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, 14 November 2024 at 2.00 pm – 4.00 pm

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

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of Minutes of previous Part I meeting held 12 September 2024 and matters arising (not on agenda)	Approve	Attached	Prof. M Thorne	7
5.	2.13 pm	Review of Action Log	Note	Attached	Prof. M Thorne	19
		Items for Decision / Non-Standing Items				
6.	2.15 pm	Lampard Inquiry Update	Note	Attached	Prof. M Thorne Dr M Sweeting	20
7.	2.20 pm	Equality Diversity and Inclusion High Impact Actions	Note	Attached	Dr K Bonney	30
8.	2.27 pm	Equality, Diversity and Inclusion Strategy.	Approve	Attached	Dr K Bonney E Hough	72
9.	2.35 pm	Winter Plan 2024/25	Approve	Attached	E Hough	110
10.	2.40 pm	Communications and Engagement Strategy	Approve	Attached	E Hough C Hankey	133
11.	2.45 pm	Emergency Preparedness, Resilience and Response Core Standards 2024/25	Approve	Attached	E Hough	184
12.	2.55 pm	Anchor Charter	Approve	Attached	E Hough	188
13.	3.00 pm	Benchmarking Analysis of Greater Manchester Review	Note	Verbal	Dr G Thorpe P Scott	-
14.	3.10 pm	Digital Achievements	Note	Attached	B Frostick	219

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Standing Items				
15.	3.20 pm	Chief Executive's Report	Note	Attached	T Abell	251
16.	3.25 pm	Quality Report, focussing on: • Mental Health, Learning Disabiilty and Autism Quality Inpatient Transformation Programme • Intensive Assertive Outreach	Note	Attached	Dr G Thorpe A Bandakpara-Taylor	260
17.	3.35 pm	Finance & Performance Report	Note	Attached	J Kearton	277
18.	3.45 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis	290
19.	3.50 pm	General Governance:				
		19.1 ICB Constitution	Approve	Attached	Prof. M Thorne	306
		19.2 Board Assurance Framework	Note	Attached	T Abell	351
		19.3 Terms of Reference (People Board, Digital, Data and Technology Board) and updated Scheme of Reservation and Delegation.	Approve	Attached	K Bonney B Frostick N Adams	367
		19.4 New and revised Policies	Note	Attached	Prof. M Thorne	421
		19.5 Approved Committee minutes	Note	Attached	Prof. M Thorne	423
		19.6 Urgent Decisions taken between Board meetings	Ratify	Verbal	Prof. M Thorne J Fielder	-
20.	3.59 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
21.	4.00 pm	Date and time of next Part I Board meeting: Thursday, 16 January 2025 at 2.00 pm, The Garden Suite, Best Western Thurrock Hotel, Ship Lane, Aveley, Purfleet-on-Thames, Purfleet RM19 1YN.	Note	Verbal	Prof. M Thorne	-

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

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

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

MID AND SOUTH ESSEX INTEGRATED CARE BOARD MEMBERS (VOTING)											
First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional	Non-Financial Personal Interest			From	To	
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

Mid and South Essex Integrated Care Board - Register of Interests
November 2024

ASSOCIATE NON-EXECUTIVE MEMBERS / ALLIANCE DIRECTORS / EXECUTIVE DIRECTORS AND REGULAR ATTENDEES										
First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
				Financial	Non-Financial Professional	Non-Financial Personal Interest			From	To	
Mark	Bailham	Associate Non-Executive Member	Enterprise Investment Schemes in non-listed companies in tech world, including medical devices/initiatives	x			Direct	Shareholder - non-voting interest	01/07/20	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Mark	Bailham	Associate Non-Executive Member	Mid and South Essex Foundation Trust	x			Direct	Council of Governors - Appointed Member	01/10/23	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Joanne	Cripps	System Recovery Director	Lime Academy Trust (education)			x	Indirect		June 2023	Ongoing	No conflict is anticipated.
Daniel	Doherty	Alliance Director (Mid Essex)	North East London Foundation Trust	x			Indirect	Spouse is a Community Physiotherapist at North East London Foundation Trust		Ongoing	There is a potential that this organisation could bid for work with the CCG, at which point I would declare my interest so that appropriate arrangements can be implemented
Daniel	Doherty	Primary Care ICB Partnership Board Member	Active Essex		x		Direct	Board member	25/03/21	Ongoing	Agreed with Line Manager that it is unlikely that this interest is relevant to my current position, but I will declare my interest where relevant so that appropriate action can be taken.
Barry	Frostick	Chief Digital and Information Officer	Nil								
Pamela	Green	Alliance Director, Basildon and Brentwood	Kirby Le Soken School, Tendring, Essex.			x	Direct	School Governor (voluntary arrangement).	September 2019	Ongoing	No action required as a conflict of interest is unlikely to occur.
Claire	Hankey	Director of Communications and Partnerships	Nil								
Emily	Hough	Executive Director of Strategy & Corporate Services	Brown University		x		Direct	Holds an affiliate position as a Senior Research Associate	01/09/23	Ongoing	No immedicate action required.
Rebecca	Jarvis	Alliance Director (South East Essex)	Nil								
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company - Mecando Limited	x			Direct	Potential Financial/Director of own Limited Company Mecando Ltd	2016	Ongoing	Company ceased activity due to Covid-19 pandemic currently dormant; if any changes occur those will be
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	x			Direct	Potential Financial/Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	2021	Ongoing	Company currently dormant; if any changes occur those will be discussed with my Line Manager
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Professor and Director of the Vision and Eye Research Institute (Research and improvements in ophthalmology pathways and reducing eye related health inequality - employed by Anglia Ruskin University	31/03/23	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Lead for Grant to Anglia Ruskin University to improve eye health, prevent eye disease and reduce eye health inequality in mid and south Essex	01/05/23	01/04/27	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various Universities	x				PhD Examiner	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various grant awarding bodies UK and overseas		x		Direct	Grant reviewer	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Visionary (Charity)		x		Direct	Trustee	20/04/22	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Cambridge Local Optical Committee	x			Indirect	Member			Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various optometry practices	x			Indirect	Optometrist	10/09/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Indirect	Research Optometrist	10/01/09	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Lucy	Wightman	Chief Executive, Provide Health	Health Council Reform (Health Think Tank)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.

Mid and South Essex Integrated Care Board - Register of Interests
November 2024

ASSOCIATE NON-EXECUTIVE MEMBERS / ALLIANCE DIRECTORS / EXECUTIVE DIRECTORS AND REGULAR ATTENDEES										
First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Type of Interest Declared			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Actions taken to mitigate risk
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Lucy	Wightman	Chief Executive, Provide Health	The International Advisory Panel for Academic Health Solutions (Health Advisory Enterprise)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Faculty of Public Health		x		Indirect	Fellow		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	UK Public Health Register (UKPHR)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Nursing and Midwifery Council		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide CIC	x			Direct	CEO Provide Health and Chief Nurse	02/04/24	Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Wellbeing	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide Care Solutions	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	React Homecare Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The Provide Group Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The Provide Group Limited	x			Direct	Director		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.

Minutes of the Part I ICB Board Meeting

Held on Thursday 12 September 2024 at 2.00 pm – 3.35 pm

Hall 1, Spring Lodge Community Centre, Powers Hall End, Witham, Essex, CM8 2HE

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Tom Abell (TA), Chief Executive, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT).
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT).
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Peter Fairley (PF), Partner Member, Essex County Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Stephan Liebrecht (SL), Director of Adult Social Care, representing Mark Harvey, Partner Member, Southend City Council.
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.
- Emma Timpson (ET), Associate Director of Health Inequalities Prevention, MSE ICB.
- Andrew Pike (AP), Chief Operating Officer, Mid and South Essex NHS Foundation Trust (MSEFT).
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Mark Harvey (MHar), Partner Member, Southend City Council.
- Ian Wake (IW), Partner Member, Thurrock Council.
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Samantha Goldberg (SG), Director of System Coordination Centre/Urgent Emergency Care, MSE ICB.

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

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

MT formally introduced Tom Abell, Chief Executive, MSEICB, and a round table of introductions were given.

Apologies were noted as listed above.

MS provided an update on the Lampard Inquiry and advised that the Mid and South Essex Integrated Care Board (MSEICB) had been named a core participant in the ongoing Lampard Inquiry. This status reflected the critical role played in providing information and insight into issues under investigation.

The ICB expressed its deepest sympathy to all those who had lost loved ones and those who had been and remained affected by the matters that the Inquiry was examining.

The ICB understood that this could cause uncertainty or concern for staff within the ICB, families, and carers. Assurance was provided that all necessary steps were being taken to support staff during this time. Regular updates would be provided to Board members, as well as access to resources and guidance being made available for any questions or concerns that arose.

It was anticipated that there would be increased media interest as the Inquiry progressed. The communications team would manage this, and assurance was provided of the ICB's commitment to full transparency and cooperation, integrity and high standards of care and the well-being of residents remained at the forefront of all discussions.

The Board was asked for their continued support in maintaining focus, whilst recognising the sensitivity and gravity of the ICB's involvement in the Inquiry.

PS echoed MS words in relation to the severity and the gravity of matters being addressed which was being taken extremely seriously. Alongside the other main provider of mental health services, North East London Foundation Trust (NELFT), Essex Partnership University Foundation Trust (EPUT) opening statements were provided to the Inquiry, which included an unreserved apology for failings that had led to loss of life in the past and a commitment to candour and openness in working with the Inquiry. Sympathy was expressed to all the families involved who had fought so hard for the Inquiry and the difficulty in reliving their experiences was acknowledged.

The Chair and Chief Executive Officer (CEO) from EPUT had spent a week at the Inquiry and two EPUT Board members would be present every day to provide full participation.

There were three priorities: to fully serve the Inquiry and ensure transparency by being proactive in providing evidence and information; maintaining confidence and engagement with patients, their families, our communities, and staff; and to continue to drive improvements in mental health care in Essex.

The continued support of the Board was welcomed.

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

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

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

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

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

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

David Birch asked whether effective communication about the ICB's situation with all communities including South Woodham Ferrers was a priority across the ICB and its Alliances. TA advised that the ICB was committed to engagement across the Integrated Care System (ICS) and in mid and south Essex (MSE), and more importantly, at each alliance level, with staff working with community organisations and patients and communities in each area, including South Woodham Ferrers. The ICB would continue to keep people informed about the challenges faced by the ICB and the progress made across the NHS and would continue to foster an open and constructive dialogue to address patient concerns about services.

Paul Osman queried the current proportion of cancers being diagnosed at stages 1 and 2 in MSE and asked how confident the Board was that the national standard of 75% would be met by 2028. JK advised that currently circa 54% of patients were diagnosed at an early stage in MSE. To achieve the Long-Term Plan requirement that 75% of people were diagnosed at an early stage by 2028, the ICB and Mid and South Essex NHS Foundation Trust (MSEFT), with the Cancer Alliance, had plans to support early diagnosis. Clinical leads and cancer stewards worked to promote pathway and service improvements that would support achievement of the 75% target. The Trust were a pilot site for targeted lung health checks which, to date, had identified 137 patients with confirmed lung cancer (67% of the total). Cancer screening was an area of focus and MacMillan GPs and primary care colleagues continued to promote, and had increased uptake, of screening which helped identify people at risk at an early stage and supported early diagnosis.

Peter Blackman asked if the ICB would work with South Woodham Ferrers Health and Social Care Group and other partners to review the widening and increasing transport problems for patients across MSE. EH advised that the ICB recognised the importance of supporting patients, carers, and their families to access health and care services, and welcomed the

work undertaken by MSEFT to restore the shuttle bus to Broomfield Hospital, and by Essex County Council (ECC) to replace services lost by the closure of the Dart and Arrow public transport service. The strength of feedback by those who responded to the public consultation on the future of community services across MSE had been noted around the importance of travel, transport, and parking. The ICB's response to the consultation was under consideration. Working in partnership with local authorities, local residents and others would be key to developing future plans. The ICB, through the Mid Essex Alliance, were engaged with work led by ECC to consider the infrastructure challenges in the Maldon district including those related to travel and transport.

Whilst the ICB recognised the importance of good transport links for patients and the public who attended health and welfare services, the ICB was not ultimately responsible for public transport, but would be happy to participate in any review undertaken by the South Woodham Ferrers Health and Social Care Group and work with partners to improve services where possible.

4. Minutes of the ICB Board Meeting held 11 July 2024 (presented by Prof. M Thorne).

MT referred to the draft minutes of the ICB Board meeting held on 11 July 2024 and asked members if they had any comments or questions.

No comments were submitted.

Resolved: The Board approved the minutes of the ICB Board meeting held on 11 July 2024, as an accurate record.

5. Matters arising (presented by Prof. M Thorne)

There were no matters arising.

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

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

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

7. Health Inequalities Update Report and Health Inequalities Annual Statement 2023/24 (presented by E Hough)

EH advised that the report provided an update on work undertaken to better understand health inequalities experienced by our population. There had been a huge contribution across the ICB Board, alliances, the wider system, and partners which reflected how health outcomes were being impacted across the population. There would be continuous review to understand the barriers to access care for the local population as part of ongoing conversations with the Population Health Improvement Board that was set across the Integrated Care Partnership (ICP).

ET advised that the focus continued to be the delivery of the five strategic priorities to reduce health inequalities, utilising the NHS CORE20PLUS5 framework as well as a focus on prevention of ill health. Good progress continued to be made on the priority areas, with several proactive programmes in clinical areas, particularly cardiovascular disease (CVD), respiratory, and children and young people, which had been nationally recognised. Data

insight and engagement had improved, and the health inequalities programme was maturing.

The ICB were working closely with partners to ensure improved access to all. In the next six months further work would be undertaken to review how experience could be improved based on the General Practice (GP) survey results.

The ICB worked collaboratively with local authorities with regards to broader health and wellbeing programmes, for example reducing smoking in pregnant women at the time of delivery.

The report outlined several areas where improvements were being seen in the CORE20PLUS5 framework, the work undertaken within the alliances, areas of focus over the next 6 months and the risk to programme delivery in relation to capacity.

GO asked to what extent childhood vaccinations were being targeted and noted that the Black and Asian community were underrepresented on elective waiting lists and whether there were any challenges with access. ET advised that focused work was being undertaken to identify and address unvaccinated children in partnership with providers and local authorities. The research and engagement network reached out to gain further insight and understanding to the barriers across the prevention programmes of work, including elective access.

MT suggested a review of models used elsewhere to encourage childhood vaccinations which could soften the fear of needles, such as vaccination parties. ET advised that health inequalities funding supported an outreach vehicle, which visited disengaged populations to offer integrated health and wellbeing services. EH highlighted that MSEFT had undertaken work to better understand health inequalities, the demographics and challenges on the elective care waiting lists and was exploring actions to address specific challenges identified. MHop confirmed that health inequalities would feature in the development of the next 3 to 5-year plan.

SP referred to the national drive to reduce complications and mortality in maternity within the global majority community and asked if the issues were understood and if any progress had been made to address this. ET advised that MSEFT had an equity and inequalities action plan with regards to this specific issue. GT confirmed that outcomes for women and pregnant people from the global majority was a focus for the Local Maternity and Neonatal Safety Board (LMNS) and following deep dives into neonatal mortality and maternal deaths, there was no evidence that women from the global majority had higher mortality rates. However, the experience of women and pregnant people from the global majority was different to those who identified as white and the maternity and neonatal voices partnership (MNVP) were working with the Trust to ensure their voices were heard, so that services became more culturally sensitive.

PS thanked ET for the comprehensive report showcasing the ongoing work undertaken by system partners and asked if measured impacts on outcomes, such as mortality, co-morbidities, and prescribing would be included in future reports. EH confirmed an outcomes framework had been established with several health inequalities indicators that would be tracked. The ICB's business intelligence provider supported data retrieval and was an area requiring further work.

LW acknowledged the availability of intelligence was challenging and asked whether public health, locally and regionally, could support, particularly with regards to outcomes. EH noted how strongly the public health leaders were coming together and a task and finish group from the Population Health Improvement Board had been implemented to review the current and

future position and progress the development of the data dashboard.

Resolved: The Board:

- **Noted the work undertaken by the ICB and in collaboration with partners to reduce health inequalities for the population of mid and south Essex.**
- **Ratified the ICB's Health Inequalities Information Statement 2023/24.**

8. System response to NHSE Letter on Corridor Care (presented by E Hough and A Pike)

MT advised that a letter from NHSE sought the position of each of the 42 ICBs in relation to maintaining focus and oversight on quality of care and experience in pressurised services, following a television programme which highlighted that people were often spending long periods of time sitting in hospital corridors due to limited bed availability.

EH advised that the report demonstrated the collective action taken across the system and invited AP to provide the Board with assurance on the breadth of activity underway to minimise the use of corridor care across MSEFT.

AP explained that corridor care could not be wholly eliminated, however the aim would be to work towards it occurring by exception and if it did occur, that it was safe and for a limited time.

The report detailed the measures taken as a system to effectively manage demand daily, to reduce the risk of corridor care. The Trust was awaiting confirmation of funding for the Unscheduled Care Coordination Hub (UCCH) to operate fully for this winter, which helped significantly to manage demand last year. The measures taken to ensure complete focus on improving flow throughout the hospitals was also detailed. Since the peak of 2022, there were 240 less beds due to an improvement of one day in length of stay (LoS) and the hospitals' management of safer ward care processes. The number of patients who required a complex discharge had also significantly improved. These improvements reduced the risk of hospitals becoming congested and having to use corridor care.

The continuous flow model was being used, so if there was a surge of ambulances, and resuscitation and major cubicles were full, rather than have patients left in ambulances, a corridor space would be designated and staff would be allocated to these areas, for a limited period, to allow offload of ambulances to occur and the 'Full Capacity Protocol' was implemented. Further work was required with partners and Basildon Hospital to ensure a better match between bed capacity and demand and the Trust was working on a pilot with NELFT for speedier discharge of patients.

Managing winter challenges would compound the issues being managed.

MT asked how the Trust compared to others. AP advised that MSEFT were between 17 and 22 minutes for ambulance offload and was recognised as one of the best in the region due to introduction of the continuous flow model.

AD asked if the ambulance offload and corridor care metric would be included on Board reports during the winter period. AP advised that data was collected daily so could be supplied.

GT advised that the national team were developing a dynamic risk assessment approach in relation to corridor care. The Mid and South Integrated Care System requested to be an early adopter to test the approach and would provide further assurance that clinical risk was being managed in a safe way preceding the winter period.

GW asked whether there were enough beds in the community to maintain flow during the winter period and what was required in the community to minimise corridor care. GW also asked if any support was required with the request for regular non-executive member walkabouts. AP confirmed that the Trust non-executive directors had recommenced their visiting programme. The Trust approach was utilisation of virtual wards, the urgent community response teams (UCRT), the bridging service, and the intermediate care length of stay (LoS) to manage bed requirements. The Trust endeavour to minimise stay in hospital and maximise the use of virtual wards or intermediate care beds or other community placements for complex patients to manage the flow pressure. Work was ongoing with the community nursing college to ascertain whether some patients could be discharged without a complex care package.

PS advised that the System Flow Group brought all aspects of the system together and was focused on ensuring people were discharged from hospital as quickly as possible. The delivery of the system winter plan would be monitored monthly. There would be enough community beds if LoS in the community was reduced, and key work was being undertaken with the community collaborative to facilitate this.

In response to a query from JF, AP explained that the front door of the ED and GP practices ensured that interventions were in place, particularly for those with chronic conditions to avoid admissions to hospital. Further work was required with ambulance colleagues to ensure the diversionary options were fully utilised.

TA commented that this would be an area of focus across the system in view of the risks associated with every winter in the NHS. Guidance from NHSE had been published about single points of access. However, access to the UCCH needed to be extended to other areas, such as care homes.

Resolved: The Board noted the system response to the NHSE letter on Corridor Care.

Action: JK to work with AP to include the ambulance offload handover and corridor care metric on future performance reports to Board during the winter period.

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

TA highlighted key points from the report.

The system financial position was discussed at a Board seminar and required focus and drive. The first phase would stabilise the financial position for 2024/25, with a focus on 'grip and control', with actions across all partners within the system. The second phase, running in parallel, was the development of the medium-term plan, and changes required to the way services were delivered to make them more sustainable from a financial, access and quality perspective.

TA noted that the Darzi Report had been published, some themes for solutions highlighted in the report matched the system's medium-term plan, including empowerment of patients, engagement of staff, shifting care closer to home, simplifying how care was delivered and greater use of technology.

NHSE had shared the ICBs annual assessment, and a response was being drafted, particularly in those areas where NHSE had identified opportunities for improvement.

NIB sought assurance on the ask to reach the elective care Referral to Treatment (RTT) target of zero by 30 September 2024. TA and MHop explained assurance processes and stated that the region was confident, in view of the number of patients being treated each week, that apart from a small number of patients who chose not to have their treatment in September, the expectation of zero 65+ waits by 30 September 2024 would be delivered.

MT expressed gratitude to the Trust for the delivery of its promises and SP echoed thanks for improvements in ophthalmology outpatient services.

JF asked if a waiting list cleanse could be completed on the 52 and 65 week waits. MHop confirmed that validation of the waiting list was an ongoing exercise. Strict rules ensured that patients were not removed unnecessarily. It was acknowledged that waiting 52 or 65 weeks for a first outpatient appointment was a long time for those in pain and discomfort, so the MSEFT Trust Board was very clear that staff should look beyond the 52- and 65-week target to ensure that waiting times were as short as available resources allowed.

Resolved: The Board noted the Chief Executives Report.

10. Quality Report (presented by Dr G Thorpe)

GT highlighted the following key areas:

A deep dive was undertaken for Special Educational Needs and Disability (SEND) across MSE with a focus on improving how service availability was communicated to families. There were significant challenges within the system due to increased demand and an increase of complex presentations versus limited capacity across both Health and Social Care. Local Authority partners were thanked for their support to minimise the backlog in assessments as quickly as possible and ensuring that families were supported whilst waiting for assessments.

An update had been provided for the Babies, Children and Young People (BYCP) key programmes of work. It was noted that the ICB held a statutory responsibility to have oversight of the BCYP programme across the system, for the Board to be apprised of this, and reference was given to the work on health inequalities, particularly the oversight of provision for long-term conditions with a focus on BCYP.

The completion of Initial Health Assessments (IHAs) for looked after children was an ongoing safeguarding concern held across all three local authorities, due to the lack of paediatric consultant capacity. Regulation 7 of the care planning placement and case review regulations stated that IHAs must be completed by a registered medical practitioner. This had been escalated to NHS England and a proposed solution was being put forward, as exercised by another ICB, and supported by the Royal College of Nursing and the Royal College of Paediatrics and Child Health. However, until a change in the rules could be negotiated, there would continue to be a backlog of children who required an IHA.

The notice to remove Section 31 (S31) conditions on the licence of maternity services at Basildon hospital had been received and progressed. The reinspection of maternity services at Broomfield Hospital had been concluded; there had been no immediate safety concerns and the LMNS Board would work with the Trust to respond once the formal report had been received.

Feedback from the ethnic community leads of the maternity and neonatal voices partnership had been received. There would be a focus on Equality, Diversity, and Inclusion (EDI) for the populations served, and work continued to ensure that culturally sensitive services were in place as noted under item 7.

Resolved: The Board noted the Quality Report.

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

JK highlighted the following key points:

The Chief Executive's report had detailed the Intervention and Improvement (I&I) process and the increased oversight by NHS England (NHSE) and external partners to support with the system financial position.

At month 4, the ICB declared a year-to-date (YTD) adverse variance to planned delivery, largely due to the financial risk regarding All Age Continuing Care (AACC) materialising. The outcome of the deep dive report being received by Finance and Performance (F&P) Committee would be reported to a Board seminar. The focus had intensified, with discussions held with regional colleagues and other ICBs that faced the same pressures. The small forecast outturn variance was due to unexpected costs that were being managed and would not yet materialise within the month 5 report.

The overall system position showed a YTD adverse variance against the agreed deficit plan of £96 million, which led to additional oversight from NHSE colleagues. The system worked closely with NHSE to support interventions to get back on track in 2024/25. Collaborative working would continue to ensure a good understanding and that collective action was taken to deliver the control total for the financial year.

MT invited TA, PS and MHop to provide a view on their current position and the capability and capacity to deliver the control total expected.

TA advised that the key risk for the ICB was AACC and the unexpected level of growth in demand and cost of care packages, with all other ICBS in the East of England in a similar position. Steps being taken to strengthen the leadership of the team should be in place by the end of September. There was also significant opportunity to work with local authority partners on brokerage (cost of placements). The ICB was considering undertaking a pilot with Southend City Council around brokerage and joining up some contracting activities. PF confirmed that Essex County Council (ECC) was also in full agreement and discussions had commenced.

