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, 9 May 2024 at 2.00 pm – 4.00 pm

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

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Acknowledgement of Petition.	Note	Attached		
4.	2.03 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
5.	2.13 pm	Approval of Minutes of previous Part I meeting held 21 March 2024 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	6
6.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	17
		Items for Decision / Non-Standing Items				
7.	2.15 pm	People Management Strategy	Approve	Attached	Dr K Bonney	18
		Standing Items				
8.	2.30 pm	Chief Executive's Report	Note	Attached	T Dowling	35
9.	2.40 pm	Quality Report	Note	Attached	Dr G Thorpe	44
10.	2.55 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty A Mecan R Jarvis	56
11.	3.10 pm	General Governance:				
		11.1 ICB Board Risk Appetite	Approve	Attached	Prof. M Thorne	76
		11.2 Amendments to ICB Constitution	Approve	Attached	Prof. M Thorne	84
		11.3 Board Assurance Framework	Note	Attached	T Dowling	128

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		11.4 Revised Policies	Note	Attached	Prof. M Thorne	144
		11.5 Approved Committee minutes	Note	Attached	Prof. M Thorne	146
12.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
13.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 11 July 2024 at 2.00 pm, Committee Room 4a, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, Essex, SS2 6ER.	Note	Verbal	Prof. M Thorne	-

Register of Board Members' Interests
May 2024

MID AND SOUTH ESSEX INTEGRATED CARE BOARD MEMBERS (VOTING)											
First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional	Non-Financial Personal Interest			From	To	
Kathy	Bonney	Interim Chief People Officer	Nil								
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate
Anna	Davey	ICB Partner Member (Primary Care)	Essex Cares	x			Indirect	Close relative is employed	06/12/21	On-going	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
Anna	Davey	ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	On-going	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Tracy	Dowling	Interim Chief Executive Officer	Health Innovation East - Company limited by guarantee supporting the adoption and spread of innovation in healthcare in the East of England	x	x		Direct	Chair of the Board since April 2022. Non-Executive Director from January 2020 until March 2022.	01/01/20	Ongoing	Mid and South Essex is not in the geography of Health Innovation East - but if a situation arose where there was a conflict I would remove myself from the discussion and decision making.
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x			Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Peter	Fairley	ICB Partner Member (Essex County Council)	Essex Cares Limited (ECL) ECL is a company 100% owned by Essex County Council. ECL provide care services, including reablement, equipment services (until 30 June 23), sensory services and day services, as well as inclusive employment	x			Direct	Interim CEO	03/04/23	Ongoing	Interest declared to MSE ICB and ECC. Be excluded from discussions/deicsions of the ICB that relate to ECL services or where ECL may be a bidder or potential bidder for such services. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Personal relationship with Director of Operations for North East London area (Board Member)	01/03/19	Ongoing	As above.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England and Improvement	x			Indirect	Close family member employed as senior strategy manager	Jan 2023	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
Matthew	Hopkins	ICB Board Partner Member (MSE FT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive	01/08/23	Ongoing	Interest to be declared, if and when necessary, so that appopriate arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Jennifer	Kearton	Chief Finance Officer	Nil								

Register of Board Members' Interests
May 2024

MID AND SOUTH ESSEX INTEGRATED CARE BOARD MEMBERS (VOTING)											
First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional	Non-Financial Personal Interest			From	To	
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Essex Partnership University NHS Foundation Trust	x			Direct	Chief Executive Officer	01-Jul-23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Matthew	Sweeting	Executive Medical Director	Nil								
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Borough Council	x			Direct	Employed as Corporate Director of Adults, Housing and Health.	01/03/21	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Joint Health and Wellbeing Board		x		Direct	Voting member	01/06/15	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Dartmouth Residential Ltd	x			Direct	99% Shareholder and in receipt of income.	01/10/15	Ongoing	Interest to be declared if and when any matters relevant to this company are discussed so that appropriate arrangements can be implemented.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

Mid and South Essex ICB - Register of Interests
April 2024

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

Minutes of the Part I ICB Board Meeting

Held on 21 March 2024 at 2.00 pm – 3.30 pm

Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD

Attendance

Members

- Professor Michael Thorne (MT), Chair of Mid and South Essex Integrated Care Board (MSE ICB).
- Tracy Dowling (TD), Interim Chief Executive of MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Lisa Adams (LA), Executive Interim Chief People Officer, MSE ICB.
- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.
- George Wood (GW), Non-Executive Member.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member.
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Ian Wake (IW), Partner Member, Thurrock Council.

Other attendees

- Professor Shahina Pardhan (SP), Associate Non-Executive Member.
- 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.
- Neill Moloney (NM), Executive Director of System Recovery, MSE ICB and Mid and South Essex NHS Foundation Trust (MSEFT).
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Samantha Goldberg (SG), Director of System Coordination Centre (SCC)/Urgent and Emergency Care (UEC), MSE ICB.
- James Wilson (JW), deputising for Stephanie Dawe, Chief Executive, Provide.
- Alison Ansell (AA), deputising for Peter Fairley, Partner Member, Essex County Council.
- Gerdalize Du Toit (GDT), Director of Community, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- Stephanie Dawe (SD), Chief Executive Officer, Provide Health.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Peter Fairley (PF), Partner Member, Essex County Council.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.

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

MT welcomed everyone to the meeting and thanked LA and SD, who would shortly be leaving their current roles, for all their work and contributions and wished them well for the future. MT introduced Rebecca Jarvis, Alliance Director (South East Essex) and Neill Moloney, Executive Director of System Recovery. 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 managed.

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

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

MT advised that several questions had been submitted by a member of the public, as set out below.

- **Mr Peter Blackman** asked about the parking issues at Broomfield Hospital and the amalgamation of hospital services. MT advised that Mid and South Essex Hospitals NHS Foundation Trust (MSEFT) had been asked to provide a response.

- **Mr Peter Blackman raised queries relating to** services not currently within the remit of the ICB and was responded to by email on 19 March 2024. TD added that there would be an opportunity to consider future provision once the responsibility of specialised commissioning was delegated to the ICB. Some elements of neurorehabilitation were being considered as part of the reconfiguration of stroke beds as there was a preference for as many people to receive rehabilitation within Essex as possible. However, a balance was required between the size of need and the requirement to deliver the service economically and in a clinically sustainable way. In response to Mr Blackman's question regarding the rehabilitation strategy, TD advised that the system would be extremely challenged with addressing immediate delivery concerns in the next year and that the futures strategies needing development would be considered through 2023/24.

4. Minutes of the ICB Board Meeting held 18 January 2024 and matters arising (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 18 January 2024 and asked members if they had any comments or questions. No comments were submitted and there were no matters arising.

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

Resolved: The Board approved the minutes of the ICB Board meeting held on 18 January 2024 as an accurate record and noted the updates on the action log.

5. Joint Forward Plan (presented by E Hough)

EH advised that each Integrated Care Board (ICB) was required to review and refresh their Joint Forward Plan (JFP) annually and the Mid and South Essex (MSE) ICB would aim to publish their JFP following Board approval with further updates later in the year.

The approach to the refresh was to remain committed to the strategic ambitions set out in the JFP for 2023-28, which was developed in partnership with local stakeholders. The 12 strategic ambitions would be grouped into areas of focus, which would include how we work with others in the system to develop plans and provide assurance on the quality and value of services offered, delivery and quality (including health inequalities), population health improvement and operational delivery and the enablers in the system, such as workforce, digital, financial sustainability and research and innovation.

The ICB plans over the next five years would include building on the stewardship programme, continuing to build partnerships with Alliances, virtual views platform, partnerships with voluntary, community, faith and social enterprise sectors, community collaborative, primary care collaborative, mental health, and partnerships with other local authorities.

The successes delivered over the last 12 months were detailed in section 2 of the JFP and included the development of the Urgent Care Coordination Hub (UCCH), ageing well stewardship work, launch of virtual views platform, Integrated Neighbourhood Teams (INTs) and the progress of the collaboratives.

Section 3 of the JFP would be published in June 2024, following the publication of the national guidance, which would set out the 2024/25 operational planning requirements.

In response to a query from MT, EH confirmed that only significant amendments would need to be reapproved by the Health and Wellbeing Boards, so the refresh to the plan would not require further consultation.

TD advised that during a focus workshop at the Essex Health and Wellbeing Board, concern was expressed that the ICB had not prioritised children's services. GT provided assurance that Babies, Children and Young People (BCYP) was a focus in the JFP and ICP Strategy and a key area of priority was specifically BCYP with Special Educational Needs and Disabilities (SEND) and would be working closely in partnership with directors of children's services across the three local authorities.

Resolved: The Board approved the MSE Joint Forward Plan.

6. Specialised Commissioning – Approval of Delegation (presented by Dr M Sweeting)

MS reminded Members that there was a Board seminar in December 2023 dedicated to specialised commissioning that indicated the need for approval of the governance documentation for delegation from the Board in March 2024. MS reminded members that NHS England (NHSE) had chosen the East of England to be a pilot site for specialised commissioning which involved the delegation of 59 services to the ICB. Specialised commissioning related to services that were highly technical and involved small numbers of individuals but at high cost, that could not be delivered locally, such as some forms of chemotherapy, renal, genetics, and spinal rehabilitiation.

GDT advised that the ambition of NHSE was to delegate to ICBs to ensure integration and harmonisation of pathways, and provided an opportunity to review and redesign pathways and address health inequalities with access to specialised commissioning services. The first year focus would be to hold a steady state position and develop a specialised commissioning strategy for the next 3-5 years. MSE have an interdependency with London, who were not receiving delegation from NHSE.

There were a number of documents for consideration by the Board:

- Collaboration agreement which included the six ICB's in the East of England Region and NHSE.
- Delegation agreement based on the template provided by the NHSE.
- Financial risk sharing arrangement which ensured that no fellow ICB's were disadvantaged.

TD asked if funding for specialised services for the MSE population was allocated to London and if there would be capacity and skills in MSE for the repatriation of services. GDT confirmed that funding was included in the MSE budget and there would be a blend of repatriating services, with some services remaining in London as time progresses in line with the developing strategy.

PS commented that it would be important to get more visibility on spend for specialised commissioning and also to use system leverage to influence commissioning in London. The Board would need to understand the financial risk as specialised services could be a high growth area year on year. GDT confirmed that there were no concerns with the cost pressure for 2024/25, but 2025/26 was uncertain. The strategy, alongside the services, would reflect the growth, staff and required skills and the financial risk profile. JK confirmed that for 2025/26 a cost pressure would be inherited and a phased approach would be required to consider during medium term financial planning. The services and trends would need to be understood before any radical changes were made and providers may need to be formally accredited to deliver the specialised services, for which NHSE would retain accountability.

GW commented that consideration was required with regards to oversight and governance. JK confirmed that the system would be working with the host ICB (Bedfordshire, Luton and Milton Keynes) and would report through the Finance and Investment Committee and other committees (such as quality) as appropriate.

Resolved: As recommended by the Finance and Investment Committee, the Board:

- **Agreed that the ICB would be bound by decisions taken collectively with the other ICBs in the East of England in line with the Collaboration**

Agreement, relating to delegated specialised services.

- **Approved the delegation of 59 specialised services and authorised the ICB Chief Executive to sign the Delegation Agreement between the ICB and NHSE.**
- **Approved the Collaboration Agreement between the ICBs in the East of England and NHSE to manage the commissioning of the specialised services in a joint endeavour.**
- **Noted the governance arrangements and the terms of reference of the Joint Commissioning Consortium.**

7. Equality Delivery System Assessment 2023/24 (presented by Dr G Thorpe)

GT advised that the ICB had a regulatory and statutory duty to deliver responsibilities under the Equality Act 2010. Two interim equality objectives had been set by the ICB focussing firstly on the duty as an employer to create an inclusive environment where staff feel valued and supported and secondly, to ensure equitable access, excellent experience, and optimal outcome of patients through the ICB role as a commissioner.

By way of explanation GT noted that the Equality Delivery System (EDS) requires an assessment against three domains, which were commissioned and provided services, workforce health and wellbeing and inclusive leadership. The EDS evaluation was undertaken in partnership with provider organisations and was supported by wider community groups to ensure a whole system approach. The evaluation concluded that the ICB was in the development phase in all three domains. The assessment would be published on the ICB website, in due course.

TD highlighted that several actions were to be completed in 2024/25 and suggested that an update should be provided to the Board every 6 months on progress and how strategic development was continued.

In response to a question from PS, GT confirmed that following engagement there was a stronger focus on service users' involvement and the silent voice of underrepresented groups, which consequently would be an area of focus for the Inclusion and Belonging Steering Group.

In response to a query from SP regarding the actions from previous years, GT confirmed that the actions from 2022/23 had all been completed.

Resolved: The Board endorsed the Equality Delivery System Report.

8. Urgent Emergency Care Performance (presented by S Goldberg)

SG advised that the Urgent and Emergency Care (UEC) recovery plan for 2023/24 was launched at the beginning of the year and focused on ambulance attendances, the release of Category 2 ambulances within 30 minutes, and for patients to be seen quicker in Emergency Departments (ED) to be either discharged or admitted within a four-hour period.

SG provided specific details regarding performance and provided insight as to the work undertaken to improve performance and streamline care, alongside the work required for continued improvement. SG noted that NHSE advised that five priority areas should be

focussed on, which were streaming and redirection, Rapid Assessment and Treatment (RAT), Urgent Treatment Centres (UTC), improving ambulance handovers and reducing time in ED. Support had been provided by NHSE colleagues with several webinars.

Members asked questions regarding the detail contained in the presentation. In responding SG confirmed there was continued oversight of the position to support sustained delivery with a focus on admission avoidance through the virtual hospitals and urgent community response teams (UCRT), as the ageing population could worsen the situation.

TD thanked SG and the co-ordination centre team, noting that the focus should be on how data and evidence could be used to understand the variation in performance, and whether the changes made were promoting a sustainable improvement. SG advised that the care coordination hub focused on prevention and ensured that patients do not attend hospital and would be looking at supporting care homes, GP practices, and mental health services in future phases.

Resolved: The Board noted the Urgent Emergency Care Report.

9. Chief Executives Report (presented by T Dowling)

TD advised that the report indicated key activities undertaken over recent months, including visits to mental health services, community services and Thurrock integrated medical and well-being centres. The report also provided an update on the Chief Executives' individual priorities.

TD congratulated MS in his substantive appointment of Executive Medical Director and welcomed Neill Moloney, which was a joint appointment between the ICB and MSEFT, to focus on service provision improvement and better value.

It was highlighted that partnerships were crucial and difficult decisions would need to be made over the course of the year. The focus should be on safety, quality, and the stewardship of the NHS pound.

This was the first report to provide updates to the Board from the Executive Committee (following its formal establishment as a sub-committee of the Board) and the accompanying report highlighted the decisions taken by the Executive Committee.

MT thanked MS for the stewardship event, which highlighted the amazing leaders across every aspect of our clinical and clinically related activity, who supported change.

Resolved: The Board noted the Chief Executives Report.

10. Quality Report (presented by Dr G Thorpe)

GT presented the quality report to provide the Board with assurance on the key quality and patient safety issues, risks, escalations, and actions. The following key items were highlighted:

The System Quality Group (SQG) undertook a deep dive following a 'prevention of future deaths' report regarding the death of a 10-year-old child with asthma to ensure that children and young people with asthma were supported with early reviews and appropriate prescription and administration of medication.

The SQG also supported the future development of both the system Learning from Deaths Group and a Harm Free System Group to further the learning from incidents.

In highlighting emerging safety concerns and national updates; GT relayed that the Chief Nursing Officers of MSEFT would be applying to be in the first wave of hospitals to implement Martha's rule (measures being established nationally to support patients with rapid deterioration) and there was an expectation that Martha's rule would be further delivered in community and mental health settings in 2025. In addition, updates were noted regarding lessons from the independent review of mental health in Greater Manchester and the CQC review of legislation regarding visitors to care homes.

Following a request for assurance from the System Oversight and Assurance Committee (SOAC), an operational group would be established to report on oversight of mental health performance to the Quality Committee.

GT highlighted that whilst some areas of infection prevention and control risks had improved, there was an increase in methicillin-resistant staphylococcus aureus (MRSA) cases that was being addressed.

TD commented that the quality report provided assurance of the conversations being held across the system. Several items were due to return for further review, such as the follow-up of recommendations from the Greater Manchester review and TD highlighted that it would be beneficial to have a timescale.

MT requested triangulation on the SEND agenda and asked the local authority representatives whether they were directly involved in the preparation work. All local authority partner representatives in attendance were aware and fully engaged.

GW asked if the system had sufficient funding to manage the SEND population and requested an update at a future Board meeting. GT advised that a SEND deep dive would be prioritised for Quality Committee and fed back to the Board.

Resolved: The Board noted the Quality Report.

Action: GT to provide a report to a future Board meeting on the SEND deep dive presented to the Quality Committee.

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

JK presented an overview of the financial performance of the ICB as at month 10 (31 January 2024) and outlined performance against constitutional standards, noting that this was the first report since the forecast outturn was formally adjusted with NHSE. The following highlights were noted.

The overall system allocation held by the ICB had increased by £20m, with all additional allocations having been fully committed. The ICB continued to forecast its agreed outturn position of £10m surplus. Continuing Health Care and Discharge to Assess continued to be pressures that were a core focus for the ICB where efficiencies needed to be delivered. JK warned that the achievement of the planned position was supported by a one-off action that would not be available in the next financial year.

The overall health system position at month 10 was a deficit of £60m, which was off plan by

£25m, largely reflective of the shortfall in delivery of the efficiency programme. The system forecast outturn position was £60m deficit, which was in line with national expectation given the impact of industrial action incurred during month 10. JK noted the joint appointment of the Executive Director of System Recovery had been made to support the move to a more sustainable position. At month 10 the system had £70m of efficiency plans in delivery, which was forecast to be £75m at the end of the year, a shortfall against the £113m target.

JK presented the performance position and noted that the earlier Urgent and Emergency Care presentation demonstrated the work that occurred behind the constitutional standards performance reported at every Board meeting.

There had been a slight improvement in diagnostic waiting times and cancer standards which were beginning to rectify some of the variance in the plan for this financial year. The mental health standards continue to be delivered.

MT thanked mental health colleagues for the sustainable position. PS advised that the physiotherapists had completed a huge amount of work.

TD commented that although the overall size of the waiting lists had significantly reduced month on month, there were still too many people waiting and for too long. As a system, it was priority to develop a robust elective activity recovery plan, to optimise and maximise the financial opportunities. There was also improvement in performance in wait times for cancer services, particularly in terms of suspected skin cancer. There were good trends in the faster diagnosis standard, which was 28 days from point of referral to the point when a diagnosis is made. However, further work was required to move to the next level of transformation on many cancer pathways so that diagnostic and treatment times could be consistently met. This work was supported by the cancer stewards.

NIB asked how the system was looking forward and reviewing innovations in diagnostic capabilities, which could improve waiting times and patient experience. TD commented that the system should be embracing innovation, however there would need to be sufficient change in capacity and capability to achieve the quantum of change that was needed.

MS advised that a combination of technology innovation and transformation by the cancer stewards was making a difference. By way of example, there were significant improvements in the waiting times for dermatology, which were using tele dermatology innovations. The lung cancer programme was identifying more Stage 1 and Stage 2 lung cancers with a greater chance of curative treatment by utilising different technologies.

SP commented that there was appetite amongst clinicians for change and utilising new technologies.

Resolved: The Board noted the finance and performance assurance report.

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

PG advised that the new report demonstrated the connectivity between primary care business and the work of the Alliances at place level. The report provided an update (by exception) of the key developments across the teams over the past two months.

PG stated that there had been major transformation programmes in the Alliances developing the INTs with system partners. This would be presented at the next Board meeting, with a

timeline on how the INTs would be developed in every neighbourhood.

The Transfer of Care Hubs (TOCHs) commenced at the beginning of December and had a positive impact on relationships between acute hospital and community colleagues, voluntary sector, and primary care. TOCHs had supported the system discharge process and enabled patients transition between hospital and home a more positive and supportive experience.

AD highlighted that the total number of consultations in primary care had increased 7.1% over the previous year, which had an impact on the number of patients seen within 2 weeks. The estates issue continued to be a problem, with additional staff having no space to see patients. MT reported that work was ongoing to review primary care estates and requested an update at a future Board meeting to ascertain what the issues were.

Action: A report on primary care estate to be presented to Board outlining estates issues that needed to be addressed.

TD advised that the annual primary care capital allocation was minimal, and the development of primary care estate would require strategic national conversation and decision making. It would be necessary to review the utilisation of the total public sector estate and how funding could be used to refurbish or repurpose the estate, as well as lobbying for capital funding for the development of new estate. IW commented that the success of the approach would be having shared space for a wide range of professionals.

SP recalled the recent Board seminar presentation for the GP total triage system and asked if that would be more widely used in Primary Care. PG advised that it would be important to have a peer network of those who had already implemented so there was a forum to test ideas confidently but securely. It would also require discussion with the public, on a neighbourhood-by-neighbourhood basis. The appetite of all Primary Care Networks (PCNs) was being assessed and there was a national debate regarding digital tools for primary care.

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

13. Expiring Contracts (presented by J Kearton)

JK confirmed that the report had been presented to the Finance and Investment Committee (FIC) and the Board were receiving the report due to the value being over £10 million. However, FIC had completed the due diligence by reviewing the paperwork on behalf of the Board.

The contracts would be expiring at the end of the month and were a range of NHS contracts, including the main ambulance service contract and some independent sectors. These were being extended through the compliant procurement direct award process A (DAP A) which was in accordance with the Provider Selection Regime rules.

MT advised that the Chair of FIC had not raised any concerns following review.

Resolved: The Board:

- **Noted the status and recommended course of action reported for each contract.**
- **Approved the recommendation to proceed with the identified procurement route, under the Provider Selection Regime.**
- **Approved the recommendation by FIC to proceed with the proposed course of**

action.

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

14.1 Board Assurance Framework

TD outlined the Board Assurance Framework (BAF) paper which presented the key risks to the achievement of ICB objectives and included assurances regarding how they were being managed alongside their RAG (Red, Amber, Green) ratings. It was noted that the risks were discussed in more detail under the respective agenda items.

TD thanked colleagues for completing the detailed risk report. The way risks were managed was changing with the implementation of the risk management system 'RL Datix DCIQ'. The system would enable the risks to be actively managed and would ensure the Board had a real time dynamic understanding of the risks for the ICB and ICS. Following implementation, the reporting would be timelier, with a focus on the live risks, the actions taken and the extent to which those actions reduce and mitigate the risks. The system would also be used for the management of complaints and any corporate incidents. In response to a question from NIB, NA confirmed that implementation of the new system would begin from April 2024.

It was noted that work had been undertaken by the Executive team to reconsider the ICB risk appetite and tolerance statement, which would be included at a future Board development seminar.

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

14.2 Approved Committee Minutes.

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

- Clinical and Multi-professional Congress (CliMPC), 29 November 2023 and 31 January 2024.
- Finance and Investment Committee (FIC), 10 December 2023, 11 January 2024, and 23 January 2024.
- Primary Care Commissioning Committee (PCCC), 6 December 2023 and 10 January 2024.
- Quality Committee (QC), 15 December 2023.
- System Oversight and Assurance Committee (SOAC), 10 January 2024.
- Audit Committee (AC), 10 October 2023.

Resolved: The Board noted the latest approved minutes of the CliMPC, FIC, PCCC, QC, SOAC and AC.

14.3 Delegation to Audit Committee

MT advised that this was the standard delegation to the Audit Committee with regards to the signing off the annual report and accounts due to the timings required by NHSE.

Resolved: The Board formally delegated responsibility for approval of the ICB Annual Report and Accounts to the AC, having had assurance regarding the accounts from the FIC.

15. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

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

Thursday, 9 May 2024 at 2.00 pm, in Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, CM1 1JE.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
38	16/11/2023	9	**Health Inequalities** Add Health Inequalities interim evaluation report to the Board agenda for March 2024.	S O'Connor	11/07/2024	This item has been deferred until July Board meeting.	In progress
39	16/11/2023	12	**Quality Report** Provide an update report at a future meeting on the cultural perinatal groups that had been set up.	P Green	11/07/2024	Deferred to July Board meeting.	In progress
44	18/01/2024	11	**Primary Care Report:** Provide a report on any quality/safety issues that have been identified on Pharmacy, Optometry and Dentistry.	Dr G Thorpe	30/04/2024	Please refer to Primary Care and Alliance Report.	Complete
45	18/01/2024	12.3	**Board Assurance Framework:** Revisit the Cyber Security Risk to decide whether to include in future iteration of Board Assurance Framework.	N Adams	30/06/2024	The cyber security risk is included on the risk register. This was not considered to be a 'BAF' risk and will be managed through the operational risk process.	Complete
46	21/03/2024	10	**Quality Report:** Provide a report to a future Board meeting on a SEND deep dive which would initially be presented to Quality Committee	G Thorpe	11/07/2024	Included on the Quality Committee workplan.	In progress
47	21/03/2024	12	**Primary Care and Alliance Report** A report on primary care estate to be presented to Board outlining estates issues that need to be addressed.	P Green	11/07/2024	Scheduled for July Board meeting.	In progress

Part I ICB Board meeting, 9 May 2024

Agenda Number: 7

MSE ICB People Management Strategy

Summary Report

1. Purpose of Report

To gain Board approval for the launch of the new MSE ICB People Management Strategy.

2. Executive Lead

Kathy Bonney, Interim Chief People Officer.

3. Report Authors

Kathy Bonney, Interim Chief People Officer.

4. Responsible Committees

Executive Committee

Remuneration Committee

5. Link to the ICB's Strategic Objectives/Core Principles

Having a workforce to deliver the core principles of the Integrated Care Board

6. Impact Assessments

An equality impact assessment has been undertaken.

7. Financial Implications

None identified.

8. Conflicts of Interest

None identified.

9. Recommendation/s

Board members are asked to approve the People Management Strategy, subject to any comments they might have.

1. Introduction

The MSE ICB restructure process, several grievance cases where the focus is on poor managerial behaviours, the issues raised by the Freedom to Speak up Champions and those escalated to the Freedom to Speak up Guardian, the Staff Survey results, all have suggested a need to improve the way we communicate with and manage our staff.

2. Aims of the People Management Strategy

This People Management Strategy aims to drive improved managerial behaviours, in turn making this a place that staff would recommend others to work, improving sickness absence and lessen the need for formal casework interventions, without compromising on effective performance management, having the difficult conversations and at times making difficult decisions.

The ICB has a Duty of Care to all its staff and most of that duty rests with managers.

The People Management Strategy will be embedded through the work of the Managers Learning Network, the Managers Toolkit, which is about to be launched in May and contains information and links to useful content that will help managers be effective in turning the strategy into action.

3. Conclusion

Adherence to the strategy will result in managers that are competent to manage effectively, and which will contribute towards more effective performance management and an increase in our overall productivity.

4. Recommendation(s)

Board members are asked to approve the MSE ICB People Management Strategy subject to any comments they might have.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Mid and South Essex ICB:

People Management Strategy

March 2024

BONNEY, Kathy (NHS MID AND SOUTH ESSEX ICB - 99E) NHS | [COMPANY ADDRESS]

Contents

Introduction

NHS Mid and South Essex Integrated Care Board) is committed to becoming an employer of choice by creating a sustained and transparent employee pathway. The pathway has nine key parameters that are underpinned by a relevant and accessible set of HR policies and procedures.

Our people are vital to the delivery of our strategy, vision, and values.

We are collaborative

We are compassionate

We are innovative

We are living well

This strategy is different to a workforce strategy which looks at the skills development needs and recruitment hot spots; its aim instead is to develop an organisation where management competence ensures that our staff deliver excellent performance. That each day staff feel involved, inspired, appreciated, fulfilled, happier and healthier at work. Other core management skills involve the successful design of our organisation and the jobs within it.

The key objectives for this strategy are to deliver the objectives contained within the NHS People Promise which underpins the delivery of the NHS People Plan. This strategy acknowledges the MSE ICB Inclusion and Belonging Strategy and its Organisational Development Plan but has a specific focus on the internal human resource processes that our ICB has in place to develop and promote excellent people management. The creation of several staff networks and Freedom to Speak up and Wellbeing Champions and Mental Health First Aiders alongside an ICB Inclusion and Belonging Steering Group demonstrates our commitment to create a work environment in which our staff feel supported and psychologically safe. The ICB also recognises and works closely with Trade Union Representatives to ensure transparency of decision making in matters that affect our staff.

The ICB is committed to supporting staff to perform at their best, which requires active participation in structured 1:1s and Appraisals. The new 1:1 paperwork also encourages the celebration of any success as well as actions to progress delivery against objectives. It also encourages both Wellbeing and Career Conversations as well as the opportunity to identify development needs. Our reputation as an employer is dependent on the way we treat our staff throughout their time with us. Robust people management practices keep our ICB and the individual safe, to support the creation of a high performing organisational culture, where staff feel accountable for and proud of the quality of the work that they deliver.

Consistency in management practices creates a strong platform for whole organisations to perform well.

Designing our Organisation

Our transition to become an Integrated Care Board, has given us the opportunity to review our structures and think creatively about how we organise our staff in a way that best delivers what we want to achieve. Well-designed roles and a balanced organisational structure create an environment which allows for effective communication, delegation, performance management and delivery.

Too many structural layers can mean that people at the front line are too removed from the key influences driving the organisation forward. Ideally, reporting lines should have fewer than 10 direct reports and, career progression and succession planning, and talent management should be accessible to all.

Appropriate gaps between bandings should be considered when designing any structure. Too big a gap and the delegation lines break down; whereas too small a gap can result in roles blurring and a lack of freedom to act which is an important element of creating job satisfaction.

As our ICB evolves we will continuously review our organisational structures and job design, to ensure staff have fulfilling roles.

MSE ICB also has an ambition to reduce siloed working both internally and in our system as a whole, to create more varied opportunities for staff to contribute to the delivery of the system priorities and objectives. We are committed to working differently to bring to life the concept behind an Integrated Care System, positively promoting our Collaboratives and Integrated Care Partnerships. This will involve creating a myriad of opportunities for staff to work across system priorities from a clear functional base, both internally and externally embracing a matrix management approach, which will offer opportunities for solid career progression as well as flexibility to deliver what is a fast-moving agenda in the NHS.

There are multiple reasons as to why we are doing this. To work in a system, it is key to understand the whole system and having wider exposure to different parts will lead to well-rounded future system leaders and staff who understand how to make a difference. We want staff to have fulfilling and challenging roles which will help us to retain our talent.

Our overall goal in the ICB is to create a work environment that is agile, flexible, and resilient to deliver our mission, vision, objectives and values in order that as a system we provide better patient care, improve patient care and make a contribution to the delivery of healthier and more prosperous communities.

Creating rewarding jobs

The weighting between each element of a job role must be in balance, or frustration and / or burnout can occur. The HR Team can offer support on the design of structures and jobs, and the job evaluation process will provide feedback on the design of the role in terms of appropriate remuneration, ensuring its fit against national role profiles and avoiding pay creep. As an employer we need to ensure we keep our organisational structure in balance and have a fair, equitable and transparent approach to the way we recruit and pay our staff.

The key job elements are:

Know How = Technical experience, planning, organising, controlling, communicating, and influencing skills.

Problem Solving = Thinking environment, thinking challenge, first principles or following a process.

Accountability = Freedom to Act, magnitude/breadth of the role and impact.

Attracting great talent

MSE ICB is an evolving organisation which is starting to identify the nature of the talent we require to future proof ourselves. The MSE ICB Inclusion and Belonging Strategy champions the opportunity to engage with applicants from diverse backgrounds by ensuring our language in adverts and job descriptions is inclusive and our presentation of information is accessible.

MSE ICB has a workforce of 429 directly employed staff of which 35 are employed on a Fixed Term contract. In addition, there are approximately 75 others who work within the ICB structure, mostly GPs as Clinical Leads or members of the board, as well as system partners who contribute to our delivery of services. The ICB has clear procedures for the safe employment of staff and as required the deployment of these staff, this is through employment checks, fit and proper person tests, safe to practice checks, a Memorandum of Understanding and the use of honorary contracts, secondment agreements, on site and first day induction, and compliance with relevant organisational policies and procedures.. Where services are contracted from individuals, this is done in the way most applicable to take account of employment and tax legislation and in line with contracted and agency staff NHS regulations.

What our partners and our staff can expect from us our organisational values and behaviours

We believe passionately that employing a diverse workforce is central to our success and so we aim to make recruiting decisions based on experience, skills and diversity. We ensure our policies and processes from hire to retire are fair and equitable and are inclusive for all staff. This strategy was co-produced between members of the HR Team, and the Integrated Care Board (ICB) Equality, Diversity and Inclusion Advisory Group (EDI).

This strategy is intended to help to provide equal opportunities for potential candidates, regardless of their personal characteristics or circumstances and to ensure that career progression and movement within our organisation and around our Integrated Care System is accessible to all staff. We will ensure our organisation's commitment to diversity and inclusion is a core part of corporate branding. We aim to expand our shared understanding of the benefits and meaning of inclusive processes with a range of cultural awareness, skills and experience that will positively benefit the ICB in performance and productivity.

The MSE ICB Recruitment Policy has been modified to include value-based recruitment and for Band 8a and above candidates will undertake a situational judgement test in relation to our values and be asked competency questions relating to the NHS Leadership Competency Framework. The ICB Board have committed to delivery against the NHS 6 High Impact Equality and Diversity Actions and all HR and Workforce Projects are being mapped against them. Our employee brand is important to us, and we are registered as a Mindful Employer and a Disability Confident Employer, and all staff are paid above the Living Wage.

As we mature on our diversity journey, we will ensure that entry into our organisation will be inclusive and without any discrimination or bias, so that good candidates are neither disadvantaged nor disillusioned by our recruitment processes.

Good / fair recruitment processes are the external window into any organisation, and candidates whether successful or unsuccessful, should have a good story to tell. Our intention is to recruit the people who best demonstrate our values and behaviours and come with a set of skills and knowledge that also add value in the wider context of the ICB's development.

Cloning is a common failure of many a recruitment process, where the panel appoints people who they perceive as like themselves. It is also called recruiting in your own image. This practice negatively affects any opportunity of making the organisation more diverse. Another common mistake is called seeing the coming of the messiah where panels perceive a candidate to have the power to rescue the organisation and solve the inherent organisational problems, which may cloud their capacity to adequately assess the candidate against the role they are applying for. Neither approach is helpful.

Whilst candidate selection is not an exact science, great skill and care must be applied when selecting candidates. Hence the completion of more than just an interview will give the best chance to assess. A panel must also be prepared to adjust the process if required to meet individual needs and the whole process itself should be designed to give the individual their best experience and a fair opportunity to demonstrate their knowledge, skills, competence, and values.

MSE ICB also encourages all recruiting managers to undertake Unconscious Bias training available on ESR. Having a workforce that reflects the communities that we serve will help the ICB/ICS to deliver services that better meet the needs of its patients.

The other benefits of fostering diverse and inclusive recruitment and retention practices are improved innovation and good employee morale because people feel valued as individuals and the trust that follows allows for far greater creative thinking. This inclusive ambition comprises of three key priorities and identifies the actions we will take over the next five years. It outlines the key roles and responsibilities and how we will track progress and measure success.

- **Workforce diversity** – recruit from a diverse group of candidates to increase diversity of thinking and perspective.
- **Workplace inclusion** – foster a culture with behaviours that encourages collaboration, flexibility and fairness to enable employees to contribute to their potential and increase retention.
- **Sustainability and accountability** – identify and breakdown systemic barriers to full inclusion by embedding diversity and inclusion in policies and practices through adherence to the behaviours in the ICB values equipping leaders with the ability to manage diversity and to be accountable for their practice.

