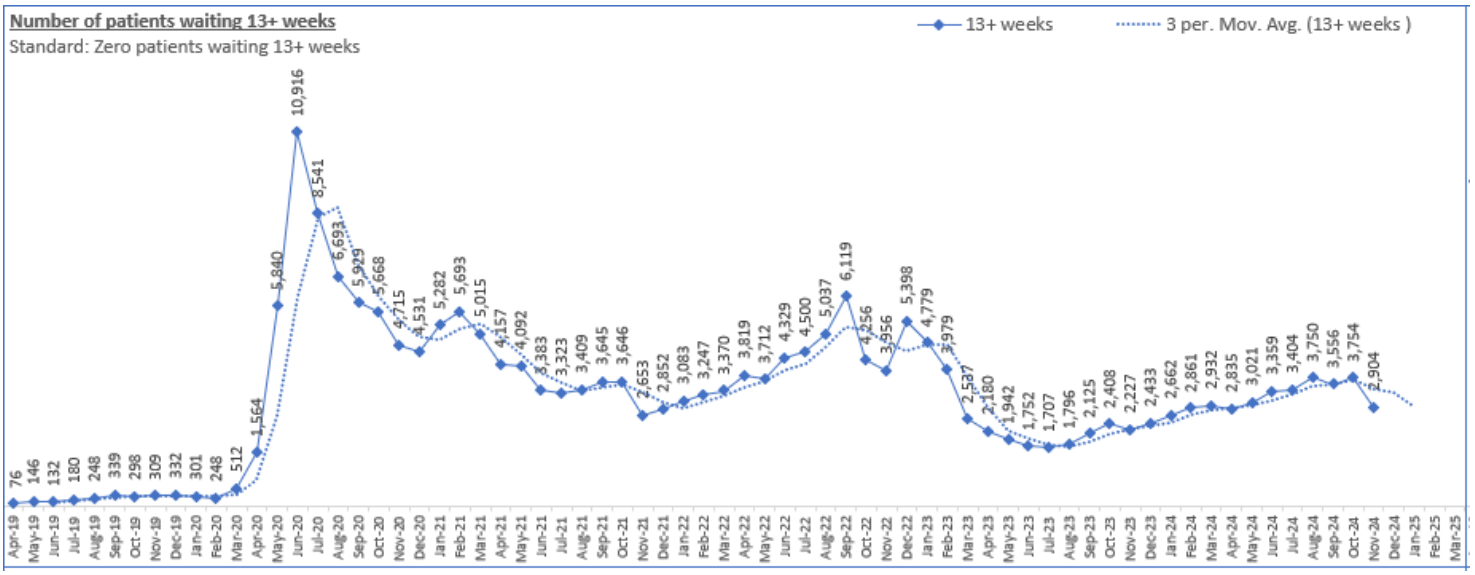
The performance does not meet the targeted national standard as set out below.

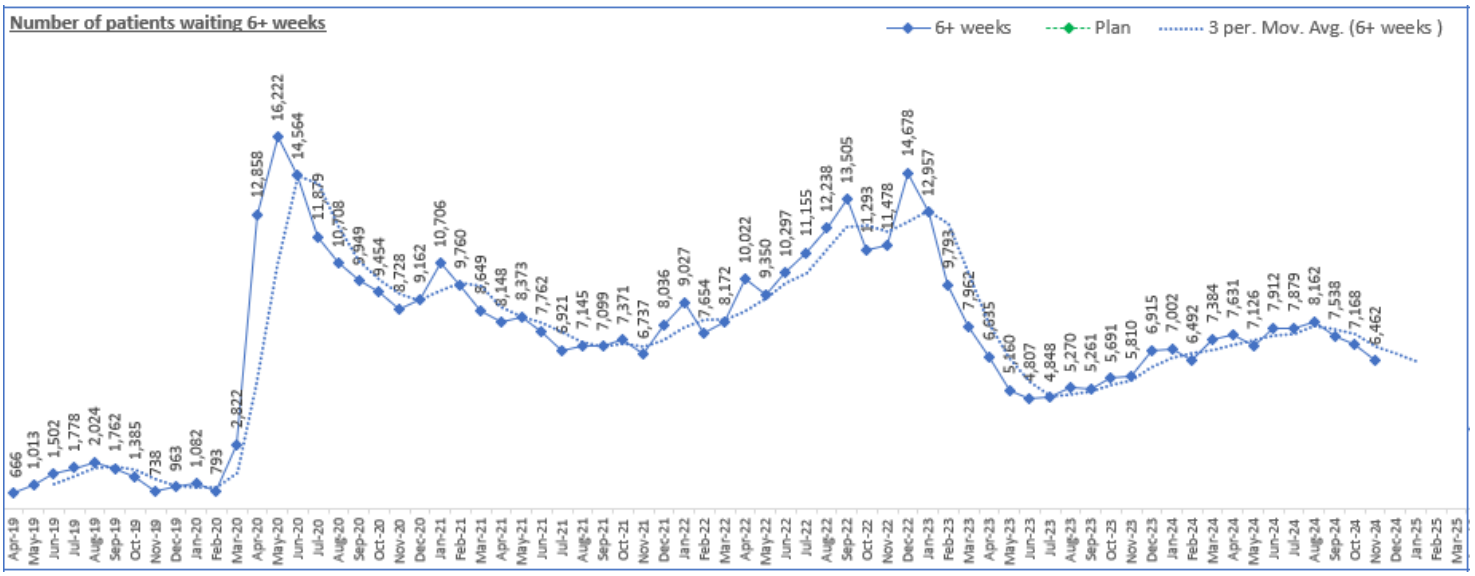
Diagnostics Waiting Times

Standard:

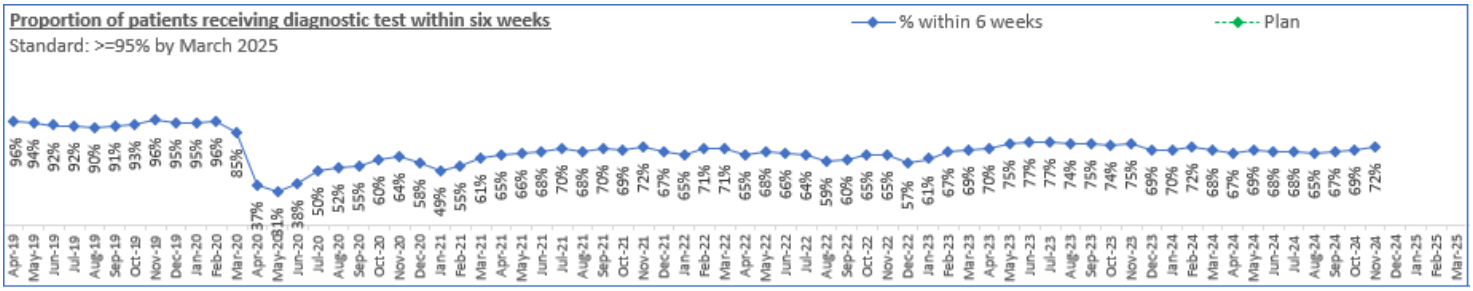
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

The following graphs show the total number of Mid and South Essex residents waiting 13+ and 6+ weeks across all providers to November 2024.





The graph below shows the proportion of patients receiving their diagnostic test within 6 weeks of their referral.



At November 2024, 2,904 people waited over 13 weeks (standard: zero) and 72% of all people waiting for their diagnostic test were seen within six weeks (standard: >=95%).

The following table shows the number people waiting over 13 and 6 weeks for their diagnostic test by test type. The areas of risk are as follows:

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

Nov-24	MSEFT: Diagnostic DM01 waiting list summary		
	Diagnostics	Number of patients waiting 13+ weeks Standard: 0	Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%
MSE patients at all providers			
Imaging	Barium Enema	0	
	CT	6	94.3% (174)
	DEXA Scan	27	88.9% (131)
	MRI	5	90.7% (434)
	Non-Obstetric Ultrasound	691	76.1% (978)
Physiological Measurement	Audiology Assessments	15	95% (55)
	Cardiology Echocardiography	650	52.2% (2028)
	Peripheral Neurophysiology	168	48.3% (255)
	Respiratory Physiology Sleep Studies	28	25.8% (175)
	Urodynamics - Pressures & Flows	0	83.3% (6)
Endoscopy	Colonoscopy	628	42.9% (1093)
	Cystoscopy	55	55.7% (136)
	Flexi sigmoidoscopy	166	39.3% (272)
	Gastroscopy	465	42.8% (725)

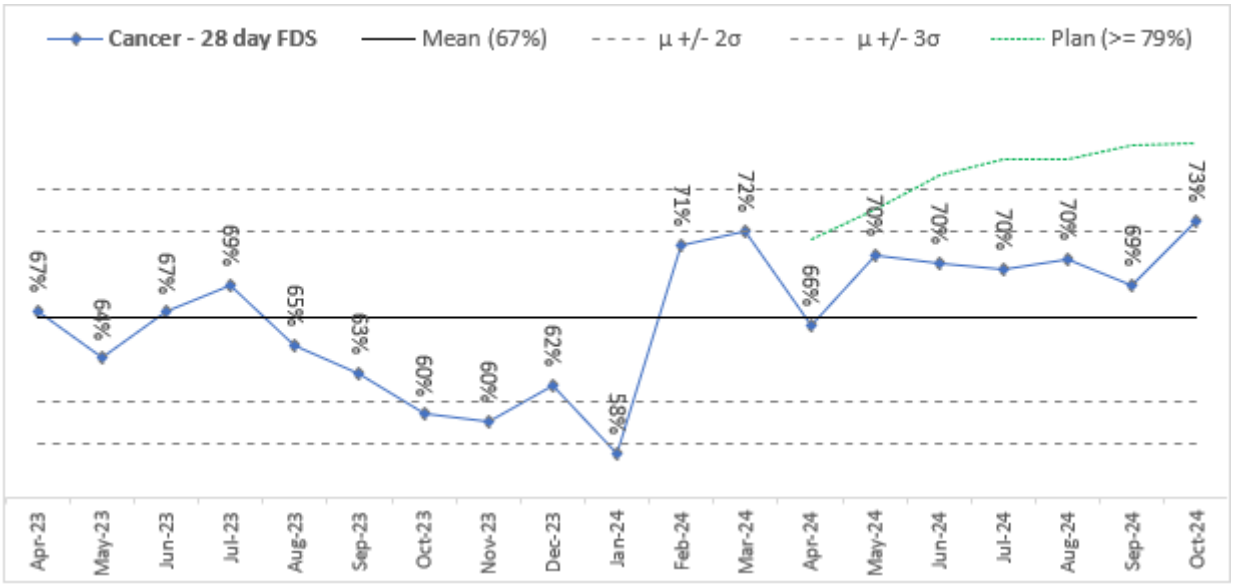
Cancer Waiting Times

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.

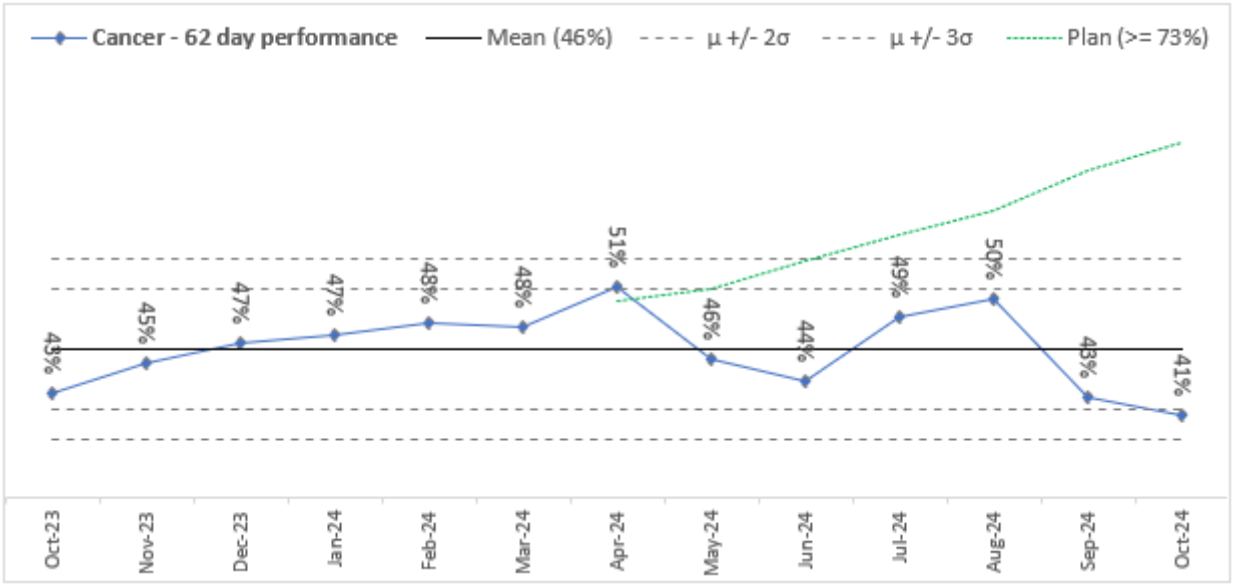
The waiting times for patients on a cancer pathway are not meeting the NHS constitutional standards.

The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. The October 2024 performance at 73% did not meet the operational plan to achieve the 2024/25 priorities and operational planning guidance requirement of >= 77% by March 2025 from September 2024.



The following graph shows the 62-day general standard performance. The October 2024 performance was 41%. MSEFT plan to meet the 2024/25 Operational Planning guidance ask to improve performance to >= 70% by March 2025. The constitutional requirement is 85%.

The Trust is in national oversight Tier 1 for cancer performance.



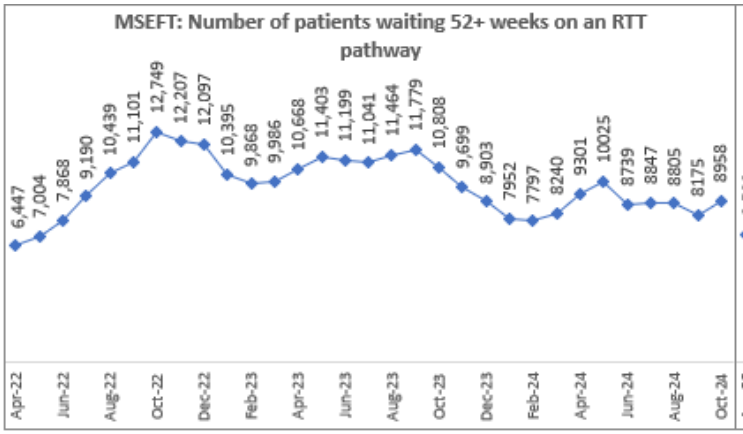
Referral to Treatment (RTT) Waiting Times

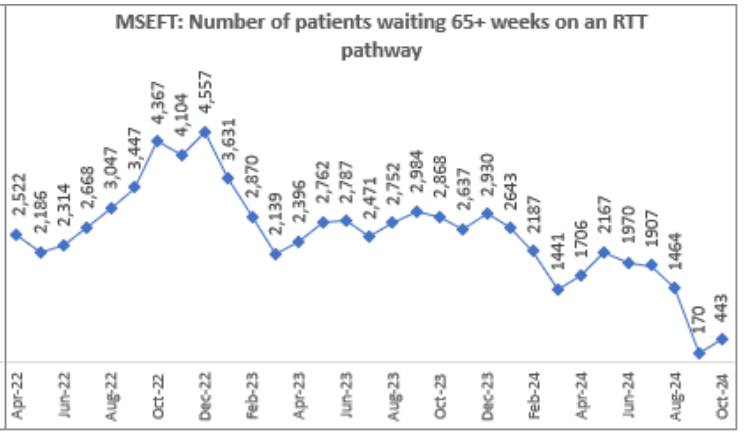
Standard:

- 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 Operational Planning guidance.

As of October 2024, the following number of patients were on a RTT pathway:

- 443 patients waiting 65+ weeks.
- 8,958 patients waiting 52+ weeks.





The operational plan to have zero people waiting over 65 weeks by September 2024 has not been achieved.

The following table summarises the latest MSEFT RTT position (October 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	**164,041**	**17**	**48**	**8,958**	**443**
General Surgery	8,390	19	51	599	15
Urology	9,202	17	48	497	27
Trauma and Orthopaedic	18,290	19	51	1,354	91
Ear Nose and Throat	16,384	25	55	1,630	114
Ophthalmology	13,174	16	46	527	6
Oral Surgery	4,525	27	57	694	51
Neurosurgical	99	29	47	3	0
Plastic Surgery	5,539	15	47	321	20
Cardiothoracic Surgery	1	-	-	0	0
General Internal Medicine	2,257	13	37	25	1
Gastroenterology	9,467	16	45	347	11
Cardiology	10,902	13	37	146	1
Dermatology	13,088	15	50	863	3
Respiratory Medicine	4,455	15	37	58	1
Neurology	5,985	18	46	212	10
Rheumatology	2,763	14	39	28	1
Elderly Medicine	792	6	24	6	0
Gynaecology	12,514	17	42	345	12
Other - Medical s	13,640	13	42	483	14
Other - Mental Health	0	-	-	0	0
Other - Paediatric s	4,072	22	55	433	40
Other - Surgical s	6,289	13	44	273	12
Other - Other s	2,213	16	50	114	13

The Trust is in national oversight Tier 1 for RTT performance.

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: October 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: October 2024).

3.0 System Performance Report Conclusion

The System has in place oversight groups whose core concern is the delivery of the constitutional targets or Operational Plan delivery. Performance is reviewed and progress monitored with escalation to the MSE ICB Finance and Performance Committee as required.

Across the System there remains a challenge in achieving delivery of the Constitutional Standards in a number of areas. The oversight of acute delivery includes the national Tier 1 meetings being held fortnightly and the Urgent Emergency Care Portfolio Board for the Integrated Care System.

4.0 Recommendation

The Board is asked to receive this report for information.

Part I ICB Board Meeting, 16 January 2024

Agenda Number: 12

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

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 – Basildon and Brentwood

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
Vicki Decroo, Deputy Director of Integration
Paula Wilkinson, Director of Pharmacy and Medicines Optimisation
William Guy, Director of Primary Care

4. Responsible Committees

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. Recommendation

The Board is asked to note this update.

Primary Care and Alliance Report

1. Main content of Report

Primary Care – General Practice

Updates have been provided to the Executive Committee and Audit Committee on the early impact of Collective Action being undertaken by general practices. Initial impact is particularly focussed on elements of prescribing that are being undertaken by general practice that could be undertaken within other services particularly relating to a number of community based services; therefore work is underway with the Community Collaborative to mitigate this. The Integrated Care Board (ICB) is working closely with stakeholders on other emerging issues. One such example is the prescribing and safety monitoring for Attention Deficit Hyperactivity Disorder (ADHD).

The Connected Pathways team have made significant progress in the implementation of the Primary Care Access Recovery Programme. All areas of the plan have been progressed since it was approved by the Board in November 2023. Significant progress has been made on the use of digital tools with the majority of practices in mid and south Essex (MSE) regularly using tools such as AccuRx, eConsult and Patchs. A promotional campaign will shortly commence to increase public awareness about Modern General Practice, total triage, and self-referral.

Primary Care – Pharmacy

The Primary Care Commissioning Committee (PCCC) approved funding for 24 community pharmacy Primary Care Network (PCN) engagement leads. This expands upon an existing pilot with six leads. The aim of this is to enhance the role that community pharmacies play within Integrated Neighbourhood Teams (INT).

Pharmacy First is now fully implemented in MSE. 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. 3,000 people a month are self referring and 2,000 referrals are being made from GP practices monthly.

Primary Care – Dentistry

The PCCC approved two important business cases in the last period. This includes the extension of the Access Pilot where we are seeking to expand an already successful scheme which has now seen an additional 21,000 of patients in evenings, weekends and bank holidays. A business case to embed the Care Homes Service as a core service was also approved. Both schemes will require further governance approval.

Estates

Alliance Teams have been progressing several smaller Section 106 estates developments working with a range of practices across MSE. This includes

development of premises at Sutherland Lodge and Halstead X-Ray block. Significant strategic planning work is underway for Rochford.

The ICB has supported the extension of the Void Space scheme for a further three-year period, which allows primary care providers to utilise void space in buildings at a subsidised rate. This has seen improvements in utilisation across the ICB particularly in Thurrock where Corringham Health Centre, South Ockendon Health Centre and Stifford Clays Health Centre have all seen rooms utilised.

Focus of Alliance Committees and partnership work

There are now 23 out of 24 Integrated Neighbourhood Teams (INT) in place. These operate with varying levels of maturity. Metrics are currently in development to demonstrate the impact of these functions.

There has been an increase in the number of GP Training Practices in MSE. These are critical for increasing the number of GPs working within the ICB. Thurrock in particular has seen growth in numbers to 7 practices and 1 training PCN.

Basildon and Brentwood Alliance is utilising the development of the Central Basildon INT to share good practice. The PCN recently presented the INT concept and High Intensity user impact data as part of a “grand round” with Basildon Hospital.

Basildon and Brentwood Alliance have had some dedicated community diagnostic hub mobilisation meetings to ensure primary care and wider partner inclusion in the pathways and economic opportunities are being taken. The ‘start well’ domain has approved a number of early years interventions.

South East Essex (SEE) Alliance Committee received an update on delivery across each of the 'Healthy' priority areas as set out in the SEE Alliance Delivery Plan. A comprehensive review of the Better Care Fund (BCF) and related programmes was shared. Intentions to mobilise this funding to support outcomes around flow including mental health floating housing support, community falls support and social prescribers from the voluntary sector in Southend hospital was supported.

SEE Health Inequality Trusted Partner process was shared at SEE Alliance Committee for endorsement and £313k was awarded for 7 projects spanning children and young people (CYP) and adults to tackle inequalities via this process.