MHop confirmed MSEFT welcomed the additional support and acceleration of the existing plan had progressed with additional capacity and transactional schemes to support spending restraints. The leadership team and Board were fully supportive and although parts of the organisation were clear of expectations, there had been some reticence from certain groups of staff that was being managed. The MSEFT plan was predicated on not opening escalation beds this winter so there would be an element of support required from system partners to deliver this expectation.

PS explained EPUT's plan focussed upon addressing high use of bank and agency staff. A new clinical and workforce model was being implemented which required fewer temporary staff and ensured patients returned home to their communities quicker. Two risks were

highlighted; the timing and delay with region on the green financial plans, and the static recruitment market which meant recruitment was currently off track. An additional challenge was changing clinical practice whilst under the scrutiny of an Inquiry which would be difficult for colleagues. However, the Board and leadership teams were supportive and remained confident regarding delivery.

JK advised that whilst performance was off plan, the ongoing work on system flow, UCCHs and maximising the community services to support flow and ambulance handovers was recognised. Work was ongoing with the Finance and Performance Committee to refine the level of detail within reports to provide improved assurance to the committee and Board.

There had been a steady decrease in relation to RTT and cancer waits. There was also sustainable achievement against metrics relating to mental health constitutional standards.

MT asked when all three of the Community Diagnostic Centres (CDC) in MSE would be operational. MH confirmed that work on the Braintree CDC and Thurrock CDC had commenced and both should be ready early 2026. The arrangements for the Pitsea CDC had been approved by MSEFT Board, but the completion date had not yet been confirmed. Diagnostic capacity would be paramount to achieving the standards by 2028 and would support cancer and general routine diagnosis.

Resolved: The Board noted the Finance and Performance Report.

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

PG presented the report outlining the development of services by the Alliance teams (including primary care) and highlighted the following key points:

A national agreement was in place regarding collective action (CA) by general practice. The ICB had responsibility as delegated commissioner for primary care to evaluate the impact of CA across the wider system and support any actions required. There had been a further appeal nationally to evaluate and demonstrate the impact on workload across primary care.

Recent activities with care homes around dental work which mitigated health inequalities for care home residents and looked at improving the experience of our dental hygiene staff and increased their scope of practice was presented to the Integrated Care Partnership. It was noted that the ICP were impressed with the positive patient stories that were relayed.

There had been some changes in primary care estate regulations which were detailed in the report. The difficulty in building premises had not been solved due to the complexity of capital between district valuers and the ownership arrangements of primary care estate. However, the changes to regulations provided more flexibility and work was ongoing with local authority colleagues in relation to the Section 106 funding attributed to health when building to support health infrastructure.

The activities on digital infrastructure within primary care continued to improve, with good uptake of cloud-based telephony and total triage. National funding had been invested into digital triage support tools, with roll out supported by local alliance teams.

There had been good engagement with the Pharmacy First approach where 95% of pharmacies had signed up to treat 10 minor ailments. Awareness continued to be reinforced through local communication campaigns.

Alliances continued to develop Integrated Neighbourhood Teams (INTs) which supported flow, early intervention, expedited discharge, and utilised community services better, increasing the simplicity of getting those from ward-based care to discharge. The alliance delivery plans were being replicated across all four places to relate to financial recovery and system flow.

The 'Better Care Fund' (BCF) (pooled funds with the three Local Authorities) had been approved by all local authorities with no escalation issues.

MT commented that the regional team had referred to the care home dentistry work as exceptional. SP had been working with hospital colleagues on an outreach model for optometry and a conversation would be held with local authorities in the ophthalmology commissioning area.

GO commended good progress on INTs and requested further information on the criteria of a thriving place and whether it would support the prevention agenda. DD invited GO to visit the people and places involved and advised that the measures were multifactorial and placed control nearer to populations to self-determine.

PF advised that Thurrock Healthwatch gathered views from professionals and patients around their experience with the Transfer of Care Hubs (TOCH) and asked if something similar could be completed in Essex. This was agreed.

DD thanked the estates and finance teams for their support in relation to the change in premises directions. There had been areas, primarily in Mid Essex, where Section 106 funding had been unlocked, albeit in areas where there was little or no impact on long-term revenue, but it demonstrated traction on Section 106 schemes.

JF asked if there were any solutions to the interoperability issue for GPs on the cloud-based services. BF agreed to provide further insight to JF.

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

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

13.1 Board Assurance Framework

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

TA noted that work was ongoing with the risk hierarchy and would include the national Quality Boards proposals on how risk management could be improved in a complex system risk. This would be presented to the Executive Team and would feature at a future Board seminar.

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

Action: NA to add Risk Management to a future Board seminar.

13.2 New/Revised Policies

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

- 004 Accounting and Financial Management Policy
- 006 Banking Cash Management Policy
- 007 Creditor and Purchase Policy
- 008 Debtor and Sales Order Policy
- 016 Policy for Developing Policies
- 022 Legal Services Policy
- 025 Management of Violence, Aggression and Vexatious Behaviour Policy
- 026 Counter Fraud, Bribery and Corruption Policy
- 029 Security and Lockdown Policy
- 039 Probation Policy
- 050 Parental Leave Policy
- 052 Fostering Policy
- 060 Close Personal Relationships at Work Policy
- 061 Domestic Violence and Abuse Policy
- 067 Management of Serious Incidents Process Policy

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

13.3 Approved Committee Minutes.

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

- Audit Committee (AC), Extraordinary, 19 June 2024.
- Clinical and Multi-professional Congress (CliMPC), 26 June 2024.
- Finance and Investment Committee (FIC), 2 July 2024
- Finance and Performance Committee (F&P), 6 August 2024
- Primary Care Commissioning Committee (PCCC), 12 June 2024 and 10 July 2024.
- Quality Committee (QC), 28 June 2024.

Resolved: The Board noted the latest approved committee minutes.

14. Any Other Business

There were no items of any of business raised.

MT thanked the members of the public for attending.

15. Date and Time of Next Board meeting:

Thursday, 14 November 2024 at 2.00 pm, Basildon Sporting Village, Cranes Farm Road, Basildon, Essex, SS14 3GR.

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action Required	Lead	Deadline for completion	Update / Outcome	Status
45	18/01/2024	12.3	**Board Assurance Framework:** Revisit the Cyber Security Risk to decide whether to include in future iteration of Board Assurance Framework.	N Adams S O'Connor	30/09/2024	Cyber security is a long standing risk on the corporate risk register and is currently not considered to be sufficiently significant a threat for inclusion on the Board Assurance Framework.	Complete
52	12/09/2024	8	**System response to NHSE Letter on Corridor Care** JK to work with AP to include the ambulance offload handover and corridor care metrics on future Board reports during the winter period.	J Kearton/A Pike	16/01/2025	Verbal update to be provided at Board on 14 November 2024.	In progress
53	12/09/2024	13	**Board Assurance Framework** Risk management to be added to the Board Seminar plan.	N Adams	14/11/2024	Scheduled for the 16 January 2025 meeting.	Complete

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 6

Lampard Inquiry Update

Summary Report

1. Purpose of Report

To update the Board on the establishment of the Lampard Inquiry and the development of the joint cross Essex ICBs response to the Inquiry.

2. Executive Lead

Dr Matthew Sweeting, Chief Medical Officer

3. Report Author

Mike Thompson, Associate Director, System Programmes

4. Responsible Committees

Executive Committee.

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

None directly applicable to this report. The Lampard Inquiry is being conducted publicly, the ICBs have, and will, issue communications as necessary in support or response and communications teams is a core part of the programme management structure going forward.

8. Conflicts of Interest

None identified.

9. Recommendation

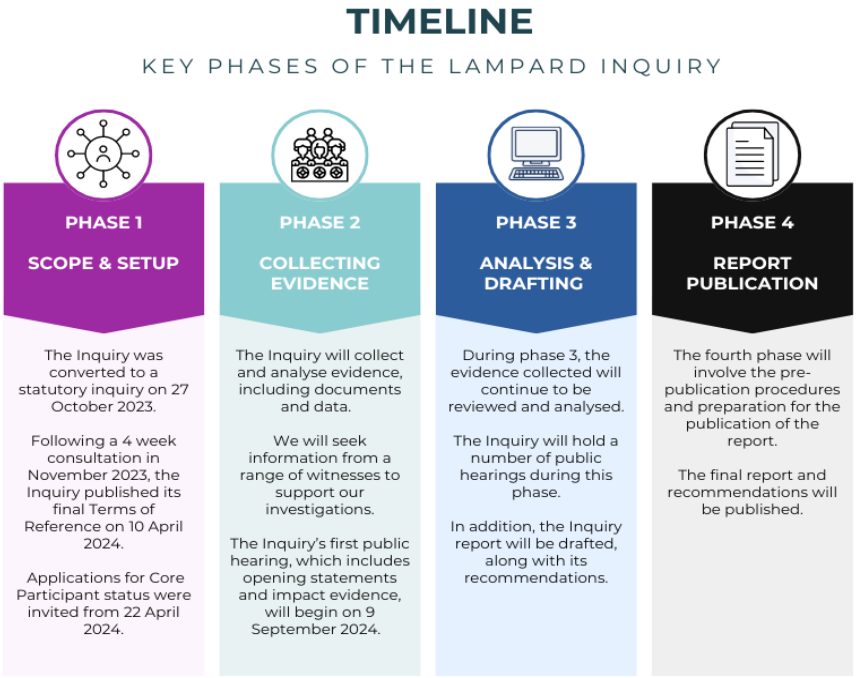
The Board is asked to note the report and the progress in developing the cross ICB approach to responding to the Inquiry.

Lampard Inquiry Update

1. Introduction

In June 2023 it was announced that the Essex Mental Health Independent Inquiry (established in 2021) would be granted statutory status (Public Inquiry) under the Inquiries Act 2005. In April 2024 final Terms of Reference were published and the first public hearings began on 9 September 2024. The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trusts in Essex ("the Trusts") between 1 January 2000 and 31 December 2023.

The Inquiry is expected to continue into 2026. A schematic of the phases of the Inquiry is shown below.



2. Main content of Report

The three Essex Integrated Care Boards (ICBs), namely Mid and South Essex, Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWE) ICBs, agreed to work collaboratively to respond collectively and effectively to the requirements of the Inquiry.

Each of the ICBs has been designated a 'core participant' to the Inquiry. A Core Participant is an individual, organisation or institution that has a specific interest in the work of the Inquiry. Core Participants have a formal role and special rights in the Inquiry process.

A shared programme office was established over the summer comprising:

- Programme Director (part time) – Commenced July 2024
- Senior Project Manager (1 whole time equivalent (WTE)) – Commenced 1 October 2024
- Administrative Support (1 WTE) – Commences 2 December 2024

With the commencement of the Project Manager a cross ICB Project Board and project structure will be established in November supported by workstreams/working groups that will provide focus on key commissioning functions – including mental health commissioning, information governance, human resources, communications. This will enable a pro-active coordination and response to the needs of the inquiry, for example responses to Rule 9 requests (see Section 2. below)

Mills & Reeve LLP have been appointed as legal advisors.

Programme and legal costs are being apportioned: 1/7 to SNEE, 1/7 to HWE and 5/7 to MSE ICB.

A weekly meeting takes place with the three ICB Executive Senior Responsible Officers (SROs) and the programme director and legal advisors as necessary. This has been an effective 'touch point' in maintaining progress and ensuring appropriate executive leadership and sign off of key milestones, e.g. Rule 9 submission and opening statement. The 3 SROs are:

- Lisa Nobes, Chief Nurse, SNEE
- Dr Matt Sweeting, Chief Medical Officer, MSE
- Beverley Flowers, Deputy Chief Executive, HWE

They are supported by ICB Lampard leads:

- Mike Thompson, Programme Director and MSE lead
- Tom McColgan, Governance & Compliance Manager, SNEE
- David Wallace, Deputy Director of Nursing & Quality, HWE

There are two notable milestones / issues to report on at this stage.

2.1. Commencement of the first of the public hearings on 9 September 2024 including receipt of the three Essex ICBs' opening statement.

The hearings commenced on 9 September 2024 in Chelmsford. The ICBs were represented by Counsel appointed by the ICBs on recommendation of our legal advisors.

The first week of hearings received opening statements (some of which, including the ICBs were read out) from core participants including; the Inquiry; families; ICBs; Essex Partnership University NHS Foundation Trust (EPUT); North East London NHS Foundation Trust (NELFT); NHS England; Care Quality Commission (CQC); and the Department of Health & Social Care.

Executive Directors of each ICB attended the hearings during this phase with other key staff given livestreaming access.

The second and third week of hearings (from 19 September 2024) received 'Commemorative and Impact Accounts' from families. A further, virtual hearing is

planned from 25 November to 5 December this year, which will continue to be commemorative and receive impact accounts from families and friends of those who died.

A copy of the ICBs' opening statement is attached as **Appendix A** to this report.

2.2. Receipt on 15 July 2024 of the first 'Rule 9' request for information from the ICBs.

A Rule 9 is a request for information. It can be a request for documents and/or a witness statement. It's called a rule 9 request because it's made under the power set out in Rule 9 of The Inquiry Rules 2006. There are specific and relatively short timescales for response.

The request received related to:

"which mental health inpatients, and in what circumstances, mental health patients were placed and treated in units outside of Essex but remained "under the care of NHS Trust(s) in Essex".

This was deemed an important part of the background of how mental health services were being provided by Trusts in Essex during the Relevant Period, and vital to finalising a list of deaths in scope.

The ICBs responded at pace, and well, considering the request was unexpected at that point and the shared programme management arrangements were not yet in place. Mental health commissioners in particular were responsive to the needs and urgency of the request. A response was submitted on the due date of 8 August 2024.

The response focussed on the areas and process covered in recent years by the ICBs and to a degree the former Clinical Commissioning Groups (CCGs) but not the full range of the Inquiry period. However, the response included the offer to engage directly on any 'gaps' and provide any further information as necessary. The response highlighted:

- The complexity of the commissioning and provider landscape of the Inquiry period and the number of commissioning organisations across Essex over that period.
- The complexity of processes in place, and the need for clear lines of inquiry on, for example, definitions of out-of-area or non-contractual placements.
- The differing arrangements for electronic and physical document storage and retention (that the project will need to address).

There was therefore positive learning from this request that can be fed into the project processes to be able to better respond in future. Ongoing engagement with the Inquiry Team, in particular through Mills & Reeve, will ensure that any requests or follow-up effectively supports the work of the inquiry allowing the ICBs to better understand the rationale and need behind requests to respond effectively.

3. Findings/Conclusion

The ICBs have worked effectively to create a joint approach to the Inquiry and responded positively to the initial Rule 9, and pro-actively in the creation of the opening statement and engagement with the Inquiry. The establishment of the project team and structure as wells as associated workstreams with reporting over the coming months will allow for more effective responses to Inquiry requests and will provide assurance to constituent Boards that the ICBs are meeting their responsibilities and duties to the Inquiry.

This report content has also been received by the Boards of Herts and West Essex and Suffolk and North East Essex ICBs.

4. Recommendation(s)

The Board is asked to note the report and the progress in developing the cross ICB approach to responding to the Inquiry note the current position.

5. Appendices

Appendix A – Essex ICBs' Opening Statement to the Inquiry.

Appendix A

THE LAMPARD INQUIRY

OPENING STATEMENT ON BEHALF OF THE
MID AND SOUTH ESSEX INTEGRATED CARE BOARD
HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD
SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD

Introduction

1. The Mid and South Essex, Hertfordshire and West Essex and Suffolk and North East Essex Integrated Care Boards ("ICBs") would like to, at the outset of this opening statement, express their deepest sympathy to all those who have lost loved ones and those who have been, and remain affected by the matters that this Inquiry is examining. It is hoped that the Inquiry's robust investigation will provide the answers that many have been waiting for. The ICBs would like to recognise the courage of those engaging with this process, despite their loss and suffering.

2. The ICBs are committed to engaging with the Inquiry in full openness and transparency to assist it in discharging its Terms of Reference. The ICBs recognise the considerable work being done by the Inquiry and are keen to establish an ongoing dialogue to ensure that the ICBs can be as helpful as possible. To date, the ICBs have provided a draft Rule 9 statement with accompanying documents and stand ready to respond to further requests for evidence. The ICBs have been proactive in beginning a scoping exercise of potentially relevant material and by putting in place structures to ensure they can engage with and respond to the Inquiry as effectively and efficiently as possible.

3. The ICBs are grateful for the opportunity to participate in the Inquiry, to listen to those impacted, and to learn necessary lessons for the future. The ICBs are committed to better understanding and responding to the needs of people accessing mental health services in their areas of responsibility.

4. Throughout the remainder of this statement, I will provide a brief overview of the role and functions of ICBs, some background to the changing landscape that led to the establishment of ICBs in 2022 and, to assist the Inquiry and those listening to better understand where the ICBs fit within the context of the Inquiry's areas of consideration.

Integrated Care Boards

5. The three ICBs that have responsibility for the population of Essex (one within Essex and two that also have responsibility for the populations of Hertfordshire and Suffolk) were established in July 2022 as part of wide ranging reforms introduced through The Health and Care Act 2022 ("the 2022 Act") . The Act legally established Integrated Care Systems ("ICSs"). There are 42 ICSs in England[1] and they consist of ICBs and Integrated Care Partnerships ("ICPs"). ICBs are required to work with local authorities to establish ICPs, drawing together a wider pool of representatives such as those from public health, social care and housing providers. ICPs are responsible for developing an integrated care strategy to address the health needs of the population in the relevant area, which ICBs are required to have regard to when making decisions.

6. The 2022 Act abolished CCGs and consequently, ICBs took on the commissioning functions of CCGs as well as some of NHS England's commissioning functions.

7. The 2022 Act outlines the general duties of ICBs including with regard to:
    a. Improvement in quality of services
    b. Reducing inequalities
    c. Promoting involvement of patients and carers
    d. Patient choice
    e. Obtaining appropriate advice to effectively discharge its functions
    f. Promoting innovation and research
    g. Promoting integration of health services

[1] NHS England, 'What are integrated care systems?'

8. The explanatory notes to the 2022 Act outline that ICBs have the ability to exercise their functions through place-based committees, while remaining accountable for them, and they are directly accountable for NHS spend and performance within the system. In terms of structure, ICBs must have as a minimum a Chair, Chief Executive Officer and representatives from NHS Trusts and NHS Foundation Trusts, general practice and local authorities. Local areas have the flexibility to determine any further representation in the area. ICBs are also required to ensure they have appropriate clinical advice when making decisions and that at least one ordinary member has knowledge and experience in connection with services relating to mental illness.

Commissioning

9. A core function of ICBs is commissioning. Their duty under section 3(1) National Health Service Act 2006 (as amended) ("the NHS Act 2006"), is to arrange for the provision of health services to such extent as it considers necessary to meet the reasonable requirements of the people from whom it has responsibility.

10. . NHS England defines commissioning as follows:

'Commissioning is the continual process of planning, agreeing and monitoring services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.'[2]

11. In summary, commissioning involves a range of activities including; assessing needs, planning services, procuring services and quality assessment. There is an important distinction between the provision of health care services and their commissioning. Whilst the particular statutory duties have changed over the years, the duty has been one of

[2] NHS England, What is commissioning?

'arrangement' rather than direct involvement in patient care, which is delivered by care providers such as an NHS Trust.

12. The commissioning arrangements are designed so that an individual ICB may not have, or need to have, knowledge of who or what services it is commissioning for each specific person that passes through them. This is intended to enable the efficient provision of services under existing contracting arrangements to best meet the needs of the population. The arrangements recognise that expertise in care, treatment and clinical decision making in individual cases is at the provider level, rather than the commissioner level. In cases where individuals have complex needs and require bespoke commissioned care, systems exist enabling commissioners to work collaboratively with providers to deliver this.

Changing Landscape

13. As the Inquiry is undoubtedly aware, significant reforms have taken place throughout the time period under examination. At the beginning of 2000, NHS providers were funded by Health Authorities and GP fundholders, rather than being paid directly by the Secretary of State. Primary Care Trusts ("PCTs") began to be established throughout 2000 and 2001, reflecting a desire to shift the balance of influence of services towards local communities.

14. PCTs became the lead NHS organisation in assessing need, planning and securing all health services and improving health. Strategic Health Authorities were to be established to replace Health Authorities, and led to the strategic development of the local health service and performance managed PCTs and NHS Trusts.

15. In 2010, the coalition government published the white paper '*Equity and Excellence: Liberating the NHS'*.[3] This was aimed at fundamentally changing the role of the Department of Health to become more strategic, while empowering clinicians to have a greater say in commissioning as part of a move towards becoming more outcomes focused; and responsibility for public health moving to local authorities.

[3] Department of Health, '*Equity and excellence: Liberating the NHS'* July 2010

16. PCTs were formally disestablished and replaced by Clinical Commissioning Groups ("CCGs") following the Health and Social Care Act 2012. CCGs were responsible for commissioning most NHS Services, supported by and accountable to the NHS Commissioning Board. Responsibility for some specialist services such as in-patient services for children and adolescents (Tier 4 services) transferred from PCTs to the NHS Commissioning Board.

17. As we know, the 2022 reforms then disbanded CCG's as ICB's, together with NHS England, became responsible for commissioning NHS services.

Conclusion

18. The various legislative and policy changes that have led to several structural changes over many years presents a complex picture. It is hoped that this brief overview provides a useful introduction in understanding the changing landscape, and the current picture in respect of ICBs. The ICBs look forward to providing further explanation and evidence as the Inquiry progresses.

19. The ICBs would like to reiterate their firm commitment to supporting the Inquiry in its investigation, In particular, the ICBs would like to highlight their willingness to reflect on key learning that emerges from the Inquiry, to enable them to ensure that the people they are responsible for can safely and confidently access mental health services in future. As such, the ICBs will listen carefully to the evidence and contributions from other Core Participants, and look forward to the Inquiry's report and recommendations in due course.

Zeenat Islam
Temple Garden Chambers
Instructed by Mills & Reeve LLP
30 August 2024

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 14 November 2024

Agenda Number: 7

Board update on the Six Equality, Diversity and Inclusion (ED) High Impact Actions - Annual snapshot.

Summary Report

1. Purpose of Report

To update the Board on the current performance against the six National ED&I High Impact Actions.

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Dr Kathy Bonney, Interim Chief People Officer.

4. Responsible Committees

People Board

5. Financial Implications

No financial implications

6. Conflicts of Interest

None identified

7. Recommendation(s)

The Board is asked to note the content of the report, including the challenges for collective action and where progress has been made.

Board update on the Six Equality, Diversity and Inclusion (ED) High Impact Actions - Annual snapshot.

1. Introduction

In November 2023 the Board agreed to commit the Integrated Care System (ICS) to deliver against the six National ED&I High Impact Actions. The majority of these require annual reporting so much of this data is sourced within the year 2023/24. Where feasible data has been included up to and including May this year.

The organisations referenced in this report are Mid and South Essex Integrated Care Board (MSE ICB), Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT). There is partial data available for Provide Community Interest Company (Provide), with an ambition to have a full data set for next year's report along with an equal ambition to include Local Authority data in the future.

The six High Impact Actions are:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

2. Main content of Report

The slide deck attached as **Appendix A** of this report contains the ICS data. This report was reviewed by the People Board on 11 July 2024 as part of the EDI Workstream reporting. Nunzio Toscano, ICB People Directorate, is acknowledged for the detail of this work. This work supports the delivery of the ICS Equality, Diversity, and Inclusion sub-group of the People Board.

The overall Amber RAG rating reflects partial progress and ongoing challenges.

The ICS position in response to the six actions.

High Impact Action 1

All ICB Board members have specific and measurable (SMART) EDI Objectives. Both MSEFT and EPUT Board members also have identified ED&I objectives.

High Impact Action 2

For meeting the Workforce Race Equality Standard (WRES), both the ICB and EPUT remain below the national benchmark whilst MSEFT remains within the national benchmark. However, when compared against other ICBs MSE is performing better (Slides 6 & 7).

For meeting the Workforce Disability Equality Standard (WDES), EPUT is below the national benchmark but the ICB and MSEFT are both within the national benchmark. In terms of performance against national figures, the ICB is in a good position along with MSEFT, whilst EPUT is below average (Slides 7 & 8).

In relation to NHS organisations acting fairly in terms of career progression, EPUT is above the national benchmark whilst the ICB and MSEFT are currently below. All organisations are on an upward trajectory (Slide 9).

However, ethnicity remains the biggest barrier to career progression in all 3 NHS organisations and there are also barriers to career progression for staff with long term conditions (Slide 10).

