Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Thursday, 18 May 2023 at 3.00 pm – 4.30 pm

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

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	3.00 pm	Welcome and Apologies for Absence	Note	Verbal	Professor M Thorne	-
2.	3.01 pm	Review of Register of Interests and Declarations of Interest	Note	Attached	Professor M Thorne	3
3.	3.02 pm	Questions from the Public	Note	Verbal	Professor M Thorne	-
4.	3.15 pm	Minutes of ICB Board meeting held 16 March 2023 and matters arising.	Approve	Attached	Professor M Thorne	5
5.	3.17 pm	Review of Action Log	Note	Attached	Professor M Thorne	17
		Items for Decision				
6.	3.20 pm	Draft Joint Forward Plan	Approval	Attached	J Cripps J Kearton	19
7.	3.30 pm	Shared Care Record	To endorse	Attached	B Frostick	246
8.	3.40 pm	Integrated Community Equipment Contract	To endorse	Attached	K Wesson	254
		Items For Noting				
9.	3.45 pm	Quality Report including: • Patient Safety Specialist Update	Note Note	Attached Presentation	F Bolger K Flitton	257 -
10.	4.00 pm	Performance Report	Note	Attached	K Wesson	264
11.	4.10 pm	Fuller Stocktake Update	Note	Attached	Dr A Davey	269

No	Time	Title	Action	Papers	Lead / Presenter	Page No
12.	4.20 pm	General Governance:				
		12.1 Amendments to Committee Terms of Reference	Approve	Attached	Professor M Thorne	275
		12.2 Approved Committee minutes:	Note	Attached	Professor M Thorne	278
		• Audit Committee				279
		• Clinical and Multi-Professional Congress				289
		• Finance & Investment Committee				292
		• Primary Care Commissioning Committee				301
		• Quality Committee				310
		• System Oversight and Assurance Committee				319
		12.3 Adoption of Organisational Change Policy	Approve	Attached	Professor M Thorne	326
		12.4 Board Assurance Framework	Note	Attached	A McKeever	328
13.	4.29 pm	Any Other Business	Note	Verbal	Professor M Thorne	-
14.	4.30 pm	Date and time of next Part I Board meeting: Thursday, 20 July 2023 at 3.00 pm, in the Gold Room, Orsett Hall, Prince Charles Ave, Orsett, Grays RM16 3HS.	Note	Verbal	Professor M Thorne	-

Agenda Item 2

Register of Board Members' Interests - May 2023

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Frances	Bolger	Interim Chief Nursing Officer	Suffolk and North East Essex ICB	x			Direct	Director of Midwifery	03/01/23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Hannah	Coffey	ICB Partner Member (Mid and South Essex Foundation Trust	Mid and South Essex NHS Foundation Trust				Direct	Interim Chief Executive		Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in any discussion, decision making, procurement or financial authorisation involving the Colne Valley PCN.
Anna	Davey	ICB Partner Member (Primary Care)	Essex Cares	x			Indirect	Close relative is employed	06/12/21	On-going	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented
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.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x	x		Direct	Employed as Consultant Anaesthetist	20/06/05	Ongoing	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Mid and South Essex Foundation Trust	x			Indirect	My wife is employed by MSEFT as a Consultant Anesthetist.	24/06/05	Ongoing	I will declare my interest if at any time issues relevant to MSEFT or anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Springfield Hospital/Ramsay Healthcare	x			Direct	I carryout Private Medical Services at Springfield Hospital	20/06/05	Ongoing	I will declare my interest if at any time issues relevant to Springfield Hospital or Private anaesthetic services are discussed so that appropriate arrangements can be implemented.

Agenda Item 2

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				Financial	Non-Financial Professional Interest	Non-Financial Personal Interest			From	To	
Ronan	Fenton	Medical Director	Springfield Hospital/Ramsay Healthcare	x			Indirect	My wife carries out private medical services at Springfield hospital	26/06/05	Ongoing	I will declare my interest if at any time issues relevant to Springfield Hospital or Private anaesthetic services are discussed so that appropriate arrangements can be implemented.
Ronan	Fenton	Medical Director	Fentons Limited	x			Direct	I ama a registered officer of "Fentons Ltd" which is a company which offer general and specialist medical services	22/06/05	Ongoing	I will declare my interest if at any time issues relevant to this company or private anaesthetic services are discussed so that appropriate arrangements can be implemented.
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Personal relationship with Director of Operations for North East London area (Board Member)	01/03/19	Ongoing	As above.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England and Improvement	x			Indirect	Close family member employed as senior strategy manager	Jan 2023	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
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 iniaitives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Ruth	Jackson	Executive Chief People Officer	Nil								
Jennifer	Kearton	Executive Director of Resources	Nil								
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	MACS et al Ltd	x			Direct	Director of wholly owned company through which I contract with the NHS for interim and other services.	02/03/20	Ongoing	As of 3/10/2020 I am employed and paid through NHS payroll for my role in Mid and South Essex. However, I will declare my interest in MACS et al Ltd if and where required so that appropriate arrangements can be implemented.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Royal Society of Medicine (RSM)		x		Direct	Fellow	02/03/20	Ongoing	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	Faculty of Medical Leadership & Management (FMLM)		x		Direct	Fellow	02/03/20	Ongoing	No immediate action required.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	NHS IMAS' Strategic Advisory Board - Board Member		x		Direct	Board Member	01/03/23	Ongoing	No immediate action required. Any potential conflict will be managed in consultation with Chair as and when the ICB's business concerns IMAS.
Anthony	McKeever	Chief Executive of the Mid & South Essex Integrated Care Board	UCL Partners Limited - Board Member		x		Direct	Board Member	01/03/23	Ongoing	No immediate action required. Any potential conflict will be managed in consultation with Chair as and when the ICB's business concerns UCL Partners.
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.
Mike	Thorne	ICB Chair	Nil								
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.
George	Wood	Non-Executive ICB Board Member	Barking, Havering and Redbridge University Hosptals NHS Trust (BHRUT)	x			Direct	Chairman of hospital charity.	01/01/15	Ongoing	Interest to be declared if and when any matters relevant to BHRUT are discussed so that appropriate arrangements can be implemented.

Minutes of the Part I Board Meeting

Held on 16 March 2023 at 3.00 pm – 4.30 pm

Committee Room 1, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, SS2 6ER

Attendance

Members

- Professor Michael Thorne (MT), Chair of Mid and South Essex Integrated Care Board (MSE ICB).
- Anthony McKeever (AMcK), Chief Executive of MSE ICB.
- Dr Ronan Fenton (RF), Medical Director, MSE ICB.
- Jennifer Kearton (JK), Director of Resources, MSE ICB.
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Dr Ruth Jackson (RH), Chief People Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member.
- Dr Neha Issar-Brown (NIB), Non-Executive Member.
- George Wood (GW), Non-Executive Member.
- Dr Anna Davey (AD), Primary Care Board Member.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust.
- Peter Fairley (PF), Partner Member, Essex County Council.
- Mark Harvey (MH), Partner Member, Southend City Council.

Other attendees

- Jo Cripps (JC), Executive Director of Strategy and Partnerships.
- Dr Tiffany Hemming (TH), Interim Executive Director of Oversight and Delivery, MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood), MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid and South Essex), MSE ICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Dr Pete Scolding (PSc), Assistant Medical Director, MSE Integrated Care System.
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB.
- Mike Thompson (MTh), Chief of Staff, MSE ICB.
- Claire Hankey (CH), Director of Communications and Engagement, MSE ICB.
- Nicola Adams (NA), Deputy Director of Governance and Risk, MSE ICB (minutes).

Apologies

- Hannah Coffey (HC), Partner Member, Mid and South Essex NHS Foundation Trust.
- Les Billingham (LB), Partner Member, Thurrock Council.
- Ruth Hallett (RH), Alliance Director (South East Essex), MSE ICB.

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

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

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

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

Declarations made by ICB Board and committee members were listed in the Register of Interests available on the ICB website**.**

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

MT advised that questions had been submitted by nine members of the public relevant to the items on the agenda and summarised the themes raised:

- **Susan Cross** raised concerns about difficulties in making appointments to see a GP.
- **Tom Kelly** raised concerns about the telephony system at Blackwater medical centre and the action being taken to improve the health infrastructure in the Maldon area to meet the needs of an increasing population.
- **Joe Cooke** asked questions regarding GP visits to house-bound patients, whether Primary Care Networks should become social enterprise companies, the future of ICB governance and queried whether there was a role for public governors. A similar question was also asked by another individual.

Written responses had already been provided to Ms Cross, Mr Kelly, and Mr Cooke, although Mr Cooke subsequently submitted some follow-up questions regarding premises for the Primary Care Network covering Benfleet, which would be responded to as soon as possible.

- **Chris Gasper** asked questions relating to the development and communication of the Mid and South Essex Integrated Care Strategy, which would be discussed under agenda item 7.
- **Julia Hopper** raised concerns regarding the provision of Special Educational Needs and Disabilities services and Mental Health. Ms Hopper also queried the mechanisms the ICB has in place to interact with the public and asked why the ICB does not have public governors.

  In relation to this last question, which is similar to one asked by Joe Cooke, the ICB's Constitution and the legislative framework behind it was different to that of Foundation Trusts, reflecting their key responsibility for providing services and care directly. In our case, the Integrated Care Partnership, with its wider membership including the community and voluntary sector and Healthwatch, brought together patient and public perspectives.
- **Owen Richards** asked if the ICB could say when local people would start to see improvements in dentistry appointments. It was noted that the proposed delegation of responsibility for dentistry, as well as optometry and pharmacy services, from NHS England to the ICB with effect from 1 April 2023, would be discussed at item 13.1.

- **Paula Farrow** raised queries relating to support provided by EPUT for those with a learning disability, who may or not be autistic, and those who are neurodivergent but do not have a learning disability.
- **Sukhdev Sanger** asked whether the ICB would consider a trial to look at testing aeroallergens with advice on how to lower exposure to lead to better outcomes for patients.
- **Peter Blackman** asked what lessons had been learnt following the winter pressures experienced this year to inform preparations for the winter of 2023/24.

Peter Blackman also asked that the ICB's respects to Ken Edwards, who sadly passed away on 12 February 2023, were recorded by the ICB. Dan Doherty, the Alliance Director for mid Essex, responded with a short statement acknowledging Ken's contribution over the years.

"I was shocked and saddened to hear about the recent death of Ken Edwards. I was privileged to work alongside Ken for over 15 years, he was a true champion for our local NHS. Ken had an incredible passion for public services and wanted to ensure the local NHS was there for all when needed now and in the future. Ken was intelligent and articulate, and his insights were always worthy of close attention. Never afraid to challenge Ken certainly kept me on my toes over the years. That said, he always treated those of us who work in NHS management fairly and with the utmost respect.

I am sure colleagues of the mid and South Essex ICB will join me in sending our deepest sympathies to Sue and family, and I know this will be echoed by all my colleagues from predecessor organisations"

Action: NA to arrange for written responses to be provided to questions raised by members of the public.

4. Minutes of the ICB Board Meeting held 9 February 2023 and matters arising (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 9 February 2023 and asked members if they had any comments or questions. No comments were submitted.

There were no matters arising.

Resolved: The Board approved the minutes of the ICB Board meeting held on 9 February 2023 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. Operational and Strategic Planning 2023/24 Update (presented by J Kearton and J Cripps)

JC presented the approach being taken to develop the ICB Operational Plans for 2023/24 and the NHS Joint Forward Plan (JFP), including the 'sign-off mechanisms' to meet the required

submission dates stating that it was a new requirement to have a Joint Forward Plan (JFP) over 5 years.

Assurance was provided over the process being followed and the Board were asked to delegate approval of the Operational plan and JFP to the Chief Executive Officer.

It was noted that there was a longer timeframe for the submission of the JFP with the draft being submitted on 30 March 2023 and final published by 30 June 2023 The requirement for engagement on the plan was noted as having to take place post-election, but that there had been much engagement regarding priorities in the development of the Integrated Care Strategy, which formed the basis of the JFP.

MT echoed the sentiment from JC, recognised the timescales for submission and sought questions from Members. There were no questions raised.

Resolved: The Board:

1. **Delegated authority for approving and submitting the operational plan to the ICB Chief Executive Officer, noting that it would receive a full update on plans submitted at the April meeting.**
2. **Delegated authority for endorsing the draft Joint Forward Plan (JFP) (for submission to NHS England by 31 March 2023) to the ICB Chief Executive Officer, working with Chief Executive Officers from NHS Partner organisations.**
3. **Approved the period of engagement on the JFP with partners, to take place during May/early June to observe the local election period.**
4. **Approved the arrangements for the publication of the JFP by all NHS Partners (3-June 2023).**

The Board further Noted:

5. **The process of development for the operational plan 2023/24.**
6. **The requirements of the Joint Forward Plan (JFP) as per guidance from NHS England.**
7. **The approach and progress on completing operational plans and developing the JFP with partners.**

7. MSE Integrated Care Strategy (presented by J Cripps and J Banks)

JC introduced the Integrated Care Strategy developed by the Integrated Care Partnership (ICP), noting that the Health and Care Act 2022 required the ICB to have due regard to the Strategy set by the ICP in exercising its functions.

JC noted that upper tier local authorities had approved the strategy and so the ICB needed to respond, review, and endorse the Strategy. The Board recognised the work of Jeff Banks and others involved in developing the strategy.

It was noted as a new requirement for the ICP to develop a strategy and acknowledged that a lot of engagement work was undertaken with all ICB stakeholders, as well as considering the strategies of partners in the NHS and local authority, particularly those of the Health and Wellbeing Boards. A data and evidence approach to the development of aspects of the strategy was also recognised.

JC referenced the diagram on page 35 of the Board papers that depicted the model of 'our Common Endeavour' with the key focus to reduce health inequalities. JC explained the diagram and how the system would work together to deliver its aims, noting system priorities and pressures around workforce, operational pressures, digital enablement, and the need to focus on prevention and early intervention.

JC pointed out the 'we' statements that would provide measures of success for the strategy and noted that the ICB needed to understand, recognise it, and draw the strategy into its delivery plans. Further, that the ICP was expected to approve the strategy at its meeting in March.

MT noted the thorough engagement exercise; over 170 people and invited questions from Members. There were no questions raised.

Resolved: The Board:

1. **Approved the Integrated Care Strategy.**
2. **Agreed to have regard to the Strategy in exercising its functions.**
3. **Agreed to ensure it sets out steps for delivering the Strategy in the Joint Forward Plan.**

8. Stewardship Stocktake and White paper response (presented by Dr R Fenton and Dr P Scolding)

PSc presented an update on the Stewardship Programme and an overview of the intended actions and progress expected over the next 18 months.

PSc explained the principles of stewardship and how to deliver best value for residents, noting that the purpose of the groups was to bring together hard data and soft intelligence with best practices to shape the direction of the areas for which they were established and steward the resources associated with them e.g., stroke, ageing well, urgent and emergency care.

PSc outlined the high-level timeline, noting that the second cohort were now in place and so ICB partners AGEM had conducted a stocktake of the programme, for which a response was outlined in the Board paper. Learning would ensure that the second cohort would condense and streamline induction to become effective more quickly.

In concluding PSc stated that stewardship had become a hallmark of our system.

RF added that the ICB was unique as a system having instigated the stewardship programme and that the overarching aim was to develop and deliver clinical and multi-professional leadership at the frontline.

RF informed the Board that the ICB had been congratulated for having 50 clinical and multi-professional leaders across the system continuing to support us and noted that hard outcomes were not expected in the first two years of the programme; this was about educating the leaders so that they could contribute to the ICB.

RF sought support from the Board to continue to the programme to achieve the ambition to deliver 25 care areas by 2025: the golden aim of true engagement of clinical and multi-professional leaders.

MT thanked AMcK acknowledging what front line staff and patients could bring to developing our stewardship approach. MT referenced the evidence in the appendix of the stocktake, commenting 'they were glancing blows' and that if the stewardship programme really took hold, it would be fundamental to service development and transformation. MT expressed gratitude to partner organisations and the stewards who were involved in the process and hoped that the next phase would include the community collaborative. Questions were invited from the Board.

PF commended the report and programme asking whether the plans for phase II could include a more strengthened focus on Alliances as well as care groups, and whether we needed to be more explicit over the expectations of Alliances. RF agreed and acknowledged that Alliance Directors were ready to get involved. PG added that it was important to recognise feedback and the impact on the workforce: where stewards were interviewed, candidates' feedback was that the model was translatable to their own organisation and to partners over the system.

ACTION: PSc to consider whether the support pack is developed sufficiently to underpin the work of the stewardship groups.

Resolved: The Board: Noted and endorsed the content of the NHS Arden and Greater East Midlands Commissioning Support Unit stocktake on Stewardship and the ICB's 'White Paper' responses outlining actions to be taken.

9. Quality Report (presented by Frances Bolger)

FB presented the quality report summarising the key quality and patient safety issues, risks, escalations and actions taken in response and provided assurance to the Board over the management of quality. FB specifically highlighted that feedback had been received following the SEND inspection that outlined some areas of good performance and some areas for improvement. FB outlined that it was a new East of England framework involving both the Care Quality Commission (CQC) and OFSTED which focussed on the experience of families and that they had worked with schools, primary care and ICB staff to triangulate experience and performance.

MT invited any questions on the Quality report. NIB welcomed the positive move to the model of triangulation and provided assurance that the Quality Committee scrutinised these areas.

Resolved: The Board:

1. **Noted the key quality concerns and escalations as identified by the Quality Committee.**
2. **Received assurance that mitigating actions were being undertaken to address concerns.**

3. **Noted the recent Care Quality Commission (CQC) inspection and findings, and the ICB oversight processes for supporting improvement of services.**

4. **Noted the recent findings in the CQC Maternity Survey and the Local Maternity and Neonatal Board oversight processes for supporting improvement in maternity care.**

5. **Noted the planned CQC and Ofsted Inspection of Southend Special Educational Needs and Disabilities (SEND) services.**

10. Performance and Assurance Report (presented by Tiffany Hemming)

TH presented an overview of the position (where it was available) against the NHS constitutional standards and outlined the governance arrangements for oversight and assurance for each area.

TH reiterated positive news regarding NHS talking therapies and early intervention in psychosis having met their associated standards. Furthermore, that Ambulance response times had also improved. Cancer performance continued to recover with good trajectories around dermatology, in particular and the 28-day faster diagnosis standards.

Finally, under the referral to treatment target (RTT), 1 patient continued to wait over 104 weeks, but the remainder of the backlog had been cleared. The team continued to track well to eliminate the waits, notwithstanding the junior doctors' strike, and the system control centre managed very well given the circumstances

TH expressed thanks to MSEFT and EPUT for keeping patients safe during this period, which were echoed by MT who also wanted to record thanks for the hard work of every person working in our system, particularly around ambulance times during those challenging times. MT invited questions from the Board.

GW requested consideration of separating out Emergency Department performance to determine if patients were seen in the most appropriate setting. TH noted that the team had started looking at data in a new way for patients in a cubicle less than 60 mins, which meant they did not need to be there, this related to 30% of patients. Work was underway to see how this could be addressed by the system.

In response to JF, AMcK confirmed that the currency of data at the Board related to the published information that NHS ministers had shared centrally and provided assurance that progress had been made on targets such as 78 week waits.

Resolved: The Board noted the Performance and Assurance report.

11. Fuller Stocktake Update (presented by Dr A Davey)

AD provided an update on progress relating to the Fuller Stocktake / Our Plan for Patients, noting that the ICB continued to make significant progress towards the ambitions set out in the Fuller Stocktake and that the next quarter was critical in defining the Integrated Neighbourhood Teams (INTs) landscape across Mid and South Essex and identifying the transformative requirements in each of the Neighbourhoods.

AD highlighted the Primary Care Network (PCN) clincial strategy devleopment work, which was on target to complete 28 PCNs by the end of the work through the 4 Alliances. This would align to the approach with the Fuller Stocktake and allow greater clarity over local

priorities. AD gave examples of developing INTs and the work underway to involve them more around transformation and integration. AD provided some more specific examples from the Board paper in relation to primary care consultations, patients seen on the same day, 1 day or 14 days performance and in relation to workforce.

MT acknowledged that Clarie Fuller presented at a Board seminar, who was very encouraging and supportive of the progress the ICB was making. MT thanked AD, RF and the team on the encouraging work and questioned why Southend had a reduction in the number of consultations (22k), although noted this was above the 2019/20 levels.

ACTION: RF to provide some insight as to why Primary Care Consultations at Southend had reduced.

MT invited questions from the Board.

PG supported the paper commenting that the Alliance plans include the Fuller stocktake pillars and so would support this way of working.

In response to a question from PF regarding the volume of face to face consultations at Basildon and Brentwood, AD attributed the high number of consultations to full recruitment to the Additional Roles Reimbursement Scheme (AARS) staff.

PS enquired about investment in PCNs for Mental Health nurses and noted it would be helpful to reflect on how this is working and contributing to performance.

ACTION: Investment into mental health nurses in PCNs to be included in future Fuller Stocktake reports.

AMcK noted the fundamental importance of the work outlined in the paper, that more GPs, responding to workforce challenge reinforces the need for practices and PCNs to work together and at scale as per the recommendations of the Fuller report. AMck and PS acknowledge the role of the community collaborative in supporting primary care.

RF and AD discussed the challenges of recruiting to the ARRS roles at pace and the importance of the ARRS academy and Primary Care workforce hub. Further discussion was held regarding PCN GP assistance hybrid roles between Health Care Assistants and skilled care co-ordinators as well as digital transformation officer and champions in supporting patients.

RF concluded by reflecting on the programme being a massive cultural shift over a number of years; the three pillars of Fuller to make sure there is timely access to acute care in community and consistent access by creating neightbourhoods collaboratively across community, social care, and voluntary sector for our patients / residents.

MT concluded by thanking those involved and noting that the Alliance Directors would be providing vital input to take this forward.

Resolved: The Board noted the Fuller Stocktake and Our Plan for Patients update.

12. Finance Report Month 10 (presented by J Kearton)

JK presented the report on financial performance for the ICB at Month 10 and provided a broader perspective on outturn across partners in the Mid and South Essex system. It was noted that after a thorough review of the forecast outturn position, including external support

and Chief Executive oversight, the system had agreed and negotiated a change to its forecast outturn position to a stretching target of £46.4m deficit and that the month 10 position was on track to deliver the outturn position by 31 March 2023. It was further noted that the system was mobilising its reponse to the forecast outturn change protocol and efforts continued to ensure the finanical plan position for 2023/24 was fully triangulated with activity and workforce plans so that the system had a complete understanding of how to move forward together to deliver financial stability.

JK noted that the large allocation for Primary Care transformation was largely due to delegation (£9million of the £10million related to delegation of Pharmacy, Optometry and Dental (POD). JK also noted that the NHSE MOU provided some additional funding and the ICB had been working with universties and education regarding health inequalities and distribution of that funding.

JK assured the Board that there had been significant conversation about the next finanical year and how financial trajectories would be managed.

MT acknowleded the role of the Finance and Investment Committee in financial management and that there had been a number of Board seminars to explain and understand the financial position and future challenges. MT acknowledged that the system was not in a good position, but was determined to move into the trajectories to spend what was expected and not more. MT thanked the finance team and all partner Chief Executives working together to try and improve the position, acknowledging that our autonomy as an ICB and sytem could otherwise be impacted. Questions from the Board were invited. There were no questions raised.

Resolved: The Board noted the Finance Report for Month 10.

13. General Governance (presented by Professor M Thorne)

13.1 Delegated Commissioning: (Pharmacy, Optometry and Dental).

RF presented an overview of the proposed delegation of Pharmacy, Optometry and Dental (POD) services from NHS England to Integrated Care Boards from 1 April 2023, summarised the arrangements for the management of the functions and sought the approval of delegation from the Board.

RF noted that, given delegation had not yet been provided, the question on dental services from a member of the public could not be answered at that time.

RF stated that through due diligence processes, Mid and South Essex ICB had made a significant number of preparations for the forthcoming delegation of POD services. These had largely been focussed on a controlled approach that initially focussed on embedding and stabilising the functions before undertaking strategy development to then maximise the opportunities that taking delegation presented. There remained several risks that continued to be mitigated.

The process for delegation of the management of pharmacy and optometry commissioning to Hertfordshire and West Essex ICB was outlined, noting that accountability remained with our ICB.

MT invited questions from the Board noting that the first step was to transfer the delegation to the ICB in a controlled environment before we could start to tackle any issues or associated risks.

GW explained that there was limited experience regarding the delegation of POD services and therefore a short paper describing supply and demand would be useful to understand the scale of the financial challenge within mid and south Essex.

ACTION: The Primary Care Commissioning Committee to navigate and report back to the Board on the scale of the financial and commissioning challenge with POD delegation (e.g. supply and demand).

JK acknowledged that the cost pressure was a national problem. NHSE had undertaken the planning for the next financial year, and the ICB was just understanding the cost pressures and would work closely with NHSE to understand and unpick the finances in the coming financial year.

TH enquired whether the allocation included capital. JK confirmed budgets were revenue based, but capital had not been allocated as yet.

AMcK highlighted that where national contracts were in place, there were difficulties to influence services at a local level. The question from Mr Richards pointed to a misalignment and that a strong environment was needed to control the finances. AMcK noted that there had been stewardship groups discussing optometry services bringing the hospitals together, but that Pharmacy and Dentistry would be more problematic, given the little flexibility within the national contracts.

Resolved: The Board noted the proposed delegation of Pharmacy, Optometry and Dental Services from NHSE to ICBs and approved the MSE ICB receiving this delegation.

13.2 Thurrock Alliance Terms of Reference (presented by Aleksandra Mecan).

AM introduced the Terms of Reference for the Thurrock Alliance and sought approval from the Board. There were no questions.

Resolved: The Board approved the draft Thurrock Alliance Terms of Reference.

13.3 Annual amendments to Committee Terms of Reference and the ICB Scheme of Reservation and Delegation.

MT presented the governance changes required for the ICB to receive delegation for POD services, namely amendments to the Scheme of Reservation and Delegation and minor changes to the Primary Care Commissioning Committee Terms of Reference.

The ICB delegation of specialised commissioning had been deferred until April 2024, but in the meantime the East of England Specialised Services Joint Commissioning Committee would operation as a regional joint committee of all six ICBs in shadow form until delegation was received.

MT also noted further minor amendments to the SORD and Finance & Investment Committee Terms of Reference to strengthen the governance arrangements in place. MT invited questions from the Board, there were none.

Resolved: The Board:

- **Approved the revisions to the Scheme of Reservation and Delegation.**
- **Approved the revisions to the Primary Care Commissioning Committee Terms of Reference.**
- **Approved the ICB's membership of the regional Specialised Services Joint Commissioning Committee for 2023/24 (SSJCC) and agreed that the joint working arrangements can be signed by the Chief Executive Officer.**
- **Approved the minor changes to the membership of the Finance & Investment Committee.**

13.4 Delegation of approval of Annual Report and Accounts to Audit Committee.

MT stated that as a result of national timetables, delegation of authority from the Board to the Audit Committee had been sought for the approval of the ICB Annual Report and Accounts. MT invited questions from Members, none were raised.

Resolved: The Board agreed to delegate authority to the Audit Committee to approve the annual report and accounts.

13.5 Approved Committee Minutes.

The Board received copies of the latest approved minutes of the following main committees:

- Audit Committee (AC), 17 January 2023.
- Clinical and Multi-Professional Congress (CliMPC), 26 January 2023.
- Finance and Investment Committee (FIC), 1 February 2023.
- Primary Care Commissioning Committee (PCCC), 18 February 2023.
- Quality Committee (QC), 25 November 2022.
- System Oversight and Assurance Committee (SOAC), 8 February 2022.

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

13.6 Adoption of ICB Policies.

MT advised that the Board was asked to ratify two new ICB policies which had received prior approval by the relevant committees as set out in the report.

Resolved: The Board ratified the following new ICB Policies:

- **MSEICB 009 - Allocations and System Reporting Policy.**
- **MSEICB 086 - Under and Over Payments Policy.**

13.7 Board Assurance Framework (BAF)

MT outlined the Board Assurance Framework paper presenting the key risks to the ICB, noting that the issues raised were discussed throughout the agenda and invited questions from the Board, none were raised.

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

14. Any Other Business

There was no other business discussed.

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

Thursday, 18 May 2023 at 3.00 pm, Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, Essex, CM1 1JE

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
4	01/07/2022	9	**Appointment of Lead Roles** Include appointment of Deputy Chair of the ICB to the agenda of a future Board meeting.	M Thompson	31/08/2022	Deferred until future Board meeting.	In progress
9	13/10/2022	8	**Digital Strategy and Investment Priorities** Secure investment requirements over future years.	System Leaders Finance Group/ J Kearton	Ongoing	Electronic Patient Record investment case worked through with finance partners (MSEFT, EPUT and ICB). A match funding profile confirmed as part of the outline business case -currently in regional / national review cycles. Shared Care Record funding confirmed as part of the MTFP. An identified funding approach for 23/24 to go to System Leaders Finance Group 15 May for approval. Patient Know Best – funding confirmed between MSEFT and EPUT to support. Additional funding request from NHSE submitted to accelerate role out. Strategic Data Platform – temporary investment utilising existing contractual agreements with AGEM has been used, however a wider investment case is being developed for wider partner alignment.	In progress

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
21	16/03/2023	3	**Questions from the Public** Arrange for written responses to be provided to questions raised by members of the public	N Adams	30/04/2023	Completed.	Complete
22	16/03/2023	8	**Stewardship Stocktake** Consider whether the support pack is developed sufficiently to underpin the work of the stewardship groups.	P Scolding	11/05/2023	Confirmation received that all actions contained within the White paper, endorsed by the Board, will be picked up. Action closed.	Complete
23	16/03/2023	11	**Fuller Stocktake** Provide some insight as to why Primary Care Consultations at Southend have reduced.	R Fenton	11/05/2023	Explanation provided to Prof. Mike Thorne on 11 May 2023.	Complete
24	16/03/2023	11	**Fuller Stocktake** Investment into mental health nurses in PCNs to be included in future Fuller Stocktake reports.	W Guy	13/07/2023	To be included from July 2023.	In progress
25	16/03/2023	13.1	**Delegated Commissioning (Pharmacy, Optometry and Dental)** The Primary Care Commissioning Committee (PCCC) to report back to the Board on the scale of the financial and commissioning challenge with Pharmacy, Optometry and Dental delegation (e.g.	R Fenton/ W Guy	13/07/2023	To be considered by PCCC at its June meeting and reported to Board, 20 July meeting.	In progress

Part I ICB Board meeting, 18 May 2023

Agenda Number: 6

Final Draft Joint Forward Plan

Summary Report

1. Purpose of Report

This report provides the Board with the final draft of our first Joint Forward Plan for discussion and approval.

2. Executive Lead

Jo Cripps, Executive Director of Strategy & Partnerships

3. Report Author

Jo Cripps, Executive Director of Strategy & Partnerships

4. Responsible Committees

The ICB has received updates on the approach to developing the JFP.

The ICB also held a seminar session to discuss the Joint Forward Plan in March 2023.

The CEO Forum has discussed the approach to the Joint Forward Plan on various occasions.

Relevant Boards/Committees with responsibility for NHS Long Term Plan commitments have authored and assured their relevant sections (parts 2 and 3).

5. Impact Assessments

Not applicable to this report. Where any service changes arise from the Joint Forward Plan, once agreed, relevant impact assessments will be completed.

6. Financial Implications

Not applicable to this report. Where any financial impacts arise from the Joint Forward Plan, once agreed, these will be considered via the appropriate routes.

7. Details of patient or public engagement or consultation

The draft Joint Forward Plan builds on the integrated care strategy, on which there was significant engagement with partners and key stakeholders.

Our expectation is that engagement with our communities and co-production is mainstreamed into our work and the ICB will wish to receive assurances, on a case by case basis, that this has been the case.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The ICB is asked to approve the final draft Joint Forward Plan, noting that there may be changes following receipt of the Plan by provider Boards, Health and Wellbeing Boards and further engagement with stakeholders taking place over May and June.

The ICB is further asked to delegate final approval, to achieve publication by 30 June 2023, to the Chairman, Professor Mike Thorne, ensuring that relevant feedback from the above is reflected as appropriate in the final publication.

Final Draft Joint Forward Plan

1. Introduction

Following the formation of Integrated Care Boards (ICBs) as statutory bodies, NHS England (NHSE) issued guidance on the new duty for ICBs and their NHS partner trusts to develop a plan over 5 years – known as the Joint Forward Plan (JFP) – and to update this plan annually in line with national operational planning requirements.

This paper asks the ICB to approve the final draft Joint Forward Plan. The draft JFP will also be presented to provider Boards during May/June for approval and will be shared with Health and Wellbeing Boards of our three upper tier local authorities.

2. The Joint Forward Plan

In line with national guidance, our draft JFP describes how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet our population's physical and mental health needs, including the delivery of universal NHS commitments. It also addresses the four core purposes of the Integrated Care System, and outlines how we shall meet our various legal obligations. Crucially, the draft JFP supports the delivery of the new integrated care strategy (developed by the ICP) and the local health and wellbeing strategies of our upper tier local authority partners.

Ordinarily, the JFP would need to be completed by the start of the financial year – 1 April - in line with the NHS operational planning cycle. However, for this first year, and in recognition of the ongoing development of guidance for integrated care systems, NHSE specified that the date for publishing and sharing the final plan with NHS England, our integrated care partnership (ICP) and our three local Health and Well-being Boards (HWBs), is 30 June 2023.

Guidance states that ICBs and their partner trusts must consult with 'those for whom the ICB has core responsibility and anyone else they consider appropriate'. This should include the Integrated Care Partnership (ICP) and NHS England (with respect to the commissioning functions that will be delegated to ICBs). The development of our integrated care strategy involved wide-ranging engagement with partners and the public, and the development of the JFP will use and build upon the insight gained during this engagement process.

In future, the JFP will be reviewed and updated on an annual basis, in line with annual operational planning guidance (with the operational plan submission effectively forming 'year one' of the rolling 5 year plan.

In line with guidance, a draft of this plan was submitted to NHSE by 31 March, and feedback has been incorporated into this final draft.

Engagement with HWBs

JFP guidance states that ICBs and their partner trusts 'must involve relevant HWBs in preparing or revising the JFP'. Local elections have meant that two of our three upper tier local authority health and wellbeing boards were held in abeyance until the elections had concluded. This means that engagement with the HWBs and the sharing of this draft will take place during June. HWBs will be asked to give an opinion on the JFP, specifically as to the extent to which the plan takes into account our integrated care

strategy and the joint health and wellbeing strategies and joint strategic needs assessments conducted by our local authority partners.

Engagement with Stakeholders

Building on and continuing the engagement undertaken to develop the integrated care strategy, we are embarking on a series of 'spring conversations' with stakeholders at venues across Mid and South Essex and on-line. This is part of a series of regular conversations, workshops and seminars, bringing together partners with community members to explore what is working well across health and care in MSE, the challenges we face and how best we can work together, with our communities, to address these. These sessions are open to anyone who works in or benefits from health or care services in MSE, and are structured so as to encourage open exchange of ideas and conversations about how we can better support our population. The topic of conversations in this round of engagement will be the draft Joint Forward Plan.

Our approach to developing the JFP

The Board has received updates on the development of the JFP and discussed the approach to development in one of its strategy sessions. There was a shared desire to ensure that, alongside the varied NHS commitments, our JFP was able to pinpoint the most impactful issues that NHS partners would work together on. The draft JFP is therefore presented as a 3-part document:

Part 1 – provides some background to the current challenges the NHS is facing in Mid and South Essex, and identifies a number of areas where, as NHS partners, we will work together to make an impactful change. Detailed plans will be developed to ensure that we deliver on these commitments, together.

Part 2 – provides the underpinning aspects of our approach, describing our work on population health improvement, health inequalities and prevention. Part 2 also describes our approach to local delivery – through our Alliances.

Part 3 – contains a number of appendices which describe our approach to delivering on NHS Long Term Plan commitments and other statutory duties placed upon the NHS. These commitments are delivered by various partners across our system, working in provider organisations and the ICB – each appendix describes the governance arrangements for ensuring delivery, including oversight and assurance arrangements through our relevant system governance mechanisms.

Route to Approving the JFP

We are asking the ICB to approve the draft JFP at its meeting on 18 May.

We will then share the draft with provider Boards, who will be asked to approve the plan over the course of May and June.

We will also share the draft with our Health and Wellbeing Boards w/c 5 June, to give sufficient time for the Boards to be formed after local elections and to ensure that all three HWBs are given equal opportunity to consider the draft Plan. HWBs are asked to provide an opinion on the extent to which the JFP has incorporated local strategies, needs assessments and our integrated care strategy.

Our 'spring conversations' are also taking place over May/early June.

As a result of the above, there may be changes to the draft JFP after the ICB Board meeting.

3. Recommendation(s)

The ICB is asked to approve this final draft of the Joint Forward Plan, noting that there may be changes following receipt of the Plan by provider Boards, Health and Wellbeing Boards and further engagement with stakeholders taking place over May and June.

The ICB is further asked to delegate final approval, to achieve publication by 30 June 2023, to the Chairman, Professor Mike Thorne, ensuring that relevant feedback from the above is reflected as appropriate in the final publication.

4. Appendices

Appendix 1 – Draft Joint Forward Plan

Mid and South Essex Integrated Care System

NHS Mid and South Essex

DRAFT FINAL

NHS Mid and South Essex

Joint Forward Plan 2023-2028

Table of Contents

Foreword from our Chair

I'm delighted to present this, our first Joint Forward Plan, as the Mid and South Essex Integrated Care System. This plan outlines the joint ambitions of NHS partners in Mid and South Essex, which both respond to and support the joint health and wellbeing strategies of our three upper tier local authority partners (Essex County Council, Southend City Council and Thurrock Council), and the integrated care strategy that we have jointly developed, under the auspices of the Integrated Care Partnership.

As is the case for many newly established Integrated Care System, we face a number of challenges. The Covid pandemic has exacerbated health inequalities in our population, our primary care services are under extreme pressure, demand on our mental health, urgent and emergency services are significant, we have long waits for planned treatments and we are not meeting nationally set standards in relation to cancer care. Collectively, our providers are carrying significant vacancies and we over-rely on bank and agency staff to fill rotas – as a result the quality of care we offer can sometimes suffer. We have a significant underlying structural deficit, and we are not meeting our planned financial position.

Within these many challenges, we are also a system that has high ambitions to improve the health and wellbeing of the population that we serve. We have delivered a number of impressive and long-lasting improvements and have had many successes. This plan will look to continue to build on those positives. It incorporates detailed operational and financial plans for the first year, 2023/24, in line with NHS England guidance, and outlines the ambitions and plans of NHS partners over the coming 5 years in key areas.

We are committed to continuing to work together to do all that we can to improve outcomes for our local population.

Professor Michael Thorne CBE
Chair
NHS Mid and South Essex Integrated Care Board

About this Document

This document is the first Joint Forward Plan (JFP) for NHS partners since the inception of the statutory Integrated Care System (ICS) in Mid and South Essex.

The production of this plan has followed guidance issued by NHS England (NHSE) and the detailed operational planning and financial framework issued to NHS organisations for 2023/24.

We have split the JFP into three distinct parts:

This first section (**part 1**) provides an overview of our collective view of the NHS system over the next 5 years. This describes how the NHS will take forward the Integrated Care Strategy, taking into account the Joint Local Health and Wellbeing Strategies of our upper tier local authorities, along with the strategic ambitions of NHS and wider partners. Part 1 can be considered the executive summary for the Joint Forward Plan.

Part 2 of this plan describes the underpinning approach we will take to deliver on our collective ambition to improve population health and reduce health inequalities.

We will seek feedback from partners on this first part as to how well they consider the plan reflects the current challenges and ambitions of partner organisations and strategies.

Part 3 of the plan is a series of appendices which describe how we will meet the statutory requirements placed upon the NHS – offering an overview and a high-level delivery plan for each Long-Term Plan commitment and statutory function for the NHS. This section of the plan has been produced by subject matter experts, working across NHS partners, to reflect on delivery of the NHS Long Term Plan.

The NHS operational planning guidance for 2023/24 NHS operational planning guidance link has set out clear expectations for delivery and our collective submissions to NHS England aggregate our shared ambitions and commitments for 2023/24 – this is year 1 of the Joint Forward Plan.

We will share the appendices in Part 3 with partners, who may wish to review some or all of the sections. However, through the usual course of our work, it is our expectation that residents, patients, and partners, will be fully involved in defining and supporting delivery of these priorities.

Part 1: The Collective Ambition of NHS Partners

Upping our game: in it together for long healthy lives and the best of care, clinical outcomes and careers.

Introduction

At the time of inception of our Integrated Care System, all partners agreed that our main objective should be to 'up our game'. Consequently, NHS partners have agreed that, in this Part 1 document, we should set out our collective ambitions to both address the significant challenges we face and set a strategic ambition for the NHS we want our residents to experience.

NHS partners agree that 'warm words' will not deliver this ambition – our leaders and organisations are committed to working together and with local authority partners in a way not seen previously, with concrete agreements and actions, to deliver for our population. We realise that improvement across the board means opening up our individual organisations so that they can benefit from our collective ideas and experience while respecting our statutory independence.

We want people to live longer, healthy lives, to be able to access the best of care and to experience the best clinical outcomes, and for us to be exceptionally able to attract good people to work with us, recognising we offer meaningful careers. We are clear that delivering this ambition must start now and reflect our challenging starting position.

We are committed to delivery of the Integrated Care Strategy, recently co-developed with partners through our Integrated Care Partnership (ICP). The Integrated Care Strategy draws heavily upon the joint health and wellbeing strategies of our upper tier local authorities, and so we expect that our plans will contribute to the delivery of those strategies through our Primary Care Networks (PCNs) and neighbourhoods, the Alliances and (where appropriate) across the Mid & South Essex (MSE) system.

Central to our Integrated Care Strategy is our desire to see residents united with health and social care services around the single '**Common Endeavour**' of **reducing inequalities together**.

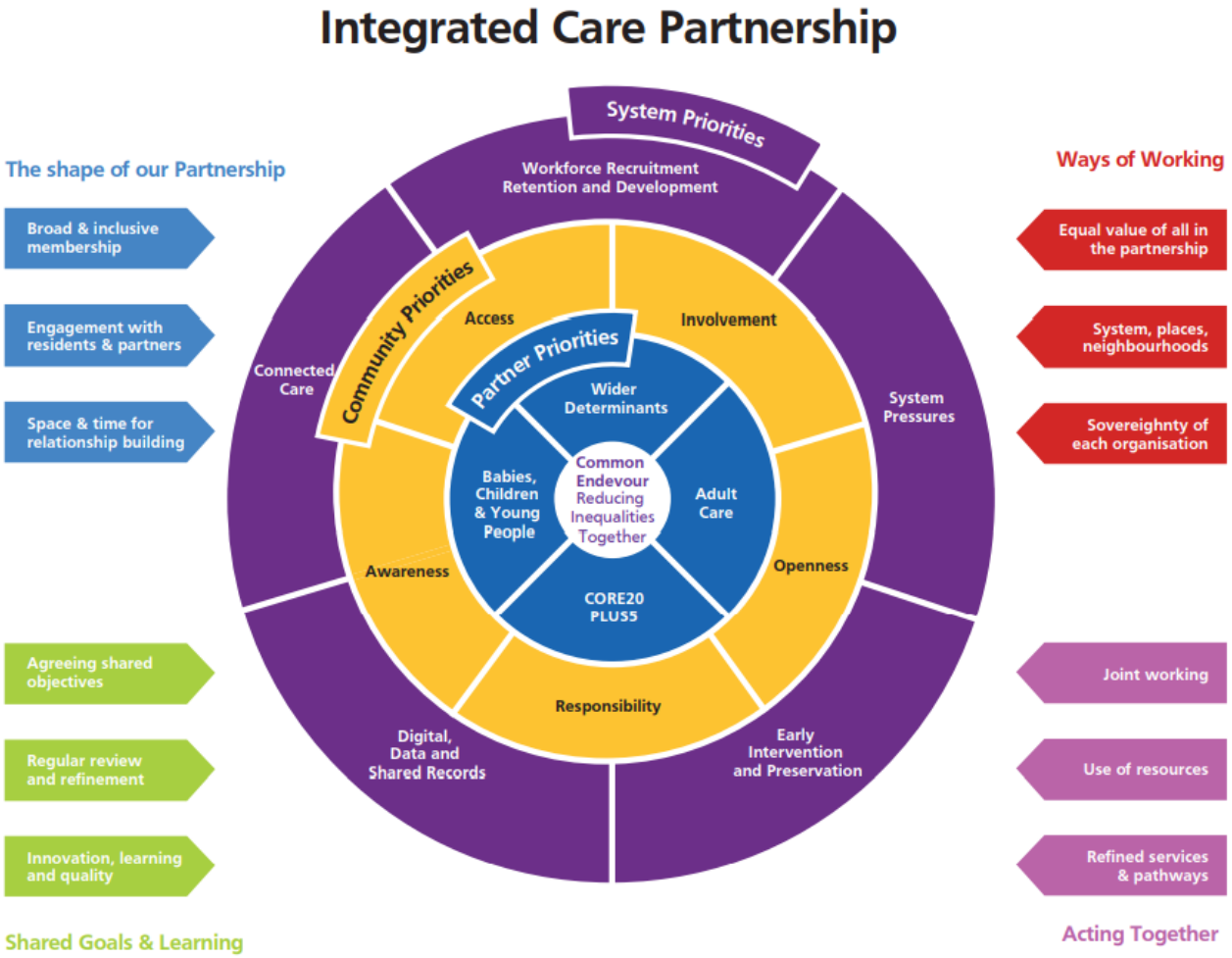


Fig 1: *The Mid and South Essex ICS Integrated Care Strategy, plan on a page, March 2023.*

Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system.

As NHS partners in the Integrated Care Partnership, the Common Endeavour expresses our collective desire to work to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations, and agencies, focussing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

Our Integrated Care Strategy (Integrated Care Strategy link) states that this cannot be achieved by statutory partners alone – and we are committed to ensuring voluntary, community, faith and social enterprise organisations, residents, and others are invited to join us in our Common Endeavour. Together we will significantly increase focus on individual and community engagement, wider determinants, early intervention, and prevention.

The Scale of the Challenge

We must be honest about the challenges faced by the NHS locally.

- Demand for complex care across all services is rising as our population ages; we often duplicate service offerings or fail to deliver the joined-up, personalised care.
- We are not well resourced in terms of workforce – with particular shortfalls in primary care, and significant nurse, support worker, allied health professionals and in some clinical specialities, medicine vacancy rates. Both recruiting and retaining staff has been problematic in recent years.
- We are challenged operationally – struggling to maintain standards in some areas whilst escalation capacity usually reserved for winter is often required year-round. Length of stay in our services has increased significantly.
- We have a substantial historical structural deficit and we have failed to deliver our financial improvement plans. We have posted a system financial deficit for 2022/23, driven largely by a failure to deliver efficiencies and an over-reliance on bank and agency staffing – underpinned by rising demand in certain areas of care, more complex treatment regimes in some specialities and a failure to prevent chronic disease exacerbation. A key consequence of our deficit is that we have been limited in the investment we have been able to make in transforming health and care. We do not wish to cede control over our operations that is a likely consequence of not resolving our deficit. We wish to retain our autonomy within the agreed NHS framework.

- Our patients have not received the highest quality care in some cases – we have quality and safety challenges across many services.
- We are failing to meet many of the statutory requirements set out in the NHS Constitution.
- Constrained capital is now creating pressures and limiting our ability to transform due to irretrievable equipment/infrastructure breakdown.

In order to turn this set of circumstances around, we need not only to do things differently, but to do different things. As NHS partners, we are making a set of commitments in this joint forward plan that we must take forward together.

Commitments

Over the course of this Joint Forward Plan, NHS partners are committed to the following actions (further detail can be found below and in the appendices):

- A focus on **reducing health inequalities** experienced throughout our population. We will focus our work on delivering against the **Core20+5 frameworks** for adults and children at neighbourhood, alliance and system level, using a population health improvement approach.
- The delivery of **local, personalised, coordinated services**, delivered through **Integrated Neighbourhood Teams**, managed through our four Alliances.
- Making significant progress on **reducing avoidable mortality** in the following areas:
  - Cancer
  - Cardiovascular disease
  - Respiratory conditions
- Increasing our work, in partnership, on the following **preventative activities**:
  - Tobacco cessation
  - Healthy weight
  - Physical activity
- Continuing our work to **amplify clinical and professional leadership** in our system – using our **Stewardship programme** and leadership development opportunities to develop a future view of services that enable the highest professional standards, and a multi-professional approach.
- Increasing the amount we **invest 'up-stream' in evidence-based interventions and preventative activities that take place closer to the resident** – underpinned by a commitment to understanding the impact of our work on health inequalities and ensuring we have explored the prevention aspect of all investments.

- Using **population health management** to support us in setting ambitious targets for prevention investment annually. Our ability to do so will require a concomitant reduction in crisis/acute sector spend and a commitment to use available transformational funding differently, evaluating and embedding embed what works.
- Developing a clear demand and capacity model for the system that is used to underpin **integrated operational decision-making that is organisationally agnostic** and focussed on how best to meet the needs of the population.
- **Investing strategically in our Voluntary and Community, Faith and Social Enterprise (VCFSE)** to support wellbeing, prevention and early intervention,
- Continuing to **evolve our relationship with communities** – involving them in designing service offers and being open with them about the limitations and challenges we face.
- Placing an emphasis on **equality, diversity and inclusion** – for our workforce and our patients.
- Learning from and building upon existing and future **innovative practice**.
- Considering social value in our approach, linking to our **Anchor Charter**.

Ground Rules

A number of 'ground rules' have been agreed, either through national directives applied to all ICSs, or through local agreement. These are summarised below:

- As a system in deficit, a 'triple lock' lock is applied to any new investment across revenue and capital monies. This means that investments above a certain value or those which are unbudgeted will be scrutinised by NHS England as well as by the Integrated Care Board and provider Boards.
- Resources are allocated in line with national directions where they apply.
- Growth funding will flow to providers where growth in activity is demonstrated.
- A joint commitment to deliver against a trajectory for vacancy reduction (and concomitant reduction in bank and agency which will be stratified by speciality) along with targeted actions on recruitment, retention, adoption and spread of new roles and securing a sustainable future pipeline of staff.
- A programme to rationalise estate and backlog maintenance bills is agreed and delivered.
- Demand and capacity are clearly understood and underpins decisions on investment, delivery and operational performance.

- Access to elective care will be based on clinical prioritisation, health inequalities, and a commitment to reducing the longest waiting times within core levels of activity agreed across NHS and independent providers.
- The Integrated Care Board (ICB) will reduce its running costs from £22m to £17.2m by 1st April 2025.
- Collective prioritisation and deployment of transformation funds (subject to the triple lock described above) will be targeted towards those areas that support the reduction of health inequalities, focus on prevention and generate a system return on investment that is impactful for our population.
- The primary care 'working together' framework is implemented to incentivise proactive care.
- Evidence based efficiency programmes will be delivered, underpinned by equality and health inequality impact assessments for all programmes.

Our Key Strategic Ambitions

We have established a Chief Executive Forum spanning the ICB, Mid & South Essex Foundation Trust (MSEFT), Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (CIC). The commitments outlined above have thus been agreed and recommended by the partner organisation's respective CEOs before being adopted by the Integrated Care Board and provider Boards.

Over and above the commitments in the 2023/24 operational plan, and the delivery plans outlined in the appendices of this Joint Forward Plan, the Chief Executive Officers (CEOs) / Boards have committed to:

Improving Quality

Access, Experience and Outcomes

Why is this important

Our residents describe difficulties in accessing healthcare services.

Our regulators have placed enforcement and improvement actions on some of our providers.

Our clinical and professional leaders have a pivotal role in ensuring quality and we must support them to deliver the best quality services they can.

How will we do it

What we will do	When we will do it by
Use continuous improvement approaches within an overall quality management framework for all aspects of the system.	Ongoing
Deliver and sustain the 'must' and 'should do' actions, as identified by the Care Quality Commission (CQC) (MSEFT and EPUT), to improve quality of services for our population.	March 2024
Make required improvements to Maternity, Referral to Treatment (RTT) and Cancer performance so that Undertakings are removed (MSEFT)	September 2023
Improve in patient experience of Primary Care through Integrated Neighbourhood Teams process evidenced by an improvement in National patient satisfaction Survey outcomes by 15% (to 80%) by 2025 and 25% (to 90%) by 2027 from current values of median satisfaction scores of 65%.	2025 onwards

Health Inequalities

Our Common Endeavour – the NHS must play its part in reducing health inequalities

Why is this important

We know that existing health inequalities have been exacerbated by Covid, our integrated care strategy, adopted by all partners, has reducing health inequality as the unifying 'common endeavour'.

We must listen to the experience of individuals and communities regarding their experiences, and work with them to help us design support, together.

How will we do it

What we will do	When we will do it by
Working together with partners on the wider determinants of health, raising awareness of the important role that local authorities, VCFSE and communities play in prevention and early intervention and supporting new partnership approaches.	March 2024
Deliver our agreed plans in relation to Core20+5 frameworks for adults and children with defined	March 2024

programmes for the most deprived populations, our plus groups (at local and system level) and the prescribed clinical areas.	
Further development of the Anchor Charter, and through the ICP Outcomes Framework, demonstrate impact for our local population.	September 2023
Use experience-based co-design, learning from innovation, coproduction and data to understand frequent users of our services (health and care) – developing mechanisms to gather insights, through lived experience, to better understand and implement support needs	September 2023

Financial Sustainability

A collective commitment to live within our means.

Why is this important

As a system, we ended the 2022/23 financial year with a deficit of £46.4m. We worked collectively to deliver in-year financial improvement and we will continue to develop our plans as a system to deliver financial stability.

We are subject to increased regulatory financial scrutiny from our NHS England National and Regional offices because of our position.

We must balance the need for financial sustainability with the need to innovate and invest in areas that require improvement and can demonstrate benefit for patients.

How will we do it

What we will do	When we will do it by
Commit to delivering improvements in productivity by understanding our system cost base and developing our clinical stewardship approach to support collective value-based decision-making.	April 2023 and ongoing
Deliver the action required to remove costs and increase efficiencies as a system, using benchmarking and local intelligence, acknowledging that efforts in one space may create benefit in another but as a system the ultimate benefit is to our residents.	April 2023 and ongoing
Agree and deliver a programme of corporate function consolidation across co-terminus partners, to offer best value to our population.	April 2023 and ongoing

What we will do	When we will do it by
Agree and deliver against trajectory for vacancy reduction (and concomitant reduction in bank and agency which will be stratified by speciality) through a dedicated programme of system-wide recruitment, retention and new role development.	April 2023 and ongoing
Accelerate our joined-up approach to Estates, as part of a system-wide Infrastructure Strategy, which will support efficient use of resources across the system.	April 2023 and ongoing
Consider opportunities presented through delegation of specialised commissioning including the exploration of more affordable care models, to offer best value to our population.	April 2023 and ongoing
Reduce the ICBs running costs from £22m to £17.2m by April '25	1 April 2025

Operational Delivery

A commitment to improving our operational planning and delivery functions

Why is this important

Competing organisational needs and priorities, and differing levels of capacity and capability can distort operational delivery that is focussed on offering the best care to our patients.

Through benchmarking, we know that we can make improvements in productivity and access to services.

How will we do it

What we will do	When we will do it by
Initial demand and capacity model including whole system data (beds) developed to enable organisationally agnostic decision-making.	April 2023 (initial)
Further enable demand and capacity modelling to support decisions on future community capacity (virtual and bedded) and operational / clinical interfaces.	May 2023
Consider, with partners, longer-term capacity requirements for care settings, to include health and social care settings.	July 2023

Identify a rolling programme of productivity improvements, including future service delivery models, aligned with tools such as Getting It Right First Time (GIRFT), Model Hospital.	April 2023 onwards

Supporting our Workforce

Recruit and retain the best staff, give local people opportunities to work across health and care services.

Why is this important

Current pipelines for professional staff across health and social care will not meet demand trajectories. We must commit to new roles and ways of working now, in order to see a difference by the end of this JFP period.

How will we do it

What we will do	When we will do it by
Develop a system-wide approach to workforce planning that is closely aligned to finance and activity planning.	March 2023
Through the planning round quantify the volume of enduring vacancies based upon the metrics of provider performance and the known opportunity within our undergraduate pipeline.	March 2023
Agree the volume of enduring vacancies that will be replaced with new roles in each organisation to include Training Nurse Associates (TNAs), Advanced Clinical Practitioners (ACPs) , Physician Associate (PAs), enhanced Healthcare Support Workers (HCSW) roles and apprenticeships.	April 2023 onwards
Stratify our workforce hotspots by speciality and undertake focused intervention on recruitment, retention, transformation and staff wellbeing.	June 2023
Launch our Healthcare Support Worker (HCSW) academy as a ‘one workforce’ initiative which champions the recruitment, on boarding and education of new entrants to health and care. In addition, the academy will provide educational and Continued Professional Development (CPD) opportunities, career coaching and mentorship to support, value and retain HCSWs and map out career pathways into	June 2023

apprenticeship pathways across a range of professional groups including nursing, AHPs and medicine.	

Let staff lead

Growing our stewards for the future

Widespread development of quality improvement and leadership skills

Why is this important

We know that we must enhance the capability and capacity of our clinical and professional staff to lead and engage with transformation activities across the ICS.

Not only will this ensure that services are forward focused, and use the range of skills available to us, but it can also contribute to better satisfaction at work and enhance retention.

How will we do it

What we will do	When we will do it by
Delivery of agreed clinical stewardship training and development modules to enable formation of stewardship groups for all agreed care areas.	April 2023 and ongoing
Launch hosting arrangements to enable testing and implementation of stewardship of resources at the level of a whole care area level – with stroke care as the first pilot. Stewards and host organisation to work together on care area.	September 2023
Create the environment to support integrated, multi-organisational, multi-disciplinary working; Removing silo working and enabling patient-focussed, asset-based thinking in the delivery of services.	Ongoing

Population health improvement

Focus on prevention, early intervention and targeted approaches.

Providing more personalised care that addresses existing health inequalities.

Measure what matters to our residents.

Why is this important

Traditionally the NHS has focused on treatment and curative activities. While we have, more recently concentrated on early identification and intervention, we recognise that we must play a full part, with our public health teams and wider partners, on prevention. Our Population Health Improvement Board (PHIB) will support both the Integrated Care Board and the Integrated Care Partnership to realise these ambitions.

Our Integrated Care Strategy outlined commitments, encapsulated in a series of "I" and "We" statements, which we fully adopt.

How will we do it

What we will do	When we will do it by
Over the course of this JFP, we commit to shifting resources to evidence-based upstream and preventative activities (described in detail in the appendices) using population health management information and benchmarking to determine the ambition.	March 2028
Full implementation of the personalised care framework.	March 2024
Refresh the ICS Outcomes Framework and set medium and long-term ambitions for specific work programmes.	May 2023
Develop baseline and measures for the 'I' and 'We' statements from the Integrated Care Strategy and report these via the ICP.	April 2023 onwards

Digital, Data and Technology

Gearing up our system to become more digitally enabled

Supporting our residents to use digital tools

Why is this important

We have historically struggled to join up our digital offer. We are making great progress in this area and recognise that we must involve patients and professionals in our future plans.

We have a poor data/BI (Business Intelligence) infrastructure and recognise the need to enable staff with these specialist skills to work together to join up our approach and ensure best data quality.

We will look to exploit opportunities to ensure health and care data is shared amongst professionals to enable improved decision-making and care provision for our residents.

We will look to empower residents to have better control and access to their own records.

How will we do it

What we will do	When we will do it by
Procure and install a single Electronic Patient Record (EPR) across our main providers.	March 2025
Implement the Shared Care Record (SCR) which is accessible to health and care partners.	June 2024
Continue to build our strategic data platform (Athena) to enable sharing of data to enhance population health improvement, planning and operational delivery.	Rolling programme
Work to create a virtual data/BI team to enable resilience, learning and improve data quality and literacy.	March 2024
Implement an integrated digital patient interface for our residents.	March 2024
Through our local authority partners, increase the use of digital social care records.	Rolling programme
Improve our core infrastructure and access to services across partner organisations...	Rolling programme
Create a digital capability approach to support our professional workforce.	Rolling programme
Drive efficiencies and improved workflow through Robot Process Automation.	Rolling programme

Mobilising and Supporting Communities

The assets in our communities and supporting them to flourish

Why is this important

Patients have told us, through the development of the integrated care strategy, that they want to be involved, informed and supported to take responsibility for their own health and wellbeing and that of their loved ones. In return they want us to be open

and honest about the challenges we face, and enable them access to personalised, integrated services, close to where they live.

We recognise and appreciate that as NHS partners we need to improve our interaction with individuals and communities, building trust in our services and enabling people to self-care, support one another.

How will we do it

What we will do	When we will do it by
Develop a model/blueprint for Integrated Neighbourhood Teams (INTs) categorising the service offer, staff model and interaction with our Community Voluntary Services (CVS), against population need.	September 2023
Working with partners, develop an asset-based community development approach.	September 2023
Fully establish our Community and Voluntary Sector Assembly aligned to system and place through our Alliances.	June 2023
Establish a partnership-based Co-Production and Engagement Steering Group to ensure effective planning, accountability and inclusion.	June 2023
Establish an influencer network to ensure we can diversify our approach to community building and engagement.	June 2023
Develop and implement an engagement impact framework to ensure efficacy and inclusion in our engagement approaches.	September 2023
Deliver an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our ICS.	June 2023 onwards
Grow our Community Campaign approach, develop a Human Library and Lived Experience network, which will ensure a better approach to immersive practice as a system.	June 2023
Develop a paired learning Leadership Programme with and for the VCFSE and our clinicians.	December 2023

Improving our System Oversight Framework (SOF) rating

Why is this important

Providers are subject to a range of interventions (from national and regional and the CQC) – there is a risk this will impact provider, and potentially ICB, SOF ratings.

We are agreed as NHS partners that we would wish to remain within current SOF ratings and be enabled to deliver our improvement plans.

How will we do it

What we will do	When we will do it by
Work with our regulators to ensure effective oversight and assurance of our collective activities.	March 2023 and ongoing

Research and Innovation

Bringing benefits for patients, staff and the local economy.

Why is this important

Research and Innovation are integral parts of the NHS constitution and key enablers in driving improvements in clinical care.

We have an established track record of innovation – MSEFT host national innovation schemes, and we have an ICS innovation fellowship programme. There are opportunities to build on this.

Research active organisations are beneficial for residents and staff alike – and have important benefits for the economy. We have the scale and scope to generate opportunities and maximise our research activity.

We should link these activities to a wider commercial strategy for the system.

How will we do it

What we will do	When we will do it by
Develop a system-wide research and innovation strategy that supports a culture of research and sets our ambition for research infrastructure, income and participation.	October 2023
Develop a commercial strategy for the system that enables us to build our approach to working with industry partners, universities, University College	Autumn 2023

London Partners (UCLP - as our Academic Health Science Network partner) and research organisations.	

Further developing our system

Why is this important

We are committed to on-going development of our integrated care system.

How will we do it

What we will do	When we will do it by
The Community Collaborative will operate under a single contract (commencing in shadow form for 2023/24).	April 2023
The Community Collaborative will be part of the NHSE accelerator collaborative programme.	April 2023 – March 2024
Our mental health provider continues to operate as part of the specialist provider mental health collaborative.	April 2023 and ongoing
We are exploring a mental health collaborative approach across MSE.	September 2023
The ICB will assume delegated pharmacy, optometry and dentistry commissioning responsibilities.	April 2023
Play a full part in delegation of specialist commissioning functions as defined by NHSE.	April 2024

Part 2 – Improving population health and reducing health inequalities

This is our first Joint Forward Plan. We have taken the approach of splitting our plan into our high level, collective ambitions (see Part 1) and in this Part 2 document, we have outlined the key enablers to deliver the NHS' contribution to the common endeavour outlined in our Integrated Care Strategy – to reduce health inequalities, together.

In preparing this JFP, we have had regard for the regulatory and statutory requirements, particularly the 2023/34 planning guidance, and the four key aims established for Integrated Care Systems:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

We have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, requiring them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by both themselves and other relevant bodies

Integrated Care

Although this is a plan for NHS organisations, we work closely with wider partners across the integrated care system.

Our partnership comprises the following partners:

Three top tier local authorities and **seven** district, borough and city councils

Over **149** GP practices, operating from over **200** sites, forming **27** Primary Care Networks

Three community and mental health service providers working as a community collaborative

Nine voluntary and community sector associations

One hospital trust with main sites in Southend, Basildon and Chelmsford

A range of other partners, including Essex Police, Fire and our three local universities

One ambulance trust

Three Healthwatch organisations

Our priority is to integrate services at every level:

Neighbourhoods - based around our primary care networks, we are working to develop **integrated neighbourhood teams** as the footprint for people to access support and care locally, be that through their own networks and communities, through contact with community and voluntary sector services, or statutory health and care services.

Alliances - where statutory and non-statutory partners are coming together in geographical areas to support asset-based approaches. Our four alliances are progressing in building relationships and partnerships locally and further detail can be found at **Appendix 1**.

System – working together through our integrated care partnership, comprising partners including our upper tier local authorities, our district, borough and city Councils, community and voluntary sector organisations, universities and NHS partners.