  Much of the discrimination that occurs during the candidate attraction part of the recruitment process is unintentional, but a candidate may experience a sense of direct or indirect discrimination. Candidate feedback will form part of the success criteria. The application process will be open to all, and we aim to attract job applicants from as wide a talent pool as possible to build a diverse workforce.
- **Job advertisement** – we will review job advertisements to ensure that the language in advertisements is inclusive, in plain English and welcoming to people from all backgrounds. We will include a statement in the job advertisement that explicitly sets out the organisation's commitment to equality, diversity and inclusion. All ICB jobs will be advertised widely through a range of job platforms and social media clearly welcoming applications from all groups of the community and particularly those under represented protected characteristics in our ICB, including Global Majority, Disability and LGBTQ+ groups. We positively encourage potential employees to feel comfortable to bring their whole self to work. Specifically in our adverts we state,

  We are passionate about creating an inclusive workplace that promotes and values diversity. We know through experience that the different ideas, perspectives and backgrounds create a stronger and more creative work environment that delivers better patient outcomes. We welcome applications regardless of people's age, disability, sex, gender, identity and gender expression, sexual orientation, race or ethnicity, religion or belief. We have policies and procedures in place to ensure that all applicants are treated fairly and consistently at every stage of the recruitment process, including the consideration of reasonable adjustment for people who have a disability. We would also encourage applicants to raise any personal circumstances they would like us to be aware of so that we can consider possible adjustments.
- **Summary of the job and first paragraph** - we will ensure that the first paragraph of the job description matches the job's unique requirements and ensure that the first paragraph of the job description and advertisement include relevant facts about the vacancy in a way that positively encourages applicants to identify this as a possible opportunity for them.
- **Family friendly** - we will ensure we welcome introductions to potential employees from the families and communities that our staff are part of. We encourage staff to promote us as an employer of choice.

- **Hybrid working** - we will ensure as an organisation with limited requirement to travel we are more accessible for people with a disability that makes travelling difficult and for people who have local caring responsibilities and who cannot regularly commute.
- **Flexible working** - we will ensure that applicants are able to find the key job elements easily including the information in the main body of the job advertisement. For example, basic but important information such as whether or not the vacancy is full or part time, the provisional start date, the salary range, benefits, the formats in which the employer will accept an application and the application deadline.
- **Application process** - we will ensure our application process is accessible for all and there is no bias because of who you are or where you come from.
- **Short-listing** - we will ensure all identifiable information is removed before short-listing and scores are given against set criteria of the job specifications.
- **Training** - we will ensure all recruiting officers have completed the recruitment and selection training and unconscious bias training.
- **Job interviews** - we will ensure all interview panels are diverse and members have appropriate training and address any unconscious bias that may exist.
- **On boarding** - we will ensure on boarding starts at the minute the job is offered and new recruits are contacted throughout the joining process. That new starters are greeted on their first day of employment and managers conduct an immediate on entry induction.
- **Talent management** - we will ensure that staff through appraisal and one to one process are regularly asked about their aspirations and career plans and their training and development needs are identified and supported. We positively encourage career conversations through regular one to ones and appraisals.
- **Promotion** - we will ensure that all jobs are advertised internally as well as externally and internal candidates are given an equal candidate experience. Where we believe we have the skills to fill a role internally we will do an internal advert in the first instance. We will positively encourage a focus on the individual career journey rather than a set of rules to follow and value competence alongside qualification.
- **Roles and responsibilities** - all employees have the responsibility to maintain an environment that is safe, respectful, and productive. Everyone has the right to be treated fairly within the workplace in an environment that recognises and celebrates diversity. We can all contribute by participating in workplace diversity and inclusion activities and opportunities and complying with all anti-discrimination and workplace diversity legislation.

  Managers and supervisors can contribute by displaying a positive commitment to workplace diversity and inclusion, being role models, fostering an inclusive workplace culture, dealing quickly and effectively with inappropriate behaviour, and participating in diversity training and encouraging team members to attend. The success of the strategy is dependent upon the support of everyone in the ICB. Everyone has a responsibility for contributing to a culture which supports and values diversity and inclusion.

Our values

Working together for better lives

Our organisational values aren't just words on a page – they're the foundation of our culture and the compass that guides our actions. We're committed to weaving them into everything we do, from day-to-day operations to long-term planning. They'll even play a role in how we bring new team members on board, helping us find people who share our values and can contribute to our success.

There are four values that all staff are expected to demonstrate:

1. **We are collaborative** - We actively seek out partnerships and work together across disciplines to achieve the best outcomes for our patients and communities.
2. **We are innovative** - we embrace creativity and continuously strive to find new and better ways to deliver healthcare, improving efficiency and effectiveness.
3. **We are compassionate** - we ensure that compassion and inclusion are central to the care we provide and the way we work with each other. We respond with humanity and kindness to each person, acknowledging their individual needs and circumstances.
4. **We are living well** - we are dedicated to promoting health and wellbeing, both for those we serve and for our staff, encouraging a culture that supports personal wellness and empowers individuals to lead fulfilling lives both inside and outside of work.

For each value, there are also a set of behavioural standards. Our behavioural standards aim to enhance consistency in our actions and communications to support others. These standards are applicable to our interactions with colleagues, stakeholders, and residents, across all aspects of our work. It is vital for each of us to consider how these behavioural norms can be integrated into our respective roles

We are collaborative

- Actively seeking input and feedback from colleagues when making decisions.
- Sharing information and resources openly and transparently.
- Working together across departments or teams to solve problems or achieve goals.
- Recognising and appreciating the contributions of others.
- Being willing to compromise and find common ground to reach consensus.

We are innovative

- Thinking creatively to find new solutions to challenges.
- Experimenting with new ideas or approaches.
- Embracing change and being open to trying new methods or technologies.
- Encouraging a culture where failure is seen as an opportunity for learning and improvement.
- Seeking out opportunities for professional development and staying informed about advancements in healthcare.

We are compassionate

- Demonstrating empathy and understanding towards patients, their families, and colleagues.
- Ensuring inclusivity and diversity in all aspects of care delivery, actively seeking to understand and accommodate the unique needs and backgrounds of every individual we serve.
- Taking the time to listen actively and attentively to others' concerns.
- Going above and beyond to provide comfort and support to those in need.
- Advocating for the needs and rights of vulnerable populations.
- Treating everyone with dignity and respect, regardless of their background or circumstances

We are living well

- Prioritising work-life balance and taking breaks when needed to recharge.
- Encouraging healthy habits such as regular exercise, good nutrition, and sufficient sleep.
- Offering support and resources for managing stress and maintaining mental health.
- Promoting a culture of self-care and mutual support among colleagues.
- Recognising and celebrating achievements both professionally and personally.

How we are embedding our values

How we behave every day, what we do and how we act and interact with others is where we really see the demonstration of our values.

It's in the way we recruit and induct people into the organisation; how we carry out reviews and develop personal development plans. How as teams we strive to be better and work together, and how we tackle the challenging aspects.

We encourage everyone to implement them in their work behaviours, decision-making, contribution and interaction with others.

Our expectations

We expect all staff, members and colleagues who engage with the NHS Mid and South Essex ICB to always share and demonstrate these values whilst interacting with, or on behalf of our organisation. We are committed to ensuring that everyone who encounters our organisation experiences a safe, welcoming and inclusive environment, where everyone is respected and valued, and professional boundaries are upheld.

We do not tolerate any behaviour that goes against our values and may be deemed offensive, abusive, racist, sexist, homophobic or any other discriminatory or abusive behaviour. We will always call out, challenge, act on and, if necessary, report all unacceptable behaviour.

Joining our ICB

Induction, mandatory training, and probation are key parts of the joining and engagement of new recruits with our values our mission vision objectives and values.

Early investment in new staff through a well-managed probation can solve a myriad of problems later in the employment relationship. This also is the first exit point on our employee pathway. Alternatively, a successful completion of the probation period should trigger the first performance appraisal. Probation objectives should be smart and must include all mandatory training completion. Our ICB is currently re-energising a comprehensive and meaningful induction process for all new starters. We are also developing a Managers' Learning Network to ensure all new and existing managers understand their roles and responsibilities as outlined in the NHS England » The expectations of line managers in relation to people management and alongside this we are creating a Managers' Tool kit, which will include links to guidance and policies relevant to the role.

We are a hybrid working organisation and so onboarding to our ICB requires significant extra focus and care by our line managers. We will aspire to all new staff having a face-to-face induction meeting in our ICB Head Office and regular face to face team meetings to be able to build relationships with their colleagues. They will have completed a Display Screen Workstation Assessment to ensure their workplace at home is both safe and fit for purpose, and we will ensure they have the equipment that they need to undertake productive work. Managers must ensure that staff with any requirement for reasonable adjustments should be responded to very quickly as part of the onboarding process.

Developing and managing our performance and competence

Maintaining staff at optimum performance is an understated part of the manager's role. The potential to do better needs constant nurturing, and under performance needs appropriate and reasonable challenge. Organisational Development is the planned and sustained enabling of individual performance in an organisation, through the motivation and involvement of its people. Line management relationships and commitment are fundamental to achieving this.

MSE ICB has several policies in place to support the management of performance which are Appraisal; Learning and Development; Flexible Working; Managing Performance; Disciplinary; Absence Management; Stress Management; Dignity at Work.

The recent NHS survey 2023 results reported that 74% of staff had received an appraisal in the last 12 months, compared with 44% of staff in 2022. However, the quality and impact of the appraisal process requires further work.

Improving the performance of our leaders and manager

360-degree appraisals are available to all who request them via the NHS Leadership Academy and are based on the NHS Healthcare 9 Leadership Dimensions. An online self-assessment can also be accessed in this way.

Keeping our staff and our organisation safe

MSE ICB has a duty of care to each individual staff member. This duty of care underpins the work of the HR Team and the support it offers to Managers, the Executive Team and the Board and runs through most HR Policies. Individual employment rights and fair access to opportunity are demonstrated through every HR process, but particularly in managing organisational change, health and safety, managing stress management flexible working, freedom to speak up whistle blowing, dignity at work, shared parental leave, domestic violence and abuse, Disclosure and Barring Service, DSE home working risk assessment, stress risk assessment, equality in employment, maternity adoption and paternity, professional registration, probation, conflict of interest and safe recruitment policy.

These are all policies and processes available to keep our staff safe whilst at work. Our 2023 staff survey reports that 48% of our workforce had felt unwell in the last 12 months due to workplace stress. We are developing training for line managers in effective people management which will include the planning and organising work and individual a well as how and where work is carried out and the culture and climate of where work happens.

Whilst 44% of our staff reported that the ICB takes positive action on health and wellbeing, 74% of staff believe that their immediate line manager takes a positive interest in their health and wellbeing and so we will work towards sharing and maximising this good practice.

The staff survey further identified 13% of staff perceive that they have been bullied or harassed at work in the last 12 months an ongoing challenge to the health and wellbeing of the ICB. Our Performance Appraisal and one to one paperwork already asks staff to benchmark their competence in relation to our values. In this appraisal round, managers will be encouraged to ask questions about an individual's understanding of the impact of their behaviour on others and give the staff member the opportunity to give feedback to their manager on how things are working between them.

We have developed a number of staff networks that support staff health and wellbeing, they are the Diversity Network, the LGBTQ+ network, the Women's Network, the Positive Ways to Wellness Group and the Staff Engagement Group. We also have a group of Wellbeing Champions who deliver an annual plan of support of both local and national initiatives and are developing a group of Freedom to Speak up Champions and trained Mental Health First Aiders.

There is a regular programme of promoting a healthy lifestyle amongst staff. Wellbeing work life balance and flexible working are all part of one to one conversations. In the 2023 staff survey results, 75% of ICB staff are satisfied with the opportunity for flexible working patterns – this was an improvement from 68% in 2022. We are currently reprocuring our Occupational Health contract and the new specification will include the requirement to collect data on protected characteristics. We will also continue to work closely with our occupational health provider, through quarterly meetings, to monitor service quality and volumes of take up and

support the health of our workforce and address any long-term ill health issues, and we continue to access psychological support of ICB Teams through our Here for You provision.

We adopt a positive approach to keeping individuals at work or supporting an early return to work when ill health issues arise. We make adjustments to working patterns where necessary and support staff by implementing equipment and other tangible changes. The main aim is to develop and maintain a happier and healthier workforce. Building on existing activities, policies and guidance to promote a healthy lifestyle amongst staff, we encourage health and wellbeing initiatives. This also involves working closely with our occupational health service provider to offer a range of services. We will monitor the impact of this through the staff survey and sickness absence levels. In the 2023 NHS Staff survey, 70% of staff said that the organisation made reasonable adjustments to enable them to carry out their work, an improvement on 63% in 2022.

Our improvement journey will be tracked through the NHS Quarterly Pulse survey a new initiative for our ICB.

We have also recently launched an ICB Menopause policy, which gives further information, advice and guidance to managers and staff around supporting colleagues experiencing symptoms of menopause.

We will also ensure that all ICB staff make an annual declaration of any interests to ensure there are no conflicts.

Resolving Conflict

MSE ICB is committed to early conflict resolution. Following the ACAS Guidance outlined in the link below www.acas.org.uk/dealing-with-a-problem-raised-by-an-employee the ICBs Grievance Policy has an informal stage of the process. Managers should actively support staff in finding ways to resolve issues which may involve formal mediation which can be arranged by the HR Team.

Listening to our staff

At our ICB we provide staff with a range of ways to share feedback and ask questions, including All Staff Briefings with Q&A sessions, touch point surveys about our internal communications and staff events. We consult formally with staff representatives on individual and whole organisational matters that affect our staff. All significant staff and structural changes are subject to a formal consultation process where staff are encouraged to comment on any proposed changes.

We actively encourage all staff to take part in the annual NHS National Staff Survey which allows us to compare our results to that of other NHS organisations. The results are analysed and reported, based on the top-ranking scores; the least favourable scores; and areas for improvement.

Our staff are actively encouraged to speak up about things that may concern them. Firstly, with their line manager but if that does not feel appropriate, we have a Freedom to Speak up Guardian and Freedom to Speak up Champions that are contactable through our intranet and there is also a Staff Engagement Group who have been involved in key pieces of work, e.g. formulating staff survey action plans.

Reward and recognition

Where appropriate, when an individual feels that their post has developed to trigger a higher banded payment, roles can be sent for assessment of the job description and possible re-banding. Where potentially sensitive this can be done through an external company to achieve an independent view. Otherwise, the HR Team is also trained to undertake these processes. Additional duties payment can also be made when a member of staff is asked to pick up higher banded work for a period of time to cover an absence or to take on a particular time limited piece of work that requires them to use a skill set that is a stretch, these opportunities are sometimes called a stretch assignment. Any payments made outside the Agenda for Change rules must be approved by the Remuneration Committee. Such changes can only be made for a time limited period with considerable rationale e.g., overtime payments for Band 8a and above, which were applied during the pandemic. The ICB is committed to paying above the living wage for all staff. The ICB has a well-developed pay policy and an establishment control process which ensures fair and transparent pay practices and opportunities for secondments and promotions. In June this year the ICB will introduce Staff Recognition Awards based on our values.

Managing our talent and working flexibly across our ICB and our ICS

Talent will be managed appropriately with internal opportunities on offer to allow progression supported by internal recruitment; our secondment and acting up policies ensure fairness and transparency of approach. We support staff to develop their talent through one-to-one career conversations, ensuring all new jobs are advertised internally and providing opportunities for promotion and greater job enrichment.

The performance appraisal system has also been further developed to identify talent and through this we can create a career pathway map, which can inform our future workforce planning. Self-directed learning and the opportunity to work across the organisation and the system in a matrix way will enhance competency development and a system mindset and so offer more opportunities for career enhancement.

An accessible Teams learning site gives staff the opportunity to access any development or support in the form of coaching or mentoring and guidance on how to map your career pathway. Where function and delivery responsibilities are devolved to sit within an Integrated Care Partnership (ICP,) this may be delivered via integrated neighbourhood teams and through our alliances and collaboratives.

Many of our ICB staff will hold a portfolio of work and may therefore have a combination of an ICB/provider and/or an ICP set of functions and responsibilities. This will be acknowledged and delivery of this range of responsibilities will be supported within the ICS delivery structure as our ICS matures.

Where the parties involved consider that the Transfer of Undertakings (TUPE) regulations apply then both the transferring organisation and the receiving organisation will act in accordance with those regulations. The TUPE regulations are designed to protect the employment of workers in the event of a transfer of business ownership or a service transfer. Information on the regulations can be found at business transfers, takeovers, and TUPE: Overview - GOV.UK (www.gov.uk). In the event the TUPE regulations are found not to fully apply to this transfer, both parties agree to manage the transfer, in the spirit of the law relating to such transfers. The protection of employment will be undertaken, on the basis that the regulations do apply. Engagement with affected staff and the Duty to Inform of any post transfer measures will be a necessary part of the staff changes process. A named operational manager will be identified to work with the transferring staff and their current line manager to ensure a safe staff transfer, with proper induction and orientation to the receiving organisation's processes and procedures.

HR Teams from both the transferring organisation and the receiving organisation will work together to ensure that due legal process is followed in relation to employment law.

Finance teams will also work together to ensure that salary costs, with oncosts and any equipment/property costs transfer too. The information Governance team will also oversee the safe transfer of information, to include employee records.

Moving on and leaving well

We support staff to achieve their aspirations, and this may sometimes mean they leave our ICB. As a system we positively promote job opportunities to staff and celebrate it as success if we retain talent within it. The way staff are supported to leave our ICB through individual choice, mutual agreement or termination of employment, through redundancy or dismissal should always be done with dignity and within employment law and best practice. The MSE ICB will always seek to promote its reputation as an employer of choice.

It is for this reason that we need a consistent approach to the management of staff, whether they are joining or leaving the organisation, so we operate within clearly defined policies and procedures. We are conscious of the impact of 'knowledge drain' and always offer a face-to-face exit interview, ensure a transfer of skill and knowledge whenever possible and encourage all staff to complete the leavers' questionnaire.

The HR Team follow up on any issues of concern that are raised through this process so that lessons can be learned. There are several reasons why people leave the ICB These may include, a new job opportunity, a change in life circumstances or aspirations and sometimes redundancy, retirement, or an exit because of poor performance. A policy of listening to all staff leaving the organisation is important to us, regardless of the circumstances. The reasons for staff leaving are reported to the Executive Committee via the quarterly workforce report.

Part I ICB Board meeting, 9 May 2024

Agenda Number: 8

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer.

3. Report Author

Tracy Dowling, Interim Chief Executive Officer.

4. Responsible Committees / Impact Assessments / Financial Implications / Engagement

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

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

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Interim Chief Executive covering key issues, progress and priorities since the last update received on 21 March 2024. Section 4 of the report also provides information regarding decisions taken at the weekly executive committee meetings.

2. Main content of Report

2.0 Key activities undertaken over the last two months:

Over the last two months I have continued to visit services and to meet with key partners across Mid and South Essex.

2.1 Wethersfield Asylum Accommodation Centre:

On 22 April 2024, with the Executive Chief Nurse and Mid Essex Alliance Director, I visited the Wethersfield Asylum Accommodation Centre. In addition to a tour of the site we also spent time in the medical centre and talked to staff about the services they provide, the partnerships they have formed with visiting services and the challenges they have overcome in meeting the healthcare needs of men seeking asylum.

We were satisfied with the standard and breadth of primary care services provided, and with the reasonable adjustments we could see being made to help people seeking asylum receive the healthcare that they need.

2.2 Stewardship Summit:

On 20 March 2024 I attended the Spring Stewardship Summit meeting at Anglia Ruskin University. The presentations from the Clinical Stewards working across all sectors in Mid and South Essex were phenomenal. The innovations which have been developed and implemented have improved emergency care performance, reduced admission rates, dramatically reduced time to diagnosis for suspected skin cancer, supported frail people in our communities and reduced the rate of admissions to hospital, and developed new models of access for musculo-skeletal services - to name just a few.

The clinical leadership working together across primary and secondary care interfaces to improve quality of care, to use data to evidence the impact and the scale of the improvement, gives enormous optimism for reaching our ambitions to improve health and reduce health inequalities.

2.3 Meeting with MPs:

On 12 April 2024 I joined colleagues from Essex Partnership University Foundation NHS Trust (EPUT), Mid and South Essex Foundation NHS Trust (MSEFT) and North East London Foundation NHS Trust (NELFT) at Basildon Hospital to brief local MPs on our local health services. We discussed the performance improvements made in all sectors in 2023-24; as well as the challenges and ambitions we are currently addressing. We especially focussed on primary care and dental care access and activity levels; on children and young people's mental health; and on mental health access. This was followed with a visit to the Mental Health Urgent Care Unit.

2.4 Community Services Consultation:

The community services consultation closed on 11 April 2024 after running for eleven weeks. Over 5,000 responses have been received and there are also a number of surveys, meeting records and a petition to consider. We anticipate that we will not receive the independent analysis of the consultation responses until the end of May. We will then be drafting the Decision-Making Business Case regarding the three proposals we asked people to consider:

- Potential changes to the places where we provide some community hospital intermediate care and stroke rehabilitation services.

- Making permanent the temporary move of the freestanding midwife-led birthing unit from St Peter's Hospital to, Maldon to the William Julien Courtauld Unit at St Michael's, Braintree.

- The possibility of moving all other patient services at St Peter's Hospital, Maldon to other locations, mostly in and around Maldon.

The business case will come to the ICB Board for decision making. It is planned that this work concludes for the July Board meeting; however, until the outcomes of the consultation are received it is not possible to accurately plan the extent of the work which needs to follow, therefore this date is provisional at present.

2.5 Meetings with Partners:

Other meetings with partners that require note include:

- Essex County Council Health and Wellbeing Board where we focussed on children's health and wellbeing.
- Meeting with partner ICB Chief Executives who commission mental health services from EPUT regarding investment in the 'Time to Care' in-patient service model.
- Meeting regarding cancer services transformation in Mid and South Essex led by the national clinical director for cancer, Professor Peter Johnson.

3. Priorities for the ICS:

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

3.1 To develop the maturity of the Integrated Care Board (ICB):

The Board continues to be actively developed. Since the last Board meeting, we have appointed Dr Matthew Sweeting to the substantive Executive Medical Director role.

Lisa Adams, Interim Chief People Officer completed her fixed term tenure with the ICB, and I would like to thank Lisa for her significant contribution. I am pleased to welcome Kathy Bonney as Acting Chief People Officer. Kathy was previously Human Resources Director with the ICB.

We are in the process of delivering the ICB Organisational Development Programme and as part of this continue our monthly staff briefings and communications. I have also completed Executive Director appraisals and agreed objectives and development plans for 2024-5 with each director. I can confirm that as part of this every Executive Director has an objective in respect of Equality, Diversity, and Inclusion.

We have held a Board seminar on risk appetite and risk tolerance; and are in the process of undertaking Board and subcommittee evaluations to critically consider how we might continue to improve governance, risk management and delivery of the ICB four main purposes. We also had a Board seminar called 'Making Data Count' which advises using a process called Statistical Process Control (SPC) data to manage performance improvement. We will be adopting this over future months as we develop the analytical capability across the ICB.

3.1.1 Response to the NHS Staff Survey:

The ICB NHS Staff Survey was published on 7 March 2024. The results for Mid and South Essex ICB were the lowest of the ICBs who took part in the survey. The results summary is shown below:

Executive summary (part 2 of 2)

Top 5 scores vs Organisation Average	Org	Picker Avg
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	96%	94%
q5a. Have realistic time pressures	26%	24%
q11e. Not felt pressure from manager to come to work when not feeling well enough	88%	88%
q17b. Not experienced unwanted behaviour of a sexual nature from other colleagues	99%	99%
q17a. Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	100%	99%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25c. Would recommend organisation as place to work	28%	52%
q26c. I am not planning on leaving this organisation	31%	51%
q19c. Organisation ensure errors/near misses/incidents do not repeat	48%	66%
q25f. Feel organisation would address any concerns I raised	31%	49%
q19a. Staff involved in an error/near miss/incident treated fairly	42%	59%

Most improved scores	Org 2023	Org 2022
q23a. Received appraisal in the past 12 months	74%	44%
q3a. Always know what work responsibilities are	65%	57%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	70%	63%
q4d. Satisfied with opportunities for flexible working patterns	75%	68%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	69%	63%

Most declined scores	Org 2023	Org 2022
q25c. Would recommend organisation as place to work	28%	43%
q26c. I am not planning on leaving this organisation	31%	45%
q25a. Care of patients/service users is organisation's top priority	52%	64%
q8d. Colleagues show appreciation to one another	60%	71%
q26b. I am unlikely to look for a job at a new organisation in the next 12 months	25%	36%

p.5 | NHS Mid and South Essex ICB - NHS Staff Survey 2023

Picker

Tables are based on absolute % differences, not statistical significance

These are important results, and this is the second year that staff in the ICB have expressed their dissatisfaction. This is disappointing, but not surprising given the fact that over the last two years many of our workforce have had to contend with the re-organisation of five CCGs into one ICB; which has then re-structured twice, initially to establish the ICB structure and then again to respond to the NHS England requirement to reduce headcount by 30%.

This latest survey was undertaken during the last re-structure.

It is vital that we have a motivated, satisfied and committed workforce and therefore we need to act in ways that demonstrate to our staff that they are valued colleagues. We have taken a number of actions as part of the Organisational Development (OD) Plan, and the People Management Strategy is being presented to Board today for approval.

We have re-energised the staff networks; we have monthly Chief Executive Officer (CEO) led staff briefings with a focus on our people; and we are focussing on developing managers throughout the organisation. The highlights of the OD Plan are included in **Appendix 1**.

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

The 2024-5 planning process continues, and I reflect that whilst the planning context is extremely challenging, the way all system partners have worked together demonstrates the value of integrated care systems (ICS), and the collective ownership of the difficult choices we need to make.

We hope to conclude the planning process in May and then to be able to publish our plans for 2024-25. I would like to reassure the Board that the ICB and all our partners are progressing actions and implementation in parallel with the planning process so that we do not lose the first two months of delivery progress whilst plans are finalised.

Board members will know that MSEFT are in National Oversight Framework Level 4 due to the underlying financial deficit. We welcome the support that this brings to the Trust and the system to support us in developing and delivering plans that will see the Trust and the wider system return to sustainable financial balance.

3.3 To ensure that the ICS delivers the improvements to urgent care, cancer, elective care, and mental health services in line with improvement trajectories set by NHS England:

The year end outcomes for March / Q4 demonstrated significant improvement in performance across Mid and South Essex. I would like to thank colleagues in all our provider organisations for their focus and hard work during a year when industrial action presented significant risk to activity and performance delivery. Overall outcomes indicate:

- Minimum 76% A&E 4 hour wait time – whilst not achieving the 76% target for March, the achievement of 71.16% is over 9% improvement on 2022-23.
- Category 2 ambulance handover times within 30 mins were 84.2%.
- Elective waiting list performance improved as follows:
    - reduction in patients waiting over 65 weeks of 745.
    - the number of people waiting over 52 weeks reduced by 1858.
    - more than additional 7000 patients were treated compared to 2022-3.
- The target for clearing the backlog of over 62-day cancer waits from diagnosis to treatment was exceeded and a letter of appreciation was received from the national NHS Cancer programme leads – there was an overall reduction in over 62 day waits of 261 patients.
- Performance in the Faster Diagnosis Standard improved to 71% (to be validated)

3.4 To develop ICS wide systems of assurance, delivery, partnership, and risk management to enable the ICB to undertake its role as system convenor and ultimate accountable NHS organisation:

The governance and assurance structure for the system financial recovery programme has been agreed; including how it links into the governance of sovereign NHS organisations. The programme management to ensure oversight and tracking of delivery through robust PMO functions is under development; and an area to enhance.

The next stage, as the plans are approved, are to ensure that each programme has the necessary involvement of partners and stakeholders so that implementation is co-ordinated and unintended consequences are negated.

The risk management of the ICB is developing through the new Datix system, and this process will also support the risk management of the recovery programme in addition to all other ICB and ICS business.

3.5 To ensure that the Mid and South Essex Alliances, working with partners in primary care and in our communities, continue to address health inequalities and impact positively on the health of their populations:

Through the planning process the ICB and Integrated Care Partnership (ICP) have agreed priorities for addressing health inequalities and impacting positively on the health of our populations.

The ICP approved the following priorities:

These priorities are reflected in the operational plans of the ICB directorates.

3.6 Conclusion

The Mid and South Essex ICB and ICS continues to improve performance and to reduce waiting times for access to key services. There has been much progress over 2023/24; but

at a cost that is unaffordable for the system as a whole. The priority for 2024/25 is to develop and deliver plans that address the financial sustainability of the delivery of NHS care across the ICS. The NHS partners have worked collaboratively to develop these plans and we hope to conclude the planning process by the end of May.

4. Executive Committee

Since the last report, there has been six weekly meetings (from 19 March 2024 to 23 April 2024)

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

- Gender Pay Gap, Workforce Race Equality Standard (WRES) and Equality Delivery System 2022 (EDS2) reports.
- Individual Health Assessments (for looked after children), approved subject to ongoing work with the community collaborative to ensure value for money is achieved alongside quality-of-service provision.
- A move to a single 'silver' on call rota process subject to engagement with the staff affected.
- Strategic Plans from Internal Audit, Counter Fraud and Security Management Services.
- Uplift of Continuing Healthcare funding, subject to negotiation and understanding the differential between ICB and Local Authority Funding.
- Medicines optimisation local enhanced service and prescribing incentive scheme budget.
- Lapse of contract for iPlato (GP messaging service).
- New deputy Senior Information Risk Owner, Caldicott Guardian, Information Asset Owners and staff handling personally identifiable data arrangements approved alongside new reporting arrangements for Freedom of Information requests.
- Use of Health Inequalities Funding with a proportion of funding being held in a 'reserve pot' (£600k), £237k being moved to support financial efficiency, prioritised funding to support targeted areas of Cardiovascular Disease, Cancer, Respiratory or where there is a defined population health need with delivery health benefit.
- Mental health response vehicle – approval of the continuation of service from 1 vehicle, with the decision to expand to a further vehicle being deferred pending a review of mental health urgent care pathways.
- One off investment (£50k) to support the development of the Primary Care Collaborative.
- Revisions to the personal health budgets policy.
- The development of a Women's Health Hub model of care across Primary Care Networks (£102k).
- Formal establishment of the ICB Operational Group as a sub-group of the Executive Committee.
- People Management Strategy
- Early Years Oral Health programme (£605k) approved subject to approval by NHS England through the Triple Lock process.

The following items considered by the Executive were either rejected or deferred subject to further work to refine proposals:

- Medicines optimisation restructure, deferred to ensure consistency of requests.
- ADHD medication monitoring local enhanced service, deferred subject to all enhanced services being considered by the Executive Committee together.
- Review of matrix working across administrative teams within the ICB.

The committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability, development of the ICB annual report and worked together in preparation for the NHS England quarterly review that took place on 19 April 2024.

Feeding back the work of the Executive Committee to all staff commenced from the meeting held on 23 April, whereby a summary of the meeting was provided to all staff within the staff communication channel ‘connect’.

5. Recommendation(s)

The Board is asked to:

- Note the current position regarding the update from the Interim Chief Executive.
- Note the work undertaken and decisions made by the Executive Committee.

6. Appendices

Appendix 1 – ICB Organisational Development: Response to staff survey

Appendix 1 – ICB Organisational Development: Response to Staff Survey

- The motivation and well-being of our own organisation is central to the ICB's ability to drive the level of recovery required across our system.
- Whilst the 2023 survey coincided with the most challenging two months of the second massive restructure in two years - and we are reasonably confident there has been an uptick in morale since – there is no room for complacency.
- Main themes from survey:
  - Diminished confidence in service delivery to patients and the population we serve
  - Staff would not recommend the organisation to others as a great place to work
  - Increased burnout and work-related stress
  - Erosion of trust in leaders and line managers, including freedom to speak up/be heard
  - Sense of lack of agency to influence direction and shape work
  - Mistrust between teams
- The Board and Executive Team are committed to addressing the results through a structured and phased OD plan that is already underway:

REPAIR & RECOVER **Jan – March 2024**	**RESET & REBUILD** **Jan – May 2024**	**Refocus & Re-energise** **March - June 2024**
• Sharpened ICB Mission and Vision • Revised Core Values co-produced with staff • Regular all-staff briefings • Performance and Development conversations • Mandatory training compliance • Implementation of first phase of National EDI Implementation Plan (Board EDI objectives) • Refreshed Staff Networks (LQBTQ+, Diversity, Women, Positive Ways to Wellness) • Refreshed Staff Champion roles (Staff Engagement, Wellbeing; and Freedom to Speak up, Mental Health First Aiders) • Unpacking of Staff Survey results	• Publication of new People Management Strategy for the ICB • Staff Survey Action Planning and implementation • Induction and onboarding for new cohort of joiners post-restructure • Learning Networks for Managers • Internal staff development events including focus on psychological safety, building trust, and handling difficult conversations • Accessing national and regional community of practice offers and webinars • Proactive Talent Management: succession planning and career conversations	• Prioritisation of work aligned to delivery plan (May) • Mid-year Performance and Development conversations (June) • Workplace coaching and mentoring programme • System wide Learning events aligned to Recovery Plan • Reviewing and celebrating ICB achievements post-restructure and a deep dive with staff (June) on progress against Staff Survey objectives. • Staff Recognition Awards

Part I ICB Board Meeting, 9 May 2024

Agenda Number: 11

Quality Report

Summary Report

1. **Purpose of Report**

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

2. **Executive Lead and Report Author**

   Dr Giles Thorpe, Executive Chief Nursing Officer.

3. **Responsible Committees**

   ICB Quality Committee.
   ICB System Quality Group.

4. **Impact Assessments**

   No impact assessments were discussed at either committee or group.

5. **Financial Implications**

   Not applicable for this report.

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

   Not applicable for this report.

7. **Conflicts of Interest**

   None identified.

8. **Recommendations**

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

Quality Report

1. Introduction

1.1 The purpose of this report is to provide the Board with a summary of the key quality and patient safety issues, risks, escalations, and subsequent actions taken in response, to provide assurance of oversight on all aspects of quality within the Mid and South Essex (MSE) Integrated Care System.

1.2 The System Quality Group last met on 10 April 2024, and the Quality Committee last met on 26 April 2024.

2. System Quality Group Escalations (SQG)

2.1 The Group received an update from the Care Quality Commission (CQC) regarding the new Single Assessment Framework (SAF). The group were informed of the new ways of working in which providers and systems would have ongoing assessments, in addition to inspections. The Quality Statements aligned to the Five Key Domains within the CQC Framework would be scrutinised and decisions made on which statements required further investigation and potential inspection. Members of the group thanked the CQC for the update and it was noted that system level inspections had been delayed whilst ongoing piloting and finalisation of frameworks were concluded.

2.2 An update from the Local Maternity and Neonatal Safety Board to the group focussed on the analysis of neonatal deaths which identified a variety of different areas of focus, which were already being addressed. A deeper understanding of different ethnic and cultural groups' impressions of accessing maternity services was required, and work between maternity services and communities was already underway, supported by the Maternity and Neonatal Voices Partnership (MNVP).

2.3 As part of the Primary Care update, it was noted that a practice within the system had been receiving ongoing enhanced scrutiny. It was recognised that the practice was now engaging with support, and that the CQC and ICB Quality Team were due to attend the practice. Post-meeting it was noted that the visit had not raised any immediate safety concerns, and following a risk summit meeting, it was determined that enhanced scrutiny could be de-escalated.

2.4 Finally, an update in relation to specialist eating disorder services was received by the East of England Provider Collaborative – it was noted that a business case to develop virtual centres and day centres for children and young people (CYP) was underway to minimise admissions into hospital. It was also noted that the national plan was to reduce specialist eating disorder beds for CYP and where required manage admissions within the general CYP mental health bed base.

