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, 12 September 2024 at 2.00 pm – 3.30 pm

Spring Lodge Community Centre, Powers Hall End, Witham, Essex CM8 2HE

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	3-6
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of Minutes of previous Part I meeting held 11 July 2024	Approve	Attached	Prof. M Thorne	7-17
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	18
		Items for Decision / Non-Standing Items				
7.	2.15 pm	Health Inequalities (HI) Update Report and HI Statement 2023/24.	Ratify	Attached	E Hough	19-97
8.	2.25 pm	System Response to NHSE Letter on Corridor Care	Note	Attached	E Hough	98-116
		Standing Items				
9.	2.35 pm	Chief Executive's Report, including MSE ICB Annual Assessment 2024/25	Note	Attached	T Abell	117-131
10.	2.45 pm	Quality Report	Note	Attached	Dr G Thorpe	132-136
11.	3.00 pm	Finance & Performance Report	Note	Attached	J Kearton	137-149
12.	3.15 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis	150-166
13.	3.25 pm	General Governance: 13.1 Board Assurance Framework 13.2 Revised Policies	 Note Note	 Attached Attached	 T Abell Prof. M Thorne	 167-182 183-185

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		13.3 Approved Committee minutes	Note	Attached	Prof. M Thorne	186-241
14.	3.29 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
15.	3.30 pm	Date and time of next Part I Board meeting: Thursday, 14 November 2024 at 2.00 pm, Basildon Sporting Village, Cranes Farm Rd, Basildon, Essex SS14 3GR.	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - August 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	
Tom	Abell	Chief Executive Officer	Aidsmap, a HIV information service charity			x	Direct	Chair of Trustees	Jan 2020	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Tom	Abell	Chief Executive Officer	Community First Responder			x	Direct	Community First Responder (voluntary)	Nov 2023	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Kathy	Bonney	Interim Chief People Officer	Nil								
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in
Anna	Davey	ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	Ongoing	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Peter	Fairley	ICB Partner Member (Essex County Council)	Director for Strategy, Policy and Integration, at Essex County Council (ECC)	x			Direct	Essex County Council (ECC) holds pooled fund arrangements with NHS across Mid and South Essex. I am the responsible officer at ECC for the Better Care Fund pooled fund. ECC commissions and delivers adults and childrens social care services and public health services. ECC has some arrangements that are jointly commissioned and developed with NHS and local authority organisations in Mid and South Essex. ECC hosts the Essex health and wellbeing board, which co-ordinates and sets the Essex Joint Health and Wellbeing Strategy	01/07/22	Ongoing	Interest declared to MSE ICB and ECC. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Peter	Fairley	ICB Partner Member (Essex County Council)	Essex Cares Limited (ECL) ECL is a company 100% owned by Essex County Council. ECL provide care services, including reablement, equipment services (until 30 June 23), sensory services and day services, as well as inclusive employment	x			Direct	Interim CEO	03/04/23	Ongoing	Interest declared to MSE ICB and ECC. Be excluded from discussions/deicsions of the ICB that relate to ECL services or where ECL may be a bidder or potential bidder for such services. If in potential conflict take the advice of the Chair/ Monitoring Office and if need be absent one's self from the vote/ discussion.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director of Company - provides individual coaching in the NHS, predominantly at NELFT and St Barts	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Partner is NELFT's Interim Executive Director of Operations for North East London (Board Member).	01/03/19	Ongoing	I will declare my interest as necessary to ensure appropriate arrangements are implemented.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England	x			Indirect	Son (Alfred) employed as Head of Efficiency.	Jan 2023	Ongoing	No conflict of interest is anticipated but will declare my interest as necessary to ensure appropriate arrangements are implemented.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
Matthew	Hopkins	ICB Board Partner Member (MSE FT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive	01/08/23	Ongoing	Interest to be declared, if and when necessary, so that appopriate arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Jennifer	Kearton	Chief Finance Officer	Nil								
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Essex Partnership University NHS Foundation Trust	x			Direct	Chief Executive Officer	01-Jul-23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.

Mid and South Essex Integrated Care Board
Register of Board Members' Interests - August 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	
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Borough Council	x			Direct	Employed as Corporate Director of Adults, Housing and Health.	01/03/21	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Thurrock Joint Health and Wellbeing Board		x		Direct	Voting member	01/06/15	Ongoing	Interest noted on ICB Board register of interests presented to each meeting. Interest to be highlighted where necessary in accordance with Conflicts of Interest Policy so that appropriate arrangements can be implemented.
Ian	Wake	ICB Partner Member (Thurrock Borough Council)	Dartmouth Residential Ltd	x			Direct	99% Shareholder and in receipt of income.	01/10/15	Ongoing	Interest to be declared if and when any matters relevant to this company are discussed so that appropriate arrangements can be implemented.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

Mid and South Essex Integrated Care Board - Register of Interests
August 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
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.
Lucy	Wightman	Chief Executive, Provide Health	University of Essex		x		Indirect	Honorary Professorship		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Health Council Reform (Health Think Tank)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The International Advisory Panel for Academic Health Solutions (Health Advisory Enterprise)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Faculty of Public Health		x		Indirect	Fellow		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	UK Public Health Register (UKPHR)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Nursing and Midwifery Council		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide CIC	x			Direct	CEO Provide Health and Chief Nurse	02/04/24	Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Wellbeing	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.

Mid and South Essex Integrated Care Board - Register of Interests
August 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
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Lucy	Wightman	Chief Executive, Provide Health	Provide Care Solutions	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	React Homecare Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The Provide Group Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.

Minutes of the Part I ICB Board Meeting

Held on Thursday 11 July 2024 at 2.00 pm – 3.40 pm

Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend-On-Sea, Essex, SS2 6ER.

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tracy Dowling (TD), Interim Chief Executive, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Mark Harvey (MHar), Partner Member, Southend City Council (up to item 11).
- Ian Wake (IW), Partner Member, Thurrock Council.
- Peter Fairley (PF), Partner Member, Essex County Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Neill Moloney (NM), Executive Director of System Recovery, MSE ICB and Mid and South Essex NHS Foundation Trust (MSEFT).
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- 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.
- Tonino Cook (TC), Executive Business Manager, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.

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

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

MT formally introduced Lucy Wightman, Chief Executive Officer, Provide Community Interest Company, and a round table of introductions were given.

Apologies were noted as listed above.

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

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

Declarations made by the Integrated Care Board (ICB) Board members and other attendees were listed in the Register of Interests within the meeting papers.

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

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

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

Sue Rogers queried the length of time that members of the public were given to submit their questions of the Board. NA explained that the requirement to submit questions three working days before the Board meeting was to enable a response to be prepared, which had been extended this month due to the election period.

However, general enquiries could also be sent to the ICB enquiries inbox as indicated on the ICB website, which would be responded to accordingly.

Steve Rogers asked whether the raw data associated with the results of the consultation regarding medical services in Maldon could be shared. CH explained that unfortunately the raw data could not be shared, which was due to the data collection processing notice not stating that the information provided by the public could be shared with other people.

Eric Watts asked what progress had been made in implementing NICE Guideline (NG 197) regarding shared decision making and what was the intentions in respect of appointing a patient director. MS explained that there was a high focus on shared decision making, both within the stewardship programme, and the clinical lead for personalised care, which had been outlined previously. There were no plans to appoint a patient director presently, but this would be kept under review.

Peter Blackman sought clarification regarding the neurological rehabilitation services considering the 'contract award for Neurological Rehabilitation Services (level 2b inpatients) across the ICB' as noted in the Chief Executive's Report. TD clarified that the contract award was classed as an 'urgent' contract award because the existing contracts for level 2b neurological rehabilitation service standards were due to expire and without a block contract, the service would need to be spot purchased for every patient who required this service, including inpatients, at a higher price and less guarantee that places could be secured in neurological rehabilitation centres in the East of England. The executive team therefore supported the recommendation to extend the existing block contracts for a further 12 months. Specialist commissioning services had now been delegated to the ICBs, led by the Bedfordshire, Luton, and Milton Keynes ICB, with the expectation there would be a review of neuro rehabilitation and other specialist rehabilitation commissioning, although no timeline had been confirmed. One of the potential benefits of delegating responsibilities to the ICBs, was that it provided more flexibility to look at the feasibility, both clinically and financially, of bringing specialised services closer to home.

4. Minutes of the ICB Board Meeting held 9 May 2024 and matters arising (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 9 May 2024 and asked members if they had any comments or questions.

No comments were submitted and there were no matters arising.

Resolved: The Board approved the minutes of the ICB Board meeting held on 9 May 2024, as an accurate record.

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

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

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

6. Proposed changes to services at local community hospitals: draft consultation outcome reports (presented by E Hough)

EH advised that the ICB had completed the public consultation to seek the views on proposals related to community hospitals including potential changes to community hospitals intermediate care (IMC) and stroke rehabilitation services; to make Braintree the permanent location of the midwife led birthing unit in Mid and South Essex (MSE); and the potential relocation of other services from St Peters Hospital to other locations in and around the Maldon district.

The consultation took place between 25 January and 11 April 2024, supported by Stand, an expert independent consultation agency. The Board were reminded of their duties and responsibilities with consultations on significant changes, in relation to equality and health inequalities and having due regard to how inequality could be addressed, particularly regarding access, outcomes and services. The Board also had a specific duty to receive and review these reports which continued through to decision making, conscientiously considering the feedback received from members of the public and staff, alongside other relevant factors, such as clinical, financial, and practical operational factors.

In line with best practice, there would be a period to allow for members of the public to

feedback on the draft report on points of accuracy until 31 July 2024 and an online meeting, facilitated by Stand, would be held on 18 July 2024.

EH introduced PP and thanked him and his team for the huge amount of work with supporting this process. PP thanked everyone for taking part in the consultation and summarised the findings of the consultation response draft report. The slides and a video summary of the consultation response were available on the Virtual Views platform on the website.

Response to the consultation included 5,544 survey responses, 310 people attended events, 407 staff members attended staff events, 61 people took part in focus groups being run by local organisations and 14 groups of individuals and public representatives prepared evidence, which was presented at one of the consultation hearing sessions held in March and April. There were more than 20,000 page views on the website and 216 media stories and television coverage. It was noted that 577 people attended other events, including the event held by Sir John Whittingdale, MP for Maldon, and 1108 responses were received to his additional survey.

Two reports were published, the main consultation report, which was feedback from all channels set up; and the consultation hearing report which related to the proceedings and requested feedback to ensure there was an adequate reflection of the evidence provided. The analysis report for Sir John Whittingdale's survey had been omitted from the Annexes due to the election restrictions and a delay in sharing the report with Sir John Whittingdale for his review and response prior to it being published.

PP outlined the profile of people responding to the survey and provided detailed insight to those responding to each section of the survey which was included in the full report on the website. The following key recurring themes were noted:

- Requests for the ICB to reconsider the refurbishment or rebuilding of St Peters Hospital (SPH).
- Frustration about perceived under investment and mismanagement and a history of unfulfilled promises.
- If SPH was sold, the proceeds should be returned to the NHS in the Maldon district for reinvestment.
- Concerns regarding travelling and access difficulties, including increase travel for support networks, increased costs, difficulties with public transport, parking and the associated stress and inconvenience.
- Decisions being financially driven and not patient centred.
- Positive feedback for the midwife led birthing unit that was newer, fit for purpose, increased capacity, 24-hour staffing and proximity to Broomfield, improving outcomes.
- Uncertainty for the local population, particularly elderly residents.

MT opened questions and asked if the ICB had adequately made people aware of the proposed changes, particularly in the Maldon district. PP advised that there had been more responses received to this consultation than most NHS organisations would expect.

GT asked if Stand were satisfied that sufficient efforts had been made to contact the most vulnerable people affected, specifically the underrepresented voices of maternity services

around the Maldon area. PP advised that the response rates had been monitored throughout the process, and where response rates were low, the process was revisited which had resulted in a higher response rate.

GW asked if any specific issues were consistently raised across the different groups. PP confirmed that concern regarding travel and transport was consistently raised as a key issue.

NIB asked if there was a gender breakdown and what channels were used to reach new mothers. PP advised that specific groups in the network were targeted, and system partner organisations provided support to reach those groups. The initial response was low and other groups were then reached. Two responses were received from LGBT mummies group and the demographics for that section of the consultation were set out in the report.

RJ noted the low engagement from the Voluntary, Community, Faith, and Social Enterprise (VCFSE) forums and asked for assurance that the targeted outreach was sufficient and if there was a process in place to continue engagement with those groups until the end of the consultation. PP confirmed that enough responses had been received. CH commented that consultation was the formal process with regards to decision making, and the engagement and involvement work would continue throughout the process with key stakeholder groups, particularly VCFSE and Healthwatch organisations.

Following a question from MB, PP explained that any inaccuracies raised and substantiated would be made and shared with the ICB Board and made publicly available.

SP asked how members of the public who had literacy issues were reached and if support was provided. PP confirmed that as standard, an easy read format of the survey was published, and support provided with completing the surveys. The voluntary sector groups also supported with translations.

GO asked if there had been any impacts on the process following the recent elections. PP confirmed that the process had proceeded as planned. The only impact was the time of publishing the draft consultation report which originally should have been 19 June 2024, but was delayed due to the election restrictions.

Following a question from MS, PP advised that staff engagement was completed by the trusts and Stand received the outputs, which were included in the report. A total of 407 attended the staff consultation events.

JF noted the strong consensus of feeling and asked if there were any notable areas where stakeholders had significantly different opinions. PP advised that the variances were quite small with the midwife led birthing unit proposal. However, for the different options for Stroke and IMC, the people of Brentwood preferred Option B, there was a small preference from Rochford residents and staff for Option A.

TD asked how the petitions received were considered as part of the consultation process. PP advised that the petitions received were noted in the analysis report and considerations should be given to these in addition to the report.

Resolved: The Board noted the draft outcome of the consultation report and the consultation hearing report and acknowledged that members of the public who took part in the consultation process had until 31 July 2024 to provide feedback to Stand on the contents of the outcome report.

7. MSE ICB Annual Assessment 2024/25 (presented by Prof M Thorne

and T Dowling)

TD reported that the ICB had recently undergone its annual assessment with NHS England, which was a nationally mandated process for which the ICB was awaiting the outcome.

TD stated that there was a focus on partnership working, with presentations from Active Essex, supporting peoples mental health and wellbeing; Dr Sarah Zaidi and colleagues from the Virtual Wards Integrated Care Team who demonstrated how data and shared records were used to assess people exhibiting signs of frailty, and the impact in terms of personalised care for reducing hospital admissions for people in last two years of life; and the health and care academy on how the system was attracting people to work in health and care, and also how advanced skills could be developed in the workforce.

The second part was a closed meeting with NHSE, where feedback was received following a survey with stakeholders. TD noted that complimentary comments were received on the strengthening relationships across the system. Excellence in clinical leadership and innovation, as seen through the stewardship programmes was recognised. It was suggested, due to the changing environment over the last two years, to conduct a review of governance, particularly where there were challenges with finance and performance, but ensuring there is no detriment to quality and workforce and delivering good, safe, and quality services to patients. The finance plan for 2024/25 must be delivered at the agreed deficit of £96 million for the system. NHSE were concerned to see a strengthening of performance improvement through the system during the year, both with delivery of the financial plan, but also accelerated delivery of wait times, access to services and subsequent outcomes.

Resolved: The Board noted the verbal update of the MSE ICB Annual Assessment 2024/25.

8. Annual Report and Accounts 2023/24 (presented by Prof. M Thorne)

MT advised that the annual report and accounts had undergone significant scrutiny through the committee structures, reviewed by external bodies and it was noted they had been submitted as required.

GW commented that the auditor was very complimentary with regards to the financial and governance processes for this year and recognition should be given to the relevant teams. No other comments or questions were raised.

Resolved: The Board noted the Annual Report and Accounts 2023/24.

9. Joint Forward Plan (presented by E Hough)

EH advised that the MSE ICB Joint Forward Plan (JFP) had been refreshed and published in March 2024 for the period 2024 to 2029 and recommitted the ICB to the twelve strategic ambitions developed with system partners in 2023. The plan had been updated following feedback from NHSE and the development of section 3 of the plan, which set out how the ICB would deliver on the commitments in 2024/25 and beyond.

MT asked if there would be a requirement to share the plan again with system partners. EH confirmed that, as there was no significant change, formal guidance stated it did not need the level of engagement that was initially required. Conversations had been held with MSEFT and EPUT on the development of the JFP and an offer was made to update local authority

partners, if required. MHar and IW advised that an update would be beneficial following the change of portfolio holders in local authorities.

In response to a query from MB, EH confirmed that the actions would be tracked through existing governance routes, such as the recovery programme, Finance and Performance Committee or Quality Committee.

Resolved: The Board noted the updated MSE Joint Forward Plan for 2024-2029 and supported the upload on the ICB's website.

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

TD highlighted key points from the report.

The development of the Infrastructure Strategy, reviewing the system estate was underway to utilise estate to best effect. The system had a considerable maintenance backlog and significant demands for additional and expanded estate. There was lack of good, clear up to date information about how well the systems existing estate was being used, which needed to be understood.

The NHS premises costs directions for primary care were amended in May 2024 and the most significant change was the use of Section 106 monies where the required contribution from GP Practices was removed, but some challenges regarding District Valuer assessments remained.

Following the results from the staff survey undertaken in November 2023, there had been significant organisation development which embarked upon a programme of improvement activity, monitored through quarterly pulse surveys. This had demonstrated of improvement, but some areas, such as people feeling discriminated against, required further understanding and action. The second pulse survey had been published for completion.

In response to the letter on pressurised services following the Channel 4 documentary, TD requested that the Board receive a report in September on the performance standards on Urgent and Emergency Care and ambulance delays. Boards were being asked to receive assurances on corridor care, and the flow patients from urgent and emergency care, through hospitals and into the community, including assurance on the steps taken in MSE to prevent people from being admitted who do not need to be in hospital, and instead can use Urgent Care Hubs and Virtual Wards.

MT thanked TD for her contribution and support during her tenure of office and for the positive differences being made in the ICB resulting from her leadership.

Resolved: The Board noted the Chief Executives Report.

Action: Urgent and Emergency Care and Flow Leads to provide an assurance report on corridor care and flow for urgent and emergency patients and admission avoidance.

11. Quality Report (presented by Dr G Thorpe)

GT introduced the quality report that provided the Board with a summary of the key quality and patient safety issues, risks, escalations, and subsequent actions to provide assurance on the oversight of all aspects of quality across the system, the following key areas were highlighted:

An update was provided from national guidance on the quality care functions required of Integrated Care Systems under the Health and Social Care Act. A gap analysis was being undertaken to provide assurance via the Executive Committee and Quality Committee that the ICB was appropriate discharging those responsibilities.

A Rapid Quality Review (RQR) meeting had been held with regards to the maternity services in Broomfield, following a Section 31 warning notice raised by the Care Quality Commission (CQC). GT thanked colleagues from MSEFT and stakeholder partners for their engagement in the process. Assurance was provided that work was underway to address the concerns raised by the CQC and further oversight and assurance would be undertaken through the revised and strengthened maternity improvement group within the Trust, a further rapid quality review meeting would be convened if concerns persisted.

MHop advised that the RQR meeting was well chaired, and the tone was appropriate given the amount of work and the ongoing response to the CQC. There was recognition of room for improvement, but it was felt that the timescale to receive the reports were challenging.

Resolved: The Board noted the Quality Report.

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

JK presented an overview of performance from the ICB and wider system as well as performance against constitutional standards. JK confirmed that planning guidance had been received and confirmed that the 'system' (the ICB, MSEFT and EPUT) had agreed a plan position of £96 million deficit and agreed the performance metrics that NHS England (region and national teams) would be monitoring and seeking assurance on throughout the year.

In month 2, the ICB continued to forecast a break-even position, and the system continued to forecast to £96 million deficit (made up of an £85 million deficit within acute services and £11 million deficit across community and mental health services).

The year-to-date position for the ICB showed was challenged, predominantly in Continuing Health Care (CHC) services, which had a wide-reaching efficiency programme. The majority of ICBs across the country were facing similar pressures in relation to CHC and prescribing costs. Final conclusive information on prescribing spend was awaited, noting that the costs associated with the introduction of new drugs would need to be accommodated.

The system forecast outturn position was as expected for month 2 due to the reprofiling of efficiencies delivered, but challenges were expected in months 3 and 4. Continued oversight from NHS England had increased, and the system would ensure pace and focus on delivery with improvement anticipated as the year progressed.

MT asked for the rationale for the increase of CHC spend and how it could be resolved and asked for an update on hospital spend. JK advised that in CHC, there were variances in volume and price, and a step change in demand, particularly the packages for patients on the discharge to assess pathway. A deep-dive review would highlight if there was disproportionate need in specific areas, which would be reported back via ICB governance. GT advised that there could be further efficiency gains in relation to process and productivity within the core function of CHC (also referred to as All Age Continuing Care AACC) and a focus on Personal Health Budgets. The discharge to assess pathway was designed to ensure that system partners were supported for people to return home, where able, at the earliest opportunity, which could minimise or prevent harm.

MT asked whether the new drugs referred to would be expensive. MS explained new medications such as the dementia and obesity drugs were expected and could be expensive. Therefore, a logical review of how we could best serve our populations was needed to ensure efficiency and effectiveness in the use of the drugs. JK commented that whilst volume had increased, the cost of the drugs being prescribed had also increased.

SP asked if the new drugs would lead to less people having complications from diseases, such as diabetes, which would positively impact secondary care. MS advised that the whole focus would be to move towards prevention.

MHop advised that the cost of radiological imaging and chemotherapy related to the increased spend on drug costs for the trust. However, more cancer patients were being treated. MHop noted the trust had closed 80 beds (as expected) by 1 July 2024, on the Southend and Chelmsford sites, by reducing length of stay and ensuring that patients stayed in hospital for only the most appropriate and shortest time. Staff car parking had been reviewed and charges for staff were reinstated. The trust had promised that it would fulfil a range of initiatives to reduce its financial deficit, which were underway.

NM advised that the month 2 position demonstrated that the anticipated delivery could be realised (based on the reprofiling of expected savings throughout the year). Confidence was expressed that elective activity would get back on track and the ambition expressed on the financial plan would be delivered.

JK advised that the next performance report would reflect the commitments made in the plan submitted to NHS England. Improvements had been made with the core constitutional standards and work was ongoing to understand how improvement could be sustained. The Finance and Performance Committee would have oversight of performance.

IW asked if there was any progress on the 62-day cancer wait times which had remained static. MHop advised that the figures were moving back to the agreed trajectory.

Resolved: The Board noted the Finance and Performance Report.

Action: JK and GT to provide a report on the deep dive into the increase of CHC deficit.

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

PG presented the report outlining the development of services by the Alliance teams (including Primary Care) and highlighted key points.

There had been an increase in primary care workforce in MSE. Negotiations were ongoing with the Local Medical Council (LMC) relating to potential strike action from general practice.

There had been significant project delivery in dentistry. The Care Home pilot had been rolled out to all care homes and the local dental market delivered 90% of contracted levels, which was higher than other areas in the East of England.

The Alliances had led a prioritisation exercise linked to the financial recovery, which had resulted in a reduction in the engagement work normally undertaken.

The approach to the development of Integrated Neighbourhood Teams (INT), which was the delivery model to provide better care for MSE, had strengthened with 20 out of 24 initiated.

Pharmacy First had been fully implemented in all pharmacies across MSE, which supported the population to access care rapidly and locally and supported reduced demand.

In response to a query from MT, PG clarified that the national funding secured for a hypertension case finding programme within dental practices related to high-risk patients and identified blood pressures at point of intervention.

SP asked if there was confidence in reaching the metric for dental appointments for next year. PG advised that there was a buoyant market in dentistry and negotiations were ongoing with dental colleagues related to increasing activity and reviewing contracts where required.

GO asked to what extent were the Alliances involved with the national investment in long-term conditions service. PG advised that the wider determinants of health were the key focus for delivering care differently and was determined by the lived environment and economic stability. 30% of general practice work was non-medical and linked to loss of work, unstable housing, unsocial behaviour, and work continued at INT level to address those.

AD reinforced the care home dentistry work, which had received excellent feedback, and commended the dental commissioners and those involved with the programme.

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

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

14.1 Board Assurance Framework

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

TD highlighted the increased risk of workforce and commented that although there had been a reduction in vacancy rates, turnover and sickness rates, the use of bank and agency staff had not sufficiently reduced and was a major risk in the financial recovery plan. The level of risk in primary care had reduced as highlighted in the Primary Care and Alliance Report presented at item 13. The risk for Urgent and Emergency Care and System Coordination had slightly reduced due to an increase in performance.

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

14.2 Revised Committee Terms of Reference

MT referred members to the following revised Committee Terms of Reference which had been approved by the Committees themselves.

- Audit Committee
- Remuneration Committee
- Primary Care Commisioning Committee
- Finance and Performance Committee
- System Oversight and Assurance Committee
- Qulaity Committee
- Clinical and Multi-Professinal Committee
- Executive Committee

There were no comments or questions raised.

Resolved: The Board approved the revised Committee Terms of Reference

14.3 New/Revised Policies

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

- 035 Job Matching and Evaluation Policy
- 036 Disclosure and Barring Policy
- 037 Nurse Revalidation Policy
- 038 Professional Registration Policy
- 040 Stress Management Policy
- 047 Annual Leave Policy
- 072 Quality Assurance Visits Policy

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

14.4 Approved Committee Minutes.

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

- Audit Committee (AC), 16 April 2024 and 22 April 2024.
- Clinical and Multi-professional Congress (CliMPC), 24 April 2024.
- Finance and Investment Committee (FIC), 1 May 2024 and 4 June 2024.
- Primary Care Commissioning Committee (PCCC), 10 April 2024 and 7 May 2024.
- Quality Committee (QC), 26 April 2024.

Resolved: The Board noted the latest approved committee minutes.

14.5 Corporate Objectives

MT referred members to the ICB Strategic Objectives for 2024/25. No comments or questions were raised.

Resolved: The Board ratified the ICB Strategic Objectives for 2024/25.

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, 12 September 2024 at 2.00 pm, in Spring Lodge Community Centre, Powers Hall End, Witham, Essex, CM8 2HE.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
45	18/01/2024	12.3	**Board Assurance Framework:** Revisit the Cyber Security Risk to decide whether to include in future iteration of Board Assurance Framework.	N Adams S O'Connor	30/09/2024	A revised risk hierarchy and associated criteria is being developed and will be shared with Executives and the wider Board in September, following which a decision will be made on which risks will be included within the Board Assurance Framework.	In progress
46	21/03/2024	10	**Quality Report:** Provide a report to a future Board meeting on a SEND deep dive which would initially be presented to Quality Committee	G Thorpe	11/07/2024	A SEND deep dive took place at Quality Committee on 28/06/24, the minutes of which are included in the September Board meeting papers.	Complete
47	21/03/2024	12	**Primary Care and Alliance Report** A report on primary care estate to be presented to Board outlining estates issues that need to be addressed.	P Green	30/08/2024	An Estates update has been provided within Primary Care and Alliance report to the Board meeting on 12 September 2024.	Complete
49	09/05/2024	9	**Quality Report** Provide an update on the benchmarking analysis for the Greater Manchester Review for EPUT and NELFT in a future Quality Report to Board.	G Thorpe	14/11/2024	Scheduled for November Board meeting.	In progress
50	11/07/2024	10	**Chief Executives Report** An assurance report to be provided relating to corridor care and flow for urgent and emergency patients through hospital and into the community and the steps taken to prevent people being admitted to hospital who could follow an alternative pathway.	S Goldberg	12/09/2024	Report being submitted to Board meeting on 12 September 2024.	Complete
51	11/07/2024	12	**Finance & Performance Report** Provide a deep dive report into the increase of the deficit relating to Continuing Health Care (CHC) costs.	G Thorpe J Kearton	14/11/2024	CHC deep dive is on the agenda for Finance & Performance Committee in October 2024 and will be summarised and reported to the Board at its November meeting.	In progress

Part I Board meeting, 12 September 2024

Agenda Number: 7

Health Inequalities Update

Summary Report

1. Purpose of Report

To provide an update on work to support reducing health inequalities for the population of mid and south Essex (MSE).

2. Executive Lead

Emily Hough, Executive Director of Strategy and Corporate Services.

3. Report Author

Emma Timpson, Associate Director Health Inequalities and Prevention.

4. Responsible Committees

This report reflects work overseen by the Population Health Improvement Board.

The Quality Committee and Audit Committee reviews the risk register in relation to Health Inequalities delivery.

5. Link to the ICB's Strategic Objectives

To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.

6. Impact Assessments

Individual impact assessments are undertaken in relation to specific projects, opposed to the programme as a whole.

7. Financial Implications

The MSE ICB has committed £3.55m recurrently to support the reduction of health inequalities. This is in addition to the work being undertaken to ensure health inequalities are addressed in commissioning, contracting reviews and decision making regarding universal access to services.

In 2024/25, there was a one-off contribution to the system financial deficit position of £1.35m from the health inequalities budget.

8. Details of Patient or Public Engagement or Consultation

Patient and public engagement is embedded within the delivery of the Health Inequalities programme and through the Equality and Health Inequalities Impact Assessments.

9. Conflicts of Interest

None Identified.

10. Recommendation/s

The Board is asked to:

- Note the work being undertaken by the ICB and in collaboration with partners to reduce health inequalities for the population of MSE.
- Ratify the ICB's Health Inequalities Information Statement (Annual Report) 2023/24 at Appendix A.

Reducing Health Inequalities

1. Introduction

Reducing health inequalities is at the heart of the mid and south Essex (MSE) Integrated Care System (ICS) strategy and is one of the key strategic objectives of the ICB. The gap in life expectancy across MSE is as much as 12 years between some of the wealthiest and most deprived neighbourhoods. An estimated 133,000 people in MSE live in the 20% most deprived areas nationally, that equates to 10.5% of the total population of MSE.

Within MSE the top three contributors to premature mortality attributable to socioeconomic inequality are cancer, cardiovascular disease (CVD) and respiratory disease. Alongside this, the greatest risk factors impacting on population health and health inequalities are tobacco, blood pressure and dietary risks. However, wider determinates of health, including lifestyle behaviours, socio-economic factors and environment account for up to 80% of variation in health outcomes.

The ICB's priorities for 2024/25 for health inequalities are to:

- Deliver on the Core20PLUS5 approach for adults and children and Young People.
- Focus on prevention of ill-health including provision of lifestyle programmes and behaviour interventions to address inequalities in cardiovascular disease.
- Continue to deliver against 5 strategic planning priorities for tackling health inequalities:
    - Restoring services inclusively
    - Mitigating against digital exclusion
    - Ensuring datasets are complete and timely
    - Accelerating preventative programmes
    - Strengthening leadership and accountability.

2. Strategic Planning Priorities

Progress continues to be made on the five Strategic planning priorities as set out by NHS England. The following gaps and risks have been identified:

- Data completeness, where the focus up to now has been on improving ethnicity recording. Resources and incentives to improve data recording of other groups that are risk of health inequalities and poor outcomes, known as PLUS groups in the NHSE framework, have yet to be identified.
- Alliances and Primary Care Networks (PCNs) are locally undertaking work that supports addressing digital exclusion. However, there is lack of ICB leadership in this area to coordinate actions and implementation of the Digital Inclusion framework at a system level.

- Funding and capacity risks within MSEFT, ICB and other partners, to ensure continued focused on health inequalities and inclusive recovery, with focus on financial recovery and consolidation of teams and programmes.
- Continued delays in EPUT establishing Mental Health inpatient tobacco dependency service. Following escalation and a letter of intent being issued a sub-contracting arrangement has now been agreed with Provide Community Interest Company (Provide).

Strategic planning priorities **Achievements in last 6 months**	**Next steps over forthcoming 6 months**
1. **Restoring services inclusively:** • ***Primary Care*** access recovery programme resourced with Cloud based telephony solutions now in place across most practices, self-referral pathways introduced and a number of practices implemented "Modern General Practice" to improve triage and management of demand	Consider opportunities for improving the experience of quality of care for those groups that have lower than average experience of GP services (from GP Patient Survey published 2024), i.e. those with mental health conditions, dementia or learning disability.
• ***Community Collaborative*** have worked in partnership with Healthwatch to develop Pulmonary Rehabilitation co-production model engaging with seldom heard groups. Targeted approach piloted for reducing health inequalities and increasing diabetes checks in localities of highest needs.	Review of health inequalities across priority areas of Virtual ward (admissions), Urgent Community Response Team (referrals), IMC and Stroke beds (admissions), and Community Paediatrics.
• ***MSEFT*** annual health inequalities impact report and evaluation of access and patient experience presented to June 2024 Board. Improved access and 'did not attend' (DNA) reduction, through adoption of User centred design 'Better Letters programme'. Veterans Aware Accreditation achieved in March 2024.	Improving equity of access to research by using learnings from Research Engagement Network (REN). Implement ImpactEQ digital EHHIA tool. Deliver yearly improvement plans as part of EDS2 - Equality Delivery System commitment by March 2025.
2. **Mitigating against digital exclusion** • Good Things Foundation utilised to provide digital access including SIM cards and devices, for example to support access to Maternity pathways and support resources.	Stocktake against NHS digital inclusion framework, subject to resource identification
3. **Ensure datasets are complete and timely** • Primary care data completeness for recording of ethnicity continues to improve, increasing from 90% in March 2022 to 96% in April 2024. • PLUS groups data and insights developed by Population Health Management (PHM) to quantify numbers in specific PLUS groups and resulting health inequalities.	Adoption of the PLUS groups insights and dashboard onto Athena platform.

Strategic planning priorities Achievements in last 6 months	Next steps over forthcoming 6 months
4. **Accelerate preventative programmes (not covered under Core20PLUS5)** • **Weight Management**. Establishment of the Healthy Weight Steering Group and delivery plan. Increase in referrals into Digital Weight Management Programme (DWMP) above NHSE Target from 10% eligible referrals in October 2023 to 15% in June 2024 compared to NHSE target of 13%. • **Diabetes**. 50% increase in referrals to the National Diabetes Prevention Programme in 24/25 YTD compared to 23/24. Type 2 Diabetes in the Young rolled out across GP practices. Transfer of Colne Valley PCN patients to locally commissioned diabetes service to ensure equity of access. • **Tobacco Dependency**. In-house maternity service launched in Q4 23/24 and now in place across all 3 hospital sites. Acute referral pathway into community pharmacy for ongoing support established. Pilot staff stop smoking, telephone support, launched in Basildon Hospital. • **Vaccinations**. ICB worked with School Age Immunisation Service to support "catch up" clinics for childhood vaccinations including drop in clinics in communities with particularly low vaccination rates.	Increasing access to Tier 2 services including DWMP. Procurement of new Tier 3 provider and implementation of revised access criteria. Improving performance on achieving 8 care processes. Exploring opportunity to integrate foot screening and retinopathy checks. Launch mental health inpatient service, delivered by Provide on behalf of EPUT by November 2024. Develop a Tobacco Dependency business case for substantive funding of service to support recruitment and retention. Improve data recording for stop smoking services. Autumn/winter plan for Covid/Flu/Pneumovax and RSV in development with focus on areas with anticipated lower uptake.
5. **Strengthening leadership and accountability** Equality, Diversity and Inclusion strategy with objectives being finalised. Draft internal audit review of Health inequalities provides assurance there is strong governance and monitoring arrangements in place. Narrowing the Gap report published. EHIIA Panel terms of reference drafted. Lunch and Learn session delivered to over 90 staff across ICB.	Engagement and communication of EDI strategy. Establishment of EHIIA panel from September 2024. Adoption of Health inequalities action plan within core ICB contracts.

3. Core20PLUS5 Frameworks

Good progress continues to be made on delivering against the Core20PLUS5 frameworks. The following gaps and risks have been identified across the programmes of work:

- ICB staffing resource to support Health inequalities and prevention is fixed term capacity until 31 March 2025. A case will be developed and presented to Executive Committee to commit Health inequalities and sustainable

development funding (SDF), funding staff recurrently to support continued programme delivery.

- Lack of business intelligence (BI) capacity to support development of greater insights to support delivery, and the accessibility of data to enable operational change at practice/PCN level. There is also a key theme, across a number of areas, regarding data quality and lack of consistency of submissions and reporting.
- Health partners are yet to commit to ImpactEQ, digital EHIIA tool, the ICB will proceed with user testing and implementation whilst a business case is developed for wider adoption across the system.
- Short term funding of some projects, such as Research Engagement Network, which risks sustainability and benefits realisation. Additional external funding continues to be explored.
- MSE is at risk of not meeting the national ambition to reduce stillbirths, neonatal and maternal deaths and serious brain injury by 50% by the end of 2025. This is despite the implementation of national safety initiatives. MSE is in line with the current national position.
- Lack of programme management support to the Early Cancer Diagnosis pathways work and support for ensuring progress towards the national target of 75% of cancers diagnosed at stage 1 or 2 by 2028.
- Greater clarity required between NHS and Public Health role in commissioning of health promotion interventions, such as Oral health and Pneumonia campaigns, recognising the longer term benefit such upstream prevention activities deliver.

Core20PLUS5 Frameworks for adults and children	
Achievements	**Next steps**
Core 20% most deprived • Alliances continued focus on most deprived communities. Examples include West Basildon PCN Wellbeing Cafes to support secondary prevention, educational sessions and promote health and wellbeing. • Mid Essex Alliance utilising Thriving Places Index to inform Healthy housing and economic demonstration projects. • PCNs in South East Alliance undertaking active outreach programmes providing holistic health and wellbeing events. • Thurrock Alliance continued focus on health and digital literacy training. • CVD Local Enhanced Scheme (LES) being implemented in 12 out of 14 PCNs with greatest population need.	Health inequalities skills enhancement training for PCN Health inequalities leads. Alignment of Integrated Neighbourhood models and health inequalities plans including focus on high intensity users. Implementation of CVD HI funded schemes with PCNs by March 2025.

Core20PLUS5 Frameworks for adults and children	
Achievements	**Next steps**
PLUS groups • MSE PLUS groups dashboard developed. • Sport for Confidence 'big health day' took place June 2024 in Basildon to improve care offered to residents with Learning Disabilities • Health checks for people with Learning Disabilities continue to increase, and are 35% higher YTD 24/25 compared to YTD 23/24. LeDeR review not increased prevalence of health checks undertaken. SET 3 year LeDeR Deliverable Plan 2024-2027 priority is Improving uptake and effectiveness of annual health checks. • Homeless Needs Assessment across MSE led by charity expert partner commenced. • Research Engagement Network (REN), 18 community champions trained. Increased number of people from PLUS groups involved in health and care research.	PHM team to support Alliances in utilising PLUS groups dashboard to prioritise areas of focus. Roll out of Learning Disabilities GP accreditation scheme Increase Health Action Plans completed for those with Learning disabilities an uptake of health check in those under 18 years. Establishment of Homeless Health Inequalities Steering Group to develop action plan arising from needs assessment Secure further external REN funding to improve sustainability of programme.
5 Clinical areas (adults): • **Mental Health** – Health checks for people with Severe Mental Illness continue to increase, and are 20% higher as of July 2024 compared to previous year, above regional and England average. • **Maternity** – Perinatal mental health services offered and provide equitable access to care, in collaboration with family hubs in areas of deprivation. Maternity and Neonatal Health Inequalities dashboard launched. • **Respiratory** – Pneumococcal vaccine campaign supported delivery of a 2.6% increase YTD June 2024 compared to previous year. External funding secured for Respiratory diagnostics health inequalities models (RDHIM) to deliver spirometry by utilising the health inequalities funded van to outreach into communities. • **Cancer** – Improvements seen in cervical and bowel cancer screening rates across all Alliance areas between Jan 2024 and July 2024. Breast screening has shown a reduction in uptake, below regional and national average.	Develop standard operation procedure for delivery of SMI health checks "Don't just screen, intervene" and ensure consistency in recording. Review of Midwifery Continuity of Carer teams to inform further rollout plans. Continue implementation of Saving Babies Lives Care Bundle v3. Repeat Pneumococcal campaign as part of Winter plan. Implement Respiratory diagnostics health inequalities model from September 2024. Education of PCN care and cancer care coordinators regarding improving uptake. Working with screening units (including breast screening to change appointment processes. Implementation of CVD LES and QOF Hypertension extension scheme by March

Core20PLUS5 Frameworks for adults and children	
Achievements	**Next steps**
• **CVD** –BP@Home Health inequalities extension scheme with additional machines provided to those practices with the greatest need. CVD LES in planning phase with delivery to start in Q3 2024/25. Quality Outcomes Framework (QOF) Hypertension extension scheme to incentivise practices to deliver above upper QOF threshold of 77% to support delivery of national 80% target of patients treated to target. Lipid management training course offered to PCNs and Practice to support lipid optimisation.	2025. Engagement with PCNs on Community Outreach Grant Scheme to target patients who have not had BP checked in last 12 months and incorporate holistic checks including diabetes, respiratory, vaccinations.
Children and Young People: • ***Child Oral Health*** – Bright smiles campaign launched and achieved positive engagement and feedback. Supervised toothbrushing programme rolled out in Basildon and Brentwood. • ***Asthma –*** Primary Care guidance document developed with supporting education and training sessions regarding asthma diagnosis and treatment. • ***Epilepsy*** - Self assessment completed against national bundle of care for Epilepsy. • ***Diabetes –*** GIRFT national visit taken place and recommendations received. • ***Mental Health & Neurodiversity*** – Mental Health support teams progressing, with programme of support for schools. Access to CYPMH services is good but challenges remain with reporting. SEND data dashboard completed. SNAP service mobilised to provide pre and post diagnosis neurodiversity support. Multi Schools Council continue to engage with hard to reach groups to inform service development.	Increase CYP dental access through delivery of community based oral health promotion in schools. Recommence Community Dental Service elective GA provision to reduce waiting list. Development of action plan to address gaps identified from Epilepsy self-assessment and Diabetes GIFT national visit. Procurement of low level mental health offer. Recruitment to all age neurodiversity lead for ICB.

4. Recommendation(s)

The Board is asked to:

- Note the work being undertaken by the ICB and in collaboration with partners to reduce health inequalities for the population of MSE.
- Ratify the ICB's Health Inequalities Information Statement (Annual Report) 2023/24 at Appendix A.

5. Appendices

Appendix A: Health Inequalities Information Statement (Annual Report 2023/24).

Health Inequalities Information Statement - Annual report 2023/24

Document Control:

Date: 24/07/24
Version: v1.1

Contents

Health Inequalities Information Statement background

- Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs.
- In November 2023 NHSE published new guidance on how NHS bodies discharge their responsibility to report information on health inequalities

NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)

- The guidance reflects a proportionate and phased approach to gathering and making use of available information on health inequalities and that this will evolve over time.
- NHSE provided list of indicators that NHS bodies should collect, analyse, and publish on health inequalities.

NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

- MSE ICB's annual report sets out how it meets its legal duty regarding the need to reduce health inequalities that includes:
    - Taking a population health improvement approach to understanding health needs and designing interventions that reduce health inequalities.
    - Utilising the Core20plus5 frameworks to target and prioritise resources for the greatest impact.
- This Health inequalities information statement is supplementary to the MSE ICB annual report and together provides MSE position against the NHSE guidance.
- MSE reporting on health inequalities will continue to develop in maturity.

Health Inequalities reporting in MSE

MSE ICB working with its partners in public health and Arden & GEM CSU to strengthen its use of business intelligence to understand and respond to population needs through use of:

- Local Authority Joint Strategic Needs Assessments
- Integrated health and social care data and its expansion to include other socioeconomic factors such as housing data.
- Population segmentation tool that provides insights at Alliance, PCN and Practice level
- Core20plus5 Alliance and PCN packs to inform priority setting and opportunities.
- Health Inequalities dashboard in development
- Reports developed with standard Health Inequalities functionality enabling review by deprivation, ethnicity, sex, and age.
- Health Inequalities Impact Assessments and development of digital Impact EQ for use across health providers in MSE

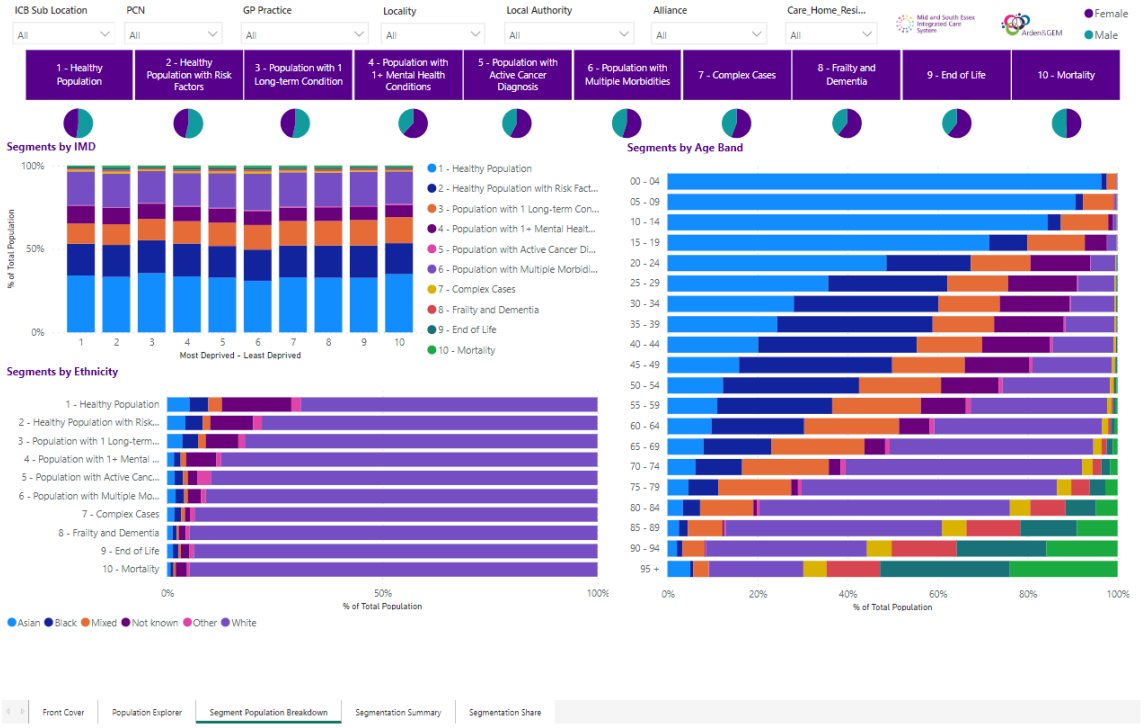


Photo of an example of a data dashboard

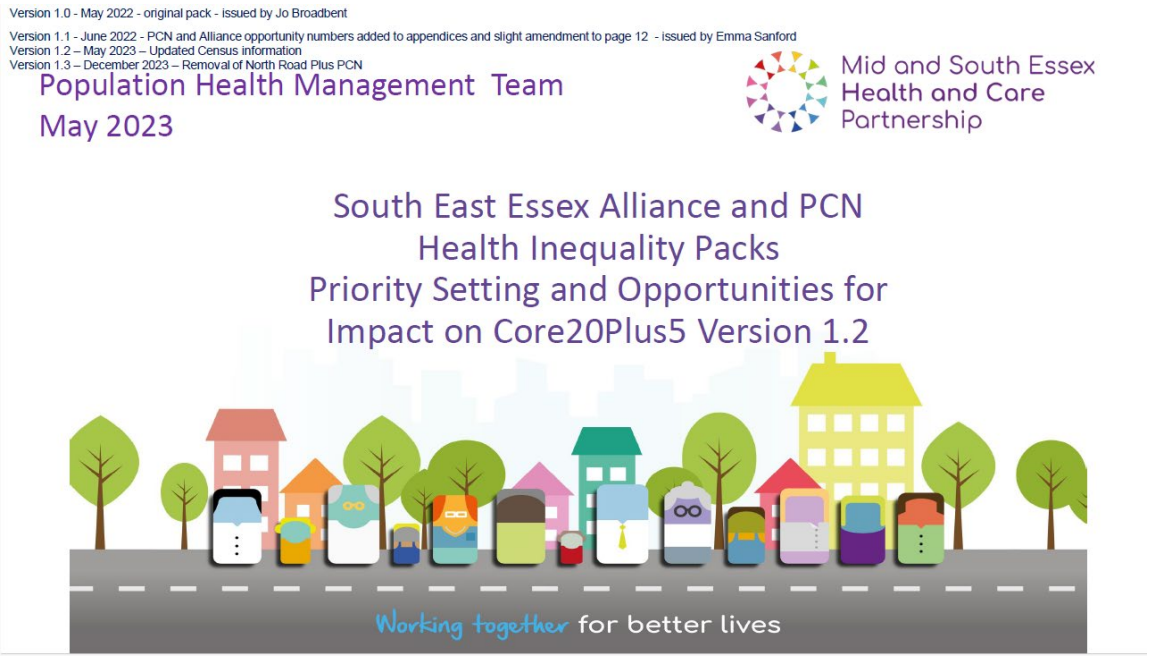
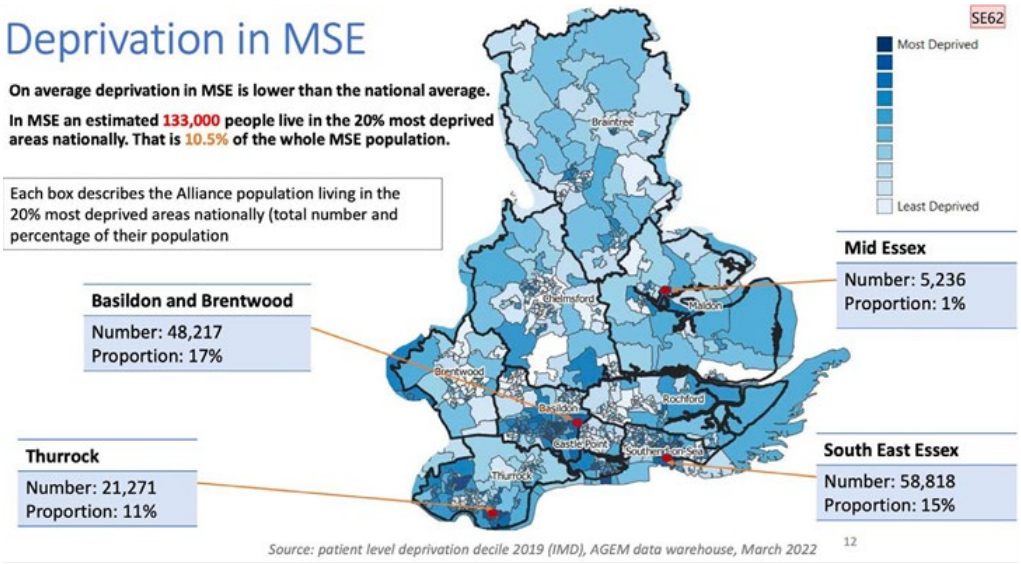


Photo of a Data pack example, titled South East Essex Alliance and PCN Health Inequalities Packs Priority setting and opportunities for impact on Core20Plus5 Version 1.2

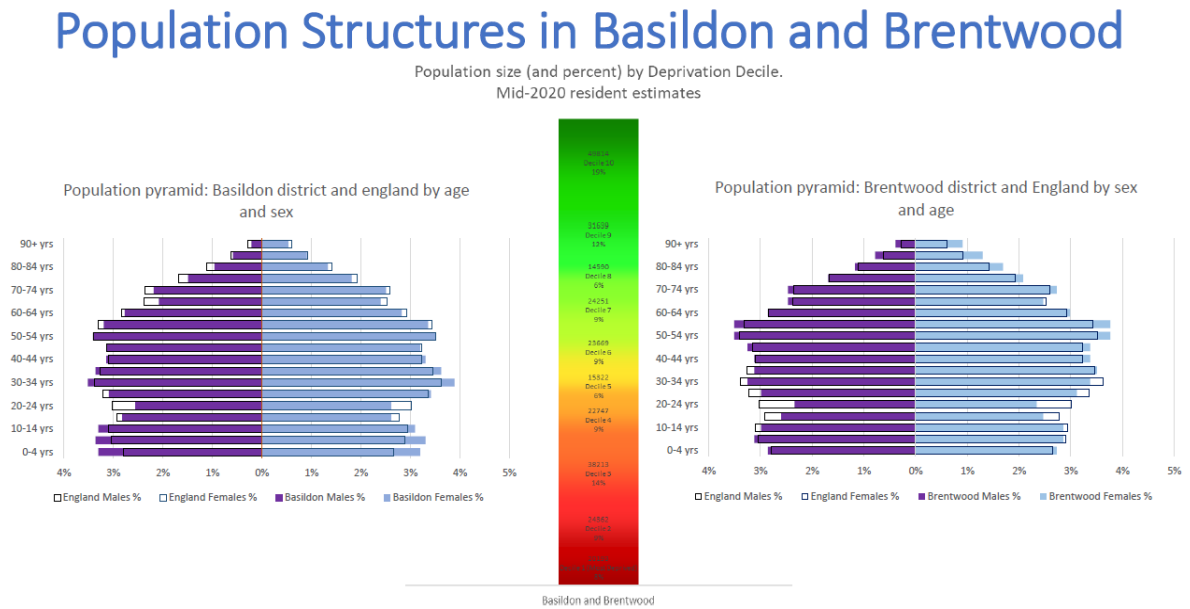
MSE population



The image is a colour-coded map of mid and south Essex. Labels on the map indicate the names of the 4 Alliance area along with their population living in the 20% most deprived areas and the percentage of their population: Basildon & Brentwood being 48,217 which is a 17% proportion, Mid Essex being 5,236 which is a 1% proportion, Thurrock being 21,271 which is a 11% proportion and South East Essex being 58,818 which is a 15% proportion.

Different shades of blue fill the districts, indicating varying levels of deprivation. High levels of deprivation are shown in Thurrock, Basildon, Canvey, Southend and some part of Chelmsford and Braintree.

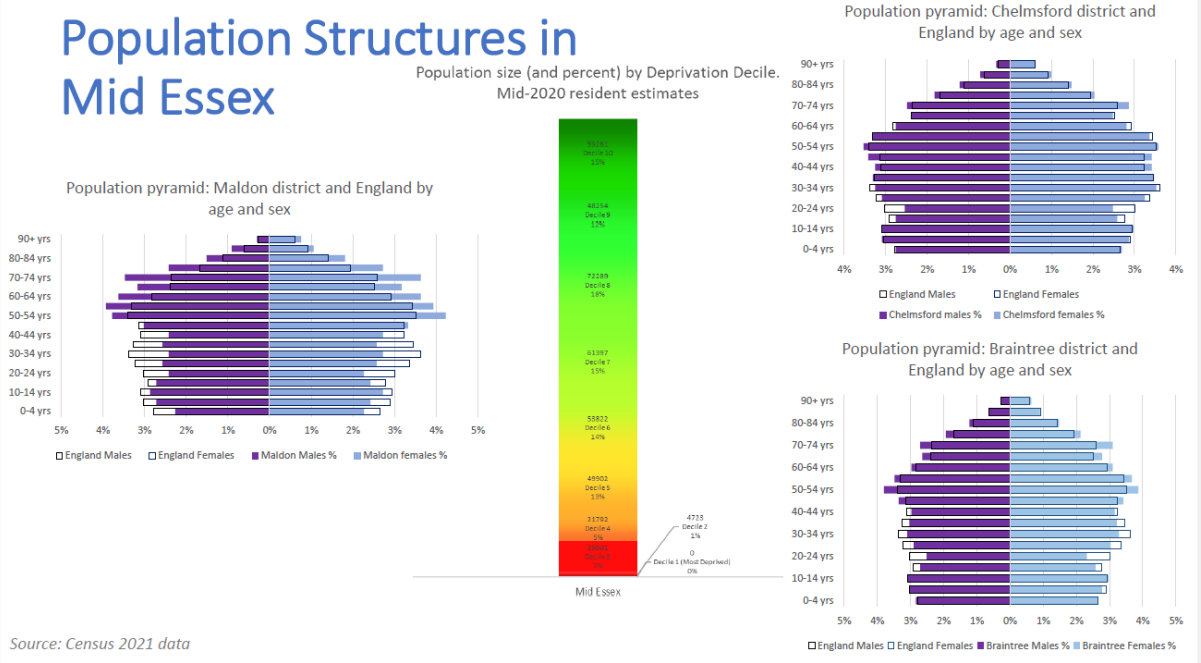
Population structures in Basildon and Brentwood



The image shows the population size and percent by deprivation decile, showing the population pyramid for Basildon district comparative to England by age and sex and Brentwood respectively.

17% of the population of Basildon and Brentwood reside in the two most deprived deciles.
In Basildon there is a higher proportion of children 14 years and under compared to the England average
In Brentwood there is a greater proportion of older people aged 55 years and above

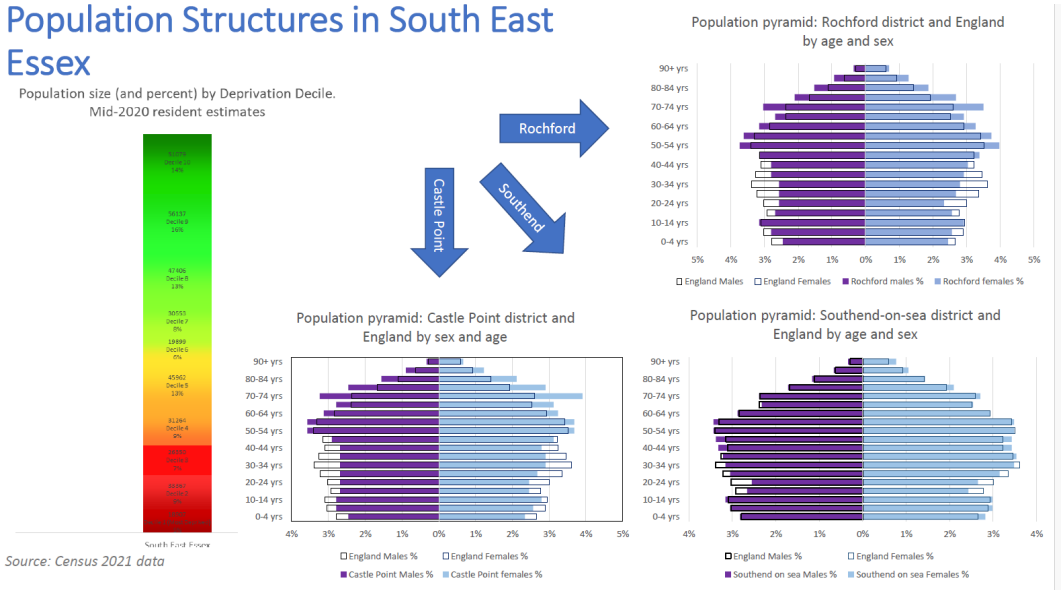
Population structures in Mid Essex



The image shows the population size and percent by deprivation decile, showing the population pyramid for Maldon district comparative to England by age and sex and Braintree and Chelmsford, respectively.