The Importance of Local Delivery

The golden thread to our approach is to work with our local communities. Our Alliances have made positive developments to link with residents and the VCFSE locally. Alliances take a lead role in delivering and coordinating work on health inequalities and prevention, using data to make evidence-based interventions, with a clear focus on the wider determinants of health. From an NHS perspective, a key deliverable is to make improvements in primary care and ensure local health services meet the needs of the local population.

Appendix 1 describes our local approach.

Stewardship

Stewardship is our vehicle for achieving the triple aim in MSE: improving the health and wellbeing of our population, improving the quality of our services, and using our resources efficiently and sustainably, whilst addressing existing inequalities within each of these.

The programme is based upon the work of Nobel Prize winner Elinor Ostrom, who studied the sustainable, equitable management of shared resources by the resource users. It applies her ground-breaking work to our health and care settings.

***Stewardship in MSE**: bringing 'resource-users' (frontline and back-office staff and residents) together within care areas to act as stewards – delivering the greatest value for residents from our pooled resources.*

Over the past two years we have developed significant, unique capacity via our cohort 1 stewardship groups (Ageing Well, Cancer, Cardiac care, Respiratory, Stroke and Urgent and Emergency Care). These groups have now begun to provide important leadership within their care areas, resulting in both tangible and intangible changes and improvements.

Selected highlights:

Cancer: With active support and encouragement from the Cancer Stewards, a new day zero Patient Tracker List (PTL) approach was launched in November 2022. At that point there were around 1,000 patients waiting 62 days for a diagnosis after a GP referral. This has subsequently been reduced to 595 and is expected to be under 100 by March 2023. The day zero PTL is a real game changer. The action-oriented strategy ensures patients who don't have cancer are appropriately and speedily informed and taken off cancer pathways, meaning those with cancer are quickly and appropriately directed to the correct service. The team's next focus is on prostate cancer pathways.

Ageing Well: Through the guidance and efforts of the Ageing Well Stewards, the MSE electronic frailty care coordination system (efraccs) register was designed, built and launched in April 2022. It now has more than 8,000 people with frailty and dementia added. This resource enables prioritisation and increased visibility of residents with frailty and complex needs for more seamless, proactive and effective care coordination between providers. The team have also championed the Frailty Consultant hotline, which now takes over 350 calls / month, and is associated with admission avoidance rates at 80%.

Challenges and areas for development

Role: Different groups have engaged in different mixes of strategic and operational work, influenced by group membership and care area needs. Awareness of stewardship and the groups is not currently widespread across the system at all levels.

Relationships: Tensions have occurred over relationships with existing transformational capacity, or where such capacity is lacking.

Resources: Whilst stewardship teams have been developed at a care area level, care area budgets remain unclear and accountability for resource management remains distributed by organisation. This has restricted stewards' opportunities, leading to a focus on service improvement within existing siloed budgets, rather than being able to meaningfully steward and help flex resources across settings for greater population benefit within their care area.

Opportunities:

- Stewardship positioned as a key enabler to achieve the triple aim, with hosting of whole care areas necessary to unlock further potential.
- System-wide communication of the vision of stewardship for whole system transformation rather than incremental improvement.
- Empowerment of stewardship groups to influence long term plans.

Through one of our own clinicians and National Clinical Lead for Innovation, Professor Tony Young, we continue to support in partnership Anglia Ruskin University deliver the world's largest and most successful workforce development programme focussing on clinical innovation. The NHS Clinical Entrepreneurship programme (NHSCEP) is now entering its 7th cohort with many of those successfully applying working within MSEFT, and equally we have seen innovation adopted into our Trust because of connections made through NHSCEP.

MSE innovation works closely with our local Academic Health Science Network (AHSN) University College London Partners, HealthTech Enterprise, Health Education England, and Accelerated Access Collaborative, local universities, as part of partnership working. MSE ICS has achieved great successes with partners including Ford Motor Group for the Essex Covid Vax/Respiratory Van and British Heart Foundation for the BP@Home solutions.

One example of this that we have heard from local development strategies and health and wellbeing plans, "MSEFT is a lead steering partner with Essex County Council and Basildon District Council to consider the feasibility of a Health and Social Care Innovation Incubator in the Basildon area. Citizens with innovative ideas would be supported to develop and grow, building on existing relationships with our Universities, Enterprise Hubs, and local Industry partners to address the wider determinants of health through grass-roots innovation".

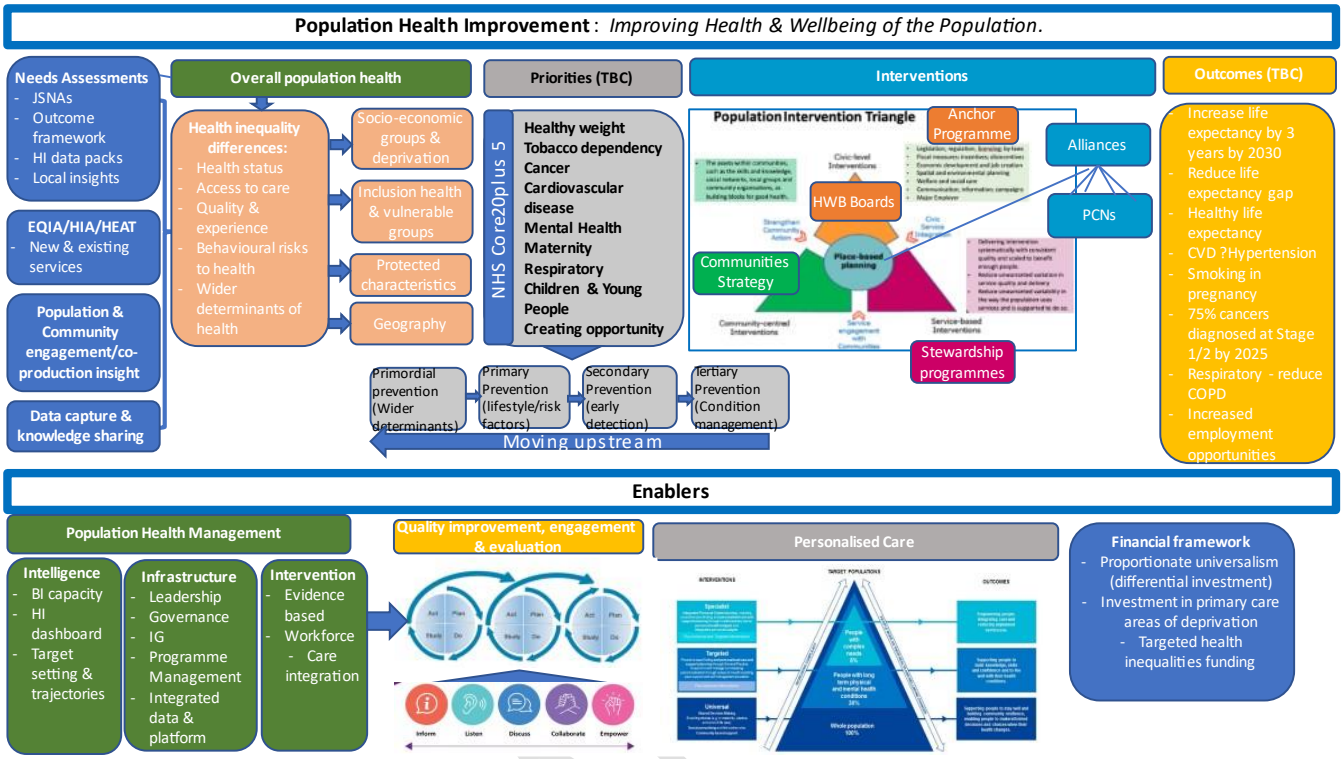
Further information on Stewardship can be found at **Appendix 2**.

Improving Population Health

At the heart of our work is a desire to improve population health. We know that we can only do this by working in partnership with our local authority colleagues, with public health teams, professionals and residents themselves. To help guide our efforts and maintain accountability, we have established a **MSE Population Health Improvement Board (PHIB)**. This brings together our partners to align our work on:

- Population Health Management
- Inequalities
- Prevention and early intervention
- Personalised care

- Anchor institutions



*Above diagram of health improvement governance arrangements across MSE.

The PHIB has a dual line of reporting – to both the MSE ICP, to bring together the work around wider determinants of health; and to the ICB, to drive improvements around specific healthcare priorities. The Population Health Improvement Board's programme has a broad remit which is summarised below.

To deliver our ambition the PHIB will ensure that the needs of our population and existing health inequalities are understood and areas for intervention prioritised with an emphasis on moving prevention work upstream.

Reducing Health Inequalities – the Core20Plus5 Frameworks

Reducing health inequalities reflects both a core statutory duty that we share as NHS organisations, and also the central '**common endeavour'** from our integrated care strategy (Integrated Care Strategy link).

Within the NHS, we have prioritised our work around the Core20+5 framework for adults and children. This enables us to:

- Concentrate efforts on the **20% most deprived communities** within our ICS, as identified by the national Index of Multiple Deprivation (IMD).
- Identify and work with **'plus groups'**– communities that may experience poorer access to good health outcomes as a result of their characteristics – this includes, but is not limited to, black and minority ethnic residents, carers, people with living with a learning disability or some neurodiverse residents, people at risk of homelessness, veterans, gypsy, Roma and traveller groups, refugees, asylum seekers and migrants. We have identified these groups at both system and Alliance level and targeted our engagement resources towards working with communities directly to understand their experiences and see how best we can support their health and care needs. Focus on a small number of **clinical conditions** –

Adults
Maternity
Severe Mental Illness
Chronic respiratory disease
Early cancer diagnosis
Hypertension case finding and lipid optimal management

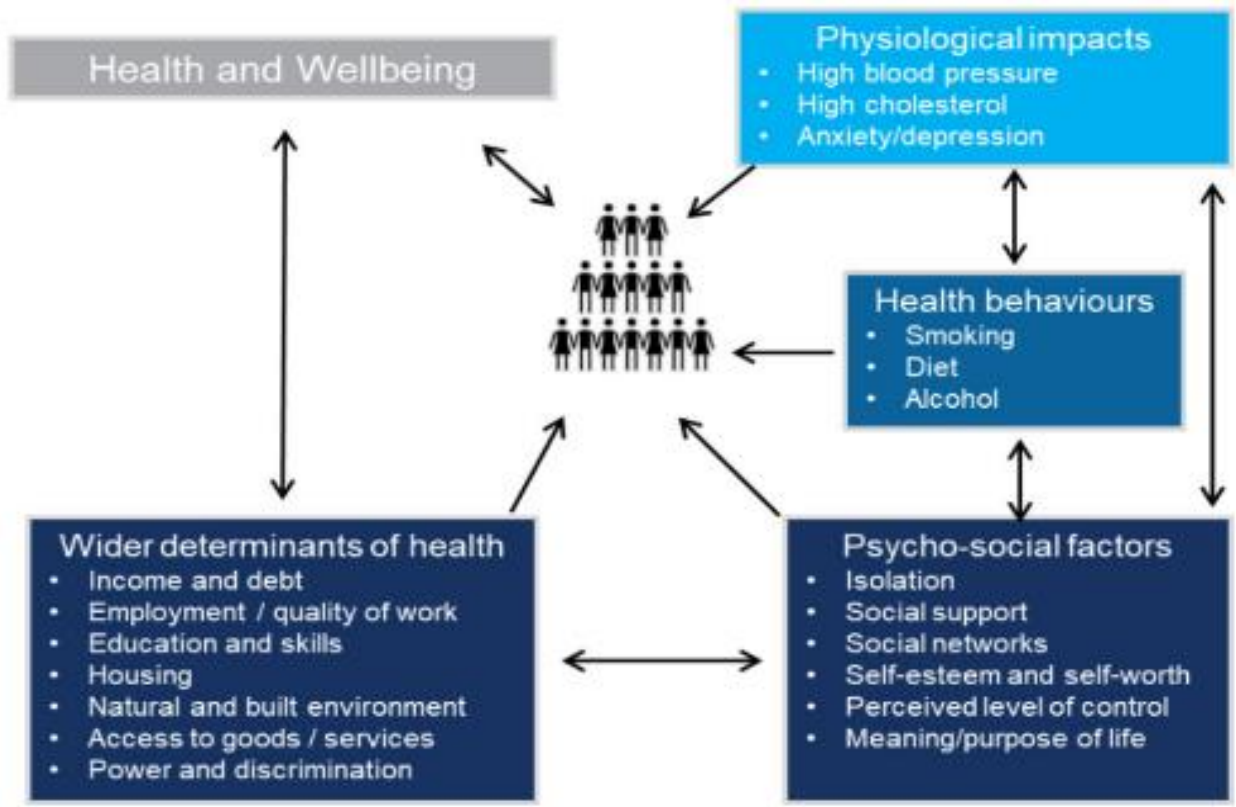
Children and Young People
Asthma
Diabetes
Epilepsy
Oral Health
Mental health

We recognise the need to embed a health inequalities approach to all of our work so that we think about this as a first principle in all that we do. We must therefore:

- Improve **data collection and reporting** to ensure improved completeness of recording regarding ethnicity, inclusion groups and other plus group status such carers to enable us to support these residents better.
- Continually review the **restoration and delivery of services** to ensure that at risk groups are not further disadvantaged.
- **Mitigate digital exclusion**, through adoption of our agreed digital exclusion principles, to support residents in accessing digital services through skills development.
- Embed the comprehensive use of **Health Inequalities Impact Assessments** (HIIA) with identified actions delivered.

The MSE ICS common endeavour of **Reducing inequalities** requires us to work together to create a broad and equal partnership of individuals, organisations and agencies, focussed on prevention and early intervention, to provide high-quality, joined-up health and care services, when and where people need them.

Reducing inequalities is a complex picture with no single action or single organisation able to have impact alone, it requires a sustained organised collaborative focus. The adapted Labonte model summarises the complex system that causes inequalities to thrive. It encapsulates the different factors that impact our health, where they stem from (the wider determinants of health), how they interact, multiply, reinforce and act both in sequence and simultaneously.



Our approach builds on the adapted Labonte model and reflects that interventions must focus on 'treating' the environment and place and not just people, as acting on only one factor is likely to provide a partial and incomplete response to the situation.

Through the PHIB we will:

- Deliver a series of deep dives bringing together partners to take a holistic view of need and provision for specific Plus groups.
- Improve the identification and data recording for Plus groups to take a data driven approach to identify current gaps and inequalities.
- Collaborate with partners to map community assets

Case Studies

There are already examples of good practice within the system which we learn and build upon including:

- 'Southend the Southend Integrated care for Homeless' programme link
- 'Understanding Inequality project', run in partnership by Mid and South Essex NHS Foundation Trust and Healthwatch Essex involving people with learning disabilities to improve to access and experiences of hospital services (Understanding Inequality Project link)
- 'Improving access to health services for Thurrock's Gypsy, Roma, Traveller and Showman communities' link
- MSE Anchor programme supporting people living in some of the most deprived areas of Southend to secure quality work at Southend Hospital or in another local health or care organisations (MSE Anchor programme link)
- 'Core20plus Connectors programme' focusing on Chronic Obstructive Pulmonary Disease (COPD) and working within the six most deprived wards in Southend. (Southend Core20plus Connectors Programme link)
- Improving Health and Digital Literacy for those in most deprived wards in Thurrock by working with library teams who already support volunteers to deliver digital skills training to residents. (Improving Health and Digital Literacy in Thurrock link)
- Utilising the 'Outreach bus' 'to visit deprived areas in Canvey to increase hypertension case finding, cancer screening and vaccination uptake, health and wellbeing advice and onward referral thus increasing contact with appropriate services and alleviating loneliness and increasing wellbeing.
- The MSE ICS has been successful in becoming one of seven ICS Core20PLUS accelerator sites and a Core20PLUS Connectors site.
- Through our community engagement programme we will listen, engage and co-produce future interventions.

Case Study – Children's Oral Health

This group is overseen by the Children and Young People (CYP) Growing Well Board and has representation from key partner organisations across the ICS.

The Child Oral Health Inequalities Steering Group (COHISG) has sent out key objectives to drive collaborative action to toward reducing CYP oral health inequalities. The identified principles of these actions will be:

- Identify areas for improvement in reducing oral health inequalities across MSE
- Inform and influence wider system CYP policies and programs which would improve child oral health
- Identify opportunities to implement oral health prevention strategies into current CYP workstreams
- Mapping of current child oral health prevention activities across MSE and identify gaps for improvement
- Use a data informed approach to drive preventative activities in those areas of highest need
- Inform the wider system on sustainable action to reduce oral health inequalities

Using the Core20PLUS5 we have identified our priority PLUS groups as Special Educational Needs and Disability (SEND), Looked After Children (LAC), Deprivation, Refugees, Asylum Seekers and Migrants; to deliver targeted preventative actions. In addition to preventative actions, we are working with commissioners to increase access to dental services. This has included identification of dentists prioritising access for LAC.

Waiting list analysis has been undertaken for those children under 10 currently on elective general anaesthetic waiting lists within MSEFT. Complete analysis will be extended to included waiting list data from Community Dental Services. Trends identified will inform an action plan to mitigate disparities identified.

Implementation of a supervised toothbrushing program in partnership with Community Dental Services is being rolled out to 20 pilot sites in areas of deprivation within Southend and Basildon. It is expected that on evaluation this will be scaled up to further sites across MSE. Further planning is in progress to increase the delivery of targeted interventions which support families and children to adopt positive oral health behaviours.

Case Study:

The approach undertaken by Mid and South Essex Foundation NHS Trust to review and deliver action plans that begin to address inequalities seen in their waiting list when viewed by ethnicity, age, area of deprivation is being adopted more widely by community services. This will become a rolling programme of work.

Health Inequalities Funding

As part of our commitment to health inequalities, the Health Inequalities Funding is committed recurrently to deliver improved outcomes for the population of Mid and South Essex. In 2022/23 the NHS invested £3.9m to support innovative partnership solutions around the Core20plus5 priorities that were identified as meeting local needs by our four Alliances. The range of projects that were supported include:

Basildon and Brentwood Alliance

- Child oral health
- Transition from primary to secondary schools in deprived areas
- Physical activity schemes supporting Core20 and specific plus groups
- Social prescriber for children and families in areas of high deprivation
- Young people employment opportunities from most deprived areas
- Supporting those affected by dementia

Mid Essex Alliance

- Young Carer support and their family members
- Pilot COPD patient education
- Outreach within traveller communities and Severe Mental Illness (SMI) health checks
- Extending transport services for those unable to attend clinic appointments
- Men's Mental health
- Outreach clinics in warm spaces
- Sensory inequalities ambassador

South East Essex Alliance

- Cardiovascular disease case finding and alleviating system flow pressures
- Loneliness and improving access to service
- Suicide prevention
- Veterans mental health and access to services
- Family and childhood mental health and resilience
- Focus on mental health through the green agenda
- Dental access for deprived and the young

Thurrock Alliance

- Obesity transformation
- Lifestyle risk management through motivational interviewing
- Workplace Health Champions to provide smoking cessation
- Gypsy, Roma, Traveller and Showman communities improving access to health services
- Thurrock's homeless communities improving access to health services
- Health and digital literacy
- Enhancing safeguarding, health and mental wellbeing for vulnerable young people and young parents

The ICS has commissioned the University of Essex as an Evaluation partner to provide a framework and evaluation tools to assess outcomes from these investments. The Framework with the tools will be available Q1 2023/24 and we are expecting evaluation of the projects to be completed by the end March 2024. A lesson learnt exercise will inform the future approach to the deployment of the funding to ensure that it supports addressing those with the greatest need.

Health Inequalities research

We will work with our university partners to ensure that we are developing our Health Inequalities approach based on the latest research evidence. There are two specific multi-disciplinary and multi-stakeholder partnership projects that are forthcoming in 2023/24:

- 'Innovate' a project to improve Mental health and wellbeing by mobilising community assets to tackle health inequalities
- Building a community of practice to identify barriers and priorities and solutions to the right of access to healthcare for Travelling Communities.

A focus on Prevention

The NHS Long Term Plan has a strong focus on the treatment and prevention of illness by supporting patients to adopt improved healthy behaviours. We are taking forward the specific commitments set out in the NHS Long Term Plan whilst, through the work of the ICS Stewardship groups, ensuring a focus on prevention across broader NHS activities.

We continue to work in collaboration with our local authority partners and their funded services to deliver joined up and seamless approaches to prevention.

We will adopt a framework for the clinical priority area that considers the upstream pathway interventions to reduce risky lifestyle behaviours and the contribution that the wider determinants of health have on preventing ill health.

The work of PHIB recognises that the frameworks under development as part of the community strategy and stewardship programmes will feed into the Alliance-based approach.

Our Initial Prevention Priorities

In 2023/24 we are focusing on a prevention work programme, through interim financial support from NHS England. This has enabled focus on three areas which are proven to be most impactful to prevent a variety of conditions and ill health.

Cardiovascular Disease

Cardiovascular disease (CVD) is one of the leading causes of premature death. Hypertension is the biggest risk factor for CVD and is the second top risk factor for all premature death and disability in Mid and South Essex. Through the establishment of the Cardiology Programme Board there will be a focus on delivering the following prevention activities in relation to CVD:

- **BP@home** – continue with the successful roll out of the national pilot of recruiting over 59,000 residents to test out how residents can improve their health outcomes through the self-monitoring, by expanding the scheme working alongside our community pharmacists and through integration into relevant clinical pathways such as Renal. The ambition is to have over 75,000 residents monitoring their blood pressure by end of March 2024 with community schemes in place in areas where health inequalities are most prevalent.
- K**ardia AliveCor** – maximise the use of these mobile heart monitors that allows individuals to detect, monitor and manage heart arrhythmias with automatic analysis, located in GP surgeries, community centres and on our outreach bus. We are anticipating that the National Institute for Health and Care Excellence (NICE) will publish guidance during 2023/24, following completion of the Digital Technology Assessment Criteria (DTAC), that supports the use of Kardia AliveCor mobile device for detecting atrial fibrillation. We will therefore look to further adopt this technology as part of an integrated prevention approach during 2024/25.
- **Innovation for Health Inequalities Programme** - expand the mobile unit (outreach bus) to a targeted core20Plus population, to include broader CVD risk assessment and management (including arterial fibrillation (AF), blood pressure, cholesterol, smoking) by developing trusted communication to reduce inequality of healthcare provision to this group. This programme will commence in Q1 2023/24 with an outcome assessment completed by the end of the 2023/24 financial year.
- **Community Pharmacy Hypertension Case finding** – increase identification and diagnosis of hypertension by Community Pharmacy to improve outcomes and reach people who may not attend general practice, by doubling the number of individuals that have a blood pressure check at their Community Pharmacy by 2024/25.
- **UCLP Proactive care framework** – roll out the adoption of the framework following the PCN pilot based on risk stratification and prioritisation of atrial fibrillation, blood pressure, cholesterol and type 2 diabetes to optimise treatment early in those with greatest need. During Q1 2023/24 we will review

the outcomes from Phase 1 pilot, phase 2 roll out will commence Q2 with the scheme being available to all PCNs by the end of 2023/24.

- **Financial framework** – implementation of a primary care transformation support scheme to support a holistic approach to implementation of a CVD prevention scheme in 2023/24.

Healthy Weight

In 2020/21 nearly two thirds of adults in Mid and South Essex were overweight or obese and are at increased risk of heart and circulatory diseases like heart attacks, strokes and vascular dementia.

Together with our local authority partners, we are working with an industry partner to transform and integrate Tier 2 and Tier 3 weight management services. We aim over the next two years to:

- Commission a smoother, more personalised patient experience of weight management services, accessible to an increased proportion of the eligible population, with reduced hurdles and barriers to accessing support and treatment
- Deliver a clearer, more outcomes-focused evaluation framework, to understand impact on individual, population and system outcomes, including impact on inequalities.

Adopt shared accountability across the health and care system for weight management outcomes

We will continue to promote and ensure that the ***Digital weight management service*** is offered to those adults living with obesity who also have a diagnosis of diabetes, hypertension or both. Alongside encouraging the uptake of ***the Enhanced service specification for weight management*** by primary care.

Tobacco Dependency

Treating tobacco dependence is specifically identified as a key service that can improve the prevention of avoidable illness. The NHS long term plan commits to providing NHS-funded tobacco treatment to all patients admitted to hospital and pregnant women by 2023/24.

We have already commenced recruitment of Healthy Hospital Managers and Smoking Cessation Support works to support the new smoke-free pregnancy pathway. In 2023/24 additional workforce will be recruited to enable all those admitted to our hospitals or specialist mental health services will be offered NHS funded tobacco treatment services. Along with developing further integration with Community Pharmacy providers as part of the delivery of the ***Community Pharmacy Advanced Service*** Specification - NHS Smoking Cessation Service.

Innovative partnerships with industry

We will continue to explore industry partnerships, focused on providing care for patients with type II diabetes within Mid and South Essex, enabling a financial model which will immediately allow type 2 diabetes patients to access the proven outcomes of DDM Healths low carb diet diabetes management programme.

Future areas of focus

We will look to undertake focused work to support improved pathways and service models in:

- ***Antimicrobial resistance*** - support implementation and delivery of the NHS plan's five-year action plan (March 24)
- ***Alcohol*** – explore the learnings from those ICS with Specialist Alcohol Care Teams and work in partnership with our local authorities to improve access and outcomes (April-Sept 24)
- ***Making Every Contact Count*** – building on the lessons learnt from the Covid vaccination programme and the subsequent use of the mobile unit to outreach into seldom heard communities we will expand the approach across the four Alliance areas (23/24)
- ***Children and Young People*** – within the Growing Well Board agenda there is a significant focus upon prevention programmes of work, we will look to ensure that an all age and family holistic approach can be taken to preventing ill health (23/24)

Enabling Improvements in Population Health

Our clinical and professional teams work across the system to transform and improve health services every day. There are a number of critical enabling activities that support their work:

- Population Health Management (PHM) – *see* ***Appendix 2***
- Workforce and Clinical Leadership – *see* ***Appendix 3***
- Estates – *see* ***Appendix 4***
- Finance – *see* ***Appendix 5***
- Digital and data – *see* ***Appendix 6***

Improving Operational Performance

Our teams work incredibly hard to deliver safe and effective care, every day. We know, however, that many of our services are not currently meeting the requirements of the NHS Constitution, and we experience challenges in delivering high quality care consistently.

Our plans to improve services can be found at **Appendix 7**.

Supporting System Development

Our statutory arrangements under the Health and Care Act 2022 are new and developing. **Appendix 8** of this plan describes our governance arrangements and the steps we are taking on new duties such as the ICS Green Plan, duties in relation to Violence and Aggression against Women and Girls (VAWG).

Part 3 – Delivery Plans

In a series of appendices, this part of the JFP provides our plans to deliver on NHS Long Term Plan commitments and statutory duties placed on the NHS.

Appendix 1 – Local Delivery

Within this section you will find long term plans relating to our Alliances, Primary Care and the development of Integrated Neighbourhood Teams:

- Basildon and Brentwood Alliance
- Thurrock Alliance
- South East Essex Alliance
- Mid Essex Alliance
- Primary care and Integrated Neighbourhood Teams
- Primary Care Digital Access
- Developing our Community Services

Basildon and Brentwood Alliance

What have our residents told us?

Our partners from Healthwatch and Achieve, Thrive, Flourish have provided valuable insights into the views of our residents. There is currently an Asset Mapping exercise being undertaken which will provide further insight and it is imperative that we use the information gathered and ensure there is increased engagement going forward.

Current Conditions

Population size and demographics

Basildon and Brentwood have a GP registered population of 279,000 and a very mixed demography of very affluent areas alongside some of the most deprived wards in the country. There are areas of high-density housing as well as low density rural communities. It is anticipated that by 2037 the overall population will have grown by 18% with those aged over 65 growing by 61%.

Health Inequalities

Across the Basildon and Brentwood area there are 48,217 people living in the 20% most deprived areas in England, which amounts to 17% of our total population, the highest across Mid and South Essex. Life expectancy for males and females is higher than the national average in Brentwood but lower in Basildon. Additionally, in Basildon there is a 10-year difference in life expectancy between the least and most deprived areas.

Using the Core20Plus5 framework has helped to understand our local challenges and aligned to our Live Well strategy will help to address these health inequalities.

Local population health data indicates that cancer, circulatory disease, and respiratory disease prevention should be our areas of focus.

Smoking prevalence among people with a long-term mental health condition is relatively high amongst comparators and increasing in both Basildon and Brentwood.

Physical activity amongst children and young people is relatively high but low for adults in Basildon.

The suicide rate and emergency hospital admissions for intentional self-harm has been increasing in Basildon and Brentwood overall with relative rates in Brentwood the highest in Essex.

Obesity in children in Basildon is relatively high and continues to increase, whilst levels of obesity in adults across both Basildon and Brentwood are high and increasing.

Workforce:

The average number of patients per GP is high in the area.

There are high numbers of vacancies across all sectors of health and social care.

Whilst additional staff have been recruited through the Additional Roles Reimbursement Scheme (ARRS), recruitment and retention is an ongoing issue.

Similarly, recruitment and retention issues exist in the care sector.

As an Alliance there is a great opportunity to work together, promote our assets such as jointly appointed posts, training and development and make this an area where staff want to come and work.

Estate:

Many of our surgeries are now struggling to accommodate additional staff because of lack of space.

Our current estate across health and care is generally old and does not support our ambition to integrate health and care.

As an Alliance we are investigating the potential to share space and progress innovative solutions to overcome current constraints as well as pursuing opportunities for new builds.

What is the requirement from the NHS?

Over the next 5 years the Basildon and Brentwood Alliance will lead on a significant transformation journey, underpinned by an ethos of partnership working and cultural change. We will focus on proactive care and prevention so that our residents live longer healthier lives.

Our Ambition

Basildon and Brentwood Alliance have recently been re-established with a wide range of partner organisations committed to working together to tackle health inequalities and the wider determinants of health. To achieve this, partners have signed up to a Live Well strategy that comprises of 6 domains (Start Well, Feel Well, Be Well, Stay Well, Age Well and Die Well) that cover the entire life course of our residents. This will be the key strategy over the next 5 years with a distributed leadership model supporting domain leads from all partner organisations.

The development of Integrated Neighbourhood Teams (INT) will be the foundation of our work, and these will enable health, social care, and voluntary sector organisations to work collaboratively at local level using an asset-based approach to deliver the strategy.

We will be outcomes driven and prioritise our combined efforts by using reliable population data, shared across all sectors as well as the local intelligence of our workforce and residents. We will develop, shared training and development, joint posts across sectors and will also share estate to improve efficiency and further cement relationships and a collaborative culture with partners. Existing funding mechanisms such as the Better Care Fund (BCF) will be used effectively and strategically in areas where there is the greatest level of inequality, and we will build upon this to develop additional areas of pooled resource.

The Alliance will build upon the legacy of the 2012 London Olympics, funding through Sport England local delivery pilot via Active Essex and the subsequent Find Your Active Basildon and Brentwood, initiatives to give our residents and workforce multiple opportunities to increase the amount of physical activity they undertake. Sport is a non-judgemental medium and that has enabled communities to think differently about their wellbeing and embedded a culture change within the local system leadership that supports the wider Alliance ambitions. All our GP practices will be Active Practices and all our residents will be able to access an activity that suits their ability, preference and circumstances.

Delivery priorities:

- Stabilising and developing Primary Care
- Developing Integrated Neighbourhood Teams
- Supporting urgent and episodic care
- Prevention
- Communication with residents.

Ensuring Delivery:

SRO: Pam Green
Clinical Lead: Dr Boye Tayo

The Alliance Committee was re-established in 2022 and is Chaired by the Alliance Director. The delivery priorities listed were agreed through this committee, and sub committees are in place or being developed to support delivery. These include Alliance Executive, Clinical and Professional, Health Inequalities, Voluntary Sector, Operations and Resilience, Domains, and Integrated Teams. Membership is broad and committees will be led by the most appropriate organisations. Each subgroup will feed back into the Alliance Committee to ensure delivery.

The Committee has approved an Asset Mapping commission that will focus the Alliance on available resource as well as highlight gaps that will need to be addressed if we are to make positive change

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Embed the Live Well Strategy and six domains across the Alliance	Quarter four 2023/24
Six Integrated Neighbourhood Teams established	First half of 2024/25
Reduction in Health Inequalities	Quarter four 2023/24
Maximise resources to increase sustainability of primary care	Quarter three 2023/24

Thurrock Alliance

What have our residents told us?

Residents have told us that access to GP services in Thurrock is 'patchy', and in some instances very difficult. Travel around the borough is not easy, especially for older and disabled residents which makes getting to appointments a challenge.

Current conditions:

Within the borough of Thurrock there are 27 GP practices comprising 4 Primary Care Networks. The population of Thurrock (2021 Census) is 178,000. Key facts:

- Thurrock is the second most under-doctored area in England
- 40% of children at year 6 are obese in Thurrock (this is the highest in EoE)
- 21,271 Thurrock residents are in the core 20 Plus 5 categories (11%)
- Obesity in adults sits at 78% (this is the highest in EoE)
- The deaths of 2,522 Thurrock residents were directly attributable to socioeconomic inequality Between 2003 and 2018

As well as demographic and health inequality challenges, there are some key problems which are limiting quality improvement efforts:

Workforce

Nursing vacancies in two of our key local providers – MSEFT and EPUT – stand at 12 – 13%, and retention of ARRS roles in primary care is becoming an increasing challenge due to a lack of career progression opportunities.

Data quality and lack of effective business intelligence

This prevents us driving quality improvement and targeting resources in the most effective way.

Estates

The general state of the estate in Thurrock is poor, with a large number of primary care sites in need of significant modernisation/upgrade.

What is the requirement from the NHS?

Health, social care, and voluntary sector will be organised so operational delivery will happen collaboratively at neighbourhood level. Connected, integrated neighbourhood models will be the mechanism for ensuring support is coordinated, anticipatory, and personalised to the needs of the individual. Using the Human Learning System model of personalisation and change management.

Our ambitions:

By 2025, the Thurrock Alliance aims to have fully delivered the implementation plan from the Better Care Together Thurrock (BCTT) Strategy for all residents in the borough.

The Better Care Fund, and any other delegated finances, will be used strategically to ensure resources are targeted to those areas where they can be most impactful in addressing health inequalities. The Thurrock BCF will be reviewed during the latter part of the 2022/23 financial year, working with Thurrock Council and the Local Government Association, delivering an agreed locus of expenditure to tackle the common areas of the MSE integrated care strategy, the Thurrock Health and Wellbeing Board Strategy and the BCTT Implementation plan.

Our work will be underpinned by reliable and timely data, competently triangulated with local intelligence from our residents and workforce. Key priorities will be identified through targeted discovery phases focused on enquiry questions, for example, how does poor housing impact on the respiratory health of residents in our Core20 wards?

The Alliance is currently developing its five-year strategy, with a 2023/24 action plan to drive and monitor progress.

Delivery Priorities

A focus on health inequalities delivered through neighbourhood models. The opportunities to respond to these challenges must focus on the Fuller Stocktake framework of addressing:

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

The Alliance is driving forward the PCN Accelerator Programme to support the development of Clinical Strategies and the creation of Multi-Morbidity Hubs across the borough.

The GP Fellowship Scheme has been established to support development within the body of doctors in the borough.

Clinical Leads have been recruited to support the Alliance Clinical Director in delivering targeted support to primary care for specific condition management.

Supporting Urgent and Episodic Care

We are working with local providers on a number of initiatives which will address increased demand over the winter months, whilst embedding sustainable improvements, including

- Targeting improvements in vaccination uptake for both Covid and Flu
- Targeted prevention to reduce falls is being explored with the falls provider (NELFT)
- Understanding the needs of High Intensity Users and developing alternative support mechanisms
- Social Prescribing Review to begin in Q4 (2022/23) to develop learning networks
- Continuance of the Acute Respiratory Hub to June 2023 to reduce ED attendances

Developing relationships between Primary and Secondary Care

Deep dives to gather intelligence are underway with practices with higher ED attendances to strengthen relationships between primary and secondary care. Open dialogue between clinicians across both settings to explore alternative solutions to support their population out of hospital.

In future, where appropriate and in line with the local population's digital literacy, there will be a suite of digital offers to support people to manage their own health and wellbeing. We will adopt system-wide technology, and work with our residents to test and implement in ways that meet their needs. This has already begun in relation to weight management.

Ensuring Delivery

SRO: Aleksandra Mecan
Clinical Lead: Dr Manjeet Sharma

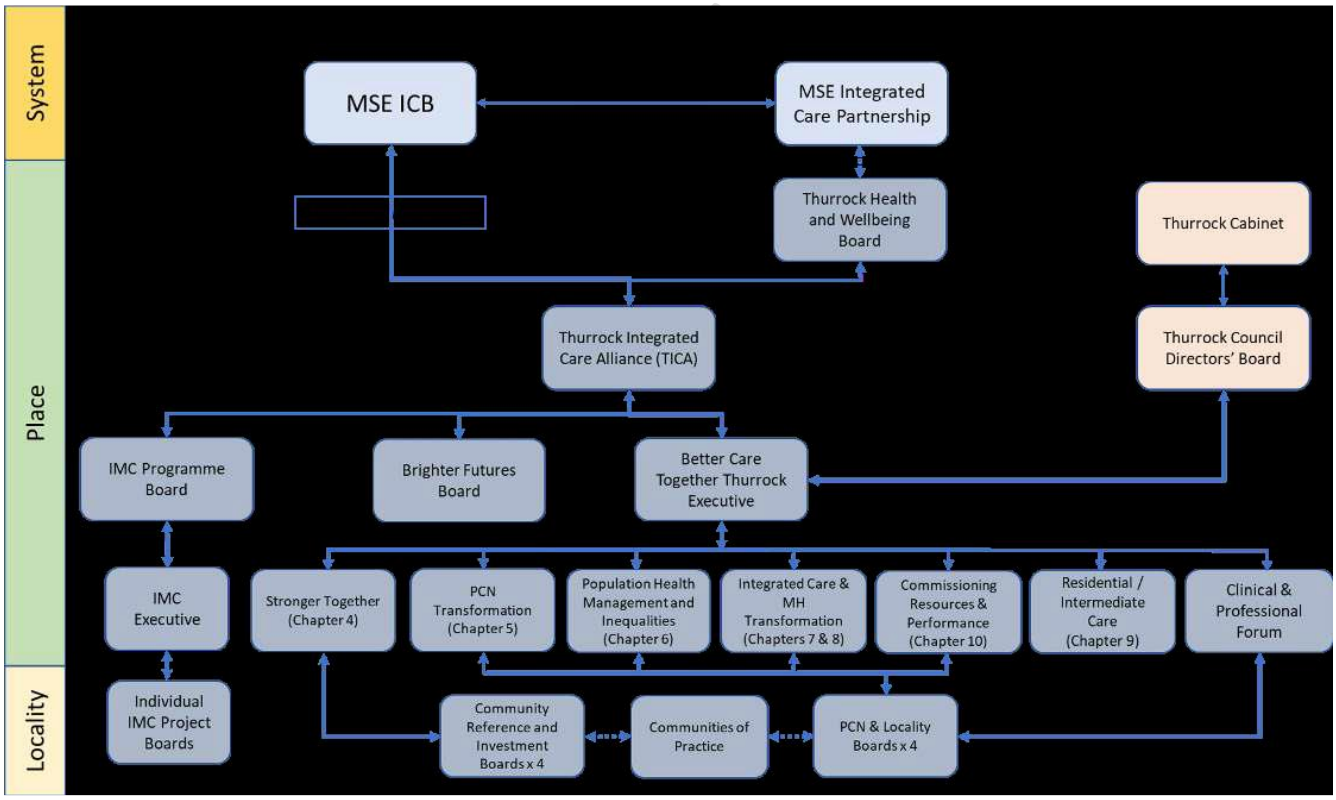
The Thurrock Alliance has spent much of 2022 on a development journey, with the explicit aim to build a clear purpose and a sense of trust. The governance structure is now signed off, but in the interim significant amounts of work have been done to deliver the Better Care Together Thurrock Implementation plan. Alliance team members are now identified to lead or contribute to local working groups that report to the Thurrock Integrated Care Alliance Board, which is directly linked to Thurrock HWB Board and the ICB Board.

Local Governance architecture in Thurrock

Through the Health Overview and Scrutiny Committee, and the BCTT Executive/Thurrock Integrated Care Board, the Alliance achieves a degree of public and political scrutiny, and we are committed to building a strong and meaningful rapport with our residents. Through the use of the Human Learning System (personalisation) model, we are working with residents and partner organisations to deliver a radical change to service provision. This will become the basis of all work with residents as we move forward.

Our residents and voluntary sector are valuable assets and as an Alliance we are committed to meeting them where they are – in their neighbourhoods. This outreach approach aims to deepen our understanding of the lived experience of people in Thurrock.

The below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Fuller stocktake supporting and developing primary care	From quarter one to quarter four 2023/24
Standardising access to primary care across borough for all residents	From quarter one to quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Increase covid vaccinations rates and flu immunisation	From quarter one to quarter four 2023/24
Increase targeted prevention to reduce falls increasing effectiveness of strength and balance programme	From quarter one to quarter four 2023/24
Assess and identify alternatives for high intensity users	From quarter one to quarter four 2023/24
Provide alternatives for frequent GP attenders, this is the subject of an Human Learning System (HLS) experiment (this work will continue throughout 2023/24)	From quarter one to quarter four 2023/24
Create social prescribing learning networks and new social prescriber opportunities	From quarter one to quarter four 2023/24
Ongoing resident engagement across borough based on the HLS approach which test assumptions. The approach is refined based on engagement with residents (these activities will continue throughout the year)	From quarter one to quarter two 2023/24
Supporting GP fellowship enhanced service increasing numbers of specialist GPs	From quarter one to quarter four 2023/24. Achieve four of 12 by Quarter four.
Deliver carers matrix across Thurrock with targeted actions throughout the year	From quarter one to quarter four 2023/24
Build on SMI/LD health checks ensuring residents equitably supported (target improvement rates for SMI/LD cumulative totals)	From quarter one to quarter four 2023/24

South East Essex Alliance

What have our residents told us?

At recent conversations with residents at the Healthwatch community assembly we heard that residents are frustrated with the pace of change and that they would like to feel improvements. There was appreciation for the comprehensive, unbiased, and inclusive community and resident engagement we led in Shoebury to identify the preferred site for the new Health and Wellbeing Hub.

From May 2023, we will be strengthening relationships through neighbourhood-level conversations. Initially, these will be led by the Alliance team, but we will be supporting them to become self-governing in 18-24 months. Insights from these conversations will inform further iterations of the Alliance Plan, and we will collectively develop improvement projects with residents.

Current Conditions

Across South East Essex there are 58,818 people living in the 20% most deprived areas in England, which amounts to 15% of our total population. With this level of deprivation, in combination with an ageing population, we are experiencing greater numbers of people presenting with complex long-term needs, poor mental health, leading to a population with poorer disability-free life expectancy.

In order to understand our local challenges, the South East Essex Alliance adopts the CORE20plus5 framework. Local population health data analysis suggests that cardiovascular disease, cancer, and respiratory prevention are key focus areas. In addition, our local community engagement work, has shown there are low levels of

awareness of self-care tools and pharmacies which can provide an alternative to GP or hospital services.

As well as demographic and health inequality challenges, there are some key problems which are limiting quality improvement efforts:

Workforce:

Nursing vacancies in two of our key local providers – MSEFT and EPUT – stand at 12 – 13%, and retention of ARRS roles in primary care is becoming an increasing challenge due to a lack of career progression opportunities.

Data quality and lack of effective business intelligence:

This prevents us driving quality improvement and targeting resources in the most effective way.

Estate:

We currently do not have the right size or type of space both within the hospital or to support the development of our primary care aligned teams or other primary and community services. In addition, significant areas of South East Essex are at serious risk of flooding due to climate change.

What is the requirement from the NHS?

By 2028, the South East Essex Alliance aims to have fully aligned its committee and partnership members, and member organisations, in the common endeavour of tackling health inequalities across the entire life course of our residents, pre-birth to death.

Our Ambitions

Health, social care, and voluntary sector will be organised so operational delivery will happen collaboratively at neighbourhood level. Connected, integrated neighbourhood models – such as PCN-aligned community teams (PACT) – will be the mechanism for ensuring support is coordinated, anticipatory, and personalised to the needs of the individual.

The Better Care Fund, and any other delegated finances, will be used strategically to ensure resources are targeted across South East Essex to those areas where they can be most impactful in addressing health inequalities.

Our work will be underpinned by reliable and timely data, competently triangulated with local intelligence from our residents and workforce. Key priorities will be identified through targeted discovery phases focused on enquiry questions, for example, how does poor housing impact on the respiratory health of residents in our Core20 wards.

The Alliance is currently developing its five-year strategy, with a 2023/24 action plan to drive and monitor progress. As the South East Essex Alliance spans two Local Authorities, we have a particular challenge to blend existing health and wellbeing frameworks into consistent and meaningful strategic architecture within which the Alliance can operate successfully. It is a testament to our Alliance members that we already have initiatives in place that span these boundaries and deliver benefit to our collective population.

Delivery Priorities

A focus on health inequalities delivered through neighbourhood models. The opportunities to respond to these challenges must focus on the Fuller Stocktake framework of addressing:

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

The mechanism for delivery is through neighbourhood models. Primary care is already beginning to work in an integrated way with community health, mental health, social care, and the voluntary sector. We are working with all partners to develop PCN clinical strategies to further embed integrated ways of working. The PACT model lends itself to supporting any cohort of a PCN population which presents with complex needs where multi-agency support can be coordinated to effectively safety-net the individual to stay safely in their home.

Supporting Urgent and Episodic Care

We are working with local providers on a number of initiatives which will address increased demand over the winter months, whilst embedding sustainable improvements, including

- Targeted media campaigns to reduce Walk-ins to A and E in 20–34-year-olds
- Improving vaccination uptake
- Targeted prevention to reduce falls
- Understanding the needs of High Intensity Users and developing alternative support mechanisms
- Developing robust training to optimise deployment of volunteers in the emergency department
- Social Prescribing in our local Urgent Treatment centre

Developing relationships between Primary and Secondary Care

- Deep dives to gather intelligence are underway with practices with higher ED attendances to strengthen relationships between primary and secondary care. Open dialogue between clinicians across both settings to explore alternative solutions to support their population out of hospital.
- Exchanges - Clinicians from primary care and the acute shadowing each other to deepen understanding of respective knowledge and pressures.

In future, where appropriate and in line with the local population's digital literacy, there will be a suite of digital offers to support people to manage their own health and wellbeing. We will adopt system-wide technology, and work with our residents to test and implement in ways that meet their needs.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish eight PCN-Aligned Community Team (PACT) models in South East Essex (SEE)	First half of 2024/25
Apply evaluation framework based on the triple value ethos and apply to at least two workstreams	Quarter four 2023/24
Develop a SEE communication network - led by community partners SAVS	Quarter one 2023/24
Moving mental health First Response provision into the neighbourhood delivery model - phased implementation with delivery in one PCN, but scoped for all	Quarter three 2023/24
Develop a change model for addressing FrEDA adoption - place-based adoption of the system-wide anticipatory and personalisation approach	Quarter four 2023/24
Develop a coordinated approach to tackling obesity in SEE, taking an asset-based approach	First half of 2024/25
Implement integrated primary care paediatric asthma nurses, with the asthma team aligned to all 8 SEE PCNs	Quarter three 2023/24

Mid Essex Alliance

What have our residents told us?

Listening to our residents is at the heart of all we do within the mid Essex alliance. We have worked with Healthwatch Essex to engage residents across a wide range of geographies, demographic characteristics and seldom heard communities. Healthwatch have helped us hear from communities such as veterans, those with sensory impairment, LGBTQIA+, as well as other minority communities.

The overwhelming message from our communities is to 'Build on what's strong, not what's wrong' and this has become something of a mantra for the mid Essex Alliance. It drives our approach to Asset Based Community Development or ABCD.

Our populations have informed a number of our key priorities. In terms of our NHS, we know that access to services, especially primary care, is at the forefront of resident concerns. Likewise, diagnosis rates of dementia and support to those with Autism Spectrum Disorder (ASD) and learning disabilities are also of concern to our public.

Wider afield, our public tell us they are concerned over the well-being of children and young people, more so since the pandemic. Childhood obesity rates, the mental health of children and young people and managing childhood illness all feature prominently in conversations with our public.

Finally, tackling the high suicide rates amongst our population is a significant priority for us. Many of our communities have been sadly impacted by suicide so it remains a common theme we hear

Current Conditions

Population size and demographics:

Today's population size of nearly 403,000 people in mid Essex is projected to increase to almost 418,000 by 2030, and almost 440,000 by 2043. Within this, the over 70 age group will see the largest increase – 14% by 2030 and 40% over the next twenty years. With female and male life expectancy in mid Essex higher compared to the England average, this large increase in population size and ageing demographic will see an increase in demand for health and care services. This will be further compounded by an increase in the complexity of care required, a high prevalence of ill health and lifestyle factors that negatively impact on overall health and wellbeing.

Health inequalities:

There are 5,236 people in mid Essex live in the lowest deprivation decile – 1% of the total population. Within this, there are clear challenges, e.g., high smoking rates in

the most deprived areas of Braintree and Maldon, and poorer uptake of flu vaccinations.

By more broadly applying the national CORE20PLUS5 framework to support understanding and management of health inequalities, data indicates that the greatest impact in mid Essex could be achieved by focusing on cardiovascular disease, cancer and respiratory prevention.

Workforce:

Whilst there has been very good progress in recruitment to roles within primary care, it should be noted that we now have 35 (25 Full Time Equivalents -FTEs) fewer GP Partners working in Mid Essex than in 2015. The loss of GP Partners has mainly been offset by a rise in salaried GPs and more GP trainees entering the system. However, around one third of GPs, nursing and administrative staff in primary care are over 55 years, a figure that is above the national average, presenting a risk for a surge in retirement from those staff groups.

Furthermore, a fragmented approach to employment across health and social care increases artificial competition, reduces flexibility and limits opportunities for career progression, impacting on recruitment and retention.

Data and Information:

Limitations around data sharing provides a challenge to meaningful integration of partners to deliver care differently. Poor data quality inhibits ability to inform decision making and understand impact.

Geography and Estate:

Mid Essex has large areas of rurality, making efficient service delivery and access to care more challenging. Clinical estate is limited and, in order to manage immediate demands, may not be prioritised for the development of integrated neighbourhood teams. Even though a more flexible approach that considers alternative settings for care and the use of technology may alleviate some pressures, there is a need for a comprehensive, all-partner plan for ensuring the right type of estate to deliver agreed priorities.

What is the requirement from the NHS?

Over the next five years, the Mid Essex Alliance will further strengthen and develop its partnership approach to jointly understand and address wider determinants of health, enabling a shift in focus from reactive care to proactive and preventative early intervention.

Our ambitions

There will be an emphasis on enabling the wider community to maximise local knowledge through active participation in the design and delivery of sustainable health and wellbeing interventions. Health inequalities will be better understood, and services will be developed to effectively address inequity, supporting the most disadvantaged in our communities to improve their quality of life. Integrated neighbourhood teams (consisting of health, social care and voluntary sector partners) will provide a bespoke, flexible vehicle for delivery, removing artificial divides between organisations and instilling a united 'one team' approach that considers each individual and their unique needs.

Delivery Priorities

Health Inequalities:

Utilise data and 'soft intelligence' to work with partners to shape priorities and design interventions that will see a reduction in health inequalities. Jointly design an outcomes-based framework that will articulate a common vision and ensure efforts are focused on the most in need.

ABCD:

Embedding Asset Based Community Development will be the standard approach across the Alliance, building on assets that are found in the community and mobilising individuals, associations, and institutions to come together to realise and develop their strengths, ensuring widespread community awareness of all assets and building support networks from the ground up.

Develop primary care and build Integrated Neighbourhood Teams:

Implement recommendations from the Fuller report to effectively deliver urgent/episodic and complex care, and support prevention. Enable development of PCNs as the preferred primary care delivery model, supporting sustainability and providing the basis for integration with community health, mental health, social care and the voluntary sector as a cohesive, fully functioning integrated team that designs and delivers local population health management through Integrated Neighbourhood Teams.

Support ICS and national priorities:

Utilise local knowledge and networks to support delivery of broader priorities such as cancer screening, referral to treatment times and winter resilience.

Ensuring Delivery

SRO: Dan Doherty
Clinical Lead: Dr. Matthew Sweeting

The Alliance membership currently meets as a formally recognised group, Chaired by the ICB Alliance Director. Membership extends beyond traditional boundaries of health and social care, including wider system partners. To date, key achievements through this partnership include successful distribution of funding to support health inequalities schemes, and a collaborative approach to producing a single outcomes framework with shared deliverables and accountability. The Alliance also participated in the Place Development Programme in 2022, lessons from which will inform further thinking around the Alliance approach, Alliance development and governance arrangements.

Early in 2023, members will consider ongoing governance options. This is likely to include the introduction of additional sub-groups, each focussing on defined Alliance priorities that drive forward the overall strategic vision. Two further sub-groups – finance and data/BI – will hold responsibility as enabling functions. Membership of all groups will be broad but determined by the area of focus, with 'leadership' of each group assigned to the most appropriate partner organisation, reflecting the equitable nature of an integrated care system approach. Careful consideration will be given as to how the 'citizen voice' will be meaningfully included across all tiers of governance.

The aforementioned Alliance Outcomes Framework will shape Alliance priorities and governance structures, and, through ongoing reporting of progress, will provide a key indicator of delivery towards the long-term vision. This will be complemented by an appropriate level of programme management oversight.

District Health and Wellbeing Boards feed into the Alliance, ensuring a two-way communication channel that values local insight and influence.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Review Alliance governance arrangements and establish model able to provide strategic direction/oversight as well as operational delivery	Quarter two 2023/24
Agree approach to ensuring 'citizen voice' is heard and able to contribute to Alliance priorities and plans	From quarter one to quarter two 2023/24
Partners design a joint outcomes-based framework, building on population health data, Alliance priorities and emphasising collective responsibility for delivery	From quarter one to quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Establish mechanism for reporting against agreed outcomes and commence monitoring	Quarter two 2023/24
Promote Asset Based Community Development training across partners, identifying local 'champions' to ensure wider buy-in and cultural change	From quarter two to quarter three 2023/24
Develop Integrated Neighbourhood Teams (INTs): project governance established. Alliance partners jointly determine geographical footprint, model, strategy and timeline for roll out.	Quarter two 2023/24
Pilot INTs commence	From quarter two to quarter four 2023/24
Evaluation of pilot INT sites	From quarter four 2023/24 to first half of 2024/25
Wider roll out of additional INT sites	From quarter four 2023/24 to first half of 2024/25
Local networks and knowledge deployed to support delivery of ICS and national priorities (e.g., screening uptake, LD health checks and dementia diagnosis), with clear support plan developed	From quarter one 2023/24 to 2025/28

Transforming Primary Care

What have our residents told us?

Patients value primary care services and primary care delivers in excess of 80% of all patient interactions with the NHS.

Patient experience of primary care services has fallen following the Covid pandemic. Mid and South Essex has amongst the lowest overall satisfaction with primary care services in our region and nationally.

Current Conditions

Primary Care is currently experiencing significant challenges on a number of fronts.

Workforce - Nationally and locally, there is a reducing number of GPs working within primary care. This issue is further compounded by existing low levels of GPs compared to peer systems. We have an ageing profile of GPs and practice nurses within Mid and South Essex.

Demand – Demand upon primary care services has increased over recent years and whilst overall capacity has increased, demand often outstrips available capacity. Unmet demand in other parts of the system e.g., acute long-term follow-ups have an inevitable impact on primary care as patients seek alternative clinical input. The result is that satisfaction with primary care access has fallen.

What is the requirement from the NHS?

In line with the Fuller Stocktake, we seek to enable a primary care model of Integrated Neighbourhood Teams.

Our Ambitions

To align the collective workforce and assets around the needs of our local populations to provide:

- A system wide approach to Urgent and Episodic Care to improve same day care for patients and ensure sustainability for practices
- An integrated neighbourhood team approach to Complex Care Management which is more psychosocial in its approach to supporting holistic health and wellbeing
- Interventions to improve Preventative Care on a primary and secondary prevention basis using analytics and population health approaches.
- prevention basis using analytics and population health approaches.

Delivery Priorities

Strategically, Mid and South Essex ICB will implement a transformation programme that will, over 3-5 years, enable Integrated Neighbourhood Teams across our system to deliver Urgent and Episodic Care, Complex Care and Preventative Care.

This will be delivered through bottom-up transformation led by our Alliances, supported by system enablers.

There are two national specific requirements within the national planning guidance for 2023/24;

- Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- In addition, there is a requirement to "Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need"

We are anticipating further guidance (due March 23) from NHS England that sets out requirements from ICBs in regard to the Recovery of Access to Primary Care Services.

Ensuring Delivery

SRO: Dr Anna Davey
Clinical Lead: Dr Anna Davey

Primary Care reports through to the Integrated Care Board via the Primary Care Commissioning Committee (a formal subgroup of the ICB). This meets on a monthly basis and receives regular reports on Quality, Workforce, Finance, Estates, and Digital. In addition, the Primary Care Commissioning Committee makes decisions on key contractual matters and where required the operational implementation of primary care transformation.

To support the delivery of our Integrated Neighbourhood Team Vision, we will establish a new Oversight Group and refocus our existing Development and Delivery Group. A standard set of INT principles and a delivery framework will be co-developed alongside the Alliances. This will provide the standardised vision and expectations. More locally Alliances will work alongside their forming INT colleagues to localise the delivery from the bottom up to ensure initial priorities are formed around their neighbourhood needs.

The programme is likely to require additional transformation resource in order to deliver within the expected timeframe.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Agreeing Vision for Integrated Neighbourhood Teams	Quarter one 2023/24
Implementing Phase One of our Integrated Neighbourhood Team Working Together Scheme	Quarter one 2023/24
PCNs mobilising priorities within their Clinical Models e.g., PACT approach	From quarter one to quarter four 2023/24
Development of Model for Urgent and Episodic Care	From quarter one to quarter two 2023/24
Development of Road Map for long term Integrated Neighbourhood Teams	From quarter two to quarter three 2023/24
Review and align our strategic and operational approach to estates, data and workforce to underpin implementation of our INTs	From quarter one to quarter two 2023/24
Design and deliver engagement programme with providers to prepare for delivery of 2024/25 national contract changes	From quarter three 2023/24 to first half of 2024/25

Digital Access to Primary Care

What have our residents told us?

Residents tell us that access to primary care is challenging in part driven by increased demand and in part by the traditional model for accessing primary care services which centres on calling practices first thing in the morning.

Current Conditions

Different digital services are offered to and by GP practices and other avenues of care are not socialised or properly developed.

Pathways are not efficient as information is not shared across care settings often resulting in additional contacts with primary care clinicians to enable completion of tasks.

The full capabilities of the existing technology are not fully exploited, and many applications and systems have been deployed to primary care with little business change, implementation or training. The use of technology varies by service and is often dependant on costs or clinical perception.

Nationally, the new GP contract settlement (23/24) and the as yet to be published Access plan place significant onus on improving the use of digital technologies to improve the user and workforce experience.

What is the requirement from the NHS?

NHS Long Term Plan:

- By 2023/24 every patient in England will be able to access a digital first primary care offer Section 1.43. Digital technology will provide convenient ways for patients to access advice and care.
- Digital NHS ‘front door ‘including advice, symptom checking, telephone and video consultations. Supporting remote monitoring of conditions. Online resources to support Mental Health and recovery.

Fuller Stocktake:

- Demand and Capacity
- Improve the telephone journey,
- Improve the online journey
- Enhance triage and care navigation
- Better manage practice workload

Our Ambitions

To provide a digital environment that delivers the flexibility demanded by a modern multi agency service. The formation of Locality services will see a range of clinical services offered by many different providers from the same location.

The digital environment should be an enabler to optimise the quality of care provided. There should be a consistent access model across modes of entry to ensure the right care at the right time at the right place.

Delivery Priorities

We will look to deliver improvements in access and drive efficiencies working with our ICS partners and wider regional organisations, focusing on a number of key areas:

- Providing applications and digital services to support the following:
    - Expanding the role of community pharmacy and making patient records available to be both read and written to.
    - Making it easier for patients to contact their practice to make an appointment and access other services via Telephone, Web, App and other routes
    - Cutting bureaucracy and unnecessary workload within a practice such as delivering the on-line registration of new patients
    - Building Capacity where most needed by the use of business intelligence

Ensuring Delivery

ICS SRO	William Guy
ICS Programme Lead	Alex Hemming
CCIO	Taz Syed

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
NHS App integration with People Know Best (PKB)	Quarter two 2023/24
Prospective record access for all patients by 31/10/23	Quarter three 2023/24
Successful implementation of access improvement plans by 31/03/24	Quarter four 2023/24
GP Online registrations in all practices	Quarter four 2023/24
GP practice website procurement and rollout	Quarter four 2023/24
Development of PCN S1 hubs and their interaction with integrated neighbourhood teams	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Digital champion programme to support residents in the use of digital tools to interact with primary care	Quarter four 2023/24
Digitisation of all Lloyd George records in primary care	First half of 2024/25
All practices to be on cloud-based telephony system by end of 2025 (Note: this deadline may be brought forward)	Second half of 2024/25

Developing our Community Services

What have our residents told us?

Residents/Patients have been engaged in the redesign of Community services and the following themes have been consistent:

- Community services should be delivered locally as possible
- Teams should work together to offer seamless provision without the need for people to tell story multiple times.
- To be supported in their own home where possible
- Consistent service offer removing any postcode lottery

Current Challenges

Community services act as the glue between primary and acute care, so pressure experienced in either sector has an effect on community services. In recent times there have been 3 significant challenges for Community services to contend with

- **COVID-19** - With staff having to work in very different ways or being redeployed from their usual services (and those temporarily suspended) and directed to support the response to the pandemic. This has taken a toll on staff but has also created increased waiting times to access community services.
- **Urgent and Emergency Care** - Community services play a significant part in providing urgent and emergency care with a focus on admission avoidance and ensuring people receive high quality urgent care at home where clinically safe and appropriate. Community services are also instrumental in supporting discharge. Urgent and emergency care in MSE has been under incredible sustained pressure which has directed capacity and focus away from preventative and routine work with the subsequent impact on service provision.
- **Workforce** - As alluded to in the sections above the workforce toll due to the Covid-19 pandemic and the sustained pressure from urgent and emergency care cannot be underestimated.

What is the requirement from the NHS?