SEE Alliance Committee heard about ongoing partnership working with colleagues at Southend Hospital, across Primary Care and wider SEE Alliance partners to accelerate delivery of our shared ambitions for system recovery. This was further supported by an overview of the Thurrock Healthwatch Discharge Report, pulling out the potential similarities with Southend, all with a view of taking forward learning.

INT development has also formed a key focus of Mid Essex Alliance work. There have been 11 INT forums in recent months with 300 partners engaged.

Mid Essex Alliance has worked very closely again with multi-agency partners to commence healthy housing and respiratory projects looking to identify those that need energy support. Intermediate Care recommissioning project was also reviewed with Essex County Council

Thurrock Alliance continues to have a strong bias towards health promotion and prevention and is engaging a wide range of stakeholders in their endeavours.

Better Care Fund (BCF)

An MSE wide BCF quarterly meeting was held in October during which an overview of projects for shared learning with all three local authority (LA) partners was provided. These included:

- An update on the All-Age Continuing Care workplan and backlog reduction.
- A presentation from Thurrock LA relating to adult social care activity.
- A presentation on the proposed development of the discharge cell and how partners can support this work.
- A discussion on supporting winter planning and further work to ensure winter capacity utilising the BCF planning.

Transfer of Care Hubs (TOCH)

(Case study included in the Appendix to this report)

Standard Operating Procedures have been updated to reflect best practice ways of working– connecting Hospital discharge teams right into the heart General Practice INT to facilitate improved discharges and more streamlined aftercare. Each hub is sharing learning to improve effectiveness and outcomes.

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. 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.

2. Recommendation

The Board is asked to note this update.

3. Appendices

Appendix A - Primary Care and Alliances Highlight Report, January 2025

Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight Report

January 2025

www.midandsouthessex.ics.nhs.uk

Case Study – Transfer of Care Hub (TOCH) Impacts

Case Study

A patient living in Sheltered Housing in Basildon was a known hoarder and reluctant to accept care due to embarrassment about his home environment. Social prescribers and other team members from the Primary Care Network (PCN) Integrated Neighbourhood Team (INT) had previously conducted home visits to build trust.

Intervention:

- The patient was admitted to the hospital for a hip replacement.
- TOCH (Transfer of Care Hub) was informed about the patient's circumstances, including the unsafe condition of his home.
- Coordination between TOCH and BERT (Basildon Early Intervention Team) on the Primary Care Network, led to the patient being discharged to Mountnessing Court Intermediate Care Ward for rehabilitation, instead of his home.

Collaborative Actions:

- The patient's home was assessed and cleared by a small healthcare team, including local social prescribers and the patient's niece.
- Necessary modifications were made to ensure the home was safe and liveable.

Outcome:

- The patient returned home with a comprehensive package of care and ongoing home visits from social prescribers.
- The patient and his niece highlighted the improved quality of life and reduced stress.
- The collaboration showcased how effective communication and proactive teamwork lead to positive outcomes.

Supporting a Patient's Transition to Wellness

Background:

A patient discharged from TOCH was identified by BERT as needing additional support during a follow-up welfare call.

Intervention:

- BERT involved a social prescriber who conducted a home visit to assess the patient's needs.
- The patient was introduced to wellness cafes, providing opportunities for socialisation and community engagement.

Outcome:

- The patient now regularly attends wellness cafes and has reintegrated into the community.
- This proactive approach prevented potential isolation and promoted mental well-being.

NHS
Mid and South Essex

Primary Care

www.midandsouthessex.ics.nhs.uk

Primary Care - General Practice

Reporting Month	Jan 2025	Executive Lead	Pam Green	SRO	William Guy/Jenni Speller	RAG	Amber

Overall Summary

Primary Care Networks (PCN) Reconfiguration Requests:

- The Alliances and Primary Care Team have received a number of PCN reconfiguration requests across three Alliances. These are being worked through in dialogue with the affected practices to try and ensure the most optimal outcome for the local population.
- Where approved, these will come into effect on 1 April 2025.

Expanding Premises Capacity in Primary Care:

- The Primary Care Commissioning Committee (PCCC) approved a paper that seeks to enable the small capital allocation available for primary care estate to be used for small premises improvements. In addition, we seek to increase the proportion of ICB capital allocation for primary care schemes.
- In addition, progress on the digitalisation of Lloyd George records (historical paper-based records for GP patients) was shared. 1.289m records across Mid and South Essex have now been digitised. This has freed up space at practices to accommodate additional staff/services.
- The PCN Void Space Scheme has been approved for a further two years (to March 27). This scheme aims to make void space in ICB funded premises available at subsidised rates for PCNs. The scheme has been well received where space is available.

British Medical Association (BMA) Collective Action:

- Risk has been identified regarding some elements of prescribing currently undertaken by GPs where GPs have indicated that it should be undertaken by other services/clinicians. This particularly affects several community services. Work is being undertaken with the Community Collaborative to consider how this might be mitigated. GPs continue to prescribe in the interim.
- The ICB is working with the LMC (Local Medical Committees) and other partners regarding other areas of concern including the prescribing of ADHD (attention-deficit/hyperactivity disorder) medication for adults and the undertaking of ECGs (electrocardiogram).
- The ICB is working with several service providers to ensure that referral processes are efficient and effective and do not place a significant bureaucratic burden on practices.

Financial Recovery Programme

- The Primary Care Team are continuing to make progress on Financial Recovery Programme schemes including a review of APMS (alternative provider medical services) project, a review of Local Primary Care Schemes and NHS Property Service arrangements.
- Several savings have been secured both in year (24/25) and 25/26.

Emerging GP Primary Care Collaborative

- The GP Primary Care Collaborative will be central to the identification of left shift primary care priorities during the latter part of 2024/25.

Primary Care – Access Recovery Programme/Connected Pathways

Reporting Month	January 2025	Executive Lead	Pam Green	SRO	Jenni Speller/Ali Birch	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"	All sites have either a compliant solution fully installed or have their install booked within the next quarter.	Completed
Communication of Modern General Practice and various aspects of the Recovery Plan to stakeholders	Comprehensive comms campaign has commenced. This includes • Promotion (to public) of NHS App and messaging function to reduce cost to ICB of text messages. • Promotion (to practices and public) to consent to use email function into reduce cost to ICB of text messages. • Promotion to use practice/PCN websites. • Improved awareness of self-referral pathways/Frontline. • Improve the public's understanding of the new model of primary care, including impactful promotional campaign on the new model, new roles, alternative provision. • Increase public awareness of community pharmacy services, as part of our Integrated Neighbourhood Team model.	On Track
Digital Tools – supporting implementation of Modern General Practice through digital tools	136/145 practices using AccuRx (including 65% using Floreys, 90% using SMS and 48% using booking functions). E-Consult, Anima and Patchs also being used. Practice website audit underway – discussions with practices on how to improve 1800 referrals through Frontline and 7000 signposts.	Completed
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. By March 25, over 50 practices will have implemented a total triage approach	Over 50 practices have established a total triage approach in line with Modern General Practice. These practices have received transitional support funding to support this arrangement	Completed

Primary Care – Community Pharmacy & Optometry

Reporting Month	January 2025	Executive Lead	Pam Green	SRO	William Guy/Paula Wilkinson	RAG	Amber

Community Pharmacy

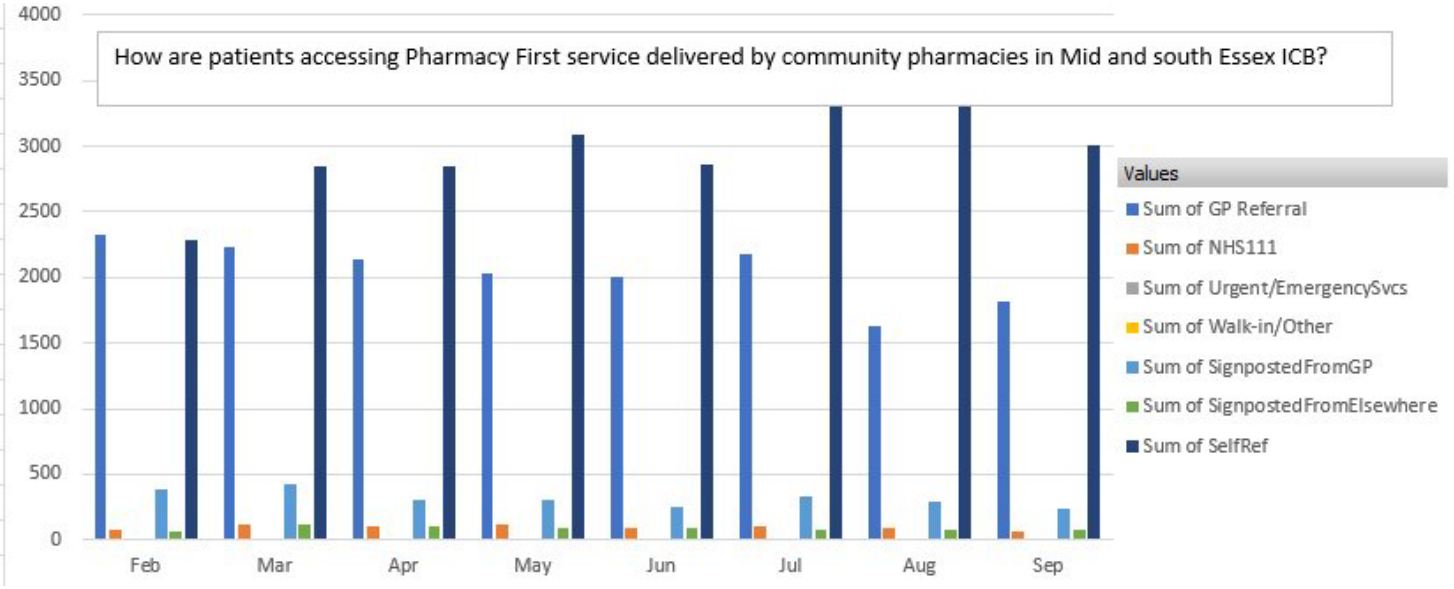
As of 1 December 2024, there are 196 Community Pharmacies operating in Mid and South Essex (MSE). This is a reduction from 212 noted in the October 22 Pharmacy Needs Assessment.

Around 3,000 patients a month are self-referring to Pharmacy First and a further 2,000 patients are being referred to pharmacies by GP practices. The graph on the right shows a breakdown of referrals by source into the Pharmacy First schemes.

The ICB has four Community Pharmacies participating in the Independent Prescriber Pathfinder scheme. Consultation numbers under this pilot average 250-300 per month. This number is expected to rise given that all four pathfinder sites are now live.

Following approval from the Primary Care Commissioning Committee (PCCC), the INT Community Pharmacy Engagement Leads project has been commenced. This aims to put in place a community pharmacy engagement lead within all PCNs across MSE.

Community Pharmacies and in particular the Pharmacy First programme have played a key role in the ICB's winter planning approach. Community Pharmacies are also key providers of the seasonal vaccination programmes.



Community Optometry

The PCCC received an update for quarter 2 Optometry Contracting produced by the Herts and West Essex hosted Pharmacy and Optometry Team. The ICB currently has 107 Mandatory Services Contract Holders and 22 Additional Services Contract Holders. A key programme of work being take forward by the contracting team is the reissuing of contracts to ensure that all current Terms and Conditions are in place. 74 of 78 contracts have been finalised.

The ICB gave an update on several local issues relating to optometric services. Self-referral to Optometry practices is being prioritised within the Connected Pathways comms campaign this winter. Progress has been made on prescribing under FP10 to ensure that where available, patients do not have to be referred back to their GP or HES for further prescriptions.

Primary Care – Dentistry

Reporting Month	January 2025	Executive Lead	Pam Green	SRO	William Guy	RAG	Amber

Dentistry

- The Dental Access Pilot which provides access evenings, weekends, and bank holidays has now seen over 21,000 additional patients. Approval has been given to extend the pilot to March 2027. To date 41% of appointments are now booked via 111 with patients directly booked into practice appointment books. The patient survey results demonstrate positive experience particularly on the theme of access with an average rating of 9.35/10 for ease of access to services.

- The Dental Care Home Pilot which covers all circa 8,400 care home beds within MSE ICB has had Board approval to be commissioned for a further five-year period (as a contracted service). The scheme has been given national recognition by a variety of industry publications. Again, patient reported improvements in access have been recorded. Access to dental services at the outset of the pilot was rated as 3.56, access is now rated at 8.76 out of 10.

- The roll out of the Children and Young people's Dental pilot is underway. Interest from providers is greater than we initially expected which will enable more comprehensive coverage in the first phase of the pilot that we initially expected. To date 154 of the 325 Schools within MSE ICB now have a direct link with a participating dental practice who will send dentists and their teams into the school and provide access to children and their families to the practice if treatment is required.

- As part of the national hypertension case finding service pilot, MSE ICB is participating and will be going live within 12 selected dental practices. The pilot aims to increase the number of patients identified as having hypertension by testing blood pressure in dental practices

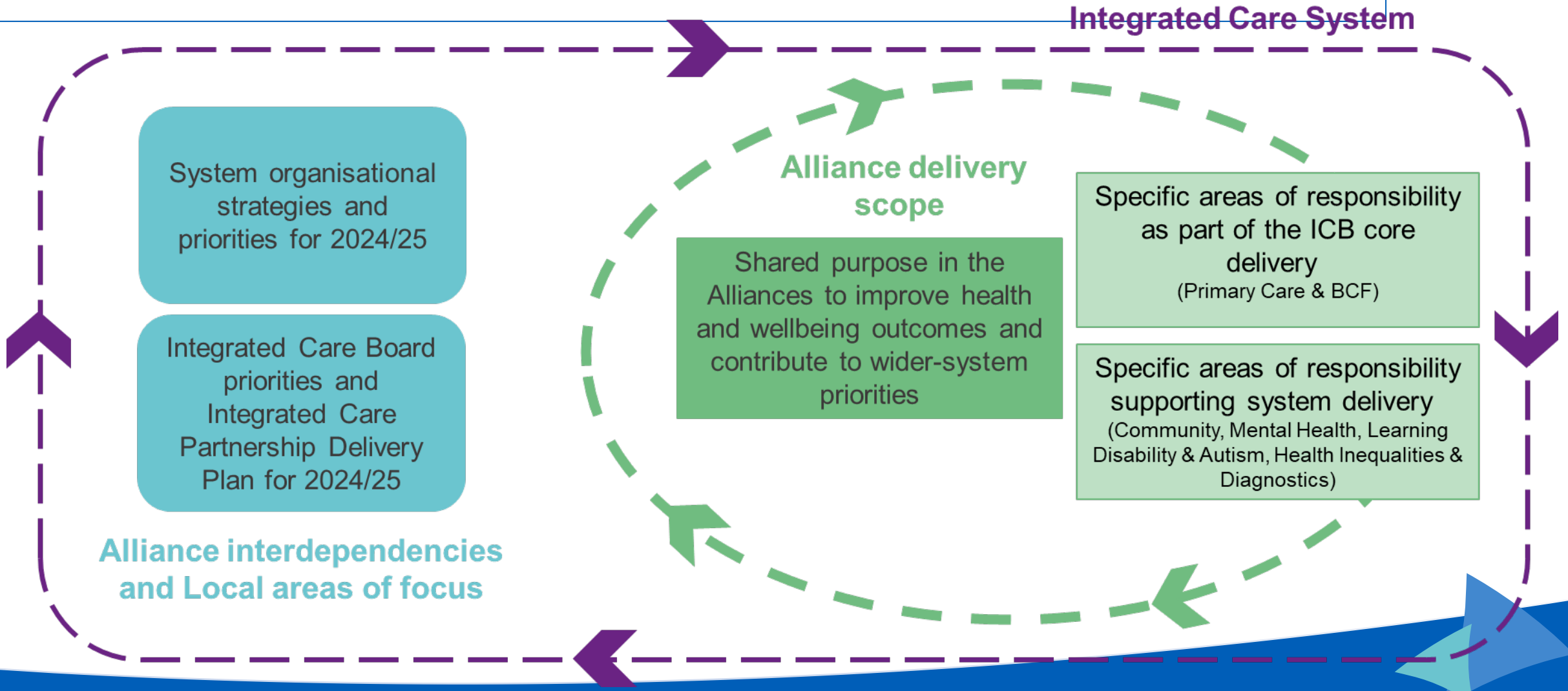
- As part of the national dental recruitment scheme, MSE ICB providers have managed to successfully recruit to two of the three new dentist posts, work is underway with the third practice.

- MSE ICB approved in September 2024 that providers could deliver up to 110% of their 2024/25 contract allowing a 10% access increase to primary care dental services including Orthodontics.

NHS
Mid and South Essex

Alliances

The Alliance Delivery Model



Priority Work Areas- Alliances 1

Work Area	*Aim*	*Update on actions*
Diabetes	To support people with diabetes to live well, and to address inequities in diabetes care across MSE by delivering an optimised, consistent and locally integrated model of diabetes care for MSE.	Focus on left shift and delivery of diabetes care in primary care. Working with Stewardship to take forward. Testing and developing through GP Provider Collaborative. Stakeholder workshop 30th January.
End of Life (EOL) Registers	To Improve identification of EOL in the last 24 months of life and the effective utilisation of the EOL registers to support proactive, personalised and anticipatory planning and delivery of care. Inclusive of promoting the Frail+ training resources on Our People, Your Future with a focus on compassionate conversations, evidenced approaches and techniques.	Self-assessments are underway in each Alliance inclusive of local Hospices to provide a baseline. From these, action orientated plans will be developed to increase awareness of the registers and to provide earlier access to support.
FrEDA roll out	Roll out of best-practice, proactive, personalised and frailty-focussed assessment and care delivery tool, based on all 5 domains of a comprehensive geriatric assessment (CGA). Permitting delivery of CGA, identifying persons with frailty/Dementia or any adult with end of life care needs significantly earlier, measuring and recording frailty more accurately in our population. Identify and share good practice and approaches	Workshop held 19/12/24 with Ageing Well Stewards and clinical leads. Task & Finish group to be established to develop a concise and compelling narrative. Exploring opportunities for data collation to benchmark achievement and progress.
Dementia Diagnosis Rate	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rates across MSE to meet the national target. The NHS has a goal of diagnosing 66.7% of people who are estimated to have dementia within the population by March 2025.	A new working group has been established, and a new work plan is being drawn up. This will be finalised in January 2025. Data to be used to highlight outliers in delivery of diagnosis rates and plans developed with outliers to deliver actions to achieve the target.
Serious Mental Illness (SMI) Health checks	Improve quality of life, effectiveness of treatment, and care by increasing the SMI rates to meet the national target.	Review underway of current achievement and trajectory to this point last year. Targeted visits to outliers to support in developing delivery plans to increase performance.
LD Health checks	Improve quality of life, effectiveness of treatment, and care by increasing the SMI rates to meet the national target	Review current achievement and trajectory to this point last year. Targeted visits to outliers.

Priority Work Areas- Alliances 2

Work Area	*Aim*	*Update on actions*
Integrated Neighbourhood Teams (INT)	The aim is to deliver more joined up preventative care at a neighbourhood level. By sharing resources and information, understanding and utilising local assets, teams can work together more collaboratively to simplify and streamline access to services.	Recent presentations to Clinical Strategy Board and at Grand Round to raise awareness at MSEFT where general awareness is low. Agreement across system to focus on frailty and High Intensity Users (which needs developing for each stakeholder). See slides 14 and 15 for more detail.
Health Inequalities funding	To reduce health inequalities at place level through dedicated place based funding. Trusted partner arrangements in place with process for allocation of funding in line with local priorities	Mobilisation plans for the 2025/26 Trusted Partner programme are in development in each Alliance area, mobilisation expected in February/March 2025.
Health inequalities targets- focus on Cardiovascular Disease and Hypertension	To develop, test and implement a community health intervention that supports improved outcomes for people at risk of or living with CVD. As well as supporting prevention and treatments in primary care. Hypertension identification and management.	All areas are meeting the targets for lipid lowering medications. Skills enhancement programme for PCN clinical leadership to utilise health creation approach to HI work, induction workshop and first action learning sets completed.
Medicines Optimisation	To provide Alliance based staff with key information and messages that can be delivered locally to support the Medicines Optimisation recovery plan.	Regular Meds Ops/Alliance meetings in place and knowledge levels increased. Shared folder holding most up to data available for Alliance teams. Plans to deliver key messages in development.
VCSFE Discharge Spend	Embed VCSFE provision into the discharge process, supporting safe and sustainable transition back into the home environment. Taking forward the learning from 2024/25 into planning and further development in 2025/26	Framework reporting template shared for Qtr 4 completion. Review of model and planning for 25/26 commenced, light touch specification drafted for review and feedback, ambition for consistent approach to delivery and outcomes.