It is interesting to note that more staff with long term health conditions and those from black, Asian and minority ethnic (BAME) backgrounds strongly agree to the statement that they are able to access the right learning and development opportunities. (Slide 11). The suggested explanation for this is that they have lower expectations.

High Impact Action 3

The gender pay gap for both MSEFT and the ICB are above the national average whilst EPUT is below. From this year onward all NHS organisations are required to create an ethnicity pay gap report (Slides 13,14,15).

High Impact Action 4

In answer to the question "*my immediate manager takes a positive interest in my health and well-being*." MSEFT had the lowest agreement rate and is in line with the national average, with MSE ICB showing some fluctuating trends but a significant improvement, and EPUT with the highest level of agreement. Notably, the differences in agreement rates in all NHS organisations, between staff living with disabilities, BAME staff, and all staff is minimal. (Slides 17,18 &19). Provides data is available against this metric and shows a similar trend (Slide 21).

Sickness absence rates across all three NHS organisations are showing a downward trajectory (Slide 20).

High Impact Action 5

The 2023 NHS staff survey did not capture any responses from staff identifying as "Internationally Recruited" within the ICB. Therefore, data for this specific metric for the ICB is unavailable.

However, for MSEFT Internationally recruited staff feeling a sense of inclusion, is slightly below the average for other staff but for EPUT it is on a worrying downward trajectory (Slides 23 & 24).

Interestingly, this is not the same trend for internationally staff feeling bullied or harassed which shows MSEFT performing worse than EPUT but again it is a concern that for both NHS organisations there is a sharp upward trajectory (slides 25 & 26).

Turnover for internationally recruited staff is also increasing across both MSEFT and EPUT whilst for domestic staff there is a slight decline (slide 27).

High Impact Action 6

Levels of bullying and harassment against all groups of staff are higher in the ICS than average benchmarks (slides 29, 30 & 32).

Staff in MSEFT from the LGBTQ + community and staff with long lasting conditions in EPUT and the ICB, report the highest levels of bullying and harassment from colleagues, although bullying experienced by staff from all ethnic groups combined is also high, when compared with all staff (slide 31).

Discrimination in relation to Ethnic Background is the most common form across all NHS three organisations (slide 33).

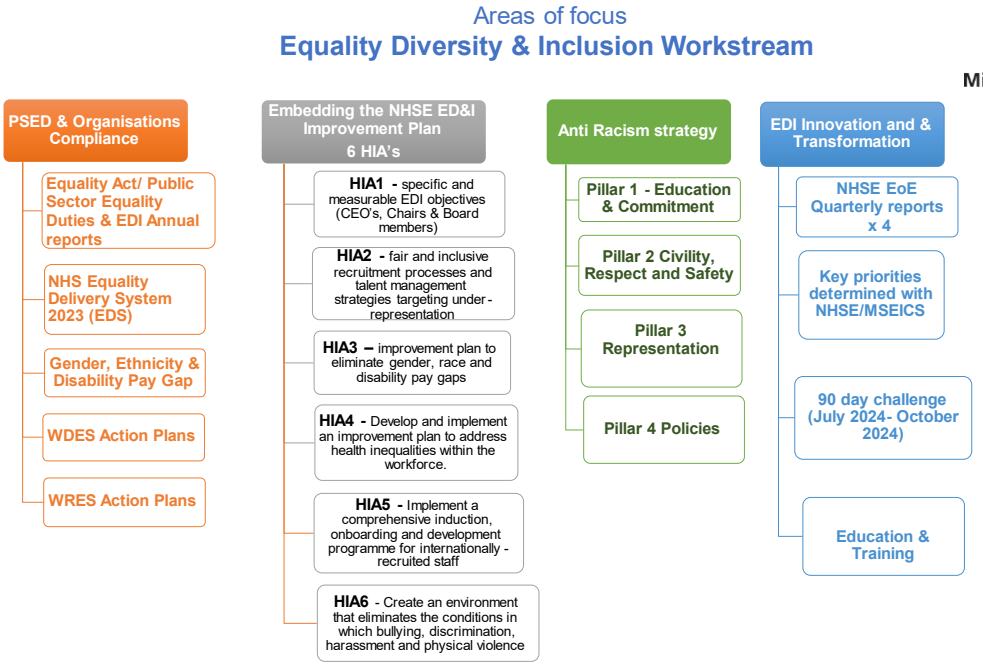
Staff in all three NHS organisations have been the target of at least one incident of sexual behaviour from patients or other members of the public. But all are below the national median (slide 34).

Staff in all three NHS organisations have been the target of at least one incident of a sexual nature from colleagues, with MSEFT reporting the greatest number and higher than the median (slide 35).

Provide's data in relation to bullying and harassment is added at slide 36.

3. Findings/Conclusion

There is clearly significant work to be done across the six ED&I High Impact Actions. The ICS has formed a subgroup of the People Board specifically to address the issues raised in this report. The overarching strategy for the group appears in the infographic below. It is acknowledged across the ICS that the equality agenda must run as a golden thread across everything we do. An enduring ambition and commitment to make a clear difference for our staff in MSE ICS is central to this being achieved



4. Recommendation(s)

The Board is asked to note the content of the report, including the challenges for collective action and where progress has been made.

5. Appendices

Appendix A - ICS 2023/24 EDI Six High Impact Actions / Annual Snapshot Report.

NHS
Mid and South Essex

Annual Snapshot Report on Equality, Diversity and Inclusion (EDI)
The six high-impact actions for MSE ICS
April 2024.

We are collaborative
We are compassionate
We are innovative
We are living well

6 High-impact Actions

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

RAG rating

	Action	MSEFT RAG	EPUT RAG	MSE ICB RAG	Provide Community
1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.				Awaiting data
2	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.				Awaiting data
3	Develop and implement an improvement plan to eliminate pay gaps.				Awaiting data
4	Develop and implement an improvement plan to address health inequalities within the workforce.				Awaiting data
5	Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.			N/A	Awaiting data
6	Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.				Awaiting data

Action 1 Summary

1

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

MSE ICB

All executive and non-executive members of the ICB board have Specific and measurable (SMART) EDI Objectives.

MSEFT

All MSEFT executive and non-executive members of the ICB board have Specific and measurable (SMART) EDI Objectives.

EPUT

All EPUT executive and non-executive members of the ICB board have Specific and measurable (SMART) EDI Objectives.

PROVIDE

Awaiting data

Action 2 Summary

2

Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

MSE ICB

In 2023, MSE ICB met the WDES benchmark but exceeded the WRES benchmark, with a value of 1.33. White candidates were more likely to be appointed from a shortlist. Furthermore, only 42% of staff believed their organisation acted fairly in promotions, the lowest rate in the ICS. This perception was even more pronounced among BAME staff, with only 27% agreeing.

MSEFT

MSEFT, in the 2023 Report, met the benchmark for both WRES and WDES. Moreover, staff perception of organisational fairness regarding promotions and career progression has seen a 4 % points improvement since 2022.

EPUT

EPUT, in 2023, was out the benchmarks for both WRES and WDES, indicating that BAME staff were more likely to be appointed from shortlists compared to their representation in the workforce. Additionally, non-disabled individuals were more likely to be appointed from shortlists. Despite these disparities, EPUT's perception of fairness was the highest in the ICS, with 60% of staff describing the organisation as fair.

PROVIDE

Awaiting data

Action 2

Slide 6

WRES/WDES Data

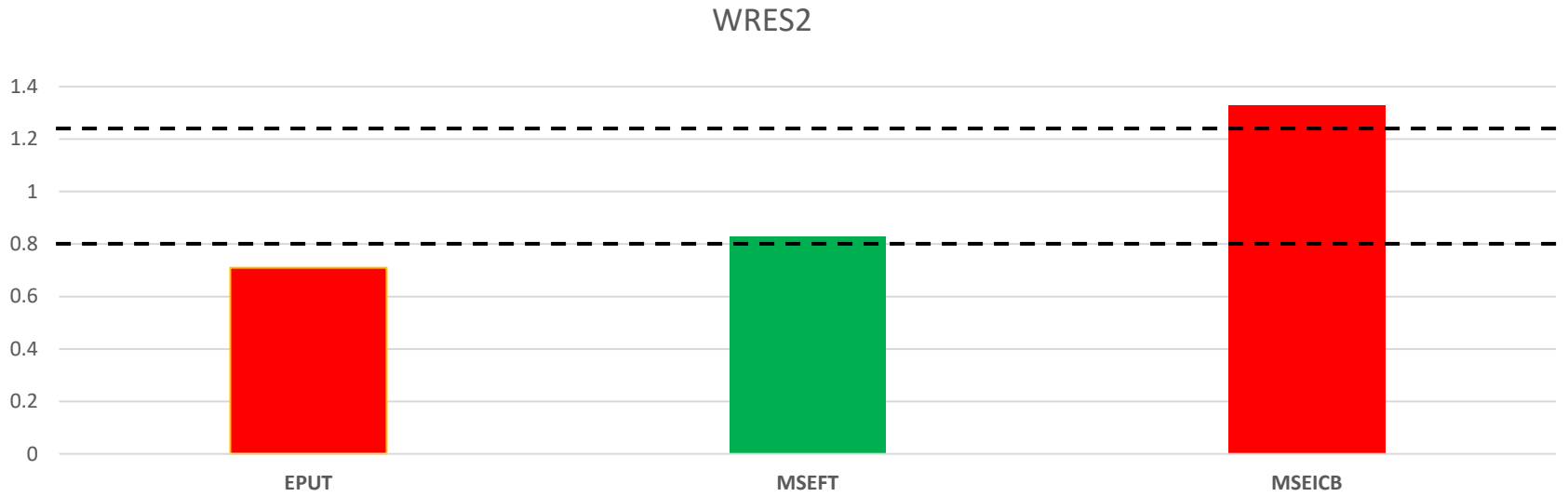
The top graph compares the WRES values for EPUT, MSEFT, and MSE ICB, with the dotted line representing the benchmark. The bottom chart also depicts WRES values.

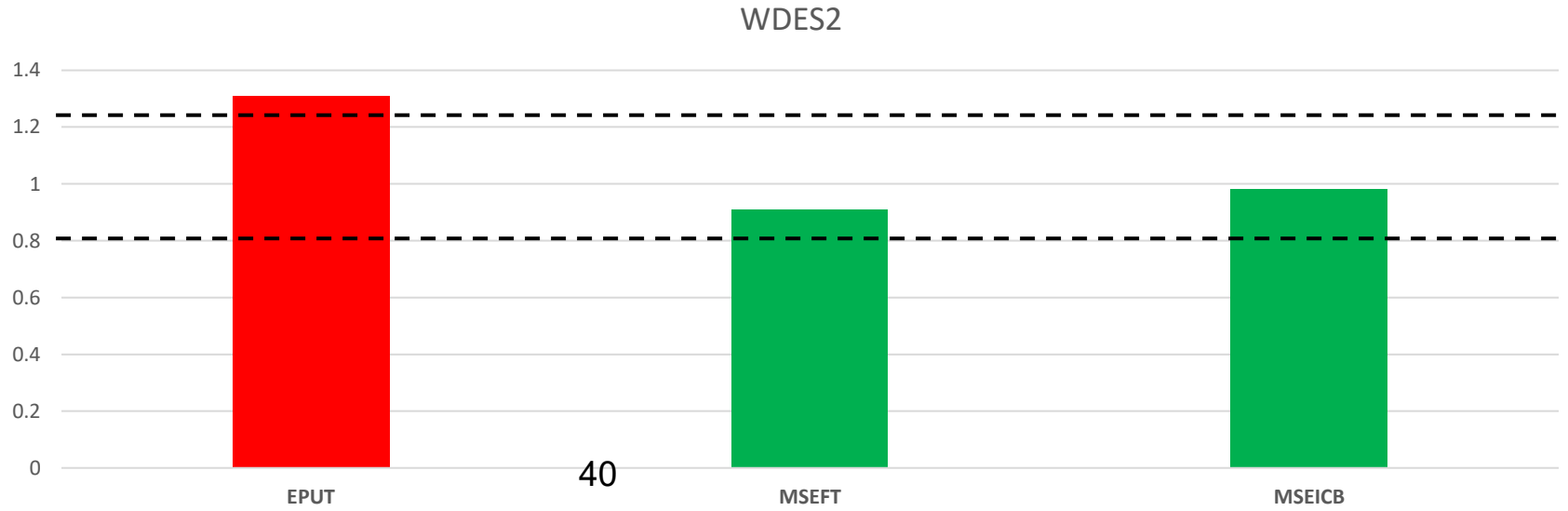
As noted, EPUT is out of benchmark for both WRES and WDES, while MSE ICB is out of benchmark for WRES.

WRES2.

Chance of being appointed following shortlisting between white and BAME applicants.

A value greater than one shows that White staff / non-Disabled are more likely to be appointed from being shortlisted.
A value less than one shows that BAME staff / Disabled are more likely to be appointed from being shortlisted.





Action 2

Slide 7

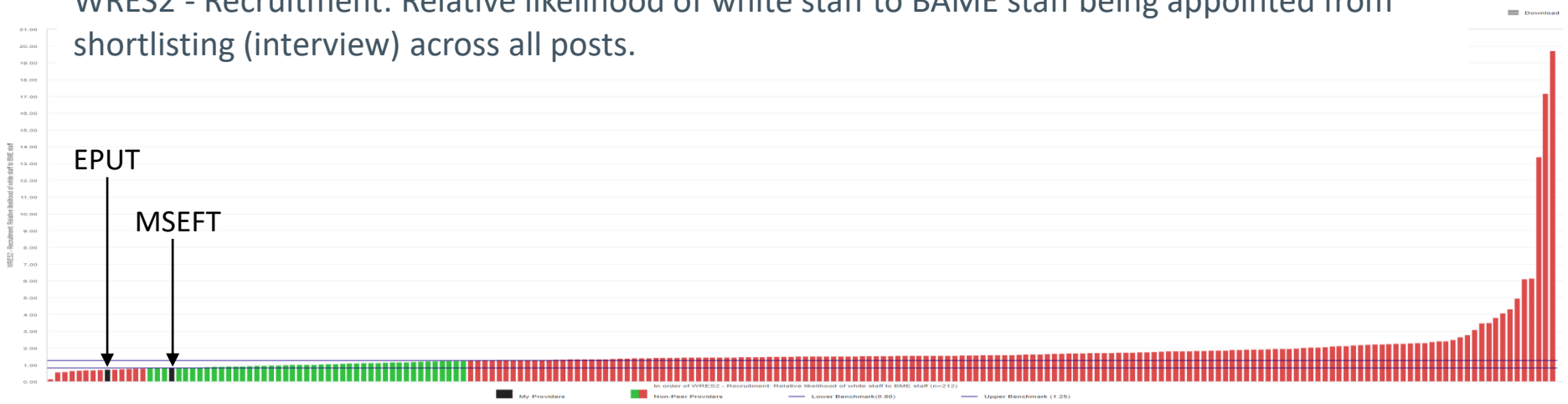
WRES/WDES Data

These charts compare MSEFT and EPUT (in black) with other NHS England organisations. Green bars indicate organisations within the benchmark, while red bars represent those out of the benchmark. Each bar represents an NHS organisation.

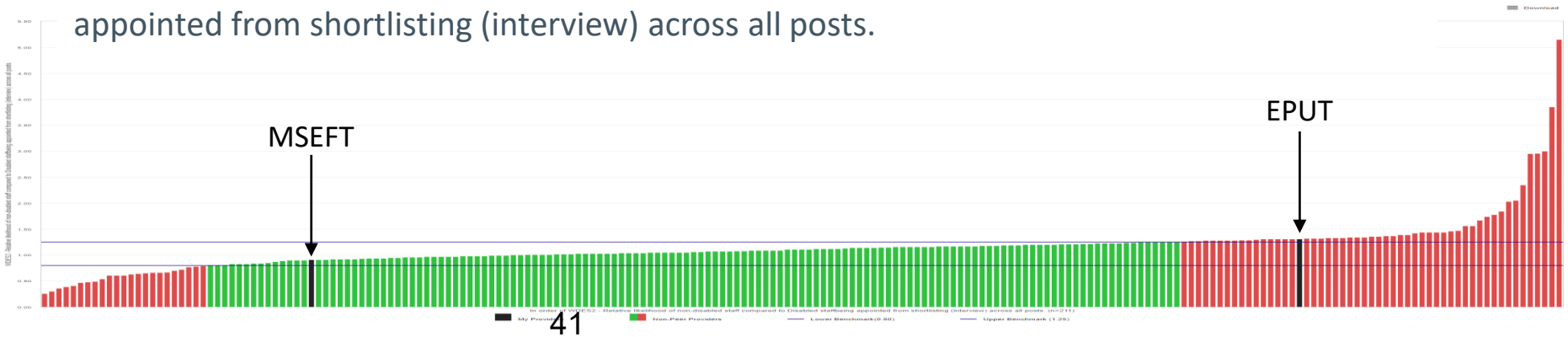
How does our organisation compare to other trusts in terms of WDRES and WRES?

A value greater than one shows that White staff / non-Disabled are more likely to be appointed from being shortlisted.
A value less than one shows that BAME staff / Disabled are more likely to be appointed from being shortlisted.

WRES2 - Recruitment: Relative likelihood of white staff to BAME staff being appointed from shortlisting (interview) across all posts.



WDES2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting (interview) across all posts.



Action 2

Slide 8

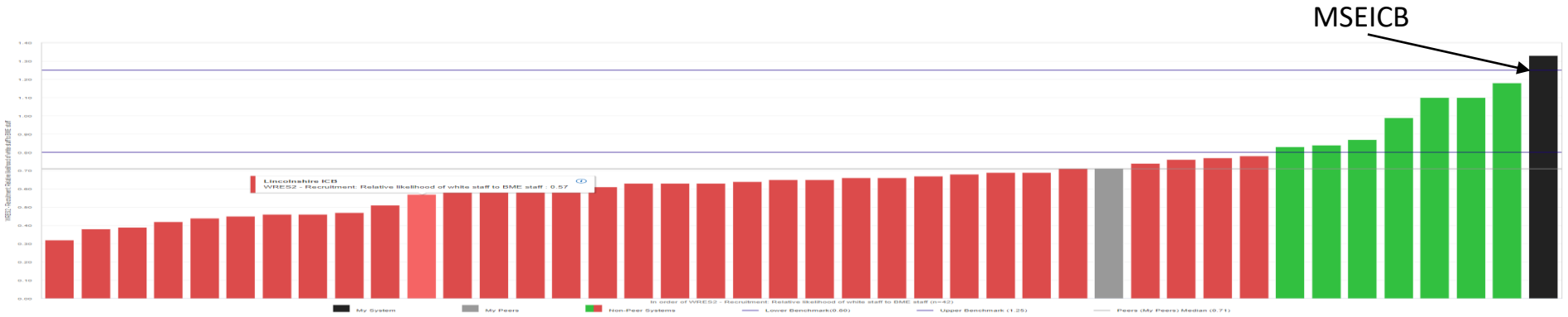
WRES/WDES Data

These charts compare MSE ICS (in black) with other NHS England ICBs. Green bars indicate ICBs within the benchmark, while red bars represent those out of the benchmark. Each bar represents an NHS ICB.

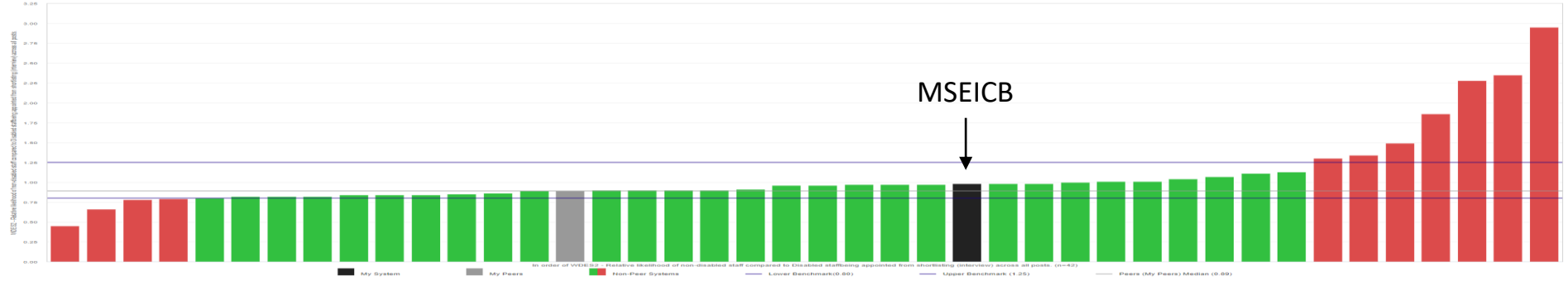
How does MSEICB compare to other ICBs in terms of WDRES and WRES?

A value greater than one shows that White staff / non-Disabled are more likely to be appointed from being shortlisted.
A value less than one shows that BAME staff / Disabled are more likely to be appointed from being shortlisted.

WRES2 - Recruitment: Relative likelihood of white staff to BAME staff



WDES2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting (interview) across all posts.



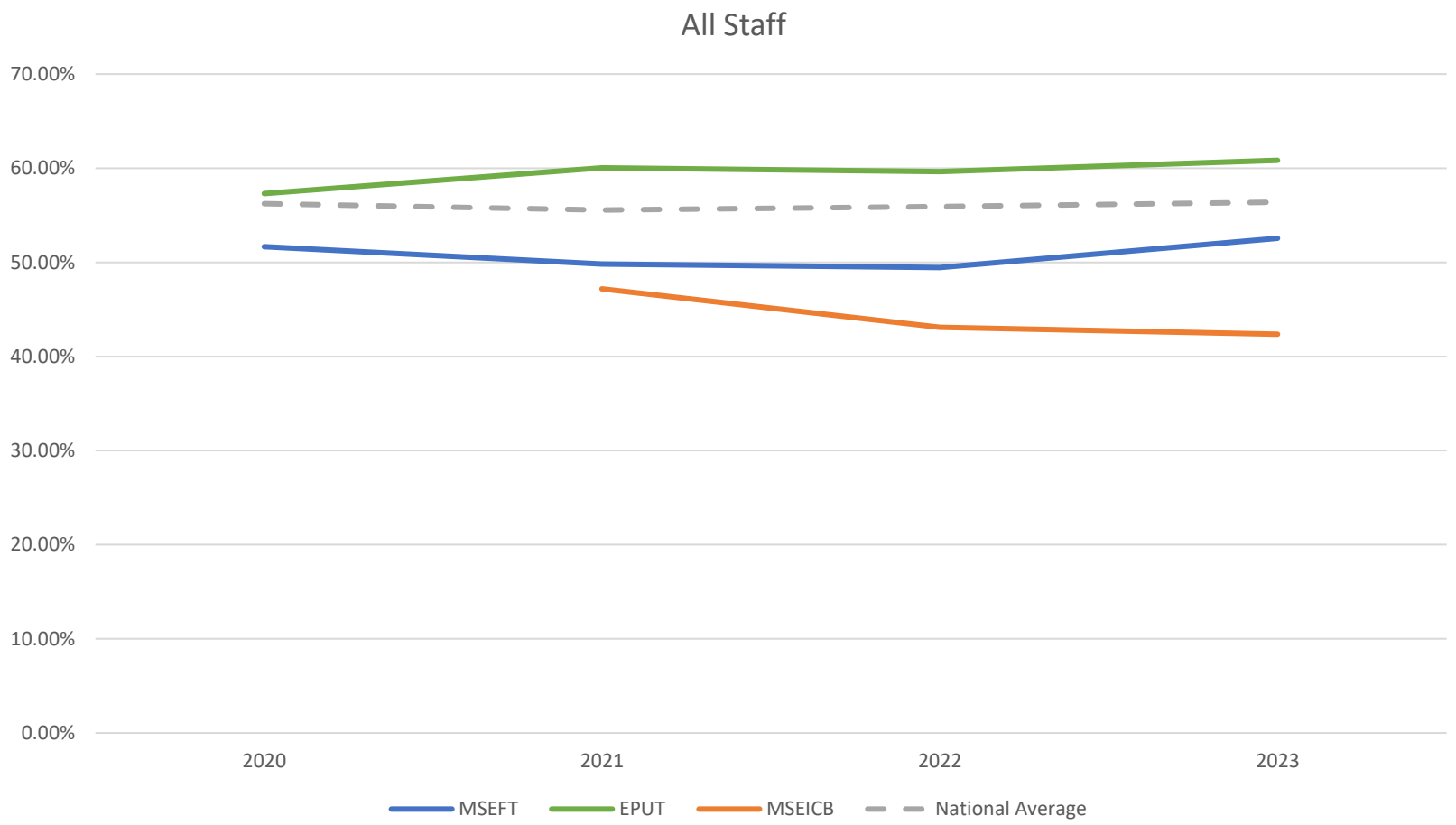
Action 2

Slide 9

2023 NHS staff survey

This graph compares the percentage of staff who agree that MSEFT (blue), EPUT (green), and MSE ICB (orange) act fairly regarding career progression and promotions. The dotted line represents the national average.
EPUT was the best-performing ICS trust, followed by MSEFT and then MSE ICB. Both MSEFT and EPUT have seen an increase since 2022, while MSE ICB has experienced a slight decline.