National NHS planning objectives 2023/24

- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

Our Ambitions

To deliver best in class community health and care services to the residents of Mid and South Essex

Community health teams play a vital role in supporting people with complex health and care needs to live independently in their own home for as long as possible. Many services involve partnership working across health and social care teams, made up of a wide variety of professionals including GPs, community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers

in line with the NHS Long Term Plan our ambitions are to:

- shift more care from hospital to the community
- bring together different professionals to coordinate care
- help more people to live independently at home for longer
- develop more rapid community response teams to prevent unnecessary hospital spells and speed up discharges home
- upgrade NHS staff support to people living in care homes
- improve the recognition of carers and support they receive
- make further progress on care for people with dementia
- give more people more say about the care they receive and where they receive it, particularly towards the end of their lives

Delivery Priorities

We will build on the established MSE Community Collaborative as the main delivery vehicle to drive the improvements in community service provision. We have aligned the delivery priorities for Community services with the vision to integrate, innovate and improve

Integrate

- Work alongside Alliance and primary care colleagues to embed integrated neighbourhood teams
- Work with system partners, residents and patients to design, produce and implement integrated intermediate care services that optimise independence
- Standardise delivery of community services where it makes sense to do so. Service areas include:
    - Adult Speech and Language Services
    - Diabetes
    - Children and Young People (ASD)
    - Virtual Wards (Respiratory and Frailty) and Community Beds
    - Urgent Care Response Team (UCRT)

- Stroke
- Wheelchairs

Innovate

- Introduce and optimise technologies and innovations to drive efficiency and productivity and release clinical time to be patient facing – introduce dictation software, route planning and optimise the use of Whzan and raiser chairs in care settings and virtual wards including remote monitoring

Improve

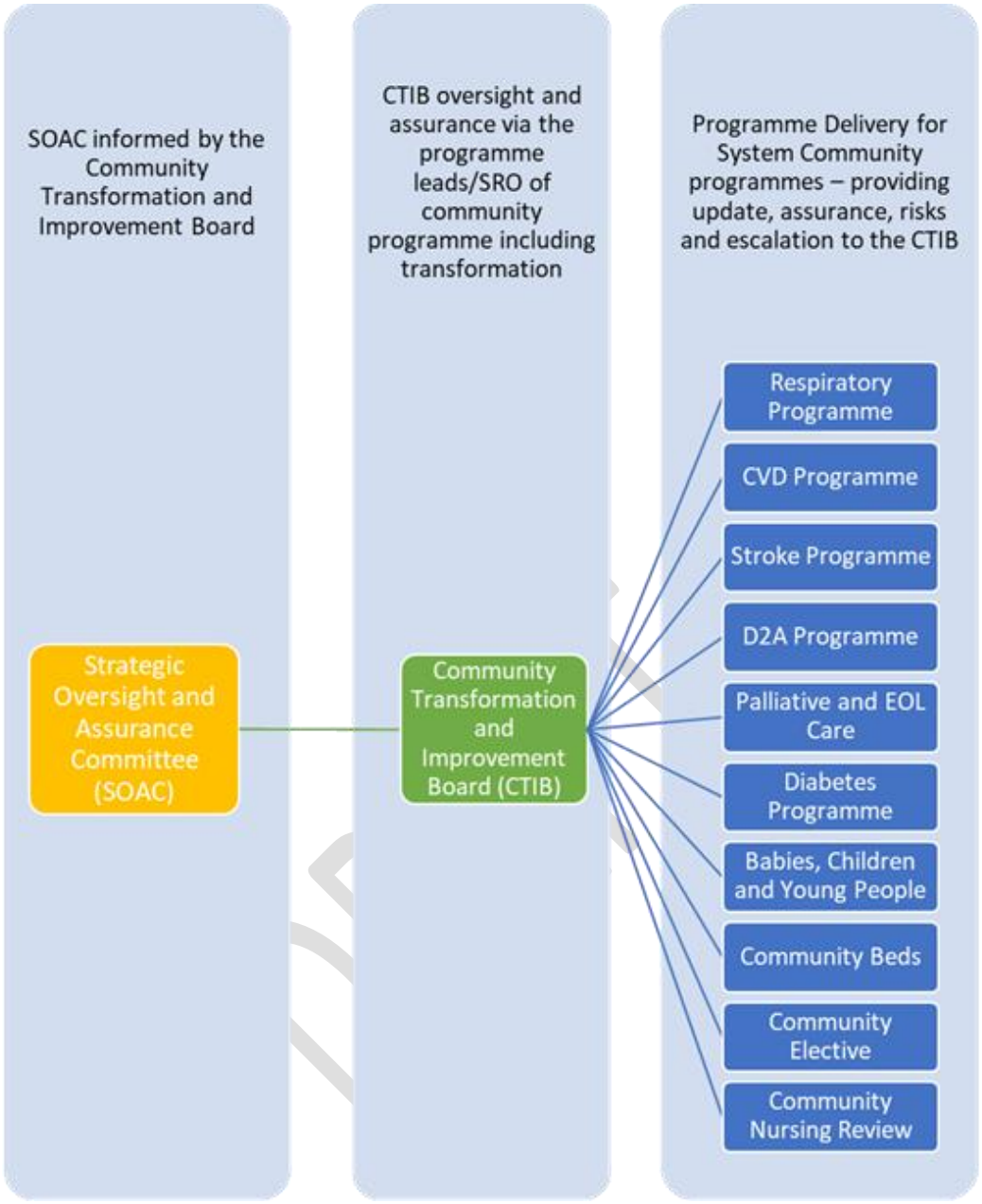
- Optimise efficiency and effectiveness of Virtual wards
- Ensure compliance with zero 65 week waits for community services by March 2024
- Introduce self-referral to falls response services, musculoskeletal services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.
- Continue to improve the offer and identification for carers through 6 monthly coordination of place and system carers maturity matrix

As part of forming the architecture for the future we will recontract the community collaborative to create the conditions for improving, integrating and innovating community services, together

Ensuring Delivery

SRO: Gerdalize du Toit
Clinical Lead: Dr Sarah Zaidi

The Community Transformation and Improvement Board will oversee the transformation, recovery, and performance of the community workstreams and is a subcommittee of the System Oversight and Assurance Committee.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
480 virtual hospital beds in place by Dec 23	Quarter three 2023/24
Reduce long waits to less than 65wks	Quarter four 2023/24
Reduce long waits to less than 52wks	Second half of 2024/25
Design and implement new integrated intermediate service	Quarter three 2023/24
Standardise delivery of community Services	Quarter four 2023/24
Support the design, deployment, and delivery of Integrated Neighbourhood teams	From quarter one 2023/24 to the first half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Introduce and optimise technologies and innovations to release clinical time	Quarter four 2023/24
Reach mature on all eight domains of the Carers Maturity matrix	2025/2028
Establish longer term commissioning arrangements for the Community collaborative	From quarter three to quarter four 2023/24

Appendix 2 – Improving Population Health

Within this section you will find long term plans relating to:

- Population Health Improvement Board (PHIB)
- Personalised Care
- Population Health Management
- Stewardship
- Innovation

Population Health Improvement Board (PHIB)

What have our residents told us?

From extensive engagement with residents across the system and more locally through our Alliances, we hear that residents feel that things need to change. All understand that improving the health and care of people in MSE requires a re-balancing of our activities towards prevention, early intervention and anticipatory care.

Current conditions

Reducing inequalities is a complex picture with no single action or single organisation able to achieve this in isolation. Reducing inequalities requires a sustained, organised, collaborative focus. The adapted Labonte model summarises the complex system that causes inequalities to thrive. It encapsulates the different factors that impact our health, where they stem from (the wider determinants of health), how they interact, multiply, reinforce and act both in sequence and simultaneously.

What is the requirement from the NHS?

Our ICS has a shared common endeavour of **reducing inequalities** which reflects our desire to work together to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations and agencies, focussing on prevention and early intervention and providing high-quality, joined-up health and care services, when and where people need them.

Our ambitions

Our ambition is to eliminate avoidable health and care inequalities by focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

We have established a MSE ICS Population Health Improvement Board to drive an integrated approach to inequalities improvement. This board brings together the programmes of work across the ICS on Health Inequalities, Population Health Management, Prevention, Personalised Care and the Anchor Programme and the work of the Children and Young People's Growing Well Board.

Delivery Priorities

We have adopted the national NHS 'Core20PLUS5' framework to prioritise work on reducing health inequalities, focusing on:

- Most deprived 20% of the national population
- Plus groups those that experience poorer health outcomes. We have thus far identified Black and Minority Ethnic groups, Carers, People with Learning Disabilities, people experiencing Homelessness, Gypsy, Roma and Traveller communities, veterans.
- Five clinical areas of focus:

Adults focus

Maternity
People with Serious Mental Illness
Early Cancer diagnosis
Chronic Respiratory Disease
CVD with focus on Hypertension

Children and young people focus

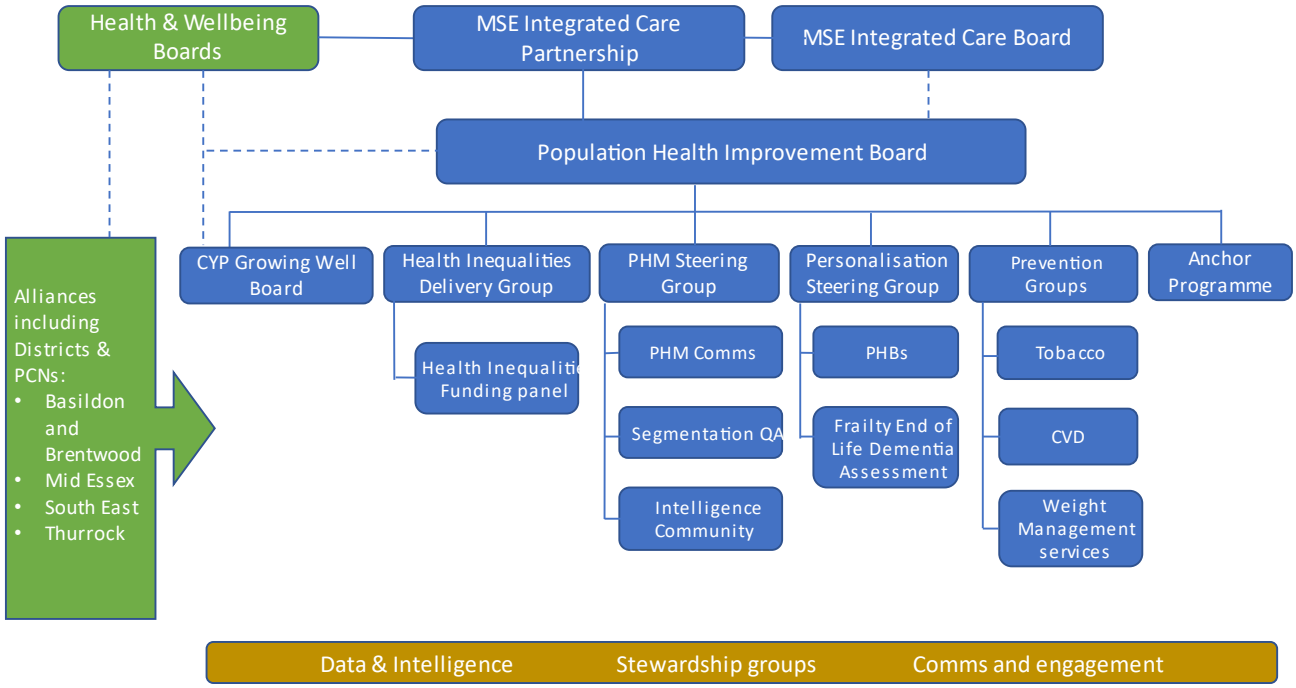
Asthma
Diabetes
Epilepsy
Oral Health
Mental Health

- The delivery priorities are to ensure equitable access by:
- Embedding system wide adoption of Health Inequalities Impact Assessments (HIIA) utilising a digital tool, together with system development approach of co-designing of services with residents, engaging with those from vulnerable groups.
- Improved data collection and reporting to ensure improved completeness of recording regarding ethnicity, inclusion groups and other groups such as carers
- Continually reviewing the restoration and delivery of services to ensure that at risk groups are not further disadvantaged. A rolling programme will address inequalities seen in waiting lists when viewed by ethnicity, age, area of deprivation.

- Working with system partners to mitigate digital exclusion, through adoption of our agreed digital exclusion principles, to support residents in accessing digital services through skills development.
- Development of a financial framework that adopts principle of proportionate universalism to deliver at scale services that are proportionate to the needs of our population

Ensuring Delivery

SRO: Jo Cripps



Clinical Leads: Dr Sophia Morris (Health inequalities), Luke Tandy (PHM), Dr Anita Pereira (Personalised Care) and Dr Peter Scolding (Prevention)

The Population Health Improvement Board will develop an outcomes framework linked to the integrated care strategy that will track whether we are making a difference. The key outcomes will include:

- improving healthy life expectancy
- narrowing the gap between the most and least deprived areas
- reducing the proportion of our population that are obese and the number that smoke
- increasing healthy lifestyle behaviours such as physical activity
- diagnosing cancers at an earlier stage
- equitable access to services measured across waiting lists, health checks, screening and vaccination uptake

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Deliver PHIB and Health inequalities dashboard to monitor outcomes and impact that reflects ICP Strategy	Quarter two 2023/24
Health inequalities funding for 2023/24 prioritised and implementation commenced	Quarter three 2023/24
Evaluate the outcomes from 2022/23 Health Inequalities Funding	Quarter three 2023/24
Financial strategy development to support PHIB priorities around health inequalities and prevention investment including confirming partner contributions	First half of 2024/25
Organisational development support to embedding equality mindset including development and delivery of ICS Wide Health Inequalities Impact Assessment Digital Tool and Equality Delivery System	Quarter four 2023/24

Personalised Care

What have residents told us?

Shared Decision making (SDM) is a key component of the comprehensive model of personalised care and brings together residents and clinicians in equal partnership to make decisions. Many of our residents want to be involved in shared decision-making conversations to have more choice and control over their care.

As part of a co-production empowerment campaign a baseline survey of over 600 residents concluded that:

- 70% of people understand what is meant by SDM
- 80% of residents stated they want to participate and would find handy prompt questions useful

Current Conditions

Working with the National Institute of Health Research, a behavioural science research study has been conducted, that tells us the prevalence, enablers, and challenges for practitioners to adopt SDM in routine practice. The study reveals that:

- > 40% of professionals incorporate SDM in over 75% of their conversations with people
- 45% of professionals are confident in holding SDM conversations
- 40% of professionals stated that time is a constraint to undertaking good SDM conversations and to do more in practice
- 75% of professionals agreed that focussed training in SDM skills will help improve conversations.

What is the requirement from the NHS?

The NHS Long Term Plan commits to making Personalised Care business as usual reaching 2.5 million people by March 2024.

The comprehensive model for personalised care comprises of six components that provides a framework of evidence-based principles, tools and resources for whole population, universal and targeted interventions.

The model provides the conditions for relationships between residents and professionals to respond to population health management intelligence of the rising complexity of needs and wider determinants of health by starting with a collaborative Shared Decision-Making process to address disparities in outcomes, access, and experience.

Our Ambitions

The ambition is to reduce the prevalence of health inequalities by adopting a culture of personalised care, focusing on those at greatest risk of poor health identified within the Core20Plus5 Framework for Mid and South Essex.

Delivery Priorities

Leadership

- Develop clinical and peer leaders, champions and sponsors in personalised care implementation and innovation in delivery.

Culture Development

- Build upon good practice and foster a continuous learning culture through a 'community of practice' and by offering innovative training programmes such as Immersive Simulation training embedding health coaching skills across the system.
- Empower people to exercise choice and control meaningfully for them, their families, and communities by producing tools, resources, and policy to encourage innovation in delivery through shared decision making and supported self-management, personalised care and support planning, and personal health budgets as solutions to reflect diversity.

Supporting Strategy

- Continuously improve our working relationships with voluntary sector wider system partners such as pharmacies to identify, implement and project further proactive personalised care.
- Produce qualitative evidence of the impact personalised care has on improving outcomes, access, and experience aligned with the priorities of the Integrated Care System Strategy.
- Work collaboratively with to generate capacity for non-medical interventions through personalised care models.

Quality Improvement

- Support implementation of Personalised Care and Support Planning practices for managing e.g., frailty and End of Life (EoL) care.
- Scope the potential for digitisation of Personal Health Budgets (PHB) tools and resources to support development and enable growth in the legal right to have cohorts such as PHB in Section 117 aftercare pathways.

Ensuring Delivery

SRO: Emma Timpson, Associate Director, Health Inequalities and Prevention
Clinical Lead: Clinical Leads for Health Inequalities and Personalised Care

Reducing health inequalities is at the heart of the Integrated Care System strategy. Personalised care is a key strand of work overseen by the Population Health Improvement Board.

To co-ordinate the programme we have established a system wide Personalised Care Steering Group accountable to the PHIB.

Working in partnership through the Personalised Care Steering Group, we will design a local appropriate outcomes approach including national requirements.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
3,630 PHBs in Place	Quarter one, two and four 2023/24
24,534 Personalised Care and Support Plans in Place	Quarter one, two and four 2023/24
10 professionals per month trained in coaching skills	From quarter one to four 2023/24
300 Professionals trained in Personalised care skills for managing frailty by virtual reality	From quarter one to four 2023/24
Develop connectivity between PCSG and Community Assembly, strategic co-production to develop clinical championship and peer leadership for personalised care.	Quarter one, two and four 2023/24
Continue to deliver Adopting Coaching Skills Approach Course	From quarter one to quarter two 2023/24
Establish and Launch Coaching Supervision Framework	Quarter two 2023/24

Population Health Management

What have our residents told us?

The NHS Long Term Plan defines a mature as ICS as one with Population Health Management (PHM) capabilities which support the design of new integrated care models for different patient groups, with strong PCNs and integrated teams and clear plans to deliver the service changes set out in the Long Term Plan; improving patient experience, outcomes and addressing health inequalities.

What is the current state of play/local challenges?

Progress has been made recently in the underpinning infrastructure for PHM and the sharing of insights for example through PHM Health Inequalities Data Packs. Ongoing challenges include:

1. Ensuring system-wide access to PHM integrated dataset and segmentation model
2. Culture change, including confidence to engage with data-based insight and to build interventions through co-production
3. Enhancing system-wide understanding of PHM and building the skills to maximise its potential

What is the requirement from NHS?

Facilitate alignment of PHM approaches Across the system and with financial mechanisms

What is the ambition?

By 2028, multiple cohorts of residents/patients will be identified annually for focused projects that design, implement and evaluate (and scale where appropriate) evidence-based interventions (with a focus on early intervention and prevention) to have the greatest impact on population health from the available resources.

These interventions will contribute towards the ICS Core Outcomes

- Improving outcomes in population health and healthcare systems
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money

It is also envisaged that more work will be done across system partners, including NHS and Local Authorities as well as providers, residents, and the Voluntary Sector to begin to make change in those wider determinants of health including (but not limited to):

- The built environment (e.g., housing, planning)

- Reducing risks (e.g., tackling obesity through whole system approaches)
- Support for residents in the lowest socioeconomic groups (e.g., reducing or mitigating the impacts of poverty and fuel poverty)
- Giving children the best chance at success in life (e.g., education, healthy diet, exercise)

Working together on these wider determinants would contribute towards the ICS Core Outcome of supporting broader social and economic development.

What are the delivery priorities?

PHM specific priorities include:

- Supporting Alliances, PCNs and Stewardship programmes to deliver their outcomes, embedding a PHM approach.
- Using the segmentation model to identify cohorts of individuals who are progressing too quickly or undetected towards ill health and co-designing interventions which will address that.
- Delivering on the system priority of early intervention and prevention

Governance

SRO: Jo Broadbent, Director of Public Health, Thurrock Council
Clinical Lead: Luke Tandy, PROVIDE

How will we ensure delivery?

The PHM steering group is a sub-group of and is overseen by the Population Health Improvement Board. It is very closely linked in terms of content and priorities to the Health Inequalities Delivery Group, Personalisation of Care Delivery Group, and Prevention Delivery Group.

The PHM steering group also has subgroups including:

1. The segmentation model quality assurance sub-group
2. Communications sub-group
3. Various project delivery groups

PHM also has a very close relationship and dependency on Business Intelligence including the infrastructure they provide for access to data, and Council Public Health teams.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
PHM Governance in place for all PHM related projects	Quarter one 2023/24
Expand PHM support to all areas including prevention, inequalities, personalised care, stewardship	Second half of 2024/25
Slowing progression to ill health through segmentation model	2025/28

Stewardship

What have our residents told us?

MSE residents have engaged positively with the model of community mobilisation via social media piloted with our Ageing Well stewardship group. They will also play a significant and increasing role in working with our stewardship groups to and identify and elucidate strategic priorities as part of their annual reporting.

Current conditions

The current systems, incentives and culture are not conducive to delivering value for the population in an optimal way. Health and care resources are therefore not always directed to where they are needed most. There is a general trend towards increasing levels of clinical intervention, particularly in the acute sector; whilst this may represent a better outcome or experience for an individual, at a population level this trend poses a challenge.

An opportunity cost exists, relating to the missed opportunity for investing progressively further in activity which would deliver higher value to our residents, including both up-stream and downstream care. Stewardship is therefore our radical approach to redressing this, and ensuring that care pathways are viewed holistically, with resources targeted towards those activities that represent high value to our citizens, including addressing the wider determinants of health, and away from those that represent low value.

What is the requirement from the NHS?

The ICS needs to work collaboratively to use allocated resources to optimally, and equitably, improve the health and wellbeing of the 1.2 million people we serve.

Our Ambitions

We will adopt a culture of stewardship. This means using common resources wisely for population segments for the good of all in that care area - not for the good of our own organisation or team.

We will equip and support resource users (notably clinicians, patients and residents) with the skills and wherewithal to make decisions about how resources should best be used, giving them responsibility for doing so and enabling clear accountability.

This programme therefore defines both how we make decisions about particular care areas, but also aims to shift the culture within the whole integrated care system accordingly.

Delivery Priorities

- Stewardship groups formed for 25 care areas by 2025
- Personal development programme rolled out for each cohort
- Mechanisms for shifting resources (e.g., Hosting) implemented
- Stewardship BI dashboards developed and implemented
- Organisational development for ICS to embed culture of stewardship across organisations

Our duty to seek advice

Our system Clinical and Multi-Professional Congress, chaired by the ICB Medical Director, brings together frontline staff from community, primary, secondary, social, and urgent and emergency care, mental and public health, pharmacy, and patient engagement sectors.

They provide support to the ICB board where requested in developing and delivering clinical and care strategy, effective use of resources, innovation and horizon scanning, enabling and engaging clinical and care leadership, changing clinical and care mindsets and supporting assurance and statutory adherence.

Ensuring Delivery

SRO: Dr Ronan Fenton
Clinical Lead: Dr Peter Scolding

How will we ensure delivery

- The programme is overseen by the Stewardship Programme Board
- Assurance of the Stewardship Programme will take place the ICB System Oversight and Assurance Committee.
- From 2023 we will also publish an annual report based on both care areas and population segments, demonstrating progress against our aims and comparing our performance with others.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
25 stewardship groups functioning by 2025	Second half of 2024/25

Innovation

What have our residents told us?

We continue to work with service users and those within our communities to understand barriers to uptake of innovation, inequality and how we can address areas of exclusion, through effective partnership and strengthening of local networks, assets, and relationships. As a system of Anchor organisations, we need also to consider ways to build social value and address social determinants of health in doing this as we have heard the value of local assets and the power of innovation in doing this.

Current conditions

Innovation has been subject to the same challenges seen across the NHS and social care, resulting in lack of capacity within organisations to implement new innovations.

The ICS landscape is new and fertile, and whilst formal structures are established, MSE innovation has continued to work in collaboration and partnership.

In 2019, a collaboration between MSEFT and the Innovation Unit saw the development of MSEFT's 5 Stage Model to Create an Innovation Culture. The stages are:

- Developing a vision and strategy
- Developing a case for change
- Establishing key priorities
- Run a staged selection process
- Build an innovation function.

We continue to have a joint programme and jointly chaired Innovation Advisory Group.

Some developments such as digital care models and ongoing Outpatient transformation present additional opportunities for innovation but also the need to be mindful of pace required to deliver recovery trajectories.

System digital maturity, appetite and strategy needs to be considered for innovation choices and readiness.

Through one of our own clinicians and National Clinical Lead for Innovation, Professor Tony Young, we continue to support in partnership Anglia Ruskin University deliver the world's largest and most successful workforce development programme focussing on clinical innovation. The NHS Clinical Entrepreneurship programme (NHSCEP) is now entering its 7th cohort with many of those successfully

applying working within MSEFT, and equally we have seen innovation adopted into our Trust because of connections made through NHSCEP. MSE innovation works closely with our local AHSN (University College London Partners), HealthTech Enterprise, Health Education England, and Accelerated Access Collaborative, local universities, as part of partnership working. MSE ICS has achieved great successes with partners including Ford Motor Group for the Essex Covid Vax/Respiratory Van and British Heart Foundation for the BP@Home solutions.

What is the requirement from the NHS?

The NHS LTP commitments include accelerating uptake of selected innovative medical devices, diagnostics, and digital products to patients faster, through existing MedTech Funding Mandate policies, or similar programmes.

In line with the 2023/4 Planning Guidance, the innovation programme will continue to progress use of machine learning, Artificial Intelligence (AI), and new ways of organising and providing care for example, using innovations such as Deep Medical that increase efficiency in our outpatient recovery programme around driving down avoidable appointment Did Not Attends (DNAs); and 'C the Signs', supporting with earlier cancer diagnosis opportunities.

Our Ambitions

The MSE Innovation programme has been operating at a system level, since 2019. The programme aims to build a culture of innovation to help deliver our Common Endeavour of reducing inequalities together. Over the next five years MSE ICS will increase its innovation reach within residents, students, staff, and partner organisations by becoming a nationally recognised innovative system. This will be done by:

- Increasing adoption of innovation, developing Anchor innovation and innovations that support these goals in practice,
- Increased participation of student, staff, and residents/carers in formal innovation development activity, positively increasing home-grown innovation.
- Inward investment to MSE through grants and awards, including self-sufficiency to pump-prime innovation investment
- Evolution of innovation policies; including Intellectual Property
- Using innovation as an enabler to address health inequalities
- Enhancing innovation culture and readiness, cross-system
- Collaborating with industry to boost partnership working
- Use collaborative innovations to improve working practices and person-centre outcomes

Delivery Priorities

The themes for MSE Innovation Fellows continue to be aligned to the key national, regional, and local objectives e.g., workforce, reducing health inequalities (in line with CORE20PLUS5 Adults), Children and Young People's Mental Health (in line with CORE20PLUS5 Children and Young People) and Covid-19 recovery. This intentional alignment will continue for the next five years linking local innovation with planning guidance and Long-Term Plan goals, while supporting our common endeavour in MSE ICS.

MSE innovation delivery priorities include

- Increased adoption of innovations in line with ICS objectives year on year from 2022/23 baseline.
- Develop Anchor Innovation - social value incubator
- Develop innovations that progress Anchor goals in practice
- Students and staff members participating in formal innovation development activity
- Increase in industry partnerships or innovation
- Inward investment to MSE through grants and awards
- Agree Intellectual Property Policy across ICS
- Progress innovation as an enabler of addressing health inequalities
- Use collaborative innovations to improve working practices and person-centre outcomes

Ensuring Delivery

SRO: Charlotte Williams
Clinical Lead: Professor Tony Young

MSE innovation is monitored through a monthly MSEFT Innovation Working Group and a quarterly system-wide Innovation Advisory Group.

The mapping of each provider organisation's focus areas is underway to ensure a joined up collaborative approach.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Develop Anchor Innovation - social value incubator	From quarter one 2023/24 to first half of 2024/25
Students and staff members participating in formal innovation development activity 1. Monitored via use of MediShout QI 2. Identifying new staff innovations each month via the working and advisory group	From quarter one to 2025/28
Increased adoption of innovations in line with ICS objectives year on year from 2022/23 baseline.	From quarter one to quarter two 2023/24
Increasing of MSE Innovation Fellows year on year	Quarter three 2023/24
Inward investment to MSE through grants and awards	From quarter one to 2025/28
Increase in industry partnerships or innovation	From quarter one to 2025/28

Appendix 3 - Workforce

Within this section you will find long term plans relating to:

- Workforce
- Clinical Care and Professional Leadership
- Nursing and Quality

Workforce

What have our residents told us?

The MSE system continues to reset activity following substantial winter pressures overlaid by Covid and elective recovery. The system has high vacancy levels across core services and an unsustainable dependency on bank and agency staffing. There is a requirement for the consistent review workforce data quality and reporting to ensure that there is robust oversight of workforce trends.

Current Conditions

- Complexity of the system geography including proximity to London and providers delivering across multiple ICS's
- High levels of vacancy impacting staff morale, retention, absence, and turnover
- High dependency on temporary staffing with usage increasing (6.6% of pay bill)
- Workforce data anomalies

What is the requirement from the NHS?

The aim is to implement robust, integrated workforce planning, reduce temporary staffing usage and adopt and embrace new roles and ways of working.

What is the ambition

To meet the needs of our local communities there is a requirement to increase focus on recruitment and retention of staff, with particular emphasis on registered nurses, medical staff and support to clinical roles.

Delivery Priorities

Our new people strategy sets out the following priorities designed to address these areas of concern across our ICS workforce:

- Recruit at scale and across the system via a centralised programme. 'One workforce' approach, streamlining the recruitment process to enhance applicant experience.
- Use branding of MSE as the recruiter for the system for health and care – 'great place to work, develop and live'.
- Agree percentage of current vacancies to support joint recruitment initiatives to substantially grow assistant/associate roles which will form our workforce pipeline leading to a suite of apprenticeship roles.

- Active, consistent engagement with schools and colleges – influencing and supporting younger ages e.g., from Cadets 12 years plus. Creating local pipelines for future workforce supply
- Registrant roles involved in shaping future workforce models – adopting new skill mix and use of digital/technology e.g., learning from Virtual Hospitals.
- Blended education and training to support the skill gaps of current and future workforce utilising our Academy and local HEIs
- Strategic workforce planning at ICS level linking with the Framework 15 programme- embed new roles and workforce transformation in this process.
- Implement flexible working initiatives to support retention and growth in all areas and target workforce hotspots.
- People Board to form a workforce planning steering group to sequence the activities in this refresh and start to build more granular workforce plans, starting at system level and filtering down

Ensuring Delivery

SRO: Chief People Officer

- Strategy and operational plans enacted via the People Board
- Workforce metrics monitored monthly at System Oversight and Assurance Committee (SOAC)

Delivery Plan

For detailed delivery plans for 23/24 please see operational planning submission

Clinical and Care Professional Leadership

What have our residents told us?

There is variation across our alliance areas in care received and while work has been undertaken to ensure consistency, it is Clinical and Care Professional Leadership (CCPL) that will make a difference to our population.

Current Conditions

This workstream both supports and is challenged by our workforce issues and huge demand and capacity mismatch.

However, the aim of this work is to assist with the recruitment and retention of clinical and professional staff groups. The insights and actions of our CCPL's will address and improve the effectiveness of our efforts to address our operational delivery pressures in all areas.

What is the requirement from the NHS?

- Improving outcomes in population health and healthcare – establish and maintain a pipeline of trained and supported leaders to lead at System, Alliance, and Place level.
- Tackling inequalities in outcomes, experience, and access – Support the work of the System clinical Leads for Inequalities by the incorporation of managing inequalities in all System and Alliance work.
- Enhancing productivity and value for money – by ensuring CCPL leaders are included in the design and decisions within our system's services.
- Helping the NHS support broader social and economic development – through our partnership within and outside health and social care including engagement in the education and private sectors.

Our Ambitions

To put clinical and multi-professional leadership at the heart of our system by creating a distinctive and attractive offer to support the active participation of staff within MSE to lead as part of their day-to-day work.

- To fulfil the requirements and work within the 5 principles set out within the white paper Building strong integrated care systems everywhere paper link.
- To reflect this commitment in our governance structure and leadership arrangements.

- To strengthen and further develop our CCPL arrangements for current and future leaders.
- To ensure that CCPL leaders are empowered and accountable for the delivery of high-quality care and to exercise effective clinical advocacy for individuals and groups who are the most unequal or excluded in its communities.
- To develop and maintain a framework document that sets out the ambitions and strategy of this programme of work.

Delivery Priorities

There are effective structures and communication mechanisms to connect CCPLs at each level of the system:

- A strategic framework and offer that identifies, recruits, and retains an inclusive group of motivated clinical leaders
- Complete and refresh CCPL framework

Clinical and Care Professional Leads working within ICS governance to support collective accountability for whole-system delivery:

- System Clinical Leads supported re-appointed/refreshed
- Alliance Clinical Directors (ACDs) supported and re-appointed/refreshed
- Alliance Clinical Leads (ACLs) supported and re-appointed/refreshed

A culture of shared learning to collaborate and innovate with a wide range of partners, including patients and local communities e.g., through engagement events, surveys and annual check-ins

CCPLs are given protected time, support, and infrastructure to carry out their system leadership roles.

- CCPL Council Monthly meetings
- Establish CCPL Faculty and Special Interest Groups
- Establish and Support Special Interest Groups

Clearly defined and visible support to develop the leadership skills to work effectively across organisational and professional boundaries.

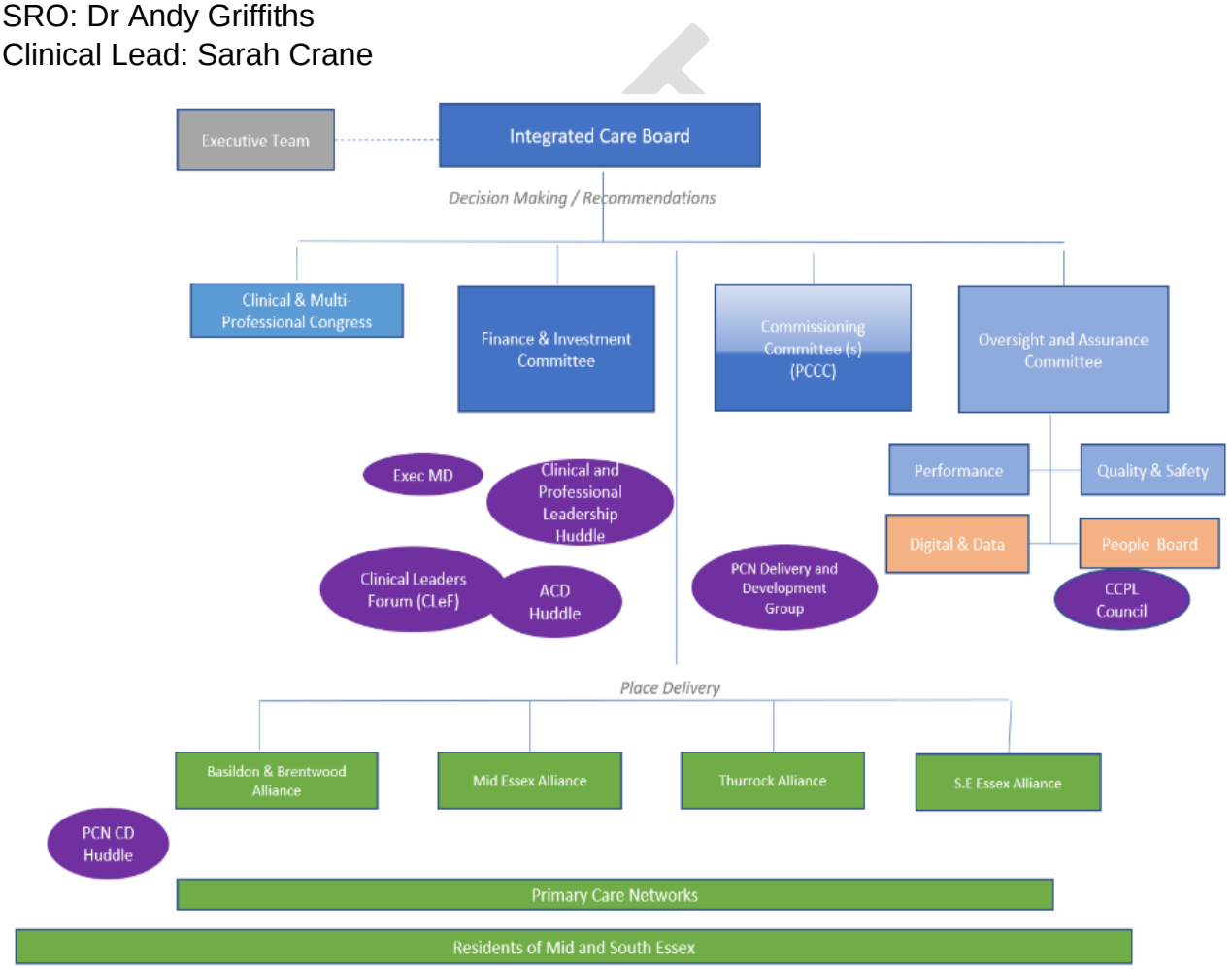
- Engage with Anglia Ruskin University (ARU) / University of Essex (UoE) on collaborative apprenticeships and Health and Care Academy formation (Principle 2, 3, 4 and 5)
- UoE on collaborative apprenticeships
- Care at Home/Health and Care Academy formation at ARU
- Leading within MSE ICS continues

Stewardship is an approach to health and care services that we are developing across the Mid and South Essex Integrated Care System. It is about bringing together teams of health and care staff and managers within a care area, to get the best value from our shared health and care resources. Stewardship groups providing health services within allocated resources; advising convening and supporting across system services

- Establish and support 25 stewardship groups by 2025
- Recruit System Medical Director Team
- Recruit Two clinical fellows annually
- Clinical Transformation/Veterans Lead
- Two DSMDs

Ensuring Delivery

SRO: Dr Andy Griffiths
Clinical Lead: Sarah Crane



The above shows the System governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
4 x alliance clinical directors recruited supported and refreshed	Quarter one 2023/24 and first half of 2024/25
22 system clinical leads recruited supported and refreshed	Quarter one 2023/24 and first half of 2024/25
Alliance clinical leads recruited supported and refreshed	Quarter two 2023/24, first half of 2024/25 and 2025/28
Clinical Care Professional leadership (CCPL) council developed and maintained	Quarter one 2023/24, first half of 2024/25 and 2025/28
CCPL engagement events developed and delivered	Quarter three 2023/24
CCPL faculty developed and maintained	Quarter three 2023/24

Nursing Quality and Safety

What have our residents told us?

Overwhelmingly through engagement with our residents, three key themes arise. They want to:

- feel safe
- feel listened to
- be respected

Current conditions

Teams within Mid and South Essex ICS already perform an outstanding job every day to deliver healthcare services. However, they are facing multiple challenges which impacts on their ability to achieve the quality of service they would like to provide including challenges in recruitment and retention, financial pressures, relentless and growing pressure from infectious diseases as well as long-term conditions, coupled with an ageing population.

Despite the processes in place for monitoring the safety of services, patients sometimes suffer harm. Consequently, health and care teams need robust systems and processes to ensure care provided is of high quality and safe. To support us to achieve this aim, we have developed six key principles that underpin decisions around quality.

What is the requirement from the NHS?

The programme of transformation across mid and south Essex presents clear opportunities for health and social care organisations, education, and police partners to work together to address current quality and inequality challenges. We recognise that each organisation has its own statutory duties in relation to ensuring the quality and safety of services.

Our ambitions

Our approach does not seek to replace these duties, rather it aims to deliver:

- A streamlined and efficient approach to quality measurement and monitoring
- Opportunities to increase the voice of patients/residents
- A better understanding of health quality and wider system inequality variation across integrated pathways, rather than looking at quality in silos
- The structure, process and guidance needed by teams to ensure regulatory compliance
- Better use of data, including the effective triangulation of multiple sources of data and quality surveillance to enable early warning and prevention

- Agreement on the approach to defining, measuring and monitoring quality under new contractual arrangements.

Clear quality and health inequality impact assessments are undertaken for all change and transformation programmes.

Delivery Priorities

A shared commitment to quality:

- By end of 2023, we will have an agreed suite of documents that describe our committees and information flows
- By 2024, we will collectively support services to improve by undertaking a programme of peer reviews to assess the quality provided. Findings from the reviews will feed the provider of care and our Quality Committee
- By 2025, there will be a series of learning events to educate us on what good looks like and to drive innovation. **The aim will be for CQC to rate our services as 'good' and 'outstanding' by 2028**.
- Establish a system-wide quality improvement approach by end of 2027.

Population focussed:

- By 2024, we will develop a suite of quality measures that will help us to identify those most at need of high-quality care, and to improve their ability to access these services.
- We will have a good understanding of our most vulnerable neighbourhoods.
- The Local Maternity and Neonatal Strategic Board will continue to strive to provide services that mothers and family's desire and to ensure services are safe by implementing the Single Maternity Plan due to be published March 2023.
- We will continue to embed and strengthen the delivery of Personalised Care throughout our healthcare services.
- We will continue to work towards our ambition of delivering care closer to home.

Coproduction with the people using the services:

- By 2025, we want to have established a culture where coproduction and listening to people is part of the way we do things. We will learn from our complaints and enhance skills through training and education to truly coproduce care.

- By end of 2023 we will have appointed our Patient Safety Partners

Clear and transparent decision making:

- We will work collectively together to create a culture of transparency and trust within the ICS.
- By 2027, our workforce will feel able to speak out about safety concerns without fear and we will measure progress via our NHS Staff Survey.

Timely and transparent information sharing:

- By end of 2023, we will have a robust framework for safeguarding assurance
- By 2024 we will have developed a clinical quality dashboard to review our performance
- By 2026, we will produce a collaborative system learning programme to support sharing, training, innovation and effectiveness.

Subsidiarity:

- By end of 2023, we will have embedded processes to support our GP practices, optometrists, community pharmacies and dental surgeries to improve their safety.

Ensuring Delivery

SRO: Frances Bolger
Clinical Lead: Frances Bolger

The National Quality Board outlined two key requirements for quality oversight in an ICS:

1. To ensure fundamental standards of quality are delivered thus managing patient safety risks and addressing inequalities and variations in care.
2. To continually improve the quality of services, in a way that makes a real difference to the people using them.

Our unitary board members have collective and corporate accountability for the performance of our organisation and will be responsible for ensuring its functions are discharged.

Providers of NHS services will continue to be individually accountable for:

- Quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and CQC registration requirements

- Delivery of any services or functions commissioned from or delegated to them, including by our NHS ICS body, under the terms of an agreed contract and/or scheme of delegation.
- Participation in system working with other statutory partners

As an ICS, we will collectively oversee and improve the safety and quality of services through the development of a system wide quality dashboard which captures health inequalities, multi- organisation membership on the ICB Quality Committee and strengthening our patient voice.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Set up task and finish groups to develop outcome metrics for dashboard and complete build of dashboard by June 2024 to strengthen system oversight and assurance for the delivery of safe care. Strengthen to citizen feedback of services to drive improvement and reduce variation of care across the ICS.	First half of 2024/25
To enhance the quality and safety of care by continued implementation of the Patient Safety Strategy and the Patient Safety Incident Framework by end of December 2023	Quarter four 2023/24
Establish a revised safeguarding structure across the ICB that provides safeguarding expertise at a strategic, Place and provider level. Develop a 2-year work programme, which will include provisions of the Domestic Abuse Act 2021 and other statutory guidance.	Quarter two 2023/24

Appendix 4 – Infrastructure

Within this section you will find long term plans relating to:

- Estates
- Capital Estates Planning
- Sustainability and Net Zero Climate Commitments

Estates

What is the current state of play/local challenges

Like many systems MSE faces challenges from aging Estate that has not received the necessary investment to maintain its condition or appropriate functionality, to keep up with the growing populations and the objective to deliver services closer to people's homes.

The Naylor review identified "NHS England has a small programme of capital grants to build or expand primary care premises, but this will be inadequate to facilitate the vision of the 5 Year Forward View (5YFV)". No changes have been made to address this issue as capital investment for the system is constrained by both the national limits and direct award to the foundation trust.

This converts the risk for Primary Care into an issue that it cannot deliver against the existing demands, let alone the growing one. This will start building a risk in relation to maintenance and both building and patient safety.

What is the requirement from NHS

Recognition of investment best practice and benchmarking from other large complex estates, where expenditure is not prescriptive between capital and revenue. The Naylor report concluded that major investment is required to develop new models of primary care. Analysis and evaluation of the different estate models to deliver the new models of care is required, to best develop the case for new capital investment in the estate.

Commitment to the new Government Property Standard and the requirement to monitor and report on the performance across all aspects of the estate using the metrics specified for use across government.

Along with the adoption of the Government Property Data Standard to improve data quality, consistency, and interoperability throughout the public sector estate. Adoption of this common approach to collecting, referencing and reporting all property usages, including land and buildings will help drive Value for Money across the One Public Estate.

What is the ambition

Create new models of care delivers the Long Term Plan by leveraging best practice, data, and targeted investment to offer our residents a range of services in an easily accessible way, making the best use of one public estate and the opportunities to consolidate resources.

We would then be able to make better, outcome focussed decisions about how to optimise our infrastructure across the system. Enabling us to deliver estate

improvements within the financial challenges we face as we recognise the impact of the built environment to improve the wellbeing and health outcomes of staff and residents and address health inequalities within our system.

What are the delivery priorities

Embracing the opportunity to work together to identify and acquire appropriate sources data, to build a collective understanding of our Estate, its condition and use to help inform decision making on how to optimise the estate through a coherent System Infrastructure Strategy.

Our Alliances are fundamental in bringing all voices together around the local needs and requirements to ensure our physical estates supports us to deliver the services when and where we need them to be.

We must prioritise appropriate planning across all areas of estate to ensure we deliver value for money and efficient use of resources.

Governance

SRO: Jen Kearton

How will we ensure delivery

The Systems property and digital function's governance and strategy will promote appropriate, proportionate, and consistent ways of managing and investing in its infrastructure.

The governance and management framework will be documented, showing system overview, structures, decision making processes, terms of reference job roles, and defines remits and authority limits for decision-making. It will include systems for agile responses or adjustments to change, incorporating improvement opportunities.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Data and Management Information	Quarter one 2023/24
Stocktake of all current Estate across the System	Quarter one 2023/24
Evaluation of strategic themes and priorities	Quarter two 2023/24
Building Capability and Capacity	Quarter two 2023/24
Design a Target Operating Model	Quarter two 2023/24
Recruit, train and retain a high performing team	From quarter two to quarter three 2023/24
Estate and Capital Planning and Decision Making	From quarter one to 2025/28

Capital Estates

What have we heard from residents/patients

We take on board patient feedback as part of the request process for projects. For material programmes there is a project and steering group structure which includes patient and carer stakeholders.

What is the current state of play/local challenges

The ICB is in the second year of an agreed three-year capital funding envelope.

The ICB has an agreed allocation of £2m for 2023/24.

The two provider Trusts have an agreed envelope of £59.8m. In addition, the system has access to further discretionary capital subject to the delivery of the agreed financial position for 2022/23. This totals £4.5m and has been allocated £2.1m to MSEFT and £1m to EPUT for safety schemes. The residual sum of £1.4m is being held by EPUT and will be managed via the MSE System Investment Group, for system priorities.

The ICB continues to identify further external funding in respect of the development of:

- Electronic Patient Record (£21m across both Trusts)
- Community Diagnostic Centres at MSEFT (£21.7) and Development of a 23-hour surgical hub at MSEFT (£9.9m).
- Funding for IFRS16 leases by both Trusts (£10.6m).

What is the requirement from NHS

MSE is committed to working together, to make best use of the resources we have available.

Although the ICB has submitted a capital expenditure plan in line with funding, the system as a whole remains overcommitted in excess of £135m. Where possible, the system is seeking additional funding through allocations, and individual organisations are looking at potential estate disposals with a view to increasing the level of capital investment to be made.

What is the ambition

We want high quality, facilities and equipment to deliver digitally enabled services in and efficient and effect way.

We hope to plan and prioritise all developments for the system to enable us to deliver a pipeline of improvements within the financial challenges we face as we recognise the ability of long-term investments to drive wellbeing of staff and residents as well as efficiencies for our population.

What are delivery priorities

The plan includes spend of £36.2m on the procurement and development of a joint Electronic Patient Record of which £27m is DHSC funded. The Business Case is going through Department of Health & Social Care (DHSC) governance.

Backlog maintenance, ward refurbishments and equipment replacement make up the majority of the rest of the programme.

Organisations are holding minimal levels of contingency (£2.8m combined) to address any in-year risks or bids.

EPUT is holding a further £1.4m of discretionary capital for the system which remains unallocated and is subject to an in-year prioritisation and bidding process.

The allocation is a significant constraint to enabling us to deliver the breadth of improvements required to improve quality as well as capacity and access.

Governance

SRO: Trevor Smith, EPUT

How will we ensure delivery

The system has operated a System Investment Group, chaired by EPUT since October 2021. This forum has been used to discuss and recommend major investment cases to the Senior Financial Leaders Group, and more recently the Finance Investment Committee, since the creation of the ICB.

The System Investment Group has also been the forum at which capital allocations and plans are reviewed and agreed.

In addition, the capital teams work closely together on a less formal basis, and meet weekly for the last two months of the year to ensure the maximum deployment of the system capital allocation and manage within the ICB envelope. The ICB delivered the capital plan with a small overspend of £43k in 2022/23.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Capital Planning	Quarter one 2023/24
National review of the Electronic Patient Record business case	From quarter one to quarter three 2023/24
Development of EPUT, MSE and ICB Estates Strategies	From quarter one to quarter three 2023/24
NHS Infrastructure Strategy	From quarter two to quarter three 2023/24

Sustainability

What have we heard from residents/patients

This is an area that has lots of public support and will require their co-operation as we change the way services are delivered – for example through the virtual wards, reduced car travel, changing inhaler type etc.

What is the current state of play/local challenges

MSE has its Green Plan in place, which has a clear set of actions to deliver on the 9 areas of focus included in the Greener NHS Programme. The challenge is in managing competing expectations to enable sustainability to be taken seriously and prioritised amongst a multitude of other priorities.

What is the requirement from NHS

The Greener NHS Programme has committed the NHS to being the first health service, in the world, to be net carbon zero. This is by 2040 for scopes 1 and 2, and 2045, for scope 3.

What is the ambition

To embed sustainable thinking into all the different work programmes that MSE has. The ambition is to ensure existing work is effectively captured to prevent duplication and ensure we embed sustainable practices and processes in all we do.

What are delivery priorities

The MSE Green Plan has a set of priorities to deliver on the 9 areas of focus as set out by the Greener NHS Programme. These are designed to align with existing work programmes, to prevent duplication, but also to provide a clear link to the sustainability work so we can report on progress through the sustainability governance channels.

The main focus for 2023-24, to ensure we align with the regional focus, will be on:

1. Reducing the reliance on fossil fuels and minimising energy consumption
2. Avoiding single-use items
3. Recycling items instead of disposing of them
4. Increasing the social value delivered by the Trust

This process will enable MSE to reposition its delivery aims to they are in line with regional priorities, enabling more flex in priorities. As a part of this reshaping work, MSE is also aligning the Trust and ICS Green Plans to allow a more consistent and symbiotic approach.

Governance

SRO: Jonathan Dunk
Clinical Lead: Ronan Fenton/Paula Wilkinson

How will we ensure delivery

The ICS has a Sustainability Board that is chaired by the Executive SRO lead. This Board feeds into wider ICB and Provider Boards.

There is an exec lead in place for the majority of the areas of focus, and quarterly meetings take place with them and the Head of Sustainability to measure progress. For areas of focus that are linked to numerous elements – such as Adaptation and Sustainable Models of Care, MSE is developing sophisticated measurement tools and KPI's These conversations are taking place with the Exec Lead, as a part of the wider governance development processes.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Governance processes redefined and embedded	From quarter one to quarter two 2023/24
Carbon footprint of the Trust baselined and clear actions for reducing	Quarter two 2023/24
Air pollution pilot completed and Trust has clear actions for reducing air pollution in the supply chain at Southend	From quarter four 2023/24 to first half of 2024/25
Project to highlight the importance of reusing materials, and reducing energy to take place	From quarter three to quarter four 2023/24
Focused approach to increasing the social value delivered by the Trust	From quarter four 2023/24 to first half of 2024/25
Energy project with NHSE to have identified alternative energy options for the Trust	From quarter three to quarter four 2023/24
Alignment of priorities to existing work programmes – i.e., digital, workforce etc.	From quarter one 2023/24 to first half of 2024/25
Funding opportunities identified to bring in organisations such as Jump, to raise awareness	From quarter two to quarter four 2023/24

Appendix 5 - Finance

Within this section you will find long term plans relating to:

- Finance
- Procurement and Supply Chain
- Specialist Commissioning

Finance

What is the current state of play/local challenges

Our system has faced increased and sustained operational challenges which have frustrated our ability to address our underlying deficit position. We have a good collective understanding of our cost drivers, and we are focusing our efforts to specifically address areas where we know we need to do something differently so we can continue to support everyone we need to.

What is the requirement from NHS

NHS organisations are required to operate within the resources they available to them. As a system of NHS organisations, they have a duty to corporate together to deliver breakeven and as part of the wider health and care system we are committed to delivering sustainable services for our population.

What is the ambition

As a system we have the ambition to develop systems and resources to support people to take proactive control of their health. Our aim is to ensure we make evidence-based investments to ensure stable sustainable services and support prevention of ill-health. We must ensure we only invest where there is no resource improvement potential, ensuring we prioritise value for money and maximise our system pound.

We must bring our system back to balance through productivity and cash releasing efficiencies savings in the fastest most sustainable, following our clinical leads to deliver change.

What are the delivery priorities

We continue to pursue our core principles. Working collectively as a system we intend to drive up our reporting, costing and intelligence sharing so we can empower our clinicians and stewards to drive evidence-based resource allocation.

We are working together to support the efficiency programme, benchmarking, and monitoring to ensure we understand where we are making a difference. We must continue to reduce waste and duplication wherever it manifests to ensure we deliver the best for our residents.

Governance

SRO: Jen Kearton

How will we ensure delivery

We have an established System Finance Leadership Group and System Investment Group which is supported by deputies across all our organisations in health and social care.

Our Finance leads are embedded into our programme groups to ensure we bring together our governance streams.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Annual Planning 23/24	Quarter one 2023/24
Medium Term Financial Planning/Recovery and Efficiency and Capital	From quarter one to quarter two 2023/24
Continued development of costing and service line approach to resource management	From quarter two to quarter four 2023/24

Procurement

What have we heard from residents/patients

We have heard from our residents and patients, that they want high quality care that is safe and effective. We know that our patients want care that is delivered and enabled close to home. Procurement plays a key part in enabling clinical services to deliver care to our patients safely and effectively, ensuring that we purchase high quality products and services affordably, and deliver the best value for every pound spent from the public purse.

What is the current state of play/local challenges

MSE Procurement teams have been collaborating for over 2 years, with the introduction NHSE's 34 step plan which is supporting the alignment of how we manage and govern procurement services across the MSE ICS.

There are a number of joint procurements now in place across the ICS. There are challenges across teams with different systems, making data comparison sometimes challenging.

MSE are working collaboratively on the current supply chain issues to ensure resilience on product shortages.

What is the requirement from NHS

MSE is committed to working together, utilising the NHSE 34 step plan, to make best use of the resources we have available. We must make efficient use of budgets to procure high quality products and services whilst delivering cost efficiency programmes.

What is the ambition

A unified procurement service across the ICS, that enables standardisation of products, whilst delivering economies of scale. We know that helping clinicians to standardise products, leads to reductions in variations of care, and better outcomes for our patients.

MSE will be working collaboratively with our suppliers to ensure that there is social value contribution including net zero in all tenders and contracts for our system.

MSE will also look at how it can better manage inventory to reduce waste and increase Just In Time (JIT) procurement opportunities.

What are delivery priorities

MSE procurement teams will continue to build relationships and collaboration across procurement teams in the MSE. Sharing of current practice, processes and data, to look for areas of opportunity for alignment.

Review of existing resources across the MSE to look at how we best utilise our expertise to deliver savings, but also at how we retain and develop our staff.

The review of how we currently work will form the baseline of service understanding that then will support us to design and develop our ICS strategy for procurement, and to build a unified procurement function across MSE.

Governance

SRO: Jonathan Dunk
Clinical Lead: TBC

How will we ensure delivery

This forms part of the MSE Corporate Services reconfiguration group, which is overseeing opportunities for the alignment across Organisations. Progress on the design of the future unified MSE procurement service will be reported and governed through this group.

The workstream ICS procurement group is already established, and ongoing progress is monitored through the NHSE 34 steps plan.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Development of the ICS strategy for procurement	From quarter two to quarter three 2023/24
Review of existing resources across MSE	From quarter one to quarter two 2023/24
Review of current systems and data across MSE	From quarter one to quarter two 2023/24
Shared training and development plan across	Quarter two 2023/24
Ongoing opportunities for collaboration across contracts	From quarter one to quarter two 2023/24
Development of an aligned process for managing social value and net zero commitments	From quarter two to quarter three 2023/24
Design and implementation of a unified procurement service across ICS	From quarter three 2023/24 to first half of 2024/25

Specialist Commissioning Services

Current Issues

Full delegation of specialised services will occur in April 2024. Therefore, 2023/24, will be preparatory 'shadow' year, where NHSE will set up a statutory Joint Commissioning Committee for Specialised Services, which will require ICB leadership, engagement and representation in the Committee. Through 2023/24, the statutory Joint Commissioning Committee will manage the full portfolio of specialised services.

The 'shadow' year will enable ICBs and NHSE regional office to test the arrangements for full delegation in April 2024. This includes the proposed hosting arrangements for the Specialised Commissioning team in Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board.

What is the requirement from the NHS?

From April 2023, Integrated Care Boards (ICBs) entering Joint Working Agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services and for any associated Joint Functions.

Our ambition

NHS England and ICBs will form a statutory Joint Committees that collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transition mechanism for ICBs that require additional support before they are ready to take on full delegated commissioning responsibility

What are the delivery priorities

The 23/24 priorities for ICBs are to:

1. Establish the Joint Committee and associated delegation framework and agreement.
2. Implement a joint work programme reflecting the clinical and service priorities for 23/24 and beyond and building on the prioritisation process established in autumn '22.
3. Commence transformation of three priority pathways, these being specialist cancer services, neonatal services and specialist mental health services.
4. Develop the governance, capacity and capability associated with full delegation using the Pre-Delegation Assessment Framework (PDAF) and

safe delegation checklist to create and embed the local management arrangements required to deliver effective commissioning.

The deliverable and success criteria will be the transfer of full delegated responsibilities on 1st April 2024.

Ensuring Delivery

SRO: Tiffany Hemming
Clinical: Not applicable until after Delegation

Delivery of the joint work programme will be overseen by the Joint Commissioning Committee for Specialised Services, with regular updates submitted to the Board of the ICB.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implementation of Medical Thrombectomy	First half of 2024/25
Cardiac Transformation	Quarter four 2023/24
Knee Revisions Project Phase 2	Quarter three 2023/24
Mount Vernon Cancer Centre Review	Quarter three 2023/24
Set up working group to devise interim planning and prioritisation process for 2024/25 and beyond.	Quarter two 2023/24
CYP Professional Support Gender Identity Development Services (GIDS)	Quarter four 2023/24
Full delegation of specialist commissioning responsibilities to ICBs	First half of 2024/25
East of England (EoE) Region Mental Health Provider Collaborative, Phase 2 Devolving of Services	2025/28

Appendix 6 – Digital, Data and Technology

Within this section you will find long term plans relating to:

- Patient Knows Best
- Shared Care Records
- Data Quality
- Electronic Patient Record
- Strategic Data Platform
- Digitising Social Care Records

Patient Knows Best (PKB)

What have heard from our residents

“The ability to see my appointments and information online has saved me missed appointments due to letters not turning up in the post. If I wanted to, I can share my records with family to support my care needs.”

Current Conditions

The Digital Patient Interface is a collaborative approach being implemented with support from the ICB into two trusts to enable more effective use of resources.

The NHS App, delivered by NHS Digital, is a simple and secure way to access a range of NHS services on a smartphone or tablet and is available to all patients aged 13 and over who are registered with a GP practice in England. This first of its kind national integration allows patients with a PKB personal health record to directly access their combined dataset from PKB within the NHS App interface.

PKB is contracted for more than 12 million people to use the service across the UK. The PKB platform includes health information generated from GPs as well as hospitals, community and mental health services and the patient’s own contributed data, for example from monitoring devices or questionnaires.

What is the requirement from the NHS?

The NHS Long Term Plan sets out the vision of empowering people through their ability to access, manage and contribute to their health and care record through digital tools. It calls out the need to create straightforward digital access to NHS services, for both patients/residents and carers. It sets out a new service model for the 21st century with out of hospital care boosted, dissolution of the historic barrier between primary and secondary care, people empowered with more control over their health and mainstreaming digitally enabled primary and out-patient care.

NHS LTP: In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App.

By March 2024 Acute Hospitals will have Patient Engagement Portal supporting outpatient management.

Our Ambitions

Our ambition is to put patients in charge of their health and care records enabling them to manage their own information digitally.

Delivery Priorities

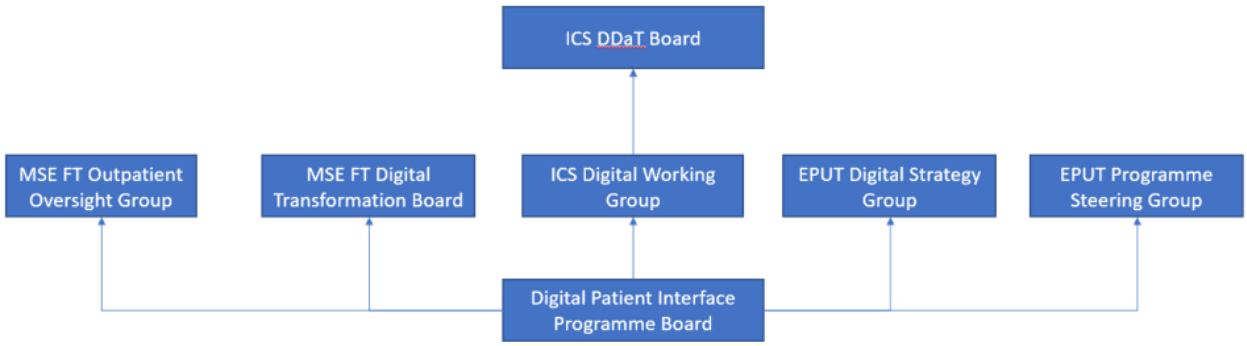
- Reduction in administrative burden: using pre-assessment questionnaires saving care team time
- Reduction in (Did not Attend) DNAs and slot utilisation: greater visibility of appointment information and easier access to information on changing appointments will reduce DNAs
- Deliver cost savings through Digital rather than paper communication: reduction in the number of letters sent via post as patients with access to the portal can opt out of paper communication. Information previously shared as paper leaflets can also be shared via the portal.
- Improve patient experience: patients are empowered with control over their own health record
- Supports improved outcomes: patients can track and monitor their own health and be supported via digital guidance.

Ensuring Delivery

SRO: Barry Frostick
Clinical Lead: Sam Neville CNIO

Project resources have been provided across the partner organisations and governance is delivered by way of an ICS programme board. The Digital Patient Interface Programme Board is a decision-making board made up of each of the partners involved in the delivery of the digital patient interface.

Below delivery governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implementation commences	Quarter one 2023/24
Implementation complete with MSEFT and EPUT	Quarter four 2023/24

Shared Care Record (SCR)

What have we heard from our residents?

Our residents and clinical workforce are dealing with fragmented care records resulting in decisions and actions being taken without always the full knowledge of the care record to hand.

“I am going through all sorts of tests again because the trust can’t access my records, which I am really mad about. I wish it was all one system and I wouldn’t have to go through all of this all over again.” (Female Patient)

Current Conditions

In 2019 a short-term tactical information sharing solution (Cerner Health Information Exchange (HIE)) was put in place with the contract due to end in July 2024.

This solution was part of much wider regional programme under ‘My Care Record’ banner. HIE was selected as an approach to create sharing capabilities for some of our partners across the ICS. Whilst this has provided some immediate benefits on viewing data it is recognized that the current solution does not support the ambition set out in the NHS Long Term Plan and therefore does not meet the full ICS Digital Strategy priorities.

There will be a significant transformation programme required to maximise the opportunities a shared care record will bring.

The programme is in an advanced procurement state – aiming to award contracts Q1 23/24 and start planning and implementation immediately following.

What is the requirement from the NHS?

NHS LTP: By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and Local Health and Care Records (LHCRs) will cover the whole country.

Our Ambitions

To procure and implement a System - wide Shared Care Record (SCR) which meets the diverse needs of end users and therefore can make a difference to improving resident and patient care across different care settings within MSE.

The SCR ambition has been set against the following success factors:

- A shared care record which takes information from each of the in-scope service providers
- Interoperability across systems, such that each team works primarily from host/local single front-end, whilst still accessing the shared care record
- As near to real-time data to support crisis management and multiple same-day interactions in the integrated care team for patients
- Move towards bi-directional integration to ensure that accurate, timely and appropriate information is captured in each service providers system (avoiding additional double-keying)
- Reporting and analytics capability aligning to data platform strategy to support benefits tracking, identifying service usage patterns, prioritisation of spend and commissioning planning
- Reporting and analytics capability aligning to data platform strategy to support benefits tracking, identifying service usage patterns, prioritisation of spend and commissioning planning

Delivery priorities

The SCR Programme has been keen to ensure that there is strong representation from various professional groups (clinical, operational, technical, procurement and finance) across all System partner organisations. The Programme has striven to promote the ethos of co-production throughout the procurement process to ensure that there is maximum buy-in from organisations in the implementation phase.

We will work with our partners to create the technical supporting infrastructure and functions to support new integrated ways of working.

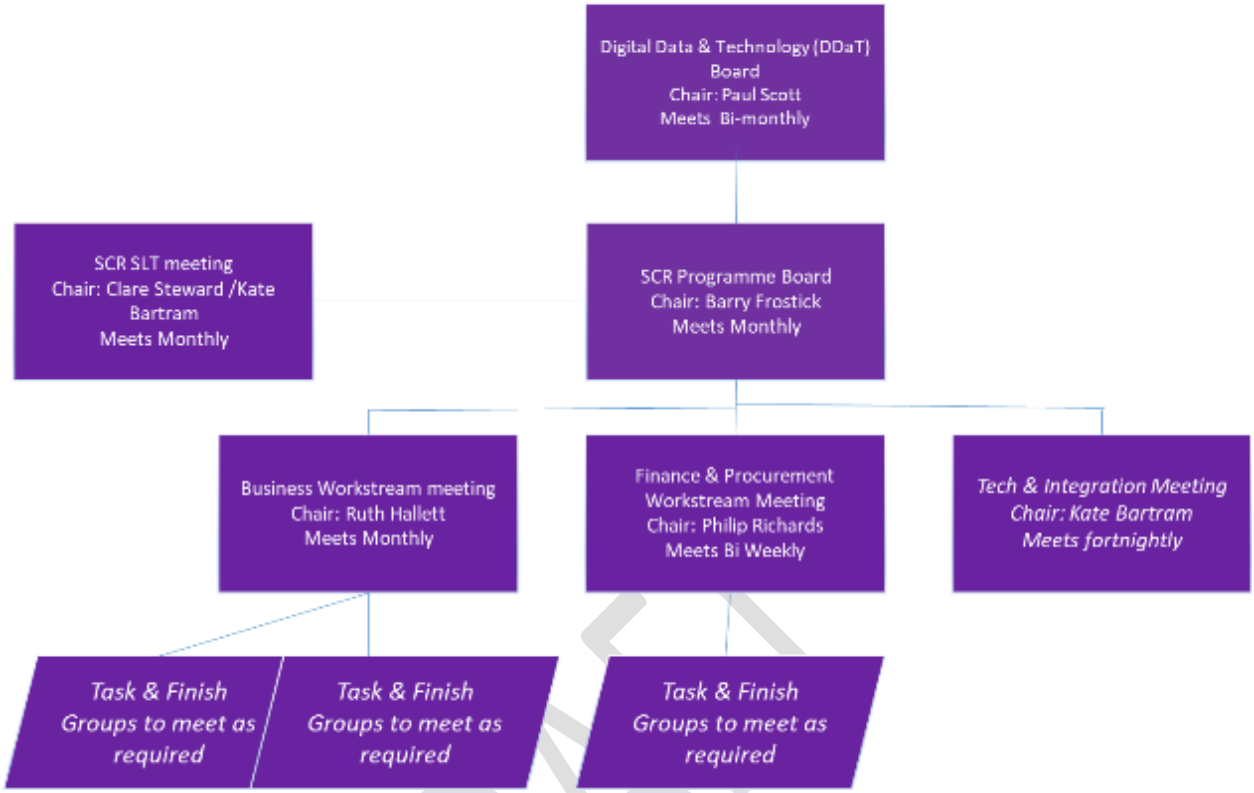
Through our Business workstream we will work with front line teams to maximise the benefits and positive impact of having integrated patient records and workflow across our system.