3. Quality Committee Escalations

3.1 Catheter Care

The committee received a presentation and deep dive into catheter care and the impact this has on residents in Mid and South Essex. A recent audit identified that several actions were required to reduce the number of urinary catheters being used across the system, which included the consistent use of catheter passports, a pro-active action for all clinicians to promote continence and use other tools and products. Most importantly, for urinary catheters to only be used in specific circumstance and where clinically indicated, as the presentation showed that in some cases inappropriate decision-making had occurred.

The Committee tasked leaders to ensure appropriate communication was shared across providers, and that the findings of the presentation were to be shared with the regional continence working group. The potential to improve outcomes, experience and reduce complications associated with catheter use were clearly articulated and it was recognised that all clinicians within our system were responsible for improving practice.

A video outlining the impact of improper catheter use on people and their carers was shown to the committee, which was considered in depth.

3.2 Emerging Safety Concerns/National Update

The impact of 'Right Care Right Person', which changes the way in which the police force will respond to cases of challenging behaviours and absconding from hospitals, is being discussed at a national level. Locally, in Essex, the proposals and memoranda of understanding are being considered across the Safeguarding Partnership Boards and within health providers. Concerns regarding the impact on CYP is being raised through the Association of Directors of Children's Services, and communication continues between all partners to identify mutually agreeable solutions.

Working Together (2023) guidance focussing on Safeguarding Children has been published, with recommendations which change the way in which statutory partners engage in oversight and strategic planning for children's safeguarding moving forward. All three Children's Safeguarding Partnership leads are involved in agreeing a way forward, with support from national leads. Statutory responsibilities as lead safeguarding partners now rests with the Chief Executive Officers of the Integrated Care Boards, Local Authorities, and the Chief Constable. Further work is underway to enact the recommendations.

The Regional Quality Group (RQG) for NHS East of England has directed all systems to have clear oversight over the Special Educations Needs and Disabilities (SEND) agenda. Within MSE, the Southend SEND inspection has already been concluded, with an associated improvement action plan in place. Both Essex and Thurrock are currently in preparation for future inspections, although no date has been shared at the current time. This will remain an area of focus for all partners within the system to evidence an improvement against national standards for delivery, and engagement with patient carer groups and fora to ensure the voices of CYP are heard as part of improvement planning.

As a point of note following concerns being raised previously regarding oversight and assurance of mental health performance, the Executive Chief Nursing Officer shared that an operational governance group was being finalised to discuss all aspects of mental health delivery within MSE. The group would include full involvement of all mental health providers to ensure an all-age approach.

However, it was also noted that this was also required within the CYP physical health arena, and therefore the interim Director of Mental Health, Neurodiversity and Children and Young People was working closely with the Community Collaborative to ensure that a similar group was convened including all system partners delivering healthcare to CYP. This group would then report into the Growing Well Programme Board, to provide assurance that services were equitable in delivery across the system, highlighting any risks to quality and performance.

3.3 Safeguarding Quarterly Report

An update was received from the ICB Safeguarding Team regarding areas of change and focus. The key discussion related to proposed changes regarding the review of Domestic Homicide Reports (DHRs), which will have a significant impact on operational delivery of safeguarding capacity at ICB level. The Executive Chief Nursing Officer has raised the concern regarding capacity to deliver this, alongside other Chief Nurses in the East of England. A meeting has been arranged with the national safeguarding lead for 7 May 2024.

3.4 Medicines Management

The Director of Pharmacy and Medicines Optimisation presented an update report to the committee outlining progress on the harmonisation of antibiotic usage, to reduce the course of antimicrobial prescribing, with a date set for June 2024 where a uniform reduction in length would be made default.

Furthermore, a conversation regarding the reduction in use of opioid medications for people was held, outlining the challenges of potential addiction to medications which were legitimately prescribed for pain. Several actions were underway including provision of guidance to cover management of addiction and withdrawal of all dependency forming medications, a focus on non-pharmacological interventions to support pain management, and consideration of a collaborative addiction service that would tackle addiction of both prescribed and illicit drugs. Alliance Directors offered their support in considering how this could be progressed with third sector partners to best make use of resource in supporting people stop the use of opioids in the longer term.

3.5 Palliative and End of Life Care Update

The committee received a report regarding actions being taken relating to Palliative and End of Life Care. Several programmes of work were noted and including the launch of an Electronic Palliative Care Co-ordination System (EPaCCs) across MSE in May, which will allow performance to be monitored through a dashboard. In addition, the impact of comprehensive training for clinical staff was shared with 92% of attendees highly rating the workshops. Further work is underway to increase access to workshops and training. Furthermore, a new digital platform is being launched which has both patient and professional facing web pages that will act as a directory of all local services and provide guidance to enable self-management, as well as

access to symptom control guidance to professionals at the point of care.

Finally, the work focussed on developing Compassionate Communities was shared, with several events planned for the year ahead, engaging with communities across MSE, providing support and understanding for End-of-Life Care.

The Committee gratefully received the update and requested that for the next report a dataset was provided to enable it to understand in greater depth how people were being supported across the system to gain further assurance around delivery.

3.6 Independent Review into Greater Manchester NHS Foundation Trust

The Committee receive a presentation from Essex Partnership University NHS Foundation Trust into The Edenfield Centre, which provided forensic medium and low secure services within the Greater Manchester area. The independent review identified several factors that enabled poor care including:

- Patients and families/carers not being taken seriously.
- A weak clinical voice.
- Unsafe levels of staffing and high use of temporary staff.
- A poor physical environment.
- Poor culture, including a lack of psychological safety and low morale.
- Conditions leading to staff to note adhere to clinical policies.
- Staff being treated unfairly because of a protected characteristic.

The presentation is available at **Appendix 1** of this report for the Board's information. The committee thanked EPUT for sharing this and called all providers and system partners to review the detail of this report, with a particular focus on the causation of failures and to give due consideration whether this could be happening within partners' own organisations, and what was required to focus on emerging risk.

It was noted that throughout the committee meeting a request for an analysis of data was being made on an ongoing basis. It was recognised that there was significant data available for consideration, but that information and meaning was not always available easily. A challenge for all partners was to consider how data would be presented in the future, and a reference to the importance of Statistical Process Control (SPC) charting was key to evidence improvement over time.

3.7 Policy Approval

The Committee approved both the Terms of Reference for the Patient Safety Collaborative Forum and the Patient Safety and Incident Response Framework (PSIRF) Peer Review Forum, noting that both would report into the System Quality Group.

4. Recommendation

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

NHS
Essex Partnership University
NHS Foundation Trust

The Findings of an Independent Review into the care and treatment provided by Greater Manchester NHS Foundation Trust

26 April 2023

EPUT

CONTENT

- The Edenfield Centre is a mental health medium and low secure service, supporting patients with a range of complex needs in Greater Manchester. In September 2022, the BBC broadcast an episode of their current affairs programme *Panorama* which showed evidence of shocking abuse and poor care of patients at the Edenfield Centre.
- In November 2022, NHS England commissioned an Independent Review of the Trust, led by Professor Oliver Shanley.

Factors that enabled poor care

- Patients, their families and/or carers not being listened to or taken seriously;
- A weak and fragmented clinical voice;
- Unsafe levels of staffing and high use of temporary staff;
- A poor physical environment;
- Poor culture, including a lack of psychological safety and low morale, including unsupportive leadership behaviours, unsound HR practices including perceived unfair recruitment and promotion, and a lack of transparency about formal investigations;
- Conditions leading staff to not adhere to clinical policies such as record keeping and observations;
- Some staff described being treated unfairly because of a protected characteristic.

GMMH ability to respond and learn when things went wrong

- How the organisation (and its partners) responded to concerns raised by a patient in its secure services;
- Inpatient deaths through suicide, and the extent to which the organisation was responding to, and learning from, these tragic events;
- How the Trust has responded following the death of a person in its inpatient care, and;
- The Trust's improvement plan, and how well this enables learning.

Commonalities in the Trust's management of concerns

- A slow pace of change - some of these issues are very long-standing, have been known about for a long time and yet improvements are difficult to identify.
- A lack of transparency and/or clarity in reporting - found that management information (whether in the form of incident reporting, quality metrics or Board/Committee reporting) was opaque.
- A lack of scrutiny of key information - a need for more effective scrutiny of information presented to key forums (including sharing this with clinicians at an early stage), and a clearer and more coherent response from management and Executives to challenge posed by Non-Executive Directors.
- A lack of rigour in the monitoring of change – there has been a tendency for the organisation to be overly optimistic in its reporting of changes made since all of these events.

The review raised a number of concerns

- Missed opportunities to act on concerning findings relating to National Staff Survey results, information relating to levels of restrictive practice, a cultural audit in 2019 which raised concerns, staff vacancies, the instability of ward management and high consultant turnover.
- Poor leadership visibility in the service, as well as weak governance processes and a practice of suppressing ‘bad news’ in the organisation.
- The hallmarks of a closed culture, including an absence of psychological safety, incivility between staff, poor leadership, and a lack of team working.
- That the expansion of the Trust services had not seen a corresponding investment in quality oversight.
- That healthy debate and challenge had been discouraged, and that information provided to the Board was often poor and provided insufficient or inaccurate information to underpin Board assurance.
- Repeated stories of senior managers treating staff poorly and fostering a culture of fear and intimidation in order to maintain performance standards.
- Greater Manchester Mental Health NHS Foundation Trust has had higher vacancies than the national average in some professional groups, notably nursing and medicine. The workforce information the Board received was insufficient and there was not a clear strategy to address either the recruitment or retention of staff.

Recommendations

- The voice of Patients, families and carers
- Clinical Leadership
- Culture
- Workforce
- Governance
- System oversight

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, May 2024

Agenda Number: 10

Primary Care/ Alliances reporting to Board

Summary Report

1. Purpose of Report

The purpose of this report is to provide an update by exception of the key developments across Primary Care and Alliances during the previous two-month period. This includes performance against several key metrics, developments within Integrated Neighbourhood Teams (INTs), Transfer of Care Hubs (TOCHs) and progress in implementing the Primary Care Access Recovery Plan that was approved by the Board in November 2023.

2. Executive Lead

Pam Green, Alliance Director, Basildon, and Brentwood and ICB Primary Care Lead

3. Report Author

Simon Williams – Deputy Alliance Director – Basildon and Brentwood.
Caroline McCarron- Deputy Alliance Director – South East Essex.
Margaret Allen- Deputy Alliance Director – Thurrock.
Kate Butcher - Deputy Alliance Director – Mid Essex.
William Guy – Director of Primary Care.
Paula Wilkinson – Director of Pharmacy and Medicines Optimisation.
Vicki Decroo – Deputy Director of Integrated Commissioning (ICB / Essex County Council (ECC)).

4. Responsible Committees

The commissioning of Primary Care services is overseen by the Primary Care Commissioning Committee on behalf of the ICB. Each of the 4 Alliances has a formal Alliance Committee in place to oversee highlighted work.

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board are asked to note the updates in this report.

Primary Care and Alliances Update

1. Main content of Report

Primary Care – General Practice

- Primary care consultation numbers continue to rise. February data shows an 8.6% increase year on year (2022/23 versus 2023/24).
- Significant progress on Additional Roles Reimbursement Scheme (ARRS) recruitment was made during 2023/24. There are now 600 ARRS staff in place in Primary Care Networks (PCNs) across Mid and South Essex (MSE). The impact of this recruitment will result in consultation numbers continuing to rise in 2024/25.
- The ICB is working with the Local Medical Committee (LMC) and other stakeholders to support the development of a GP Provider Collaborative across MSE. This follows similar developments across the country and seeks to provide a clearer voice for primary care within the system.
- In April 24, all ICBs received formal notification from the British Medical Association (BMA) that they are in formal contract dispute with NHS England regarding the 2024/25 contract settlement. Whilst no specific actions were identified by the BMA, the ICB continues to monitor this situation closely and is working with the LMC and emerging Primary Care Collaborative to understand local impact.

Primary Care – Access Recovery Programme

- Progress continues to be made on the roll out of cloud-based telephony across practices in MSE. 55 practices have signed contracts. 27 have had their systems implemented (an increase of 12 on the previous March report). 16 contracts signed for phase 2 of the programme (increase of 13 since the March report).
- Several practices have moved onto Total Triage solutions as part of their implementation of 'The Modern General Practice'. 13 practices have been validated as implementing the new approach through our Transitional Funding process.
- A process for enabling practices to access Transitional Funding to support their move towards The Modern General Practice is in place.

Primary Care – Community Pharmacy

- There have been no further closures of community pharmacies in MSE since the last report.
- Pharmacy First has been widely rolled out across MSE. The first dataset on activity is due to be published imminently.
- We are working with the Local Pharmaceutical Committee to promote contraceptive services and blood pressure monitoring services that are available in community pharmacies across MSE.

Primary Care – Dentistry

- The Dental Access Pilot is progressing well with good utilisation across MSE. Full integration into 111 is now underway – we believe that this is the first model in England to have this level of integration with 111.
- Our oral health in care homes pilot continues its successful expansion. Dental practices have now been secured to ensure coverage of all eligible care home beds in MSE. The remaining homes will be on boarded in quarter 1.
- A new pilot service for cardio vascular patients will go live in May 24. This will ensure that people awaiting cardiac surgery and not delayed due to oral health issues.

Alliances, including Integrated Neighbourhood Teams (INT) development

- During the month of April, all Alliances have established their priorities for 2024/25 with their stakeholder partners.
- An additional 6 INTs are now in place across MSE (15 in total). All INTs expected to be operational by end of 24/25.
- A common approach to metric development underway
- A maturity review of INTs is due to be completed in quarter 1.
- The development of INTs is included within the financial recovery plan for the ICB.
- A Local Enhanced Service for Cardio Vascular Disease prevention has been rolled out in 12 PCNs. This will be rolled out in 2 further PCNs.

Alliances – Better Care Fund (BCF)

- Governance for BCF established across all 4 Alliances
- Mechanism to share good practice across MSE in place
- BCF guidance for 2024/25 has been published nationally, this is being reviewed to ensure local compliance.
- The Discharge Fund for 2023/24 was fully utilised. Monthly reporting on its impact is in place.

Transfer of Care Hubs (TOCHs)

- All TOCHs took part in the system multi agency discharge event (MADE). The outcome of this will feed into service development.
- A digital workshop will be taking place in May to support the digital integration agenda.

2. Recommendation

The Board is asked to note the updates in this report.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight report

May 2024

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Key for Project Updates

Key for project updates

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

Primary Care - General Practice

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

Overall Summary

Key developments

- The national contract for 24/25 has been fully published by NHS England. Key developments include trying to reduce elements of non-clinical workload and provide greater assurance around performance related elements of the GP contract (Quality & Outcomes Framework (QOF) and Investment and Impact Fund (IIF) payments). The Network Direct Enhance Services (DES) (Primary Care Networks (DES)) has been specifically amended to try and empower PCN Clinical Directors to have flexibility to take forward the development of services. Integrated Neighbourhood Teams (INTs) have been referenced in the Network DES for the first time.
- Primary Care Workforce has continued an upward trajectory. In April 2023, there were 635 full time equivalent GPs in post in Mid and South Essex (MSE); by Feb 24, that figure had risen to 656. Across the ICB there are now over 600 Additional Roles Reimbursement Scheme (ARRS) staff in place including 130 pharmacists, 60 care coordinators, 55 paramedics and 45 physios.
- ARRS staff have led to a continued growth in consultations (see data below). We forecast that the full year impact of staff recruited in 23/24 will mean our overall consultation numbers continue to climb in 24/25.
- The Spring COVID Vaccination programme has commenced. This is being led by PCNs and Community Pharmacy with additional support from EPUT. Planning has already commenced for the autumn/winter programme.

The ICB is working with the Local Medical Committee (LMC) and other stakeholders to support the development of a general practice provider collaborative across MSE. Similar collaboratives exist across the country. The collaborative seeks;
To provide a credible GP voice within the ICB.
To engage and consult with colleagues across primary care.
To identify potential areas of service development and available funding streams.
To support the planning and development of services across the ICB.
To provide a link between front line GP providers and the decision makers.

Emerging Risk: All ICBs have received a formal letter from the British Medical Association to advise that the BMA is in formal dispute with NHS England regarding the 24/25 contract settlement. Whilst there is no indication yet of what action the BMA may take as a result of this dispute, the ICB is aware of increased concern from practices on workload being referred into primary care from other sectors of the ICS i.e. secondary care, mental health and community services. Ensuring that the interfaces between various parts of the ICS function efficiently and effectively is a key priority within the Primary Care Access Recovery Programme and our financial recovery programmes.

Key data

- Between April 2023 – Feb 2024, there was:

A total of **6.2m** consultations in GP practices

An additional **490k** consultations in GP practices compared to 2022-23

8.6% year on year increase.

- During the same period, nearly **4.8m** of these appointments were undertaken face to face. This equates to **77%** of all consultations.
- Of the 6.2m appointments, **5m are seen within 2 weeks** of the patient contacting the practice. This equates to **81%** of all appointments.

Primary Care – Access Recovery Programme/Connected Pathways

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

Overall Summary

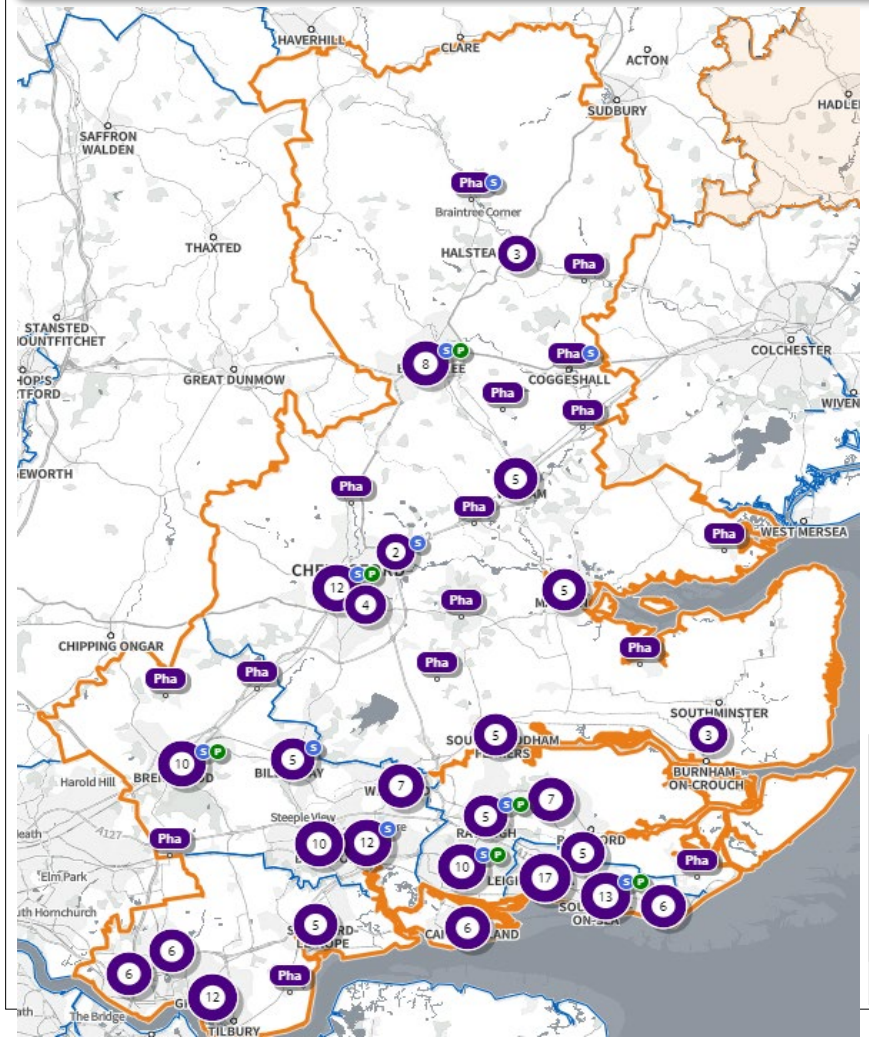
Significant progress has been made on a number of deliverables within the Primary Care Access Recovery Programme

Development	Progress	Status
Cloud Based Telephony - "we will establish Cloud Based Telephony across 45 practices identified as critical"	Phase 1 – 55 practices included in scope. All contracts signed with new providers. 27 implement (+12 on last report) Phase 2 – 30 further practices identified for improvements. 16 contracts signed (+13 on previous report).	On Track
Communication of Modern General Practice and various aspects of the Recovery Plan to stakeholders	Hub page up and running. Practice support visits under way.	On Track
Digital Tools – supporting implementation of Modern General Practice through digital tools	Awaiting guidance from NHS England regarding the digital framework. Approach to 24/25 being reviewed. Local implementation plan in place.	Delayed
Pharmacy/Dental/Optometry - 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	20 Applications for Transitional Funding Reviewed. Further support being provided by Connected Pathways team where not approved.	On Track

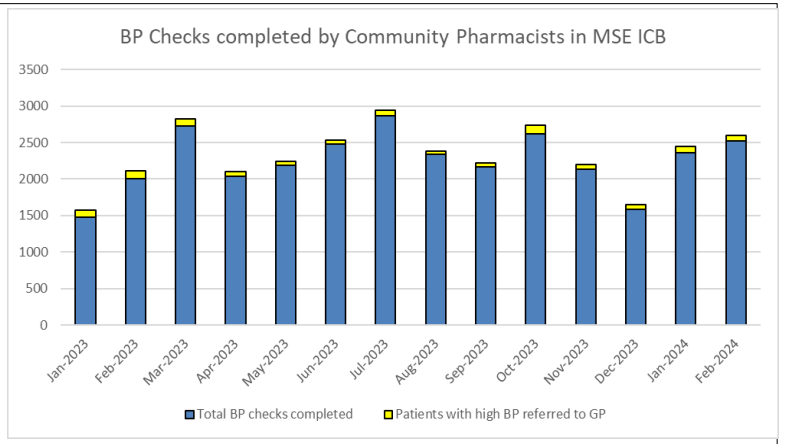
Primary Care – Community Pharmacy

Reporting Month	May 2024	Executive Lead		SRO	William Guy/Paula Wilkinson	RAG	Amber

Community Pharmacy



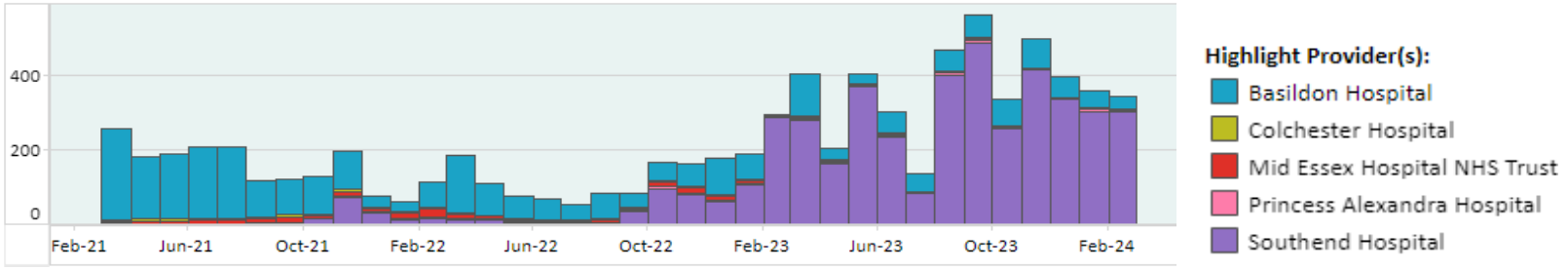
- No further closures of pharmacies in MSE-pharmacies located as shown.
- Pharmacy First service now fully implemented and well received by patients-awaiting first set of data.
- 15 pharmacies (S) are signed up to and 9 (P) are providing the Pharmacy Contraceptive service. This is a new service and in the early stage of implementation so activity numbers are still low.
- Focus on optimising the use of Blood Pressure Check service
- Community Pharmacy Independent Prescribing Pathfinder (CPIPP)- 3 community pharmacies have now gone live with Pharmacy First Plus service using paper prescriptions until the electronic solution is available.
- Referrals from MSE hospitals to community pharmacies for Discharge Medicines service well established in Southend and small numbers from Basildon. Broomfield awaiting IT solution before they can start using this service. By referring patients to community pharmacy on discharge with information about medication changes made in hospital, community pharmacy can support patients to improve outcomes, prevent harm and reduce readmissions.



Work to continue:

- Essex Pharmaceutical Needs Assessment 6-month review meeting taking place on 30th April.
- CPIPP Hypertension Service to be agreed and implemented
- Encouraging referrals to Pharmacy First by GP practices to support primary care access.

Hospital discharge monthly referrals trend by Provider



Primary Care – Dentistry

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

Dentistry

- Initial requirements of the national programme to Improve Access to Dental Services have been implemented locally. This includes a premium payment for dentists to see patients that have not accessed dental services in the previous 24 months and a minimum Units of Dental Activity (UDA) value. We await further guidance from the national team on other elements of the plan. The ICB will not be part of the mobile dental access solution in 24/25
- The care home pilot now covers all eligible care home beds in Mid and South Essex. Work is being undertaken to ensure that the final few care homes engage with this pilot. External support has been sourced to support a review of this service.
- Additional activity was undertaken in Jan – March to reduce waiting times for Orthodontic services in mid and south Essex.
- A new pilot service for cardio vascular disease has been established. This will support the early detection and treatment of cardio vascular disease to ensure patients are orally fit for surgery. This goes live in May 24.
- We have commenced a programme of work to review services for Children and Young People.

Dental access - actions

NHS Mid and South Essex

Action to improve access to dentistry since delegation:

- NHS Mid and South Essex has allowed practices to deliver an **additional 10% of their contracted activity 2023/24.**
- **Around 10,000 residents have already benefitted** from a pilot to improve dental access supporting urgent, on the day access to dental treatment evenings, weekends and bank holidays. Aim is that no-one has to suffer dental pain.

Expected to deliver ~ **40,000** additional 30-minute appointments across 10 practices.

Available to all patients, via practice, 111 or referral from other dentist.

Learning and evaluation from this pilot will inform a longer-term model.

Dental access

NHS Mid and South Essex

Dental Facts and Figures

Delegated from NHS England to ICB's on 01/04/2023

119 NHS General Dental Contracts in Mid and South Essex ICB

11 Orthodontic Contracts plus Minor Oral Surgery, Sedation, Domiciliary and Special Care Community Services (CDS).

£68m expenditure

- £60m primary dental care – 1,810,240 UDAs plus 10% over performance
- £6m orthodontic activity = 75,365 UOA
- Ring fenced dental development funding
- Working with University of Essex to develop dental workforce therapy training programmes

Alliances

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

Thurrock

The Thurrock Alliance Committee took the opportunity to review and update the Committee's Terms of Reference and implementation plan for 2024/25 at the April meeting.

A new workstream in the implementation plan has been created to respond to the frailty agenda and to reduce the number of hospital admissions which are falls related. An ambitious programme of work to re-design falls provision in the borough is in development. The Senior Responsible Officer for this work is the Alliance Deputy Director.

Three of the 4 PCNs have established their INT in Thurrock and the fourth PCN will launch their INT on 12 June 2024. Once this has happened further work will be led by the Alliance team to support the INT maturity matrix, and to assist the PCNs to respond to the Connected Pathways programme.

A new compact with the voluntary community faith and social enterprise (VCFSE) sector in the borough is in development which will support the Community Assembly work within the ICB.

The Thurrock Better Care Fund (BCF) is being reviewed with the support of the national BCF team and Local Government Association (LGA). The final report on this work is due in June 2024

Basildon and Brentwood

The Alliance Committee used the April informal meeting for a patient transport summit. This was based upon user feedback about the difficulties of attending medical appointments and potential reasons for "Did Not Attend". All providers of patient transport attended along with committee members to share and learn about the offers across the locality. Action plans were developed that will help to design an improved offer and utilise and unblock some of the tools that are already available.

Senior managers from Essex County Council, North East London Foundation Trust and the Alliance Team to progress work to further establish Integrated Neighbourhood Teams. Agreement to test and learn using a shared base for social workers, community health teams and primary care to work together and resolve issues with complex patients/residents. Will go live in April with a plan to review four weeks after this has been tested for feedback from teams and intention to adapt and roll out more widely.

Members of the team were part of an engagement event in Basildon in support of a bid for National Lottery funding. We are looking to set up a Share Shack across two of our most deprived areas to help address health inequalities through sharing of resources including sports equipment, gardening tools and cooking utensils. This will further strengthen communities where there is already a strong base of engagement.

Integrated Neighbourhood Teams plans presented to Local Pharmaceutical forum . Community Pharmacy representative now established in Basildon area and linking in with Central Basildon INT to maximise pharmacy opportunities through Pharmacy First scheme and identification of vulnerable individuals.

Alliances

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

Mid Essex

The Alliance Executive Oversight Committee met in April and discussed the overarching planning for INTs going forwards, recognising the need for some focus areas of work to support the alliance in delivering key priorities that impact all partners. There was also an ask of the group to support the ongoing Thriving Places Index (TPI) work with some dedicated resource. The group agreed that TPI needs to be used as the data source and evidence base for organisational workstreams and agreed to develop further plans to embed this way of working across partner organisations. Finally, the group discussed the need for Alliance development and agreed what support was needed for this.

The focus of the Alliance Committee in April was Asylum Seekers. Various partners presented on the work they are doing to support this cohort and the impact this has on organisations and the health and care system. It was agreed that a follow up piece of work would be done to document the impact on all partners and to try and collectively move forwards in a proactive way, working in collaboration wherever possible to minimise any negative impact on the wider health and care system and maximise outputs and outcomes for this group of residents.

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

South East Essex

The Alliance has built strong foundations for partnership working and recognises the need to remain agile and create the opportunities to continue to co-design and deliver collaborative ways of working to achieve our purpose. There is a desire to take positive action, building and maintaining momentum , ensuring our priorities align to the financial recovery of core place and system services. Our focus in April has been to work with our key delivery partners to develop an agreed approach to a 2024/25 plan setting out delivery of focussed priorities. Aligning system organisational strategies together with specific areas of responsibility as part of the ICB core delivery e.g. Primary Care, Engagement, Carers, BCF etc., provides the framework to deliver against our shared purpose. We are also adapting the Alliance governance model to enable delivery the plan and provide assurance to the Alliance Committee, Integrated Care System, Health and Wellbeing Boards and wider partners.

Our ambition is to be a data-driven and intelligence led Alliance, ensuring we are focussing on the needs of our local population, to support this we have begun a project working with the ICB Digital team and AGEM (the ICB's IT provider) to test new ways of working with the future intention to develop a dashboard that brings together insight, demand, quality and performance into a single view to aid our decision making and collaborative working.

The South East Essex Strategic Integrated Neighbourhood Group (SEE SING) is building momentum with its third meeting in April, bringing together all strategic partners and representatives from each of the eight neighbourhoods in SEE to drive forward and accelerate the development of integrated neighbourhood teams. A key focus has been on the development of intelligent profiles for each neighbourhood and the co-design of a robust outcomes framework.

Integrated Neighbourhood Team (INT) development

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

Overall Summary

6 additional INTs in place across MSE from April, taking the total to 15
Joint Alliance discussion on overarching metrics for INTs
Joint Alliance discussion and broad agreement on INT priority/focus areas for 24/25, these need some refinement (see planned activities)
Q1 INT maturity position review underway

Planned activities

Completion of INT maturity position reviews
Agreement on INT metrics and reporting
Sharing priority/focus areas with wider ICB and partners to get collective agreement and ensure buy in from key partners and alignment to their priorities

INT overview per Alliance area

Indictors	Alliances			
	Basildon and Brentwood	**South-East Essex**	**Mid Essex**	**Thurrock**
Total number of established Integrated Neighbourhood Teams	2	3	3	3
Ambition for total number of Integrated Neighbourhood Teams	6	8	6	4

INT Summary - reviewed in Q1 24/25

Framework Criteria	Integrated Neighbourhood Team								
	Stanford lee hope	West Basildon	Central Basildon	Canvey Island	SS9	Benfleet	Maldon, Dengie & SWF	Braintree South	Chelmsford Central
Neighbourhood-based boundaries recognised by the community	5	3	2	4	2	2	3	3	3
Diverse providers meeting specific population needs	3	3	3	3	3	3	3	3	3
Comprehensive care across health, care, and societal pillars	3	2	2	3	2	3	2	2	2
Empowered core providers at the heart of INTs	4	2	4	2	3	4	3	3	3
Co-produced design for shared ownership and strategic coherence	4	2	2	1	1	1	2	2	2
Incremental transformation based on joint learning and common endeavour	4	2	2	2	3	3	3	3	3
Flexible approach, adopting place-wide strategies when appropriate	3	1	1	2	2	2	1	1	1
Single governance structure for day-to-day delivery	2	1	1	2	2	2	1	1	1
Mutual accountability for service outcomes	3	2	2	2	3	3	2	2	2
Investing in continuous workforce	1	2	2	2	2	3	1	1	1
People-centred estate design, supporting neighbourhood teams	1	1	1	1	1	2	1	1	1
Totals	33/65	21/65	22/65	24/65	24/65	28/65	22/65	22/65	22/65

Marking guidance	
(1) Initiation	The INT is at the beginning stages of incorporating the criteria. There is recognition of the importance of the criteria, but actions to implement it are just starting.
(1) Development	The INT has started making progress on the criteria. Actions have been taken, but the criteria are not fully integrated into the team's practices or there are significant areas for improvement.
(1) Implementation	The INT has largely incorporated the criteria into their processes, and it forms a part of the team's ongoing activities. There may still be room for refinement and optimisation.
(1) Management	The INT consistently meets the criteria. It is fully integrated into the team's processes and there is a clear commitment to maintaining this level of performance.
(1) Optimisation	The INT not only meets the criteria, but is also actively refining and improving their approach. They are setting a standard for other INTs to follow.

Alliances

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

Overall Summary

Area of work	Commentary	Current RAG rating
Dementia Diagnosis	Alliance teams are supporting the completion of the new dementia self-assessment toolkit that is currently being tested with our ICS. This project is being funded centrally by the Department of Health and Social Care as part of a national pilot. The toolkit is designed to be completed by each "place", or Alliance, within Mid and South Essex ICS and is not directed at any particular provider. This is a unique opportunity to showcase what is happening across our ICS and raise areas we would like support in to a national level. Whilst Thurrock, Southend, and Castle Point & Rochford are all meeting the target, Mid Essex and Basildon and Brentwood are still below target, however significant improvement has been made during 23/24.	
Learning Disability Health checks	Joint working with Southend Essex Thurrock (SET) LD Forum. Regular training/promotion of work needed at Time to Learn session with primary care. Monthly IIF dashboards including LD AHC performance are circulated to PCNs. Follow-up discussions at PCN level are held by Alliance clinical leads where required. Regularly review and initiate action on LD health check performance at local Health Inequalities Groups. Latest data (January 2024) indicates a 4% increase in the number of health checks completed year on year.	
Cardiovascular Disease (CVD) Prevention	The Alliance teams are supporting the health inequalities team in the implementation of the CVD Local Enhanced Service (LES), promoting and encouraging PCNs to sign up to the LES. The LES aims to improve CVD outcomes and in the longer-term reduce emergency admissions and prevent the escalation of risk. It asks PCNs to collaborate and provide holistic care through **multimorbidity clinics** with clinical interventions determined within the PCN, by utilising the wider PCN network and workforce in delivering care. 12 of the 14 identified PCNs are now signed up to this LES.	
Seriously mentally Ill (SMI) Healthchecks	Regular training/promotion of work needed at Time to Learn session with primary care. Monthly performance circulated to PCNs. Follow-up discussions at PCN level are held by Alliance clinical leads where required. Regularly review and initiate action on Serious Mental Illness (SMI) health check performance at local Health Inequalities Groups. Supporting the MSE accelerator site project for SMIs by working closely with PCNs and the central team to help embed processes and learning.	