Percentage of staff who agree with the statement “Does your organisation act fairly with regard to career progression / Promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?”



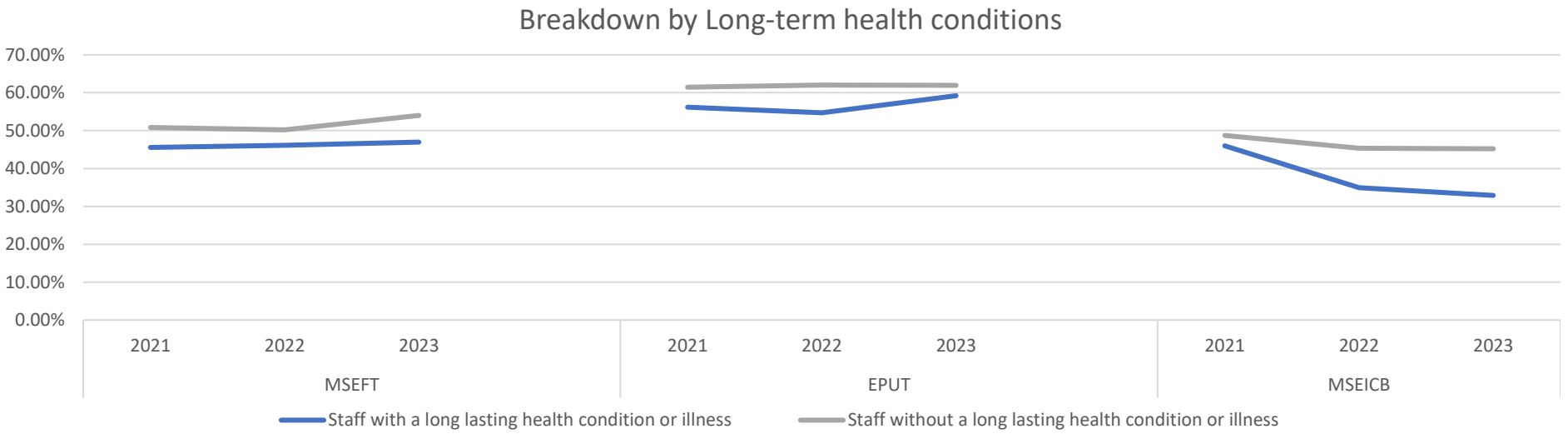
Action 2

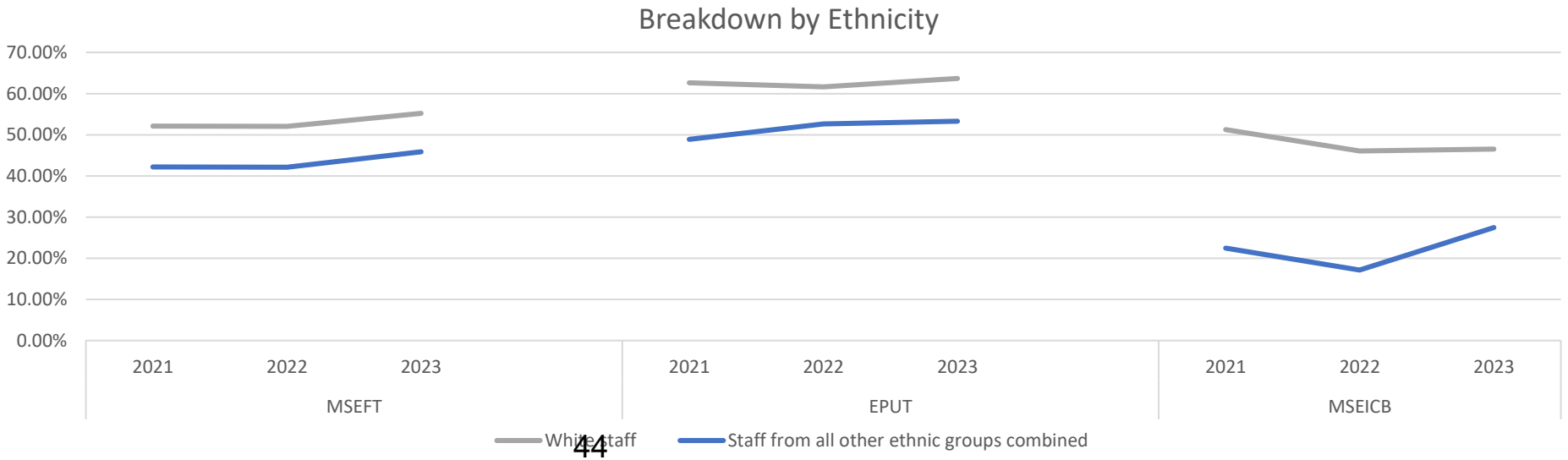
Slide 10

2023 NHS staff survey

Like the previous slide, this graph compares staff perceptions of fairness in career progression and promotions, but this time it focuses on the responses from staff with disabilities and BAME staff. Both staff categories are less likely to describe the organisations as fair, with BAME staff being 10 percentage points lower than their white counterparts for MSEFT and EPUT and 20% points lower for MSE ICB.

Percentage of staff who agree with the statement "Does your organisation act fairly with regard to career progression / Promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?"



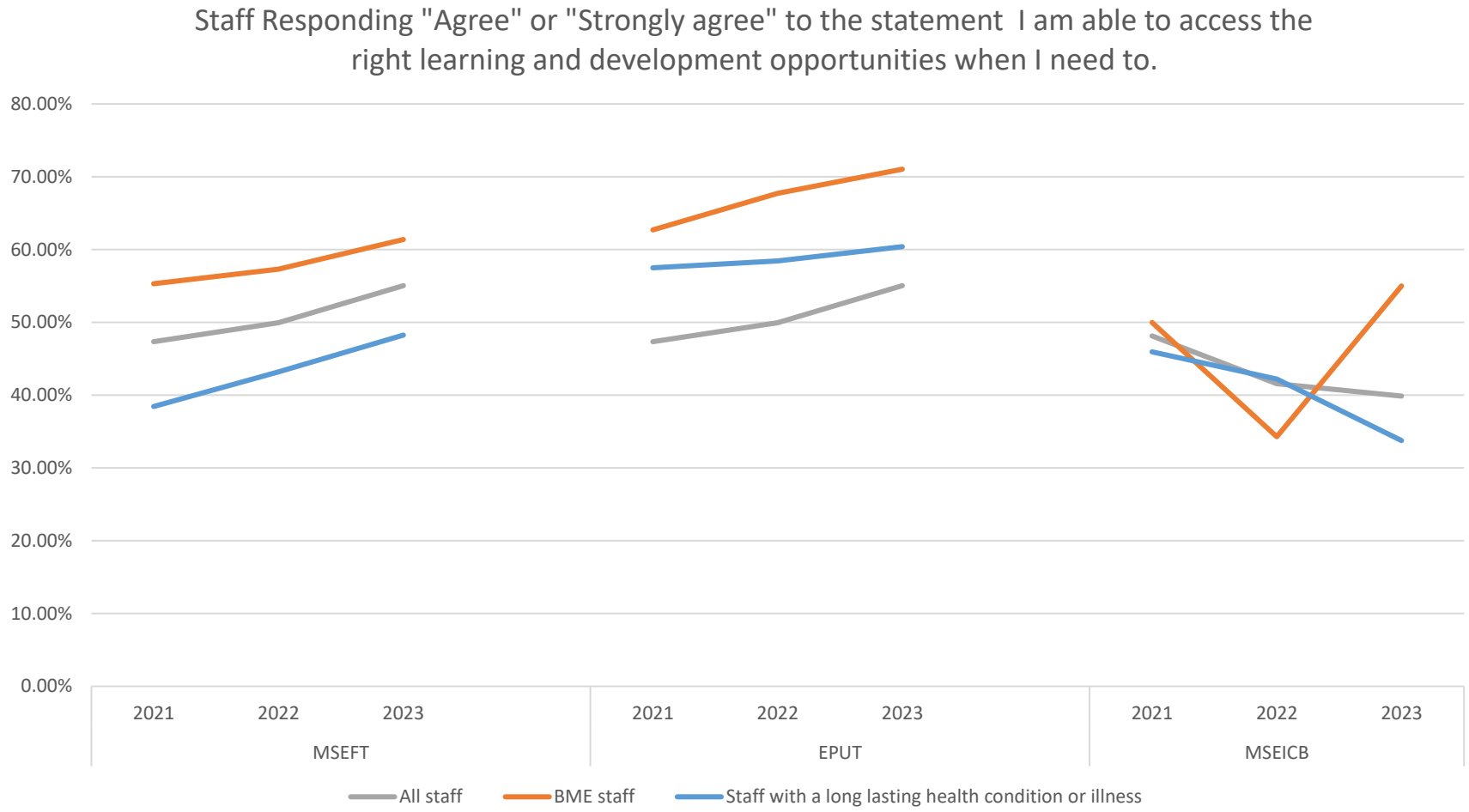


Action 2

Slide 11

2023 NHS staff survey

The graph shows staff agreement with the statement "I am able to access the right learning and development opportunities when I need to." All organisations have improved. BAME staff consistently have higher agreement rates than all staff in 2023.



Action 3 Summary

3

Develop and implement an improvement plan to eliminate pay gaps.

MSE ICB

While the MSE ICB's gender pay gap remains wider than the NHS England average by approximately 6 percentage points, there have been gradual improvements observed in this metric over the past few years. When compared to other ICBs, MSEFT's gender pay gap is situated in the middle range.

MSEFT

MSEFT, despite its progress in reducing the gender pay gap, continues to have the highest gap among the Integrated Care System (ICS) and ranks within the highest quartiles of trusts in NHS England.

EPUT

EPUT, while experiencing a slight increase in its gender pay gap from 2022 to 2023, continues to outperform the national average for NHS England. The trust's gap currently falls within the second quartile, indicating a mid-lower quartile ranking among NHS trusts.

PROVIDE

Awaiting data

Action 3

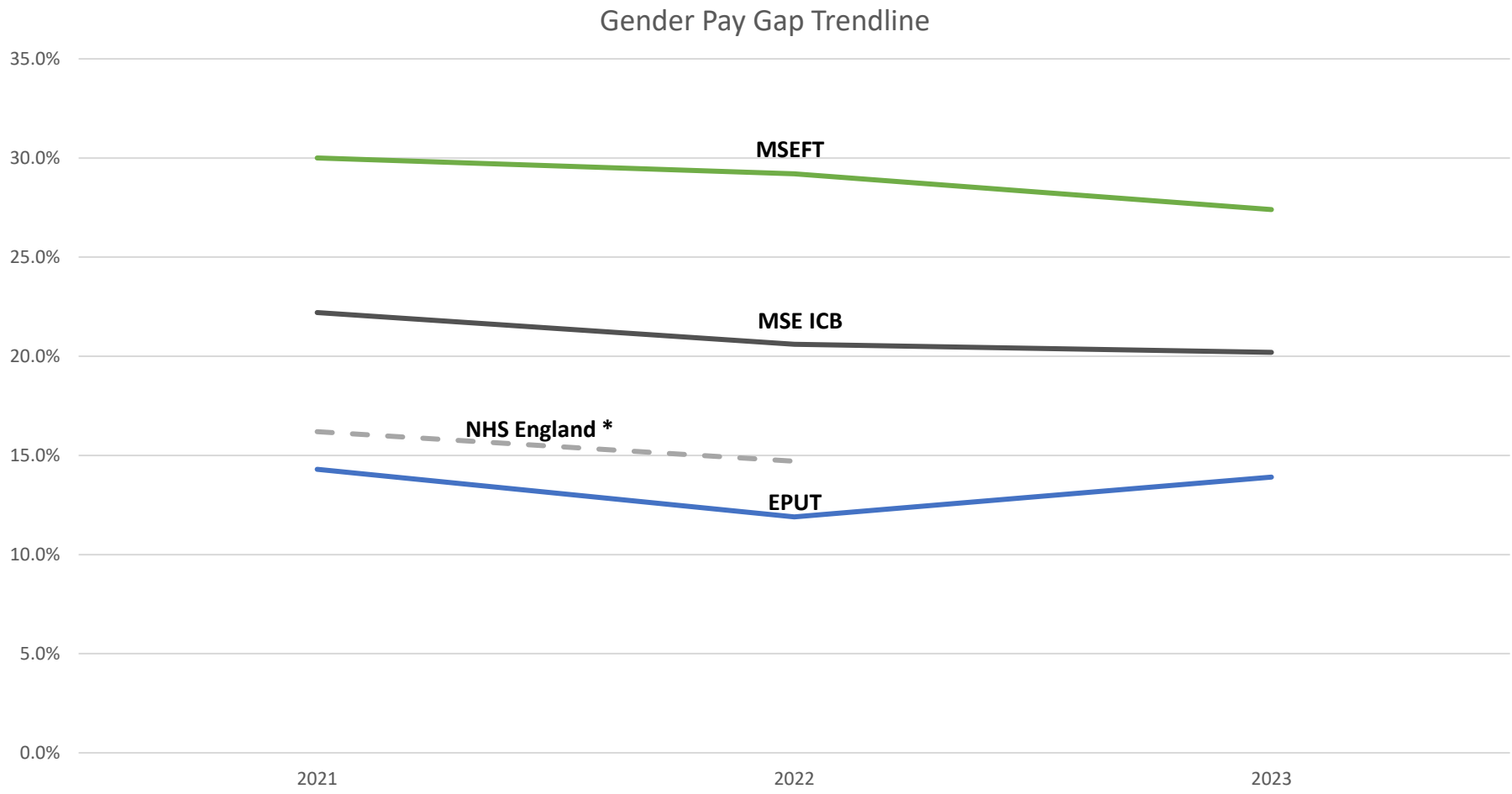
Slide 13

Pay gap Report

This graph illustrates the gender pay gap at MSE ICB, MSEFT, and EPUT, and how it has changed over time compared to the NHS England average.

Gender Pay Gap.

Higher percentages of the gender pay gap indicate a significant disparity in earnings between men and women



*NHS England 2023 Data not yet published

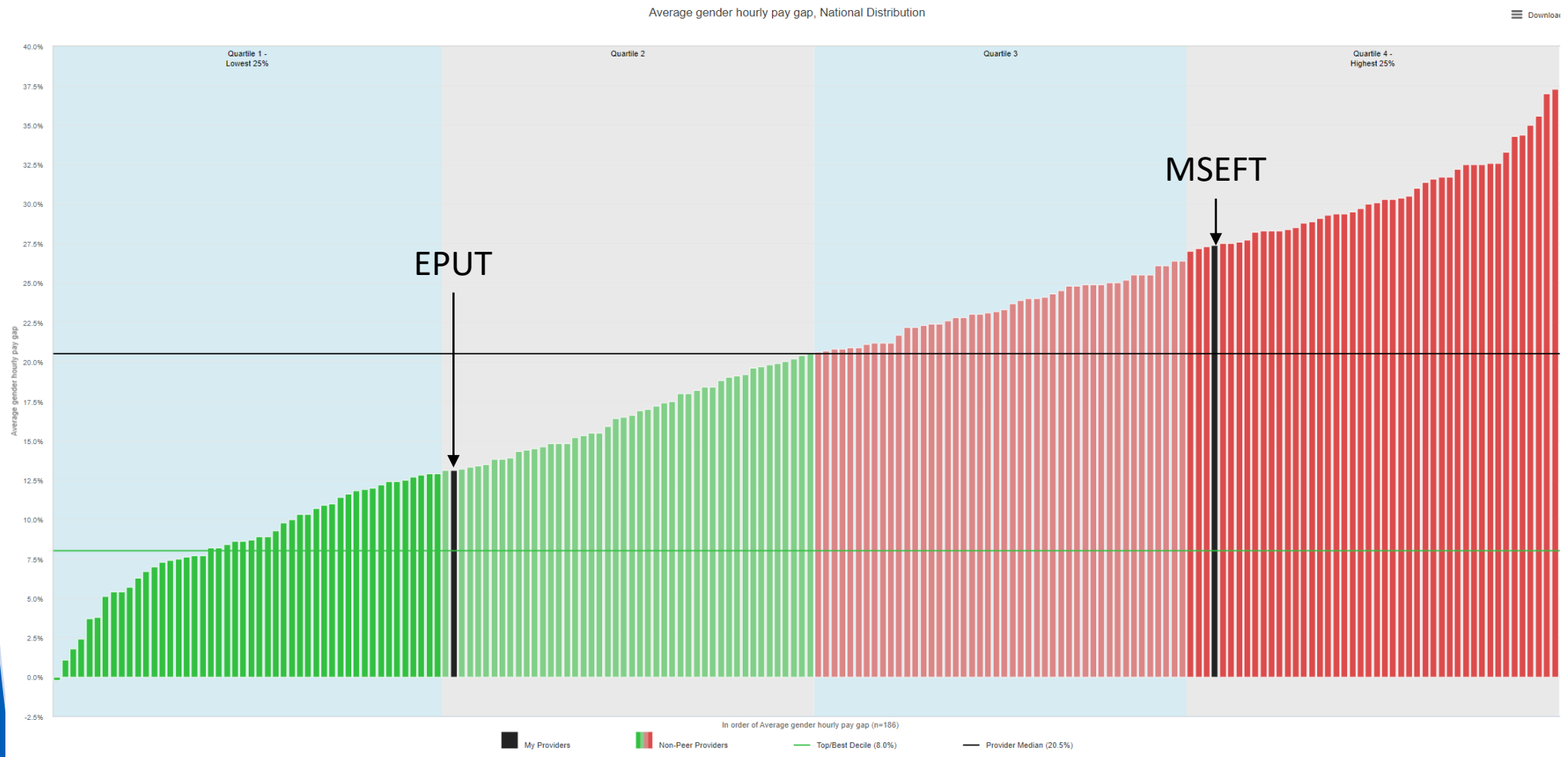
Action 3

Slide 14

Pay gap Report

This graph illustrates the gender pay gap at MSEFT and EPUT compared to other NHS England Trusts (red and green bars). The black bar represents our organisation.

How does our organisation compare to other trusts in terms of the gender pay gap (MSEFT and EPUT)?



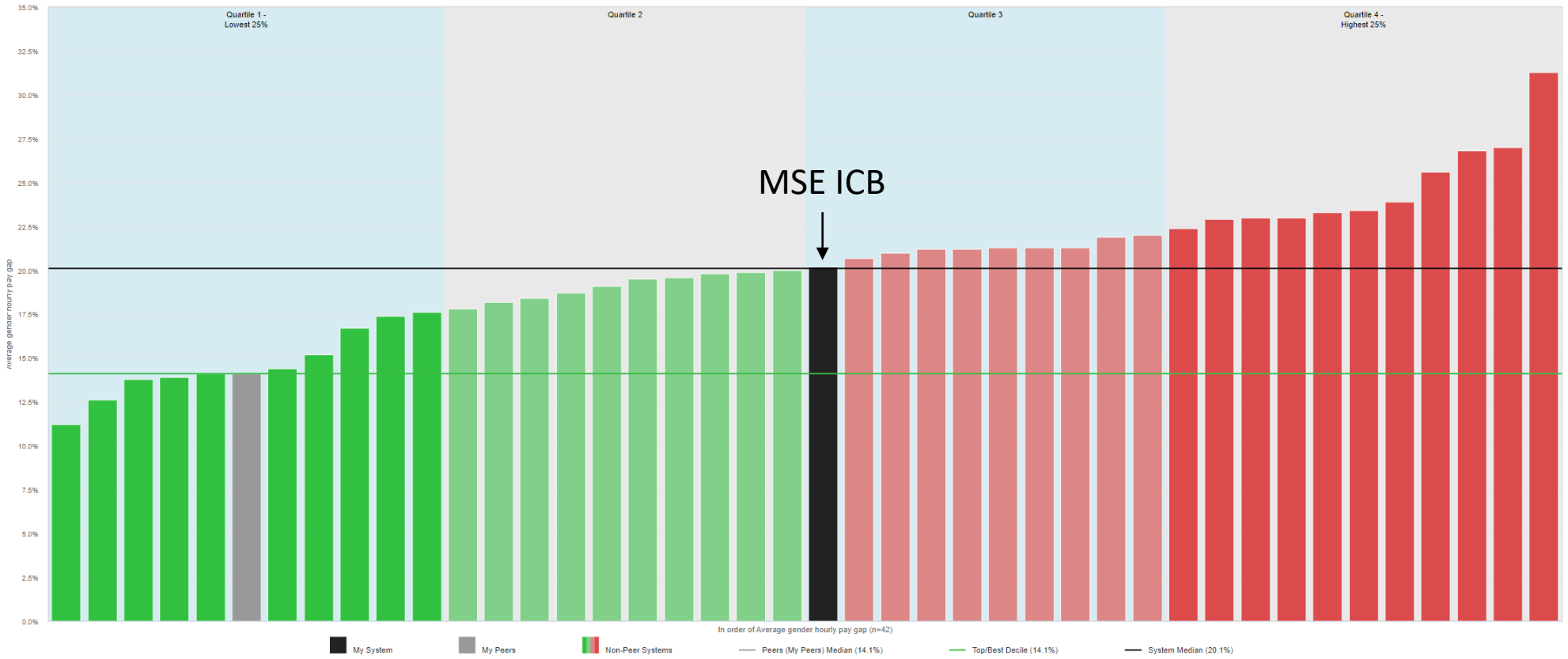
Action 3

Slide 15

Pay gap Report

This graph illustrates the gender pay gap at MSE ICB compared to other NHS England ICBs (red and green bars). The black bar represents our organisation.

How does our organisation compare to other ICBs in terms of the gender pay gap (MSE ICB)?



Action 4 Summary

4 Develop and implement an improvement plan to address health inequalities within the workforce.

MSE ICB

MSE ICB saw a sharp decline in 2022 in staff's perception of organisational health and well-being interest, though it has improved since. Despite this, staff generally appreciate their line managers' interest. The sickness rate for staff with disabilities has returned to the overall level after a peak in December 2023 (Slides 1,2,4)

MSEFT

While still low, MSEFT has seen an increase in staff's belief that the organisation and line managers are interested in their health and well-being. Additionally, sickness rates have decreased since their peak in December 2023.

EPUT

EPUT has seen a steady increase since 2022 in staff's belief that the organisation and line managers are interested in their health and well-being. While the sickness rate remains higher than other ICS organisations, it is within the typical range for mental health trusts.

PROVIDE

The current data is limited to one survey and one data point. However, the available data suggests a 11-percentage point difference between staff with disabilities and their counterparts in their perception of health inequalities within the workforce. There is no noticeable difference between BAME and White staff in this regard.