We will partner with ICS's who are already implementing Shared Care Records to learn and accelerate our delivery.

Ensuring Delivery

ICS SRO	Barry Frostick
ICS Programme Director	Clare Steward
CCIO	Taz Syed

Below diagram of governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Contract Award to Preferred supplier to provide Shared Care Record	Quarter one 2023/24
Implementation (Phasing to be confirmed as part of contract signature)	Second half of 2024/25

Digital – Data Quality

Current Condition

Recurrent issues with data quality mean that, as a system, we struggle to make operational and strategic decisions using a data-driven approach.

We need to adopt the MSEFT data quality framework and vision, which is in line with our organisational strategy and the wider Integrated Care System digital strategy. This outlines the importance of:

- Capturing and maintaining patient information accurately to support excellent clinical care.
- Ensuring accurate corporate data to provide more efficient processing of staffing, finance and corporate information.
- Greater integration between systems and providers.
- Fostering an organisational culture that is committed to high quality data
- A need to increase operational ownership for resolution of DQ (Data Quality) issues because of poor data entry by operational users.

What is the requirement from the NHS?

A need to provide accurate and reliable performance and management information for services.

Better alignment and coaching from NHS England on the use of the Data Quality Maturity Index (DQMI)

Our ambitions

- To embed high quality data into the everyday working of staff throughout the organisation, ensuring it is a central theme of a wider business management approach reinforcing right data, first time, every time.
- To have a published DQMI that is delivered to the ICS board
- To create a consistent approach in managing data quality concerns which are raised with clear operational ownership for resolution.

Deliver Priorities

- Recruitment of a Data Quality (DQ) Lead to deliver on the DQ Framework
- Assessment of the current state of DQ across ICS
- Rollout of the DQ Framework across the ICS.
- Resolution of highlighted data quality issues including RTT and Discharge (NCTR)

- Integration of DQ into operational governance for assurance and agreement on resolution paths.

Ensuring Delivery

- All developments are run through a business intelligence governance board and where appropriate we request clinical and business leads to own future data quality, by each relevant system.
- Data quality items will feed through existing operational meetings and report to the System Oversight and Assurance Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Recruitment of a Data Quality Lead	Quarter two 2023/24
Assessment of the current state of Data Quality across ICS	Quarter three 2023/24
Rollout of the Data Quality Framework	Quarter four 2023/24

Electronic Patient Record (EPR)

What have our residents told us?

There are many areas across the MSE ICS where our residents have overlapping needs across acute, mental health and community care – yet our systems are not setup to manage this effectively as evidenced by:

Our EPR approach offers a solution to this by:

- Building an integrated health care solution infrastructure for the first time in the UK.
- Providing clear data across shared pathways allowing a view of the whole person when providing care – regardless of their point of access to the system and regardless of their needs.

Current Conditions

Our system currently relies on an “unintegrated” digital health infrastructure with over 10 siloed clinical systems.

Lack of EPR integration prevents staff from having an overall picture of the patient’s clinical journey and consistent access to viewing patient records and notes. This leads to gaps in the patient’s clinical pathway and poses risks.

MSEFT have 3 EPR’s and EPUT have 7 EPR’s. In MSEFT they have multiple patient indexes in use meaning a patient could have three records if they are seen at more than one hospital site. Resolving this level of fragmentation and complexity will underpin a number of resolutions for Data Quality issues, unwarranted variation of clinical care and a reduction of integration requirements.

There is no system in the UK market that currently delivers the functionality required across all care settings. MSEFT and EPUT would be 'first movers' in this space. The collaboration is strengthened by a clear vision and history of delivering complex programmes together. EPUT and MSEFT are actively collaborating on various programmes of work to integrate digital and data systems, e.g., the Shared Data Platform.

What is the requirement from the NHS?

All ICS’ and their NHS Trusts are aiming to have core digital capabilities, including electronic health records, in place by March 2025.

All providers, across acute, community and mental

health settings, will be expected to advance to a core level of digitisation by 2024.

Our Ambitions

The objective of this programme is to procure and implement a new unified ICS enterprise-wide electronic patient record (EPR) system for mental health, community, acute services with an integrated electronic prescribing and medicines administration (ePMA) functionality.

The scope is for functionality provided by an EPR system to support the clinical and administrative processes, improve the safety and delivery of patient care, patient experience and outcomes.

It supports the NHSE national ambitions by entering a EPUT and MSEFT into a partnership to procure a unified EPR solution. Investment in a unified EPR solution also supports the strategic, digital, and system visions and priorities for both Trusts and enables the Trust and ICS Digital Strategies to work as an integrated system.

Delivery Priorities

Delivery of NHSE priorities including ‘a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS’, recognising that ‘digital services and data interoperability give us [the NHS] the opportunity to free up time and resources to focus on clinical care and staying healthy.’ It sets the expectation that ‘all providers, across acute, community and mental health settings, will be expected to advance to a core level of digitisation by 2024.’

NHSE aims to support healthcare providers by accelerating the rollout of EPR systems, aiming for 90% of NHS trusts to have an electronic patient record (EPR) in place by December 2023.

The Trusts do not currently have a single electronic patient record. There is a clear mandate from NHSE to improve their current level of digitisation to a core level.

We are working in partnership with our providers to deliver this ambitious and challenging programme.

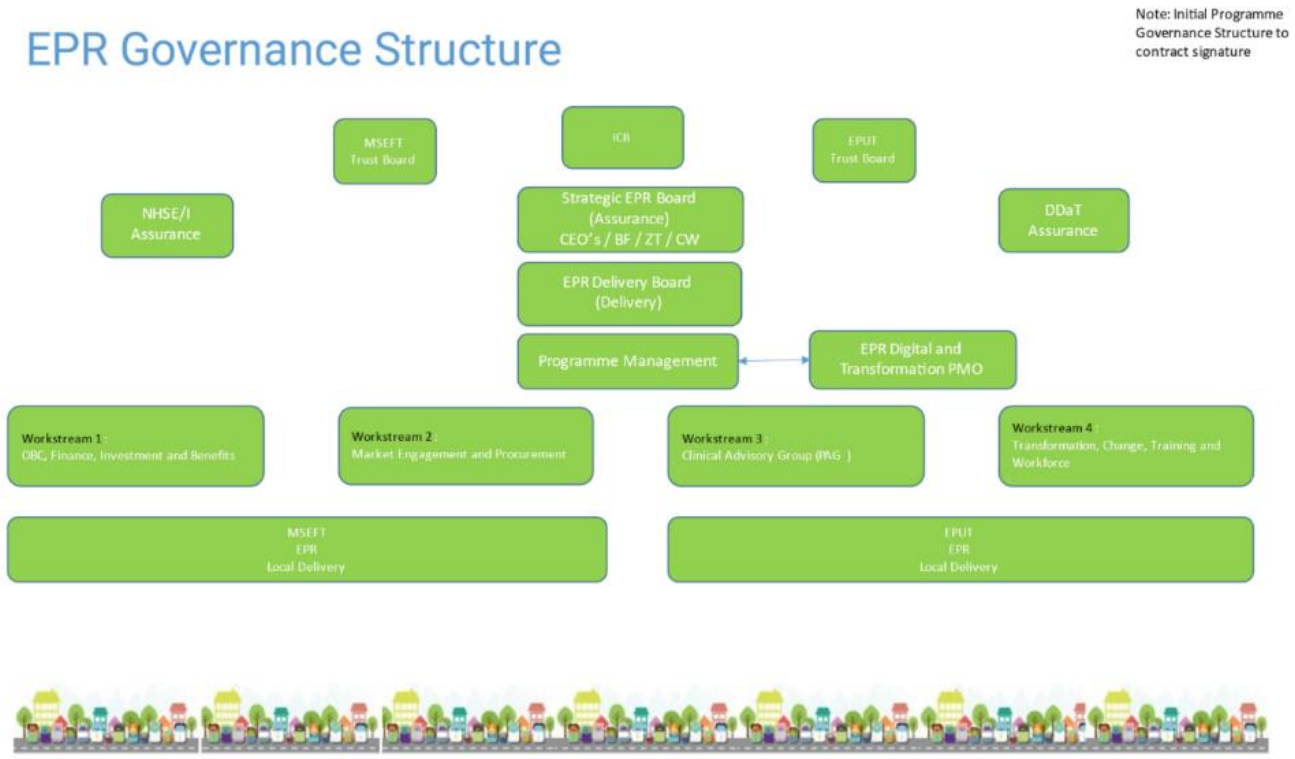
Ensuring Delivery

ICS SRO (name)	Anthony McKeever/Barry Frostick
ICS Programme Director	Clare Steward
EPUT Lead SRO	Paul Scott/Zephan Trent
MSEFT Lead SRO	Hannah Coffey/Charlotte Williams
EPUT Delivery Lead	Adam Whiting
MSEFT Delivery Lead	Gemma Lawrence

There is an existing Digital, Data and Technology Board in place.

There are Trust level programme teams in place at both EPUT and MSEFT and workstreams are aligned and established.

The organogram below shows the feed of work streams into the Programme Board, Delivery Board and ultimately the Strategic Board. The Strategic Board membership includes MSE and EPUT CEO's, Senior Responsible Officers (SRO's) and the ICS Chief Digital Information Officer (CDIO), providing the appropriate governance, oversight and empowerment to action recommendations and resolve escalations.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Outline Business Case Approved	Quarter one 2023/24
ITT and Specification published	Quarter two 2023/24
Intent to award published	Quarter three 2023/24
Full Business Case Approved	Quarter four 2023/24
Contract Signature	Quarter four 2023/24
Deployment TBC – subject to supplier choice and full business case approval	To be confirmed

Digital – Strategic Data Platform

What have we heard from our residents

Whilst impactful to residents this is not a resident facing product/programme of work

Current Conditions

In April 2021, MSE ICS approved our Business Intelligence Strategy. This set out a number of recommendations around people, processes, information, and technology, to deliver on the key messages of improving the lives of our residents. Central to this was the creation of a Strategic Data Platform (now known as Athena) where data can be manipulated and collated to provide a single source of truth.

This will enable better planning at an ICS level, to provide evidence-based decision making and the ability to focus on improving services and the health and wellbeing needs for the 1.2m population in MSE.

What is the requirement from the NHS?

National guidance outlines that ICS' must "develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including:

- actionable insight for frontline teams.
- near-real time actionable intelligence and robust data (financial, performance, quality, outcomes).
- system-wide workforce, finance, quality and performance planning; and
- the capacity and skills needed for population health management.

Our Ambitions

The implementation of a strategic data platform is one of the main foundations to:

- unlock the full potential of our vast data sets
- improve operational planning and more effectively target our finite resources
- empower our Stewardship programme
- improve the health of our residents through the proactive targeting of services
- provide a single source of data for our system partners

Delivery priorities

- To give all MSE partners access to platforms a single view of data.
- Integration of data into population health systems
- Creation of virtual analytics team

- Data alignment
- Future data resilience

Ensuring Delivery

SRO: Steve Gallagher

All developments are run through a business intelligence governance board and where appropriate we request clinical leads to own future dashboards

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Data sharing and sub license agreements that will enable all ICS partners access to the data	Quarter two 2023/24
Create a more enriched view of our residents including non-health data, such as housing, education etc	Quarter two 2023/24
Single Data Services for Commissioners Regional Office (DSCRO) feed ideally via AGEM for all Essex residents, including neighbouring ICBs (SNEE and Herts and West Essex) data too	Quarter two 2023/24
To build a virtual advanced analytics team in conjunction with AGEM and ECC, to support future requirements around predictive analytics and demand and capacity	Quarter three 2023/24
Create a single view of the data architecture across MSE, to enable a better understanding of how data flows across the organisation, to identify bottlenecks, data quality issues, migration concerns	Quarter three 2023/24
Create a data quality framework, that includes an assessment, programme, education and metrics, to improve the quality of data across the ICS and keep at a more consistently high level	Quarter three 2023/24
To migrate all necessary GEMIMA reports to the Athena platform	Quarter one 2023/24
Ensure all GPs have signed data sharing agreements (DSAs) allowing access to patient held data	Quarter one 2023/24
To move towards the creation of a single virtual (or physical) data and analytics team for the ICS, teaming or sharing resources, technologies, methods of delivery etc.	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Alignment with the Federated Data Platform and Secure Data Environment strategies with NHS England	First half of 2024/25
Implementation of a consistent methodology for the development, testing and release of future dashboards, including upskilling the workforce, as and where appropriate	Quarter two 2023/24
The inclusion of additional data flows to Athena, including non-health data, workforce etc	Quarter two 2023/24
Development of the ICS SDP Business Case to secure funding and ensure the platform can be sustained in the next 3-5 years	Quarter one 2023/24

Digital – Digitising Social Care Record (DSCR)

What have our residents told us?

NHSE is running a programme to help CQC registered care providers to adopt a digital social care record (DSCR) system. They will fund 50% of providers first year implementation costs. In MSE, providers can claim up to a maximum of £10,000.

Over 87% of care providers who do not have a DSCR system have said they would be interested in acquiring a system to enable them to spend less time on paperwork and more time delivering care, leading to better and quicker care plan creation and an overall increase in the quality of care they deliver.

Current Conditions

At the current time the care market is challenged by way of capacity to respond and draw down resources even when they may be of benefit. Our priority is to look at how the ICS invests further in resource to support the engagement of the care market as part of a match funding arrangement over the remaining two years of the national programme.

Working in partnership the MSE ICS DSCR team resource have run a baselining exercise with neighbouring ICSs to establish how prevalent the use of DSCR systems are across our market. So far, this has indicated 37% of the market use a DSCR system, which is significantly below what CQC have stated, however, we have had difficulty in engaging with the market to the extent we have hoped (18% of MSE based providers (111/619) have responded to our baselining survey to date) and we are working to increase the response rate.

Locally across the MSE ICS three local authority footprints, there is an issue with the systems available to our care providers. The systems eligible for funding must come from the NHS assured supplier list. For example, in Essex, the Access Group have a high share of the market, but they are not on this list. This has led to some providers not wanting to pursue funding.

What is the requirement from the NHS?

NHSEI have set a target of 60% of care providers to have a DSCR system by 31st March 2023, and 80% by 31st March 2024.

From April 2023, the project will also include funding for falls technology, and a wider scope for what providers can claim for in regard to digital social care records. For example, they will be able to apply for funding for rostering systems.

Our Ambitions

- Ensure that all CQC registered care providers have a digital social care record system.
- To create a locally led falls programme and reduce the risk of and occurrence of falls within our health and care system. The 10% of residents most at risk of falls will have sensor-based falls technology in place by the end of the programme.

Delivery Priorities

MSE to achieve 60% of the market having an “NHS assured supplier” DSCR system in place by 31st March 2023, and 80% having one by 31st March 2024.

Ensuring Delivery

ICS SRO	Barry Frostick
ICS Programme Director	Clare Steward

The DSCR programme reports to the MSE ICS Digital, Data and Technology Board. The work is being led by Essex County Council on behalf of Thurrock and Southend local authorities.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
60% CQC registered care providers to have a DSCR	Quarter one 2023/24
80% CQC registered care providers to have a DSCR	Quarter four 2023/24

Appendix 7 – Improving Operational Performance

Within this section you will find long term plans relating to:

- Maternity Services
- Elective Care (including Patient Choice)
- Cancer Services
- Primary Care
- Adult Mental Health Services
- BCYP Mental Health Services
- Neurodiversity Services
- Babies, Children and Young People Services
- Urgent & Emergency Care Services
- Respiratory Breathlessness Services
- Outpatients Services
- Diagnostic Services
- Stroke Services
- Cardiac Services
- Cardiovascular Services
- Palliative and End of Life Care Services
- Diabetes Services
- Dermatology Services
- Eye Care Services
- Pharmacy and Medicines Optimisation
- Musculoskeletal and Pain Services

Maternity

What have our residents told us?

Listening to women, people, and their families, is fundamental to improving maternity and neonatal services. The Maternity Improvement Programme brings together all associated activity needed to address regulatory, national, and local requirements led by defined workstreams. Its progress is supported by representatives from the LMNS and the Maternity and Neonatal Voices Partnership (MNVP – a service user representative group), demonstrating the collaborative nature of this approach. This ensures maternity and neonatal services are coproduced and developed in conjunction with those using them.

Current conditions

Currently, local maternity services in mid and south Essex, are challenged by significant midwifery vacancies. To overcome this, the LMNS, MSEFT and the ICS are working collaboratively to ensure all avenues for both recruitment and retention are pursued, with both a short-term and long-term view.

Maternity services at MSEFT are currently rated as ‘’Requires Improvement’’ by the CQC, following their inspection in 2022. The maternity service at Basildon has a Section 31 CQC Warning Notice in place and associated legal undertakings which are monitored and supported by the LMNS, ICB and NHSE.

Another important area of focus for local maternity services is their maternity governance team, who following recent re-organisation, are working to embed their work. MSEFT is working closely with their NHSE Maternity Improvement Advisor (MIA) to review governance processes, ensuring they are effective and robust to underpin the safety of the service.

What is the requirement from the NHS?

The NHS Maternity and Neonatal Long-Term Plan commits to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025.

It also seeks to reduce pre-term births by 25%, with a reduction in the preterm birth rate from 8% to 6%. In conjunction with this over the next five years (2023-2028), maternity and neonatal services will focus on delivery of the Maternity Transformation Programme priorities and improving the quality of maternity and neonatal care to enable the movement of the CQC’s maternity services rating from ‘’Requires Improvement’’ to ‘’Good’’.

Our Ambitions

The MSE LMNS comprises a wide variety of individuals and organisations involved in maternity and neonatal services, including representatives for those who use them. It is committed to improving both the quality of care and the experience of those using maternity services, ensuring it reflects a safe, personalised, and equitable service, based around the needs of a woman or person, and her family. We are working to implement the vision set out in Better Births (2016) through delivery of the national Maternity Transformation Programme.

Alongside this, the LMNS will continue to have oversight of the Immediate and Essential Actions identified within the final Ockenden report as well as the recommendations from the independent investigation into East Kent's maternity services. These will continue to inform maternity services organisation and care delivery, which is key to the ongoing improvement and learning needed by our services.

Delivery Priorities

The key priorities for the LMNS and maternity services provided in Mid and South Essex include:

- Supporting the provision of midwifery continuity of carer, as the default model of care by ensuring the building blocks are in place for continued safe rollout.
- Ensuring the implementation of the five elements of the Saving Babies Lives care bundle v2, including any future iterations of it.
- Ensuring ongoing participation in the national Maternity and Neonatal Safety Improvement Programme.
- The establishment of Maternal Medicine Networks, so that women with significant medical problems have timely access to specialist advice and care at any stage of pregnancy.
- The LMNS will support the delivery of the Equity and Equality action plan, to reduce health inequalities in maternity and neonatal care.
- The development of smoke free pregnancy pathways, reflecting the NHS Long Term Plan.
- Implementation of Maternal Mental Health Services, initially for those who have experienced the loss of a baby, as part of a collaboration between perinatal mental health and maternity services.
- The development of local Perinatal Pelvic Health Services (PPHS) in conjunction with specialist midwives and physiotherapists.
- Ensuring all women are offered a personalised care and support plan (PCSP) underpinned by a risk assessment and in line with national guidance. These

will be developed in collaboration with Maternity and Neonatal Voices Partnerships (MNVPs).

MSE Long Term Plan stillbirth rate ambition

Rates and numbers of live and stillbirths	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
The number of stillbirths during a calendar year	60	51	49	46	44	42
The number of live births and stillbirths occurring during a calendar year	13,987	13,987	13,987	13,987	13,987	13,987
Ambition rate per 1,000 live births and stillbirths	4.3	3.6	3.5	3.3	3.1	2.9
Actual rate per 1,000 live births and stillbirths	4.3	3.12	3.24			

MSE Long Term Plan neonatal mortality rate ambition

Rates and numbers of neonatal mortality	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
The number of neonatal deaths during a calendar year	60	51	49	46	44	42
The number of live births occurring during a calendar year	13,927	13,927	13,927	13,927	13,927	13,927
Ambition rate per 1,000 live births and stillbirths	1.0	0.9	0.8	0.8	0.7	0.6
Actual rate per 1,000 live births and stillbirths	1.0	2019 1.27	2020 1.06			

Note: National data reported by calendar year with availability to 2020 currently. There is acknowledgement that the pandemic had an impact on rates of stillbirth and preterm birth (which may result in more neonatal deaths), which will have impacted figures for 2020/21 and possibly onwards, and this should be taken into consideration. This is likely to have impacted the anticipated reduction in stillbirths for example and could provide some explanation relating to why the rate has increased from 2019 to 2020.

Ensuring Delivery

SRO: Frances Bolger
Clinical Lead: Gemma Hickford

The LMNS has clear governance processes in place that ensures oversight is provided by the LMNS Steering Board, which is chaired by the Maternity SRO and Chief Nurse for the ICB. In line with NHSE guidance, the LMNS is responsible for full and ongoing oversight of quality, and this understanding of the quality of local maternity and neonatal services informs transformation.

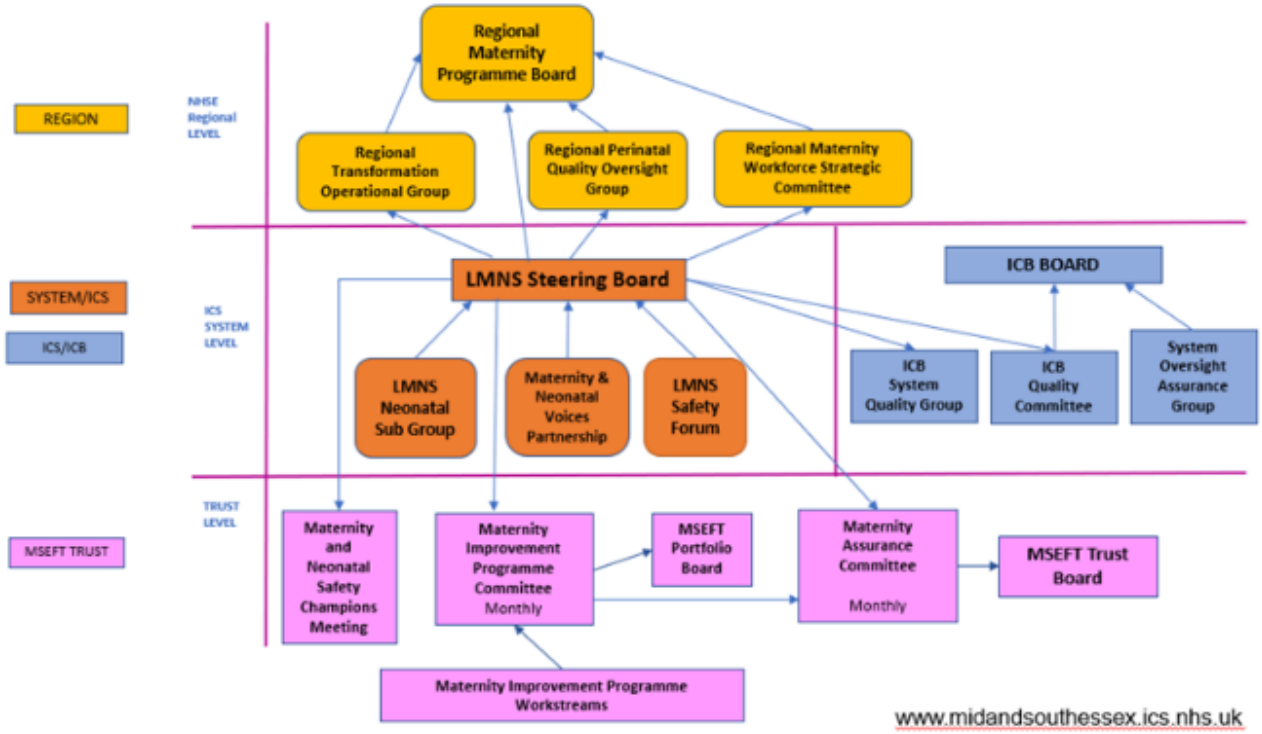
In conjunction with this, the revised Perinatal Quality Surveillance Model has been implemented, detailing the clear lines of responsibility and accountability held by the trust, LMNS/ICS, regional and national NHSE teams, in terms of addressing quality concerns at each level of the system.

Several of the priorities identified are operationally overseen by Trust based workstreams, organisational escalation at Trust level is then expected to be through the Maternity Improvement Programme Committee.

The LMNS Steering Board will also receive escalations and maintains system oversight of progress against priorities for transformation.

The below shows the System governance structure.

Mid & South Essex LMNS Organogram 2022/23



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Reduce rates of maternal, neonatal deaths stillbirths and brain injury by 50%	Second half of 2024/25
Increase proportion of smoke free pregnancies to 94% or greater	Quarter two 2023/24
Improve access to perinatal mental health care	Quarter three 2023/24
Provide improved access to specialist pelvic health services	Quarter three 2023/24
Ensure all women and pregnant people are offered a personalised care and support plan during pregnancy	Quarter three 2023/24
Reduce preterm birth rates by 25%, from 8% to 6%	Second half of 2024/25

Elective Care (Including Choice)

What have our residents told us?

Our residents want the ability to choose provider, they want to be able to receive care close to home and in a timely manner.

Current Conditions

The key challenge for elective recovery is the ability to provide continued service when capacity for delivery is impacted by wider non-elective pressures within the system. We continue to work with other System partners (Independent Sector and Community Providers) so we can maximise capacity to support, manage and treat people awaiting elective care. Sustaining focus on other key areas for example virtual clinic appointments and patient initiated follow ups will be the key to releasing capacity both now and for the future.

Enabling people to be well and as fit as possible whilst waiting for care is critical to ensuring we can deliver treatments / procedures as quickly as possible. Information and communication for people waiting has been developed – this is promoted via the MyPlannedCare website. This is a national platform for the public to access information about local services, including provider waiting times so that patients can exercise choice as per the national Choice Framework.

What is the requirement from the NHS?

Mid and South Essex System is required to respond to the national planning asks for elective operating priorities, which are supplemented with asks from national team throughout the year.

Our Ambition

As outlined in the Long Term Plan our focus for Elective care remains:

Bringing Care Closer to Home:

- Joining up our different health, care and voluntary services means we can bring services closer people's homes –whether that is through support on-line, or by bringing health and care services into the community such as some hospital outpatient appointments, tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

Improving and Transforming Our Services:

Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, to live as well as they can.

Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical

advances and new ways of working to treat people at an earlier stage, avoid more serious illness, and to live as well as they can for longer.

Delivery Priorities

- Having clear recovery trajectories and plans for the key asks as per the 2023/24 National Planning Guidance. Operating priorities will be subject to change as Planning Guidance is released and refreshed annually.
- There were additional elective recovery asks sent to each System within the National Tier 1 and Tier 2 letter. The MSEFT board completed its assessment against these – these are overseen via the Elective Board.
- The key RTT deliverable is to have zero patients waiting 65+ weeks from March 2024 onwards.

The below table shows the Mid and South Essex system planned RTT 65+ week backlog trajectory to a zero position from March 2024.

Date	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023
No.	4,383	3,985	3,585	3,187	2,791	2,391	1,994

Date	November 2023	December 2023	January 2024	February 2024	March 2024
No.	1,596	1,196	799	402	0

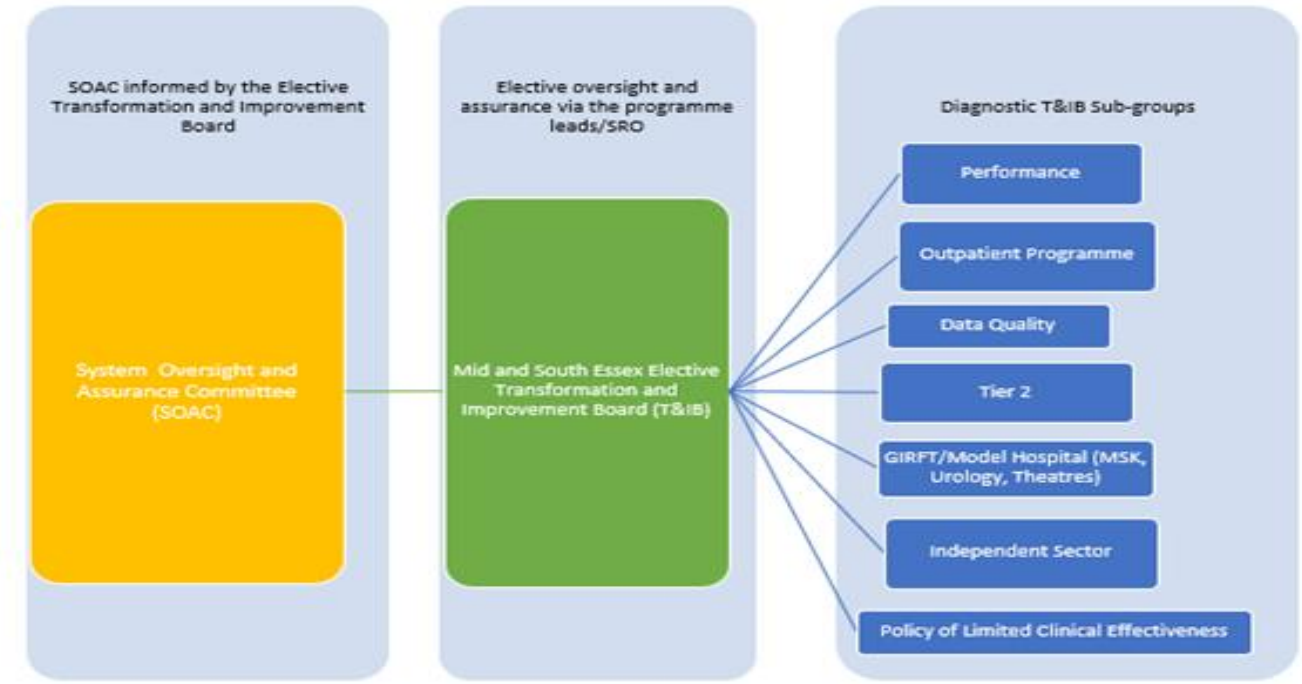
Ensuring Delivery

SRO: Andrew Pike
Clinical Lead: Ronan Fenton

The Mid and South Essex Transformation and Improvement Board for Elective Care oversees all aspects of elective (referral to treatment). The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex System Oversight and Assurance Committee (SOAC).

The below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
For detailed plans for 23/24 see operational planning submission	From quarter one to quarter four 2023/24
Achievement of zero patients waiting over 65 weeks for their procedure	Quarter four 2023/24
Continue to increase number of patients receiving virtual outpatient appointment	From quarter one to quarter four 2023/24
Continue to increase number of patients receiving their follow up appointment as patient initiated as opposed to a pre-booked appointment (empowering the patient)	From quarter one to quarter four 2023/24
Continue to reduce patients waiting over 52 weeks for their procedure	From quarter one 2023/24 to second half of 2025/28

Cancer Services

What have our residents told us?

Currently our patients are waiting too long to find out if they have a cancer diagnosis, or for their treatment.

Cancer Stewards to continue to lead the Cancer transformation programme across MSE including involvement in best practice pathway review and sustainability, allocation of Cancer Alliance resources for the optimum outcome that supports the short-, medium- and long-term System ambition for cancer services and population health.

Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, through implementation of best practice pathways. Demand for services is changing, we will use technology to implement new ways of providing care.

Personalisation is paramount to how we engage with our population and underpinned by leadership and a skilled workforce who can respond to population needs, this includes use of shared decision making to ensure that the patient pathway is right for them.

To achieve our ambition, we need to understand what our population want from us and ensure that any change is underpinned by experience, feedback and engagement from service users, ensuring use of co-production in future pathway redesign.

Recognising the importance of pre-habilitation and rehabilitation and improving post treatment care for those individuals, their families and carers. Empowering people to re-engage with services as part of their self-management plan.

Current Conditions

To effectively deliver best practice pathways and develop cancer services we need the right workforce across all specialties. Succession planning, recruitment and retention of workforce is essential to service delivery. The right staff and ongoing training must be part of our workforce plans. Workforce considerations for effective and safe cancer services need to include diagnostics and pathology because without capacity here the ability to recover cancer services will be impacted.

Across Cancer services working with all partners including primary care networks (PCNs) is critical, work with the PCNs is essential to improving information shared with referrals to enable patients to be actively triaged to the right pathway for them.

The System is moving services closer to home, particularly for diagnostics and chemotherapy.

What is the requirement from the NHS?

Mid and South Essex System is required to respond to the national planning asks for cancer, these are supplemented with asks from national team throughout the year.

Our Ambitions

As outlined in the Mid and South Essex Long Term Plan our focus for Cancer remains:

- Promoting use of screening and tests to enable early diagnosis across cancer services including access for marginalised groups. This promotion extends to non-invasive tests to support early diagnosis.
- Consolidation of the Rapid Diagnostic Service for patients to incorporate a consistent offer across our population this will include non-site specific symptoms which could indicate cancer and ensure people are on the correct pathway.
- Implementation of a range of Targeted Interventions to enable case finding and active promotion and prevention for individuals
- Continuing National Targeted Lung Health Checks to support earlier diagnosis of lung cancer as per National requirement.

Delivery Priorities

To enable safe care our patient pathways, need to be supported by enablers including the shared patient record, so that wherever the patient attends for their care, their clinical team can see their records to reduce delays.

Joining up our different health, care and voluntary services means we can bring services closer to people's homes. Opportunities for care closer to home include chemotherapy, infusions, surveillance diagnostics, local tests and access to medication.

We will develop a System wide approach for cancer patients ensuring effective pathways and partnership working and following Nationally agreed best practice pathways.

We will continue to work with our patient population. The two pilots in development:

1. VGCCR (Virtual Group Cancer Care Reviews)
2. Prostate Case Finding pilot

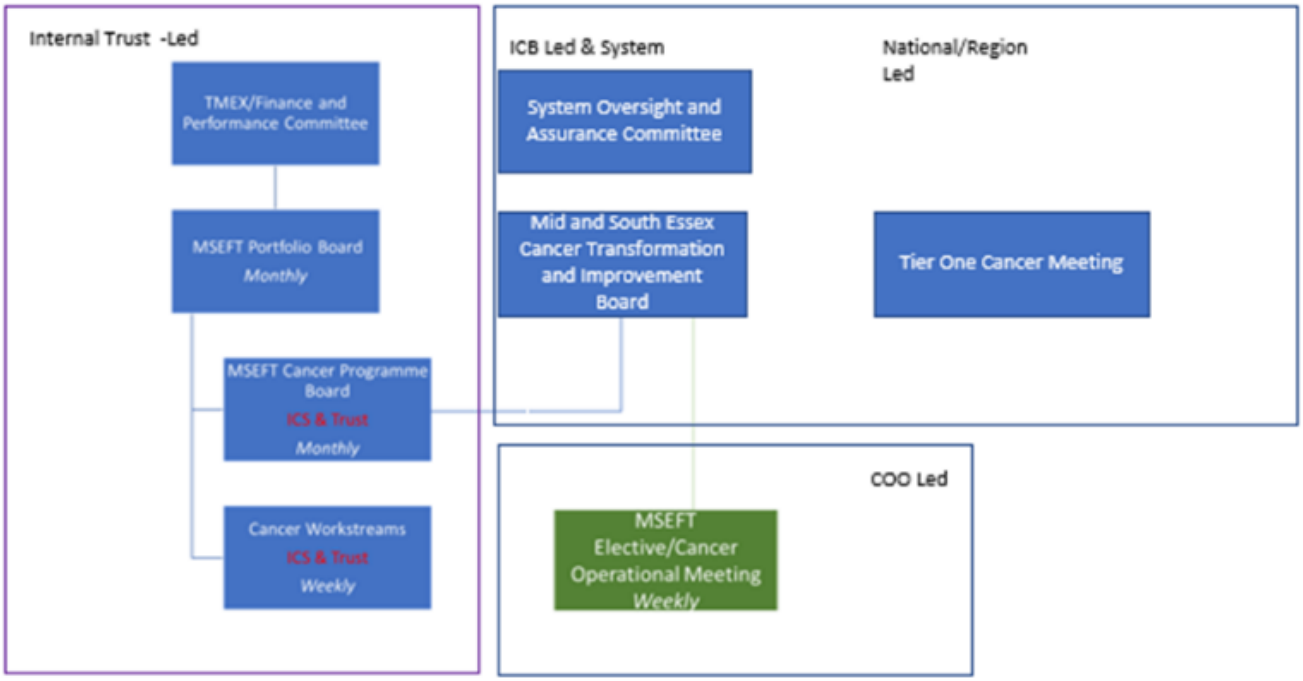
are two examples of co-production that have involved patients from the very start, and we are committed to build on co-production work.

We will continue to involve and listen to our MSE Patient Champion Engagement Committee.

Ensuring Delivery

SRO: Karen Wesson
Clinical Liz Towers

The Mid and South Essex Transformation and Improvement Board for Cancer oversees all aspects of cancer care. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance. This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex System Oversight and Assurance Committee.



The above shows the System and internal Trust governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
The priority pathways with continued initial focus for 2023/24 to reduce patients waiting over 62 days are: • Skin • Colorectal • Prostate • Gynaecology • Breast *(For detailed plans for 23/24 see operational planning submission)*	From quarter one to quarter four 2023/24
Trust tracking of tumour site trajectories for Haematology, Head & Neck, Lung and Upper GI Intestinal during 23/24	Quarter two 2023/24
28 day Cancer faster diagnosis standard (67.5% - June 23 / 70% - Sept 23 / 72.5% - Dec 23 / 75% - March 24)	Quarter four 2023/24
Targeted improvement and recovery plans for increasing % of cancers diagnosed at states 1 & 2 *(See 23/24 operational plan for further details relating to –* • Lynch Testing • Prostate Case Finding • Cervical Screening • IT system improvement • Pathology systems improvements • Bowel Screening • Non-specific Symptoms pathways (NSS) • Targeted Lung Health Checks (TLHC)	From quarter one to quarter four 2023/24

Adult Mental Health Services

What have our residents told us?

Working with our communities and against national guidance has been key to how we transform mental health services. The message from our local population has been an ask for services to be more joined up, ensuring users and communities are part of co-producing services, making care individualised and responsive with prevention and early intervention to support them live well in their communities.

We continue to hear from local residents, staff working within the ICS and in the ICB about the challenges of joined up working. This spans across the acute, secondary, and primary care space and across physical and mental health care and social arenas. This means a change in language, physical and digital space and building confidence in the workforce to be able to hold the whole person in mind and make sure that we optimise every contact.

Current Conditions

Our Mental Health Partnership Board through the Whole System Transformation Group (WSTG) has overseen the development of the transformation to enhance effective delivery on the LTP commitments through the Mental Health Investment Standard (MHIS). The current transformation of community mental health services whilst ongoing has highlights of a system with significant reliance on inpatient services, a workforce challenge and sometimes a lack of defined structure between system and place.

Through our focus on the wider determinants of health, our primary care networks, and place-based plans, we want to ensure the system rebalances in favour of prevention, early intervention, resilience, and recovery.

What is the requirement from the NHS?

Mental health transformation continues to take place in Mid & South Essex, aligned with the calls to improve and widen access to mental health support outlined in the 2021 report from the independent Mental Health Taskforce review, the Five Year Forward View for Mental Health1 and the NHS Long Term Plan.

Our Ambitions

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021, (being refreshed 2022) articulated a common vision and ambition for the development of high-quality mental health care, around the commitment to “ensure that everyone needing support in Southend, Essex and Thurrock–including families and carers –get the right service at the right time from the right people in the right

way"2. The Strategy explicitly acknowledged the 8 principles set out in the NHS Five Year Forward View for Mental Health.

Our vision for mental health in Mid & South Essex ICS is to:

- Improve urgent and emergency care mental health – crisis response and care.
- Integrate social care, mental health and physical health – parity of esteem and care closer to home.
- Promote good mental health and preventing poor mental health – early intervention and prevention.
- Moving the narrative to a 'we/our' shared language rather than 'them/us' language, to support understanding and confidence in the system about the person's journey through services.
- Collocating services either physically or virtually so that every contact can be maximise and skills can be shared.
- Commitment to all age MH strategy and delivery through a collaborative as part of the strategy implementation

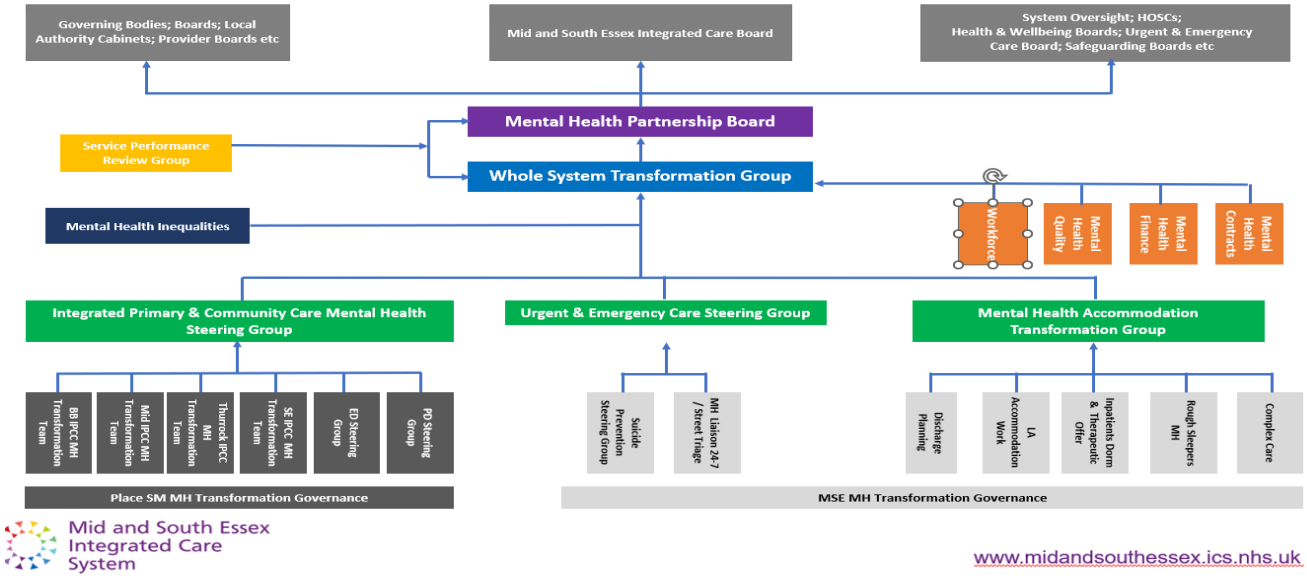
Delivery Priorities

1. Urgent and Emergency Care (UEC) Mental Health
2. Liaison Mental Health
3. Adult and Older Adult Crisis
4. Acute Care (including Out of Area Placements (OAPs)
5. Community Serious Mental Illness services for Adults and Older Adults
6. Early Intervention in Psychosis (EIP)
7. Individual placement services (IPS)
8. Serious Mental Illness – Physical Health Checks
9. Advancing Inequalities in Mental Health
10. Integrated Primary and Community Care Mental Health
11. Community Chronic Mental Illness (CMI) for Adults and Older Adults
12. IAPT (Improving Access to Psychological Therapies)
13. Perinatal
14. Integrated model
15. Dementia
16. Functional Older Adults
17. Suicide Reduction & Bereavement
18. Bereavement
19. Complex Care & and move from Care Programme Approach (CPA)

Ensuring Delivery

SRO: Zephan Trent
Clinical Lead: Amy Bartlett

Below organogram of system governance arrangements.



Mid and South Essex Integrated Care System

www.midandsouthessex.ics.nhs.uk

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
A range of complementary and alternative crisis services to A&E and admission (including in VCFSE/ local authority-provided services) within all local mental health crisis pathways;	Quarter three 2023/24
Deliver against ICB-level plans to eliminate inappropriate adult acute out of area placements as against planned trajectory	Quarter four 2023/24
The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings ("Time to Care")	First half of 2024/25
Established new specialist mental health provision for rough sleepers	Quarter two 2023/24
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides with a suicide bereavement plan in place	Quarter one 2023/24
All areas within MSE ICB will maintain the existing Talking Therapies referral to treatment time and recovery standards	Quarter three 2023/24
Supporting women to access evidence-based specialist mental health care during the perinatal	First half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
period. This will include access to psychological therapies and the right range of specialist community	
Provision of NHS specialist treatment for people with serious gambling problems.	Quarter four 2023/24
Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response via a MH ambulance car in line with clinical quality indicators	Quarter two 2023/24
Continuation of the new integrated community models for adults with SMI (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision and implementation of the complex care pathway with a move to "personalised Care "for greater choice and control, moving away from the care programme approach	Quarter three 2023/24
Implementation of recovery colleges and improving access to Individual Placement and Support (IPS) to be doubled, enabling people with severe mental illnesses to find and retain employment. Ensuring over 60% of people experiencing a first episode of psychosis will have access to a NICE-approved care package within two weeks of referral. 60% of services will achieve Level 3 NICE concordance by end 2023/24	Quarter four 2023/24

Children and Young People Mental Health

What have we heard from residents/patients

The evidence tells us that Children and Young People (CYP) are continuing to recover from the impact of the pandemic which for some has had a negative effect on their development, emotional wellbeing, and mental health.

Families tell us it remains difficult to access specialist mental health services in a timely way and that the wide variety of services on offer are challenging to navigate.

What is the current state of play/local challenges

The demand has risen for services with the number of children who have concerns with their mental health increasing to 1 in 6 in comparison to 1 in 9 only 5 years ago (Young MINDs).

What is the requirement from NHS

The NHS LTP sets out the ambition to expand CYP Mental Health Services widening the access to services closer to home, reduce unnecessary delays and deliver specialist mental health care in ways which work better for families. This builds on the commitment from the Children and Young Peoples mental health green paper which brings together the Department for Education and Department of Health in a programme of work to strengthen the support and offer in educational settings. Working in partnership we will continue to educate families and young people in managing and preventing the potential risks of online harm and high-risk behaviours.

What is the ambition?

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy is an all-age strategy which identified specific areas for focus including Eating Disorders, Crisis services, integrated care within local acute trusts, improving access and ability to measure outcomes and use of digital technology to support care.

We know the support young people require as they move into adulthood often needs to be bespoke and holistic to this age group and will be working across the sectors to develop this further.

What are the delivery priorities?

1. To continue with the expansion and transformation of mental health services, as set out in the NHS Mental health Implementation Plan and improve the quality of MH care across all ages.
2. There are clear pressures in relation to CYP referrals (demand), acuity and severity of needs. A whole system approach is needed to harness effective

prevention and early intervention initiatives. This acknowledges the health inequalities which are influenced by economic factors, relational influences, individual and family health and wellbeing and environment in which we live.

3. To increase access and equality, build capacity and capability in the system and build resilience in the community.
4. Priorities prevention and early intervention across education, health and care and VCFSE pathways and continue to transform services to deliver better outcomes and more resilient CYP

Governance

SRO: To be advised – Lead Director: Dr Tiffany Hemming
Clinical Lead: Amy Bartlett

Delivery of the strategic ambitions and programme will be overseen by the Children's Commissioning Collaborative for Southend, Essex and Thurrock with the development of the Mental health Strategy Implementation Group which will provide the oversight for both adults and children mental health programmes of work. Mid and South Essex publish our Open Up Reach Out Local Transformation Plan annually which identifies areas of investment and progress on delivery.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transformation of the CYP Eating Disorder Pathways to include STARs roles	From quarter three to quarter four 2023/24
To use feedback tools and routine outcome measures to ensure the voice of the CYP is centre and care is person centred.	Quarter four 2023/24
Develop the service offer for 18-25 year olds to support transition to adulthood.	From quarter one to quarter four 2023/24
Expansion of Mental health Support Teams in Schools waves 7 & 9	From quarter three 2023/24 to first half of 2024/25
Embedding CYP MH practitioners in a phased approached with Primary Care.	From quarter three 2023/24 to second half of 2024/25
Expansion of Learning Disability /Neuro Diversity Child and Adolescent Mental Health (CAMHs) Team	From quarter four 2023/24 to second half of 2024/25
Capital development programme for CYP Eating Disorder Service	From quarter four 2023/24 to first half of 2024/25
Review and design a model of care with VCFSE providers for MSE.	From quarter two 2023/24 to first half of 2024/25

Neurodiversity

What have our residents told us?

The current challenge is to fully understand the models of provision and identify the gaps and variations across MSE and (where appropriate) on the greater Essex landscape. This includes working with a wider set of partners, stakeholders and communities, experts by experience and their families to obtaining feedback to help shape and deliver modern fit for purpose models of neurodiversity provision.

Current Conditions

Currently neurodiversity services are delivered by a range of statutory and voluntary agencies which are not aligned or delivered within an agreed strategic approach. This presents with challenges of inequitable access, variation in provision, fragmented delivery which is not maximising the opportunities of working collaboratively within an all-age approach to provide the best and most efficient models of care for people requiring support with neurodiversity presentations.

What is the requirement from the NHS?

We need to ensure the provision and commissioning of models of care meet the statutory requirements.

To ensure local provision reflects the needs and requirements of the standards or codes of conduct to addresses inequalities in access, variations in provision.

To ensure appropriate governance and oversight of the provision of services, to continuously review and evaluate the models of provision to reflect the changing socio-economic situations impacting on local populations.

Our Ambitions

For NHS, Local Authorities, voluntary services and others to work collaboratively to co-produce services that are equipped and designed to around family health models.

To deliver models of care that maximise resource allocation within a whole system, all age pathways.

To develop new and innovative ways of partnership working that focus on family health models (all age models) with better alignment between the NHS, local authority and associated partners.

To address the growing demand for access and whole system models of provision that maximise resources.

Delivery Priorities

2023/24 we will undertake a comprehensive mapping of current service provision and identify the gaps to inform an all age, whole systems joined up approach to deliver fit for purpose Neurodiversity programmes.

The ICB Board has approved the appointment of a dedicated project lead post on a fixed term basis to undertake this mapping work.

We will develop new partnership models for delivery of our Neurodiversity programmes which aligns to the babies, children and young people's programme, and in line with the spirit of the Integrated Care Strategy. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Ensuring Delivery

A senior responsible owner (SRO) will be identified at ICB Board level for the Neurodiversity portfolio.

Clinical Lead: Dr Maria Crowley

The delivery of programme of work for Neurodiversity will be set out in 2023/4 and remain accountable to the ICB board on deliverables. The ICB Board will provider oversight and governance on the programme and will want to ensure alignment to the CYP and mental health programmes of work.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
ICB in consultation with partners and providers undertake an all-age review of the current provision of services across Essex, identifying the current pathway and provision, identify gaps in provision.	Quarter one 2023/24
Develop new partnership models for delivery of the Neurodiversity programmes which aligns to the babies, children and young people programme and is in line with the Integrated Care Strategy.	Quarter two 2023/24
Ensure appropriate procurement and commissioning of fit for purpose, evidence based modern models of care for Neurodiversity that is aligned to CYP and mental health commissioned services.	Quarter three 2023/24
Review and evaluation of the commissioned models of provision to inform ongoing service developments in consultation with stakeholders which takes into account research findings, new and emerging policy changes.	From quarter four 2023/24 to first half of 2024/25

Babies, Children and Young Peoples Services (BCYP)

What have our residents told us?

Co-production with CYP and families is central to the development of our strategic direction and is reflected in the development of agreed values and principles.

Current Conditions

Mid and South Essex has a Children population of circa 270k and although there are similarities in health needs there are also significant variations associated with demographics and wider determinants of health.

MSE will have a CYP Panel to support the strategic work of the ICB which will be further developed with CYP in parallel with the Children's Partnership Framework.

We continue to shape services adopting the principles of a person-centred approach to care and preparing CYP and their families for effective transition to adulthood.

What is the requirement from the NHS?

The ICS will deliver the ambitions of the NHS LTP supported by the partnerships and identifying synergies with wider Government Strategies including Levelling Up and Regeneration, Social Care reforms, Schools white paper opportunity for all and Family Hubs and Start for Life programme.

The NHS has specific statutory requirements under the Children's and Family Act and SEND Code of Practice in relation to Special Educational Needs and Disabilities and will continue to work in partnership with the Local Areas SEND Boards in delivery of the respective SEND Strategies and Inclusion Plans.

The Core 20+5 Framework for CYP has identified areas for focus including Diabetes, Epilepsy, Asthma, Oral Health and Mental Health. There will be a continuous focus on improving the outcomes for those in our most deprived areas and cohorts of CYP where the outcomes are not comparable with their peers such as children who are in care, SEND and those involved in the youth justice system.

The CYP ambitions will be the responsibility of the Growing Well Programme Board (GWPB) led by the Director for CYP and clinical lead. The GWPB will align and connect with the Essex, Southend and Thurrock CYP partnership forums and the 4 Alliances.

Our Ambitions

As a partnership, we are committed to improving the lives of CYP and it stands as a top priority for us as a system. To support this ambition, we have developed a

Partnership Framework which recognised the strategies and priorities held by many organisations and is designed as an enabler recognising that we can have a bigger impact by working on factors that influence health and wellbeing, not just at the point of illness or crisis.

In 2023/24 we will develop new partnership models for delivery of our CYP and Neurodiversity programmes, working with a wider set of partners and stakeholders and communities, in line with the spirit of the Integrated Care Strategy. It is anticipated this will see us securing additional resources to bring this work forwards. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Delivery Priorities

We have 6 priority areas of work with associated programmes. These include CYP Mental health, Special Education Needs and Disability, Neurodiversity, Palliative and End of Life, Transformation of Community Services and Urgent and Emergency pathways.

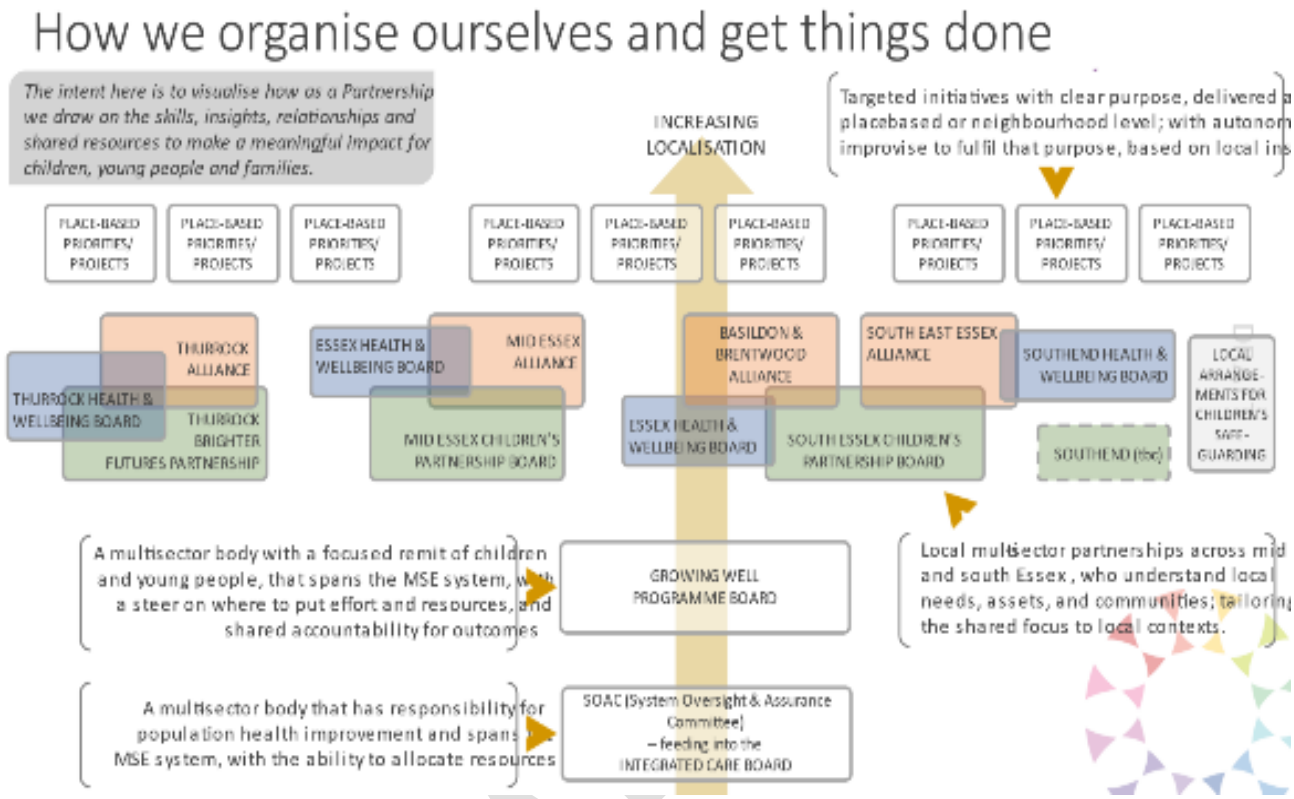
There is an opportunity with existing partnerships to secure development resources to form a new integrated BCYP approach, starting with early years health and care and then extending into all CYP.

Ensuring delivery

SRO: To be advised – Lead Director: Dr Tiffany Hemming
Clinical Lead: Dr Sooraj Natarajan

The CYP ambitions for the NHS LTP will be the responsibility of the Growing Well Programme Board led by the Director for CYP and clinical lead. The GWPB will align and connect with the Essex, Southend and Thurrock CYP partnership forums and the 4 Alliances.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Asthma: CYP Community Asthma team aligned to 8 PCNs in South East Essex by March 2024	Quarter four 2023/24
CYP End of Life (EoL): Agreed CYP EOL Ambitions Framework Implementation Plan by December 2023	First half 2024/25
CYP EOL: 24/7 Palliative and End of Life Care service in place by March 2025	Second half 2024/25
Diabetes: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24
Diabetes: Increase access to Continuous Glucose Monitoring (CGM) and insulin pumps within agreed protocols and NICE Guidance by 25/26	2025/28
Epilepsy: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Urgent & Emergency Care (UEC): Hospital@Home pilot in place by September 2023	First half of 2024/25
UEC: Long-term Paediatric Acute Respiratory Infection (ARI) Model in place by December 2023	Quarter two 2023/24
To reduce the number of children requiring higher levels of mental health services by strengthening early intervention, support and education for Schools and Colleges.	Quarter one 2023/24
To improve access to specialist CYP MH Services	Quarter one 2023/24
To improve the outcomes and experience of children and young people with Special Educational Needs and Disabilities and ensure the ICB meets it statutory requirements.	Second half of 2024/25

Reducing Pressure on Urgent and Emergency Care Services

What have our residents told us?

Co-production with patients and families and system partners is central to the development of our strategic direction for Urgent and Emergency Care (UEC) services.

Current Conditions

The urgent care system is under significant pressure and this impacts on our responsiveness to sustain delivery to elective and cancer services. All partners are working hard to address urgent care pressures and ensure service provision for people alternative to Emergency Department that meet their needs and requirements.

We have three established sub-systems for urgent and emergency care (southeast, southwest, and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services, which feed into the Mid & South Essex UEC Transformation & Improvement Board

111 Service:

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services. NHS111 provision from Mid & South Essex is provided by IC24, who went live with the online NHS111 in December 2022, as well as the continuation of the telephony service.

As part of the national Pathways Light programme, from April 2023 our IC24 Provider will be increasing service provision to incorporate access to Dental Service Advisor, urgent repeat prescriptions and Minor Injuries Service Advisor.

Same Day Emergency Services (SDEC):

All three hospitals offer a same day emergency service for 12 hours/day, 7 days/week. These services provide fast access for patients to diagnostics and treatment and reduce hospital admissions.

The Same day emergency service models are currently under review to ensure maximise service provision opportunity to ensure same day treatment.

Alternative to Emergency Department (AtED):

Mid & South Essex will be an early adopter, commencing in Q1 2023/23 for AtED (Alternative to Emergency Department) to support the delivery of a roadmap for individuals to be aware of service existence, and how to access the service. As well as overview of gaps in the roadmap for further interventions/investment.

Older People's Service:

Our three hospitals have worked to develop assessment and treatment units specifically to meet the needs of older people.

At Broomfield, the operating hours of the Frailty Ambulatory Service is 08.00-20.00 Mon-Sun.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00.

Basildon offers a full 7-day frailty service.

Virtual Wards:

The current baseline of virtual ward capacity for MSE is 175 virtual ward beds. The virtual ward baseline as at 31.03.23 is as follows:

- Respiratory Virtual Ward: 45 beds
- Frailty Virtual Ward: 60 beds
- Hospital@Home Virtual Ward: 55 beds
- Heart Failure Virtual Ward pilot: 15 beds

We continue to work towards the national ambition of 480 virtual ward beds operational by December 2023. Our current plans include a revision of our Respiratory virtual ward based on recent occupancy from 45 to 15 virtual wards beds; plus inclusion of our virtual ED of 42 VW beds delivered via our Urgent Community Response Teams (UCRT).

The Frailty Virtual Ward will soon incorporate an additional 15 unplanned out of hours response VW beds, and 60 further VW beds delivered via the complex wound care team. We intend to include these within our Virtual Wards from the end of May following completion of our governance processes.

The ongoing efficiency programme including a focus on digital, workforce and communications enablers will be a key ongoing element of developing our capacity and occupancy – particularly within the Frailty virtual ward where we know the biggest opportunity lies.

In addition, our Stroke Earlier Supported Discharge pathway will deliver 60 Virtual Ward beds and the Mental Health Crisis Response Teams and Dementia Services a further 30 Virtual Ward beds.

All of the above equates to an assumption for September 2023 that 370 Virtual Ward beds will be available within our system with further pathways are being developed including Children's Hospital at Home, MSK Post-surgical, and further expansion of Frailty Virtual Ward to include AKI.

Urgent Community Response Team (UCRT):

Full geographic coverage from 8am-10pm 7 days a week is in place across MSE. The service provision covers the nine clinical conditions or needs, including level 2 falls, in line with the national 2-hour guidance. Scoping has commenced to identify potential demand outside of operational hours and considerations of extending beyond core hours underway.

Newly enhanced service whereby UCRT work in collaboration with East of England Ambulance Service (EEAST) to support in clinically appropriate referrals being shared with UCRT to support visits and care to patients requiring urgent care, enabling the ambulances to be released to support those individuals requiring emergency care. MSE are consistently exceeding the minimum threshold of reaching 70% of 2-hour crisis response demand within 2 hours.

Further exploration in progress in implementation of 'call before you convey', working with System partners and EEAST to support ambulances with alternative options to ED, and all crews will dial one number whereby they will have an Multi Disciplinary Team (MDT) to support patients into alternative pathways, excluding priority and C1 calls. Rollout anticipated for Q3 in 2023/34

Improving Discharge:

Implementation of data platform systems to support with real-time decision making to support patient flow and discharge throughout the System. Shrewd Resilience and Teletracking systems will be utilised to daily monitor the discharges identified against the requirement to ensure patients flow from front to back door, and early intervention implemented where there a deficit is identified.

By the end of June 2023 Criteria Led Discharge will be implemented across the hospital sites, which will provide a framework to facilitate 'home for lunch' discharges as well as increasing weekend discharge rates.

What is the requirement from the NHS?

The ICS acknowledges the requirements within the NHS England published national delivery plan for recovering urgent emergency services.

Date published: 30 January 2023

Our Ambitions

A system that provides more, and better care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

Everyone to receive the very best urgent and emergency care, raising standards of quality and safety patients and their families:

We will work to expand and better joining up health and care outside hospital: stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

We will make it easier to access the right care: ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

Delivery Priorities

- Expand 111 service offer in accordance with pathways light programme.
- 111, Primary Care and EEAST Ambulance to directly book Same Day Emergency Care (SDEC) slots into the service in Q2 of 2023/24.
- Improve awareness and access to alternative services avoiding emergency departments.
- Expansion of virtual ward capacity increasing referrals and utilisation of the virtual ward capacity.
- Identify potential UCRT demand outside of operational hours and considerations of extending beyond core hours.
- Implement MDT support number for ambulance crew support to ensure alternatives to ED fully optimised.
- Increase 'home for lunch' discharges through criteria led discharge initiatives.

Ensuring delivery

Whole pathway responsibility:

Clinical Lead: Dr Eddie Lamuren, Clinical Director (Emergency Care), Mid and South Essex Foundation Trust, supported by Hospital Site Emergency Department Clinical Leads

Senior Responsible Owner: Hospital Site Managing Directors, Mid and South Essex Foundation Trust

111 Governance:

SRO: Samantha Goldberg
Clinical Lead: Dr Sanjeev Rana

Delivery will be monitored via the daily and monthly NHS111 volumes and performance metrics, as well as increase in alternative to ED dispositions.

Same Day Emergency Care Governance:

SRO: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Delivery will be monitored through the monitoring of referrals received and accepted into the service and reduction in admission into acute hospital beds

Alternatives to ED Governance:

SRO: Samantha Goldberg
Clinical Lead: Sarah Zaidi / Matt Sweeting

Delivery will be monitored through the volume of ambulance conveyed to the hospital, ambulance offload times, and increase in referrals to alternative services.