Better Care Fund/Discharge Fund

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

BCF and Discharge fund

BCF - All 4 Alliances maintained partnership BCF governance groups with local authority (LA) partners.
An MSE wide BCF group has being established to share good practice and learning across the Health and Wellbeing footprints, this meet for the first time in April with a focus on the upcoming refresh of the capacity and demand models and planning update due to NHSE in June.
The 24/25 BCF guidance has been released by NHSE, this is being built into BCF and Discharge fund planning the core areas are:
ICBs and local authorities should use this funding, alongside wider local investment in discharge services, to meet projected needs and minimise discharge delays. In doing so they should have a particular focus on national condition 3 of the BCF, and ensure the funding is used in conjunction with wider funding to:

- build additional social care and community-based reablement capacity
- maximise the number of hospital beds freed up
- deliver sustainable improvements for patients

<u>Recent presentations covering iBCF projects and outcomes within Essex LA meetings have included:</u>

- An update on the Care home support service work in Castle Point & Rochford (CPR) and the refocus of this work
- An update on the South West (SW) home from hospital pilot (trailing a different focus for bridging in SW) linking to the Intermediate care model work Essex County Council (ECC) wide
- An end of project evaluation regarding the Primary care Carers project was received with positive outcomes.
- An overview of the carers projects in the Mid Alliance areas was reviewed and a proposed approach recommended for consideration
- A Recent ECC wide meeting focused on planning and review of the ASC and ICB discharge fund for 24/25, many of the projects are already in place and will continue into the next year.

Thurrock are in the process of having a deep dive on the BCF spend supported by the Local government association as part of BCF regional support offer, the learning for the wider system will be shared as it progresses.

Discharge Fund -
The ICB fully discharged the spend against the discharge fund in 23/24 with no underspend and have reported spend to NHSE on schedule.

A further evaluation session has been completed to support the prioritisation of the 24/25 spend in relation to supporting discharge, this was in response to a review linked to the system financial pressures to reassess against known key objectives for the financial recovery plan.

- Monthly reporting on the discharge fund has been maintained, however this will move to Quarterly in this new reporting year which will release the administration burden on teams in the reduced frequency.

Transfer of Care Hubs (TOCH)

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

Transfer of Care Hubs

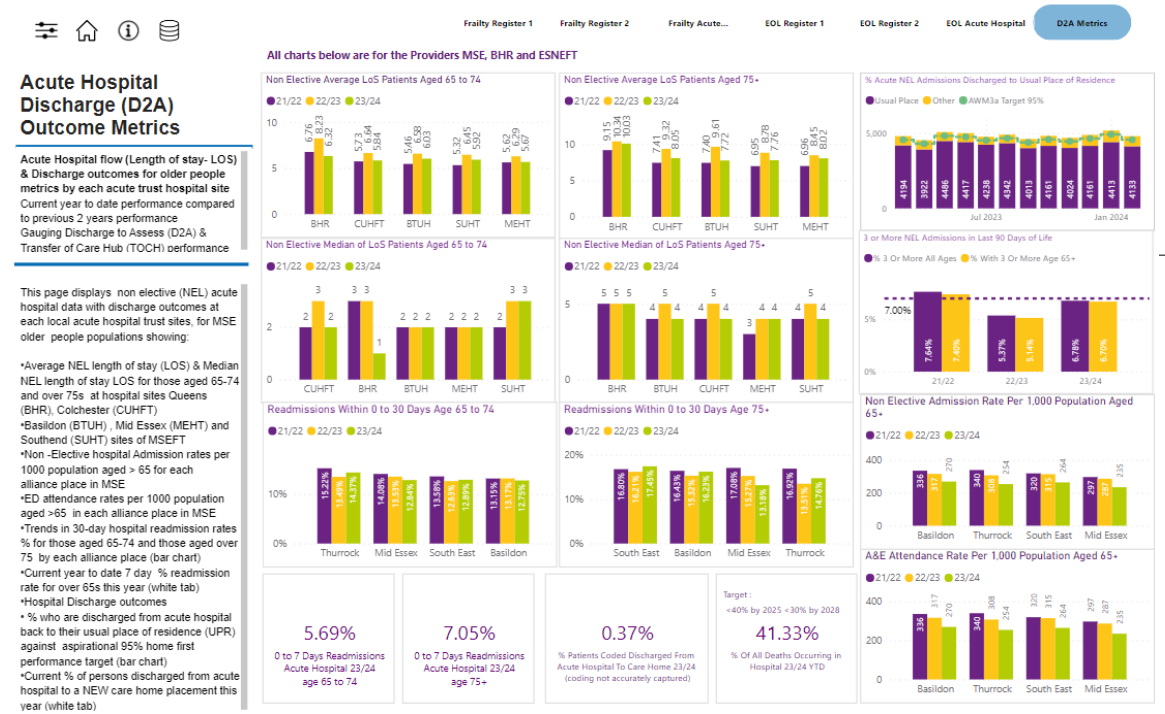
- All 4 TOCH took part in the Acute Multi Agency Discharge Event (MADE) in the run up to Easter, this allowed for further testing of the TOCH processes and multidisciplinary working and networks, the outcomes of this will be used on phase 2 as part of ongoing learning.
- The Evaluation of the first 3 months running is in progress to support Phase 2 planning, Alliance teams are feeding in narrative for the Evaluation
- A digital workshop is planned for May to support the digital integration agenda, Shared Care record going live in June remains part of the solution for Digital integration
- The voluntary sector support model for the TOCHs is being reviewed across the Alliance to build into Phase 2 planning.

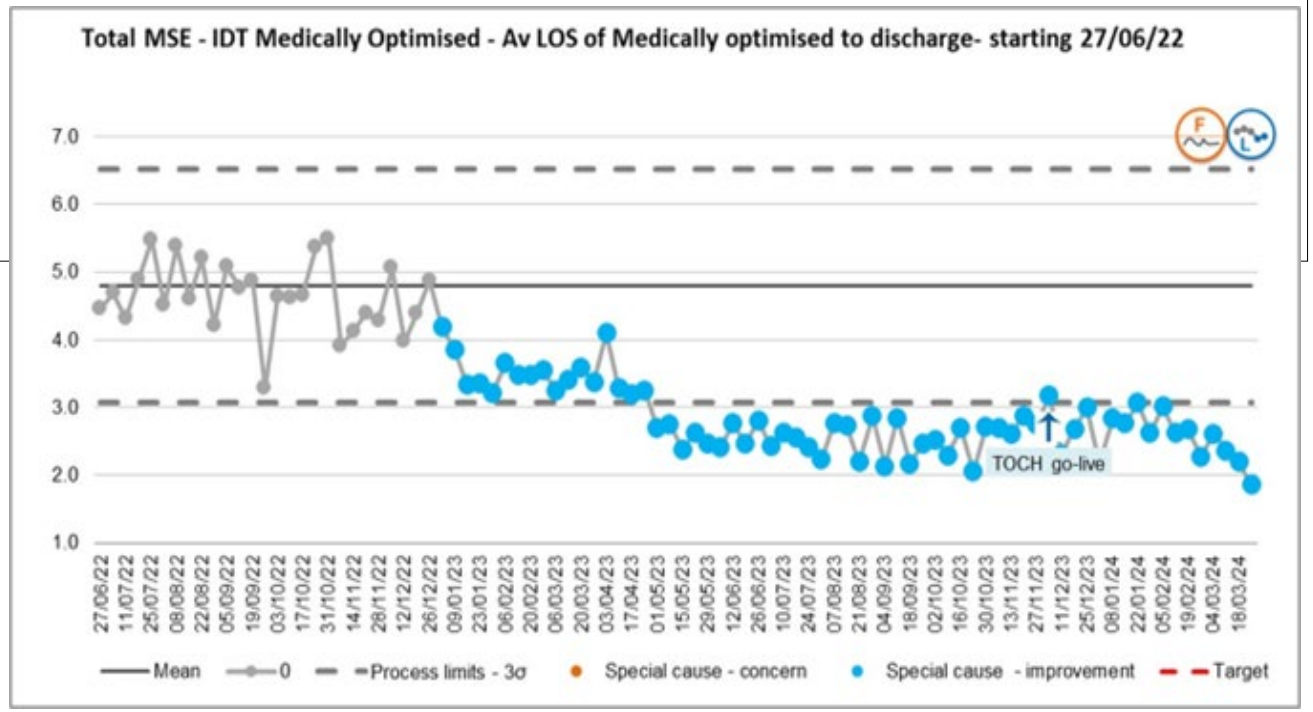
Transfer of Care Hubs (TOCH)

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

Transfer of Care Hubs

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





Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Alliance Directors
Dan DOHERTY,
Pam GREEN,
Aleksandra MECAN,
Rebecca JARVIS,

www.midandsouthessex.ics.nhs.uk

Part I ICB Board Meeting, 9 May 2024

Agenda Number: 11

ICB Risk Appetite Statement

Summary Report

1. Purpose of Report

Following consideration of risk appetite at the Executive Committee on 11 March 2024 and a Board seminar on 11 April 2024, feedback from the Board Members has been collated to present the risk appetite of the Board using the Good Governance Institute risk appetite matrix. Appendices 1 and 2 provide further detail to how the statement has been developed.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer

3. Report Authors

Nicola Adams, Deputy Director of Governance and Risk
Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

The ICB Board has responsibility for setting the organisations Strategic Objectives and Risk Appetite Statement.

5. Financial Implications

The Risk Appetite Statement sets out the organisations approach to financial risks.

6. Details of patient or public engagement or consultation / Conflicts of Interest / Impact Assessment

None.

7. Recommendation(s)

The Board is asked to:

- Approve the ICB's Risk Appetite Statement, outlining the amount of risk that the ICB is willing to accept in the pursuit of its strategic objectives. Noting the statement will be incorporated within the ICBs Risk Management Policy.
- Note the intention to review the Risk Appetite Statement at least every six months, or sooner should the environment in which the ICB operates necessitate this.

Risk Appetite Statement

Mid and South Essex Integrated Care Board (the ICB) recognises that long-term sustainability depends upon optimising risk in relation to the delivery of its strategic objectives and that the relationship with partner organisations, patients, staff, contractors, the public, and other stakeholders is key to its success.

Risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain, or take in pursuit of its strategic objectives. It represents risk optimisation - a balance between the potential benefits of innovation and the threats that change inevitably brings (recognising that most risks cannot be eliminated).

This statement reflects the Board's decision on the appropriate exposure to risk it will accept to deliver its objectives and strategies.

In setting its risk appetite, the Board has considered the importance of ensuring that the ICB is not exposed to risks that it cannot tolerate, or taking an overly cautious approach which could stifle innovation.

The Board therefore has considered risk tolerance levels, which reflect the boundaries within which the executive management team and other members of the Board are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they execute the ICB's strategic objectives.

Risk tolerance levels are reflected via the ICB's risk management arrangements which enable risks to be regularly reviewed, rated in terms of consequence and likelihood, and escalated (or de-escalated) to the Board, committees, and other groups/organisations as appropriate for oversight and challenge.

In practice, the organisation's risk appetite addresses several dimensions including:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

The Board is therefore cognisant that the controls it implements must be appropriate to the type and level of risk the organisation is prepared to take. Where necessary, further controls will be implemented to address any gaps identified.

The Board will also seek robust assurance that the controls upon which the ICB relies are effective. These assurances will be reflected within the Board Assurance Framework and regularly reviewed by the Board. Where necessary, further assurances will be sought to address any gaps identified.

The table below reflects the current risk appetite level for each of the five types of risk as defined by the Good Governance Institute's risk appetite matrix for the NHS at Appendix 2 and sets out the Board's ambition for its future risk appetite, where this is noted as being materially different.

<u>Context of setting our risk appetite</u>

Financially, the ICB faces a significant structural deficit that has prevented us from meeting our planned financial positions (across the system). Recovering this will be a priority for the ICB in 2024/25, which reflects a specific ask of our regulator.

Following the national task of reducing our ICB workforce by 30%, the ICB now has a much-reduced capacity within which to discharge its responsibilities and meet its strategic objectives.

With the lingering effects of the COVID-19 pandemic, there are continued health inequalities within our community, highlighting vulnerabilities that require urgent attention. Notably performance against waiting time targets are still in a recovery phase, although we have made significant inroads to recover them.

Finally, the system workforce challenges, alongside the financial deficit have a significant impact on our ability to deliver our constitutional standards despite increasing capacity in primary care for example.

It is within the context of this complex and challenging background that the ICB sets its appetite for risk as follows:

Risk Type	ICB Risk Appetite Level
Financial How will we use our resources? Current: **3 (Open)** Ambition: **4 (Seek)**	The financial risk appetite reflects the position of the ICB as it will be required to lead on making several difficult decisions in the coming year to deliver the financial targets set for both the ICB and wider system health partners. The Board is prepared to accept some financial risk if appropriate controls are in place. The ICB has a holistic understanding of value for money (VFM) with price not being the overriding factor. However, where it is appropriate to do so, the Board will invest for the best possible return and accept the possibility of increased financial risk in line with its ambition for greater risk appetite.
Regulatory How will we be perceived by our regulator(s)? Current: **2 (Cautious)** Ambition: **3 (Open)**	The Board's regulatory risk appetite reflects the potentially conflicting nature of the requirements of different regulators or different functions within a single regulator. The ICB will always engage with regulators prior to making difficult decisions that link to our appetite for risk in this area. The Board is prepared to accept the possibility of limited regulatory challenge and would seek to understand where similar actions had been successful elsewhere before taking any decision. However, the Board will be prepared to accept the possibility of some regulatory challenge if it can be reasonably confident it would be able to challenge this successfully, in line with its ambition.
Quality How will we deliver safe services? Current: **3 (Open)** Ambition: **4 (Seek)**	The Board's quality risk appetite acknowledges the potential conflicts between financial sustainability and striving for excellence in the services it commissions. The Board is prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards, and it actively supports innovation. However, when possible, the Board will pursue innovation where decisions made in relation to the quality of outcomes may have higher inherent risk, but the potential for significant longer-term gains is sufficiently great.

Risk Type	ICB Risk Appetite Level
Reputational How will we be perceived by the public and our partners? Current: **4 (Seek)**	With the challenging environment the ICB operates in, it is understandable that it will be forced to take decisions that the public or partners may find challenging. However, the Board will always make those decisions having engaged with members of the public and having completed assessments to manage any potential impact to residents. The Board is willing to take decisions that are likely to bring about scrutiny of the organisation and will outwardly promote new ideas and innovations where potential benefits outweigh the risks, following rigorous assessment.
People How will we be perceived by our staff? Current: **3 (Open)** Ambition: **4 (Seek)**	The Board acknowledges the difficult journey its staff have had since inception and therefore the Board will continue to work with them to ensure their well-being remains a priority, and ultimately the ICB will be a workplace of choice. The Board is prepared to accept the possibility of some workforce risk, as a direct result from innovation if there is the potential for improved recruitment and retention, and development opportunities for staff. However, in certain circumstances, the Board will pursue workforce innovation further in line with its ambition to deliver a workforce for the future. The Board is willing to take risks which may have implications for its workforce but could improve the skills and capabilities of staff. The Board recognises that innovation is likely to be disruptive in the short term, but where the potential of longer-term gain is identified, there is an ambition to explore this where appropriate to do so.

This statement will be reviewed by the Board at least every six months, or sooner if the environment in which the ICB operates necessitates this.

Appendix 1 – Development of the Risk Appetite Statement

Introduction

The ICB's risk management arrangements include a Board Assurance Framework, Corporate Risk Register; Risk Management Policy and supporting policies; risk management training (mandatory training and bespoke training depending on the remit/responsibilities of staff), and regular review of risks by ICB managers, the Board, and its committees.

The ICB is also required to have a risk appetite statement which is included within its Risk Management Policy (Policy Ref 017). The Board reviewed its risk appetite during March and April 2024 and consequently is seeking to revise its risk appetite statement as set out within this paper.

What is Risk Appetite

Defining the organisation's risk appetite is important because it provides a framework to make informed planning and management decisions. It enables organisations to ensure they are not exposed to risks that cannot be tolerated, or that they do not take an overly cautious approach which could stifle innovation.

The Good Governance Institute (GGI) provides the following definitions:

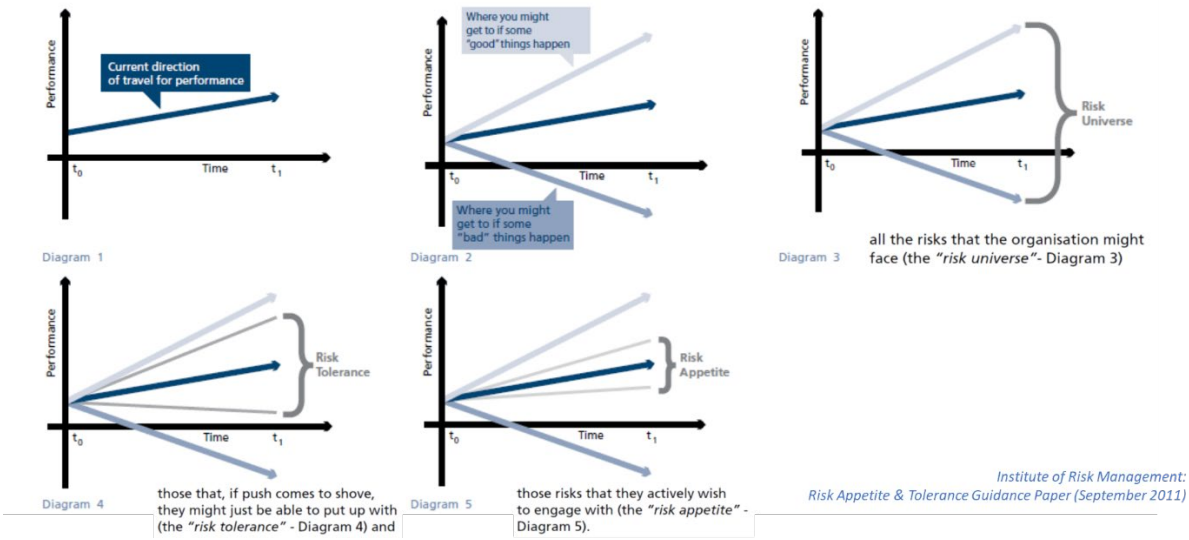
Risk appetite is the amount and type of risk that an organisation is prepared to pursue, retain, or take in pursuit of its strategic objectives. It represents risk optimisation - a balance between the potential benefits of innovation and the threats that change inevitably brings.

Risk tolerance reflects the boundaries within which the executive management team and other members of the Board are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the ICB's strategies and risk appetite.

Put simply:

- **Risk appetite** is the level of risk within which we aim to operate.
- **Risk tolerance** is the level of risk within which we are willing to operate.

The Institute of risk management guidance paper further explains the risk universe, tolerance and appetite using the following example, which was used to guide Board discussions.



Review of Risk Appetite

The 'risk types' and 'risk appetite levels' defined by the Good Governance Institute (GGI) were used to help develop the Board's risk appetite statement and are summarised in tables 1 and 2 below.

Table 1: Risk Types

Risk Type	Definition
Financial	How will we use our resources?
Regulatory	How will we be perceived by our regulator(s)?
Quality	How will we deliver safe services?
Reputational	How will we be perceived by the public and our partners?
People	How will we be perceived by our staff?

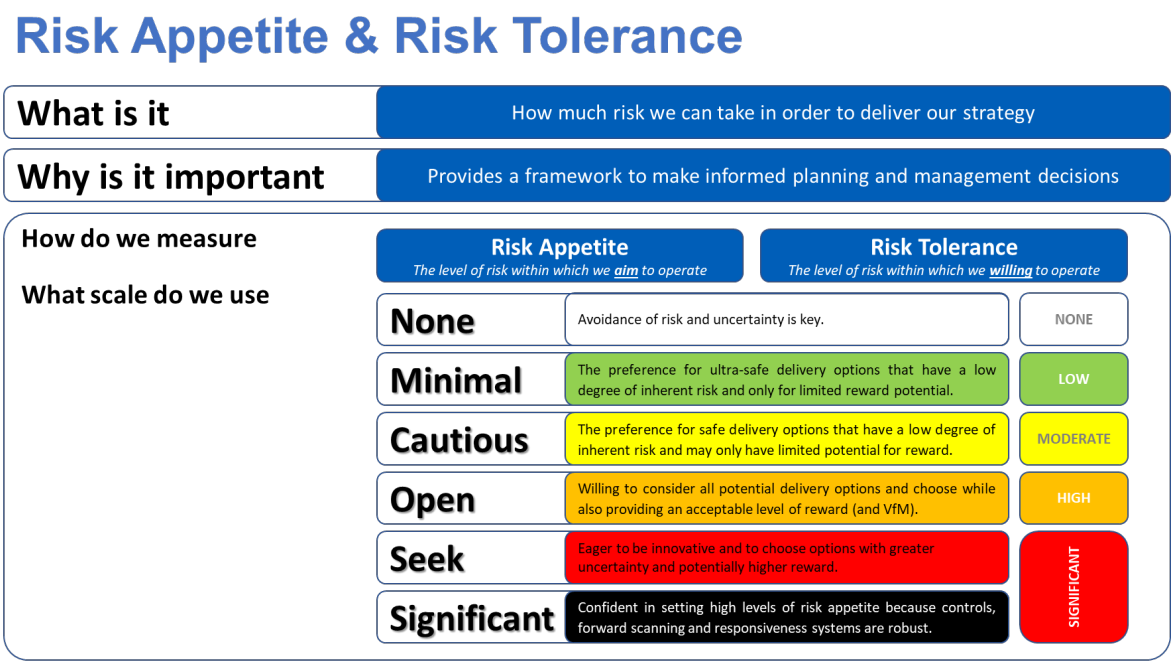
Table 2: Risk Appetite Levels

Risk Appetite Levels	Definition
0 - None	Avoidance of risk is a key organisational objective
1 - Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential
2 - Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.
3 - Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Appetite Levels	Definition
4 - Seek	Eager to be innovative and choose options offering higher business rewards (despite greater inherent risk).
5 - Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

The full GGI risk appetite matrix is provided at **Appendix 2.**

The diagram below depicts how the ICB has brought together the approach set out by the GGI under its own risk management framework.



Engagement with the ICB Board

Risk appetite was initially considered by the executive directors on 11 March 2024. This was followed by an online survey seeking all Board members' views on risk appetite levels according to the categories set out within the GGI matrix. The outcome of the survey (completed by 9 members) was discussed at a Board Seminar on 11 April 2024 (attended by 15 representatives) with the aim of reaching consensus on the risk appetite level for each risk type.

In reaching an agreed position, the Board considered how it made several recent decisions. This enabled members to ensure the revised statement reflects how the Board currently, and in future, wants to behave when making decisions considering significant financial constraints and the ever-changing environment in which the ICB and partner organisations operate.

Appendix 2: Risk Appetite for NHS (Good Governance Institute)

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources? ▶	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator? ▶	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services? ▶	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners? ▶	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners? ▶	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

Part I ICB Board Meeting, 9 May 2024

Agenda Number: 11.2

Changes to ICB Constitution

Summary Report

1. Purpose of Report

To present for approval changes to the ICB Constitution required because of the updated model constitution guidance from NHS England (NHSE). The proposed changes mirror the requirements of NHSE and do not alter the fundamental principles of ICB Governance.

The changes reflect:

- Formalisation of deputy chair arrangements.
- Formalising arrangements for members other than those constituted to contribute to the Board.
- Ensuring terms of office for Chair and non-executive members are clear.
- Updating reference to procurement rules.
- Removing clauses related to the establishment of ICBs
- Minor changes to references within the document and to legislation.

2. Executive Lead

Tracy Dowling, Interim Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Board retain responsibility for approving any changes to the ICB Constitution prior to submission to NHSE in accordance with associated legislation and guidance.

5. Impact Assessments

There has been no material change to the constitution and therefore there is no impact to consider.

6. Financial Implications / Engagement / Conflicts of Interest

Not applicable to this report as it reflects minor updates to governance documents.

7. Recommendation(s)

The Board is asked to approve the amendments to its constitution for submission to NHS England.

Mid and South Essex
Integrated Care Board

NHS Mid and South Essex Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
v1.0	N/A	1 July 2022
V1.1	N/A	Minor changes
V1.2		1 December 2022
V1.3		

CONTENTS

1 Introduction

1.1. Foreword

1.1.1 NHS England has set out the following as the four core purposes of ICSs:

a) Improve outcomes in population health and healthcare.
b) Tackle inequalities in outcomes, experience and access.
c) Enhance productivity and value for money.
d) Help the NHS support broader social and economic development.

1.1.2 The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- Improving the health of children and young people.
- Supporting people to stay well and independent.
- Acting sooner to help those with preventable conditions.
- Supporting those with long-term conditions or mental health issues.
- Caring for those with multiple needs as populations age.
- Getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is the NHS Mid and South Essex Integrated Care Board ("the ICB").

1.3 Area covered by the Integrated Care Board

1.3.1 The area covered by the ICB comprises the Borough of Basildon, District of Braintree, Borough of Brentwood, Borough of Castle Point, City of Chelmsford, District of Maldon, District of Rochford, City of Southend-on-Sea, and the Borough of Thurrock.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution which must comply with the

requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This constitution is published at www.midandsouthessex.ics.nhs.uk

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act).
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act).
c) Duties in relation children including safeguarding, promoting welfare etc. (including the Children Acts 1989 and 2004, and the Children and Families Act 2014).
d) Adult safeguarding and carers (the Care Act 2014).
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35).
f) Information law, (for instance, data protection laws such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018 and the Freedom of Information Act 2000).
g) Provisions of the Civil Contingencies Act 2004.

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:

a) Section 14Z34 (improvement in quality of services).
b) Section 14Z35 (reducing inequalities).
c) Section 14Z38 (obtaining appropriate advice).
d) Section 14Z40 (duty in respect of research)
e) Section 14Z43 (duty to have regard to effect of decisions).
f) Section 14Z45 (public involvement and consultation)
g) Sections 223GB to 223N (financial duties).
h) Section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) Where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) Where NHS England varies the Constitution of its own initiative (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive may periodically propose amendments to the Constitution, which shall be considered and approved by the Integrated Care Board prior to making an application to vary the Constitution to NHS England.
b) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) **Standing orders** – which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published:

a) **The Scheme of Reservation and Delegation (SoRD)** – sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) **Functions and Decision map** - a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions** – which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:
   - The above documents a) – c).
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.6.2.
   - Detailed arrangements for the nomination and selection process of board members, as required.

e) **Key policy documents** - which should also be included in the Governance Handbook or linked to it, including:
   - Standards of business conduct policy.
   - Conflicts of interest policy and procedures.
   - Patient and public engagement policy.

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.midandsouthessex.ics.nhs.uk

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) A Chair.
b) A Chief Executive.
c) At least three Ordinary members.

2.1.4 The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy requires the ICB to appoint the following additional Ordinary Members:

a) Three executive members, namely:
   - Director of Finance (known locally as the Chief Finance Officer).
   - Medical Director.
   - Director of Nursing (known locally as the Chief Nurse)
b) At least two non-executive members.

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below:

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description.
- The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.
- The upper tier local authorities that are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors. The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

2.2 Board membership

2.2.1 The ICB has 6 Partner Members:

a) Two members, one of whom brings the perspective of the acute sector and the other of whom brings the perspective of the mental health sector delivering services across the ICB's area.
b) One member nominated and selected to bring the perspective of the primary care sector within the ICB area.
c) Three members nominated by the upper tier local authorities whose area coincides with or includes the whole or any part of the ICB's area.

2.2.2 The ICB has also appointed the following further Ordinary members to the board:

a) One additional Non-executive Member.
b) Chief People Officer.

2.2.3 The board is therefore composed of the following members:

a) Chair.
b) Chief Executive.
c) 2 Partner members NHS trusts and foundation trusts.
d) 1 Partner member primary medical services.
e) 3 Partner members local authorities.
f) 3 Non-executive Members (one of which, but not the Audit Committee Chair, will be appointed the Deputy Chair).
g) Chief Finance Officer.
h) Medical Director.
i) Chief Nurse.
j) Chief People Officer.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular participants and observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting but may not vote.

a) 3 Associate Non-Executive Members
b) Executive Director of Strategy and Corporate Services
c) Executive Chief Digital Information Officer
d) 4 Alliance Directors
e) Chief Executive of Partner Organisations not represented on the Board

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

2.3.4 Participants and/or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the standing orders.

3 Appointments Process for the Board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the “fit and proper person test”.
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles).
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.
d) Be willing to uphold the principles of the East of England Leadership Compact.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted:

a) In the United Kingdom of any offence, or
b) Outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

3.2.5 A person who has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a health service body, has been terminated on the grounds:

a) That it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office.
b) That the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings.
c) That the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest.
d) Of misbehaviour, misconduct or failure to carry out the person's duties.

3.2.7 A Healthcare Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) The person's suspension from a register held by the regulatory body, where that suspension has not been terminated.
b) The person's erasure from such a register, where the person has not been restored to the register.
c) A decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded.

d) A decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) A disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) An order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) Section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
b) Section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be a maximum of three years and the total number of terms a Chair may serve is three terms (a maximum of nine years).

3.4 Deputy Chair

3.4.1 The Deputy Chair is to be appointed from amongst the Non-executive members by the board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit Committee and Deputy Chair at the same time.

3.5 Chief Executive

3.5.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 The Chief Executive must fulfil the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) Subject to clause 3.5.3(a), they hold any other employment or executive role.

3.6 Partner Members – NHS trusts and foundation trusts (FTs)

3.6.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition:

a) East of England Ambulance Service NHS Trust.
b) Essex Partnership University NHS Foundation Trust.
c) Mid and South Essex NHS Foundation Trust.
d) North East London NHS Foundation Trust.

3.6.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be a CEO or Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One member must provide current and on-going experience of the acute hospital sector.
c) One member must provide current and on-going knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.6.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.6.4 These members will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.6.1 will be invited to make one nomination for each role (one for acute and one for mental health).
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.2 and 3.6.3.
- The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms. However, where more than one trust can act on behalf of their sector the nomination and selection process will be revisited at the end of each term at the discretion of the Chair.

3.7 Partner Member - providers of primary medical services

3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area and that are primary medical services contract holders responsible for the provision of essential services within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be registered with the General Medical Council.
b) Be a practising provider of primary medical services within the ICB area.
c) Work as a GP in the ICB area for a minimum of 1 session per week.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role specification.

3.7.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.7.5 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.7.6 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make one nomination.
- Each nomination must be seconded by one of the other eligible organisations described at 3.7.1 and listed in the Governance Handbook.
- Eligible organisations may nominate an individual from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do

agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
   - If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
   - In the event that there is more than one suitable nominee for the role, the full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.3 and 3.7.4.
   - The panel will select the most suitable nominee for appointment via the shortlisting, interview, and selection process set out in the Governance Handbook.

c) Chair's approval:
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this Partner Member will be three years, subject to re-appointment following the process described in 3.7.5, and the total number of terms they may serve is three terms.

3.8 Partner Members - local authorities

3.8.1 These Partner Members are jointly nominated by the upper tier local authorities whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Essex County Council
b) Southend on Sea City Council
c) Thurrock Council

3.8.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1.
b) The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

a) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.8.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.8.4 This member will be recommended for appointment by the ICB Chief Executive subject to the approval of the Chair.

3.8.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.8.1 will be invited to make one nomination for each role.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c):
- If the number of nominations is equal to the number of partner member roles, there will be a confirmation process with the ICB Chair to ensure that the nominated partner member meets the criteria for board membership including the requirements of the role description and person specification and the disqualification criteria.
- In the event that there is more than one suitable nominee for each of the partner member roles, the full list of nominees will be considered by a panel convened by the Chief Executive.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- The panel will select the most suitable nominee for appointment via the shortlisting, interview and selection process set out in the Governance Handbook.

c) Chair's approval:
- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for these Partner Members will be three years and the total number of terms they may serve is three terms.

3.9 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Medical Practitioner.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.9.1 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.9.2 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.10 Director of Nursing (known as the Chief Nurse)

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Be a registered Nurse.
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.10.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.10.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.11 Director of Finance (known as the Chief Finance Officer)

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.
b) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.11.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.11.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.12 Non-Executive Members

3.12.1 The ICB will appoint three Non-executive Members.

3.12.2 These members will be appointed at the recommendation of the selection panel subject to the approval of the Chair of the ICB.

3.12.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be employee of the ICB or a person seconded to the ICB.
b) Not hold a role in another health and care organisation in the ICB area.
c) One member shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee.
d) One other member should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee.
e) A third member with specific knowledge, skills and experience that makes them suitable for their role.
f) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.12.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.
b) They hold a role in another health and care organisation within the ICB area.

3.12.5 The term of office for a non-executive member will be three years and the total number of terms an individual may serve is three terms, after which they will no longer be eligible for re-appointment.

3.12.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.12.7 Subject to satisfactory appraisal, the Chair may approve the re-appointment of a non-executive member up to the maximum number of terms permitted for their role.

3.13 Other Board Members – Chief People Officer

3.13.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act.

3.13.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply.

3.13.3 This member will be appointed by the ICB Chief Executive subject to the approval of the Chair.

3.14 Board Members: Removal from Office

3.14.1 Arrangements for the removal from office of board members is subject to the term of appointment and application of the relevant ICB policies and procedures.

3.14.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this constitution, regulations or guidance.
b) If they fail to attend two consecutive meetings to which they are invited or show a pattern of absence (unless such absence has been agreed with the Chair in extenuating circumstances). A subsequent meeting with the Chair shall take place to determine whether the individual is able to continue to hold office.
c) If they are deemed to not meet the expected standards of performance at their annual appraisal.
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise.
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life.
f) If they are deemed to have failed to uphold the principles of the East of England Leadership Compact.

3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.14.2 apply.

3.14.4 Executive Directors (including the Chief Executive) will cease to be board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.14.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) Terminate the appointment of the ICB's Chief Executive; and
b) Direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.15 Terms of Appointment of Board Members

3.15.1 A proposal for the Chair or non-executive to serve on the board for longer than six years will be subject to rigorous review to ensure their ongoing independence, and they will not serve as a board member for longer than nine years in total.

3.15.2 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration Committee in line with the ICB remuneration policy and any other relevant policies published on the ICB website, and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by a Non-executive Member remuneration panel, as set out in the Governance Handbook.

3.15.3 Other terms of appointment will be determined by the Remuneration Committee.

3.15.4 Terms of appointment of the Chair will be determined by NHS England.

3.15.5

4 Arrangements for the exercise of our functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.2 General

4.2.1 The ICB will:

a) Comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations.
b) Comply with directions issued by the Secretary of State for Health and Social Care.
c) Comply with directions issued by NHS England.
d) Have regard to statutory guidance including that issued by NHS England.
e) Take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) Respond to reports and recommendations made by local Healthwatch organisations within the ICB area.

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) Any of its members or employees.
b) A committee or sub-committee of the ICB.

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter into partnership arrangements with a Local Authority under which the Local Authority exercises specified ICB functions or the ICB exercises specified Local Authority functions, or the ICB and Local Authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation (SoRD)

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full in the Governance Handbook on the ICB website.

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) Those functions that are reserved to the board.
b) Those functions that have been delegated to an individual or to committees and sub committees.
c) Those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published in the Governance Handbook on the ICB website.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB.
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body.
d) Functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB will be required to:

a) Submit regular decision or assurance reports to the board.
b) Ensure attendance at board meetings of either the Chair or deputy Chair, when requested by the ICB Chair.
c) Comply with internal audit and external audit recommendations and the recommendations of committee effectiveness reviews.
d) Specify the arrangements for their meetings in their terms of reference in line with the standing orders or any specified alternative arrangements.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of or include persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this constitution, including the Standing Orders as well as the SFIs and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit Committee:** This committee is accountable to the board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

   The Audit Committee will be chaired by a Non-executive Member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-executive Member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- Conducting the business of the ICB.
- The procedures to be followed during meetings.
- The process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and forms part of this constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook on the ICB website.