1% of the population of Mid Essex reside in the two most deprived deciles.
Maldon has a significantly older population compared to national average.
In Chelmsford there is a higher proportion of working age 35 years to 65 years.
Braintree also has a higher older population, aged 50 years to 80 years.

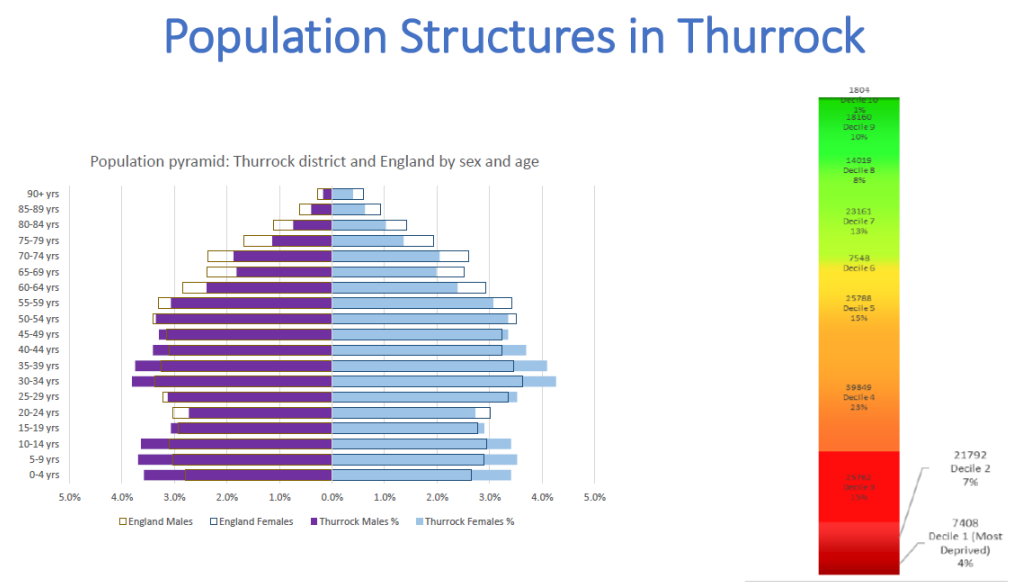
Population structures in South East Essex



The image shows the population size and percent by deprivation decile, showing the population pyramid for Castle Point district comparative to England by age and sex and Rochford and Southend-on-Sea, respectively.

14% of the population of South East reside in the two most deprived deciles
Castle Point and Rochford have significantly older populations compared to national average. Southend-on-Sea has a higher working age population, aged 40 to 60 years.

Population structures in Thurrock



The image shows the population size and percent by deprivation decile, showing the population pyramid for Thurrock district comparative to England by age and sex.

11% of the population of Thurrock reside in the two most deprived deciles.
Thurrock has a higher working age population, aged 30 to 50 years.

2021 Census ethnicity data

2021 Census Ethnicity data

na=not available due to small number suppression — 000s

Area Name	Total	White British	%	Other White	%	Mixed	%	Asian	%	Black	%	Other	%
Basildon	188	154	81.91%	10	5.32%	5	2.66%	8	4.26%	9	4.79%	2	1.06%
Braintree	155	140	90.32%	7	4.52%	3	1.94%	3	1.94%	2	1.29%	na	na
Brentwood	76	64	84.21%	4	5.26%	2	2.63%	4	5.26%	2	2.63%	na	na
Castle Point	89	83	93.26%	2	2.25%	1	1.12%	2	2.25%	1	1.12%	na	na
Maldon	64	62	96.88%	2	3.13%	na	na	na	na	na	na	na	na
Rochford	85	80	94.12%	3	3.53%	1	1.18%	1	1.18%	na	na	na	na
Chelmsford	182	150	82.42%	10	5.49%	5	2.75%	10	5.49%	5	2.75%	2	1.10%
Southend-on-Sea	182	147	80.77%	12	6.59%	6	3.30%	10	5.49%	5	2.75%	2	1.10%
Thurrock	176	116	65.91%	19	10.80%	5	2.84%	12	6.82%	21	11.93%	3	1.70%
Total	1,197	996	83.21%	69	5.76%	28	2.34%	50	4.18%	45	3.76%	9	0.75%

Data taken from the 2021 Census data Some suppression is present in smaller groups.

https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationandhouseholdestimatesenglandandwalescensus2021

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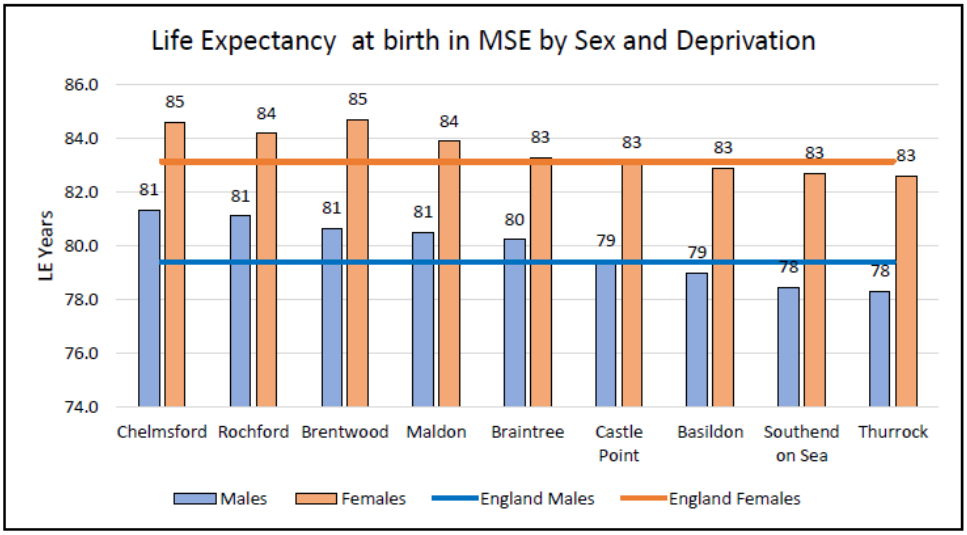
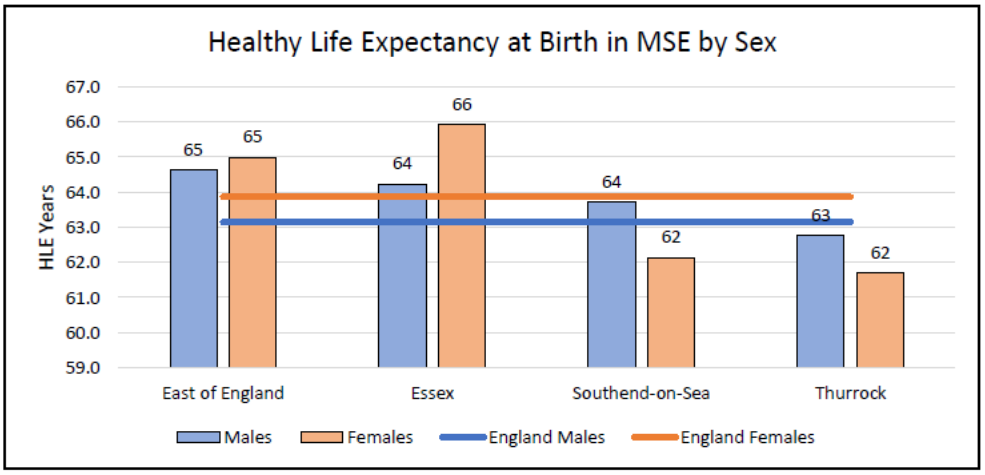
The image shows the 2021 census ethnicity data across the 9 district areas within MSE.

83% of the population of MSE is White British. This is a higher proportion compared to England as a whole 73.5%.
The second largest ethnic group is 'Other white,' which represents 5.76% of the MSE population.
Basildon, Southend, and Thurrock have the greatest Black, Asian and Minority Ethnic groups.

(Healthy) Life Expectancy in MSE



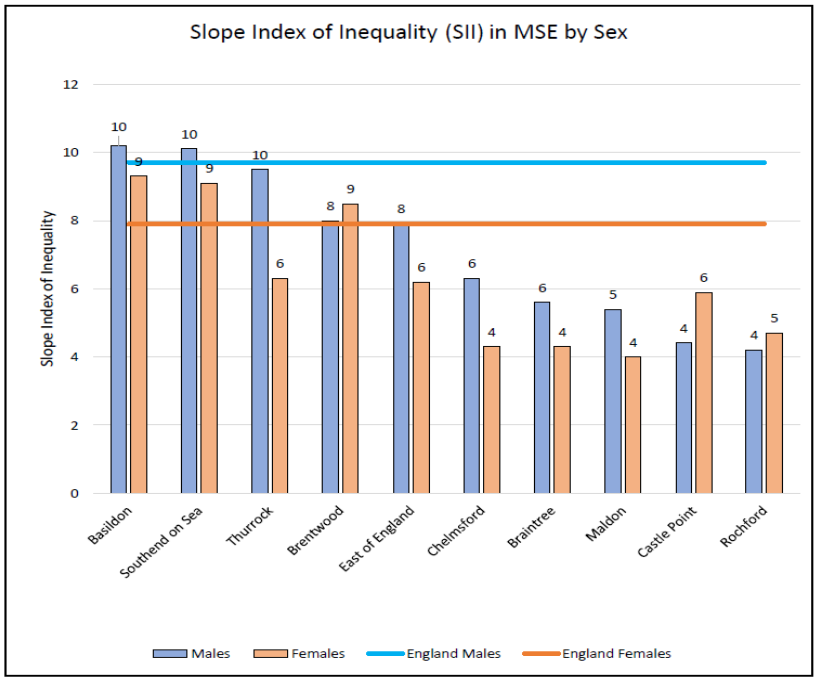
The image shows a graph of life expectancy at birth in MSE by sex and deprivation, showing the 9 areas within MSE, comparing to the England average. Life expectancy for males in MSE varies from 78 years to 81 years, compared to the England average of 79 years. Life expectancy for females in MSE varies from 83 years to 85 years, compared to the England average of 83 years.



The image shows a graph showing healthy life expectancy at birth in MSE by sex, comparing the 3 local authority areas: Essex, Southend-on-Sea, and Thurrock, to the England average.

- Life expectancy is a key metric for assessing a population's health. Healthy life expectancy indicates how long a population is expected to experience good health.
- Overall, Females have a higher life expectancy than Males.
- Male healthy life expectancy is lower than East of England average across Mid and South Essex but lower than England average only in Thurrock.
- Female healthy life expectancy is higher in Essex than that the England average, however in Southend-on-Sea and Thurrock it is much lower.

Inequality in Life Expectancy in MSE

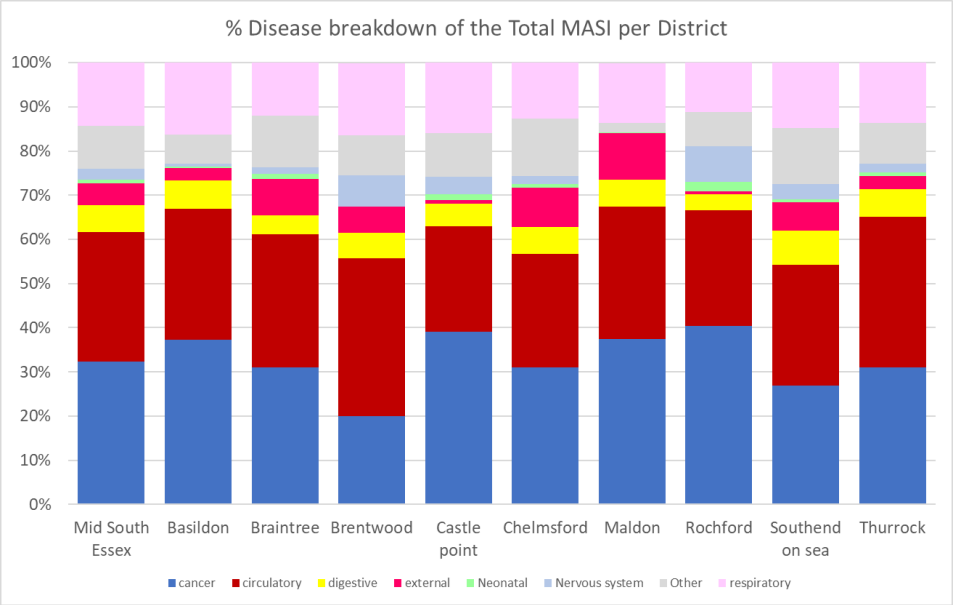


Source: ONS data from fingertips 2020

The image is of a graph that shows the slope index of inequality in MSE by sex, comparing the 9 areas within MSE, to the England average.

- The Slope index of inequality is a measure of the social gradient in life expectancy, i.e., how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within each area and summarises this in a single number. This represents the range of years of life expectancy across the social gradient from most to least deprived.
- Basildon and Southend-on-Sea have an inequality gap within their than is greater than the average for England for both men and women. Brentwood has a greater inequality gap than average for women.
- Chelmsford, Braintree, Maldon, Castle Point and Rochford have an inequality gap within their populations that is lower than England average.
- The areas that have a lower life expectancy overall (Thurrock, Southend-on-Sea, and Basildon) also have a greater inequality of life expectancy within their populations.

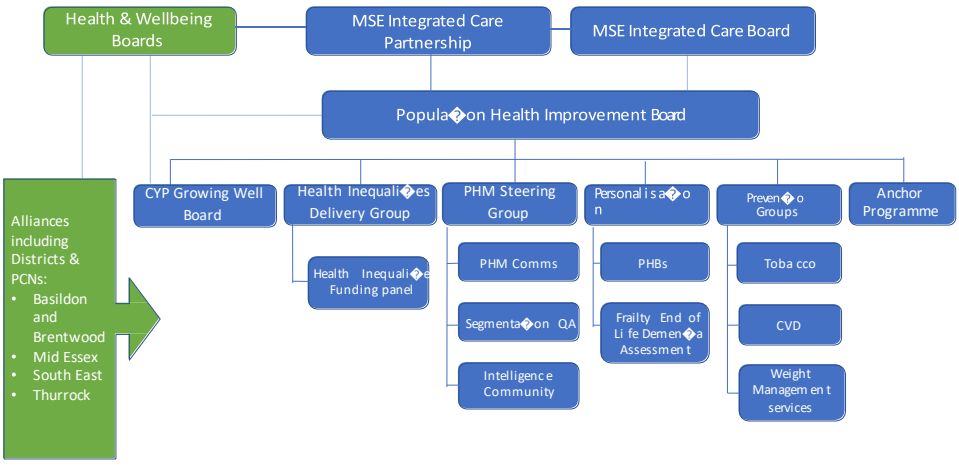
Mortality attributable to socioeconomic inequality



The image is of a graph showing percentage disease breakdown of the total mortality attributable to socioeconomic inequality per district.

- Mortality attributable to socioeconomic inequality (MASI) relates to excess number of deaths compared to the least deprived areas in England.
- There are over 14,500 excess deaths in mid and south Essex relating to socioeconomic inequality.
- The graphs show percentage that each disease category contributing to MSAI overall.
- All districts in mid and south Essex have Cancer, Circulatory disease, and respiratory disease in their top three contributors to MASI.
- Patterns are similar in most districts.

Health inequalities governance in MSE



The image shows a flow chart to demonstrate the health inequalities governance in MSE.

MSE established a Population Health Improvement Board with representation from partners across the system to drive an integrated approach inequalities improvement.

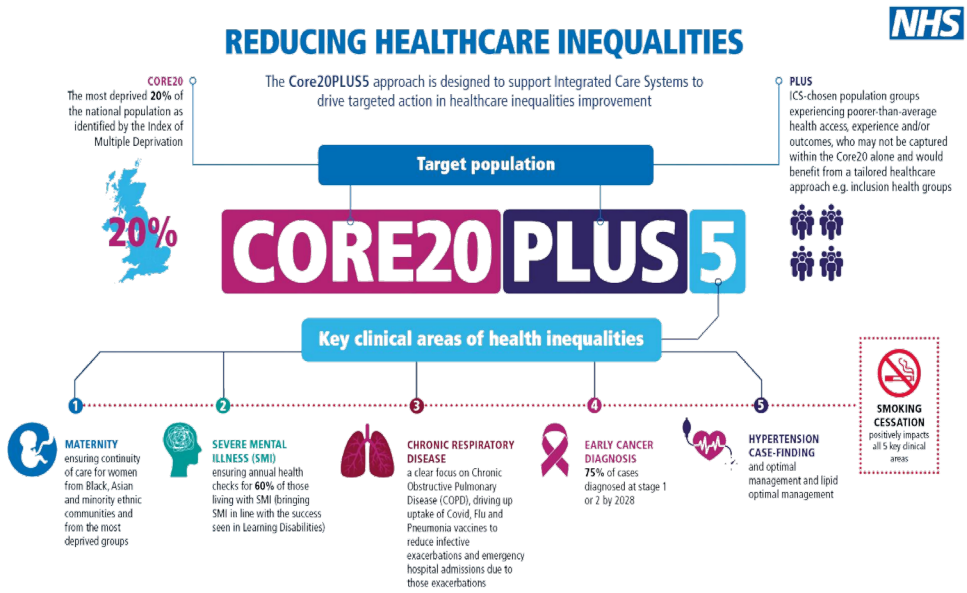
This Board brings together programme of work across:

- Health inequalities
- Population Health Management
- Prevention
- Personalised Care
- Anchor programme

The Population Health Improvement Board reports up to both the MSE Integrated Care Partnership to bring together the work around wider determinants of health and to the Integrated Care Board to drive improvements around specific healthcare priorities.

Mortality MSE has adopted the NHS Core20PLUS frameworks

Reducing Healthcare inequalities: Core20Plus5 adults



The infographic covers the Core20PLUS5 approach for adults to tackling health inequalities:

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

PLUS: PLUS population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

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

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

2. Severe mental illness (SMI): Ensure annual physical health checks for people with SMI to at least nationally set targets.

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

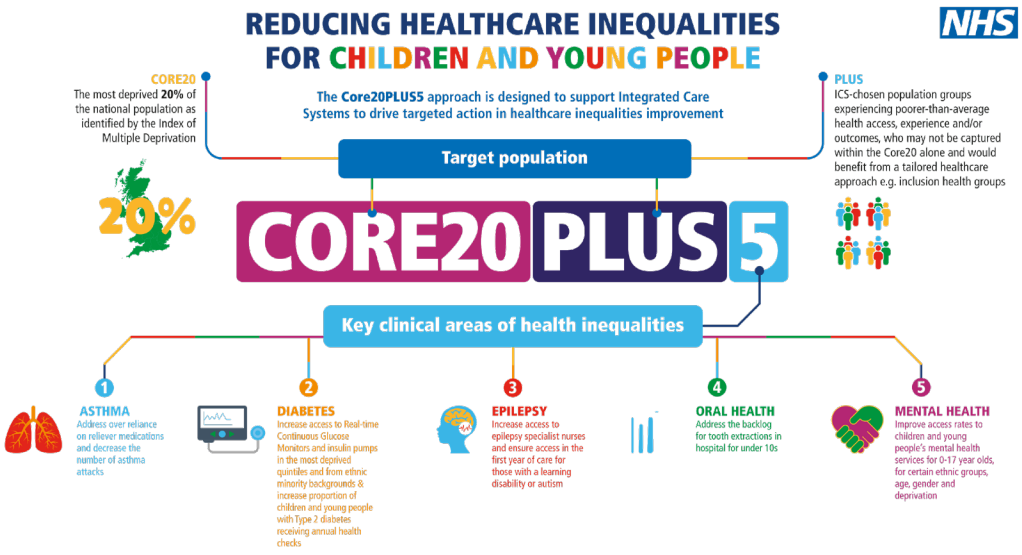
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management: To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Adult Plus groups identified in MSE that may experience poorer health outcomes:

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

<u>Reducing Healthcare inequalities: Core20Plus5 children</u>



The infographic covers the Core20PLUS5 approach for children to tackling health inequalities:

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

PLUS: PLUS population groups include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Specific consideration should be taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5: The final part sets out five clinical areas of focus. The five areas of focus are part of wider actions for Integrated Care Board and Integrated Care Partnerships to achieve system change and improve care for children and young people. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve aims.

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

2. Diabetes: Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and

Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

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

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

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

Children and Young People Plus groups identified in MSE that may experience poorer health outcomes:

- Young Carers,
- Ethnic minorities
- Roma, Gypsy, Travellers,
- Looked After Children, Care Givers

- Learning Disability
- Special Educational Needs and Disabilities (SEND),
- Neurodiversity (ASD and ADHD, Tics and Tourette's)
- Young people in the criminal justice system
- Families in Temporary Accommodation,
- Emotionally Based School Avoidance (EBSA),
- Unaccompanied asylum seekers, migrants
- CYP affected by Domestic Abuse

Addressing health inequalities in everything we do

In 2023/24 the MSE health inequalities programme has focused on developing a culture of addressing health inequalities across all our business areas. In support of that ambition, we have:

- Ensured equitable access through use of Equality and Health Inequalities Impact Assessments to identify impacts of service changes and set out appropriate mitigations to ensure health inequalities are addressed.
- Invested in the development of a digital Equality and Health Inequalities Impact Assessment tool 'ImpactEQ.' This will enable us to ensure high quality assessment are delivered consistently and roll out in 2024/25 will be supported by an organisational development approach that emphasises co-designing of services with residents and engaging those from vulnerable groups.
- Developed Health inequalities champions across the system including Finance Fellows as part of the Healthcare Financial Management Association (HFMA) Health Inequalities Finance Programme to support existing health inequalities ambassadors.
- Promoted Narrowing the gap in health inequalities through; the first jointly hosted conference with the Royal College of GPs, a system wide webinar with Allied Health Professionals (AHP) via and promotion of published Core20PLUS5 articles and case studies.
- Showcased the good practice being undertaken in MSE on CVD at national and regional networks. Alongside sharing work on SMI health checks with NHS confederation, NHSE and Institute for Health Improvement as part of being a Core20PLUS accelerator site.
- Embedded evaluation into the work the ICB is undertaking on Health inequalities by working with our partner the University of Essex.

Working with our most deprived communities – CORE20

Narrowing the gap in health inequalities in our most deprived communities is a priority for all our four Alliance partnerships. Each Alliance has tailored their approach and focused on specific areas, groups or conditions based on the needs of their local populations and the engagement work undertaken with their communities.

Basildon Alliance

- Working in partnership with Sport for Confidence to support people with Learning disabilities to access services and make informed decisions about cancer screenings and vaccinations.
- SMI health checks increased to over 60% through collaborative working between Vita Health and GP practices by offering greater choice in preferred location of health checks.
- Established Wellbeing Cafes in collaboration with Motivated Minds and Achieve Thrive Flourish to provide support on a range of topics including mental health, health and wellbeing, nursing, childcare, housing officers, social services, and Citizens Advice Bureau. The cafes offer a mixed programme of activities including social, exercise, talks on health-related topics. The cafes have shown to support participants to:
    - Develop social interactions and relationships, reducing feelings of isolation.
    - Improve physical activity.
    - Access to other voluntary and statutory services
    - Build resilience, provide coping mechanisms, and reduce dependency on the health services.

Mid Alliance

- Utilising the Thriving Places index (TPI) to provide a framework to identify those groups that are most of risk of health inequalities but also includes community indicators such as housing quality, education, and green infrastructure.
- In 2023/24 there has been a focus on the following population interventions; Serve Mental Illness (SMI) and Learning Disability health checks, Colne Valley Low Carb Programme, weight management services, sensory wellbeing specialist service and roll out of MSE wide initiatives.
- Clinical outreach scheme led by Chelmer PCN in partnership with, amongst others, Sanctus, Chess and Provide to support to those experiencing homelessness to develop confidence to engage with statutory services.

South East Alliance

The priorities in 2023/24 were:

Mental health & wellbeing, incorporating supporting long-term independence; Aging Well; unpaid carers and autism.

- Weight management, physical activity & obesity.
- Alcohol & substance misuse.
- Supporting long term independence incorporating social prescribing and loneliness and self-care community resilience.
- Health inequity and wider determinants of health incorporating: the food environment and food poverty, homelessness, and accommodation (decent, affordable, stable).

Thurrock Alliance

The focus in 2023/24 was:

- Obesity and Weight management. Nearing 10,000 adults identified and contacted to attend healthy lifestyle clinics.
- Tobacco control. A tobacco control strategy and smoking cessation implementation plan has been in place, the current activity is focussing on small businesses in Thurrock, providing training, stop smoking packs, and ongoing support to the 16 companies that have signed up to this initiative.
- Hypertension detection and management. A proactive initiative designed to reduce the number of cardiac events by the additional involvement of pharmacies, to support individuals at medium risk of CVD-related events with a diagnosis of hypertension that this not being actively treated.

PLUS groups

The ICB PHM team are developing local data and insight for the 'PLUS' groups within MSE to identify areas of greatest need and best practice interventions. However, based on national insight we continue to undertake programmes of work to address underlying health inequalities in our 'PLUS' groups including:

Ethnic Minority Groups

- Changing the way GP practices communicate with patients in BAME community by encouraging face to face meetings to help break down cultural barriers and allay concerns to improve uptake in cancer screening

Veterans

- Using Veterans voices to inform how services are delivered utilising research conducted by Healthwatch. MSEFT awarded veteran aware accreditation.

Homeless

- Bringing together the NHS, Southend-on-Sea City Council, food banks, soup kitchens, hostels, outreach teams, hospital, mental health, and substance misuse providers to deliver an integrated health service to those experiencing homelessness.

People with Learning disabilities

- Implementation of improvement plan has seen a year-on-year increase in % of individuals having a health check through greater partnership working between the LD specialist health team and primary care colleagues

Gypsy, Roma, Traveller Communities

- Improving access to health services in Thurrock through a monthly programme of visits to deliver preventive health interventions and facilitate registration with a GP practice.

Inclusion health groups

- MSE first ICS in EoE to commission Pride in Practice offering free training and support to over 25 accredited practices.

5 Clinical Priorities - Adults

Work has continued in 2023/24 around the five clinical priority areas for adults:

Maternity

- Implementation of the Maternity Equity and Equality action plan reduce risk of preterm births with focus on those from a black ethnic background.
- Creation of a patient information leaflet highlighting the risks around ethnicity
- Introduction of preterm birth digital tool 'QUiPP' app to improve prediction and care of those who may be in preterm labour.
- Launch of Smoke Free Pathway including provision of in-house smoking cessation support

Severe Mental Illness

- Spread of learnings across localities with strengthening of relationships between primary care and VCSE partners.
- Participation in NHSE Core 20 accelerator site with focus on quality improvement and co-production
- Delivered year on year improvement in uptake of annual health check and performance in upper quartile nationally.

Respiratory

- Continued focus on promoting Covid and Flu vaccine uptake with at risk groups.
- Adopting a Make Every Contact Count (MECC) approach as part of outreach work.
- Delivering higher uptake across most ethnicity groups in MSE compared to national average.
- Launch of Pneumococcal vaccine awareness and education campaign, with easy-to read document developed in partnership with voluntary sector groups to increase awareness and uptake among those with learning disabilities.

Cancer

- PCNs act on data received on cancer screening uptake by deprivation and at-risk groups.
- Development of culturally competent communication with videos from local doctors about how to recognise signs and symptoms of some of most common cancers.
- Expansion of national lung cancer screening programme to Castle Point and Rochford with continuation in Thurrock and Southend.

Hypertension

- Over 92,000 residents participating in the programme with distribution of 2,000 blood pressure machines to GPs in most deprived areas.

- Outreach clinics undertaken in deprived areas of Southend to improve identification and management of hypertension.
- On trajectory to achieve national targets regarding hypertension management and prescribing of cholesterol lowering therapies

5 Clinical Priorities - Children and Young People

Work has continued in 2023/24 around the five clinical priority areas for children and young people:

Asthma

- Utilising data to identifying those most at risk of exacerbations and who would benefit from proactive care.
- Roll out of Childhood Asthma training for primary care.
- Encouraging access to education tool for children and their family to support them in learning more about asthma, triggers, and effective management.

Diabetes

- Improvement plan in development in Q4 of 2023/25 to increase access to Continuous Glucose Monitoring and insulin pumps within agreed protocols and NICE Guidance by 2025/26

Epilepsy

- Improvement Plan is under development overseen by the MSE Growing Well Board to implement the national care bundle for children and young people with Epilepsy.

Oral Health

- Adoption of a system wide approach to child oral health working across health providers, education sector, public health and with community and voluntary sector groups
- Thurrock was chosen by NHSE as pilot site for Early Year Oral Health Improvement through its Family Hubs
- Initiatives include supervised toothbrushing in earl years and distribution of toothbrush packs.

Mental Health

- Growing Well Board has prioritised SEND and neurodiversity and committed health inequalities funding toward pre and post diagnosis support.
- Recruitment of PCN based Children and Young People's Mental Health Practitioners commenced.
- Working in partnership across system to strengthen early intervention, support and education for Schools and Colleges.

Planning priorities 2023/24 – Health inequalities

Restore NHS services inclusively

- Elective Recovery Equality Health Impact Assessment completed with mitigation action to reduce identified barriers to access.
- Elective waiting list data analysed by ethnics, sex, and deprivation with regular reporting to MSEFT Board and Elective Care Board
- Gap in waiting times between the most deprived and second most deprived areas halving in last 23 months.

Mitigate against digital exclusion

- Access to primary, secondary and community care continues to be offered via digital, face to face and by telephone for all.
- Digital Inclusion Framework established with principles being adopted by all partners within the ICS.
- Recruitment to digital transformation roles with primary care and existing social prescribing link workers and health and wellbeing coaches to support patient with access via digital health apps and improving digital and health literacy.
- Working closely with local authorities to support digital infrastructure, digital affordability, and signposting patients.

Ensure datasets are complete and timely

- Shared Decision Making four questions campaigned rolled out to support personalisation in primary care.
- Targeted investment in Health Inequalities, contracting Alliance 'trusted partners' to facilitate investment in local schemes.
- Hosted 'Narrowing the Gap' conference with RCGP for over 80 system attendees, including primary care and VCFSE.

Accelerative preventative programmes

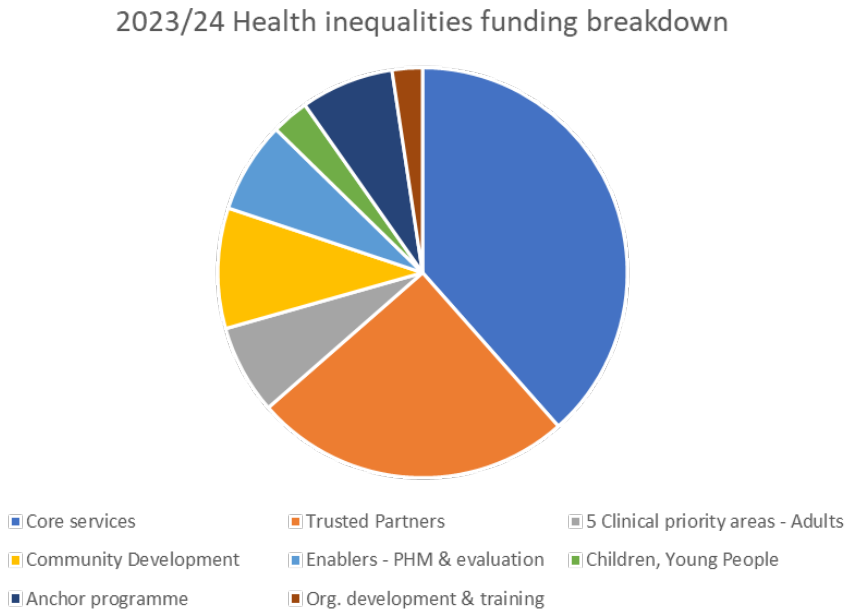
- MSE ICB continues to accelerate prevention programmes through its adoption of the Core20PLUS5 frameworks.
- CVD Prevention programme supported with Health inequalities funding has delivered improvements in hypertension and lipid management.
- Launch of tobacco cessation programme for inpatient services and pregnant women
- Increased access to weight management services

Strengthen leadership and accountability

- Clear leadership, governance, and accountability for health inequalities through the Population Health Improvement Board reporting to ICB Board and the Integrated Care Partnership
- Clinical leadership strengthened with two system clinical leads in post, Alliance Clinical Leadership and PCN Health Inequalities focused on delivering reductions in health inequalities across all levels with the system.

Health inequalities Funding

The ICB committed £3.4m of its baseline funding towards reducing health inequalities. Its approach evolved in 2023/24 with appointment of 'Trust partners' in each Alliance, predominately CVS organisations to support the administration and management of the funds.



The image is of a pie chart showing 2023/24 health inequalities funding breakdown showing the two biggest proportions of spend going to Core services and trusted partners. Other spends in order of proportion are community development, anchor programme, Enablers – PHM & evaluation, 5 clinical priority areas – adults, children, and young people and lastly organisation development and training.

The funding supported reducing health inequalities across its Core services, Core20PLUS5 priorities and to meet identified local population needs.

Funding has been committed against a smaller number of schemes in 2023/24 with a focus on clinical priority areas of cardiovascular disease and cancer.

The Growing Well Board has prioritised funding to reduce health inequalities via an Oral Health Programme and Pre and Post Neurodiversity Diagnosis Support for children and young people.

In 2022/23 the ICB committed its £3.4m health inequalities funding from NHSE to support over 70 innovative projects to reduce health inequalities against the Core20plus5 priorities and to meet local population needs. The ICB is working with the University of Essex to evaluate the impact of these schemes.

Basildon – Feeding the family; Give, Guide, Grow

Provided support for 700 low-income families including teaching cooking, hygiene advice and tips on reducing food waste, energy, and bills. Recipients reported positive impact on their lives with reduced social isolation and loneliness.

Southend – Let's Keep Moving and Age Better

Over 100 people with multiple long-term conditions supported by Community Interest Company to increase levels of physical activity, improve healthy weight and reduce risk of falls.

Mid Essex – Young Carers Thrive

Provided support to 200 young carers and family members in Mid Essex. Participants reported improvements in managing their carer responsibilities and feeling happier at school as a result of the programme's support.

Thurrock – Access to health services

Monthly programme of health and wellbeing services visits across 5 main gypsy, Roma, Traveller sites. 210 patients seen, with 16 new patients registered with the GP, a fifth reviewed by pharmacist, 13% referred to GP for review of diabetes, hypertension, or cholesterol.

Health inequalities Indicators 2023/24

Domain: Elective Recovery

Elective waiting lists

- Mid and South Essex Foundation NHS Trust reports regularly to their Board on health inequalities within elective waiting lists as part of the integrated performance report
- Elective Recovery Equality Health Impact Assessment completed with mitigating actions outlined and reported to the Elective Care Board
- Community Collaborative have set out a programme for reviewing health inequalities across priority areas of Virtual Ward (admissions), UCRT (referrals), IMC and Stroke beds (admission), Community Paediatric (all waits) in 2024/25.
- Further work is to be undertaken in 2024/25 to identify and address health inequalities within elective waiting lists and activity.

Indicator: Elective waiting lists

Ethnicity Focus. There is an under-representation in all ethnicities except "other ethnic group" on the waiting lists. Under-representation can suggest difficulty in accessing care.

Black, Asian, and Mixed patients are all under-represented, Therefore, it is important to focus on whether patients from an ethnic minority background are having difficulties accessing care. There is a 20-25% gap in recording of ethnicity data which is impacting our ability to understand if patients are under-represented or just unknown in the data.

Image showing 3 graphs showing ethnicity in relation to; Diagnostic waiting list 23/24, RTT waiting list 23/24 and cancer waiting list 23/24.

Gender Focus. Females are over-represented, meaning they are more likely to appear on our waiting lists than males. This could be attributed to females living longer than males in MSE. The next step is understanding if females have longer waiting times based on population distribution or delays in receiving treatment.

Image showing 3 graphs showing gender in relation to; Diagnostic waiting list 23/24, RTT waiting list 23/24 and cancer waiting list 23/24.

Age Focus. Our age distribution in hospital does not reflect that of the population. We see an over-representation of patients over 65, but this is expected. Our previous analysis did not suggest over 65s are waiting longer.

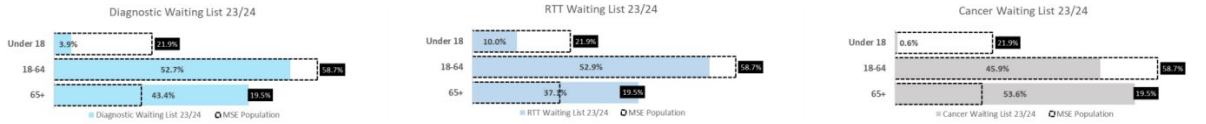


Image showing 3 graphs showing age in relation to; Diagnostic waiting list 23/24, RTT waiting list 23/24 and cancer waiting list 23/24.

Deprivation Focus. Those living in the 2nd most deprived quartile are over-represented on our waiting lists and those in the least deprived areas are under-represented. This could suggest our more deprived populations have poorer health outcomes and/or our more deprived patients are waiting longer.

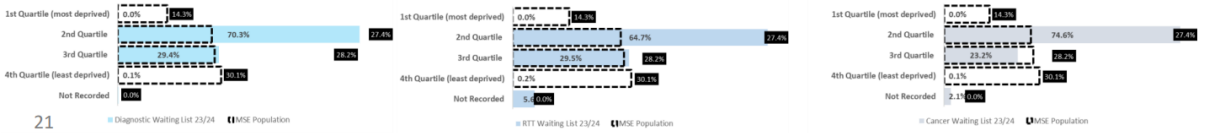


Image showing 3 graphs showing deprivation in relation to; Diagnostic waiting list 23/24, RTT waiting list 23/24 and cancer waiting list 23/24.

General projects

Patient Communication: Work being taken forward by Associate Director Patient Experience & Engagement. Patient communication strategy meeting held Feb 24.

National Voices: Preparing end of project report on Lived Experience Coaching to share learning. Lived experience is a key theme in MSEFT 10-year strategy development programme using recommendations from the National voices report. Two insight reports –

1. Experiences of people with Dementia and 2. experiences of shared decision-making being used for project development.

Digital EHIA Assessment Tool and Improved Staff Training and awareness: ICS wide tool will significantly improve how staff approach and complete meaningful assessments for service changes impacting people with protected characteristics. Final elements are now being completed and testing /soft launch is underway. Contract and commercial issues are being resolved with the help of a specialist. Last business case to finalise future maintenance funding will be shared with leads once commercial considerations have been confirmed.

Anchor Social Value: Final Social Value session to develop Framework for Mid and South Essex completed 11 Jan 24. Next steps for detailed plans and community/ business consultation to be worked up and completed by early summer 2024. Team also supporting conversation on updated Anchor Charter for all ICS partners and successfully delivered an event on 27th Feb, which was attended by more than 75 partners supporting Anchor.

MSE Innovation fellowships: Cohort 4 launched 6 November 23 - focus on inclusion health, education & training, and net zero. 18 new fellows, 27% MSEFT, 26% ICS and remainder from clinical entrepreneur programme or small/medium enterprises. 59 Alumni Fellows, 12 with strong link to health inequalities. Preparations underway for Cohort 5 Fellowship themes.

Projects under theme of Access

Integrated Impact Assessment for Community Beds: Strategy Unit have produced an Integrated Impact Assessment for Community Capacity. This is currently in the public domain as part of the public consultation.

Working Age Women: Focus Groups have been held with Patients and Staff to understand the restrictions, opportunities and issues faced. Some feedback has been analysed and Strategy leads are considering the regional women's hubs for this work.

Rapid Diagnostic Centre and Endoscopy short films and Easy Read Leaflets: Short films and leaflets supporting patients with LD and/or anxiety etc. when they access services are being finalised. LD team presenting a poster on their work with LD ambassadors at the IHI forum in London on 11-12 Apr.

OVRcome: Project won 'Diversity In Innovation' award at the Innovation Awards 2023. Successful SBRI bid awarded Nov 2023 for £438K, with the project starting 2 Jan 2024. 6 co-production sessions held (5 initial & 1 final session) for those with lived experience, supporters, and staff. Feedback and plan for video/content creation socialised at final session; 104 contributions across the sessions and survey. 20 participants recruited for pilot. Medical device regulatory work underway for the OVRcome tool. Presented to EOE Regional Community Learning disability and Acute Liaison Nurse Forum.

Veterans' Aware accreditation: MSEFT secured Veteran's Aware Accreditation by March 2024, with the identification of the following best practice; governance (working group), Patient identification, staff training, communications, and recruitment.

Projects under theme of Outcomes

CardMedic: 858 users (increase of 35) are registered, and maternity has been particularly engaged with this project. CardMedic covers all specialty areas, with 49 languages now available. CardMedic working group provide guidance for future projects and remote engagement across MSEFT. MSEFT feedback survey completed on usage of CardMedic. Ongoing work around inclusion within Translation policy. Exploring funding routes for contract renewal.

Industrial Action Analysis: Strategy Unit produce industrial action impacts analysis regularly to Execs and board to ensure understanding continues to grow. Last analysis shared March 24 public board.

Youth Work in Hospital: Expansion of original programme close to mobilisation. Extension into Long Term Conditions is advanced with youth work practitioners joining Long Term Conditions Clinic for Diabetes and Epilepsy. Additional funding to extend project to October 2025 - will greatly assist establishing new service and extending to all three hospitals. Includes development of Southend test cohort which is currently in planning stage.

Anchor Ambition 25: Project has completed mobilising Mid and South Essex expansion plan including on-boarding of four Anchor Ambition Employment Support Officers. Community hubs identified - with revised capacity the project has seen numbers increase exponentially to 1,004 participants and 196 job offers since Feb 23. Project has delivered Hundo component supporting MSE's pipelines and commenced delivery of its traineeships for disadvantaged young people (Care Leavers).

Projects under theme of Experience

Learning Disability Understanding Inequalities Co-Design Programme LD programme is being delivered by the LD service as BAU. Reasonable adjustment cards available since February following printer set up. Makaton Training is available.

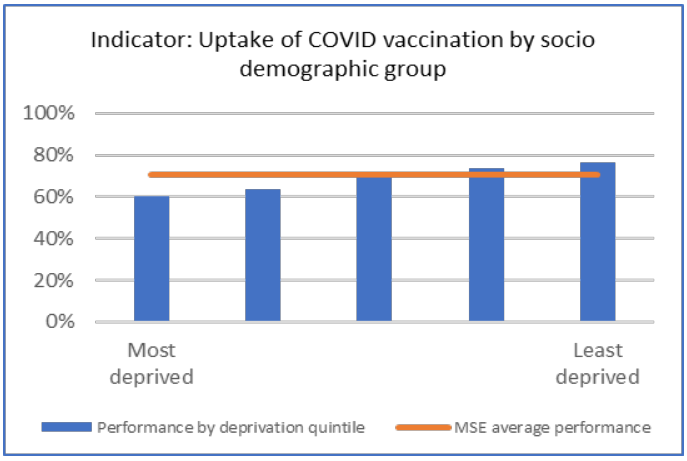
User Centred Design (UCD) Better Letters are live in Renal, Pain, Audiology (Southend), Virtual Visits, and ORC service clinics. DNA reduction is evident in some of the more established areas. The team are working with the Outpatient Transformation Programme rolling out pilots with audiology; cardiology; gastro; general surgery and breast; neurology, oncology; paeds; respiratory; upper GI, colposcopy and vascular. Team are also looking at clinical letters for the Cervical Screening Service. Urology and the ORC Fast Track team are also now on board.

Shared Decision Making. The programme has secured resources through the Portfolio Board decision in early April to help develop a methodology with pilot services that will then be rolled out across the organisation.

Domain: Respiratory

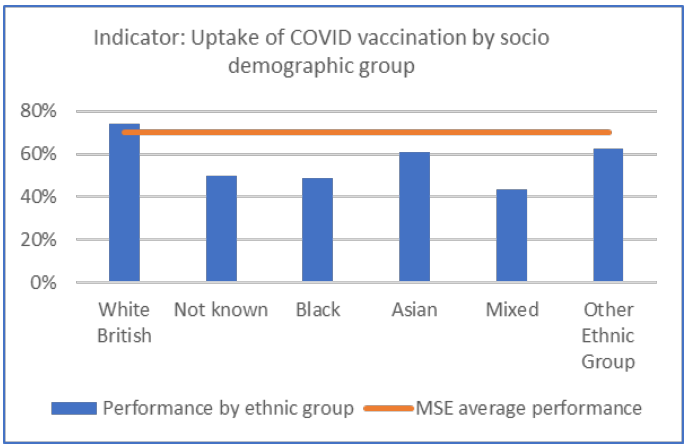
Indicator: Uptake of COVID vaccination by socio demographic group

Graph 1: the uptake of Covid vaccination by socio demographic group - performance by deprivation quintile



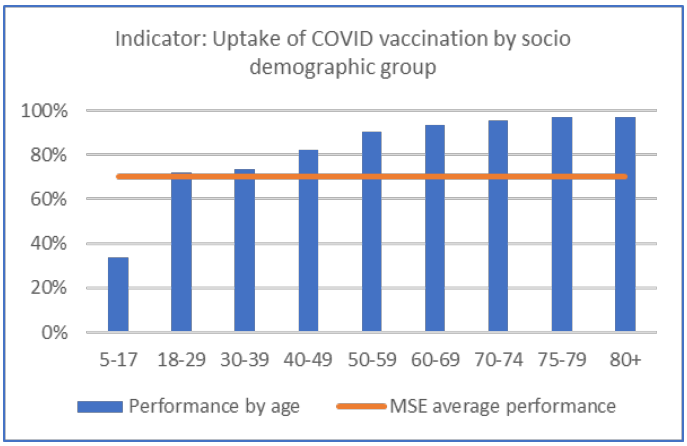
Graph 1 shows the uptake of Covid vaccination by deprivation quintile, with quintile 1 (most deprived) being 60%, quintile 2 being 63%, quintile 3 being 71%, quintile 4 being 74% and lastly quintile 5 (least deprived) being 76%, comparative to the MSE average performance of 70.3%.

Graph 2: Uptake of Covid vaccination by socio demographic group - performance by ethnicity



Graph 2 shows the uptake of Covid vaccination by ethnic group, with white British being 73.8%, not known being 49.5%, black being 48.9%, Asian being 60.9%, mixed being 43.3% and lastly other ethnic group being 62.4%, comparative to the MSE average performance of 70.3%.

Graph 3: Uptake of Covid vaccination by socio demographic group - performance by age



Graph 3 shows the uptake of Covid vaccination by age, with age range 5-17 being 33.6%, 18-29 being 72.1%, 30-39 being 73.3%, 40-49 being 82.1%, 50-59 being 90.3%, 60-69 being 93.6%, 70-74 being 95.3%, 75-79 being 96.8% and lastly 80 and over being 97.1%, comparative to the MSE average performance of 70.3%.

Observed health inequalities

- Higher levels of vaccination are observed in less deprived and older age groups. In addition, ethnicity has an impact of relative rates of vaccination with White British having the higher levels of vaccination and mixed, black, and unknown ethnicities having lower levels of vaccination. Further analysis is being undertaken but initial review suggests that this is not down to access as there not a significant variation in uptake in relation to proximity to vaccination services amongst different areas of deprivation.

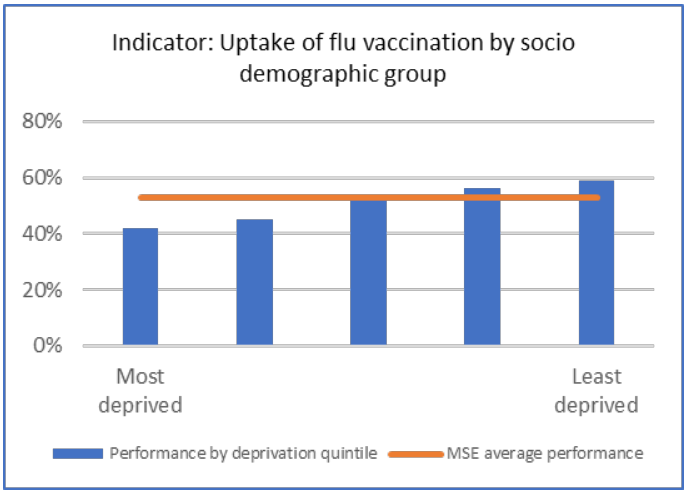
Action being taken to address these health inequalities

- Building on the successes of the initial covid vaccination programme, various targeted initiatives have been undertaken to try and improve uptake rates in specific cohorts of the population. We have increased the number of venues offering covid vaccinations particularly in areas of Southend, Basildon, and Thurrock. A number of pop-up vaccination clinics are run targeting areas with historically low uptake. Our comms campaign targets particular postcodes in areas of high deprivation through a variety of mechanism such as bus adverts, social media adverts and other promotional campaigns. PCNs maintain links into key communities and leads within those communities to try and encourage uptake. We will review the autumn/winter campaign to understand areas of greatest impact and then spread good practice.

Source: Foundry (NHS England Data Extraction as at 23/01/24)

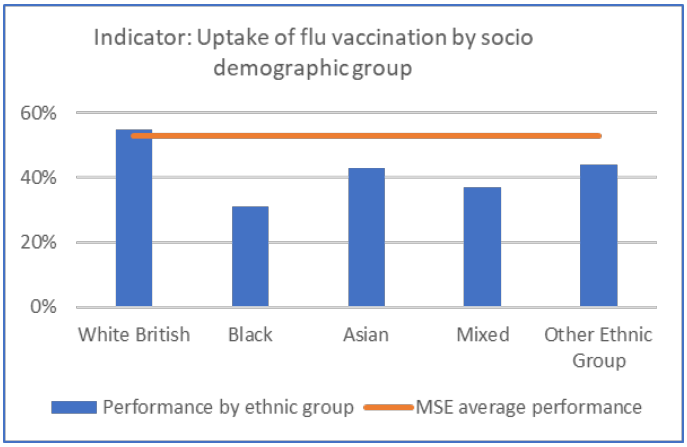
Indicator: Uptake of flu vaccination by socio demographic group

Graph 1: the uptake of flu vaccination by socio demographic group - performance by deprivation quintile



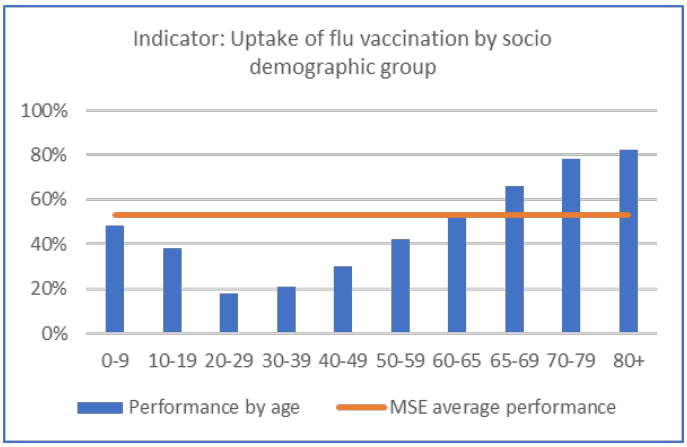
Graph 1 shows the uptake of flu vaccination by deprivation quintile, with quintile 1 (most deprived) being 42%, quintile 2 being 45%, quintile 3 being 53%, quintile 4 being 56% and lastly quintile 5 (least deprived) being 59%, comparative to the MSE average performance of 53%.

Graph 2: the uptake of flu vaccination by socio demographic group - performance by ethnicity



Graph 2 shows the uptake of flu vaccination by ethnic group, with white British being 55%, black being 31%, Asian being 43%, mixed being 37% and lastly other ethnic group being 44%, comparative to the MSE average performance of 53%.

Graph 3: the uptake of flu vaccination by socio demographic group - performance by age



Graph 3 shows the uptake of flu vaccination by age, with age range 0-9 being 48%, 10-19 being 38%, 20-29 being 18%, 30-39 being 21%, 40-49 being 30%, 50-59 being 42%, 60-65 being 54%, 65-69 being 66%, 70-79 being 78% and lastly 80 and over being 82%, comparative to the MSE average performance of 53%.

Observed Health inequalities

- Across the various vaccination programmes in Mid and South Essex there is a consistent inequality in levels of vaccination across two key factors - deprivation and ethnicity. There is a general trend that the lower the levels of deprivation, the higher the rate of vaccination. Analysis suggests that this is not driven by access to vaccinations with the number of places offering vaccinations not varying significantly between areas of high and low deprivation. Willingness to engage in the vaccination programme appears to be the most significant factor. Efforts to address the variation must be targeted at engaging with more deprived communities on the importance of the vaccination programme.
- For ethnicity, vaccination rates amongst white British cohorts are higher than other ethnicities. Rates are particularly low amongst the black population.

Action being taken to address these health inequalities

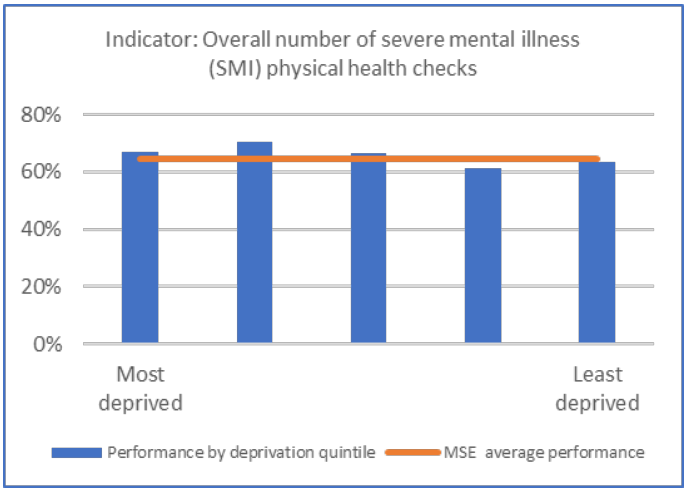
- Data is being analysed at a Primary Care Network level to understand which PCNs had a greater impact on addressing inequality. The Covid and Flu Vaccination team are working with those PCNs to cascade best practice. We will utilise access and inequalities funding to invest into initiatives that demonstrate an impact. We will continue with the promotion of covid and flu vaccines as part of our overarching winter campaign.
- Building on the success of the Covid vaccination

Source: Foundry (NHS England Data Extraction as at 23/01/24)

Domain: Mental Health

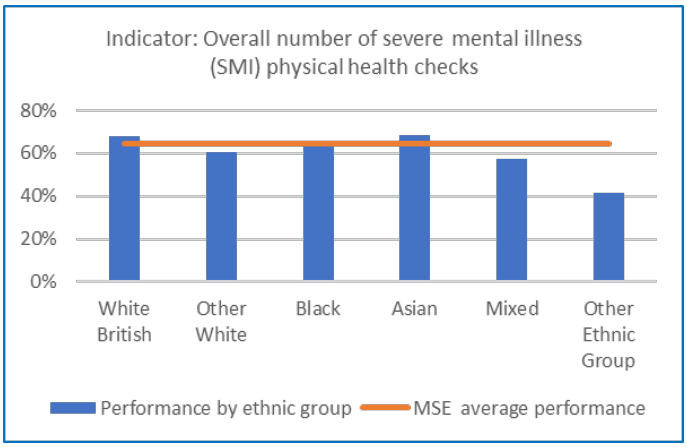
Indicator: Overall number of severe mental illness (SMI) physical health checks

Graph 1: Overall number of severe mental illness (SMI) physical health checks – performance by deprivation quintile



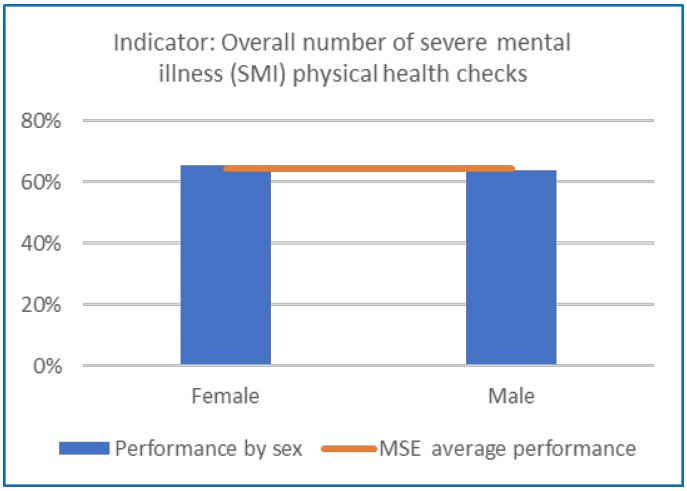
Graph 1 shows the overall number of severe mental illness (SMI) physical health checks performance by deprivation quintile, with quintile 1 (most deprived) being 66.8%, quintile 2 being 70.6%, quintile 3 being 66.5%, quintile 4 being 61.3% and lastly quintile 5 (least deprived) being 63.5%, comparative to the MSE average performance of 64.6%.

Graph 2: Overall number of severe mental illness (SMI) physical health checks – performance by ethnicity



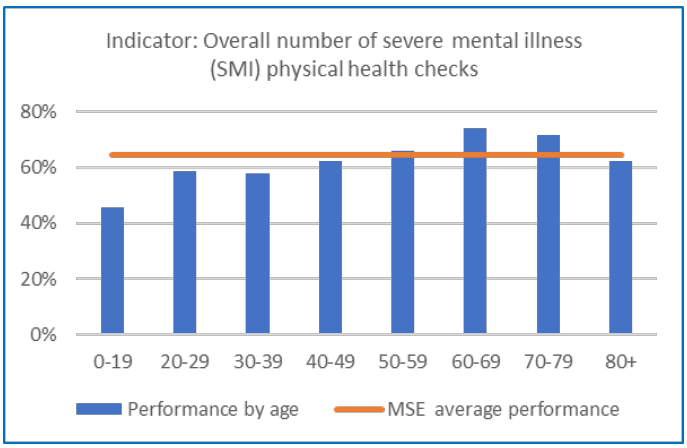
Graph 2 shows the overall number of severe mental illness (SMI) physical health checks performance by ethnic group, with white British being 68.1%, other white being 60.3%, black being 64.5%, Asian being 68.6%, mixed being 57.5% and lastly other ethnic group being 41.4%, comparative to the MSE average performance of 64.6%.

Graph 3: Overall number of severe mental illness (SMI) physical health checks – performance by gender



Graph 3 shows the overall number of severe mental illness (SMI) physical health checks performance by gender, with female being 65.4% and male being 63.8%, comparative to the MSE average performance of 64.6%.

Graph 4: Overall number of severe mental illness (SMI) physical health checks – performance by age



Graph 4 shows the overall number of severe mental illness (SMI) physical health checks performance by age, with age range 0-19 being 45.6%, 20-29 being 58.7%, 30-39 being 58%, 40-49 being 62.4%, 50-59 being 65.8%, 60-69 being 73.9%, 70-79 being 71.6% and lastly 80 and over being 62.2%, comparative to the MSE average performance of 64.6%.

Observed health inequalities

- Uptake does not significantly vary by deprivation, but analysis shows lower uptake in younger age groups
- Performance by ethnic group highlights that those identified as other white and other ethnic group have lower uptake.