Older People Services Governance:

SRO: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Virtual ward Governance:

SRO: Gerdi Du Toit
Clinical Lead: Sarah Zaidi / Matt Sweeting

UCRT Governance:

SRO: Samantha Goldberg
Clinical Lead: Yvonne Mubu

Monitored through the increase in referrals from EEAST to UCRT and reduction in C3 ambulances conveyed to the hospital

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
111 dental advisors, urgent repeat prescriptions and minor injuries advisor go live	Quarter one 2023/24
SDEC direct booking slots available (111, Primary Care, Ambulance Services)	Quarter two 2023/24
Commence early adoption of alternative to ED roadmap	Quarter one 2023/24
480 virtual ward beds operational by December 2023.	Quarter three 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
MDT EEAST alternative to ED contact system rolled out	Quarter three 2023/24
Criteria led discharge fully implemented across hospital sites	Quarter two 2023/24

Respiratory Services

What have our residents told us?

Our residents /patients want to be fully involved in the co-production of respiratory transformation plans and a co-production approach is currently being developed with our patient focus group, with support from Health Watch and the voluntary sector. Services need to be easily accessible, and a combination of both physical and remote provision is welcomed where appropriate.

Current Conditions

Only one in three patients newly diagnosed with COPD receives a spirometry-based screening and this can result in unnecessary hospital attendances and admissions, on average three attendances per patient.

The requirement to pause respiratory diagnostics during the COVID-19 pandemic has led to an increased backlog of patients waiting for these tests. As a result, the existing services need to be enhanced to meet the increasing demands and reduce waiting times. To achieve this training and review of staffing skill mix is required, to build the clinical knowledge and expertise across MSE ICS at the scale required.

Current limitations around estates and suitable clinical spaces to undertake Spirometry and associated respiratory diagnostics for people, have necessitated looking to alternative options to facilitate the restoration of respiratory diagnostic services following COVID-19.

In respect of the virtual ward there is an ongoing need to raise awareness within secondary care of the services being provided by the virtual ward teams that they can refer into.

What is the requirement from the NHS?

The integrated Breathlessness and Diagnostic Service model has been identified by respiratory and cardiology stewards as a means of reducing duplication of care interventions, aligning care pathways and improving care outcomes for patients experiencing breathlessness across MSE. The proposed holistic model also provides opportunity for ongoing efficiency savings going forward.

Our Ambitions

The long-term plan is for the Integrated Breathlessness and Diagnostic Service to deliver joined up respiratory health, care and education for the MSE population aged 12 years and older, improving the quality of respiratory services locally and moving clinical activity from secondary care into community and primary care to prevent accidents and emergency attendances, avoidable admissions and reduce unnecessary outpatient appointments.

Respiratory Virtual ward

There are currently three respiratory virtual wards across MSE ICS, providing 15 virtual ward beds per area and 45 in total. The number of beds is to be reviewed by September 2023, as other virtual wards come online, as this is impacting the level of occupancy, for example those patients that are frail and also have a respiratory condition. The virtual ward provides both step up and step-down access to support early discharge from secondary care and prevent unnecessary admissions.

What are our delivery priorities?

1. **Early and Accurate diagnosis:** with a particular emphasis on spirometry testing in the community to offer breath tests and discussion to assess lung cancer risk in mobile units, with any patient at risk to have an immediate low-dose CT scan.
2. **Pulmonary Rehabilitation:** offer a structured exercise and education programme designed for those with lung disease or breathlessness.
3. **Correct Medication:** Pharmacists in primary care networks will undertake a range of medicine reviews, including educating patients on the correct use of inhalers and contributing to multidisciplinary working.
4. **Pneumonia:** to ensure a consistent use of risk scoring to reduce avoidable admissions, increased training provision and awareness sessions, as well as nurse-led supported discharge services to support safe out of hospital care.
5. **Flexible Learning:** a 'first contact' package will be developed to support those diagnosed with COPD and asthma, and form part of the treatment plan. This will include face to face and digital options.
6. **Breathlessness:** the NHS Long Term Plan highlights breathlessness as a common symptom shared across cardiac and lung conditions and commits to producing an evidence base for joint cardiac and pulmonary rehabilitation models, which can then be rolled out across the NHS.
7. **Respiratory Virtual Ward:** Fully optimise respiratory virtual ward by December 23
8. **Acute Respiratory Infection (ARI) Hub:** In line with the national guidance MSE ICS has plans in place to pilot ARI Hubs across MSE ICS and undertake a full evaluation and align to wider initiatives that will support further improvements in service provision e.g., Community Diagnostic Centres due to open from March 2024 in Thurrock and Mid Essex.

Governance

SRO: Selina Douglas
Clinical Lead: Dr Abi Moore, MSE ICS Respiratory

Ensuring delivery

The Respiratory Programme is one of our key priority areas and transformation of services is supported by a formal governance structure. The programme is provided with dedicated programme support provided by MSE Partners and has clinical oversight from the MSE Respiratory Stewards and MSE ICS Respiratory Clinical Lead.

In addition to this, there is an MSE ICS Respiratory Clinical Network to ensure alignment of respiratory plans and transformation across services within MSE ICS.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase diagnostic provision to include cardiac and respiratory diagnostics for breathlessness by Oct 2023 (currently being piloted in Mid Essex).	Quarter three 2023/24
Recruit additional psychologists to provide support for breathless patients across both Respiratory and Cardiology pathways by April 2023.	Quarter one 2023/24
Work with Healthwatch to develop Pulmonary Rehabilitation co-production model and then extend out across respiratory services by May 23	Quarter one and four 2023/24
Ensure MSE ICS is compliant with National Asthma and COPD Audit Programme by March 2024.	Quarter four 2023/24
All staff to be fully accredited or underway in the pathway of accreditation by the Royal College of Physicians (RCP) Pulmonary Rehabilitation Services Accreditation Scheme (PRSAS) by March 2025.	First half of 2024/25
To hold awareness raising events re the signs of pneumonia and preventative action that can be taken, which will include dedicated events for LD and neuro disability patients / carers / next of kin by June 2023.	Quarter one 2023/24
Undertake Evaluation and submit business case for sustainable ARI Hub model by June 2023 and align to fully optimized respiratory virtual wards by Dec 23.	Quarter two 2023/24

Outpatient Programme

What have our residents told us?

A patient engagement session is planned for end of March ’23 to support the new workstreams supporting the move to a single integrated access service.

Feedback from patients regarding issues affecting their ability to attend planned appointments is currently being gathered within work to better understand DNAs.

What is the current state of play/local challenges

The Programme has improved visibility of the key performance indicators (KPIs) for the operational teams using Power BI, so these metrics are now able to be reviewed weekly by the care groups to ensure continued focus and improvement. The project team will be conducting ‘health checks’ with each operational specialty before rolling improvement initiatives out to further improve performance in identified areas.

During the next year, teams will be working to improve the central access function which will deliver an improved service for patients and a better experience for our staff through enhanced training and improved technology solutions.

The programme will continue the roll out of eConsult to all specialities and introduce phase 2 of the Programme during the year.

What is the requirement from the NHS?

Key KPIs for 2023/24 is to reduce Follow-up activity by 25% (of baseline 2019/20 activity) by March 2024.

Our Ambitions

WS1 - Operational Excellence: We will equip managers with the right tools and skills to make data driven decisions to help achieve key national performance KPI's across all specialties by end March 2024

WS2 - Reshaping Access: By end of March 2026, we will deliver better patient and staff experience through implementation of consistent streamlined booking processes which will enable better management of referrals and new demand.

WS3 - Virtual Outpatients: We will adopt and implement new digital technologies and approaches that will deliver care in an innovative, efficient, and patient centric way by end of March 2024

WS4 - System Pathway redesign: We will deliver new models of care across MSE ICS, giving patients seamless experience and right care at the right time by the end of March 2024

Delivery Priority

- Better experience for patients
- £42m of improved value through reducing waste and using technology
- 2% reduction in DNAs, from current c8% to 6%
- Enhanced capacity (increase in Advice and guidance utilisation, Patient-initiated follow-up (PIIFU)
- 25% reduction in follow ups (2019/20 baseline)
- New single integrated access team

Ensuring Delivery

SRO: Andrew Pike
Clinical Lead: Professor Tony Young

The programme team will deliver using detailed project plans for each workstream on the Smartsheet system. Reporting dashboards will be used to inform sponsors, programme boards and executive groups.

Delivery Plan

Delivery Plan objectives	Quarter one 2023/24	Quarter two 2023/24	Quarter three 2023/24	Quarter four 2023/24	First half of 2024/25	Second half of 2024/25	2025 to 2028
Reduce follow up activity by 25% by end of March 2024	5%	12%	20%	25%			
Reduce DNAs from 8% to 6% by end of March 2024	8%	8%	7%	6%			
Efficiency Delivery:							
WS1: Operational Excellence	£1.1m	£1.3m	£1.4m	£1.5m	£5.8m	£5.8m	
WS2: Reshaping Access	£0.3m	£0.3m	£0.3m	£0.3m			
WS3: Virtual Outpatients – to be modelled							
WS4: System Pathway Redesign	£0.9m	£0.9m	£0.9m	£1.0m			
Total of WS1 to WS4	£2.3m	£2.5m	£2.6m	£2.8m	£5.8m	£5.8m	

Diagnostics

What have our residents told us?

Our residents want the ability to access tests to diagnose their condition close to home, they want to access diagnostics once and not have them repeated unnecessarily.

Our residents want timely results and the least invasive test to enable them to receive a diagnosis or treatment plan.

Current Conditions

The key challenge for diagnostic recovery is the ability to provide continued service when capacity for delivery is impacted by wider pressures within the system. We continue to work with other System partners (Independent Sector and Community Providers) so we can maximise diagnostic capacity to support, people to access the most appropriate diagnostic test for their condition.

We are working to increase early diagnosis and the turnaround time for results of diagnostic tests across all our providers.

We have been working with our primary care practices to increase the use of FIT tests, a non-invasive test that supports diagnosis for bowel conditions; the use of this test reduces the need for more invasive diagnostic tests whilst providing results to the patient in a timely manner.

We continue to progress the two key national requirements of Systems for diagnostics:

- Community Diagnostic Service/Centres and
- Rapid Diagnostic Service

Both of these will increase capacity and support the ambition of care closer to home and easier access locally for our residents.

What is the requirement from the NHS?

Mid and South Essex System is required to respond to the national planning asks for diagnostics, which are supplemented with asks from NHSE national team throughout the year.

Our Ambitions

As outlined in the Long Term Plan our focus for Diagnostics remains:

Bringing Care Closer to Home:

Joining up our different health, care and voluntary services means we can bring services closer people's homes – whether that is through support on-line, or by bringing health and care services into the community such as some hospital tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

Ensuring that every Place has adequate and appropriate provision, based on its demographic and need, of both Screening and diagnostic services

Improving and Transforming Our Services - Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, to live as well as they can.

Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage, avoid more serious illness, and to live as well as they can for longer.

Delivery Priorities

- MSEFT and ICB Partners are working to ensure clear recovery trajectories and plans for the key asks as per the 2023/24 National Planning Guidance. Operating priorities will be subject to change as Planning Guidance is released and refreshed annually.
- The key diagnostic deliverable is to:
    - Have increased number of patients receiving diagnostic tests within six weeks - the March 2025 ambition of 95%
    - Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
    - Increase the percentage of cancers diagnosed at stages 1 & 2 in line with the 75% early diagnosis ambition by 2028

The below table shows the Mid and South Essex system planned diagnostic trajectory for 2023/24 as the first year to achieve the planning ask.

Ensuring Delivery

SRO: Dr Ronan Fenton
Clinical Lead: Dr Ronan Fenton/Dr Qaiser Malik

The Mid and South Essex Transformation and Improvement Board for Diagnostics oversees all aspects of diagnostics including performance (escalation from sub-

group – see below), Community Diagnostic Service/Centre implementation and Rapid Diagnostic Service to support early cancer diagnosis.

The Board receives performance information from its diagnostic performance sub-group. This group focuses on the referral to diagnostic test, turnaround time for results across acute, community and independent sector providers. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

The performance sub-group escalates the key risks to the Board which are presented to the Mid and South Essex System Oversight and Assurance Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
For detailed plans for 23/24 see operational planning submission	From quarter one to quarter four 2023/24

Stroke Services

What have our residents told us?

There is variation across alliance areas in care received, particularly with reduced level of support for patients after stroke across Alliance areas. Stroke Stewards are focussing on a number of projects to improve access to post stroke care and access to local voluntary support groups.

Current conditions

Across MSE:

- Not all stroke patients are being admitted to stroke wards due to bed pressures within the acute resulting in a number of medical outliers on stroke wards. Two acute sites in MSE have an E rating on Sentinel Stroke National Audit Programme (SSNAP) for this indicator.
- Delays in scanning at arrival to hospital due to front door acute pressures thus reducing the number of patients eligible for thrombectomy.
- No community bed pathway for Covid positive patients resulting in discharge delays until patients test negative or are out of isolation period.
- Community Early Supported Discharge (ESD) services are under pressure, intensity of rehabilitation has been reduced due to the number of referrals and rehabilitation requirements, Mid Essex service is currently holding a waiting list.
- There is differential access to community services across the system
- Workforce is an issue across acute and community stroke services.

Partnership working:

- Both community bed sites, Cumberledge Intermediate Care Centre (CICC) and St Peter's are working in collaboration and now have a single acceptance criterion.
- Therapists across acute and community have worked in partnership to align patient assessments and reviews by all using the EQ-5D tool.
- Mid and South Essex ICS is part of the South East of England Integrated Stroke Delivery Network (ISDN) to support and align work plans across the region. The ICS has successfully bid for numerous funding to support different ways of working such as the MSE Catalyst funding project, focussing on growing our own Stroke MDT workforce using band 4 Rehabilitation Assistants to enhance the Community Stroke pathway across MSE.

- Stroke Programme Board and Stroke Stewardship in place with representation across primary care, community, acute and voluntary sectors.

What is the requirement from the NHS?

This below system vision links to the NHS Long-Term Plan which highlights both increased thrombectomy and improved post hospital stroke rehabilitation models.

Our Ambitions

The stroke stewardship team are reviewing the end-to-end pathway to ensure that all elements are delivered in line with the National Stroke Service Model (NSSM) and the Integrated Community Stroke Service (ICSS). A recent review of quality adjusted life years (QALYs) data demonstrated that MSE should invest less into acute services and more into community services and Thrombectomy to provide better outcomes for stroke survivors.

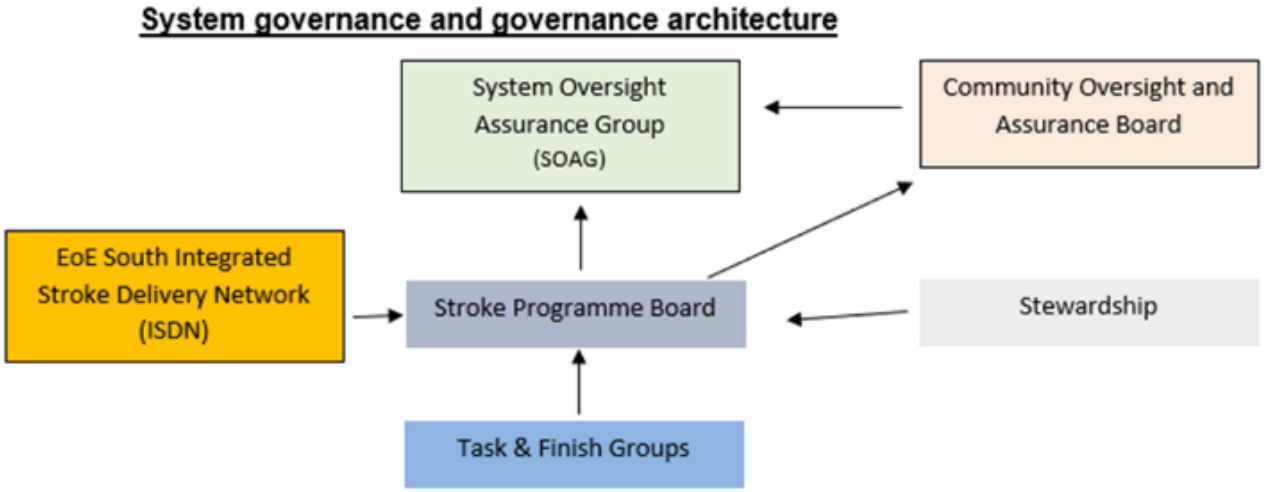
Delivery Priorities

- Acute action plans to improve SSNAP rating at all three sites by June 2023.
- Acute audit to be undertaken to identify delays in the system by March 2023.
- Community bed reconfiguration by September 2023 (subject to public consultation).
- Implement the Integrated Community Stroke Service (ICSS) model by April 2024. Implement the Integrated Community Stroke Service (ICSS) model by April 2024. The ICSS model has nine key components; integration, responsive and intensive, needs based, pathways of care, seven day working, team composition, specialist service, education and training and tailored goals and outcomes.

Ensuring Delivery

SRO: Selina Douglas
GP Lead – Dr Deepa Shanmugasundaram
Consultant Lead – Dr Ramanathan Kirthivasan

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Acute SSNAP rating to improve to an A rating by June 23	Quarter one 2023/24
Reconfigure community stroke beds (42-48) (subject to public consultation)	From quarter two to quarter three 2023/24
Implement ICSS specification ensuring all stroke survivors access to community support / rehab	First half of 2024/25

Cardiac Services

What have our residents told us?

Local residents and patients want to be able to access services closer to home. Patients also want and need all parts of the health system to communicate all of their information when they are being referred on from primary care to community, secondary or tertiary settings. This includes avoiding repeating tests or investigations when moving between care providers and levels of care.

Our approach is to provide local access to services where possible and centralise services where necessary to achieve true clinical excellence.

We aim to increase the provision of tertiary and quaternary services in the Essex Cardiothoracic Centre so fewer patients need to travel out of area for specialist care.

Current Conditions

We have a significant deficit in cardiac diagnostic capacity which needs to be addressed through medium- and long-term actions. Echocardiography is a key diagnostic for many cardiac conditions in both elective and acute presentation. Demand for echocardiography will continue to grow and we will need a growing cardiac physiology workforce to meet this demand. System partners will work in collaboration to implement a strategic workforce plan and career pathway for cardiac physiology to locally develop specialist staff to deliver an integrated service in hospital, in community diagnostic hubs and in other community settings.

Cardiac CT is increasingly important as a first line diagnostic test in cardiac presentations. Availability is highly variable across the system and overall, less than half the capacity recommended for our population. The new community diagnostic hubs will accommodate low risk CT activity freeing capacity in hospitals for these specialist Cardiac CT scans. This will allow us to meet overall demand and ensure equitable access to these specialist diagnostics.

Cardiac MRI is a highly specialist diagnostic currently operated from the tertiary Essex Cardiothoracic Centre. We have developed a regional hub and spoke model to improve equity of access for patients across the region. The first spoke site is Ipswich hospital. With the introduction of community diagnostic hubs freeing MRI capacity in hospitals we aim to expand this model so that patients can access this tertiary diagnostic service in their local hospital with expert oversight and support clinically from the Essex Cardiothoracic Centre.

The Heart Failure team in Basildon have an excellent service for local patients with seamless integration of community, hospital and tertiary clinical teams. This service has published national findings in optimal management of heart failure including the development of the new “Quad Score” to avoid treatment inertia and maintain focus on optimisation of heart failure medications. We will continue to roll out these clinical

models across the system to ensure that patients receive the best care. Heart failure patients require intense monitoring in the first 12 weeks to optimise management and avoid more invasive and expensive interventions. We have a significant shortfall in our specialist HF nursing workforce required to meet this need. We will be developing a workforce plan to include nursing and other roles within the multi-disciplinary team to ensure that all patients are optimally supported delivering better care and better value care overall.

Inherited Cardiac Conditions (ICC), including heart muscle disease (cardiomyopathy) and sudden arrhythmic death syndrome (SADS), affects 1 in 250 people worldwide and thorough family screening is needed to identify relatives at risk of potentially life-threatening heart disease. NHS England document A09/S/c 2013/14 “Inherited cardiac conditions” states that anyone with ICC, and their first-degree relatives, should have access to specialist ICC services within the catchment area. Genetic testing is centrally funded from April 2020, at no cost to the Trust.

All of our planned improvements in cardiac services require greater digital integration across the system, between sites and providers. Failure to achieve risks creating duplication and clinical risk.

What is the requirement from the NHS?

Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK. Cardiovascular disease is the single biggest condition where lives can be saved by the NHS over the next 10 years. The Long-Term Plan describes a number of improvement actions required.

Our Ambition

We plan to support the these aims for cardiac services through 6 key improvements:

- **Earlier diagnosis** of more people with heart conditions through increased access to specialist cardiac diagnostics including echo, CT, MRI via community diagnostic hubs and specialist hospital-based services
- Better support for patients with chronic **cardiac conditions** including heart failure and heart valve disease including access to nurse specialists working seamlessly with specialist consultants through MDT and virtual ward models
- Increased use of **genetic testing** enabling early diagnosis and treatment including development of the inherited cardiac conditions (ICC) service.
- Access to life-saving **emergency and acute** diagnosis and treatment with further improvements in rapid access to tertiary treatment for PCI, CABG and Cardiogenic shock
- Continued development of local access to **specialist tertiary services** at the Essex Cardiothoracic Centre so that patients can access the latest advances

in cardiac care locally within MSE such as minimally invasive cardiac surgery, specialist aortic surgery, percutaneous valve repair / replacement and Electrophysiology

- Expanding access to **cardiac rehabilitation** services to help people recover after treatment including diverse offers for community access and virtual support

Delivery Priorities

The recovery of access standards in cardiac services is a significant priority. Timely access to cardiac diagnostics, in particular echocardiography and CT, will be linked to collaborative system delivery of community diagnostic hubs and specialist workforce planning in cardiac physiology.

Through the Covid-19 pandemic cardiac services have unfortunately been impacted through periods of reduced activity and resultant increase in waiting lists. Increased waiting times have also led to higher clinical acuity of patients in both emergency and elective pathways. Hospital Cardiology services are working to reduce waiting times for outpatient and elective care in line with national RTT recovery trajectories. Effective use of clinical triage and of improved technologies has reduced delays in outpatient pathways. Patients now have access to virtual appointments in many cases when in person appointments are not required (for example for physical examination).

In the tertiary setting the greatest impact of the pandemic on waiting times has been for cardiac surgery. A cardiothoracic surgery recovery plan is in place and has seen good delivery through 2022. This work will continue and is reliant upon a large specialist clinical workforce and balancing the demands of elective and emergency surgery. We have invested in additional facilities within the Essex Cardiothoracic Centre to create additional capacity. Cardiac Intensive Care Unit capacity is key to supporting the surgical recovery and we will be continuing to invest in ITU clinical workforce to meet this need.

We have an excellent emergency service for primary PCI based at the Essex Cardiothoracic Centre and have made good progress with improvements in the NSTEMI pathways. We aim to further improve the NSTEMI service to reduce time to treatment in line with the national standards. This will be through extended weekend working and through earlier transfer of patients to the specialist centre by increasing capacity. We will continue to focus on clinical efficiency and value by extending our nurse-led discharge pathway.

Our ability to rapidly transfer inpatients to the tertiary centre is an important enabler for effective acute inpatient care, ensuring that we avoid delays and also supporting efficient scheduling. Current pressure on the ambulance service have impacted on cardiac transfers. We will work with the ambulance Trust to develop innovative new models and modes for patient transfer.

Ensuring Delivery

SRO: Dr Ronan Fenton
Clinical Lead: Dr Sunil Gupta

Our overall programme of work to achieve our ambition will be overseen through the Mid and South Essex ICS Cardiovascular Disease Programme Board. There will also be specific working groups leading on specialist pathways and projects including the Cardiogenic Shock Working Group (CSWG) and Cardiology stewardship group.

We aim to ensure delivery through excellent multi-disciplinary and inter-sector engagement, collaboration and commitment to delivering improvements for patients that also present a more clinical effective and resource-efficient whole system approach to cardiac care.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Comprehensive Cardiac CT service in plan in all acute hospital settings (1) developing capacity alongside CDH models sufficient to meet local population need (2)	(1) quarter three 2023/24 (2) 2025/28
Cardiac Physiology workforce strategy implemented (1) and delivering improved retention, development of teams to fill vacancies and meet clinical service need (2)	(1) quarter two 2023/24 (2) 2025/28
Standardised integrated model of care for Heart Failure patients underpinned by MDT working and collaboration to ensure that HF patients receive the care they need with no barrier to movement between providers and levels of care.	Second half of 2024/25
Rapid NSTEMI service in place across system with early inter-hospital transfer and weekend working	First half of 2024/25
Recovery of waiting times for elective cardiac surgery	First half of 2024/25
Commence Mitral Transcatheter Edge to Edge Repair (TEER) service (1) and develop to full population roll out as high-volume centre (2)	(1) quarter two 2023/24 (2) 2025/28

Cardiovascular Services

What have our residents told us?

We have conducted a survey, including interviews as well as shorter form questions, of people accessing our BP@Home programme. The results are being analysed at present.

Current Conditions

In parallel with activity nationally, our Cardiovascular Disease (CVD) detection and treatment activity dipped during the Covid-19 pandemic. We are working to restore and expand previous detection and management levels.

Whilst our Alivecor and BP@Home programmes have accelerated progress relating to AF and BP, we will need to expand capacity within the lipid management pathway to increase diagnosis and treatment levels.

Our baseline data shows the following trends in hypertension and cholesterol:

- Below national average (57%) of patients aged 18 or over with no GP-recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy.
- Below national average, and lowest in EoE Region percentage of patients aged 18 and over, with GP recorded CVD (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l.

What is the requirement from the NHS?

Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.

Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%.

The NHS is working collaboratively across primary, secondary and community care settings to improve and integrate CVD pathways and workstreams into normal working practices.

Our Ambition

Our long-term vision is to continue moving upstream in our approach to cardiovascular disease, including prevention and early detection of atrial fibrillation, hypertension and high lipids, so that our residents are able to enjoy more years of healthy life, with lower rates of heart attacks and strokes.

We will do this by focusing on:

- **Primary prevention:** working in partnership with communities and place-based teams on primary prevention, including links with our partnership approach to healthy weight and smoking.
- **Detection and 'datafication':** identifying residents with risk factors or established disease, using risk stratification approaches, and generating valuable data to drive proactive and, where possible, predictive, activity
- **Early intervention:** providing holistic, personalised support and treatment to residents with identified risk factors or early-stage cardiovascular disease.
- **Treatment:** providing holistic, personalised support and treatment to those with more established cardiovascular disease.

At system level, system programmes drawn together in alignment, with PHM, personalised care, inequalities etc running through.

Delivery Priorities

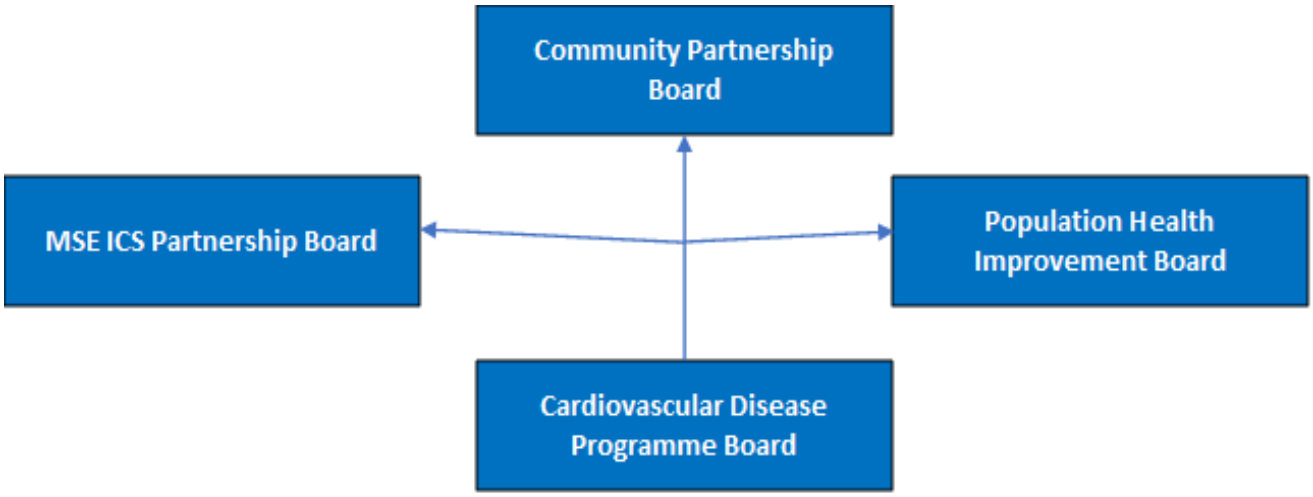
Different CVD prevention-focused workstreams will align with our system prevention approach:

- Primary prevention: linking with healthy weight and tobacco dependency support to reduce CVD-related risk factors.
- Detection
  - NHS Health checks
  - BP@Home programme
  - Breathlessness van (with mobile BP devices)
  - Exploring potential to expand use of Fibricheck whilst Alivecor use is reviewed nationally.
- Datafication, early intervention and treatment
  - Proactive care framework
  - Lipid management pathway – expanding access to genetic testing for familial hypercholesterolaemia, as well as to first- and second-line therapy.

Ensuring Delivery

SRO: Dr Ronan Fenton
Clinical Lead: Dr Pete Scolding

The different workstreams (AF, BP and lipids) will report into a system Cardiovascular Board (established Feb 23). This board will be accountable to the Community Partnership Board. See below organogram.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Expand BP@Home scheme by working alongside our community pharmacists and further integration into relevant clinical pathways such as Renal	Quarter four 2023/24
Monitor National review of Kardia Alivecor mobile heart monitors, and if re-approved expand use in GP surgeries, community centres and on our outreach bus. Scope potential to expand use of fibricheck app as alternative.	Quarter four 2023/24
Participate in Innovations for Health Inequalities Programme to expand the mobile unit (outreach bus) to a targeted core20Plus population, to include broader CVD risk assessment and management (including AF, blood pressure, cholesterol, smoking)	Quarter four 2023/24
Maximise Community Pharmacy Hypertension case finding	Quarter four 2023/24
Implement UCLP Proactive care framework for risk stratification and prioritisation of atrial fibrillation, blood pressure, cholesterol and type 2 diabetes	Quarter four 2023/24
Scope and agree approach to improving lipid outcomes.	Quarter four 2023/24

Palliative and End of Life Care (PEoLC)

What have our residents told us?

A Health Needs Assessment was undertaken in 2022 by Healthwatch Essex with the oversight of the Hospice Collaborative. Three key themes emerged:

- Improvement to accessing services: including 24/7; bereavement support; access to medication and pain relief
- Improved communication: between professionals; ease of contact for information and advice
- Clearer information: clear pathways for care, to preserve independence including sign posting and earlier referrals between services and hospices

Current Conditions

Across the ICS there are multiple organisations providing PEoLC with varying service models between Alliances with different population health needs. A gap analysis benchmarked against the National Ambitions Framework identified the following challenges:

Lack of Co-ordinated, consistent access to care:

To achieve our ambitions for PEoLC, collaboration across the full spectrum of health and social care, voluntary and third sector organisations, and local communities will be essential. The recent establishment of the hospice collaborative and the community collaborative will have a key influence. The challenge is developing 24/7 models of care that address the population needs of each Alliance in a co-ordinated, equitable, and consistent way. Lack of digital solutions to support shared care records and EPaCCS are negatively impacting on delivering co-ordinated care. Inequities in access to high quality bereavement services also affects the wellbeing of families and carers long term.

Reactive rather than proactive care:

Patient experience and outcomes that matter most are improved through early recognition of the EoL and personalised care planning for the future. To move to a proactive approach to care will require a significant cultural shift within the ICS, but one that is necessary to reduce unnecessary hospital admissions and therefore, system pressures. There is a need to empower our patients and families through practical support, information, and training in the EoL care.

Skilled workforce:

Nationally, there is known shortage of multi-professional specialists in PEoLC which is affecting recruitment and retention of staff within our ICS. Without the right

workforce, the ambition to support people and their families/carers to have the best support and outcome at the EoL will not be achieved. In addition, a recent MSE wide education gap analysis also identified that our current healthcare workforce would benefit from blended education and training programmes to increase their confidence and skills in the delivery of PEoLC.

What is the requirement from the NHS?

We are committed to the standards required to deliver high quality PEoLC services within the ICS. These include:

- Ambitions for PEoLC: a National Framework for Local Action 2021 – 26
- NHS Long Term Plan
- NHS PEoLC Statutory Guidance for ICBs, September 2022

Our Ambitions

Working in partnership across health and social care, including the voluntary sector and local communities, we will ensure that the palliative and end of life care (PEoLC) needs of people of all ages with life-limiting illness, and their families/carers, are met so that they receive the care and support they need to live and die well. This is irrespective of diagnosis or condition, and especially in the last year of life. We will focus on the "outcomes that matter most" to those we care for.

Delivery Priorities

The PEoLC Programme Board will be responsible for delivering a robust PEoLC workplan through 6 workstreams (as detailed below):

- Improving the recognition of people in the last year of life to focus on early personalised care planning and proactive anticipatory care
- Ensure that people are cared for and die in their preferred place of care, and to avoid unnecessary hospital admissions
- Ensure equity of access for our population to 24/7 co-ordinated care, information and advice, including access to anticipatory medication
- Complete the System-wide roll out of an Electronic Palliative Care Coordination System (EPaCCS) to improve co-ordinated and informed care. This will support the development of a PEoLC dashboard and its link to Population Health Management
- Support development of a single shared care record to ensure care is delivered at the right time by the right person with the right information
- Develop models of care to support the needs of families and carers

- Improve the quality of PEoLC through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of PEoLC through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services
- Improve the quality of PEoLC through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of PEoLC through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services

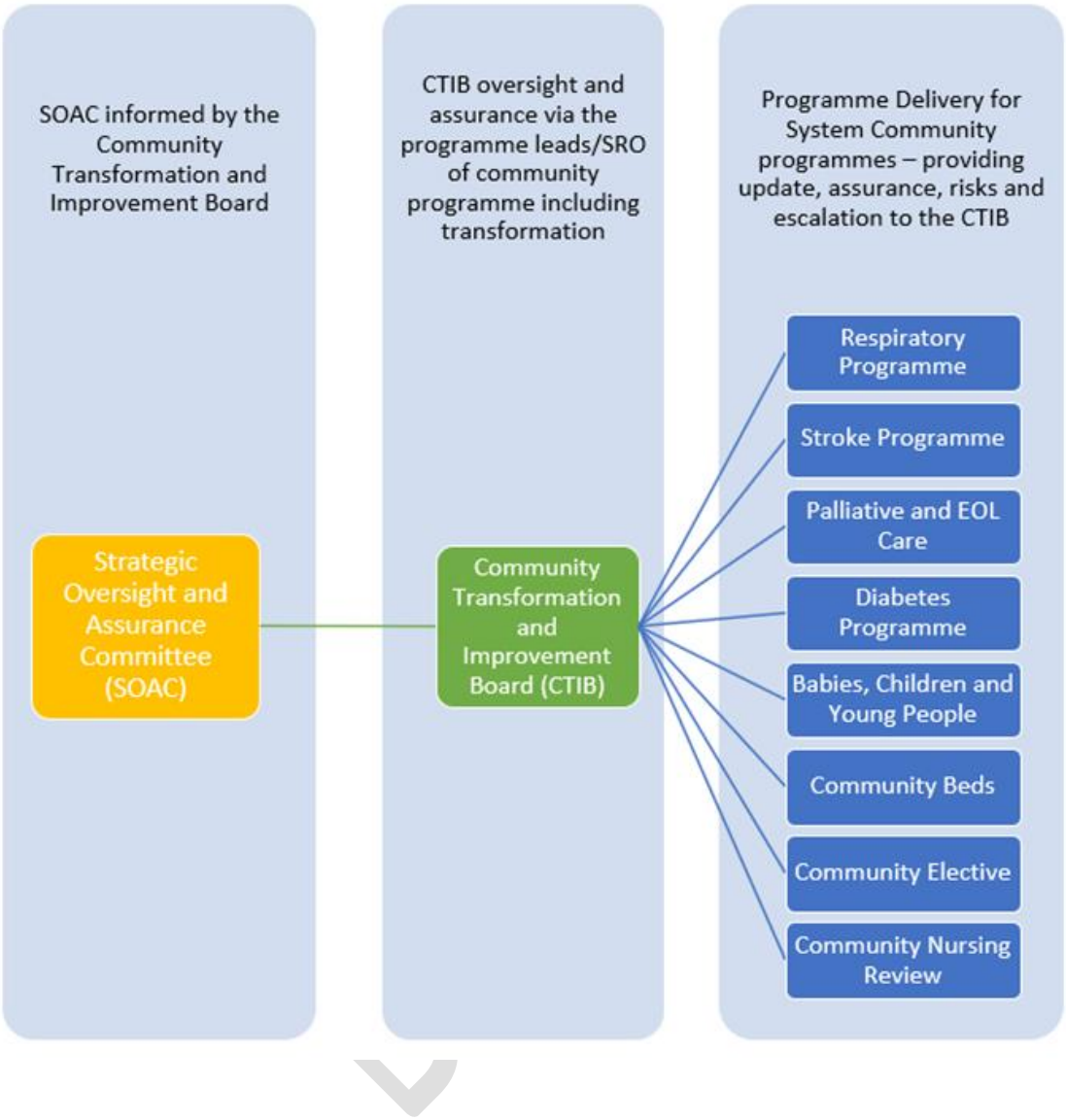
Ensuring Delivery

SRO: Karen Wesson
Clinical Lead: Dr Eva Lew

The PEoLC Programme Board will be responsible for delivering a robust PEoLC workplan through 6 workstreams (as detailed below):

The PEoLC Programme Board reports to the Community Transformation and Improvement Board which is then overseen by the Strategic Oversight and Assurance Committee. It is expected that the four MSE Alliance End of Life Network Groups will have representation on the PEoLC Programme Board and be active members on the PEoLC workstreams.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase recognition of population last 12 months of life achieving 1% by 2028	Quarter three 2023/24
Increase proportion of people offered personalised care support	Quarter four 2023/24
Deliver 24/7 coordinated care, information and advice including access to anticipatory medicine	First half of 2024/25
Deliver sustainable end of life care workforce	Second half of 2024/25

Diabetes Services

What have our residents told us?

There is variation across alliance areas in care received, for example, there is reduced uptake or completion of annual health checks in South East Essex area in comparison to others and we see increased amputation rate for diabetic foot disease in parts of this area. The ICB has led projects to improve uptake of checks and develop pathways centrally with varied results.

Current Conditions

There are approximately 69,000 (5.7% population) people living with Diabetes across MSE who could be at risk from diabetes complications, and additionally 28,705 people with Non-Diabetic Hyperglycaemia (NDH) at risk of developing Type 2 Diabetes within 3 years. Effective management of Diabetes is vital for people to avoid complications that are a detriment to quality of life and require health care interventions. An increase of preventable Type 2 diabetes could pose a significant strain onto the ICB in the medium term if preventative interventions are not made.

Challenges in community/integrated Diabetes services and hospital trusts as they work together to develop a joined up and equitable approach, aligning policy and pathways between 3 hospital sites and 3 community providers with varied models of delivery. In addition, there are increased caseloads of people presenting with complications arising after the covid-19 pandemic.

The ICB is currently going through formulation of leadership via recent recruitment of a System Diabetes Clinical Lead and the development of stewardship programme therefore these should be supportive in achieving objectives.

Need to deliver at lower cost to ensure sustainability in the system whilst meeting an increased population demand. Future investment amounts from NHSE CVDR network are currently unknown therefore planning for future quality improvement projects is challenging.

What is the requirement from the NHS?

In line with the NHS Long Term Plan, the Diabetes team are undertaking several quality improvements pilots and projects, some transformational and funded by NHSE and some now business as usual programmes that will impact prevention, patient understanding, knowledge and management of diabetes and improve pathways with aim of reducing long-term complications and health care interventions.

Our Ambitions

In line with the NHS long term plan the ICB aims to;

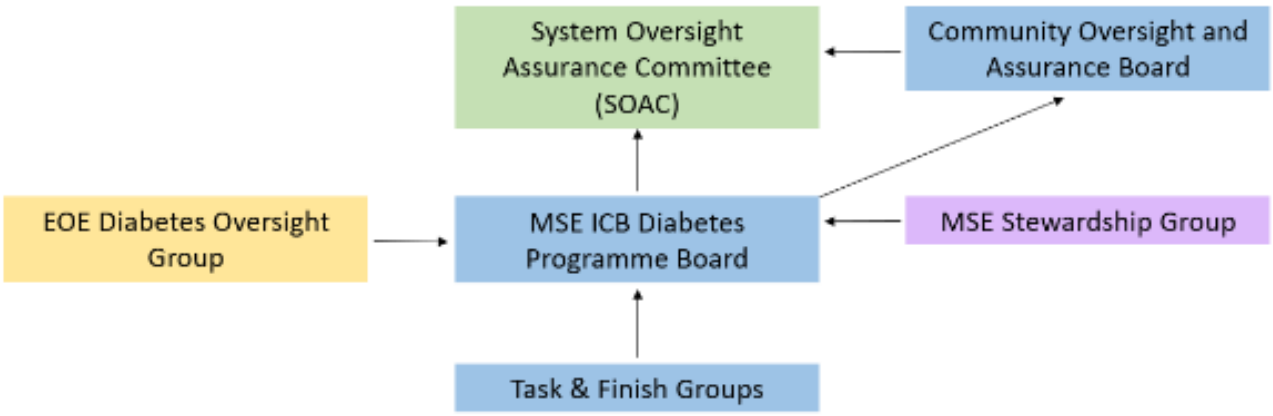
- Develop data sources and use of data and information to have better overview of population needs and health inequities with the aim of sharing data and working more collaboratively with services.
- Have a heavy focus on prevention, particularly on the significant population size at risk through preventative and educational programmes.
- Increase number of those attending structured education or using digital tools to support.
- Significant increase in completion of diabetes annual health checks and recovery of treatment targets to pre pandemic levels and above.
- Improve pathways for diabetic foot management and preventative interventions to reduce amputation rates and improve quality of life for people with a Diabetic foot condition.
- Support nursing teams to be fully staffed delivering 6-7 days services across ICS.
- Increased use of technology such as Glucose monitoring delivered to all Type 1 diabetes patients and many Type 2 multiple daily injections (MDI).

Delivery Priorities

- Diabetes dashboard to be finalised ready for analysis and identification of health inequalities, informing strategic planning by the Diabetes programme board.
- Maintain and increase referrals into services such as diabetes prevention programme, Low Calorie Diet Programme, structured education or digital tools.
- Significant increase in completion of all 8 key diabetes care processes/annual health checks to be at 34% of the diabetes population (currently 27.6%) and recovery of treatment targets to pre-pandemic levels to be at 33% (currently 27.1%) by March 2024.
- Ensure an effective and clear pathway for the Diabetic Foot in MSE with relevant preventative steps and being used effectively
- Support nursing teams to be fully staffed delivering 6-7 days services by 2024_25.
- Increased use of technology such as Glucose monitoring delivered to all T1 diabetes patients (70% by 2024 and 95% by 2025_26)

Ensuring Delivery

SRO: Dr Ronan Fenton
Clinical Lead: Deepa Shanmugasundaram



The above shows the System governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Self-management digital and education support tools to newly diagnosed patients	From quarter one to quarter two 2023/24
Improved care processes uptake from ~27% to ~34% across 8 rolling care processes	Quarter three 2023/24
Target improvements across 3 x treatments from ~27% to ~ 33%	Quarter four 2023/24
Power BI dashboard finalised and in use across ICS	Quarter four 2023/24

Dermatology Services

What have our residents told us?

The Dermatology patient survey in February 2023 found that:

- 59% of respondents had accessed care from their GP for their skin condition with 62% of patients regularly managing their skin conditions at home. Only 23% had a tele dermatology assessment.
- 44% of respondents had accessed skin treatment via a community or hospital service with mixed outcomes, the common trend being that the clinical care received by hospitals was good but often experienced long waiting times and thought the service was not patient focussed.
- 45% stated that their skin condition has impacted on their mental health and wellbeing with common themes being that skin conditions are leading to lack of sleep, increased anxiety of visual appearance.

Current Conditions

Challenges driving dermatology pressures include a shortage of consultant dermatologists and an ageing workforce, variation in diagnosis and management in primary care due to a lack of dermatological training for GPs; limited or fragmented use of available technology; inadequate triage in both primary and secondary care, limited and inconsistent coding of outpatient activity (NHS England Transforming Elective Care Services - Dermatology).

Local pressures resemble the national picture for Dermatology with increased patient waiting lists: dermatology is one of three priority areas due to significantly increasing demand for Dermatology services. The ICS has formed a Dermatology Board with representation across primary care, community and acute services. The Dermatology Board has overseen development of joint pathways with community and acute services to improve care for service users.

The Dermatology Programme Board alongside Dermatology Stewards have committed to implementing a single Community Dermatology Service across the ICS to support improvement in Dermatology services, reducing health inequalities, improving patient experience and patient outcomes, communication, and waiting times for patients.

What is the requirement from the NHS?

The Dermatology Programme Board are implementing an Integrated Community Dermatology Service, acting as a single point of access into community and secondary care services in line with national guidance. The service will be innovative and improve outcomes for service users.

Our Ambitions

Through use of tele dermatology the service will ensure that service users are seen in the right setting, first time, subsequently improving the early diagnosis of Skin Cancer and reducing hospital waiting times through triage. This links to the NHS Long Term Plan to boost out of hospital care and use technology to redesign clinical pathways.

In addition, Dermatology Stewards have identified key improvement areas. These include:

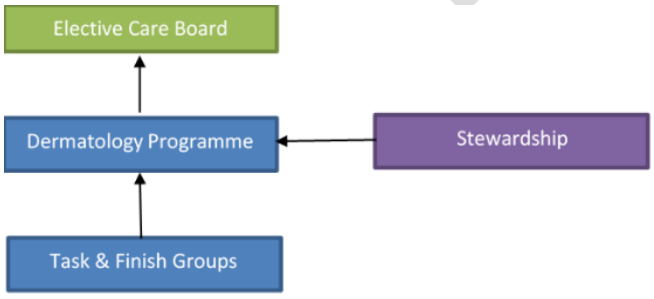
- Public health promotion of Dermatology conditions
- Continued engagement and training with General Practitioners and Health Care Professionals
- Initiatives to support the retention and training of workforce

Delivery Priorities

- Improve Skin Cancer 2 week wait and RTT waiting times
- Achieve the faster diagnostic standard for skin cancer
- Implement the Integrated Community Dermatology Service by November 2023.
- Deliver a seamless care pathway for our residents from point of prevention onwards

Ensuring Delivery

SRO: Emily Hughes
Clinical Lead: Karen Wesson
Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implement a single Integrated Community Dermatology service across Mid and South Essex by December 23	Quarter three 2023/24

Eye Care

What have our residents told us?

The common theme in feedback from residents is that the quality of care given during attendances is good, however the waiting time for appointments (particularly follow up care), delays for surgery and telephone access to the service require improvement. Care closer to home and easier to access is well received, this is supported by Friends and Family Test responses that are more positive for satellite/community locations than for attendances at the large Trust sites.

Current Conditions

Eye care services across mid and south Essex are significantly challenged as a result of year-on-year growth in demand and the added impact of the COVID-19 pandemic. The number of people waiting for appointments at hospital is at a record high particularly for those with developing or chronic conditions. This has an impact on the avoidable deterioration of vision and long-term outcomes for our population.

What is the requirement from the NHS?

By understanding our current demand and future growth in demand for eye care services we will target pathway transformation to maximise capacity to ensure patients are treated in a timely manner and as close to home as possible.

The Planning Guidance for 23/24 identifies the requirement to ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations.

Our Ambitions

The aim of the Mid and South Essex Eyecare Transformation Programme is to 'improve and preserve the vision of our residents now and in the future by achieving a system-wide sustainable and integrated eye care service across mid and south Essex'

We intend to reduce the non-admitted waiting list and improve Referral to Treatment performance, significantly reduce the overdue follow up waiting list and improve patient outcomes, particularly relating to avoidable deterioration of vision whilst waiting for treatment).

Delivery Priorities

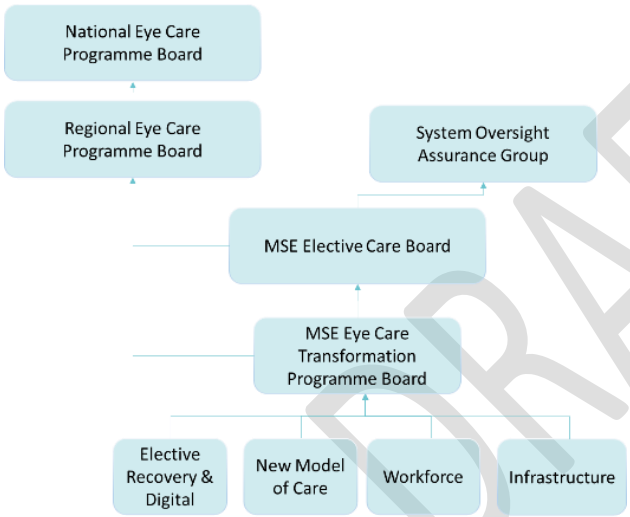
Led by the Eyecare Transformation Programme Board, improving outcomes for patients and their experience of care will be achieved through:

- Developing new pathways and increasing capacity and efficiency of services to meet growing demand
- Reducing waiting times for care
- Maximising the clinical capabilities of the ophthalmic workforce and developing new roles
- Improving estates and digital infrastructure to support the future delivery model

Ensuring Delivery

SRO: Andrew Pike
Clinical Lead: Dr Boye Tayo

Below organogram of system governance arrangements.



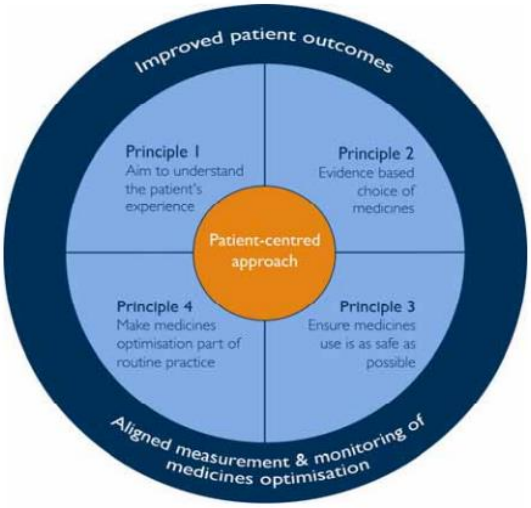
Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Complete review of 8,00 glaucoma patients	Quarter one 2023/24
Full implementation of Referral Hub with clinical triage	Quarter one 2023/24
Implement one diagnostic hub and develop specification for spokes (subject to business case)	Quarter three 2023/24
Expand use of EeRS and implement Advice & Guidance functionality	Quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Develop and implement pre-op cataract pathway and glaucoma case finding	From quarter three to quarter four 2023/24
Review and develop end to end pathways for medical retina	First half of 2024/25
Implement diagnostic pathway with associated capacity across all mid and south Essex	Second half of 2024/25
Development and mobilisation of long-term estates and infrastructure solutions for acute ophthalmic care as per the new model and pathways	2025/28

Pharmacy and Medicines Optimisation

What have our residents told us?



Current Conditions

Antimicrobial Stewardship: National target has not been achieved since November 2021, some of this increase is attributed to surge in demand for management of Group A Strep and prevention of Diphtheria and in line with increase in antibiotic prescribing seen nationally. There is steady decrease in the use of broad-spectrum antibiotics.

Patient Safety: Reduction of dependence forming medicines is a priority. MSE currently has over 1000 patients prescribed >120mg morphine daily. New guidance and implementation documents in place to support patient and prescribers.

Resources: Cost pressures arising from increasing demand for medication, increase in price due to shortages leading to price inflation and DH price concessions.

Over-prescribing: Overprescribing directly affects some groups with protected characteristics. In Oct 2022 there were 111,458 (10.87% c.f. 10.79% national average) people taking 8 or more unique medications (range across Alliances 8.33% to 11.04%) and the average number of unique medicines prescribed for all patients in MSE was 3.66 compared with 3.53 nationally.

Community pharmacy integration: Slow uptake of community pharmacy consultation service and under-utilisation of community pharmacy clinical services (both nationally and locally commissioned) to increase capacity within GP practices.

The Essex Pharmacy Leads network was re-invigorated during the pandemic and continues to support system wide working.

What is the requirement from the NHS?

- A whole system approach to medicines optimisation to improve population health.
- Improve access to medicines.
- Improve health outcomes from medicines.
- Reduce inappropriate prescribing.
- Deliver value from medicines.
- Reduce waste.
- Promote self-care.

Our Ambitions

To ensure that people living in Mid and South Essex have access to the medicines they need, in the right place and at the right time; to achieve the greatest health outcomes for themselves and the local community, within the resources available.

Delivery Priorities

- Achieve the antimicrobial prescribing metrics year on year by implementation of NICE guidance and cross-sector guidance on common infections in line with ICB AMR Workplan 2023-2026
- Patient Safety- Patient Safety- reduce the risk of medicines-related harm from high-risk drugs- Valproate Prescribing in Females under 55 and other PSIRF priorities; improved monitoring to reduce risk of harm Eclipse Patient Safety indicators
- Reduce number of patients on high dose opioids to ICB average ePACT2 Opioid Prescribing Dashboard
- Resources-make best use of NHS funding by managing cost pressures arising from increasing demand for medication and reduce variance in prescribing spend £per ASTRO-PU ePACT2 between MSE practices to drive equity, appropriate distribution and best use of resources and make best use of existing pharmacy workforce and developing a pharmacy workforce pipeline strategy.
- Reducing over-prescribing and over supply- reducing carbon burden of medication. Polypharmacy- reduce inappropriate polypharmacy- reduce variation across MSE ePACT2 Polypharmacy Prescribing Comparators
- Integration of community pharmacists and community pharmacies into ICB pathways; optimising the use of nationally commissioned services Community Pharmacy Consultation Service (CPCS) Discharge Medicines Service (DMS), Blood Pressure Check Service and Oral Contraceptive Service; development

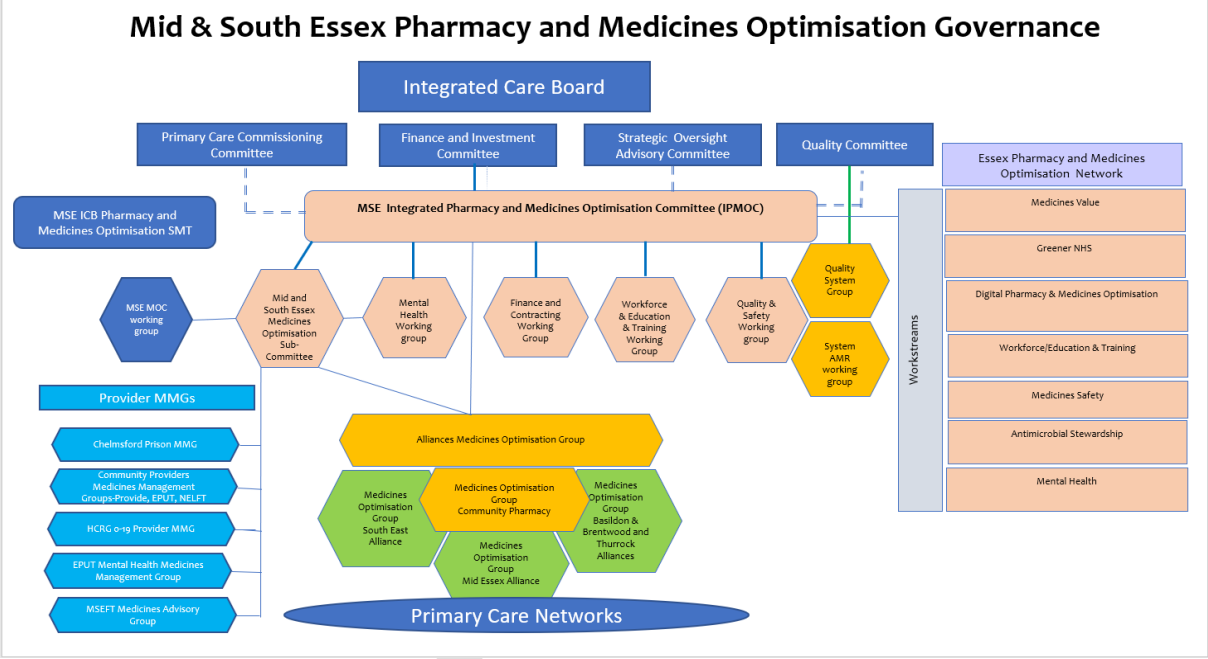
of clinical services delivered including Independent Prescribing by Community Pharmacists.

Ensuring Delivery

SRO: Paula Wilkinson
Clinical Lead: Dr Aravinda Guniyangodage

The MSE Medicines Optimisation Committee is in place and working towards single formulary and prescribing guidance for the ICS. Evolving Integrated Pharmacy and Medicines Optimisation Committee and system/alliance medicines optimisation groups to drive systemisation of medicines optimisation and pharmacy integration

The below shows the proposed governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish MSE AMR network of PCN lead pharmacists and train the trainer programme; and audit programme to drive change	Quarter one to quarter three 2023/24
Implement and embed PSIRF; patient safety audit programme	From quarter two to quarter three 2023/24
Undertaken pharmacy workforce gap analysis and develop a pharmacy workforce strategy for MSE.	From quarter two to quarter three 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Optimise use of High Cost Drugs- use of biosimilars	From quarter three 2023/24 to second half of 2024/25
Implement annual system wide Medicines Optimisation Locally Enhanced Scheme to drive quality, equitable and cost-effective prescribing and reduce variance MOLES 23-24	From quarter one to quarter three 2023/24
Increase delivery of high-quality structured medication reviews to improve outcomes and reduce medicines-related problems for patients ensuring equity in access and focus on people with Serious Mental Illness and those with Learning Disabilities.	From quarter two to quarter three 2023/24
Develop and implement action to address the carbon impact of unnecessary prescribing and medicines waste in areas other than inhalers.	From quarter two to quarter three 2023/24
Implement and evaluate Independent Prescribing Pathfinder within community pharmacy with focus on extension of CPCS service initially.	From quarter one to quarter four 2023/24

Musculoskeletal (MSK) and Pain Service

What have our residents told us?

A small-scale survey was undertaken in 2023, 108 people responded in total with 46 expressing an interest in being involved in future discussions. An online event was held 11th May 2023 targeting the people who responded to the survey. In addition, face to face survey engagement will be undertaken at MSK, Pain and Rheumatology outpatient clinics during May.

Current Conditions

Current challenges and pressures:

- Differential access to services across the system in community and secondary care.
- Waiting list pressures in secondary care, admitted and non-admitted.
- Workforce pressures.

Partnership working:

- MSK Delivery Group in place with speciality specific task and finish groups. All groups have representation from all providers currently offering MSK care across the system including primary, community and secondary care.

What is the requirement from the NHS?

MSK is one of the three speciality priorities described in the NHS Planning Guidance 2021/22 to support a reduction in variation in access and outcomes. Within the Mid and South Essex ICS there are six providers providing MSK services across community and multiple NHS and Independent Sector delivering secondary care, which creates a variation in both access to services and pathways being delivered across the population.

Our Ambitions

MSK transformation includes trauma and orthopaedics, rheumatology, pain management and therapies. Working with stakeholders since Autumn 2021, the MSK System Delivery Group have developed a new community pathway, for people aged 16 years and over, based on the East of England MSK Pathway Improvement Framework, the Best MSK high impact recommendations and adhering to the Getting It Right First Time (GIRFT) pathway.

The proposal is to commission a single Community MSK and Pain Service for mid and south Essex which aims to triage, assess, and treat more patients outside of acute services and improve outcomes, quality and patient experience of care. Residents that cannot be managed in primary care will be referred to the community

service via a Single Point of Access (SPoA) for assessment, diagnostics, diagnosis, and treatment. Patients who require surgery or specialist assessment and/or treatment will follow a pathway through the community service into an acute service of their choice.

Delivery Priorities

- System wide community MSK and pain service to be implemented by Q4 23/24
- 80% conversion rate to surgery
- <20% discharged at first appointment.
- Support waiting list reduction.

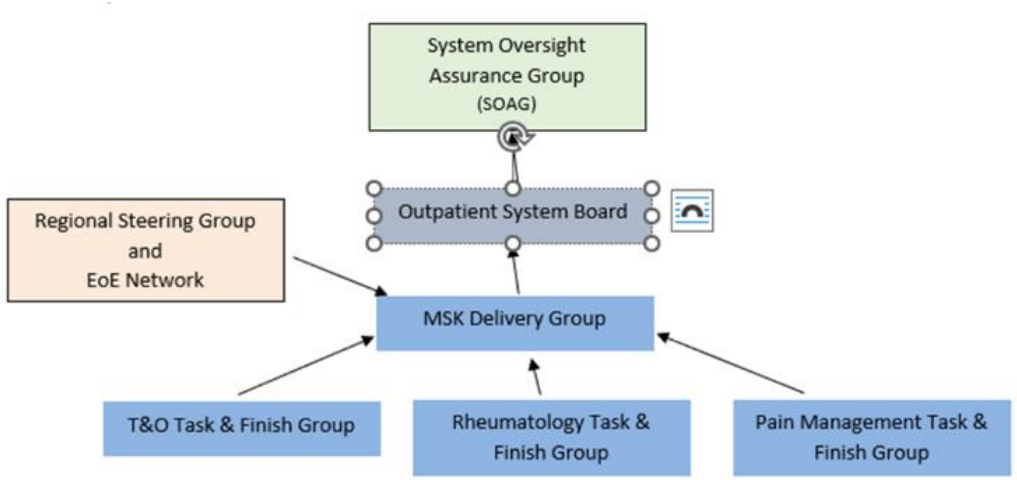
The new service will deliver high quality, patient focussed care that is innovative, improves outcomes and reduces health inequalities for patients. Expected outcomes will include:

- Delivering a population health approach focused on optimising outcomes, including reducing health inequalities
- Providing a service that delivers equitable outcomes and experience
- Improving life-long best MSK health for the population of Mid and South Essex using preventative and anticipatory care approaches
- Delivering a seamless integrated pathway
- Adherence to Referral to Treatment (RTT) standards and more efficient recovery of waiting lists.

Ensuring Delivery

SRO: Tiffany Hemming
Clinical Lead: Gurvinder Saluja Clinical Lead
Clinical Lead: Mr Sean Symons MSEFT

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Specification to be signed off by the Delivery Group	Quarter one 2023/24
Further resident engagement event	Quarter one 2023/24
Scoping exercise around paediatric orthopaedic pathways	Quarter three 2023/24
System wide MSK and Pain Community Service to be in place in 23/24 Q4	Quarter four 2023/24
Identification and prioritisation of further initiatives to improve pathways and outcomes	First half of 2024/25

Appendix 8 – Supporting System Development

Within this section you will find long term plans relating to:

- System Governance
- Tackling Violence and Aggression against Women and Girls (VAWG)
- Research Studies
- Delegation of Services (Pharmacy, Optometry and Dental Services - POD)
- Specialised Commissioning
- Community Mobilisation, Transformation & Resilience

Building our ICS Governance

Governance arrangements to establish the ICB are sound, meet the requirements of the Act and were seen as good practice by NHSE. As the ICB matures to meet its objectives of subsidiarity and integration, governance must evolve to enable this maturity.

Residents/patients have asked the Board for more focussed engagement on decision making and expect standards of business conduct / transparency of decision making in line with our goals to be robust, demonstrating our accountability and influence over the performance of the system.

Governance is an enabling function and so must work closely with all directorates to achieve its objectives and the ICB ambition.

What is the requirement from NHS

The ICB must ensure that systems of internal control are robust to manage system and local ICB risks that threaten the achievement of ICB objectives and maintain and strengthen compliance with legislation and codes of governance.

This includes the approval of plans, strategies, and business cases as well as scrutiny of decisions and seeking assurances and legal advice that ICB functions are delivered appropriately. As the ICB develops, taking on delegated functions from NHSE, strengthening subsidiarity and integrating with our partners, governance will need to evolve to enable these functions to be delivered.

What is the ambition

To maintain compliance with statutory duties and good governance practices. In line with the NHS Long Term Plan and ICP Strategy:

- Support integration with partner organisations – strong system decision making and risk management
- Establish governance to support Subsidiarity – fully integrated and streamlined Provider Collaboratives / lead provider model

Satisfactory outcome to CQC inspection of Integrated Care Systems

What are the delivery priorities?

- Maintain good governance and compliance with statutory duties for example the duty to obtain appropriate advice.
- Enhance reporting and information flows to the Board and committees using synthesised ‘highlights and exception’ approach for escalation of performance (incl. constitutional standards, quality, and finance) risk and assurance as the key components of core reporting.