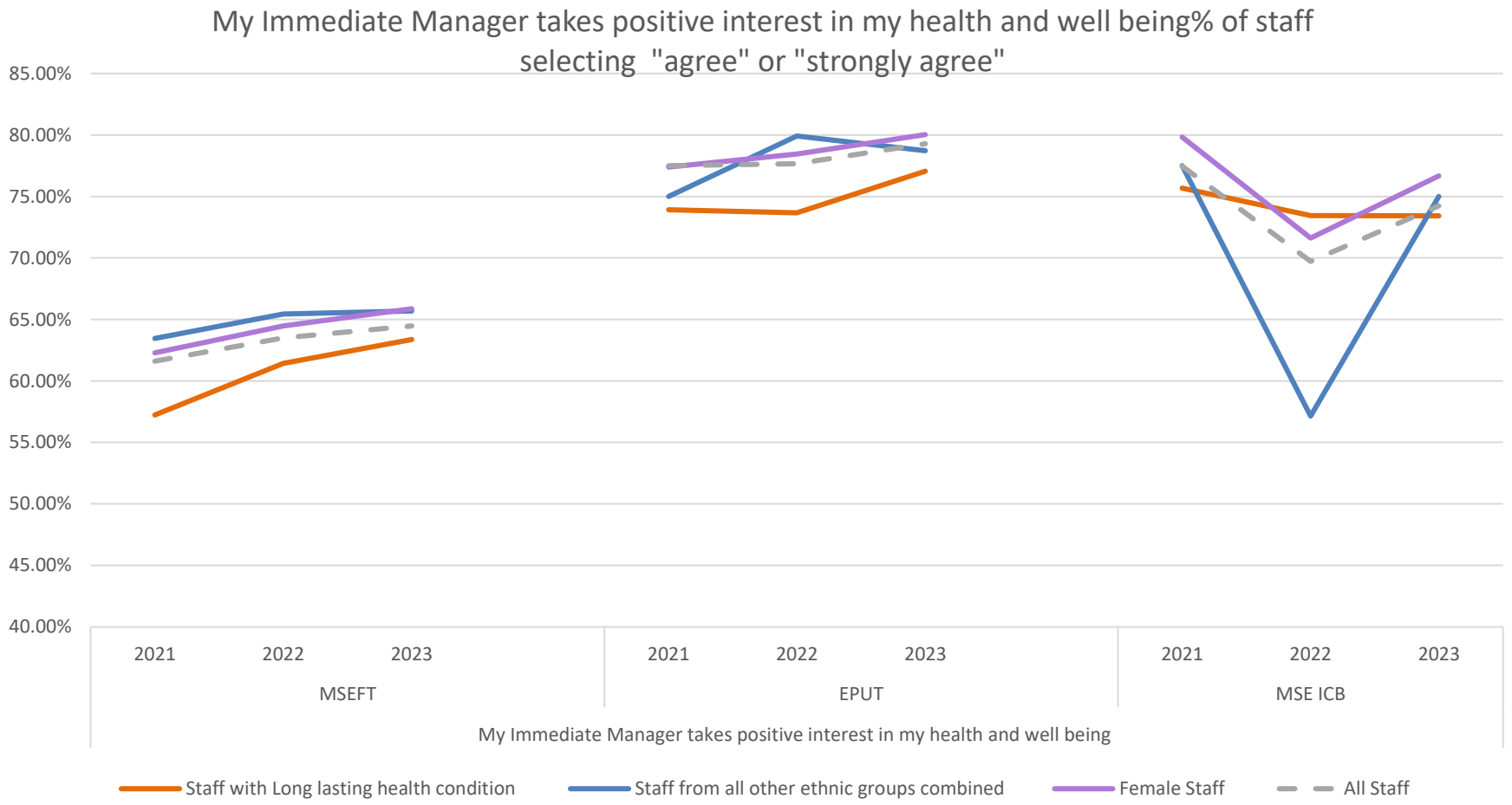
Action 4

Slide 17

2023 NHS staff survey

This graph illustrates the percentage of staff who agreed with the statement **'My Immediate Manager** takes a positive interest in my health and well-being.' From left to right, MSEF had the lowest agreement rate at 64%, followed by MSE ICB at 74.2%, and EPUT with the highest agreement at 79.3%. Notably, the differences in agreement rates between staff living with disabilities, BAME staff, and all staff were minimal.

The percentage of staff that agreed with the sentence: My Immediate Manager takes positive interest in my health and well-being



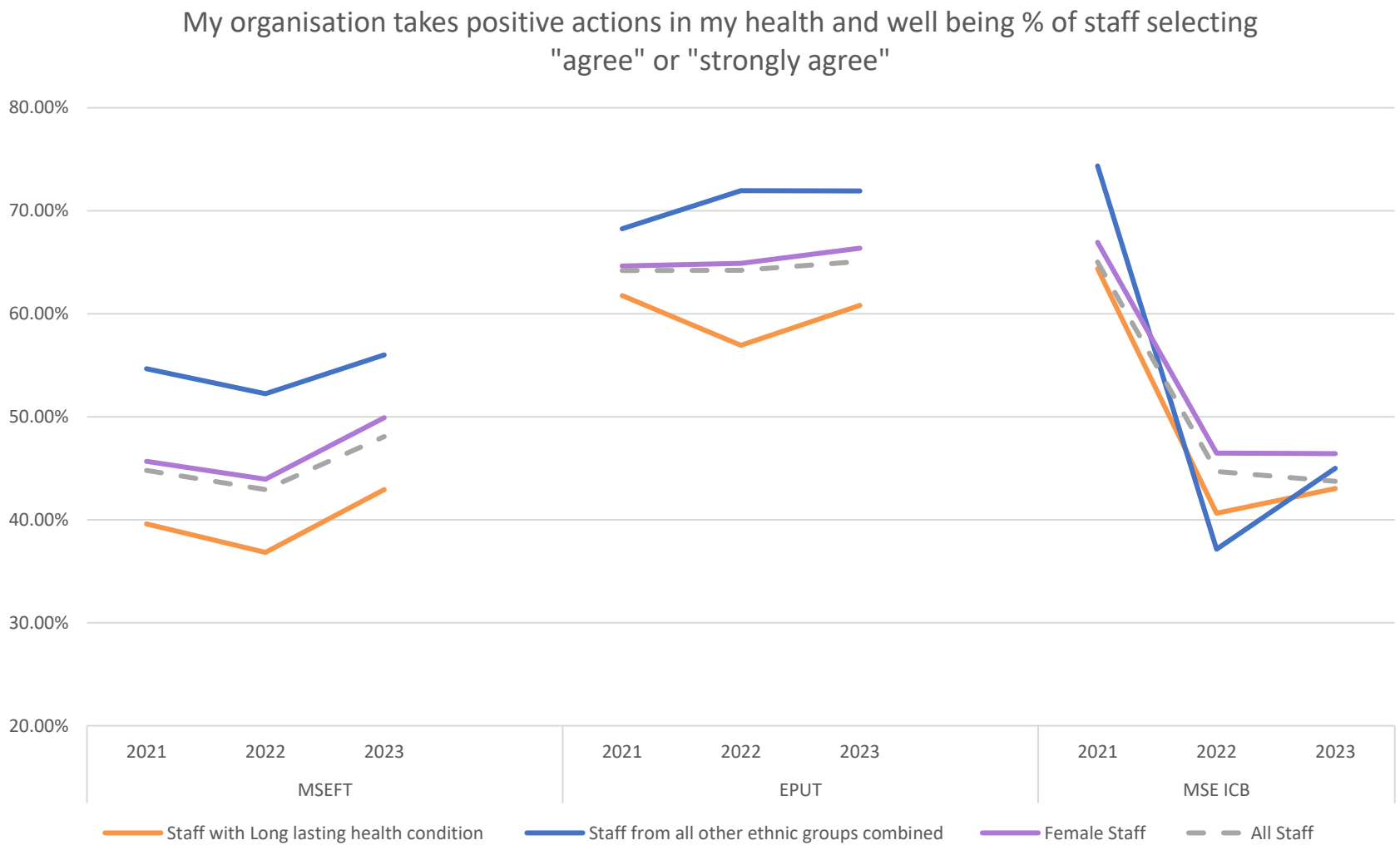
Action 4

Slide 18

2023 NHS staff survey

This graph illustrates the percentage of staff who agreed with the statement '**My organisation** takes positive actions in my health and well-being.' From left to right, MSE ICB had the lowest agreement rate at 43%, followed by MSEFT at 48%, and EPUT with the highest agreement at 65%. Unlike the previous slide, the differences in agreement rates between staff living with disabilities, BAME staff, and all staff were significant. BAME staff were more likely to agree with the statement, while staff living with disabilities were less likely to do so.

The percentage of staff that agreed with the sentence: My organisation takes positive actions in my health and well-being



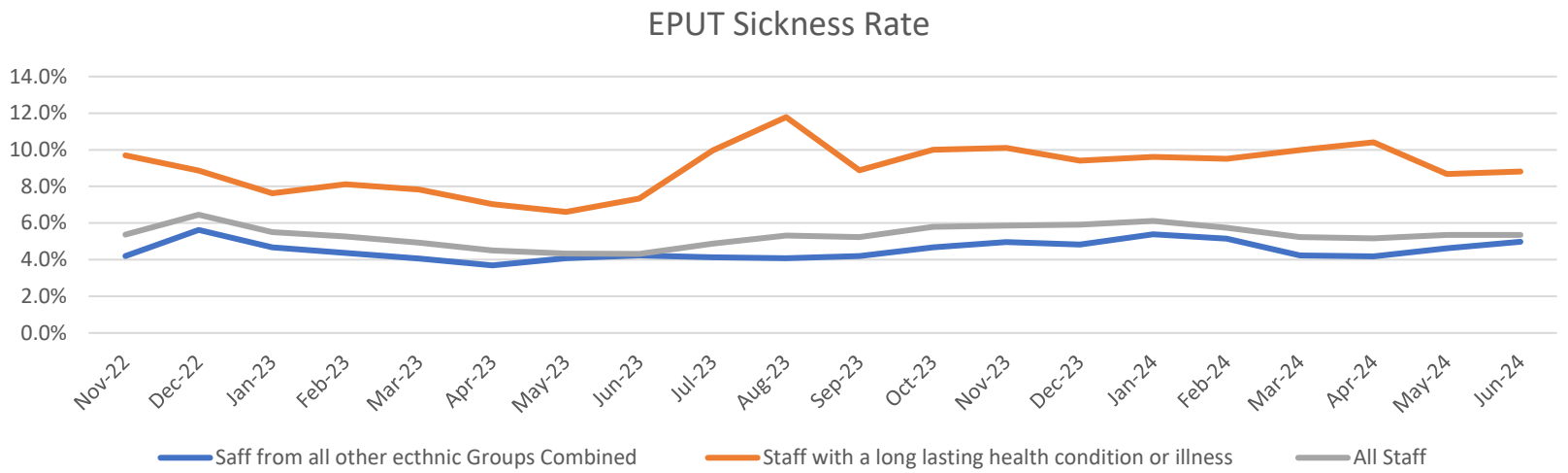
Action 4

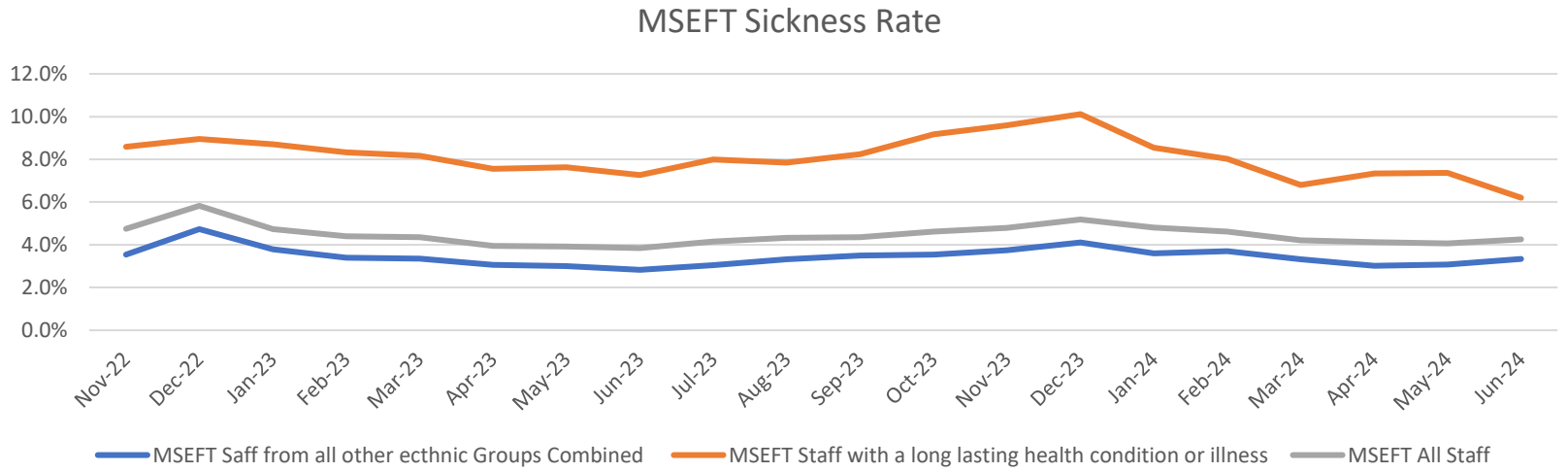
Slide 19

ESR Data

The Top Graph shows the sickness rate since November 2022 for EPUT, which has been between 4 % and 6 % for all staff. Staff with disabilities have experienced a higher rate, ranging from 8 % to 10 %. While MSEFT staff with disabilities also exhibit a higher sickness rate compared to their non-disabled colleagues, the overall sickness rate for MSEFT staff is slightly lower than that of EPUT.

Sickness rate in the last year broken down by Staff with long-term health conditions or illnesses, and BAME staff members.





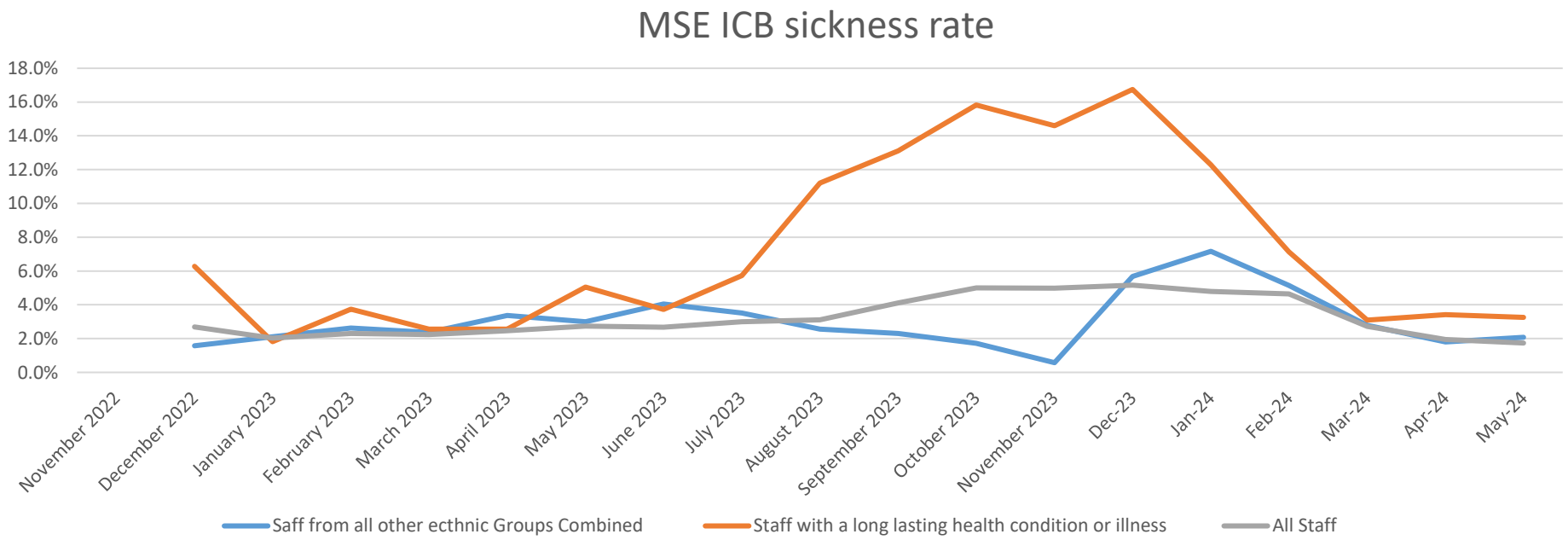
Action 4

Slide 20

ESR Data

This graph illustrates sickness rates over the past two years for BAME staff (blue), staff with disabilities (orange), and all staff (grey).

Sickness rate over time



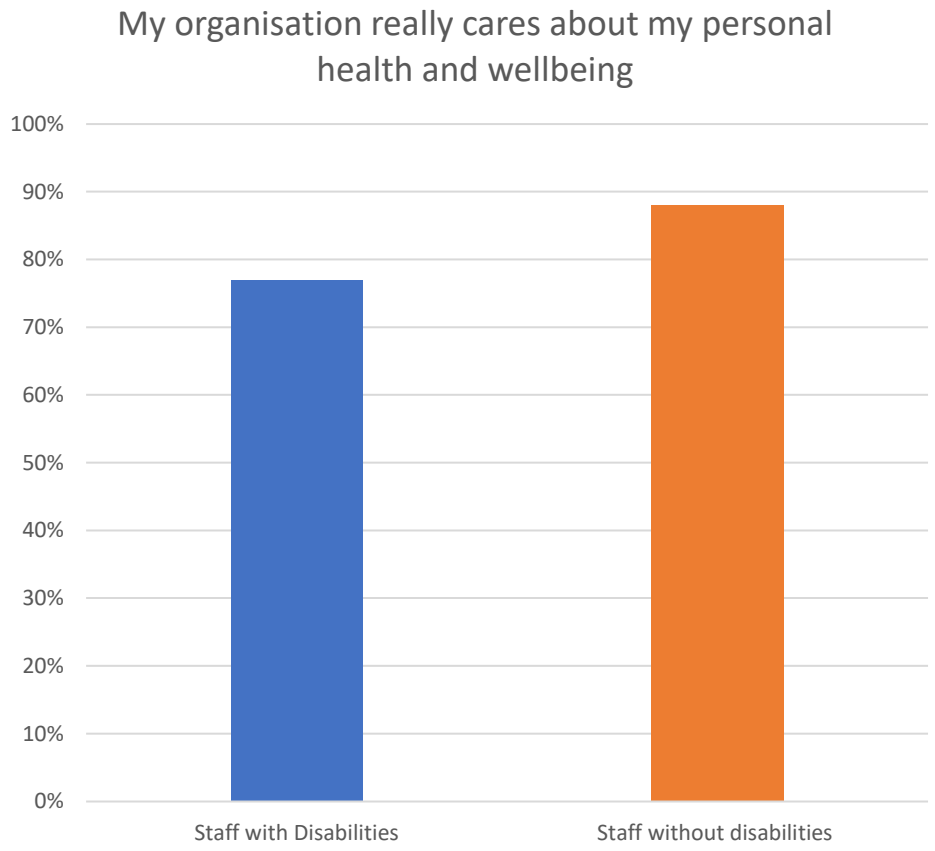
Action 4

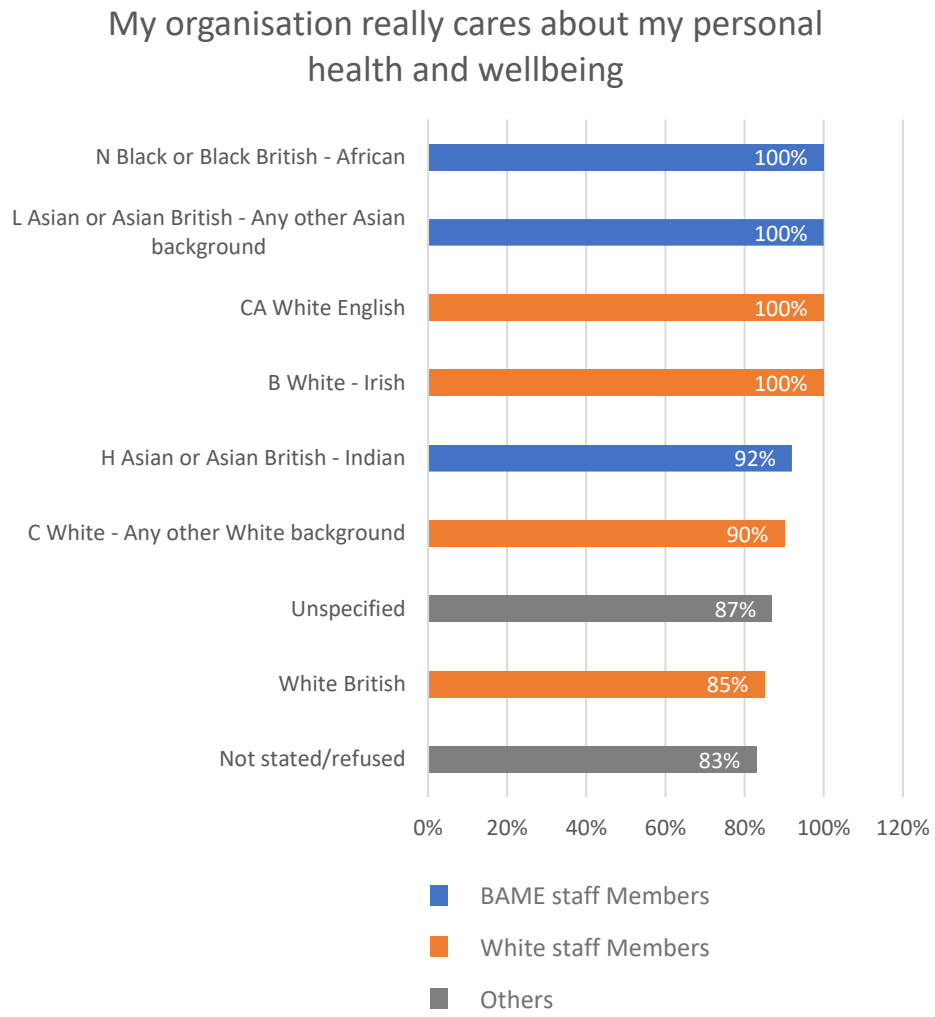
Slide 21

Provide Engagement survey.

The first chart (left) compares the responses of staff with disabilities and staff without disabilities to the question 'My organisation really cares about my personal health and wellbeing.' The second chart presents the same data broken down by ethnicity.

Provide Community Data





Action 5 Summary

5

Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

MSE ICB

No data were available for internationally recruited staff in the 2023 NHS Staff Survey for MSE ICB.

MSEFT

Internationally trained staff at MSEFT continue to face higher rates of bullying, harassment, or abuse from colleagues than domestic staff, with incidents from managers increasing. Domestic staff turnover is decreasing, while international staff turnover remains stable, widening the gap

EPUT

International staff at EPUT are more likely to experience bullying, harassment, or abuse from colleagues and less likely to feel a strong sense of belonging within their teams. Moreover, international staff turnover has increased significantly since February 24, surpassing domestic staff turnover by 9 percentage points.

PROVIDE

Awaiting data

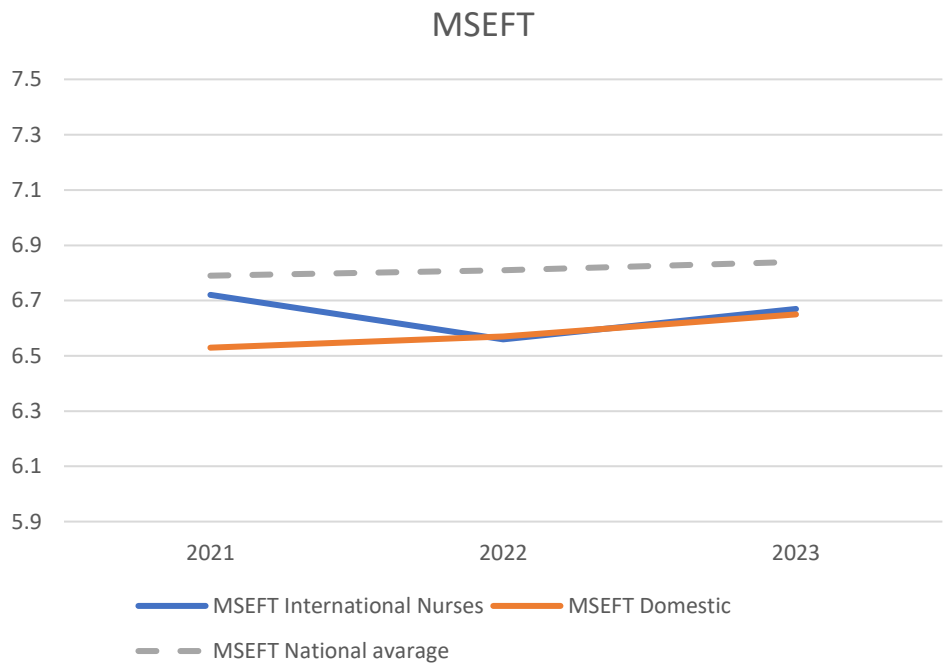
Action 5

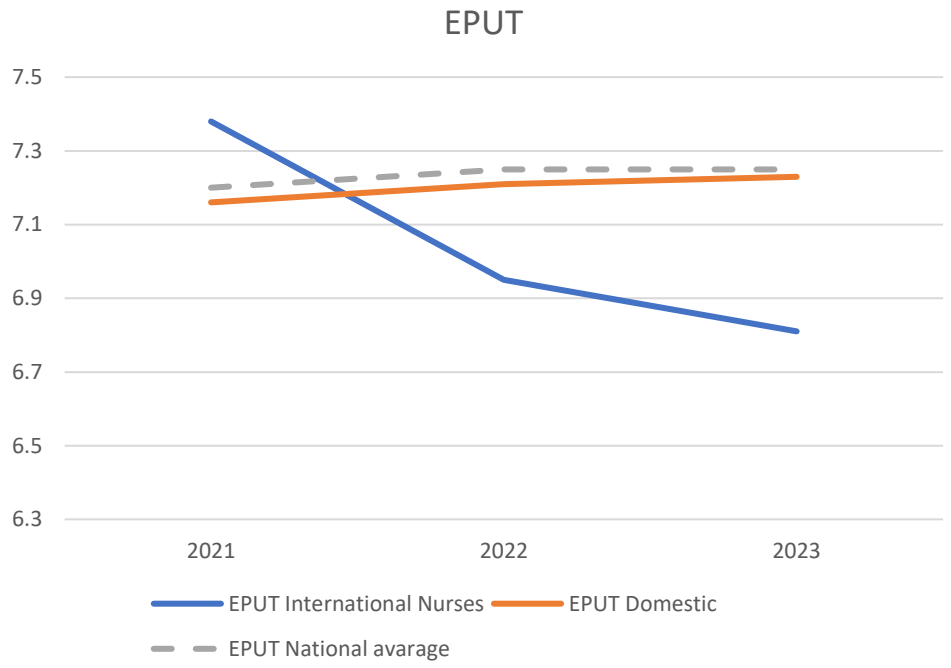
Slide 23

2023 NHS staff survey

These graphs illustrate changes in the inclusion score over time, calculated based on responses to the following questions: 'I feel valued by my team,' 'I feel a strong personal attachment to my team,' 'The people I work with are understanding and kind to one another,' and 'The people I work with are polite and treat each other with respect.'.