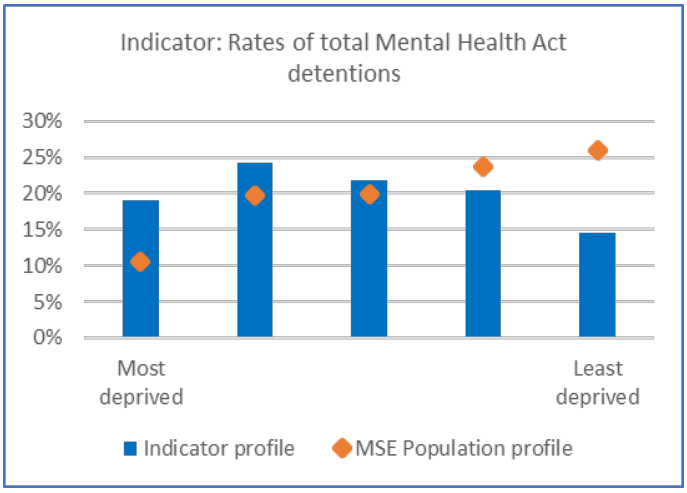
Action being taken to address these health inequalities

- Review of patient data of SMI patients currently accessing health checks to identify the demographics of those who are underrepresented, these groups will be targeted for engagement which might be informed by ethnicity, age, gender, or geographical location.
- Participation in the Core20plus accelerator programme to take a quality improvement and engagement approach to improve uptake.
- Engagement with stakeholders completed to gather insight on their experience of, and potential barriers to accessing their annual physical health check.
- Engagement with patients and carers to understanding their experience of, and barriers that exist to accessing subsequent interventions to improve health e.g., smoking cessation and weight loss
- Adapting communication methods by increasing proportion of patients contacted by phone and offering home visits for those who are unable to attend practices.

Source: MSE local dataset – Athena

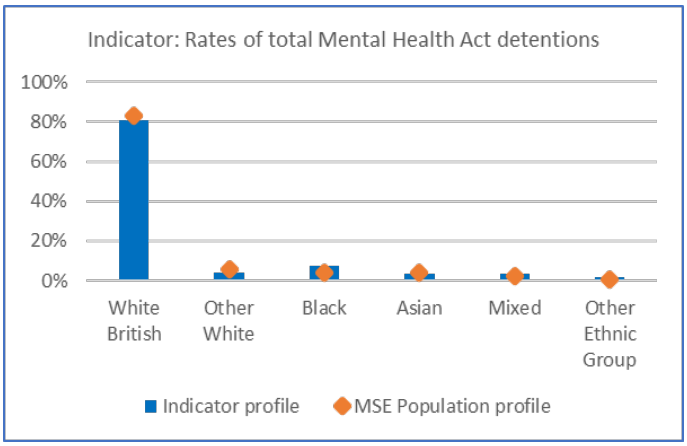
Indicator: Rates of total Mental Health Act detentions

Graph 1: Rates of total Mental Health Act detentions – performance by deprivation quintile



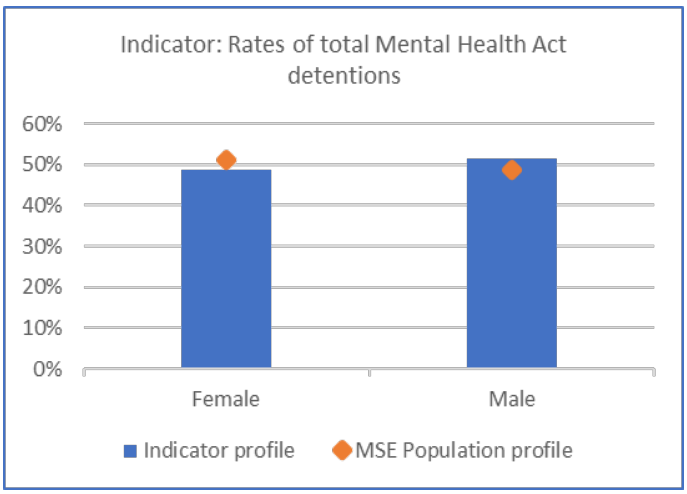
Graph 1 shows rates of total Mental Health Act detentions by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 19.1% compared to 10.6%, quintile 2 being 24.2% compared to 19.6%, quintile 3 being 21.7% compared to 20%, quintile 4 being 20.4% compared to 23.7% and lastly quintile 5 (least deprived) being 14.6% compared to the MSE population of 26%.

Graph 2: Rates of total Mental Health Act detentions – performance by ethnicity



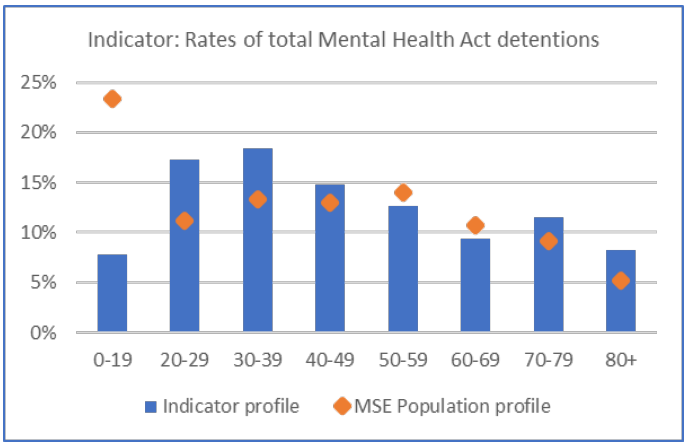
Graph 2 shows rates of total Mental Health Act detentions by ethnic group, comparing the indicator profile against the MSE population profile, with white British being 80.6% compared to 83.21%, other white being 4% compared to 5.76%, black being 7.1% compared to 3.76%, Asian being 3.5% compared to 4.18%, mixed being 3.3% compared to 2.34% and lastly other ethnic group being 1.4% compared to the MSE population of 0.75%.

Graph 3: Rates of total Mental Health Act detentions – performance by gender



Graph 3 shows rates of total Mental Health Act detentions by gender, comparing the indicator profile against the MSE population profile, with female being 48.7% compared to 51.2% and male being 51.3% compared to the MSE population of 48.8%.

Graph 4: Rates of total Mental Health Act detentions – performance by age



Graph 4 shows rates of total Mental Health Act detentions by age, comparing the indicator profile against the MSE population profile, with age range 0-19 being 7.8% compared to 23.4%, 20-29 being 17.3% compared to 11.2%, 30-39 being 18.4% compared to 13.3%, 40-49 being 14.8% compared to 13%, 50-59 being 12.6% compared to 14%, 60-69 being 9.4% compared to 10.7%, 70-79 being 11.5% compared to 9.2% and lastly 80 and over being 8.2%, compared to the MSE population of 5.2%.

Observed health inequalities

- Higher rates of detentions are seen in the more deprived areas, however 19.8% of patients had no postcode match or unknown postcode and therefore deprivation IMD could not be established.
- Performance by sex suggests to be somewhat similar to the MSE Population average, with Males performing just above the average.
- As in previous years, the detention rate nationally was highest among black or black British people in 2022-23 at 227.9 per 100,000 population, 3.5 times the rate for white people (64.1) (Source NHS Digital). MSE follows a similar pattern to that nationally, with a higher detention rate for black people compared to the local population profile.

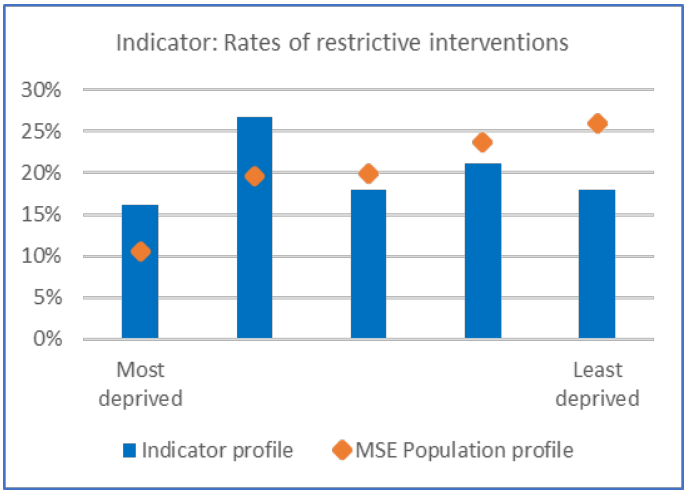
Action being taken to address these health inequalities

- Further analysis is being undertaken to establish number of detentions under the Mental Health Act per 100,000 people, by aggregated ethnic group (standardised rates).
- Further identification of the demographics of those who are underrepresented, these groups will be targeted for engagement which might be informed by ethnicity, age, gender, or geographical location.
- Crisis Response NHS111(2) & CRT – Continued delivery, review, and refinement of an inclusive model to ensure early intervention to support reduction in waiting time for those detained under s136 from and detentions of under the MHA. Current s136 average of 9hrs to 6.5hrs. They have also seen a reduction in the volume of individuals we detain by 32% which equates to around 228 less detentions. To work with EPUT around MH act detention to elicit similar impact.
- Data represents patients not the instances of detentions or interventions, Apr23-Jan24.

Source: EPUT Dataset – direct patient records

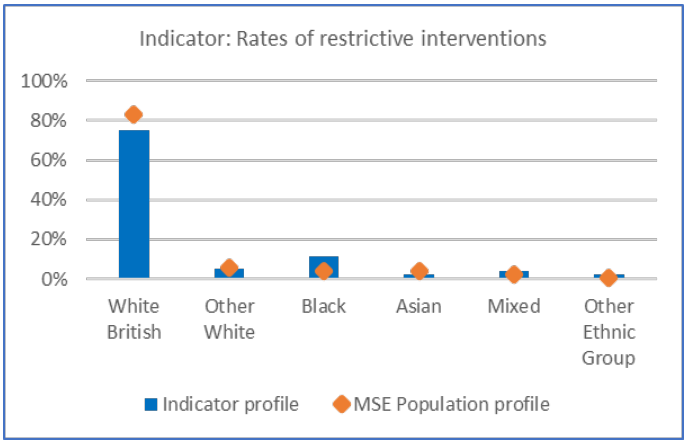
Indicator: Rates of restrictive interventions

Graph 1: Rates of restrictive interventions – performance by deprivation quintile



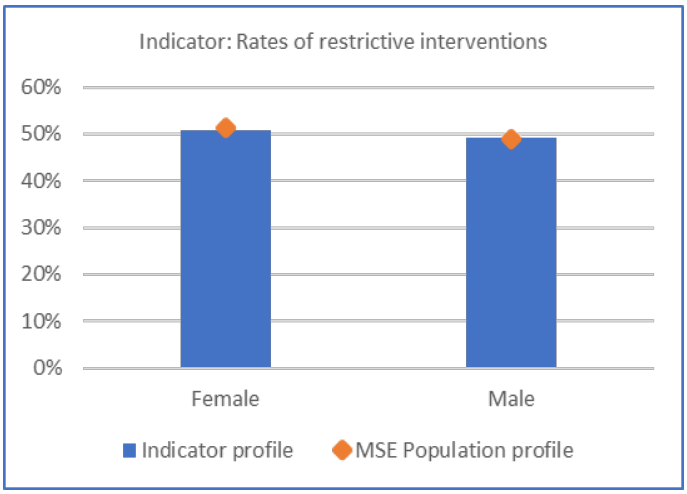
Graph 1 shows rates of restrictive interventions by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 16.1% compared to 10.6%, quintile 2 being 26.7% compared to 19.6%, quintile 3 being 18% compared to 20%, quintile 4 being 21.1% compared to 23.7% and lastly quintile 5 (least deprived) being 18% compared to the MSE population of 26%.

Graph 2: Rates of restrictive interventions – performance by ethnicity



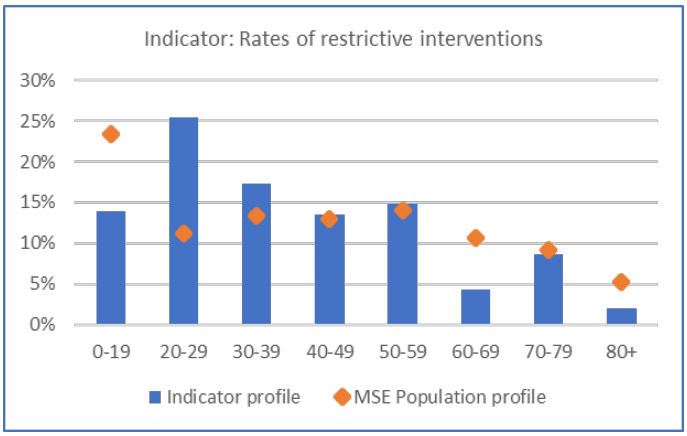
Graph 2 shows rates of total Mental Health Act detentions by ethnic group, comparing the indicator profile against the MSE population profile, with white British being 75.4% compared to 83.21%, other white being 5% compared to 5.76%, black being 11.6% compared to 3.76%, Asian being 2% compared to 4.18%, mixed being 4% compared to 2.34% and lastly other ethnic group being 2% compared to the MSE population of 0.75%.

Graph 3: Rates of restrictive interventions – performance by gender



Graph 3 shows rates of total Mental Health Act detentions by gender, comparing the indicator profile against the MSE population profile, with female being 50.7% compared to 51.2% and male being 49.3% compared to the MSE population of 48.8%.

Graph 4: Rates of restrictive interventions – performance by age



Graph 4 shows rates of restrictive interventions by age, comparing the indicator profile against the MSE population profile, with age range 0-19 being 13.9% compared to 23.4%, 20-29 being 25.5% compared to 11.2%, 30-39 being 17.3% compared to 13.3%, 40-49 being 13.5% compared to 13%, 50-59 being 14.9% compared to 14%, 60-69 being 4.3% compared to 10.7%, 70-79 being 8.7% compared to 9.2% and lastly 80 and over being 1.9%, compared to the MSE population of 5.2%.

Observed health inequalities

- Higher rates of restrictive interventions are seen in the more deprived areas, however 22.6% of patients had no postcode match or unknown postcode and therefore deprivation IMD could not be established.
- A quarter of restrictive interventions are in those aged 20-29 years.

- Black people are overrepresented with a higher proportion experiencing restrictive interventions compared to the MSE population profile.

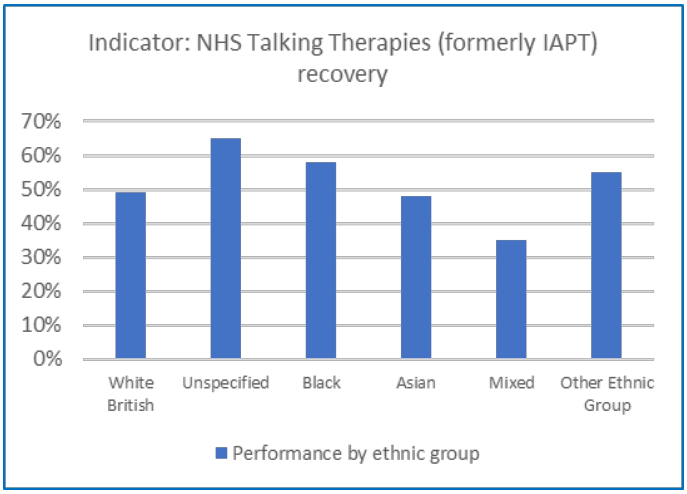
Action being taken to address these health inequalities

- As part of the Mental Health Learning Disability and Autism inpatient quality programme, action is being taken on the following:
  - Reducing Restrictive Practice Strategy
  - Updating policies
  - Restrictive Practice awareness campaign to support staff in understanding the meaning of restrictive practice and its impact.
  - Engaging with experts by experience to support ward staff with training and development.
- Data represents patients not the instances of detentions or interventions, Apr23-Jan24.

Source: EPUT Dataset – direct patient records

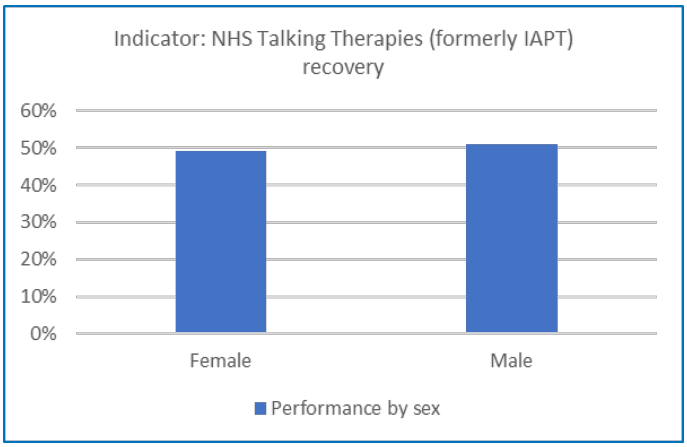
Indicator: NHS Talking Therapies (formerly IAPT) recovery

Graph 1: NHS Talking Therapies (formerly IAPT) recovery – performance by ethnicity



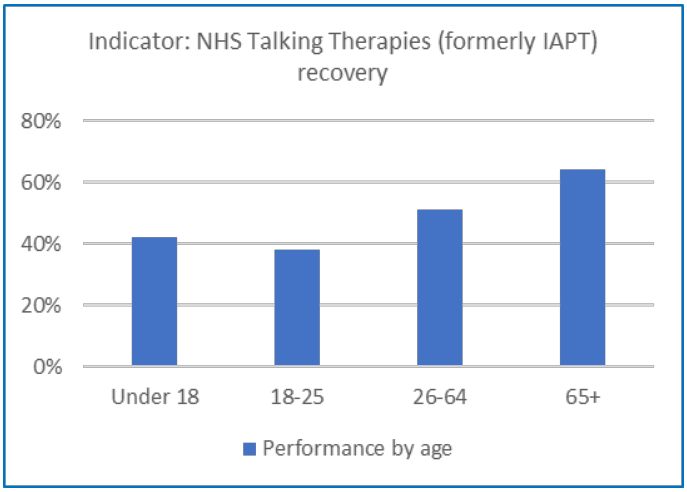
Graph 1 shows NHS Talking Therapies (formerly IAPT) recovery performance by ethic group, with white British being 49%, unspecified being 65%, black being 58%, Asian being 48%, mixed being 35% and lastly other ethnic group being 55%.

Graph 2: NHS Talking Therapies (formerly IAPT) recovery – performance by gender



Graph 2 shows NHS Talking Therapies (formerly IAPT) recovery performance by gender, with female being 49% and male being 51%.

Graph 3: NHS Talking Therapies (formerly IAPT) recovery – performance by age



Graph 3 shows NHS Talking Therapies (formerly IAPT) recovery performance by age, with those under 18 being 42%, 18-25 being 38%, 26-64 being 51%, and lastly 65 and over being 64%.

Observed health inequalities

- IAPT recovery is 15% lower for mixed ethnic groups than White British. Recovery rates for Black, other ethnic groups and those unspecified is significantly higher.
- Recovery rates are lower in the younger age groups, with those aged 25 years and below significantly below those aged 65 and over.

Action being taken to address these health inequalities

All four providers in MSE have:

- Communication and engagement plan with targeted outreach to inform people of the NHS Talking Therapies offer and to break down stigma regarding Mental Health
- Champion roles for clinicians to champion groups and work with them
- Review of Equality, Diversity, and Inclusion material for training purposes
- Engage in training offers and keep up to date with best practice guides for NHS Talking Therapies

Source: NHS Talking Therapies Protected Characteristics Dashboard

Indicator: Children and young people's mental health access

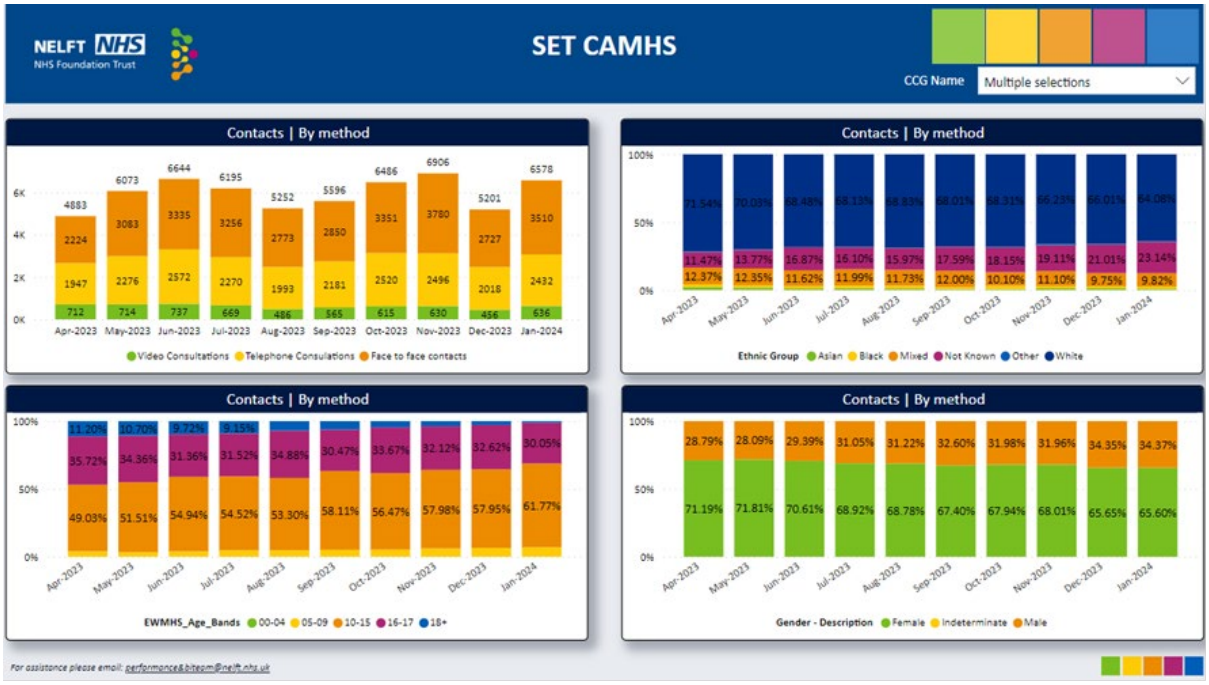


Image shows NELFT dashboard on Southend, Essex, and Thurrock CAMHS, including 4 tables displaying data on contacts | By method, with the first showing monthly data on video consultations, telephone consultations and face to face contacts. The second graph shows monthly data on ethnic group. The third graph shows monthly data on age ranges and lastly the fourth graph shows monthly data of gender.

Observed health inequalities

- The proportion of contacts where the ethnic background is not known has been increasing
- The proportion of contacts has been increasing in the younger age groups those 10-15 years, with proportionately fewer in those 16 years and above
- A significantly higher proportion of individual accessing the service are female, although this has been reducing over time.

Action being taken to address these health inequalities

- Prioritisation of the expansion of MHST teams for wave 11 includes mandated 8 EMHP's as per NHSE guidance and aligned to the workforce model.

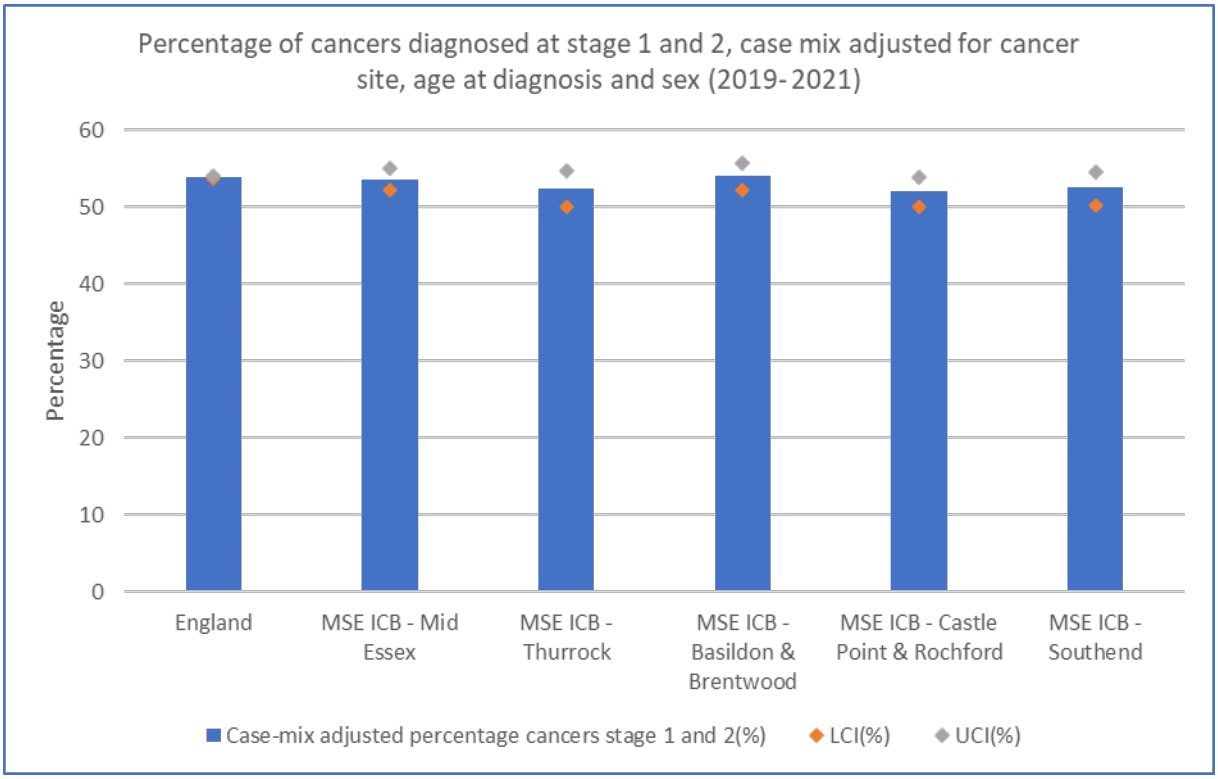
- Learning from previous waves has allowed us to think differently about roles within MHSTs, with a particular focus on recruitment and retention of the MHST workforce.
- The specific learning from previous MHST implementation has provided the opportunity to continue development of a workforce strategy and adapt this accordingly in line with the NHSE Improving Staff Retention Guide.
- The intention is that this will build evidence on closer collaboration between education and health, including working collaboratively across professional boundaries, training for non-health staff and creating environments that facilitate best possible outcomes for children and young people by primarily targeting the increasing identified age group of 10-15 years.

Source: NELFT dataset

Domain: Cancer

Indicator: Children and young people's mental health access

Graph 1: Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis and sex (2019- 2021)



Graph 1 shows percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis and sex (2019- 2021) showing England average Case-mix adjusted percentage cancers diagnosed at stage 1 and 2 as being 53.9% MSE ICB – Mid Essex's Case-mix adjusted percentage cancers stage 1 and 2 being 53.6%. MSE ICB – Thurrock's Case-mix adjusted percentage cancers stage 1 and 2 is 52.4%. MSE ICB – Basildon & Brentwood Case-mix adjusted percentage cancers stage 1 and 2 is 54%. MSE ICB – Castle Point & Rochford's Case-mix adjusted percentage cancers stage 1 and 2 is

52%. MSE ICB – Southend's Case-mix adjusted percentage cancers stage 1 and 2 is 52.5%.

Observed health inequalities

- MSE ICB has a lower proportion of cancers diagnosed at stage 1 and 2 in comparison to the England average
- There is variation between the localities in MSE with the highest proportion of cancers diagnosed at an early stage in Basildon and Brentwood.
- Lowest early cancer detection rates are in Castle Point and Rochford

Action being taken to address these health inequalities

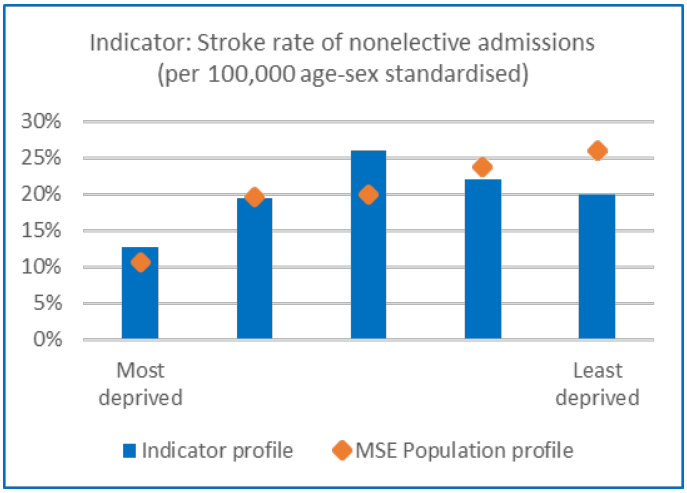
- PCNs receive data on cancer screening uptake by deprivation and includes protected groups including patients with Learning Disabilities, ethnic groups, and patients with SMI.
- Opportunities for improvement in uptake are identified, support provided and information on best practice shared including tailored communication packages.
- Development and roll out of accessible information on cancer screening programmes for those with learning disabilities
- Development of culturally competent communication with videos from local doctors talking about how to recognise and identify the signs and symptoms of some of the most common cancers
- Expansion of lung cancer screening programme to Castle Point and Rochford following successful roll out in Thurrock and Southend

Source: Cancer Registry staging data in three year cohorts

Domain: Cardiovascular disease

Indicator: Stroke rate of non-elective admissions (per 100,000 age-sex standardised)

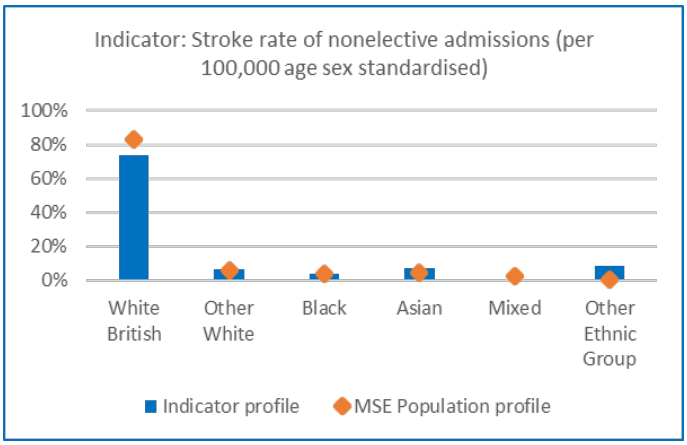
Graph 1: Stroke rate of non-elective admissions (per 100,000 age-sex standardised) – performance by deprivation quintile



Graph 1 shows stroke rate of non-elective admissions (per 100,000 age-sex standardised) by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 12.6% compared to 10.6%, quintile 2 being 19.4% compared to 19.6%, quintile 3 being 25.9% compared to 20%, quintile 4 being 22%

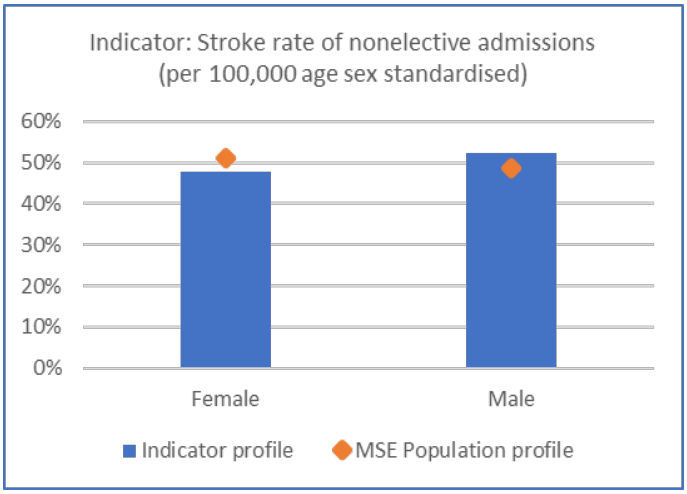
compared to 23.7% and lastly quintile 5 (least deprived) being 20% compared to the MSE population of 26%.

Graph 2: Stroke rate of non-elective admissions (per 100,000 age-sex standardised) – performance by ethnicity



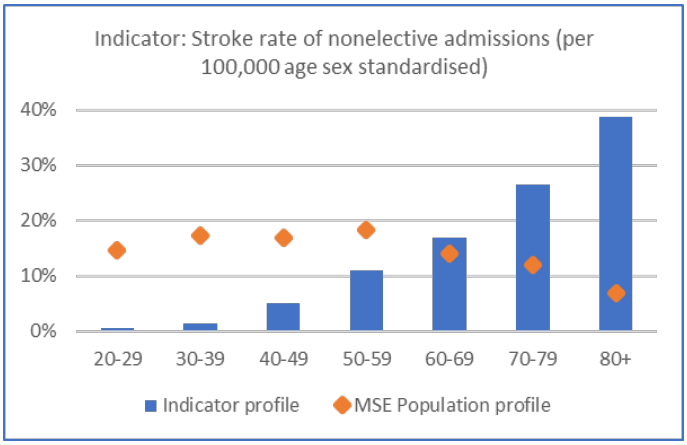
Graph 2 shows stroke rate of non-elective admissions (per 100,000 age-sex standardised) by ethnic group, comparing the indicator profile against the MSE population profile, with white British being 73.4% compared to 83.21%, other white being 6.6% compared to 5.76%, black being 4.1% compared to 3.76%, Asian being 7% compared to 4.18%, mixed being 0.5% compared to 2.34% and lastly other ethnic group being 8.4% compared to the MSE population of 0.75%.

Graph 3: Stroke rate of non-elective admissions (per 100,000 age-sex standardised) – performance by gender



Graph 3 shows stroke rate of non-elective admissions (per 100,000 age-sex standardised) by gender, comparing the indicator profile against the MSE population profile, with female being 47.7% compared to 51.2% and male being 52.3% compared to the MSE population of 48.8%.

Graph 4: Stroke rate of non-elective admissions (per 100,000 age-sex standardised) – performance by age



Graph 4 shows stroke rate of non-elective admissions (per 100,000 age-sex standardised) by age, comparing the indicator profile against the MSE population profile, with age range 20-29 being 0.6% compared to 14.6%, 30-39 being 1.4% compared to 17.4%, 40-49 being 5% compared to 16.9%, 50-59 being 11% compared to 18.3%, 60-69 being 16.9% compared to 14%, 70-79 being 26.5% compared to 12% and lastly 80 and over being 38.7%, compared to the MSE population of 6.8%.

Observed health inequalities

- Reduced stroke rate of nonelective admissions (per 100,000 age-sex standardised) in least deprived group.
- Reduced stroke rate of nonelective admissions (per 100,000 age-sex standardised) in White British group.
- Reduced stroke rate of nonelective admissions (per 100,000 age-sex standardised) in Female, males over-represented.
- Age distribution does not reflect that of the MSE population with over representation in those over 60 years, but this is to be expected.

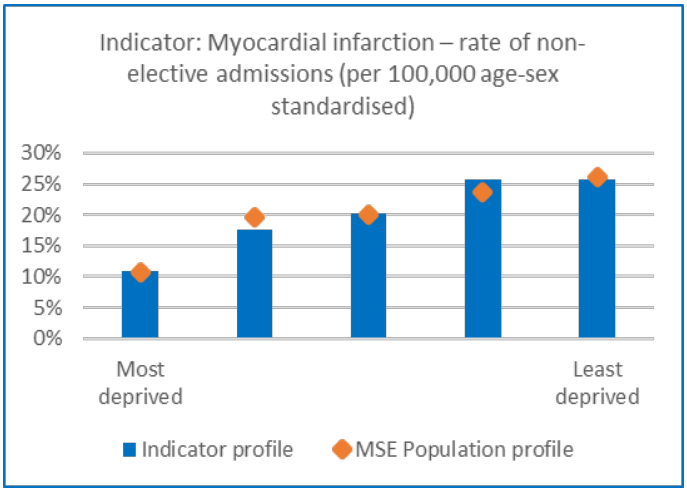
Action being taken to address these health inequalities

- These findings will be reviewed and considered in our MSE Stroke Network Meeting.

Source: MSE local dataset – Athena

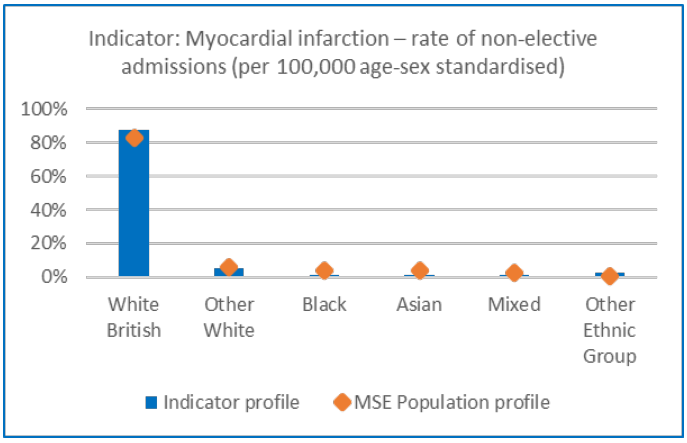
Indicator: Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)

Graph 1: Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)– performance by deprivation quintile



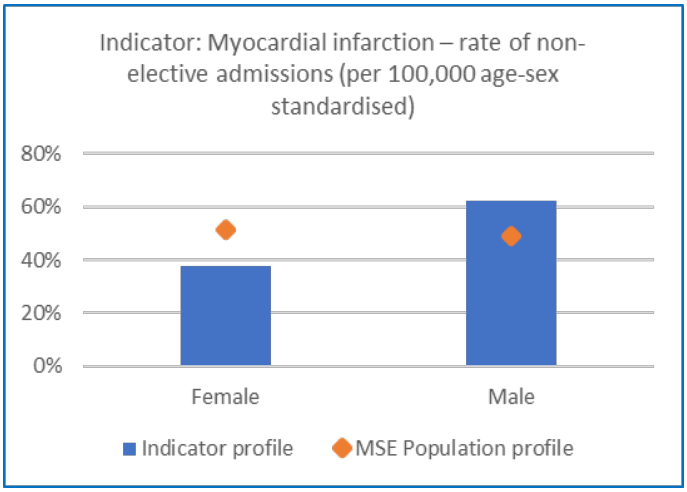
Graph 1 shows Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised) by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 10.8% compared to 10.6%, quintile 2 being 17.6% compared to 19.6%, quintile 3 being 20.3% compared to 20%, quintile 4 being 25.7% compared to 23.7% and lastly quintile 5 (least deprived) being 25.7% compared to the MSE population of 26%.

Graph 2: Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)– performance by ethnicity



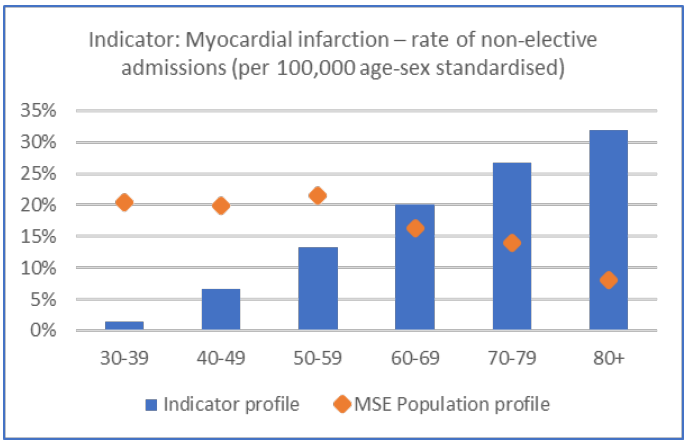
Graph 2 shows Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised), comparing the indicator profile against the MSE population profile, with white British being 87.5% compared to 83.21%, other white being 5.6% compared to 5.76%, black being 1.4% compared to 3.76%, Asian being 1.4% compared to 4.18%, mixed being 1.4% compared to 2.34% and lastly other ethnic group being 2.8% compared to the MSE population of 0.75%.

Graph 3: Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)– performance by gender



Graph 3 shows Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised) by gender, comparing the indicator profile against the MSE population profile, with female being 37.8% compared to 51.2% and male being 62.2% compared to the MSE population of 48.8%.

Graph 4: Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)– performance by age



Graph 4 shows Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised) by age, comparing the indicator profile against the MSE population profile, with age range 30-39 being 1.3% compared to 20%, 40-49 being 6.7% compared to 20%, 50-59 being 13.3% compared to 21%, 60-69 being 20% compared to 16%, 70-79 being 26.7% compared to 14% and lastly 80 and over being 32%, compared to the MSE population of 8%.

Observed health inequalities

- Rate of non-elective admissions by ethnicity is similar to MSE's population profile with the expectation of those of Black, Asian, and mixed backgrounds whose admission rates are lower.
- Profile by sex highlights higher admission rate in Males compared to the MSE population profile.
- Age distribution does not reflect that of the MSE population with over representation in those over 60 years, but this is to be expected.
- MI rates of non-elective admissions (per 100,000 age-sex standardised) broadly map to population deprivation profile and ethnic profiles.
- Gender analysis shows higher rates of MI non-elective admissions in males compared to population proportion than females.

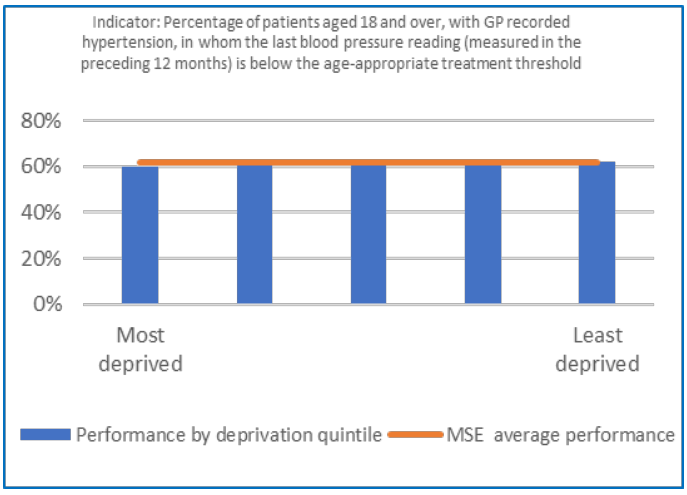
Action being taken to address these health inequalities

- MSE's CVD Prevention Programme focuses on key Cardiovascular priorities of hypertension and lipids with the aim of increasing opportunities for early identification and intervention to reduce further risk of heart attack or stroke.
- CVD identified as the focus for the MSE Community Provider collaboratives: Improving equitably - Peer learning and coaching programme.
- CVD Board will review analysis and be discussed amongst partners including MSEFT.

Source: MSE local dataset – Athena

Indicator: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold

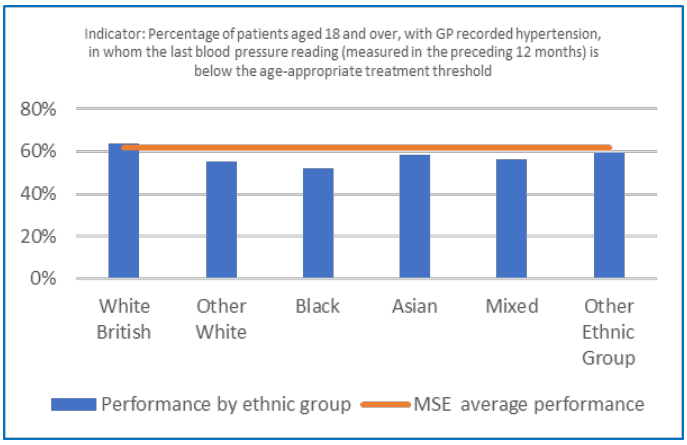
Graph 1: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – performance by deprivation quintile



Graph 1 shows Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold performance by deprivation quintile, with quintile 1

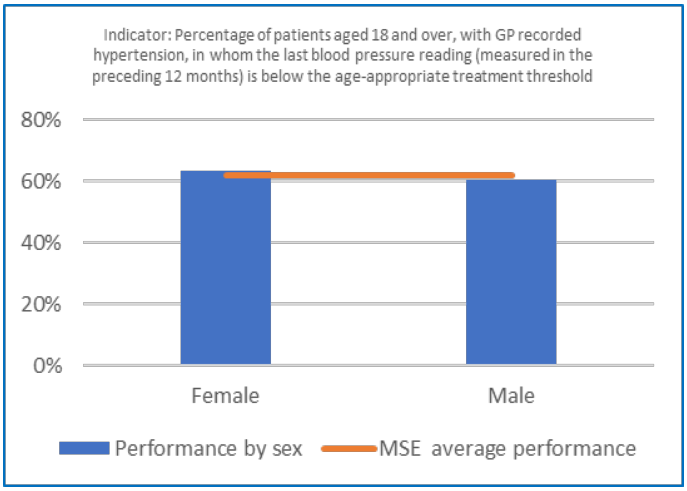
(most deprived) being 60%, quintile 2 being 61%, quintile 3 being 63%, quintile 4 being 63% and lastly quintile 5 (least deprived) being 62%, comparative to the MSE average performance of 62%.

Graph 2: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – performance by ethnicity



Graph 2 shows Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold performance by ethnic group, with white British being 63.6%, other white being 55.4%, black being 51.9.5%, Asian being 58.2%, mixed being 56.4% and lastly other ethnic group being 59.2%, comparative to the MSE average performance of 62%.

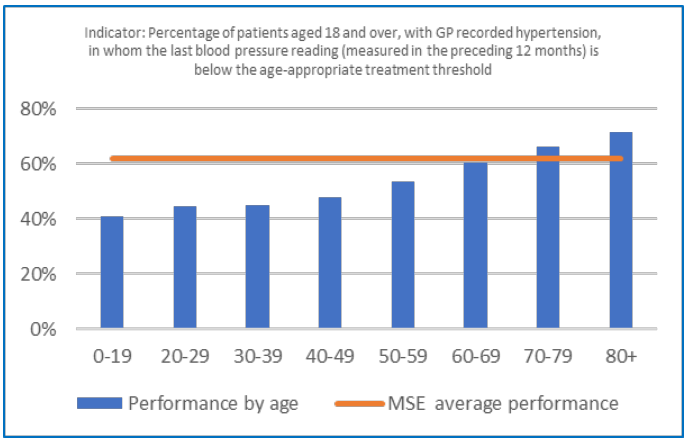
Graph 3: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – performance by gender



Graph 3 shows the Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12

months) is below the age-appropriate treatment threshold performance by gender, with female being 63.5% and male being 60.5%, comparative to the MSE average performance of 62%.

Graph 4: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold – performance by age



Graph 4 shows the Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold performance by age, with age range 0-19 being 40.9%, 20-29 being 44.6%, 30-39 being 45.1%, 40-49 being 47.7%, 50-59 being 53.7%, 60-69 being 60.5%, 70-79 being 66% and lastly 80 and over being 71.3%, comparative to the MSE average performance of 62%.

Observed health inequalities

- Performance does not significantly vary by deprivation or sex.
- Performance by ethnic group highlights that other than White British, other ethnic groups have a higher proportion of patients not managed to treatment thresholds with the highest underrepresented being those from a Black ethnic group.
- Performance by age group indicates we are currently performing significantly below MSE Population average for all age groups under 60 with only those ages 70-79 and 80+ performing above average.

Action being taken to address these health inequalities

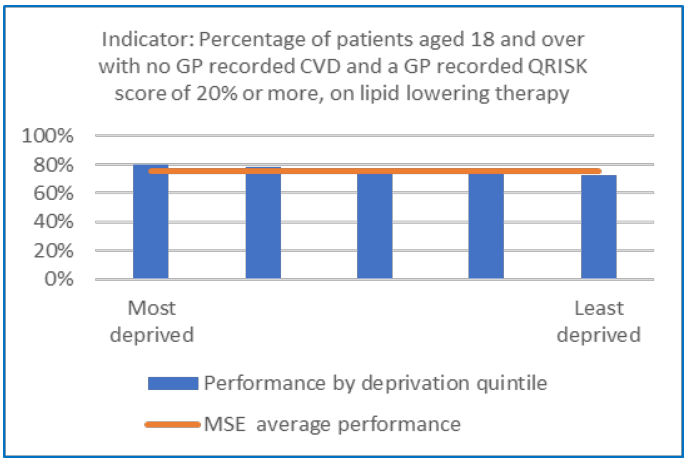
- Introducing an MSE pilot BP@home Health Inequalities Extension, targeting practices within the 20% most deprived areas with the highest levels of CVD risk, providing BP monitors to patients within plus groups/unable to afford to purchase their own to tackle health inequalities relating to home blood monitoring.
- MSE is developing a BP in the Community pilot which will look to case find potential hypertension amongst Plus groups and those less likely to be engaged with health care services, taking a community outreach approach.
- Hypertension is also an area of focus within the Mid and South Essex CVD Local Enhanced Service (LES), identifying patients living in the 20% most deprived areas

and uses the UCLP risk stratification tool medium risk patents on multiple disease registers. As part of the scheme, practices are encouraged to focus on specific cohorts of patients with hypertension including Black and South Asian Ethnic groups.

Source: MSE local dataset – Athena

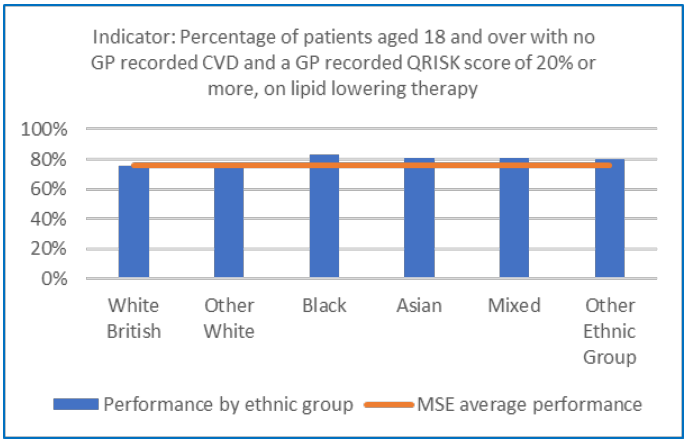
Indicator: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy

Graph 1: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy – performance by deprivation quintile



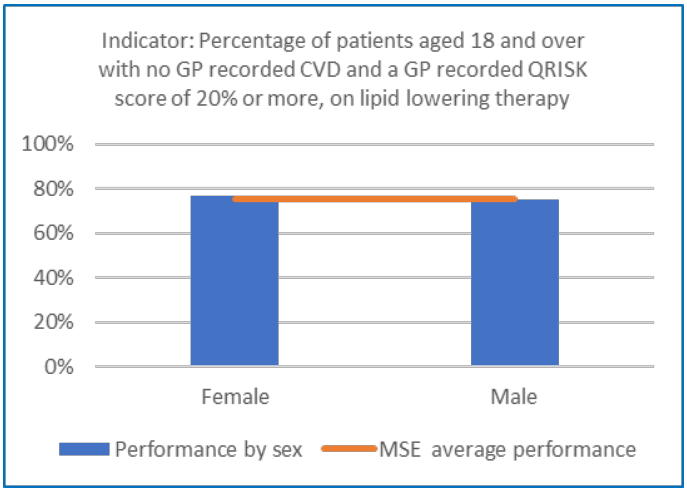
Graph 1 shows Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy by deprivation quintile, with quintile 1 (most deprived) being 80%, quintile 2 being 79%, quintile 3 being 76%, quintile 4 being 75% and lastly quintile 5 (least deprived) being 73%, comparative to the MSE average performance of 75.6%.

Graph 2: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy – performance by ethnicity



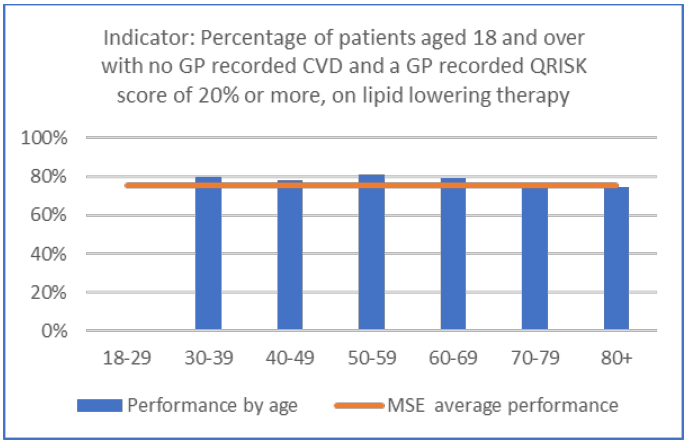
Graph 2 shows Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy performance by ethnic group, with white British being 75.5%, other white being 76.4%, black being 83.1%, Asian being 80.8%, mixed being 80.5% and lastly other ethnic group being 80.1%, comparative to the MSE average performance of 75.6%.

Graph 3: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy – performance by gender



Graph 3 shows the Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy performance by gender, with female being 76.9% and male being 74.8%, comparative to the MSE average performance of 75.6%.

Graph 4: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy – performance by age



Graph 4 shows the Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy performance by age, with age range 18-29 being 0%, 30-39 being 80%, 40-49 being 78.2%, 50-59 being 81.2%,

60-69 being 79%, 70-79 being 74.6% and lastly 80 and over being 74.8%, comparative to the MSE average performance of 75.6%.

Observed health inequalities

- Performance does not significantly vary by deprivation or sex.
- Performance by ethnic group indicates performance is somewhat similar to the MSE population average, with Black, Asian, Mixed and Other Ethnic Groups all performing above the average.
- Performance by age group indicates performance is somewhat similar to the MSE Population average with those age 70-79 and 80+ being slightly below average. There are no patients within age groups 0-19 and 20-29.

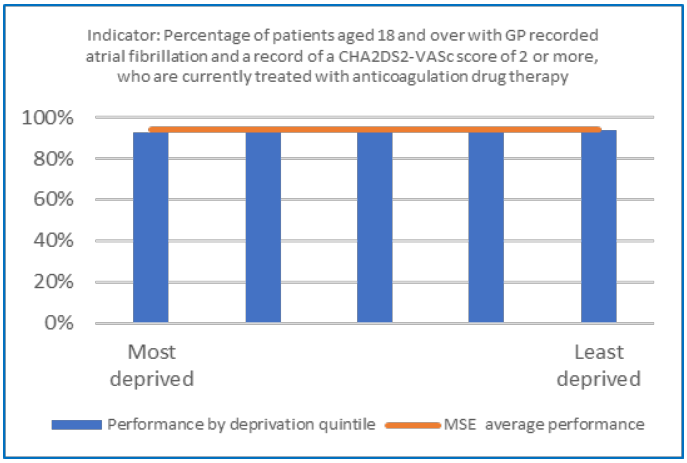
Action being taken to address these health inequalities

- MSE have introduced a Lipid QOF Extension, offered to practices identifying with the highest CVD need within the most deprived areas. This incentives practices to increase the % of patients that are optimising lipid lowering therapy.

Source: MSE local dataset – Athena

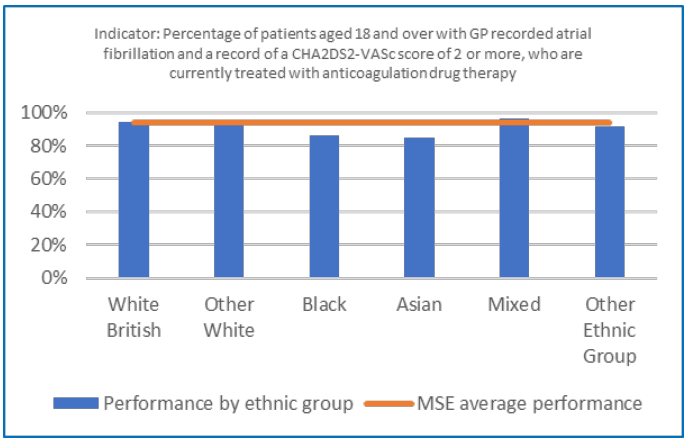
Indicator: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

Graph 1: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy – performance by deprivation quintile



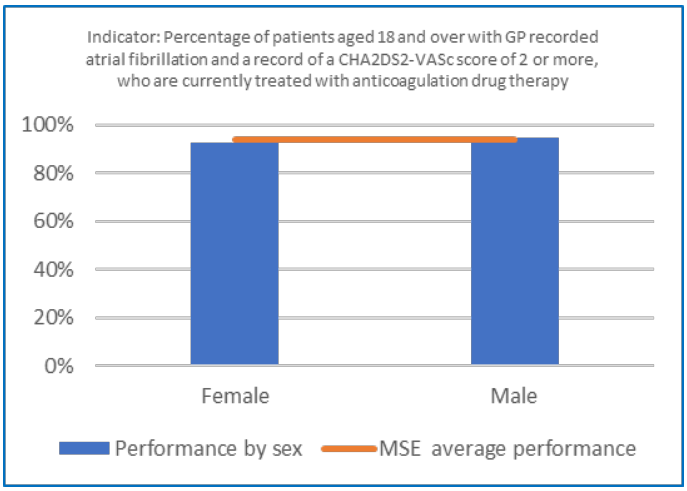
Graph 1 shows the Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy performance by deprivation quintile, with quintile 1 (most deprived) being 93%, quintile 2 being 93%, quintile 3 being 94%, quintile 4 being 94% and lastly quintile 5 (least deprived) being 94%, comparative to the MSE average performance of 93.8%.

Graph 2: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy – performance by ethnicity



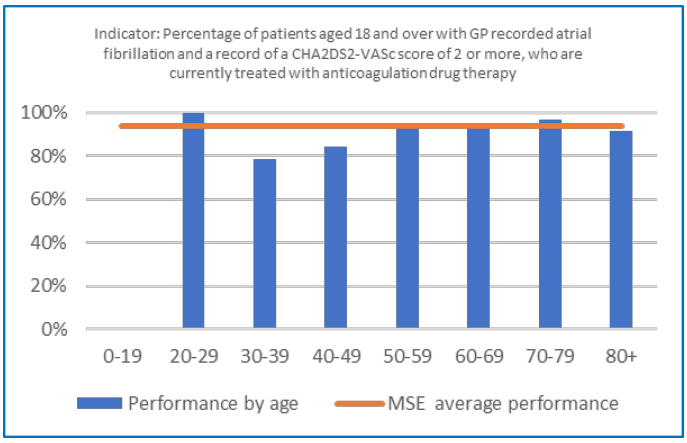
Graph 2 shows the Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy performance by ethnic group, with white British being 94.1%, other white being 93.8%, black being 86.4%, Asian being 84.7%, mixed being 96.4% and lastly other ethnic group being 91.1%, comparative to the MSE average performance of 93.8%.

Graph 3: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy – performance by gender



Graph 3 shows the Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy performance by gender, with female being 92.6% and male being 94.9%, comparative to the MSE average performance of 94%.

Graph 4: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy – performance by age



Graph 4 shows the Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy performance by age, with age range 0-19 being 0%, 20-29 being 100%, 30-39 being 78.6%, 40-49 being 84.5%, 50-59 being 94.1%, 60-69 being 94.5%, 70-79 being 96.7% and lastly 80 and over being 94%, comparative to the MSE average performance of 94%.