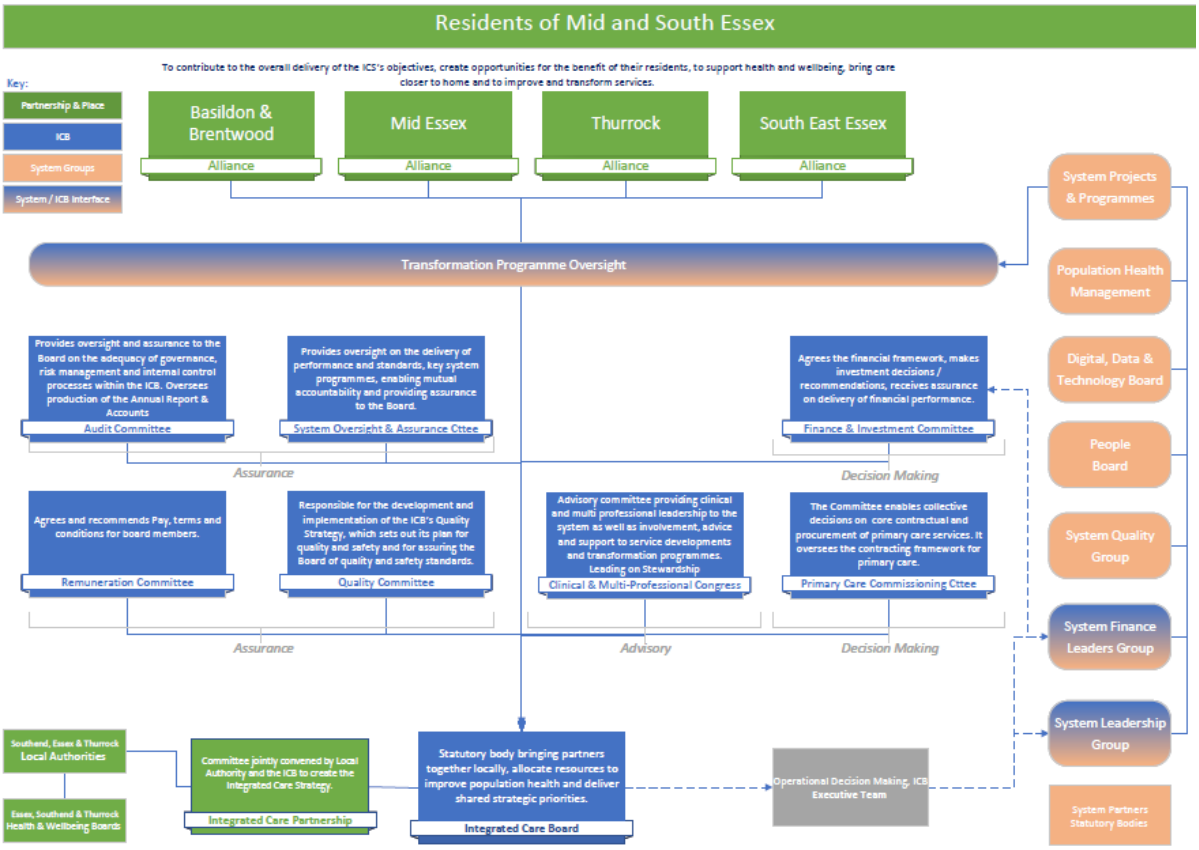
- Embed and enhance robust governance and the ICBs standards of business conduct at all relevant levels including arrangements for effective decision making, management of conflicts of interest and ensuring all aspects of the ICS uphold the Nolan Principles of conduct in public life
- Utilise data and dashboards to ensure that assurance of performance to Board and committees is high quality, contemporary and serves the need of the organisation's governance.
- Create the appropriate governance functions in support of the delegation of NHSE commissioning functions for podiatry, optometry and dentistry and shadow arrangements for specialised commissioning, as well as delegation to place, collaboratives, the role of stewardship groups etc.
- Create more effective and agile decision making that aligns, where appropriate, organisational governance processes to support delivery of system priorities e.g. business cases for transformational investment, financial recovery programme(s).
- Develop collaboration with partners to support ICS integration and the management of risk across the system that enables individual accountability and collective responsibility.

Governance

SRO: Anthony McKeever
Lead: Mike Thompson

How will we ensure delivery

The below diagram shows the ICB accountability structure



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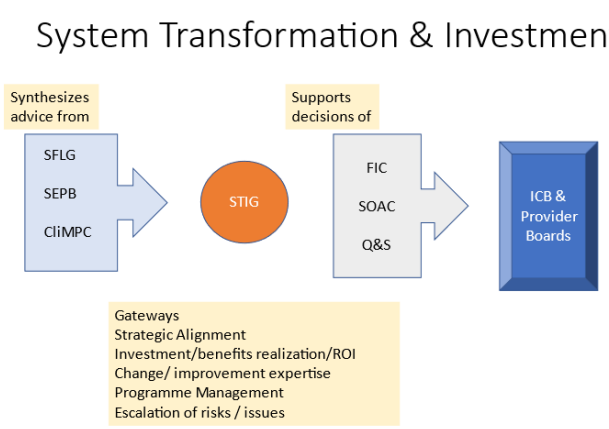


Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Maintaining robust governance to keep the ICB safe / meet statutory requirements e.g., annual report, duty to obtain appropriate advice.	From quarter one 2023/24 to 2025/28
Enhance performance quality and finance reporting to ICB Board and assurance through committees	Quarter one 2023/24
Revise and update business case process	From quarter one to quarter two 2023/24
Review and update Scheme of Delegation for decision making and onward delegation	Quarter two 2023/24
Support effective use of system transformation and investment group	From quarter one to quarter two 2023/24
Guidance and training for staff on effective decision making	Quarter two 2023/24
Support the delivery of the governance peer review	Quarter one 2023/24
Implement strengthened governance outcomes from the peer review	From quarter two to quarter three 2023/24
Establish governance for Specialised Commissioning	Quarter four 2023/24
Work with system partners and place to fully understand what governance structure is required.	From quarter one to quarter two 2023/24
Support the development of delegation to place, collaboratives	From first half 2024/25 to 2025/28
Develop integration of governance with partners and system risk management	From quarter two to quarter four 2023/24
Co-ordinate the preparation for and response to CQC inspection of the integrated care system	From quarter two 2023/24 to second half of 2024/25

Victims of Abuse (including VAWG)

What have our residents told us

Everyone has the right to live safely, free from abuse and neglect. Abuse and neglect can occur anywhere; at home, public place or whilst receiving services such as health care, education, or in social care setting. There are many forms of abuse; sexual, physical, psychological, domestic, discriminatory, financial and neglect.

What is the current state of play/local challenges

Victims of abuse are also more likely to develop a dependency to or misuse alcohol and/or drugs and domestic abuse has been strongly associated with sleep and eating disorders and exacerbation of psychotic symptoms. Individuals with mental health problems may also be more vulnerable to domestic abuse.

Abuse can result in a wide range of significant impacts on the health of an individual ranging from physical to mental health concerns. Prolonged exposure to physical abuse can lead to significant long-term health problems or death. Domestic abuse can have a widespread and significant impact on mental health and can lead to conditions such as anxiety, depression, suicidal behaviour, and post-traumatic stress disorder (PTSD).

ICB statutory duties within the Domestic Abuse Act 2021

ICB statutory duties within the Serious Violence Duty 2022

What is the requirement from the NHS

Breaking the cycle of domestic abuse is one of the priorities in the Police and Crime Plan for Essex. The Government's Violence Against Women and Girls Strategy 2016-20 follows a framework that includes: provision of services, partnership working and pursuing perpetrators. It has a focus on the need to transform service delivery, have a change in social action to achieve a sustainable long-term reduction in the prevalence of abuse and to break the inter-generational consequences of abuse.

Reducing violence in in our communities and the impact of drug driven violence, is the key priority for the Essex Violence and Vulnerability Partnership.

What is Our Ambition

The ICB has committed to work in partnership with Police, Social Care and many of our local charities and voluntary organisations to address the many forms of abuse and violence our residents are experiencing.

- Partners in the Southend, Essex and Thurrock Domestic Abuse Board working together to commission a range of specialist victim and perpetrator services and raising awareness and recognition of abuse.

- Partners in the Essex Violence and Vulnerability Partnership commissioning a joint strategic approach in preventing violence and protecting the vulnerable in our communities
- Partners with the Community Safety Partnership teams which bring together organisations and groups that share responsibility of tackling crime and disorder, anti-social behaviour plus drug and alcohol related offending

What are the delivery priorities?

Domestic Abuse Strategy five key outcomes:

- Children & young people can recognise and form healthy relationships;
- People experiencing and at risk of experiencing domestic abuse are supported to be and feel safe;
- Everyone can rebuild their lives and live free from domestic abuse;
- Supporting and disrupting perpetrators to change their behaviour and break the cycle of domestic abuse;
- Communities, professionals, and employers can recognise domestic abuse at the earliest opportunity and have the confidence to act.

Violence and Vulnerability Strategic Objectives

- Voice of our communities
- Targeting interventions
- Developing the workforce
- Communications – raising awareness
- Improving understanding

Community Safety Partnership Objectives

- Tackling violence against women and girls
- Tackling community based antisocial behaviour and safeguarding victims
- Safer communities
- Human trafficking, modern day slavery and organised immigration crime

Governance

SRO: Jeff Banks
Clinical Lead: Linda Moncur Director of Nursing for Safeguarding

How will we ensure delivery

Through partnership working across the ICP the ICB will deliver its statutory duties and realise the outcomes identified in the Domestic Abuse Strategy, the Violence and Vulnerability Strategy and the Community Safety Partnership Priorities.

The strategic working of the Alliance Groups is inclusive of the need to address the social determinants of healthcare and health related behaviours between areas and communities and the need to address inequalities particularly through the work on Core20PLUS5 Framework.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Existing or new partnership established for joint decision making with partners	Quarter one 2023/24
Evidence based analysis completed identifying local serious violence issues	Quarter three 2023/24
Prepared local strategy to contain prevention and reduction initiatives	Quarter four 2023/24
Review and refresh of needs analysis and strategy	First half of 2024/25

Research in Primary Care and Community

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

Relatively little health-related research has been conducted in Mid and South Essex compared to other areas of England. This is partly due to the absence of large research-based academic institutions and medical schools in the area. This may be having a damaging effect on the local health care economy by reducing opportunities for innovation and research available to local patients, reducing the attractiveness of the area to high performing health care professionals and reducing the investment that is associated with research centres.

In addition, all community services are suffering with workforce shortages, increased clinical needs and backlogs caused in part by the Covid pandemic. Primary care in particular is fragile with its highly fragmented structures, limited and variable management capacity and poor morale and retention.

Increasing research activity and collaboration between partners may achieve economies of scale, mutual support and better outcomes. In addition, it may help attract and retain highly skilled staff and create a virtuous circle of more sustainable health care systems.

What is the requirement from NHS

Community, Primary Care and other out of hospital Health Services in Mid & South Essex include

1. 150 GP practices organised into 27 Primary Care Networks
2. 3 Community and Mental Health Providers
3. approx. 550 schools
4. >69 care homes
5. 3 hospices
6. 1 prison

Plus many more community dentists, pharmacists and optometrists.

Currently each community provider is conducting research supported through its own research office which provide varying levels of support to researchers.

In addition, the North Thames Clinical Research Network, which currently covers MSE, supports the implementation of research in partner organisations including primary care and agile settings such as those above. Funding is from the NIHR (National Institute of Health Research) via the local primary care office based in Broomfield Hospital. This covers Mid & South Essex, West Essex, Luton and Herts

Valleys. In April 2024 the footprint will alter so that MSE will become part of the East of England Local Clinical Research Network. Although the footprint and relationships will change the underlying NIHR priorities and funding should remain similar.

What is the ambition

As a system, Mid & South Essex aims to increase the number of research studies conducted in the community and to increase the number of research-active primary care networks.

It will help achieve this in partnership with the Local Clinical Research Network by promoting research activities through its publications and website, through incorporating research activity in its commissioning activities and supporting Research Champions in primary care.

There are four themes to the Vision:

1. Research is available and responsive to the health and care needs of our population
2. Adaptive connection of research systems and processes to Primary Care systems
3. Strategic engagement and incentivisation in Primary Care
4. Strategic development of the Primary Care Research Workforce

The longer-term vision is to partner with local academic institutions to increase the local base of academic expertise to lead more locally-designed and locally-relevant research studies. The Anglia Ruskin University Medical School is developing its long-term strategy in partnership with the ICB to deliver this. Ultimate goal to establish a Centre for Advancing Primary & Integrated Care (CAPIC)

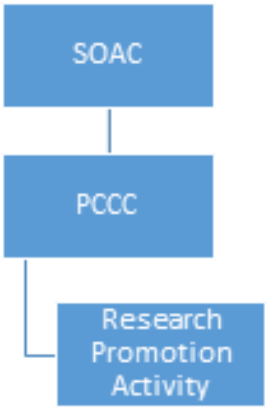
What are the delivery priorities

- Develop community of practice in out of hospital research between providers: NELFT, EPUT, Provide, Primary Care. Initial meetings commenced Nov 2022 and planned quarterly contact meetings to explore and support options for collaboration and mutual support and development. To initiate by April 2023.
- Identify options to increase capacity to support and develop research through funding applications to employ a coordinator for primary and community care research. Sept 2023
- Support collaborative links with local universities to develop and champion primary care and community research within M&SE. Agree joint strategy. Sept 2023
- Recruit and support research champions in primary and community care across MSE. Sept 2023 and ongoing.

Governance

SRO: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery



Above organogram of system governance arrangements.

Currently the research workstream in MSE ICB has no budget allocation. It relies on soft leadership, networking and influence to work with partners to meet its objectives. Reporting is proposed to be via the PCCC.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish community of practice	Quarter one 2023/24
Agree options to support and develop activity	Quarter two 2023/24
Links with academic institutions	Quarter two 2023/24
Research Champions	Quarter three 2023/24
Increase collaboration across community-based research active organisations	Second half of 2024/25
Increase quantity, quality and proportion of locally-led research through CAPIC	2025/28

Research in Acute Setting

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

MSEFT has a proud and growing reputation as a centre of innovation and research but only 33 of >700 consultants are research-active and we are unsure of other healthcare professional involvement. However, our geography means we compete with larger London research institutions. We should look to work with partners to define the unique offer that MSEFT has and to develop a long-term system wide research strategy.

In addition to this, we must consider how we improve training provision to increase the overall satisfaction of staff with their onsite training. Our GMC National Teaching Survey scores continue to be lower than our peers. Continuing to grow our partnership with the medical school at Anglia Ruskin University and with the University of Essex will help to build our teaching capability.

What is the requirement from NHS

The Health and Care Act 2022 (the 2022 Act) sets new legal duties on ICBs around the facilitation and promotion of research in matters relevant to the health service, and the use in the health service of evidence obtained from research.

What is the ambition

Key points in the draft R&D strategy document:

1. Establish a culture where research is appreciated across all staff groups and embedded into routine practice
2. Develop a High-Quality Research Portfolio offering access to patients across all specialties and sites
3. Increase quantity of research
4. Patients and public are engaged with, participate in and benefit from research
5. Research is adequately funded via NIHR funding, external grant applications, commercial research income and charity funding
6. Research is well governed, managed, supported and delivered and studies are delivered as agreed

What are the delivery priorities

The immediate plan is to develop a system-wide research strategy that incorporates research in acute settings with research in community and primary care (see separate JFP). This will cover People, Partnerships, Portfolio of assets, and Patients/Populations.

Joint funding from the Anglia Ruskin University, ICB and MSEFT has allowed recruitment to two posts to create a research strategy team.

They are currently involved in a stakeholder engagement exercise to draw up the priorities for a strategy, which is due to be published in June 2023.

Engagement will take place in the summer of 2023. Draft objectives are stated above.

Governance

SRO: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery

Short term collaborative funding has supported the establishment of a small research strategy group. Delivery of the strategy will depend on system-wide partners including NHS providers, academic institutions and the ICB.

National support through NIHR and other funding sources. Oversight will be through the Clinical & Professional Leadership Directorate. Overall governance to be agreed.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Conduct initial stakeholder engagement	Quarter one 2023/24
Publish System-Wide Research Strategy	Quarter two 2023/24
Further engagement and final strategy production	Quarter three 2023/24
Implement Research Strategy	From quarter four 2023/24 to 2025/28

Pharmacy, Optometry and Dental Services (POD Delegation)

What have our residents told us?

Access to all primary services (including Pharmacy, Optometry and Dental services) is a priority for our local population. Many residents see accessing these services as both an alternative to hospital-based care and as the gatekeeper to hospital-based services where required.

Residents are struggling to access dental services particularly in some more deprived areas of the ICB. Many residents access private dental services due to a lack of NHS provision.

Current Conditions

Pharmacy optometry and dentistry (POD) services will be delegated to ICBs as of 1 April 2023. Transition plans are underway, but there are significant challenges in taking on these responsibilities including access to care, quality and finance.

Access to dental services nationally is a significant challenge. This is in part due to workforce constraints but also is attributed to the existing contractual settlement with dentists. The contract framework is currently under review nationally.

Nationally, there are also challenges within the community pharmacy workforce. There is concern that the planned expansion of community pharmacy services as an alternative to general practice cannot be supported within the current resource constraints.

What is the requirement from the NHS?

The Planning Guidance for 23/24 identifies the following requirements that impact on Pharmacy, Optometry and Dental services.

- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
- Increase the use of Community Pharmacy Services as an alternative to general practice
- Ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations
- Recovery of secondary care dental service waiting lists as part of overall waiting list recovery

Our Ambitions

The ICB seeks to ensure that POD services form a key part of our Integrated Neighbourhood Team model for urgent and episodic care, complex care and prevention.

Delivery Priorities

Pharmacy, Optometry and Dental Services will be delegated to ICBs from 1st April 2023. As such, our initial priority is to stabilise arrangements and ensure we are delivering our business-as-usual functions effectively. From this foundation we will then undertake a process of strategy development over a six-month period. We will engage with stakeholders throughout this process.

From the end of 23/24, we will seek to deliver upon our strategic ambitions.

Ensuring Delivery

SRO: Dr Ronan Fenton, Medical Director ICB
Clinical Lead: Dr James Hickling

A number of subgroups of the Primary Care Commissioning Committee will oversee the effective commissioning of Pharmacy, Optometry and Dental services. In addition, the PCCC will oversee the development of clear local strategies that link in with our Integrated Neighbourhood Team ambitions.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transfer and stabilise services following delegation from NHS England	Quarter one 2023/24
Ensure Business as Usual functions are undertaken effectively	Quarter two 2023/24
Develop Community Pharmacy and Dental Strategies (and continue Ophthalmology Stewardship programme)	From quarter three to quarter four 2023/24
Implement Strategies	From first half on 2024/25 to 2025/28

Community Resilience and Engagement

What have our residents told us?

We knew it was essential that the building-blocks of our strategy and the ambitions of the JFP were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in the NHS, plus our local authorities.

In developing the integrated care strategy, we held eight workshops based in community venues, collectively engaging over 170 people from all parts of our system, including elected councillors, system leaders, staff and, most importantly, members of our community. We also used the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question.

We use our Community Campaign Model and our emergent Community Assembly to convene and engage with our communities iteratively, we have a network of 10,200 Community Groups. We have engaged digitally with 3000 members of the public to support the development of the Assembly. This is an approach we intend to continue to evolve to support the delivery of the Joint Forward Plan.

We have adopted a convening, iterative engagement approach that; meets people where they are and focuses on appreciative enquiry.

We have asked people what is working well and what could we do more of. The emergent themes from our community conversations are:

- **Access:** Personalisation and complexity remain a challenge both physically and digitally for our communities. We must make our offer obvious and our systems intuitive with a focus on primary care, urgent care and care closer to home
- **Equitable and Honest:** More work is required to meet inclusion health groups where they are, whilst being open on what is possible. This will become an ongoing feature of the work of the ICP as it moves forward. Additionally, a commitment to learning from issues and sharing this openly.
- **Awareness:** Further development of behaviour change support to address the wider determinants of health through collaboration around early intervention and prevention
- **Building Responsible Community Together:** Active listening and development of equitable mechanisms that offer a proportionate way for communities to work with us to solve the societal challenges we all face.

Current Conditions

We cannot service our way out of the current service and societal challenges we face. Communities are our greatest asset in driving behaviour change to empower people to Live Well - this requires a new model of civic infrastructure. This means we will need to meet people where they are and work shoulder to shoulder with our people to leverage the best outcomes for our communities.

What is the requirement from the NHS?

As articulated in the MSE Integrated Care Strategy, "Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of our Partnership"

Our Ambition

We will create a whole system, asset-based approach to working with communities. We will empower people to connect face to face and virtually around societal, system and neighbourhood-based challenges, that are important not only to communities of place, purpose and interest but also supports driving social movements that ensure better system outcomes, that are relevant to the communities MSE serves, this will create the foundations of resilient, citizen-led communities that can truly level up and reduce health inequalities.

We believe that engagement with our communities should be:

Organisation:

1. Supported by those with the power to change things
2. In an inclusive society, public engagement should be built into the decision-making.
3. Processes of systems, funding bodies, innovators and communities themselves to drive a series of common endeavours

Open to Experimentation:

4. Supportive of a focus on Citizen-led approaches from arts-based engagement to the use of social media that can highlight concerns that can be missed in institutional engagement.

Purposeful:

5. Engagement should be about shaping priorities and decisions rather than simply a consultation to gain acceptance of the public for a new policy or strategy

Sensible about measures of success:

6. A report is often the outcome of engagement activity. However, public engagement can do much more than this. Just as important as the formal, documented outcomes should be how the process itself influences participants and leads to open and surprising discussions about societal issues that matter to our communities

Participants - Targeted at Specific and Universal Audiences:

7. A sensitively focussed approach that includes but is not dominated by an interested and motivated group only. Our thoughtful engagement approach seeks to consider how we meet diverse communities and those with protected characteristics on their terms

Beneficial for Participants:

8. Crafting an engaging experience for participants, or offering support, skills and training that empowers participants to act as community organisers and intermediaries between the statutory and community sector.

Methods Informed and Facilitated:

9. Ensuring our teams have skills in engagement that enable them to explore different views, to provide information where necessary and then to use judgement to interpret findings.

Delivery Priorities

- **We** will establish a Community Assembly model that aligns to system and place through our Alliances, an Independent and Private Providers Network, and a Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives.
- **We** will establish a partnership-based Co-Production and Engagement Steering Group to ensure effective planning, accountability and inclusion.
- **We** will create a paired leadership and learning programme for VCSE and Clinical Leaders to support better collaboration and growth for our people
- **We** will establish an influencer network to ensure we can diversify our approach to community building and engagement.
- **We** will further develop our approach to Volunteerism to support system pressures and communities themselves
- **We** will establish an engagement impact framework to ensure efficacy and inclusion of our engagement approaches

- **We** will develop an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our ICP.
- **We** will grow our Community Campaign approach, to consider a digital first approach to engagement and peer support, we will develop a Human Library and Lived Experience network, which will ensure a better approach to immersive practice as a system
- **We** will co-produce a Community Engagement Benefits framework with our Communities to ensure equity and reciprocity for participation in our engagement approaches.
- **We** will deliver a mid-point review on our Year 1 and 2 approaches to confirm and challenge impact and efficacy.

Year 4 and 5 to be determined by Year 3

Ensuring Delivery

SRO: Kirsty O'Callaghan
Clinical Lead: To be established after approval at Steering Group

The governance routes are being established re engagement steering group and assembly - both of which are in co-production phase now. There is a draft and not yet agreed model for the engagement steering group in development and approval of this will be an action for completion in due course.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Community Assembly Model Agreed and Established	From quarter one to quarter four 2023/24
Co-Production and Engagement Steering Group Operational	Quarter one 2023/24
Influencer Community Builder Enabling Network Established	Quarter two 2023/24
VCSE Partnership and Engagement Framework Agreed	Quarter three 2023/24
Community Conversation Cycle	From quarter two 2023/24 to second half of 2024/25
Expansion of Community Campaign Digital First Programme	From quarter one 2023/24 to second half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Community Engagement Benefits Framework	From quarter three 2023/24 to second half of 2024/25
VCSE and Clinical Paired Leadership Programme	From first half 2024/25 to second half of 2024/25
VCSE Referral Tool delivered	From quarter two 2023/24 to second half of 2024/25
Efficacy Review Interdependent	2025/28

Glossary of Acronyms

A

ABCD – Asset Based Community Development
ACDs – Alliance Clinical Directors
ACLs – Alliance Clinical Leads
ACPs – Advanced Clinical Practitioner
A&E – Accident & Emergency
AF – Atrial Fibrillation
AGEM – Arden & Gem Commissioning Support Unit
AHP – Advanced Health Practitioner
AHSN – Academic Health Science Networks
AI – Artificial Intelligence
AKI – Acute Kidney Infection
AMR – Antimicrobial resistance
ARI – Acute Respiratory Infection
ARRS – Additional Roles Reimbursement Scheme
ARU – Anglia Ruskin University
ASD – autism spectrum disorder
AtED – Alternative to Emergency Department

B

BAU – Business as Usual
BCTT – Better Care Together Thurrock
BLMK – Bedfordshire, Luton and Milton Keynes
BCF – Better Care Fund
BI – Business Intelligence

C

CAMHS – Child and Adolescent Mental Health
CABG – Coronary artery bypass graft
CAS – Clinical Assessment Service
CAPIC - Centre for Advancing Primary & Integrated Care
CCIO - Chief Clinical Informatics Officer
CCPL - Clinical and Care Professional Leaders
CIC - Community Interest Company
CEOs - Chief Executive Officers
CGM - Continuous Glucose Monitoring
CLF - Clinical Leaders Forum
COHISG – Child Oral Health Inequalities Steering Group
COPD - Chronic obstructive pulmonary disease
CPA - Care Programme Approach
CPCS - Community Pharmacy Consultation Service
CPD - Continuing Professional Development
CSWG - Cardiogenic Shock Working Group

CTIB - Community Transformation and Improvement Board
CQC - Care Quality Commission
CYP - Children & Young People
CVD - Cardio-vascular disease
CVS – Community and voluntary sector

D
DHSC – Department of Health and Social Care
DMS - Discharge Medicines Service
DNSa - Did Not Attend
DSAs – Data Sharing Agreement
DSCR – Digitising Shared Care Record
DTAC – Digital Technology Assessment Criteria
DQ – Data Quality
DQMI - Data Quality Maturity Index

E
ECC – Essex County Council
ED – Emergency Department
EEAST - East of England Ambulance Trust
efraccs - Electronic frailty care coordination system
EIP - Early Intervention in Psychosis
EoE – East of England
EoL – End of Life
EPaCCS – Electronic Palliative Care Coordination System
EPR – Electronic Patient Record
EPUT – Essex Partnership University Trust
ePMA – Electronic prescribing and medicines administration
ESD – Early Supported Discharge

F
FBC – Full Business Case
5YFV - Five Year forward View
FTE - Full time equivalent

G
GA – General anaesthesia
GIDS - Gender Identity Development Services
GIRFT - Getting It Right First Time
GP – General Practitioner
GWPB – Growing Well Programme Board

H
HCSW - Healthcare Support Worker
HIE - Health Information Exchange

HIIA - Health Inequalities Impact Assessments
HWB - Health & Wellbeing Board
HWE - Herts and West Essex

I
ICB – Integrated Care Board
ICP -Integrated Care Partnership
ICS - Integrated Care System
ICS - Integrated Care Strategy
ICSS - Integrated Community Stroke Service
INTS - Integrated Neighbourhood Teams
IPS - Individual Placement Services
ISDN - Integrated Stroke Delivery Network
ITU – Intensive Care Unit

J
JFP - Joint forward Plan

K

KPIs - Key Performance Indicator

L
LAC – Looked after Children
LD – Learning Disability
LHCRs – Local Health and Care Record
LMNS – Local maternity and neonatal system
LTP - Long Term Plan

M
MDI – Multiple Daily Injections
MDT – Multi-Disciplinary Team
MHIS – Mental Health Investment Standard
MIA – Maternity Improvement Advisor
MNVP – Maternity and Neonatal Voices Partnership
MRI – Magnetic resonance imaging
MSE – Mid and South Essex
MSEFT – Mid Essex Foundation Trust
MSK – Musculoskeletal
MVCC – Mount Vernon Cancer Centre

N
NCTR – No Criteria to Reside
NDH – Non-Diabetic Hyperglycaemia
NELFT – North East London Foundation Trust
NHSCEP – NHS Clinical Entrepreneurship Programme
NHSE – NHS England
NICE – National Institute for Health and Care Excellence
NIHR – National Institute of Health Research
NSS – Non-specific Symptoms pathways
NSSM - National Stroke Service Model
NSTEMI – Non-ST-elevation myocardial infarction

O
Out of Area Placements (OAPs)

P
PAs – Personal Assistants
PACT – PCN-aligned community teams
PCCC - Primary Care Commissioning Committee
PCI – Percutaneous coronary intervention
PCNs - Primary Care Networks
PCSG – Personalised Care Steering Group
PCSP - Personalised care and support plan
PDAF - Pre-Delegation Assessment Framework
PEoLC – Palliative and End of Life Care
PHBs - Personalised Health Budgets
PHIB – Population Health Improvement Board
PIFU - Patient-initiated follow-up
PKB – Patient Knows Best
PHM - Population Health Management
POD - Pharmacy, Optometry and Dentistry
PPHS - Perinatal Pelvic Health Services
PRSAS - Pulmonary Rehabilitation Services Accreditation Scheme
PTL - Patient Tracker List
PTSD - Post-Traumatic Stress Disorder

Q
QALYs - Quality adjusted life years

R
RCP - Royal College of Physicians (RCP)
Resp - Respiratory
RTT - Referral to Treatment (RTT)

S

SADS – Sudden arrhythmic death syndrome
SAVS – Southend Association of Voluntary Services
SCR – Shared care Record
SDEC – Same Day Emergency Services
SDM – Shared Decision Making
SEE – South East Essex
SEND – Special education needs and disabilities
SIGS – Special Interest Groups
SNEE – Suffolk and North Essex
SOAC – Strategic Oversight and Assurance Committee
SOF – System Oversight Framework
SRO – Senior Responsible Owner
SSNAP – Sentinel Stroke National Audit Programme
STARs – Short Term Assessment and Reablement

T

TBC – to be confirmed
TEER - Transcatheter Edte to Edge Repair
TLHC - Targeted Lung Health Checks
TNAs – Trainee Nurse Associates

U

UCR – Urgent Community Response
UCRT – Urgent Care Response Team
UEC – Urgent and Emergency Care
UoE – University of Essex

V

VAWG - Violence and Aggression against Women and Girls
VCSFE - Voluntary and community, Faith and Social Enterprise
VGCCR - Virtual Group Cancer Care Reviews
VCSE - Voluntary, Community, Social Enterprise

W

WSTG - Whole System Transformation Group

Part I ICB Board Meeting 18 May 2023

Agenda Number: 7

MSE ICS Shared Care Record Full Business Care

Summary Report

1. Purpose of Report

To provide the Board members with an overview of the Shared Care Record (SCR) Full Business Case (FBC) and to seek their endorsement.

2. Executive Lead

Barry Frostick, Chief Digital and Information Officer

3. Report Authors

Clare Steward, Programme Director – Digital Transformation
Kate Bartram, Deputy Director of Patient Centred Transformation

4. Responsible Committees

The table below details Committees involved in the sign off process:

Committee Name	Date	Outcome Points
SCR Programme Board	11 April 2023	• Minor amendments to the supporting documentation
Senior Finance Leaders Group (SFLG) (1)	17 April 2023	• Gap in Year 0 costs will be mitigated (completed) • Benefits in relation to productivity to be reviewed **(completed)**
MSEFT Investment Group	20 April 2023	• Approved
MSEFT Finance and Performance Committee	27 April 2023	• Approved
Finance Investment Committee (FIC)	11 May 2023	
MSE ICS Digital and Data Technology Board	11 May 2023	
Senior Finance Leaders Group (SFLG) (2)	15 May 2023	
ICB Board	18 May 2023	
MSEFT Board of Directors	26 May 2023	

5. Link to the ICB's Strategic Objectives

- Reduce health inequalities

- Support health and wellbeing, through prioritising prevention, early intervention and self-care
- Bring as much care as is safe and possible closer to where people live
- Improve and transform our services

6. Impact Assessments

EQIA Part 1

7. Financial Implications

The programme governance and funding approach which was signed off by all ICS Chief Executive Officers (CEOs) at the end of 2022 via a Memorandum of Understanding (MOU), stated that the ICS will meet the agreed costs associated with the procurement, scoping and delivery of the SCR in its overall financial planning. To this end, the ICS forward financial plans include an assumed cost of £2.4m per annum for the duration of the proposed 5 year contract. This sum was informed by the Outline Business Case (OBC) and is set at a level which includes the cost of the contract for the preferred bidder along with costs within system partner organisations.

The Full Business Case (FBC) will reconcile the actual costs in line with the financial analysis of the preferred bid, and the Board should be assured that whilst the financial envelope for bidders was set at £1m - £1.5m, all bids received have costs that are lower than this. The FBC confirms that the envelope of c. £2.4m per annum planned by the system is adequate to cover the costs of the system, its implementation, integration and support costs, however the phasing of the required funding is different to that in the MSE ICS Medium Term Financial Plan, with £1.1 of resourcing requirements falling in the second half of 2023/24. SFLG have asked that a plan is developed to cover this cost without adding further financial pressures to the system, and we have been engaging with partner organisations to review how the implementation and integration costs between Oct 2023 and March 2024 can be covered within existing resources or covered by partners themselves. Supplier costs in 2023/24 can be covered with the help of Provide who can report expenditure in 2023/24 with expected income to cover this in future years.

Furthermore, the FBC will define a series of financial and non-financial benefits that will be achieved by the implementation of the SCR.

8. Details of patient or public engagement or consultation

The Programme continues to aim to engage widely with stakeholders across all system partners, voluntary, charity and third sector organisations. Resident engagement will continue be undertaken at organisational level in line with the wider stakeholder engagement plan.

9. Conflicts of Interest

Conflicts of interest have been managed strictly in line with the ICB's Conflict of Interest policy and the procurement process.

10. Recommendations

It is recommended that the Board endorses the approach adopted to finalising the Shared Care Record Full Business Case and the next steps detailed above.

Mid and South Essex ICS Shared Care Record (SCR)

Full Business Case (FBC) Outline.

1. Introduction

The following report is provided to ICB Board members with the purpose of seeking endorsement of the Shared Care Record (SCR) Full Business case (FBC) as part of the overall governance sign-off process for the investment case. As MSEFT are the designated contracting authority for the SCR, the sign-off of the case is via the MSEFT governance approvals process, with final sign-off being sought from the MSEFT Board of Directors meeting on 25 May 2023.

2. Main content of Report

Background and tender process

The SCR Outline Business Case (OBC) was approved by the SCR Programme Board and ICS Digital and Data Forum in July 2022. The SCR programme was endorsed by the ICB Board on 15 Sept 2022 as one of our key strategic priorities which will enable better integrated care for our residents.

An intention to procure notice was subsequently launched to the market. A series of system-wide stakeholder engagement events were held throughout October and November 2022 with the aim of both testing the market and gathering the technical and functional requirements for the tender from all partner organisations, including health, social care, mental health, community providers, primary care, charities, voluntary sector and third sector organisations.

A two-stage tender process was subsequently launched at the end of November 2022, with 8 suppliers coming forward as part of the first stage. The mandatory requirements evaluation took place in January 2023, which concluded with a short-list of 5 suppliers going forward into the second stage.

Supplier demonstrations were held during February and March 2023, receiving strong engagement from ICS system partners. The focus of these sessions was built around three complex use cases that had been developed by front line teams pertaining to Frail Older People, Children and Young People and Mental Health services. The use cases were designed to ensure that the SCR solutions demonstrated by suppliers could meet some of the most challenging needs of our population across MSE.

The second stage of the evaluations concluded with a week of moderated sessions at the beginning of March 2023, with evaluators from a range of partner organisations, across a variety of professional groups, including clinical, social care professionals, operational, technical, finance and information governance.

The outcome from this process was that a preferred supplier (Supplier C) was identified. Subsequently the full business case was approved by the Shared Care Record Programme Board prior to submission to System Finance Leadership Group (SFLG) on 17 April 2023.

Development of the business case (March - April 2023)

The SCR business case sets out the investment case for Mid and South Essex ICS, (through MSEFT as the contracting authority) to procure a new SCR solution with the functionality to enable joined up care across Health, Mental Health, Social Care, Primary Care Networks (PCNs), community services as well as Voluntary, Charity and third sector organisations through transforming data integration and information flows between our partner organisations.

The SCR ambition has been clearly set out in the NHS Long Term Plan which is detailed below:

'By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and ShCRs will cover the whole country'. (The NHS Long Term Plan 2019 p.99)

The recent NHSE ShCR Strategy update following the National ShCR Summit in March 2023 clearly demonstrates the significant progress that has already been made nationally in meeting the objectives set out in the Long Term Plan with all 42 ICBs providing some degree of a shared record. However, it sets out the ambition is to extend this interoperability to Social Care by March 2025. This direction of travel is further underpinned by the DHSC's recent Major Condition's Strategy highlighting the need to shift to integration to enable 'whole person care' within six priority areas: cancer, cardiovascular disease, chronic respiratory disease, dementia, mental health and MSK.

The rationale for procuring a new SCR as described in the OBC remains relevant as the FBC is based on the idea that the current system was put in place in 2019 as a short-term tactical information sharing solution (Cerner Health Information Exchange (HIE)) with a contract due to end in July 2024. This solution was part of a much wider regional programme under the 'My Care Record' banner and HIE was selected as an approach to create sharing capabilities for some of our partners across the ICS. Whilst this has provided some immediate benefits on viewing data, it is recognised that the current solution does not currently support the ambition set out in the NHS Long Term Plan and therefore doesn't meet the full ICS Digital strategic priorities which were agreed as part of a 3-year Digital Strategy signed-off by the MSE ICS Board in September 2022.

The FBC describes the capability of the SCR solution to enable better informed decisions between health and care professionals at the point of care, particularly in situations where there is multi agency involvement in time critical situations, through good quality, relevant information being accessible to the health and social care professionals that need it. Some of the key areas of functionality are set out below which will enable capability:

- Shared care record will take information from all in-scope service providers.
- Interoperability across systems, such that each team works primarily from host/local single front-end, whilst still accessing the shared care record.

- As near to real-time data to support crisis management and multiple same-day interactions in the integrated care team for patients.
- Move towards bi-directional integration to ensure that accurate, timely and appropriate information is captured in each service provider's system (avoiding additional double-keying).
- Reporting and analytics capability aligning to data platform strategy to support benefits tracking, identifying service usage patterns, prioritisation of spend and commissioning planning.

As part of the business case development, system partner organisations were asked to submit their estimated local integration and resource costs which have been factored into the financial model of the investment case. (Please refer to Section 7 of the report for more detail).

The other major area of development for the case has been the benefits plan. System partner organisations have been required to submit baseline data for each of their agreed benefits. As a result of the need to ensure that this has been comprehensive, comparisons have been drawn from other ICS SCR implementation sites. An ICS SCR benefits overview has been drafted to ensure that the productivity achievements to-date are highlighted and the potential scale of development in this area in line with the future implementation of the new solution has been articulated. (This has been included in the FBC supporting documentation Appendix D.1 in the FBC which is available to members on request).

Key Risks and Issues

The programme RAID log is included as Appendix E of the FBC and is available to members on request. The main themes across risks scored 12 and above have been summarised below.

- The most severe risk (scoring 20) relates to lack of resource resulting from other major strategic digital programmes within the system.
- The majority of risks score 15 or above relate to resources or resource planning.
- There are a number of risks relating to the procurement being unsuccessful.
- There are a number of risks related to the system’s financial position and the implications of poor contract monitoring.
- There are number of risks relating to lack of stakeholder engagement, scale of culture change and change management.

Currently the contingency plan as the result of procurement failure is being discussed as part of developing an understanding of Suffolk and North East Essex ICS’s strategy in relation to the future extension of the contract with Cerner HIE beyond July 2024.

In addition, the supporting MSEFT Procurement team are finalising the appropriate KPIs and metrics to be included as part of the contractual agreement with the preferred supplier, subject to award going ahead on 26 May 2023. It is anticipated that financial penalties will be included for failure to meet contractual metrics.

Governance Sign Off Process – feedback to date

To date the FBC has been to a number of Committees within the ICS and MSEFT. Feedback overall has been positive and the FBC has been well received, however at the ICS's Senior Finance Leaders Group (SFLG) on 17 April 2023, there were challenges raised around mitigating year zero costs as well as the lack of quantifiable efficiencies. This has since been addressed in the narrative in Section 7 of the covering paper and via the benefits overview (Appendix D.1 of the FBC supporting documentation, available to members upon request).

In addition, over the past two weeks, the Chief Digital Information Officer, Programme Director, CFO Sponsor for Digital and Programme Manager have successfully met with each of the partners to ensure that they are content with the following:

- Financial implications of the SCR
- Benefits to be realised
- Potential impact / implications of the SCR on their own systems
- Any additional considerations that they would wish the programme to be cognisant of.

Next Steps

In anticipation of the successful sign off of the FBC and to ensure the programme is adequately prepared for a new phase of the programme following contract award at the end of May, the programme is undergoing a number of activities to 'review, reset and refresh', including a Lessons Learned Review, Programme Governance Review and Workplan Review.

As a result of the reset and refresh activities, the key next steps are detailed below:

- A commitment from each partner organisation to field consistent representatives to form a proactive and engaged membership for the Programme Board and workstream meetings.
- Develop and aligned and embedded governance approach across system partners to drive transparent system wide programme progress coupled with local accountability and ownership for delivery.
- Clarity of communications routes, supported by detailed understanding of the stakeholder landscape for each of the partner organisations.

3. Conclusion

The conclusion of the full business case is in line with the outline business case in recommending the procurement of a new SCR solution and preferred supplier (Supplier C) following the outcome of a two-stage tender process.

4. Recommendation(s)

It is recommended that the Board endorses the approach adopted to finalising the Shared Care Record Full Business Case and the next steps detailed above.

5. Appendices *(available to members on request)*

- Final Shared Care Record Full Business Case
- Appendix A -SCR PID
- Appendix B -SCR Milestone Plan
- Appendix C -Change Management Plan
- Appendix D -Benefits Register
- Appendix D.1 -Benefits Overview
- Appendix E -RAID
- Appendix F -Resource Plan
- Appendix G -Glossary
- Appendix H-Financial Tables
- Appendix I -Procurement Report
- Appendix J -Spending Objectives

Part I Board, 18 May 2023

Agenda Number: 8

Award of Intregrated Community Equipment Contract for 2023-2028

Summary Report

1. Purpose of Report

To update the Board on the award of the community equipment contract to the successful bidder following a procurement process lead by Essex County Council (ECC).

The current community equipment service, which works on behalf of both local authority and NHS partners across Essex, supported 33,000 residents with 140,000 items of equipment in the last year.

This service complements wider system services such as reablement, domiciliary care support and supporting the acute hospitals for discharge and admission aviodance. The aims of the service are to promote independence and enable people to gain, regain and maintain skills, as well as helping to prevent hospital admissions.

The Board is asked to retrospectively support to award the Integrated Community Equipment Service (ICES) contract to the successful provider, Medequip Assistive Technology Ltd, for five years with the option to extend for up to a further two years, at an anticipated expenditure of up to £83m (total contract value for full 7 years); £57m from ECC (co-ordinating commissioner) and £26m of the cost is accountable to health (see section 8 below for the partners included), section 7 details the financial contribution from the MSEICB.

It is recommended that the MSE ICB be supportive of the contract being awarded to the successful provider because this contract will provide a fully integrated service which will combine the procurement and sourcing of equipment and the management of the community equipment service going forward.

This will improve the current services from end to end and drive out inefficiencies, resulting in better value to the Council and Health and Local Authority Partners and improve the quality of end-user experience.

This procurement has been fully supported by Attain on behalf of health partners.

2. Executive Lead

Tiffany Hemming, Interim Executive Director Oversight, Assurance and Delivery

3. Report Author

Emma Branch, Transformation and Engagement Lead, Basildon & Brentwood Alliance

4. Responsible Committees

MSE ICB Finance and Investment Committee (19/04/2023) – recommended approval by the Board.

ECC Cabinet (10/02/2023) – approved.

Mid and South Essex CCG Joint Committee 16/12/2021 – approved.

5. Link to the ICB's Strategic Objectives

The Community Equipment Service links with the following objectives for the ICB and wider system:-

Creating opportunities – The service will offer employment to the population of Mid and South Essex and the wider Essex footprint

Supporting health and wellbeing – The service will enable residents of the MSE to remain a level of interdependence within their own homes, or temporary place of residence. The service will also support with prevention and reducing demand on health and social care services.

Improving and transforming our services - The landscape has changed significantly in health and social care in the last two years, with a sustained increase in demand for faster delivery of community equipment to support the Home First ambition and the Discharge to Assess pathway against the challenges posed by the Covid-19 pandemic, workforce pressures and climate change this service will allow flexiability

6. Impact Assessments

ECC undertook an Equalities Comprehensive Impact Assessment – Head of Service Review, which is available on request.

7. Financial Implications

The Financial Forecast for the Community Equipment Contract held with ECL for 22/23 as at the time of this report was £15,701,427 with £2,609,619 being attributable to Mid and South Essex ICB:

Partner/Place	Forecast at M10	% of Pooled Fund
Mid Essex	£1,239,262	7.89%
Basildon and Brentwood	£726,655	4.63%
Thurrock	£643,703	4.10%
ICB	**£2,609,620**	**16.62%**

The tender demonstrated that the submitted prices benchmark favourably against current costs and could therefore result in a significant saving (based on assumed activity).

The volume and mix of equipment and activities commissioned via the community equipment service have increased in recent years. There are multiple drivers behind the increased activity levels, including more residents needing equipment, rising acuity

of need, backlogs of reviews and de-conditioning due to lockdown, and faster delivery speeds to enable the hospital discharge pathway.

8. Details of patient or public engagement or consultation

The following members of the partnership have been engaged with throughout this process and market testing suitability of the value and services specification has been completed.

Members of the partnership are:-

- Essex County Council (Co-ordinating Commissioner)
- Mid and South Essex ICB
- Essex Partnership University NHS Foundation Trust
- Thurrock Council
- ESNEFT

As part of normal commissioning processes, in Summer 2021, a project group led by the ECC commissioning team undertook an options appraisal to understand the available options for the reprovision of services upon the conclusion of the current contract in March 2023 and in doing so, identified a preferred recommendation of seeking a new contract via the open market. This was supported by the former Mid and South Essex Clinical Commissioning Groups Joint Committee in December 2021.

9. Conflicts of Interest

None identified

10. Recommendations

The original procurement was approved by pre-decessor organisations (mid and south Essex Clincal Commissioning Groups). Given that the procurement was not therefore originally approved by the ICB and the value of the contract would ordinarily have required Board approval, the Board are being asked to retrospectively support the contract award.

Part I ICB Board meeting, 18 May 2023

Agenda Number: 9

Quality Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Frances Bolger, Interim Executive Chief Nurse

3. Report Author

Frances Bolger, Interim Executive Chief Nurse

4. Responsible Committees

Quality Committee

5. Link to the ICB's Strategic Objectives

Improve outcomes by adherence to clinical policies, procedures and standards by enabling services to operate in a safe and effective way.

6. Impact Assessments

None required for this report.

7. Financial Implications

None relevant to this report.

8. Details of patient or public engagement or consultation

None applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is asked to:

- Note the key quality concerns and escalations as identified by Quality Committee.
- Receive assurance that mitigating actions are being undertaken to address concerns.
- Note the recent Care Quality Commission (CQC) inspection and findings, and the ICB oversight processes for supporting improvement of services.
- Note the recent communication from the Essex Mental Health Independent Inquiry team and that future updates will be brought back to ICB Board.
- Note the recent findings in the 2022 NHS Staff Survey for Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust.

Mid and South Essex Quality Report

1. Introduction

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

2. CQC Inspection – Essex Partnership University NHS FT (EPUT)

2.1 The ICB Board has been made aware of the CQC report publication following the unannounced inspection of Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units, on 5 and 6 October 2022.

2.2 The service has been rated 'Inadequate' for the Safe domain, with all other domains remaining unchanged. The overall rating of the Trust remains unchanged. The CQC action plan was submitted to the Regulator on 25 April 2023.

2.3 The Trust is now awaiting the draft report following the full unannounced CQC inspection that occurred between November 2022 to January 2023, and the well-led inspection in January 2023.

2.4 A follow-up Rapid Quality Review meeting was held 2 February 2023. The next steps included the development of an overarching quality improvement plan to include the actions from all reports and investigations. As each CQC report or investigation is finalised, the new actions arising from the report will be incorporated into one overarching quality improvement plan, following completion of executive sign off. The next reiteration, which includes the most recent CQC actions, is due to be signed off by the executive directors on 18 May 2023.

2.5 Two workshops, with representation from the Trust and three ICBs, have been held to strengthen quality assurance processes, including the 'reset' of the Evidence Assurance Group meeting. The Evidence Assurance Group will support the interrogation and robustness of evidence prior to an action being closed.

2.6 A follow-up Rapid Quality Review meeting will be held once the next CQC report is published. Ongoing oversight and assurance of improvements being made be provided to the System Oversight and Assurance Committee (SOAC) and ICB Quality Committee.

3. Independent Inquiry - Essex Partnership University NHS FT

3.1 The ICB Board has been made aware of recent national conversations in relation to the Independent Inquiry and the possible adverse media attention.

3.2 On 12 January 2023, Dr Geraldine Strathdee published an open letter on the Independent Inquiry website in response to a low number of EPUT staff coming

forward to provide evidence and an additional 400-500 mental health patient deaths being identified (Updates - Essex Mental Health Independent Inquiry (emhii.org.uk)).

3.3 On 10 January 2023, Dr Strathdee met with the Secretary of State for Health, Steve Barclay to share her concerns regarding the investigation process.

3.4 On 17 April 2023, Dr Strathdee, met with the Health Secretary, the Rt Hon Steve Barclay, and Minister Neil O'Brien, to provide an update on the work of the Inquiry. Dr Strathdee confirmed that due to several factors her view remains that the Inquiry cannot meet its terms of reference with a non-statutory status.

3.5 The Government is currently in a pre-election period of sensitivity, until the end of local elections on 4 May 2023. Therefore, the government is not able to make any announcements regarding the work of the Inquiry until the end of this period.

3.6 ICB Board are to be informed of additional announcements made by the Inquiry team.

4. CQC Inspection - St Andrews Healthcare, Essex

4.1 The ICB Board has been made aware of the CQC report publication of an independent provider within Mid and South Essex ICS. St Andrews Healthcare provides services for those people with a personality disorder and/or mental health issues within a low secure and locked environment. EPUT utilises beds at the Provider, however patients are placed from around the United Kingdom including other areas of the East of England, Kent and Wales

4.2 The Provider was inspected by CQC in June 2022, but due to sickness within the CQC team, the report publication was delayed until March 2023. Services were rated as 'Inadequate' for the Safe and Effective domains. Themes identified relate to Mental Capacity Assessments, regularity of undertaking observations and involving families/ patients in their care.

4.3 Since the June inspection, improvements have been made. The Mental Health Provider Collaborative and MSE ICB are working collaboratively to support the Provider to make the required improvements.

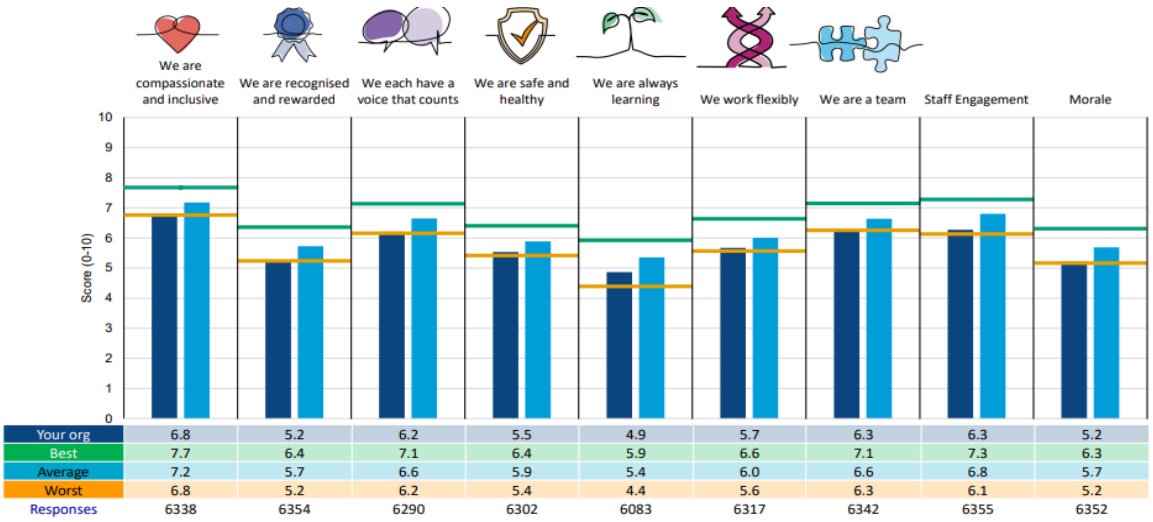
4.4 The ICB will continue to provide assurance to the ICB Quality Committee that improvements in care are being made.

5. NHS Staff Survey Results for Mid and South Essex NHS Foundation Trust (MSEFT) and EPUT

5.1 The ICB Board has been made aware of the MSEFT and EPUT NHS Staff Survey results published 9 March 2023. MSEFT scored below the national average for all 9 domains, whilst EPUT scored average against peers for all 9 domains.

5.2 MSEFT

5.3 41% of staff undertook the survey compared to 44% nationally. The Trust scored below the national average against each of the nine domains, scoring in the 'worst' category for five of the domains - compassion and inclusion, recognised and rewarded, voice that counts, team and morale.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.8	5.2	6.2	5.5	4.9	5.7	6.3	6.3	5.2
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	6338	6354	6290	6302	6083	6317	6342	6355	6352

5.4 Key themes from the results were staff felt patients weren't treated as a top priority by the Trust, and they would not recommend the organisation as a place to work, however staff felt they were encouraged to report incidents and treated fairly when an incident occurred.

5.5 The table below compares the recent results to last year and demonstrates six areas where the Trust is significantly lower than the previous year.

The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	6.9	6787	6.8	6338	Significantly lower
We are recognised and rewarded	5.4	6954	5.2	6354	Significantly lower
We each have a voice that counts	6.3	6663	6.2	6290	Significantly lower
We are safe and healthy	5.6	6733	5.5	6302	Significantly lower
We are always learning	4.8	6332	4.9	6083	Not significant
We work flexibly	5.7	6901	5.7	6317	Not significant
We are a team	6.3	6812	6.3	6342	Not significant
Themes					
Staff Engagement	6.4	6962	6.3	6355	Significantly lower
Morale	5.3	6946	5.2	6352	Significantly lower

5.7 EPUT

5.8 42% of staff undertook the survey compared to 50% nationally. The Trust scored average across most domains when compared to their peers. The domains have either improved or remained the same except for:

- Discrimination of grounds of ethnic origin. The WRES data highlights this is particularly from other staff rather than patients.
- Happy with the standard of care.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.5	6.2	6.9	6.2	5.7	6.8	7.1	7.0	6.1
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2
Responses	2541	2531	2518	2528	2411	2522	2535	2538	2540

5.9 The ICB Board are asked to note that the Trusts are currently analysing the results and formulating improvement actions in response to the survey. The survey reports are progressing through the trust governance processes, however both trusts have discussed the survey results with staff and their Boards during March 2023.

6. Conclusion

6.1 On the basis of the information supplied and analysed, the specific actions being taken to address the concerns identified, and the detailed work overseen by the Quality Committee, the Board can be assured of the measures being taken to ensure quality of services across MSE.

7. Recommendations

7.1 The Board is asked to:

- Note the key quality concerns and escalations as identified by Quality Committee.

- Receive assurance that mitigating actions are being undertaken to address concerns.

- Note the recent Care Quality Commission (CQC) inspection and findings, and the ICB oversight processes for supporting improvement of services.

- Note the recent communication from the Essex Mental Health Independent Inquiry team and that future updates will be brought back to ICB Board.

- Note the recent findings in the 2022 NHS Staff Survey for Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust.

Part I ICB Board meeting, 18 May 2023

Agenda Number: 10

Performance and Assurance Report

Summary Report

1. Purpose of Report

This paper is intended to provide members with an overview of the current position (where available) against the NHS constitutional standards and to outline the governance arrangements for oversight and assurance of each area.

To confirm the system submitted the 2023/24 planning round trajectories. Where these link to Board reported standards they will be incorporated into the future Board papers.

2. Executive Lead

Tiffany Hemming, Interim Executive Director Oversight, Assurance and Delivery.

3. Report Authors

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

4. Responsible Committees

This paper has been developed using information shared within the ICB assurance cycle meetings. The performance outlined in this paper is within the assurance and planning papers submitted to the System Oversight and Assurance Committee (SOAC).

5. Conflicts of Interest

None identified

6. Recommendation

The Board is asked to discuss and note the performance and assurances contained within the report and that from June 2023 report trends will be incorporated as per board request.

Performance and Assurance Report

1. Introduction

The following section gives the headline position in terms of performance against the NHS constitutional standards[1] and outlines the governance in terms of boards overseeing performance, planning and assurance.

To confirm the system submitted the 2023/24 planning round trajectories and trends. Where these link to Board reported standards, they will be incorporated into future Board papers.

2. Performance

2.1 Urgent and Emergency Care (UEC)

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.

Key issues for the UEC programme include the following where performance is below standards:

Ambulance Response Times

Standards:

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

The ambulance response times remain below the NHS constitutional standards. The following table shows the 90th centile and mean response times for the East of England Ambulance Service for each of the four categories of calls and respective standards for March 2023.

East of England Ambulance Service
Mean and 90th centile response times for March 2023

Category		Mean	90th centile
Category 1 mm:ss	Standard	<= 7min	<= 15min
	Actual	9:34	18:05
Category 2	Standard	<= 18min	<= 40min
	Actual	53:59	01:58:22
Category 3 hh:mm:ss	Standard		<= 02:00:00
	Actual		06:20
Category 4 hh:mm:ss	Standard		<= 03:00:00
	Actual		11:23

[1] Handbook to the NHS Constitution for England - GOV.UK (www.gov.uk)

Emergency Department – waiting times.

Standard:

- *95% of patients have a maximum 4-hour wait in A&E from arrival to admission, transfer, or discharge.*

Within MSEFT A&E (Type 1), the 95% four-hour performance is below the constitutional standard as per the following table.

Metric		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Emergency Department - 4 hour standard - type 1 (Standard: >=95%)	*Total*	*28,178*	*31,126*	*29,876*	*29,832*	*27,584*	*27,696*	*29,894*	*29,641*	*30,806*	*26,212*	*26,153*	*30,196*
	Breaches	*9,881*	*10,223*	*10,007*	*10,430*	*10,072*	*10,749*	*11,844*	*12,148*	*14,747*	*10,123*	*10,092*	*12,049*
	Performance	64.9%	67.2%	66.5%	65.0%	63.5%	61.2%	60.4%	59.0%	52.1%	61.4%	61.4%	60.1%

2.2 Elective Care

Key issues for the Elective programme include waiting time performance being below standards for Diagnostics, Cancer and RTT (Referral to Treatment).

Diagnostics Waiting Times

Standard:

- *The constitutional standard is no more than 1% of patients waiting 6 weeks or more for a diagnostic test and no patients waiting 13+ weeks.*

The waiting times for diagnostic tests remain below the NHS constitutional standards.

The following table shows the latest MSEFT position (February 2023) with the number of patients waiting 6+ and 13+ weeks by test.

Test		Feb-23				
		13+ Weeks		6+ Weeks		Total WL size
		No.	%	No.	%	
Imaging	Magnetic Resonance Imaging	109	2%	1,319	23%	5,828
	Non-Obstetric Ultrasound	2,403	25%	4,302	45%	9,491
	Computed Tomography	147	3%	1,034	21%	4,848
	Barium Enema	0		0		0
	DEXA Scan	175	15%	474	42%	1,130
Endoscopy	Colonoscopy	20	2%	57	7%	853
	Cystoscopy	83	33%	116	47%	249
	Flexi Sigmoidoscopy	7	3%	27	12%	234
	Gastroscopy	59	8%	110	15%	727
Physiological Measurement	Audiology - Audiology Assessments	469	25%	754	41%	1,845
	Cardiology - Echocardiography	227	6%	1,228	32%	3,780
	Cardiology - Electrophysiology	0		0		0
	Neurophysiology	226	48%	240	51%	475
	Respiratory Physiology - Sleep Studies	54	16%	129	38%	337
	Urodynamics - Pressures & Flows	0	0%	3	8%	38
Total Diagnostic Tests		3,979	13%	9,793	33%	29,835

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

As highlighted above, a significant acute challenge lies in non-obstetric ultrasound. An identified

issue includes workforce capacity regarding Sonographers.

Cancer Waiting Times

Standards: For people with suspected cancer:

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

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

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

Two week wait	Two week wait breast symptomatic	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day standard	62 day standard (Screening)	62 day standard (Upgrade)
Standard (>=93%)	Standard (>=93%)	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=90%)	
65.7%	28.1%	63.9%	86.6%	94.2%	92.5%	57.1%	54.6%	57.1%	56.5%

The MSE HCP Cancer, Palliative & End of Life Care Board oversees cancer assurance and transformation supported by sub-groups including the Cancer Programme Delivery Group (for assurance and focus on national, regional, and local commitments and deliverables); Quality Cancer meeting; and the Palliative Care Delivery group.

Referral to Treatment (RTT) Waiting Times

Standards:

- *The constitutional standard is starting consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. Since the significant increase in waiting times following the global pandemic the NHS is working to achieve the following 2022/23 planning round asks:*
  - *eliminate waits of over 104 weeks as a priority by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer).*
  - *Reduce the number of patients waiting 78+ weeks on an RTT pathway to zero by March 2023.*
  - *Reduce the number of patients waiting 52+ weeks on an RTT pathway to zero by March 2025.*

As at February 2023, there were zero patients waiting 104+ weeks and 9,868 patients waiting 52+ weeks on an RTT pathway at MSEFT.

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

2.3 Mental Health

A key issue for the mental health work programme is workforce capacity and constraints with recruitment to mitigate against workforce vacancies. In terms of governance, performance is overseen at the Mental Health Partnership Board.

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.*

The six and 18-week waiting time standards for people referred to the IAPT programme to start treatment is being sustainably achieved across Mid and South Essex (latest position: January 2023).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across Mid and South Essex (latest position published January 2023 at 100%.

3. Findings/Conclusion

Through the respective oversight groups the constitutional standards aligned to them are overseen, actions reviewed and progress monitored with escalation to System Oversight and Assurance Committee where there is a variance to plan.

4. Recommendation(s)

The Board is asked to discuss and note the performance and assurances contained within the report and that from June 2023 report trends will be incorporated as per Board request.

Part I ICB Board meeting, 18 May 2023

Agenda Number: 11

Primary Care: Update on the Fuller Stocktake / Our Plan for Patients

Summary Report

1. Purpose of Report

To provide a regular update to the Board on progress relating to the Fuller Stocktake / Our Plan for Patients, as agreed at the Board meeting 13 October 2022 where our action plan was first presented.

2. Executive Lead

Dr Ronan Fenton, Medical Director.
Dr Anna Davey, Fuller Advocate and ICB Member for Primary Care.

3. Report Author

Jack Short, Interim cover for Ed Cox (Director of Clinical Policy)
William Guy, Director of Primary Care

4. Responsible Committees

Primary Care Commissioning Committee.

5. Conflicts of Interest

None Identified for this report.

6. Recommendations

The Board is asked to note and discuss the Fuller Stocktake and Our Plan for Patients Update.

Fuller Stocktake and Our Plan for Patients Update

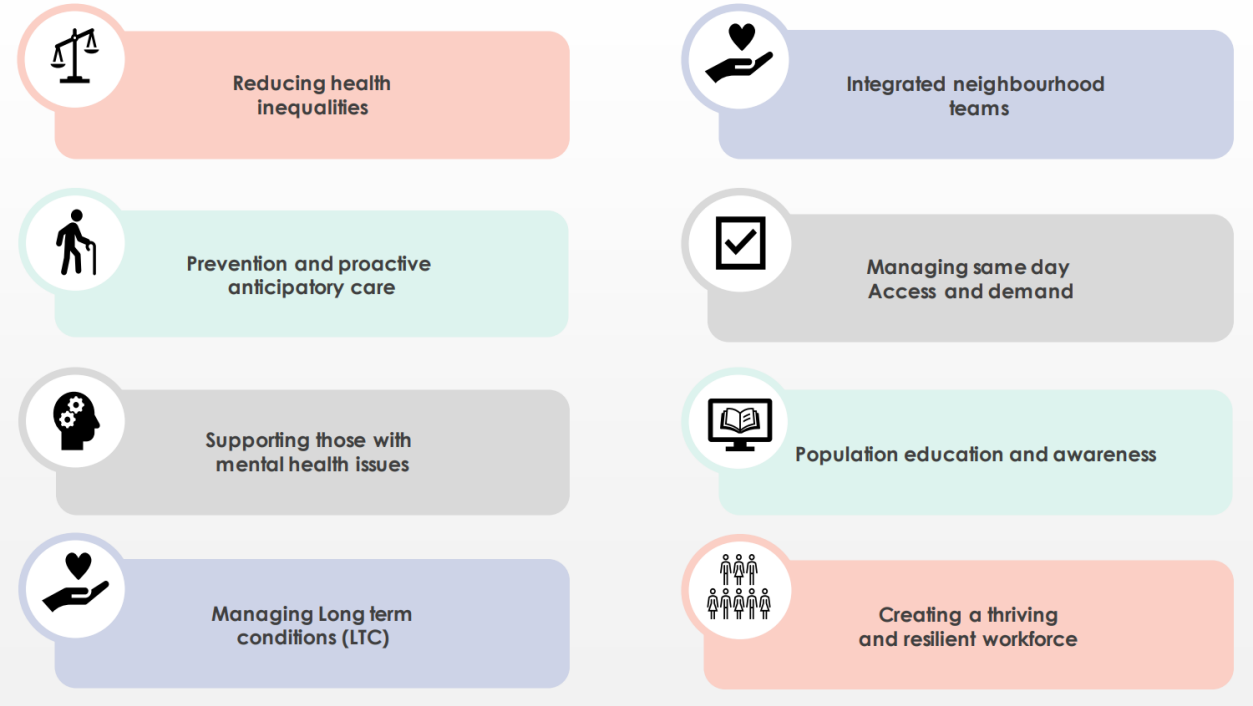
1. Introduction

This report forms part of a regular update to the ICB on progress against our plans to implement the Fuller Stocktake and Our Plan for Patients locally.