Priority Work Areas- Process and Flow

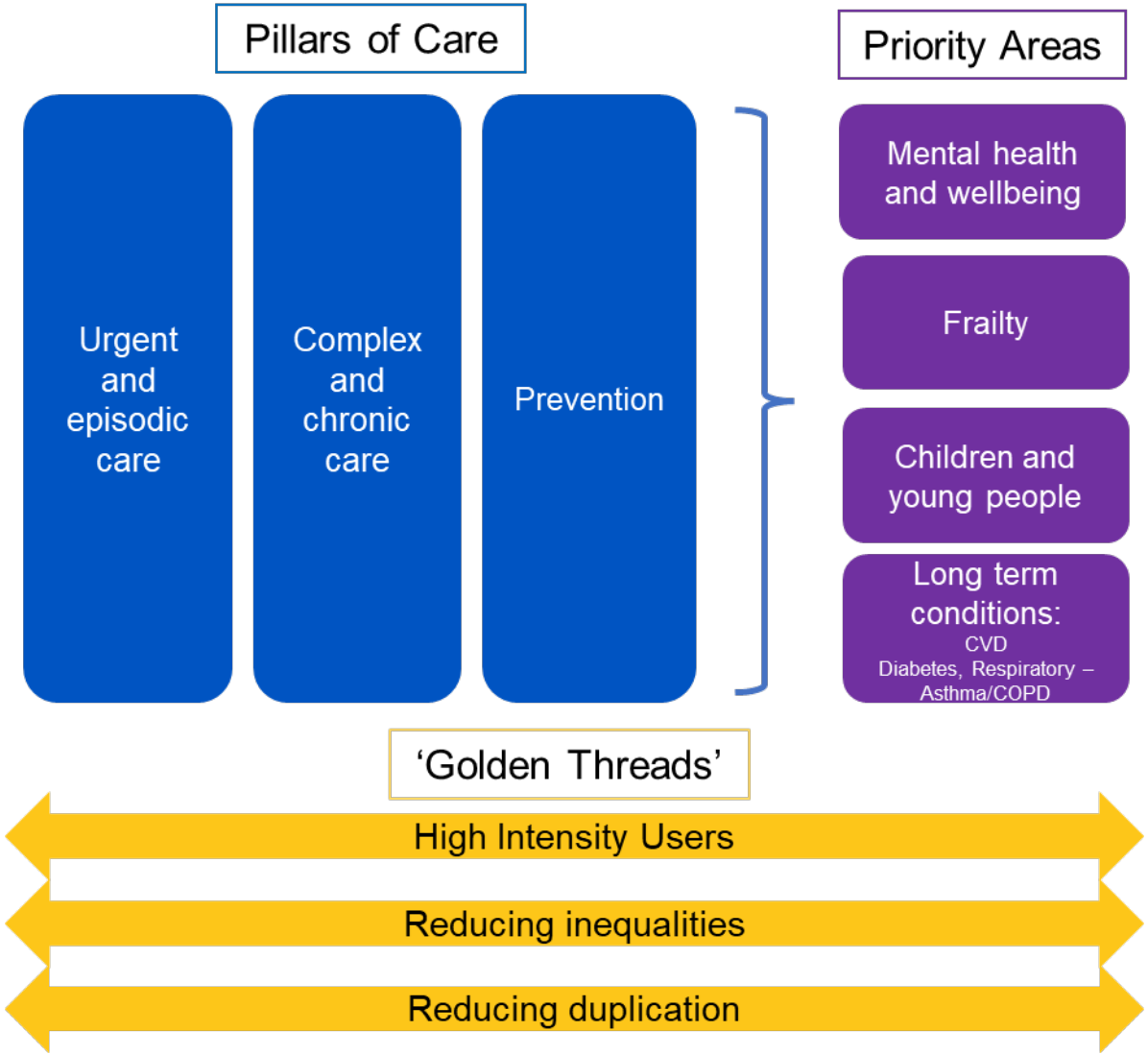
Work Area	*Aim*	*Update on actions*
Transfer of care hub (TOCH)	To Support effective identification of the most supporting of discharge pathways and to support 'pull' from assessment areas. To utilise metrics to support maturity of TOCHs	The transfer of care hubs work is integrating with the discharge cell to support flow over winter. A patient discharge experience survey has been developed and launched on the ICBs Virtual Views platform since the last report and is being fed back to the leadership group.
Intermediate Care Model	To support the development of an integrated IMC model for people using reablement services. Reviewing Southend Enhanced Discharge Service (SEDs), and bridging models in ECC and Thurrock.	In ECC the bridging model evaluation is progressing to support the transition of the model in April 2025. The SEDs model has been revised and capacity aligned, this is now being monitored with operational teams.
Better Care Fund (BCF) **iBCF** **Discharge Fund**	Oversight and monitoring of all projects linked to the BCF and related projects including evaluation and reporting. Supporting the BCF Policy objectives to • Enable people to stay well, safe and independent at home for longer. • Provide the right care in the right place at the right time • Capacity and demand planning for intermediate care services, including discharge.	All 4 Alliances maintained partnership BCF governance groups with LA partners. The ICB discharge fund spend remains on target currently to be fully utilised by year end. We are broadly on track to achieve the 3 core data metrics for the BCF across MSE. The Q3 BCF report is being updated for submission due in Feb 24
High Intensity Users	Identification and proactive, multi-agency approaches to support and develop interventions for high frequency users of services and high frequency admissions to support in managing demand across the system. Initial focus on delivery through Integrated Neighbourhood Teams.	Progress information governance arrangements with MSEFT, embedding data sharing protocols. Benchmarking of programmes and initiatives within Integrated Neighbourhood Teams to date is underway.
Southend ABSS transition plan	Working with partners to understand and mitigate the impact of the National Lottery funded A Better Start Southend programme (ABBS), coming to an end. Supporting transitional arrangements.	Programme review completed to identify service lines aligned to ICB delivery and the links to existing transformation plans, likely emphasis on outcome framework development.

Priority Work Areas- Estates

Work Area	*Aim*	*Update on actions*
Estates	To ensure the most effective utilisation of the MSE primary care and community estate including the most cost effective use of funding opportunities. Alliance Level estates plans to be drawn-up to inform the access to available Section 106 (S106) and Community Infrastructure Levy (CIL) funding.	Review of available S106 funding completed per Alliance area. A draft pilot of Primary Care Estates Plan produced for Rochford and to be rolled out across Alliances. Expression of Interest (EOI) and decision making framework in development to provide effective and transparent governance processes to support S106 and estates investment.

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



Overview

- 23 of 24 INTs are now live with varying levels of maturity. Remaining 1 to be live by March 2025.
- Oversight of INT development is provided through the Primary Care Commissioning Committee
- System focus on frailty and supporting INTs to be the delivery mechanism.

Work over the last period has included:

- Ageing Well stewards and INT system wide group working on plans to roll out FrEDA tool and more integrated care for our frail population
- Grand round and Clinical Strategy Board presentations, highlighting the positive impact of care co-ordination and integrated working on those who frequently attend GP practices and A&E.
- Achievements/best practice being shared across Alliances and through broader meetings such as Time to Learn

Examples of successes so far

- **Central Basildon**

Focussed on supporting individuals who had >25 GP appointments and >10 A&E appointments over 12 months.
(600 patients, using 12,000 GP appointments)
GP appointments reduced by 48% and A&E attendance reduced by 30%
Involved care co-ordination, networked with over 60 organisations and many “non health” successful alternatives such as Active Essex

- **Benfleet**

Data indicated higher than average readmissions for over 65s (approx. 19%, predominantly frail elderly). Working as an INT has brought this down to 6%. Care co-ordination key and has included partners in housing, across NHS organisations and even the RSPCA!

Important to note that success has come through working with partners outside of health and understanding the wider determinants.

Alliance Summary 1

Reporting Month	January 2025	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Local Areas of focus:

Stop Smoking

VCFSE development

Healthy Weight EYOH programme

The Alliance committee discussed: Reviewing the Terms of Reference for the committee; setting workshops to determine a place-based response to the Secretary of State letter; governance on health-related matters which will later go into the public domain, and comments on the new North East London Foundation Trust strategy which is at draft stage.

Work on local areas of focus the last period has included : Smoking cessation tracking is in place. In Thurrock this covers a 12-week monitoring period with data sharing managed by the Quit Manager.

An autumn Community Voluntary Faith Social Enterprise (CVFSE) sector Conference was held in November and a new collaborative charter was launched "Stronger Together" sets out the intentions and plan for closer working between the council the Integrated Care Board and the CVFSE sector. Additional funding from the London Port Gateway will be provided to the sector in Thurrock to support large scale expansion of the sector over the next 5 years.

The Mid and South Essex-wide collaborative on Healthy Weight continues with the Alliance working with the Public Health team in Thurrock Council to support aligned plans to improve the weight of people in Thurrock.

The Early Years Oral Health programme was reported on at the Integrated Care System Board in December. The programme has already delivered significant improvements in training, supervised toothbrushing and the number of children now registered with Dentists in Thurrock. An increase of 386 children are now registered. The Early Years Oral Health staff are also working with the Dental Commissioners to collaborate across different initiatives.

Basildon and Brentwood

Local Areas of focus:

Start well
Feel Well
Be well
Stay well
Age well
Die well

The Alliance committee discussed:

Planned Community Diagnostic Centre aligned to the hospital strategy to work more closely with partners and the local community. Considering local training needs to enable local people to be part of the required workforce.

The roll out of health check equipment (predominantly for blood pressure) and an aspiration to work in areas such as industrial sites where workers are historically less likely to attend health check appointments. Proposing to leave equipment on site for at least 2 weeks at a time.

The proposed merger of 2 GP practices where a landlord has served notice on the premises. Options discussed so all partners clear on complexity and legality and able to discuss within organisations.

Work on local areas of focus in the last period has included:

Agreeing to fund (via Basildon Council Health and Wellbeing Grant) a number of Start Well schemes to ensure local children get the best start in life and enabling families to support this aim.

Supporting Basildon Councils 25 in 25 scheme, generating positive individual stories to share and inspire others (includes weight loss, increased activity, stopping smoking)

Alliance Summary 2

Reporting Month	January 2025	Executive Lead	Deputy Alliance Directors	SRO	Alliance Directors	RAG	Amber

Mid Essex

Local Areas of focus:

Thriving places Index priority areas:
Healthy Housing
Respiratory
Economic Wellbeing

The Alliance committee discussed: Representatives from the Mid and South Essex Foundation Trust joined the meeting to brief the committee on their strategy development, explaining their agreed strategic goals and key focus priorities. The committee was asked for feedback on the priorities and vision, as well as how best services can work together to support the development of care models that will most benefit our communities. The updated strategy will be brought back to a future meeting.

The committee also received an overview of the proposed future direction of the Intermediate Care Programme, and an update from the Integrated Care Board on current planning work on priority areas, GP collective actions, the community beds consultation and flu, covid and RSV vaccinations. The committee reviewed the winter plans from Alliance partners and an updated version was shared with the group.

Work on local areas of focus in the last period has included: progression of our Thriving Places Index programme, in which a broad cross-section of partners work together to understand and address factors impacting on whether a community thrives, bridging the gap between 'health' and those agencies able to influence the wider determinants of health:
-Launch event for Healthy Housing/Respiratory. Jointly identified priority projects, including reviewing eligibility criteria of new retrofit/energy grants for those most in need; layering data from multiple agencies to understand who/how to prioritise; improving awareness and pathways between agencies (e.g. front line clinical teams to housing teams, energy advisors and financial support). Similar plans underway for launch event for Economic Wellbeing.
Agreement to fund an Enhanced Winter Respiratory Service, providing the clinical component to support those at most risk and inform ongoing approach to our Healthy Housing strategy.
-District level workshops have taken place, introducing TPI and identifying focus areas at local level. This has already started to shape funding decisions, e.g. Maldon DC have applied it to utilisation of their UKSPF grant.

South East Essex

Local Areas of focus:

Healthy Neighbourhoods
Healthy Start
Healthy living
Healthy Mind
Healthy Aging

The Alliance committee discussed: Achievement updates across each of the 'Healthy' priority areas, highlighting the shape and scale of delivery across SEE, no new escalations noted. A comprehensive review of the Better Care Fund (BCF) and related programmes was shared, providing high level oversight and assurance. Available iBCF funding in Castle Point and Rochford was noted as an opportunity to be explored with all partners including the Voluntary sector, iBCF funding is supporting several new programmes in SEE including mental health floating housing support, community falls support and social prescribers from the voluntary sector in Southend hospital.

An update on the progress of the transition of the A Better Start Southend programme was given, noting the National Lottery funding comes to an end in March 2025 and recognising the learning and legacy from the 10 year investment. A presentation was delivered on the ICB Pseudo Dynamic Purchasing System (PDPS) Framework and opportunities for the voluntary, community, social enterprise and faith sector. An overview of the Health Inequality Trusted Partner process was shared for endorsement.

Ongoing partnership working with colleagues at Southend Hospital was highlighted, presenting a collaborative place based plan with key drivers for transformation to support performance recovery and service delivery. This was further supported by an overview of the Thurrock Healthwatch Discharge Report, pulling out the potential similarities with Southend, all with a view of taking forward learning.

Local delivery highlights include a BBC coverage of the Southend Homeless Project, particularly in terms of vaccination delivery to support wellbeing. Excellent progress with Arden Gem on the development of a risk stratification tool, based on PHM segmentation and including multiple risk factors, Benfleet Primary Care Network will be trailing the tool in January

Mid and South Essex

Alliance Directors

Dan DOHERTY
Pam GREEN
Aleksandra MECAN
Rebecca JARVIS

www.midandsouthessex.ics.nhs.uk

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, 16 January 2025

Agenda Number: 13.1

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

Tom Abell, 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 the latest iteration of the BAF and seek any further assurances required.
- Note that the annual internal audit of the ICB's governance and risk management arrangements received an opinion of 'substantial' assurance for 2024/25.

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 Board itself supported 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, alongside the full risk registers that relate to their committee 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). The risk rating for each risk has remained the same since the last Board meeting.

- 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

Each risk is linked to one or more of the ICB's 7 strategic objectives, these being:

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 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.

*NB: An abbreviated version of these objectives is used in **Appendix 1**.*

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 Associate Director of Corporate Services met with NHS England colleagues to commence a pilot developing the ICB approach to system risk management following guidance from the National Quality Board for assessing and managing risks across integrated care systems. This will run alongside the development of the risk framework for the ICB and how we collaborate with partners to manage risks.

4. Internal Audit of Governance and Risk Management 2024/25

The Board is asked to note that the annual internal audit of the ICB's governance and risk management arrangements received an opinion of 'substantial' compliance for 2024/25.

5. Recommendation

The Board is asked to:

- consider the latest iteration of the BAF and seek any further assurances required.
- Note that the annual internal audit of the ICB's governance and risk management arrangements received an opinion of 'substantial' assurance for 2024/25.

6. Appendices

Appendix 1 - Board Assurance Framework, January 2025.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

January 2025

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 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 4 = 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 • Infrastructure Strategy • Digital Priorities and Investment	J Kearton	• Reporting to ICB Finance and Performance 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	S Goldberg	• MSE UEC Board oversees programme. • Discharge Cell and enhanced Unscheduled Care Co-ordination Centre established. • Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness system calls.	**4 x 4 = 16** ⟷
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Dr M Sweeting	• Finance & Performance Committee (F&P) 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. • Quality, Contract, Performance Meetings between provider and ICB oversees performance not covered by the above.	**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 and Performance Committee and Chief Executives Forum, also discussed at SLFG and Exec Committee. • Internal and External Audits planned.	**4 x 4 = 16** ↓
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	R Jarvis	• 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 out of area placements and reduced length of stay. • Mental Health Partnership Board & Whole System Transformation Group (WSTG). • Reports to F&P and Quality Committees to identify key quality/performance risks and action being taken. • 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. Inaccuracies in data reporting for HCAs has been identified as a concern.	**Risk Score: (impact x likelihood)**	**4 x 4 = 20 (based on highest rated risks on Datix which are rated between 16 and 20.)**
Risk Owner/Lead:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Good quality care within financial envelope; Develop and support workforce; System partnership working.	Associated Risks on Datix:	ID Nos 4, 53, 54, 55 and 56.

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against a target of 11.55%, overall vacancies have been declining month on month for 6 months down to 9.46% in Nov 2024 . Nursing and midwifery vacancies are down to 5.7% overall (from significant high of 10.8% for nurses & 10.2% for midwives Nov 23). Medical & Dental vacancies are also down to 7% in Nov 2024 against a target of 11.5%. **EPUT:** The overall vacancy rate is now at 13.5% against 12% target. For HCAs this figure is below 10%.
TURNOVER: MSEFT: Continued downward trend from a peak of 15.6% in August 2022 to 10.5% in July 2024, and in November 2024 turnover is 11% against an overall 13% target. Nursing turnover is down to 8.5%, midwifery 5.3% (8.3% in Nov 2023). For Medical and Dental the improvement is to 11.7% against target of 12% (This figure was 13.1% in November 2023 **). EPUT:** Staff Turnover is to 9.8% in November 2024, similar to Oct 2024 when turnover was 9.7% against 12% target.
BANK & AGENCY: Both EPUT and MSEFT remain on a significant downward trajectory for their bank spend, however, at M10 they remain below plan - EPUT 709 whole time equivalent (WTE) below plan and MSEFT 334 WTE below plan.

How is it being addressed? (Current Controls)

Whilst the trajectory of the reduction in Bank and Agency Spend is going in the right direction, pace is an issue. MSEFT has completed a deep dive in the usage of Bank and Agency in the Emergency Departments which is a real hot spot and work has been undertaken with Care Group Managers to encourage better staffing models across all departments. Establishment Control Processes are being tightened to include overtime requests. MSEFT have undertaken a review of all active tiles on the roster which is 80% complete resulting in savings. MSEFT have moved their temporary staffing service to Litmus for a 1 year period to run and manage the service. The MSEFT bank team will be TUPE across to Litmus for 1 year. Delegated authorisation to fill shifts with bank and agency staff has been severely restricted. The ICB continues to scrutinise all vacancy fill, contract extension requests, against a set of predetermined criteria. Reducing headcount remains a challenge for both MSEFT and EPUT as the move from temporary staff to substantive so some peaks and troughs will naturally appear in their trajectories. .Scrutiny for both organisations remains on the following areas,

- Substantive recruitment
- Admin & Clerical bank and agency requests
- Medical locum, bank and agency requests
- Nursing bank, agency and overtime requests
- Long term contracts / locums (non-clinical and medical)
- System and region agency price cap compliance pilot project.

EPUT also is moving in the right direction and is also subject to the same controls on all staffing spend. They are also looking at rostering where it is clear this is still not being done far enough in advance and results in gaps being filled with Bank and Agency. EPUT have stopped all bank spend for Health Care Assistants from 1 November 2024. For all non-clinical, and clinical bank and agency roles of greater than four weeks a review of requirements is taken to Establishment Control Panel. Outside of this, temporary staffing process involves the Matron identifying requirements and ward/service managers signing this off. EPUT are also looking at Care Groups and work is ongoing in this area.

Both organisations are embarking on a corporate staffing review, looking at encouraging staff to move from temporary to permanent and participating in a regional project to price cap agency spend.

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. 2025/26 operational planning to agree affordable staffing levels and commitment to manage to that workforce plan (commenced December 2024).
3. Scoping for system and region agency price cap compliance pilot project (January 2025).

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 (no change since November BAF report)**
Risk Owner/Lead:	Pam Green – Basildon & Brentwood Alliance, Executive 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, Additional Roles Reimbursement Scheme (ARRS), Hospital performance, reputational damage.	Associated Risks on Datix:	ID Nos 3, 21

Current Performance v's Target and Trajectory

Workforce:

- National guidance now published on GP additional roles reimbursement scheme (ARRS) role – some PCNs have commenced recruitment – further update in January 2025.
- Fellowship scheme: National funding has ceased. Alternative local arrangements being considered.

Demand/Capacity:

- Available Appointments: Continued increase in overall consultation in primary care.
- Number of practices undertaking Total Triage has increased. ICB is promoting the use of transitional funding to support practices implement new approaches

Barriers (Gaps)

- Collective Action being taken forward by the British Medical Association (BMA). ICB continuing to monitor the local impact of this. Concerns identified with regard to prescribing and certain pathways e.g. electrocardiograms (ECGs), out of area providers with patients requiring continuous monitoring etc.
- Resource for investment in infrastructure especially for estates improvements.
- Increase in overall demand on primary care services.
- Primary/Secondary interface. Specific work programme in place
- Overall funding of primary care

How is it being addressed? (Current Controls)

- Access Recovery Plan – Over 50 practices have now been supported to move to the Modern General Practice model.
- Workforce development e.g. ARRS optimisation.
- Primary/Secondary Interface – programme of work to improve effectiveness
- Initiatives for new GPs / Partners and to support other roles in practice teams.
- Refresh of 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.
- 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 March 2025. (23 of 24 in place)
- Digital tools solution for 25/26 (provision now in place for 24/25)
- Transitional funding for practices – scheme will conclude by March 25. Approximately 25 practices are currently being supported with their applications.
- BMA Collective Action – continue engagement with Essex Local Medical Committee. Working through specific solutions e.g. prescribing of certain medications

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 (no change since November)**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer. Ashley King, Director of Finance and Estates	Directorate: Board Committee:	System Resources Finance & Performance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives:	Good quality care within financial envelope. Improve standards of operational delivery.	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 capital departmental expenditure limits (CDEL).

How is it being addressed? (Current Controls)

- Evolving Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance & Performance Committee, System Finance Leaders Group and Executive Committee.
- System Investment Group sighted on 'whole system' capital and potential opportunities to work collaboratively.
- Working with NHS England (NHSE) / Trusts to deliver the benefits associated with the sustainability and transformation plan capital.
- Prioritisation framework for primary care (PC) capital now established and under regular review.
- Alliance level estates plans being developed to support prioritisation, with initial focus on Rochford.
- Maximising use of developer contributions where available for general practice improvements.
- Development of proposals for 2025/26 ICB programme of work under the banner 'MSE Expand'.

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)

- Primary care projects review on-going.
- Promotion of available developer contributions to support affordable developments.
- Understand opportunities through PC Estate Utilisation & Modernisation Fund (March 25).
- Training for Board members & executives (senior managers) on capital funding framework (post approval of Infrastructure Strategy) and consideration of future capital requirements.