Observed health inequalities

- Performance does not significantly vary by deprivation or sex.
- Performance by ethnic groups highlights performance amongst Black and Asian ethnic groups to be relatively lower than the MSE Population average with all other groups performing somewhat similar.
- Performance by age group shows age group 20-29 to be exceeding the MSE Population average whilst age groups 30-39- 40-49 to be performing significantly under the average rate. All other age groups are performing somewhat in line of the average.

Action is being taken to address these health inequalities

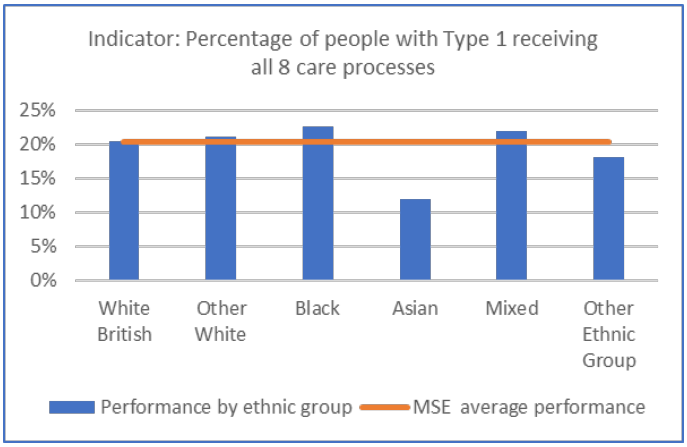
- MSE BP in the Community programme supports further case finding for hypertension amongst Plus groups and those less likely to engage with health care services by taking a community outreach approach
- MSE have identified the opportunity to carry out AF case finding to further support to identify undiagnosed or unmanaged cases of AF.

Source: MSE local dataset – Athena

Domain: Diabetes

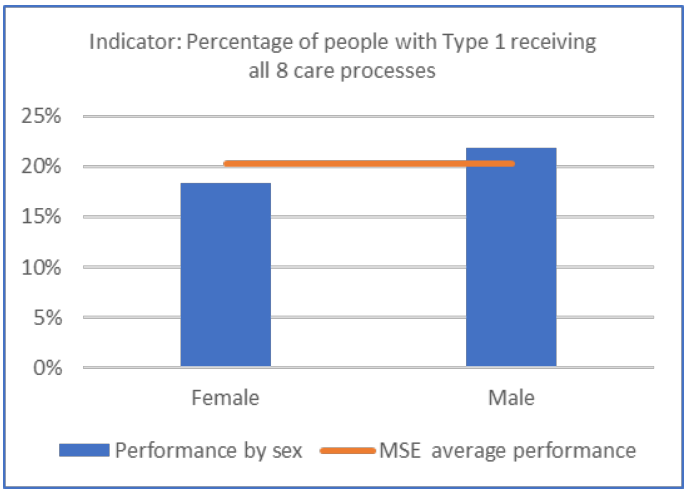
Indicator: Percentage of people with Type 1 receiving all 8 care processes

Graph 1: Percentage of people with Type 1 receiving all 8 care processes – performance by ethnicity



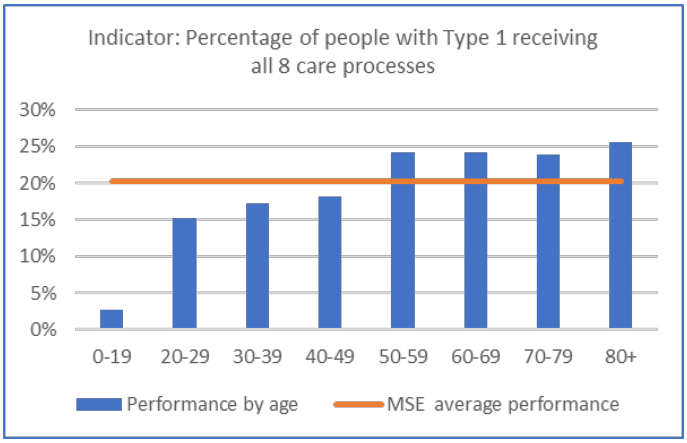
Graph 1 shows the Percentage of people with Type 1 receiving all 8 care processes performance by ethnic group, with white British being 20.5%, other white being 21.1%, black being 22.7%, Asian being 11.9%, mixed being 21.9% and lastly other ethnic group being 18.2%, comparative to the MSE average performance of 20.3%.

Graph 2: Percentage of people with Type 1 receiving all 8 care processes – performance by gender



Graph 2 shows the Percentage of people with Type 1 receiving all 8 care processes performance by gender, with female being 18.3% and male being 21.9%, comparative to the MSE average performance of 20.3%.

Graph 3: Percentage of people with Type 1 receiving all 8 care processes – performance by age



Graph 3 shows the Percentage of people with Type 1 receiving all 8 care processes performance by age, with age range 0-19 being 2.7%, 20-29 being 15.2%, 30-39 being 17.3%, 40-49 being 18.1%, 50-59 being 24.2%, 60-69 being 24.1%, 70-79 being 23.9% and lastly 80 and over being 25.5%, comparative to the MSE average performance of 20.3%.

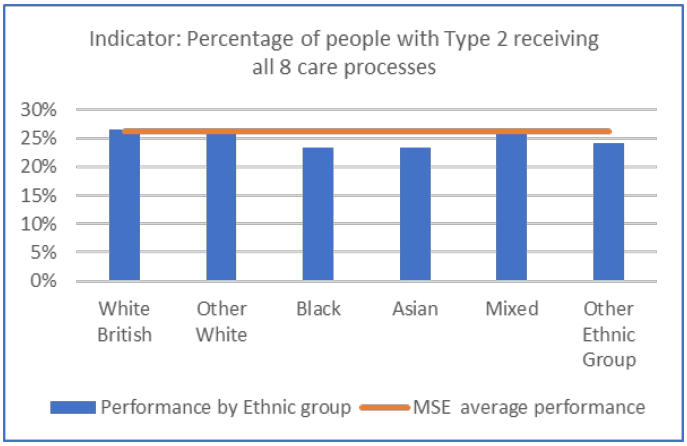
Observed health inequalities

- Health inequalities analysis regarding deprivation has yet to be completed for the people with Type 1 receiving all 8 care processes
- There is a higher proportion of people from a black or mixed background receiving all 8 care processes. People from an Asian ethnicity background are less likely to have received all 8 care processes.
- A higher proportion of males have received all 8 care processes
- Those over 50 years are more likely to have received all 8 care processes.

Source: MSE local data set Athena

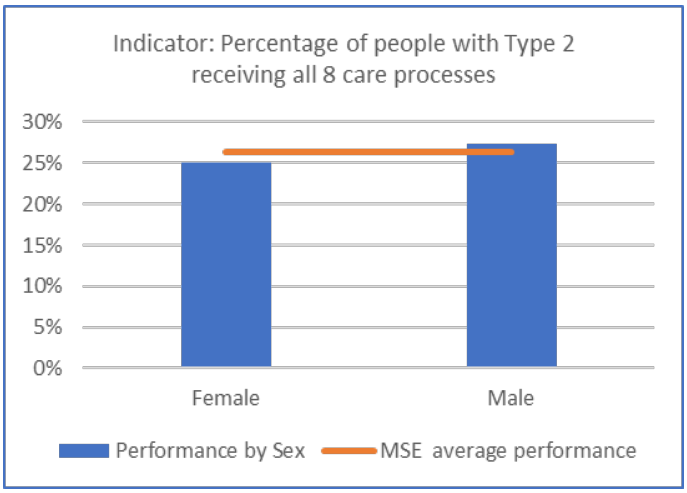
Indicator: Percentage of people with Type 2 receiving all 8 care processes

Graph 1: Percentage of people with Type 2 receiving all 8 care processes – performance by ethnicity



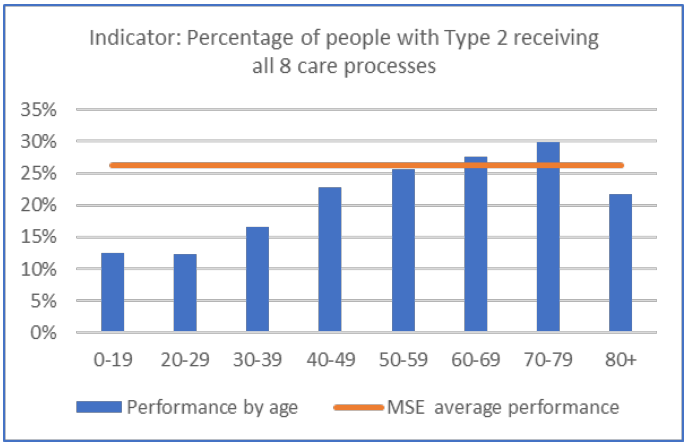
Graph 1 shows the Percentage of people with Type 2 receiving all 8 care processes performance by ethnic group, with white British being 26.5%, other white being 26.8%, black being 23.3%, Asian being 23.3%, mixed being 26.4% and lastly other ethnic group being 24.1%, comparative to the MSE average performance of 26.2%.

Graph 2: Percentage of people with Type 2 receiving all 8 care processes – performance by gender



Graph 2 shows the Percentage of people with Type 2 receiving all 8 care processes performance by gender, with female being 25.1% and male being 27.3%, comparative to the MSE average performance of 26.2%.

Graph 3: Percentage of people with Type 2 receiving all 8 care processes – performance by age



Graph 3 shows the Percentage of people with Type 2 receiving all 8 care processes performance by age, with age range 0-19 being 12.5%, 20-29 being 12.4%, 30-39 being 16.6%, 40-49 being 22.8%, 50-59 being 25.7%, 60-69 being 27.7%, 70-79 being 29.9% and lastly 80 and over being 21.6%, comparative to the MSE average performance of 26.2%.

Observed health inequalities

- Health inequalities analysis regarding deprivation has yet to be completed for the people with Type 2 receiving all 8 care processes
- There is a higher proportion of people from a black or mixed ethnic background receiving all 8 care processes. People from other ethnic groups are less likely to have received all 8 care processes.
- A higher proportion of males have received all 8 care processes
- Those over 50 years are more likely to have received all 8 care processes.

Source: MSE local data set Athena

Indicator: Percentage of people with Type 1 and 2 receiving all 8 care processes

Action being taken to address these health inequalities

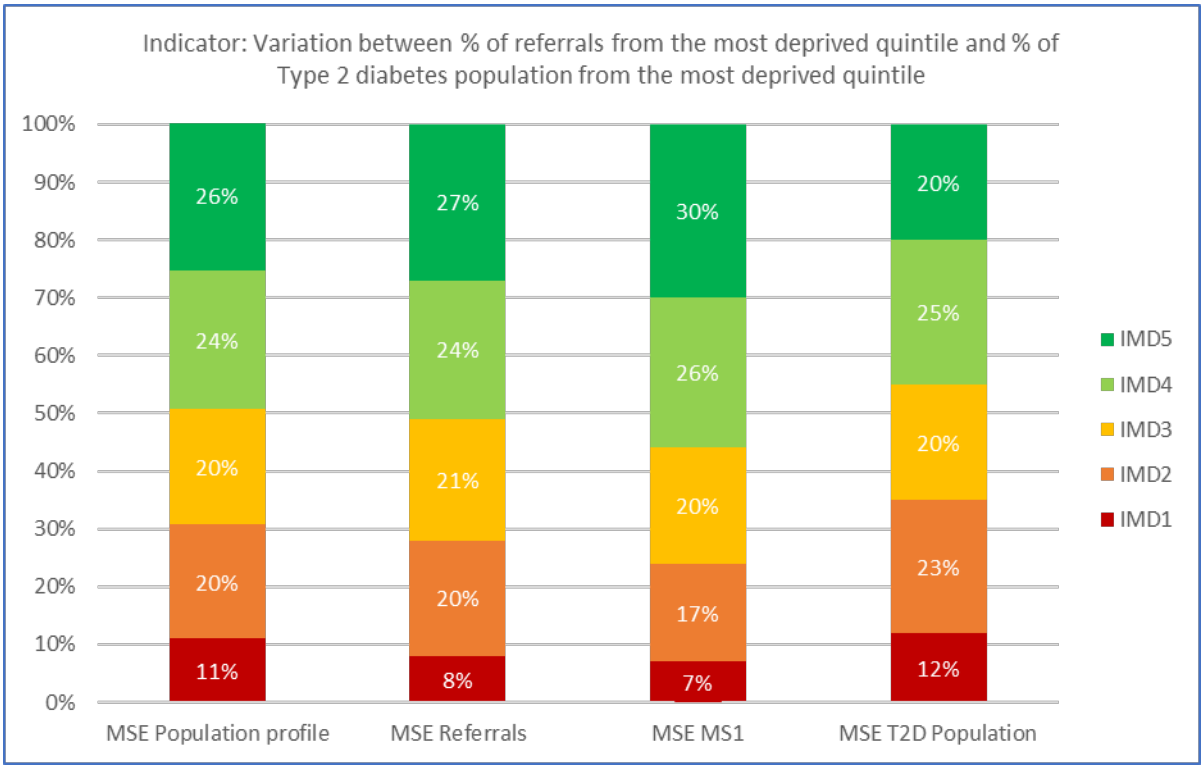
To improve the % of people with Type 1 and 2 receiving all eight care processes MSE ICB has:

- Introduced care bundle test requesting in the pathology and radiology system (ICE) which means with a single click all Diabetes tests (hba1C, Creatinine, cholesterol, urine ACR) can be requested in the system without missing any tests.
- Monthly Eclipse training for the past year on how to use data to improve diabetes care. Eclipse is a data support tool that assists GP Practices in optimising treatment for patients.
- Regular monthly reporting at an Alliance and Practice level is undertaken to identify opportunities for improvements in performance.
- Educational training and supported has been delivered via “Time to learn” sessions, through existing Clinical leadership meetings (CLef), lunch and learn and evening GP sessions
- Standardise data capture and ensure consistency of processes through the utilisation of a Diabetes template in Ardens.
- Development of a Diabetes Dashboard that enables primary care to access data and ability to reidentify patients will become available for practices to target patients.
- Currently reviewing the award winning PARM tool, a health management tool for people with diabetes, to assess whether it can be used in MSE to risk assess patients.
- Funding given to Community Collaborative to support 2 PCNs, Southend Victoria PCN and Tilbury and Chadwell PCN, to improve 8 Care process during 2023/24. As at Mid-December nearly 600 patients have now had the care processes reviewed and captured. A one stop Foot and Retinopathy screen is also being trialled in one of the PCNs. The evaluation will be completed during 2024/25 and good practice and learnings spread across MSE.
- Implementation of the ‘T2Day: Type 2 Diabetes in the Young’ programme where patients benefit from extra one-to-one reviews as well as the option of new medicines and treatments where indicated, to help better manage their diabetes
- Planning Diabetes case finding trial in practice to roll out in MSE. This will alert practices to code 2 abnormal high HBA1C as Diabetes.

- All providers with MSE have been challenged to target resources in areas facing health inequalities including in areas of deprivation.

Indicator: Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile

Graph 1: Framework 2 contract (Dec2020-Nov2023): Index of Multiple Deprivation (IMD) demographic of patient referrals & of programme starters (MS1) vs local type 2 diabetes prevalence



Graph 1 shows Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile, with MSE Population profile having 26% in IMD5, 24% in IMD4, 20% in IMD3, 20% in IMD2 and 11% in IMD1. For MSE referrals 27% are in IMD5, 24% in IMD4, 21% in IMD3, 20% in IMD2 and 8% in IMD1. For MSE MS1 30% are in IMD5, 26% in IMD4, 20% in IMS3, 17% in IMS2 and 7% in IMD1. MSE Type 2 diabetes population 20% are in IMD5, 25% in IMD4, 20% in IMD3, 23% in IMD2 and lastly 12% in IMD1.

Observed health inequalities

- Referrals into the National Diabetes Prevention Programme (NDPP) are closely representative of the MSE population profile
- The number of programme starters is higher in the least deprived areas (IMD4 and IMD5) with proportionally lower numbers from the most deprived backgrounds (IMD1 and IMD2) which is an under representation of the type 2 diabetes prevalence for these groups.

Action is being taken to address these health inequalities

- PCN level data shared identifying those PCNs where % of referrals for people in IMD1 has not matched local T2D prevalence.
- Engagement with PCN lead GPs and Ops manager understand barriers to making referrals.
- Training and awareness sessions undertaken with PCN staff (focused on ARRS roles) on how to refer to NDPP
- Communication and promotion materials for NDPP developed and available on MSE Primary Care Hub
- Lunch n Learn webinars regularly delivered by the new service provider Xyla Health & Wellbeing.

Free Continuing Professional Development accredited training on non-diabetic hyperglycaemia testing, Type 2 Diabetes risk factors and the NDPP from Royal College General Practitioners and Primary Care Diabetes Society

Source: National Diabetes Prevention Programme Dashboard

Domain: Smoking Cessation

Indicator: Proportion of adult acute inpatient settings offering smoking cessation services

Action being taken to address health inequalities

A smoking cessation in-house service is currently available across all wards in Basildon and Broomfield Hospitals and will be in all wards in Southend Hospital by March 2024. The service engages with smokers who are an adult acute in-patient regardless of home address, ethnicity, socio-economic status, or any other criteria. The service has access to a translation service should patient who does not use English as their first language require support. The service is available to all, except for those who are under the age of 18 and not an inpatient.

Mid and South Essex NHS Foundation Trust are procuring a data collection, management, and reporting solution for Smoking Services. Whilst some data is currently collected it is incomplete so once there is a comprehensive dataset available in 2024/25 an assessment will be undertaken to identify if there are any inequalities to accessing the service and address as required.

Indicator: Proportion of maternity inpatient settings offering smoking cessation services

Action being taken to address health inequalities

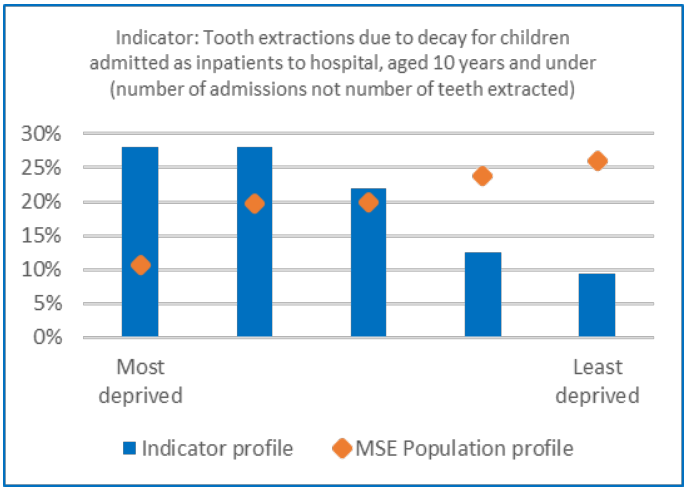
MSE Maternity launched a full in-house smoking cessation service on 05/02/2024 across the three hospital sites: Basildon, Broomfield, and Southend. Providing women divulge their smoking status, electronic reports are set up to capture the personal details of all birthing people who ‘currently smoke’ and those who have ‘quit since conception.’ All women and birthing people within this category receive a telephone call during the next working day

irrespective of their postcode and or deprivation level. Once we have several months data, analysis will be completed to determine if there is any correlation with opt out and areas of deprivation or inequalities. Targeted work will be undertaken to address health inequalities that may be identified.

Domain: Oral Health

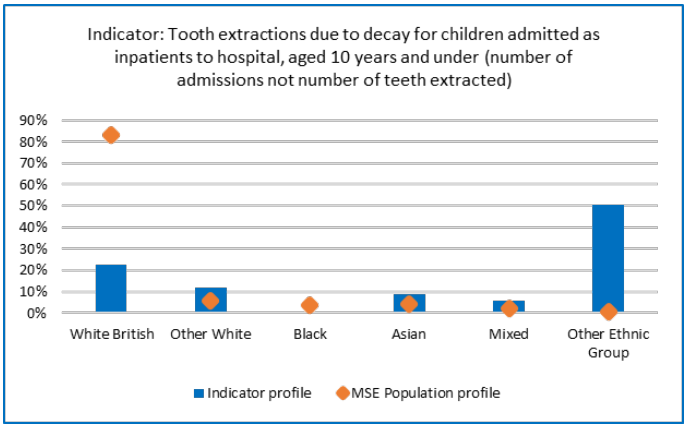
Indicator: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under

Graph 1: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under – performance by deprivation quintile



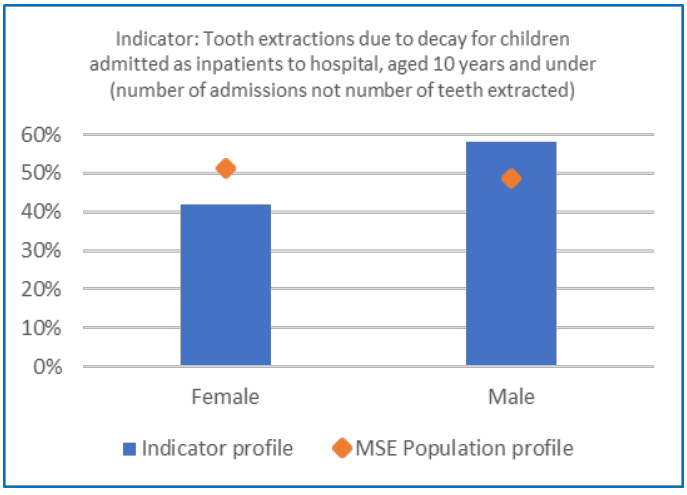
Graph 1 shows Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 28.1% compared to 10.6%, quintile 2 being 28.1% compared to 19.6%, quintile 3 being 21.9% compared to 20%, quintile 4 being 12.5% compared to 23.7% and lastly quintile 5 (least deprived) being 9.4% compared to the MSE population of 26%.

Graph 2: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under – performance by ethnicity



Graph 2 shows Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under by ethnicity, comparing the indicator profile against the MSE population profile, with white British being 22.4% compared to 83.21%, other white being 11.9% compared to 5.76%, black being 0% compared to 3.76%, Asian being 9% compared to 4.18%, mixed being 6% compared to 2.34% and lastly other ethnic group being 50.7% compared to the MSE population of 0.75%.

Graph 3: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under – performance by gender



Graph 3 shows Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under by gender, comparing the indicator profile against the MSE population profile, with female being 41.8% compared to 51.2% and male being 58.2% compared to the MSE population of 48.8%.

Observed health inequalities

- Tooth decay is almost entirely preventable, yet tooth decay is the number one cause of admission to hospital for 5-9yrs old children.

- MSE has a disproportionate over representation of children having teeth removed in a hospital setting who live in areas of deprivation. This trend is seen nationally where decay-related tooth extraction rates are nearly 3.5 times higher for children living in the most deprived areas compared to more affluent areas.
- The ethnicity profile is currently being reviewed as data quality discrepancies have been identified regarding ethnicity recoding for children
- A higher proportion of boys have tooth extractions

Action being taken to address these health inequalities

A MSE ICP collaborative approach is being taken to accelerate oral health prevention:

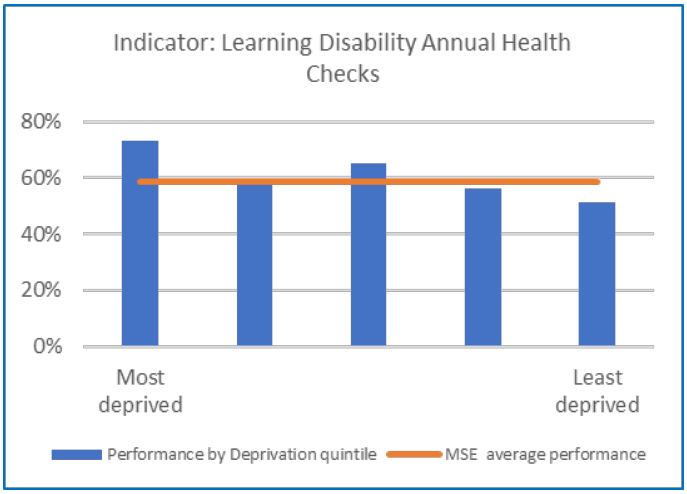
- Use a data informed approach to drive activities in areas of highest need, development of a dashboard to track progress on child oral health. We currently planning on how to analysis waiting list data consistently across providers to identify inequality gaps and implement mitigating actions.
- Embed oral health preventative activities within wider system CYP policies and programs – in 2022/23 we committed health inequalities fundings to implement supervised toothbrushing schemes within two of our four place Alliances. For 24/25 this program is being spread across the remaining two Alliances. Additionally, Southend City Council are planning to extend supervised toothbrushing into school settings.
- Using the Core20PLUS5 approach we have identified our priority PLUS groups as to SEND, LAC, Deprivation, Refugees, Asylum Seekers & Migrants; deliver more targeted oral health prevention areas. In addition, we are working with commissioners to increase access to dental services including identification of dentists prioritising access for LAC and ensuring children are considered in our dental care access pilot.
- MSE has been selected as NHSE CYP Transformation pilot site which aims to test and develop a suite of evidence-based interventions. This program will work with the Family Hubs in Thurrock to enhance early years services with a consistent oral health promotion theme running through.
- Create widespread awareness of oral health promoting practices. This will be through resident facing communications and through early years workforce training

Source: MSE local dataset – Athena

Domain: Learning disability and autistic people

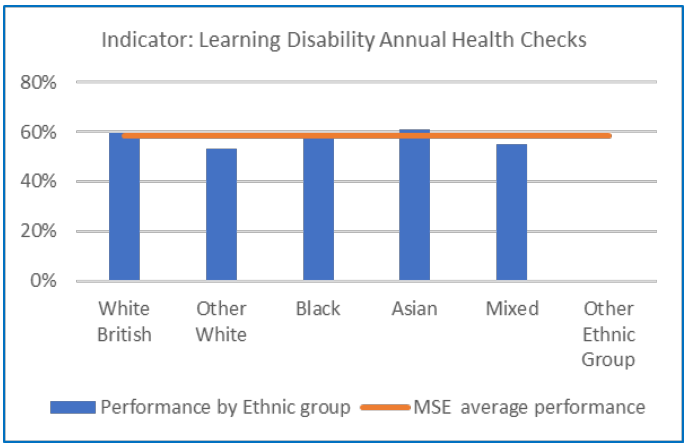
Indicator: Learning Disability Annual Health Checks

Graph 1: Learning Disability Annual Health Checks – performance by deprivation quintile



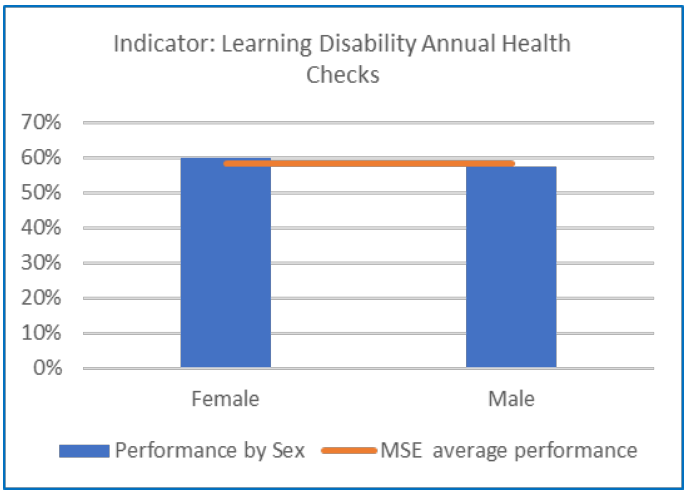
Graph 1 shows Learning Disability Annual Health Checks performance by deprivation quintile, with quintile 1 (most deprived) being 72.9%, quintile 2 being 57.9%, quintile 3 being 65%, quintile 4 being 56.1% and lastly quintile 5 (least deprived) being 51%, comparative to the MSE average performance of 58.4.6%.

Graph 2: Learning Disability Annual Health Checks – performance by ethnicity



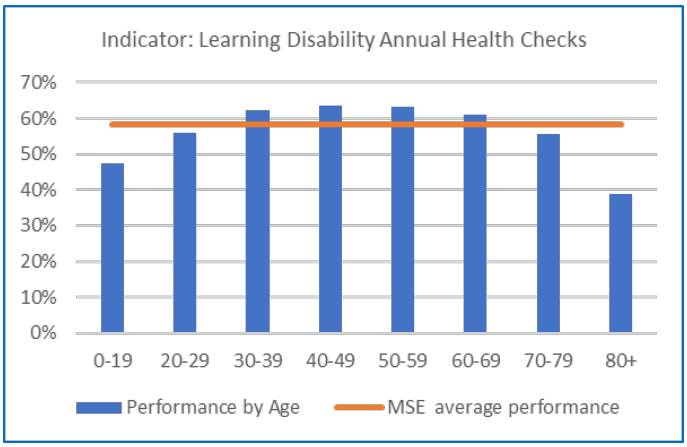
Graph 2 shows Learning Disability Annual Health Checks performance by ethnic group, with white British being 59.7%, other white being 53.2%, black being 58.7%, Asian being 60.7%, mixed being 55.1% and lastly other ethnic group being 0%, comparative to the MSE average performance of 58.4%.

Graph 3: Learning Disability Annual Health Checks – performance by gender



Graph 3 shows Learning Disability Annual Health Checks performance by gender, with female being 59.8.4% and male being 57.5%, comparative to the MSE average performance of 58.4%.

Graph 4: Learning Disability Annual Health Checks – performance by age



Graph 4 shows Learning Disability Annual Health Checks performance by age, with age range 0-19 being 47.5%, 20-29 being 55.9%, 30-39 being 62.1%, 40-49 being 63.4%, 50-59 being 63.3%, 60-69 being 61.1%, 70-79 being 55.7% and lastly 80 and over being 38.7%, comparative to the MSE average performance of 58.4%.

Observed health inequalities

- The uptake of Learning disability health checks is higher in the most deprived areas
- There is a slightly lower uptake of health checks from people of an 'other white' or mixed ethnic background
- There is little variation between males and females
- Learning disability health checks are lower in the younger (29 years and below) and older (70 years and above) age groups

- Within the SET LeDeR Annual Report 22/23 it was noted that some of the most vulnerable people with a Learning Disability who passed away are among those who did not receive an Annual Health Check that could be evidenced in the notes.

Action being taken to address these health inequalities

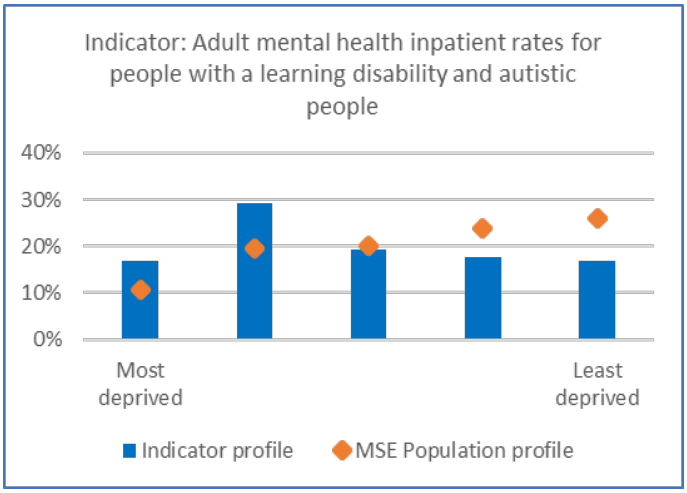
- A Mid and South Essex Learning Disability Annual Health Check forum has been established in 2023 to discuss Annual Health Checks with a local lens and share learning.
- The SET 3 Year LeDeR Deliverable Plan 2024-2027 has a priority for the 2024/25 financial year as 'Promote Preventative Health: Improving the Uptake and Effectiveness of Learning Disability Annual Health Checks and Health Action Plans.' This work will be championed through the MSE LD AHC Forum.

Source: MSE local dataset – Athena

* Please note MSE performance is likely better than the graphs to left indicate as there has been a national issue which has over inflated the LD (QoF) Register in error which is being addressed. Indications from NHSE data which is months behind local date is overall more LD AHCs have been completed than in the same period in the previous financial year.

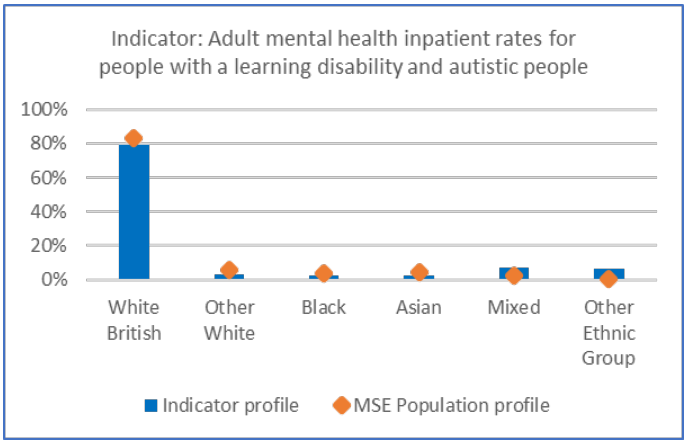
Indicator: Adult mental health inpatient rates for people with a learning disability and autistic people

Graph 1: Adult mental health inpatient rates for people with a learning disability and autistic people – performance by deprivation by quintile



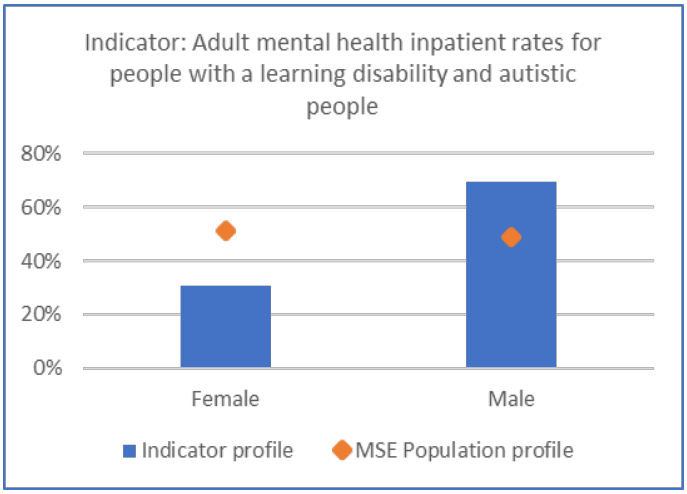
Graph 1 shows Adult mental health inpatient rates for people with a learning disability and autistic people by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 16.9% compared to 10.6%, quintile 2 being 29.2% compared to 19.6%, quintile 3 being 19.2% compared to 20%, quintile 4 being 17.7% compared to 23.7% and lastly quintile 5 (least deprived) being 16.9% compared to the MSE population of 26%.

Graph 2: Adult mental health inpatient rates for people with a learning disability and autistic people – performance by ethnicity



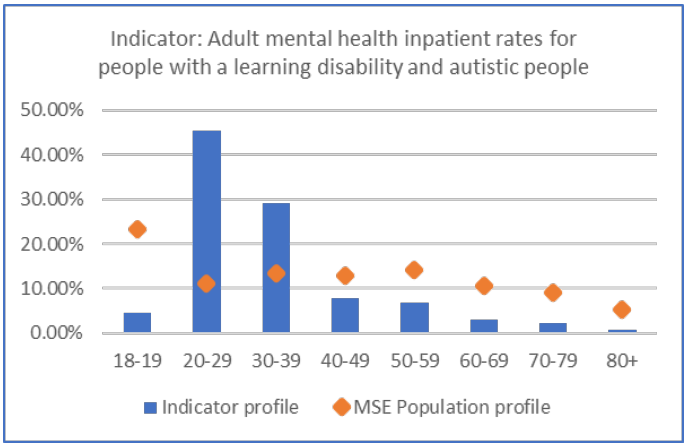
Graph 2 shows Adult mental health inpatient rates for people with a learning disability and autistic people by ethnic group, comparing the indicator profile against the MSE population profile, with white British being 79.2% compared to 83.21%, other white being 3.1% compared to 5.76%, black being 2.3% compared to 3.76%, Asian being 2.3% compared to 4.18%, mixed being 6.9% compared to 2.34% and lastly other ethnic group being 6.2% compared to the MSE population of 0.75%.

Graph 3: Adult mental health inpatient rates for people with a learning disability and autistic people – performance by gender



Graph 3 shows Adult mental health inpatient rates for people with a learning disability and autistic people by gender, comparing the indicator profile against the MSE population profile, with female being 30.8% compared to 51.2% and male being 69.2% compared to the MSE population of 48.8%.

Graph 4: Adult mental health inpatient rates for people with a learning disability and autistic people – performance by age



Graph 4 shows Adult mental health inpatient rates for people with a learning disability and autistic people by age, comparing the indicator profile against the MSE population profile, with age range 0-19 being 4.6% compared to 23.4%, 20-29 being 45.4% compared to 11.2%, 30-39 being 29.2% compared to 13.3%, 40-49 being 7.7% compared to 13%, 50-59 being 6.9% compared to 14%, 60-69 being 3.1% compared to 10.7%, 70-79 being 2.3% compared to 9.2% and lastly 80 and over being 0.8%, compared to the MSE population of 5.2%.

Observed health inequalities

- Higher mental health inpatient rates for people with learning disability and autistic people are seen in the areas of greater deprivation
- The profile of adult mental inpatient rates is broadly in line with the ethnic profile of MSE population
- A greater proportion of admissions are Males
- The age profile is concentrated in the 20 to 39 year age group
- The high proportion of 18-19 year olds represents predominantly Autistic young people transitioning to adult services.
- Lack of specialist providers can lead to avoidable Adult Mental Health admission to inpatient services.

Action is being taken to address these health inequalities

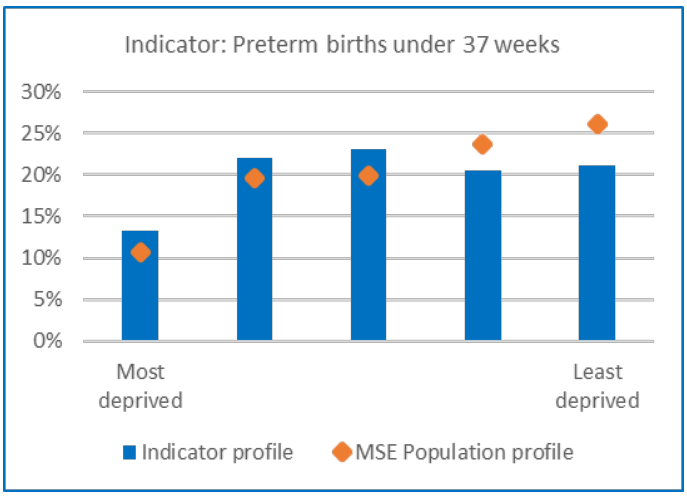
- The creation of a new Dynamic Support Register which launched at the end of 2023 will help to identify those that need support before they become at risk of admission and / or enter a crisis.
- Work is ongoing to establish better links between Mental Health Services and Learning Disability services and Autistic people services.
- Wider work into preventing avoidable admissions is also taking place alongside case management of those at risk of admission.

Source: Mental Health Services Data Set

Domain: Maternity and neonatal

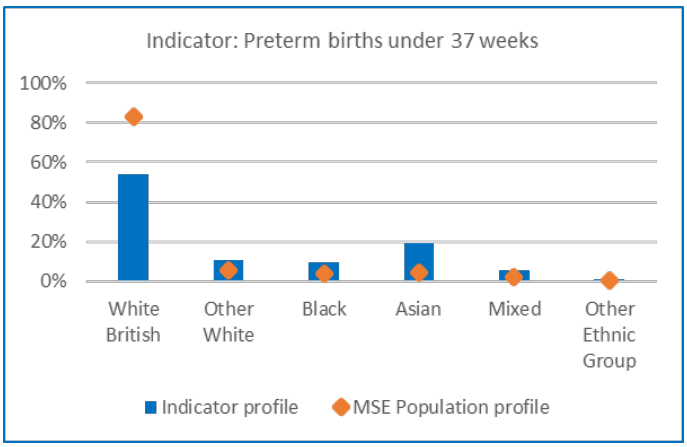
Indicator: Preterm births under 37 weeks

Graph 1: Preterm births under 37 weeks – performance by deprivation by quintile



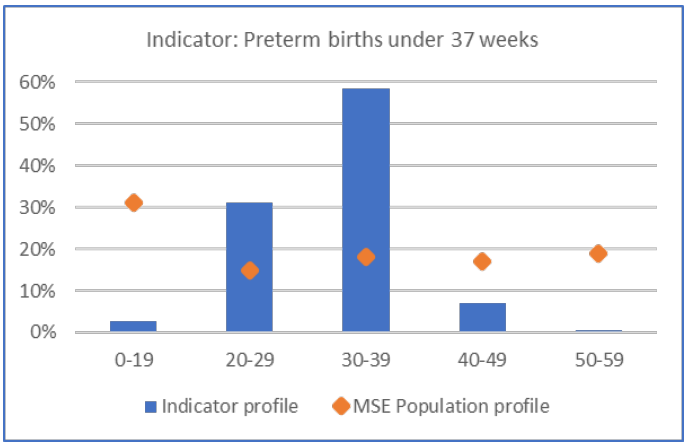
Graph 1 shows Preterm births under 37 weeks by deprivation quintile, comparing the indicator profile against the MSE population profile, with quintile 1 (most deprived) being 13.2% compared to 10.6%, quintile 2 being 22% compared to 19.6%, quintile 3 being 23.1% compared to 20%, quintile 4 being 20.5% compared to 23.7% and lastly quintile 5 (least deprived) being 21.2% compared to the MSE population of 26%.

Graph 2: Preterm births under 37 weeks – performance by ethnic group



Graph 2 shows Preterm births under 37 weeks by ethnic group, comparing the indicator profile against the MSE population profile, with white British being 54% compared to 83.21%, other white being 10.7% compared to 5.76%, black being 9.4% compared to 3.76%, Asian being 19.4% compared to 4.18%, mixed being 5.5% compared to 2.34% and lastly other ethnic group being 0.9% compared to the MSE population of 0.75%.

Graph 3: Preterm births under 37 weeks – performance by age



Graph 3 shows Preterm births under 37 weeks by age, comparing the indicator profile against the MSE population profile, with age range 0-19 being 2.7% compared to 31%, 20-29 being 31.1% compared to 15%, 30-39 being 58.6% compared to 18%, 40-49 being 7% compared to 17%, and lastly 50-59 being 0.6% compared to the MSE population of 19%.

Observed health inequalities

- In MSE after White British women, Asian women experience the highest rate of preterm births (19.4%). This group observed the largest percentage increase in preterm births in 2020-21 nationally (ONS, 2023).
- The MSE data reflects a variation from national statistics, where women from Black ethnic groups have the highest proportion of preterm births.
- Deprivation data shows that the 2nd and 3rd quintiles of deprivation have the highest rates of preterm birth.
- The age range where preterm birth occurs most frequently is shown here as 30-39 and this is likely to be attributed to this age group because they have the highest proportion of births.

Action being taken to address these health inequalities

- Implementation of the Saving Babies Lives Care Bundle version 3
- Provision of a Preterm Birth Lead Team at every maternity site
- Patient Information Leaflet created – highlighting risks including ethnicity and age
- Preterm Birth Risk Assessment is undertaken at every maternity booking appointment
- Introduction of a preterm birth digital tool – QUiPP app to improve prediction and care of those who may be in preterm labour
- A Smoke Free Pathway has been launched in maternity services
- A Maternal Medicine pathway to support those with complex pregnancies
- Continuity of Midwifery Care Team at Broomfield Hospital – targeted to areas of deprivation and ethnicity

- Where preterm birth is anticipated – the PERIPrem care bundle is used to optimise the baby's wellbeing.

Source: MSE local dataset – Athena

Part I ICB Board Meeting, 12 September 2024

Agenda Number: 8

Unplanned Care and Flow Update: NHS England Letter: Maintaining focus and oversight on quality of care and experience in pressurised services

Summary Report

1. Purpose of Report

The report is to provide assurance to the Board that the Mid & South Essex (MSE) Integrated Care System (ICS) is working in collaboration in maintaining a focus and oversight on quality of care and experience in pressurised services in mid & south Essex in response to the NHS England letter received on 26 June 2024.

2. Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services, Mid & South Essex Integrated Care Board (MSE ICB)
Matthew Hopkins, Chief Executive Office, Mid & South Essex Foundation Trust (MSEFT)

3. Report Author

Samantha Goldberg, Urgent Emergency Care System Director, MSE ICB
Andrew Pike, Chief Operating Officer, MSEFT

4. Responsible Committees

Executive Meeting – MSE ICB
Trust Management Executive – MSEFT
Trust Board – MSEFT

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)

There are no recommendations associated with the paper.

The paper is for assurance to demonstrate that the ICS is working in collaboration in maintaining focus and oversight on quality of care and experience in pressurised services, and that there is Executive oversight of daily operational and strategic patients flow across MSE.

NHS England Letter: Maintaining focus and oversight on quality of care and experience in pressurised services

1 Introduction

On 26 June 2024 NHS England issued a letter, [*Appendix 1*] to all Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs), NHS Trusts, Regional Directors, and copied to Local Authorities, entitled Maintaining focus and oversight on quality of care and experience in pressurised services. The letter highlighted the pressures and challenges that are evident in hospitals with reference to urgent emergency care (UEC) settings and requested that every NHS Board assured themselves on local system working to avoid emergency department attendance and admission and to maximise in-hospital flow. This report sets out the collective system action mid and south Essex (MSE) is taking in these areas to provide the ICB Board with assurance.

2 Managing Demand / Excess Pressure Across MSE

There is acknowledgement that to maintain focus and oversight on quality of care and experience in pressurised services it is a shared responsibility of all partners to have a role in ensuring a joined-up approach to managing risks to patients across the system.

The System Co-ordination Centre (SCC) is well established within MSE with a daily tactical call to the ensure that the system is aware of the plan and ask of partners to support patient flow. The SCC within the ICB has a role in ensuring a consistent and collective approach to managing system demand and capacity as well as mitigation of risks – this is informed by SHREWD Resilience, a tool that shows the operational situation of the urgent care systems as a simple view in real-time, used in conjunction with the NHSE Operational Pressures Escalation Level (OPEL) framework.

It is recognised that during periods of pressure hospitals may need to operate differently, and operate corridor care, or care outside a normal cubical environment, whether in the Emergency Department (ED), acute wards, or other care environments. When Mid & South Essex Foundation Trust (MSEFT) are full they will enact their 'Full Capacity & Escalation Policy', [*Appendix 2*] which is implemented based on triggers whereby:

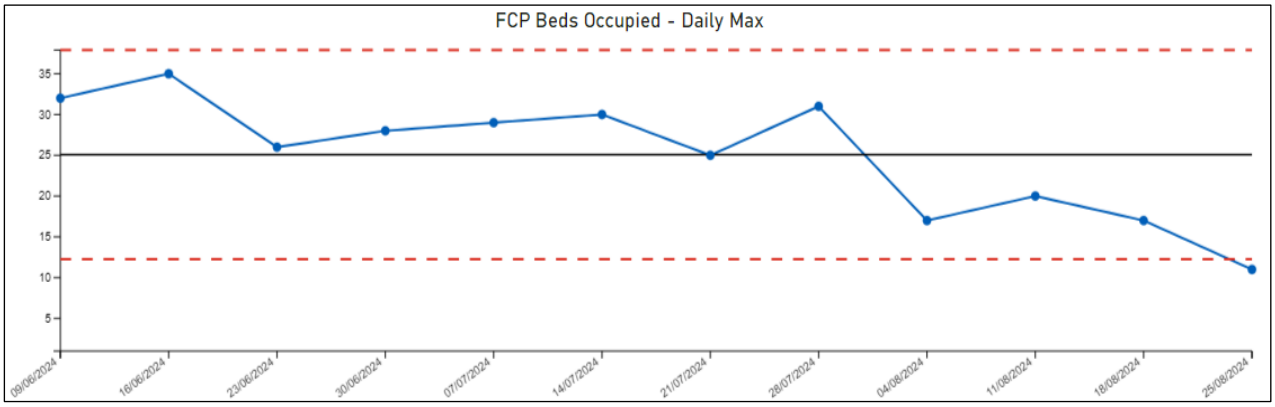
- The ED has more patients than it can potentially safely care for.
- Patients are waiting an excessive amount of time for ambulance offload.
- Those in the community waiting a category 1 or category 2 ambulance assistance whereby an ambulance is not available to dispatch due to being at a hospital site awaiting offloading or a patient handover or
- Reducing the overall length of stay in the ED and assessment unit areas and ensuring patients reach ward care in a timely action.

The Full Capacity and Escalation Policy will only be enacted on a hospital site with Executive Board level and Chief Nurse approval. Corridor care within MSEFT is only operational between 0800 – 1400 hours to ensure safe oversight of patients and the delivery of plans and action associated to facilitate the onward transitioning of the patients from corridor care to their allocated Emergency Department cubicle, assessment trolley or inpatient bed.

Corridor care utilisation is electronically recorded within MSEFT on the patient Teletracking system to enable all patients to be visible, and the plans associated with the patient care and onward ward transfer are also recorded on Teletracking. The volume of patients and utilisation of care is recorded for each of MSEFT's hospital sites and reviewed at the MSEFT Urgent Emergency Care, Patient Flow & Discharge Improvement Board. Since July 2024 there has been a reduction in

corridor care across MSEFT hospitals, which is in conjunction with the quality improvement patient flow programmes launched across MSEFT, as shown on the following table:

Corridor Care at MSEFT:



It is noted that the Full Capacity and Escalation Policy is not without risk and is only implemented once following actions have occurred:

- all transfers from ED to allocated beds have been undertaken.
- patients accepted by Same Day Emergency Care services.
- all confirmed discharges moved to discharge lounge (discharge letters, transport bookings and medication ordering can occur from there).

The policy ensures safe and effective flow of emergency care, and is limited for the shortest period of time possible, with patient dignity and respect being maintained throughout. Acute illness and admission to hospital cause anxiety and concern to patients and their families. The policy ensures that patients and their family/carers (where accompanied) are kept updated about the progress of their admission and the plans to facilitate their transfer to a suitable bed in the correct ward. An information letter is available to support staff to explain the current NHS pressures and the current processes to respond to these, which has recently been communicated to staff following the approval of the updated policy.

The letter received from NHS England asked every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to ED attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility.

Board members across ICS partners were further requested within the letter to individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter.
- basic standards of care, based on the Care Quality Commission's (CQC) fundamental standards, are in place in all care settings.
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund.

- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance.
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level.

3 Findings/Conclusion

This table below provides an overview of how each of these requirements are being delivered across Mid & South Essex (MSE):

Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
Within MSE, there are a variety of services across the system that support alternative to Emergency Department attendance and admission avoidance, particularly for those frail older people: **NHS111 care home pilot** Since June 2024 IC24 have been undertaking a pilot working in collaboration with the top five care homes across MSE who depend more on support from East of England Ambulance Service NHS Foundation Trust (EEAST) for their residents. IC24 have contact with the care homes twice a day on Saturday and Sunday and undertake a virtual ward round to establish if there are patients that require intervention and allocate these to the necessary pathways, or support with a GP face to face visit or medication or, where required, to avoid an ambulance request and potential conveyance to the EDs, retaining the patient in their place of residence. Pilot outcomes are in progress stage to establish the benefits and impact in reduced ambulance conveyancing, and whether the pilot has been successful to support further opportunities to work with the Unscheduled Care Coordination Hub this winter as part of the multi-disciplinary workforce (MDT) workforce and potentially scale up the pilot and increase the number of care homes, with opportunities to explore weekday virtual ward rounds. **Unscheduled Care Co-ordination Hub (UCCH):** The UCCH consists of a multi-disciplinary team of clinicians and administrative staff, working from a blend of providers across the ICS located at Rochford Hospital. The team have direct links to ambulance control and live visibility of 999 demand, as well as SHREWD Resilience, with an overarching aim of optimising alternative pathways and avoiding inappropriate ambulance conveyance to EDs. The team pro-actively interrogate the ambulance stack for Category 2, 3 and 4 patients; pulling directly from the stack and responding to crews on scene and other clinical providers to provide clinical expertise/advice working in partnership with the single aim of safely supporting the patient. The UCCH is incorporated within the EoE Regional New Models of care work: To fully implement 6x ICB UCCH's that meet a consistent minimum viable product specification, this builds upon the "access to 999 stack" and "call before convey" schemes already delivered during 2023/2024. Outcomes from delivery of UCCH pan regional scheme: ° Consistent and rapid access to clinical advice and appropriate services via a Single Point of Access. ° Improve Category 2 response times and maximise impact of Category 2 999. ° Reducing unnecessary ambulance conveyances through an MDT management approach coordinated by the hubs and enabling direct referral to appropriate community services ° Increasing Hear and Treat rates, reducing face to face responses with full delivery of Category 2 999 segmentation

- Reduce on scene times for non-conveyed Ambulance patients by having an MDT/Single Point of contact approach.
- Reduce Ambulance patient conveyances to EDs subsequently reducing Ambulance patient handover delays.
- Improvement in 4-hour access in the ED
- Improvement in utilisation of community service and direct access to Same Day Emergency Cares (SDEC) in hospitals.
- To improve patient outcomes and experience by providing the right care, in the right place, at the right time, first time.
- Create a workforce with ability to work across organisational boundaries.
- Identify gaps in health & social care services, by adopting an MDT approach for the management of patients.
- Develop communication and relationships whilst removing organisational barriers across all UEC providers with the EoE region. Ensure cross organisational psychological safety and increased appetite and understanding about risk sharing.

Urgent Community Response Team (UCRT):
Full geographic substantive and embedded operational UCRT service provision from 0800-2200 seven days a week. The service covers all nine clinical conditions/needs, including level two falls, in line with the national 2-hour guidance.

- All clinicians undertake wound closure using skin adhesive to support with management of minor injuries sustained during a fall.
- Expanding beyond the nine clinical conditions has commenced.
- Intravenous Therapy (IV) is live through collaborative working with the frailty virtual ward and Hospital at Home teams.
- Point of Care Testing offer is live.
- Refers patients into the virtual wards from the community and care homes reducing the need for acute admission.
- Work closely with UCCH and EEAST to increase referrals into the service and pull suitable category 3 – 5 calls from the ambulance 999 stack using the EEAST Clerical Portal.

Virtual Wards:
Through the Unplanned Care/ Flow Programme Portfolio Group a review of the current Virtual Ward model is in place to ensure it operates at higher capacity levels to support flow and deliver a minimum of 80% occupancy. Current Virtual Wards include frailty and respiratory:

- Flow optimisation through the virtual wards.
- Optimise Virtual Ward flow regular MDTs are held throughout the week to facilitate discharge planning, team includes consultant, pharmacist, therapists, and social care.
- Further optimise Virtual Ward there are touchpoints throughout the day between UCRT and Virtual Ward teams to maximise referrals, as well as liaison with frailty teams in the hospital to identify suitable patients for admission to frailty virtual wards.
- Regular Pharmacist led medication reviews take place across the virtual wards.
- Community and Hospital teams working together to raise awareness of Frailty Virtual Ward and how to refer and develop referral pathways.

Frailty Assessment Units at MSEFT
Acute frailty units operate at each of MSEFT's hospital sites, which incorporate an Acute Frailty Assessment Unit. The services are operational for a minimum of 10 hours a day Monday to Friday, with weekend service provision at Basildon and Southend hospitals. The service operates a 'pull' model from the ED with patients being seen by a senior clinical decision-maker to avoid their unnecessary admission. The patient is seen by the MDT who perform a comprehensive geriatric assessment.

The team aim to improve the patient's health sufficiently to enable discharge back to place of residency with/without virtual ward or community care, or transfer into the short stay ward where possible on the same, and where required into a frailty ward within 72 hours.

The system will participate in NHSE Frail-TeD reviews in September to establish where there are pathways and service opportunities to support attendance avoidance to EDs and admission avoidance. This work is scheduled for completion at the end of October 2024.

EEAST & EPUT Ambulance Mental Health Joint Referral Car

The Mental Health Joint Referral Car incorporates multiagency staffing and operates from 1300 to 0100 hours. The allocation of work is from calls by EEAST following a call via 999. The team review live ambulance demand screens and respond to calls and offer advice to Emergency Operations Centre or crews on scene to present and attendance avoidance to an acute ED and support to ensure the patient is put onto the correct mental health pathway with the right support.

There is the potential for a second car before to enable the service to operate 24 hours a day, which is pending funding of EEAST staff.

Essex Partnership University NHS Trust (EPUT) Mental Health Urgent Care Department (MHUCD)

The MHUCD service is a 24-hour service for patients in the MSE area aged 18 years or over experiencing mental health crisis. Access to the service is mostly via the 111 mental health option/professionals' line, EEAST conveyances or 'walk in' self-presentations. The service works in conjunction with existing liaison services and is not a replacement for them. The service is supported by a multidisciplinary team which includes Consultants; Psychologists; Social Care Staff; qualified clinical staff; security staff; admin and reception staff; support staff; pharmacy staff; and voluntary staff

Each of the three hospitals within MSEFT have a mental health suite within the ED footprint, managed by EPUT, with each suite able to accommodate a minimum of two patients.

Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility

The MSE Unplanned Care and Flow Portfolio Group features four individual programmes with underpinning workstreams designed to deliver improved end to end patient flow throughout the ICS from patient referral to care in the community or a return to home. The group provides oversight of the delivery of the programmes of work, which are all led by a senior responsible officer assigned to delivery *[Appendix 3]*:

- Flow Enablers: Maximising the right community capacity – SRO: Becky Jarvis
- EPUT Flow Improvement / OOA Placements – SRO: Sue Graham
- System UEC Attendance/Admission Avoidance – SRO: Samantha Goldberg
- MSEFT UEC Improvement Programme – SRO: Andrew Pike
  - The MSEFT UEC Improvement programme is led by the Senior Responsible Officer, Andrew Pike, and delivery of hospital site improvements led by the Managing Directors. The programme incorporates 12 individual workstreams which relate to either urgent emergency care or patients' flow. Using the quality improvement methodology, making improvements in maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or onto community bedded or virtual ward capacity.

Mid & South Essex Foundation Trust (MSEFT) has been rated as a tier 3 organisation for urgent emergency care service by NHS England, which is positive, although does not allow access to national improvement resources and recovery support, which is dedicated to tier 1 and 2 organisations. However, in collaboration with East of England NHSE colleagues support has been provided to undertake peer reviews in collaboration with the EoE NHSE and ICB UEC teams for SDEC services to establish improvement opportunities to support admission avoidance. As well a review of the ED at Broomfield Hospital to obtain assurance against the 2-year recovery plan and opportunities for further improvements. Formally requested for the review to be replicated at Basildon and Southend Hospital sites to conclude a full Trust review.

Organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter

Maintaining progress

The UEC Recovery Plan is a 2-year plan, and the level of ambition for 2024/25 was set out in the NHS priorities and operational planning guidance, which indicated to improve on the year 1 plan and:

1. improve A&E performance with 78% of patients being admitted, transferred, or discharged within 4 hours by March 2025.
2. improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25.

This operational planning guidance asked systems to focus on three areas to deliver these ambitions:

1. maintaining the capacity expansion delivered through 2023/24
2. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.
3. continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance, and hospital discharge.