2. Main content of Report

2.1 Primary Care Network (PCN) Clinical Strategy Development

Working alongside Health Integration Partners (HIP) the PCNs, as planned, have developed their clinical strategies with the last few currently under final review by their respective PCN. The findings and recommendation from the Fuller Stocktake are a common theme throughout. At an aggregated level the Key strategic themes are as follows:



PCNs have 2 initial planning deadlines:

- To outlined at a high level their key priorities moving forward (by 12 May 2023)
- To set out a detailed plan to delivery their strategy (by 30 June 2023)

In addition to the Clinical Strategy, HIP continue to work with both the Alliances and PCNs to provide a further PCN level estates strategy, outputs of which will be ready to share at the next Board meeting.

2.2 Neighbourhood Engagement

Wider engagement remains a key activity at all levels. Anna Davey in her role as Fuller Advocate has visited PCN Clinical Directors (CDs) in 21 of the 27 PCNs to discuss the Fuller recommendations and provide an opportunity for further dialogue. During April, visits were made to Chelmsford West PCN, Chelmsford City PCN, Colne Valley PCN, Braintree

PCN, West Central PCN, Witham and Maldon PCN, Aegros PCN, East Basildon PCN, ASOP PCN, Stanford-le-Hope PCN, Canvey, Rayleigh and Rockford PCNs and Wickford PCN.

There is a good level of knowledge amongst the PCN CDs and most have a good vision for the Fuller work and developing Integrated Neighbourhood Teams (INTs). Estates is a common issue and workforce (but not always Additional Roles Reimbursement Scheme (ARRS) recruitment). Some places are fully recruited to ARRS roles and some are much more concerned about GP workforce. There was widespread interest in the GP Fellowship schemes but more needs to be done to promote the Training Hub as a source of support to the wider workforce.

The vast majority of the PCNs (22/27) have made good progress in outlining what they will initially be focussing on. The team continues to provide support to the outlying PCNs.

The immediate challenge for the system is to enable the localisation of the Fuller/INT approach. Primary care and community teams will need to prioritise the focus of initial implementation whilst delivering both the impacts of the ICB restructure and the new recovery targets. Work continues to support this through development of an INT framework and specific solutions for patients access across the 3 pillars of Fuller. Multiple workshops have taken place and are planned to formulate local priorities as well as showcasing some of the great examples of integrated working already underway.

2.3 Oversight and Governance of the delivery of Fuller/INTs

The newly formed role of Fuller Implementation Lead has been successfully appointed to. Katherine Smith has formally taken on the role and alongside Anna Davy as the ICB Fuller Advocate will provide the programme leadership and oversight to the Alliance delivery of Fuller.

The scale of this transformation is huge. To provide the necessary conversation and expertise bandwidth within the ICB the INT Programme Reference Group has been formed to support the overall evolution towards INTs. The day-to-day governance and reporting lines remain unchanged with formal progress being reported through PCN Delivery and Development group which over time will become the INT Delivery and Development Group to reflect widening of responsibilities in line with the future transformation.

The accountability of the overall programme will need to remain with the ICB, and the Alliances will oversee local delivery through the individual neighbourhoods.

2.4 Local Progress

There are numerous complementary pieces of work underway presently. As previously outlined the PCN clinical strategies will outline much of the intent and enable multiple streams of work to come together. Notable progress at each place includes:

In Mid Essex, the NHS, Essex County Council (ECC), and Provide collaborative positions are now in post. They have conducted asset mapping and organised workshops to better understand the resources available in local neighbourhoods. Recruitment into the PCN in Dengie and South Woodham Ferrers has accelerated, and they are working with the existing Dengie neighbourhood team to enhance the model. Chelmsford West is on track to launch total triage across the PCN using Accurx on 1 June 2023, with project management support from Lucy Frost.

Basildon and Brentwood: A voluntary sector organisation (VSO) event was recently held in Basildon and Brentwood, with another planned for 9 June 2023. Basildon Central is collaborating with community teams and VSOs to provide support to patients with mental health issues. They are exploring the option of partnering with Accurx for total triage. Meanwhile, Brentwood has hired an occupational therapist to work with Sport for Confidence on a pilot occupational therapy program. The program aims to increase the uptake of learning disability (LD) annual health checks, support the delivery of the enhanced health in care homes framework, and provide occupational therapy to registered patients who are coded as moderate/severely frail. Early feedback has been positive, with increased uptake of health checks and positive feedback from care homes.

South East Essex: The PCN Advanced Community Team (PACT) model for frailty and complex needs patients in South East Essex is constantly improving. Specifically, the areas of Benfleet, West Central, and SS9 are leading the way and serving as a model for other PCNs. Benfleet is collaborating with EPUT to test a care home training program to reduce duplication and maximise the impact of care for residents.

Thurrock: Continue to develop their models of care which will improve access for patients with complex needs and improve management and prevention of obesity and cardiovascular disease (CVD). Widespread engagement underway with other partners to jointly build a strategy that is meaningful to the people of Thurrock.

2.5 New Primary Care Access Recovery imperatives

The Secretary of State (SoS) has outlined the key priorities moving forward. These are unsurprisingly focussing on improving patient access in Primary Care, Urgent Care and Elective care. New recovery targets and detail are expected to be shared with the Primary Care team on 9 May 2023. Key messages received to date.

- The NHS will be held to account by the SoS on three key areas Elective Recovery, Urgent and Emergency Recover and Primary Care Access Recovery. These will be primary focus.
- Primary Care will be expected to improve the common experience of patients being told to call back.
- Options will be required to expand alternatives to primary care (e.g. pharmacy), care navigation, effective Directory of Services etc.
- Commitment to backfill staff (a) to design and implement new models (b) to undertake training to support delivery.
- There will be a programme of support offers available to support practices and PCNs.
- The ICB will need to play multiple roles; enabler, performance manager, strategic oversight in addition to being performance managed by the region.

2.6 Funding and Incentivisation

PCNs have received funding to incentivise their first steps to evolving towards an INT. PCNs alongside Alliance teams will submit plans outlining how this funding will be utilised to delivery integrated working schemes across the 3 pillars of Fuller. These plans will form part of the overall clinical strategy outlined earlier in this paper.

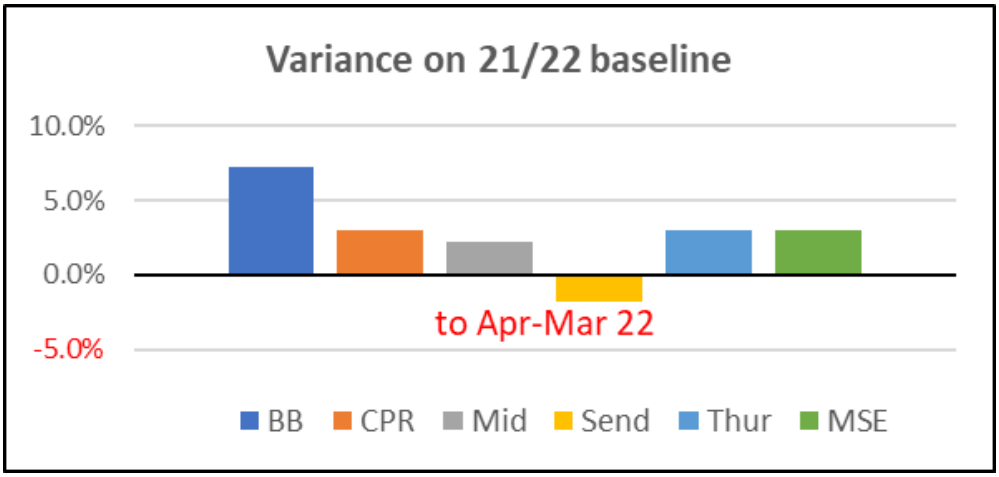
Moving forward it will be vital to create the right funding conditions to drive behaviour change and integrated working. A recommendation of the Fuller Stocktake was:

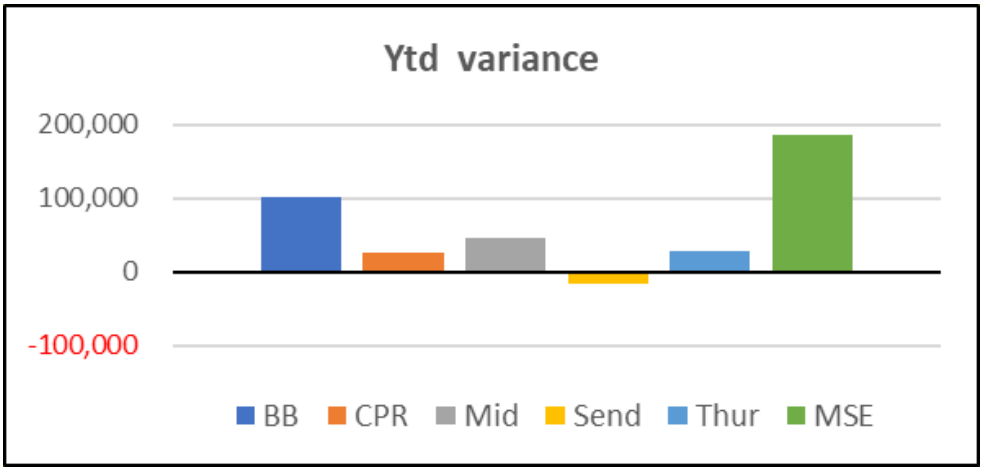
"DHSC and NHS England should rapidly undertake further work on the legislative, contractual, commissioning, and funding framework to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes"

Delivery of the above will create many of the levers required to deliver true integration. As an ICB we will need to ensure that the above is progressing alongside our own transformation of out of hospital services.

2.7 Progress/Achievements

Overall consultation levels for 22/23 were greater than 21/22. All former CCG areas saw an increase in consultation levels with the exception of Southend which experienced a slight reduction.





Within the national “Plan for Patients”, there is an ambition for patients to be seen within two weeks of contacting primary care. The table below shows the proportion of patients seen within key time periods (for April – January 2022/23);

Period	MSE ICS	National
Same Day	42.1% (increase on previous period)	43.7%
Within 1 Day (cumulative)	50.2% (increase on previous period)	51.9%
Within 14 days (cumulative)	83.3% (reduction on previous period)	84%

2.8 Workforce

2022/23 has seen positive improvements in ARRS recruitment.

- 120 FTE roles were recruited across MSE between April 2022 and March 2023.
- 437 FTE roles are now in place across the twenty-seven PCNs, which equates to 480 staff (headcount).
- 87% of all roles were recruited to plan for 2022/23 (based on workforce plans). 66 FTE roles were not recruited from planned intentions.
- A total of £14.7m was claimed by PCNs, a 57% increase from last year.
- 58% of roles are employed directly, with the remainder employed via provider organisations (VSO, agency, trust, etc.)

At Alliance level recruitment of ARRS staff against the PCNs 22/23 planned recruitment is as follows;

- South East Essex 95%
- Basildon and Brentwood 96%
- Mid Essex 76%
- Thurrock 75%

3. Findings/Conclusion

We continue to make significant progress towards the ambitions set out in the Fuller stocktake. The next quarter is critical in defining the INT landscape across Mid and South Essex and identifying the transformative requirements in each of our Neighbourhoods.

4. Recommendation(s)

The Board is asked to note the Fuller Stocktake and Our Plan for Patients Update.

Part I ICB Board meeting, 18 May 2023

Agenda Number: 12.1

Committee Terms of Reference

Summary Report

1. Purpose of Report

To request Board approval of the revised Terms of Reference for the Remuneration Committee and Quality Committee.

2. Executive Leads

- Ruth Jackson, Executive Chief People Officer
- Frances Bolger, Executive Chief Nurse

3. Report Author

Sara O'Connor, Head of Governance and Risk.

4. Responsible Committees

The revised Terms of Reference were approved by the relevant committees as below:

- Remuneration Committee, 19 April 2023.
- Quality Committee, 21 April 2023.

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to approve the revised terms of reference for Remuneration Committee and Quality Committee.

Committee Terms of Reference

1. Introduction

The Terms of Reference (ToR) for the Remuneration Committee and Quality Committee were reviewed and updated as part of the annual reviews of committee effectiveness.

The revisions were approved by the relevant committees on the following dates:

- Remuneration Committee, 19 April 2023.
- Quality Committee, 21 April 2023.

2. Summary of Amendments

Revisions to Remuneration Committee Terms of Reference

A number of minor amendments were made to terminology to provide clarity within the terms of reference. In addition, the following changes were also made:

- Meetings will be planned monthly, subject to there being necessary business to transact.

- The committee, as reflected in the scheme of reservation and delegation has the authority to approve policies and procedures within its remit on behalf of the Board.

Revisions to Quality Committee Terms of Reference

A number of minor amendments were made to terminology to provide clarity within the terms of reference. In addition, the following changes were also made:

- Committee membership has been updated to include representatives from partner organisations as follows:

    - Non-Executive Member of the Board (Chair).
    - ICB Executive Chief Nurse.
    - ICB Medical Director.
    - At least 2 ICB Alliance Directors.
    - ICB Patient Safety Partner.
    - MSEFT Chief Nurse.
    - EPUT Chief Nurse.
    - Essex Community Collaborative Chief Nurse.
    - Senior Healthwatch representation.
    - Director level representation from Local Authority partners.
    - NHSE Regional Quality Director.
    - Director of Pharmacy and Medicines Optimisation.

- Quorum was amended from ‘50% of total number of members’ to ‘6 members’.

- Duties of the committee were updated to include Pharmacy, Optometry and Dentistry and oversight of the Individual Funding Request Policy.

3. Recommendations

The Board is asked to approve the revisions to the Remuneration Committee and Quality Committee Terms of Reference.

Part I ICB Board meeting, 18 May 2023

Agenda Number: 12.2

Committee Minutes

Summary Report

1. Purpose of Report

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

- Audit Committee (AC), 7 March 2023.
- Clinical and Multi-Professional Congress (CliMPC), 23 February 2023
- Finance and Investment Committee (FIC), 8 March 2023.
- Primary Care Commissioning Committee (PCCC), 15 March 2023.
- Quality Committee (QC), 27 January 2023.
- System Oversight and Assurance Committee (SOAC), 8 March 2023.

2. Chair of each Committee

- George Wood, Chair of AC.
- Dr Ronan Fenton, Chair of CliMPC.
- Joe Fielder, Chair of FIC.
- Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.
- Anthony McKeever, Co-Chair of SOAC.

3. Report Author

Sara O'Connor, Head of Governance and Risk.

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

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

Minutes of the Audit Committee Meeting

Held on 7 March 2023 at 11.00am – 1.30pm

Via MS Teams

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Chair.
- Peter Fairley (PF), Partner Board Member, MSE ICB (*although not attending in person, comments were received in advance of the meeting for consideration and to enable quoracy for decisions*).

Other attendees

- Jennifer Kearton (JK), Director of Resources, MSE ICB. From Item 9 onwards.
- Mike Thompson (MT), Chief of Staff, MSE ICB.
- Sara O'Connor (SOC), Head of Governance and Risk, MSE ICB.
- Tendai Mnangagwa (TM), Deputy Director of Finance for Financial Services & Management, MSE ICB.
- Jane King (JKi), Governance Lead (Minute Taker), MSE ICB.
- Colin Larby (CL), Deputy Head of Audit and Assurance, WMAS.
- Eleni Gill (EG), Lead Counter Fraud Manager, WMAS.
- Emma Larcombe (EL), Director, KPMG LLP.

Apologies

- Peter Fairley (PF), Partner Board Member, MSE ICB.
- Nicola Adams (NA), Deputy Director of Governance and Risk, MSE ICB.
- William Guy (WG), Director of Primary Care, MSE ICB

1. Welcome and Apologies

GW welcomed everyone to the meeting. Apologies were noted as listed above. PF had provided his comments in relation to the committee papers in advance of the meeting to ensure decisions required by the committee were quorate (Items 3, 5, 7a, 7b, 7c, 8a, 8b and 9c).

2. Declarations of Interest

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

Declarations made by ICB Board and committee members were also listed in the Register of Interests available on the ICB website.

There were no declarations raised.

3. Minutes and Action Log

The minutes of the last meeting of the ICB Audit Committee on 17 January 2023 were received.

Outcome: The minutes of the meeting held on 17 January 2023 were approved as an accurate record.

The Action Log was reviewed, and the Committee noted the one outstanding action (no 23) due for completion by April 2023.

4. Board Assurance Framework

MT introduced the latest iteration of the Board Assurance Framework (BAF) which included mental health quality assurance, as requested by the ICB Board at the meeting on 17 November 2022, and also an updated summary of MSEFT and EPUT's key risks. The risks had been taken through the relevant committees of the Board, as appropriate, and the latest BAF, subject to any amendments requested by Audit Committee members, would be presented to the ICB Board at the next meeting on 16 March 2023.

The BAF presented, detailed the 8 'red' rated risks currently faced by the ICB which related to Workforce, Primary Care, Capital, Unblocking the Hospital, Diagnostics, Elective Care and Cancer Performance, System Finance Performance, Inequalities and Mental Health Quality Assurance. Details on how risk controls were monitored, their effectiveness and next steps were set out for each risk.

SOC explained that the ICB also maintained a separate full register of risks, which included those on the BAF, and presented a copy to the Committee. SOC advised there were a few risks that had not yet been reviewed/updated by risk leads and that a final version would be circulated to the committee once updated.

ACTION: Final version of Register of Risks to be circulated to the Audit Committee.

A risk management system was currently under consideration and, if approved, the database would be implemented early 2023/24 and would provide staff with autonomy for managing risks at a local level.

GW requested that an individual risk review was undertaken at each Audit Committee meeting to provide an opportunity to look at the information behind the risk to understand the rationale for the risk management decisions taken. GW suggested starting with the 'Unblocking the Hospital' risk, which was of particular concern, and followed by the mental health risk. MT advised that a hospital discharge paper was to be presented at the Part II Board meeting on 16 March 2023 which would provide background on the risk.

ACTION: BAF risk review to be added to the committee workplan for each Audit Committee meeting. The first deep-dive review in June should focus in 'unblocking the hospital'.

Outcome: The Committee NOTED the Board Assurance Framework and ICB Risk Register update.

5. Scheme of Reservation and Delegation

MT presented an updated version of the Scheme of Reservation and Delegation (SORD) for consideration to enable and set up the governance for delegation of Pharmacy, Optometry and Dental (POD) Services from NHS England. In addition to the delegation of POD Services, the paper detailed other minor amendments made to the SORD.

Governance arrangements to fully enable POD delegation included the establishment of a Primary Care Delegation Agreement with NHS England, updated Primary Care Commissioning Committee (PCCC) Terms of Reference and the establishment of sub-committees to discharge primary care commissioning functions, which had been approved by the PCCC and presented to the Audit Committee for information (under Item 8), but would be presented to the ICB Board for final approval on 16 March 2023.

MT explained the role of the Audit Committee was to review the SORD and seek assurance where required before recommending to Board for formal approval. MT explained that further changes to the SORD were required which related to business case and investment approval and would be brought to the Audit Committee in June 2023.

GW invited questions from Members, there were none.

Outcome: The Committee APPROVED the Scheme of Reservation & Delegation and recommended to the Board for approval.

6. Management of Conflicts of Interest

MT provided an update on the management of Conflicts of Interest (CoI). Following Health Education England's withdrawal of the online CoI training resource at the end of 2022, a new CoI training pack was in development by the Deputy Director of Governance and Risk and Head of Governance and Risk. Due to capacity constraints, training would be rolled out during Q1 of 2023/24. CoI training would also be provided via the corporate induction programme for new employees which was currently in development.

As of 23 December 2022, of the 306 ICB staff required to undertake CoI training (including 33 Clinical Leads/Non-Executive Directors who may have completed the training elsewhere, for which the ICB did not hold records), 126 (41%) had completed the CoI online training since the establishment of the ICB on 1 July 2022. There was currently no replacement CoI online course available through the Electronic Staff Record (ESR) system.

In February 2023, an internal audit review of the ICB's Management of Conflicts of Interest, Gifts and Hospitality took place. The scope of the audit included a review of the policy framework, provision of CoI training and support for staff, maintenance and publication of Registers of Interest and oversight of CoI management by the Audit Committee. The final audit report provided a 'reasonable' assurance opinion and outlined several recommended management actions. ICB management responses were included in the report.

CL advised that all ICBs were in the same situation following the withdrawal of online CoI training and suggested it could be useful to reach out and share good practice.

PF enquired whether there was any value, or need, for ICBs and local authorities to develop joint CoI training or share training guides. MT and SOC agreed this could be considered as part of the development of CoI training. SOC added that, prior to the establishment of the ICB, local authorities were contacted regarding their CoI training offer and had confirmed similar processes were in place.

The ICB Board Register of Interests was also included in the meeting pack for information.

Outcome: The Committee NOTED Management of Conflicts of Interest Update and the ICB Board Register of Interests.

7. Audit Committee Annual Self-Assessment and Terms of Reference

MT explained that in accordance with good practice guidance, each formal sub-committee of the ICB Board was required to undertake an annual review of its effectiveness. The Committee's annual self-assessment summarised how the Committee performed over the past year and provided opportunity for recommendations on how the Committee may be strengthened going forward. An updated Committee Terms of Reference (ToR) v1.2 and Work Programme for the coming year were also required to be reviewed. The Board would receive a summary of all annual reviews for Committees of the ICB Board.

GW felt the self-assessment was fair and comprehensive and welcomed input from both the internal and external auditors on how Audit Committee ToRs, self-assessments and BAFs of peer ICB organisations compared to ensure the Committee's work was on track and would help determine any recommendations on how the operation of the committee may be strengthened going forward.

ACTION: Internal and External Auditors to provide a comparison on peer Audit Committee effectiveness for the next meeting to enable the Committee to complete the self-assessment.

PF's advanced comments stated there was argument for considering a third core member.

CL enquired about the addition of authority within the ToR to create a sub-committee and/or group. MT explained this was to give Information Governance Steering Group a committee to feed assurance into. CL highlighted the synergy of the addition, given the Audit Committee had oversight of the Data Security and Protection Toolkit submission.

MT advised that the work plan was an iterative process and further versions would be brought back to the committee as the work plan developed. As discussed under Item 4, a deep-dive on selected BAF risks would be added to the workplan for each Committee meeting.

GW requested that Pharmacy, Optometry, Dentistry (POD) and Specialised Commissioning were also added to the work plan and would take the lead from NA/JK on suitable frequency. It was agreed to invite the Director of Primary Care to attend the Audit Committee in August 2023 on behalf of the Primary Care Commissioning Committee (PCCC) to provide an update on POD risks identified during the first three months of delegation

ACTION: Pharmacy, Optometry, Dentistry and Specialised Commissioning to be added to the Work Plan, consideration to be given to frequency.

ACTION: Invite the Director of Primary Care to attend the Audit Committee in August 2023 on behalf of PCCC to provide an update on POD risks identified during the first three months of delegation.

Outcome: The Committee NOTED the draft Annual Self-Assessment of the Audit Committee.

Outcome: The Committee APPROVED the Audit Committee Terms of Reference (v1.2) and recommended to the Board for approval.

Outcome: The Committee APPROVED the proposed 2023/24 Audit Committee Work Plan, subject to the additions discussed.

8. Committee Terms of Reference

Primary Care Commissioning Committee

MT presented the updated committee Terms of Reference (TOR) and explained that as the Audit Committee had oversight of governance arrangements for the ICB, MT explained that new or draft ToR relating to formal committees of the Board would be received for approval. The proposed updated PCCC ToR considered the governance arrangements required to enable delegation of POD services to the ICB. The draft PCCC ToR (v1.3) were approved by the PCCC on 15 February 2023. The Audit Committee were asked to approve the draft and recommend to the ICB Board for formal approval. MT explained that an exception report would be taken to Board outlining the changes to the ToRs.

JKi advised that since the papers were distributed, following feedback received from the PCCC Chair, minor changes had been made to wording to provide clarification.

Outcome: The Committee APPROVED the Primary Care Commissioning Committee Terms of Reference and recommended to Board for approval.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) was responsible for the co-ordination, supervision, and direction of the work of others, as appropriate, to ensure the ICB maintained a co-ordinated approach to Information Governance.

The IGSG was accountable to the Audit Committee, therefore the Audit Committee received draft IGSG ToR for approval. The Audit Committee ToR (as per the draft provided under agenda item 7) had been updated accordingly. The draft IGSG ToR presented to the committee was approved by the IGSG on 27 February 2023.

Outcome: The Committee APPROVED the Information Governance Steering Group Terms of Reference.

9. Internal Audit

Draft Head of Internal Audit Opinion

CL presented the draft Head of Internal Audit Opinion (HoIAO), required as part of the annual report process, which provided 'Reasonable' assurance. CL highlighted that HoIAO work was still in progress and subject to change before the final version was issued. All

final reports issued to date gave 'Reasonable' assurance. The outcome of the review of BAF and risk management arrangements was outstanding at the time of the meeting. CL commented that third party assurance may impact opinion, but this would not be available until year-end.

In response to PF's advanced queries on whether an opinion could be judged without the themes of performance and HR (which had not been covered) CL clarified that these audits were in progress and their outcomes would be included in the overall opinion.

GW commented that the draft Head of Internal Audit Opinion report indicated a very good start for the ICB given the complexity of bringing together five separate organisations, strategies and Board Assurance Frameworks. MT also welcomed the draft report and hoped it reflected the final version.

Outcome: The Committee NOTED the Draft Head of Internal Audit Opinion.

JK joined the meeting at 11.32am.

Internal Audit Progress Report

CL presented the Internal Audit Progress Report which noted that good progress had been made on delivery of the plan and seven reports had been completed at the time of the meeting. Since the last Audit Committee meeting, the Management of Conflicts of Interest and Gifts and Hospitality audit had been finalised and received a 'Reasonable' assurance opinion.

The Assurance Mapping review, a non-assurance exercise, was also complete and concluded that the ICB had established a governance framework in line with NHS guidelines, including the establishment of Board Committees and supporting groups to enable effective oversight of the delivery of its statutory functions and duties. MT was reassured that, given the ICB was a new and different type of organisation, the committee structure and governance framework was on the right track and the ICB was in a good place as it approached the end of year.

PF's advanced comment noted a difference in some of the opinions detailed within the Statutory Duties assurance section (Appendix A) between the different lines of assurance.

In response to GW, CL confirmed that the Data Quality audit would look at both data quality and data processes across the system, however the audit had been postponed as further scoping work was needed. CL explained the Population Health Management review would look at the underpinning of processes, how data was collected and processed and how this informed policy decision making. Further changes to the timing of the IT element of the plan due to the delay in the publication of guidance had been discussed with management.

GW highlighted the number of overdue recommendations on the tracker that related to previous CCG provider contracts. MT advised he had been in touch with the team responsible who had confirmed all actions, except one, were complete and that JKi would coordinate evidence for the auditors to remove the completed actions from the tracker.

ACTION: JKi to coordinate and provide evidence for the outstanding and completed actions to the auditors for them to be removed from tracker before the next Audit Committee.

CL highlighted that evidence needed to be received before the closed Ockendon recommendation could be removed from the tracker. GW requested that the outstanding recommendations were chased at a senior level.

Outcome: The Committee NOTED the Internal Audit Progress Report.

Internal Audit Plan and Strategy 2023/24

CL presented the proposed draft Internal Audit Plan and Strategy 2023/24 which also incorporated the Internal Audit Charter. The draft plan included reference to the ICB's identified risks where appropriate to provide assurance on the scope of the assurances to be provided. CL advised that he was awaiting comment from executive officers on the focus and timing of the draft plan and strategy.

The draft plan included POD contract management. The Committee noted that whilst Hertfordshire and West Essex ICB would host Optometry and Pharmacy services, accountability for these functions remained with the MSE ICB. A review of Serious Incident management system oversight was scheduled for Q3 and would include a review of the processes implemented following the introduction of the new Patient Safety Incident Response Framework (PSIRF) in the Autumn 2023.

GW enquired where mental health was covered on the plan. JK explained that mental health would usually be covered in the clinical/patient safety area. JK and MT agreed to raise the inclusion of mental health on the audit plan with the executive team. MT stressed that the scope of a mental health review needed to be precise.

ACTION: The inclusion of a mental health internal audit review be discussed with Executive Team.

Outcome: The Committee APPROVED the proposed Internal Audit Plan and Strategy 2023/24.

10. Counter Fraud Progress Report

EG provided an update on the counter fraud work undertaken during the last quarter. EG advised there were two investigations underway. The investigation previously reported to the Audit Committee related to travel claims had reached a significant point in investigation and EG was due to meet with JK to agree a way forward. A new investigation had commenced regarding a potential conflict of interest.

EG presented the draft 2023/24 Counter Fraud Work Plan to the Committee for approval and invited questions and comments from Members. There were no questions or comments received.

Outcome: The Committee NOTED the Counter Fraud Progress Report and APPROVED the 2023/24 Counter Fraud Plan.

11. External Audit Update

EL advised that since the last meeting of the Audit Committee, the audit of the Mental Health Investment Standard (MHIS) of the five CCGs had concluded. It found that all of the

CCG's Statement of Compliances had been properly prepared in accordance with the criteria set out in the MHIS 2021/22 guidance published by NHS England.

Planning and risk assessment procedures had commenced ahead of the audit for the ICB. A formal plan and risk assessment would be presented to next Audit Committee. EL explained that it was likely there would be a risk around financial sustainability linked to the wider system position.

EL highlighted that for the three month CCG period, control findings had been raised in respect of related parties, however advised she was working with TM and JK on this. There was also a risk around the Remuneration Report with a specific risk around the Greenbury Report and pensions allocation reports, in that the pensions allocations report would not be split by 3 / 9 months respectively for the CCGs and ICB. As this posed an actuarial issue, disclosure wording would be included to reflect this.

JK advised she was happy with progress of the audit plan and welcomed having regular meetings with EL. JK acknowledged the challenges the Finance Team faced having both 3 month and 9 month reporting periods for 2022/23 and extended thanks to TM and the wider finance team for their hard work.

MT informed the Committee that due to the annual reporting timetable; a recommendation would be taken to the Board on 16 March 2023 to delegate the approval of the annual report and accounts to the Audit Committee. MT confirmed the Chair would be briefed on the Annual Report and Accounts timetable.

GW suggested it would be useful to receive a good draft of the Annual Report for review prior to the Audit Committee meeting. TM confirmed a timetable for the financial year-end was in place and that she would link in with the Governance Team to ensure the timetable was embedded.

EL reiterated that the approved final version of the Annual Report and Accounts must be the version published by the 30 June 2023 deadline (for which there was a scheduled audit committee on 20 June). CL suggested it would be useful for GW, EL, JK and TM to discuss the progress of the annual report at the end of May 2023.

ACTION: GW, EL, CL, JK and TM to discuss the progress of the annual report at the end of May 2023.

GW reiterated the need to work on narrative with the CEO and Chair from the outset. GW queried whether a great deal of interest or scrutiny was expected of the ICB's Annual Report and Accounts. JK advised there was not usually a great deal of interest. CL added that the Remuneration Report usually attracted the most interest.

Outcome: The Committee Noted the External Audit Update.

12. Waiver Report

JK presented the Waiver Report which, in line with the MSE ICB Scheme of Reservation and Delegation (SORD), set out the waiving of quotations and tenders which must be reported to the Audit Committee. The Director of Resources was the only ICB officer authorised to waive quotations and tenders, subject to Standing Orders and Standing Financial Instructions.

JK explained the three waivers reported to the Committee were necessary to enable the ICB to fulfil its statutory functions due to limitations in the supply market and did not arise from failure to plan procurement properly.

JK acknowledged that work to align contract governance was required and underway and, as a consequence, the Committee was likely to see a number of waivers reported. An update on the contract governance work would be brought back to the Audit Committee.

Outcome: The Committee Noted the Waiver Report.

13. Losses and Special Payments

JK advised there were no losses or special payments to report to the Committee.

14. Pharmacy, Optometry and Dentistry delegation

MT presented the POD paper on behalf of the Director of Primary Care who was required to attend an urgent meeting with the CQC. In December 2022, NHS England confirmed that, subject to final due diligence, POD services would be delegated to Integrated Care Boards from 1 April 2023.

The Committee noted that the six ICBs in East of England were taking a collective approach to the undertaking of POD Commissioning functions. Under this arrangement, day-to-day Pharmacy and Optometry Commissioning would be hosted by Herts and West Essex ICB on behalf of all six ICBs but accountability for these functions remained with each individual ICB. Each ICB would directly take responsibility for day-to-day dental commissioning. The necessary changes to the ICB's governance arrangements had been made to ensure relevant committees received necessary assurance from Herts and West Essex ICB and can make decisions where recommendations were made that require ICB approval.

MT highlighted that the paper provided assurance around the robust due diligence process undertaken to take on POD services. There would be inherent risks, but the specific risks would be managed and reflected in the risk management process. GW suggested it would be useful for the Board to receive a 'snapshot' of the key risks the ICB would inherit with POD.

ACTION: A 'snapshot' of the key risks the ICB would inherit with Pharmacy, Optometry and Dentistry delegation be presented to a future audit committee.

PF's advanced comments suggested that POD would be a useful topic for MSE ICB Board members to be briefed on during a seminar.

ACTION: Consider Pharmacy, Optometry and Dentistry services for Board Seminar topic.

Outcome: The Committee NOTED Delegation of Pharmacy, Optometry and Dental Services update.

15. Items for Information

The following items were included for information:

- Minutes of Finance & Investment Committee Meeting – 27 July 2022

- Minutes of Finance & Investment Committee Meeting – 7 September 2022
- Clinical and Multi-Professional Congress – 28 July 2022
- Clinical and Multi-Professional Congress – 29 September 2022

Outcome: The Committee Noted the Minutes presented.

16. Any other Business

In response to GW, MT confirmed shortlisting for the Associate Non-Executive member was in progress and interviews scheduled for the latter end of March 2023.

It was noted that the Audit Committee cycle of meetings would be held on a Tuesday afternoon as Executive meetings would take place on a Tuesday morning. MT advised that, on occasion, Executive meetings could run into the afternoon and therefore Audit timings may need to be adjusted. GW felt that a maximum of 2 hrs was adequate for the Audit Committee and suggested a start time of 2.00 pm, where possible.

ACTION: JKi to ensure where possible that audit committee meetings do not clash with meetings of the ICB Executive Team.

17. Items to Escalate

To BAF

- Pharmacy, Optometry and Dentistry risks.

To Primary Care Commissioning Committee

- Invite the Director Primary Care to August 2023 Audit Committee to provide an update on POD risks identified during the first three months of delegation.

To Board

- Scheme of Reservation & Delegation for Approval
- Audit Committee Terms of Reference for Approval
- Primary Care Commissioning Committee Terms of Reference for Approval
- Summary of Committee Effectiveness for Noting
- Snapshot of inherited key Pharmacy, Optometry and Dentistry risks

18. Date of Next Meeting

Tuesday, 11 April 2023

Mid and South Essex Health and Care Partnership
Clinical and Multi-Professional Congress (CliMPC)

23rd February 2023
9:00 - 10:00 am
Via MS Teams

Attendees
Peter Scolding (PS), Sarah Zaidi (SZ), Babafemi Salako (BS), Rachael Marchant (RM), Krishna Ramkhelawon (KrR); Gbola Otun (GO); Olubenga Odutola (OO), Gerdalize De Toit (GDT), Stuart Harris (StH), Russell White (RW), Kelly Robinson (KeR), Scott Baker (SB), Radha Sehgal (RaS), Robert Spackman (RoS)

Guest presenters:
Alison Hawley (AH) - *Programme Manager & Deputy SRO, Leadership & Organisation Development at Arden & GEM*
Margaret Joyce (MJ) - *Senior Consultant, Leadership & Organisation Development at Arden & GEM*

Apologies
Ronan Fenton, Jose Garcia, Kirsty O'Callaghan

Meeting Summary

Item No	
1.	**Welcome**
	PS welcomed colleagues to meeting. Twelve members of the CliMPC were present therefore the meeting was quorate as per the ToR. Conflicts of interest were declared by: - PS, SZ and GDT: have all been directly involved with the Stewardship programme The minutes and recommendations from the previous meeting were taken as accurate. PS gave an overview of the objective of the meeting, which was to discuss the Stewardship Stocktake process. The report 'Mid-South Essex Stocktake 2022-23' has been taken to the System CEO forum last week, and Congress members' views were welcomed prior to the report being presented to the ICB Board.
2.	**Stewardship Stocktake – Presentation and Discussion**
	PS welcomed speakers AH and MJ to the group who were invited to present and congress members to consider the Stewardship Stocktake report.

AH and MJ presented an overview of the findings of the stocktake and high-level recommendations. Members were initially asked to consider their thoughts on the report and its findings including any points for clarification, and then to address two questions:

1. What should the role of stewards/stewardship be in our system?
2. How can stewards become more effective/influential in the system?

KrR – Raised the idea of developing case studies vignettes as a way to help visualise this resource and how it can support wider transformation. Supportive of the incremental approach initially, with awareness of the need for a whole system approach. Shared his view that public health needs further embedding within the programme.
StH – Raised the concern around Arden & Gem being the ones delivering the training and also reviewing the process and asked for clarity around this.
AH – Made it clear that both AH and MJ were not involved in the training process at all and were asked to lead this report as they had no prior involvement. Recognised need to make this clearer in the report.
RM – Asked the question how does this all join up? Currently we have a few random groups but is there a plan for how this will all fit together? Currently does not see how this fits in with the alliances and ICB. These groups are made up of experts trying implement positive change but will not be successful if it isn't all joined up. Risk of neglecting important issues.
MJ – Stated that there was intentional variety in the first selection of groups, based on different care areas as a place to start. Some are quite broad like cancer, others are more focussed such as stroke.
PS – Acknowledged that these key questions need to be included in the white paper that goes to Board.

MJ asked the group to consider the two questions posed for discussion.
SZ – Emphasised the need to link with existing networks such as big transformation boards at ICB level, to bring stewardship into our approach to doing things. Informally this has started e.g. in the end of life programme board. Maturity of stewardship groups will be an iterative process, with smaller areas like stroke being in a position to do things earlier than broader groups. Need to become part of the existing programme structures.
RM - There is a huge difference in each of the six areas e.g. ageing well vs stroke. Need to evaluate what those groups should be and a cross system look at these groups and how they work. If they are all going to work in the same way they all need to map in the same way. In order for stewards to be more influential, we need to improving transparency, i.e. why we have them, what they should cover and who the groups are made up of.
KrR - Feels that public health and stewardship are not well aligned. Community and primary care are key elements that are missing in the report.
GDT – Highlighted the tension between system infrastructure/ governance and the ability to act as a steward. Not as integrated as they could be. Stewardship needs to be part of the governance of the system to be more effective. Need to be careful at how we position it in the system.
RM – Suggested that the pack should have a structural graphic to show how the governance and finance flows.
SZ – Emphasised that the pack describes the stocktake well but doesn’t summarise stewardship well enough for those that know little about it. For example, the report could include what the stewardship groups have been tasked

	and the principles this is based on. The report does not highlight the data dashboards work based on 3V framework. AH and MJ thanked the group for their feedback.
3.	**AOB**
	Next meeting is 30th March.

Minutes of ICB Finance & Investment Committee Meeting

Held on 8 March 2023 at 10.00

Plume Room, Wren House, Hedgerows Business Park, Colchester Road Chelmsford, Essex CM2 5PF

Attendees

Members

- Joe Fielder (JF), Non-Executive Member, Committee **Chair,** MSE ICB
- Loy Lobo (LL), Finance and Performance Committee Chair, EPUT (via MS Teams)
- Julie Parker (JP), Finance and Performance Committee Chair, MSEFT
- Jennifer Kearton (JK), Director of Resources, MSE ICB (via MS Teams)
- Jo Cripps, (JC), Executive Director, Strategy & Partnerships, MSE ICB (via MS Teams)
- Dr Tiffany Hemming (TH), Interim Executive Director of Oversight, Assurance and Delivery, MSE ICB (via MS Teams)

Other attendees

- Mike Thompson (MT), Chief of Staff, MSE ICB (via MS Teams)
- Les Sweetman (LS), Deputy Director of Programme Delivery, MSE ICB
- John Swanson (JS), Head of Infection Prevention and Control, MSE ICB (observing) (via MS Teams)
- Emily Hughes (EH) (item 11a), Deputy Director of System Pathway Development, MSE ICB (via MS Teams)
- Katie Arnold (KA) (items 11b & 11c), Portfolio Director – Commercial, MSEFT (via MS Teams)
- Jonathan Dunk (JD) (items 11b & 11c), Chief Commercial Officer, MSEFT (via MS Teams)
- Emma Seabrook (ES), Resources Business Manager, MSE ICB (minutes)

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were received from Anthony McKeever (AMcK), Chief Executive Officer, MSE ICB. The Committee were confirmed quorate.

2. Declarations of Interest

The Committee noted the register of members interests. JP declared an interest in agenda item 11(a) Eyes Electronic Referral Service (EeRS) Business Case in the role as Non-Executive Director for MSEFT and confirmed she would leave the room at the point the item is discussed.

LL advised he had a new interest pending and would share full details for the register of interests once formalised. He confirmed this presented no conflict to the agenda items being discussed today.

3. Minutes of the previous meeting

The minutes of the last meeting of the ICB Finance & Investment Committee on 1 February 2023 were received. The following points of accuracy were highlighted:

- Pg 9 (section 6): It was clarified this should read: *There was a suggestion that wording was factored into contracts to support organisations overcome the issue where staff being trained leave and come back into the workplace via an agency*

  The Chair added although the action was to report directly back to LL an update to the Committee would be helpful.

Members who were not conflicted were in receipt of the confidential minutes of 1 February 2023 meeting; there were no comments.

Outcome: The minutes of the meeting held on 1 February 2023 were approved as an accurate record subject to the amendments above.

The confidential minutes of 1 February 2023 were approved with no amendments.

4. Action log/ Matters arising

The Action Log was noted and updated accordingly.

The Committee were advised the shortlisting for the recruitment of independent Associate Non-Executive Members had taken place. As per the action there was a meeting scheduled to discuss the recruitment of a Partner Member s151 Officer as per the membership requirements within the Terms of Reference.

GP IT VOIP (Telephony)

LS provided an update on GP IT VOIP noting that following some further work and engagement with practices around their requirements the Committee was informed telephony for GPs has been descoped from the current telephony solution.

As part of the 2023/24 GP contract changes, practices would be required to procure their telephony solutions only from the framework once their existing telephony contracts expired. A piece of work was underway to look at wider primary care access and for the ICB to move away from a provider of telephony to a support/advisory role. The delivery plan for recovering access to primary care would describe further support available for practices who indicated they were interested in making this move in 2023/24.

LL highlighted the achievable efficiencies with an online solution for patient registrations which would free up capacity and enable patients to undertake this in their own time.

Corporate Telephony

LS explained that the process to establish a new contract with Wavenet for corporate telephony was underway based on a one-year contract with an option to extend by a further year. LS confirmed he had linked in with finance colleagues following the £3k increase in costs. It was noted Basildon Community Hospital had been included within the scope to provide a more robust and clinical safe service following issues with the existing offering.

The ICB had secured mobile handsets owing to the need to upgrade to ensure handsets were compliant. JP asked if there was a need for handsets given the access staff had to Microsoft Teams it was raised handsets were used by some individuals as a clinical device for example in

dermatology. It was agreed further work was required around the educational piece with staff on the use of personal handsets and associated risks.

MSEFT/ICB Recovery Plan Session

The Chair advised the Committee a date for the session was being arranged.

Items for Assurance

5. Finance Update – Month 10 Financial Performance Update

The Committee were presented with an overview of financial performance for the ICB and the wider Mid and South Essex system as at Month 10 (period ending 31st January 2023) by JK.

The MSE system had been reporting a forecast outturn deficit position since month 9, at month 10 the system was reporting a year-to-date position in line with the deficit outturn.

The Committee were assured the system was on track to deliver its year-end forecast outturn deficit position.

The Chair welcomed a visual aid in future reporting to show the movement of the run rate month on month to provide the assurance as a system we will deliver the agreed plan. JK took as an action and welcomed any further feedback to factor into future reporting.

A typo was highlighted within table 1 (page 17) of the report. It was clarified the final line within the table should have read: Total ICB (Surplus)/Deficit (ICS should read ICB). The table reported on the 9-month position alongside the 3-month CCG position.

It was explained following a surplus from the CCGs in Q1 that the ICB position partly offsets this with the overall position still to deliver a surplus for the full year.

It was highlighted some systems had received delegation of direct commissioning functions from NHS England for pharmaceutical, ophthalmic, and dental. Mid and South Essex was due to receive full delegation in April 2024.

JP flagged the importance of delivering the commitments around capital investments and asked if the right mechanisms were in place. JP spoke of a significant need within MSEFT for maintenance works to be carried out plus the need to invest in vital equipment.

The Committee were advised teams were working closely across the system to look at the ask and recognise the need to look at how we prioritise as a system.

Correspondence had been sent to ICBs from Lord Markham, Department of Health and Social Care regarding the direction of a joined-up capital plan. It was advised work was underway to develop an Estates Infrastructure Strategy and that other systems were further ahead following a national pilot. LL raised the benefit of a revenue based commercial model and would link in with the Estates Advisor at the right time.

The Chair, JF agreed that this should be looked at but also cautioned that the increased cost of money (interest rates) should also be considered as potentially significant.
Outcome: The Committee received and noted the month 10 finance update.

ACTION: JK to incorporate a visual aid in future reporting of the finance update to show the movement of the run rate month on month to provide the assurance as a system we would deliver the agreed plan.

6. Medium Term Financial Plan (MTFP)/ 23/24 Planning

The Committee were advised by JK that initial feedback had been received following the draft submission to NHS England on 23 February; the system was working together to form a response.

A Board Strategy Session to focus on operational financial and strategic plans would take place ahead of the March ICB Board and the next CEO Forum would look at the plans and assumptions around activity, performance and workforce in further detail to ensure delivery and flag any early warnings.
JK stated that the Medium-Term Financial Plan (MTFP) 23/24 was in progress, it was anticipated the plan would be taken to the ICB Board in May.

The draft submission of 23 February 2023 highlighted a MSE system deficit of £68.9m reflecting a breakeven position for the ICB, £18m deficit within EPUT with the remaining deficit sitting within MSEFT.

It was highlighted there were some material movements into next year for some systems within the region who were moving from a balanced plan this year to a significant deficit next year. Norfolk and Waveney were reporting a similar position to MSE and were congruent with our approach.

Following discussion, it was agreed a separate session was needed to review the risks and challenges in greater depth, to provide the clarity and assurance the system plan would deliver. It was agreed the invitation for a session planned for April with Board Members would be extended to JP and LL.

Outcome: The Committee noted the update on the medium-term financial plan.

ACTION: *The invitation for the April Board session covering the risks and challenges with the medium-term financial plan be extended to JP and LL.*

7. Efficiency Programme Update Report

JK presented the Committee with a report summarising the performance as at the end of January 2023 against the system efficiency target for 2022/23 of £84m.

JK highlighted a focus on efforts for the 23/24 Financial Sustainability Programme to deliver the £103m efficiencies required. It was noted £20m of the efficiency ask related to contracting and the application of the national deflator, £70m was resting within MSEFT and £10m with EPUT who were looking to identify further efficiencies.

A System Transformation Improvement Group (STIG) was being established; the group would review efficiency plans in order to gain assurance against delivery of the financial sustainability position.

JP highlighted the size and scale of the challenge to make cashable efficiencies especially for MSEFT and queried the effectiveness of the gateway process. JP highlighted the extent to which cashable efficiencies were required and the challenges that brings. It was noted the gateway process differs between the Trusts. It was highlighted everything that goes onto the list for EPUT had already been subject to challenge.

Outcome: The Committee noted the content of the Efficiency Programme report and the actions being taken to improve the delivery of efficiency.

8. Specialised Commissioning Delegation

MT informed the Committee of the establishment of a Joint Working Agreement (JWA) for 2023/24, between NHS England and the ICB for a Specialised Services Joint Commissioning Committee to operate in shadow form until delegation in April 2024. The Committee were asked to recommend the membership and adoption of the agreement to the ICB Board.

The Committee noted the financial risk: the move to population and then need based budgets from the existing provider budget approach. ICBs would need to be assured funds match the services commissioned and for systems, with challenged finances, they would need to be confident that specialised services would not worsen their position.

The Committee were asked to note the progress in developing joint working arrangements which would be refined to ensure this was providing the necessary assurance. The Joint Commissioning Committee would link in with key Committees to provide the oversite around quality and delivery. The Committee would be kept abreast of developments.

Outcome: The Committee:

- **recommended the [specialised commissioning] Joint Working Agreement (JWA), including the draft regional ToR, and the setting up of a Joint Commissioning Committee in 2023/24 to the ICB Board to adopt.**
- **recommended that the JWA could be signed by the ICB's Chief Executive Officer on behalf of the ICB.**
- **noted the further work required for transition to full delegation to ICBs from April 2024.**
- **noted the nomination of Tiffany Hemming as the lead Executive Director.**

9. Board Assurance Framework

The Committee was in receipt of the latest version of the Corporate Risk Register pertaining to the remit of the Committee. MT highlighted the Board Assurance Framework (BAF) was missing from the report.

It was clarified risk FIN01 System Financial Performance was not listed correctly within section 2 of the paper. The Committee were informed this was a red risk (scoring of 20) and has been escalated to the GBAF.

Outcome: The Committee noted the Board Assurance Framework (risk register) report.

10. Review of Terms of Reference

MT presented the revised Committee Terms of Reference that had been updated to reflect:

- The remit of the committee to investigate and seek information pertaining to its terms of reference.
- The addition of a third independent Associate Non-Executive Member, to support matters of quoracy and the management of conflicts of interest.
- Minor amendments to ensure consistency of language.
- Clarity over the committee's ability to approve policies and business cases in accordance with the details set out within the scheme of reservation and delegation.

It was clarified in line with the scheme of reservation and delegation, the Committee was able to approve policies and business cases however there were some exceptions that would require approval from the ICB Board.

It was suggested there was an addition to the Terms of Reference to reflect where systems are in financial deficit the NHSE Regional CFO would be in attendance at Committee meetings for consideration of any new investments (incremental to those in the agreed budget). It was agreed a line is added to this effect.

Outcome: The Committee approved the Terms of Reference subject to the inclusion of wording as above.

ACTION: *Terms of Reference to reflect where systems are in financial deficit the NHSE Regional CFO would be in attendance at Committee meetings for consideration of any new investments (incremental to those in the agreed budgets).*

ACTION: *The review of the Committees effectiveness for 22/23 to come the April meeting.*

11. Business Case Approvals

(a) Eyes Electronic Referral Service (EeRS)

JP declared an interest in the agenda item in the role as Non-Executive Director for MSEFT and left the room whilst the item was discussed.

KA presented the Business Case for the continued provision of the Eyes Electronic Referral Service (EeRS) across Mid and South Essex. The service delivers an electronic referral, advice and guidance and image sharing system to facilitate connectivity between primary care Optometrists and secondary care Ophthalmology acute care providers.

The current service improved the quality and speed of triaging (bidirectional flow of images, clinical data and messages pre and post appointment), reduced serious patient harm (permanent loss of vision) and supported the wider transformation programme. The service also supported waiting lists ensuring that service users were only referred to secondary care following agreed criteria.

Following a query from LL around the storing of data and the risk it presented when transitioning, EH advised this was historic data and believed it had not been moved between Providers.
It was suggested when obtaining consent to use patients' data this was done in the primary care setting, it was raised this had not been explored by region however was worth considering.

The Committee were advised the implementation and licencing for the EeRS service had been funded by NHSE for the past two years and the license was due to expire at the end of March 2023. The service was funded as a 2-year pilot, it was hoped funding would flow for year 3 but this has not been the case. The Business Case was seeking to secure £229k non-recurrent funding (no identified funding) with an option to extend to 2024/25, dependent upon the delivery of a national solution which was anticipated within the next 12-18 months.

LL added how services are recurrently funded beyond a pilot should be considered in advance of pilot being able to progress.

The Committee recognised no funding was identified, the cost pressure this presented and the need to not set a precedent. The importance of the service however was highlighted, the quality of life this provided to patients and the catastrophic impact this could have on individuals who could end up with permanent loss of vision. It was agreed the Business Case was approved, **JK, TH and EH to liaise outside of the meeting to identify a funding route.**

Outcome: The Committee <u>considered and approved</u> the business case for the continued commissioning of the Eyes Electronic Referral Service (EeRS) across mid and south Essex.

ACTION: ***JK, TH and EH to liaise outside of the meeting to identify a funding route.***

(b) Braintree Community Diagnostic Centre (CDC)

The Committee was in receipt of the Business Case for the Braintree Community Diagnostic Centre (CDC) and were advised by KA that funding had been agreed by the national team. The Braintree CDC was the first of four centres intended for the Mid and South Essex system. The key objective of the CDC was to address the growing demand on diagnostic services by providing additional capacity to address the growth in waiting times.

It was noted the centre was expected to deliver circa 50k additional diagnostic tests per annum once fully operational. It was clarified both the Braintree and Pitsea CDC were aligned to the ICS digital strategy.

Sufficient workforce was flagged as the most significant challenge to the case. The system had developed detailed workforce plans for the large modalities within the centres and the system was exploring the commercial market should additional workforce support be required on an interim basis until workforce was in place.

The case requests £13.3 million capital inclusive of VAT and supporting revenue. National guidance stated that revenue money would come from the programme up to and including 2024/25. After this date, the money would flow through adjusted system allocations. It was highlighted that without this system allocation, the Trust could no longer support the running of the centre.

LL asked if there was a central planning assumption that works across the centres and asked how the workforce challenges would be addressed. It was noted a programme team was leading the workforce aspect. Plans had been shared with the Imaging Network, CDC regional workforce team and HEE who were working with the programme team to support the workforce plans going forward. The need to ensure triangulation in terms of planning was flagged important.

There was a wider discussion around the workforce challenges and risks this presented to the revenue budget in relation to agency costs. There was a suggestion an international recruitment campaign posed the most sensible solution.

JP highlighted her concern around the financial risk posed beyond 2024/25 and the anticipation that this funding would be issued via system allocations.

It was noted 'other' costs related to the Trust early adopt schemes in order to maintain activity while the Braintree CDC was developed and the decant of existing services took place. In 2023/24 the mobile costs would be phased out and revenue costs such as consumables, digital software/licences, building operation costs etc would then begin to be incurred.

Outcome: The Committee supported the case for onward implementation of the Braintree Community Diagnostic Centre noting that national funding had been agreed.

(c) Pitsea Community Diagnostic Centre (CDC)

KA advised the Committee national approval on the 23/24 revenue funding for the Pitsea Community Diagnostic Centre (CDC) was anticipated in April. The Committee were asked to approve the Pitsea CDC business case for onward decision by the NHS England CDC national team.

In response to a question from the Chair, it was clarified the centre expected to deliver more than 140k diagnostic tests greatly improving capacity and access to diagnostic services and with the inclusion of an endoscopy unit made it the largest of the centres.

LL asked if an opportunity was being missed to create urgent care capacity to reduce E&D pressure from Basildon by establishing a walk in/urgent care centre. It was confirmed this was being considered as part of future aspirations and would form a separate business case. It was added this was factored in when identifying a preferred site.

LL asked if there was the ability to utilise mobile units in parallel to the centres to boost activity to support the reduction of the waiting list. It was confirmed a piece of work was being coordinated around the early adopter scheme and need to deliver the 95% target of patients receiving a diagnostic test within six weeks by March 2025.

Outcome: The Committee approved the Pitsea CDC business case for onward decision by the NHS England CDC national team.

12. Feedback from System Groups

The Committee noted the minutes of the System Finance Leaders Group, System Efficiency Programme Board and System Investment Group.

It was advised the System Efficiency Programme Board and System Investment Group will be reviewed following the establishment of the System Transformation Improvement Group (STIG).

The Chair welcomed a conversation outside of the meeting to understand the impending changes, ownership and accountability.

ACTION: ***AMcK to clarify with JF the ownership and accountability of the newly created System Transformation Improvement Group (STIG).***

JP welcomed sight of the minutes which played an important part of assurance to rely upon.

13. Items to Escalate

To the ICB Board for approval:

- Specialised Commissioning Delegation (approval of the Joint Working agreement and delegation for the Chief Executive Officer to sign the agreement on behalf of the ICB).
- Finance & Investment Committee Terms of Reference

14. Any other Business

Nothing declared.

15. Date of Next Meeting

10.00-12.00, 19 April 2023 via MS Teams.

ACTION: ***Invites for future meetings to be circulated to the Committee.***

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 15 March 2023, 9.30 am – 12.00 pm

Via MS Teams

Attendees

Members

- Sanjiv Ahluwalia (SA), Associate Non-Executive Member – Chair.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dan Doherty (DD), NHS Alliance Director for Mid Essex.
- Caroline McCarron (CMc), NHS Deputy Alliance Director for South East Essex (Deputising for Ruth Hallett). Nominated deputy.
- James Hickling (JH), Associate Medical Director (Deputising for Ronan Fenton). Nominated deputy.
- Ashley King (AK), Director of Finance Primary Care and Strategic Programmes (Deputising for Jennifer Kearton). Nominated deputy.
- Jackie Barrett (JB), Deputy Director of Nursing (Deputising for Viv Barker). Nominated deputy.

Other attendees

- Jennifer Speller, Deputy Director of Primary Care.
- Alison Birch (AB), Head of Primary Care Oversight & Assurance.
- Vicky Cline (VC), Head of Nursing, Primary Care Quality.
- Simon Williams (SW), NHS Deputy Alliance Director Basildon Brentwood.
- Kate Butcher (KB), NHS Deputy Alliance Director Mid Essex.
- Nicola Adams (NA), Deputy Director of Governance and Risk.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Jane King (JKi), Governance Lead (minute taker).
- Alex Henning (AH), Head of Digital Transformation.

Apologies

- Ronan Fenton (RF), Medical Director.
- Pam Green (PG), NHS Alliance Director for Basildon Brentwood.
- Aleksandra Mecan (AM), NHS Alliance Director for Thurrock.
- Margaret Allen (MA), NHS Deputy Alliance Director for Thurrock.
- Jennifer Kearton (JK), Director of Resources.
- Sarah Cansell (SCa), Contract and Support Manager, NHS England.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and a round of introductions took place. Apologies were noted as listed above.

It was noted the meeting was quorate.

2. Declarations of Interest

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

To support the management of conflicts of interest at the Primary Care Commissioning Committee (PCCC) meetings and the development of the PCCC Register of Interests, for those Members and Attendees registered with a GP in the Mid and South Essex area, details of the practice were provided.

Declarations made by ICB Board (one of whom is also a committee member) were also listed in the Register of Interests available on the ICB website.

Under Agenda Item 9 (Local Enhanced Services), it was noted that Dr Anna Davey was a practicing GP at The Coggleshall Surgery and member of the Colne Valley Primary Care Network. Item 9 did not require any specific action to manage the noted conflict.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 15 February 2023 were received.

Outcome: The minutes of the ICB PCCC meeting on 15 February 2023 were approved.

4. Action log and Matters Arising

The action log was reviewed and updated accordingly. The Committee noted the three outstanding actions (13, 24 and 25) were all due for completion by April 2023 and that the Committee Work Plan (28) would be included on the next agenda.

5. Pharmacy, Optometry and Dentistry Delegation

WG presented the final governance arrangements for Pharmacy, Optometry and Dentistry (POD) delegation which had received approval from the Executive Team and would be presented for ICB Board approval on 16 March 2023. WG confirmed that POD delegation was on track to commence from 1 April 2023.

WG advised that the ICB would initially adopt NHSE's quality assurance approach for POD services. However, as this was significantly different to the approach the ICB had in place for general practice quality assurance, a period of transition was required to align all assurance processes across primary care. SA commented that provider engagement would be key to levelling up the quality assurance process.

WG advised there were some concerns around the provider payment process, however work-around solutions were being considered. The committee noted a cost pressure on pharmacy budgets as these could no longer be offset by a dental underspend due to new ring-fencing arrangements and the matter had been escalated to NHS England for resolution. The Committee noted that these financial risks were common to all ICBs.

To support the undertaking of POD functions, several staff from the Dental, Primary Medical Services, Contracting and Finance teams would TUPE across to the ICB.

SA invited comments or questions from members.

PW queried whether the difference between clinical and pharmaceutical waste had been determined and requested clarification on who was responsible for clinical waste (pharmaceutical waste was currently dealt with through a contract with NHS England). WG agreed to discuss with PW outside of the meeting. The committee were advised that a national procurement for clinical waste was underway.

PW stressed the importance of identifying the lead for Controlled Drugs, as these drugs carried specific requirements.

SA requested that the committee was regularly appraised regarding strategic discussions and decisions affecting Primary Care services early in the process.

ACTION: WG and NA to consider how the Primary Care Commissioning Committee can be regularly appraised regarding strategic discussions and decisions affecting Primary Care services early in the process.

WG took the opportunity to extend his thanks to all ICB colleagues involved in the preparations for POD delegation.

Outcome: The Committee NOTED the final governance arrangements for Pharmacy, Optometry and Dentistry Delegation and ENDORSED receiving Delegation.

6. Alliance Added Value Report

AK reminded the committee that, at its meeting in December 2022, a discussion took place on the value of information provided at Alliance level and what additional information, overlaid against financial resources utilised, would provide meaning to the Committee (Action Ref 16). As a result, AK had compiled an Added Value Framework which would support the Committee to monitor progress against the ambitions outlined in the current Health and Care Partnership 5 Year Strategy.

AK highlighted the vast amount of information available on general practice that could support the framework. Following discussion by a number of officers from within the ICB, it was proposed that the framework sought to answer 'whether the resource invested into General Practice provided improvements in patient experience and outcomes'. AK explained the framework was intended for use at Alliance level, not intended to be a practice level performance dashboard.

SA thanked AK for undertaking the complex work and producing the framework and invited comments. Committee members agreed that the report and framework was comprehensive and would be a useful tool.

PW asked for the framework to consider the inter-relationship between GP Practice and Community Pharmacy and how hospital pharmacies could be linked in.

AD welcomed the outlined approach to working with Primary Care but suggested this would need to be carefully embedded via Clinical Directors. AD suggested that it would be useful for reporting metrics to include cancer wait times, from referral to treatment, as this had a significant impact on Primary Care in supporting patients during this period.

JH remarked that proxy measures should focus on matters that provided a positive difference on patient outcomes. JH was keen to receive exception reporting initially, then undertake a deeper look into the overall data available. JH queried whether the ICB had the ability to ask Anglia Ruskin University (ARU) for evidence-based measures to support the work being undertaken. SA agreed to have a separate conversation with WG regarding support required from ARU.

SA commented that the framework would support conversations in Primary Care which required broad clinical input, as well as GP input and reiterated that the framework was not a performance management tool.

JS stated that the framework was not intended to be shared with PCNs and providers. AK concurred and stated that the framework was created as an Alliance comparative tool for use by Alliance Directors and the committee, although this might change in the future.

DD commented that local level interest was around qualitative not quantitative data and metrics to measure reputation / relationship with community would need to be considered. VC agreed and highlighted that significant quality concerns needed to be flagged to Alliances. The Committee agreed that patient complaints provided learning and complaint themes were useful to Alliances.

JH commented that although the framework was not a performance management tool, at times it would be useful to identify under-performing practices and would help the ICB to engage with those practices. JH commented that for transparency it would be useful to consider sharing the framework with practices to explain its use and how it could assist the ICB in offering support to practices if required.

SA highlighted that the framework's primary purpose needed to be clear, which currently was to ensure a good alignment between finance, services and Alliances to support integration of care and give patient improvement. SA hoped the framework would enable an ICB collaborative approach for equality.

AK thanked Committee Members for the valuable conversation and contribution. AK would continue to work with primary care colleagues on the framework and identify the appropriate proxy issues with the Alliance Directors and Clinical Directors. AK agreed to bring a progress update to the Committee on the development of the Added Value Framework by June 2023.

ACTION: AK to bring a progress update to the Committee on the development of the Added Value Framework by June 2023.

Outcome: The Committee NOTED the Alliance Added Value Report

7. Fuller Stocktake

WG provided an update on the progress made against implementation plans arising from the Fuller Stocktake Report and 'Our Plan for Patients' in mid and south Essex. The committee noted that the Primary Care Network (PCN) Clinical Strategy Development work was due for completion by the end of March 2023.