6 Arrangements for Conflict of Interest Management and Standards of Business Conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website.

6.1.3 All board, committee and sub-committee members and employees of the ICB will comply with the ICB policy on conflicts of interest in line with their terms of office and/or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict and is subject to the provisions of this constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest.
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest.
c) Support the rigorous application of conflict of interest management principles and policies.
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation.
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the principles of the East of England Leadership Compact, and the following principles:

a) Subsidiarity: arrangements should be designed to facilitate decisions being taken as close to local communities as possible, and at a larger scale where there are clear benefits from collaborative approaches and economies of scale.
b) Population-focused vision: decisions should be consistent with a clear vision and strategy that reflects the four core purposes
c) Shared understanding: partners should have a collective understanding of the opportunities available by working together and the impact of individual organisational decisions on other parts of the system.
d) Co-design and co-production: addressing system challenges and decision-making should involve working with people, communities, clinicians and professionals in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.
e) Timely access to information and data: system partners should share accurate and complete data (quantitative and qualitative) in an open and timely manner to enable effective decision-making.
f) Clear and transparent decision-making: system partners should work in an open way ensuring that decision-making processes stand up to independent scrutiny.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB.
b) Members of the board's committees and sub-committees.
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1.

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should:

a) Act in good faith and in the interests of the ICB.
b) Follow the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).
c) Comply with the ICB Standards of Business Conduct Policy and any requirements set out in the policy for managing conflicts of interest.
d) Be willing to uphold the principles of the East of England Leadership Compact.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring Accountability and Transparency

7.1 Principles

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The constitution and Governance Handbook will be published as well as other key documents including but not limited to:

a) Conflicts of interest policy and procedures.
b) Registers of interests.
c) Other key documents and policies, as appropriate.

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- Sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- Sections 223GB and 223N (financial duties).

And

- Proposed steps to implement the Integrated Care Strategy, having due regard to the Essex Joint Health and Wellbeing Strategy, Southend Health and Wellbeing Strategy, and Thurrock Health and Wellbeing Strategy.

7.3 Scrutiny and Decision Making

7.3.1 At least three Non-executive Members will be appointed to the board, including the Chair, and all of the board and committee members will comply with the Seven Principles of Public Life (the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) The establishment of a provider selection regime review group and governance structure to deal with any challenges to decisions about provider selection.

b) Maintaining the audit trail of decision making for transparency purposes.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.3.5 The ICB will comply with the current procurement regulations at the time for all non-clinical goods/services purchases.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) Explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards).
b) Review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan).
c) Review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration Committee which is chaired by a Non-executive member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration Committee is determined by the board. No employees may be a member of the Remuneration Committee, but the board ensures that the Remuneration Committee has access to appropriate advice by:

a) HR advisers being in attendance at meetings.

8.1.4 The board may appoint independent members or advisers to the Remuneration Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook on the ICB website.

8.1.6 The duties of the Remuneration Committee include:

a) Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
b) Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and board members (other than Non-executive Members).
c) Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Change Terms and Conditions.
d) Overseeing any discretionary payments outside of Agenda for Change pay policy for all staff.
e) Determining the arrangements for termination payments and any special payments for all staff.

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) The planning of the commissioning arrangements by the Integrated Care Board.
b) The development and consideration of proposals by the ICB.
c) Changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them.
d) Decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB has made the following arrangements to engage with its population on its system plan:

a) Overarching strategic communications and involvement planning through the system communications and engagement network in collaboration with partners across the ICS including NHS, local authority, community and voluntary sector organisations and through alliances.
b) Partner-led local conversations and awareness raising, community assets and place-based involvement plans.
c) Clinical and managerial involvement.
d) Communications and conversations with the population that are clinically and professionally informed and led.
e) Patient and public involvement in the development of communication materials and assets as appropriate.
f) Detailed conversations with professional bodies and trade unions.
g) Complying with Health Overview and Scrutiny requirements.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities, set out below.

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.

e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 In addition, the ICB has set out its vision for community involvement in more detail in the Mid and South Essex patient and public engagement policy which can be found on the ICB website.

9.1.5 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.6 These arrangements include a range of engagement activities, including, but not limited to patient participation groups, 'Virtual Views' citizens' panel and targeted outreach sessions. The ICB will have lead responsibility for the ICS engagement framework and provide advice, guidance and training to encourage a culture of co-production among wider teams to support its delivery as close to our communities as possible.

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders. In Mid and South Essex these are also referred to as 'Alliances'.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description.

	• The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Director of Finance	Known locally as the Chief Finance Officer.
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.
Health Care Professional	An individual who is a member of a professional regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1 Introduction

1.1 These Standing Orders have been drawn up to regulate the proceedings of Mid and South Essex Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's constitution.

2 Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

2.2 The Standing Orders will be reviewed on an annual basis or sooner if required.

2.3 Amendments to these Standing Orders will be made as per clause 1.5.2 of the Constitution.

2.4 All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3 Interpretation, application and compliance

3.1 Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB constitution and as per the definitions in Appendix 1.

3.2 These Standing Orders apply to all meetings of the board, including its committees and sub-committees, unless otherwise stated. All references to the board are inclusive of committees and sub-committees unless otherwise stated.

3.3 All members of the board, members of committees and sub-committees and all employees should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4 In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.

3.5 All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6 If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

4.1.1 Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with two calendar days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3 A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting that is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the board.

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the deputy Chair shall preside over meetings in the Chair's stead.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the assembled members to appoint a temporary Deputy for the purpose of chairing the meeting.

4.2.4 The ICB board, acting on the advice of the Chair, shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.midandsouthessex.ics.nhs.uk

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be reviewed in accordance with the arrangements published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak but may not vote on their behalf.

4.5.1 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.2 If a member of the ICB is unable to attend two consecutive meetings, other than as a result of illness or other exceptional circumstances, the member will meet with the Chair to determine their future ability to fulfil their role.

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this. Arrangements for governing this process are included in the Governance Handbook.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be seven members, including at least the following:

a) Either the Chair or Deputy Chair.
b) Either the Chief Executive or the Chief Finance Officer.
c) Either the Medical Director or the Chief Nurse.
d) At least one other independent member
e) At least one Partner Member.

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest shall no longer count towards the quorum.

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

a) For a limited period, the quorum will be reduced by one per vacancy.

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional participants and observers will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

<u>Disputes</u>

4.9.3 Where helpful, the board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent Decisions

4.9.4 In the event of extraordinary circumstances requiring urgent decisions to be taken, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply:

4.9.5 The powers which are reserved or delegated to the board may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances (minimum of one other member).

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board (or committee in the case of committee urgent decisions) for formal ratification and Board urgent decisions will be reported to the Audit Committee for oversight.

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be approved by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation

of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press and other members of the public shall be confidential to the members of the board.

5 Suspension of Standing Orders

5.1.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members.

5.1.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.1.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

6 Use of seal and authorisation of documents

6.1.1 The ICB will use a seal for executing documents where necessary.

6.1.2 The seal shall be kept by the Chief Executive or a nominated manager in a secure place.

6.1.3 The following individuals or officers are authorised to authenticate use of the seal by their signature:

- The Chief Executive.
- The ICB Chair.
- The Chief Finance Officer.

6.1.4 The full procedure and other conditions for the use of the seal, including the register of sealing, are included in the Governance Handbook.

Part I ICB Board meeting, 9 May 2024

Agenda Number: 11.3

Board Assurance Framework

Summary Report

1. Purpose of Report

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

2. Executive Lead

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

3. Report Author

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

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

5. Conflicts of Interest

None identified.

6. Recommendation/s

The Board is asked to consider and comment upon the Board Assurance Framework and seek any further assurances required.

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks. This is discharged through oversight of the Board Assurance Framework (BAF) by the Audit Committee which reviews the BAF at each committee meeting. The ICB's main committees also receive excerpts from the BAF in relation to risks within their remit.

2. Risks currently on the Board Assurance Framework

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

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

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

3. Review of ICB Risk Management Arrangements

The annual audit of the ICB's risk management and assurance framework 2023/24 identified 'reasonable' assurance with 1 medium priority recommendation regarding the ICB's risk appetite statement. The ICB's risk appetite statement, which will be incorporated within the Risk Management Policy, is included on the Board agenda for approval.

The ICB continues to implement the RLDatix DCiQ database (Datix) which includes a module to manage risks and the Board Assurance Framework (BAF). All current risks were recently uploaded to the database and work is ongoing to refine the system; set up user accounts and permissions; and design reporting templates. Training on how to use the system will then be provided to directors, risk leads and business managers. Future Board Assurance Reports will be produced via Datix.

4. Recommendation

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

5. Appendices

Appendix 1 - Board Assurance Framework, May 2024.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

May 2024

Contents

- Summary Report.
- Individual Risks - controls, barriers, assurance and actions.
- Main provider risks (MSEFT & EPUT).

BAF Risks – Summary Report

No	Risk and Key Elements	SRO(s)	Key Assurances (further information on individual risk slides)	RAG
1.	**WORKFORCE:** • Workforce Strategy • Primary Care Workforce Development (see Primary Care Risk) • Provider recruitment • Managing the care market	K Bonney	• Regular Workforce reporting to System Oversight and Assurance Committee (SOAC) and People Board • Regional Provider Workforce Return (PWR). • Reduction in unfilled vacancies and Improved attrition and turnover rates. • Reduction in bank and agency usage leading to positive impact on patient safety/quality. • Improved resilience of workforce.	**4 x 4 = 16** ↓
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	P Green	• Patient Survey Results. • Workforce Retention. • Improved Patient to GP Ratio. • Better patient access, experience and outcomes • Consultation data (volume, speed of access), digital tool data (engagement and usage)	**4 x 5 = 20** ↔
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	J Kearton	• Oversight via System Investment Group reporting to ICB Finance Committee. • Delivery of system infrastructure strategy. • Progress reporting on investment pipeline. • Monthly reporting of capital expenditure as an ICS to NHSE.	**4 x 4 = 16** ↔
4.	**UEC AND SYSTEM CO-ORDINATION ('Unblocking the Hospital)** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	E Hough	• Monthly MSE UEC Board monthly oversees programme and reports into SOAC and ICB Board. • MSE Executive Discharge Group oversee patient flow. • Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness 10am system call.	**5 x 4 = 20** ↔
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Dr M Sweeting	• SOAC maintains oversight of performance against all NHS Constitutional Standards. • Diagnostics: MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group. • Cancer: MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust. • RTT: Elective Care Board: MSEFT RTT Long Wait Report. 52+ week waiting list size growth is the significant risk overseen via elective board. Fortnightly meetings with National Team as a Tier 1 Trust.	**5 x 4 = 20** ↔
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	J Kearton	• Preparation of plan position for Board, Regional and National Sign-off. • Development of financial insights through Medium Term Financial Plan. • Overseen by the ICB Finance Committee and the Chief Executives Forum, also discussed at SLFG and Executive Committee. • Internal and External Audits planned.	**5 x 4 = 20** ↔
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	E Hough	• Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE. • Improvement in access and reduction of health inequalities as shown in the performance metrics, of which our priorities are currently being developed. • Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.	**4 x 3 = 12** ↓
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Dr G Thorpe	• CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR. • Reporting to Clinical Quality Review Group. • Outcome of Quality Assurance visits. • Improved flow and capacity, reduction in OOA placements and reduced length of stay. • Mental Health Partnership Board & Whole System Transformation Group (WSTG). • Reports to SOAC to identify key quality/performance risks and action being taken. • Internal Audit of Oversight of MH Services - Reasonable Assurance (Dec 22). • Accountability review with focus on performance	**4 x 4 = 16** ↔

Risk Narrative:	**WORKFORCE:** Risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank/agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (reduced from 20/Red)**
Risk Owner/Dependent:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	BAF Risk Ref:	PO1, MENH12

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against target of 11.55%, vacancies have been improving month on month for 6 months down to 8.9% in February 2024 (from high of 15.6% in July 22). Nursing and midwifery vacancies down to 8.5% (from significant high of 19.1% for nurses & 24.6% for midwives July 22). Medical & dental vacancies down to 7.6% in February 2024 against target of 11.5%. **EPUT:** overall vacancy rate now at 8.5% against 12% target. EPUT on plan for substantive staffing.
TURNOVER: **MSEFT:** Continued downward trend from a peak of 15.6% in August 2022 to 11.1% in February 2024 against target of 12%. Nursing turnover down to 8.8%, midwifery 7.9% (19.1% in July 2022). Medical and dental less improvement - 13.1% against target of 12% (17.5% in July 2022 **). EPUT:** Staff Turnover down to 9.2% against 12% target
BANK & AGENCY: EPUT agency spend in February 2024 is £2.3m lower than Feb 2023, but 7% of the total pay bill so still above the required 3.5%. EPUT are still operating significantly over establishment, currently using unbudgeted temporary workforce to support observation and engagement. Awaiting figures for MSEFT.

How is it being addressed? (Current Controls)

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

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

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

Barriers (Gaps)

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

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

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

Next Steps:

1. Ongoing compliance and control tracking.
2. 2024/5 operational planning to agree affordable staffing levels and commitment to manage to that workforce plan.

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner:	Pam Green – Basildon & Brentwood Alliance, Exec Lead for Primary Care William Guy, Director of Primary Care.	Directorate: Board Committee:	Clinical and Professional Leadership Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, ARRS, Hospital performance, reputational damage.	Risk Register Ref:	CPLPC02, CPLPC03, CPLPC07

Current Performance v's Target and Trajectory

Workforce:

- Additional Roles Re-imbursement Scheme (ARRS): Good progress has been made on the recruitment of ARRS staff: 600 FTEs in place as of March 2024.
- Fellowship scheme: New scheme now in place and first fellows have commenced roles.
- Patient to GP Ratio: Basildon & Brentwood and Thurrock in top 10 worst ratio in country.

Demand/Capacity:

- Patient Experience National Survey: Poor performance locally in terms of access.
- Available Appointments: 7.7% increase on consultations Apr – Dec 24 (vs 2023)
- Impact should be noticeable in the 2023/24 survey (to be published July 2024).

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- Access Recovery Plan – 10 Self-referral pathways established, Cloud Based Telephony roll out to ensure all practices have compliant system by end of June 2024.
- Workforce development e.g. Additional Roles Reimbursement Scheme (ARRS) workforce and practice level initiatives (impact over 3-5 years).
- Additional investment in Digital solutions planned for 24/25 – new scheme expected to go live by June 24.
- Initiatives for new GPs / Partners and to support other roles in Practice Teams.
- Supporting succession planning within GP practices.
- Primary Care Network (PCN) Development.

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

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

Next Steps (and date):

- Cloud Based Telephony (CBT) – Phase 2 roll out to be completed by end of June 2024.
- Integrated Neighbourhood Teams – all INTs expected to go live by end of March 2025.
- Access Recovery Plan – transitional funding for practices – scheme in place, all practices expected to apply by end of September 2024.
- BMA Contract Dispute – continue engagement with Essex Local Medical Committee to understand impact of dispute on local primary care provision (ongoing timeline outside of local control).

Risk Narrative:	**CAPITAL:** Insufficient capital to support all system needs, necessitates prioritisation and reduces our ability to invest in new opportunities, for transformational impact.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer. Ashley King, Director of Finance Primary Care, Financial Services & Infrastructure	Directorate: Board Committee:	System Resources Finance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	BAF Risk Ref:	SREST02

Current Performance v's Target and Trajectory

- Delivering the capital plans as per the investment plan (pipeline).
- Future decisions to be made based on available capital and revenue resources.

Barriers (Gaps)

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

How is it being addressed? (Controls & Actions)

- Developing Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- System Investment Group sighted on 'whole system' capital and potential opportunities to work collaboratively.
- Working with NHSE / Trusts to deliver the benefits associated with the sustainability and transformation plan capital.
- Prioritisation framework for Primary Care Capital now established and under regular review.
- Prioritised list of investments informed submission of the 2024/25 capital plan (submitted May 2024).
- Work commenced on System ICS Infrastructure Strategy

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

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

Next Steps:

- Infrastructure Strategy (indicative July 2024).
- Primary Care Projects Review on-going.
- Training for Board members & executives (senior managers) on capital funding framework (Q1 24/25).
- 2024/25 Capital Plan Development & Submission.

Risk Narrative:```````	**UEC and System coordination (formerly 'unblocking the hospital'):** Risk that ICB and providers organisations are unable to effectively manage / coordinate the capacity across the system and the inability to deliver effective care to patients.	**Risk Score:** **(impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Emily Hough, Director of Strategy and Corporate Affairs Samantha Goldberg, Urgent Emergency Care System Director	Directorate: Committee:	Oversight, Assurance and Delivery. MSE Strategic UEC Board and System Oversight and Assurance Committee (SOAC).
Impacted Strategic Objectives:	Improving and transforming our services.	BAF Ref:	PLAC04 and UNPC05

Current Performance v's Target and Trajectory

Emergency Department performance below constitutional standard, as are ambulance response times, although improvement in reducing ambulance delays 30+ minutes delays across MSEFT. Ambulance demand reverted to pre-pandemic levels. Targets for delivery 78% ED Performance and 90% 30 minute ambulance performance.

Barriers (Gaps)

- Health and Social Care capacity to facilitate discharge into the right pathway impacts on MSEFT flow and community.
- Workforce challenges (See Workforce Risk slide).

How is it being addressed? (Current Controls)

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

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

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

Next Steps

- The UEC & Flow Improvement programme for 2024/25 is a pillar within the MSE Transformation & Improvement Programme reporting into the Executive Discharge Meeting, which is designed to align efforts across the System to optimise both acute and community hospital capacity, increase the provision of alternative care outside the hospital setting, contribute to financial sustainability and improve patient flow. The aim will be to sustain the closure of escalation beds and support the reduction of beds
- Expected outputs from the UEC & Flow schemes to triangulate into the MSEFT bed model, equating to length of stay or admission avoidance reduction to demonstrate overall reduction in bed occupancy – May 2024
- Establish funding source for the continuation of the Unscheduled Care Co-ordination Hub and further deployment of model to maximise alternative pathway direct referrals / attendance/admission avoidance. Evaluation from 2023/24 demonstrated alterative urgent car pathways utilised and reduction in ambulance conveyances. Ongoing and risk of reduced model due to financial constraints.
- Demand and capacity modelling continues with the System Co-ordination Centre undergoing training.
- MSEFT escalation capacity circa 41 beds, by the end of April 2024.
- Reduce Beds occupancy to 92% and reduction in General & Acute core beds July 2024.

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation (Cancer) Aleks Mecan, Alliance Director Thurrock (Diagnostics) Karen Wesson, Director Oversight Assurance (Elective)	Directorate: Committee:	Oversight, Assurance & Delivery. System Oversight & Assurance.
Impacted Strategic Objectives:	Recovery of constitutional waiting times standards for diagnostics, cancer and Referral to Treatment (RTT), achievement of Operational Planning commitments.	BAF Ref(s):	PLAC01, PLAC02 and CANC02.

Current Performance v's Target and Trajectory

Diagnostics: Increased backlog for 13+ weeks, planning submission for 2024/25 is being developed.
Cancer: Waiting times continue not to meet NHS constitutional standards. MSEFT recovering the variance from the 23/24 plan submission in the number of people waiting over 62 days.
Referral to Treatment:

- 65+ week wait: MSEFT updated trajectory to reduce as per Operational ask to meet national expectation.
- 52+ week waits: 2024/25 plan submission to reduce. Required to meet the national expectation position of zero people by March 2025.

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – programme refresh to enable this work to happen – supported by Stewards. Cancer Alliance Service Development Funding (SDF)
- **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.

How is it being addressed? (Current Controls)

Diagnostics:

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

Cancer:

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

Referral to Treatment (RTT):

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

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

- SOAC maintains oversight of performance against all NHS Constitutional Standards/Operational Plan asks.
- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group.
- **Cancer:** MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** Elective Care Board: MSEFT RTT Long Wait Report. 52+ week waiting list size is a significant risk overseen via elective board. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions to be implemented and ongoing)

RTT and Cancer:

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

Operational Planning 2024/25:
System are working on the submission due 2 May 2024.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** The System is financially challenged and is currently in the process of agreeing it's plan for 2024/25. Failure to deliver the financial plan will place increased pressures across the whole system, impacting on our ability to deliver our intended outcomes.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer	Directorate: Committee:	System Resources Finance Committee
Impacted Strategic Objectives:	Financial sustainability	Risk Ref:	SRFO01 and SRFO03, SRPH02, SRPH01, SRFO04

Current Performance v's Target and Trajectory	Barriers (Gaps)
The System is in the process of agreeing its plan for 2024/25. Expectations currently being MSEFT deficit, EPUT deficit, ICB breakeven. Performance against trajectory will be known as we move into Month 2 reporting.	- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery. - System pressures to manage delivery (capacity). - Capacity due to vacancy freeze.

How is it being addressed? (Controls & Actions)

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

How will we know controls are working? (Internal Groups & Independent Assurance)	Next Steps:
• 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.	- Agree trajectory for financial delivery and implement on-going monitoring arrangements. - Delivery of system efficiencies programme for 2024/25. - Refresh risk and narrative following agreement of system financial plan. - Medium Term Financial Plan developed, to inform future planning.

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**4 x 3 = 12 (reduced from 4 x 4 = 16/Red)**
Risk Owner:	Emily Hough, Executive Director of Strategy and Corporate Affairs Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Partnerships Population Health Improvement Board.
Impacted Strategic Objectives:	Reduction of Health Inequalities	**BAF Ref:**	GOSD06, GOSD17

Current Performance v's Target and Trajectory

- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Core20PLUS5 (Adult) inequalities data packs are being actioned by the Alliances.
- Core20PLUS5 (Children & Young People) inequalities data packs are currently being developed by the PHM team and will be shared with the Growing Well Board.
- Population Health Improvement Board will be establishing MSE system priorities. Key metrics and a dashboard will be established over coming months in collaboration with PHM and BI teams.

Barriers (Gaps)

- Capacity and resources to support Prevention and health inequalities programmes when ICB focused on financial recovery
- Availability of Business Intelligence/Population Health Management resource.
- Quality improvement support for interventions.
- Financial resources are not yet sufficiently adjusted to reflect needs of population groups (proportionate universalism).

How is it being addressed? (Current Controls)

- Population Health Improvement Board (PHIB) provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with the Alliances will provide oversight and direct priorities for the £3.4m p.a health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project. Digital EHIIA tool revisions complete following testing. Training and support material developed. Real life testing with small number of projects planned for Q1 24/25. Implementation plan and governance to be established subject to ICB identifying supporting resources.
- Equality Delivery System (EDS) report for 2023/24 published on ICB website that provides follow up on 22/23 actions and assessment of Urgent Community Response Team, Topaz Ward Detox Service and Learning Disability services.
- Health inequalities information statement for the 23/24 annual report completed, with exception of Elective care waiting list analyse due early May 24. Report presents health inequalities data and actions being taken or planned to close the gaps in outcomes.
- Health inequalities funding of £3.4m pa reviewed and reprioritised allowing for one off contribution towards deficit of £1.6m. Alliances funding via trusted partners will be more targeted on specific health inequalities priorities and schemes yet contractually committed will be subject to additional scrutiny and triple lock process.

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

- Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE.
- Improvement in access and reduction of health inequalities as shown in the performance metrics, of which our priorities are currently being developed.
- Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.

Next Steps (Actions to be implemented by March 2024)

- Launch of digital EHIIA tool (May 2024).
- Creation of a health inequalities dashboard (May 2024).
- Improvement in identification of groups at greatest risk anticipated by (June 2024).
- Establishment of 'Equity & Diversity Impact Assessment Panel' to review EHIIA as part of formal governance (June 2024).

Risk Narrative:	**MENTAL HEALTH QUALITY ASSURANCE:** MSE Mental Health (MH) services have been identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on the highest rated risk referred to below)**
Risk Owner/Dependent:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient Experience, Workforce, Reputational Damage	Risk Ref(s):	GOSD15, MHLD01 & 02, MENH04, 11 & 12 (also related to PO1/ Workforce slide)

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators, lack of formal contractual oversight for escalation.
- Demand, capacity and flow issues resulting in long length of stay and continued out of area (OOA) placements of patients above the Long Term Plan (LTP) expectation.
- Significant external scrutiny from media, Care Quality Commission (CQC) / Regulators.
- The Lampard Inquiry (Essex Mental Health Statutory Inquiry) Terms of Reference were published on 10th April with a wider scope and increased timeline which will be looked at.
- Ongoing HM Coroners cases with possibility of Regulation 28 Prevention of Future Deaths Reports (PFDR).
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder (ASD) and wider neuro divergent pathway (NDD).

Barriers (Gaps)

- Strategic approach to all age Mental Health service, however lack of delivery pan-Essex.
- Data Quality issues and IT systems.
- Workforce challenges impacting on all services (see Workforce Risk PO1 - slide 4).
- System pressures to manage delivery (capacity).
- Flow through inpatient services.

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

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

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

- CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR.
- EPUT Reporting to MSE ICB Quality Committee
- Outcome of Quality Assurance visits.
- Improved flow and capacity, reduction in OOA placements and reduced length of stay.
- Mental Health Partnership Board & Whole System Transformation Group (WSTG).

Next Steps:

- Implementation of recommendations from England Rapid Review into Inpatient Services published June 2023 with focus on recommendations which state twelve months (June 2024).
- ICBs working collaboratively across Essex to review the financial risk share agreement on inpatient acute mental health provision to include out of area expenditure (Sept 2024)
- Essex ICBs/EPUT establishing regular contract governance and oversight meetings (first meeting scheduled for May 14th 2024)

Partner Organisation Self Identified Key Risks (and scores)

MSEFT - 11 Red Risks. Risk scores remain the same as per previous report.

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

Partner Organisation Self Identified Risks

EPUT red risks, as of March 2024

5 Red Strategic Risks (all scored 20)

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

1 Red Corporate Risk (scored 20)

- Observation and Engagement

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

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Part I ICB Board Meeting, 9 May 2024

Agenda Number: 11.4

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

Kathy Bonner, Interim Chief People Officer.

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Remuneration Committee

Audit Committee

5. Link to the ICB's Strategic Objectives:

To maintain compliance with statutory functions.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

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

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on revised policies which have been approved by the relevant committees since the last Board meeting.

2. Revised Policies

The following policies have been revised and approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Remuneration Committee 17 April 2024.	040 Stress Management Policy 044 Absence Management Policy 049 Maternity Adoption and Paternity Policy and Paternity Leave Application Form. 041 Flexible Working Policy 048 Special Leave Policy 051 Shared Parental Leave Policy 055 Organisational Change Policy
Audit Committee 16 April 2024.	001 Media Policy 002 Social Media Policy 018 Conflicts of Interest Policy 019 Standards of Business Conduct Policy 020 Lone Working Policy 021 Health & Safety Policy

3. Findings/Conclusion

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

4. Recommendation

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

Part I ICB Board meeting, 21 March 2024

Agenda Number: 11.5

Committee Minutes

Summary Report

1. Purpose of Report

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

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

2. Chair of each Committee

- George Wood, Chair of AC.
- Dr Matt Sweeting, Chair of CliMPC.
- Joe Fielder, Chair of FIC.
- Sanjiv Ahluwalia, Chair of PCCC.
- Neha Issar-Brown, Chair of QC.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

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

Committee Minutes

1. Introduction

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

2. Main content of Report

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

Audit Committee, 16 January 2024

The committee considered reports on the following:

- Board Assurance Framework and Corporate Risk Register, including a deep dive on health inequalities.
- The timetable for production of the ICB's 2023/24 Annual Report and Accounts and month 9 Governance Statement. Delegation for approval of the annual report and accounts by the Audit Committee was escalated to the Board for approval.
- Proposed changes to the ICB Scheme of Reservation and Delegation and other governance documents primarily required as a result of the introduction of the Provider Selection Regime, the ICB restructure, corporate review and changes required for delegation of Specialised Services from NHS England in April 2024, all of which were subsequently approved by the ICB Board at its January meeting.
- The latest iteration of the ICB's Gifts and Hospitality Register, Register of Procurement Decisions, an update on Losses and Special Payments and the Waiver report.
- Emergency Preparedness, Resilience and Response which included information on the System Control Centre function.
- Information Governance report which provided an update on action taken to strengthen compliance with the Data Security and Protection Toolkit during 2023/24.
- Internal Audit and Counter Fraud reports.
- External Audit report.
- Minutes of the ICB's other main committees.
- The committee noted one decision taken between meetings to approve the Provider Accreditation Process and associated policy, and a decision taken by the ICB Board to approve the Heavy Menstrual Bleeding Service Restriction Policy.
- Procurement of the new internal audit service commencing April 2024.

The committee also approved the following:

- The new Freedom to Speak Up Policy and the new Commissioning Policy (Service Restriction).
- An extended review period for the Conflicts of Interest (CoI) Policy and Standards of Business Conduct Policy due to new CoI training being released and pending the outcome of an internal audit of the management of CoI.
- Following consideration of a report on Continuing Health Care (CHC) Amenities, the committee approved the release of the amenities provision of £7.2 million.

Clinical and Multi-Professional Congress, 28 February 2024

The committee considered a presentation on the Weight Management Services and held a discussion on the proposals. There were no other items discussed.

Finance & Investment Committee, 21 February 2024

The Committee considered reports on the following:

- The 'Trip Lock' process which had been implement as a consequence of moving the forecast outturn position at month 9.
- A deep dive on financial risks relating to continuing healthcare.
- An update on specialised commissioning outlining the ICB's preparedness to take on full delegated commissioning of these services from NHS England on 1 April 2024.
- Talking Therapies.
- Month 9 Finance report and a verbal update on the Month 10 position.
- ICB Financial planning for 2024/25.
- Efficiency Programme, including actions being taken to improve the delivery of efficiencies.
- Feedback from System Finance Leaders Group (SFLG) and System Investment Group (SIG) meetings held since the last committee meeting.

The Committee took the following decisions:

- Following receipt of a report on Adult Social Care Discharge Fund, the committee agreed the 2024/25 discharge fund budget.
- Approved a new contract to be awarded to Provide for Tier II services out of scope of the Community Collaborative to the value of £6.7 million.
- Endorsement of the Electronic Patient Record Full Business Case.

Finance & Investment Committee, 14 March 2024

The Committee considered reports on the following:

- Financial risks.
- Update on ICB financial budgets, noting that an extraordinary FIC meeting would be scheduled for the sign-off of the 24/25 ICB financial budgets.
- Update on the 2024/25 system financial plan.
- Month 10 finance report and a verbal update on Month 11.
- Update on system efficiency programme.
- Minutes of SFLG and SIG meetings held since the last committee meeting.

The Committee took the following decisions:

- Endorsed and supported a 2-year extension of the existing pathology joint venture contract from October 2024 to October 2026 and agreed to the additional cost of £8.4m impact (over 2 years) under 'Triple Lock' protocols, to be further approved by MSEFT and the NHSE Regional Team.
- Recommended the approval of governance arrangements for the delegation of specialised commissioning to the Board.
- Recommended a procurement route to be considered by the Board for the Community contract.

Finance and Investment Committee, 11 April 2024

This meeting was held to sign-off the ICB budgets. An update was also provided on the financial outturn for 2023/24.

Primary Care Commissioning Committee, 29 February 2024

The committee receive reports on:

- Legal advice sought in relation to a potential change in control of a GP service.
- Dental contracts.
- Primary care quality and patient safety.
- The minutes of the Dental Commissioning and Transformation Group held on 15 December 2023.

The committee also took the following decisions:

- Approved the intention to commission local enhanced services (LES) via General Medical Services (GMS) / Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts from 1 April 2024.
- Approved the intention to extend contracts with several providers to continue existing provision of equivalent LES for 2024/25 or until mutual agreement that this arrangement was no longer required (NB: no later than 31 March 2025).
- Approved the national inflator of 3.45% to be applied to enhanced services.
- Approved the transfer of Disease-modifying antirheumatic drugs (DMARD) and Warfarin arrangements currently managed through Mid and South Essex Hospitals NHS Foundation Trust (MSEFT) into the ICB's local enhanced service commissioning arrangements (subject to Triple Lock approval).
- Approved the inclusion of adult attention deficit hyperactivity disorder (ADHD) prescribing within the enhanced monitoring service from April 2024 (subject to Triple Lock approval).
- Approved the continued commissioning of local transformation schemes, in line with previous commitments subject to further discussions regarding funding.
- Supported the proposal to invest £50k into improving primary care resilience by supporting the development of the newly formed Primary Care Collaborative (the Collaborative), (subject to Triple Lock approval).
- Supported escalation of the delays in approval of the Premises Development Scheme at a Medical Centre new build, and house extension to NHS England.
- Approved the subsidy of service charges, to the level of 85% (an indicative impact to the ICB of a net £21k per annum) for a GP Surgery to support the proposed additional primary care capacity at Halstead Hospital. This will remain in effect for two years before being reviewed.
- Approved plans to (a) continue to work with Chelmsford City Council and the Chelmsford Garden Community (CGC) for the provision of temporary and permanent healthcare facility, and (b) begin the development of a business case for provision of primary care services in the proposed CGC.

Quality Committee, 23 February 2024

The committee received reports / presentations on the following:

- Lived experience story / deep dive into Sepsis.
- Work undertaken by the Safety Quality Group.
- Emerging safety concerns, including an update on enactment of Martha's Rule.
- Escalations from the ICB Board or System Oversight Assurance Committee, including how performance metrics for mental health were scrutinised.

- The executive summary of the nitrous oxide serious incident independent investigation.
- MSEFT Acute care update.
- Community Collaborative update.
- Primary Care update.
- Infection Prevention and Control update.
- Special Educational Needs and Disabilities update.
- Neurodiversity (Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD)) update.
- Patient Safety and Quality risks.
- An update on arrangements to review the effectiveness of the committee and development of the committee's workplan for 2024/25.
- Discussions regarding how lessons were learnt following serious incidents in maternity services were also held under any other business.

The committee also approved revised policies as follows:

- ICB Prevent Policy (Ref 071), Safeguarding Supervision Policy (Ref 064).

3. Recommendation

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

Minutes of the Audit Committee Meeting

Held on 16 January 2024 at 1.00pm

Via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

Other attendees

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Tendai Mnangagwa (TM), Deputy Director of Finance for Financial Services & Management, MSE ICB.
- Darren Mellis (DM), Senior Financial Control Manager, MSE ICB.
- Jane King (JKi), Corporate Services and Governance Support Manager (Minute Taker), MSE ICB.
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- Judith Low (JL), Senior HR Partner, MSE ICB (for Item 4).
- Emma Timpson (ET), Associate Director Health Inequalities and Prevention, MSE ICB (for Item 6).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (for Item 11 and Item 14).
- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB (for Item 15).
- Caroline Lowe (CL), Deputy Director for All Age Continuing Care, MSE ICB (for Item 12).
- Emma Larcombe (EL), Director, KPMG LLP.
- Nathan Ackroyd (NAc), Senior Manager, KPMG LLP.
- Zoe Picken (ZP), Head of Internal Audit, WMAS.

Apologies

- Michael Townsend (MT), Managing Director, Barts Assurance (representing WMAS)
- Eleni Gill (EG), Lead Counter Fraud Manager, WMAS.

1. Welcome and Apologies

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

2. Declarations of Interest

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

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

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the last meeting of the ICB Audit Committee on 10 October 2023 were received.

Outcome: The minutes of the meeting held on 10 October 2023 were approved as an accurate record.

GO highlighted that his title should read Associate Non-Executive Member on the list of Audit Committee Members included on the agenda for the meeting on 16 January 2024.

The Committee reviewed the updated Action Log.