Appendix 4. summarises the actions required for delivery, which are mapped against the requirements set out in 2024/25 planning guidance and commitments to delivery are incorporated within the MSE Operating Plan signed off by the ICB Board in May 2024. Oversight and delivery of work is against key performance indicators (KPIs) and associated improvement trajectories at the monthly MSEFT UEC Board, MSEFT Portfolio Board, System UEC Oversight and Assurance Board, and the System Unplanned Care and Flow Portfolio Group, which are all Director or Executive led

Basic standards of care, based on the CQC's fundamental standards, are in place in all care settings.

The CQC fundamental standards are the standards below which care must never fall. The CQC states that everybody has the right to expect these standards, which can be found in appendix 5 and the letter from NHS England clearly states that wherever a patient is receiving care, the fundamental standards must be adhered to.

In MSEFT, assurance on the basic standards of care delivered to patients is obtained through various internal and external reviews. A programme of internal compliance visits is arranged using a risk-based approach to determine the core services to be reviewed and the areas to be visited. The results of the reviews are presented to the MSE Quality Governance Group with a summary reported to the MSE Quality Governance Committee. The outcome of the reviews is considered by the relevant hospital site and service and improvement plans developed in response to the findings where needed.

The reviews focus on the CQC fundamental standards and CQC quality statements to provide assurance that the standards are being adhered to, and this includes reviewing patients who are being provided with care outside of a cubicle or bed space (corridor care).

In August 2024, the internal compliance visit focused on the core service of urgent and emergency care and incorporated a specific review on care provided to patients in the corridors on inpatient wards. The outcome of the review will be presented to the Quality Governance Group in September.

Services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund.

The Better Care Fund (BCF) facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long term residential care. In MSE the Better Care Fund is used to support the delivery of virtual ward services, UCRT, Community services and reablement capacity, supporting both admission avoidance and discharge at the point of medical optimisation. Furthermore, there is support for Hospice services for end-of-life care.

Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance.

The Seven Day Hospital Service Clinical Standards were developed to support providers of acute services to delivery high quality are and improve outcomes on a seven-day basis for patients admitted to hospital as an emergency. The Board Assurance Framework (BAF) published in November 2018 required trusts to audit and upload the results twice yearly to a national portal.

In 2020, the requirement to undertake the seven-day services audit was suspended in response to the COVID 19 pandemic. In 2021 the standards were reviewed by a clinical reference group who confirmed that the standards remain relevant and important. The new BAF for Seven Day Hospital Services was published 10 February 2022 and suggested that boards should assess at least once per year whether their acute services are meeting the four priority 7DS clinical standards. The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

The formal audit of 7DS within MSE has not been formally restarted since the audit was paused in 2020. Although some aspects of the standards may have been included within internal and external reviews or audits, these have not yet been formally reported within a report to the MSE Board or sub-committee. However, since 2019/20 we now have a wide range of seven-day services provided, some of which are provided through on-call arrangements.

The first comprehensive audit for MSEFT is currently underway and is due to be presented to MSEFT's Quality Governance Committee in September 2024.

Consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level.

Within MSE, there are robust overview and escalation processes across the UEC pathway.

SHREWD Resilience is a tool that displays urgent and emergency care data in one easily accessible dial view. SHREWD Resilience provides the opportunity to view a variety of sources of data at once, either via a mobile device or web-based application, it enables system responses to be timelier and plans to support system flow more responsive. SHREWD Resilience not only facilitates more meaningful day-to-day operational decision-making, also enables operational evidence to inform management decisions and planning.

The platform and data provide a transparent system overview of inbound and current demand across our system partners, as well as enabling the forward planning of actions to be delivered to support continuous flow for UEC pathways for our people of MSE. SHREWD Resilience interacts with the national Operational Pressures Escalation Level (OPEL) framework that focuses on operational pressures within the acute hospitals and all other providers within MSE. The OPEL levels are used in conjunction with the associated actions cards aligned to each of the OPEL levels.

The System Co-ordination Centre (SCC) is part of the Integrated Care Board and is operational 7 days a week from 08000-1800 Senior SCC Lead of the Day. The SCC utilises various information tools for decision making throughout the day to provide capacity and demand overview and support patient flow across the system. SHREWD Resilience is the primary dashboard utilised providing a real-time system 'helicopter' view.

Throughout the day there is continuous monitoring of the SHREWD Resilience and ambulance conveyance screens ensuring oversight and response to demand, capacity, and flow. Communication will occur with the necessary partners for interventions required to resolve issues as reflected in the OPEL actions and response.

In core operational hours ICS providers undertake a minimum of a twice daily capacity meeting whereby demand is reviewed against capacity to enable patient flow to be maintained throughout the day utilising SHREWD Resilience alongside internal demand tools. The meetings have senior leadership team presence and, dependent upon the OPEL score and level of the provider, will determine who chairs the meetings. For example OPEL level 1-2 will be chaired by site management and OPEL levels 3-4 chaired by Director/Executive Director. There are robust structures within organisations for patient flow, risks, or concerns to be escalated to Directors or Executive Directors, and out of hours escalation through the oncall structures, which exist across the ICS.

4 Recommendation

There are no recommendations associated with the paper.

The paper is for assurance to demonstrate that the Integrated Care System is working in collaboration in maintaining focus and oversight on quality of care and experience in pressurised services, and that there is Executive oversight of daily operational and strategic patients flow across Mid & South Essex.

5 Appendices

Appendix 1: NHS England Letter
Appendix 2: Full Capacity and Escalation Policy – Enabling Emergency Offload Capacity
Appendix 3: Unplanned Care/ Flow Programme Portfolio Group Programmes and Workstreams
Appendix 4: Operational Planning Guidance Requirements
Appendix 5: CQC Fundamental standards

Appendix 1: NHS England Letter

Classification: Official-Sensitive

NHS England

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

Publication reference: PRN01417

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer
England

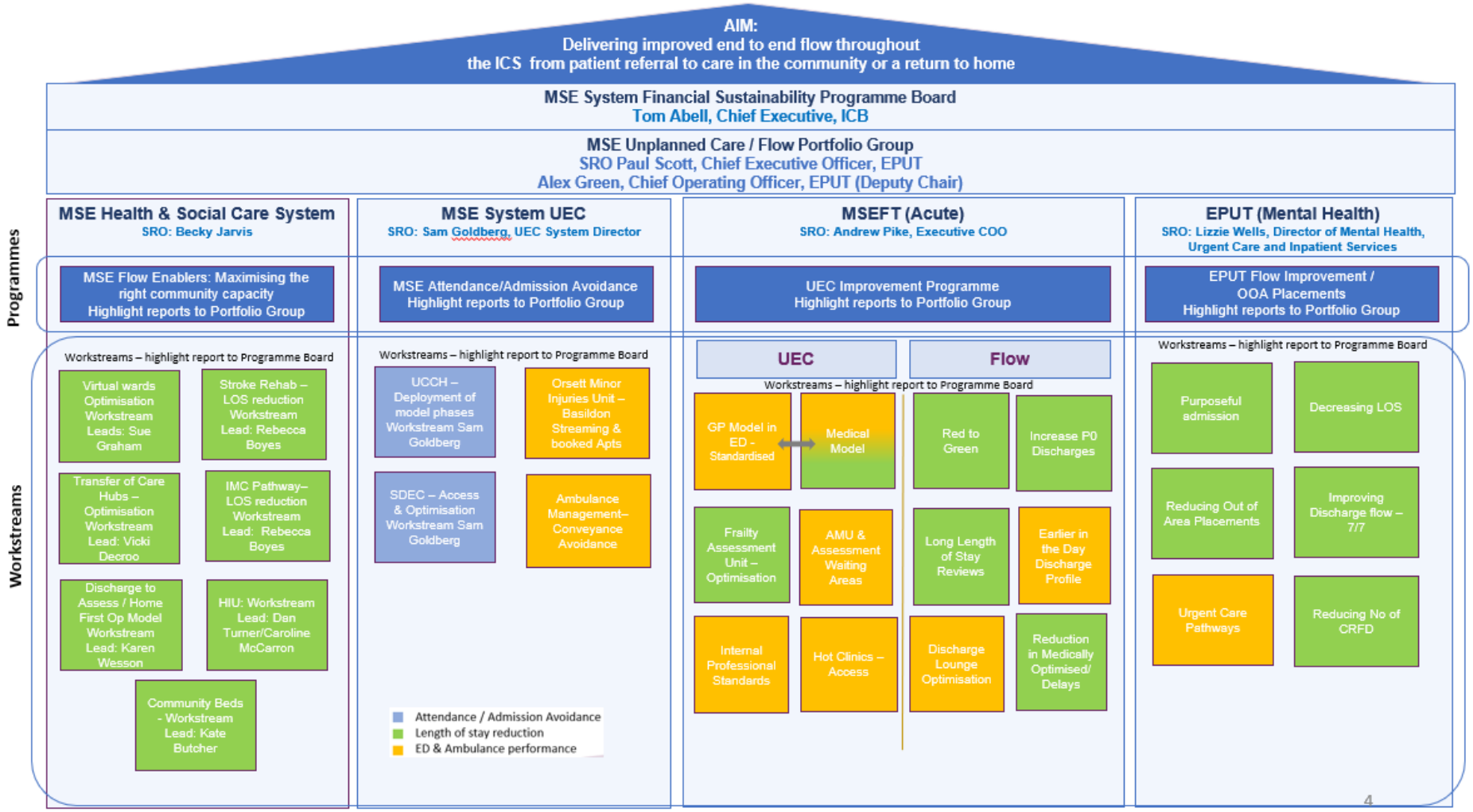
Appendix 2. Full Capacity and Escalation Policy – Enabling Emergency Offload Capacity

Note:
The updated policy is to be presented at Mid & South Essex Foundation Trust, Trust Management Executive Meeting in September 2024 for approval.

The Full Capacity and Escalation Policy has been amended to incorporate:

- Renamed to Full capacity and escalation policy – Enabling emergency offload capacity
- 6.2 Updated to reflect if there is unplanned absence of the CNO and CMO for authorisation of overnight FCP
- Removal of operational performance matrix as an objective for the policy.
- Inclusion of quick guide and patient letter
- Removal of original appendix 2 which relied on OPEL status for activation.

Appendix 3. Unplanned Care/ Flow Programme Portfolio Group Programmes and Workstreams



Appendix 4. Operational Planning Guidance Requirements

Operational planning guidance requirement	Evidence-based actions to support delivery
1. Maintain the capacity expansion delivered through 2023/424	
1A. Maintain acute G&A beds at the level funded and agreed through operating plans in 2023/24	• Maintain and monitor the 99,500 core G&A bed capacity over 2024/25. At system level this means maintaining the growth achieved by Q4 2023/24 on average over the course of the year, adjusting for seasonality.
1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals	• Maintain hours on the road/deployed ambulance staff hours. • Increase clinical assessments of calls in NHS 111 and ambulance control rooms compared to 2023/24. • Maximise opportunities to establish 'call before you convey' best practice models to increase direct referral to alternative services. • Continue the focus on deploying the paramedic workforce, including ambulance support staff, in the most effective way. • Embed culture improvement by implementing the recommendations set out in the Culture review of ambulance trusts.
1C. Focus on reduction in ambulance handover delays to support system flow	• Reducing handover delays will be a key focus and action for systems to deliver in 2024/25 and will remain a metric to better assess flow across UEC pathways and support improved patient outcomes. The delivery actions and best practice examples to support this are included across other domains above and below.
1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care	• Working jointly across ICBs and local authorities, ensure that commissioned intermediate care capacity meets projected demand, supported by the additional £400 million in the 2024/25 Discharge Fund. Plans should accurately forecast capacity needs, considering the most appropriate balance between different discharge pathways, and identify the workforce capacity and skill mix changes required to deliver sufficient rehabilitation and reablement activity to support discharge. Plans will be assured through the Better Care Fund (BCF) assurance process. • Use the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, to identify how to improve service and workforce models.
1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure, and children and young people	• Maintain capacity and improve occupancy of virtual wards, expand access to step-up and step-down capacity, and improve length of stay by pathway, through implementing best practice as set out in the virtual ward framework. • Work together locally, including with social care providers, to increase access to virtual ward services that provide an alternative to hospital attendance or admission ('step up' virtual wards) including increasing the home referrals and directing patients from ED and SDEC following initial assessment where appropriate. • Consider specialty pathways and teams according to local demand, including paediatric virtual ward services and capacity.

Operational planning guidance requirement	Evidence-based actions to support delivery
2. Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes	
2A. Focus on reductions in admitted and non-admitted time in ED	• Continue to focus on initial assessments, including continuing to increase the proportion received within 15 minutes of arrival, and increase the proportion of patients redirected to alternative services. • Work with providers to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways. • Review critical interventions along patient pathways in hospital and ensure they are aligned with best flow practice principles. • Review and audit trust internal professional standards, using the ECIST guide as a starting point. • Build on the rollout of psychiatric liaison services to support Type 1 EDs working towards ambition of responses within 1 hour of referral. • Reduce mental health patient time in EDs, including reducing length of stay for patients in acute beds waiting for a mental health bed, and in mental health beds. Systems, including local government, should focus on improving whole mental health pathway patient flow.
2B. Focus on reductions in the number of patients still in hospital beyond their discharge ready date (DRD)	• Continue to improve in-hospital discharge processes. Ensure early discharge planning, including effective involvement of patients, carers and families, in line with statutory guidance on hospital discharge and community support. • Working across the NHS and social care, maximise the effectiveness and maturity of care transfer hubs to improve quality and timeliness of discharge for patients with complex needs. • Working across the NHS and local authorities, implement trusted assessments to reduce duplication and ensure information is shared through the pathway.
2C. Focus on reductions in length of stay in community beds	• Increase productivity and capacity of community bed-based services based on maturity self-assessments. • Extend the implementation of best practice flow principles to community beds, including tracking length of stay. • Reduce discharge delays from community bedded units through process improvements, and through timely access to ongoing packages of care supporting transition and continuation of rehabilitation and reablement at home, building on good practice in care transfer hubs in acute settings.
2D. Improve consistency and accuracy of data reporting	• Ensure all trusts are consistently and accurately recording key metrics including SDEC activity in ECDS, community discharge information on the community SitRep/SUS, DRD, data on reasons for discharge delays, and the Ambulance Data Set. • Ensure system co-ordination centres are fully embedded and made ready for system OPEL. • Consider how to disaggregate data based on age, to understand demand and monitor performance for children and young people.

Operational planning guidance requirement	Evidence-based actions to support delivery
3. Continue to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance and hospital discharge	
3A. Increase referrals to and the capacity of urgent community response (UCR) services	• Increase UCR referral volumes and number of patients treated. • Explore the use of technologies and point of care testing to optimise existing capacity, and consider referral pathways from technology enabled care (TEC) providers and SDEC.
3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week	• Ensure SDEC compliance of 12 hours a day, 7 days a week. • Increase utilisation by working with partners (including ambulance trusts) to increase the proportion of patients with direct access, direct referrals from outside the ED (NHS 111, 999 and primary care), and reduce variation in the proportion of ED patients who are treated through the SDEC. • Increase productivity by implementing the minimum standards of delivery outlined in the SAMEDAY strategy. • Improve consistency of reporting SDEC into the Emergency Care Data Set (ECDS) by March 2025.
3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week	• Ensure acute frailty service compliance of 10 hours a day, 7 days a week, implementing a comprehensive geriatric assessment at the front door, and the minimum standards in the FRAIL strategy, to increase patient flow and the proportion of patients over 65 with a Clinical Frailty Score. • Understand and work across systems to reduce numbers and variations in care home referrals to ED.
3D. Provide integrated care co-ordination services	• Work to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity holistically across all relevant services. Work with local authorities to link this to BCF demand and capacity planning for intermediate care. • Establish core operational integrated care co-ordination structures as a minimum by October 2024, with a focus on paramedic access to clinical advice to support alternative pathways to ED. • Ensure surge acute respiratory infection provision, including for children.

Appendix 5 – CQC Fundamental standards

Person-centred care – You must have care or treatment that is tailored to you and meets your needs and preferences.

Visiting and accompanying – If you're in hospital, a care home or hospice, you should be able to have visitors. If you are living in a care home, you should be able to go out on visits without difficulty. And if you need to go to hospital or a hospice for an appointment, you should be allowed to have someone with you.

Dignity and respect – You must be treated with dignity and respect at all times while you're receiving care and treatment. This includes making sure you have privacy when you need and want it; Everybody is treated as equals; You're given any support you need to help you remain independent and involved in your local community.

Consent – You (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.

Safety – You must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills, and experience to keep you safe.

Safeguarding from abuse – You must not suffer any form of abuse or improper treatment while receiving care. This includes neglect, degrading treatment, unnecessary or disproportionate restraint, inappropriate limits on your freedom.
Food and drink – You must have enough to eat and drink to keep you in good health while you receive care and treatment.

Premises and equipment – The places where you receive care and treatment and the equipment used in it must be clean, suitable, and looked after properly.

Complaints – you must be able to complaint about your care and treatment. The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.

Good governance – The provider of your care must have plans that ensure they can meet these standards. They must have effective governance systems to check on the quality and safety of care. These must help the service improved and reduce any risks to your health, safety, and welfare.

Staffing – The provider of your care must have enough suitably qualified, competent, and experienced staff to make sure they can meet these standards. Their staff must be given the support, training, and supervision they need to help them do their job properly.

Fit and proper staff – The provider of your care must only employ people who can provider care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants criminal records and work history.

Duty of candour – The provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provider support and apologise.

Display of ratings – The provider of your care must display their CQC ratings in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.

Part I ICB Board meeting, 12 September 2024

Agenda Number: 9

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

The Board is asked to note the current position regarding the update from the Chief Executive 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 Chief Executive covering key issues, progress and priorities since the last update. The report also provides information regarding decisions taken at the weekly executive committee meetings.

2. Main content of Report

2.0 Key activities and issues over the last two weeks:

This is my first report as Chief Executive, and at the time of writing had been in post for two weeks. I want to firstly put on record my thanks to everyone within the ICB and across our system for being so welcoming and generous with their time.

Clearly since the last report there has been significant change nationally with the result of the general election and the announcement by the Department of Health and Social Care of the development of the 10 year plan for the NHS. This is something that we will want to engage with as the timeline and details become clearer to help shape the future of the NHS across mid and south Essex.

2.1 Annual Accountability Review

Since the last Board meeting, we have received the outcome of the annual assessment by NHS England of the ICB. This noted the good progress that has been made over the course of the past year, with the following areas being particularly noted:

- Strong collaborative leadership on the development and alignment of the system's strategy and operational plans.

- Active leadership on improvement programmes across the system and focus on adopting the Core20PLUS5 Framework.

- The development of the integrated health and care dataset.

- Support for innovators and innovation adoption.

There were also areas for improvement noted within the assessment, which included:

- Further review and development of the system governance.

- Strengthening of contract management, alongside the consideration of greater operational leadership.

- The need for a targeted focus on provider Care Quality Commission areas, particularly quality.

- A focus on financial grip and control across the system, alongside improved triangulation of workforce, activity and financial information.

The full letter from NHS England with accompanying appendix is attached with this report (Appendices 1 and 2).

I have started to work with the Executive Team on how we will deliver improvement in these areas, which I intend to include as an ongoing area of update within these reports.

2.2 Financial recovery

The Board will be aware that we face significant financial challenges across our system. At the time of writing the system was significantly off the agreed plan with NHS England. The scale of this is such that the system has been identified as one of nine Integrated Care Systems (ICSs) in England to be placed in the 'Intervention and Improvement' (I&I) programme by NHS England and therefore subject to greater scrutiny and support.

We are currently finalising the output of the Phase 1 element of work through the I&I programme which had the following scope:

- Reviewing grip and control.
- Reviewing pay and non pay spend.
- Reviewing governance arrangements for financial improvement and cost improvement.
- Reviewing 2024/25 cost improvement and other efficiency plans.
- Reviewing 2024/25 financial plans.
- Making recommendations on further interventions and actions that can be taken across the system to improve the financial position.

Alongside the finalisation of the Phase 1 work, I am working with partners across the system to:

- Mobilise the interventions proposed.
- Working to identify further opportunities in order to bring the system back to plan over the course of 2024/25.
- Agree the package of support to underpin successful delivery as part of the I&I programme and ensuring this aligns with the support that Mid and South Essex NHS Foundation Trust (MSEFT) will receive through the National Oversight Framework Level 4 (NOF4) programme.
- Developing the medium term planning work to set out how and when the system will return to a sustainable financial position.

The achievement of this work is high risk and will require absolute focus and reorientation of resource to deliver successfully.

2.4 Community Services Consultation:

Work is still ongoing to develop the Decision Making Business Case in respect of the Community Services Consultation, taking on board the broad range of feedback that has been received.

I will provide a further update on the progress in respect to this at the Board meeting when we meet.

3. System Performance

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

Urgent and Emergency Care

There is a national requirement to improve A&E waiting times, with a minimum of 78% of patients seen within 4 hours in March 2025. The MSE System A&E July 2024 performance of 72.5% remains below the Operational Plan of 81%. There is a portfolio board in place to oversee urgent and emergency care performance and transformation, including pre and post hospital pathways of care. During 2024/25 this Board will oversee improvement to achieve the expected March 2025 position.

Elective Care

In June 2024, there were the following number of patients on a Referral to Treatment (RTT) pathway at MSEFT. In line with the NHS Operational Planning commitment, the ICB is working with the Trust to achieve zero people waiting over 65 weeks at the end of September 2024:

- 0 patients waiting 104+ weeks.
- 18 patients waiting 78+ weeks.
- 1,970 patients waiting 65+ weeks.
- 8,739 patients waiting 52+ weeks.

MSEFT is in Tier 1 for RTT performance and has fortnightly oversight meetings with the NHS England national team.

Cancer

- Performance in the cancer Faster Diagnosis Standard for June 2024 was 70%, requiring improvement to achieve a minimum of 77% by March 2025.
- Performance in the 62 day referral to treatment target was 44% at the end of June 2024, compared to an expected position of 70% by March 2025.
- The Trust is in Tier 1 for cancer performance and has fortnightly oversight meetings with the NHS England national team. The ICB Cancer Oversight and Assurance Committee is ensuring that the service developments needed to deliver sustainable cancer performance are put into practice.

Mental Health

- MSE submitted a plan to achieve 66.8% of the estimated dementia register size by March 2025. The latest MSE position as of June 2024 is ahead of plan at 66.5% versus plan of 65.2%.
- MSE submitted a plan to achieve 75% of people with Serious Mental Illness (SMI) receiving their physical health check by March 2025. The latest MSE position as of July 2024 is slightly below plan at 65.1% versus plan of 66.0%.
- Perinatal: Increase the number of people accessing perinatal mental health. MSE ICB's fair share of the ambition is >=1,394. Year to date position as of June 2024 is 1,355 versus plan of 1,472.

4. Executive Committee

Since the last report, there have been ten weekly meetings (from 25 June 2024 to 27 August 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:

- Scope and direction for projects across the four alliances within (MSE).
- Recommissioning of Southend, Essex and Thurrock Keyworker Service, in collaboration with other ICBs across Essex and Essex County Council.
- Review of Home Oxygen Service provision up to January 2025, with a further review for longer term provision to be undertaken.
- Annual Review & approval of the Executive Committee's Terms of Reference.
- Review & approval of the system's Triple Lock Terms of Reference.
- Individual Funding Requests (IFR) for patients across the system who exceed the existing delegation limit for the ICB's internal IFR panel.
- Review of risk share arrangements across mental health with other ICBs across Essex.
- To undertake a review of clinical leadership across the system, for 2024/25, with further review required for long-term provision.
- To undertake a formal procurement exercise to re-commission children and young people counselling services across the system.
- For an initial work programme to be started to review the ICB's Commissioning Intentions for 2025/26.
- A 3-year pilot for dental access for children and young people across MSE, which will include scope full coverage of all schools within MSE.
- Organisational sign up of the MSE Anchor Charter.
- Approval of the ICB's Women's Health Strategy.
- To undertake a review of system corporate estate, which will include a needs analysis across the system.

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

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

5. Conclusion

It is clear that the ICB has made significant progress over recent months. However we need to relentlessly focus on making further progress, particularly on how we best support delivery and improvement across our system. We also need to set out a clear and deliverable plan by which we will support our ambition to become a sustainable system which consistently delivers on health improvement and high quality care for the communities of MSE.

6. Recommendation(s)

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

7. Appendices

Appendix 1 – Letter dated 31 July 2024 from Clare Panniker to Prof. Michael Thorne

Appendix 2 – MSE ICB Annual Assessment 2023/24 - Draft

NHS England

To: Professor Mike Thorne CBE, Chair
Mid and South Essex ICB

NHS England – East of England
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

31 July 2024

Dear Mike,

Annual assessment of NHS Mid and South Essex Integrated Care Board's performance in 2023-24

I am writing to you pursuant to Section 14Z59 of the NHS Act 2006 (hereafter referred to as *"The Act"*), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making this assessment, we have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that my team and I have had with you and your colleagues throughout the year.

This letter sets out the assessment of your organisation's performance against the specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2023/24 financial year.

The assessment has been structured to consider your role in providing leadership and good governance within your Integrated Care System (ICS) as well as how you have contributed to each of the four fundamental purposes of an ICS. For each section of the assessment, I have summarised those areas where I believe your ICB is displaying good or outstanding practice and could act as a peer or exemplar to others. I have also included any areas where further progress is required, and any support or assistance is being supplied by NHS England to facilitate improvement.

In making the assessment, we have also considered how you have delivered against the local strategic ambitions as detailed in your Joint Forward Plan which you have reviewed and re-baselined. A key element of the success of Integrated Care Systems will be the ability to balance national and local priorities together and I have aimed to highlight where I feel you have achieved this.

I thank you and your team for all your work over this financial year in what remain challenging times for the health and care sector, and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

Clare Panniker
Regional Director
NHS England – East of England

Cc: Tracy Dowling, Interim Chief Executive Officer, Mid and South Essex ICB

Simon Wood, NHS England Regional Director of Strategy and Integration, and Executive Lead for Hertfordshire and West Essex ICB

2023/24 Assessment against the following duties:

System Leadership

The ICB has grown in maturity and has successfully brought together its providers, three upper tier Local Authorities, Primary Care Networks, three Healthwatch organisations and several community and voluntary services. A solid foundation in partnership working has been developed over the last year, with the ICB leading the system in the development and delivery of well aligned strategic and operational plans. Future success will require the ICB to consolidate its own position and move away from the five legacy Clinical Commissioning Groups and continue to develop place to harness the benefits this will bring.

In 2023, the ICB committed to 12 strategic ambitions for the health and care system. This was supported by a focus on the triple aim via Partnership, Delivery and Enablers and an ICS Population Health Improvement Board, with representation from partners across the system, working together to drive an integrated approach to delivery of priorities and reducing Health Inequalities.

Robust governance systems and processes have been established and joint forums used to collectively test system assumptions, identify, and escalate key risks and issues. They have supported the development of a shared system view and approach to delivery and mitigation. Whilst the ICB has reviewed the effectiveness of their governance structure to ensure that it provides the appropriate level of Executive oversight, there are still further opportunities to review the governance and structure of the ICB, particularly in relation to performance and the gap in a Chief Operations Officer/Performance role. There is also a need to review key meeting dates/times across the ICS to avoid clashes and ensure key individuals can attend important meetings.

Through the identification of quality issues within the system, an improving Quality governance structure has evolved, which includes the development of a Patient Safety Strategy and Patient Safety Incident Framework and the establishment of a Quality Committee and a System Quality Group. The ICB has supported providers through the introduction of Rapid Quality Reviews - a process designed to be supportive as well as address the issues identified.

The ICB has a place-based alliance structure with nine Integrated Neighbourhood Teams that ensure that the local population receives, and has access to, services that are better aligned to their needs.

Following delegation of the commissioning of Pharmacy, Optometry and Dental Services from NHS England, the ICB has implemented two key pilot service developments in Dental, established a Local Optometry Committee which has further developed Ophthalmology Services (and relationships) and worked well with Community Pharmacy to roll-out Pharmacy First.

It is recognised that the recent re-structure had a significant impact on the capacity and experience of the ICB’s contract team, resulting in issues not always being escalated and considered by the most appropriate forum in a timely manner. This has been highlighted previously, and whilst the focus has been on building relationships with providers, the ICB needs to ensure accountability through the contracting process with a clear escalation process in place for contractual issues which supports the team to manage effectively.

The stewardship programme has put clinical leaders at the centre of driving transformational change and gives the system access to expert advice when considering any clinical and operational pathways changes. The impact being made by the ten Stewardship programmes has been described during the routine ICB review meetings with NHS England.

One of the key transformational successes for the ICB and the Stewardship programme has been the development and implementation of the Dermatology Pathway, which resulted in whole pathway change, reducing delays, and benefiting patients. It was positive to see the team reach out for support, and it is an excellent example of the progress that can be made when primary and secondary care work together, with leadership and guidance from the ICB. This pathway was achieved in a relatively short timescale and the ICB needs to learn to move at pace if it is to support transformation, improve services for patients and release efficiencies.

A review of clinical system leadership is taking place supported by the Clinical Leadership and Innovation Directorate.

Working through Alliance Partnerships and a system wide community assembly, the ICB has collaborated with community, voluntary, faith and social enterprise sector partners. However, there is still more opportunity to go further with non-statutory and voluntary sectors, as well as the further development and embedding of Place-based arrangements.

Engagement with public and patients has been strengthened through the new Virtual Views Platform where people can share their views, experiences and ideas across health and care services.

The ICB has actively sought help in several areas from both NHS England regional and national colleagues. Examples include Time to Care (Essex Partnership University NHS Foundation Trust), Maternity Services Support Programme (Mid and South Essex NHS Foundation Trust), support with contract management processes, Getting it Right First Time and Tiering support for Mid and South Essex NHS Foundation Trust to address operational performance challenges. The ICB has been actively involved, with support from the NHS England Reinforced Autoclaved Aerated Concrete (RAAC) Programme team, in assessing GP premises to ensure that there are no safety issues as a result of RAAC via a combination of desk-top assessments and surveys. No RAAC has been found to date and the assessment was on track to be completed in June 2024 in line with plan.

Improving Population Health and Healthcare

The ICB's strategy highlights prevention and improving population health overall as a core focus. The Population Health Improvement Board has been established and is overseeing work to improve population health since 2022. 2023/24 saw a focus on the five planning priorities, adoption of the Core20PLUS5 framework, targeted investment in health inequalities and its shared decision making ‘four questions’ campaign.

Positive improvements were seen in the delivery of the 2023/24 Operational plan, Referral to Treatment waiting times and Cancer backlogs were reduced, and more diagnostic activity delivered. These improvements were accomplished despite industrial action throughout the year. However, the performance did not achieve the level of improvement required and there needs to be a clear focus on delivery of the cancer standards in the months ahead. The ICB

also needs to ensure a greater focus on sustainable improvement and delivery while managing many priorities.

There have been notable improvements made via the targeted improvement plan for Urgent and Emergency Care. In Ambulance Category 2 performance, the ICB was the best performing system in the region for year-end performance at 38.6 minutes against the 30-minute target. The System was also a front- runner in the region for their Access to the Stack and Urgent Community Response Programmes. For performance against the Emergency Department 4 hour wait target, the acute Trust improved performance across the year from 68.7% in April 2023 to 73% in March 2024.

The ICB has made progress delivering more GP appointments and improved access to perinatal mental health services. Out of Area mental health placements were reduced and consistent improvement in delivery of the dementia diagnosis rates seen.

The Joint Forward Plan supports personalised care implementation, however Mid and South Essex benchmark poorly nationally for the rate of personalised care interventions (for personal health budgets) and the rate of personalised care plans. We suggest an exploration of the potential to increase social prescribing interventions and consider the inclusion of personalisation in Board level reporting as this would increase oversight of progress and delivery of targeted outcomes.

Tackling Unequal Outcomes, Access, and Experience

The ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA (1), in their Annual Report and has encouraged their providers to do the same.

Progress has been made to push forward with a structured approach to delivery on Population Health Management. The ICB has developed an integrated data set using data from all parts of the health and care system, which drives a population segmentation tool and provides insights on where health inequalities exist at Alliance and Primary Care Network level. The statement on Health Inequalities details where inequalities exist and includes an overview of actions being taken at a system and Alliance level to close the gaps. Recovery plans have been developed taking into consideration the need to balance the identification and reduction in health inequalities alongside the need to improve the system's financial stability.

The ICB has supported and led several preventative programmes throughout the fiscal year, including a focus on cardiovascular disease prevention, implementation of a Maternity Equity and Equality action plan and childhood asthma training for primary care alongside a promotional and educational support tool for children and their families.

Enhancing Productivity and Value for Money

In aggregate, the system delivered a deficit of £27.2m in 2023/24 failing to deliver against the, adjusted*, break-even target. Both Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust failed to meet their financial objectives with Mid and South Essex NHS Foundation Trust finding delivery of efficiency schemes challenging and Essex Partnership University NHS Foundation Trust incurring financial challenges relating to their ongoing inquiry both increasing in scope and becoming statutory.

In-year pressures were also faced in relation to industrial action, inflationary pressures, and cost challenges on Prescribing and Continuing Healthcare within the ICB. The system is working to complete financial recovery plans.

Organisation	2023/24 Surplus / -Deficit (£m)		
	Plan	Outturn	Variance
Mid and South Essex ICB	9.7	22.3	12.6
Essex Partnership University NHS Foundation Trust	0.0	-19.7	-19.7
Mid and South Essex NHS Foundation Trust	-9.7	-29.7	-20.0
Mid and South Essex ICS	-0.0	-27.2	-27.2

*Original plan included a deficit of £40.3m. This was replaced by a contra loan issued in Q4 2023/24 resulting in break-even plan.

Within this position the system delivered its planned efficiencies (£119.7m compared to £119.6m target). Whilst this is positive it is important to note that £70.5m (59%) of the efficiencies were delivered on a non-recurrent basis contributing, in part, to the financial shortfall in 2024/25.

ICB cost pressures were partly offset by a £1.3m underspend on running costs. This is a positive move noting the further reductions in running costs required to be delivered in 2024/25 and should help the ICB move towards this goal.

For 2024/25, the system has submitted a deficit plan of £96m (3.6% of allocation), with additional net risks of £79.8m (a further 3% of allocation). Even delivering this level of deficit is recognised as presenting a challenging target with the system requiring £154.8m of efficiency savings (5.8% of ICB allocation). It is important that the system continues to drive improvements in triangulation of workforce, performance, and financial plans to ensure plans developed are holistic and underpinned by robust data, particularly workforce data.

The system has been in the Triple Lock process since Quarter 4 2023/24 and Mid and South Essex NHS Foundation Trust is receiving national support given its National Oversight Framework 4 rating. A Recovery Director is supporting the process with the aim of making the whole system financially sustainable.

In relation to workforce, it is noted the providers have planned to reduce agency costs by a challenging £49.8m and Bank costs by a further £60.8m between 2023/24 and 2024/25. Whilst reducing reliance on temporary staffing is undoubtedly the best for both patient care and system economics it is vital that the providers have a robust process in place to ensure these improvements are delivered. The system will also need to balance the requirement for clinical expansion as part of the long-term workforce plan whilst managing workforce within short-term budget constraints.

The system's implied productivity reduction of 14.9% between 2019/20 and 23/24 was marginally better than the Average Regional Reduction of 15%. There is a need to continue to focus on improving productivity to protect performance whilst maximising value for money. For Mid and South Essex, innovation will need to be at the fore and will be vital to support the challenges within the system. There is evidence of innovation, with the ICB supporting an

innovation Fellowship with 18 innovators in 2023/24 and the ICB also has several anchor innovation programmes, but there are more opportunities which could be taken.

In 2023/34, Mid and South Essex secured funding to develop a Research Engagement Network which is being developed in partnership across the system and supports groups that are traditionally underrepresented.

Helping the NHS to Support Broader Social and Economic Development

The ICB has worked closely with the wider system to develop and deliver the wider strategic priorities. It has an ambitious Anchor programme; teaming up with health and care partners, local councils, and the voluntary and education sector with the aim to reduce environmental impact, improve health, reduce inequalities, and create employment through volunteering and apprenticeship opportunities**.** This programme has been recognised nationally. The ICB and its provider partners remain committed to being an anchor in their community.

Summary

The ICB has demonstrated a real commitment to partnership working and is working hard to create the leadership capacity that will further drive and sustain the performance, productivity and efficiency improvement that is required for recovery. In recent months, assurance has been provided of a strengthened delivery focus and this is starting to pay dividends in some areas. Progress has been made in a number of areas as follows:

- Establishment of a collaborative, joined-up, system governance structure to facilitate shared oversight and ownership of risks, issues, and mitigating actions
- Better engagement with the regional and national teams in seeking operational support in performance and quality areas
- Collaborating effectively with partners to drive improvements in population health
- Positive working with the voluntary, community and social enterprise sector
- The Essex Anchor Network is an example of excellent pan-system/organisation working
- The Stewardship programme is putting clinical leaders at the centre of driving transformational change
- Reduction in the number of patients waiting 78 weeks on a referral to treatment pathway, currently being the best performing system in the region
- The attention and priority given to improving population health and reducing inequalities, specifically the ICB's focus on those most at risk.

Equally, there are always opportunities to improve, and I trust you will embrace the recommendations and steer outlined in this letter. I look forward to seeing ongoing and sustainable progress of a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them. My team and I will continue to work alongside you in the year ahead and we look forward to working with you to support improvement throughout your system, with a focus on the following:

- Delivery of the system financial plan, maximising productivity and efficiency supported by a robust workforce plan
- Reduction in agency and bank costs
- Delivery of cancer standards through sustainable improvements and transformation

- Targeted focus on provider Care Quality Commission areas requiring improvement, especially quality
- Being more stringent in expectations of delivery and performance management with a clear escalation process for contractual issues
- A further review of the governance and structure of the ICB, particularly in relation to performance and the gap in a Chief Operations Officer/Performance role
- Further development of opportunities with non-statutory and voluntary sectors
- An exploration of the potential to increase social prescribing interventions and consider the inclusion of personalisation in Board level reporting.

Finally, I would like to take this opportunity to thank you and your teams for their hard work over the last year. We will continue to work with you in our shared ambition to improve healthcare for the local population and across the system.

I ask that you share my assessment with your leadership team and consider publishing this alongside your annual report at a public meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments in line with our statutory obligations.

MSE Summary - ICB Annual Assessment 23/24 - Draft

ICB	Oversight Segment	System Leadership	Improving Population Health and Healthcare	Tackling Unequal Outcomes, Access and Experience	Enhancing productivity and value for money	Helping the NHS to support broader social and economic development
Mid and South Essex (MSE)		• Strong collaborative leadership on the development and the alignment of the system's strategic and operational plans. • Place-based alliance structure and Integrated Neighbourhood Teams ensure local populations receive services aligned to their needs, with a focus on the Triple Aim. • Ongoing review and development of the system's governance continues. Contract management (NHS and non-NHS) needs to be reviewed and strengthened and the addition of a Chief Operating Officer considered. • There are a large number of system priorities that need to be delivered and whole system support is required to deliver and sustain the targeted improvement.	• The ICB has actively led improvement programmes across the system and focused on adopting the Core20PLUS5 framework, with targeted investment in health inequalities, supporting tools and dashboards. • Progress has been made reducing backlogs in Referral to Treatment and Cancer, improving diagnostic and GP appointments and increasing dementia diagnosis rates, but further work is required to deliver sustainable improvements in Cancer standards. • The ICB is working with community and voluntary, faith and social enterprise sector partners through Alliance Partnerships and as system-wide community assembly. Engagement with public and patients has been strengthened through the new Virtual Views Platform. • The ICB has actively sought help from regional and national teams to improve services and outcomes. • A targeted focus on provider Care Quality Commission areas requiring improvement, especially quality, is required.	• The ICB has exercised its functions consistently as evidenced in the Annual Report and has encouraged its providers to do the same. • During 2023/24 the ICB developed an integrated health and care data set. This data set drives a segmentation tool and provides insights on where health inequalities exist at Alliance and Primary Care Network level. This informs ICB focus and activities to close the identified gaps.	• The system has supported innovators and evaluates and adopts innovations at a local and national level. • The ICB recognises that continued focus on financial grip and control and further system collaboration is needed to manage £79.8m of net risks and £154.8m of efficiency savings in the 2024/25 financial plan. • The ICB needs to continue to lead the system approach to improve productivity and protect performance whilst maximising value for money and reducing temporary staff costs. • Better triangulation of workforce, activity and financial information will be essential to achieving this.	• There are positive examples of the ICB working closely with the whole system to develop and deliver wider strategic priorities. • The ICB contributes to the wider social and economic development through the Anchor Programme, which promotes; workforce opportunities, ensuring high standards in procurements, making better use of resources, and developing the system's Greener NHS Plan.

Part I ICB Board Meeting, 12 September 2024

Agenda Number: 10

Quality Report

Summary Report

1. **Purpose of Report**

   The purpose of this report is to provide the Board with a summary of the key quality and patient safety issues, risks, escalations, and actions being taken for assurance.

2. **Executive Lead and Report Author**

   Dr Giles Thorpe, Executive Chief Nursing Officer.

3. **Responsible Committees**

   ICB Quality Committee.
   ICB System Quality Group.

4. **Impact Assessments**

   No impact assessments were discussed at either Committee or Group.

5. **Financial Implications**

   Not required for this report.

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

   Not required for this report.

7. **Conflicts of Interest**

   None identified.

8. **Recommendations**

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

Quality Report

1. Introduction

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

1.2 The Quality Committee met on 28 June 2024, with an update provided in the report below. In addition, the report will alert the Board to maternity services. No System Quality Group meetings were held since the last Board meeting.

2. Quality Committee – 28 June 2024

Special Educations Needs and Disabilities (SEND)

2.1 A presentation was shared with committee members focussing on the oversight of the SEND system in Mid and South Essex (MSE), including any emerging issues. It was noted that the ICB had been working with Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWE) ICBs to prepare for an Ofsted inspection in Essex, and to agree the joint vision for SEND. This vision aligns with the Southend, Essex and Thurrock (SET) Local Authority SEND strategies focussing on inclusion, equity and an ambition to ensure that the voices of children and young people (CYP), and their families are listened to.

2.2 A main area of focus was providing support to children awaiting an assessment and their families/carers. Three community health providers have worked to provide resources and tools, including the online Kids Autism Hub, to support young people awaiting an assessment. A sensory toolkit for teachers and support staff across SET local authority areas was also in place. Within MSE particularly, 'My Care Bridge' had been implemented to parents' expectations when waiting diagnosis, and resources for ongoing support. Parent/carer forums were also involved in workstreams within the SEND system to ensure that the voices of CYP and families are heard.

2.3 One area to be developed further was how to communicate service availability to families. There were significant challenges/risks in the system, including increased demand (significant increases in requests for assessment) and complexity of presentations, versus limited capacity in both health and social care, leading to increasingly long waiting times. An ongoing plan of work is underway, in partnership with the local authorities to minimise the backlog as quickly as possible through close working with the MSE Community Collaborative and other providers.

Babies Children and Young People (BCYP) Update

2.4 The Committee also received an update from the BCYP commissioning team in relation to activities being undertaken to assure the provision of service across MSE. Key programmes of work shared included:

- Mental Health – including further development of mental health in schools' teams (MHSTs) and CYP counselling services.

- Urgent and Emergency Care – expanding youth workers in A&E.
- Children and Young People Community Collaborative development
  - Development of a single collaborative offer for CYP community services to minimise place-based inequalities.
  - Implement the Initial Health Assessment (IHAs) for looked after children action plan to reduce waiting times and work in partnership with local authorities and providers to address the backlog position.
- Long Term Conditions oversight and service provision – with a focus on CYP CORE20PLUS5 conditions.
- Neurodevelopmental – a continued focus on Attention Deficit Hyperactive Disorder (ADHD) and Autism Spectrum Disorder (ASD) services.
- Support for children and young people with Learning Disabilities – through Essex County Council via Section 75 arrangements. A clear focus on reducing reliance on inpatient mental health settings and that people 14 years of age and over on the GP Learning Disability Register receive annual health checks.

2.5 The committee were also advised of the strengthened governance arrangements within the ICB for Children and Young People, via the MSE Growing Well Programme Board, which has reset its focus on oversight and assurance of the delivery of the ICB's CYP programme, in line with local, regional, and national strategies. The Board will now be chaired by the ICB's Executive Chief Nursing Officer.

2.6 In addition, to ensure that the voices of professionals and clinicians working with CYP are heard the BCYP Clinical Engagement Group (CEG) will be re-established. The focus will be to maximise clinical engagement in decision-making and for any proposals for service change and commissioning. This will be chaired by the BCYP Clinical Lead in the ICB.

Quality Accounts

2.7 The Quality Committee fulfilled its function by ratifying the ICB's responses to the 11 Quality Accounts received into the Nursing and Quality Directorate, which were signed by the ICB's Executive Chief Nursing Officer. This thereby has ensured that the ICB has fulfilled its assumed responsibilities for the review and scrutiny of quality accounts.

3. Quality Committee – 30 August 2024 – matter arising

Initial Health Assessments for Looked After Children

3.1 The Quality Committee received the Children and Young People's Safeguarding Report which has highlighted an ongoing risk in relation to providing Initial Health Assessments (IHAs) within the statutory timescales. MSE ICB is the commissioner of this service across providers for the system.

3.2 Regulation 7 of the Care Planning, Placement, and Case Review (England) Regulations (2010) states that IHAs 'must be done by a registered medical practitioner'. There are insufficient appropriately trained registered medical practitioners available to undertake IHAs within MSE, meaning that the statutory timescales for IHA completion (20 days) is only being achieved in 5% of cases.

Demand for IHAs continues to increase, and despite close partnership working between local authorities, community providers and the ICB, the position is not improving.

3.3 The Executive Chief Nursing Officer of the ICB has raised this concern to regional and national colleagues. Whilst the Royal College of Nursing and the Royal College of Paediatrics and Child Health both support other healthcare practitioners undertaking IHAs, if they are appropriately trained, the legal position has not changed. Therefore, to allow other practitioners to do undertake these assessments, the ICB would be condoning a legal breach.

3.4 For children who are placed out of the MSE system, it has been noted that other systems have accepted this risk to allow other healthcare professionals to undertake assessments. However, these cannot be legally recognised as valid, and therefore the MSE Safeguarding Team are working with partners to ensure that any 'out of area' child who is identified as having an IHA completed, confirms that this has been completed by a registered medical practitioner.

3.5 MSE ICB continue to lobby NHS England to raise this ongoing risk with the Department of Health and Social Care, and to liaise with the Department for Education under which the legislation sits.

4. Maternity Services

Section 31 Notice – Basildon Hospital

4.1 Mid and South Essex NHS Foundation Trust (MSEFT) has received communication from the Care Quality Commission (CQC) of a 'notice of proposal' to remove the section 31 conditions on license for maternity services at Broomfield Hospital. Formal confirmation is expected within the coming weeks.

Section 31 Notice – Broomfield Hospital re-inspection

4.2 The re-inspection of Broomfield Hospital maternity services, post implementation of section 31 conditions on license, has been concluded. During initial feedback no immediate safety concerns were noted, and areas of improvement had been identified against previous areas highlighted. A formal report is awaited from CQC for factual accuracy checking, and the ICB will support the Trust in its ongoing liaison and improvement plans on this site.

Local Maternity and Neonatal Safety Board (LMNSB)

4.3 The LMNSB last met on 30 July 2024, where a deep dive into the experience of women and pregnant people from the Global Majority (formerly referenced as Black, Asian and Minority Ethnic (BAME)), was shared by the Ethnic Community Leads from the Maternity and Neonatal Voices Partnership (MNVP). Key issues identified from these community groups were:

- Patient Medical Conditions – the need to ensure awareness and understanding of individual medical histories.
- Compassionate and culturally/religious sensitive care – providing respectful and culturally aware support.

- Pain management – enhancing pain relief options and communications about their use.
- Racism and implicit biases – addressing and mitigating biases in medical care.
- Follow-up feedback – the importance of gathering detailed feedback on labour and postnatal care experiences to minimise future trauma.
- Improving health literacy for non-English speaking women and pregnant people.

4.4 The MNVP continue to work closely with MSEFT in developing actions to support women and pregnant people engage more closely with services, and education for clinical teams in understanding specific sensitivities, fears and worries to create a more inclusive and supportive culture.

5. Recommendation

The Board is requested to note the content of the Quality report and seek any further assurances required.

Part I Board Meeting,12 September 2024

Agenda Number: 11

Month 4 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the financial performance of the ICB to-date and offer a broader perspective across partners in the Mid & South Essex system (period ending 31 July 2024).

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

2. Executive Lead

Jennifer Kearton – Chief Finance Officer.

Report Author

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

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance & Performance Committee on 3 September 2024.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to receive this report for information.

Finance & Performance Report

1. Introduction

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

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

2. Key Points

2.1 Month 4 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB, has increased by £20.4m of anticipated allocation.

Table 1 – Allocation movements between month 3 and month 4

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
Recurrent	Programme	2,217.09	2,217.03	0.06
	Delegated - Specialised	279.92	279.92	0.00
	Co-Comm	220.21	220.21	0.00
	Delegated - DOP	104.47	104.47	0.00
	Running Costs	19.88	19.88	0.00
	Total	**2,841.56**	**2,841.50**	**0.06**
Non-Recurrent	Programme	98.61	78.86	19.75
	Delegated - DOP	2.34	1.75	0.59
	Delegated - Specialised	(51.03)	(51.03)	0.00
	Total	**49.92**	**29.57**	**20.34**
Total		**2,891.47**	**2,871.07**	**20.40**

The ICB has a small forecast variance at month 4 relating to additional unplanned work in respect of financial recovery. For M5 the position will return to breakeven as the cost of delivery is expected to be covered from efficiencies delivered by the programme.

Our year-to-date position reflects the risks identified across continuing health care and discharge to assess, materialising and impacting our ability to stay on plan at month 4. The ICB has an efficiency plan in this area and has redirected resource into supporting the mitigation of both the operational and financial impacts.

We are recognising further year to date pressures across high-cost drugs and primary care with further action required in these areas to bring them back into line with plan.

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

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

Table 2 – summary of the position against the revenue resource limit for month 4.

Summary of ICB Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m	Full Year Variance Mth on Mth Change £m
Allocation	(975.91)	(975.91)	(0.00)	0.00	(2,892.17)	(2,892.17)	(0.00)	(0.00)
Acute	466.86	466.77	0.09	0.62	1,374.41	1,376.49	(2.09)	(0.06)
Community Health Services	78.87	79.04	(0.16)	(0.17)	232.46	232.84	(0.38)	(0.38)
Continuing Care	52.94	55.87	(2.93)	(1.02)	158.82	170.93	(12.11)	(5.73)
Mental Health	89.58	88.65	0.93	0.91	272.33	271.37	0.96	0.26
Other Commissioned Services	1.50	1.54	(0.05)	(2.35)	4.49	(10.76)	15.25	6.84
Other Programme Services	6.24	6.19	0.05	0.03	18.57	19.16	(0.59)	(0.59)
Primary Care	193.50	194.03	(0.53)	(0.36)	580.54	581.59	(1.05)	(0.35)
Programme Reserve & Contingency	0.00	0.00	0.00	(0.00)	2.29	2.29	(0.00)	(0.00)
Specialised Commissioning	79.89	79.89	(0.00)	(0.00)	228.89	228.89	(0.00)	(0.00)
Corporate	6.41	6.38	0.02	(0.25)	18.99	19.17	(0.19)	(0.25)
Hosted Services Admin	0.13	0.15	(0.02)	(0.01)	0.39	0.45	(0.06)	0.00
Total	**(0.00)**	**2.60**	**(2.60)**	**(2.60)**	**(0.00)**	**0.25**	**(0.25)**	**(0.25)**

2.2 ICB Finance Report Conclusion

The ICB is beginning show divergence from plan at month 4, we understand the drivers for the challenge and are taking deliberate steps to mitigate. The Finance and Performance committee will continue to receive deep dive reports on progress across these areas with escalation to the System Oversight Assurance Committee and the ICB Board.

2.3 Month 4 System Financial Performance

At month 4 the overall health system position is a deficit of £62.3m. This position is off plan by £16.2m.

Table 3 – summary of the System position against the revenue resource limit for month 4.

Organisation	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m	FY F/Cast £m	FY Variance £m
⊟ ICB						
Allocation	975.91	975.91	0.00	2,892.2	2,892.17	0.00
Expenditure	(975.91)	(978.51)	(2.60)	(2,892.2)	(2,892.42)	(0.25)
⊟ Provider						
Income	668.67	673.83	5.15	2,014.2	2,014.24	0.00
Non-OP Expenditure	(15.55)	(14.46)	1.09	(46.5)	(46.48)	0.00
Expenditure	(699.26)	(719.07)	(19.82)	(2,063.5)	(2,063.45)	0.00
Total	**(46.13)**	**(62.31)**	**(16.18)**	**(95.7)**	**(95.95)**	**(0.25)**

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

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

2.4 System Efficiency Position

At month 4 the system has delivered £27.4m of efficiencies against a year-to-date plan of £36.8m reflecting the revised planning submission made to NHS England in June 2024. The system is still forecasting delivery of the full requirement of £167.8m.

Our overall financial position is dependent on the delivery of efficiencies and the system is collectively working together to redirect resource to the areas of greatest need and return in order to bring the efficiency position rapidly back on track.

2.5 System Capital Position

The forecast capital spend for the system is £133.2m, £4.7m below plan due to EPR spend being re-phased. Our actual spend year to date is £19.3m against a planned position of £21.3m. It is expected that delivery will gain pace throughout the year and prioritised capital commitments will be fulfilled.

Table 4 – Capital Spend Summary

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
Externally Financed						
MSEFT	7.86	6.16	1.71	72.85	73.30	(0.45)
EPUT	3.24	2.48	0.76	14.46	9.27	5.18
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	**11.10**	**8.63**	**2.47**	**87.30**	**82.57**	**4.73**
Internally Financed/System CDEL						
MSEFT	7.55	8.11	(0.56)	38.73	38.73	0.00
EPUT	2.24	2.08	0.16	9.92	9.92	0.00
ICB	0.40	0.52	(0.12)	1.99	1.99	0.00
Total	**10.19**	**10.71**	**(0.52)**	**50.64**	**50.64**	**0.00**
Total	**21.29**	**19.34**	**1.95**	**137.94**	**133.21**	**4.73**

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
ICB - Potential new IFRS 16 leases						
ICB	5.00	0.00	5.00	20.00	20.00	0.00
Total	**5.00**	**0.00**	**5.00**	**20.00**	**20.00**	**0.00**

2.6 System Finance Report Conclusion

At month 4 the system is working toward its agreed planned year end position of a £96m deficit.

The system is focused on delivering its Operating Plan for 2024/25, ensuring financial efficiencies are delivered whilst mitigating any potential risks to the plan in year.

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

2.7 Urgent and Emergency Care (UEC) Performance

The UEC Strategic Board oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS111, A&E, Urgent Community Response Team (UCRT), Mental Health Emergency Department (ED) and has members from both health and social care.

The MSE 2024/25 Operational Plan is to meet the national ask of >=78% of patients will have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge in March 2025.