Risk Narrative:	**Urgent Emergency Care (UEC) and System coordination** Risk that ICB and providers organisations are unable to effectively manage / coordinate capacity across the system, impacting on the system's ability to deliver effective care to patients.	**Risk Score:** **(impact x likelihood)**	**4 x 4 = 16 (no change since November BAF report)**
Risk Owner/Lead:	Samantha Goldberg, Urgent Emergency Care System Director.	Directorate: Committee:	Strategy & Corporate Services MSE Strategic UEC Board and Finance & Performance Committee
Impacted Strategic Objectives:	Good quality care within financial envelope; Improve standards of operational delivery, Effective oversight, assurance and compliance; System partnership working.	Datix Risks:	ID No 26 (other associated risks under review)

Current Performance v's Target and Trajectory

Emergency Department (ED) performance below constitutional standard, as are ambulance response times at MSEFT. ED performance – Q1: 75.2% and Q2: 72.5% and Q3 (Oct/Nov) 70.25% . Ambulance handover performance – Q1 89.6%, Q2 84.3% and Q3 (Oct/Nov) 80% Please refer to performance pack for trajectories.

Barriers (Gaps)

- Health and Social Care capacity to facilitate discharge into the right pathway impacts on MSEFT flow and community.
- MSEFT constraints to increase non-elective activity into SDEC due to bedded as escalation overnight capacity, specifically at Basildon and Broomfield hospitals.
- Workforce challenges (See Workforce Risk slide).

How is it being addressed? (Current Controls)

- The strategic and operational approach to managing winter incorporates a comprehensive plan to ensure the system can handle fluctuations in increased demand, potential disruptions whilst maintaining patient flow across the system, ensuring timely care and treatment, and good patient experience. There are four pillars 1) Operational resilience, ensuring the MSE system can withstand and respond to increased pressures during winter. 2) Improving co-ordination and collaboration & streamlining patient flow and discharge, a joined-up approach to enhance operational resilience with the creation of a Discharge Cell and co-location of services. 3) Enhancing urgent emergency care, strengthening service to provide timely and effective care overseeing plans to improve increased demand into SDEC and the deployment of the Unscheduled Care Co-ordination Hub (UCCH) minimum viable product. 4) Promoting preventative measures in encouraging vaccinations and supporting people & staff to stay well with strategies and approaches by communications.
  The Bed Model and the OPEL framework are frequently utilised as triggers and actions for delivering flow across the system and maintaining the 66 core G&A bed closures in MSEFT and minimising risk to opening of escalation capacity.
- Minimise attendance at ED by maximising attendance avoidance with all alternative urgent care pathways.
- Maximise discharge opportunities within the Discharge Cell with out of hospital virtual and physical capacity.
- Delivery of ED and Ambulance handover targets.

How will we know controls are working?

- Monthly MSE Urgent Emergency Care (UEC) Board oversees performance reports into F&P committee and ICB Board.
- MSE System Recovery Unplanned Care/Flow Portfolio Group oversee patient flow.
- Hospital discharges monitored hourly/daily, shared with social care and continuing health care teams via daily situation awareness system meeting.

Next Steps

- Continuous monitoring of daily operations across providers to ensure delivery against winter plan, and adjust plan where require (*ongoing).*
- Implementation of the Mental Health OPEL framework. *18 December 2025.*
- Implementation of Handover 45 mins (HO45) across MSEFT to support ambulance offloads. *Implemented December 2024*
- Quality Improvement programmes at MSEFT to improve ED performance and ambulance handover delays, reduce length of stay, improve flow and retain escalation bed and general and acute bed closures by focusing on: 1) Board and ward rounds, 2) Home before lunch, 3) Red 2 Green and 3+ LOS (length of stay) daily reviews. *Ongoing.*
- Same Day Emergency Care (SDEC) plans to increase streaming patients to SDEC to reduced contribute toward ED performance reduce admission avoidance by supporting same day interventions for patients. *1 December 2024*
- Co-location of the System Co-ordination Centre (SCC), UCCH and Discharge Cell to enhance communications and real time actions to improve patents discharge and flow. *30 January 2025.*

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional or Operational Performance Standards.
Risk Owner/ Lead:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation Aleks Mecan, Alliance Director Thurrock, Diagnostic SRO Karen Wesson, Director Oversight & Assurance (Elective & Cancer)
Impacted Strategic Objectives.	Good quality care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Effective oversight, assurance and compliance; System partnership working.

Risk Score: (impact x likelihood)	**5 x 4 = 20 (based on highest rated risk score for diagnostic risk)**
Directorate: Committee:	Clinical Leadership and Innovation, Thurrock Alliance, Resources MSE ICS Cancer Committee, MSE Diagnostic Board
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, currently performance 63% (the ask is to increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)
Cancer: Cancer Plan currently off track for delivery against operational performance For October 2024: Faster Diagnostic Standard 72.6% vs plan 76.6%, 62-day performance 41.3% vs plan of 62%
Referral to Treatment:
65+ week wait: MSEFT missed the National Operational Plan ask of zero people waiting over 65 weeks at the end of September 2024, the Trust are now working on plans for recovery of this position to ensure patients are treated and not waiting over 65 weeks.

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – System Delivery Fund (SDF) funding approved, MSEFT recruiting to the posts to support pathway delivery, Pathway analyser being completed to identify where there are opportunities for pathway improvement .
- **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 to achieve recovery plans for 65+ weeks, reported and overseen within the Tier 1 RTT meeting.

How is it being addressed? (Current Controls)

Diagnostics:
- MSEFT have revised recovery plans for all modalities and trajectories will be overseen via the Quality, Contract, Review Meeting (QCPM) and incorporated into the 2024/25 operational plan.

Cancer:
- Daily review of patient tracking list (PTL) and next steps with all tracking focused on trajectory compliance. Weekly "huddle", monthly Cancer Transformation and Improvement Board, Cancer Committee and via the National Tier 1 meetings. Cancer Service Development Fund (SDF) schemes for 2024/25 in place to support cancer performance recovery.

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, this will show the impact of actions via the performance reporting.
- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board.
- **Cancer:** MSEFT Cancer performance report: Monthly System Oversight via Cancer Committee and Monthly Transformation and Improvement Board held which tracks delivery against SDF commitments. Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** 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 with the national and regional team with oversight of actions, recovery and performance position continue.
- MSEFT Insourcing to support recovery and progression of mutual aid ask.
- Independent Sector support being progressed to support RTT recovery.

Quality, Contract, Performance Meeting (QCPM)
- Will oversee operational performance delivery vs plan.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** MSE is a system facing significant financial challenges, agreeing a £96m deficit plan with NHSE for 2024/25. As part of the M6 position NHSE provided repayable Deficit Allocation Funding which adjusts the £96m deficit to breakeven. 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)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer	Directorate: Committee:	System Resources Finance Committee
Impacted Strategic Objectives:	Good quality health care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Develop and support workforce; Effective oversight, assurance and compliance; Innovative service improvement; System partnership working.	Associated Risks on Datix	ID Nos 7, 10, 14, 42.

Current Performance v's Target and Trajectory

The System has agreed its plan for 2024/25 submitting a revised profile in June 2024. At month 8 the overall health system position is a deficit of £31.2m against the revised plan of breakeven. This has seen an improvement in M8 compared to M7 (£32.1m deficit).

Barriers (Gaps)

- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery.
- System pressures to manage delivery (capacity).
- Capacity due to vacancy chill.

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 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.
- Consultants (PWC) undertook Investigation and Intervention work with local implementation of identified actions.

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

- 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.

Next Steps: (Actions)

- On-going monitoring of financial position.
- Delivery of system efficiencies programme/financial sustainability programme for 2024/25.
- Medium Term Plan development with PA Consulting identifying 5 key areas to drive system sustainability, 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 (no change since November)**
Risk Owner/Lead:	Rebecca Jarvis, Alliance Director South-East Essex. Emma Timpson, Associate Director of Health Inequalities and Prevention .	**Directorate: Committee:**	South East Alliance. Quality Committee; Audit Committee; Population Health Improvement Board.
Impacted Strategic Objectives:	Reduce health inequalities; System partnership working.	**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 and Children & Young People) inequalities data packs are being actioned by the Alliances and via Growing Well Board.
- PLUS group insights from Population Health Management team that identifies inequalities in health outcomes for certain groups circulated to Alliances highlighting opportunities for improvement in data capture.
- Health Inequalities dashboard complete and in final sign off phase. Population Health Improvement Board (PHIB) reviewing system ambitions based on JSNAs and PHM data and insights.

Barriers (Gaps)

- Capacity and resources to support prevention and health inequalities programmes when ICB focused is 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)

- PHIB provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with Alliances provide oversight and direct priorities for health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project including those part of financial recovery programme. EHIIA panel embedded and meeting monthly. Digital EHIIA tool final testing completed and further revisions required by Provide Digital before launching.
- Equality Delivery System (EDS) collective scoring event completed for services under review for 2024/25.
- Health inequalities annual statement for 2023/24 published on the ICB website. "Narrowing the gap" report published on ICS website highlighting work undertaken. Bi-annual reports to the MSE ICB Board and ICP undertaken, last reports were September 2024. Health inequalities dashboard published on Athena to identify and track impact of HI work.
- Targeted health inequalities funding in 2024/25 is supported Alliance level investment through trusted partners and system-wide strategic initiatives to address health inequalities for agreed priorities groups. All investments are subject to appropriate financial controls and triple lock.
- Bi-annual reporting to ICB Board on health inequalities activities.

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

- Internal audit report on ICB health inequalities arrangements provides substantial 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 performance metrics within HI dashboard.
- Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.

Next Steps (Actions)

- Launch of digital EHIIA tool (March 2025)
- Development of 2025/26 Health inequalities funding programme (January 2025)
- Development of MSE ICS Ambitions for Improving Population Health (March 2025).

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, rated between 12 and 16)**
Risk Owner/Lead:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality
Impacted Strategic Objectives:	Good quality health care within financial envelope; Reduce health inequalities; Improve standards of operational delivery; Develop and support workforce; Effective oversight, assurance and compliance; Innovative service improvement; System partnership working.	Risks on Datix:	ID Nos 5, 22 and 23.

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators including SMI health checks and Out of Area (OOA) placements with 37 people placed out of area against a plan of 5 as of the 27th of December 2024 and SMI performance currently at 58% against 75% of achievement in 12 months to end of the period (total percentage to get full check)
- 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.
- 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 (NDP).

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 on slide 4).
- System pressures to manage delivery (capacity).
- Flow through inpatient services.

How is it being addressed? (Controls)

- Provider reports taken to Quality Committee, alongside monitoring via the Quality, Performance, Contracting Meeting (QCPM).
- Attendance with check and challenge at weekly Clinically Ready for Discharge (CRFD) meetings with EPUT, with regular Multi-Agency Discharge Events (MADE) to ensure good flow and capacity.
- Quality Assurance Visits (QAV) attended by EPUT and Pan Essex ICBs to promote continued collaborative working, check and challenge, assurance of quality and patient safety, and compliance with regulatory requirements.
- Ongoing dialogue with EPUT' inquest team and Patient safety team to ensure information flows of upcoming HM Coroner cases are provided, to allow for ICB communications and senior leadership notification, ICB patient safety specialist and quality team continue to work with EPUT.
- Continued re-procurement of services alongside review of service provision

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

- Improved quality and contract indicators which are embedded and sustained.
- Improved and sustained capacity and flow, reduced length of stay, and reduced OOA placements.
- Outcome of Quality Assurance visits with embedded culture, quality, patient safety, and compliance with all contractual and regulatory requirements.
- Oversight of PFDR with the provider ensuring that all actions are embedded into practice.
- Accountability review with focus on provision and performance.
- Recent CQC inspection of Adult wards and PICU.

Next Steps (Actions):

- MSE ICB to chair MADE events to ensure system attendance, compliance, and oversight (December 2024).
- Continued joint QAV with system partners. (Ongoing)
- Commence monthly update meetings with EPUT for PFDR horizon scanning (December 2024).
- Implementation of the mental health learning disability autism (MHLDA) inpatient quality transformation with final plan submitted 28 June 2024 (March 2025).
- Await recent CQC visit report and action plan (April 2025)

Partner Organisation Self Identified Red Risks (and scores)

MSEFT - 10 Red Risks, as of October 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)

*MSEFT's Board paper 10 October 2024. The BAF risks have not been Presented to MSEFT Board since that date.

Partner Organisation Self Identified Risks

EPUT red risks, as of December 2024

- Capital resource for essential works and transformation programmes (20)
- Use of Resources: control total target / statutory financial duty. (20)
- Workforce Sustainability (16)
- Staff Retention (16)
- Organisational Development (16)

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Nicola Adams
Associate Director Corporate Services
Nicola.adams15@nhs.net

Sara O'Connor
Senior Manager Corporate Services
sara.oconnor@nhs.net

www.midandsouthessex.ics.nhs.uk

Part I ICB Board Meeting, 16 January 2025

Agenda Number: 13.2

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.
Dr Kathy Bonney, Interim Chief People Officer.

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Quality Committee and Remuneration 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 new and revised policies which have been approved by the relevant committees since the November Board meeting.

2. Revised Policies

The following policies were 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
Quality Committee 20 December 2024.	The Quality Committee approved the following: • Amendments to the Patient Safety Incident Response Framework (PSIRF) Policy (Ref 089) • Defining the Boundaries Between NHS and Private Care Policy (Ref 080) which is a new policy. • Extension of the review date of the Communicable Disease Outbreak and Incident Management Policy (Ref 074) until February 2025.
Remuneration Committee	The Remuneration Committee were advised that the three policies listed below which had been subject to review by the committee, were also shared with the Staff Engagement Group, with no further comments received. The policies were therefore approved: • Absence Management Policy (Ref 044) • Learning & Development and (Ref 053) • Dignity at Work (Ref 056).

3. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The policies will be published on the ICB's website.

4. Recommendation

The Board is asked to note the new and revised policies set out in this report.

Part I ICB Board meeting, 16 January 2024

Agenda Number: 13.3

Committee Minutes

Summary Report

1. Purpose of Report

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

- Clinical and Multi-Professional Congress (CliMPC) – 28 August 2024
- Finance & Performance Committee (FPC) 1 October 2024, 5 November and 3 December 2024.
- Primary Care Commissioning Committee (PCCC): 9 October 2024
- Quality Committee (QC): 25 October 2024.

2. Chair of each Committee

- Dr M Sweeting, Chair of CliMPC.
- Joe Fielder, Chair of FPC and PB.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Dr 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 above committee meetings.

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 that have been approved since the last Board meeting.

Clinical and Multi-Professional Congress, 28 August 2024

The following items of business were considered:

- A review of the commissioning arrangements for wigs and hairpieces was considered by the committee. The committee agreed the process of standardisation and communication for dermatology patients. For oncology patients, further information was requested regarding the charity route for wigs and hairpieces.
- The committee supported the recommendation from the Women's Health Programme Board to update the Heavy Menstrual Bleeding Service Restriction Policy (SRP) to include the choice of Uterine Artery Embolisation for fibroids, subject to shared decision making between the women and their specialists and that ongoing monitoring should be put in place to better understand the impact of reintervention rates.
- The new Foetal Alcohol Syndrome Disorder SRP was supported by the committee.
- The committee received a 'horizon scanning' update on SRPs.

Finance and Performance Committee, 1 October 2024

The following items of business were considered:

- The committee supported the business case for the Southend Community Diagnostic Centre (CDC) and for Mid and South Essex Hospitals NHS Trust (MSEFT) to enter into an independent sector partner 12-year contract for the CDC.
- A financial deep dive of All Age Continuing Care expenditure.
- System finance and performance report for month 5.
- Update on the Investigation and Intervention process (financial scrutiny) being undertaken within MSEFT, noting that Phase 1 was complete, and Phase 2 had commenced.
- System financial recovery.
- The first draft of the Medium-Term Financial Plan was shared with the committee which had been submitted to the region at the end of September 2024.
- Risks within the remit of the committee and financial board assurance framework (BAF) risks.
- Minutes of the System Investment Group meeting held on 15 July 2024.

Finance and Performance Committee, 5 November 2024

The following items of business were considered:

- System Finance and performance report for month 6.
- Capital update.
- System recovery report
- Integrated Pharmacy and Medicines Optimisation Committee annual report, including updated terms of reference which were approve by the committee.
- The committee approved the provision of the care home dental care pilot.
- The committee received an overview of the proposed 'Time to Care' inpatient mental health programme and requested further key financial data.
- Learning disability 2-year contract extension was agreed by the committee.
- Commissioning intentions: Independent sector provider contracts.
- Finance and performance risks on the Board Assurance Framework and other risks within the remit of the committee were reviewed.
- An overview of the 2024/25 strategy for winter management. The MSEFT 2024/25 bed model was presented for information.
- Minutes of the System Finance Leaders Group (SFLG) held 19 August 2024 and the System Investment Group (SIG) meeting held 23 September 2024 were noted.

Finance and Performance Committee, 3 December 2024

The following items of business were considered:

- The Business Case for Hybrid Closed Loop systems for managing blood glucose levels in Type 1 diabetes was supported by the committee, subject to clarification of a number of issues.
- An update from SIG regarding development of a 10-year capital plan.
- System finance and performance report for month 7.
- System recovery report.
- An update was provided on the bed outlook over the winter period.
- Revised terms of feference for the Provider Selection Regime Group were approved.
- Minutes of the SFLG meeting held on 28 October 2024 and minutes of the SIG meeting held 21 October 2024 were noted.

Primary Care Commissioning Committee, 9 October 2024

The following items of business were considered:

- Primary medical services contracts update.
- Finance update.
- The primary dental services care home pilot was supported as a commissioned service for a 5-year period (3 plus 2-year extension).
- Delegated primary care self-assessment action plan update.
- Primary care risk register and relevant BAF risk.
- Minutes of the Dental Commissioning and Transformation Group meeting held on 7 August 2024.

Quality Committee, 25 October 2024

The following items of business were considered:

- A patient experience video was shown highlighting the positive and negative experiences of a patient with mental health issues and the challenges they faced when accessing mental health services.
- A deep dive on patient experiences at Essex Partnership University NHS Foundation Trust (EPUT) was presented.
- The ICB's Executive Chief Nurse reported escalations from Safety Quality Group and provided an update on emerging safety concerns.
- An update was provided on the gap analysis undertaken by EPUT and North East London NHS Foundation Trust following the Greater Manchester Review report by Prof. Oliver Shanley.
- MSEFT Acute care update.
- Community Collaborative update.
- Primary care update.
- Pharmacy, Optometry and Dentistry (POD) update.
- Southend SEND Strategic Action Plan summary.
- Medicines Management update.
- Infection Prevention and Control update.
- Patient Safety and Quality Risks update.
- The Committee approved the Terms of Reference for the Quality Oversight of Investigations Panel and Multi Agency Resource Forum.
- The committee approved the revised Health Inequalities Impact Assessment Policy; Equality and Health Inequality Impact Assessment Panel Terms of Reference; Safeguarding Adults and Children Policy; Mental Capacity Act 2005 and Deprivation of Liberty Policy; and extended the review dates of three other policies.

3. Recommendation

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

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 28 August 2024 at 09.30 am – 11.00 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Fatemah Leedham (FL), Pharmacy.
- Babafemi Salako (BS), Primary Care.
- Sarah Zaidi (SZ), Primary Care.
- Donald McGeachy (DM), Urgent and Emergency Care.
- Owen Richards (OR), Resident Engagement.
- Simon Griffiths (SG), Social Care.

Attendees

- Helen Chasney, Corporate Services & Governance Support Officer (Minutes).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Danielle Lawrence (DL), Public Health Registrar.
- Karandeep Nandra (KN), Public Health Registrar.

Apologies

- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Krishna Ramkhelawon (KR), Public Health.
- Rachael Marchant (RM), Primary Care.
- Feena Sebastian (FS), Mental Health.

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. It was confirmed that the meeting was not quorate, however the Deputy Chair would be approached for their views on items requiring discussion and approval. This would ensure quoracy.

MS introduced the new members to the committee, Simon Griffiths, Director of Adult Social Care, representing Social Care and Owen Richards, Healthwatch Southend, representing Resident Engagement. MS advised that Gavin Tucker had stepped down from Congress to return to clinical practice.

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 26 June 2024 were approved.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 26 June 2024 were approved.

4. Matters Arising/Action Log

Action 3 – The SRP updates were reported to Portfolio Board as part of the recovery programme, and then Executive Committee, with support from Congress, if required. Action closed.

Action 4 – An induction/refresher session would be held on 10 September 2024 at 4.00 pm for new and existing members. The session would be recorded for all members unable to attend. Action closed.

There were no further matters arising.

5. Review of commissioning arrangements for wigs and hairpieces

PW advised that mid and south Essex had identified a potential savings opportunity with this service and as a result, the Service Restriction Policy (SRP) was reviewed, where it was identified that the arrangements for obtaining wigs were inequitable across the system.

The budget for wigs was held with the Integrated Care Board (ICB), so the decision not to commission wigs at all could be made and was detailed as one option in the report, as patients could obtain wigs from various charities. There was an added complication that the National Institute of Clinical Excellence (NICE) had recently agreed the funding of a drug to treat severe alopecia areata, so if the position was taken to not fund wigs at all, the system would still be mandated to fund the drug. Historically, for patients being treated with chemotherapy, there had been a long-standing approach that funding would be available for wigs and commissioning for predominantly oncology and dermatology patients was a common approach across many ICBs. The types of alopecia would also need to be considered, such as whether there was permanent or temporary loss of hair and scarring or non-scarring.

The report included a proposed SRP that supported patients who permanently lost their hair through treatment with chemotherapy and/or radiotherapy and for those with scaring alopecia and severe alopecia, which met the criteria in the NICE guidance, and included alopecia totalis. A restriction would be put in place on the amount of funding for wigs, which varied in cost, with a further restriction for acrylic wigs, rather than offering human hair, and also limited the number of wigs a patient would be entitled to per year. The actual cost of the discounted price for medication was approximately £3,000 per annum per patient, and there was no cut off providing the patient met the criteria after 4-6 months, so an alternative option for a wig would be more beneficial.