GW was concerned that action 48 was overdue and requested that the mental health representatives were invited back to the next Audit Committee to provide an update on the mental health risk and that the overdue action was escalated to the responsible Executive Lead. JKe confirmed that, following the organisational restructure, the Executive Chief Nurse was responsible for mental health services.

ACTION: Invite mental health representatives to the next Audit Committee to provide an update on the mental health risk. Escalate the Committee's concern around the overdue action to the Executive Chief Nurse.

4. Freedom to Speak Up Policy

JL presented the new Freedom to Speak Up (FTSU) Policy, following the NHS England requirement for systems to adopt the national FTSU Policy by the end of January 2024. Guidance was also issued around ICBs' roles in system assurance and expectations for system FTSU arrangements.

GW stressed that the FTSU policy should be intrinsic to the ICB's culture and requested that the policy was added to the Executive Team agenda to ensure it was shared with directorates to raise awareness. JL confirmed there were a number of opportunities within the organisation to embed the FTSU policy, and other policies, including the corporate induction programme.

ACTION: Add FTSU policy to Executive Team agenda and ensure policy is disseminated by executives to directorate colleagues to ensure awareness across the organisation.

GO welcomed GW in the role of FTSU Guardian and recommended that in due course the policy was reviewed for its effectiveness. GO also enquired whether trade unions had been

involved in the policy's development. JL confirmed she would work with the FTSU Guardian and Champions on themes and response times which would provide an indication of the policy's effectiveness which would be communicated to the Executive Team. JL agreed that, if not already undertaken, unions would be briefed on the ICB's FTSU policy.

GW confirmed that effectiveness of the FTSU policy, along with staff survey results and details of any arising actions would be shared with the Board. NA advised that the Board had delegated policy approval to the relevant sub-committees, therefore the FTSU policy did not require Board approval.

Outcome: The Committee APPROVED the Freedom to Speak Up Policy.

5. Board Assurance Framework and Corporate Risk Register

NA presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 16 November 2023. The BAF would also be submitted to the next Part I ICB Board meeting on 18 January 2024. There were 8 ICB red rated risks outlined in the BAF.

A copy of the Corporate Risk Register was also presented to the Committee, which detailed 53 risks. There were 4 new risks added to the Risk Register; 1 red rated risk and 3 amber rated risks.

The paper outlined one Quality risk recommended for closure by the relevant lead. There were no concerns raised prior to the relevant committee being asked to formally approve its closure and it was noted that closed risks could be reopened at any time.

GO enquired how often the workforce issues were reviewed. NA advised that the BAF was regularly updated by the relevant leads, however if GO had any specific workforce questions, they could be taken back to the Chief People Officer. GW confirmed that workforce issues were regularly discussed at the System Oversight and Assurance Committee (SOAC) meetings. JKe added that a Workforce working group had been established which included Finance and HR teams which fed into, and supported, SOAC workforce conversations. JKe stressed that it was a key system priority to reduce bank and agency costs.

GW suggested it would be useful to view BAFs, including risk levels, from other local ICBs for comparison and requested EL to obtain these.

ACTION: EL to obtain the BAF, including risk levels, from other local ICBs for comparison.

Outcome: The Committee NOTED the Board Assurance Framework and Corporate Risk Register update.

6. Risk Deep Dive – 'Health Inequalities'

GW welcomed ET to the meeting to present a deep dive into the Health Inequalities risk and provide assurance to the committee that there was a plan with appropriate metrics and milestones in place to mitigate the risk.

The inequalities risk was associated with the identification of groups at most risk of experiencing health inequalities and action was being taken to reduce these by improving access and outcomes.

ET explained that the Population Health Improvement Board (PHIB), along with the Alliances, would provide oversight and direct priorities for the health inequalities funding. The PHIB reported to the MSE Integrated Care Partnership and ICB Board.

Key metrics and a dashboard would be established over coming months in collaboration with Public Health Management and Business Intelligence teams. The ICS had developed an integrated data set that collected data from across the health and care system to enable a greater understanding of our population need. Additionally, the Core20plus5 framework for Adults and Children and Young People provided insight into where health inequalities existed at Alliance and Primary Care Network (PCN) level which helped to develop targeted programmes of work. A system wide ImpactEQ tool was due to be rolled out to ensure a consistent approach to tackling health inequalities. An ICB 'Equity Panel' was to be established to consider and sign off Health Inequalities Impact Assessments. Evaluation would be embedded into decision making for health inequality schemes as well as being driven by data analysis.

The committee agreed that a system wide focus on the top three health inequalities priorities was required in order to make a substantial impact. MH stressed it was important to link in with local authorities as there was already lots of health inequalities work being undertaken.

GW commented that the ICB needed to identify the amount of funding required to improve the top health inequalities projects. JKe advised there were system development funds to address health inequalities. Consideration would also be given during budget planning for the following year to ensure funds were linked to health inequalities.

GO suggested that new ways of working needed to be identified, e.g., having demographic champions to work with and build trust with communities.

GW enquired how initiatives working well in one area could be widely shared and gave the example of a cost-of-living leaflet & baby bank initiative rolled out in Southend. ET agreed to consider how this could be done.

NA asked whether there was any feedback or additions required on the risk review template and whether there were any areas of focus required for future meetings. GW commented that it would be useful to understand the work undertaken with stakeholders across the system within the template. GW said that the risk reviews were data driven and a work in progress, therefore the template may require further iterations.

ACTION: Incorporate work undertaken with stakeholders across the system within the template.

JKe commented that a changed approach to health inequalities was being considered to provide wider opportunities across MSE.

Outcome: The Committee NOTED the deep dive presentation on the Health Inequalities Risk.

7. Annual Report and Accounts Timetable and Month 9 Governance

NA presented the paper which provided an update on the draft timetable for preparation and governance approval of the ICB Annual Report and Accounts and Month 9 Governance Statement.

The ICB was required to submit a Month 9 Governance Statement outlining any key risks likely to be included in the Annual Report. NHS England had recently made the Governance Statement template available for completion which would be approved by the Executive Team and shared with the Audit Committee. TM highlighted that the NHSE submission on 24 April 2024 would also include the draft Annual Accounts.

EL expected that KPMG would complete the Annual Report and Accounts audit by 13 June 2024 and the final sign-off would be near the end of June 2024. The committee agreed to request delegation for the approval of the Annual Report and Accounts from Board at the ICB Board meeting on 21 March 2024.

GW commented that it would be ideal to have fewer iterations of the Annual Report than the previous year.

ACTION: Request delegation from the ICB Board to the Audit Committee for the approval of the Annual Report and Accounts at the ICB Board meeting on 21 March 2024.

Outcome: The Committee NOTED the update on the timetable and governance for the ICB Annual Report and Accounts.

8. Updated Governance Documents

NA presented the paper which outlined the changes to the ICB Scheme of Reservation and Delegation (SORD) and other governance documents resulting, primarily, from the introduction of the Provider Selection Regime (PSR), but also took account of changes resulting from the ICB restructure, the corporate review and changes required for delegation of Specialised Services from NHS England from April 2024.

A key change was the introduction of the Executive Team as a formal committee of the Board with delegated powers to approve financial spend which would enable robust and agile decision making. As a result, the value of business cases presented to the Finance and Investment Committee was increased.

Changes to the SORD enabled formal delegation of accountability for the management of the Better Care Fund to Alliances. There was also some consolidation of how the detailed delegated financial limits were presented and clarity over the governance around committing expenditure and signing contracts, as well as some aspects of delegated functions performed by individuals such as the specific statutory roles overseen by the Executive Chief Nurse. The changes were supported by the Executive Team and Finance and Investment Committee.

JKe advised that a group to review investment and disinvestment decisions was required, however it was essential that stakeholder engagement must first be undertaken. Financial planning for 2024/25 was underway which would also consider commissioning intentions. NA highlighted that the Decision Making Policy would support initial investment considerations before business case recommendations were made for consideration.

In response to GW, EL explained that the Value for Money audit did not explicitly look at how money was spent, but would look at the governance around decision making.

GO enquired whether the changes in governance were based on national guidance. NA explained the Provider Selection Regime (PSR) was a change in legislation and procurement advisors supported the ICB to comply with legislation.

GW thanked NA and commented that a good piece of governance work had been undertaken.

Outcome: The Committee -

- **APPROVED** the revised Scheme of Reservation and Delegation, recommending to the Board for approval.
- **APPROVED** the revised Procurement and Contracting Policy.
- **APPROVED** the revised Standing Financial Instructions.
- **APPROVED** the establishment of and terms of reference for the PSR Review Group as a sub-committee of the Finance & Investment Committee, recommending to the Board for approval.
- **SUPPORTED** the principle of collaborative working under a memorandum of understanding (to be developed) with the EoE ICBs to provide independent members for the PSR Review Group.
- **APPROVED** the establishment of and terms of reference for the Executive Team Committee as a formal sub-committee of the ICB Board, recommending to the Board for approval.
- **APPROVED** the revised terms of reference of the Finance & Investment Committee recommending to the Board for approval.
- **NOTED** that revisions have been made to the business case template and contract governance documents created to support the implementation of PSR.

9. Policy Approval

Commissioning Policy (Service Restriction)

NA presented the new Commissioning Policy (Service Restriction) which ensured that the ICB funded treatment only for clinically effective interventions delivered to the right patients. It set out the overarching framework and governance process to support commissioning decisions and identification of treatments deemed to be of insufficient priority to justify funding from the available budget. For a number of commissioned treatments, the ICB had specific policy statements setting out restrictions on access, based on clinical evidence of effectiveness or relative priority for funding. These were known as Service Restriction Policies. The Commissioning Policy also sets out the governance of how the ICB revisits decisions to restrict services.

There were no questions or comments.

Outcome: The Committee APPROVED the Commissioning Policy (Service Restriction).

MSE ICB Policies for Review

NA presented the rationale for the request to extend the policy review timescales for two Governance policies because of the capacity within the team due to the restructure. Additionally, the outcome of a recent Conflicts of Interest internal audit and the release of new Conflicts of Interest training may also have an effect on the requirements of the policies requiring review. Delaying the review would ensure the policies were fully up to date.

There were no questions or comments.

Outcome: The Committee APPROVED an extended review period for the Conflicts of Interest Policy and Standards of Business Conduct Policy until end April 2024.

10. Gifts and Hospitality Register

NA presented the MSE ICB Gifts and Hospitality Register which detailed a record of any declarations made by staff in relation to gifts and/or hospitality whether accepted or declined. A reminder was published in the Connect Newsletter on 6 December 2023 for the requirement for staff to re-familiarise themselves with the ICB's Conflicts of Interest Policy, which includes guidance on when gifts and hospitality may be accepted or must be refused. Staff were also asked to declare any offers or gifts, or hospitality made to them for inclusion in the ICB Gifts and Hospitality Register. The latest Gifts and Hospitality register would be made available on the ICB website following review by the Audit Committee.

JKe requested a check was undertaken to ensure Stewards were aware of the ICB's policy around gifts and hospitality.

ACTION: NA to ensure that Stewards were aware of the ICB's policy around gifts and hospitality.

The Committee noted the outcome of the recent internal audit of conflicts of interest was awaited.

Outcome: The Committee NOTED the Gifts and Hospitality Register.

11. Contract Governance

JJ presented the Register of Procurement Decisions taken, either for the procurement of a new service or any extension or material variation of a current contract. The Register detailed the 60 procurement decisions logged for Mid and South Essex Integrated Care Board between 20 September 2023 and 15 December 2023. A report detailing grant awards and other financial arrangements agreed with partner stakeholders was also presented to the Committee.

The Provider Selection Regime (PSR) came into force on 1 January 2024 and must be applied when procuring healthcare services. Each procurement process must be run, and award decisions made, under the law as applicable at the point at which that process began. This applied even if the process was ongoing and completed after PSR had taken effect. An independent panel would be set up by the Government to oversee disputes arising from decisions made under PSR to help ensure that procurement processes were transparent, fair, and proportionate.

Following the ICB re-structure, there was no longer a central contract governance function, however internal processes had been revised, setting out the new mechanism and governance forms for the award and extension of healthcare and non-healthcare contracts across the ICB. The responsibility for producing future waiver reports and the register of procurement decisions would transfer to Attain. Additional support would be provided by Attain to assist with the introduction of the PSR. Internal governance and processes had been reviewed and updated to support the requirements of PSR which would need to be monitored and reviewed regularly to ensure compliance with the SORD, the Procurement and Contracting Policy and the new requirements under PSR.

The Committee noted that robust governance would become more important and subject to greater scrutiny under PSR where transparency of decision making was a key component of the reforms.

GO enquired whether decisions made under PSR would be included on the Register of Procurement Decisions presented to the committee and whether any procurement challenges would be reported on the register. JJ confirmed the register would include details of all procurements; the waiver report would cover non-healthcare services.

ACTION: Ensure procurement route detail was included on future Procurement Registers.

JJ advised that the acute low value, low volume contracts on the Procurement Register were not new services and that the ICB were associates to the contracts, but for accuracy all were included and recorded.

NA suggested that an annual report on procurement challenges could be included in the committee work programme if necessary.

In response to GO, JKe confirmed there was a role for grants. A standard NHS grant paperwork was available but further work needed to be done on this. JJ added that a trusted partner approach had been implemented this year for small providers.

MH noted that delegated support commissioning budgets were not covered by PSR and procurement arrangements. JKe explained there were internal governance arrangements in place for delegated support commissioning budgets and suggested sharing Better Care Fund/Section 75 information with the Audit Committee could be part of the new year reset.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

Outcome: The Committee NOTED the Contract Governance update.

12. Continuing Healthcare (CHC) Amenities

CL presented the paper which provided an update on the Continuing Healthcare (CHC) Top Up (amenities) Charges and to request release of the amenities provision of £7.2m originally created to meet potential claims for redress. Claims to-date had been insignificant and it was proposed to release the full provision as it was no longer required.

EL commented that the Continuing Healthcare (CHC) Top Up (amenities) Charges would need to be reviewed as part of the year end audit.

Outcome: The Committee APPROVED the release of amenities provision of £7.2m.

13. Losses and Special Payments

JKe advised that the ICB Board had approved three administrative write-offs and one payment in relation to a claim for interest on late payment of commercial debts. The total administrative loss in relation to three invoices written-off was £1,840.10. The write-offs were approved by the Chief Finance Officer, in line with the ICB's Standing Financial Instructions. A sum of £591.39 was also paid in relation to a claim relating to late payment of commercial debts by Southend CCG in 2020/21.

Outcome: The Committee NOTED that the ICB had written-off three invoices with a total value of £1,840.10, which will be recorded as an administrative loss, and made one payment of £591.39 in relation to a claim for late payment of commercial debts.

14. Waiver Report

JJ presented the Waiver Report. There were 22 new waivers authorised during the period 20 September 2023 to 15 December 2023, totalling £49,638,788. It was noted that £46m related to the rapid access services provided by Farleigh, St Luke's and Havens hospices.

All waivers were reviewed by the Purchase of Healthcare Team and the ICB procurement partner (Attain) prior to requesting authorisation from the Executive Chief Finance Officer. Waivers for health services were expected to reduce following the introduction of PSR.

Outcome: The Committee NOTED the Waiver Report.

15. Emergency Preparedness Resilience & Response

JC presented the Emergency Preparedness Resilience & Response (EPRR) quarterly report. Following the internal audit in Q4 2022/23 (to ensure appropriate processes were in place to manage the ICB EPRR responsibilities and included the System Control Centre function), the actions as a result of the 'requires improvement' outcome had been completed.

As part of the Annual EPRR Assurance process, the ICB was required to demonstrate it could deal with a wide range of incidents and emergencies that might affect health or patient care while maintaining services through its compliance with the NHS Core Standards for EPRR. As a 'Category 1 Responder', the ICB must also ensure the local NHS and commissioned providers were also compliant with relevant guidance and standards. The NHS England EPRR Assurance Letter, which set out levels of compliance for the ICB and its providers, showed all but one provider was compliant with the core standards. The EPRR Team were working closely with the provider to support them to move from non-compliance to partial compliance by 31 March 2024.

JC advised that the impact of the recent industrial action on patient care was being collated, which would include identifying whether there were any patient safety issues for maternity services, a concern raised at the last Audit Committee meeting. A comprehensive debrief process with system partners was also due to take place following the conclusion of the latest industrial action. GW was assured that the impact of industrial action on patient

safety was on the team's radar, therefore there was no need to further update the Audit Committee.

JC advised that the internal risk register from Braintree District Council covering the Wethersfield premises was still awaited.

There were no questions raised.

Outcome: The Committee NOTED the EPRR update.

16. Information Governance

IGe presented the quarterly Information Governance (IG) report which provided an overview of the work undertaken on the recommendations following the Data Security & Protection Toolkit (DSPT) audit to strengthen compliance for 2023/24, following the 'Standards Not Met' submission for 2022/23. The team were working with internal auditors on the remaining actions from the audit and deadlines had been extended to the end of February 2024.

Minor changes had been made to the IG Framework and Policy which was presented to the Committee for approval. The framework and toolkit had been reviewed and approved by the IG Steering Group and would be used as evidence against the 2023/24 DSPT.

GO noted there had been two FOI breaches reported in Q3 and enquired if there was any impact as a result. IGe explained that the cause of the breach had been identified and the lessons learned had been shared to avoid it happening again.

The Audit Committee noted that the 2023/24 DSPT did not require 95% IG training compliance, as previously required.

In response to GW, IGe confirmed that the ICB did have a Cyber Security procedure in place. JC added that a system wide Cyber exercise was planned for March 2024.

Outcome: The Committee NOTED the Information Governance update.

17. Internal Audit

ZP presented the Internal Audit Progress Report which provided an update on the ICB's internal audit service and progress made against the Internal Audit Plan for 2023/24. The Financial Governance audit was complete and gave an opinion of substantial assurance. An internal audit of Key Financial Systems was planned for Quarter 4 2023/24, which would include testing of the application of controls to further support the Head of Internal Audit Opinion.

The original Information Governance audit (agreed as part of the Internal Audit Plan for 2023/24), was replaced with a Fit and Proper Persons Test (FPPT) audit following updated guidance from NHS England which required internal audit to assess the processes, controls and compliance supporting the FPPT assessments every three years. The ICB believed it had sufficient assurance around Information Governance following the DSPT: Management Processes internal audit finalised in March 2023 with 'reasonable' assurance and two management actions which were implemented immediately. Furthermore, a full audit of the DSPT (V6) was planned for March 2024.

Follow up work had resulted in 19 management actions being closed following validation of evidence since the last Audit Committee meeting in October 2023. As of 31 December 2023, no management actions were overdue, 4 were to be implemented by the end of January 2024 and the remaining 11 were due later in the year.

Outcome: The Committee NOTED the Internal Audit follow up position.

18. Counter Fraud

ZP presented the Counter Fraud progress report on behalf of EG, noting that since the last report 66 of the 70 planned proactive days had been delivered as well as all of the 5 planned reactive days.

Since the last Audit Committee update there had been 3 investigations closed and 2 new investigations opened. A further two Primary Care referrals had been received, 1 was being investigated by the Essex Police and did not affect the ICB and the other related to potential pharmacy fraud and had been forwarded to NHS England.

JKe advised that EG was looking into the possible reasons for an increase in referrals in primary care, which had also been seen in other ICBs.

JKe acknowledged that TM would be leaving the organisation and took the opportunity to thank TM for her hard work and support. Natalie Brodie would be stepping into the ICB's Counter Fraud role.

JKe and EG were looking into governance around Personal Health Budgets.

Outcome: The Committee NOTED the Counter Fraud progress report.

19. External Audit

EL presented the KPMG update which reported that the Mental Health Investment Standard expenditure (for year to 31 March 2023) testing was underway and planning discussions had commenced ahead of the audit of the ICB for the year ended 31 March 2024. The full audit plan and Value For Money risk assessment would be presented at the next Audit Committee.

It was anticipated that the vast majority of audit work would be undertaken by the end of May 2024 and completed in June 2024. Annual Report and Accounts would be signed by end June 2024.

Outcome: The Committee NOTED the update from External Audit.

20. Minutes of other ICB Committees

It was noted that a summary of the minutes of other ICB Committees was presented to Board. The following minutes were presented for information:

- Minutes of the Primary Care Commissioning Committee - 4 October 2023
- Minutes of the System Oversight & Assurance Committee – 11 October 2023
- Minutes of Quality Committee – 27 October 2023
- Minutes of Primary Care Commissioning Committee – 1 November 2023

- Minutes of the Finance & Investment Committee – 22 November 2023.

Outcome: The committee noted the minutes of other ICB Committees.

21. Decisions outside Audit Committee

The Committee noted the decision taken to approve the following in between scheduled Audit Committee meetings:

Provider Accreditation Process and associated Provider Accreditation Policy – ICBs were mandated by NHS England to accredit new Providers for services where the legal rights to choice applied under the Procurement Patient Choice and Competition Regulations (PPCCRs). This predominantly related to elective, consultant led services within the population catchment area.

22. Board decisions

The Committee noted the decisions taken to approve the following in between scheduled Board meetings:

Heavy Menstrual Bleeding Service Restriction Policy - to update the Heavy Menstrual Bleeding Service Restriction Policy to include the choice of myomectomy for fibroids where a woman wishes to preserve her fertility, subject to shared decision making between the women and their specialists.

23. AOB

There was no other business.

24. Items to Escalate

To Board:

- Scheme of Reservation and Delegation.
- Establishment of and ToR for the PSR Review Group.
- Establishment of and ToR for the Executive Team.
- Revised ToR for the Finance & Investment Committee.
- Delegation for approval of Annual Report & Accounts to the Audit Committee.

25. Date of Next Meeting

1.00pm – 3.00pm, Tuesday, 16 April 2024.

Meeting finished at 3.11pm.

A Part II confidential session was held with Members only regarding the procurement of a new Internal Audit Services to commence from April 2024.

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 28 February 2024 at 09.30 am – 10.35 am

Via MS Teams

Members

- Peter Scolding (PS), Assistant Medical Director (Deputy Chair).
- Fatemah Leedham (FL), Pharmacy.
- Olugbenga Odutola (OO), Primary Care.
- Gerdalize Du Toit (GDT), Community Care.
- Babafemi Salako (BS), Primary Care
- Holly Middleditch (HM), Senior Clinical Fellow.
- Krishna Ramkhelawon (KR), Public Health.
- Feena Sebastian (FS), Mental Health.

Attendees

- Emma Timpson (ET), Associate Director for Health Inequalities and Prevention, MSEICB.
- Sarah Hurst (SH), Programme Manager for Integrated Weight Management, MSEICB.
- Helen Chasney, Corporate Services & Governance Support Officer, MSEICB (Minutes).

Apologies

- Matt Sweeting (MS), Interim Executive Medical Director (Chair).
- Rachael Marchant (RM), Primary Care
- Christopher Westall (CW),
- Sarah Zaidi (SZ), Primary Care.
- Gavin Tucker (GT), Senior Clinical Fellow. MSEICB.
- Donald McGeachy (DM), Urgent and Emergency Care.
- Stuart Harris (SH), Acute Care.

1. Welcome and Apologies

PS welcomed everyone to the meeting and apologies were noted as listed above. It was confirmed that the meeting was quorate.

2. Declarations of Interest

PS 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 31 January 2024 were approved.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 31 January 2024 were approved.

4. Matters Arising

There were no matters arising.

5. Weight Management Services (WMS) proposal – Presentation

ET explained that the proposal relates to the options appraisal around Tier 3 Weight Management Services (WMS) and requesting members review the specialist support which is commissioned by the ICB.

ET reported that Obesity prevalence was significant in the mid and south Essex (MSE). Data from the Quality and Outcomes Framework (QOF) showed a strong correlation between rates of obesity and deprivation levels and on average more than 13% of the population had a BMI of 30 or above. Data from the self-reported survey showed that at district level, a third of the adult population reported as obese and two thirds as overweight, however this figure does vary but was increasing and placing growing demand on WMS.

There were currently two commissioned providers of Tier 3 WMS in MSE which reflected historical CCG commissioned arrangements, with a total of with 447 places. A procurement process would begin this year to commission one provider, for the service to begin on 1 April 2025. It was noted that increase in demand for this service could be due to several factors; the national GP enhanced payment scheme for referrals into either Tier 2 or Tier 3 WMS and an increased public awareness of the weight loss medication called Wegovy. NICE had stipulated that the delivery of the drug needed to be supported with a specialist weight management programme, which included the behavioural change element. Locally, awareness and accessibility to Tier 2 services continue which were commissioned by local authorities.

In December 2023 the ICB Executive Committee approved temporarily pausing referrals to Tier 3 WMS, whilst the access criteria and management of demand was reviewed. At that time the waiting list held 2,500 patients which equated to a waiting time of over three years and would have continued to increase if the same access criteria were applied. All patients on the waiting list have been contacted and provided support and access to alternative services.

Congress were being asked to make recommendations on the appropriate access criteria for Tier 3 WMS and should demand increase above forecast levels, consideration of an optional criteria that may be based around prioritisation of people applying the index of multiple deprivation (IMD).

In terms of the development of the additional criteria, a small group of multi professional

representatives reviewed and modelled the criteria to meet the best needs of the population for the commissioned 447 places per annum.

Two staging criteria were considered, and a modified version of the Kings criteria was the preferred model. The criteria had been modelled to determine the size of the eligible and subsequent referrals. The data for those patients had been reviewed with practices who were sharing data 92-93% and where relevant coding was in place for BMI and other co-morbidities, so could model the likely demand by applying that criterion. There were some limitations in the data quality and therefore would be making assumptions on the data that was available.

SH advised that the current criteria for Tier 3 WMS was adults 18 or over, BMI>35 with Type 2 diabetes or another obesity related condition or BMI>40 without significant co-morbidities or BMI>27 for BAME service users.

The different options for the service access criteria were as follows:

Option 1 – Individuals with BMI >40 and should meet at least 1 of the following criteria to be eligible as documented in the report, Respiratory condition; Cardiovascular condition; Type 2 Diabetes; Subfertility; or Oesophageal condition.

The exclusion criteria would be the same as the current Tier 3 WMS.

If this criterion was applied, 10,500 individuals would be eligible, with 530 referrals, based on 5% referral rate, and if drop our rates were included, there would be an expected figure of around 345. However, there was an expectation that the referral rates would increase, so a referral rate figure of 10% had also been included.

Option 2 – Individuals with BMI >35 and should meet at least 3 of the criteria as in Option 1 but would be at an earlier stage.

If this criterion was applied, 4,500 individuals would be eligible, with 234 referrals, based on 5% referral rate. The numbers were low compared to capacity but there was a significant difference in numbers if the criteria met was amended to 2 and the service would have been oversubscribed, particularly when based on the assumption that referrals could increase.

Health Inequalities was reviewed in relation to the criteria, as the modelling may not have matched up to the commissioned capacity. If demand exceeded capacity, would deprivation be considered in order to prioritise individuals. Option 1 was reviewed if the 3 or 4 most deprived quintiles of the population were applied and how that would impact the numbers. This was considered for option 2 as the numbers were already under capacity. Additionally, modelling was completed with numbers for both options with the population deprivation and ethnicity breakdown.

PS summarised that there were two main areas for discussion; recommendations on service access criteria with two different options provided, based on the individual higher risk group or the lower group where intervening would be done earlier, and to also consider whether to utilise IMD to support with prioritising the waiting list, following the application of the service access criteria.

6. Weight Management Services (WMS) – CliMPC discussion

PS asked what the likelihood of the 10% referral rate was and how would the high numbers

be managed. ET explained that for option 1, a 5% referral rate would be 345 places, with a commissioning envelope for 447, so would allow for some element of growth. It was likely that growth would reach that level as obesity levels were increasing and a significant proportion were not accessing the weight management services. The demand would be closely monitored, and consideration would be given to refining the criteria. There was national movement with regards to Wegovy access, and GP prescribing was currently being piloted. The re were also other weight management services medications being introduced and was currently a rapidly changing field so could only model on current aspects with a view to the broader changing environment.

PS suggested that it would be beneficial to identify who would not now have access that previously did and who has gained access. The major differences would then be which population group would be prioritised.

GDT asked if the referral rate was consistent across groups of people as it seemed that people with complex health needs could have a lower referral rate and was there a deprivation score for people who were eligible. SH advised that data regarding patients with more complex needs being referred in was not currently held. Modelling was completed on referrals compared to the demographics in our population, which looked at ethnicity and deprivation, compared to the number of referrals received, which broadly matched, so were confident from an equalities point of view that a large chunk of people were not missed. PS advised that the equalities impact detailed that people with learning difficulties and severe mental health issues had a higher risk of being overweight, but the evidence of the difference in the completion rate was not detailed. SH advised that both providers had a readiness for change process and would also be included in the procurement for the new service. One provider advised that if they based their prioritisation on readiness of change, they would potentially exclude some individuals from more deprived areas. GDT suggested that consideration may be needed for people in greater deprivation that could have a lower readiness for change score.

In response to a query from KR, SH confirmed that areas such as mental health would not be excluded and if the individual's mental health was stable, they should be eligible to access the programme.

KR asked for clarity on the growth and how soon could there be the increase in demand and what would be anticipated over the next three years. ET advised that there was an increase in demand over the summer up to September 2023, which aligned with the NICE announcement of Wegovy. The demand had levelled out, however there was an awareness of growing waiting lists potentially in primary care. The period had not been long enough to have the confidence to model three years in the future, and reasonable growth had been allowed for the option 1 solution.

KR asked how the demand would be managed as there was an expectation that primary care would be doing more in terms of referral into the service and how would the most deprived areas be targeted. ET advised the tier 2 services and the national service offers had been reviewed and there was capacity around the digital WMS offers which is underutilised. Work has been done to ensure that primary care was aware of that service offer. Some of the demand could be managed through other routes, such as diabetes programme of work and support. The proactive working and targeting areas of low deprivation would be an ongoing piece of work, which would be included in the procurement evaluation criteria on how the providers would flex their offer to meet the needs of the most deprived population.

KR noted that the Tier 2 service was significantly underused from primary care and must work with the Primary Care Networks (PCNs), if the most deprived areas were being targeted, so there is a support mechanism for people in the system before being upscaled to Tier 3.

FS advised that there were concerns around increase of suicidal ideation and self-harming behaviour with the use of some medications and asked how stable mental state would be defined. SH explained that the individual would be referred into the service for the wraparound support and then screened for the drug, which would be reviewed after six months. Providers would screen people for eligibility to the service and then screened for the medication, so if not eligible for the medication the service can still be accessed. The referrer would make the judgement of stable mental health following assessment. PS suggested that the access criteria should be made clear to the referrer and provider.

BS asked if the Equality Impact Assessment was accurate as was completed by Queens Hospital in 2019 and raised concern that estimations were too optimistic, and the numbers could be higher than anticipated. The underutilisation of the Tier 2 service could be because it is the patient responsibility to make contact for the service, which could cause discouragement. KR confirmed that Southend is direct referral, which was the ideal route and should be similar across the system.

ET advised that the criteria for access to Tier 3 services was also that the individual should have initially participated in the Tier 2 WMS and had not achieved a positive outcome. It was agreed that further work should be completed on the offer of the Tier 2 service in place.

PS advised that with regards to service access criteria, the first option focused on slightly more severe disease and the second option focused on people with slightly earlier disease, with a view to intervene earlier to prevent the development of co-morbidities. The first option for people with established co-morbidities was in line with NICE principles, so prioritising by clinical need, and the economic benefits were in addressing the established co-morbidities. The negatives would be if there were any benefits to intervening earlier. The second option would be intervening earlier; however, would this exclude people with established obesity related co-morbidities without other options in terms of weight management services. The second option would be too big an issue to endorse.

FL commented that being proactive was better than being reactive, however equally the numbers would be higher than anticipated. PS agreed that the modelling reflected that and if the second option was used the numbers would go up significantly.

PS asked Congress members if they had any concerns with regards to the additional criteria in terms of inequalities and using IMD to prioritise waiting lists, which would also have a strategic fit for the system.

GDT reflected that instinct would be to treat people earlier and there was a slight unease that individuals would be treated further on with their condition. In terms of the second question, an evaluation could be completed and would be a blueprint approach for other waiting lists.

SH advised that there were other services that could support individuals with a BMI below 40. However, when you reach a BMI40, some of the Tier 2 services have an exclusion criterion. The rationale would be that all Tier 2 and national services would support those individuals who are at that earlier stage.

PS referred to inequalities and highlighted that the current criteria included people who were

breastfeeding which had not been detailed in the new criteria. SH advised that the two providers commission in different areas and slightly differently and was due to historical commissioning and contract detail. The criteria would be streamlined when one provider was commissioned. PS suggested clarification of the exact intentions and rationale.

PS advised that the previous criteria for the BAME population was BMI 27–35 which would potentially exclude them from the new proposals because there was provision for a lower BMI in that population. SH advised that discussions were held and the reduction in BMI for BAME was because of risk, so once BMI 40 was reached the condition was already established and so the BMI was not adjusted down. Many Tier 2 services have entry points with two BMI criteria and the Tier 3 service did previously, but it was the risk of developing certain conditions that were picked up earlier, whereas individuals that already had those conditions would be already dealt with, so there was no benefit to be gained from including two BMIs. Further detail would be provided for clarification.

PS summarised that there was agreement to go with first option in terms of service access criteria and the population to prioritise was with established obesity related disease or co-morbidities and there was support for using the IMD based approach to prioritise the waiting list. Some points have been raised regarding the Equalities Impact Assessment and providing detail of who might lose out and who would gain from the new proposals. The role of patient activation in different groups and what impact that has, in terms of capacity and growth, and the suggestion to build in a review period, making better use of the Tier 2 service and detailing the practical criteria to support the referrers.

KR advised that the Population Health Management Board would support the direction of travel with the ICS strategy and five areas of priority for year 1 had been identified, one of which would be healthy weight and would focus on Tier 2 services.

7. Horizon Scanning

There were no items of horizon scanning discussed.

8. Any other Business

There were no items of any other business raised.

9. Date of Next Meeting

Wednesday 27 March at 9.30am – 11.30am via MS Teams.

Minutes of the ICB Finance & Investment Committee Meeting

Held on 21 February 2024 at 10.00

Meeting held virtually via MS Teams

Attendees

Members

- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB, **Chair**
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Chief Finance Officer, MSE ICB
- Loy Lobo (LL) EPUT Finance and Performance Committee Chair (part)
- Julie Parker (JP) Finance and Performance Committee Chair, MSEFT

Other attendees

- Karen Wesson (KW), Director Oversight and Assurance, MSE ICB (agenda item 7)
- Caroline McCarron (CMc), Deputy Alliance Director, South Essex Alliance, MSE ICB (agenda item 6)
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care, MSE ICB (agenda item 7)
- Ashley King (AK), Director of Finance Primary Care, Financial Services & Infrastructure, MSE ICB (agenda item 6, 7 and 13)
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB (agenda item 10)
- Zepth Trent (ZT), Executive Director of Strategy, Transformation and Digital, EPUT (agenda item 10)
- Charlotte Williams (CW), Chief Strategy and Improvement Officer, MSEFT (agenda item 10)
- Alan Brown (AB), Support to the EPR Project (agenda item 10)
- Alfie Bandakpara-Taylor, (AB-T) Deputy Director Adult Mental Health, MSE ICB (agenda item 11)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and confirmed the Committee quorate.
Apologies were received from:

Tracy Dowling (TD) Chief Executive Officer, MSE ICB,
Joe Fielder (JF) Non-Executive Member, Committee MSE ICB

The Chair advised JF had reviewed the papers and provided comments to some papers in advance of the meeting.

2. Declarations of Interest

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

LL raised a potential conflict for agenda item 11) Talking Therapies in his role as Non-Executive Director for EPUT. He also had a commercial interest in an associated company to Talking Therapies. As the agenda item was for discussion only, was not commercially sensitive and did not require a decision, NA confirmed LL could remain present for the item.