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

Ambulance Response Times

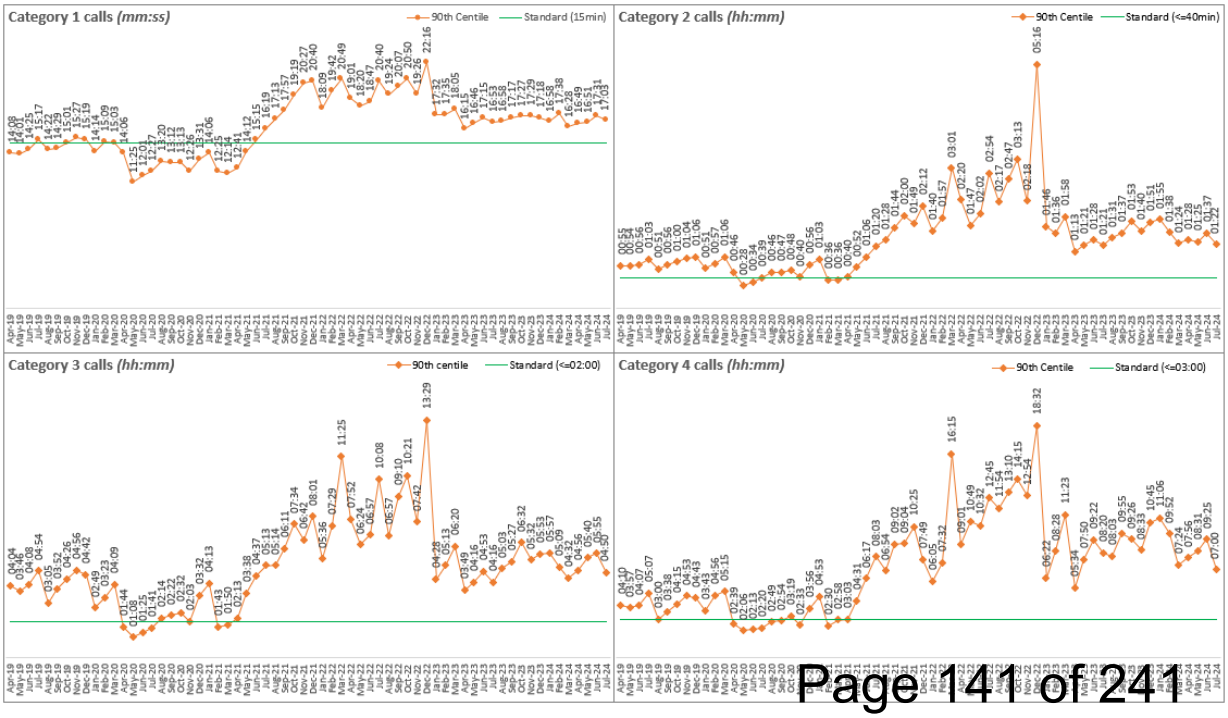
Standards:

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

East of England Ambulance Service
90th Centile Response Time by call category for rolling 12 months
Please note: response times:
- Green where meeting standard
- Red where not meeting standard

Call Category	Standard	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Category 1 Calls MM:SS	<= 15min	00:16:58	00:17:17	00:17:27	00:17:29	00:17:18	00:16:58	00:17:38	00:16:28	00:16:49	00:16:51	00:17:31	00:17:03
Category 2 Calls HH:MM	<= 40min	01:31:02	01:37:54	01:53:22	01:40:03	01:51:43	01:55:17	01:38:19	01:24:10	01:28:06	01:25:57	01:37:43	01:22:33
Category 3 Calls HH:MM	<= 02:00:00	05:03:23	05:27:18	06:32:07	05:32:03	05:53:50	05:57:39	05:09:33	04:32:13	04:56:03	05:40:22	05:55:02	04:50:42
Category 4 Calls HH:MM	<= 03:00:00	08:03:34	09:55:23	09:26:17	08:33:54	10:45:25	11:06:28	09:52:04	07:24:13	07:56:42	08:31:59	09:25:15	07:00:12

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

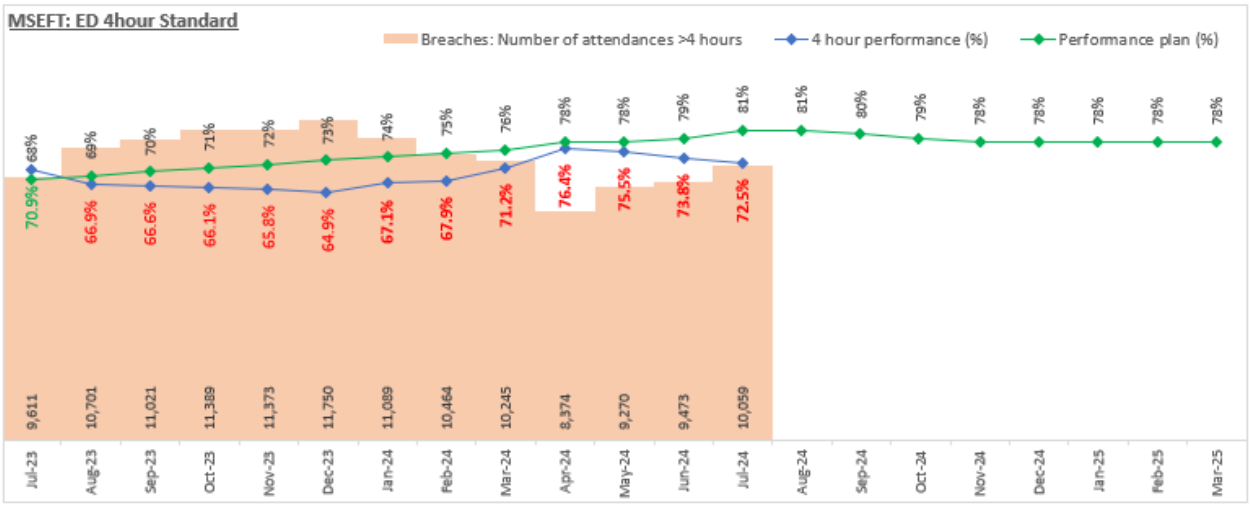


Emergency Department – waiting times

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

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

The MSEFT A&E performance to date for April to July 2024 is shown in the table below, the July 2024 achievement of 72.5% remains below the Operational Plan of 81%. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

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

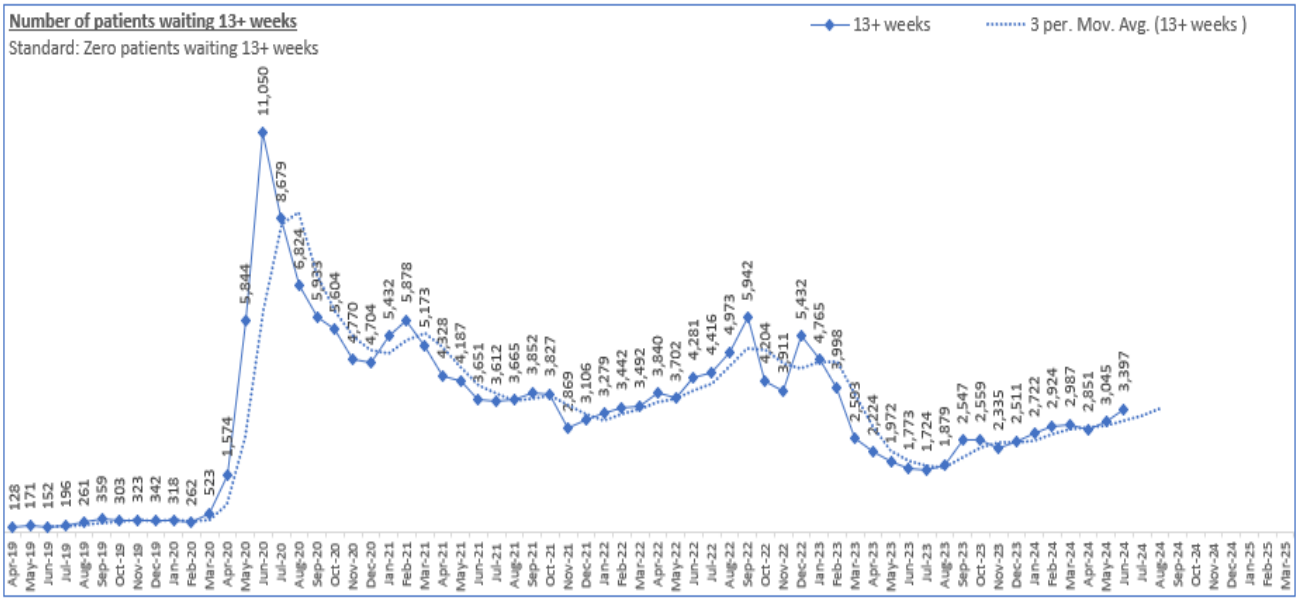
Our current performance is below the targeted national standard as set out below.

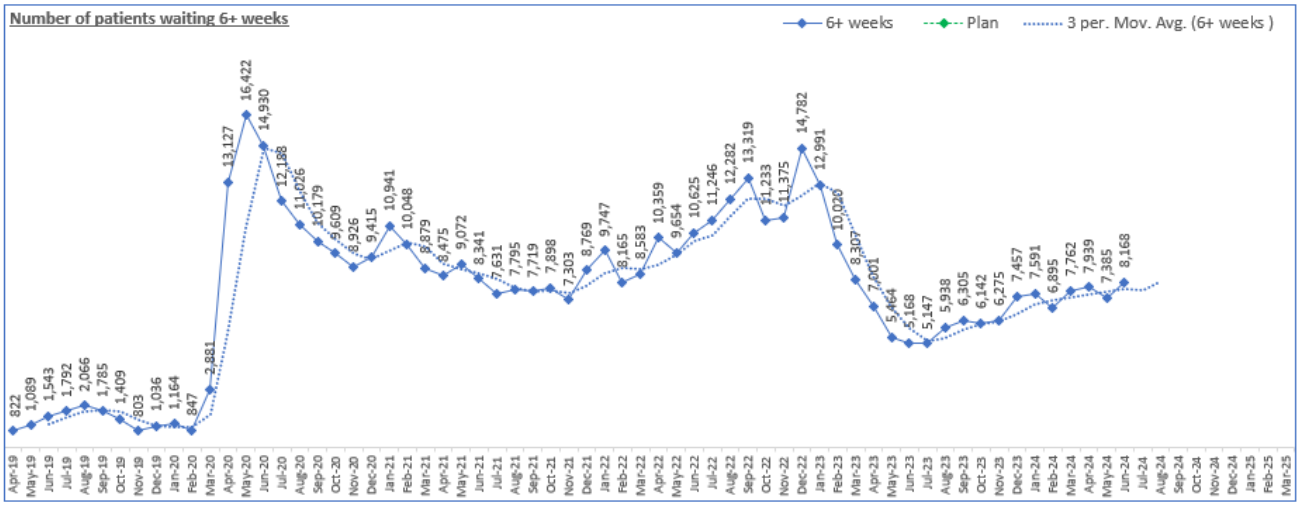
Diagnostics Waiting Times

Standard

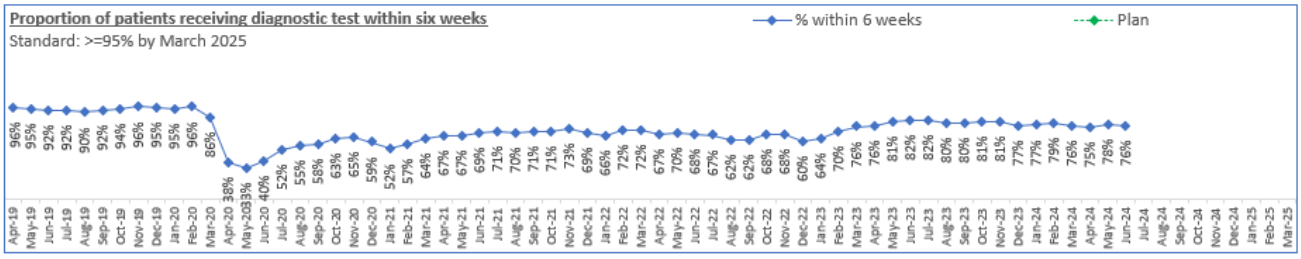
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

The below tables show the total number of Mid and South Essex residents waiting 13+ and 6+ weeks across all providers June 2024.





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



At June 2024, 3,397 people waited over 13 weeks (standard: zero) and 76% of all people waiting for their diagnostic test were seen within six weeks (standard: >=95%).

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

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

Mid and South Essex: Diagnostic DM01 waiting list summary for Jun-24		
Diagnostics		Number of patients waiting 13+ weeks Standard: 0
Test		Total
Imaging	Barium Enema	1
	CT	23
	DEXA Scan	43
	MRI	80
	Non-Obstetric Ultrasound	1,326
Physiological Measurement	Audiology Assessments	25
	Cardiology Echocardiography	990
	Peripheral Neurophysiology	187
	Respiratory Physiology Sleep Studies	43
	Urodynamics - Pressures & Flows	8
Endoscopy	Colonoscopy	299
	Cystoscopy	47
	Flexi sigmoidoscopy	87
	Gastroscopy	237

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

Mid and South Essex: Diagnostic DM01 waiting list summary for Jun-24		
Diagnostics		Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%
Test		Total
Imaging	Barium Enema	87.5% (3)
	CT	91.9% (268)
	DEXA Scan	85.1% (179)
	MRI	86.3% (671)
	Non-Obstetric Ultrasound	80.1% (2,617)
Physiological Measurement	Audiology Assessments	90.1% (112)
	Cardiology Echocardiography	49.5% (2,660)
	Peripheral Neurophysiology	44.3% (290)
	Respiratory Physiology Sleep Studies	71.4% (186)
	Urodynamics - Pressures & Flows	75.3% (20)
Endoscopy	Colonoscopy	70.4% (524)
	Cystoscopy	72.5% (72)
	Flexi sigmoidoscopy	65.5% (152)
	Gastroscopy	73% (413)

Cancer Waiting Times

Standards: For people with suspected cancer:

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

The waiting times for patients on a cancer pathway remain below the NHS

constitutional standard. The tables below reflect the NHS Constitution and 2024/25 operational planning requirements.

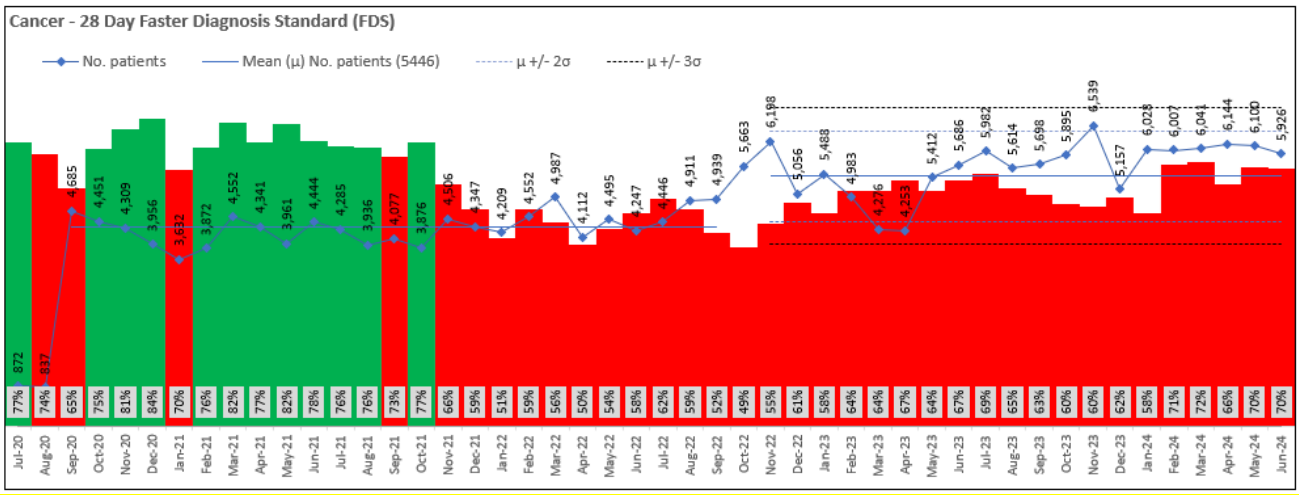
The following table shows the latest MSEFT position (June 2024) for each of the waiting time standards by specialty.

Tumour Site	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day general standard	62 day standard (Urgent Suspected Cancer)	62 day standard (Screening)	62 day standard (Upgrade)	62 day standard (Symptomatic Breast)
	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=85%)	Standard (>=90%)		Standard (>=85%)
Total	**70.0%**	**77.8%**	**92.4%**	**61.0%**	**51.5%**	**43.9%**	**36.6%**	**47.1%**	**61.6%**	**100.0%**
Acute leukaemia		100.0%				100.0%			100.0%	
Brain/Central Nervous System	71.4%	100.0%				100.0%			100.0%	
Breast	85.8%	72.6%				48.1%	35.4%	63.6%	70.0%	100.0%
Children's	96.2%									
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	91.8%									
Gynaecological	62.8%	63.2%				24.2%	0.0%	50.0%	50.0%	
Haematological	41.7%	96.2%				45.0%	50.0%		33.3%	
Head & Neck	58.9%	75.0%				50.0%	40.0%		100.0%	
Lower Gastrointestinal	49.2%	71.4%				39.2%	46.2%	0.0%	36.8%	
Lung	85.9%	94.1%				44.6%	25.0%	0.0%	58.0%	
Other	0.0%	66.7%				50.0%	50.0%			
Sarcoma		100.0%								
Skin	76.8%	74.7%				50.0%	48.0%		69.2%	
Testicular	65.0%	100.0%				100.0%	100.0%			
Upper Gastrointestinal	74.5%	100.0%				70.7%	40.0%		88.5%	
Urological	50.8%	73.8%				33.2%	26.9%		54.5%	

The following table benchmarks the performance to all trusts nationally.

Pathway	Standard	Metric	Mar-24	Apr-24	May-24	Jun-24
28 Day Faster Diagnosis Standard	>=75%	Performance %	72.0%	66.0%	70.4%	70.0%
		Rank (1= highest)	121	130	123	123
		No. of Trusts	141	144	142	140
31 Day First Treatment	>=96%	Performance %	80.3%	82.4%	82.4%	77.8%
		Rank (1= highest)	136	125	135	136
		No. of Trusts	139	139	140	138
31 Day Subsequent Treatment: Drug Treatments	>=98%	Performance %	94.9%	85.8%	90.4%	92.4%
		Rank (1= highest)	105	119	116	102
		No. of Trusts	122	121	121	120
31 Day Subsequent Treatment: Radiotherapy Treatments	>=94%	Performance %	57.3%	60.4%	51.4%	61.0%
		Rank (1= highest)	58	58	61	54
		No. of Trusts	60	66	63	58
31 Day Subsequent Treatment: Surgery	>=94%	Performance %	45.1%	58.4%	57.4%	51.5%
		Rank (1= highest)	131	120	123	129
		No. of Trusts	133	133	131	131
62 Day General Standard	>=85%	Performance %	48.0%	51.1%	45.6%	43.9%
		Rank (1= highest)	136	133	141	138
		No. of Trusts	145	149	149	149
62 Day Standard (Urgent Suspected Cancer)	>=85%	Performance %	40.2%	44.9%	37.2%	36.6%
		Rank (1= highest)	130	124	134	133
		No. of Trusts	138	139	139	142
62 Day Standard (Screening)	>=90%	Performance %	82.4%	51.9%	50.6%	47.1%
		Rank (1= highest)	46	94	97	104
		No. of Trusts	125	122	124	126
62 Day Standard (Upgrade)	N/A	Performance %	66.7%	67.4%	68.9%	61.6%
		Rank (1= highest)	124	117	114	130
		No. of Trusts	142	145	143	140
62 Day Standard (Symptomatic Breast)	>=85%	Performance %	100.0%	-	-	100.0%
		Rank (1= highest)	1	-	-	1
		No. of Trusts	63	56	72	61

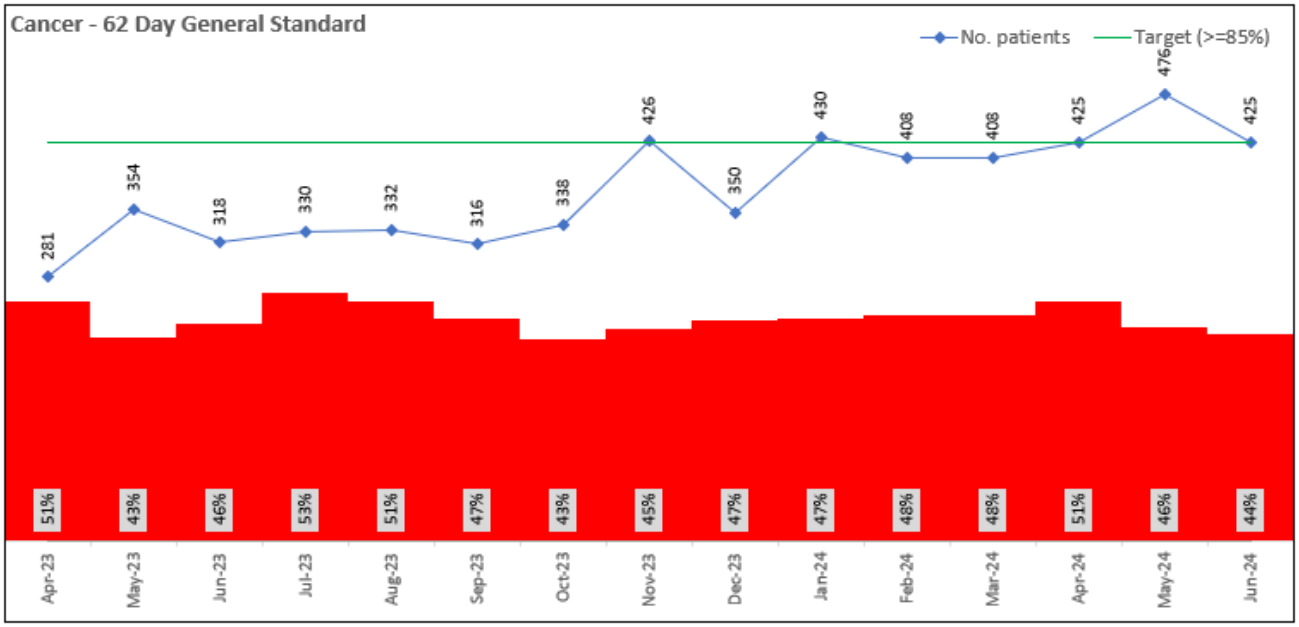
The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard and the number of patients. For June 2024 performance was 70%. The 2024/25 priorities and Operational Planning guidance requires performance of 77% by March 2025. MSEFT intention is to achieve 77% from September 2024.



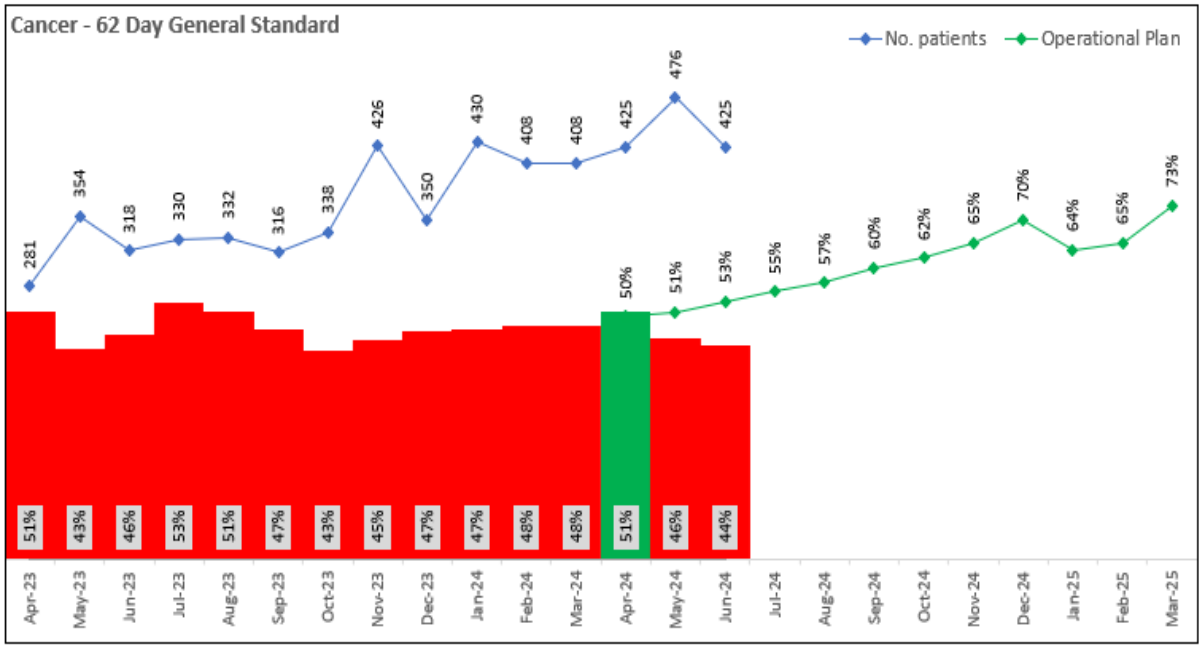
The following graph shows the 62-day general standard performance. The June 2024 performance was 44%. MSEFT plan to meet the 2024/25 Operational Planning guidance ask to improve performance to >= 70% by March 2025. With the Constitutional requirement to achieve 85%.

The reporting of this standard changed to include urgent suspected cancer, Breast Symptomatic, Screening and Consultant Upgrade, MSEFT achieved 43.9% in June 2024. The below graph shows achievement against Constitutional Cancer Standard of >85%.

The Trust is in national oversight Tier 1 for Cancer.



The below table shows Operational Plan requirement of >70% by March 2025, and the MSEFT delivery against plan at June 2024:



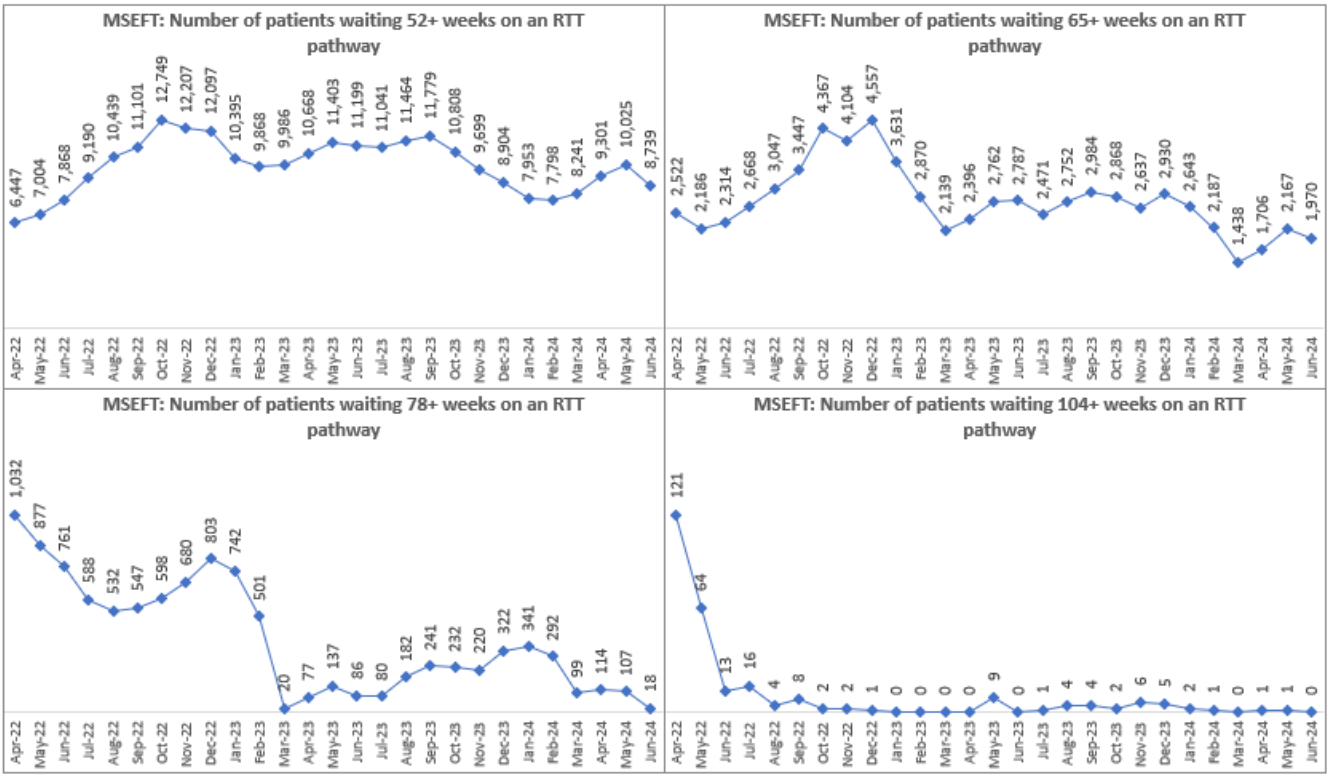
Referral to Treatment (RTT) Waiting Times

Standards:

- The constitutional standard is starting consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Since the significant increase in waiting times following the global pandemic the NHS is working to eliminate waits of over 65 weeks by September 2024 as outlined in the 2024/25 Operational Planning guidance.

As at June 2024, there was the following number of patients were on a RTT pathway:

- 0 patients waiting 104+ weeks
- 18 patients waiting 78+ weeks.
- 1,970 patients waiting 65+ weeks
- 8,739 patients waiting 52+ weeks



The system plan is to have zero people waiting over 65 weeks by September 2024.

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

Specialty	Total waiting list size	Average (median) waiting time in weeks	92nd percentile waiting time in weeks	Total number of patients waiting 52 plus weeks	Total number of patients waiting 65 plus weeks	Total number of patients waiting 78 plus weeks
Total	**168,040**	**17**	**47**	**8,739**	**1,970**	**18**
General Surgery	8,770	20	47	427	89	0
Urology	9,481	17	45	347	86	0
Trauma and Orthopaedic	16,255	20	53	1,379	364	1
Ear Nose and Throat	14,722	22	56	1,613	313	2
Ophthalmology	13,613	17	48	766	75	0
Oral Surgery	4,889	30	60	838	210	8
Neurosurgical	92	19	48	5	2	0
Plastic Surgery	5,314	16	52	434	161	7
Cardiothoracic Surgery	16	-	-	0	0	0
General Internal Medicine	1,866	10	33	13	3	0
Gastroenterology	9,595	16	46	468	134	0
Cardiology	11,997	15	40	230	33	0
Dermatology	11,360	17	46	152	2	0
Respiratory Medicine	5,049	13	33	13	1	0
Neurology	5,577	18	42	212	67	0
Rheumatology	2,818	13	38	35	1	0
Elderly Medicine	823	8	29	0	0	0
Gynaecology	12,446	17	42	384	52	0
Other - Medical Services	17,003	13	42	521	134	0
Other - Mental Health Services	0	-	-	0	0	0
Other - Paediatric Services	4,399	20	53	376	95	0
Other - Surgical Services	7,400	15	50	473	141	0
Other - Other Services	4,555	8	37	53	7	0

The system Elective Oversight and Assurance Committee oversees RTT delivery for MSEFT, Independent Sector, Community (RTT services) and Tier 2.

2.9 Mental Health

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

Improving access to psychology therapies (IAPT)

Standards include:

- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.

This standard is being sustainably achieved across Mid and South Essex (latest position: June 2024).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across Mid and South Essex (latest position: June 2024).

3.0 System Performance Report Conclusion

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

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

4.0 Recommendation

The Board is asked to receive this report for information.

Part I ICB Board Meeting, 12 September 2024

Agenda Number: 12

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

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

3. Report Author

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

4. Responsible Committees

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

5. Impact Assessments

Not applicable

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to note this update.

Primary Care and Alliance Report

1. Main content of Report

Primary Care – General Practice

The British Medical Association (BMA) confirmed that their members have voted in favour of Collective Action. The Primary Care Team have been supporting the wider ICS to understand the impact of this.

NHS England have announced a number of contract changes for 24/25 including an uplift on the pay elements of the GP contract by 6% and the introduction of Additional Roles Reimbursement Scheme (ARRS) funding for newly qualified GPs.

The Connected Pathways team have made significant progress in the implementation of the Primary Care Access Recovery Programme. All areas of the plan have been progressed since it was approved by the Board in November 2023. Cloud Based Telephony has been rolled out or install dates agreed for all phase 1 practices and the majority of phase 2 practices. The ICB has supported practices to access an increased range of digital tools to support workflow and workload management. Most recently, this has included the funding of Accurx.

Primary Care – Pharmacy

The Primary Care Commissioning Committee have approved the funding of 24 community pharmacy PCN engagement leads. This expands upon an existing pilot with six leads. The aim of this is enhance the role that Community Pharmacies play within Integrated Community Teams.

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

Primary Care – Dentistry

The Primary Care Commissioning Committee has approved a decision to deliver up to 110% of contracted values in 2024/25. This will support improvements to access to dental care locally.

The Primary Care Commissioning Committee received a comprehensive presentation on the impact and outcomes of the nursing home pilot.

A proposal to deliver a pilot Children and Young Peoples dental access service was approved by the PCCC and Finance and Performance Committee. This will commence in the autumn.

Focus of Alliance Teams

The Alliance Teams have continued to prioritise a number ICB wide initiatives alongside the implementation of Integrated Neighbourhood Teams (INTs).

All four INTs in Thurrock are now live. Alongside this, Thurrock is leading the ICB's response to the Lampard Inquiry and the Community Diagnostic Programme.

Basildon and Brentwood have recently commissioned a report on Social Prescribing and how it can be optimised and a more consistent offer provided to the local population. The INTs in Basildon and Brentwood are currently reviewing high intensity users across health and social care. Team members are supporting a number of Financial Recovery Schemes including Musculo-skeletal (MSK) and diabetes services.

The Mid Essex Alliance are working with Local Authority Partners on the delivery of "Thriving Places". Mid Essex have also led a number of ICB wide Community Commissioning Financial Recovery Schemes.

South-East Alliance have supported the development of an Alliance wide Delivery Plan (2024-26) to deliver activity to improve outcomes and contribute to the financial position of the ICS and system recovery programme. To support this, the Alliance continues to lead on ICS system improvements to unplanned care and flow.

Better Care Fund (BCF)

All BCFs for 2024/25 have been approved through their respective governance processes. An MSE wide BCF quarterly review meeting has been held in order to share best practice/learning. The ICB's discharge fund remains on course to be fully utilised in 24/25.

Transfer of Care Hubs

Standard Operating Procedures have been updated to reflect best practice ways of working. Each hub is sharing learning to improve effectiveness and outcomes.

A data set is being collected to review the effectiveness of pathways. It is too early to draw conclusions from this data.

2. Recommendation(s)

The Board is asked to note the Primary Care and Alliance update report.

3. Appendices

Appendix 1 - MSE ICB Primary Care and Alliances Highlight Report July 2024

NHS
Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight Report

September 2024

www.midandsouthessex.ics.nhs.uk

Primary Care - General Practice

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

Overall Summary

-BMA Collective Action

- *At the end of July 24, the BMA announced that their members had voted in favour of Collective Action to seek to address the workload demands on primary care, shift of work from other parts of the systems and the level of resourcing invested in primary care services.*
- *The ICB has worked with system partners to understand what actions are being taken forward by general practice (the BMA published a range of potential actions practices could undertake). The initial impact has been limited but is expected to increase over time.*
- *The ICB has been contacted by practices and system partners on a range of issues including whether provision of certain interventions is within GMS contract requirements, the potential to not follow referral protocols/processes locally and referring activity that may have traditionally been picked up in general practice. These issues are being worked through on a case by case basis.*
- *The ICB meet regularly with the LMC to discuss local issues.*

-Contract Updates

- *In early August, NHS England confirmed changes to the GP contract in 24/25. This includes a 6% uplift in the pay elements of the GP contract (4% on top of the 2% already confirmed) and confirmation that ARRS roles will be extended by October 24 to include the employment of newly qualified GPs (roles that had previously been excluded from ARRS resources),*

-Financial Recovery Programme

- *The Primary Care Team are continuing to make progress on Financial Recovery Programme schemes including a review of APMS project, a review of Local Primary Care Schemes and NHS Property Service arrangements.*

-Emerging GP Primary Care Collaborative

- *The ICB have supported local representatives in the process for establishing the GP Primary Care Collaborative. The GP Primary Care Collaborative led the process for the suspension of iRefer due to concerns relating to the lack of interoperability with other clinical systems in primary care. Solutions are being worked through and there is a desire to reinstate the functionality when the interoperability issues are resolved.*

Primary Care – Access Recovery Programme/Connected Pathways

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

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 – All Phase 1 practices have now had their solution installed or have an install date booked. Phase 2 – 37 practices identified. The majority have contracts signed off for additional provision.	On Track
Communication of Modern General Practice and various aspects of the Recovery Plan to stakeholders	Comms plan for public and key stakeholders defined and agreed. Brief is out with agencies. Launch plan will be collated once agency appointment made. Dedicated area within the MSE ICB Primary Care Hub page for PCARP now live and promoted to practices via Alliance PM meetings.	On Track
Digital Tools – supporting implementation of Modern General Practice through digital tools	Internal and external processes completed to deliver Accurx Gold + Bookings and contract has been implemented and is live. Contract is until March 2025 with a one-year extension pending NHSE funding decision 2025-26. E-Consult and Patches contract in place until March 25 iPlato contract has ended	On Track
Pharmacy/Dental/Optom - strengthen the role of other primary care services to help manage patient need	Vast majority of community pharmacies now delivering Pharmacy First. Community Optometry Services being further promoted to practices/PCNs including self referral pathways. Dental access pilot now fully integrated into 111	On Track
Self Referral Pathways – By March 24 we will establish at least 10 self referral pathways	11 Self Referral pathways are now available to all patients across MSE. Further opportunities being scoped.	Completed
Total Triage – By March 24 5 practices will have implemented a total triage model in line with Modern General Practice	57 Applications for Transitional Funding reviewed (up from 47 in previous report). Further support being provided by Connected Pathways team where not approved. Total Triage lunch and learn undertaken. Promoting GPIP programme	On Track

Primary Care – Community Pharmacy & Optometry

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

Community Pharmacy

The Primary Care Commissioning Committee approved the funding of 24 Community Pharmacy PCN Engagement Leads across the MSE. This expands upon an existing pilot of six leads and aims to enhance the role community pharmacy play within Integrated Neighbourhood Teams. This initiative is being funded from Community Pharmacy Integration Money and delivered in conjunction with Essex Local Pharmaceutical Committee's provider arm "Healthy Living Partnership".
NHS England have announced that they have finalised arrangements to roll out electronic prescribing for the Community Pharmacy Independent Prescribing Pathfinder sites. Three out of our four community pharmacy pathfinder sites are live and using paper prescriptions; the fourth pharmacy should be going live with paper prescriptions shortly. The pharmacies will transition to electronic prescribing in due course as part of the NHS England led roll out.
Community pharmacies across MSE are now carrying out around 8,000 Pharmacy First consultations per month. In July 2024 559 patients used the Community Pharmacy contraceptive service and over 4000 patients had their blood pressure checked with a further 160 using the 24-hour blood pressure monitoring service.

Community Optometry

The Primary Care Commissioning Committee received an update from the Local Optometry Committee lead and primary care team on the development of Optometry services locally.

The Optometry Team hosted by Herts and West Essex ICB continue to provide a comprehensive contract management function on behalf of all ICBs in the East of England.

Optometry continues to play an important role in the wider transformation of ophthalmology services across Mid and South Essex. The Connected Pathways Team are working closely with the LOC to try and better promote the pathways available to patients (many of which are available via self referral).

The Primary Care Commissioning Committee are seeking to resolve a current pathway issue in regards to enabling independent prescribers to prescribe without the need to refer patients back to their GP or the Hospital Eye Service.

Primary Care – Dentistry

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

Dentistry

- The Primary Care Commissioning Committee have approved providers to deliver up to 110% of contracted values in 24/25. This has been communicated to providers. It is expected that this early notification of the position will enable more providers to deliver this level of activity.
- The Primary Care Commissioning Committee received a comprehensive presentation of the Care Homes Pilot, a local provider and the community dental service presented an overview of cases and impact the service has made. This was well received by the Committee who will be asked to consider the continuation of the service through a business case in October 24.
- The Primary Care Commissioning Committee, Exec Committee and Finance and Investment Committee have signed off a Childrens and Young People pilot. It is hoped that this pilot will commence in autumn 24.
- Our urgent access pilot continues to be successful. This aims to improve access to dental services by utilising capacity in the evenings and at weekends. Recently developments have included a software integration with 111 which allows for the direct booking of patients into available slots.
- The new pilot service for cardio vascular disease went live in May 24. At present only limited numbers of referrals have been made to this service. Further promotional work continues.
- The ICB has been working through the model for a hypertension case finding programme in dental practices. This is being funded through national pilot funding. We are aiming to launch this pilot in autumn 2024.

Primary Care – Estates

Reporting Month	September 2024	Executive Lead	Pam Green/Jen Kearton	SRO	Ashley King/William Guy	RAG	Amber

Dentistry

Premises Cost Direction Changes

The ICB makes payments to General Practice in relation to recurring and non-recurring premises costs under the Premises Costs Directions. In May 2024 Government published the Premises Costs Directions 2024 (PCD24) replacing the Premises Costs Directions 2013. Key changes include;

- ○Requirement for GMS contractor contribution, period of abatement/guaranteed use, scope and 'repayability' of Improvement grants.
- ○Rent review process and repayment terms including VAT.
- ○Increased ability to reimburse Stamp Duty Land Tax and professional costs incurred when entering into an agreement for lease.
- ○Greater assurances to contractors (and commissioners) around sharing premises with commissioner approved third parties.
- ○Greater emphasis on contractors' obligation to ensure that services are provided at the premises in a clean, safe, secure and suitable environment that is fit for purpose – and contractors are not entitled to seek improvement grants where they have failed to meet existing minimum statutory premises requirements

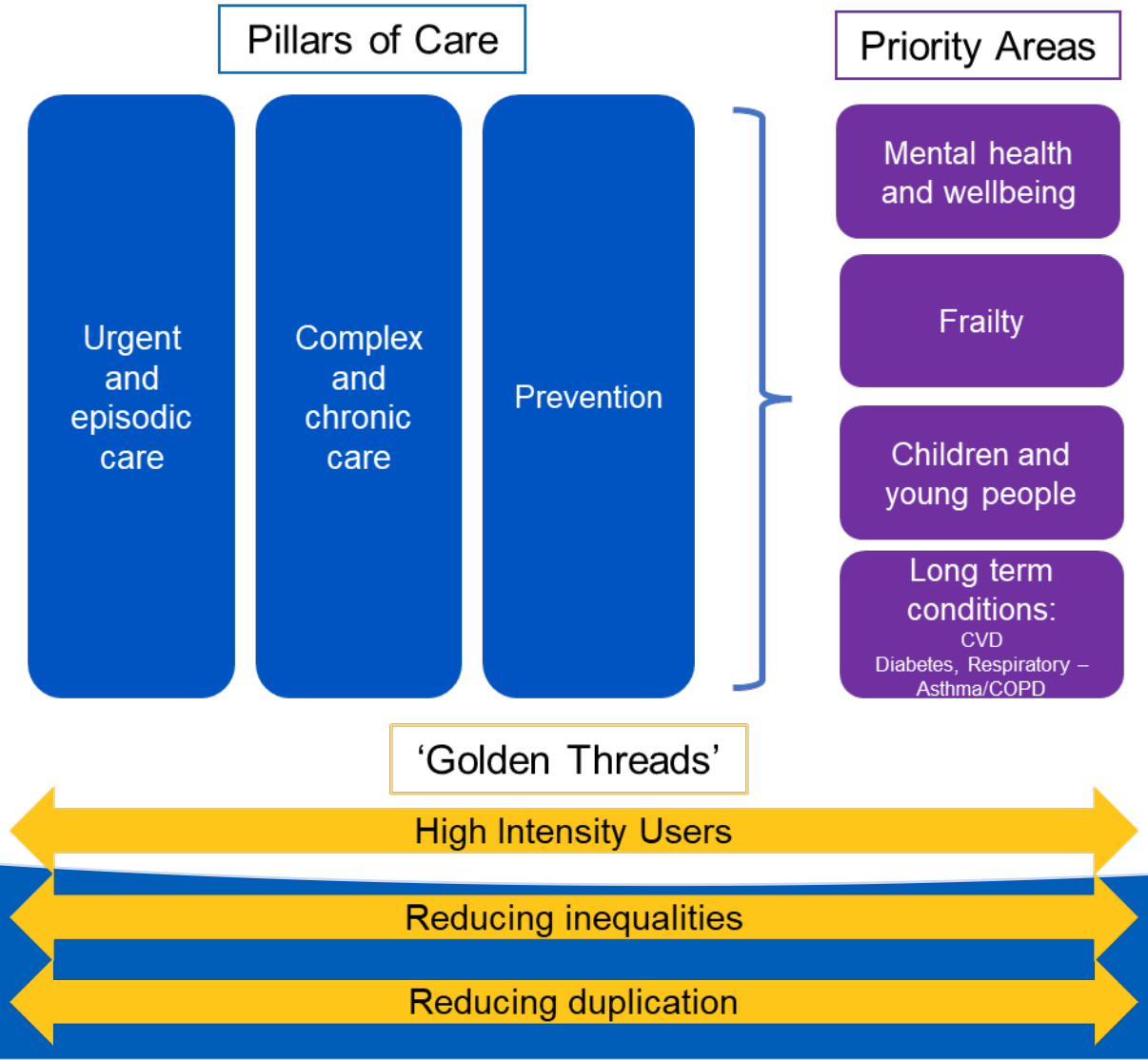
- There was no change in the requirement for rent reimbursements to align to District Valuer valuations meaning this previous constraint for new developments remains with limited to no local powers to resolve.
- A key change is the removal of the requirement for GMS contractors to contribute a minimum 34% to any estate's development or improvement project. This created a barrier as many practices have been unwilling, or unable, to fund this. This was of significant impact where developer contributions were available (Section 106 or Community Infrastructure Levy funds) following housing developments – resulting in funding being held by planning authorities and the NHS not benefiting from the available funding. The removal of this requirement provides the ICB with the opportunity to maximise the benefit available through developer contributions.
- The principle remains that premises improvements/developments are 'Practice Led' and as such responsibility sits with them. The ICB has a role in assurance, adherence, support and approval but isn't the project lead.
- The ICB has established a clear Business Case Process from EOI through to Full Business Case with clear governance processes identified.

•It is a requirement for any new build to be considered affordable and value for money, in part evaluated by the District Valuers assessment of a fair CMR generally presented as a £/sqm. At present there is significant variation between the DV assessment and that quoted by developers and the ICB has currently agreed a cap of £250 per sqm including supplement. There are examples of proposed developments where developers are requesting rent reimbursements in excess of £300/sqm compared to DV assessment being below £250 per sqm.

•Working with the Alliance Teams, the ICB estates team have regularly reviewed the current schemes that remained on original list and recently reclassified them to identify those in train, those requiring a decision, those which have ceased and those that have not progressed to any form of proposal over the past 14 months.

Integrated Neighbourhood Teams (INTs)

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



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

Integrated Neighbourhood Team (INT) development

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

Overall Summary

The current INT position:

There are 21 live INTs across MSE with varying levels of maturity.

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

Planned activities

- Establish system wide strategic group including senior represntatives from all Councils and health organisations
- Establish operational group to strengthen metrics and reporting
- Share best practice and publish System 1 searches to gain further consistency
- Define project areas for each INT

Alliances 1

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

Thurrock

Thurrock Alliance plan, was presented at the June meeting of the Alliance Committee which approved it and signed it off. The plan brings together the requirements of the FRP, the Updated JFP and the Thurrock Strategy. All 4 PCNs in Thurrock have now launched their INTs. Currently a scoping exercise is being undertaken to establish the maturity level of each INT and to identify areas of support/enablement that each INT will need to progress to the next stage of maturity.

The evaluation of patient experience of hospital discharge is now complete and the report by HealthWatch Thurrock has been published. It was presented to the Alliance Committee in July and approved. The findings of the report are being used to inform the next stage of TOCH development. Task & Finish group meetings have been set up, looking at key failure points and mitigations across system partners and data is being utilised, to evidence improvements from both the acute trust and community services.
Children's oral health is one of the 5 key clinical areas of the CORE20PLUS5 approach to reducing health inequalities. Thurrock Alliance team is supporting this key area through the Bright Smiles, and Child Oral Health Improvement Programme which is being rolled out across MSE.

Thurrock is leading the ICB's relationship, and assurance process, with MSEFT in the delivery of the Clinical Diagnostic Programme, and supports the wider system diagnostics agenda. This includes leadership of the Systems Diagnostic Board, response to transformation activities and the provision of assurance reports to ICB committees e.g., SOAC, FIC.
Thurrock is leading and coordinating the response, on behalf of MSE, HWE and SNEE ICBs, to the Lampard Inquiry. This includes development of a programme team, evidence repository and management of responses to Rule 9 requests.

Basildon and Brentwood

The July Alliance Committee received a commissioned report focussing on Social Prescribing and the different models that exist across Basildon and Brentwood. The report identified differing levels of support and knowledge levels and highlighted that training will be needed to provide a more consistent offer. Opportunities were also identified for joint learning with services such as the Essex Wellbeing Service and all members agreed that wider knowledge regarding the role across all partners would be beneficial. There was also a presentation from Essex County Council on the Climate Action Plan across Essex and what this means locally as well as an update on Integrated Neighbourhood Teams.
A new INT leadership group has been established looking at high intensity users across health, social care and the police force, looking at how we work together better and provide best support to our staff and residents.

Alliance team members continue to support financial recovery through involvement in contract reviews and procurement programmes.

Central Basildon INT held a seminar in their local community "Managing your child's anxiety" as part of their ambition to work as a community to improve mental wellbeing. Supported by different health organisations, voluntary organisations, a local yoga teacher and the community, showing how integration truly works!

Alliances 2

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

Mid Essex

The focus of the last Alliance Committee in July was a focus session on mental health and the Southend, Essex and Thurrock (SET) Mental Health Strategy. The Alliance were asked to discuss and input into how the Alliance can support any current/ongoing local place-based areas of work with a focus on resilience and wellbeing. It was agreed that individual organisations would review and share commitments with the lead and that an implementation plan would be developed to share at a future meeting. Essex County Council provided an update on the process for their upcoming Care Quality Commission (CQC) inspection.

The Alliance team continue to work on the development and delivery of the Thriving Places Index work, working with local authorities in Chelmsford, Maldon and Braintree, and system partners. There are focus groups looking at respiratory and housing and how we can reduce inequalities in these areas in each district. With support from estates and other colleagues, the Mid Alliance/ICB responded to the Chelmsford City Council development plan for proposed growth, which proposes a c.50,000 population increase over some 15 years. With support from both ICB and wider partners, we will need to establish an agreed approach for healthcare provision across the Chelmsford District.

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

The team remain heavily involved in supporting the Community elements of financial recovery.

South East Essex (SEE)

The July Committee meeting reviewed the Alliance Committee Terms of Reference to reflect the revised governance model embedding streamlined oversight and assurance. Anthony Quinn, CEO of SAVs was supported to continue in the role of SEE Alliance Committee Chair. Progress on the development of the 2024/26 SEE Alliance Delivery plan was reviewed with a view to sign-off in September.

SEE Alliance continues to support financial recovery through the development of this plan and targeting activity to contribute to our system recovery position. This includes bringing together Seniors Leaders from the ICB, MSEFT and Community to better understand what we can do differently at place. SEE Alliance also continues to lead on Health and Care in the unplanned care and flow portfolio, the high-intensity user workstream and market development, supporting the AACC programme.

ABSS is a National Lottery funded programme to support families, specifically those with babies and children up to the age of 4, in the 6 most deprived wards in Southend. The programme was created to enable system change over 10 years and comes to an end in March 2025. The discussion highlighted both the potential opportunities for a sustainable legacy and the risks tof the programme ending. The Committee was asked to support the recommendation to take a shared approach to the sustainability and transition of the ABSS programme.

The current position of Southend Enhanced Discharge Service (SEDS) was discussed, outlining the ongoing capacity and financial risks within the pathway. Good progress is being made by system partners who are working collaboratively to implement changes/initiatives to resolve challenges and bring both risks and activity in line with sustainable practice.

Essex County Council provided an update on the process for their upcoming Care Quality Commission (CQC) inspection.

Alliances 3

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

Overall Summary

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

Better Care Fund/Discharge Fund

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

BCF and Discharge fund

BCF - All 4 Alliances maintained partnership BCF governance groups with LA partners.

The locality groups with ECC are focused on reviewing spend against forecast and in reviewing the outcomes of the bids put forward for iBCF and LA discharge funds underspend in the ECC allocation to ensure we have finalised spend plans to the end of the Year.

An MSE wide BCF Quarterly meeting was held in July in which we had an overview of the evaluation of the recovery to home beds in ECC and he MSEFT wide discharge projects for shared learning.

The ICB discharge fund spend remains on target currently to be fully utilised by year end.

Thurrock: The BCF review is now in its 3rd and final phase – this phase covers a line-by-line evaluation of areas of expenditure, using a VfM tool to identify any potential areas of investment/disinvestment in the coming financial year. The final report is expected in January 2025. The findings and recommendations from the evaluation will be aligned to the discharge fund expenditure and profile.

Southend – The BCF plan for 24/25 has been formally reviewed and signed off.

The Q1 BCF update is due to NHSE in late August – this is focused on the activity and spend at the Discharge fund exclusively, a wider update on capacity and demand modelling is expected to be needed for Q2 reporting.

Transfer of Care Hubs (TOCH)

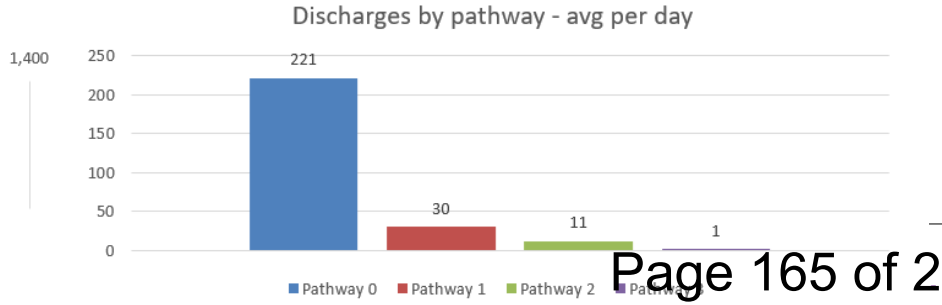
Reporting Month	August 2024	Executive Lead	Deputy Directors	SRO	Alliance Directors	RAG	Green

Transfer of Care Hubs

- Teams have been working on updating the Standard Operating procedure to ensure it reflects current and evolving ways of working in the transfer of care hubs.
- We are developing a Matrix of areas of good practice in each hub that should be standard across the 4 hubs in is development to support Maturity of the hubs across the patch.
- The voluntary sector support model for the TOCHs is being reviewed across the Alliance to build into Phase 2 planning, this case was presented with Parners for discussion at the MSE BCF board and further feedback gained.
- Learning from the discharge experience report produced in Thurrock by Healthwatch has been shared with the Leadership group for joint learning.
- Learning from the pilot work being undertaken on 3 wards in Broomfield hospital and one ward at Basildon is due to be shared with the Leadership group in September.
- 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 however 2 of the last 3 months have shown lower P2 discharges. 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.

Discharges vs operational plan

- Pathway zero: proportion of pathway zeros is above the 83% operational plan. The actual number of discharges on pathway zero has been consistent since May 2023.
- Pathway One: proportion of pathway one is above the 10% operational plan. The actual number of discharges on pathway one is consistent since January 2024.
- Pathway Two: proportion of pathway two is below the 4% operational plan. The actual number of discharges on pathway two significantly decreased from October 2023 and again since May 2024.
- Pathway Three: proportion of pathway three is below the 3% operational plan.



NHS
Mid and South Essex

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Key for project updates

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

Part I ICB Board meeting, 12 September 2024

Agenda Number: 13.1

Board Assurance Framework

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

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

5. Conflicts of Interest

None identified.

6. Recommendation/s

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

Board Assurance Framework

1. Introduction

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

2. Risks currently on the Board Assurance Framework

The current BAF, provided at **Appendix 1**, includes the following strategic risks, all of which are rated red (scored between 15 and 25) with the exception of Health Inequalities which is scored 12 (Amber). The risk rating for each risk has remained the same since the last Board meeting.

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

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

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

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, September 2024.

Mid and South Essex Integrated Care System

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Mid and South Essex

Board Assurance Framework

September 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 = 20**
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	P Green	• Patient Survey Results. • Workforce Retention. • Improved Patient to GP Ratio. • Better patient access, experience and outcomes • Consultation data (volume, speed of access), digital tool data (engagement and usage)	**4 x 4 = 16**
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	J Kearton	• Oversight via System Investment Group reporting to ICB Finance Committee. • Delivery of system infrastructure strategy. • Progress reporting on investment pipeline. • Monthly reporting of capital expenditure as an ICS to NHSE.	**4 x 4 = 16**
4.	**UEC AND SYSTEM CO-ORDINATION ('Unblocking the Hospital')** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	E Hough	• Monthly MSE UEC Board monthly oversees programme. • MSE Executive Discharge Group oversee patient flow. • Hospital discharges monitored hourly/daily and shared with social care and CHC teams via situational awareness 10am system call.	**4 x 4 = 16**
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Dr M Sweeting	• Finance & Performance Committee maintains oversight of performance against all NHS Constitutional Standards. • Diagnostics: MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group. • Cancer: MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust. • RTT: Elective Care Board: MSEFT RTT Long Wait Report. 52+ week waiting list size growth is the significant risk overseen via elective board. Fortnightly meetings with National Team as a Tier 1 Trust.	**5 x 4 = 20**
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	J Kearton	• Preparation of plan position for Board, Regional and National Sign-off. • Development of financial insights through Medium Term Financial Plan. • Overseen by the ICB Finance Committee and the Chief Executives Forum, also discussed at SLFG and Exec Committee. • Internal and External Audits planned.	**5 x 4 = 20**
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	E Hough	• Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE. • Improvement in access and reduction of health inequalities as shown in the performance metrics, of which our priorities are currently being developed. • Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.	**4 x 3 = 12**
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Dr G Thorpe	• CQC action plan progression / Implement recommendations from CQC inspections and HM Coroner's PFDR. • Reporting to Clinical Quality Review Group. • Outcome of Quality Assurance visits. • Improved flow and capacity, reduction in OOA placements and reduced length of stay. • Mental Health Partnership Board & Whole System Transformation Group (WSTG). • Reports to F&P and Quality Committees to identify key quality/performance risks and action being taken. • Accountability review with focus on performance.	**4 x 4 = 16**

Risk Narrative:	**WORKFORCE:** Risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank/agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies.	**Risk Score: (impact x likelihood)**	**4 x 4 = 20 (all associated risks on Datix are rated 20 – no change since July BAF report)**
Risk Owner/Lead:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	Associated Risks on Datix:	ID Nos 4, 53, 54, 55 and 56.

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against target of 11.55%, vacancies have been improving month on month for 6 months down to 8.3% in April 2024 (from high of 12.3% in April 23), May vacancy rate is 9.8%. Nursing and midwifery vacancies down to 8.2% (from significant high of 14.0% for nurses & 15.5% for midwives Jun 23). Medical & dental vacancies down to 8.8% in June 2024 against target of 11.5%. **EPUT:** overall vacancy rate now at 12.2% against 12% target. EPUT on plan for substantive staffing.
TURNOVER: **MSEFT:** Continued downward trend from a peak of 15.6% in August 2022 to 10.7% in Jun 2024, May 2024 turnover 10.8% against 12% target. Nursing turnover down to 8.4%, midwifery 7.3% (10.1% in Jun 2023). Medical and dental less improvement - 11.2% against target of 12% (15% in Jun 2023 **). EPUT:** Staff Turnover down to 9.4% in Jun 2024, May 2024 turnover 9.4% against 12% target.
BANK & AGENCY: EPUT agency spend in February 2024 is £2.3m lower than Feb 2023, but 7% of the total pay bill so still above the required 3.5%. EPUT are still operating significantly over establishment, currently using unbudgeted temporary workforce to support observation and engagement. Awaiting figures for MSEFT. No update on actual spend but both EPUT and MSEFT are on a downward trajectory.

How is it being addressed? (Current Controls)

Whilst the trajectory of the reduction in Bank and Agency Spend is going in the right direction pace is an issue. MSEFT is undertaking a deep dive in the usage of Bank and Agency in the Emergency Departments which is a real Hot Spot and work is being undertaken with Care Group Managers to encourage better staffing models across all departments. Establishment Control Processes are being tightened to include overtime requests. The ICB is scrutinising all vacancy fill, contract extension requests, against a set of predetermined criteria. Reducing headcount remains a challenge for MSEFT. Scrutiny is on:

- Substantive recruitment
- Admin & Clerical bank and agency requests
- Medical locum, bank and agency requests
- Nursing bank, agency and overtime requests
- Long term contracts / locums (non-clinical and medical).

EPUT also is moving in the right direction and is also subject to the same controls on all staffing spend. They are also looking at rostering where it is clear that this is still not being done, far enough in advance and results in gaps being filled with Bank and Agency.

For all non-clinical, and clinical bank and agency roles of greater than four weeks a review of requirements is taken to Establishment Control Panel. Outside of this, temporary staffing process involves the Matron identifying requirements and ward/service managers signing this off. EPUT are also looking at Care Groups but no impact of this work is being seen at present,

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

Barriers (Gaps)

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

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

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

Next Steps: (Actions)

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

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (no change since last BAF report)**
Risk Owner/Lead:	Pam Green – Basildon & Brentwood Alliance, Executive Lead for Primary Care William Guy, Director of Primary Care.	Directorate: Board Committee:	Basildon and Brentwood Alliance Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, Additional Roles Reimbursement Scheme (ARRS), Hospital performance, reputational damage.	Associated Risks on Datix:	ID Nos 3, 21

Current Performance v's Target and Trajectory

Workforce:

- Additional Roles Re-imbursement Scheme (ARRS): Good progress has been made. Focus is now on retention of staff. National guidance due on new GP ARRS role (October 2024)
- Fellowship scheme: 30 GPs have now been recruited to the MSE system with support of the fellowship scheme. The national programme has been reduced for 2024/25.