Sense of inclusions for internationally recruited staff





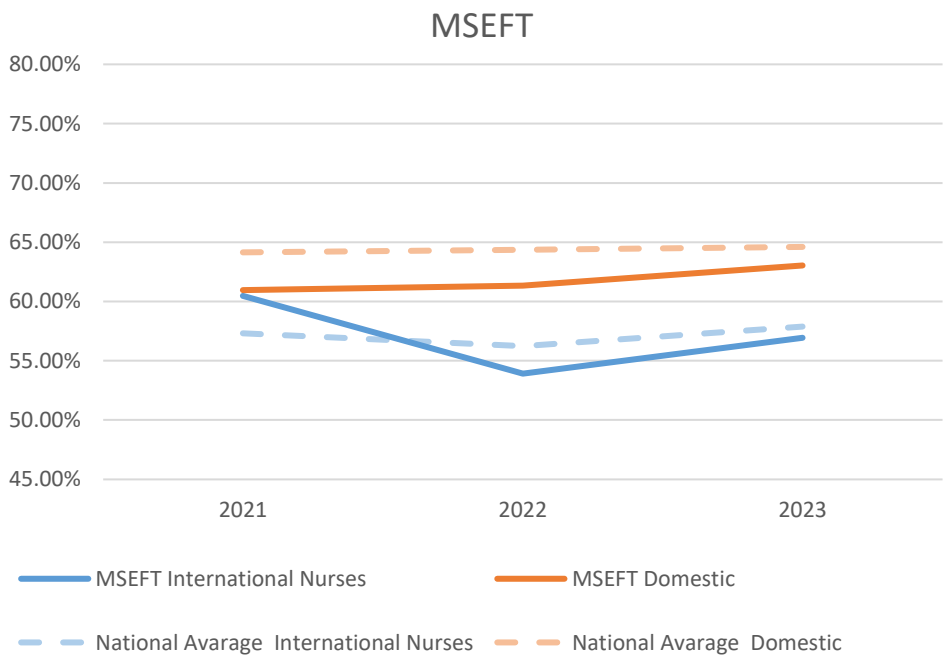
Action 5

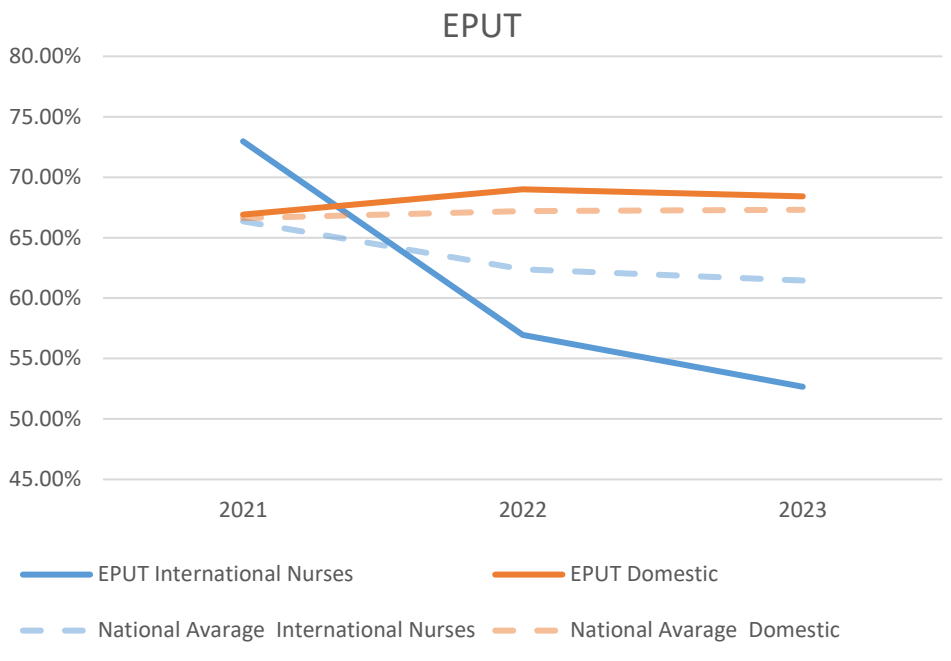
Slide 24

2023 NHS staff survey

This graph compares the responses of internationally trained (blue) and domestic nurses (orange) to the question 'I feel a strong personal attachment to my team' comparing them to their respective benchmark groups (dotted lines).

Percentage of staff members respond “Yes” to the question “I feel a strong personal attachment to my team”





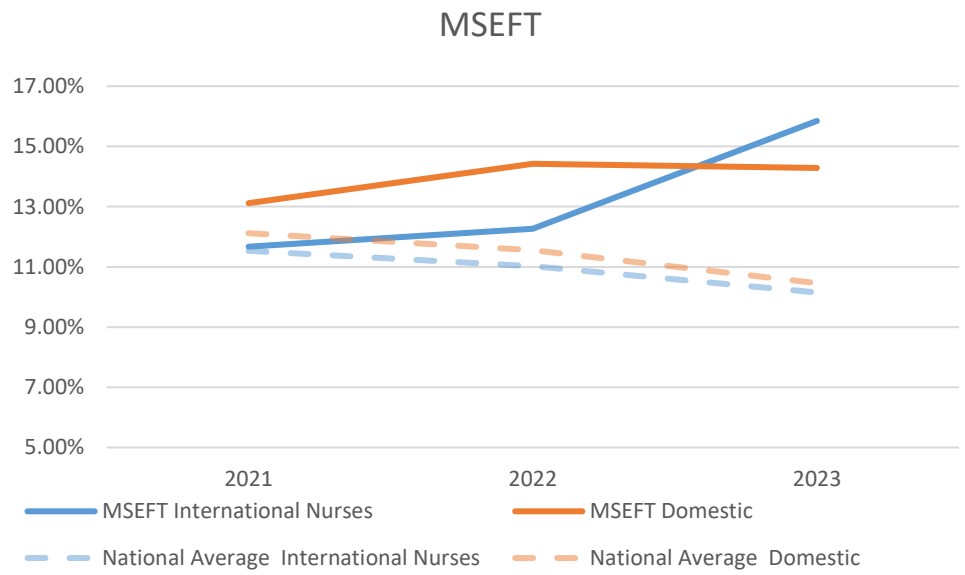
Action 5

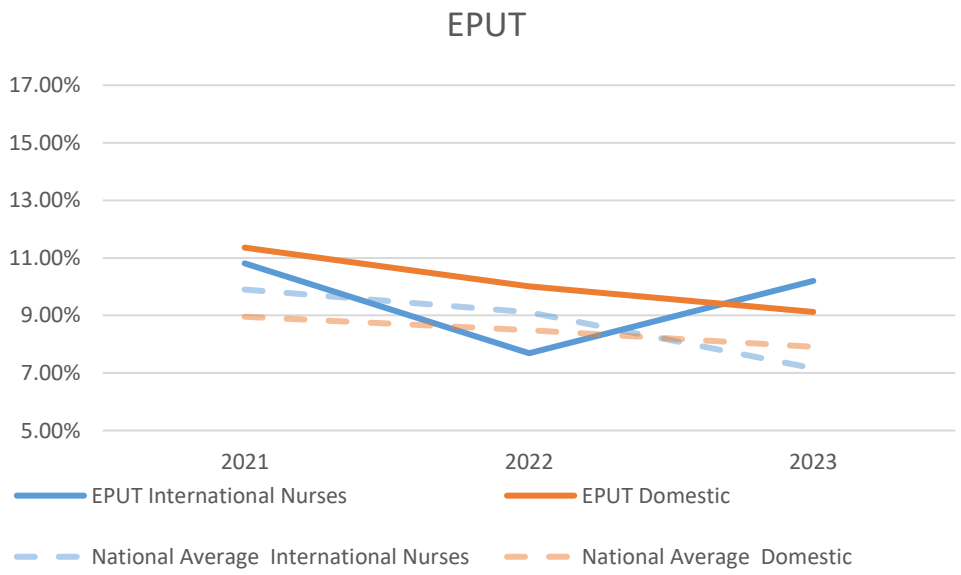
Slide 25

2023 NHS staff survey

This graph compares the number of incidents of bullying, harassment, or abuse **by managers** in the past 12 months for internationally trained (blue) and domestic colleagues (orange), and compares them to the benchmark group (dotted lines).

Percentage of staff having experienced at least one incident of bullying, harassment, or abuse by managers in the last year.





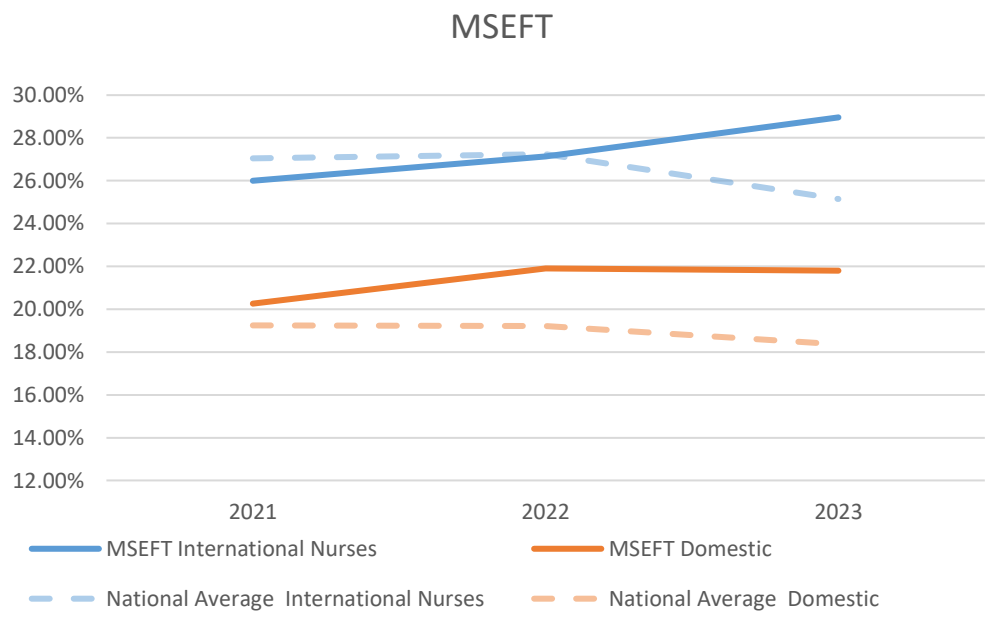
Action 5

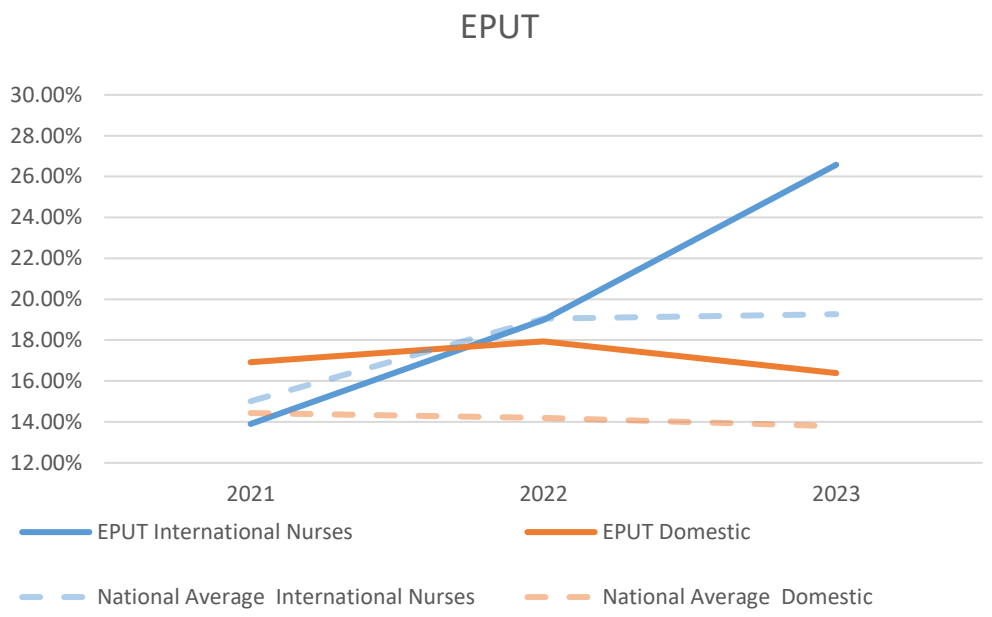
Slide 26

2023 NHS staff survey

This graph compares the number of incidents of bullying, harassment, or abuse **by colleagues** in the past 12 months for internationally trained (blue) and domestic colleagues (orange), and compares them to the benchmark group (dotted lines).

Percentage of staff having experienced at least one incident of bullying, harassment, or abuse by other colleagues in the last year.





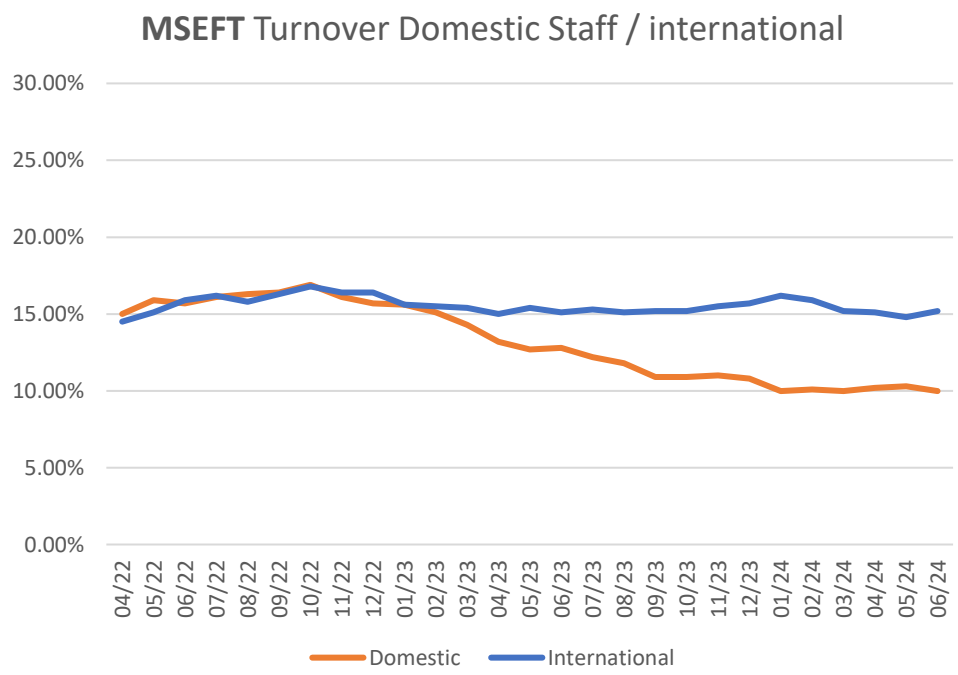
Action5

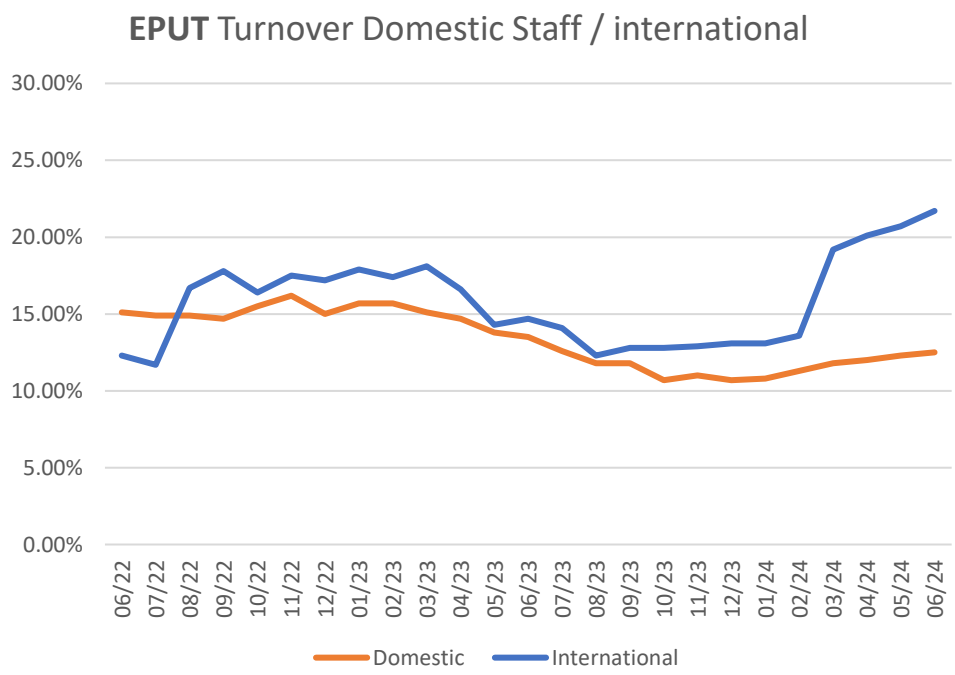
Slide 27

ESR
NHS Eproduct

These graphs illustrate the change in turnover rates for internationally trained (blue) and domestic (orange) nurses over the past two years.

International / Domestic Recruited staff Turnover comparison





Action 6 Summary

6

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

MSE ICB

While incidents of bullying, harassment, or abuse (BHA) remain above benchmark levels, the ICB has seen a positive trend in the past year with a decrease in BHA incidents from colleagues. However, this is counterbalanced by a rise in BHA incidents reported by members of the public.

MSEFT

Although incidents of bullying, harassment, or abuse (BHA) remain largely above the benchmark, MSEFT has experienced a decline in BHA incidents from members of the public. Conversely, similar incidents from managers and colleagues have been on the rise.

EPUT

EPUT has seen a decrease in all types of bullying, harassment, or abuse (BHA) incidents. While still above the benchmark, the gap has narrowed.

PROVIDE

The current data is limited to one survey and one data point. However, from the last Staff engagement survey emerged that staff with disability and BAME staff is on average more likely to experience Discrimination within the Company.

Action 6

Slide 29

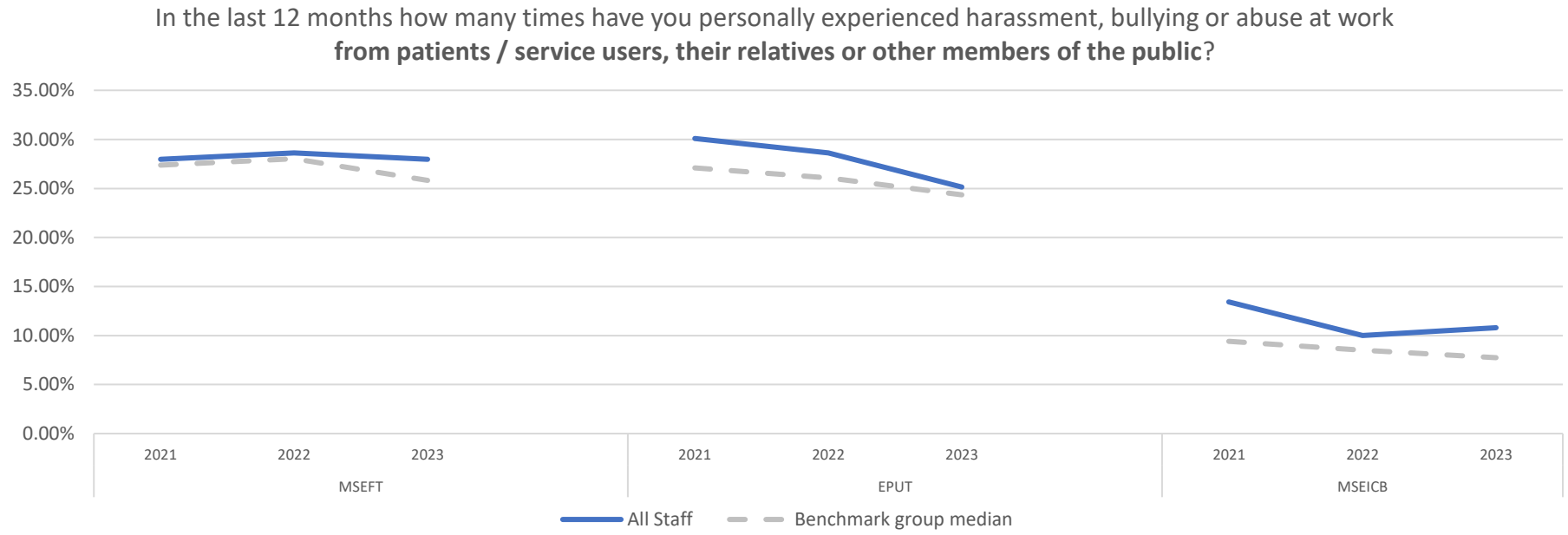
2023 NHS staff survey

This graph shows the percentage of staff within each organisation who have experienced harassment, bullying, or abuse **from patients, relatives, or the public.** The Grey dotted line represents the benchmark median.

Every organisation has a higher incidence of harassment, bullying, or abuse than the benchmark. MSEFT and EPUT have seen a decrease from 2022 while MSEICB has seen an increase

Percentage of staff having experienced at least one incident of bullying, harassment, or abuse in the last year by

- Managers
- Other colleagues
- Patients/service users, their relatives or other members of the public.