3. Minutes of previous meetings

The minutes of 23 January 2024 were agreed as an accurate record.

Outcome: The minutes of the meeting on 23 January 2024 were approved.

4. Action Log / Matters arising

The action log was discussed and updated accordingly. All items were on track for the stated completion date.

NA referred to action 72 (Bayman Ward) and confirmed the System Discharge Executive decided not to proceed with the Business Case. Clarification had been received no spend had occurred to date.

5. Triple lock process update

JK provided a verbal update on the triple lock process in place as a consequence of moving the forecast outturn position at Month 9.

Triple lock ratification was required for spend in the excess of £25k (including VAT) for non-pay expenditure including non-patient facing agency spend. Requests would be presented to the ICB Executive Panel on a Tuesday for consideration and then submitted to region (NHS England) the same day by 5pm. It was anticipated a decision would be made by Friday of the same week.

As part of the process a Workforce Tracker had been completed by Mid and South Essex NHS Foundation Trust (MSEFT) to review its compliance against metrics. A review of the process was anticipated in March.

JK hoped to present some themes at a future meeting once the process had embedded.

LL suggested Microsoft Planner might be a good tool to create, approve and audit requests.

Outcome: The Committee noted the update on the triple lock process.

Financial Governance

6. Adult Social Care Discharge Fund

CMc presented the paper to provide an overview of the Discharge Fund for 2024/25 in its second year of funding. The ICB would receive an allocation of £9.972m for 2024/25 to support patient care and improve patient outcomes, there was no confirmation of funding for future financial years. The funding mechanism would be applied through the Better Care Fund (BCF) and be monitored nationally under a number of metrics, reported on both a monthly and quarterly basis.

Work had taken place in accordance with the evaluation process to propose a number of schemes for 2024/25. An exercise was underway to test value for money on services to ensure best use of public money. Ward reablement had been introduced as a new scheme placing less reliance on care packages. A review of controls for discharge to access and inappropriate referrals was underway, CMc spoke of a home first approach.

The Chair welcomed the approach to evaluate and stop schemes not providing an impact, and referred to comments provided in advance by JF who queried the utilisation of the underspend and

what the voluntary sector grants aimed to deliver. JK clarified any underspend would remain within the BCF as part of the legality within the Section 75 agreement.

CMc advised grants had been allocated to support the safe discharge of patients and to enable them to maintain independence at home.

LL noted that the portfolio of interventions showed an overall net benefit, but it was difficult to identify benefits delivered by individual schemes. LL welcomed sight of the whole portfolio and the wider outcomes to understand what recurrent benefits could be considered by the System. CMc advised the team could summarise the evaluations and provide some further information on the portfolio.

Outcome: The Committee agreed the 2024/25 discharge budget spend noting the small underspend would be manged in line with ICB governance and would be reviewed following final mandates for the 2 new projects noted for 2024/25.

The Committee noted that Alliance directors have scope within BCF governance to flex spend within the available budget to ensure any changes in year can be managed effectively.

ACTION: A summary of the evaluations and further information on the portfolio of social care discharge fund schemes to be provided to a future Finance and Investment Committee.

7. Deep Dive on Financial Risks – Continuing Healthcare

CL presented detailed information regarding Continuing Healthcare activity and risks. The Committee were advised of actions being undertaken within the team to reduce the current backlog, review assessments within the national defined period, review discharge to assess processes and implement spend controls through reduced delays and improved processes.

A ‘plan on a page’ had been developed outlining a number of objectives to maximise efficiencies in the delivery of all age Continuing Healthcare and the commissioning of care.

KW advised the Discharge Executive had provided funding to support the team with additional resource to undertake backlog reviews for discharge to access patients.

KW assured the Committee of steps being taking internally to capture the themes of the issues and advised work was underway to develop a model using best practice to assess what workforce was required to ensure the service was sustainable. KW outlined the desire for a home first approach.

LL suggested the use of a stimulation model to understand what sustainability might look.

JP highlighted the need to escalate with Local Authority should issues be found to be of a strategic nature.

Outcome: The Committee noted the deep dive on Financial Risks – Continuing Healthcare.

8. Specialist Commissioning update

NA provided a verbal update on the progress of specialist commissioning in readiness of the ICB taking on full delegated commissioning from 1 April 2024.

The ICB had been working through the safe delegation checklist in readiness for April which included the implementation of a Collaboration Agreement that brought together ICBs and NHS England under one arrangement to discharge the functions. The risk share arrangement was set out within the agreement.

A Terms of Reference was being developed for the Joint Commissioning Consortium set up to

provide a forum for ICB representatives to make decisions. It was noted the Consortium alone would not have any delegated powers.

JK advised the ICB would be delegated an allocation sufficient to consume the level of activity required for specialist commissioning and although this was a pressure in other areas this was not the case for Mid and South Essex. It was not anticipated there would be much change in the ICBs first year of delegation.

A full paper would be brought to the March meeting.

Outcome: The Committee noted the update provided on Specialist Commissioning.

9. Expiring Contracts

JJ advised that Members at the December Finance and Investment Committee had recommended the expiring contracts for Board approval, that included the Tier II community services to the value of £6.7m. Following an increase in the approval threshold for the Finance and Investment Committee (within the Scheme of Reservation and Delegation), this was a decision that could now be taken by the Committee, rather than the ICB Board.

JJ highlighted there had been no formal agreement for the community contract and raised the need to align Tier II procurements for future.

It was noted this did not pose a cost pressure and was within the ICB financial budget.

Outcome: The Committee approved the course of action supported by the Finance and Investment Committee in December 2023 for a new contract to be awarded to Provide for Tier II services out of scope of the Community Collaborative to the value of £6.7m.

Business Cases

10. Electronic Patient Record (EPR)

ZT presented the paper and Full Business Case to implement a single Unified Electronic Patient Record (UEPR) across Mid and South Essex acute, community and Mental Health services.

Significant national investment had been aligned to the project; formal national approval was anticipated during the summer of 2024.

ZT had attended a recent ICB Executive Committee to look at how the programme would deliver benefits across the whole System. Work was taking place within Primary Care to look at how the System would integrate with existing capabilities.

The case would provide both cash releasing and non-cash releasing benefits plus societal benefits. Costs to the case had increased since the outline business case by £9m, this was largely due to an increase in the preferred providers tender costs compared to what had been modelled prior to going to procurement.

Capital affordability was a key risk (£16m unidentified), this was noted as worst case. Work was ongoing to address the gap and discussions were taking place with NHS England. JK spoke of a commitment from the three organisations to prioritise the Capital Department Expenditure Limit (CDEL) System funding to support the case. The Committee were informed of a £10m revenue pressure for 26/27 (the year of Go-Live).

The Chair referred to a question provided by JF and asked if the programme could be accelerated. The Chair asked if there was confidence the costs would not increase further.

ZT recognised the urgency to deliver benefits but advised this had been carefully balanced against the credibility and realism of the management case to deliver the change. The proposed timeline was also in line with best practice.

JP highlighted the need to be explicit on the consequence of prioritising investment in this case compared to other areas. There was recognition of the conflicting System priorities and the direct impact this would have on patient care should the case not be progressed.

Following a request for assurance by JP that the service Go-Live date would not be delayed, AB confirmed this had been factored into costed risks and assurance had been received from the provider.

In response to a question from JP, CW advised the number of services included within the scope was higher than what was originally anticipated.

The Chair requested the Finance and Investment Committee receive regular updates on how the case was progressing.

Outcome: The Committee endorsed the Electronic Patient Record Full Business Case.

ACTION: An update on progress with the Electronic Patient Record Full Business Case be added to the Finance and Investment Committee Workplan.

11. Talking Therapies

Following an earlier declaration from LL of a potential conflict, it was agreed he could remain present as the agenda item was for discussion only, was not commercially sensitive and did not require a decision.

AB-T advised of the intention to procure an integrated Mental Health Service and explained that the item was to update the committee in preparation for a future business case being presented. It was explained the current service was commissioned through historic CCG arrangements and as such was provided by four separate providers. This was inconsistent in its approach and contributed to a lack of equity across Mid and South Essex. As well as improving outcomes and providing a better experience for patients the integrated service would enhance value for money seeking any potential System efficiency.

LL was concerned the approach may reduce choice and contribute to poorer outcomes. AB-T explained the lack of choice in some areas compared to others and confirmed the approach would enable greater choice and enhance best practice.

LL highlighted a triage function to direct patients to the most appropriate service was key. He encouraged the consideration of digital solutions to allow choice and enable patients to access services more quickly and to evidence outcomes and experiences to inform future commissioning.

Outcome: The Committee noted the update on Talking Therapies.

Assurance

12. Month 9 Finance Report and Verbal update on Month 10

JK presented the Month 9 Finance Report and highlighted a year-to-date System deficit of £55m. It was noted the Essex Partnership University NHS Foundation Trust (EPUT) position at Month 9 had exceeded the anticipated forecast outturn, causing a financial pressure. The Committee was advised due to some technical elements the position would be brought back in line for Month 11 and Month 12 reporting. The Chair suggested a focus on Month 10 to see if EPUTs position headed towards its anticipated forecast outturn.

JK explained, in line with the change to the forecast position in Month 9, a review of the net risk

position was underway, this would be reflected in Month 10 reporting.

Headlines for Month 10 showed the position continued to be precarious. MSE had received confirmation the System would receive further support for industrial action, and this would be provided on a proportionate fair share basis.

Outcome: The Finance update was noted.

13. ICB Financial Planning

JK presented slides on the ICB draft financial planning for 2024/25 and agreed to circulate to members. The paper provided a summary of the financial allocations for 2024/25 together with the latest financial plan for the ICB based on key assumptions and potential financial risks in the absence of planning guidance.

JK explained Mid and South Essex were funded above what was considered to be our fair share allocation and as a result a convergence factor of -1.36% had been applied. It was anticipated the System exit underlying position would be circa £130m.

The expected ICB revenue allocation was £2,643,877, JK advised the System would be required to set out the repayment of the deficit accrued in 2022/23 over the next 3 years (capped at 0.5% of the allocation); a proposal was being set out as to how the repayment would be distributed. For planning purposes, it had been assumed the impact of the deficit would fall to where it had been accrued.

Although the majority of the ICB System Development Funds (SDF) were committed for 2024/25, it was proposed, given the financial situation, funding would be subject to deliver a 5% efficiency on SDF plans during 2024/25 (excluding maternity, diagnostics, and Mental Health).

JK explained how the ICB base budget had been set and advised a breakeven ICB plan was anticipated for 2024/25 (with no reserve).

Work continues to prioritise schemes against the ICB Capital Allocation of £1,988k. JK confirmed the development of a System infrastructure strategy was underway with the support of NHS Property Services and would provide an update to the Committee in May.

Following a query around asylum funding it was noted although it was anticipated funding would be sufficient for 2024/25 there was concern over pressures for future years.

A Board Seminar on the System Financial Plan was anticipated to take place on 18 March 2024.

The wider System position and sign off of the ICB budgets for the new financial year would be presented at the March meeting.

Outcome: The Committee noted the draft planning position and assumptions for Mid and South Essex ICB.

ACTION: ICB draft financial planning slides for 2024/25 to be circulated to Members.

ACTION: Update on the Infrastructure Strategy to be added to the Committee Workplan for May 2024.

14. Efficiency Programme

The Committee were in receipt of the report on the System Efficiency position for 2023/24 and the work underway to progress schemes to delivery.

The Committee recognised the challenges for 2024/25 as a large element of 2023/24 efficiencies were non-recurrent. 2024/25 was further challenged given a limited number of programmes had been identified to date, far below the efficiencies required.

Outcome: The Committee noted the content of the efficiency programme report and the actions being taken to improve the delivery of efficiency.

15. Feedback from System Groups

The minutes of the System Finance Leaders Group held on 8 and 15 January 2024 and System Investment Group on 21 November 2023 were presented for information. JF had raised concern over the reduced scope for Pitsea and Thurrock diagnostic centres and asked if they would still be fit for purpose and deliver what our communities needed. It was suggested the query was passed to the Thurrock Alliance Director who would be able to provide an update.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

ACTION: ES to contact the Thurrock Alliance Director for an update on the reduction in scope for the Pitsea and Thurrock diagnostic centres.

16. Any other Business

Nothing raised.

17. Items for Escalation

Nothing raised.

18. Date of Next Meeting

Thursday 14 March 2024
2.30pm – 5.00pm

Minutes of the ICB Finance & Investment Committee Meeting

Held on 14 March 2024 at 2.30pm

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee MSE ICB, **Chair (part)**
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB, **Chair for agenda item 12**
- Tracy Dowling (TD) Chief Executive Officer, MSE ICB,
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB (part)
- Jennifer Kearton (JK) Chief Finance Officer, MSE ICB
- Loy Lobo (LL) EPUT Finance and Performance Committee Chair
- Julie Parker (JP) Finance and Performance Committee Chair, MSEFT

Other attendees

- Margaret Hathaway (MH) Director of Procurement and Contracting, MSEFT (agenda item 5)
- Gerdalize du Toit (GdT) Community Director, MSE ICB (agenda item 6 & 7)
- Nina van-Markwijk (Nv-M) Finance Director, MSEFT (agenda item 5)
- Alfie Bandakpara-Taylor, (AB-T) Deputy Director Adult Mental Health, MSE ICB (agenda item 12)
- Celia Harris (CH) Senior Transformation Manager, MSE ICB (agenda item 12)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

The Chair welcomed everyone to the meeting and confirmed the Committee quorate. There were no apologies.

2. Declarations of interest

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

The Chair and LL highlighted a potential conflict for agenda item 8, Talking Therapies. LL raised a further conflict for agenda item 7, Community Contract. The Chair and LL agreed they would leave the meeting at the point the agenda items were discussed.

JP highlighted her role on the Pathology Joint Venture for Mid and South Essex NHS Foundation Trust (MSEFT) in relation to agenda item 5 (pathology contract extension). 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.

3. Minutes of previous meetings

The minutes of 21 February 2024 were agreed as an accurate record.

Outcome: The minutes of the meeting on 21 February 2024 were approved.

4. Action Log / Matters arising

JK referred to action 56 (consideration of future reporting to reflect the direct correlation between the progress of PIDs (Project Initiation Documents) through to implementation, and the subsequent impact on the 'run rate') and explained the majority of PIDs within MSEFT would not be profiled until they reach Gateway 3. JK was unable to complete this action from a system perspective until work had taken place in both Trusts. JK asked that the May meeting invite be extended to the Executive Director of System Recovery as this was an area of focus.

Following a query from the chair regarding the inclusion of performance within the remit of the committee, it was agreed oversight of performance data was vital to inform discussions. this would support the financial recovery agenda and broaden the role and membership of the committee.

It was agreed from May 2024 the committee would move to the first Tuesday afternoon of the month. The 3 April meeting would be stood down and an extraordinary Finance and Investment Committee established in the coming weeks to sign off the ICB budgets.

ACTION: Neill Moloney, Executive Director of System Recovery to be invited to the May meeting.

Triple Lock Ratification

5. Pathology contract extension

MH presented the paper to endorse a 2-year extension of the pathology contract operating in south Essex by MSEFT. It was noted the case would be subject to the triple lock process. MH outlined that the increase in charges had been included within the financial affordability envelope for the procurement.

The case required funding of £8.4m over 2 years and was an increase of 7.5% of the existing contractual value. This could increase to 15% should a non-incumbent supplier be successful. The case would be subject to a revenue cost of £1.79m to upgrade the digital operating system 'LIMB'.

MB queried the delay to commence the procurement and asked if the financial pressure had been factored into the Trust position. NvM advised a cost pressure risk assessment had been captured within planning for 24/25 but not to the scale outlined within the paper.

MH explained the procurement was complex bringing two services into one. A non-incumbent supplier would need time to build and mobilise their own laboratory as the existing facilities were owned by the incumbent supplier. Whilst the increase in costs were significant, costs aligned with market conditions. The Trust had been engaging with NHS England to understand if the case was subject to their approval.

JK asked if the extension factored in the opportunity to review inflation to seek possible savings in year 2. MH advised the uplift was based on the motivation of the incumbent supplier to fulfil the extension and reflected the risk the supplier was taking on equipment.

In comparison to the total contract value, TD highlighted the identified efficiency savings of £250k-£385k per annum fell significantly below what was required.

The committee were advised the additional cost had been negotiated down and work had taken place within clinical colleagues to reduce the scope within the service specification. JK highlighted concern the uplift was even more considerable in comparison to the service offer.

Following a query why the Trust was looking to outsource pathology services, MH advised a report had been commissioned early in the process and deemed outsourcing of the service was the most optimal solution.

The chair asked if a session with Board members and the incumbent supplier was sensible to provide broader scrutiny from the system.

Outcome: The Committee:

- **endorsed** and **supported** a 2-year extension of the existing pathology joint venture contract from October 2024 to October 2026.
- **agreed** to the additional cost of £8.4m impact (over 2 years) under 'Triple Lock' protocols, to be further approved by MSEFT and the NHSE Regional Team.
- **noted** that MSEFT Board approval for the contract extension would be sought on the 28 March 2024 and that triple lock approval would be sought in parallel via the NHSE Regional Team.

The chair highlighted although the committee had endorsed and supported the case and subsequent recommendations, this was supported with reluctance by the majority of members. The committee were not confident all routes of the case had been explored to provide best value for the population but were limited in terms of timing and acknowledged the decision to approve remained with MSEFT and NHS England.

Business Cases

6. Specialist commissioning

GW attended the meeting in his role as chair of the Audit Committee and would jointly chair the agenda item alongside JF.

GdT presented the paper and advised that from 1 April 2024, the responsibility for commissioning 59 specialised services would be delegated from NHS England to the ICB. The ICB had been working in shadow arrangements the past year.

Over the past few months, the three regions and NHS England had been working together to develop a Delegation Agreement and a Collaboration Agreement, which sets out how the six ICBs would work together to commission services, with Bedfordshire, Luton, and Milton Keynes ICB hosting the director responsible for the commissioning team.

It was anticipated that there would be very little if any change in the ICBs first year of delegation whilst the ICBs established a longer-term strategy. GdT clarified any decisions outside of the delegated authority of members attending the Joint Commissioning Consortium (i.e., the system Medical Director) would be directed through usual ICB governance in accordance with the Scheme of Reservation and Delegation.

GW suggested additional information be included in the presentation to the Board outlining what the ICB would need to do differently once delegated e.g., if any committees needed to receive assurance regarding specialised commissioning. Following a query on adhering to auditing procedures, JK confirmed similar risk sharing arrangements had been in place previously and although the risk document doesn't detail out the steps, the process could be articulated if required.

Outcome: The Committee recommended that the Board:

- **agreed** that the ICB would be bound by decisions taken collectively with the other ICBs in the East of England in line with the Collaboration Agreement, relating to delegated specialised services.
- **approved** the delegation of 59 specialised services and **authorised** the Chief Executive to sign the Delegation Agreement between the ICB and NHS England
- **approved** the Collaboration Agreement between the ICBs in the East of England and NHS England to manage the commissioning of the specialised services in a joint endeavour.
- **noted** the governance arrangements and the terms of reference of the Joint Commissioning Consortium.

ACTION: The chair suggested a system wide Board seminar was arranged on specialist commissioning to enable a broader discussion and to explore possible opportunities in due course.

7. Community contract

Minute redacted for confidentiality and in response to managing conflicts of interest.

8. Finance risk register

The committee were presented with risks associated to finance; the report was noted, and members recognised that the risks contained in the register were discussed throughout the agenda, there were no further comments.

Outcome: The Committee noted the Finance Risk Register.

9. ICB financial budgets 24/25

JK advised the team had been unable to present the committee with final budgets due to a number of extenuating factors and requested that an Extraordinary Finance and Investment Committee was established to sign off the ICB financial budgets for 24/25.

Outcome: The Committee noted the update on the ICB Financial Budgets.

ACTION: Extraordinary Finance and Investment Committee to be scheduled for the sign off of the 24/25 ICB Financial Budgets.

10. System financial plan 24/25

The committee were advised a Board seminar would take place on 18 March 2024 to consider the draft system financial plan for 24/25. The plan had been developed based on draft guidance as formal guidance was awaited.

The 24/25 flash submission on 14 March 2024 highlighted a system deficit of £149m and had been based on circa £90m-£100m non-recurrent funding measures.

JK explained although mid and south Essex had received an uplift, its allocation had been significantly impacted by the convergence factor (£22m reduction to reflect over funding in previous year and a rebasing to correct levels). The system was also required to repay the deficit it had accrued in 22/23, capped at 0.5% of the core allocation.

A proposed system deficit of £149m was not accepted by the national team. The system was expected to deliver a deficit of £60m with a view to improve. Following the flash submission and subsequent follow up discussion with the national team, the system was asked to outline the service implications should certain measures be required, and this was under consideration.

The system was asked to increase elective recovery to 115%.

Over the last week 'rapid review' sessions had taken place with each of the organisations to discuss plans, its financial position, and opportunities. JK flagged the position was complex with several pressures in each of the three organisations. A further session would take place on 18 March with the national team to understand what actions are taking place.

LL referred to minutes of the System Investment Group and highlighted the cost pressures emerging around Community Diagnostic Centres (CDCs). He queried if the work should be stopped/paused given the current financial climate.

There was a wider discussion around the need for transformation programmes to help create a step change. JK spoke of the need to review investments made in the last 3 years to understand if they are achieving the required benefits.

Outcome: The Committee noted the update on the 24/25 system financial plan.

11. Month 10 finance report and verbal update on month 11

The committee were in receipt of the month 10 report. JK welcomed the committee to feedback any questions directly.

The chair highlighted a disconnect on the workforce graphs between bank and agency and would discuss offline. He added the Mental Health Investment Standard (MHIS) should be included as one of the reporting standards.

JK clarified any controls would continue into 24/25 until formally stood down by region. Discussions were ongoing concerning what further controls could be implemented.

The month 11 position had been discussed earlier in the agenda.

Outcome: The Committee noted the month 10 finance report.

12. Talking Therapies

Minute redacted for confidentiality and in response to managing conflicts of interest.

13. Efficiency programme

The paper provided an update on the system efficiency position for 23/24 and the work underway to progress schemes to delivery, the report was noted.

LL had some comments and would provide them directly to NvM/JK.

Outcome: The Committee noted the content of the report and actions being taken to improve the delivery of efficiencies.

14. Feedback from system groups

The minutes of the System Finance Leaders Group held on 5 and 19 February 2024 and System Investment Group on 22 January 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

15. Any other Business

There were no items of any other business.

16. Items for Escalation

The following items were escalated and recommended for Board approval:

- Specialised commissioning
- Community contract
- Talking therapies, integrated primary care community services and recovery colleges contracts

17. Date of Next Meeting

- Tuesday 7 May 2024

It was agreed the 3 April 2024 meeting would be stood down and an extraordinary meeting set up in the coming weeks to sign off the ICB budgets.

Minutes of the Extraordinary ICB Finance & Investment Committee Meeting

Held on 11 April 2024 at 2.00pm

Meeting held virtually via MS Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee MSE ICB, **Chair**
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB,
- Tracy Dowling (TD) Chief Executive Officer, MSE ICB,
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Jennifer Kearton (JK) Chief Finance Officer, MSE ICB

Other attendees

- Ashley King (AK) Director of Finance Primary Care, Financial Services & Infrastructure, MSE ICB
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB (minutes)

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and confirmed the Committee quorate. There were no apologies.

As the purpose of the meeting was to sign off the ICB budgets, only ICB members were invited to attend the meeting.

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. None were raised.

3. ICB Financial Budgets

JK presented the ICB Budgets noting that the Board, at its meeting on 21 March, delegated to the Finance & Investment Committee authority for the committee to approve the ICB budgets that will later be reported to the Board. JK also noted that the final deadline for the planning submission was 2 May, for which the ICB was on target to submit.

JK summarised the allocations received and their use, with a total confirmed allocation of £2,646m, noting that the prior year deficit had been removed with the intention that the ICB pay the £10.9m deficit back over a three-year period.

JK set out approach to budget setting, noting that detailed line by line budgets had been set and once approval had been received from the committee, they would be uploaded to the finance

system. It was noted that the budget was set on the forecast outturn for 2023/24 adjusted for non-recurring item, known cost pressures and investments, uplifted for inflation and growth, then further adjusted for the required convergence (£24m distributed across providers) and efficiency factors. JK informed members that the elective recovery position was based on cost and volume, with non-elective remaining on a fixed contract.

Physical and virtual capacity funding would be applied to support growing pressures in discharge to assess beds and out of area placement beds as well as continuing out of hospital capacity. This funding had been fully committed and therefore there would be no additional funding previously termed 'winter monies'.

It was expected that system development funds (SDF) would be released in line with existing commitments but would be subject to a 5% efficiency. Some SDF would be ringfenced and so to achieve the overall efficiency, it would be disproportionate across the budgets.

It was noted that the ICB budget position was balanced, but this was heavily reliant on £48m efficiencies target. The system was required to begin paying back the deficit incurred in 2022/23, which had been adjusted from the system allocation (£10.861m). Financial controls continued to be in place until further notice with the ICB holding a vacancy freeze, there was no contingency or reserves.

JK continued and presented the summary level budgets explaining the assumptions relating to the setting of the budget.

Following a question from TD, JK noted that the £11m deficit in the acute line was a reduction in funding based on forecast outturn for this year and that repayment of the deficit was assumed to fall where it was accrued.

MB sought clarity on the vacancy freeze, where JK explained the establishment control panel and prioritisation process that was followed. Given the pressure on the teams and posts that were deemed statutory or critical, some requests could be presented the NHS England. MB recommended a variance column to show the change from 23/24 to 24/25.

Responding to JF, JK noted that the deficit was not subject to interest but was capped. However, there would be an interest charge applied to Trust borrowings.

JK explored the profile of the £48m efficiencies that would enable the ICB to break-even, noting NHS England was encouraging a surplus. Members acknowledged this was a difficult position, especially given the £2.2m (5%) that remained unidentified.

Discussion was held regarding clarity over the 5% efficiency target noting that it excluded funding that was earmarked. Communications regarding this would need to be clear.

Further discussion was held regarding the run rate and inflection points. JK confirmed that the profile of the ICB savings would be developed and set to show the run rate and inflection point by the May meeting. MSEFT efficiencies would differ because the unidentified savings in the Trust was much bigger.

JK highlighted the potential impact of risk to the budget position to the ICB of £10.9m, particularly given there was no contingency or reserve. Industrial Action could impact on the Trust position but would not affect the ICB position.

ACTION: Final budgets to be presented to the Committee in May (including a variance column showing the difference between current and previous year).

Members discussed the need for a higher level of scrutiny month on month. EH noted the need for directorate budgets to enable better scrutiny and to hold the Executive to account and enable true accountability. JK stated that 'Power BI' and 'Atamis' would support the Executive in owning and managing their budgets.

Outcome: The Committee approved the ICB Budgets to be uploaded.

Standard Reporting

JK presented structured reporting for the Committee going forward, each meeting would receive a finance report, system report and a recovery report. In addition, quarterly stocktake meetings would be held to 'deep dive' into performance where the Chief Finance Officers of the Trust would also attend the Committee. JF noted he had not yet met the Recovery Director.

ACTION: An introductory meeting with JF, JK and NM to be set up.

JK also informed Members of the intention to have an integrated performance and finance report, with triangulation of workforce data, but this would be explored further as part of committee reviews to prevent duplication and promote committee effectiveness. TD urged that the committee reviews consider the role of each committee to ensure their added value, particularly that of SOAC.

ACTION: A meeting be set up with TD, JK, and NEMS to consider remit of FIC and SOAC.

Outcome: The Committee noted the new reporting arrangements

Financial Outturn 2023/24

JK explained that the ICB met its planned position of £22m surplus, MSEFT was likely to achieve the £70m agreed deficit position. However, EPUT, whilst achieving within £100k of their planned £10m deficit position, would be hampered by costs of the Lampard Inquiry. The System would have therefore achieved the rapid reset position aside from the Lampard Inquiry.

The planned meeting with the ICB Chair on 26 April would likely be open to other NEMS to communicate the position. The latter part of the next Committee meeting on 1 May would also likely open to additional attendees to review the submission for the following day.

Outcome: The Committee noted the financial outturn position.

4. Any other Business

Nothing raised.

5. Items for Escalation

Nothing raised.

6. Date of Next Meeting

Wednesday 1 May 2024 13:30 - 16:00

Minutes of ICB Primary Care Commissioning Committee Meeting

Thursday, 29 February 2024, 1.30–3.00pm

Anglia Ruskin University, School of Medicine

Attendees

Members

- Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- James Hickling (JH), Deputy Medical Director (Nominated deputy for Dr Matt Sweeting).

Other attendees

- Caroline McCarron (CMc), Deputy Alliance Director for South East Essex.
- David Barter (DBa), Head of Commissioning.
- Vicky Cline (VC), Head of Nursing, Primary Care Quality.
- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- Simon Williams (SW), Deputy Alliance Director Basildon and Brentwood.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Jane King (JKi), Corporate Services & Governance Support Manager.
- Maggie Glover (MG), Local Optical Committee.

Apologies

- Dr Matt Sweeting (MS), Interim Medical Director.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.

1. Welcome and Apologies

SA welcomed everyone to the meeting.

Apologies were noted as listed above. It was noted the meeting was quorate.

2. Declarations of Interest

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

Members noted the register of interests. For Item 5, Commissioning Intentions, it was noted that Dr Anna Davey was a provider of services included within the scope of the paper, therefore was excluded from the decision-making process. The Local Medical Committee were the representative body for the providers of services included within the scope of the paper but were not in attendance at the meeting.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 10 January 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 10 January 2024 were approved. Approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

It was noted that the outstanding actions (73, 80, 84, 85, 92, 93 and 95) were all within timescales for completion.

5. Local Enhanced Services

WG presented the paper outlining the proposed changes to the commissioning of Locally Enhanced Services (LES) in 2024/25, which included changes to the contracting approach, continuation of supplementary arrangements and inclusion of two additional enhanced monitoring schemes. The proposals were as follows:

1) Change in Contracting Arrangement

Prior to delegation, for the majority of Clinical Commissioning Groups in Mid and South Essex, contracting arrangements for any local enhanced service commissioned from primary care took the form of an NHS Standard Contract, following a direct award process which included a robust assurance procedure. This arrangement had remained in place following delegation of primary care services. It was proposed to transition commissioning of all LES via General Medical Services (GMS) / Personal Medical Services (PMS) / Alternative Provider Medical Services (APMS) contracts with effect from 1st April 2024.

In response to AD, WG confirmed that GP contracts would not be affected by the proposed change.

Outcome: The Committee APPROVED the intention to commission LES via GMS/PMS/APMS contracts from 1 April 2024.

2) Extension of Contracts

There were several residual contractual arrangements in place where practices had previously opted out of direct provision of enhanced services. Where practices were unable to provide an enhanced service themselves, the ICB's preferred position was that the practice would subcontract to a third party, e.g., another practice within their Primary Care Network (PCN). To ensure continuity of care, these contracts would continue for the intermediary period whilst new arrangements were put in place. The contract extensions would be at current budgeted levels (i.e., no additional cost pressure). The extensions included DMARD (disease modifying anti-rheumatic drug), warfarin and denosumab monitoring.

WG explained that, following the organisational restructure, the Primary Care Team was responsible for the LES contracts which would allow oversight of commissioned services.

DD noted the DMARD contracts listed were in the Basildon & Brentwood and South East Essex areas only and queried whether there was a service difference. WG confirmed the DMARDs contracts for extension all were enhanced services.

Outcome: The Committee APPROVED the intention to extend contracts with the aforementioned providers to continue existing provision of equivalent locally enhanced services for 2024/25 or until mutual agreement that this arrangement was no longer require (NB: no later than 31st March 2025).

3) Application of National Inflator

The ICB had received confirmation that the national inflator for the 2024/25 National Tariff Payment System would be 3.45%. It was the ICB's intention to apply the uplift to enhanced services.

Outcome: The Committee APPROVED the national inflator of 3.45% to be applied to enhanced services.

4) **DMARD Shared Care and Warfarin Monitoring Transfer**

Previously, Mid and South Essex Foundation Trust (MSEFT) had made provision for DMARD shared care and warfarin monitoring for several practices that had served notice on this provision. The arrangement was put in place during the Covid period and there was no associated transfer of funding. During the intervening period, the ICB had harmonised LES commissioning arrangements that had resulted in a DMARD Shared Care arrangement and warfarin monitoring enhanced service across MSE.

MSEFT had recently flagged that the services were a cost pressure to them and was unsustainable. The ICB and MSEFT collectively agreed that it made sense to commission provision for all patients under the enhanced service arrangements. This would result in an estimated cost pressure for the ICB of £116,000 to be funded from Delegated Budgets but would reduce an unfunded cost pressure within MSEFT to the equivalent value. This was subject to securing approval through the Triple Lock process.

KSS commented that a review of patients under the Warfarin service would identify those who no longer required monitoring. WG agreed and expected patient numbers to reduce as more patients receive DOACs rather than Warfarin.

Outcome: The Committee APPROVED the transfer of DMARD and Warfarin arrangements currently managed through MSEFT into the ICB's local enhanced service commissioning arrangements (subject to Triple Lock approval).

5) New Enhanced Monitoring Arrangement – Adult Attention Deficit and Hyperactivity Disorder (ADHD) Medication

The ICB had received several requests for funding of Adult ADHD Medication because of increased diagnosis of ADHD in adults and the "NHS Right to Choose" policy that had led to an increased number of patients receiving a diagnosis and the initiation of prescribing from independent sector providers under NHS funded care.

The Enhanced Service Working Group (a sub group of the Primary Care Commissioning Committee) noted that the costs of the monitoring, undertaken by independent sector providers through NHS funded provision, was greater than the cost of this being undertaken by specialist services. Whilst this would present a cost pressure to the ICB, it would be a lower cost pressure than if patients stayed within other NHS funded arrangements. The cost would be funded through delegated budgets but was subject to securing approval through the Triple Lock process.

PW highlighted that ADHD medications were controlled drugs and prescribers should be familiar with controlled drug legislation. SA queried whether the budget for ADHD medications would be transferred or whether it would be a cost pressure on primary care. WG confirmed that Local Enhanced Service payments would be funded from delegated funds but was subject to Triple Lock approval. The new service was an investment and would support primary care sustainability. VC queried how the ICB could ensure that it was not paying twice for medication per patient, e.g., via both primary care and mental health services. WG confirmed the ICB would need to work with the mental health team to prevent this.

In response to JH, WG advised that, once the ADHD monitoring scheme was in place, the mental health team would be able to help identify the patients under independent mental health providers and arrangements made to bring these patients back under primary care services. Full details of the arrangement would be developed in conjunction with Medicines Optimisation Team and would include pathways for patients who had been discharged back to the GP but did not get on with their medication.

Outcome: The Committee APPROVED the inclusion of Adult ADHD prescribing within the enhanced monitoring service from April 2024 (subject to Triple Lock approval).

DD left the meeting.

6) Local transformation and local commissioning schemes

In line with previous commitments, the ICB would continue to commission local transformation schemes at place in South East Essex, Mid Essex and Basildon and Brentwood. As part of the Financial Recovery Programme, the Primary Care Team would

lead a review of the arrangements, alongside all arrangements over and above core primary care funding. This review was not intended to release a cash saving but to ensure that investments improve outcomes, make primary care sustainable, address inequality, support the ICB's priorities and offer value for money. The scope of the review would be presented to the committee.

SA enquired whether discretionary funds would be directed to support the Primary Care Strategy and whether the funding was for 12 months from April 2024.

JS advised that providers had been advised that investment was to support the Fuller Stocktake recommendations around primary care integration.

JH queried why Thurrock was not included on the list for local transformation schemes. WG advised that there was additional primary care investment in Thurrock, but this would be picked up in the review e.g., provision of APMS contracts, specific funding for Additional Roles Reimbursement Scheme (ARRS) enhancements and other Thurrock based issues. However, as part of the review, the ICB would need to address any unwarranted variation in funding. SW stressed the importance of having clear audit trails to communicate the schemes to providers to ensure awareness.