Demand/Capacity:

- Patient Experience National Survey: Published in July 2024, overall experience has plateaued where other ICBs continue to deteriorate.
- Available Appointments: Continued increase in overall consultation in primary care.

Barriers (Gaps)

- Collective Action being taken forward by the British Medical Association (BMA). ICB continuing to monitor the local impact of this.
- Resource for investment in infrastructure especially for estates improvements.
- Increase in overall demand on primary care services.
- Primary/Secondary interface. Specific work programme in place
- Overall funding of primary care

How is it being addressed? (Current Controls)

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

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

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

Next Steps (Actions)

- Integrated Neighbourhood Teams – all INTs expected to go live by end of March 2025.
- Implementation of new digital tools (commissioned by the ICB) where not being used (ongoing).
- Transitional funding for practices – scheme in place, all practices expected to apply by end of September 2024 (40 practices have submitted requests to-date).
- BMA Contract Dispute – continue engagement with Essex Local Medical Committee to understand impact of dispute on local primary care provision (ongoing – timeline outside of local control).

Risk Narrative:```````	**Urgent Emergency Care (UEC) and System coordination** Risk that ICB and providers organisations are unable to effectively manage / coordinate the capacity across the system and the inability to deliver effective care to patients.	**Risk Score:** (impact x likelihood)	**4 x 4 = 16 (no change since July BAF report)**
Risk Owner/Lead:	Emily Hough, Director of Strategy and Corporate Affairs. Samantha Goldberg, Urgent Emergency Care System Director.	Directorate: Committee:	Strategy & Corporate Services MSE Strategic UEC Board and Finance & Performance Committee
Impacted Strategic Objectives:	Improving and transforming our services.	Datix Risks:	ID Nos 19, 26, 32

Current Performance v's Target and Trajectory

Emergency Department (ED) performance below constitutional standard, as are ambulance response times, although improvement in reducing ambulance delays across MSEFT. Ambulance demand reverted to pre-pandemic levels. ED performance Q1: 75.2% against 78% target and ambulance handover performance: Q1 89.6% against 90% target.

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- The UEC & Flow Improvement programme for 2024/25 is a pillar within the MSE System Recovery Unplanned Care / Flow Portfolio Group reporting System Financial Sustainability Programme Board, 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 escalation beds.
- The well-established MSEFT bed model is the tool that is utilised for incorporating all hospital and system transformational schemes, to translate the delivery into length of stay reductions and 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 SROs accountable for delivery.
- Escalation capacity circa 41 beds, closed by the 30 April 2024, and reduction in 66 general and acute beds in MSEFT by 1 August 2024.
- Reduce Beds occupancy to 92% and reduction in General & Acute core beds.
- Minimise attendance to ED by maximising 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 oversees performance reports into F&P committee and ICB Board.
- MSE System Recovery Unplanned Care / Flow Portfolio Group oversee patient flow.
- Hospital discharges monitored hourly/daily and shared with social care and continuing health care teams via situational awareness 10am system call.

Next Steps

- The UEC & Flow Improvement programme for 2024/25 is a pillar within the MSE Transformation & Improvement Programme reporting into the Executive Discharge Meeting, which is designed to align efforts across the System to optimise both acute and community hospital capacity, increase the provision of alternative care outside the hospital setting, contribute to financial sustainability and improve patient flow. The aim will be to sustain the closure of escalation beds and support the reduction of beds.
- Expected outputs from the UEC & Flow schemes to triangulate into the MSEFT bed model, equating to length of stay or admission avoidance reduction to demonstrate overall reduction in bed occupancy – Ongoing: bed model regularly reviewed, updated to capture progress/slippage.
- MSEFT escalation capacity circa 41 beds, by the end of April 2024 - Escalation beds closed at Basilson, which was the remaining hospital site.
- Reduce General & Acute (G&A) core beds - G&A bed reduction delivered at Southend, and Broomfield to close 16 beds mid-September on top of the 44 bed closures delivered and sustained.
- Unscheduled Community Care Hub (UCCH) funding risk remains, although expecting a letter from East of England (EoE) NHS with funding and minimum viable product direction for standardisation in UCCHs across the ICBs in the EoE – September 2024.
- Quality Improvement programmes progressing at MSEFT to reduce length of stay and improve discharge profile to earlier in the day to support patient flow, reduce ED wait times and improve ambulance handovers.

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 & Performance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	Associated Risks on Datix:	ID 58

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

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

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

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

Next Steps: (Actions)

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

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 (based on highest rated risk score for diagnostic risk)**
Risk Owner/ Lead:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation (Cancer) Aleks Mecan, Alliance Director Thurrock (Diagnostics) Karen Wesson, Director Oversight Assurance (Elective)	Directorate: Committee:	Clinical Leadership and Innovation, Thurrock Alliance, Resources Cancer Assurance Committee, Diagnostic Board Elective/Planned Care Group
Impacted Strategic Objectives:	Delivery of Operational Planning commitments/Recovery of constitutional standards for diagnostics, cancer and Referral to Treatment (RTT).	Associated Risks on Datix:	ID Nos 1, 2 and 13.

Current Performance v's Target and Trajectory

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

- 65+ week wait: MSEFT updated trajectory to achieve operational plan commitment, in response to National ask MSEFT have confirmed the plan to achieve zero 65 weeks waiting patients at 30 September remains on track

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – System Delivery Fund (SDF) funding approved, MSEFT recruiting to the posts to support pathway delivery, Pathway analyser being completed to identify where there are opportunities for pathway improvement
- **Diagnostic Capacity –** capacity across diagnostics is impacting delivery of the Faster Diagnostic Standard, this is being reported and overseen in terms of actions taken via the Diagnostic Performance Sub-Group of the MSE System Diagnostic Board and the Tier 1 Cancer meeting.
- **Elective –** Delivery of capacity and optimisation of the Surgical Hub at Braintree

How is it being addressed? (Current Controls)

Diagnostics:

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

Cancer:

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

Referral to Treatment (RTT):

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

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

- ICB maintains oversight of performance against all NHS Constitutional Standards/Operational Plan asks**.**
- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group.
- **Cancer:** MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** Elective Care Board: MSEFT RTT Long Wait Report. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions)

RTT and Cancer:

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

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

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**4 x 3 = 12 (no change since July BAF report)**
Risk Owner/Lead:	Emily Hough, Executive Director of Strategy and Corporate Affairs Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Corporate Services. Quality Committee, Audit Committee and Population Health Improvement Board.

Current Performance v's Target and Trajectory

- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Core20PLUS5 (Adult) inequalities data packs are being actioned by the Alliances.
- Core20PLUS5 (Children & Young People) inequalities data packs developed by the PHM team and will be shared with the Growing Well Board.
- PLUS group insights from Population Health Management team outlining opportunities to reduce health inequalities.
- Population Health Improvement Board (PHIB) will be establishing MSE system priorities. Key metrics and a dashboard in Phase 1 development.

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- PHIB provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with Alliances will provide oversight and direct priorities for health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project including those part of financial recovery programme. Draft terms of reference developed for the EHIIA panel. Digital EHIIA tool under review and final testing..
- Equality Delivery System (EDS) annual reviews undertaken with 2023/24 report published on ICB website and areas for review in 2024/25 identified.
- Health inequalities annual statement for 2023/24 published on the ICB website. "Narrowing the gap" report published on ICS website highlighting work undertaken.
- Health inequalities funding of £3.5m pa reviewed and reprioritised allowing for one off contribution towards deficit of £1.3m in 2024/25. Alliances funding via trusted partners will be more targeted on specific health inequalities priorities and schemes not yet contractually committed will be subject to additional scrutiny and triple lock process.
- Bi-annual reporting to ICB Board on health inequalities activities.

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

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

Next Steps (Actions to be implemented by March 2025)

- Launch of digital EHIIA tool (Sept 2024)
- Health inequalities dashboard Phase 1 launch (Aug 2024).
- Establishment of 'Equity & Diversity Impact Assessment Panel' to review EHIIA as part of formal governance under Board approved EDI Strategy (Sept 2024).

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

Current Performance v's Target and Trajectory

The System has agreed its plan for 2024/25 submitting a revised profile in June 2024. The planned position has the ICB breaking even with both MSEFT and EPUT in deficit.

Performance is behind trajectory.

Barriers (Gaps)

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

How is it being addressed? (Controls)

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

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

- Delivery of the agreed position in-year and at year-end.
- Improved delivery throughout the medium term (5 years) to system breakeven.
- Being overseen by the Finance Committees and the Chief Executives Forum.
- Internal and External Audits planned.

Next Steps: (Actions)

- Finalise on-going monitoring arrangements.
- Delivery of system efficiencies programme/financial sustainability programme for 2024/25.
- Medium Term Financial Plan developed, to inform future planning.

Risk Narrative:	**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/Lead:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient Experience, Workforce, Reputational Damage	Risks on Datix:	ID Nos 5, 8, 22 and 23.

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators.
- 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).
- 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 on slide 4).
- System pressures to manage delivery (capacity).
- Flow through inpatient services.

How is it being addressed? (Controls)

- System Oversight and Assurance Committee (SOAC) monitor performance and quality of services with provider reports now taken to Quality Committee.
- Evidence Assurance Group, chaired by MSE ICB, attended by MSE ICB and EPUT.
- Monthly 'Quality Together' meeting attended by NHSE, EPUT and ICB senior staff, alongside EPUT and ICB 'Safety huddles' held on a weekly basis.
- Quality Assurance Visits, new approach – EPUT plan the visits, the ICB chair the visit, Quality Assurance Visits (QAV) are attended by EPUT and ICB colleagues.
- Multi-agency delayed transfer of care meetings to ensure good flow and capacity, held weekly on Fridays with system partners.
- Essex ICBs' quality teams 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 Out of Area (OOA) placements, reduced length of stay.
- Reports to Finance & Performance and Quality Committees identify key quality/performance risks and action being taken.

Next Steps (Actions):

- Implementation of recommendations from England Rapid Review into Inpatient Services published June 2023 with focus on recommendations which state twelve months, currently delayed whilst awaiting NHSE guidance (October 2024).
- ICBs working collaboratively across Essex to review the financial risk share agreement on inpatient acute mental health provision to include out of area expenditure (Sept 2024).
- Lampard Inquiry – MSE ICB have been granted core participant status.
- Implementation of the mental health learning disability autism (MHLDA) inpatient quality transformation with final plan submitted 28 June 2024 (March 2025).

Partner Organisation Self Identified Red Risks (and scores)

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

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

*NB: MSEFT's Board did not receive a BAF report during August.

Partner Organisation Self Identified Risks

EPUT red risks, as of August 2024

- People (National challenge for recruitment and retention)
- Capital resource for essential works and transformation programmes.
- Use of Resources (control total target / statutory financial duty)
- Engagement and Supportive Observation (CQC found observation learning not embedded)

Mid and South Essex Integrated Care System

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Part I ICB Board Meeting, 12 September 2024

Agenda Number: 13.2

Revised Policies

Summary Report

1. Purpose of Report

To update the Board on policies that have been revised and approved by sub-committees of the Board.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

Kathy Bonney, Interim Chief People Officer.

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Remuneration Committee and Quality Committee

5. Link to the ICB's Strategic Objectives:

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

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

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on revised policies which have been approved by the relevant committees since the last Board meeting.

2. Revised Policies

The following policies have been revised and approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit Committee 23 July 2024.	The committee approved amendments to the following policies: • 004 Accounting and Financial Management Policy • 006 Banking Cash Management Policy • 007 Creditor and Purchase Policy • 008 Debtor and Sales Order Policy • 016 Policy for Developing Policies • 022 Legal Services Policy • 025 Management of Violence, Aggression and Vexatious Behaviour Policy • 026 Counter Fraud, Bribery and Corruption Policy • 029 Security and Lockdown Policy The committee also extended the review dates of the following information governance policies to January 2025, in recognition of the additional audit recommendations feeding into the Information & Cyber Security Policy; the change of the Data Security Protection Tool to reflect the Cyber Assessment Framework; and potential strengthening of the Records Management Policy and associated processes in light of the Lampard Inquiry and future adoption of artificial intelligence. • 011 Information Sharing Policy • 012 Records Management and Information Lifecycle Policy • 013 Access to Information Policy • 014 Information and Cyber Security Policy • 027 Forensic Readiness Policy The committee also extended the review date of the Incident Reporting Policy Ref 024 to 30 September 2024 to enable implementation of the RLDatix incident reporting module to be progressed.

Committee / date of approval	Policy Ref No and Name
Remuneration Committee 7 August 2024.	The committee approved amendments to the following policies: • 039 Probation Policy • 050 Parental Leave Policy • 052 Fostering Policy • 060 Close Personal Relationships at Work Policy • 061 Domestic Violence and Abuse Policy The committee also extended the review date of the Learning and Development Policy (Ref 053) to the end of October 2024 to enable changes to be made to the internal process for managing training and development.
Quality Committee 30 August 2024.	The committee approved amendments to the following policy: • 067 Management of Serious Incidents Process Policy The committee also extended the review dates of the following policies to 31 October 2024: • 066 Safeguarding Adults and Children at risk of Domestic Abuse • 068 All Age Continuing Care 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 revised 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, 12 September 2024

Agenda Number: 13.3

Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee (AC): Extraordinary meeting, 19 June 2024.
- Clinical and Multi-professional Congress (CliMPC): 26 June 2024.
- Finance and Investment Committee (FIC): 2 July 2024 and
- Finance & Performance Committee (F&P) 6 August 2024.
- Primary Care Commissioning Committee (PCCC): 12 June and 10 July 2024.
- Quality Committee (QC): 28 June 2024.

2. Chair of each Committee

- George Wood, Chair of AC.
- Dr Matt Sweeting, Chair of CliMPC.
- Joe Fielder, Chair of FIC / F&P.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Neha Issar-Brown, Chair of QC.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

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

Committee Minutes

1. Introduction

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

2. Main content of Report

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

Extraordinary Audit Committee, 19 June 2024

The committee received reports on the following:

- The ISA 260 report summarising the key outcomes of the audit of financial statements as at year-end 2023/24.
- The Value for Money report 2023/24 noting there were no significant weaknesses for the ICB to report and therefore a 'clean' opinion was provided.
- The first ICB's first Health Inequalities Standard Statement, setting out how the ICB was discharging its duty to reduce health inequalities, noting that its content was expected to evolve over time.

The committee also approved:

- The final draft of the ICB Annual Report 2023/24, subject to some minor formatting amendments.
- The final draft of the ICB Annual Accounts 2023/24. The committee noted the accounts had been audited by the ICB's external auditors, KPMG, following which very few changes were required.

Clinical and Multi-Professional Congress, 26 June 2024

The committee received the following reports:

- Service Restriction Policy (SRP) and Procedures of Limited Clinical Effectiveness (PoLCE). The committee recommended the merging of the SRP and PoLCE workstreams and the creation of a working group to lead on the work of reducing low value care.
- Review of committee effectiveness. The committee agreed its workplan for 2024/25 and approved revised terms of reference.

Finance & Investment Committee, 2 July 2024

The Committee considered reports on the following:

- Month 2 Finance Report and a verbal update on planning.
- Capital update confirming the System Capital Department Expenditure Limits allocation had been reduced by £5.4 million for 2024/25.
- System Recovery Report
- Board Assurance Framework and Finance Risk Register.

- Minutes of the System Finance Leaders Group meeting held on 14 April 2024 and System Investment Group meeting held on 25 March 2024 were presented for information.

Note that following the ICB Board meeting held on 11 July, the Finance & Investment Committee was renamed, with a slightly different focus, to the Finance & Performance Committee.

Finance & Performance Committee, 6 August 2024

The Committee considered reports on the following:

- An update on the Investigation and Intervention process being undertaken as directed by NHS England.
- System Finance and Performance Report for month 3.
- System Recovery.
- Capital update.
- Infrastructure Strategy.
- Clinical Diagnostic Centres programme.
- Update on review of policies within the remit of the committee.
- Minutes of the System Finance Leaders Group held on 10 June 2024 and System Investment Group on 15 July 2024.

The committee also approved the following:

- Children and Young People Dental Pilot to run for three years.

Primary Care Commissioning Committee, 12 June 2024

The committee receive reports on:

- Primary Medical Services Contracts
- Community Pharmacy Update
- Dental Provider Appeal
- Primary Care Workforce
- Primary Care Financial Summary
- Primary Care Risks
- Committee Effectiveness, Review of Terms of Reference and workplan for 2024/25.
- The committee received the minutes of the Dental Commissioning and Transformation Group meetings held on 3 April 2024 and 1 May 2024.

Primary Care Commissioning Committee, 10 July 2024

The committee receive reports on:

- Children and Young People's Dental Pilot update.
- Integrated Neighbourhood Teams (INTs) update, confirming that as planned, 20 of the 24 INTs were now live.
- Fuller Stocktake update, noting that good progress had been made across mid and south Essex to implement the recommendations.
- GP Provider Collaborative update, noting that this was having a positive impact upon general practice and its workforce.

- Primary care patient engagement outlining the variety of processes undertaken to engage with the local population on their access to and experience of primary care services.
- An update on progress with the refresh of the Primary Care Strategy.
- The committee's workplan for 2024/25.

The committee also agreed the following:

- The Childrens and Young Peoples Dental Access Pilot would run for three years (subject to approval from the Finance and Performance Committee).

Quality Committee, 28 June 2024

The committee received reports / presentations on the following:

- Deep dive into Special Educational Needs and Disabilities.
- Work undertaken by the Safety Quality Group.
- Acute Care update from Mid and South Essex Hospitals NHS Trust.
- Community update from Essex Partnership University Hospitals NHS Trust (EPUT), which included an update from the Community Collaborative and information regarding EPUT's quality performance data dashboard.
- Primary Care Update.
- Learning Disabilities and Autism update
- Babies, Children and Young People Update.
- Patient Experience update
- Patient Safety update
- Patient Safety and Quality risks.
- ICB's response to 11 provider Quality Accounts 2023/24.

The committee also approved the following:

- Quality Assurance Visits Policy (Ref 072)
- Continuing Health Care Disputes Agreement Protocol and noted that partner organisations would also be asked to comment on this document.
- The extension of review dates of six policies within the remit of the Quality Team.
- The outcome of the review of the committee's effectiveness 2023/24, revised terms of reference and workplan for 2024/25.

3. Recommendation

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

Minutes of the Extraordinary Audit Committee Meeting

Held on 19 June 2024 at 4.00pm

via MS Teams

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

- Joe Fielder (JF), ICB Finance & Investment Committee Chair, MSE ICB.
- Mark Bailham (MB), Associate Non-Executive Member & ICB Finance & Investment Committee Member, MSE ICB.
- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Head of Financial Services, MSE ICB.
- Emma Larcombe (EL), Director, KPMG.
- Nathan Ackroyd (NAc), Senior Manager, KPMG.
- Emma Timpson (ET), Associate Director for Health Inequalities and Prevention, MSE ICB (Item 7 only).

Apologies

1. Welcome and Apologies

GW welcomed everyone to the meeting and explained that the focus of the meeting was to review the final ICB Annual Report and Accounts.

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.

JF advised that his son had recently been appointed as Head of Efficiency for NHS England and his declaration of interest would need to be updated to reflect this, as well as mitigating

action required to manage any potential conflict. There were no items on the agenda affected by this declaration.

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the ICB Audit Committee meeting on 16 April 2024 and Extraordinary Audit Committee on 22 April 2024 were received.

Outcome: The minutes of the meetings held on 16 April 2024 and 22 April 2024 were approved as an accurate record.

4. ICB Annual Report 2023/24

The Committee agreed that the final annual report was a comprehensive, well written document. GW commented that the document highlighted many achievements for the ICB in 2023/24 and suggested it would be useful if the Communications Team could create a list of the top 10 highlights, including work undertaken with partner organisations, as a reference document for the NEMs and Board Members. NAd noted that there would be a 'lunch and learn' session for staff regarding the key messages in the annual report.

MB had noted a couple of formatting issues which he would share with NAd outside of the meeting.

ACTION: NAd to share the lunch and learn presentation on the highlights from the 2023/24 Annual Report, including work undertaken with partner organisations, as a reference document for NEMs and Board Members.

Outcome: The Committee APPROVED the ICB Annual Report 2023/24, subject to the minor formatting amendments required.

5. ICB Annual Accounts 2023/24

DM presented the final ICB Annual Accounts for 2023/24 following the end of year audit undertaken by KPMG. It was noted that very few changes were required. DM gave thanks to KPMG for their support.

Outcome: The Committee APPROVED the final ICB Annual Accounts for 2023/24.

6. External Audit

External Audit

NAc presented the ISA 260 Report which summarised the key outcomes of the audit of financial statements of Mid and South Essex ICB as at, and for the year ended 31 March 2024. The report was confidential and not for publication.

The Committee noted the audit was substantially completed and the list of outstanding misstatements in relation to the audit reported at the time of writing were now all complete other than signing of the audit report. There were 2 significant audit risks identified in respect of expenditure recognition. For both, the findings noted a control deficiency over

the informal journals review process but did not identify any errors in the expenditure or accruals sampled.

No issues were identified in relation to the management override of controls or regularity of transactions. The Remuneration Report required minor corrections, which have been actioned, in relation to technical requirements of the Department of Health Social Care Group Accounting Manual 2023/24.

The report noted a control deficiency risk was highlighted in respect of the Mental Health Investment Standard (MHIS) 2022/23. EL explained that the 2022/23 MHIS assurance statement would be disclaimed as, although comfortable that expenditure had occurred by the ICB, there was not enough supporting evidence available for the auditors to verify that expenditure allocated for mental health was spent on such activities. It was the assertion that this would be a one-year issue as process changes had been made to evidence the ICB mental health spend in future years. Furthermore, the reporting period related to records spanning both the predecessor clinical commissioning groups and the ICB; as well as auditing post a period of significant organisation change where the staff involved in the work, were no longer an employee of the ICB.

JKe agreed, commenting that the difficulties occurred for 2022/23 were due to the loss of corporate knowledge when the five mid and south Essex CCGs became an ICB.

JF queried, as Chair of the Remuneration Committee, whether the Remuneration Committee required any actions to be taken to avoid errors occurring in the Remuneration Report in future. NAc explained that the corrections related to the level of disclosure in reporting. EL added it was common to have reporting issues with Remuneration Report but this year there were very few due to the diligence of the Finance Team.

Value for Money Report

EL presented KPMG Value for Money (VFM) report, noting there was no significant weakness for the ICB to report in 2023/24 and a 'clean' VFM opinion was provided.

GW was happy with the outcome of the audit and thanked all teams involved.

Outcome: The Committee NOTED the ISA 260 and Value for Money reports for 2023/24.

7. Health Inequalities Standard

ET was invited to present the Health Inequalities Information Statement, a new annual standard from NHS England (NHSE) on how NHS bodies must discharge their responsibility to report information on health inequalities. NHSE had issued a list of indicators that NHS bodies should collect, analyse and publish on health inequalities. This was the first statement of its kind and ET expected its content to evolve over time.

GW commented that it was a comprehensive report that provided a good starting point for the first return and invited comments from colleagues.

In response to GO, ET advised that although only one maternity indicator was reported on in the statement (in relation to preterm births under 37 weeks), maternity services were

using a number of other health inequality indicators to support their programmes. GW highlighted that maternity was listed as one of the clinical priorities outlined for adults.

JF was pleased to see that mental health was listed as a clinical priority for both Adults and Children and Young People.

MH, the Senior Responsible Officer for Learning Disability (LD) & Autism across Essex, observed that LD annual health checks were low in mid and south Essex compared to the national delivery of annual health checks and this should be monitored. ET agreed.

GW noted that work was being undertaken in the Southend-on-Sea area to deliver an integrated health service to those experiencing homelessness, but stressed that homelessness was an issue across MSE and queried whether data should be gathered for the whole of MSE. Homelessness was something for the health services and local authorities to tackle together.

MH advised that work around homelessness was taking place at Alliance level in South East Essex, the issue was that there was not enough housing. Southend City Council were undertaking a piece of work on an Estates Strategy, but MH agreed that a wider push for a joined up approach to reducing homelessness was required and welcomed a coalition of Estates Strategies. NA confirmed that the focus for the July ICB Board seminar was on estates and infrastructure.

ET explained that work was underway on the Integrated Care Partnership (ICP) Delivery Plan which included 'Healthy Housing.' Funding to reduce Health Inequalities had been provided to a charitable organisation to undertake a needs assessment to identify where there are gaps in health provision and how meet needs of the homeless community.

GW noted that an obesity standard was not included in the return. ET explained the indicators included in the statement were taken from NHSE's guidance document. Although obesity was not included on return, ET confirmed that work was taking place across MSE.

ET reiterated that the 2023/24 Health Inequalities Information Statement followed the guidance of NHSE, but the 2024/25 return may include broader health inequalities data, aligned to the ICP's top 5 priorities for a healthy MSE, making the return less health centric.

GW suggested it would be useful to include numbers on the next return to be able to measure and compare programme outcomes. Additionally, it would be helpful to understand the funding allocated to each of the 5 clinical priorities and other health inequalities programmes across the system. GW thanked ET for presenting the Health Inequalities Standard.

Outcome: The Committee NOTED the 2023/24 Health Inequalities Standard.

8. Any other Business

No matters of any other business were raised.

9. Date of Next Meeting

1.00pm – 3.00pm, Tuesday 23 July 2024.

Approved 23 July 2024

Minutes of Clinical and Multi-Professional Congress Meeting

Held on 26 June 2024 at 09.30 am – 10.45 am

Via MS Teams

Members

- Matt Sweeting (MS), Executive Medical Director (Chair).
- Pete Scolding (PS), Clinical Director of Stewardship (Deputy Chair).
- Fatemah Leedham (FL), Pharmacy.
- Olugbenga Odutola (OO), Primary Care.
- Gerdalize Du Toit (GDT), Community Care.
- Babafemi Salako (BS), Primary Care
- Krishna Ramkhelawon (KR), Public Health.
- Sarah Zaidi (SZ), Primary Care.
- Gavin Tucker (GT), Senior Clinical Fellow. MSE ICB.
- Donald McGeachy (DM), Urgent and Emergency Care.

Attendees

- Helen Chasney, Corporate Services & Governance Support Officer, MSE ICB (Minutes).

Apologies

- Holly Middleditch (HM), Senior Clinical Fellow, MSE ICB.
- Christopher Westall (CW), Acute Care.

1. Welcome and Apologies

MS welcomed everyone to the meeting and apologies were noted as listed above. It was confirmed that the meeting was quorate. PS advised that CW has stepped down from Congress due to other commitments.

2. Declarations of Interest

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

Declarations of interest made by Integrated Care Board (ICB) members are listed in the Register of Interests available on the ICB website.

Action: HC to make the necessary amendments to the Clinical and Multi-Professional Congress register of interests.

3. Minutes

The minutes of the last Clinical and Multi-Professional Congress meeting held on 24 April 2024 were approved.

Resolved: The minutes of the Clinical and Multi-Professional Congress meeting held on 24 April 2024 were approved.

4. Matters Arising

There were no matters arising.

5. Service Restriction Policy (SRP) & Procedures of Limited Clinical Effectiveness (PoLCE) Workstream update

GT advised that the proposal being made was to merge the current work with regards to Service Restriction Policies (SRP) and Procedures of Limited Clinical Effectiveness (PoLCE) to create a new working group to lead on the work. The recommendations were for Congress to approve the merger, to approve the creation of a working group and advise on group membership, Terms of Reference and governance routes for this group.

The SRP and PoLCE were two similar programmes that were running in parallel. The SRPs were used to fund safe evidence based clinically effective interventions for patients. Historically, the SRPs were harmonised from the five Clinical Commissioning Groups (CCGs). Currently the SRP process was to review changes to current SRPs or propose new SRPs. Meetings were held on ad hoc basis with the Director of Pharmacy, System Clinical Lead for SRP and the Individual Funding Request Team.

The PoLCE was an evidence based interventions (EBI) programme which was a national initiative, where some interventions were considered as low value. The programme was not mandatory, and was part of the elective recovery dashboard, which included 40-50 different procedures and showed whether the Integrated Care System was a national outlier. The PoLCE process involved a group which supported system partners to understand whether the dashboard data, the rationale of procedures and whether a plan of action was required to reduce the incidence number of PoLCE procedures. The priorities were identified through the dashboard and linked to the financial recovery agenda.

The issues identified was there were no clear governance routes, no prioritisation, the dashboard data required validation for PoLCE programme as there were sectors that were not being captured, e.g. independent sector. There was no link to system intelligence into the clinical frontline or other clinical groups, such as stewardship groups, to realise if there were any issues for clinicians or whether opportunities could be identified as high value, low volume that could be addressed. Routes into implementation were unclear and there was no impact evaluation to patient care, quality and safety.

The proposal was to combine both pieces of work and set up a membership of those individuals currently working across both programmes, with a clear terms of reference. The purpose of the working group would include validating the preliminary data received from dashboards, identifying opportunities to disinvest in low value clinical activity, reviewing SRPs and support the implementation of reducing low value care. The group would set the priorities for deep dives which would report into Congress and would link into the financial recovery programme. There were lots of opportunities that SRP and PoLCE identified as low value clinical care but very little governance or authority to take the action forward.

MS asked how the support from specific stewardship groups would be enacted. GT explained that the procedures were divided by clinical area on the PoLCE dashboard, so could easily be matched to stewardship groups and excess activity could be pinpointed. However, not all activity was classed as bad activity. An example of the exercise ECG was provided where it had been identified as an outlier but following the deep dive, it was confirmed that there was a contract with DVLA to carry out exercise ECGs as part of their pre-employment checks. System clinical leads and Stewardship groups would be essential in data validation.

PS advised that the proposal was sensible in terms of supporting financial recovery and the stewardship groups should be involved where relevant. Concern was raised on the capacity to coordinate as benefits would be cross organisational and requested further detail on reporting and oversight. GT advised that the trust was currently looking at utilising Blueteq for approvals of high cost drugs and conducting a pilot for a specific area, which would require clinical engagement. In terms of governance, the outputs should come to Congress for validation, however as SRP and PoLCE work falls under the elective recovery priorities, should the group feed into the elective care board (ECB)? MS agreed that big service changes should come to Congress but day to day updates should be reported elsewhere.

SZ stressed the importance of the connection between ECB and clinical groups as the overall demand and where it was originating from may need to be considered. The Population Health Management (PHM) tool looked at procedures generally and directs to certain population segment groups. Much of the CT scan demand in non elective care was low value and not needed to influence management, which caused pressure further up in elective care to use other expensive procedures.

KR commented that Congress had not reviewed much cost benefit analysis. Capacity would be a challenge due to the large programme of work. The governance should lie with the ECB and Congress should receive the proposed work programme and the impact.

GT advised that the EBI programme released recommendations for procedures by clinical areas, so strong clinical engagement would be required. DM suggested that technical commissioning input would also be required because of the complexity of the coding system.

BS agreed with merging both workstreams which would strengthen the outcome. The patient voice should be included as service users and would support delivery efficiencies. GT advised that the SRP process historically had involved patients and would need to explore where in the process the patient voice would offer most value.

FL advised that the use of Blueteq had worked well with high cost drugs and commented that disinvestment in one low value service, should not be replaced by another low value service.

MS advised that the group membership, Terms of Reference and governance routes would need to come back to Congress following development. Prioritisation would be key and two or three areas should be identified where a difference could be made and the work should be data driven. A proposal paper would need to be taken to the Executive meeting.

GT confirmed that following him leaving the ICB, Scott Baker would be taking the initiative forward, with support from Sarah Lennox. GT asked Congress for any suggestions on who should be involved with the working group. MS advised that any resource restrictions and deficits in managing the programme should also be highlighted and would be raised in the Medical Directors group across the region for standardisation.

PS suggested including acute representation if the group was going to be acute focused. GT advised that Nick French, Head of Income and Commercial, and Laura Tomsett, Director of Cancer, RTT and Outpatient Access, had been involved historically from the trust. DM suggested that clinicians from relevant clinical areas should be involved. MS suggested linking in with a commissioner from the ICB delivery team. MS advised that data should be used initially to identify prioritisation, then clinical engagement could be sought. MS would discuss the governance arrangements with Emily Hough, Executive Director of Strategy and Corporate Services.

SZ suggested contacting the internal improvement groups in MSEFT with regards to the relevant clinicians. GT advised that the question would be who should be included in the tight group membership irrespective of particular topic and then which clinicians should be involved on specific topics.

Outcome: It was confirmed that Congress recommended the merging of the SRP and PoLCE workstreams and the creation of a working group to lead on the work of reducing low value care.

Action: MS to discuss the governance arrangements with Emily Hough, Executive Director of Strategy and Corporate Services.

6. Review of Committee Effectiveness, Workplan 2024/25 and Terms of Reference

PS advised that the governance team had completed the desktop review of committee effectiveness and the key points were that Congress had delivered all its objectives and the workplan for the year was driven by the needs of the system. The administration was managed well, with papers being received on time and minutes and conflicts of interest were written and dealt with appropriately. It was noted that the membership of Congress was under review. A request for expressions of interest had been published in three underrepresented areas; social care, resident engagement and acute care and interviews would be held in July.

The members survey was sent to all committee members and a number of points were highlighted, such as whether the committee was advisory or decision-making. Congress was set up as an advisory committee to the ICB Board initially, however, a small change was adopted and approved last year which enabled the group to have limited decision-making ability within scope. This was as a result of the review of the IFR policy and recognition that it had been reviewed and would not therefore go to ICB Board for discussion. A further point had been made with regards to the importance of the service user voice representation on the group, and this had been included in the EOI advert. A point had been raised on whether specific training could be beneficial for the Congress member role. The final point raised was the importance of Congress which had a frontline perspective and a broader strategic view in the context of financial recovery.

DM suggested that if the group was to become decision making rather than advisory, then could attendees be co-opted for a specific area that was being discussed.

KR advised that if the group was no longer advisory that would change the dimensions for some members as some represented the whole system; clinical, government perspective as well as Public Health. The discussions held at Congress impacted on communities and this would put social care and engagement representatives in a difficult position. A risk register would also need to be implemented and discussed at every meeting. With regards to the

membership of the group, the resident engagement representative needed to be someone with an enhanced insight of resident engagement rather than a patient representative, so that they could remain independent, e.g HealthWatch, Local government or NHS. PS confirmed that the ToR stated that Congress had an advisory role within the system. The paragraph added last year was at Paragraph 3.3 in the Terms of Reference. KR advised that Congress needed to be clear when decisions were being made as challenge could be received for some members.

MS suggested the implementation of an induction for new congress members. PS asked the committee for suggestions on training with respect to any gaps or challenges. MS suggested that a mentor could be provided for new members and an informal chat held to discuss the key functions, to ensure that the ToR was understood and the need to attend meetings regularly. GT to create a one- or two-page report with recommendations and actions.

PS advised that the ToR was discussed at the last meeting. The frequency was to remain at monthly and the quoracy to remain at eight, with a membership number of 15. Some sections, mainly purpose and responsibilities, were merged to shorten the document.

Outcome: The Committee:

- **Noted the outcome of the desktop review of committee effectiveness 2023/24.**
- **Agreed any action required to improve committee effectiveness during 2024/25.**
- **Agreed proposed amendments to the committee's Term of Reference and recommended these to the Board for approval.**
- **Approved the committee workplan.**

Action: GT to produce a one- or two-page report with regards to the process for inducting new members.

7. Horizon Scanning

MS advised that a summary of the workplan for this year had been provided at the last meeting.

GT advised that a strong response had been provided on the Tirzepatide guidance being used in primary care settings.

PS advised that discussions were being held on Lecanemab & Donanemab for treating mild cognitive impairment/dementia caused by Alzheimer's disease to scope what the changes to medication would mean, as well as all the pathway changes (imaging, referrals, assessments etc).

This paragraph has been minuted confidentially.

SZ asked what the approach was on value in respect of the NICE TAs as they were not a value-based methodology and consideration was also required to include implementation, administration and monitoring. MS advised that new models of care were being considered looking at the out of hospital approach, i.e. frailty, end of life, cardiovascular, and secondary prevention which could free capacity and support the system. Within that, harmonisation across the region of the NICE TAs and SRPs. A regional response should be provided and would be brought back to Congress when the regional work had commenced. The clinicians role was to ensure that best evidence based, value and cost was being considered. SZ

commented that the NICE TA's needed to be analysed, review the population demographic and find out what proportion of our population they would be applicable to and the implementation cost , as opposed to just the drug.

8. Any other Business

There were no items of any other business raised.

9. Date of Next Meeting

Wednesday 24 July 2024 at 9.30am – 11.30am via MS Teams.

Minutes of the ICB Finance & Investment Committee Meeting

Held on 2 July 2024 at 2.00pm

Board Room, ICB Headquarters and via Microsoft 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) Interim Chief Executive Officer, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB (via Microsoft Teams)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Loy Lobo (LL) Finance and Performance Committee Chair, Essex Partnership University NHS Foundation Trust (EPUT) (via Microsoft Teams)
- Margaret Pratt (MP) Non-Executive Director and Chair of Audit Committee, Mid and South Essex NHS Foundation Trust (MSEFT) (attending on behalf of Julie Parker via Microsoft Teams)

Other attendees

- Ashley King (AK) Director of Finance - Primary Care, Financial Services & Infrastructure, MSE ICB (via Microsoft Teams)
- Keith Ellis (KE) Deputy Director Financial Performance, Analytics & Reporting, MSE ICB
- Neill Moloney (NM) Executive Director of System Recovery (until agenda item 7)
- Emma Timpson (ET) Associate Director Health Inequalities and Prevention, MSE ICB (for agenda item 8)
- Sarah Hurst (SH) Programme Manager – Integrated Weight Management, MSE ICB (for agenda item 8)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

The Chair (JF) welcomed everyone to the meeting and conducted introductions. The Committee was confirmed quorate. Apologies were received from JP Finance and Performance Committee Chair, MSEFT, noting that MP was attending on her behalf.

2. Declarations of interest

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

MP advised she was a Non-Executive Member for MSEFT and a Board Member for Lincolnshire ICB. MP was employed by NHS England to assist on financial governance assessments. It was clarified the declarations were not pertinent to any items on the agenda for the meeting.

3. Minutes of previous meetings

The minutes of 4 June 2024 were agreed as an accurate record, there were no matters arising.

Outcome: The minutes of the meeting on 4 June 2024 were approved.

4. Action Log / Matters arising

The action log was discussed and updated accordingly. It was agreed for clarity, actions not yet due could be stated on future action logs rather than denoting items as 'in progress'.

LL referred to action reference 6 and advised the EPUT Deputy CFO was in discussion with ICB colleagues regarding future reporting as the data provided within the meeting pack was incorrect.

Following the recent review of Committee's Terms of Reference, NA highlighted a query in relation to Individual Funding Requests (IFR). NA explained this element had been removed from the Quality Committee's Terms of Reference and as it related to funding and suggested this may fall within the remit of the Finance and Investment Committee. The Chair (JF) requested this was referred back to the Executive Committee to clarify what the Finance and Performance Committee would be accountable for.

Committee Vice Chair

Following the approval of the Terms of Reference for the Finance and Performance Committee it was confirmed Mark Bailham would take on the role of Vice Chair.

ACTION: The query relating to the appropriate Committee to oversee Individual Funding Requests (IFR) was referred back to the Executive Committee for clarification.

ACTION: The classification 'not yet due' to be added to action logs and used instead of 'in progress' where appropriate.

Outcome: The Committee agreed Mark Bailham would take on the role of Vice Chair of the Finance and Performance Committee.

Assurance

5. System Finance and Performance Report – Month 2

KE presented the Month 2 System Finance and Performance Report and advised the year-to-date position outlined in the report was based on an earlier submission of the financial plan. It was explained the later revision submitted on 12th June included a reprofiling of efficiencies for MSEFT.

The Committee was advised all organisations were on track to deliver the forecast outturn position for 2024/25.

JK explained future reporting would look to include a straight-line extrapolation to measure the impact should spend continue as it was.

The System financial risk was confirmed as £93.2m, this had increased by £9m due to costs associated to the Mental Health Inquiry at EPUT.

NM highlighted insufficient non recurrent measures to offset the financial risk and highlighted further work was required for organisations to reduce spend or identify additional schemes to mitigate the risk. Year-to-date efficiencies were off plan by £3.1m across MSEFT and EPUT.

KE highlighted a £0.2m year-to-date Capital variance within the ICB for Specialised Commissioning; this was causing a pressure and had been escalated to NHS England.

The £1.1m Capital variance within EPUT related to agency spend that was above where it was

anticipated at this point in the year.

JF raised his concern on the performance for patients waiting 52+ weeks and flagged the need to monitor the position.

It was clarified the overall size of the waiting list had not increased, but the number of longer waiters had not reduced. TD queried whether there was sufficient focus on the longest waiters by speciality.

TD highlighted the need for the Finance and Performance report to mirror standards within the Operating Framework and there was a suggestion Performance colleagues be invited on a quarterly basis for a more focused meeting.

ACTION: Performance Colleagues be invited to attend the Committee quarterly.

Outcome: The Committee noted the Month 2 System Finance and Performance Report and verbal update provided on Planning.

6. Capital update

The Committee were informed the System Capital Departmental Expenditure Limits (CDEL) allocation had been reduced by £5.4m for 2024/25. The reduction was in accordance with the financial framework established to incentivise Systems to break-even.

MP highlighted the impact this would have on backlog maintenance issues and stressed the patient safety risk. It was suggested the financial risk was reflected within the Risk Register.

Mid and south Essex had resubmitted the Capital Plan and work was taking place to reprioritise schemes within the reduced envelope.

JK explained the £5.4m reduction would be subtracted from the repayment of the £96m deficit the System would incur during 2024/25.

The Committee was informed MSEFT had been awarded £4m in relation to Reinforced Autoclaved Aerated Concrete (RAAC).

There was recognition further work was required to treat Capital as a System allocation to divert spend to the areas of the greatest need.

ACTION: Reduction of the £5.4m System Capital Departmental Expenditure Limits (CDEL) allocation to be reflected within the Risk Register.

Outcome: The Committee noted the verbal update on Capital.

7. System Recovery Report.

NM presented the report to provide the Committee with an update on the System Efficiency position for 2024/25 and the work underway to progress schemes to delivery to achieve the £168m System efficiency target.

Month 2 reporting showed a slow start to the delivery of efficiencies within MSEFT and EPUT. NM explained MSEFT had not been able to deliver the level of additional elective activity it had hoped however, there had been good progress in theatres and outpatients.

Good progress had taken place within the ICB on medicines optimisation which had already seen a reduction in spend.

The Estates and Digital workstreams were flagged as areas of focus for the Portfolio Board. NM advised he was now leading on corporate redesign to reduce workforce spend.

The biggest challenge within EPUT was temporary workforce, it was noted further work was required on recruitment controls. NM clarified the reduction in workforce would not reduce the System run rate but would reduce headcount from budgets plus bank and agency utilisation.

Following a query from MB on when the reduction in headcount would be reflected within the financial position, it was confirmed the total headcount for non-clinical posts should be reduced by the end of August 2024 and clinical posts from September 2024. JK explained the trajectory for workforce efficiencies had taken account of the timing and impact of factors such as redundancy schemes and believed further work was needed to identify where temporary staffing reductions had been identified within EPUT and how this linked to the flow programme of work.

LL asked if opportunities for service consolidation across sites had been totally exhausted. NM believed there was further opportunities to explore, and this would form part of Medium-Term Financial Planning.

TD referred to the MSEFT slide on the development of schemes/confidence of delivery and welcomed the same level of reporting for EPUT. It was unclear where the gaps for EPUT were.

JF welcomed consistency in future reporting from each of the organisations. The Committee agreed the need to closely monitor the forecasted position and subsequent gaps. Recurrent efficiencies were highlighted as significant to ensure mid and south Essex was more sustainable in future.

Outcome: The Committee: noted the System Recovery Report.

Business Cases

8. This item has been minuted confidentially.

Financial Governance

9. Board Assurance Framework / Finance Risk Register

It was noted that the risk management system Datix had been implemented as part of the roll out of the new risk management framework.

The Committee was presented with the relevant finance section of the Board Assurance Framework for May, the updates for June were not available due to the timing of the report submission but would be presented to the July Board. It was noted the risk on Capital would be included in future reporting.

The Corporate team were exploring a programme of work to redefine the reporting of the Board Assurance Framework to incorporate guidance from the National Quality Board on complex dynamic risk assessments, becoming a pilot with NHS England.

There was a further discussion on the commonality and connectivity of reporting risk. NA advised although work had started to embed a system approach to risk management, there was further work required to fully align processes.

MB suggested a deep dive took place quarterly to focus on a single risk.

It was noted there was a duplication of risks within the Partner Organisation Self-Identified Key Risks for MSEFT (Cyber security).

ACTION: A quarterly deep-dive on individual finance risks be included in the committee work plan.

Outcome: The Committee noted the Board Assurance Framework and Finance Risk Register, the work taking place to enhance the Risk Management Process, and approved the recommendation that Risk ID 51, Specialised Commissioning was closed.

10. Triple Lock Ratification

There were no triple lock ratification decisions for this meeting.

11. Feedback from system groups

The minutes of the System Finance Leaders Group held on 15 April 2024 and System Investment Group on 25 March 2024 were presented for information.

The Committee was advised NHS Property Services would attend the next System Finance Leaders Group to provide an update on the development of the Infrastructure Strategy in readiness of attending the July ICB Board Seminar.

JK suggested Shared Care Record was discussed at the same time as the Electronic Patient Record at a future meeting to ensure the Committee were kept abreast of the wider digital priorities.

ACTION: Shared Care Record to be added to the Forward Planner.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

12. Any other Business

There were no items of any other business.

13. Items for Escalation

To the ICB Board:

- Tier 3 Weight Management Business Case

14. Date of Next Meeting

Tuesday 6 August 2024
2.00pm - 4.30pm
Microsoft Teams Meeting

Minutes of the ICB Finance and Performance Committee Meeting Held on 6 August 2024 at 2.00pm

At ICB Headquarters Boardroom via Microsoft Teams

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Committee MSE ICB, **Chair**
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB (via Microsoft Teams)
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB (via Microsoft Teams)
- Jennifer Kearton (JKe) Executive Chief Finance Officer, MSE ICB (via Microsoft Teams)
- Loy Lobo (LL) Finance and Performance Committee Chair, Essex Partnership University NHS Foundation Trust (EPUT) (via Microsoft Teams)
- Alan Tobias (AT) Mid and South Essex NHS Foundation Trust (MSEFT) (attending on behalf of Julie Parker) (via Microsoft Teams)

Other attendees

- Ashley King (AK) Director of Finance - Primary Care, Financial Services & Infrastructure, MSE ICB (via Microsoft Teams)
- Keith Ellis (KE) Deputy Director Financial Performance, Analytics & Reporting, MSE ICB (via Microsoft Teams)
- Neill Moloney (NM) Executive Director of System Recovery, MSE ICB
- Dawn Scrafield (DS) Chief Finance Officer, Mid and South Essex NHS Foundation Trust (MSEFT) (via Microsoft Teams)
- Trevor Smith (TS) Chief Finance Officer, Essex Partnership University NHS Foundation Trust (EPUT) (via Microsoft Teams)
- Jenny Davis (JD) Director of Finance, Essex Partnership University NHS Foundation Trust (EPUT) (via Microsoft Teams)
- David Barter (DB) Deputy Director of Commissioning, MSE ICB (Item 10 only) (via Microsoft Teams)
- Jackie Graham (JG) Dental Manager, MSE ICB (Item 10 only) (via Microsoft Teams)
- Sara O Connor (SOC) Senior Corporate Services Manager (Item 12 only) (via Microsoft Teams)
- Jane King (JKi) Corporate Services and Governance Support Manager, MSE ICB (minutes)

1. Welcome and apologies

The Chair (JF) welcomed everyone to the meeting and conducted introductions. The committee was confirmed quorate. Apologies were received from JP Finance and Performance Committee Chair, MSEFT, noting that AT was attending on her behalf and Nicola Adams, Associate Director of Corporate Services.

2. Declarations of interest

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

JF advised he had a small adjustment to make to his Declaration of Interest, however there was no particular consequence to any items on the agenda.

3. Minutes of previous meetings

The minutes of 2 July 2024 were agreed as an accurate record, there were no matters arising.

Outcome: The minutes of the meeting on 2 July 2024 were approved.

4. Action Log / Matters arising

The action log was discussed and updated accordingly. For clarity actions not yet due were stated as such on the action log, rather than denoting items as 'in progress.' A number of actions were due for completion in August which JF expected to be robustly covered at the September committee meeting.

JF expressed concern that action reference 9 had been open for some time. JKe explained that the action was still relevant and progress was being made to identify the forecast outturn position, however there were many moving components and it was expected that the Investigation and Intervention programme would be built in.

Assurance

5. Update position on Investigation and Intervention

JKe advised that since the last committee meeting, PriceWaterhouse Coopers (PWC) had been contracted to undertake an Investigation and Intervention (I&I) process, as nationally directed by NHS England (NHSE). The first investigation report was expected the following week. The purpose of the I&I process was to identify between 4 and 6 key delivery interventions to facilitate the £96m cost savings in 2024/25.

Following initial investigation work, the next phase would look at how to mobilise the interventions identified. As part the I&I process, the ICB and NHSE Regional team met with PWC twice a week, with an additional separate meeting for escalations. Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation (EPUT) met separately with PWC.

The first Part II System Oversight and Assurance Committee (SOAC) meeting was due to take place on 9 August, which would focus on the NHS Oversight Framework (NOF) 4 and look at how the I&I work would feed in to SOAC discussions.

JF and MB queried whether there were any early indications of remedial actions required to achieve the cost savings target, given it was already Month 5. LL enquired whether feasibility testing would be undertaken on the recommended interventions before they were formalised.

JKe responded that the System had been clear to PWC that they want to move to Phase II of the I&I process as soon as possible and that formal intervention recommendations had not been received. Conversations with PWC and NHSE would help ensure 'no surprises'.

TS advised that EPUT also awaited details of I&I recommendations and commented that a high volume of information requests had been received which were having an impact on resource and capacity.

AT queried whether conversations with PWC would look beyond the 2024/25 financial year. JKe stated the ICB were clear with PWC that the System had a medium-term plan, however she stressed there was immense and unprecedented pressure on NHS systems to deliver this financial year.

Outcome: The Committee noted the verbal update position on the Investigation and Intervention process.

6. System Finance and Performance Report – Month 3

Financial Report

KE presented the Month 3 System Finance and Performance Report and advised the year-to-date (YTD) position was £9.74m off plan with a forecast outturn expected to achieve £96m deficit.

For Month 3 the System financial risk was unchanged at £93.2m but this would be reviewed for the Month 4 position.

YTD efficiencies for the System were £5.2m off-plan, which was contributing to the overall YTD adverse variance of £9.74m.

TS advised that EPUT's financial pressure points were in mental health in-patient services and estate pressures. A big improvement in agency staff usage was noted, however as the figure was still some way off the planned trajectory, executive escalation on oversight was in place, led by their Chief Nurse and an action plan was in place to mitigate against this.

DS reported a cost reduction shift in pay costs for MSEFT however there was still opportunity to reduce temporary pay further. There had been an increase in non-pay, particularly for drugs and consumables. Addressing length of stay and bed closures, this was progressing well across mid and south Essex.

MB noted that over 50% of efficiencies were non-recurrent and highlighted the importance of also identifying recurrent savings. MB queried whether adequate controls were in place to ensure bank and agency staff were not used to cover vacant positions where they no longer exist and whether control over headcount was where it needed to be.

DS confirmed that good progress was being made on the Mutually Agreed Resignation Scheme (MARS). There was risk that some of the transformation work would not align with the MARS timeline so it was important to carefully manage any potential consequence in the short term. A corporate consultation would look at wider opportunity for a further reduction in posts. On completion of the annual safe care review, which would look at what minimum safe care should be in terms of nursing levels, a clinical consultation would review rotas and rosters for delivering safe care.

AK explained the ICB was seeing continued and sustained growth in Continuing Healthcare costs. JKe added it was an area of significant concern and was being escalated through the 'flow' group. JKe suggested it would be useful to have a deep-dive presentation to the committee on high-risk areas across the system and recommended that All Age Continuing Care should be the first.

The committee agreed that future finance reports should include a slide summary and a report from each of the chairs in that space. JKe would discuss any areas for potential deep dives with DS and TS.

ACTION: Financial deep dive presentation be scheduled in the committee planner for each high-risk area, beginning with All Age Continuing Health Care.

Performance Report

JKe presented the Performance Report which provided assurance of delivery against the 2024/25 National Operational Planning commitments and Constitutional Standards. The ICB Director of Oversight and Assurance would attend future committee meetings to present the Performance Report.

Members discussed performance and JKe highlighted that although the commitment to improve performance against the 28-day Faster Diagnosis Standard (FDS) was below plan with May 2024 performance at 70.4% compared to trajectory of 73.4%, there had been improvement in some areas and most tumour sites had increased in performance compared to April 2024 except skin and Lower Gastrointestinal (GI).

In terms of the total cohort of patients whose referral to treatment (RTT) wait would breach 65+ weeks by end of September 2024, the number of non-admitted pathways were decreasing closely to trajectory. However, admitted pathways were deviating from the trajectory. JKe suggested this area could be considered for a future committee deep-dive.

Outcome: The Committee noted the Month 3 System Finance and Performance Report.

7. System Recovery Report

NM presented the System Recovery Report which provided the committee with an update on the System Efficiency position for 2024/25 and the work underway to progress schemes to delivery to achieve the £168m System recovery target.

At Month 3, the ICB was reporting a break-even position for YTD and full year forecast, whilst both EPUT and MSEFT were reporting an adverse variance to plan on YTD and full year forecast. A number of schemes for both the Trusts had not yet reached delivery stage and therefore it was expected that the trajectory would improve as schemes mature.

All organisations were forecasted to deliver to the planned system outturn position of £97.5m deficit at year-end. The YTD position against the revised profiled plan showed the system £9.74m off plan.

In relation to the MSEFT workforce efficiency programme, JF stressed the importance of having MARS applications sign off promptly. JKe explained that the regional NHSE team were supportive of MARS and there was a detailed plan in place for prompt sign off. NM added that there was regional engagement as part of the NOF4 process so any delays could be highlighted via this route.

Outcome: The Committee: noted the System Recovery Report.

8. Capital update

JD presented the latest iteration of the 2024/25 Joint Capital Resource Use Plan, noting the final plan would be published on the ICB website. Since it was presented to the committee, there had been a £5.4m capped reduction as part of the penalties around planned revenue deficit (which was split equally across two providers). The overall capital plan was now £161.8m.

The key risks to the plan included a large number of unfunded schemes (in excess of £85m) and a number of major external projects that needed to be delivered on time over the next couple of years.

EH was pleased to see 'Greener NHS' content included in the plan. EH stressed the importance that any reference to the ICB public consultation (to consult on the future of community-based services) in both the Joint Capital Resource Use Plan and the ICB Infrastructure Strategy should adopt the same wording used by the ICB in consultation documentation to avoid any confusion. JD agreed to make the necessary changes.

LL remarked that given the expenditure constraints faced by the system affecting investment in capital, technology and infrastructure, queried when the system would be able to procure these.

JKe explained the system were currently identifying and prioritising commitments and that although productivity and efficiency spends should be considered, they were not top priority. Trying to unlock capital for innovation was difficult with constraints and a reducing financial envelope, however there were pockets of capital/funding available for specific items. LL suggested that capital may not

always be required by IT providers for digital solutions and there may be conversations to be had with digital providers. JKe commented that IT developments were for the Chief Digital Information Officers to consider and would take the suggestion back to them. JD added that this suggestion could be brought into the options appraisal process but was aware from the MSEFT digital team, this route had been considered previously and was not favourable therefore a balance was needed. JD suggested the system could have a pipeline of projects that were lined up, ready to bid for when capital monies become available.

JF requested that, in terms of the unfunded schemes, that the committee be informed what the £85m shortfall meant, e.g., what projects would get done and what would not get done with the budget available. More information was required around stretching the envelope and what the risks were if there was not enough capital. JD was happy to provide analysis on what was and what was not able to be prioritised.

ACTION: JD to provide analysis on what was and what was not able to be prioritised in the 2024/25 Joint Capital Resource Use Plan, due to the £85m shortfall.

Outcome: The Committee noted the update on the Joint Capital Resource Use Plan.

9. Infrastructure Strategy

JKe and AK presented the final draft of the Infrastructure Strategy and supporting Capital Template to the committee following the Board seminar on 11 July 2024 to discuss the key aspects of the strategy.

At the end of March 2024 Integrated Care Systems (ICS's) were asked to produce Infrastructure Strategies for submission to NHSE at the end of July 2024. This aligned with work that had been initiated previously by the ICB led by NHS Property Services.

The Infrastructure Strategy set out six key infrastructure objectives that would support the ICS to achieve its ambitions and would evolve as the ICB and its partners work on addressing the key elements within it.

JF recommended that the Finance and Performance committee role should be included on all relevant papers for consistency and transparency, including the route the paper had taken to reach the committee.

LL felt the strategy did not cover future ways of working, e.g., agile working and how to provide workspace for Community teams and queried what could be done in partnership with other community players.

EH remarked that the strategy vision did not align with those published on the internet for MSE and there were a few inconsistencies that needed to be picked up if the report was to be published. AK explained it was not intended to be a published document, but was an iterative plan and would link in with EH on corrections required.

MB queried whether vacant space could generate an income. JKe advised there was programme of work taking place with partners on estates and estate utilisation.

It was noted that although the cover paper stated the strategy was for approval, the document had been submitted to NHSE and presented to the committee for information. JKe agreed to share the Infrastructure Strategy with MSEFT and EPUT to take through the appropriate governance route for oversight. JF hoped that by sharing with a wider audience it would help to reach out to social care, to identify other estate opportunities.

ACTION: JKe to share the Infrastructure Strategy with MSEFT and EPUT to take through their appropriate governance routes for oversight.

Outcome: The Committee noted the Infrastructure Strategy and the Capital Template submission.

Business Cases

10. Children and Young People Dental Pilot

DB and JG presented the proposal for the Children and Young People Dental Access three-year pilot project. The aim of the pilot was for dental practices to be aligned to local schools and nurseries to provide education and guidance on oral care to young and pre-school children, parents, carers, and staff. Any necessary dental treatment required would be offered at the linked dental practice.

The total cost of the pilot over the three-year period (for 100% coverage of schools in mid and south Essex) was approximately £7.1m, however it was expected that the significant long-term savings would outweigh the cost of the pilot.

The committee noted the Dental Commissioning and Transformation Group and Primary Care Commissioning Committee had supported the development of the proposal.

In response to LL, DB advised that learning had been taken from the Care Home Dental Pilot where all care homes were linked to dental practices, with dentists and their teams making ward rounds and undertaking treatment, as necessary. It was envisaged there would be a good uptake on this pilot.

DB advised that he had worked closely with the Finance team and confirmed there was existing funding within the dental budget to undertake the pilot.