DM commented that it seemed reasonable to limit the number of acrylic wigs per year that

would be funded, however the reputational damage from patients and public objection would outweigh this saving. PW advised that the total spend for last year, across the system, was £106,000, based on the fact that patients in Basildon were mainly haematology, and were directed to a local charity for their wigs, a top up service above the £140 provision was operational at Southend and at Broomfield, patients were mainly from the dermatology service.

In response to a query from FL, PW confirmed that dermatology patients used wigs mainly for scarring alopecia and alopecia totalis. FL suggested consideration of a service restriction for cancer patients due to being a highly emotive condition.

BS, OR and SG agreed that access should be equitable across the system and BS commented that the options were to either level up or level down.

SZ requested clarification of the proportion of cancer patients with permanent hair loss versus the other conditions to understand what the implications of the different options were, and if there was a cost implication from funding the drug in the future. PW confirmed that the number of patients who experienced permanent hair loss following chemotherapy treatment were minimal. The simplest option would be to continue to fund all cancer patients.

OR commented that if the preferred option was a prescription charge, there would need to be more communication for people to understand what other types of support were available, particularly for those with low incomes. PW confirmed patients would be entitled to receive wigs free of charge if they met the low income criteria, however medication prescription charges were slightly different. The main problem would be the patients that don't meet the low income criteria but were still struggling to afford. The prescription charge collection is mandated in regulations, so if wigs were to be funded then there was a regulation that stated that the prescription charge should be collected.

SG asked if the cost could be capped and then topped up by the patient, if they preferred to have a wig with a higher cost. PW explained that top up was not allowed as the NHS Constitution states that access to the service should not be dependent upon income. The charge for an acrylic wig was £80 and the hospital would have a contract with a wig maker who would mandate the maximum cost of the wig, and collect £80 from the patient unless exempt, and then charge the hospital for the price difference. The current arrangements for top up goes outside of any other arrangements in the NHS, apart from wheelchair regulations.

MS summarised that Congress agreed with the standardisation of the process and there should be good communication around access and other accessible charities or support services, particularly if criteria was not met, and noted the regulations prescription charge. The reality of the system's current position was that any increased costs to the system would need to be taken through financial controls as part of the recovery programme.

PW reconfirmed the discussion held in that the service should be equitable, for all oncology patients through commissioned services across all hospital sites, and for dermatology patients with alopecia totalis and scarring alopecia. The people with severe alopecia, but not totalis, would not get access to wigs but would have access to medication. The costs would be controlled to an extent, due to the restriction to acrylic wigs and only allowing human hair if there was an allergy. The costs over the current spend of £106,000 would be unable to be confirmed exactly.

In response to a query from FL, PW confirmed that evidence of an allergy would need to be

provided, such as patch testing.

DM asked whether the charity in Basildon (St Lukes), could support all patients of mid and south Essex and receive a grant to cap costs. PW advised that provision of a grant would require careful consideration. One of the options was to not fund oncology patients at all or stop funding wigs entirely, apart from if they wanted the drug and met the NICE criteria. DM commented that to limit the reputational damage, an alternative solution would need to be in place. PW advised that many charities were available to support patients and advice to patients could be given as to where wigs could be accessed. Many charities had an income threshold and donations could be given.

Outcome: The committee agreed the process of standardisation and communication for dermatology patients. For oncology patients, further information would be required on the charity route (St Luke's for Basildon patients) and a further report would be presented at the next Congress meeting.

Action: PW to provide further information on St Luke's with regards to the supply of wigs, including the referral process and costings.

Action: MS to discuss with the Executive Team around the financial implications with the changes and the governance routes.

6. Review of Heavy Menstrual Bleeding (HMB) SRP to include Uterine Artery Embolisation (UAE)

DL advised that NICE guidance recommended that Uterine Artery Embolisation (UAE) should be offered to people who wished to preserve fertility and had fibroids over 3cm, and was not currently not funded in MSE due to concerns related to clinical and cost effectiveness. However, recent evidence confirmed the clinical effectiveness and awareness had been raised that a small amount of activity was taking place despite the current restriction.

Consultants had raised that UAE should be a treatment option for their patients, as it was included in NICE guidance and should be equitable across the system, as patients were going to other trusts for treatment.

The balance of whether introducing UAE would be cost effective, cost neutral or a cost pressure depended on the reintervention rates, which were between 21–35%. The radiology team had confirmed that there was capacity and capability to move the procedure from being gynaecological to interventional radiology subject to appropriate care pathways in place.

Congress were being asked to recommend the update of the SRP to introduce UAE, subject to the shared decision making between patients and their specialists, and to have ongoing monitoring to better understand the impact of those reintervention rates. It was highlighted that patient level costings were used for some modelling.

In response to a query from MS, DL confirmed that there was little evidence to support whether UAE preserved fertility, but would be less evasive than a hysterectomy. PW advised that a consultant had confirmed that he would prefer to offer a hysterectomy to women past age of fertility, however, recognised that many women would not want to follow that particular pathway.

SZ asked what the implications would be if the reintervention rates increased. DL confirmed

that it would be the cost implications and whether the option of another UAE or a hysterectomy was preferred. The cost would be neutral at 30% if you had two UAEs versus and would be 23% if hysterectomy was the preferred option. The absolute maximum would be 35% and was based on a 10-year trial, however, there was greater uncertainty with a longer term view with some studies.

FL commented that other options were available, such as partial removal and other drugs, and asked if comparisons been made with other options for effectiveness. DL confirmed that no other options had been reviewed as NICE only considered one option.

BS asked if there were processes in place for cases when specialist colleagues wanted to go ahead, such as Individual Funding Requests (IFRs). PW explained that if this procedure was included within the routine commissioning there would be no need for an IFR application and would be grouped by approval and based on shared decision making in respect to the individual patient. The hospital should have suitable governance processes in place in terms of expertise and would know who would be carrying out the procedure. With regards to the reintervention, the hospital would be asked for feedback/ notification for monitoring purposes.

In respect to question from OR, PW confirmed that patients that went outside of the trust were not processed as IFRs. Hospitals would need to adhere to their own lead commissioning policies, as they could differ, so a patient could find out what hospital delivered the treatment they required and be entitled to receive the treatment under routine commissioning.

OR asked how well embedded the shared decision making was. PW could not provide assurance that shared decision making was embedded consistently in all locations, but the use of recognised national shared decision-making tools were included in the SRPs and clinicians were asked to include evidence within their notes, and could be requested when auditing a particular policy. SZ advised that it was difficult to monitor the quality of shared decision making as it was individualised and there was confusion amongst the professional workforce between consent and shared decision making. The quality of shared decision making in general was an issue, but there were ways the ICB could standardise resources, get best evidence through visual aids and written information and make it more of a two-way process. It would be a national and cultural challenge and this would be a good example where standardisation decision making tools could be used by clinicians. PW agreed and suggested linking with the Training Hub approach (For Your Future).

In response to a query from MS, DL confirmed that the uterine artery could be embolised more than once, the initial embolisation might not be successful, so there would be a potential for reintervention.

PW agreed with MS that the information could be extracted for monitoring purposes assuming that the coding information was correct.

Outcome: The committee supported the recommendation from the Women's Health Programme Board to update the service restriction policy for heavy menstrual bleeding to include the choice of Uterine Artery Embolisation for fibroids, subject to shared decision making between the women and their specialists and that ongoing monitoring should be put in place to better understand the impact of reintervention rates.

7. Review of commissioning arrangements for Foetal Alcohol Syndrome Disorder (FASD)

KN advised that the Individual Funding Request Panel had received requests regarding referral to the Foetal Alcohol Syndrome Disorder specialist clinic and there was currently no SRP in place at MSE. Meetings had been held with ICB stakeholders and concluded that whilst national needs assessment suggested a hub spoke model where FASD was diagnosed either locally or centrally. However, diagnosis was not necessarily opening doors as there was no medical treatment, therefore the service could be ICB wide where children were identified and sent to services based on their cognitive and/or neurodevelopmental needs.

The purpose of this paper was for Congress to recommend the SRP for approval which stated that referrals to the specialist clinic for diagnosis would not be funded.

MS asked if there were currently specialist centres that someone could go to for diagnosis. KN confirmed that there was one specialist centre, based in Surrey. The diagnosis of FASD was complicated, and generally required a multidisciplinary team (MDT) which consisted of paediatricians and experts in child development, and a patient history of pre-natal alcohol exposure. There was also a request to not refer for fast diagnosis until genetic screening had been completed to rule out other causes of neurodevelopmental delay. Therefore, a clinician would need to suspect FASD, exclude other causes by genetic testing, refer to paediatricians and if they are unable to make a diagnosis within their MDT, refer to the national clinic in Surrey, which dealt with specialist cases. MS asked if the Surrey clinic was a specialised commissioned service. PW confirmed that it was a developed service, but not picked up by the specialised commissioning team.

MS asked what age spectrum would be used to diagnose the condition. KN explained that there were adults with FASD that had never been picked up and could come forward through the IFR Panel. For children, when diagnosed through the national clinic, age six would be the benchmark if milestones were not being reached. The child would need to progress through their milestones and be shown to have delays, however FASD diagnosis required impaired development in at least three of the domains which could potentially only appear when the child was much older.

SZ commented that this highlighted the quality of our neuro developmental pathways, the MDT should include within the differential and standardise the process across the neurodevelopmental pathways.

DM commented that parents would want to know their child's diagnosis so wouldn't that be reason enough to refer to a specialist centre.

PW reiterated that Congress members have feedback that children's needs were to be addressed and that there would be no restriction to having access to services, taking into account what those services were and how they could be streamlined. Having a diagnosis of FASD was not a requirement to access those services, it was dealt with on the needs of the child, in terms of how they were developing as there were many different reasons for neuro development delay. Having a diagnosis, whilst being comforting to some parents, doesn't mean that the child couldn't get the support they need, therefore would it better to invest funding in neurodevelopmental services, supporting the child's needs rather than spending on diagnostic pathways. There were many people naming FASD as a cause for their

symptoms, which costs about £2,500 - £3,000 per patient for diagnostics. The service could be reviewed in the future, however, if the preferred option were to commission the services, the business case would contain unknown costs and an undefined criteria.

SG highlighted that autism was diagnosed and the support provided was generic, although some people had individual needs and asked whether the 'looked after children' could have stayed at home if there had been an earlier diagnosis and support had been provided to them and their families. Was a wraparound specialist service provided to those 'looked after children' following a diagnosis rather than a generic oversight of their needs. PW explained that diagnosis was based on neurodevelopmental delay and the exclusion of other factors, so was more connected to the assessment of the child at that particular time with wraparound care. KN commented that FASD was a huge spectrum, in that people presented with all kinds of different delays and was a diagnosis of exclusion. The management main stay was services, and there was already a system in place of assessing child development and identifying issues. Should the investment therefore, be made to improve screening of pregnant mothers in their early maternity assessments, with proactive support for their further pregnancies.

OR commented that local services were provided to the individual, although could be more integrated with better access, so should the focus be on providing support to parents or carers. MS advised that would link in with the wraparound services.

In response to a query from MS, KN advised that the specialist clinic was for complex cases, so a paediatrician could diagnose FASD dependent upon the wraparound services and MDT decision.

MS asked for a caveat to be included in the SRP that funding would not be provided outside of locally commissioned services.

Outcome: The Committee supported the new Foetal Alcohol Syndrome Disorder Service Restriction Policy, subject to the amendment as mentioned above.

8. Horizon Scanning

MS advised that further SRPs may require review to determine whether there were any inequities and discrepancies within the policies. The region, particularly Bedford, Luton and Milton Keynes (BLMK), have started to review this at regional level to determine whether there should be a regional approach to SRPs.

MS highlighted that NICE had not recommended the use of Lecanemab (dementia medication) in the system.

PW advised that the SRP regarding pinna plasty could be brought to a future Congress meeting to determine whether it should be classed as a cosmetic procedure.

9. Any other Business

There were no items of any other business raised.

10. Date of Next Meeting

Wednesday 25 September 2024 at 9.30am – 11.30am via MS Teams.

Minutes of the ICB Finance and Performance Committee Meeting Held on 1 October 2024 at 2.00pm

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, MSE ICB, **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Jo Cripps (JC) Executive Director of System Recovery, 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) Finance and Performance Committee Chair, Essex Partnership University NHS Foundation Trust (EPUT)
- Julie Parker (JP) Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Katie Arnold (KA) Portfolio Director – Commercial, Mid and South Essex NHS Foundation Trust (MSEFT) – for agenda item 5 - Southend Community Diagnostic Centre Business Case
- Sarah Davies (SD) Finance Improvement Lead - for agenda item 6 Financial Deep Dive - All age Continuing Healthcare
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Carolyn Lowe (CL) Deputy Director of All Age Continuing Care – for agenda item 6 Financial Deep Dive - All age Continuing Healthcare
- Dawn Scrafield (DS) Chief Finance Officer, Mid and South Essex NHS Foundation Trust (MSEFT) – for agenda item 5 - Southend Community Diagnostic Centre Business Case
- John Walter (JW) Director of Operations - All Age Continuing Care – for agenda item 6 Financial Deep Dive - All age Continuing Healthcare
- Emma Seabrook (ES) Business Manager - Resources, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting in particular new members Tom Abell, Chief Executive Officer and Jo Cripps, Executive Director of System Recovery. The meeting was confirmed quorate.

2. Declarations of interest

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.

Outcome: The register of interests was noted, there were no further declarations raised.

3. Minutes of previous meetings

The minutes of 3 September 2024 were agreed as an accurate record subject to the following amendment:

- (Page 3, paragraph 1) amended to: The incumbent provider was seeking internal approval to match provision to reduce their contract value to GMS contract rates. Should this be agreed by the incumbent provider, the ICB would in place enact a 5-year contract extension and not proceed through a compliant Provider Selection Regime process.

Outcome: The minutes of 3 September 2024 were approved with the amendment above.

4. Action Log / Matters arising

The action log was discussed and updated accordingly.

Outcome: The action log was noted.

Business Cases

5. Southend Community Diagnostic Centre

KA presented the paper and advised the Southend Diagnostic Centre (CDC) was one of four centres funded nationally by NHS England. The Southend CDC differed slightly from the other centres as it was approved on the basis MSEFT outsourced the service model to an independent sector provider (ISP) as opposed to providing capital funding to build and staff the CDC.

The procurement exercise had concluded, and a preferred bidder identified; the paper sought support from the ICB to enter into a 12-year contract with a start date of April 2025.

The Committee were advised CDC activity income was funded from the national CDC programme. When the national programme comes to an end, CDC revenue would form part of the System allocation. The CDC planned to deliver £1.77m of activity against a cost of £1.676m. It was expected this would provide an annual surplus of £95k.

LL welcomed a breakdown of volume and activity and queried where the risk fell between MSEFT and the vendor. It was asked if there would be sufficient activity to ensure the centre was viable. KA explained the contract did not set a minimum activity level; the Trust would only pay for the activity that was delivered. KA took an action to provide some further analysis.

Following a query from JP on the commonality across the four CDC sites, KA advised work had commenced to standardise the booking process across the CDC sites.

Legal support had been obtained during the procurement process to develop the terms of the contract; KA confirmed feedback from system finance leaders would be incorporated into the final version of the contract.

LL raised the IT system was of age and suggested an independent verification of the cyber security risk was undertaken. JF raised a cautionary note that the risk did not transfer to the ICB.

The business case would be taken to the October MSEFT Board and would require a letter of support from the ICB.

Outcome: The Committee supported the business case and for MSEFT to enter into an independent sector partner 12-year contract for the Southend Community Diagnostic Centre.

ACTION: KA to provide a breakdown analysis of the of volume and activity and where the risk fell between MSEFT and the vendor.

Financial Governance

6. Financial Deep Dive – all age continuing healthcare

SD provided a financial overview of the directorate spend for all age continuing healthcare. The Month 5 position showed a £14.8m adverse variance to budget against the forecast outturn. SD reported the largest element of the increase in spend from Month 1 to Month 5 was due to the number of new caseloads received since 31 March 2024.

CL outlined the three pillars to support transformation and highlighted Population Health Management as a new area of focus. An extensive amount of work had taken place to significantly reduce the backlog for discharge to access and an escalation protocol established with clear reporting into the Health Social Care Flow Group.

Internal controls had been enhanced to process cases more effectively, avoiding delays ensuring patients were on the correct pathway at the earliest opportunity. A review was taking place later this week to assess capacity to help reduce delays for appeals and retrospective cases.

LL highlighted funding available in relation to the Federation Data Platform to support the Population Health work.

JK highlighted that pressures in all age continuing healthcare were reflected across the region. JK welcomed sight of historic activity data and the convergence rate between the ICB and local authority to understand how the activity had changed over time.

Financial recovery governance had been strengthened to improve oversight as this was a key financial risk for the ICB. Rehabilitation and reablement were flagged as key areas that could reduce demand and better utilise funds.

JF welcomed a future update when available.

Outcome: The Committee noted the update on the financial deep dive.

ACTION: An update on all age continuing healthcare financial risk to be added to the Committee workplan.

ACTION: Presentation of how all age continuing healthcare activity has changed over time to be included at the next deep dive on all age continuing healthcare.

Assurance

7. System Finance and Performance Report – Month 5

The Committee were presented with the Month 5 System Finance and Performance Report and the report provided for the Month 5 Financial Review meeting with region.

At Month 5, the System was reporting a £23m deficit from its planned position across the three organisations, this was an increase from Month 4 of £6.9m. MSEFT and EPUT were off plan by £20.5m, £13.3m related to pay and £15.3m for non-pay; this was offset by additional income of £7.8m. JK raised significant improvements were required in the second half of the year to deliver the agreed £96m deficit.

The trajectory anticipated an improvement in the position from Month 8. The net risk stood at £82m and was being reviewed on a monthly basis.

AK reported the ICB position at Month 5 showed an adverse variance of £2.5m to the planned forecast. A number of planning risks on contract value and growth had crystalised into the position

and there continued to be significant cost pressures in all age continuing healthcare and primary care.

MB queried the significant assumptions on workforce improvements when the reduction in headcount remained high. JK clarified cost was not solely volume but including rates for bank and agency too.

JK reported a collective effort to establish 'grip and control' on rostering within MSEFT.

Performance

JF commenced a discussion on performance of 67% for accident and emergency (A&E) waits above the 4-hours target compared to the 78% national target. There was concern over long waits, with 2,041 patients waiting 12 hours or more (as of August 2024). MS highlighted the importance of discharge and flow to aid capacity and the need to consider a different approach to support prevention.

JK reported a significant focus on out of area placements as not only was this detrimental to patients but a significant cost pressure. It was suggested a deep dive took place on out of area placements to explore learning from other systems and what further action could be taken to improve the position.

JP referred to the table within the report summarising the elective metrics within the 2024/25 operational plan and welcomed further explanation regarding the assurances provided.

JP flagged an emerging risk of industrial action for nurses.

Outcome: The Committee noted the Month 5 Finance and Performance Report.

ACTION: Financial deep dives to be scheduled throughout the year on:

- Out of area placements
- The winter plan and urgent and emergency care
- Elective care

8. Update on the Investigation and Intervention Process

JK provided a verbal update on the investigation and intervention process and reported the phase one report had been finalised. Phase two of the process had commenced within MSEFT with a focus on three key areas: workforce, procurement, and the cost improvement programme; a Turnaround Director had commenced in post.

Discussions were ongoing within EPUT as the Trust required a bespoke level of support. Grip and control recommendations identified within the report were being taking forward within the ICB.

Outcome: The Committee noted the update on the Investigation and Intervention Process.

9. System Recovery Report

JK presented the System Recovery Report to provide the Committee with an update on the current System Efficiency position for 2024/25 and the work underway to progress schemes to delivery. The report outlined areas of focus such as primary care, all age continuing healthcare and out of area placements as well as divisional schemes.

JP flagged the urgency to proceed swiftly with actions. In response to a query on procurement delays, JK advised work had taken place within the ICB to reflect on learning and consider the most effective procurement route to enhance delivery and provide better outcomes.

JF welcomed clarity on key interventions contained within the bridge to achieve the planned position in future reporting.

Outcome: The Committee noted the System Recovery Report.

10. Medium Term Financial Plan

The Committee were presented with the first draft of the Medium-Term Financial Plan submitted to region on 30 September 2024. The individual MTFP models for the ICB, MSEFT and EPUT had been consolidated to develop the plan for submission of a £87.5m deficit for 2025/26.

It was clarified this was purely a finance return and did not include elements of workforce, or activity. The return was based on a best-case scenario.

Due to the NHS Oversight Framework Level 4 requirements placed on MSEFT, current modelling for MSEFT showed the Trust would achieve breakeven in 2026/27 (year 3). Breakeven for EPUT was anticipated in 2027/28.

KE advised key cost pressures for the ICB such as all age continuing healthcare had been built into the position. The plan included an increase for inflation, a core uplift allocation of 3% and reflected a circa 1% convergence rate deduction.

Furthermore, the plan reflected an annual cost of £12m for repayment of the System deficit. There was an expectation the deficit was repaid over a period of 3 years, capped at 0.5% of the allocation.

The plan assumed a delivery of £14.2m of efficiencies for the ICB, £96.7m for MSEFT and £24.7m for EPUT for 2025/26.

A MTFP working group had been established and would be broadened to include representation from workforce and operational colleagues to ensure triangulation of the key aspects upon which financial performance was dependent.

MB queried the disparity for inflation expenditure increases for the ICB compared to providers such as MSEFT who had a larger budget and higher costs. JK explained funding would flow to the ICB for the pay award. The ICB position reflected demographic and price pressures for areas such as continuing healthcare.

JP highlighted the need to consider service transformation amongst efforts on finding efficiencies.

Outcome: The Committee noted the presentation on the Medium-Term Financial Plan and the draft submission to region.

11. Triple lock ratification

Nothing this meeting

12. Feedback from System groups

The minutes of the System Investment Group (SIG) held on 15 July 2024 were presented for information.