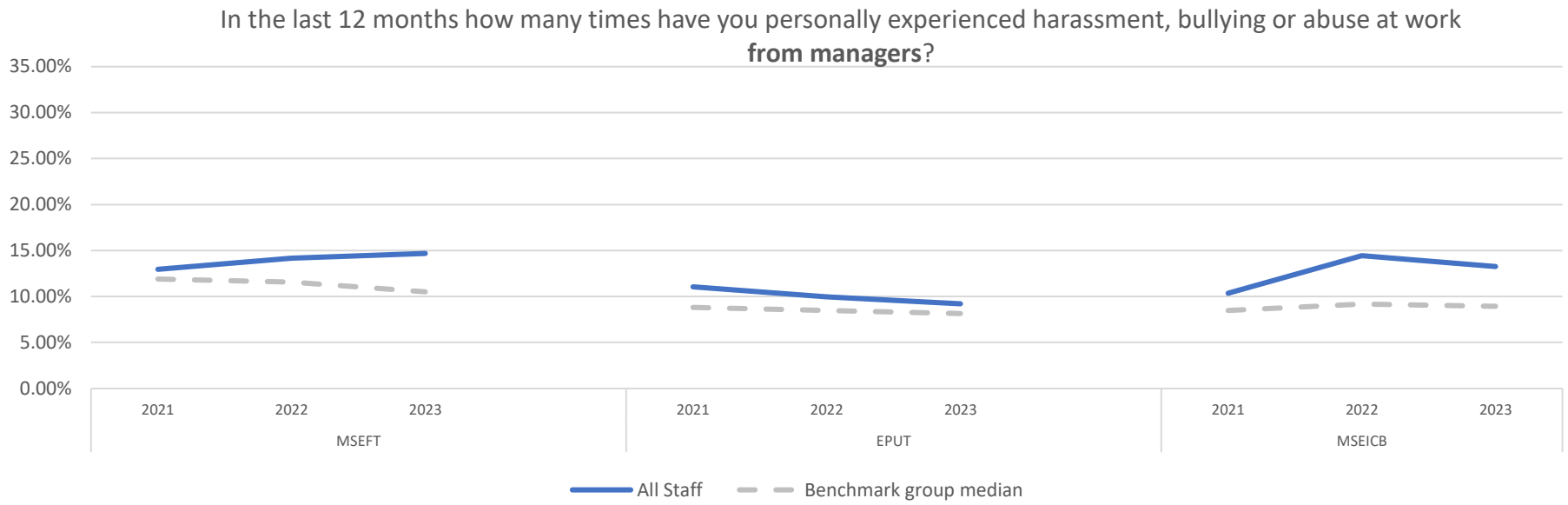


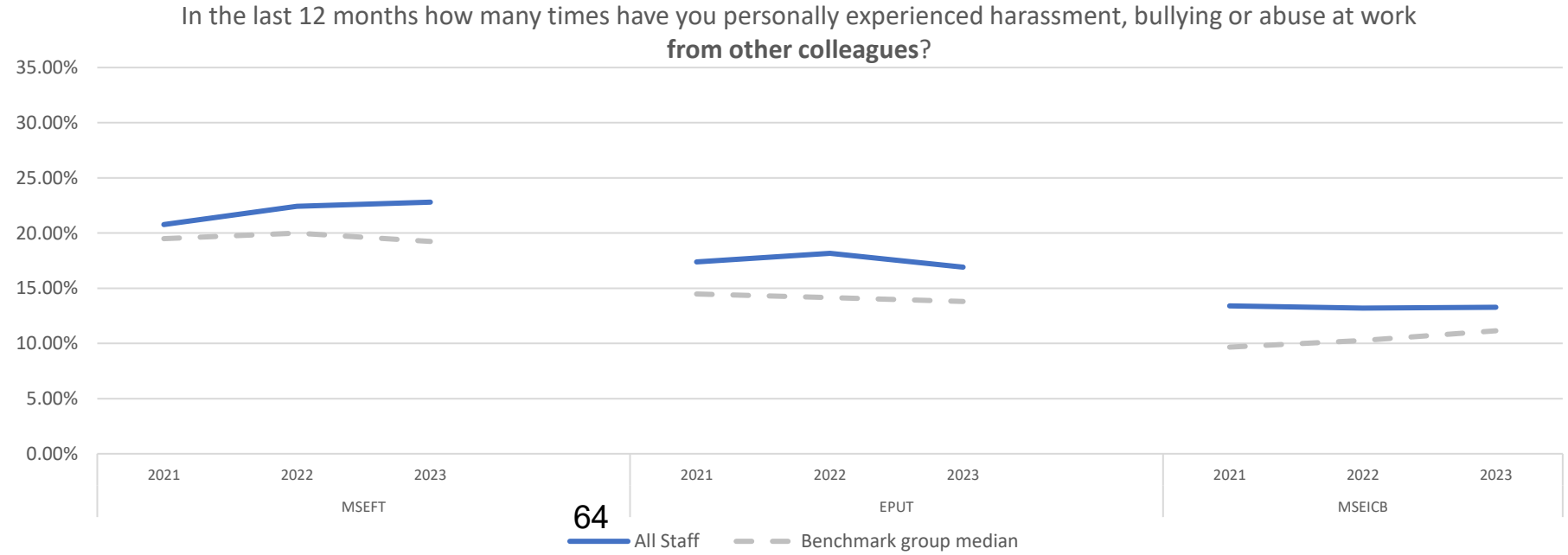
Action 6

Slide 30

2023 NHS staff survey

Similar to the previous graph, the top graph shows incidents of harassment, bullying, or abuse from managers, while the bottom graph shows these incidents from colleagues.





Action 6

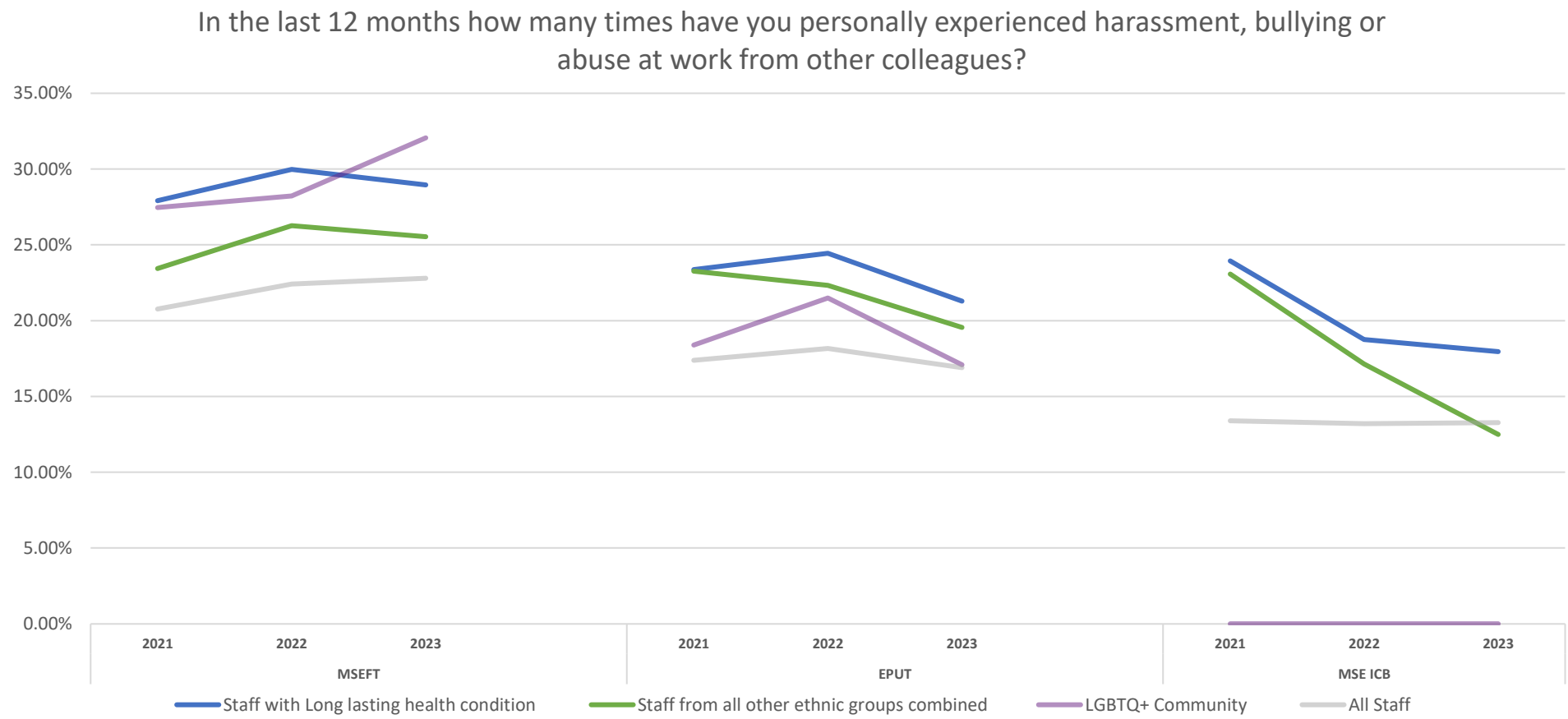
Slide 31

2023 NHS staff survey

This graph compares the rates of harassment, bullying, or abuse experienced by different staff categories (staff with disabilities, BAME staff, LGBTQ+ staff) within each organisation.

Staff with long-lasting conditions and non-white staff members are more likely to experience harassment, bullying or abuse at work from other colleagues than average.

Bullying from Colleagues in our organisation, broken down by Long-lasting conditions and Ethnic Groups combined.



Action 6

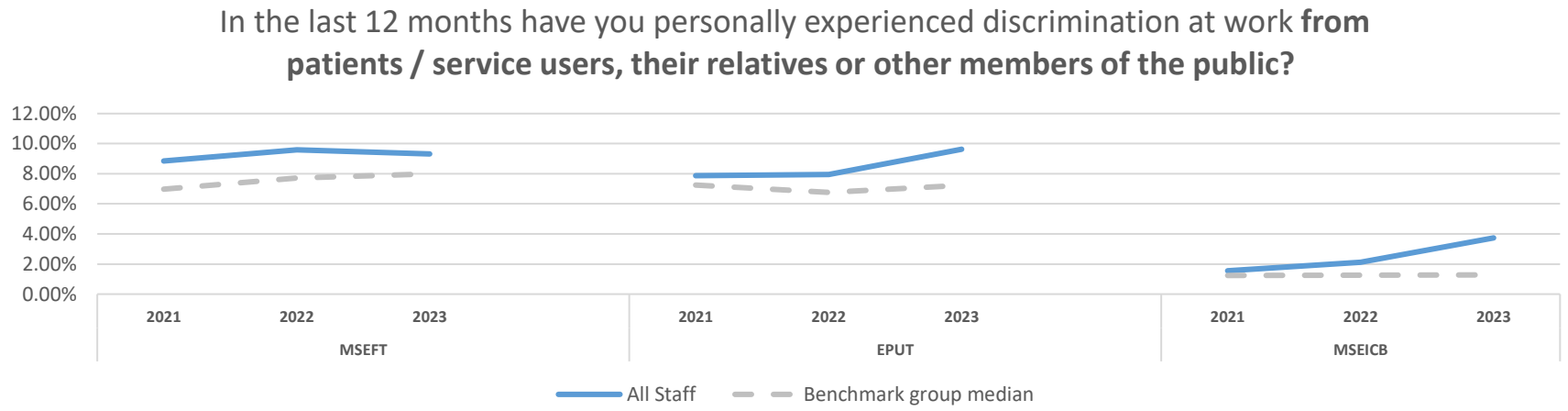
Slide 32

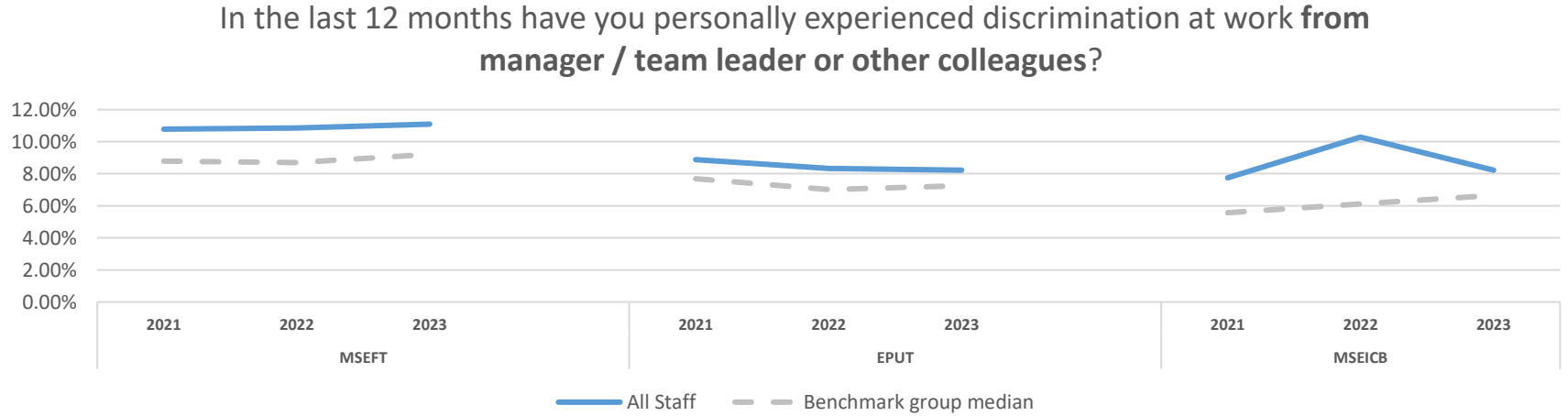
2023 NHS staff survey

Compare the percentage of staff experiencing discrimination within our organisations. The top graph shows discrimination from members of the public, while the bottom chart shows discrimination from colleagues.

Percentage of staff having experienced discrimination by:

- Patients/service users, their relatives or other members of the public.
- Manager/team leader or other colleagues



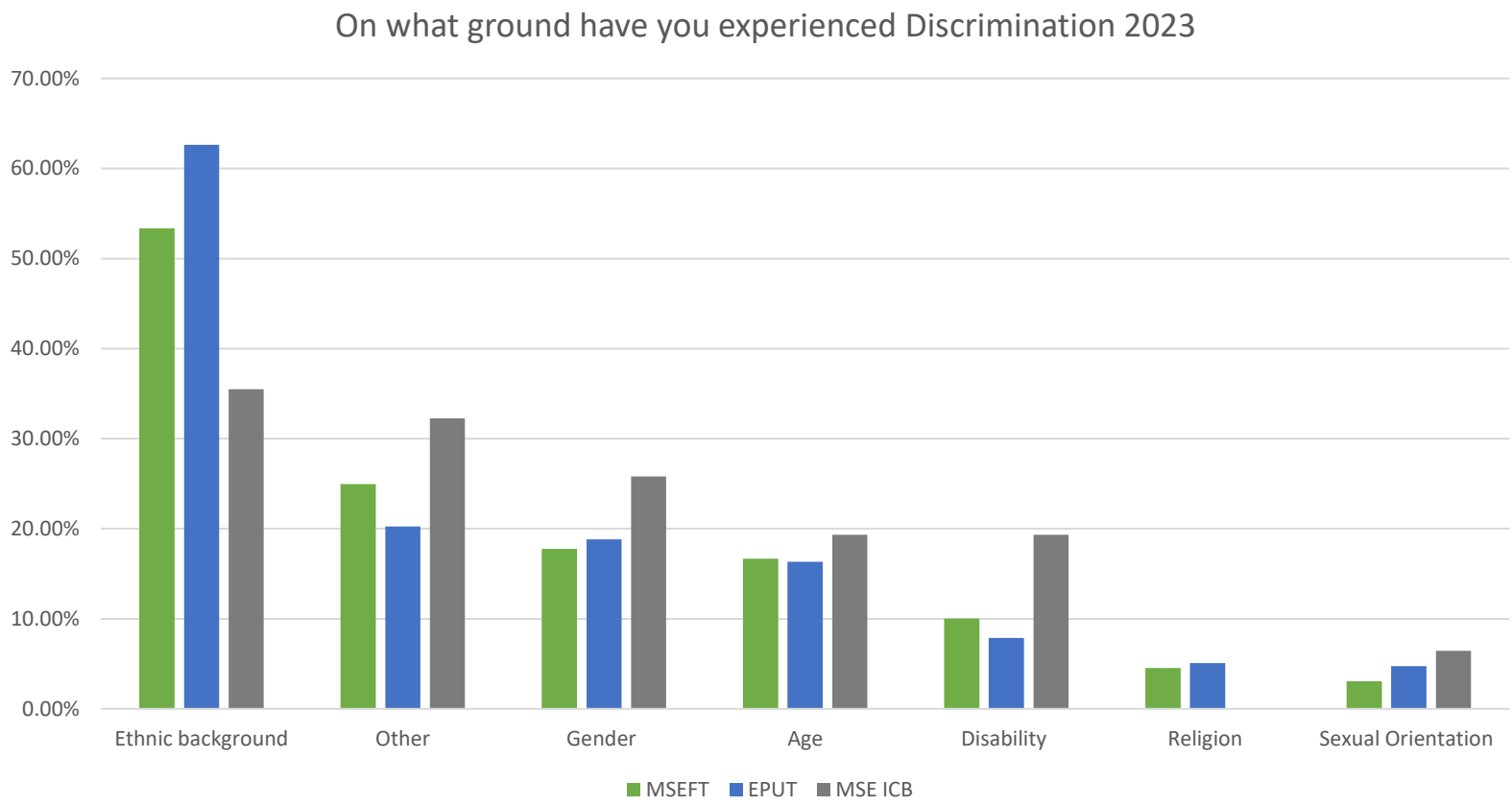


Action 6

Slide 33

2023 NHS staff survey

The graphs show the grounds on which discrimination was experienced. For all three organisations, ethnic background appears to be the primary basis for discrimination.



Action 6

Slide 34

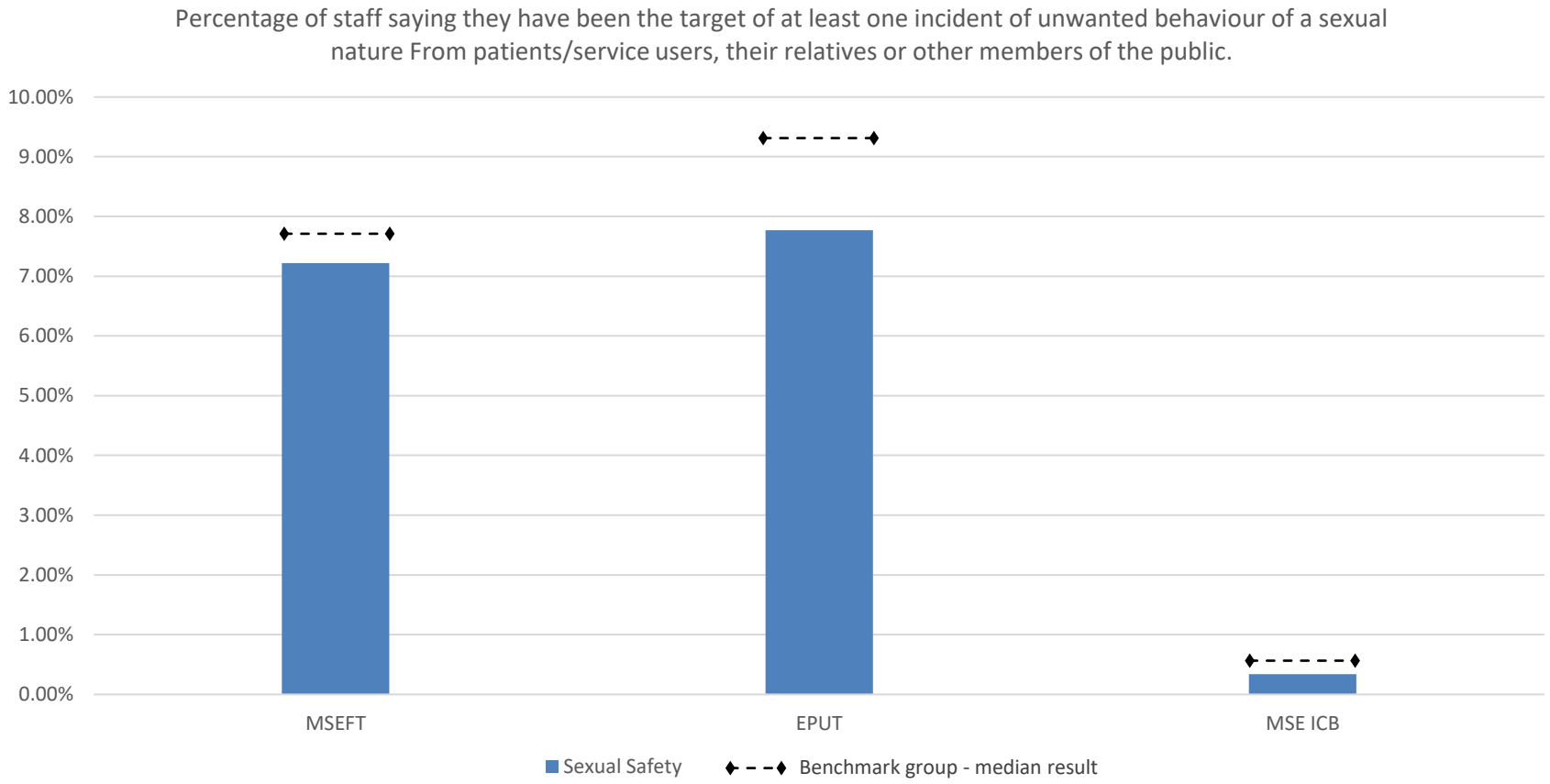
2023 NHS staff survey

This graph shows the percentage of staff members experiencing inappropriate sexual behaviour **from members of the public**. The dotted black line represents the benchmark group median.

All organisations reported fewer instances of inappropriate sexual behaviour than the benchmark median.

Percentage of staff saying they have been the target of at least one incident of unwanted behaviour of a sexual nature.

Answer to the question: In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From patients/service users, their relatives or other members of the public.



Action 6

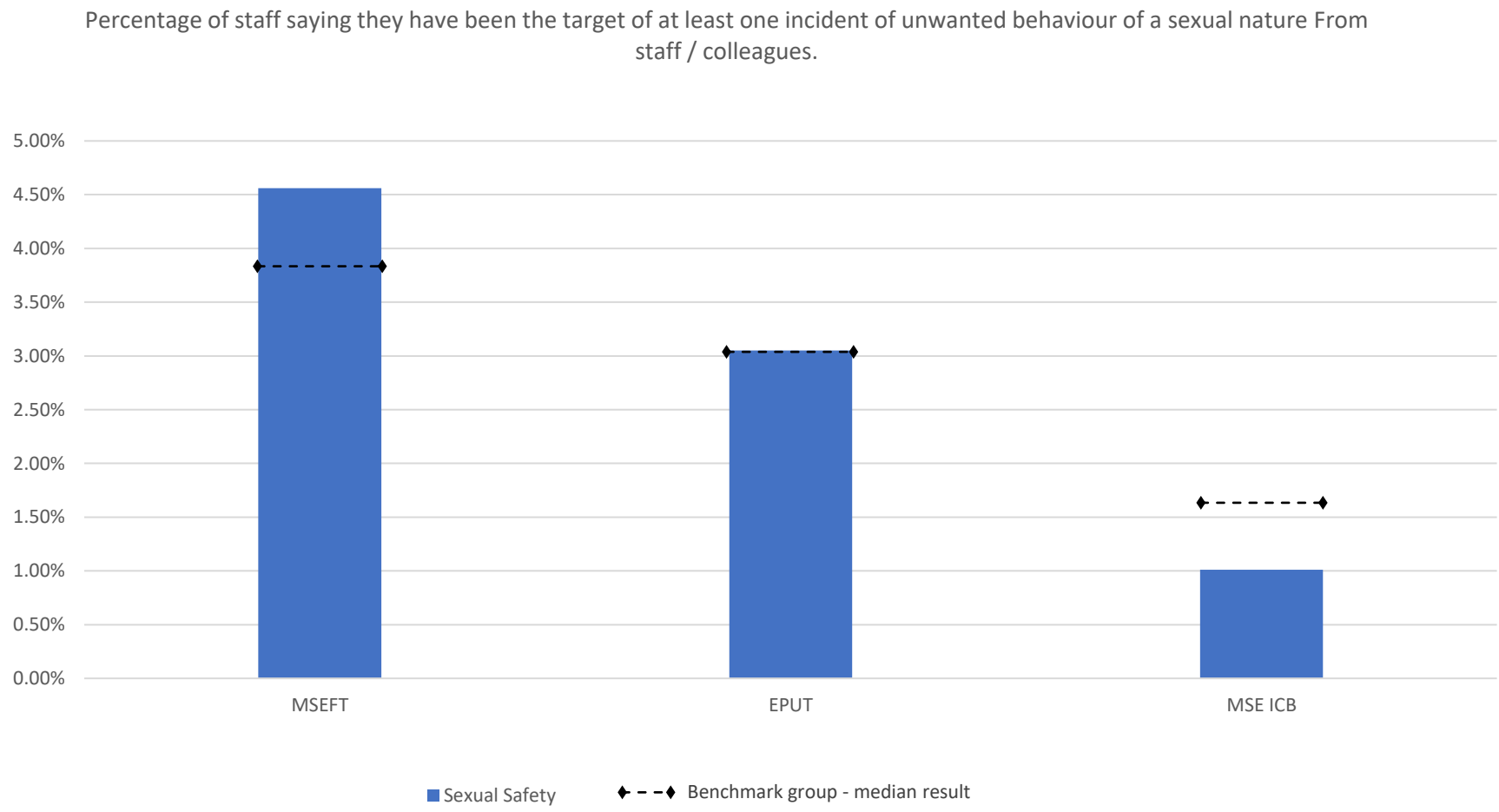
Slide 35

2023 NHS staff survey

This graph shows the percentage of staff members experiencing inappropriate sexual behaviour from **colleagues**. The dotted black line represents the benchmark group median.

Percentage of staff saying they have been the target of at least one incident of unwanted behaviour of a sexual nature.

Answer to the question: In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From Staff / Colleagues.