JKe noted that investment had recently been made in a Thurrock early years oral health programme, and queried whether there was overlap. DB confirmed there was no overlap and the programme, around supervised tooth brushing, and pilot would complement each other.

JKe was aware that the paper had been through the Executive Committee and asked if any concerns had been responded to. DB there were no concerns or actions arising from Executive meeting who were in support of the pilot.

In response to the committee's discussion around engagement and pilot evaluation, DB confirmed there was a dedicated Task and Finish Group who were due to present at the Integrated Care Partnership meeting in September 2024 to garner support from the community. JG explained that the service specification would include annual reviews and also a sample of reception children would be followed through school to year 3 to track the impact of the pilot.

JKe clarified the recommendation was not required to go through the 'new' Triple Lock process as it was budgeted for and not a cost pressure, it did go through the Executive Committee as consumed underspend of dental budget.

Outcome: The Finance and Investment Committee approved the Children and Young People Dental Pilot to run for three years at a cost of £7.1m.

Financial Governance

11. CDC referral from SOAC

JJ presented the Clinical Diagnostics Centre (CDC) paper on behalf of the ICB Associate Director, System Programmes. The report provided the committee with an update on the risks and mitigations associated with the CDC programme. The risks were escalated to SOAC in May 2024 and discussed at the Systems Diagnostic Board on 15 July 2024 where a number of actions were agreed. SOAC requested for the risk to be highlighted and an update provided to the Finance and

Performance Committee.

JF requested that the critical decision dates or when the programme would become unviable was included in the next update. JJ confirmed the role of Task and Finish Group was to quantify operational and financial risk.

ACTION: Include critical decision dates or when the programme becomes unviable in the next update for the clinical diagnostics centre risk escalation.

Since the report was written, EH explained that another CDC risk had been identified, but had hopefully been mitigated, regarding the CDC at Braintree. The CDC required the ICB to adjust the William Julien Courtauld (WJC) Midwifery Led Birthing Unit. Executives at MSEFT and the ICB had agreed a way forward and would monitor the situation. The risk would be captured in future updates. JJ confirmed the issue around risk to timescales in terms of delivery of the programme was flagged at the last System Diagnostics Board meeting.

Action: Ensure decision undertaken following the MSEFT / ICB Executive to Executive meeting regarding the William Julien Courtauld (WJC) Midwifery Led Birthing Unit was presented at the next Executive committee meeting.

JKe commented that the biggest concern for the committee was the risk of overspend on capital budgets, alongside the risk of delays.

ACTION: An update on the CDC risk be scheduled to present to the Finance and Performance Committee in September 2024.

Outcome: The Committee noted the report and request to schedule a further report in September/October for assurance on the mitigations of the risks.

12. Policy update

SOC presented the policy update paper, highlighting that all policies relating to finance (some were the responsibility of the Finance and Performance Committee, others the Audit Committee (responsible for policies relating to financial control) had been reviewed.

Although not included in the report, it should be noted the Standing Financial Instructions were reviewed in January 2024 where minor changes were made following organisational change, inclusion of Provider Selection Regime and transferred into the ICB standard template.

Outcome: The Committee noted the policy update report.

13. Feedback from system groups

The minutes of the System Finance Leaders Group (SFLG) held on 10 June 2024 and System Investment Group on 15 July 2024 were presented for information. It was noted that the System Investment Group update was also included (also goes to SFLG).

JKe highlighted that engagement with Southend and Thurrock councils had been minimal in terms of the SFLG and once the holiday period had passed, she would be reaching out to both councils. The new Chief Finance Officer from NELFT had been welcomed to the group.

JF requested an explanation around the comment 'market-shaping was a huge area of opportunity' in the SFLG minutes. JKe advised this was in relation to work being undertaken in the care home sector, led by Essex County Council with involvement from South East Essex Alliance. JF suggested it would be good to understand the work as outcomes become clearer.

ACTION: Up update on the work led by Essex County Council with the South East Essex Alliance around the care home sector be included within the committee work programme.

Outcome: The minutes of the System Finance Leaders Group and System Investment Group were noted.

14. Any other Business

JKe advised that KE was progressing the Medium-Term Financial Plan through the Deputy Chief Finance Officers Group. EH and JKe were due to review the longer-term strategy with the aim to finalise by end September 2024 so was seeking committee's permission to hold a Finance and Performance Seminar at the end of September to approve the plan.

EH suggested if an additional meeting were required it would be useful to include with the Decision Making Business Case. JF was receptive and would be guided by EH and JKe as to what was needed.

15. Items for Escalation

To the ICB Board:

- CYP Dental Pilot for Information

16. Date of Next Meeting

2.00pm–4.30pm, Tuesday, 3 September 2024

In person meeting at ICB Head Quarters.

Minutes of ICB Primary Care Commissioning Committee Meeting

Tuesday, 12 June 2024, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Ashley King (AK), Director of Finance Primary Care, Financial Services and Infrastructure (nominated deputy for Jennifer Kearton).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).
- Caroline McCarron (CMc), Deputy Alliance Director for South East Essex (nominated deputy for Rebecca Jarvis).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Nicola Adams (NA), Associate Director of Corporate Services (Item 11 only).
- Jane King (JKi), Corporate Services & Governance Support Manager (minutes).
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.
- Jackie Graham (JG), Dental Manager (Item 7).
- Dr Sarah Crane (SC), Associate Medical Director for Development, Clinical Leadership and Innovation (Item 8).

Apologies

- Dr Matt Sweeting (MS), Executive Medical Director.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.

Approved 10 July 2024

- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that the meeting was quorate.

2. Declarations of Interest

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

Members noted the register of interests.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 7 May 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 7 May 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (84, 106, 107 & 109) were all within timescales for completion. Action ref: 80 (relating to an overall primary care patient engagement proposal) was reopened as it was not completed as planned and an update paper was scheduled for the July 2024 meeting.

The Committee agreed that a face-to-face committee meeting would be held on Wednesday, 9 October 2024, with the option to attend virtually. The venue would be confirmed in due course.

5. Primary Medical Services Contracts Report

JS provided an update on primary medical service contract activity since the last paper was presented to the Committee in April 2024. The paper included an update from the Connected Pathways team on the work undertaken to support practices to move to a modern general practice access model and raise public awareness on the changes to general practice. Further updates were noted as follows:

The contract files held by NHS England had now fully transferred to the ICB.

There were 2 South East Essex GP practices undertaking a consultation to close branch surgeries prior to making a branch surgery closure application to the ICB. It was anticipated that the applications would be presented to the committee for consideration once the patient engagement exercises were complete.

A procurement exercise to secure a GP practice to operate from the new Beaulieu Health Centre, currently under construction, was underway.

Work continued with a surgery in the Mid Essex area and another in Basildon and Brentwood area to deliver their recovery action plans, supported by Section 96 payments. One further practice had submitted a formal Section 96 request which was under review and 2 further practices had approached the ICB regarding potential resilience funding requests and advice had been provided.

The ICB would be participating in the Primary Care Staff Survey, which was due to be released in October 2024, the results of the survey were due in April 2025. The survey would provide insight into the differences in staff experience and the results used to inform action plans to improve experience of primary care staff and ultimately improve patient care.

Work was being undertaken on trying to reduce unnecessary work shifting between primary and secondary care and vice versa. A detailed update would be presented at a future committee meeting.

ACTION: An update on the work being undertaken on trying to reduce unnecessary work shifting between primary and secondary care and vice versa to be scheduled for a future meeting.

Capacity issues were impacting on progress with the Alternative Provider Medical Services (APMS) contracts review. Action was being taken to mitigate this, but this may further impact on other work priorities.

SA queried the level at which the staff survey findings would be analysed to develop action plans. JS was unsure of the data that would be produced from the staff survey but would be looking for any themes. Survey results for individual organisations would need to be considered by the practices themselves. SA suggested it would be useful to have a future committee discussion regarding implementation plans arising because of the staff survey findings, to ensure plans were robust.

ACTION: Arrange future committee discussion regarding implementation plans arising from the staff survey findings, to ensure plans were robust.

BB noted one of the aims of the connected pathways work was to increase the number of consultations undertaken in primary care but there was little information included about managing demand. JS explained the information in the paper was largely linked to NHS England funding requirements and did not cover the work the ICB was undertaking with practices to understand and manage demand.

WG added that the aim to increase consultations was driven by the national requirement in the primary care access recovery programme and was largely associated to the development of Additional Roles Reimbursement Scheme (ARRS) staff. Part of the Primary Care Strategy discussion had been around the optimum model for consultations, particularly the length of consultation according to the complexity of the patient's needs.

JH commented that whilst more consultations were being provided in primary care, this did not always mean a difference in patient outcomes or the quality of care. SA suggested that consideration needed to be given to developing a set of quality metrics (e.g., around appointments) as part of the Primary Care Strategy refresh and should be a theme of the strategy meeting in July.

ACTION: WG to propose a set of quality items/metrics (e.g., around appointments) as part of the Primary Care Strategy refresh for discussion at the meeting in July.

ES queried whether an application for hypertension screening funding, available for dentistry and ophthalmology services, had been made by the ICB. WG advised that a bid had been submitted, led by the Health Inequalities Lead, for dental services hypertension funding which would provide opportunity to see how hypertension screening could be rolled out locally within optometry services with local funding. ES was disappointed that a bid for optometry service hypertension funding was not submitted at the same time.

Outcome: The Committee NOTED the Primary Medical Services and Connected Pathways updates.

6. Community Pharmacy Update

KSS presented the Community Pharmacy update. The Pharmaceutical Needs Assessment (PNA) Steering Group had reviewed a PNA for the Essex Health and Wellbeing Board area which did not identify any gaps in the provision of community pharmacy services. The PNA's for Southend and Thurrock were yet to be formally reviewed.

Previously the PCCC had requested that objective criteria were identified to define the level where significant gaps in service require consideration to subsidise a pharmacy to prevent closure. KSS advised there was a nationally commissioned Pharmacy Access Scheme (PhAS) that targeted financial support to pharmacies deemed essential for local provision of physical NHS pharmaceutical services. To be eligible for payments, pharmacies must meet certain criteria. There were 32 community pharmacies in mid and south Essex that received additional payments under this scheme.

KSS was pleased to report that applications for 3 new pharmacies in mid and south Essex had been received. In response to SA, she confirmed the applications were from small independent providers.

SW noted that Ambulatory Blood Pressure Monitoring rates were low for mid and south Essex compared to national figures. As hypertension monitoring was a system priority, SW queried whether the ICB should consider removing this as an enhanced service and switch to the nationally funded service provided by pharmacies. KSS confirmed there was capacity and a contractual framework in place if it was decided to provide the service through pharmacies, which would be funded from the national Global Sum available to pharmacies, rather than the ICB budget.

SW commented that targeted data would help identify pharmacies undertaking specific services, e.g., flu vaccines, contraceptive service, pharmacy first consultations and, by re-promoting these services, it would provide more capacity in primary care.

KSS shared that Community Pharmacy Essex recognised that more robust data was required to fully integrate with Alliance teams and Integrated Neighbourhood Teams.

A launch event with Essex County Council was taking place regarding the Healthy Living Pharmacy Level 2 & 3 Programmes which looked at local authority commissioned services alongside NHS contractual services.

Outcome: The Committee NOTED the Community Pharmacy Update.

7. Dental Provider Appeal

DB presented the paper setting out a request for a refund of the 2021/22 under-performance debt in relation to a specific contract, due to personal and extenuating circumstances that had recently come to light. The provider acted as an Urgent Dental Centre (UDC) during the COVID years. The dental provider had given a statement detailing exceptional personal and business circumstances which has led to the request for an appeal against the debt recovered by NHS England & Improvement (NHSE&I) whilst acting as UDC dental provider during COVID. The provider was requesting a full refund of the recovery made by NHSE&I. NHS England had agreed to bear the full financial impact of the refund, subject to the ICB's agreement. DB confirmed there was no underperformance by the practice.

AK sought clarification that NHSE would fully reimburse the costs and would accept the decision made by the Committee. DB confirmed this was correct and there would be no cost to the ICB.

WG explained this situation was exceptional and historic and did not envisage bringing similar cases to the Committee for a decision as there was a national policy and year-end process for dental contract management.

Outcome: The Committee SUPPORTED the reimbursement to the Provider by NHS England.

8. Primary Care Workforce

SC presented the Primary Care Workforce report which included current workforce data against operational planning targets, recruitment to Additional Roles Reimbursement Scheme (ARRS) roles and the planning and implementation of recruitment and retention initiatives.

The Primary Care Training Hub provided information to the system regarding primary care workforce, education and development. The Training Hub was viewed as high performing an innovative by the regional NHSE team and several of the Hub's initiatives were recognised regionally and nationally as exemplary.

SA commented that it was positive to see the steady increase in workforce numbers across mid and south Essex and enquired whether there was data to identify workforce hotspot areas to understand the levels of workforce challenges.

SA also queried how the wider primary care workforce could be included (e.g., Pharmacy, Optometry and Dentistry colleagues), whether there were plans to provide workforce data via Alliance or PCN and commented that relationship between primary care workforce work and staff survey needed to be better linked. In response, JS commented this data was available. The Workforce and Connected Pathways teams would be working together to plan the staff survey exercise and subsequent response.

The Training Hub contract ran until 31 March 2025, with an option to apply for an extension for a further 2 years. NHSE were seeking approval to extend the service contracts of all 35 ICS level Training Hubs procured in 2022 for the maximum allowable 2 years which would extend the end date of the contract to April 2027.

PG stressed that targeted GP and wider workforce retention aims should be included in the ICB's Primary Care strategy.

JH was concerned there appeared to be a high turnover of ARRS staff and enquired whether there was any data or anecdotal evidence regarding this. SC advised that practices were only required to report on numbers employed by each practice, not how many joined or left. JS hoped that the ARRS research project would identify any issues of high staff turnover.

SC agreed it would be useful to interrogate workforce data by Alliance to identify workforce trends. SC suggested that it would also be useful to include the outcome from the Career Conversation initiative in the next workforce report. Career Conversations were part of a national pilot whereby experienced GPs in the system were interviewed by a trained conversation facilitator to ascertain the key pull and push factors for retention. Initial data had been very positive.

SA suggested it would be useful to discuss Primary Care Workforce at the face to face in meeting in October 2024 which would fit in with the Primary Care Strategy refresh.

Outcome: The Committee NOTED the Primary Care Workforce update.

9. Primary Care Financial Summary

AK presented the Primary Care Financial Summary, providing an overview of the financial performance of the ICB in respect of its investments in, and directly influenced by, primary care during 2023/24 and the opening financial plan for 2024/25.

The report noted that the ICB closed with a surplus against the Delegated Fund, a deficit against the identified Non-Delegated Primary Care budgets and a surplus in relation to Pharmacy, Optometry and Dentistry which resulted in an overall £7.7m deficit position. The closing position contributed to the overall position of the ICB and could not be fully considered solely in isolation. The overall deficit was driven through over-performance against the Prescribing budget.

The primary care opening financial plan formed part of the wider ICB financial plan to deliver a breakeven position in the 2024/25 financial year and assumed delivery of £9.5m of efficiencies as part of a Medicines Optimisation work programme and £600k within the broader primary care portfolio. As in previous years, it was anticipated that any overspends in one area will be offset by underspends in another and the Delegated and Non-Delegated budgets were not monitored in isolation.

The report set out identified specific financial risk areas that could impact in-year financial performance and the future ability to make new investments into Primary Care which included GP Prescribing, Wethersfield Asylum Accommodation and Premises Costs.

SA said it was important for the committee to be sighted on the ICBs financial situation.

PG explained that open and honest conversations with general practice had commenced around the system's financial position and stressed that better system working, and strong relationships were key to for financial recovery.

Outcome: The Committee NOTED the Primary Care Finance update.

10. Primary Care Risks

WG presented an overview of the primary care risks included on the ICB's risk register and Board Assurance Framework. There were currently 56 risks on the ICB Risk Register, 11 of which were relevant to the work of the Committee. There were 2 red rated risks related to Primary Care Demand and Capacity and Prescribing Costs and 9 amber rated risks.

The Committee noted the proposal to close one risk regarding the lack of information on the GP 2024/25 contract settlement as the information had now been received. There were no objections to closing the risk. A new risk however was added around potential GP industrial action following a British Medical Association referendum rejecting the proposed 2024/25 GP contract changes.

It was noted that the Executive Lead for primary care risks should be updated to Pam Green.

JH enquired why initial risk ratings for all risks were the same as the current ratings, despite some of the risks being open for some time. WG explained that the risks were challenging and, although lots of work was taking place to mitigate the risk, it can take time to change the rating of a risk.

NA added that this was the first register produced from the new Datix risk management system and the initial ratings shown reflected the point when the risk data transferred across to the new system and the initial rating had not been backdated to the establishment of the ICB. NA highlighted that the new system would be able to track risk movement and trends.

The Committee agreed to receive risk updates at bi-monthly operational meetings.

Outcome: The Committee NOTED the Primary Care risk update.

11. Committee Effectiveness, Terms of Reference and Workplan 2024/25

NA explained that the Committee's annual self-assessment (or effectiveness review) assessed how the committee had performed over the last year in accordance with the objectives set within its terms of reference (i.e., has it delivered what it set out to do) and how effective it has been in discharging those responsibilities.

The initial desktop review of the committee had been completed which included a review of the committee terms of reference. A survey was distributed for feedback to members and attendees to complete with 7 responses received. A review of the self-assessment outcomes and survey results was undertaken to ascertain whether the committee had been effective throughout the year, whether it had met its objectives and whether changes were required. Several recommendations were set out in the report to consider taking forward to improve committee effectiveness.

WG added that the reflective discussion on committee progress that took place at the face-to-face development session in February 2024 and the outcome of the self assessment on delegation had identified several specific actions which were set out in the paper. WG suggested that progress against the actions identified in the delegation self-assessment and committee self-assessment would be reported to the October 2024 committee.

ACTION: Progress against the actions identified in the delegation self-assessment and committee self-assessment be reported to the October 2024 committee.

SA commented that it was both a highlight and success that there was a broader range of voices at the Committee and that the Committee had started to have face-to-face meetings.

PG felt it would be useful to undertake another effectiveness review following completion of the refreshed Primary Care Strategy to undertake a pulse check between now and formal review next year. SA agreed and commented that he was keen to see the updated strategy and how it related to the Committee's work. NA agreed that a mid-point review could be scheduled, and work programme revisited following the new strategy.

ACTION: JKi to schedule mid-point Committee Effectiveness Review following completion of the new Primary Care Strategy.

Outcome: The Committee APPROVED the revised Terms of Reference of the Committee and RECOMMENDED to Board.

Outcome: The Committee APPROVED the updated draft Committee Work Plan for 2024/25, subject to mid-point review outcome and need to update workplan.

12. Minutes of the Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 3 April 2024 and 1 May 2024 were received.

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

13. Items to Escalate

There were no items to escalate.

14. Any Other Business

There was no other business.

15. Date of Next Meeting

9.30-11.30am, Wednesday 10 July 2024
Via Microsoft Teams

Minutes of ICB Primary Care Commissioning Committee Meeting

Tuesday, 10 July 2024, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes (Nominated deputy for Jennifer Kearton).
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood (Nominated deputy for Pam Green).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (Nominated deputy for Aleksandra Mecan).
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Eleanor Shewan (ES), Deputy Director of Nursing (Nominated deputy for Viv Barker).
- Dr Anna Davey (AD), ICB Primary Care Partner Member.

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DB), Deputy Director of Commissioning.
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex.
- Michelle Cleary (MC), Alliance & Delivery Lead South East Essex.
- Katherine Cornish (KC), Fuller Implementation Lead.
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality
- Nicola Adams (NA), Associate Director of Corporate Services.
- Jackie Graham (JG), Dental Manager.
- Jane King (JKi), Corporate Services & Governance Support Manager (minutes).
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary & Clinical Lead, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- Bryan Harvey (BH), Chair, Essex Local Dental Committee.
- Tony Clough (TC), Secretary, Essex Local Dental Committee.

Apologies

- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- James Hickling (JH), Deputy Medical Director.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.

- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.

1. Welcome and Apologies

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

2. Declarations of Interest

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

Members noted the register of interests.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 12 June 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 12 June 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly.

It was noted that the outstanding actions (111, 116, 120, 121, 122, 123 and 126) were all within timescales for completion.

5. Children and Young Peoples Dental Pilot

JG presented the proposal for the Children and Young People Dental Access three-year pilot project. The aim of the pilot was for dental practices to be aligned to local schools and nurseries to provide education and guidance on oral care to young and pre-school children, parents, carers, and staff. Any necessary dental treatment required would be offered at the linked dental practice.

The total cost of the pilot over the three-year period (for 100% coverage of schools in mid and south Essex) was around £7.1m, however it was expected that the significant long-term savings would outweigh the cost of the pilot. A staged roll-out of the pilot was planned, with the first phase focussing on pre-school, reception and year 3 children. Phase 2 would aim to reach all children of pre-school and school age within mid and south Essex.

Dental practices would be asked to submit an expression of interest to join the pilot. Practices would be paid per linked school and would be required to provide evidence of delivery of sessions held within the practice and at school, plus the number of children seen requiring treatment.

PW queried whether dentists should be required to undertake dental work with schools as part of business as usual, beyond the three-year pilot. JG explained the initial pilot period was to collect data and undertake evaluation and, if successful, the work undertaken with schools would be incorporated into the dental contract as a permanent fixture.

NA highlighted the total cost for the pilot over 3 years was over £7.1m, therefore approval was required by the Executive Committee and Finance & Investment Committee.

AK queried whether finance for the project had been discussed with the Finance and Contracting teams and recommended that further work was undertaken on the cost savings referenced in the paper. AK supported the proposal, subject to confirmation that the financial detail stacked up. DBa confirmed he was working with the Finance team on funding options.

MA highlighted there was an early years' oral health programme in place in Thurrock. DB welcomed working with colleagues involved in oral health improvement programmes to share learning and to work together to put dental practices at the heart of the initiative.

BH was in support of the pilot but queried whether dentists would be willing to sign-up. BH suggested that introducing 'fluoridation' should also be considered.

DD suggested that evaluation of the pilot should include feedback from schools as previously health initiatives (on diet, exercise and minor illness etc.) had not always been well received due to time constraints on schools.

SA welcomed the shift towards prevention for some of the most vulnerable patients and queried how the ICB could ensure that children and families most in need were targeted. SA commented that it was not clear whether intelligence from children's community services, who had knowledge about children's needs, specifically vulnerable children, was captured in the paper.

AD stressed that children needed to be first seen by dental services far earlier than at school age, e.g., when babies' first teeth appeared and at their first birthday. AD suggested the early post-natal period was an important contact point to start having discussions with parents and carers on the importance of children accessing dental services.

TC was also in support of the dental pilot and said that consideration must be given to the affect it would have on dental access. For practices already taking part in the Dental Access pilot, data showed an increased uptake in dental visits. High decay rates were found in areas where dental disease was expected to be lower, therefore it was important that the pilot covered all areas of mid and south Essex.

DB confirmed the pilot would increase dental access for all children across mid and south Essex and would seek to engage with parents to encourage dental treatment for their children.

SA noted that the pilot was widely supported by the committee, however he requested that consideration was given to the financial caveats outlined by AK; how the pilot would capture the most vulnerable individuals and requested that the relationship between the pilot and broader community should be reflected in the proposal. SA suggested that the proposal was rewritten to respond to the issues raised during the discussion and agreed to consider the paper for approval outside of the meeting, via Chair's action.

Approved 14 August 2024

ACTION: Childrens and Young Peoples Dental Access Pilot paper to be rewritten to respond to the issues raised and to be shared with Chair for approval outside of the meeting, via Chair's Action.

Outcome: The Committee AGREED, subject to the changes discussed:

- For the Childrens and Young Peoples Dental Access Pilot to run for three years.

Outcome: The Committee NOTED:

- Pilot data would be presented to PCCC at regular intervals.
- A Peer Review would be completed, published, and shared with PCCC each year to gauge the progress and achievements of the pilot.

6. Integrated Neighbourhood Teams

SW gave an update on the Integrated Neighbourhood Team (INT) programme, outlining the progress made across mid and south Essex to date. As planned, 20 of the 24 INTs were now live, the remaining 4 were expected to be live by the end of the year. Although the INTs across mid and south Essex were at very different levels of maturity, there was an appetite from all to progress as momentum and possibilities grew. To ensure consistency in how INT progress was measured, a maturity matrix has been developed. Work was also taking place to share understanding of INTs and priorities with key partners.

MA presented an overview on the progress of the Thurrock INTs, known locally as Integrated Locality Teams (ILTs). INT development in Thurrock was based on the original ICB INT Framework but was nuanced to take into consideration the eight strategic ambitions outlined in the 'Thurrock Better Care Together' and 'Brighter Futures' strategies to support the local population's needs.

There were 4 INTs in Thurrock at varying degrees of development. There was a broad and proactive membership across the INTs, however MA acknowledged there were gaps and work was taking place to broaden membership. MA had recently received feedback from a local care-coordinator who gave a range of examples where individuals had experienced improved outcomes because of the work of the INTs. Future INT planning priorities in Thurrock would focus on high intensity users, nutrition, social isolation and weight management.

ES noted that Thurrock INTs did not currently include Optometry representation and requested this was highlighted to the INT leads. MA agreed to raise at the next INT leads meeting and to also highlight the gap in Dental membership.

PW commented that the Providers Register used in Mid Alliance was a useful tool for providers to record their interest in being part of INT work and enquired whether there was similar for the other Alliances. MA confirmed a Directory of Services had been built for Grays INT and shared with the other Thurrock INTs.

Outcome: The Committee NOTED the Integrated Neighbourhood Team update.

7. Fuller Stocktake Update

KC presented an update on the implementation of the Fuller stocktake recommendations which included actions to improve same day access for urgent care, build integrated teams in every neighbourhood, provide personalised care for people who needed it most and to focus on preventative care.

Some INTs were noted as being more advanced than others and had established extensive integration, collaborating with local policing teams and charities. INTs were also beginning to address health inequalities through their Population Health Management (PHM) initiatives. Some of the initial focuses included cardio-vascular disease, frailty, mental health, and cancer and improved outcomes for patients have already been seen as well as a more streamlined process for professionals, and better care coordination. All the developing INTs were fostering stronger partnerships for more cohesive care.

To improve same day access for urgent care, many practices across mid and south Essex, supported by the ICB's Connected Pathways Team, were actively transforming their approach to GP appointments by using different access models, e.g., hub total triage systems or digital tools.

A personalised care approach for patients with complex or long-term conditions was a core focus for all INTs, with patients assigned a care coordinator to ensure that patients and carers received the right support, promptly addressing any changing needs. There had also been an increased use of clinical toolkits to support personalised care.

The development of PHM dashboards helped the system better understand their populations and specific needs which helped inform preventative interventions.

The Fuller Stocktake Report also identified three key areas (known as 'Enablers') as workforce, estates and data, where the right approach could make a significant difference in helping local systems succeed in delivering the new vision for primary care.

The committee noted the good progress that was being made across mid and south Essex in implementing the recommendations from the Fuller Stocktake Report. INTs were recognised as a priority for the ICB and positive outcomes had highlighted the potential of the approach in mid and south Essex.

SA queried whether there was a mechanism available to PCNs to filter and support the prioritisation of competing agendas and targets. KC acknowledged there were different levels of work to be undertaken and manage across the system with minimal time to deliver and would welcome suggestions from Alliance colleagues on managing this.

JS suggested that consideration should be given on how to respond to and mitigate any risks created by having increased integrated services e.g., an issue experienced within a PCN or INT may have a wider impact on the system. Consideration was also needed around the ICB's approach to quality; to learn from any shortfalls in PCN governance models and the ICB's role in this. The impact on urgent and emergency care because of practices changing their access model needed to be understood as well as what INTs meant for the sustainability for general practice e.g., in Mid Essex, INT and PCN footprints were different and whether this created risk or opportunity.

SA and AD thanked KC for a comprehensive summary on such a broad topic. AD advised that conversations on the future of general practice within broader primary care had commenced as part of Primary Care Strategy conversations. Some concerns had been

raised around continuity of care for patients and how to continue to support the most vulnerable patients, whilst improving same day practice. AD explained the General Practice Provider Collaborative (GPPC) would play an important role in the strategic development of general practice within broader primary care and broader system over the next few years. The importance of Population Health Management should be revisited given the growing aging population.

SA agreed they were important points to consider as well as the need to ensure national and local priorities were managed correctly to achieve clinical and financial sustainability and improve outcomes for patients.

Outcome: The Committee NOTED the Fuller Stocktake update.

8. GP Provider Collaborative

AD provided an update on the ICB's GP Provider Collaborative (GPPC) whose role it was to support general practice and practice workforce. The future intention was to join the GPPC with other provider collaboratives, e.g. Community Pharmacy, Optometry and Dentistry. The GPPC met monthly and system level and alliance level meetings were taking place. A smaller working group was looking at developing the governance of the GPPC.

The GPPC had successfully worked with the Local Medical Council (LMC) to raise with NHS England, the interoperability issue of the iRefer system (used to triage radiology requests) with SystmOne. As a result, iRefer was switched off whilst the issue was investigated and resolved before back in use. GPPC was also able to strengthen conversations with MSEFT regarding the reorganisation of MSEFT outpatient pathways.

AD concluded that the work undertaken by GPPC would continue at a pace that practices were comfortable with. SA was pleased to note that the GPPC was having a positive impact for general practice and practice workforce.

Outcome: The Committee NOTED the GP Provider Collaborative update.

9. Primary Care Patient Engagement

WG presented the Primary Care Patient Engagement paper, outlining the variety of processes undertaken to engage with the local population on access and experience of primary care services.

The ICB's Primary Care Access Recovery Programme aimed to improve patient satisfaction of general practice services, and therefore the ICB was keen to ensure that patient engagement was sought and acted upon. This was undertaken in a variety of ways through both the Primary Care team and Alliances. All four Alliances participate in several processes to gain feedback from patients, service users and residents on a wide range of issues including primary care provision. The key findings are fed back through the Alliance governance structures and inform transformation programmes as well as provider specific feedback on operational issues.

As part of the primary care Support Level Framework visits to practices, aimed at understanding the practice's approach to improving access models, the ICB gained understanding on the variety of approaches taken by practices to gain feedback from

patients. To access funding to support costs associated to transition to the 'Modern General Practice' model, practices must demonstrate communication and engagement with patients prior to transition, their transition plans and the expected improvements. This process helped understand trends in feedback from patients, help strengthen practice processes and ensure there was a continuous loop of feedback.

The ICB also received complaints regarding access to primary care services. Whilst these often related to specific practices, complaints also covered general themes and policy areas. Results from the GP Patient Survey were also received on an annual basis.

Healthwatch organisations across mid and south Essex continuously received feedback from patients regarding accessing primary medical services. Summary reports and trends were shared with the ICB. Membership to PCCC had been expanded to include Healthwatch representatives from September 2024 which would better feed patient views into the ICB's decision making processes.

Gathering feedback from patients remained an ongoing process that informed the evolution of service models.

Outcome: The Committee NOTED the Primary Care Patient Engagement paper.

10. Primary Care Strategy

WG advised that the ICB's Primary Care Strategy was under development. An early stage document was shared, outlining the key themes emerging from the refresh work undertaken to date. The new Strategy would focus on policy direction as set out in the Fuller Stocktake and Access Recovery Programme.

Overall, there had been an increase of GPs in mid and south Essex, which was driven by an increase of trainee roles, but a reduction in fully qualified GPs and GP Partners. Consideration was needed on how to encourage GPs to stay in the profession for longer.

There had been an increase in Additional Roles Reimbursement Scheme (ARRS) roles, however, these required optimisation, alongside the development of retention strategies. The learning from ARRS roles would be applied to support the development of the broader workforce in Pharmacy and Dentistry.

Significant progress had been made with the development of INTs, however feedback had indicated there was more scope for integration, for INTs to develop to better meet patient need. There was a keenness in the system to develop relationships at Primary Care Network and INT level between General Practice, Community Pharmacy, Dentistry and Optometry.

There had been challenge that contracting and funding arrangements were at times unclear, resulting in duplication and lack of optimising provision. Clarification was required on the priorities within each element of the system and expectation of the ICB on service delivery.

Concerns were raised that fragmentation of patient pathways would result in in-efficiency, therefore it was important to focus on patient outcomes. The lack of a single patient record was a barrier to integration, therefore the digital offer needed to be better understood in

regard to patient records, navigation etc. A keenness was expressed to protect the independent contractor model which was considered to be efficient and effective.

WG advised that the Primary Care Strategy still required work to move from concept to a plan and, as the incoming ICB Chief Executive Officer (joining the ICB in August 2024) would have a view on the direction of primary care in mid and south Essex, the timeframe for completion of the refreshed Strategy would be extended beyond September 2024. WG invited views from the committee on the refreshed strategy.

ES agreed that the independent contractor model should be protected. ES said it was important that primary care service providers were aware that Optometrists were independent contractors with an NHS General Ophthalmic Service contract, to avoid any potential negativity and confusion that they are a private service who periodically undertakes work on behalf of the NHS. ES added that awareness of appropriate signposting for optometry referral pathways e.g. Minor Eye Care Services (MECS) was required.

PW stressed the need for all primary care services to be involved in the development of the refreshed Primary Care Strategy. Commissioning decisions should ensure equitable Community Pharmacy access across mid and south Essex as there was currently a variance in services offered across the system. Also to improve access, an improved commissioning approach was needed when primary pharmacy services were closed e.g., Community Pharmacy services were only commissioned to open out of hours on Christmas Day and Easter Sunday, weekend and Bank Holiday opening was voluntary.

ES and PW both agreed that lack of access to shared care records was an issue for their respective services.

SA enquired whether there was a development framework for the Primary Care Strategy and how voices beyond general practice were considered to ensure prioritisation was centred around patient need. WG explained, to date, stakeholder engagement had largely focused on primary care disciplines, however engagement with Healthwatch and other external partners was being worked through. Although the Primary Care Strategy would incorporate all primary care services, it should be acknowledged that Primary Medical Services were a significant player in the system.

AK and WG agreed that the ICB must be clear in what it was trying to achieve with the Primary Care Strategy as this would bring the most impact across the system and a shift of resource from secondary care into primary care.

JS suggested the system needed to understand and own the value of the independent contract model. Also, education across the system was required around working within the independent contractor environment as the model can bring frustrations, e.g., awareness that new digital systems would need to be rolled out to each individual practice as there was no central trainer function to facilitate this.

SA expressed concerns around fragmentation of commissioning occurring and stated that ‘whole patient care’ vs ‘partial patient care’ needed to be bottomed out. *The remainder of this paragraph has been minuted confidentially.*

Outcome: The Committee NOTED the progress of the Primary Care Strategy.

11. PCCC Work Plan 2024/25

The Committee's 2024/25 Work Plan was included for information.

Outcome: The Committee NOTED the PCCC Work Plan 2024/25.

12. Items to Escalate

There were no items to escalate.

13. Any Other Business

ES had made SA aware of an operational issue with Optometry and FP10s. SA requested that WG discuss the matter with ES and PW outside of the meeting to find suitable solution. If additional support was required in identifying resolution, PG and AD should be involved in discussions. SA requested an update be provided at the next meeting.

ACTION: WG, ES and PW to find solution to operational issues with Optometry and FP10s, as reported outside of the meeting by ES.

14. GMS Contract Decision

This item was minuted confidentially with restricted attendees in attendance.

15. Date of Next Meeting

9.30-11.30am, Wednesday 14 August 2024
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 28 June 2024 at 10.00 am – 1.00 pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member & Chair of Committee.
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member.
- Dr Giles Thorpe (GT), Execuftive Chief Nursing Officer.
- Dan Doherty (DD), Alliance Director, Mid Essex.
- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.
- Ann Sheridan (AS), Executive Nurse, EPUT.
- Geraldine Rodgers (GR), Director of Nursing, Leadership and Quality, NHS England.

Attendees

- Dr Sarah Crane (SC), Associate Medical Director (on behalf of Dr Matt Sweeting).
- Maria Crowley (MC), Interim Director Children, Mental Health and Neurodiversity.
- Claire Angell (CA), Deputy Director Children, Mental Health and Neurodiversity.
- Vicky Kline, Senior Nurse Acute/Community.
- Victoria Kramer (KD), Senior Nurse for Primary Care Quality, MSE ICB.
- Bridget Beale (BB), Provide Community Interest Company, Director of Nursing & Allied Health Professions (on behalf of Wellington Makala).
- Gemma Stacey (GS), Designated Clinical Officer for SEND.
- Andrew Graham (AG), Adults Commissioner, Southend, Essex and Thurrock Learning Disabilities, Autism and Health Equality Team (on behalf of Rebekah Baillie).
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Joanne Foley (JF), Patient Safety Partner.
- Deborah Whittaker (DW), NHS England.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB.

Apologies

- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Eleanor Sherwen (ES), Deputy Director of Nursing, MSE ICB.
- Stephen Mayo (SM) Director of Nursing for Patient Experience, MSE ICB.
- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB.
- Pam Green, Alliance Director (Basildon and Brentwood) and Primary Care Lead, MSE ICB.

- Rebecca Jarvis, Alliance Director, South East Essex, MSE ICB.
- Wendy Dodds, Healthwatch Southend.
- Owen Richards, Healthwatch Southend.
- Gemma Hickford, LMNS Consultant Midwife, MSE ICB.
- James Hickling, Deputy Medical Director for Governance, MSE ICB.
- Yvonne Anarfi, Deputy Director of Nursing for Safeguarding, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB.

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

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 26 April 2024 were reviewed and approved without amendment.

Resolved: The minutes of the Quality Committee meeting held on 26 April 2024 were approved.

4. Action log

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

Resolved: The Committee noted the Action Log.

5/6. Lived Experience Story & Deep Dive – Special Educational Needs and Disabilities (SEND)

NIB informed new committee members/attendees of the rationale for presenting 'lived experience' stories to the committee but explained it had not been possible to obtain a video this time, although it was hoped that one would be made available at a later date.

GS shared a presentation on SEND providing an overview of the SEND system in mid and south Essex (MSE) and emerging issues.

The ICB had been working with the other two Integrated Care Boards covering Essex to prepare for an Ofsted inspection and agree the joint vision for SEND. The vision aligned with the Essex and Southend/Thurrock strategies focussing on inclusion, equity and ambition in relation to children and young people (CYP) and listening to what individuals and their families were telling us.

GS highlighted the governance structure for SEND, internally and externally, which included

three SEND Partnership Boards, with the ICB being a key strategic partner on each.

A main area of focus was providing support to children awaiting an assessment and their families/carers. Three community health providers had worked to provide resources and tools, including the online Kids Autism Hub to support young people awaiting an assessment. A sensory toolkit for teachers and support staff across Southend, Essex and Thurrock (SET) council areas was also in place. Within MSE particularly, 'My Care Bridge' had been implemented to manage parents' expectations. Parent/carer forums were also involved in workstreams within the SEND system.

One area to be developed further was how to communicate service availability. There were significant challenges/risks in the system, including increased demand (18% increase in requests for assessment) and complexity versus limited capacity in both health and social care, leading to increasingly long waiting times.

GS highlighted the ways the ICB was providing support to ensure providers met statutory timescales. An audit of 5% of plans finalised since August 2023 would identify key themes, including where arrangements worked well or required further improvement. The results would be broken down by each local authority (LA) and overall.

GS was also supporting LA teams to ensure they had could interpret health information via training, monthly drop-in sessions and provision of a reference guide. The ICB was represented on Education and Health Care Plan (EHCP) panels. Following a SEND thematic review in Thurrock, feedback highlighted that health provision was not adequately captured in ECHPs and action would be taken to address this.

SP asked how parents would know their child required an assessment and which professional(s) could support them. GS advised LAs and healthcare currently had different processes, although work was being undertaken to amalgamate into one. Whether a child required an assessment was decided via conversations between parents and schools. Where there were barriers to learning, the school should put in place support, but if a child still struggled, the school/parent could request an EHCP for additional support. Each LA provided information on the process via their websites.

NIB advised that some parents were not initially aware their child required additional support, especially if they had limited contact with other children to compare learning milestones. In addition, there was occasionally resistance to intervention by schools and other health and social care professionals because of taboo regarding neurodiversity.

GT highlighted that families were suffering as a consequence of long delays and the work undertaken by GS and her colleagues would support them. For example, there had been a delay of up to seven years for some individuals in waiting for a diagnosis of ADHD or ASD. Also, parents sometimes sought a private diagnosis, but this often-meant children were unable to return to the NHS because the recommended medications were not available via the NHS formulary. This issue had been escalated to the national team as some primary care colleagues had queried whether some families were jumping the queue.

PW clarified that to enable the 'right to choose' private providers must be contracted with the NHS and GPs had to make the referral. The ICB's policy which defined the boundaries between NHS and private care stated that no one should derive benefit over those already on an NHS waiting list. The ICB received many queries in this regard and remained firm on

this stance. Consequently, the message to GPs was they must check with the ICB before referring and they should inform the ICB if they had concerns regarding the quality of service provision. However, PW noted that most private providers did not provide children's services.

MC advised that the ICB had clearly identified the areas requiring work, with improved access being a priority, as well as the right to choose. The community collaborative, i.e. EPUT, Provide and North East London NHS Foundation Trust (NELFT), would lead on reviewing the children's pathway.

GT advised that although neurodiversity was discussed significantly, the ICB, LAs and providers must not forget those children with long term complex physical disabilities, including those with tracheostomies and percutaneous endoscopic gastrostomy (PEG) tubes in-situ, who were unable to access mainstream education as schools could not meet their day-to-day needs.

Resolved: The committee noted the deep dive relating to SEND.

7. Safety Quality Group (SQG) - Escalations

GT advised that due to the general election 'purdah' rules, there were limited areas that could be discussed or progressed. Quality colleagues were focussing on deep dive presentations for the next SQG meeting and would advise the Quality Committee (QC) of any learning.

New national guidance had been issued on collective responsibilities for quality oversight at national, regional and local level, and included a section on SEND. The Nursing & Quality (N&Q) directorate were undertaking a gap analysis to be brought back to QC and the ICB Board at a later date. GT recommended that providers should undertake their own gap analysis as he knew there would be alignment against the guidance during Care Quality Commission (CQC) inspections. The CQC had advised that once the election period was over, the findings of the pilot system level inspections would be released. Further inspections would commence shortly thereafter. It was anticipated MSE would be one of the first areas to be inspected.

The Respiratory Syncytial Virus (RSV) vaccination programme had been agreed for older adults and maternal vaccination, post 28 weeks pregnancy.

New national safeguarding guidance had been released regarding an accountability framework at ICB and provider level. ICBs had increased responsibility for the child death review process and statutory duties to prevent violence.

The terms of reference (ToR) of the System Oversight and Assurance Committee (SOAC) had been revised, subject to ICB approval. There would be a strengthening of assurance to the ICB around risk management. The ICB would also be working to implement dynamic/complex risk assessment following draft guidance issued by the National Quality Board. A meeting would be held with the national team on 10 July to discuss the possibility of MSE acting as an early adopter site.

GT advised that he would be attending the ICB's newly constituted Finance & Performance Committee (the terms of reference of which would be subject to ICB Board approval on 11 July 2024). The committee would consider the presentation and triangulation of data at

system level. The committee would also need to review oversight of the circa 700 smaller provider contracts that it held, with any key quality issues being referred to QC for consideration.

In response to a query from SP regarding the timeframe for this work, GT advised that although he could not speak for the contracting team, he was aware that conversations were ongoing, although it would probably be after the summer period before work commenced. A quality dashboard was being developed and work on dynamic risk registers would require input from providers. Tom Abell, the new ICB Chief Executive, who was due to commence in early August 2024, would also need to be involved in this work.

VC confirmed that improved triangulation was occurring, and she anticipated a first draft of the quality dashboard would be available very soon.

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

8. Emerging Safety Concerns/National Update

GT had no further issues to raise.

9. ICB Board/SOAC concerns and actions

GT had no further issues to raise.

10. MSEFT Acute Care Update

DS advised that she would take the paper as read and would focus on three key issues:

All three MSEFT maternity units were inspected by the CQC in March 2024 and the reports were awaited. The Trust was awaiting a reinspection in relation to the Section 31 Notice, but was anticipating the restrictions would be removed.

The Trust was experiencing increased Urgent and Emergency Care (UEC) demand particularly for younger patients with acute problems. This was challenging as MSEFT was now at National Oversight Framework Level 4 (NOF4) and had closed some beds. The increasing number of patients coupled with longer stays on wards was proving difficult to manage.

MSEFT had reviewed its operating model and, in parallel with NOF4 and a reduction in its workforce, there was a high level of staff anxiety as to what this meant for staffing levels and quality and safety.

DS advised there were a lot of patients attending hospital with respiratory problems and intensive therapy unit (ITU) provision was challenged at the current time.

PW highlighted that Pharmacy First which covered seven common conditions, meant some patients could now be treated in pharmacies and suggested if some additional activity in A&E could be diverted to community pharmacies.

Resolved: The Committee noted the MSEFT Acute Care update report.

11. Community Update

11.1 Community Collaborative Update

BB advised she was standing in for Wellington Makala, Executive Chief Nursing Officer at NELFT, who was quality lead for the collaborative. BB highlighted the following key issues:

A community accountability framework had been developed setting out how the collaborative would work in a more formal way.

Legionella was still present in some areas of Brentwood Community Hospital (BCH). Much of the affected pipework had been removed, flushing and decontamination undertaken, taps replaced with filtered taps (including showers), an authorised engineer was appointed and monthly meetings were held. Consequently, Legionella counts were reducing. The last testing undertaken showed no Legionella pneumophilia were present and the site was now in maintenance mode, with taps flushed daily for 10 minutes.

St Peter's Hospital beds had been moved to Bayman Ward at BCH. The CQC had inspected and requested significant further information. This included an online tour/inspection of the facility, during which great care was taken to protect patient confidentiality/dignity. Members noted that some issues, such as culture, could only be properly assessed via face-to-face meetings.

The collaborative was experiencing increased acuity of patients, causing pressure on teams. Concerns had been raised by medical staff. The number of community nursing visits per day was increasing, e.g., 45 people a day in one large care home.

GT advised that CQC methodology had changed, and he understood there was now an assessment team and an inspection team in place.

Resolved: The Committee noted the Community Collaborative Update report.

11.2 EPUT Quality Performance Data Dashboard

AS advised that the Trust had implemented a quality and care strategy in April 2024, which was a co-produced piece of work focusing on safety, effectiveness, and experience. The metrics used had also been reviewed. Violence and aggression remained a challenge within the mental health inpatient unit, with a rise in violence and aggression towards staff, particularly racial abuse. The Trust had engaged specialist support in this regard.

Reducing the use of restrictive practices was also being focussed upon to ensure patients in distress were supported appropriately, and non-fixed ligature points were also under review.

The low and medium secure units in Runwell had been CQC inspected. The Trust awaited the report. A number of historic issues/incidents had prompted this inspection, following which several staff were dismissed. The Trust was undertaking work with the Higher Education Institutions to support the return of student nurses to the Brockwell Unit, following a previous decision to restrict placements there. However, the CQC had acknowledged that learning had been embedded and staff knew how to raise concerns.

Resolved: The Committee noted the EPUT Quality Performance Data Dashboard.

12. Primary Care Update

VK advised she would take the paper 'as read' but wished to highlight the following key issues:

VK asked that supporting documentation provided with her report was treated as confidential and not shared with non-committee members.

A joint visit with Hertfordshire and West Essex (HWE) ICB took place on 4 June 2024 at a pharmacy in south-east (SE) Essex following ongoing concerns originally identified via a community pharmacy assurance framework visit in August 2023. The pharmacy was being continuously monitored by the Pharmaceutical Services Regulation Committee. Issues identified included improvements required to clinical governance; concerns regarding storage of medications due to the premises being in poor condition; and a lack of assurance regarding a controlled drugs incident during the pandemic. Whilst the report would be provided by HWE, it was seen as a positive visit as new standard operating procedures were in place. MSE ICB would support HWE ICB as required moving forward.

VK informed the committee of a GP practice in SE Essex which was rated high on the primary care risk register and receiving ongoing input from the ICB, and shared information regarding another practice that had been rated 'inadequate' by the CQC. An ICB rapid review was undertaken with ongoing support visits, but there was no evidence of improved practice at the surgery. The CQC would undertake a follow-up visit and the ICB might need to take more formal action via the contractual route. The Quality Team continued to support the practice and was hopeful improvements could be made.

Resolved: The Committee noted the Primary Care Update report.

13. Learning Disabilities and Autism Update

AG presented a set of slides outlining the purpose and function of the Learning Disability and Autism (LDA) Health Equality programme including delivery of the Long-Term Plan, which included annual health checks; maximum numbers of inpatients (Adults x 41 and Children and Young People x 6) and workforce development. The various functions that delivered against the requirements of the collaborative and 'out of scope' functions were also set out within the slides.

AG highlighted several challenges including: the dynamic support register had significantly higher numbers than other areas in the East of England region; concerns had been raised regarding the quality of adult Care and Treatment Reviews (CTRs); and the number of CYP patients fluctuated, usually over the maximum threshold of 6.

GR referred to ongoing work regarding end-of-life care and advised that only 10% patients who had been identified 'not for resuscitation', had an advanced care plan in place. This issue would therefore be considered further nationally, and AG was therefore asked to be mindful of this at local level.

A strategic review of the agreement across the whole of Essex would be undertaken to address several issues identified, including parity of service provision, and he would bring an update back to the committee in approximately six months' time.

Resolved: The Committee noted the Learning Disabilities and Autism update report.

Action: SO to share Learning Disabilities and Autism update slides with committee

members.

14. Babies, Children and Young People (BCYP) Update

MC introduced CA, who would be taking over from MC in early August. MC advised the committee as follows:

MC confirmed her team were involved in many of the initiatives highlighted during previous presentations, particularly SEND and LDA due to their interdependence. MC outlined the current BCYP programmes which included a focus on improving access to mental health services. MC also outlined several CYP Community Collaborative initiatives and work being undertaken to reduce health inequalities, as set out on the slides provided to the committee.

The Growing Well Programme had reviewed its terms of reference, with GT chairing the group, to strengthen system working and oversight of delivery, value for money, reducing duplication and addressing gaps across the MSE and wider Essex footprint. A revised Clinical Engagement Group would undertake deep dives and a dashboard would need to be agreed.

Top priorities were: Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) services; becoming more accountable on outcomes and the impact; and ensuring the voice of children was taken into account. A CYP mental health strategy was in place, but as the ICB had delegated some children's services it was important that oversight was maintained.

NIB advised that it was necessary for her and other Non-Executive Members to properly understand delegation arrangements/responsible authorities, workflows and assurances in place for BCYP, LDA, SEND and other services. It was agreed that this would be arranged with relevant executive leads covering governance and oversight of delegated authorities.

Resolved: The Committee noted the Babies, Children and Young People update report.

Action: ICB's delegation arrangements/responsible authorities, workflow and assurances in place for BCYP, LDA, SEND and other services to be shared with NEMs at a future meeting.

15. Patient Experience Update

AMcM highlighted the complaints backlog and the significant challenges which led to this, including delegation of primary care complaints which led to a substantial increase in the number of cases to manage overall. The backlog was gradually reducing, but not as quickly as the ICB would wish. Implementation of the Datix complaints module had also taken time to set-up and test, but was proving very beneficial, although work was required to fully embed its use and improve reporting. AMcM drew members' attention to the data provided within her report.

A new clinical complaints officer would join the team on 1 August 2024 and the majority of clinical reviewers were in place.

Regional complaints submissions would in future include primary care complaints, with the

next to be submitted in July 2024.

Resolved: The Committee noted the Patient Experience update report.

16. Patient Safety Update

KF advised that she would take her report as read. The report was aligned to the Patient Safety Strategy released in 2019 and summarised providers' progress against the eight priorities, with good progress having been made across MSE.

The National Reporting and Learning System would officially be withdrawn on 30 June 2024, replaced by 'Learning From Patient Safety Events' (LFPSE). LFPSE was quite challenging from an ICB perspective because the system did not currently provide ICBs with much information. However, it was understood the next version, due to be released the following month, should improve this.

Acute and community providers in the East of England were the first to achieve 100% transition to the Patient Safety Incident Response Framework (PSIRF), although further work was required to support providers holding smaller contracts.

The ICB awaited a final version of the draft patient safety strategy for primary care which was released in December 2023, although work was ongoing to socialise this with three MSE GP practices having expressed an interest in becoming pilot sites.

The report provided an overview of PSIRF training delivered to-date and the number of overdue Patient Safety Incident Investigations (PSIIs) by each main provider.

Patient safety data indicated there had been an increase in incident reporting and a decrease in moderate or above harm.

KF advised that the appendix to her report summarised the MSE position with regard to improving safety culture (except for Provide, which did not participate in the NHS Staff Survey) and action being taken to improve the position, noting that MSE was in a similar position to most other NHS organisations.

Action against the National Patient Safety Alert (NPSA) relating to Sodium Valproate was progressing well and although MSEFT had three NPSAs overdue, KF anticipated the Trust would be compliant with each very shortly.

KF advised that patient safety was a huge agenda and advised that she would be happy to provide a 'deep dive' on one or more areas if required and was open to suggestions to improve future reports.

GT reiterated that the ICB was challenged due to it not having full access to LFPSE data and could not, therefore, undertake thematic analysis. GT had previously escalated this issue to the national team.

PW advised that as well as sodium valproate, new measures would need to be implemented for Topiramate which was contraindicated in pregnancy and women of childbearing potential, thus requiring pregnancy prevention plans to be implemented by GPs, whose capacity was already limited.

KF advised that a patient safety summit would take place on 14 October 2024.

Resolved: The Committee noted the Patient Safety Update report.

17. Patient Safety & Quality Risks

SO advised there were currently 7 risks within the remit of Quality Committee rated red, these being.

1. Mental Health Provider Quality Assurance.
2. Quality Assurance of Autism Spectrum Disorder (ASD) services.
3. Compliance with Mental Capacity Act 2005.
4. All Age Continuing Care Delivery.
5. Complaints – Backlog (new risk).
6. Acute Provider Quality Assurance.
7. Maternity Services

No new risks had been added since the last committee meeting, but a risk relating to the sodium valproate safety alert was in the process of being added. However, due to the revised remit of the System Oversight and Assurance Committee (SOAC), it was proposed that all risks previously allocated to SOAC would be reallocated to other ICB main committees, with some potentially moving to Quality Committee. There were no risks recommended for closure.

Appendix 1 provided an update on each risk, and Appendix 2 set out the quality and safety related risks on the ICB's Board Assurance Framework (as of March 2024), along with a high-level summary of MSEFT and EPUT's red rated risks. The BAF would be update prior to the July Part I ICB Board meeting.

SO confirmed that implementation of the Datix risk register module continued and noted her thanks to Chris Cullen, Datix Administrator, for his work on implementing the database. There were several software issues which Datix had been asked to address. Work would continue to improve risk reporting and to provide managers with risk dashboards.

The ICB had recently agreed its revised risk appetite statement, against which all risks would be mapped. The ICB would be implementing arrangements to support dynamic/complex risk assessment. This would involve reviewing the way risks were assessed and rated, noting that NHS organisations each had different risk matrices/impact assessments, as did local authority partners.

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

18. ICB Approval of Provider Quality Accounts 2023/24

Vicky Kline advised 11 draft responses to providers' Quality Accounts (QAs) 2023/24 had been included within the papers. This was an annual process whereby the ICB undertook a 'check and challenge' review of the QAs and then submitted a response, signed-off by GT, to each provider.

Resolved: The Committee ratified the ICB responses to the following provider Quality Accounts 2023/24:

19. Nursing and Quality Policies and Procedures:

19.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the revised Quality Assurance Visits (QAV) Policy (Ref 072) and revised Continuing Health Care (CHC) Disputes Agreement Protocol.

VC advised that the QAV Policy had been updated to align to national frameworks and changes in CQC standards and included a description for each type of CQC inspection.

CC advised that the CHC Disputes Agreement Protocol was also being reviewed by Suffolk and North East Essex and Hertfordshire and Wests Essex ICBs and would also be shared with local authorities for comment.

Resolved: The committee approved the following revised documents:

- **072 Quality Assurance Visits Policy**
- **Continuing Health Care Disputes Agreement Protocol, noting that partner organisations would also be asked to comment on this document.**

19.2 Extension of review dates of existing policies:

Committee members were asked to extend the review dates of the following policies:

- 032 Equality and Health Inequalities Impact Assessment Policy (to 31 October 2024)
- 068 All Age Continuing Care Policy (to 31 August 2024)
- 063 Safeguarding Adults and Children Policy (to 31 October 2024)
- 065 Management of Allegations Against Staff, Volunteers and people in Positions of Trust who work with Adults and Children Policy (to 31 October 2024)
- 070 Management of Perplexing Presentations and Fabricated or Induced Illness in Children Policy (to 31 October 2024)
- 073 Mental Capacity Act 2005 & Deprivation of Liberty Standards Policy (to 31 October 2024).

In response to a query from NIB, SO advised that extended review dates had been requested due to capacity issues within relevant teams. As the majority of ICB policies were implemented upon ICB establishment in July 2024, most had the same review date. Consequently, extending the review dates of some policies would enable future reviews to be staggered.

Resolved: The committee agreed to extend the review dates of the above policies as detailed above.

20. Review of Committee Effectiveness, Terms of Reference and Workplan 2024/25

NIB thanked those members who completed the online committee effectiveness survey and encouraged others to participate in future reviews. NIB commented that in future it would be helpful to request that a rationale was provided for all scores given, not just those scored 3 and below.

NIB noted that the timeliness of circulation of reports had been raised by several members,

although the ability to circulate papers on time was subject to the governance team receiving reports by the requested deadline.

SO mentioned that the committee's workplan set out when reports were due and asked that report authors noted in their own calendars when they were required to submit a report, although the governance team would endeavour to provide as much notice by scheduling agenda setting meetings as early as possible.

SO also noted her thanks to Helen Chasney for her assistance in completing the desktop review of effectiveness for the committee.

NIB confirmed that although it would be preferable if reports were available slightly earlier, the target to circulate reports no later than a week before the meeting would remain place.

NIB also noted that some members/attendees could not always attend on a Friday, and this could be taken into account when setting meeting dates for the next financial year.

SO advised that a summary report on the reviews of committee effectiveness would be submitted to the ICB Board. SO also asked if there were any comments on the draft workplan for 2024/25 and revised committee terms of reference. No comments were received.

Resolved: The Committee:

- **Approved the revised Quality Committee Terms of Reference and recommended them to the ICB Board for approval.**
- **Approved its workplan for 2024/25 and**
- **Agreed action to improve the effectiveness of the committee during 2024/25.**

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

NIB asked members for any items of escalation to the Board. No comments were received. NIB also asked that any suggestions for future deep dives were submitted to GT, SO and Helen Chasney.

22. Any Other Business

NIB advised that Owen Richards, Healthwatch Southend, had not been able to join the meeting, but had made a series of observations on the papers. GT had responded to Owen via email to answer his queries.