Outcome: The minutes of the System Investment Group were noted

13. Any other Business

There were no items raised under any other business.

14. Items for Escalation

To report to the ICB Board, the Finance and Performance Committee had supported the Southend Community Diagnostic Centre Business Case and would provide a letter of support.

15. Date of Next Meeting

Tuesday, 5 November 2024, 2.00pm - 4.30pm.

In person meeting at ICB Head Quarters.

Minutes of the ICB Finance and Performance Committee

Held on 5 November 2024 at 2.00pm

Boardroom, ICB Headquarters

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, MSE ICB, **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB (via Microsoft Teams)
- Jo Cripps (JC) Executive Director of System Recovery, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB (via Microsoft Teams)
- Elena Lokteva (EL) Non-Executive Director, Essex Partnership University NHS Foundation Trust (EPUT)
- Julie Parker (JP) Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting
- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Nina Van-Markwijk (Nv-M) Finance Director, MSEFT (agenda item 5 - System Finance and Performance Report)
- Jenny Davis (JD) Director of Finance – Strategy & Commercial, EPUT (agenda item 6 – Capital update)
- Paula Wilkinson (PW) Director of Pharmacy and Medicines Optimisation, MSE ICB (agenda item 8 - IPMOC Annual Report)
- Margaret Hathaway (MH) Interim Director of Procurement and Contracting (agenda item 9.1 - MSEFT Pathology Procurement)
- David Barter (DB) Deputy Director of Commissioning, MSE ICB (agenda item 9.2 – Dental care in care homes)
- Simon Covill (SC) Deputy Chief Finance Officer, EPUT (agenda item 9.3 Time to Care)
- Lizzy Wells (LW) Director of Mental Health Urgent Care & Inpatient Services, EPUT (agenda item 9.3 Time to Care)
- Alfie Bandakpara-Taylor (AB-T) Deputy Director Mental Health, LD, Spec Comm, MSE ICB (agenda item 9.4 LD Contract Extension)
- Emily Hughes (EHu) Deputy Director of Delivery, MSE ICB (agenda item 9.5) Commissioning Intentions
- Emma Seabrook (ES) Business Manager - Resources, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate. Apologies were received from Loy Lobo, Finance and Performance Committee Chair, EPUT, noting that EL was attending on his behalf.

2. Declarations of interest

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.

JP and EL had a potential conflict for agenda item 9.5 (Commissioning Intentions: Independent Sector Provider (ISP) contracts) as employees of MSEFT and EPUT and would recuse themselves from the meeting at the point the agenda item was discussed.

JP highlighted her role on the Pathology Joint Venture for MSEFT in relation to agenda item 9.1 (MSEFT Pathology Procurement). JP raised this for transparency and did not believe this provided a conflict as this was not associated directly to the joint venture. It was agreed that JP did not need to leave the meeting for the item.

Outcome: The register of interests was noted.

3. Minutes of previous meetings

The minutes of 1 October 2024 were agreed as an accurate record subject to the following amendment:

- (Page 5, paragraph 3) the word pleased amended to ‘placed’.

Outcome: The minutes of 1 October 2024 were approved with the amendment above.

4. Action Log / Matters arising

The action log was discussed and updated accordingly.

JF discussed action 56 (Consideration of future reporting to reflect the direct correlation between the progress of PIDs through to implementation, and the subsequent impact on the 'run rate’). It was noted the action was closed at the October meeting.
JF queried the assurance the run rate provided to the Committee and asked when the inflection point was anticipated in the year.

JK reported a minor improvement in the MSEFT financial position from Month 5 to Month 6 and expected impacts from interventions to improve the position in Month 8 with noticeable improvements anticipated in the Month 7 position. It was agreed there would be a need to escalate should this not be the case.

JK confirmed the review of the balance sheets for the ICB, MSEFT and EPUT were underway.

Outcome: The action log was noted.

Assurance

5. System Finance and Performance Report – Month 6

JK presented the Month 6 report.

The straight-line do nothing forecast showed a System deficit of £186m should there be no effective interventions. The System deficit plan agreed with NHS England was £96m for 2024/25.

The ICB was £4m off plan year to date (YTD) and saw a deterioration from the Month 5 position due to continued pressures on all age continuing care and prescribing.

The System was £28.6m off plan at Month 6, a deterioration of £5.6m from the Month 5 position. JK clarified the deficit cash allocation received during reporting periods was not additional monies and did not improve the planned position of a £96m deficit for 2024/25. The System would be required to pay back the deficit funding in future years.

A number of actions to bridge the position had been identified from the Price Waterhouse Coopers (PwC) Investigation and Intervention process mandated by NHS England.
Efficiencies had not delivered to the pace projected and the System had been faced with additional cost pressures over and above the planned position that was already stretched. Pressures faced within MSE were also reflected across other ICBs in the region.

Efficiencies were off plan by £15.4m for the System. Pressures of winter were flagged as a real concern alongside the need to balance safety and quality with financial performance.

Nv-M reported the efforts behind each intervention and anticipated a reduction in temporary staffing following an increase in grip and control on rostering within MSEFT. Other actions were underway within MSEFT such as the review of bank rates and alternative delivery models for temporary staffing.

The System had escalated to NHS England, the performance pressures MSEFT was experiencing from being in the National Oversight Framework Level 4 tier 1 regime and the impact this would have financially. Mental health in patients, out of area placements and all age continuing care were flagged as further high-risk areas.

A number of actions were underway as winter approached. The discharge cell went live on 1 November 2024 to drive performance and maximise flow. A proposal to mitigate pressures within all age continuing care was expected imminently to mitigate some of the pressures and ensure greater value, particularly in the discharge to assess pathway.

JF recognised efforts being made within the System to improve the position, but pace was a concern. The Finance and Performance Committee expected to see a step change in Month 7 reporting to be assured the System would be on track to deliver the planned deficit of £96m at year-end.

Outcome: The Committee noted the Month 6 Finance and Performance Report.

6. Capital update

The System was £200k behind plan on ‘local capital programmes’ but largely on track to deliver in line with the year-end forecast. ICB local programmes were slightly ahead of plan.

The System was £13.6m year to date (YTD) behind plan for ‘external funded programmes’ due to an underspend on Community Diagnostic Centres (CDCs) and Sustainability and Transformation Partnership schemes (STP). The position also reflected the reprofiling of Electronic Patient Record (EPR) funding into 2025/26 for MSEFT and EPUT, in line with the full business case.

The System Investment Group (SIG) had raised concerns on the MSEFT capital spend profile and forecast for 2024/25 and had sought assurance on external schemes. MSEFT were awaiting confirmation from the Department of Health and Social Care on the availability of STP capital funding beyond March 2025.

JD highlighted a potential delay to the completion of the Pitsea CDC to 2026/27 and raised the current stretch within 2026/27 due to pre-committed funding for EPR. There was a further capital pressure on the Thurrock CDC development presenting a cost pressure of £4m for MSEFT.

It was noted none of the acute reconfiguration programmes in phase 1 (due to complete March 2025) should be linked to benefits planned for this year either operationally, clinically or financially. Longer term delivery was dependant on the receipt of capital funding promised on merger.

The Finance and Performance Committee requested a report was provided to a future meeting on scenarios of spend for future years.

Outcome: The Committee noted the update on Capital.

ACTION: A report detailing scenarios of Capital spend in future years to be presented to the Finance and Performance Committee.

7. System Recovery Report

The System recovery report provided an update on the System efficiency position for 2024/25 and actions underway to progress schemes to delivery. JK welcomed feedback to refine the report in readiness of quarter four reporting.

It was clarified the RAG rating assessed the progress from last month and not the progress of the overall programme.

There was recognition there had been an incremental improvement in reporting risk within the report but that further work was required on the reporting of internal grip to clarify escalations and ownership.

JC explained the ICB would be procuring a programme management system that would enable an enhanced level of granular reporting and a consistent way to manage projects.

JF urged the use of weighted forecasting to provide a more accurate view of the position.

Outcome: The Committee noted the Month 6 System Recovery Report.

8. IPMOC Annual Report (including updated Terms of Reference)

The report provided an overview of work undertaken by the Integrated Pharmacy and Medicines Optimisation Committee (IPMOC) over the past year to support medicines optimisation and prescribing efficiencies. IPMOC was a subcommittee of the Finance and Performance Committee.

JP highlighted the desktop review of MSE ICB Committee effectiveness for the IPMOC did not clearly outline areas the Committee would focus its achievement on (highlighted in page one of the report) such as addressing health inequalities.

PW confirmed the use of quality impact assessments in relation to decision making and development of policies that reflected the approach taken within the team to improve access for the population.
Following a query from JF on the barometer of effectiveness, PW advised of a prescribing efficiency tracker that provided a breakdown of spend at practice level.

The main change to the terms of reference of the committee reflected the inclusion of Alliance Clinical Leads within its membership. JF suggested the quoracy was amended from 7 to 8 members and welcomed a glossary to provide the context on drugs referenced with minutes of the IPMOC meetings.

Outcome: The Committee noted the Integrated Pharmacy and Medicines Optimisation Committee (IPMOC) Annual Report and approved the IPMOC Terms of Reference.

9. Business Cases

9.1 This item has been minuted confidentially.

9.2 Dental Care in Care Homes

The purpose of the paper was to seek support from the Committee to commission the Dental Service in Care Homes model following a successful pilot to improve the oral health of patients in a care home setting. MB queried the contract term following a discrepancy within the paper, it was confirmed the contract period was five years (three plus a potential two-year extension).

JP made a suggestion the model incorporated care home staff as well as care home residents to ensure a wider reach.

Outcome: The Finance and Performance Committee approved the provision of the care home pilot at a cost of £2,740,000 as a commissioned service for a five-year period (three + two-year extension) from April 2025, contracted via a variation to existing providers of GDS/PDS contracts.

9.3 Time to Care

LW presented the paper and provided an overview of the proposed Time to Care (TTC) inpatient mental health programme. The paper sought approval of a financial contribution from the ICB in line with the TTC business case.

The model aligned to national guidance released in 2023 focusing on purposeful admission, therapeutic and trauma informed care and safe and effective discharge.

LW spoke of the aim to reduce spend on temporary staffing by creating more focused roles for unregistered staff. There was a further ambition to reduce the number of inappropriate out of area placements and the average length of stay.

There was recognition the operational changes flagged were key, however the business case did not include the granular financial detail including the proposal to repurpose the Mental Health Investment Standard.

Outcome: The Finance and Performance Committee were unable to support the business case in the absence of key financial data and agreed to consider a virtual decision in between meetings once financial information had been received.

9.4 Learning Disability Contract Extension

ABT presented the paper to request approval to enact the 2-year extension for the Learning Disability Specialist Healthcare contract with Essex Learning Disability Partnership (ELDP). The contract was held jointly between EPUT and Hertfordshire Foundation Partnership Trust and delivered across the Southend, Essex and Thurrock areas.

It was explained the 2-year contract extension would enable sovereign bodies to work with Essex County Council who manage the contract on its behalf to review the current section 75 award and collaborative agreement.

JP highlighted although the current provider was broadly delivering the service, it had not delivered all aspects of transformation in the 5 years. It was agreed the delivery of future transformation would be captured within the Programme Management Office (PMO) to monitor delivery against milestones.

NA clarified Board approval to enact the 2-year extension was not required as the original approval of the contract was based on the value of the 5 years plus optional 2 years extension. NA further

noted that the financial value of the 2-years extension was not included within the paper and agreed to liaise with ABT to circulate the values of the contract to the Committee.

Outcome: The Finance and Performance Committee

- **noted the content of the report and proposed plan for wider review of current Section 75 arrangement**
- **endorsed and approved the two-year extension of the contract.**

ACTION: The financial value of the 2 years contract extension to be circulated to the Finance and Performance Committee.

9.5 Commissioning Intentions: Independent Sector Provider (ISP) contracts

JP and EL had a potential conflict and left the meeting whilst the agenda item was discussed.

EHu introduced the item explaining the paper proposed an approach for the contracting arrangements for the Acute Independent Sector Provider (ISP) contracts. The Committee was asked to approve the proposal to undertake a 'Self Declaration' Accreditation process for the existing contracted ISPs with a view to awarding a contract for a 3-year term under the Provider Selection Regime Direct Award Process B.

EHu confirmed there were no quality concerns with the current providers.

Given the total value of contracts, the proposal would be submitted to the ICB Board for final approval.

Outcome: The Committee agreed to support, and recommend to the Board for approval, a 'Self Declaration' Accreditation process for the existing contracted ISPs with a view to awarding a contract for a three-year term under Provider Selection Regime Direct Award Process B.

10. Board Assurance Framework / Finance Risk Register

The Committee were presented with the current Finance Risk Register (Appendix 1) and the finance related risks on the Board Assurance Framework (Capital and System Financial Performance) as set out in Appendix 2 of the meeting pack. It was noted two new risks had been added to the Finance Risk Register since the last report to the Committee.

EL queried the risk appetite for risk 63- Court of Protection - Deprivation of Liberty Safeguards and risk 64- All Age Continuing Care Retrospective cases and appeals. NA advised a standard risk appetite was in place and took an action to explore the current ratings for risk 63 and risk 64.

Following a query on the accuracy of the initial and current risk rating score of 8 for risk 43 - Community beds, NA believed the risk rating was based on what had been extracted following the implementation of Datix. The Committee agreed a review of risks was required to reflect the risk on the dependency on community beds over the winter period and the optimisation of flow.

Outcome: The Finance and Performance Committee noted the Risk Register and Board Assurance Framework.

ACTION: The following risks to be reviewed to check the risk appetite / update:

63) Court of Protection - Deprivation of Liberty Safeguards
64) All Age Continuing Care Retrospective cases and appeals
43) Community beds

11. Triple lock ratification

No items presented for this meeting.

12. 2024/25 Strategy for Winter Management

Mid & South Essex Foundation Trust 2024/25 Bed Model

EH provided an overview of the 2024/25 strategy for winter management and the MSEFT 2024/25 bed model and presented the documents for information.

There was a wider discussion on the pressures emerging as the winter period approached and the challenge to balance safety and quality alongside financial performance.

Outcome: The Finance and Performance Committee noted the 2024/25 strategy for winter management and the MSEFT 2024/25 bed model.

13. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) held on 19 August 2024 and 30 September 2024 and minutes of the System Investment Group (SIG) held 23 September 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

14. Any other Business

There were no items raised under any other business.

15. Items for Escalation

To the ICB Board:

- Commissioning Intentions: Independent Sector Provider (ISP) contracts for approval.
- Time to care (subject to virtual support from the Finance and Performance Committee) for consideration
- MSEFT Pathology Procurement for virtual approval

ACTION: The Finance and Performance Committee expected to see a step change in Month 7 reporting to be assured the System would be on track to deliver the planned deficit of £96m at year end. JF agreed to raise this as a critical point in the year at the November Board meeting.

16. Date of Next Meeting

Tuesday 3 December 2024
2.00pm - 4.30pm
Microsoft Teams meeting

Minutes of the ICB Finance and Performance Committee

Held on 3 December 2024 at 2.00pm

ICB Headquarters and Microsoft Teams meeting

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, MSE ICB, **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Jo Cripps (JC) Executive Director of System Recovery, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB (part)
- Loy Lobo, Finance and Performance Committee Chair, EPUT
- Julie Parker (JP) Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB

Other attendees

- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting
- Ashley King (AK) Director of Finance and Estates, MSE ICB (part)
- Emma Seabrook (ES) Business Manager - Resources, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate. There were no apologies.

2. Declarations of interest

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.

There were no declarations of interest in relation to the agenda items.

Outcome: The register of interests was noted.

3. Minutes of previous meetings

The minutes of 5 November 2024 were agreed as an accurate record.

Outcome: The minutes of 5 November 2024 were approved.

4. Action Log / Matters arising

MSE had been chosen to pilot a system approach to risk management. NA would link in with stakeholders once the scope for the pilot was produced. It was anticipated the new process would take 12 months to fully embed within the system. A fuller update would be provided at the January meeting on the action to embed risk management within the work of the Committee.

JF raised the concern to balance financial sustainability against performance metrics and flagged the importance to anticipate risk.

LL highlighted the need for long term capital and digital investment to support strategic priorities. JK advised a 10-year Capital plan was underway and reported a capital submission was required in Month 8.

It was noted that action 38 should read 'February 2025'.

Outcome: The action log was noted.

Business Cases

5. Hybrid Closed Loop (HCL) systems for managing blood glucose levels in Type 1 Diabetes

The business case sought approval for the implementation of the national mandated NICE technology appraisal guidance (TA) 943 relating to the use of Hybrid Closed Loop (HCL) systems for managing blood glucose levels in type 1 diabetes.

The total cumulative cost of implementation over 5 years was £32m, it was confirmed £15m would be reimbursed by NHS England. The net impact to MSE ICB was £17m. Practice uptake of 100% had been factored into the case however it was not anticipated this would be implemented and therefore achieved by all practices. CH would continue to work with finance colleagues to identify a more realistic position.

LL believed the benefits would be realised over a longer period (10 years plus). JF welcomed the inclusion of both soft and hard benefits to ensure the value of the project was fully articulated. LL suggested a mechanism was enacted to monitor progress each year to ensure the trajectory was on track and to provide the assurance that the longer-term benefits would be achieved.

Following a query from JP on the cost to replace equipment, it was confirmed a four-year warranty covering the replacement of the device plus consumables was included within the modelling of the business case.

JP queried access to the service in response to the equality impact assessment. CH explained the prioritisation was to target patients with the greatest need. The service would then be redistributed to support poor aims and outcomes for patients with type 2 diabetes.

MB queried how it would be funded with current financial constraints. It was clarified ICBs were mandated to provide HCL systems but would not be fully funded. JK confirmed the case would be built into the Medium-Term Plan and future discussions on how the ICB would operate within its financial envelope.

Capturing health and socio-economic benefits plus case studies/user experience was highlighted as key.

Outcome: The Finance and Performance Committee supported the Business Case and investment of £17m over the next five years and recommended approval to the ICB Board.

There were three areas requiring further assurance to be reported back to the Committee:

- Confirmation of the transfer of the existing ICB budget for the diabetes devices to the providers. It was noted without the transfer there was a risk that if providers fail to upload to the National Diabetes Audits, the ICB may not secure the full reimbursement for the HCL devices.
- Understanding of the soft and hard benefits to ensure value for money.
- Clarification of the social value benefit to patients.

ACTION: An update on Hybrid Closed Loop (HCL) systems for managing blood glucose levels in Type 1 Diabetes to come back to a future meeting to provide assurance on the realisation of benefits and transfer of responsibility to Providers.

Assurance

6. Update from System Investment Group - Capital

The System were working together to develop a 10-year capital plan, JK would provide an update at a future meeting. A deep dive was taking place with NHS England in Month 8 to review the Capital spend for 2024/25 across the region.

The Committee noted heightened concerns on the amount of capital resource required for Community Diagnostic Centres (CDCs) and the impact of schemes being delayed to 2026/27. JK highlighted 2026/27 was already a stretched position due to pre-committed funding for the Electronic Patient Record (EPR). The position on CDCs was being escalated to the System Oversight and Assurance Committee (SOAC) on 13 December to raise concerns on the capital programme, the commissioning of the service and subsequent pressure on the contractual timeline. The Committee would be kept abreast of progress.

Outcome: The Finance and Performance Committee noted the update on Capital.

7. System Finance and Performance Report – Month 7

JK presented the Month 7 report.

There was a wider discussion on the high impact target areas within MSEFT and those presenting as the greatest challenge. Workforce, including the reduction in bank and agency usage was flagged as key focus areas.

JK said completion of PIDs provided wider visibility on programmes of work and facilitated system discussions on steps required to drive improvements.
The impact of the pay award was noted as £5.3m, had this not occurred, MSE would have seen a favourable movement in the Month 7 position.

Discussions were taking place within the ICB, MSEFT and EPUT regarding what would be required to achieve financial balance.

JF raised his ongoing concern on the ability to maintain performance and safety standards whilst ensuring financial sustainability.

The Committee noted the efforts to drive financial and performance improvement. JP raised the excellent work taking place in theatre productivity and flagged the need to showcase some of the good work taking place.

Outcome: The Committee noted the Month 7 Finance and Performance Report.

JK left the meeting.

8. System Recovery Report.

The system recovery report provided an update on the efficiency position for 2024/25 and actions underway to progress schemes to delivery.

LL referred to the workforce reduction summary and queried the potential redeployment opportunities. JC clarified the approach in MSEFT was to review by speciality and reported consideration of redeployment opportunities across the Trust. It was agreed there was further work required to look at redeployment opportunities across the system.

MB suggested an additional column was included in the ICB 2024/25 cash releasing programme update for all age continuing care to monitor progress against the baseline and provide wider context of how the programme was delivering.
The Committee agreed the report was very detailed and welcomed a condensed report in future to provide an update on key changes since the last meeting. It was suggested a report was received from the System Financial Sustainability Programme Board on key movements/concerns. This would provide a flow of reporting through governance routes, rather that duplicated reporting.

Outcome: The Committee noted the System Recovery Report.

ACTION: A report from the System Financial Sustainability Programme Board to provided going forward to replace the System Recovery Report.

AK left the meeting.

9. Bed outlook for the winter period

The level of demand within urgent and emergency care was broadly as anticipated at this point in the year. It was expected the level of demand would increase after the Christmas period. Respiratory in children was highlighted as an area of pressure, this was also reflected nationally.

Handover delays remained static compared to other areas in the east of England and current bed utilisation was 7% above plan.

The System Discharge Cell had been established and would provide additional capacity to manage the safe movement of patients through and out of hospitals. Early indicators suggested the System Discharge Cell was having a positive impact on length on length of stay, community beds and intermediate care beds.

The ICB had recently launched a pilot to improve processes for supporting people to leave hospital and continuing their care and assessment out of hospital (discharge to assess). It was anticipated this would help relieve current financial pressures in this area and provide better care for patients.