RJ enquired how were outcomes were being measured for each of the alliances. WG commented this would also be picked up as part of the review process to ensure a consistent level of feedback on outcomes and output.

The committee approved the continued commissioning of local transformation schemes. PG enquired whether there was capacity to extend the schemes. WG confirmed there was capacity to extend but this would require a waiver and would be acceptable under PSR. It was noted that the timelines for the development of local schemes may vary at a local level. For example, Basildon and Brentwood Alliance is already engaged with their PCNs regarding the development of the Acute Home Visiting model/local developments.

Outcome: The Committee APPROVED the continued commissioning of local transformation schemes, in line with previous commitments subject to further discussion between WG and AK around funding.

6. Supporting Primary Care Resilience

PG gave a verbal presentation on the proposal to invest £50k to improve primary care resilience by supporting the development of the newly formed Primary Care Collaborative (the Collaborative). Funding would be transferred to the Local Medical Committee (LMC) and be utilised to support the work in improving primary care resilience. The aim of the Collaborative was to improve the effectiveness and sustainability of general practice services and the role of primary care within the wider health and care system.

The funding would be non-recurrent and subject to Triple Lock approval. The LMC would be expected to provide regular updates on the usage of the funding in supporting the establishment of the Collaborative and the progression in the delivery of the Collaborative's objectives.

KSS requested that the Collaborative considered all primary care services.

SA queried whether the LMC was the right vehicle to support development of the Collaborative. PG believed the LMC was the right organisation to take the Collaborative forward and advised that they would provide a business case setting out their proposed use of the funding. AD agreed that the LMC was the right vehicle to develop the Collaborative.

Outcome: The Committee SUPPORTED the proposal to invest £50k into improving primary care resilience by supporting the development of the newly formed Primary Care Collaborative (the Collaborative). This is subject to the Triple Lock Review.

PG, AD, RJ left the meeting.

7. Primary Medical Services Contracts

JS provided an overview of current activities in relation to Primary Medical Services (PMS) contracts.

A few potential schemes, mostly relating to productivity schemes, rather than cash releasing schemes, had been put forward by the Primary Care Team for the Financial Recovery Programme (FRP). The team was providing advice and support to other ICB and system teams who's proposed FRP schemes involved a change process in primary care. Work was underway to establish collective impact of all proposed system schemes and to understand this in terms of demand and capacity in PMS.

It was noted that Contractor Status for Dr S Lal Vashisht Warrior Square would change from Partnership to Individual from 31 March 2024. The change was not anticipated to affect the status of notional rent reimbursements under the Premises Cost Directions.

Witham & Maldon and Phoenix PCNs had notified the ICB of their intention to merge to form a single PCN from 1 April 2024, which was supported by Mid Essex Alliance.

Three applications for discretionary Section 96 payments had been agreed. One of these was a cash flow issue and therefore will be repaid in full by the practice. A further three practices had approached the ICB regarding potential resilience funding requests and advice was provided.

The ICB was still awaiting a formal update to the 2024/25 GP contract. The uncertainty created by lack of information was creating a risk to the Optimising Additional Roles Reimbursement Scheme (ARRS) and service delivery. PCNs had been advised that some guidance had been received indicating there would be no significant changes to the ARRS budget.

Work had commenced to develop a Commercial Strategy for PMS. Consideration was being given to if/how this work could incorporate Dentistry, and a common set of Strategic Investment Principles were being developed.

In addition to locally commissioned services, the ICB held 13 APMS contracts for core PMS, all of which were due to expire by 30 September 2026. All contracts (excluding the Special Allocations Service contract which had already been extended to March 2025) had an extension option but in the case of the 5 Thurrock APMS contracts, this was only for one year. Work had commenced with the Alliance Teams to determine contracting/commissioning intentions for all local APMS arrangements to improve value and sustainability.

It was reported that all MSE practices had now signed up to George Lloyd digitalisation.

Premises Development Schemes

JS explained that a response from NHS England (NHSE) regarding the premises development schemes for the Hedingham Medical Centre new build and the Whitley House extension had been delayed beyond the anticipated approval timetable and welcomed advice on how the delays should be escalated to NHSE. The committee were made aware of the risk around Hedingham Medical Centre being homeless at end of March 2025 and associated negative quality and financial impact, if the build did not proceed to the expected timetable.

JH agreed to escalate the delays in premises development schemes with NHSE.

ACTION: JH to escalate the delay in approval of the premises development schemes for Hedingham Medical Centre new build and the Whitley House extension with NHSE.

Outcome: The Committee SUPPORTED escalation of the delays in approval of the Premises Development Scheme for the Hedingham Medical Centre new build and Whitley House extension to NHSE as discussed.

Proposed Additional Primary Care Capacity at Halstead Hospital

Through Section 106 monies and investment from NHS Property Services, the ICB was presented with an opportunity to secure £600k of capital investment to convert currently unusable space in Halstead Community hospital into functional clinical space. Section 106 requirements meant that the funding could only be used to expand primary care capacity locally, specifically that of the local practice Elizabeth Courtauld Surgery. In line with Premises Cost Directions, the ICB would pick up the cost of rent and rates of this facility on the proviso the practice would cover the costs of service charges. Following provisional discussions with the practice, the practice had initially ruled out taking occupation of the space as the recurrent service charges were too high to be sustainable for the practice.

In order not to lose the opportunity of £600k capital investment to support the national objective of reintroducing unutilised estate the ICB, on an exceptional basis, entered dialogue with the practice on terms of occupation that would be viable to the practice. As a result, the ICB offered to subsidise the service charges to the level of 85% (an indicative impact to the ICB of a net £21k per annum). This would remain in effect for two years before being reviewed.

Outcome: The Committee APPROVED the subsidy of service charges, to the level of 85% (an indicative impact to the ICB of a net £21k per annum) for F81068 Elizabeth Courtauld Surgery to support the proposed additional primary care capacity at Halstead Hospital. This will remain in effect for two years before being reviewed.

North Chelmsford and Chelmsford Garden Community

Work continued to identify a suitable provider for the Beaulieu Park site (north Chelmsford) in line with the commercial approach by the ICB Finance and Investment Committee and operating under the new Provider Selection Regime.

Following discussions with Chelmsford City Council and consortium of developers for Chelmsford Garden Community (CGC), the developers had provided a proposal for the provision of primary healthcare facilities which was expected to be submitted to the Council's Planning Committee in March 2024. If planning permission was granted, associated Section 106 planning obligations would secure delivery of the healthcare facilities. The development was expected to commence during 2025/26 but the permanent healthcare facility would not be provided until the mid-late 2030's because of mineral extraction processes in the area where the facility would be located. It was therefore proposed to provide a temporary facility within the first neighbourhood centre built in the development which would remain open until after the permanent facility was provided.

Outcome: The Committee APPROVED plans to

a. Continue to work with Chelmsford City Council and the Chelmsford Garden Community developers to agree the mechanism for provision of temporary and permanent healthcare facility provision within the CGC.

b. Begin the development of a business case for provision of primary care services in the proposed CGC.

Outcome: The Committee NOTED the Primary Medical Services Contracts Report

8. Operose Follow Up

WG presented an update on the due diligence and engagement undertaken by the ICB regarding the potential Change in Control in Operose Health Limited.

The legal advice provided to the ICB concurred with Operose's assertion that the proposed changes to their business structure did not result in a Change in Control in relation to the ICB's APMS contracts with The Practice Surgeries Ltd. Therefore, there was no formal obligation for the ICB to undertake an engagement process. The ICB, however, had proactively sought feedback from relevant stakeholders. No feedback had been received across a reasonable time, more than one month. The delivery of services under the two APMS contracts would continue to be monitored through the ICB's quality assurance processes.

Outcome: The Committee NOTED the findings of the legal advice and engagement process and SUPPORTED the recommendation that the change in ownership did not constitute a Change in Control.

9. Dental Contracts Update

DB presented the paper providing an update on recent changes and developments in Dental Services and an overview of the recent national plan to recover and reform NHS dentistry.

On 7 February 2024, NHSE published a joint NHS and Department of Health and Social Care (DHSC) plan to recover and reform NHS dentistry. The changes announced sought to build on the first reforms to the dental contract in 15 years, announced in July 2022. Measures included:

- A 'new patient' payment depending on the treatment needed to treat patients who have not seen an NHS dentist in two years or more (time limited to the end of 2024/25).
- Targeted funding to encourage dentists to work in areas which have historically been difficult to recruit to.
- A further increase in the minimum indicative UDA value from the £23 announced in July 2022 to £28 from April 2024.
- Improving access in underserved areas using dental vans.
- Dental teams into schools for preventative work.
- Potential to enable universal over performance of up to 110% of contracted values; and
- Ring fencing of dentistry 2024/25.

The Dental Access Pilot, commenced in September 2023, had 10 providers across MSE seeing patients in out of hours sessions. Of the estimated circa 40,000 half hour appointment slots in the 18-month pilot, 7,457 patients had been seen as of 16 February 2024.

There had been excellent provider engagement for the Care Home pilot which commenced in November 2023. There was take up of 86% of the 8,196 care home beds being covered to date. DB explained that work on an evaluation framework was being undertaken.

Contract baseline review work was due to commence to review providers who recurrently under deliver their contract. The ICB would support any underperforming practices.

Outcome: The Committee NOTED the Dental Contracts Update.

10. Primary Care Quality and Patient Safety Update

The Committee were advised that the primary care quality and patient safety reporting route had changed so that quality assurance now fed into the ICB Quality Committee. The PCCC were provided with a copy of the paper presented to the Quality Committee on 23 February 2024 for information.

Outcome: The Committee NOTED the Quality and Safety update and NOTED the new governance route.

11. Minutes from the Dental Commissioning & Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 15 December 2023 and 19 January 2024 were received.

Outcome: The Committee NOTED the Minutes of Dental Commissioning and Transformation Group.

12. Items to Escalate

To: Triple Lock approval process

- DMARD Shared Care and warfarin monitoring transfer.
- Investment to support primary care resilience.
- Proposed new Enhanced Monitoring Arrangement – adult ADHD medication.
- Subsidy of service charges for Elizabeth Courtauld Surgery.

13. Any Other Business

SA remarked the first face to face committee meeting had been very successful and asked members to consider the possibility and frequency of future face to face meetings to be held at Anglia Ruskin University (ARU).

ACTION: JK to investigate potential dates and logistics for future face to face meetings at ARU.

14. Date of Next Meeting

Wednesday, 10 April 2024
3.30 – 5.30 pm
Via Microsoft Teams

Minutes of Part I Quality Committee Meeting

Held on 23 February 2024 at 10am – 1pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member & Chair of Committee.
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member.
- Dr David Walker (DW), Chief Medical Officer, MSEFT.
- Joanne Foley (JF), Patient Safety Partner.
- James Hickling (JH), Deputy Medical Director.
- Wendy Dodds (WD), Healthwatch Southend.
- Alison Clark (AC), Essex County Council.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex.
- Stephanie Dawe (SD), Provide (left meeting during item 6).

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience (deputising for Dr Giles Thorpe).
- Viv Barker (VB), Director of Nursing for Patient Safety.
- Sara O'Connor (SOC), Senior Corporate Services Manager.
- Gavin Tucker (GT), Senior Clinical Fellow.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Karen Flitton (KF), Patient Safety Specialist.
- John Swanson (JS), Lead Nurse for Infection Prevention and Control.
- Maria Crowley (MC), Interim Director of Children, Mental Health, and Neurodiversity.
- Emma Douglas (ED), Babies Children and Young People Programme Support Manager.
- Kay Rumsey (KR), NELFT.
- Dawn Osborne (DO), Associate Director of Patient Safety, MSEFT.
- Lucy Millard (LM), NELFT.
- Emma Everitt (EE), Business Manager, Nursing and Quality.
- Helen Chasney (HC), Corporate Services and Governance Support Officer (minute taker).

Apologies

- Dr Giles Thorpe (GT), Executive Chief Nursing Officer.
- Dr Matt Sweeting (MS), Interim System Medical Director.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.
- Diane Searle (DS), Community Collaborative Lead.
- Peter Devlin (PD), Director of Adult Social Care Mental Health, Essex County Council.

- Amba Murdamootoo (AM), Deputy Director of Clinical Quality and Patient Safety, NHS England.

1. Welcome and Apologies

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

2. Declarations of Interest

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

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

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 15 December 2023 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 15 December 2023 were approved.

4. Action log

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

Action 48 – VB advised that the paediatric quality assurance visits for all three acute hospital sites had been undertaken and the report had been shared with Mid and South Essex Foundation Trust (MSEFT).

Resolved: The Committee noted the Action Log.

5 and 6. Lived Experience Story & Deep Dive – Sepsis

SM explained that due to the nature of sepsis it had been challenging to obtain a lived experience story, however the patient story would be weaved into the deep dive.

DO summarised sepsis national data provided by the Sepsis Trust 2024 and advised that sepsis claimed more lives than lung cancer, bowel, breast, and prostate cancer combined.

A sepsis national patient safety alert was received in 2014 with an aim to raise awareness and was communicated to clinicians in several settings, including ambulance services, acute trusts, and primary and community care. In 2006, the Sepsis 6 project was introduced and was still being used in the system.

MSEFT utilised paper and electronic sepsis tools in accordance with National Institute for Health and Care Excellence (NICE) guidelines. The Basildon site utilised the deteriorating patient tool and Southend and Broomfield sites utilised the national Sepsis 6 tool.

With the introduction of Patient Safety Incident Response Framework (PSIRF), all incidents, including sepsis, would be reviewed to identify which required further investigation. The learning identified was shared with those involved in the incident and then circulated wider using case studies for teaching. The patient safety team reviewed patient safety alerts, which were circulated trust wide and fed into divisional governance meetings.

Several training mechanisms relating to sepsis had been held and included induction for newly qualified nurses, junior doctors and healthcare assistants, team days, a rolling programme of micro teaching, grand rounds, and an e-learning package.

World Sepsis Day helped to raise awareness and there were several information sources on the intranet with links to the Sepsis Trust. Trust staff were awarded 'sepsis stars' for good practice. Recordings of good care events, audit data and oversight reports would be presented to the Deteriorating Patient Group (DPG). Following the transition to PSIRF, the DPG would also be reviewing incidents relating to sepsis, learning responses and any learning identified via thematic reviews.

A unified sepsis tool had been implemented for Children and Young People (CYP) due to the number of sepsis incidents reported. All staff groups had received teaching. Sepsis audit and compliance was reviewed and standardised across all sites. Paediatric simulation training was being developed.

New NICE guidance was published in January 2024 and MSEFT were reviewing their current position for sepsis in adults, CYP and maternity.

A Task and Finish Group, with relevant subgroups, would be reviewing the current DPG meeting structure, NICE guidance, and tools currently being utilised, with a view to standardisation across all three sites, as well as reporting processes and training resources.

SP asked how aware GPs in Primary Care and the community were of sepsis. VB advised that the responsibility to educate the public would primarily sit with public health colleagues. However, health professionals had a responsibility in understanding the red flags regardless of clinical setting. LM suggested that events could be held in shopping centres and in high streets to raise awareness to members of public.

In response to a query from NIB, DO confirmed that all incidents were reviewed daily using the PSIRF framework, with corporate oversight. If several sepsis cases had not been well managed, a thematic review would be undertaken, whilst each individual case would be reviewed to initiate duty of candour.

JH advised that access to primary care was an issue and also patient triage for recognition of the patient who required to be seen urgently. Recognition of sepsis was not part of mandatory training in primary care for clinical and non-clinical staff and could be considered. However, GPs had raised concerns that the set thresholds could result in many patients being sent to hospital, therefore judgement would be required in some cases, which was often a grey area.

LM provided an update for North East London Foundation Trust (NELFT). Since the transition to PSIRF, a patient safety incident group had been formed where all incidents were reviewed, including those relating to sepsis. A decision would be made on the investigation to be undertaken and would be linked to learning cascades, which were one-

page bulletins circulated to clinicians. Other digital options were being reviewed, such as messaging through apps on mobile phones. Patient safety champions had been introduced and were supporting the movement of information around the organisation. The outcomes of the after-action reviews and swarm huddles ensured that information was being disseminated and retained.

Training was held online and in person, which included simulation training. It was recognised that there was further work to do and there should be a continuous culture message about sepsis.

Local initiatives held included highlighting World Sepsis Day, consideration of joint pathways with ideas from system partners and patient safety partners which educated staff through lived experiences. LM provided an example of learning following two recent after-action reviews which had shaped a new work plan.

The Deteriorating Patient Policy was being reviewed in accordance with new NICE guidance, the sepsis pathway was being developed with system partners and consideration was being given to implement the option of virtual reality training in the future.

JS asked if it would be a community collaborative approach across the system. LM advised that the initial scoping had been completed and the plan would be to review how pathways could be developed collaboratively. VC advised that an update would be provided on the community collaborative approach to sepsis.

Resolved: The committee noted the deep dive relating to Sepsis.

Action: VB to provide an update on the community collaborative approach to sepsis.

7. Safety Quality Group - Escalations

SM provided a verbal update on the following key points:

The revised Terms of Reference and workplan for the Safety Quality Group (SQG) was working exceptionally well. The group had undertaken their first deep dive on childhood asthma. There were multiple points of learning with involvement from the ambulance service, acute and community providers and good assurance was provided that learning was being applied, by individual members of staff and across the system. The second deep dive focussed on Special Educational Needs and Disability (SEND) best practice standards and the requirement for providers to undertake a self-assessment for supporting children with special educational needs or a disability. This work was underway across all three system partners (Southend City Council, Thurrock Council and Essex County Council) and would be good preparation for their Ofsted inspections.

Tissue viability management was a key quality concern and consideration was being given to establishing a system harm free group to review sepsis, tissue viability and other key safety issues. A deep dive on tissue viability, to include care home settings, would be presented at the next SQG meeting.

Consideration was also being given to establish a system wide learning from deaths group as a subgroup of SQG.

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

escalations.

8. Emerging Safety Concerns/National Update

SM highlighted the following key issues:

Chief Nursing Officers and Medical Directors had been contacted regarding the enactment of Martha's rule. The ICB Executive Chief Nursing Officer met with MSEFT's Chief Nursing Officer to determine whether an expression of interest to be included in the first wave of 100 hospitals to implement Martha's rule would be submitted. It was reported in the media that there were plans to roll out Martha's rule to community and mental health settings in 2025.

An independent review on mental health services had been undertaken in Greater Manchester, which resulted in several recommendations applicable to all mental health providers. The ICB was currently reviewing the recommendations and undertaking a gap analysis to present to the Executive Team and Quality Committee for further discussion.

New visitor legislation in care home settings and hospitals had been published and would provide the Care Quality Commission (CQC) powers to assess and act where legislation was not being supported.

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

9. ICB Board/SOAC concerns and actions

SM advised of key items reported at the System Oversight and Assurance Committee (SOAC) meeting.

Concern was raised on whether the performance metrics for mental health were scrutinised appropriately. A specific group would be created, led by the ICB Executive Chief Nurse in conjunction with NELFT and EPUT, to scrutinise the reporting and performance metrics.

NIB highlighted that SOAC escalated issues to the Chief Executives Forum and the sovereign boards where no progress had been made so triangulation would occur beyond the ICB. Any issues or concerns identified at Quality Committee could also be provided to SOAC. SM advised that a quality report was provided to SOAC.

In response to a query from SP regarding the effectiveness of the training, SM advised that all training at providers was monitored and challenged when required. There were currently no concerns that the management of mental health was not being handled appropriately.

Resolved: The Committee noted the verbal update on ICB Board/SOAC concerns.

10. Outcome of Nitrous Oxide Serious Incident Independent Investigation

DW advised that the external investigation report relating to the nitrous oxide incident at Basildon maternity unit focused on the period from July 2021 to October 2022, during which the Trust received a report to advise that levels of background nitrous oxide were above safe levels. The event had not been declared a serious incident (SI) until October 2022, and following that, no further concerns were raised with regards to the management of the incident and external partners were involved from that point. The report focused on why it

was not declared a SI at the time and why appropriate actions were not taken.

The executive summary report with recommendations had been provided and would be published. The full report would be published when ongoing HR processes had been completed.

The report found an unacceptable delay in responding to and mitigating a serious risk which resulted in an unnecessary risk to staff working in the department. The Health and Safety Executive (HSE) had also investigated and were content with the actions taken. The reasons for the failure to escalate, was that although policies were in place, some individuals were unclear about their roles and responsibilities. A risk management process was in place, but the risk was not escalated to the Board until October 2022. There was also fragmented leadership and ownership throughout the organisation. The Trust was not aware of any harm caused to staff, however there was potential for harm. It was acknowledged that governance processes were not functioning properly, and an action plan had therefore been developed, which included an external governance review.

This paragraph was minuted confidentially.

In response to a query from VB, DW confirmed that the Trust's communications team was preparing for any media enquiries. VB requested that the ICB was kept informed in case any enquiries were received by the ICB.

SP asked about the process if harm was identified. DW advised that strenuous attempts were made to contact all staff who had worked in the department through several routes.

NIB advised that although no harm had been identified to-date, harm might be identified at a later date.

NIB advised that it would be beneficial for the committee to know what action had already been implemented and there must be consistency and honesty when responding to any media enquiries.

DW advised that the action plan would be based on the final report, however several actions such as the external governance review and a review of the organisational structure were underway. With regards to harm, every individual in the department was offered expert medical support and they would continue to be followed up in the future.

NIB thanked DW for presenting the report in a transparent and honest manner.

Resolved: The Committee noted the executive summary of the Nitrous Oxide Serious Incident Independent Investigation.

11. MSEFT / Acute Care Update

DW highlighted the following key issues:

Three Never Events were reported by the Trust in November 2023. The Never Event Group carried out analysis for common themes and processes were implemented to reduce the risk of reoccurrence.

The Summary Hospital-level Mortality Indicator (SHMI) had been high for some time. A coding issue had been rectified which had reduced the SHMI, but not to acceptable levels,

and problems with coding capacity remained. Coding was based on discharge summaries which gave a partial depth.

The backlog of Structured Judgement Reviews (SJRs) had been 99% cleared by 31 December 2023. The remaining cases were not completed due to the inability to locate the patient notes. No alarming themes or consistent issues had been identified.

Some pressure ulcers had been incorrectly classified and work was underway to rectify this. Staff shortages were reported in the Tissue Viability service due to vacancies and sickness. There were technical issues with Venous Thromboembolism (VTE) screening and the Trust were waiting for internet issues to be rectified before the installation of electronic prescribing which could help to prevent errors.

Harm due to patient falls had reduced but would be a continual focus.

VB referred to the poor compliance with local Key Performance Indicators (KPIs) for safeguarding training and asked what remedial actions were in place. DW advised that an ongoing specific programme was in place and reported through the Trust's Quality Committee.

VB advised that some patients who attended outpatient settings or were discharged from hospital had medication changes but did not discuss those with their GP. DW advised that the long-term solution would be digital dictation, which was currently being piloted, and if successful, would be rolled out to the whole organisation in the next six months. There were still backlog issues with letters and every department had produced a trajectory monitored through Divisional Governance Boards and monthly accountability meetings.

VB commented that the classification and early intervention of pressure ulcers was discussed at SQG and several actions linked acute and community providers. DW advised that there had been an increase over the winter period, possibly due to delays in patients getting to hospital and then waiting in Accident & Emergency (A&E).

In response to a query from SP with regards to the increase of falls resulting in harm, DW advised that the Trust saw a higher acuity of patients in the wards during the winter period.

Resolved: The Committee noted the MSEFT/Acute Care Update report.

12. Community Collaborative Update

NIB invited committee members to comment on the report.

In response to query from PW, VB confirmed that a review of district nursing in all areas was being undertaken with a view to harmonising services across the system.

Resolved: The Committee noted the Community Collaborative Update report.

13. Primary Care Update

VB reminded committee members that the paper was presented to the Primary Care Commissioning Committee and contained confidential information so should not be shared. The report was taken as read and committee members were invited to ask questions.

PW advised that discussions had been held on how quality in pharmacy and clinical

services would be monitored now that they were delivering a broader range of services, and this should be reflected in future primary care reports.

SP commented that the dashboards were difficult to read. VB provided reassurance that the dashboards were reviewed in granular detail at risk review meetings. VB agreed to provide a link to the Alliance dashboard report and advised that the dashboards inform the level of quality surveillance each practice requires.

Resolved: The Committee noted the Primary Care Update report.

Action: VB to provide a link to the Alliance dashboard report in future reports.

14. Infection Prevention and Control Update

JS highlighted the following key issues:

The C.diff rates within MSEFT reduced in the last quarter and the good work undertaken had been recognised by the national team. The review of C.diff cases had changed significantly, and the national team were looking to adopt the process across the NHS.

An upturn in bacteraemia rates was reported within the acute trust and the system. The themes were sporadic and multi factorial due to patients with complex needs. However, there was an overriding theme of poor documentation of invasive devices. The ICB Infection Prevention and Control (IPC) Team were supporting the Trust.

The Group G strep incidents within South East Essex had increased and were being monitored by the weekly incident management team meetings. There had been 31 reported cases to date. The case definition for inclusion and consideration of an outbreak was being reviewed and therefore, out of the 31 cases reported, 12 would be considered as a period of increased incidence. Group G Strep was not commonly linked to outbreaks and other organisms could also carry the Group G genetics. The prevalence of Group G Strep reported was about 1,400 cases per year within England. Work was ongoing to enhance the infection prevention and reduce transmission where possible.

PW asked if patients were showing signs of infections or was this identified through a routine swab. JS advised that patients were screened due to delayed healing of their wounds or those that looked like an infection. The Group G Strep had not been seen before in these areas so further investigation was required.

JH asked if community nursing teams took swabs not required. JS advised that EPUT referred poor and delayed healing to the Tissue Viability Nurse (TVN) service for guidance. Discussions had been held with NELFT and Provide IPC teams about processes, the re-enforcing of the organisations wound management policy and TVN provision. The learning and themes from this period of increased incidence would be shared with IPC community collaborative. There was a plan for a collaborative wound management approach across the three community providers.

Resolved: The Committee noted the Infection Prevention and Control Update report.

15. Special Educational Needs and Disabilities (SEND) Update

SM highlighted the following key issues:

The demand and capacity for SEND had increased and was being actively managed by the three local area partnerships.

The Southend area partnership received an Ofsted inspection in February 2023 and were working through the recommendations and action plans. There was a follow up visit in February 2024 which identified some positive progress, however it was identified that the impact of the improvements and changes made needed to be measured.

All areas partnerships were working through the self-assessment document to identify current strengths and areas for development.

The ICB maturity matrix reports had been submitted to NHS England (NHSE) and were rated as Amber. There were some areas detailed in the report which required further development across the local area partnerships.

The demand issues were impacting on the educational needs assessments, which were being supported by the Designated Clinical Officer (DCO) from a health perspective, and the quality-of-care plans.

The number of tribunals and appeals were increasing and being managed.

Resolved: The Committee noted the SEND Update report.

16. Neurodiversity (Autism Spectrum Disorder (ASD)/Attention Deficit Hyperactivity Disorder (ADHD)

MC presented the key highlights from the Neurodiversity demand and capacity review:

A task and finish group had been established, with input from finance and contract colleagues, data analysis and provider intelligence. The key areas reviewed were financial allocation and contracts.

The contracts provided a fragmented position with 22 contracts held for ADHD and Autism and 1 for Tourette's Syndrome. Some contracts were locked and therefore some financial information was unable to be extrapolated. The contracts totalled £6million excluding the block contracts, of which, £1.6 million was for prescribing and was continually increasing.

The data was drawn from SystmOne which, due to GPs' shared agreements, was unable to provide an accurate representation. The data from the Essex Joint Minimum Dataset, was more reliable, however did not feed into a central repository.

GTu advised that the Office for National Statistics projected that the number of children across each local authority area would plateau at the year 2030, however there would be an increase in the number of adults, which could result in an implication with contracts.

The current numbers of an ADHD and Autism diagnosis or both were in line with national estimates. Guidance provided by NHSE for ICBs planning their autism services stated an assumed level of 1.1% of population should have a diagnosis of autism but varied dependent upon age group and level of deprivation.

There was good evidence nationally to show the percentage of people referred for an autism or ADHD assessment, resulted in a diagnosis. For children and young people services who were referred for an autism assessment, 19% of them would receive another

neurodevelopmental diagnosis.

For autism, there were more children being diagnosed in primary care, and many autistic adults did not have a diagnosis. However, there was no evidence of an increased underlying prevalence. The likelihood of receiving a diagnosis depended upon a certain level of clinical disfunction and was more likely that non-medicalised support would not be available if you were in a deprived area. There was a link between age and deprivation in terms of the Autism diagnosis rate.

There was minimal national policy guidance for ADHD. A random sampling of the population showed that 1.7% of children had a hyperactivity disorder and no evidence that was linked to deprivation and the highest rise in diagnosis was men aged 18-29. In terms of health inequalities, if you were in a deprived area, you may not receive the early intervention of non-medical social support, which could result in receiving medication.

Details of emerging issues were provided as contained within the report, which included significant variation in provision and service specification of contracts, which had been extended to 31 March 2025 whilst issues were being addressed.

The recommendations for Stage 2 of the forward plan were provided, which included the requirement to develop new partnership models, national prioritisation, right to choose framework, develop data dashboards and an increased focus of support in education models.

The findings had been circulated to wider system partners and the Southend, Essex, and Thurrock local authorities. A new post had been approved to support the next stage and providers could be asked to review their contracts and join up the system thinking.

SM asked for assurance that patients with or without a diagnosis were accessing the right treatment and getting the best experience and was there a cohort not being captured as young girls presented differently with ASD. MC advised that assurance could not be provided as there were concerns that care was not being accessed at the right time in the right place. In terms of assessment, the right to choose framework had enabled people access for routes into treatment, which was the rationale for redesigning the service. GTu advised that the criteria for autism had changed in 2015 to include a broader range of presentations and meant that there would a gradual culture shift, which was also reflected in the national standard assessment tools. There was also a delay in the provision of data.

SP asked why the voluntary sector had not been included and what the actual percentages of the population from each area were and if the contracts could be mapped to identify demand and where the service was lacking. GTu advised that the next step would be to review the alliance population breakdown by children and adults. MC advised that no contracts were held in the voluntary sector. The highest need areas were being reviewed by the correlation of the three providers of children services (NELFT, Provide, EPUT). The new role would be reviewing the three areas and provide support where required.

JH commented that GPs were providing shared care out of the normal shared care agreement which they were not being paid for. A paper was being presented at Primary Care Commissioning Committee (PCCC) with a potential plan to contract GPs to provide a shared element of adult ADHD treatment and requested an estimate of how many adult ADHD patients in MSE were likely to need medication via shared care over the next five

years. GTu advised that the national primary care dataset showed that average of 60% were on medication that had a diagnosis. This would be discussed further offline.

PW highlighted that the issue with inequalities was due to waiting lists and patients seeking private treatment and then returning to GPs for ongoing prescribing. The Defining the Boundaries Policy, between NHS and private care, stated that whilst every patient has the right to return to the NHS at any point, they should not obtain benefit from doing so, which should be communicated clearly to patients.

RJ commented that there were so many synergies with Alliances and place-based working, including community engagement, Voluntary, Community or Social Enterprises (VCSE), primary care and social care and would encourage the conversation to bring the two agendas closer together.

Resolved: The Committee noted the Neurodiversity Update report.

17. Revised Policies

17.1 071 ICB Prevent Policy

SM invited the committee to provide comments to the governance team by Friday 1 March.

Resolved: The Committee approved the ICB Prevent Policy, subject to any comments submitted.

17.2 064 Safeguarding Supervision Policy

SM invited the committee to provide comments to the governance team by Friday 1 March.

Resolved: The Committee approved the Safeguarding Supervision Policy, subject to any comments submitted.

17.3 092 Provider Accreditation Policy

Following Board approval, this policy was provided to the Committee for noting only.

Resolved: The Committee noted the Provider Accreditation Policy.

18. Patient Safety & Quality Risks

SO advised there were currently 17 risks within the remit of Quality Committee, some of which were also reviewed by the ICB's SOAC and/or PCCC. The ICB's Audit Committee also received a copy of the full risk register and Board Assurance Framework (BAF) at each meeting and undertook deep dives into specific risks.

There were 6 risks currently rated red, as set out in the report, these being:

1. Health inequalities (improving access to services and patient outcomes).
2. Mental Health Provider Quality Assurance.
3. Quality Assurance of Autism Spectrum Disorder (ASD) services.
4. Compliance with Mental Capacity Act 2005
5. Acute Provider Quality Assurance.
6. Maternity Services

The remaining 11 risks were rated Amber.

There were no new risks added since the last committee meeting and none recommended for closure.

Appendix 1 provided an update on the risks.

The quality/safety related risks on the ICB's BAF were set out at Appendix 2. These were last updated for the Part I ICB Board meeting held on 18 January 2024 and would be updated prior to the March Board meeting.

Now that the reorganisation of the ICB had been completed, a full review of the ICB's risk management arrangements, including a review of the BAF, risk register, risk appetite, risk rating matrix/impact assessment table, committee responsibility would commence in mid-March in preparation for implementation of the RLDatix module for risk registers which was due to go live on 1 April 2024.

SO confirmed that Non-Executive and Partner Board members would be involved in the review in due course.

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

19. Review of Committee Effectiveness, including review of workplan and Terms of Reference

SOC advised that a review of committee effectiveness was undertaken every year. A desk-top review was being developed and it was proposed that committee members would be asked to complete a short online survey. A report on the outcome of the assessment would be submitted to the next meeting and would also include a review of the workplan and committee terms of reference.

NIB suggested that the workplan should be flexible so that urgent items could be included and requested members should attend the whole of each meeting so that full discussions could be held with shared learning. The committee paperwork would also be reviewed to maintain consistency and ensure important areas were highlighted.

Resolved: The Committee noted the verbal update on the Review of Committee Effectiveness, including review of workplan and Terms of Reference.

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

There were no escalations.

Committee members were asked to provide deep dive suggestions by Friday 1 March.

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

21. Any Other Business

SP referred to the recent incident in the media regarding a still born baby and a mix up with the scan and asked if any lessons had been learnt from previous events. DO confirmed that the incident was reviewed at the time. However, when stillbirths occur, there were a variety of mechanisms that the review goes through. Following review through the multi-disciplinary team process, the incident would be presented to a panel next week. Some actions identified had been implemented. It was not clear if the incident met the definitive criteria to be referred to Maternity and Newborn Safety Investigation (MNSI).

VB provided reassurance that all patient safety investigation meetings were attended where all incidents were discussed, and the level of harm agreed.

SP requested reassurance that the processes in place were implemented and that a difference was being made. DO advised that reporting within maternity services nationally had been different for number of years. The reporting criteria to MNSI, formerly HSIB, had meant that there had been a cohort of incidents that were investigated differently with more system-based learning. A maternity assurance committee had been formed and fed into the Trust's Quality Committee. There were significant workstreams undertaken nationally, with local learning feeding into those workstreams and linked in with NHSE and regional teams. GH had provided support with a review of previous stillbirths recently and parents were involved in the process for a collaborative review.

KF advised that there would be more shared learning once the PSRIF methodology was embedded. The Never Event classification was currently out for consultation. DO advised that the maternity team had a Local Maternity and Neonatal System (LMNS) meeting where learning was shared with Suffolk and North East Essex ICB, which would be enhanced with PSIRF.

VB advised on staffing / leadership issues at Halstead community ward which could potentially negatively impact on patient safety. To mitigate, a member of staff from Provide would take over the leadership role.

22. Date of Next Meeting

Friday, 26 April 2024 at 10.00 am to 1.00 pm via MS Teams.