At the request of NHS England, a baseline assessment was undertaken to monitor implementation progress against the Fuller Stocktake Report. AD was comfortable with the progress made to date and positive feedback had been received from Clare Fuller on the ICB's progress.

AD was undertaking visits to the 28 Primary Care Networks (PCN's) across mid and south Essex to discuss implementation plans. AD reported varying levels of understanding and views on future Integrated Neighbourhood Teams (INT). WG advised that engagement work to establish a clearer vision for INTs was being undertaken by the Interim Director of Clinical Policy. The challenge for the Integrated Care System was to identify how to incorporate the three core functions of the Fuller report (Complex Care, Urgent and Episodic and Prevention) into INT plans.

In response to SA, AD advised that the system's view on the vision of an INT was based on the Fuller Stocktake and that plans should come up from an Alliance level. AD explained that a clear INT strategy and vision was required before finances would be known.

AK disagreed that plans for INTs should be led by Alliances as contracts did not sit at Alliance level. AK requested that the Interim Director of Clinical Policy present any INT development plans to the committee for consideration. WG acknowledged that strategic planning was complex at both Alliance and ICB levels and transformation work undertaken at PCN level should continue whilst deciding on the next steps.

WG stated that implications arising from the changes to GP contracts needed to be considered as part of INT development, as well as the emphasis on front door primary care and changes to the ICB's structure, due to the required reduction in running costs. Members agreed it would be helpful for the Interim Director of Clinical Policy to attend a future committee meeting to give an update on the transition plans for INTs.

ACTION: The Interim Director of Clinical Policy to attend a future Committee meeting to give an update on the transition plans for INTs.

AH reminded the Committee that the Digital Team should be involved at an early planning stage for INTs.

Outcome: The Committee NOTED the Fuller Stocktake and Our Plan for Patients update.

8. Primary Care Contracts and Highlight Report

JS provided a verbal update on Primary Care contracts. The Alternative Provider Medical Services (APMS) mobilisation was underway in Thurrock & South East Essex Alliances,

however it was noted there was a staffing risk as a result of a delay with the new provider coming into work with existing staff.

VC advised that the new provider had raised concerns with the Care Quality Commission (CQC) regarding the current provider around patient safety. Although no specific examples were provided, VC reported that the Primary Care Quality team had not identified any major concerns.

Dickens Place Update

JS confirmed that Dickens Place list closure was confirmed for 30 April 2023. There were issues regarding the management of stakeholder communication around the decision to close the practice. DD and JS acknowledged that improvements were required to ensure that local intelligence informed local messaging. SA requested an update on how the matter was resolved and action being taken to avoid this reoccurring.

ACTION: WG to provide update at next committee on how miscommunication issue (regarding Dickens Place) was resolved, and action being taken to avoid this recurring. If necessary, the Committee would escalate to Board.

Sai Medical Centre

There was nothing further to note or action. SA invited comments and questions from Members. There were none.

Change of contract status

JS advised a change in contract status for two practices in south east Essex would require virtual approval outside of the meeting as the final details were pending. SA agreed that the papers could be circulated for approval outside the meeting.

ACTION: JS to provide contract status papers (for the two Practices in south east Essex) requiring virtual approval to JK for circulation to Committee Members.

JS had received notification of two merger applications (for Greenwood Surgery / Wyncroft Medical Partnership and Milton Road Surgery / Grays Surgery).

JS advised that NHS England had announced changes to the 2023/24 GP contracts and that the Primary Care Team were looking at how to manage the concerns the changes might bring and how practices could be supported. There were no changes to PCNs but there would be changes to access requirements. JS shared the document outlining the contract changes in the Teams chat function.

SA was concerned it would be challenging if GPs decided to act against contractual changes. JS advised that the Local Medical Committee (LMC) had shared the national message but not the local message. JS agreed that primary care would request input to any communications issued to support media response.

Outcome: The Committee NOTED Primary Care Contracts and Highlight update.

9. Primary Care Local Enhanced Services

AB presented the report outlining the commissioning intentions for local Primary Care services outside of GMS/PMS/APMS contracts (Local Enhanced Services (LES) for 2023/24). LES were locally agreed schemes between the commissioner and primary care contractors to meet identified needs and priorities.

AB explained there was a need to harmonise the services commissioned from GP practices (and PCNs) across area following the implementation of the ICS. However, several local initiatives had been developed to transform local primary care services. To prevent destabilisation of existing schemes delivering improvements to patient outcomes, experience and staff experience, a number of services would continue to be commissioned under existing arrangements temporarily.

A working group which included LMC and Practice Managers had been set up to ascertain the cost to practices for providing each service, which provided an objective price for primary care remuneration for service delivery. Service specifications and price comparisons for 2022/23 and 2023/24 were provided.

AB agreed to provide VC with details of each LES for assurance to ensure practices were able to deliver the services.

WG advised there was significant further work to be done with Alliances to agree the next steps. SA requested assurance that Alliance Directors, Clinical Directors and PCNs would be involved in conversations around LES.

SW noted a significant decrease in the proposed Minor Injury price for the Basildon Brentwood Alliance and queried whether this could be a potential risk. AB advised that very few practices made claims for Minor Injury and he did not think it would be a risk.

SW highlighted a financial breakdown for each of the Alliances had not been included in the report. SA requested that a breakdown of financial resources allocated to each of the Alliances be presented at a future Committee meeting for transparency. AK confirmed that numbers were weighted per head of population. SA also requested that descriptions of process and principles of equity for those practitioners providing same services were included in future transformation plans to ensure the committee made equitable decisions.

ACTION: AK to work with AB, JS and WG to provide input into updated Local Enhanced Service paper to be presented at the next meeting.

PW advised that a paper outlining the Medicines Optimisation Local Enhanced Service (MOLES) intentions was in progress that would require approval outside of the Committee to meet timeframes for implementation in April 2023. The Chair agreed for the paper to be circulated outside of the Committee for approval.

ACTION: JK to circulate Medicines Optimisation Local Enhanced Service paper for Committee approval to meet timeframes for implementation in April 2023.

JH commented that under the Integrated Neighbourhood Team scheme, PCNs could be asked how they would best utilise funds, however he felt it would not be possible to

implement schemes until 1 April 2024. JH stated that inflation costs pressures should be considered.

SA suggested AB and WG considered the ICB's approach to pricing and what it meant for patients and staff and bring these principles to a future PCCC meeting.

AK commented that the principle of having a suite of prices across the system made sense, however consideration needed to be given to the transactional side of having a large number of services. JS agreed the approach to pricing and strategic commissioning needed to be reviewed and brought back to the Committee for further consideration.

SA acknowledged the importance of reviewing the ICB's pricing structures and the principles used to treat providers equally.

Outcome: The Committee APPROVED the Local Enhanced Service commissioning arrangements, as outlined.

Outcome: The Committee APPROVED the Existing Primary Care Transformation Schemes to be commissioned as outlined.

10. Primary Care Risk Management

WG presented the risk management paper which gave an overview of the Primary Care risks on the ICB register, for which they were responsible. There were 2 red rated risks and 8 amber risks. WG highlighted that an additional primary care risk around APMS mobilisation (as discussed under Item 8) had been added following circulation of the papers.

SA invited comments and questions from Members. There were none.

Outcome: The Committee NOTED the updates provided on the risk register.

11. Finance Update

AK gave an overview of the financial performance of the ICB in respect of its investments in, and directly influenced by, primary care as at Month 11.

The report had evolved as the capabilities of the ICB, and the direction of the PCCC, changed. Consideration would be required in the coming months as to how financial reporting was amended to reflect the committee's responsibility for POD. An initial change had been included in this report through the inclusion of all spend identified within the ICB as 'Primary Care' including items such as GP Prescribing.

The paper concluded that the ICB would utilise circa £345m on identified Primary Care, and Primary Care related, commitments. The vast majority of the £345m, excluding prescribing costs, was through entitlements held under the nationally negotiated GP contract, although a not insignificant amount was a result of local decisions made by predecessor organisations – these legacy decisions required further review and understanding. For the current financial year, it was anticipated that contract liabilities would fall within available budgeted amounts, whilst prescribing expenditure would exceed planned levels of spend.

The report continued to evolve to meet the needs of the committee. Discussions in December 2022 initiated a piece of work looking at a value framework which had been discussed under item 6.

Whilst there were previously ambitions to evolve further it was sensible to do this in the context of the evolving remit of the committee and its soon to be expanded brief including POD commissioning.

12. Items to Escalate

There were no items to escalate.

13. Any other Business

The ICB's corporate calendar had been prepared with the 2023/24 PCCC meetings proposed to take place at the beginning of the month. However, this meant the next meeting was scheduled for 3 April, in three weeks' time. The Committee therefore agreed to hold the next meeting on 3 May 2023.

AK asked the Committee to note that the most up to date finance data would not be available at the beginning of the month.

It was agreed that Digital and Quality exception reports would be added to the May agenda.

ACTION: JK to include Digital and Quality exception reports on the 3 May 2023 agenda.

14. Date of Next Meeting

9.30am – 11.30am, Wednesday 3 May 2023

Minutes of Part I Quality Committee Meeting

Held on 27 January 2023 at 10.00 am – 12.00 noon

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member and Committee Chair.
- Frances Bolger (FB), Interim Chief Nursing Officer (items 7 to 20).

Attendees

- Stephen Mayo (SM), Director of Nursing for Patient Experience.
- Viv Barker (VB), Director of Nursing for Patient Safety.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Gemma Hickford (GH), Consultant Midwife.
- Dr Rebecca Morgan, Clinical Lead, Maternity.
- Jackie Barrett (JB), Interim Head of Nursing.
- Linda Moncur (LM), Interim Director of Safeguarding.
- Vicky Cline (VC), Head of Nursing – Primary Care.
- Sara O'Connor (SO), Head of Corporate Governance.
- Alix McMahon (AMcM), Complaints Manager.
- Carolyn Lowe (CL), Deputy Director of All Age Continuing Care.
- John Swanson (JS), Infection Prevention & Control Specialist.
- Laura Marshall (LMar), L&L Consulting.
- Ross Cracknell (RC), Senior Quality Manager Mental Health.
- Karen Flitton (KF), Patient Safety Specialist.
- Greer Phillips (GP), Patient Safety & Quality Manager.
- Eleanor Sherwen (ES), Interim Head of Nursing.
- Stephanie Williams (SW), Quality Manager.
- Eleanor Carrington (EC), Deputy Director of Nursing, Primary Care.
- Emma Everitt (EE), Business Manager, Nursing and Quality.

Apologies

- Dr Ronan Fenton (RF), Medical Director.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above.

2. Declarations of Interest

NIB reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or

should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations of interest made by Integrated Care Board (ICB) members are listed in the Register of Interests available on the ICB website**.**

3. Minutes

The minutes of the last Quality Committee meeting held on 25 November 2022 were reviewed and approved with no amendments requested.

Resolved: The minutes of the Quality Committee meeting held on 25 November 2022 were approved subject to a minor amendment as noted above.

4. Matters Arising

NIB advised that GH attended the Part I Board meeting on 19 January 2023 to provide a presentation on maternity services.

VB advised that the Care Quality Commission had recently inspected medical services at Mid and South Essex Hospitals NHS Foundation Trust (MSEFT). Verbal feedback had been received and would be covered later in the meeting.

5. Action log

The action log was reviewed and updates were noted.

Resolved: The Committee noted the Action Log.

6. Lived Experience Story – Maternity Services

GH advised that the lived experience story video outlined the experiences of Libby who had experienced a complex pregnancy.

GH confirmed that post-natal care would be focussed upon during work to improve maternity services, with patients' physical recovery being supported via a new service launching later in 2023. GH noted it was encouraging that during Libby's second pregnancy, she had continuity of carer - a significant driver to reduce poor outcomes - as well as personalisation and patient-led choice. This contrasted with Libby's less positive experience during her first pregnancy several years ago.

In response to a query from SM, GH advised that the appointment of Consultant Midwives had provided positive role-modelling and leadership. There was increasing evidence, e.g. the outcome of the latest CQC maternity survey, that patient experience was improving, although further improvements were required.

NIB noted that Libby had a good awareness of the factors affecting her pregnancy and also the questions to ask those providing care to her but suggested that future stories should outline the experiences of those who might not have the ability to effectively question health professionals.

Resolved: The Committee noted the lived experience story relating to maternity services.

7. Deep Dive – Maternity Services

GH shared a set of slides outlining the work and membership of the Local Maternity and Neonatal System (LMNS) and the committee / oversight arrangements for maternity services. The most recent CQC inspection of all three hospital sites had rated maternity services as 'Requires Improvement'. GH reminded those present that maternity services at Basildon hospital were rated 'Inadequate' in June 2020 following which a Section 31 Warning Notice was issued. Legal undertakings relating to this notice remained in place (FB noted this was unlikely to be closed off in the near future) and the ICB and NHS England (NHSE) regularly met with the Trust to monitor the sustainability of improvements made.

GH advised that filling maternity workforce vacancies, retaining existing staff and delivery of training for particular groups of staff remained challenging. Compliance rates for the regular appraisal of staff were improving, but ongoing vacancies impacted upon this.

A focus upon the retention of staff would be promoted by retention lead midwives, with preceptorship support for those in the early stages of their careers. There was also a focus upon international recruitment of midwives, with 9 already in place and 3 more expected to join shortly, and general nursing roles providing post-delivery care. Return to practice midwives, conversion courses for nurses to become midwives, apprenticeships and opportunities for specialist roles, e.g. consultant midwives, would also help to bolster the maternity workforce.

Additional maternity governance roles had been filled and the Trust was working to clear the backlog of serious incident (SI) investigations by the end of March 2023, with good progress to-date. The Trust was also progressing the investigation and closure of all other incidents reported within maternity services. SIs were reviewed by GH and the maternity commissioner working within the LMNS, to review the robustness of investigations and resulting action plans.

MSEFT was benchmarked against other organisations with over 4,000 births per annum. Currently the Trust was an outlier for the number of stillbirths which must be addressed. A thematic analysis of nearly all stillbirths, neo-natal deaths and late miscarriages occurring within a twelve month period had been undertaken by the Trust in conjunction with NHSE and other colleagues, to determine the areas of focus required. Action taken would be regularly monitored.

Implementation of recommendations made within the Ockenden Review report was not yet at full compliance. Sign-off was subject to evidence that improvements had been sustained as well as external review.

The annual CQC maternity survey of MSEFT had a response rate of 43%. The LMNS used the outcome to inform service improvements required and as a source of assurance. The latest survey identified improvements in 3 areas, but no significant improvement in the others, although there had not been a deterioration.

GH summarised that MSEFT maternity services were on an improvement journey in many areas, including pelvic health, maternal mental health services, and ongoing work to support continuity of carer. The LMNS was well positioned as an assurance mechanism for

the ICB and it was vital that ongoing collaboration between the Trust and the LMNS was maintained to deliver sustained improvements.

SM asked if the Trust was on-track with implementation of the CQC improvement plan and whether it was meeting its duty of candour in relation to SIs. GH advised that following a review of the CQC action plan in September, clearer timelines were put in place and were regularly monitored, with significant progress made to-date. The duty of candour was aligned to the SI process and was undertaken as quickly as possible, as seen via initial management reviews of SIs, although not all incidents triggered the duty. FB summarised the arrangements for review of maternity incidents to ensure the duty was met where required.

NIB advised that it would be helpful to include how many incidents met the SI criteria, as well as themes, shared learning and action taken, within future reports. NIB advised that she and SM had recently discussed and welcomed the due diligence undertaken and data provided by the LMNS which would be helpful when developing the new quality dashboard.

Resolved: The Committee noted the Deep Dive on Maternity Services.

- **Action:** GH to include the number of maternity incidents meeting the SI criteria, as well as themes, shared learning and action taken, within future reports.

8. Complaints and Lived Experience Report Quarter 3

AMcM advised there had been a general increase in the number of complaints and enquiries received, some of which related to the six commissioning policies currently undergoing harmonisation.

In response to a query from NIB regarding data, AMcM advised that NHSE had highlighted that mid and south Essex received the highest number of complaints and enquiries, both in volume and per capita. The implementation of a new database in early 2023/24 to manage complaints, as well as incidents, risks and claims, would improve the analysis and triangulation of data.

VC advised that the primary care team had started to receive NHSE data on primary care complaints which would enable the team to undertake analysis. There had been an increase in the number of concerns raised regarding residents' ability to register with a GP practice. AMcM confirmed that the ICB would take on delegated responsibility for primary care complaints from 1 April 2023 and had been offered the opportunity to shadow the dental resolution team in preparation. The ICB complaints team needed to learn and understand the processes currently used by NHSE. Process mapping would also be undertaken with the primary care team towards the end of March and the ICB's public website would be updated to reflect the changes.

AMcM advised that the ICB complaints team was not yet at full capacity, with recruitment of one post currently on hold, which impacted on response times and other work within the team.

Resolved: The Committee noted the Complaints and Lived Experience Report for Quarter 3.

9. Patient Safety and Quality Risks

SO advised that not all risks had been transferred from the old risk register spreadsheet, which became corrupt, to the new spreadsheet. As mentioned under agenda item 8 above, it was anticipated that a new database to manage risks would be in use by early 2023/24.

Patient safety and quality risks currently rated red on the risk register related to: quality assurance of mental health services (x 3); maternity services (x 2); continuing health care (x 1); and addressing health inequalities (x 1). These risks had been referred to within reports to the committee or ICB Board during the previous and/or current cycle of meetings. Mental health services and health inequalities were also included on the Board Assurance Framework, which would be shared with the Board on 16 March 2023. Risk leads would be contacted to update risks prior to the next committee meeting.

Resolved: The committee noted the verbal update on patient safety and quality risks.

10. Quality Strategy Implementation Update

LM advised that work continued to develop improved quality and safety data, although there were several barriers to overcome, including accessing data held by the ICB's business intelligence provider. LM was liaising with colleagues to implement interim arrangements. Work was also progressing on the format and content of reports to the committee to ensure reporting was succinct and informative.

NIB acknowledged the challenges but advised it was important that interim arrangements were in place to ensure that accurate data was available to managers.

Resolved: The committee noted the Quality Strategy Implementation update.

11. Acute Care

JB highlighted the following issues.

MSEFT's response times to formal complaints was poor (31.9% in November 2022) due to three vacancies within the Trust's PALS and complaints team.

MSEFT were progressing their overarching CQC improvement plan. A further unannounced inspection at all three hospital sites took place earlier in the week.

Cancer and Referral to Treatment (RTT) harm reviews and the backlog of SI investigations remained an area of concern. There were two Never Events reported in December 2022, both with no harm identified.

JB also highlighted the significant pressures being experienced by the East of England Ambulance Service Trust (EEAST) which impacted upon ambulance response times.

VB advised that high level feedback from the most recent CQC inspection of all three hospital sites identified concerns regarding documentation, patient hydration and nutrition (particularly at Southend Hospital) and the care of mental health patients in acute settings. There were also some infection prevention control and medicines management issues highlighted. The Chief Nurse at MSEFT was drafting a letter of intent to the CQC outlining immediate action taken by the Trust, which the ICB would be copied into. FB explained

that the deadlines for providing feedback to the CQC was very tight. The ICB Quality and Nursing Team had offered its support to the Trust.

SM noted that where the ICB received a complaint relating to MSEFT, the ICB's own complaints response rate was adversely affected if the Trust did not respond to concerns on a timely basis.

Resolved: The Committee noted the Acute Care update.

12. Infection Prevention and Control (IP&C)

JS advised that the antimicrobial stewardship strategy was being developed by Dr Pete Scolding and Nisha Desai. A request had been received via the joint IP&C Committee across all three hospital sites for the antimicrobial resistance (AMR) lead Pharmacist to review prescribing habits over the past 18-24 months to identify whether this was a leading factor in IP&C related incidents.

Clostridioides difficile infections were above threshold for 2022/23, although they had started to stabilise during the past month. Regional colleagues were aware and investigating potential thematic links, including reviewing cases of recurring infections experienced by some patients.

PW advised that relatively few community pharmacists prescribed independently but from 2026 all pharmacists would become prescribers. In anticipation of this, the ICB had been invited to submit an expression of interest to carry out an independent prescribing pilot across community pharmacists to understand how this could work going forward. The new arrangements would enable improved monitoring of prescribing. Updated AMR prescribing guidance would be circulated to pharmacies and uploaded to the ICB website.

Resolved: The Committee noted the Infection Prevention and Control update.

13. Mental Health

RC advised that HM Coroner had provided a narrative conclusion to a high-profile inquest, as set out in Appendix 1 of the report.

Out-of-area (OOA) placements continued to be at a high level and now stood at 91. The outcome of the OOA audit had been received and the ICB was working with the discharge matron for quality assurance regarding the findings, which would be reported to the committee in due course.

RC advised that recent CQC visits at EPUT had identified several areas of concern including staff sleeping on duty, restrictive practice, and sexual safety. The report confirmed that 27 out of 56 actions arising from these inspections had since been completed. Weekly safety huddles between the ICB and EPUT and monthly quality meetings had been arranged. A CQC Well-Led inspection at EPUT had also commenced.

RC advised that Dr Strathdee, Chair of the Essex Mental Health Independent Inquiry had released a letter (Appendix 2 of the report) detailing the reasons why it was unlikely the Inquiry would meet its terms of reference which had been escalated to the Secretary of State for Health and Social Care. The Government had since released a statement

advising it would undertake a rapid review into mental health services in England, also to be chaired by Dr Strathdee, which would run independently of the Inquiry.

PW advised that members of her team were providing support to EPUT regarding CQC concerns relating to medicines management.

Resolved: The Committee noted the Mental Health update.

14. Community Care

ES advised that although workforce challenges remained, she had been advised by the Director of Nursing at North East London NHS Foundation Trust (NELFT) that 120 additional nurses were recruited from Botswana and Zambia. The nurses were well qualified and followed a public health management approach. A further international recruitment initiative was underway which should result in 200 further nurses being recruited.

The acuity of patients and ambulance delays was impacting on community staff who often had to stay with vulnerable patients until an ambulance arrived, which then caused a knock-on effect for other staff and patients. Providers were aware of the need to support the health and wellbeing of staff.

Speech and Language Therapy (SALT) services had received funding to recruit an additional 5.5 whole time equivalent members of staff. Agency staff were being used in the interim. The community collaborative was considering how SALT resources could be shared.

Gibson ward at Brentwood Community Hospital had successfully been relocated to Mountnessing Court, although some issues remained in relation to facilities as set out in the report.

VB outlined the arrangements currently in place to highlight any concerns that might arise in relation to care provided via virtual wards but noted these would need to be refined as use of virtual wards increased in response to national requirements. VB asked ES to liaise with community collaborative colleagues and Sarah Lennox in this regard and report back to the April meeting.

NIB asked ES to advise on the support provided to the community workforce, in particular overseas staff, to support the retention of staff. ES advised that lessons had been learned from previous overseas recruitment exercises which had since been addressed.

Resolved: The Committee noted the Community Care update.

- **Action:** ES to liaise with community collaborative colleagues and Sarah Lennox regarding arrangements for oversight of care delivered via virtual wards and provide an update on this to the April committee meeting.

15. Care Sector

GP advised that ambulance delays were having a significant impact on care home patients and staff as outlined in the report. GP also outlined that the fast pace of hospital discharges was also impacting on care homes, in particular requests to accept discharges

outside of normal working hours. The Quality and Nursing Team were providing support where possible.

In response to a query from NIB, GP advised that readmission data was not currently being received by her team. However, the use of Urgent Community Response Team services by the care homes was preventing some readmissions.

SW asked whether advanced care planning decisions were being communicated effectively between care homes and primary care to avoid unnecessary/inappropriate readmissions. GP advised that the arrangements were not consistent and information sharing issues were being addressed. VC confirmed that this was also being considered by primary care colleagues.

Resolved: The Committee noted the Care Sector Report.

16. Patient Safety Specialist Updates:

16.1 NHS Patient Safety Updates

The committee noted the NHS Patient Safety updates dated 29 November 2022 and 20 December 2022.

In response to a query from PW, KF advised that she was in close contact with a member of the pharmacy team on patient safety issues and the new Patient Safety Strategy would tighten up on Medicines and Healthcare products Regulation Agency (MHRA) issues.

VB advised that she wished to put on record her thanks to KF for the significant amount of work she had undertaken in relation to patient safety arrangements across mid and south Essex.

Resolved: The Committee noted the Patient Safety Specialist updates.

17. Terms of Reference for Quality Escalation Group, MSE System Quality Group and ICB Quality Committee

SM advised that revised draft terms of reference for the following Groups had been socialised and were included within the papers, as follows:

- 17.1 Quality Escalation Group Terms of Reference
- 17.2 MSE System Quality Group Terms of Reference
- 17.3 MSE ICB Quality Committee

SM asked those present to provide any comments on the drafts to him by 20 February 2023.

PW suggested that the draft Quality Committee's ToR should be amended to reflect the ICB's responsibility for community pharmacies from 1 April 2023. NIB asked that PW covered this issue when providing comments to SM.

- **Action:** All members/attendees to provide any comments on draft Terms of Reference for Quality Escalation Group, MSE System Quality Group and MSE ICB Quality Committee to Stephen Mayo by 20 February 2023.

18. Discussion and Escalations to ICB Board

NIB advised that many of the items discussed today were standing items covered within the Quality reports submitted to the ICB Board. NIB noted that GH's Board presentation on maternity services was well received by Board members.

FB mentioned that Ruth Jackson, Chief People Officer, had advised the Board that 100% of student midwives/nurses had accepted positions at MSEFT and the Trust would focus upon retaining these staff. FB also advised that she would consider how 'soft' intelligence should be reported to the Board.

19. Any Other Business / Reporting to ICB Board

19.1 Recent CQC Inspections at MSEFT

VB advised that although recent CQC inspections had identified several significant concerns at MSEFT, inspectors visited Balmoral Ward where they found compassionate and effective care was being provided.

19.2 Mandatory Patient Safety Training

VB reminded those present to undertake their mandatory patient safety training.

19.3 Future Deep Dives

SM suggested that future deep dives should focus on primary care or challenges faced by EEAST. VC asked if a deep dive of primary care could wait until the delegation of primary care services had been implemented for a while.

PW also suggested end-of-life (EoL) care and advised that she knew someone willing to share their story. ES advised that the EoL workstream was currently undergoing some changes and it might therefore be worth waiting until this work was embedded.
VB suggested that a patient story could help to inform this week and it was therefore agreed that the next deep dive would focus on this issue.

NIB suggested that a deep dive on the challenges being experienced regarding data collection, sharing and analysis might be useful.

19.4 Quality Committee meeting dates 2023/24

SO advised that the committee meeting on 31 March would be moved to April (date to be confirmed with NIB) to enable alignment of committee meetings with the new cycle of bi-monthly Part I Board meetings during 2023/24. Calendar invites would be sent as soon as possible.

20. Date of Next Meeting

Friday, 21 April 2023 at 10.00 am to 12.00 noon via MS Teams.

Integrated Care Board (ICB) System Oversight & Assurance Committee

Minutes of meeting held 8 March 2023 at 1.00 pm – 2.30 pm via Teams

Attendees

Members (Voting)

- Simon Wood (SW), Regional Director for Strategy & Transformation NHSE/I East of England and Joint Chair of Committee
- Elizabeth McEwan (EM), Assistant Director of Programmes NHSE/I East of England.
- Jo Cripps (JC), Executive Director of Strategy & Partnerships.
- Jennifer Kearton (JK), Interim Director of Resources, MSE ICB.
- Dr Ruth Jackson (RJ), Executive Chief People Officer, MSE ICB.
- Dr Tiffany Hemming (TH), Executive Director of Oversight, Assurance and Delivery, MSE ICB.
- Claire Hankey (CH), Director of Communications & Engagement, MSE ICB.
- James Hickling (JH), Associate Medical Director for Quality Assurance & Governance / Nominated lead from Clinical and Multi-Professional Congress
- Frances Bolger (FB), Interim Chief Nurse, MSE ICB.
- Alexandra Green (AG), Chief Operating Officer, EPUT
- Ruth Hallett (RH), Alliance Director (South East Essex), MSEICB
- Alan Whitehead, EEAST

Other attendees

- Jonathan Dunk (JD), MSEFT.
- Diane Sarkar (DS), Chief Nursing Officer, MSEFT.
- Mike Thompson (MT), Chief of Staff, MSE ICB.
- James Wilson (JW), Transformation Director, Mid and South Essex Community Collaborative.
- Paul Taylor (PT), People Director, EPUT.
- Selina Douglas (SD), Executive Director of Partnerships, North East London Foundation Trust.
- Sean Leahy (SL), Executive Director of People and Culture, EPUT.
- Daniel Turner (DT), MSEFT
- Alexandra Gregg (AG) - MSEFT
- Andrew Pike (AP), Managing Director, MSEFT.
- Sara O'Connor (SO), Head of Governance and Risk, MSE ICB (minute taker).
- Viv Barker (VB), Director of Nursing – Patient Safety
- Katie Bartoletti (KB), Staff Officer, MSE ICB

Apologies Received

- Anthony McKeever (AMcK), Chief Executive Officer and Joint Chair of Committee, MSE Integrated Care Board (ICB).
- Danny Hariram (DH), Chief People & Organisational Development Officer, MSE NHS Dan Doherty
- Stephanie Dawe (SD), Chief Executive Officer, Provide Health
- Pam Green (PG), Alliance Director (Basildon and Brentwood), MSEICB.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSEICB.

1. Welcome and Apologies (presented by S Wood)

SW welcomed everyone to the meeting and noted apologies listed above.

2. Declarations of Interest (presented by S Wood)

SW reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed. Declarations made by ICB Board members are listed in the Register of Interests available on the ICB website**.**

There were no declarations of interest raised.

3. Minutes (presented by S Wood)

The minutes of the last SOAC meeting held on 8 February 2023 were reviewed and approved.

Outcome: The minutes of the meeting held on 8 February 2023 were approved without amendment

4. Action log and Matters Arising (presented by S Wood)

MT summarised the updates on the Action Log.

There were no matters arising.

Outcome: The committee noted the updates on the Action Log.

5. Workforce Priorities (presented by R Jackson)

RJ advised that the vacancy rate for MSEFT and EPUT had fallen to 11%. Overall both organisations were meeting the trajectories implemented in November 2022 which provided a more accurate picture of what was achievable, although some professional groups were off-plan.

MSEFT had experienced a steady decline in nursing and registered scientic staff vacancies and a reduction in support to clinical vacancies which had risen from spring through to autumn 2022. The National team were working with MSEFT to launch the Healthcare Worker Academy which should support a downward vacancy trend going forward.

EPUT had reduced vacancies overall, including support to clinical, although the nursing vacancy rate remained at 21%.

PT advised that EPUT had achieved 2% growth in registered nursing. Circa 270 local graduates were expected this year who would be encouraged to take up posts within mid and south Essex (MSE). A domestic recruitment drive would be held in Chelmsford.

RJ advised that workforce growth would be revisited to ensure triangulation of activity, funding and workforce. Discussions had already been held with MSEFT in this regard and RJ would liaise with EPUT colleagues during the next week.

RJ explained there needed to be a concomitant reduction in the use of bank and agency staff as vacancy rates were reduced. The data showed a substantial difference between what organisations actually used and potentially could commit to using if a multiplier of 1.5 whole time

equivalent (WTE) was applied to each vacancy. Discussions were required to agree how organisations would model bank and agency use against projected staffing levels.

In response to query from SW regarding choosing 1.5 as the multiplier, RJ advised that literature generally quoted between 1.2 and 1.6 WTE.

SW welcomed the general reduction in vacancy rates but asked MSEFT and EPUT to provide robust plans, including tighter controls, by the next committee to reduce bank and agency staff in order to realise a corresponding financial benefit.

RJ advised that many factors affected the use of bank and agency staff, including acuity of patients, but managers must work on the premise that it must be substantially reduced. Organisations must also consider where they should invest, for example, exit interviews indicated that staff wanted more flexible working patterns which could ultimately reduce bank/agency.

There were no escalations from the People Board.

Outcome: The Committee noted the Workforce Priorities Report.

- **Action 111:** MSEFT and EPUT Human Resources colleagues to submit robust plans to reduce bank and agency staff to next committee meeting on 12 April 2023.

6. Quality Report (presented by F Bolger)

FB advised that following an unannounced Care Quality Commission (CQC) inspection at MSEFT, a Section 29A notice was issued. MSEFT had reviewed the CQC findings for factual accuracy and made representations to the CQC. The main findings related to nutrition and hydration of patients and some points regarding deprivation of liberty, audit, training and governance processes. A Rapid Quality Review meeting would be held on 27 March 2023 to discuss action required and how the ICB could support the Trust going forward. Meetings to discuss progress against the Trust's legal undertakings would also take place during the coming weeks.

FB also highlighted that a recent joint CQC and OFSTED SEND inspection (the first of its kind) involved following a small group of patients through their pathways and talking to primary care, service users, schools, local authority and health colleagues. Patient experience was key and was triangulated with what organisations were telling inspectors.

Outcome: The Committee noted the Quality Report.

7. Performance Report (Presented by Dr T Hemming)

TH advised that SHREWD was now in daily use in the System Control Centre and was making quite a difference as to how meetings were conducted

With regard to cancer, it was noted that the Trust would likely not meet the overall agreed trajectory of 586 x 62 day waits by the end of March, but work continued to reduce numbers waiting*.

[*Later in the meeting AP advised that all specialties were on trend and he provided a revised forecast of 495 by 31 March 2024]

Significant data quality concerns had been identified within community paediatrics following transition of the service to EPUT, with a risk of potential 78+ week waits. Work to understand the issues and action required would be undertaken by end-April.

Mental Health services continued to experience a high number out-of-area (OOA) placements, particularly female patients who EPUT struggled to place locally. Work was ongoing to improve performance for second NHS Talking Therapies appointments in the south east area, although the standard for first appointments was met.

AG advised that EPUT was seeing a slight reduction in the number of OOA placements, which was monitored via regular Executive oversight, and the Trust anticipated being able to open additional beds in the near future.

In response to a query from JC regarding the ability of MSEFT to achieve 0% waits for 78ww, EMcE advised that NHSE was being assured by the Trust that this was possible, albeit a few cases were dependent upon patients' choice. However, it was recognised that the impending Junior Doctor strike would impact on standards nationally. TH also confirmed that MSEFT had advised they would achieve 0 by end-March, although this would be challenging for various reasons.

SW advised that he would like MSEFT to confirm to NHSE and the ICB what its expectations were in regard to referral to treatment (RTT) and cancer performance by the end of March, taking into account the Junior Doctors strike.

SW noted that no MSEFT representatives were present during this part of the discussion and therefore requested RJ to write to the Trust to request that it was fully represented at future committee meetings.

EMcE advised that discussions were taking place regarding the need for Tier 1 meetings post-March 2023.

SW asked TH when the committee would see recovery plans. TH advised that she was working closely with AP and his team to agree trajectories for several areas, some of which related to ongoing work, e.g. reducing length of stay. SW advised that there was a need to know when plans relating to agreed system priorities would be available and asked for a clearer position by the next meeting.

Resolved: The committee noted the performance report.

- **Action 112** : MSEFT representatives to confirm to NHSE and the ICB what its expections are in regard to RTT and cancer performance by the end of March, taking into account the Junior Doctors strike.
- **Action 113**: RJ to write to MSEFT to request that the Trust is fully represented at future SOAC meetings.
- **Action 114**: TH/AP to liaise to ensure clear trajectories and plans to improve performance within outstanding areas are available by the April 2023 SOAC meeting.

8. Primary Care Priorities

8.1 Alternative Primary Medical Services (APMS)

JH advised that the Alternative Primary Medical Services (APMS) contract had recently been reprocured, with a single provider successfully bidding for all six contracts. However, a challenge was made in relation to the new provider's proposed changes to its corporate structure. These proposals were subsequently withdrawn. However, challenge by the successful bidder relating to quality issues at existing provider practices was received last week. The Primary Care Team and the Head of Nursing (Primary Care) from the Quality Team therefore undertook visits at three practices but found no evidence to substantiate concerns raised.

JH explained that there remained a risk there might not be sufficient services by 1 April 2023 when the first 5 new contracts were due to commence, as the existing providers which relied on locum cover had not arranged a rota from April. The ICB had raised concerns with the new provider and was expecting it to advise by the end of next week that clinical staff would be in place by 1 April, but it was noted that there was limited time and opportunity to arrange alternative options if the ICB did not receive confirmation. The contingency plan included asking the incumbents or other practices across MSE to provide services where possible at short notice. Practices had not yet been alerted to this possibility but JH would ask the Primary Care Team to enact this plan.

SW asked RJ to email William Guy and JH requesting them to ensure full contingency plans were agreed by the end of the following week, to be shared with EMcE and AMcK.

- **Action 115:** RJ to email William Guy and JH requesting them to ensure full contingency plans are agreed by 17 March 2023, and then shared with EMcE and AMcK.

8.2 Integrated Neighbourhood Teams (INTs)

JH advised that INTs were derived from the Fuller Stocktake Review and proposed changes to the GP contract looked as though they would provide flexibility to develop INTs.

The £1,425 million funding available would enable transformation work on areas such as complex, preventative, urgent and episodic care, particularly around access. Timescales were tight due to the end of the financial year, but the ICB was endeavouring to get Primary Care Networks (PCNs) to sign-up to INTs by 31 March 2023.

The maturnity of PCNs was varied with some practices not yet working in an integrated fashion. It was anticipated that some PCNs would reach out beyond their own PCN, e.g. to EPUT. The ICB would be providing information to PCNs to allow them to identify risks and opportunities.

AG highlighted that INTs provided an opportunity for wider engagement regarding community and mental health services and provided local authorities and the voluntary sector the opportunity to promote prevention.

RH advised she had liaised with JW regarding how INTs would work and align with EPUT teams. Discussions were also ongoing with local authorities and MSEFT colleagues, including AP, and maps of deprivation were creating local conversations. The ICB wished to implement

metrics to measure, for example, the size and depth of networks and levels of trust between staff groups.

SD asked that sight of chidren's health and wellbeing and the need to address local health inequalities was maintained when developing new arrangements.

JH welcomed that Alliances were making links and introducing PCNs and advised there might be some system learning that could be taken forward. The national contract included some inequalities work, although it was necessary to consider whether proposals narrowed or increased inequalities.

JW asked how funding would be distributed. JH advised that a decision had not yet been made, but mentioned the allocation of winter surge money was based on deprivation and capitation.

SW suggested there might be merit in asking non-NHS partners, particularly local authorities, if there was a need for a collective conversation regarding INTs. With regard to metrics, SW suggested every Alliance/INT should focus upon a few measures, e.g. those aligned to ICB priorities, but then allow each INT to select metrics most relevant to their population.

JH advised that the geography of PCNs might be reviewed, which was potentially controversial, but if a PCN wished to work with another PCN where it made sense to do so, they would not be stopped. The national team were making two week access a key priority and would specify that practices must respond to patients the same day, even if only to redirect them. It was anticipated that all PCNs would try to sign-up for INTs.

SW advised it would be important for any geography changes to be discussed openly and collaboratively with relevant stakeholders.

SW suggested that the next primary care update to SOAC should be provided in approximately six months' time unless something significant arose beforehand. JH advised that as detailed strategy plans would be submitted by 30 June 2023 he would provide an update on this at the appropriate time.

9. M10 Finance Report (presented by J Skinner and J Kearton)

JK summarised changes made to the system forecast outturn position which was amended to £46.4 million and advised that at Month 10 there were no signs to indicate this was not achievable. Consequently, the attention was now on the new financial year.

The system was now beginning to receive feedback from NHSE regarding triangulation work being undertaken which the Chief Executive Forum would review ahead of the final submission of the 2023/24 Financial plan.

Outcome: The Committee noted the Month 10 System Financial position.

10. This item has been minuted confidentially.

11. Data Quality – Discharge Sitrep and 'No Criteria to Reside' (Presented by B Frostick)

BF summarised the investigation work completed in relation to the Discharge Sitrep and 'No Criteria to Reside'. BF and JK noted their thanks to those involved.

JK confirmed that future discharge planning would not be based on the metric previously used and would in future be based on a 'fair share' basis.

Resolved: The committee noted the report on Discharge Sitrep Reporting – No Criteria to Reside.

12. Progress on Planning (presented by J Cripps)

JC advised that feedback from NHSE had been received identifying some gaps regarding assumptions underpinning activity, workforce and finances which Chief Executives and Chief Finance Officers would review and a ICB Board seminar would be held on 16 March 2023 to look at progress with planning.

EMcE commented that the narrative was generally solid, although some areas needed more work, and she was happy to provide support if required before final submission.

13. Any other business (presented by Simon Wood).

There was no other business discussed.

14. Papers shared for information only.

There were no papers shared for information only.

15. Date of Next Meeting

12 April 2023* – 1.00 pm to 3.00 pm via MS Teams

*subsequently cancelled.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 18 May 2023

Agenda Number: 12.3

ICB Board Policies

Summary Report

1. Purpose of Report

To ask the Board to adopt the revised Organisational Change Policy which was reviewed and approved by the Remuneration Committee on 19 April 2023. A copy of the policy has been provided separately to Board members.

2. Executive Leads

Ruth Jackson, Chief People Officer

3. Report Author

Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

Remuneration Committee

5. Impact Assessments

An equality impact assessment is included at **Appendix A** of the policy.

6. Financial Implications

The policy outlines how any associated financial implications will be managed.

7. Details of patient or public engagement or consultation

The draft policy was shared with Trade Union colleagues for comment.

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to adopt the revised Organisational Change Policy (Policy Ref MSEICB 055).

Integrated Care Board Policies

1. Introduction

Following the transition from Clinical Commissioning Groups (CCGs) to the Integrated Care Board (ICB), the Organisational Change Policy (Ref MSEICB 055) has been developed from learning and feedback from the last organisational change process, with a view to using the updated version of the policy for the upcoming running cost review and the next organisational change process that will be required to deliver this.

2. Main Changes to Policy

A copy of the policy has been provided separately to Board members.

The main change is in section 4.13, relating to the removal of the “1 up, 1 down” provision for ringfencing. Previously colleagues could be ringfenced for roles that were either the same band as their existing role, 1 band higher or 1 band lower.

During the last consultation period, staff felt this was unfair as they were competing against colleagues at different bandings for the same roles. It also meant that ringfencing pools were larger and more complex and time consuming to manage. The Very Senior Manager (VSM) provision has not changed from the previous policy.

The “1 up, 1 down” provision remains in place when working with a displaced colleague to identify suitable alternative employment, which gives colleagues a greater chance of securing a role.

Individuals’ responsibilities and the effect of ‘acting-up’ during organisational change have also been clarified within the revised policy.

Once adopted by the Board, the policy will be posted on the ICB’s website.

3. Recommendation

The Board is asked to adopt the revised Organisational Change Policy (Policy Ref MSEICB 055).

Part I ICB Board meeting, 18 May 2023

Agenda Number: 12.4

Board Assurance Framework

Summary Report

1. Purpose of Report

To share the latest version of the Board Assurance Framework (BAF) with the Board.

2. Executive Lead

Anthony McKeever, Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

Sara O'Connor, Head of Governance and Risk

4. Responsible Committees

Each committee is responsible for their own areas of risk.

5. Conflicts of Interest

None identified.

6. Recommendation/s

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

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks. This is discharged through oversight of the Board Assurance Framework by the Audit Committee, prior to its submission to the Board.

2. Development of ICB Board Assurance Framework (BAF)

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

- Workforce
- Primary Care
- Capital
- Unblocking the Hospital
- Diagnostics, Elective Care and Cancer Performance
- System Financial Performance
- Inequalities
- Mental Health Services

The BAF also includes an updated summary of MSEFT and EPUT's red risks as of March 2023 (as set out in the relevant Board reports available on their websites).

The BAF will also be reviewed by the ICB's Audit Committee on 20 June 2023.

3. Recommendation(s)

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

4. Appendices

Appendix 1 - Board Assurance Framework.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

May 2023

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	Ruth Jackson	• Regular Workforce reporting to System Oversight and Assurance Committee (SOAC) and People Board • Regional provider workforce return	**4 x 5 = 20** ⟷
2.	**PRIMARY CARE** • Primary Care Strategy • Workforce Development • Primary Care Network Development • Financial and contractual framework.	Ronan Fenton	• Internal Audit Planned for 2023/24 • Patient Survey Results • Workforce Retention • Improved Patient to GP Ratio • Resulting in better patient experience and access.	**4 x 5 = 20** ⟷
3.	**CAPITAL** • Making the hospital reconfiguration a reality • Estates Strategy • Integrated Medical Centre Programme • Digital Priorities and Investment	Jennifer Kearton	• Developing prioritisation criteria for pipeline of investments. • Oversight by Finance & Investment Committee (FIC), System Finance Leaders Group (SFLG) and Executive / Senior Leadership Team. • Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.	**4 x 4 = 16** ⟷
4.	**UNBLOCKING THE HOSPITAL** • Managing 111 and Out-of-Hours • Flow, Discharge, Virtual Ward projects • Discharge to Assess	Tiffany Hemming	• Urgent Emergency Care (UEC) Taskforce oversight and assurance • Multi-agency discharge event (MADE) audits. • MSE Strategic UEC Board (monthly) • Reports to SOAC and ICB Board. • Delayed hospital discharges monitored hourly/daily.	**5 x 4 = 20** ⟷
5.	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE** • Clearing waiting list backlogs	Tiffany Hemming	• SOAC oversight of performance against all NHS Constitutional Standards. • Reporting to System Diagnostic Board and Diagnostic Performance Sub-Group. • MSEFT Cancer performance report: Meetings with National Team as a Tier 1 Trust. • Palliative and End of Life Care Board. • Elective Care Board: MSEFT Referral to Treatment (RTT) Long Wait Report.	**5 x 4 = 20** ⟷
6.	**SYSTEM FINANCIAL PERFORMANCE** • Financial Improvement Plan • System Efficiency Programme • Use of Resources	Jennifer Kearton	• Trajectory and management actions to deliver revised forecast outturn is confirmed. • Continued system working to understand exit run rates and triangulation of delivery into new financial year. • Focus on system efficiency programme and improved delivery of financial plans. • Oversight by FIC, Chief Executives Forum, SLFG and SOAC. • Internal and External Audits planned.	**5 x 4 = 20** ⟷
7.	**INEQUALITIES** • Inequalities Strategy • Data Analytics • Population Health Management	Jo Cripps	• Reports to Population Health Improvement Board and Health Inequalities Delivery Group. • 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/outcomes for the MSE population.	**4 x 5 = 20** ⟷
8.	**MENTAL HEALTH QUALITY ASSURANCE** • Workforce challenges • Demand and capacity • Performance against standards • External scrutiny • Addressing health inequalities/equitable offer across MSE.	Frances Bolger Tiffany Hemming	• MSE ICB inpatient rapid review outcome. • Clinical Quality Review Group / Quality Assurance visits. • Improved flow and capacity, reduction in out of area placements. • Mental Health Partnership Board & Whole System Transformation Group. • Reports to SOAC identify key quality/performance risks and action to be taken. • Internal Audit of Oversight of Mental Health Services - Reasonable Assurance.	**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 an reliable pipeline of staff to fill future vacancies.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Ruth Jackson, Executive Chief People Officer	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	BAF Risk Ref:	PO1

Current Performance v's Target and Trajectory

Recruitment and Retention rates remain static against recruitment trajectory.

How is it being addressed? (Current Controls)

- System Workforce Strategy in place.
- Data cleansing of Electronic Staff Records (ESR) by providers and focus on accurate data to facilitate agreement on current vacancy rates.
- System recruitment campaign launched October 2022.
- Regional funding received for further international recruitment campaign (Live in November 2022).
- Dedicated recruitment campaigns for hotspots e.g. Emergency Department, Paediatrics, Critical Care and Maternity.
- System Health Care Support Worker recruitment campaign and establishment of an Academy to support recruitment, retention and progress (funding received) to support the social care and health market.
- Volunteering and reservist function (recruitment commenced).
- System-wide retention programme to mitigate factors which cause high levels of turnover.
- Initiatives around the establishment and embedding of Physician Associates, Advanced Care Practitioners and trainee Nursing Associates.
- MSEFT Senior nursing support provided to candidates, e.g. flexibility regarding interview arrangements, as well as new appointees.
- EPUT implementing revised recruitment trajectories based on planning to support vacancy reduction in Nursing & Midwifery

The above actions should considerably reduce vacancy rates across providers and professional workforce groups as per trajectory agreed by System Oversight and Assurance Committee (SOAC) (also see Next Steps).

Barriers (Gaps)

- Accurate workforce dataset required.
- Very large volume of vacancies in a domestic market which is already challenged.
- Reliance on international recruitment and inadequate focus on establishing a local pipeline of staff.
- Reliance on bank and agency.
- Limit to current supervisory capacity to support mass recruitment initiatives.
- Insufficient emphasis on defining, developing and marketing system offer.
- Reluctance to adopt / embed new roles.

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

- Regular Workforce reporting to SOAC (monthly) and People Board (quarterly).
- Regional provider workforce return (PWR).
- Reduction in unfilled vacancies.
- Improved attrition and turnover rates.
- Reduction in bank and agency usage leading to positive impact on patient safety/quality.
- Improved resilience of workforce.

Next Steps (Actions to be implemented by May 2023)

- Revised planning trajectory submitted to region for review (May 2023)
- Review and analysis of planning submission being undertaken (May 2023)
- Governance monitoring to be agreed through SOAC (May 2023)
- SOAC reporting to be reviewed and amended following planning submission (May 2023)
- System Workforce Strategy refresh (May 2023).

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 5 = 20**
Risk Owner/Dependent:	Dr Ronan Fenton, Executive Medical Director William Guy, Director of Primary Care	Directorate: Board Committee:	Clinical and Professional Leadership Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, ARRS, Hospital performance, reputational damage.	BAF Risk Ref:	CPLPC02

Current Performance v's Target and Trajectory

Workforce:
Additional Roles Re-imbursement Scheme (what % of available budget spend of AARS roles) to be identified.
Fellowship scheme (no of recruitment) to be identified.
Patient to GP Ration: BB/Thurrock in top 10 worst ratio in country
Demand/Capacity:
Patient Experience National Survey: Poor performance locally in terms of access
Available Appointments: 147K more delivered this year compared to pre-pandemic year – see Fuller Stocktake Update.
Impact should be noticeable in the 23/24 (July 24) survey

Barriers (Gaps)

Nationally a lack of workforce
Resource for investment in infrastructure (estate, digital, telephony etc)

How is it being addressed? (Current Controls)

Local response to the National Access Recovery Plan
Workforce development e.g. Additional Roles Reimbursement Scheme (ARRS) workforce and practice level initiatives. (impact over 3-5 years)
Investment in Primary Care workforce / digital / estates (impact over 3-5 years)
Initiatives for new GPs/ Partners and to support other roles in Practice Teams
Supporting succession planning
PCN Development

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

- Patient Survey Results
- Workforce Retention
- Improved Patient to GP Ratio
- Resulting in better patient experience and access.

Next Steps (Actions to be implemented by September 23):

- Cloud based telephony (to be aligned with national Access Recovery programme)
- PCNs to submit Demand and Capacity responses
- Integrated Neighbourhood Team Scheme – phase one by end of June 23.
- Care Navigation (new pathways established)
- Recruitment of ARRS roles
- Project / Change Mgt Support (additional clinical leadership & project support)

Risk Narrative:	**CAPITAL:** Failure to deliver the estates strategy as a result of insufficient capital means re-prioritisation will need to be completed in order to stay in the allocation which could result in delays to improvements impacting on access to and quality / performance of services.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16**
Risk Owner/Dependent:	Jennifer Kearton, Interim Director of Resources Ashley King, Director of Finance Primary Care & Strategic Programmes	Directorate: Board Committee:	System Resources Finance & Investment Committee (FIC) Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	BAF Risk Ref:	SREST02

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

- There is currently no prioritisation framework to guide the investment pipeline.
- There is insufficient capital funding to meet the needs of the strategy.
- Impact of new accounting rules relating to the capitalising of Leases.
- Impact of financial position ('triple lock').

How is it being addressed? (Controls & Actions)

- Developing prioritisation criteria for pipeline of investments.
- Oversight by Finance & Investment Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- Working with NHSE / Trusts to deliver the Acute Reconfiguration Programme.
- Prioritisation framework for Primary Care Capital now established.
- Prioritised list of investments developed to inform the submission of the capital plan (submitted first week of May 2023) as part of overall financial plan.

How will we know its working? (Assurance)

- Throughput of business cases to FIC.
- Delivery of Estates Strategy
- Progress reporting on investment pipeline.

Next Steps:

- Training for Board & Exec (senior managers) on capital funding framework (September 2023)
- Prioritisation framework (September 2023)
- Infrastructure Strategy (Dec 2023)

Risk Narrative:	**UNBLOCKING THE HOSPITAL:** Risk of not maximising hospital discharge opportunities by prioritising patients and appropriately identifying discharge pathways.	**Risk Score:** (impact x likelihood)	**5 x 4 = 20**
Risk Owner/Dependent:	Tiffany Hemming, Interim Executive Director of Oversight, Assurance and Delivery. Samantha Goldberg, Urgent Emergency Care System Director	Directorate:	Oversight, Assurance and Delivery.
		Committee:	MSE Strategic UEC Board and System Oversight and Assurance Committee (SOAC).
Impacted Strategic Objectives:		BAF Ref:	PLACE04

Current Performance v's Target and Trajectory

Emergency Department performance below constitutional standard, as are Ambulance response times, although improvement in reducing handover long delays and 60 minutes delays (significant reductions at Broomfield and Southend Hospital): 71.4% long delay handover reduction throughout January 2023

Barriers (Gaps)

- Health and Social Care capacity to facilitate discharge into the right pathway impacts on MSEFT flow and community.
- Workforce challenges (See Risk PO1).

How is it being addressed? (Current Controls)

- Winter demand and capacity schemes implemented providing physical/virtual beds at acute and community providers until 31/03/2023. Continuation of inro 2023/24 Q1.
- MSEFT 'UEC Improvement Programme' launching in March 2023, focusing on improving a reduction in admissions, improving flow and discharge, and reducing length of stay. Collectively contributing towards 76% A&E (all-type) performance against the four-hour standard, 30 minutes category 2 ambulance handovers and 92% bed occupancy.
- Trajectories for delivery of the 76% A&E (all-type) performance against the four-hour standard will be compiled by hospital site, feeding into one aggregated MSEFT trajectory, and will factor in the improvement programme milestone.
- Increased focus on discharging those pathway zero patients.
- Community and Voluntary Sector (CVS) engagement in progress to support admission avoidance and discharge.
- Alliances developing local plans.
- SHREWD Resilience implemented February 2023 to daily monitor discharges to support patient flow and early intervention where a deficit is identified. Phase 2 of SHREWD commence on 4 May 2023.
- System Control Centres established in December 2022 to oversee UEC winter pressures and proactively work with system partners.
- MSE is an early adopter for Alternative to Emergency Departments (A-tED) - tool identifying improvement opportunities to optimise utilisation of services. Commenced in April 2023.

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

- MSE Strategic UEC Board (monthly) oversees programme and reports into System Oversight and Assurance Committee (SOAC) and ICB Board.
- Delayed hospital discharges monitored hourly/daily by hospitals and shared with both social care and CHC teams via situational awareness 10.00 am system call.

Next Steps (Actions to be implemented by [DATE]):

- Compile MSE UEC Recovery Programme from national UEC Recovery Plan. Oversight and responsibility with UEC System Director to track progression of action delivery with ICS partners at 'UEC Transformation & Improvement Board' (May 2023 UEC Board).
- Missed opportunities audits, to be linked into the UEC Recovery Programme action plan. (May 2023).
- Review of measurements, trajectories and mitigations to align to the UEC Recovery programme and ensure recovery/delivery via monthly ICB Assurance meetings pre-SOAC (May 2023).
- 'Call before Convey' to maximise alternative pathway direct referrals / attendance/admission avoidance (Soft launch scheduled June 2023).
- 2023/24 MSEFT bed model progressing for acute capacity pressures and impact of mitigation (Presentation at May 2023 UEC Board).
- Introduction of Pathway light in IC24 (Completed).
- MSE system data and BI team working with AGEM to create and adopt a MSE system bed/capacity & demand model (June 2023).

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional Performance Standards.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Karen Wesson, Director Assurance and Planning	Directorate: Committee:	Oversight, Assurance & Delivery. System Oversight & Assurance.
Impacted Strategic Objectives:	Recovery of constitutional waiting times standards for diagnostics, cancer and Referral to Treatment (RTT)	BAF Ref(s):	OAD2, OAD3 and OAD4

Current Performance v's Target and Trajectory

Diagnostics: Recovery plans being developed by modality.
Cancer: MSEFT backlog reduction did not meet plan 2022/23 plan. 2023/24 plan submission to meet national trajectory expectation.
Referral to Treatment:

- 65+ week wait: plan submitted to reduce to zero people by 31 March 2024 to meet national expectation.
- 52+ week waits: Significant growth during 2022/23, not meeting plan. 2023/24 plan submission to reduce. Required in order to meet the national expectation position of zero people by March 2025.

Barriers (Gaps)

- **Cancer -** requires one registry – work now in place with programme group to introduce one Somerset cancer registry across the three MSEFT sites. **Cancer -** requires best practice pathways in place – programme refresh to enable this work to happen – supported by Stewards.
- **Workforce - Cancer -** FIC (Finance and Investment Committee) approved top slicing cancer SDF monies to pay for workforce to mitigate risk. 2023/24 plan will incorporate sustainability for fixed term posts and includes CNS review and alternate workforce/skill mix. **Diagnostic –** capacity and workforce – currently not sufficient capacity to support cancer FDS, DM01 and CDC – review underway
- **UEC pressures impacting on elective capacity -** with implementation of full capacity protocols across MSEFT sites. System support and oversight to expedite flow in place – see hospital flow BAF
- **Data Quality –** Group overseeing the validation work across MSEFT and EPUT before return to reporting (April-2023). Potential risk of long waiters when return to reporting happens.

How is it being addressed? (Current Controls)

Diagnostics:

- MSEFT developing recovery plans for all modalities and revised trajectories
- Working with Trust to ensure clinical prioritisation and chronologically booking – initial assigned risk code remaining in clinical system.

Cancer:

- Day Zero Patient Tracking List (PtL) –focus across focussed specialities

Referral to Treatment (RTT):

- Implementation and use of Gooroo software across the three MSEFT sites to maximise capacity utilisation for long waits through optimal clinical prioritisation and chronological booking.

Next Steps (Actions to be implemented by end June 2023)

RTT and Cancer:

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

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

SOAC maintains oversight of performance against all NHS Constitutional Standards**.**

- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group.
- **Cancer:** MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** Elective Care Board: MSEFT RTT Long Wait Report. 52+ week waiting list size growth is the significant risk overseen via elective board. Fortnightly meetings with National Team as a Tier 1 Trust.

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** Due to the level of operational pressure within the system, it has been confirmed that the system will not breakeven 2022/23 financial year. It is essential to deliver financial stability to ensure transformation and service developments can be delivered.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Director of Resources	Directorate: Committee:	System Resources Finance & Investment Committee
Impacted Strategic Objectives:	Financial sustainability	Risk Ref:	FIN01

Current Performance v's Target and Trajectory

The System was set a stretch target by NHSE and at month 10 was forecasting £46.4m deficit, (MSEFT deficit of £63.2m, off-set by an ICB surplus £16.8m).

(The ICB itself had planned for breakeven and will deliver a surplus, so the risk relates to the ICB responsibility for meeting the system control total)

Barriers (Gaps)

- Meeting system efficiency target.
- System pressures to manage delivery (capacity).
- Headroom to make the necessary changes to deliver the traction from the last couple of years.

How is it being addressed? (Controls & Actions)

- Forecast Outturn Protocol implemented.
- Focus on system efficiency programme and grip and control measures.
- Continued triangulation of system plans.
- Regional oversight.
- Local oversight.

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

- Delivery of the agreed position at year end. Now confirmed - £46.2m deficit delivered against £46.4m agreed forecast.
- Improved delivery into the new financial year.
- Being overseen by the Finance & Investment Committee and the Chief Executives Forum, also discussed at SLFG and SOAC.
- Internal and External Audits planned.

Next Steps (to be implemented by December 2022):

- Submit financial plans for 2023/24 (March 2023 submission (£67.8m system deficit) plus additional 4th May submission with improved plan (£47m deficit)).
- Medium Term Financial plan being refreshed.

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 5 = 20**
Risk Owner/Dependent:	Jo Cripps, Executive Director of Strategy and Partnerships Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Partnerships Inequalities Board being established.
Impacted Strategic Objectives:	Reduction of Health Inequalities	**BAF Ref:**	SP1

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

- Availability of BI and PHM resource.
- Quality improvement support for interventions.
- Financial resources are not yet sufficiently adjusted to reflect needs of population groups (proportionate universalism).

How is it being addressed? (Current Controls)

- Population Health Improvement Board provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with the Alliances will provide oversight and direct priorities for the £3.4m 2023/24 health inequalities funding.
- Health inequalities stocktake (Q4) provided to NHS England against the 2022/23 planning requirements and delivery against the Core 20 plus 5 framework, reported to Health Inequalities Delivery Group.
- Integrated Care Partnership Strategy sets the common endeavour of reducing inequalities. PHIB has agreed the 'Plus' groups within MSE that are risk of the greatest inequalities; Ethnic minority, Learning Disabilities, Homeless, Carers, Gypsy, Roma and traveller groups, veterans.
- Health inequalities funding of £3.4m (2022/23) projects have commenced across Alliances with University of Essex commissioned to undertake project evaluation. Micro-grants scheme distributed £100k to support local community groups in addressing health inequalities.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project. Development of digital EHIIA tool funded through the HI funding commenced to embed common approach across the system.

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

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

Next Steps (Actions to be implemented by September 2023)

- Revised PHIB work programme reflecting agreed priorities (June 2023)
- Creation of a health inequalities dashboard (July 2023)
- Mobilisation of 2023/24 HI Funded Projects (September 2023)
- Improvement in identification of groups at greatest risk anticipated by (December 2023)
- 1 of 7 ICSs identified as a CORE20PLUS accelerator site (March 2024)

Risk Narrative:	**Mental Health Quality Assurance:** MSE Mental health (MH) services have been identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on the highest rated risk referred to below)**
Risk Owner/Dependent:	Frances Bolger, Executive Chief Nurse Tiffany Hemmings, Interim Executive Director Oversight, Assurance and Delivery	Directorate: Committee(s):	Nursing & Quality/Oversight Assurance 7 Delivery. Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient experience, Workforce, Reputational damage	Risk Ref(s):	GOSD15, PO1, MHLD01, 02, 04, & 12 and MEN11

Current Performance v's Target and Trajectory

- Poor performance against a number of quality and contract indicators.
- Demand, capacity and flow issues resulting in an increase in out of area placements of patients above the LTP (Long Term Plan) expectation.
- Significant external scrutiny from media (Dispatches C4), regulators CQC, Essex Mental Health Independent Inquiry (EMHII) with an announcement due post local elections about a decision as to whether the scope will change to become a statutory status.
- Multiple high profile coroners cases.
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder.
- Workforce issues.

Barriers (Gaps)

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

How is it being addressed? (Controls & Actions)

- System Oversight and Assurance Committee (SOAC) monitor quality of services.
- Monthly 'Quality Together' meeting attended by NHSE, EPUT and ICB senior staff.
- EPUT and ICB 'Safety huddles' held on a weekly basis.
- Ongoing Quality Assurance Compliance Visits.
- MH workforce subgroup established and ongoing.

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

- MSE ICB inpatient rapid review outcome.
- Clinical Quality Review Group.
- Quality Assurance visits.
- Improved flow and capacity, reduction in out of area placements.
- Mental Health Partnership Board & Whole System Transformation Group.
- Reports to SOAC identify key quality/performance risks and action being taken.
- Internal Audit of Oversight of Mental Health Services - Reasonable Assurance.

Next Steps (to be implemented by DATE):

- Regular multi-agency discharge event (MADE) events to be undertaken to ensure good flow and capacity (April 2023).
- Implement recommendations from EMHII, CQC inspections, and Coroner's prevention of deaths reports (June 2023).
- Mental Health Task Force evaluation (June 2023).
- Signoff and endorsement of Southend, Essex & Thurrock Mental health strategy (Executive sign-off May 2023).

Partner Organisation Self Identified Key Risks

MSEFT - 13 Red Risks at March 2023.
Top 6 risks are:

- Financial Sustainability (25)
- Constrained Capital Funding Programme (25)
- Workforce Instability (20)
- Estate Infrastructure (20)
- Patient Flow and Length of Stay (20) – Proposal to merge with 'Operational Pressures impacting on quality')
- Cancer Capacity (20) / Planned Care Capacity (20) – (Proposal to merge as 'Planned Care' Risk)

Other red risks (x7), scored 15 or 16, relate to: Delivery of clinical and operational systems; Governance structure; Trust Undertakings; Cyber security; Competing priorities for development; Health and wellbeing resources; Knowledge and understanding of staff engagement and development.

Partner Organisation Self Identified Risks

EPUT - 4 Red Risks (all scored 20) as at March 2023

- Patient Safety
- People (workforce capacity)
- Demand and Capacity (services)
- Capital resource for essential works and transformation programmes.
- Use of Resources to meet financial control target (new red risk)

Mid and South Essex Integrated Care System

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