The Executive Committee had in principle supported a proposal to support pathway management of community beds. The initiative aimed to reduce the length of stay for patients on pathway 2,

enhancing flow and minimising escalation pressures. There was consideration of a virtual ward for respiratory to ensure current capacity was fully utilised.

The Committee was advised work was taking place across the east of England provider collaborative on better management of out of area placements. The ICB were also looking at surge and capacity within pathways in conjunction with the local authority.

Outcome: The Committee noted the update on the bed position over winter.

10. Provider Selection Regime Group (PSR) Terms of Reference

NA presented the terms of reference (TOR) for the Provider Selection Regime (PSR) Review Group following a recent review. There had been no changes to the document. There had been no challenges raised because of procurements; since the inception of the group, and therefore no requirement for the group to meet. It was noted there had been limited escalations to the nationally enacted group.

LL referred to section 2.2 and queried the impact of having multiple approaches across organisations in relation to standing orders, Standing Financial Instructions, and the SoRD. NA clarified the TOR was mandated from NHS England and expected any nuances were not likely to be fundamental.

LL raised the standstill period was not clear within section 3.5. NA would seek guidance on the wording included as this may be specific around regulation.

NA clarified the group would review its effectiveness using the standard self-assessment for effectiveness ICB template, should it meet.

It was noted that reference to the Finance and Investment Committee required updating to the Finance and Performance Committee.

Outcome: The Committee approved the Terms of Reference for the Provider Selection Regime (PSR) Group subject to the amendment above.

11. Triple lock ratification

No items presented for this meeting.

12. Feedback from System groups

The minutes of the System Finance Leaders Group (SFLG) held on 28 October 2024 and minutes of the System Investment Group (SIG) held 21 October 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

13. Any other Business

TA provided a verbal update on Time to Care (TTC) following the presentation of a business case by EPUT at the November meeting for the management of staffing costs and the transfer of the responsibility of management for out of area placements. It was anticipated the benefits of TTC would reduce length of stay and improve the use of out of area placements.

The business case would be presented to the Finance and Performance Committee in readiness of ICB Board approval in January. It was noted virtual approval may be required, depending on the timing of meetings.

A deep-dive on out of area placements was scheduled to come to the Finance and Performance Committee, the date was to be confirmed.

LL advised this was his last meeting, Diane Leacock would join the Committee from January 2025. The Committee thanked LL for all of his vital input over the years.

14. Items for Escalation

To the ICB Board:

- Hybrid Closed Loop (HCL) systems for managing blood glucose levels in Type 1 Diabetes Business Case as the total value exceeded the Finance and Performance Committee financial threshold to approve.

The Finance and Performance Committee expected to see an improvement in Month 8 reporting.

15. Date of Next Meeting

Tuesday 7 January 2025
2.00pm - 4.30pm
Boardroom, ICB Headquarters

Minutes of ICB Primary Care Commissioning Committee Meeting

Tuesday, 9 October 2024, 1.30pm–3.30pm

Anglia Ruskin University School of Medicine, Chelmsford

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Viv Barker (VB), Director of Nursing.
- 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).
- Ashley King (AK), Director of Finance Primary Care, Financial Services and Infrastructure (nominated deputy for Jennifer Kearton).

Other attendees

- Tom Abell (TA), Chief Executive Officer.
- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.

Apologies

- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dr James Hickling (JH), Deputy Medical Director.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Jane King (JKi), Corporate Services & Governance Support Manager.

1. Welcome and Apologies

The Chair 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. No issues were raised.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 14 August 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 14 August 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (111, 116, 120, 121, 122 and 126) were all within timescales for completion.

Outcome: The updates on actions were noted.

5. Primary Medical Services Update

JS provided an update on primary medical service contract activity since the last paper was presented to the Committee in August 2024.

Care Quality Commission (CQC)

- One Practice had been downgraded to 'requires improvement' in South East Essex. Work continued with the practice to improve quality and performance.
- One CQC report was awaited, following inspection.

The Primary Care team had sought assurances from a practice within the Basildon Billericay Alliance locality around the suitability of the building they operated from for clinical services. The landlord had subsequently given notice on the building and the Practice were looking at alternative premises from March 2025.

Practice status changes

- One Practice application to change from an individual to a partnership from 1 October 2024 was approved.
- One Practice application to change from a partnership to an individual contract (due to retirement) was pending further information.

.

The ICB had been approached for advice by a number of Primary Care Networks (PCNs) regarding reconfiguration and was working through the practicalities with the practices involved.

Following the inclusion of Adult ADHD (Attention-Deficit/Hyperactivity Disorder) prescribing within the enhanced monitoring service, further discussions were underway, with input from the Local Medical Council, in relation to the enhanced monitoring process for ADHD prescribing.

The Autumn COVID and Flu Vaccination Programmes and the new Respiratory Syncytial Virus (RSV) Vaccination Programmes were underway.

Following the announcement by the British Medical Association of the GP Collective action from 1 August 2024, the ICB had written to practices and partners to outline the arrangements in place to manage the impact for this and the support arrangements available to practices and practice staff during this time.

RJ commented that a Practice had closed because of a termination of their lease by the landlord, prior to a closure application being made to the ICB. JS confirmed that assurance documentation had been requested and, once complete, the Committee would be asked to make a retrospective decision on the closure.

PW highlighted for accuracy that within the Connected Pathways update the Community Independent Prescriber Pathfinder was live and implementation of the NHSE electronic CLEO system (supporting shared care records) was underway.

In response to SA, JS advised that WG and JS were the central points of contact for issues arising as a result of the GP collective action. Additionally, the ICB's Emergency Preparedness, Resilience and Response team had oversight of monitoring and reporting the impact of collective action into NHS England.

At a previous committee meeting, a request was made for an example of how the Connected Pathways team supported primary care. An example was given relating to support for securing transitional funding, by providing strategic planning advice and solutions to training and digital take-up. This supported the long-term sustainability of services.

RJ stressed that patient insight must be considered in Connected Pathways schemes.

Outcome: The Committee NOTED the Primary Medical Services update.

PCN Void Cost Scheme

The Committee were reminded of the recommendation which was approved in August 2023 to make 'void space' available to PCNs rent free and with a subsidised service charge, which was approved up to the end of March 2025.

The PCN Void Cost Scheme had proven popular with PCN's with identified void spaces now used for the delivery of a range of primary care services. It was recommended that the Scheme was extended for a further three years (until end March 2028) on the basis it continued its previous objective to enable PCNs to access clinical space service provision. JS clarified that any applications to the PCN Void Cost Scheme, would be subject approval. No objections to extending the Scheme were raised by the Committee.

Outcome: The Committee APPROVED the extension of the void cost scheme until 31 March 2028 in principle, subject to applications being received individually.

Supplement to Global Sum

A significant proportion of general medical practice income was derived from the 'Global Sum,' a fixed value income weighted per patient, adjusted using the Carr-Hill formula based on certain criteria.

WG set out the recommendation to make a supplementary payment to a specific Practice to offset the impact of an exceptionally low Carr-Hill formula weighting. Under the current formula, the Practice received 69% of the funding available for their population, whilst most practices received a minimum of 80%.

The practice was seeking a long-term commitment to cover the gap to enable the practice to increase the number of GPs employed, maintain their training status, and improve the quality of care they were able to offer.

A subsidy to bring funding to 80% (in line with other Practices) for an initial 5-year period, retrospective from 1 April 2024, was proposed. If the Carr-Hill formula changed within the next five years, the agreement would be reviewed to ensure there was no over-funding. As it was an unbudgeted cost, the recommendation would need to be progressed through the triple lock process for consideration.

It was noted the low Carr-Hill scoring for the Practice was largely because it was built to serve a new housing development with a younger population. This prompted discussion around the potential impact of funding implications around new housing developments.

ACTION: WG and JS to understand the potential impact of funding implications around new housing developments and build into the next primary care strategy update.

Outcome: The Committee SUPPORTED the proposed supplementary payment to the Practice on the following terms:

1. That the ICB provided an adjustment to practice income equivalent to the value the practice would receive if their weighted population were at 80% of actual population.
2. That this commitment would be for an initial five-year period to enable recruitment.
3. That this would commence retrospectively as of 1 April 2024.
4. That if the Carr-Hill formula or Global Sum calculation is materially changed (beyond inflation) during this period, the agreement would be suspended and reviewed.

RJ left the meeting.

6. Finance Update

AK presented the Primary Care financial position for Month 5.

The report noted at Month 5, the ICB had received allocations totalling circa £3bn and whilst forecasting breakeven in line with financial plan, it was reporting a year-to-date adverse variance of £2.57m.

The ICB's financial plan assumed delivery of £48m of in-year efficiencies across 6 programmes of work, two related directly to Primary Care Commissioning: Medicines Optimisation and Primary Care.

At Month 5, the Medicines Optimisation efficiency programme was forecast to be in line with the plan. Primary Care efficiencies were forecast to under-deliver; revised project documentation had been received to deliver a third of the target amount which would be reflected in Month 6 reporting.

Primary Care performance, (which covered delegated Primary Medical Services and Pharmacy, Optometry and Dental allocation and a range of non-delegated budgets which were funded from core allocations), at Month 5, had a slight over-commitment of £900k, driven by overperformance on incentive schemes and prescribing.

The report set out financial risk areas that could impact in-year financial performance and the future ability to make new investments in Primary care, which included GP Prescribing, premises costs and the financial consequence of GP collective action. In summary, just under £600m funding was identified for the Primary Care portfolio. Forecasts were projecting over-utilisation and a pressure against plan. It was expected that work would take place in the remaining months to bring this back to target.

SA commented that it was useful to receive the primary care finance report in the context of wider ICB finances and enquired, for the expected £200k savings (against the forecast £600k), where the work was taking place and who owned the programmes of work. AK advised primary care and recovery governance work programmes were owned by PG and WG.

SA questioned the likelihood of achieving the efficiencies forecast. WG indicated that 2025/26 efficiencies would be realised through various programmes, largely where subsidiary provision had been made e.g., supporting Asylum hotels and care homes but it was unlikely that efficiencies of £600k would be achieved this financial year. The speed of delivery had impacted efficiencies this year, but additional savings were expected from the Alternative Provider Medical Services (APMS) review for 2025/26 which would be realised in 2026/27. Further efficiencies would be explored.

Outcome: The Committee NOTED the Month 5 Finance Update.

BB left the meeting.

7. Primary Dental Services

Dental Care Home Service

Following the successful Dental Care Home pilot in mid and south Essex which aimed to improve the oral health of patients in a care home setting, DB outlined the proposal to move from pilot stage to a fully commissioned service from April 2025, for a period of 3 years, with a potential 2-year extension. The Dental Care Home service would be written into General Dental Services (GDS) and Personal Dental Services (PDS) contracts.

The scheme was fully funded from existing delegated Primary Care Dental Service budgets. The cost for each year was £2,740,200 for 8,431 care beds. This was based on the current number of beds in care homes but could fluctuate, as new homes were opened

within mid and south Essex. The dental team would work within Provider Selection Regime (PSR) rules to select the providers under a contractual agreement from 1 April 2025.

SA recalled the presentation on the Dental Care Home pilot given at the last meeting which demonstrated the positive impact it had on care home residents. DD enquired whether there was capacity to provide a commissioned Dental Care Home service across mid and south Essex. DB confirmed that 11 dental practices had already expressed interest in covering all care home beds in mid and south Essex.

In response to DD, DB explained the care home element of the contract was in addition to the regular Units of Dental Activity (UDAs) and from uncommitted dental spend for this cohort of patients. As a result of the Dental Care Home pilot, the waitlist for the Community Dental Service had reduced by 60%, therefore was able to see more patients for other treatments.

BH confirmed the Local Dental Committee (LDC) were in support of the pilot moving to a commissioned service.

VB requested that the Primary Care Quality team engaged in setting up the commissioned service from the outset.

DB advised that the LDC were working with the Dental Managers Clinical Network on a training programme to upskill and train dental nurses which would be 50% financed by the LDC. DB reported that there had already been interest in the training programme and it was expected to be oversubscribed.

DD left the meeting.

Outcome: The Committee SUPPORTED the provision of the care home pilot as a commissioned service for a 5-year period (3 + 2-year extension) to a maximum of £13.701m from April 2025 (contracted via a variation to existing providers GDS/PDS contracts), to be presented to the Finance and Performance Committee and the Board for final approval.

Dental Access Pilot extension

DB sought approval to extend the Dental Access pilot for a further 2 years and to upscale the service by 50% to meet patient need. The aim of the pilot, previously approved by the Primary Care Commissioning Committee in 2023, was to improve access to dental services by enabling patients to access in-hours, out of hours, weekend, and bank holiday dental services. The pilot had been in operation since 1October 2023 and to date had provided 16,630 additional 30-minute appointments.

The current cost of the pilot was £1.66m per annum (to March 2025), fully funded from delegated primary dental budgets.

The proposal was to extend the pilot from 10 to 15 practices. The additional annual cost would be £0.83m per annum bringing the total annual cost to £2.489m. Part of the £0.83m would be funded through the reinvestment of £300k currently funding the Dental Trauma Pathway. The remaining £0.53m would be from an existing surplus budget allocation of £1.16m.

Guidance was awaited from NHS England on the requirements of ICB's to deliver manifesto pledges on dental access. An extension to the pilot was preferable as it would be the easiest way to accommodate any changes to dental access instructed by the Government. Further work was also required to be undertaken by the software provider to allow providers (e.g., GPs and Accident and Emergency departments) to book patients into appointments.

In response to AK, DB confirmed there was flexibility within the contract to terminate or redirect funding/resource, as necessary.

BH stated that the LDC fully supported the extension to the Dental Access Pilot.

SA commented that quality and volume of work should be monitored to evaluate value for money.

VK advised that the Quality team had regular calls with IC24 (the provider of the NHS111 service) to ensure the correct algorithms were in place to triage calls effectively and suggested the Dental team join to ensure algorithms reflect actual dental practices.

Outcome: The Committee SUPPORTED the extension of the Dental Access pilot for a further two-year period (April 2025 – March 2027) and expand the pilot to include an additional 5 practices to a total cost of £4.978m, to be presented to the Executive Committee for final approval.

MA left the meeting.

BH left the meeting.

8. Delegated Primary Care Self-Assessment Action Plan update

WG presented a mid-term report on the progress made against the recommendations arising from the 2023/24 Delegated Primary Care functions self-assessment, covering General Medical, Pharmaceutical, Ophthalmic and Dental services. It was noted that good progress had been made in all areas, although some were dependent on the updated Primary Care Strategy which was in progress.

SA acknowledged the volume of work already undertaken in relation to the recommendations and noted the action plan was a work in progress.

PW advised there were difficulties with authorisation of Patient Group Directions (PGDs) (a legal framework that allows some registered health professionals to supply and/or administer medicines) which was having a negative impact on service delivery in PCNs. In response to SA, PW welcomed the issues around PGD being formally escalated and agreed to provide TA with a briefing on the issues in order to brief NHS England.

ACTION: PW to provide a briefing on Patient Group Directions and the resulting negative impact on Primary Care Networks to enable TA to escalate the issues to NHS England.

Outcome: The Committee NOTED the update on progress with the action plan.

9. Primary Care Risk Management

WG presented an overview of the primary care risks included on the ICB's risk register and Board Assurance Framework, highlighting the move to a new system of reporting.

There were 74 active risks on the ICB's risk management database (RLDatix DCiQ), 10 of which were relevant to the work of the Committee. There was 1 red rated risk related to Primary Care Demand and Capacity and 9 rated amber.

At the time of writing, 4 risks had not been updated since the last committee meeting. The relevant risk leads had been reminded to update their risks on a timely basis, prior to each Committee meeting.

WG advised that changes were required to the risk around GP collective action (ID52) to reflect the nature of action being taken and the resulting impact on service delivery and managing patients within the system. SA highlighted that the title for risk ID52 should be amended to 'GP collective action'.

ACTION: Risk ID52 to be amended to 'GP collective action'.

WG was working with risk owners to review risk ratings to see whether the actions to mitigate the risks had any impact on the ratings, particularly those that were long standing. The next risk report was expected to see risk ratings reduce.

Outcome: The Committee NOTED the Primary Care risk update.

10. Minutes of the Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 7 August 2024 were received.

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

11. Items to Escalate

There were no items to escalate to Board or other Committees.

12. Any Other Business

There was no other business to discuss.

13. Date of Next Meeting

9.30am-11.30am, Wednesday 13 November 2024
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 25 October 2024 at 10.00 am – 12.30 pm

Via MS Teams

Members

- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) deputising for Dr Neha Issar Brown, Non-Executive Member and Chair of Quality Committee.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Joanne Foley (JF), Patient Safety Partner, MSE ICB.
- Ann Sheridan (AS), Executive Nurse, Essex Partnership University NHS Foundation Trust (EPUT.
- Christine Blanshard (CB), Chief Medical Officer, Mid and South Essex NHS Foundation Trust (MSEFT).
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company.

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB (deputising for Dr Giles Thorpe).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- John Swanson (JS), Lead Nurse for Infection Prevention and Control, MSE ICB.
- Gemma Stacey (GS), Designated Clinical Officer for Special Educational Needs and Disabilities (SEND), MSE ICB.
- Victoria Kramer (VK), Senior Nurse for Primary Care Quality, MSE ICB.
- Ines Paris (IP), Designated Lead Nurse Safeguarding, MSE ICB (deputising for Yvonne Anarfi).
- Dawn Osborne (DO), Associate Director of Patient Safety, MSEFT (deputising for Diane Sarkar).
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB.
- Vicky Cline (VC), Senior Nurse for Acute/community, MSE ICB.
- Natalie Brooks (NB), Senior Operational Manager for Children and Young People Continuing Care, MSE ICB.
- Barbara Stuttle (BS), Non-Executive Director. MSEFT.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Dr Neha Issar-Brown (NIB), Non-Executive Member, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.

- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Geraldine Rodgers (GR), Director of Nursing, Leadership and Quality, NHS England.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex, MSE ICB.
- Yvonne Anarfi (YA), Deputy Director of Nursing for Safeguarding, MSE ICB.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB.
- Carolyn Lowe (CL), Deputy Director All Age Continuing Care, MSE ICB.
- Emma Timpson (ET), Associate Director Prevention and Health Inequalities, MSE ICB.
- Wendy Dodds (WD), Healthwatch Southend.

1. Welcome and Apologies

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

2. Declarations of Interest

SP 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 30 August 2024 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 30 August 2024 were approved without amendment.

4. Review of Action log

The action log was reviewed, and updates were noted.

In relation to action 63, SP requested that an update on Black and Asian mothers with regards to health inequalities be included in the deep dive report on the maternity services improvement plan.

Resolved: The Committee noted the Action Log.

5. Lived Experience Story – EPUT

A patient experience video was shown highlighting the positive and negative experiences of a patient with mental health issues and the challenges they faced when accessing mental health services.

AS commented that the video reflected the reality of living with mental health issues, particularly for someone with emotional and complex needs, and it also highlighted the importance of accessing mental health services in a timely and appropriate manner.

JS commented that the video was powerful and emotional to watch. AS confirmed the video

was accessible to all Essex Partnership University NHS Foundation Trust (EPUT) staff and permission was given for the video to be shared with all partners.

In response to a query from SP, AS confirmed that mental health charities had access to these stories. Peer collaboration, and co-production support had been available in mental health services for many years, which provided hope and involvement to those with mental health needs and issues.

6. Deep Dive – Patient Experience – EPUT

AS advised that peer support work had been ongoing in EPUT for the last five years, and the trust now has over 500 people with peer experience working in the trust, as well as peer volunteers. One of the areas of focus was peer support at an inpatient level. The aim of peer support was for people to use their own experiences to help each other. A co-production conference was recently held in Southend which brought people and their families together to talk about their experiences with mental health services.

There was an ongoing cultural challenge with implementing peer support due to the difficulty for peer support workers to be accepted by other staff members; being included in multi-disciplinary team meetings; and obtaining patient records; however good progress was being made. As part of the Trust's 'Time to Care' programme, peer support workers would be on each ward to provide support to people on their recovery journey.

SP asked what challenges the enablers faced. AS shared a further patient story where the patient had developed mental health issues later in adult life to highlight the complex issues some patients experienced and the challenges that enablers might face when supporting them. The enablers were there to listen and advocate, to support patients to be involved in their own care plans. It was important to co-produce services and find out what was important to people, such as family. Activities such as exercising and nutritional advice should also be accessible in mental health services as an addition to traditional health care as part of recovery.

7. Executive Chief Nurse Update

7.1 Safety Quality Group - Escalations

SM advised that there were flow and capacity issues at EPUT and Mid and South Essex Foundation Trust (MSEFT). EPUT had therefore recently held a multi-agency discharge event (MADE) event which had addressed some flow issues. The event outcome report was awaited. A risk summit was planned for 9 November 2024 focusing on patients stranded in mental health beds. Feedback would be provided at the next committee meeting.

EPUT and the Mid and South Essex Integrated Care Board (MSE ICB) were heavily involved in the Lampard Inquiry.

There had been a norovirus outbreak at Basildon, but the provision of the norovirus vaccine should reduce the possibility of further outbreaks.

Maternity services remained subject to the intensive quality assurance and oversight process as well as one GP practice within MSE.

SP asked if there was any data on norovirus numbers within the different providers. JS confirmed that there were no active outbreaks currently in social care and health care in MSE, however there was high prevalence in the community, and the virus could be troublesome going into winter. The two outbreaks detailed in the report resulted in 160 bed days lost in 2 weeks which had made a big impact on the system. Due to the rapid onset of the virus, prevention measures would not always be possible.

SP asked for an update on the Lampard Inquiry. MS confirmed that an update report would be provided to the Executive Team and then to Board at their November meeting. The current phase was listening to opening statements and then individual cases would be heard. From an ICB perspective, the focus had been on commissioning. System support would be provided to primary care practitioners if they were asked to provide evidence.

AS confirmed that two executives from EPUT attended the Inquiry throughout the opening statements and commemorative statements from relatives, who showed great resilience when talking through their experiences. The EPUT staff and patients had been impacted by the Inquiry and had found the online stories distressing. Support was being provided to individuals, whilst being fully committed to supporting the Inquiry. AS had held discussions with the Inquiry team Executive Lead on helping people understand the complexities of mental health, the system partnerships and how services had evolved.

SP asked if the Inquiry had impacted on the quality of current services. AS advised that EPUT were focused on quality and there was a dedicated team meeting the data requirements of the Lampard inquiry, however information on the structure of the Inquiry was awaited. MS advised that there was a challenge to staff taking positive risks, whilst under close scrutiny. Staff were being supported through the process, particularly if they had been called to give evidence or were worried about their performance during this period.

Resolved: The Committee noted the verbal update on escalation from the Safety Quality Group.

7.2 Emerging Safety Concerns/National Update

There were no major national escalations or safety concerns.

At the Chief Nursing Officers conference the Chief Nursing Officer, NHS England (NHSE) spoke about the nursing quality strategy in line with the new long-term plan, which may be delayed due to the 'Kindness to Professionals' and 'Sexual Safety' initiatives and the new direction of the long-term plan. Amanda Pritchard spoke about draft improvement guidelines, and collaborative learning networks. It was acknowledged that there was still much work to be done in maternity and mental health services. There were discussions on winter planning and the use of virtual wards.

At the regional Medical Directors and Chief Nurses meeting, there was support with regards to dashboard development, in line with the new Secretary of State for Health and Social Care's commitment to the digital agenda. There would be developments at regional level in relation to eye care, particularly referral management centres. The Ear, Nose and Throat (ENT) community pathways would be reviewed and there had been marked improvement for MSE in relation to accessing ophthalmology and community ENT services.

MS advised that there was also a big focus on cardiovascular prevention, particularly at

Barts Hospital, and eyes and ears, such as earwax removal and reversible sight loss.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

7.3 ICB Board/SOAC concerns and actions

There were no escalations.

Outcome: The committee noted the verbal update on ICB Board/SOAC concerns.

7.4 Greater Manchester Review

SM advised that following a television coverage in relation to the Edenfield Centre in Manchester, a report was published by Prof. Oliver Shanley in January 2024. The MSE ICB Board asked for a comparative report from EPUT and North East London NHS Foundation Trust (NELFT) on the eleven recommendations made.

A gap analysis between the two organisations was completed and showed good progress on most recommendations. EPUT had a programme in progress around the fundamentals of care and included the 'culture in care' programme that NHSE were running nationally. A progress update would be provided in six months.

AS advised that key areas of the report related to not listening to the voice of patients and families and poor governance. EPUT had a focus on family liaison work. Other key areas were how staff were supported to speak up and staffing capacity. Further updates would be provided in future EPUT quality reports.

KF gave an update on the recent patient safety conference which was well attended by a diverse group of stakeholders, including smaller contractors.

Resolved: The committee noted the update on the Greater Manchester Review analysis.

Action: HC to add Greater Manchester Review – progress update on recommendations to the workplan.

8. MSEFT / Acute Care Update

DO took the report as read and highlighted the following key points.

The crude mortality rate remained within the expected range and a recovery plan was in place to reduce the backlog of Structured Judgement Reviews (SJRs).

There were no 'never events' reported in August. Five Patient Safety Incident Investigations (PSIIs) were reported, of which three were in maternity services and had been referred to the Maternity and Newborn Safety Investigations (MNSI) programme. The other two incidents were linked to local priorities and related to mental health patients. Collaborative work was ongoing with EPUT to progress the investigations. The number of outstanding serious incidents had reduced. The remaining incidents were complex in nature but investigations would be completed as soon as possible.

The complaints response rate remained better than average and work had been

undertaken to improve the PALS and complaints processes. Use of Datix DCIQ had enabled effective monitoring and tracking.

Within the pressure ulcer service a hot debrief approach had been trialled for Category 3 and 4 hospital acquired pressure ulcers. The approach included an early review to identify immediate learning, with multi-disciplinary input, and good feedback received. A similar approach was being trialled with patient falls. The number of falls decreased during August, although there was a slight increase in patient falls that resulted in harm which was being monitored.

SP asked why the Hospital Standardised Mortality Ratio (HSMR) and crude mortality rates had increased slightly from the previous period. CB confirmed that the Summary Hospital-level Mortality Indicator (SHMI) and HSMR figures were within expected range so there were no concerns. MS explained that the SHMI and HSMR markers were tracked and SJRs could identify major issues, such as sepsis and delayed end-of-life care which resulted in development of action plans.

SP asked about the status of complaints. DO explained that work had been undertaken to improve response times and ensuring that the quality of response was high. The top themes were considered within the governance framework and monitored through divisional structures for triangulation.

SP asked why there was a variance in Venous Thromboembolism (VTE) assessments recorded across sites. DO explained that Broomfield Hospital had significant WiFi issues which affected the tablets used and impacted the quality of the data. A VTE group had been set up to discuss the quality of VTE assessments and compliance. MS advised that switching over to electronic drug charts should improve the reporting at Broomfield Hospital.

MS asked if there was a cultural element to the low breastfeeding rates at Broomfield Hospital. DO agreed and advised that an event in relation to breastfeeding was planned, Events and information would normally be targeted at pregnant women and feedback would be provided to inform future learning events. In response to a query from SP, DO confirmed that all maternity systems captured ethnicity information, alongside other parameters.

Resolved: The Committee noted the MSEFT Acute Care update report.

9. Community Collaborative Update

LW advised that the Community Collaborative was in the early stages of the three-year contract. The changes made in relation to governance were to mature quality assessment and oversight, which had been a challenge with three sovereign organisations. An accountability framework had been created and triangulated the quality of services, finances and performance.

Performance was within the national guidelines and waiting times objectives, however there were separate reports for service quality and outcomes. There had been no significant incidents in the last reporting period, and deep dives into data quality were ongoing to ensure consistent reporting across all three organisations to provide the committee with a single, clearer narrative.

SP requested further detail on data in future reports. LW explained that the Community Collaborative had their own quality oversight and assurance reporting within the

accountability framework and wanted to avoid duplication. A discussion would be held with the ICB Chief Nurse to confirm the information required to provide the committee with adequate oversight and assurance.

Resolved: The Committee noted the Community Collaborative Update report.

Action: Wellington Makala and GT to discuss and confirm the information required on future Community Collaborative reports to provide the committee with adequate oversight and assurance.

10. Primary Care Update

VK took the report as read and highlighted the following points:

Two out of 144 general practices were rated Inadequate by the Care Quality Commission (CQC). Since the last update, some CQC inspection reports were received under the new CQC inspection regime. The Matching Green Surgery had moved from 'Inadequate' to 'Good' and was the second practice in 18 months where this had been achieved. The Beacon Health Group in mid Essex also received a 'Good' rating following inspection. This was considered as good progress by the committee.

A practice in South East Essex was at high risk, and was receiving high level support from the ICB. The inspection report had been published as 'Requires Improvement' and the ICB were working with them and undertaking an assurance exercise.

There had been one open quality complaint relating to primary care in MSE, which had now been closed.

The MSEICB Safeguarding Team had provided confirmation that the safeguarding escalation exercise had been completed and assurances received from the practice.

DD asked if a main practice site received a good CQC rating, would that also apply to all their branch sites. VK confirmed that the main site would be inspected and as there would be one practice manager for all sites, they should be managed in the same way and would therefore be given the same rating. Quality assurance visits were undertaken to ensure that quality was consistent across all sites.

Resolved: The Committee noted the Primary Care Update report.

11. Pharmacy, Optometry and Dentistry (POD) Update

VK took the report as read and highlighted the following points:

Pharmacy, Optometry and Dentistry (POD) was delegated from NHSE to ICBs in April 2023. MSE ICB hosted the dentistry function and pharmacy and optometry was hosted by Herts and West Essex ICB. A Memorandum of Understanding (MOU) and a Standard Operating Procedure (SOP) was in place for escalations within pharmacy and optometry.

A meeting with the CQC was being held to share intelligence in relation to dentistry to enable development of a risk register. A meeting was also being held with the Local Dental Committee (LDC) to build relationships and explain how support was offered to dental providers. There were 117 contracts for main dentistry, and further contracts for minor operations, trauma and orthodontics. There would be a review of what could be delivered

by the dentistry team due to capacity.

There were a further two ongoing pilots in addition to the three reported. The dental access pilot was working with 111 who directly booked patients into extended hours and met the government dental appointment target. The trauma pilot was where one dental professional/practice dealt with severe trauma cases.

There were currently no open complaints.

MS asked what outcome measures could be used for the pilots being undertaken. VK confirmed that following the meetings with CQC and LDC, this would be reviewed and include other metrics, such as the location of hotspots.

SP advised that the work of pharmacists and optometrists had been extended and it would be beneficial to see how that was evolving within community care. It was confirmed that the stewardship programmes could receive data.

PW advised that significant data was available for community pharmacy. A framework assessment had been developed that all community pharmacies had to meet, and her team would follow up where concerns were raised. A workforce document had recently been published highlighting issues within the community pharmacy workforce. There were numerous services being provided, including the new medicine service which impacted quality. Benchmarking figures were published with other ICBs across the country and Pharmacy First provided oversight of the medications used. The challenge was how much data do we need to identify the benefits to our population.

IP commented that the safeguarding team had been advised how NHSE would seek assurances from ICBs on POD. A pack which linked safeguarding and dental care would be distributed to all dental practices in MSE. Conversations had begun on how GP registrations could include dental practice.

In relation to a query from SP, VK confirmed that complaints were being received, although there were currently no open complaints. PW confirmed that complaints would be received by who has commissioned the service. For community pharmacists, the General Pharmaceutical Council (GPHC) would oversee delivery of registered pharmacists and would be responsible for the quality standards they worked to. When a service was commissioned from community pharmacy, NHSE would request detail from GPHC as to whether standards were being breached and whether there were restrictions on practice, so there was a mixture between the regulatory authorities and the ICB in terms of how contractors were overseen. SM noted the increase in demand since the functions were delegated from NHSE and the teams were reviewing ways to mitigate that increased risk. Discussions were being held with Alliances with regards to alternative approaches and to take the learning forward. SP noted that complains about optometry would also be received by the General Optical Council which was the regulatory body for optometrists.

Resolved: The Committee noted the Pharmacy, Optometry and Dentistry Update report.

12. Southend SEND Strategic Action Plan Summary

GS advised that the annual report highlighted the key activities undertaken by the partnership over the last 12 months and the significant progress made.

The ICB Business Intelligence (BI) leads were working with local authorities to build a data dashboard to capture information from health, education and social care.

There was a requirement from Ofsted/CQC that an up-to-date self-evaluation report was completed. The current Southend SEND self-evaluation identified strengths and weaknesses and the key priorities for the next 12 months linked to priorities in the strategic action plan and Southend's SEND strategy. Following relevant governance processes, the document would be shared on the Southend Local Offer and colleagues in the Department of Education and NHSE and would be updated regularly to provide an accurate reflection of the Southend SEND system.

SP asked what actions were being taken to mitigate worsening performance against the national average for pupils without identified special educational needs. GS advised that the partnership was aiming to have a better grasp on some of those metrics and accurately understood the position in Southend. There had been significant changes in the education team's structure and resources available. There had been greater emphasis on inclusion and work was ongoing with schools to identify funding available to support schools to develop a wider offer particularly for those who were neurodiverse.

SP requested for a progress update in the next six months.

In response to a query from SP, GS confirmed sensory toolkits were available in alternative versions. Alongside the toolkit, drop-in sessions were being held for parents, carers and school staff to ask questions and understand how to best support children.

MS and SP requested that further update reports should include progress with the recommendations and highlight successes and challenges so that assurance could be provided.

Resolved: The Committee noted the Southend SEND Strategic Action Plan Summary.

Action: HC to add Southend SEND Strategic Action Plan progress update to committee workplan, to include progress against recommendation and details of successes and challenges.

13. Medicines Management

PW took the paper as read and highlighted the following points:

MSE ICB were at the lower end of the spectrum in relation to patients taking opioids compared with other ICBs, however it would not be complacent. The data was drafted by using previous Clinical Commissioning Group (CCG) geographic areas which highlighted variances across MSE. Practices had been asked to focus on opioids and key performance indicators (KPIs) within hospital settings were in place to ensure a stop date was defined when prescribing opioids to discharged patients for post-operative pain relief, which was being monitored.

Although the number of patients on opioids had reduced since March, MSE ICB was proportionally one of the highest ICBs in the country for patients prescribed high dose opioids. There was an ongoing challenge with practices not receiving formal deprescribing support for patients on high doses of morphine as this was not commissioned. As the community Musculo-skeletal (MSK) pathway was commissioned, this provided an

opportunity for GPs to refer patients in pain on high dose opioids for management, which included deprescribing but this would be a limited offer. The KPIs focused on deprescribing and refraining from starting discharged patients on opioids unless necessary. If prescribing was required, patients would have an 'opioid contract' as a strategy to avoid long-term use of opioids.

LW supported the proactive approach with service users and patients to provide an understanding of the reason for the medication and that it would be their responsibility to manage that appropriately and safely. There was an issue with the anti-microbial data for Southend due to coding for prescribing doctors in the Emergency Department (ED). A deep dive identified that the service was commissioned by the hospital to support the EDs and the doctors coding, therefore all prescribing for that service for the whole system was being shown as Southend data. This had now been split into three codes and the data would be spread across the system. Analysis revealed that the rate of broad spectrum prescribing for the 'Doctor in ED' service was 19%. Discussions were being held to gain an understanding. Anti-microbial work was ongoing with practices, with support from the anti-microbial stewards.

A pilot was being held in relation to the e-bug campaign to raise awareness in schools, including a competition to design a poster. The winning entry would be displayed around Southend.

The length of courses of anti-biotics had improved due to the default duration on Scriptswitch which would be replicated for SystmOne.

The Sodium valproate alert action had not progressed as expected due to barriers within MSEFT and discussions were being held. A good response had been received from EPUT with regards to processes that were embedded. Pathways within the hospital setting should be changed to ensure patients seen under the pregnancy prevention programme were routinely monitored. All new patients were now required to be signed off by two specialists. The offer has been extended to males. A further detailed report would be presented to committee at the February meeting.

DO offered support to progress this issue within MSEFT. MS advised that if there was no traction, other formal routes could be taken.

MS commented that triangulation with opioids was a big issue. DD advised that he had attended the Southend Essex Thurrock suicide prevention board, where it was escalated again that the police real time suicide surveillance data showed high correlation between suicide and long-term opioid prescriptions in MSE and was being flagged by partners as a standout issue.

JS advised that e-bug pilot had been rolled across Southend based on historic high prescribing of antibiotics to paediatrics and it was anticipated the initiative would be rolled out to other areas.

Resolved: The Committee noted the Medicines Management Update report.

Action: HC to add Sodium Valproate update report to the workplan for the February meeting.

14. Infection Prevention and Control Update

JS took the report as read and highlighted the following points:

The Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. diff) bacteraemia rates had reduced to a more appropriate level. The new annual thresholds set by the national team for C.diff and other gram-negative organisms were shown in the report. MSEFT had undertaken lots of work, particularly on the Basildon site with regards to learning from C.diff incidents.

There had been a Group A streptococcus outbreak in the Southend area, affecting five individuals. The strain was unique to the area and the cases had occurred over a long period of time. Colleagues were determining the implications. Staff and patient screening was underway to determine if prevention measures were required. Work was ongoing with EPUT to improve community nursing, following the learning from other incidents and outbreaks.

There had been no new cases of Enterobacter for three weeks in the neonatal unit at Southend and there were no babies on the unit with Enterobacter. Several infection prevention and control (IPC) measures were in place and managed robustly by the organisation.

JS urged everyone to have their COVID and Flu vaccines.

MS welcomed the C.diff rates being in the stable zone and suggested it would be beneficial to see the medicines team work with antimicrobial stewardship as the two were inherently linked.

PW thanked the community pharmacists who were delivering the respiratory syncytial virus (RSV) vaccine as part of pilot, alongside GPs. There was also a low uptake of the pneumococcal vaccine and the shingles vaccine, which could also be administered by community pharmacies. MS advised that there was regional appetite to review how cardiovascular services and the vaccination programme were delivered and how a regional approach could be taken. MS advised that he would be discussing this issue with regional Medical Directors at their meeting on prevention for the new care models.

SP asked how uptake of the COVID and Flu vaccine compared to last year. JS advised that there was an element of ‘vaccine fatigue’ amongst the population post COVID and it would be a challenging winter due to low uptake of seasonal vaccinations. The COVID and Flu vaccine bus had visited communities with low access rates to offer vaccinations to as many people as possible.

Resolved: The Committee noted the Infection Prevention and Control Update report.

15. Patient Safety & Quality Risks

HC took the report as read and highlighted the following points.

There were 25 risks within the remit of Quality Committee, of which eleven were red rated. Six new risks had been added and detail of those risks were provided in the report. There were no risks recommended for closure.

The Board Assurance Framework was appended to the report and would be updated prior to submission to the Part I Board meeting on 14 November 2024.

The main software issue with Datix appeared to have been addressed and was currently being tested.

SM and SP reminded those present that risks should be updated in a timely manner.

SP referred to the workforce risk and the reliance on bank/agency staff and advised that job vacancies were sometimes advertised in places that might not be necessarily picked up by potential applicants. SM confirmed that the job link could be posted to other platforms, and would be discussed further with Kathy Bonney, Interim Chief People Officer.

MS noted that the babies, children and young people BCYP feeding and swallowing for under 1s risk had been added as a red risk and that there was ongoing work with BCYP teams to discuss this with providers as there was no service in certain areas of the system. SM to discuss with CA and feedback.

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

Action: SM and CA to discuss the ongoing work to mitigate the BCYP feeding and swallowing for under 1s risk.

16. Terms of Reference

16.1 Quality Oversight of Investigations Panel

KF advised that following transition to the Patient Safety Incident Response Framework, a Quality Oversight of Incidents Panel was developed. The panel was not responsible for the quality of learning responses but provided more of a high-level summary and considered whether there were any actions that needed to be escalated, confirmed as risks, or required a quality assurance visit.

16.2 Multi-Agency Resource Forum

NB advised that this was a review of a document that had been in place for several years relating to a multi-agency funding agreement panel that met monthly and covered all BCYP in the Essex County Council boundary.

The main updates were the improvement to documentation submitted to the panel for thorough oversight, the inclusion of mental health membership, and a review and update of funding mental health pathways and the documentation required.

MS commented that this area was challenged financially because of the niche market which was being reviewed through the flow group.

Resolved: The Committee approved the Terms of Reference for the Quality Oversight of Investigations Panel and Multi Agency Resource Forum.

17. Nursing and Quality Policies and Procedures:

17.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the following:

032 Equality and Health Inequalities Impact Assessment Policy and the Terms of

Reference for the Equality and Health Inequality Impact Assessment Panel - SM asked for committee members to provide comments within five working days and if none were received, the policy would be considered to have been approved.

063 – Safeguarding Children and Adults Policy - IP advised that the policy sets out how the ICB would meet its statutory responsibilities in relation to safeguarding adults and children. The policy was restructured to be more compliant with the role and activities undertaken by the ICB and included additional responsibilities set out in the new working together legislation. It included an additional section on the early help offer and absorbed the Safeguarding Adults and Children at risk of Domestic Abuse Policy (066) and Management of Perplexing Presentations/Fabricated Illness in Children Policy (070), which would become obsolete.

070 – Mental Capacity Act and Deprivation of Liberty Policy – IP advised that the policy had been updated to reflect legislative changes.

Resolved: The committee approved the following revised documents, subject to any comments received in the next five working days:

- **032 Health Inequalities Impact Assessment Policy**
- **Equality and Health Inequality Impact Assessment Panel Terms of Reference**

Resolved: The committee approved the following revised documents:

- **063 Safeguarding Adults and Children Policy**
- **073 Mental Capacity Act 2005 and Deprivation of Liberty Policy**

17.2 Extension of review dates of existing policies:

Committee members were asked to extend the review dates of the following policies:

- 065 Management of Allegations against Staff, Volunteers and People in Positions of Trust (to 31 December 2024).
- 068 All Age Continuing Care Policy (to 31 March 2025).
- 074 Communicable Disease Outbreak and Incident Management Policy (to 31 December 2024)

Resolved: The committee agreed to extend the review dates of the above policies as detailed above.

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

SP asked members for any items of escalation to the Board. The follow items were noted for inclusion in the next Quality Report to the ICB Board.

- Sodium Valproate and the medicines prescribing.
- National updates.
- Opioid pathway implications with the high correlation between suicide and long-term opioid prescriptions in MSE as captured by police real time suicide surveillance data.

The next deep dive would be on PSIRF and the maternity deep dive would be presented at the February meeting. MS suggested a deep dive on Dental Health Care Home work and the outcomes for the MSE population.

DD asked whether the lived experience story could be shown to Board members at a future Board Seminar or public Board meeting.

SP suggested a report on the dashboard for Allied Health Professionals in Primary Care which would influence pharmacy and optometry at a future meeting.

Action: HC to enquire whether the patient lived experience story could be shown at a future Board Seminar.

Action: GT to escalate the following items to MSE ICB Board:

- Sodium Valproate and the medicines prescribing.
- National updates.
- Opioid pathway implications with the high correlation between suicide and long-term opioid prescriptions in MSE as captured by police real time suicide surveillance data.

19. Any Other Business

No items of other business were raised.

20. Date of Next Meeting

Friday, 20 December 2024 at 10.00 am to 1.00 pm via MS Teams.