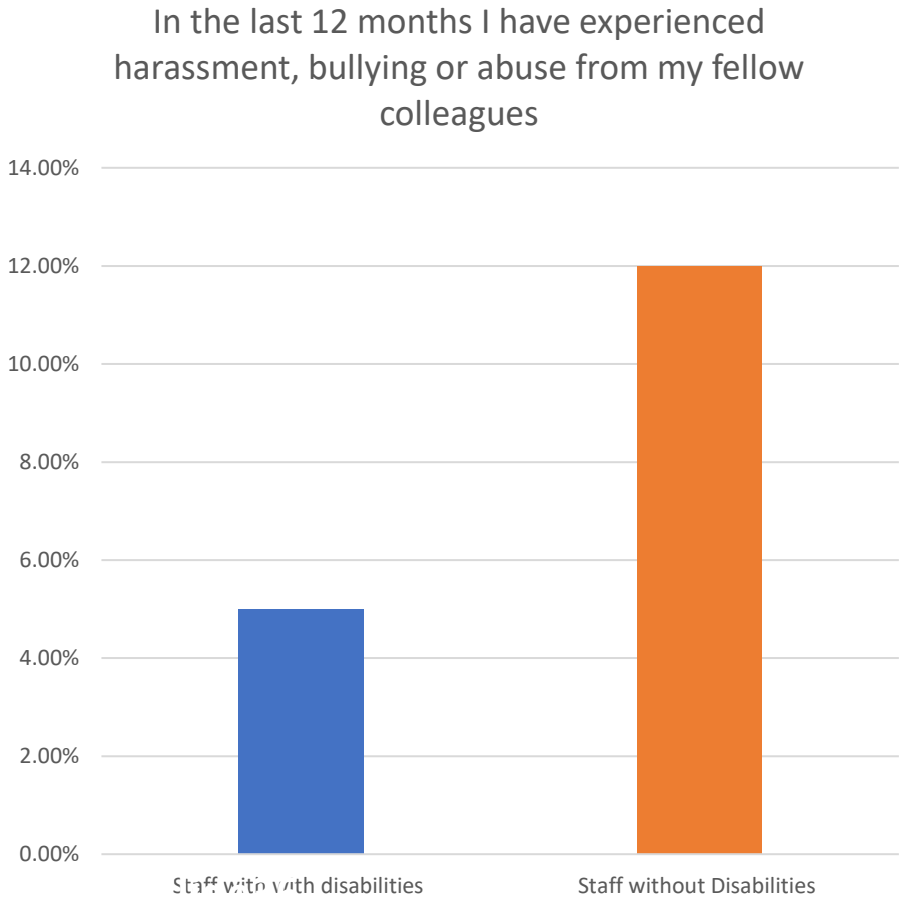


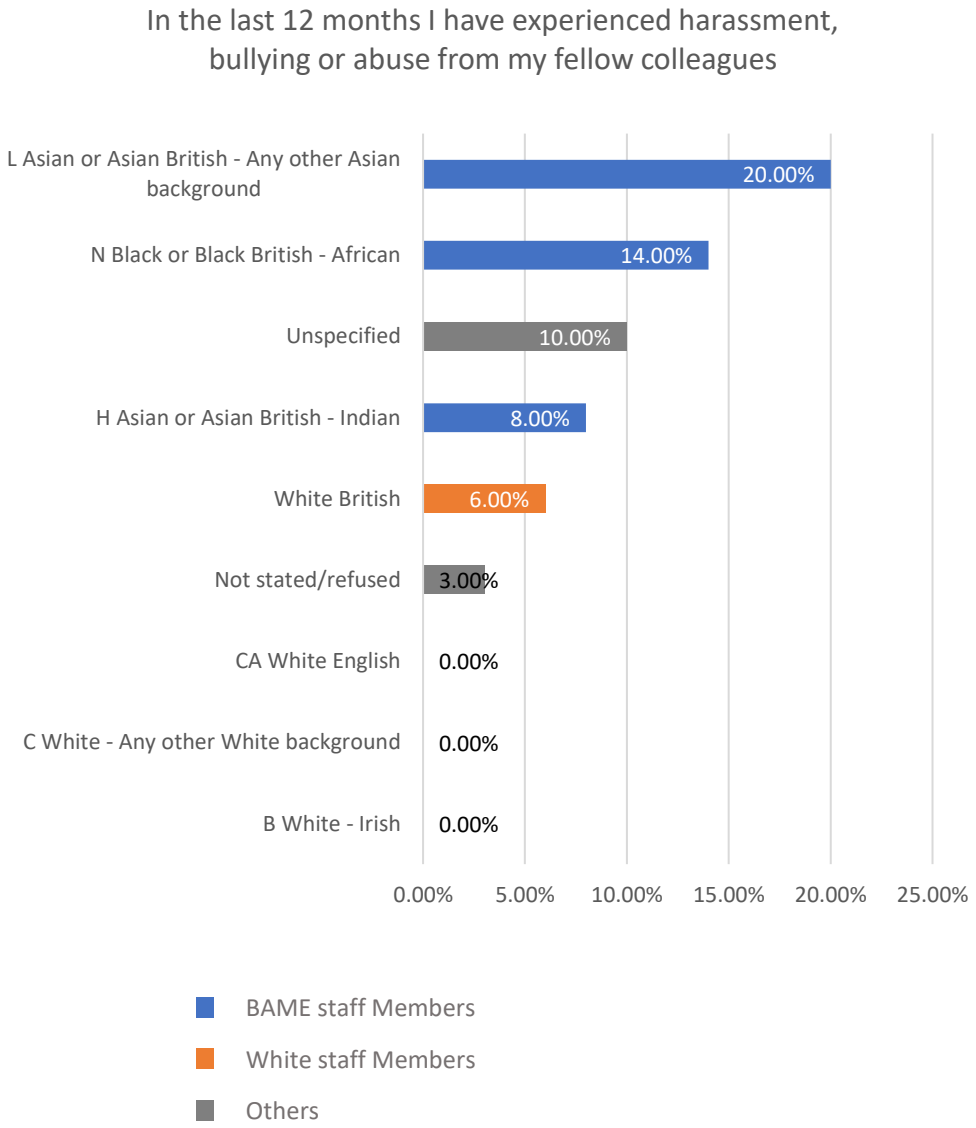
Action 6

Provide Engagement survey
Slide 36

The first chart (left) compares the responses of staff with disabilities and staff without disabilities to the question *"In the last 12 months I have experienced harassment, bullying or abuse from my fellow colleagues"* The second chart presents the same data broken down by ethnicity.

Provide Community Data





Mid and South Essex

Annual snapshot report - EDI
The six high-impact actions for MSE ICS

Last update June 2024.

Nunzio.Toscano@nhs.net

www.midandsouthessex.ics.nhs.uk

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 8

Mid and South Essex Integrated Care Board Equality, Diversity, Inclusion and Belonging Strategy

Summary Report

1. Purpose of Report

To seek approval of the ICB Equality, Diversity, Inclusion and Belonging (EDIB) Strategy 2024 - 2028.

The Strategy sets out the profile of the ICB in terms of the services it commissions for our population and the health inequalities they experience as well as the profile of our staff. It establishes the objectives of the ICB in relation to EDIB and our vision for developing EDIB over the next four years. High level actions have been included within the Strategy against each of the detailed objectives, but detailed action plans that support all of the work to deliver the strategy will be established, monitored and reported to the Executive Committee with an annual report to be provided to the Board.

The Strategy will be revisited in 2028.

2. Executive Lead

Kathy Bonney, Interim Chief People Officer
Emily Hough, Executive Director of Strategy and Corporate Services

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Executive Committee is the sponsoring committee for the EDIB Strategy and have endorsed the strategy.

Staff Networks have provided feedback on the strategy and therefore contributed to its development.

It is the responsibility of the Board to approve ICB Strategies. The Board considered the EDIB Strategy at its Board Seminar in September 2024, which largely endorsed the Strategy, requesting the context of the wider MSE 'system' be acknowledged and further feedback from individual Board members be included, which has been completed.

5. Impact Assessments

An Equality Impact Assessment has been undertaken and supports that any effect on groups with protected characteristics is either neutral or position and consequently no further actions are required in this regard.

Equality and Health Inequality Impact Assessments will be carried out as appropriate for the programme of work that will support the implementation of the strategy.

6. Financial Implications

There is no financial cost implication for approval of this Strategy. The work being undertaken to support the strategy either had funding streams identified or where funding is required, this would be progressed through the ICB governance process.

7. Details of patient or public engagement or consultation

There has been no patient or public engagement in the development of the strategy. The ICB Inclusion and Belonging Steering group and staff networks have been engaged in the development of the strategy. The Strategy has also been reviewed by [individuals within] the following groups, who provided feedback that was incorporated into the development of the strategy:

- Healthwatch Thurrock
- Healthwatch Southend
- Healthwatch Essex
- ICB Board Members
- Executive Committee
- Quality/Safeguarding Team
- Communications Team
- Medicines Management team
- People Directorate
- Alliances

8. Conflicts of Interest

None identified.

9. Recommendation(s)

The Board is asked to approve the Equality, Diversity, Inclusion and Belonging Strategy.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Equality Diversity, Inclusion and Belonging Strategy

2024 - 2028

CONTENTS

FOREWORD

I am pleased to introduce the Mid and South Essex (MSE) Integrated Care Board (ICB) Equality Diversity, Inclusion and Belonging (EDIB) Strategy.

Central to the vision set out in our Joint Forward Plan is our desire to come together in a broad and equal partnership of individuals, organisations, and agencies to serve the people living and working in mid and south Essex, including our own staff. Working together, our shared focus will be on fairness, prevention, early support and providing high quality integrated health and social care services when and where people need them. This will create an environment where everyone: our patients and our workforce alike are treated with respect, ensuring equity of access to our health service and equity of access to opportunity for our staff. Fundamental to this is ensuring we fully understand the health needs of our population as well as any barriers that exist to those needs being met; and understanding our workforce as well as any barriers that exist to us being an employer of choice.

This document sets out our commitment to taking equality, diversity, and human rights into account in everything we do whether commissioning services, employing people, developing policies, communicating with, or engaging local people in our work.

This strategy and associated plans will help the ICB tackle health inequalities, promote equality and fairness, and establish a culture of inclusiveness that will enable the ICB to best meet the needs of all our residents and staff within our given financial envelope.

Our Board commits to monitoring our progress and reporting regularly and openly on the developments in this strategy. We acknowledge and accept our roles in supporting the strategy and will play our full part in making its aims a reality.

The ICB gives its absolute commitment to equality and diversity in respect of the services that we commission for the population of our local area and for our own staff. Indeed, I am committed to Board Members actively participating in and promoting the reciprocal mentoring programme for ICB Non-Executive Members (NEMs) and Associate NEMs driving our culture at the top of our organisation.

Prof. Michael Thorne
Chair, MSE ICB

INTRODUCTION

The ICB is committed to ensuring that our local population and all those we serve have equity in access to care, a positive experience of care and improved health and wellbeing. To do that we need to fully understand the inequalities that exist within our health system and actively work to eliminate them.

We are also committed to becoming an employer of choice, as set out within our People Management Strategy. To that end we are creating a sustained and transparent employee pathway that recognises the diversity of our workforce, embracing inclusion, and developing an organisational culture of belonging.

Figure 1: Protected Characteristics

BACKGROUND

The ICB is committed to ensuring that all our activities, as a commissioner, an employer, and as a partner in the wider health system, always meet the needs of our population and staff in an equitable and fair manner ensuring kindness always. In doing so we will also ensure we meet the requirements in the Equality Act 2010 (the Act).

The Act legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, meaning that discrimination or unfair treatment based on certain personal characteristics is now against the law.

The nine protected characteristics include age, disability, sex, gender reassignment, race, religion or belief, sexual orientation, marriage and civil partnership, pregnancy, and maternity (see figure 1).

The Act also established the Public Sector Equality Duty (PSED). The PSED is made up of a general equality duty and specific equality duties (SEDs). The former is set out in primary legislation as section 149(1) of the Act, and the latter is supported by secondary legislation in the form of statutory regulations. The PSED is supported by non-statutory guidance and technical guidance issued by the Equality and Human Rights Commission (EHRC).

The ICB is committed to the principal objective of the PSED to have 'due regard' or proper consideration of the need to address three equality aims:

- **Equality aim 1:** eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
- **Equality aim 2:** advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- **Equality aim 3:** foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

All three equality aims apply to both our population and our workforce.

Vision and Context

The ICB recognises and values the diversity of the population we serve, and of our workforce. Having a focus on equality is central to our work, ensuing we commission modern, high quality health services for all. To do that we need a consistent and well-motivated workforce.

Many of our NHS staff are part of the wider population of MSE and are therefore subject to the same health inequality challenges.

Our vision, within our Joint Forward Plan, is for a health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident enabled to make informed choices in a strengthened health and care system. This means that:

- Members of the public have the right to expect the care and treatment they receive to be provided in an environment free from unlawful discrimination or harassment.
- We will tackle health inequalities and ensure there are no barriers to health and wellbeing.
- We will actively seek to understand the barriers experienced through the lens of the diverse populations we serve and making access to health services equitable.
- We will ensure our health providers also meet their legal requirements around equality and human rights.
- Our staff have the right to work in an environment that is free from discrimination, victimisation, and harassment (policies to safeguard staff are included on our staff intranet).

The ICB's equality and diversity strategy is based on:

- The Principles of the NHS Constitution
- The Equality Act 2010 and the requirements of the Public Sector Equality Duty under that Act
- The Human Rights Act 1983
- The requirements within the Health and Care Act 2022 to reduce health inequalities, promote patient involvement, and involve and consult the public.

Our approach to equality and diversity includes working closely with our upper tier Local Authorities: Essex County Council, Thurrock Council and Southend City Council; alongside our Essex, Thurrock and Southend Health and Wellbeing Boards in agreeing local needs assessments specific to those areas and developing the strategy to address these needs. We use Joint Strategic Needs Assessments (JSNAs) and population health management data to inform our commissioning intentions and decision-making. The JSNAs are a collection of research about the local people, places, and communities to which the ICB and our partners deliver services. We use the JSNA's to try to understand what needs to be done in collaboration with local knowledge and community feedback.

In developing this strategy, the ICB has considered the impact of other characteristics outside of the nine statutory protected characteristics for example the ICB feels that neurodiversity and implications for carers should have an equal focus in terms of the role of the ICB as an employer and commissioner.

This strategy sets out our equality objectives and the associated plan that places equality at the centre of all we do both for our staff and for our population. It also sets out how we will monitor and review our progress at least annually.

The Mid and South Essex Integrated Care System (ICS)

In MSE, our ICS is made up of a wide range of partners, supporting our population of 1.2 million people. The Integrated Care Partnership (ICP) is a statutory committee jointly formed between the ICB and all upper-tier local authorities (named above, page 5). It also brings together a broad alliance of partners concerned with improving the care, health, and wellbeing of our population. Our system includes:

- Three top tier local authorities and seven district, borough and city councils.
- Three healthwatch organisations.
- One hospital Trust with main sites in Southend, Basildon and Chelmsford (Mid and South Essex NHS Foundation Trust (MSEFT)).
- Three main community and mental health service providers (Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT), Provide Community Interest Company)
- One ambulance Trust.
- Over 144 GP Practices, forming 26 Primary Care Networks.
- Other partners including Essex Police, local universities, Optometrists, Dentists, Pharmacists and nine voluntary and community sector associations.

The ICP is responsible for setting the Integrated Care Strategy and holds to account the partners for delivering that strategy. The ICB facilitates ICP meetings and works with all partners in a collaborative approach to achieving the strategy.

The ICB is specifically focussed on the health element of the strategy and in its role as an ICB holds to account the health partners for the delivery of health and care in accordance with the strategy.

Central to the system's strategy is its commitment to reducng inequalities together. Collaborative working through our Population Health Improvement Board sets the strategy for how we can do this for the population we serve in MSE.

The ICB employs a system clinical lead for Health Inequalities who supports collaborative working to address inequality across the ICS. This is supported by partnership working on the Equality Delivery System 2022 which is completed in partnership on an annual basis (see also page 32).

Similarly, the ICB's People Board brings together healthcare partners to ensure people strategies have an EDI focus and are delivering improvements for our staff. Working closely with NHS England, we maintain oversight of compliance with statutory and mandatory requirements placed on health organisations in relation to equality.

The ICB is committed to working with its partners across the ICS to further strengthen compliance with EDI requirements and to create an inclusive culture across MSE.

This strategy brings together the ICB's vision and action to deliver improvements in addressing the EDI that face our population and out workforce and supports the broader system strategies. Partner organisations will also have their own strategies and delivery processes to achieve and demonstrate their commitment to and statutory compliance with EDI.

UNDERSTANDING THE POPULATION WE SERVE IN MSE

The ICB serves a population of 1.2 million people. The total population size of mid and south Essex is projected to increase by 14.7% over the next 20 years. By 2034 the largest increases are forecast for the 90+ years population.

We have undertaken an in-depth review of health inequality data, gathered from the JSNAs and population health management data published by our three upper tier local authorities and the Population Health Management teams, which we use to inform our strategy and commissioning process and summarised below. Further information can be found at 'Essex Open Data' [Home | Essex Open Data].

Life Expectancy is a key metric for assessing a population's health. The inequality in life expectancy, measures how much life expectancy varies with deprivation from most to least deprived. During Covid, there was a drop in life expectancy that has now recovered. Across MSE, females have a higher life expectancy than males.

In reviewing our individual districts within MSE we further understand some of our equality gaps and how those gaps differ across our geography. For example, Basildon and Southend-on-Sea have a life expectancy inequality gap that is greater than the average for England (which is 9.7 years for men and 7.9 years for women greater than the England average). Brentwood has a greater inequality gap than average for women. Chelmsford, Braintree, Maldon, Castle Point and Rochford have an inequality gap within their populations that is lower than England average. The areas that have a lower life expectancy overall (Thurrock, Southend-on-Sea, and Basildon) also have a greater inequality of life expectancy within their populations.

Healthy life expectancy indicates how long a population is expected to experience good health. Male healthy life expectancy in MSE is higher than the regional (East of England) average, but in Thurrock it is lower than the National average. Female healthy life expectancy is higher in Essex than that of the England average. However, in Southend-on-Sea and Thurrock Female healthy life expectancy is much lower than the England average and is also lower than male healthy life expectancy in these areas (see figure 2).

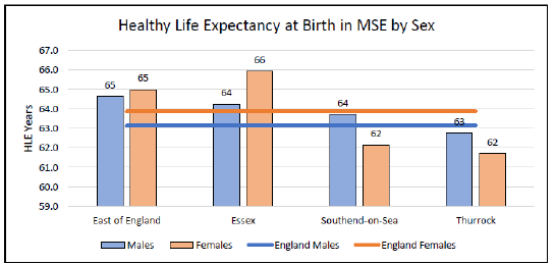


Figure 2: Healthy Life expectancy at birth in MSE by sex

Ethnicity. Based on ethnicity data from the 2021 census, 83% of the population of MSE is White British. This is a higher proportion compared to England as a whole (73.5%). The second largest ethnic group is 'Other white'. Basildon, Southend, and Thurrock have the greatest groups with ethnic diversity (sometimes referred to as Global Majority). 3.2% of the MSE Population speak a primary language that is not English. The full breakdown of ethnicity within MSE is included within the health inequalities annual statement.

Other population groups

- 16.2% of the population reside in areas of rurality.
- 19% (139,500 residents) of the MSE population aged 16-64 have a recorded disability.

Health Behaviours & Outcomes

Disease drivers. Mortality attributable to socioeconomic inequality (MASI) relates to the excess number of deaths compared to the least deprived areas in England. In 2020, there were over 14,500 excess deaths in mid and south Essex relating to socioeconomic inequality. All districts in mid and south Essex have cancer, circulatory disease, and respiratory disease in their top three contributors to MASI. Further information can be found within the MSE health inequalities annual statement.

Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease (COPD).

The number of people diagnosed with Dementia in MSE has increased from 9,314 to 10,627 in 2024. Mental health conditions are increasing in adults and children. The number of people in contact with NHS funded secondary mental health, learning disabilities and autism services in MSE increased from 49,230 in 2020/21 to 53,510 in 2023/24.

Tobacco, high blood pressure and dietary risks are the top 3 cross-cutting risks that have been identified in MSE populations. These are the factors that will have the greatest impact on population health outcomes and health inequalities.

Overweight and obesity is currently the fastest rising behavioural risk factor in England. There are high and increasing proportions of overweight or obese adults - in all but one district (Chelmsford) more than 60% of adults are overweight or obese. This is as high as 76% in Thurrock. Likewise, there are increasing numbers of overweight or obese children in early years schooling - 20-26% of children in MSE are already overweight or obese when they arrive at primary school in reception year (age 4).

Smoking impacts on quality of life and increases the risk of premature death. Smoking prevalence in adults in MSE is 11.1% compared to England average (11.6%) (2023 annual population survey). Smoking prevalence amongst adults is particularly high in Basildon (14.2%) and Thurrock (14.6%).

Neurodiversity and our carer community

Data recording the neurodiversity of our community is being collated, however it is likely under reported given the potential for those on the lower scale of neurodiversity who have not sought diagnosis and the current waiting lists for ADHD and ASD services.

Similarly, 37,100 of the population within MSE is recorded as having a carer status for someone with a disability or long-term condition. This is also likely understated where carers have not registered their status. We work at neighbourhood, Alliance, and system level with all partners to improve the identification, experience, support and health and wellbeing of unpaid carers in MSE and have identified carers as one of our local 'Plus 5' groups in the CORE20PLUS5 approach to reducing health inequalities. We have committed to continue to develop and improve our

offer to carers as outlined within our Joint Forward Plan.

Education, Employment & Prosperity

Deprivation has increased across the 1.2m population within MSE.

On average deprivation in MSE is lower than the national average. In MSE an estimated 133,000 people live in the 20% most deprived areas nationally. That is 10.5% of the whole MSE population (see figure 3 below).

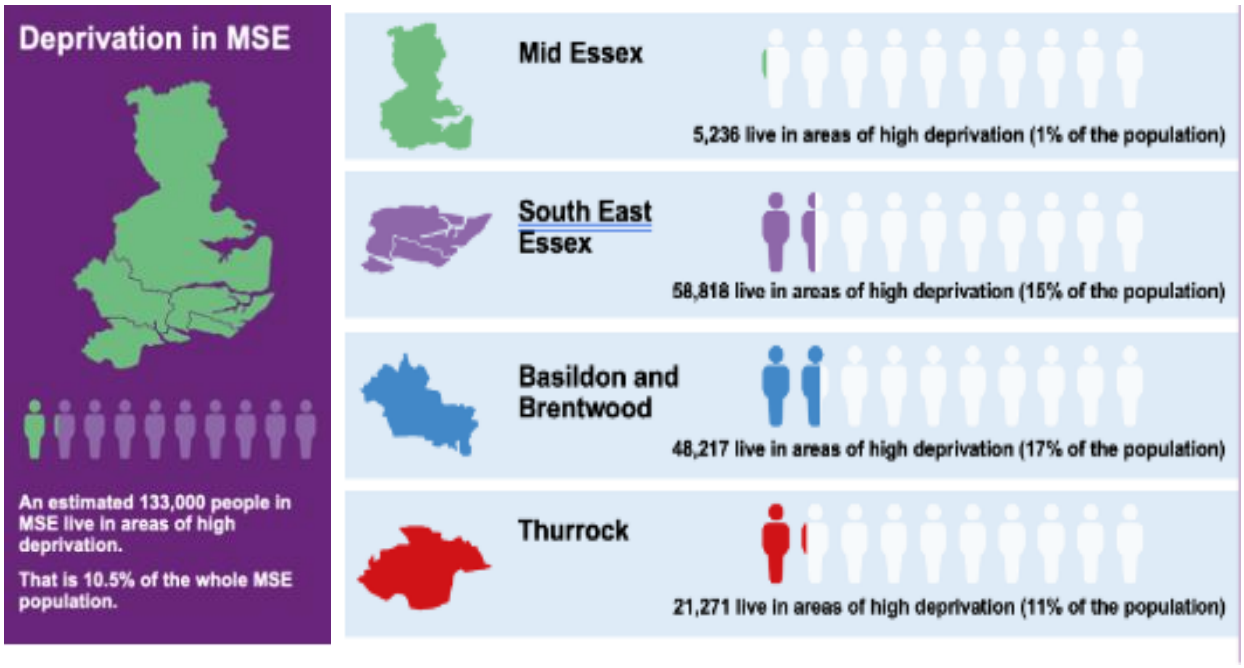


Figure 3: Distribution of MSE residents living in the most deprived areas.

The child population for MSE accounts for approximately 10.7% of the total population, 12% of the child population live in the 20% most deprived areas.

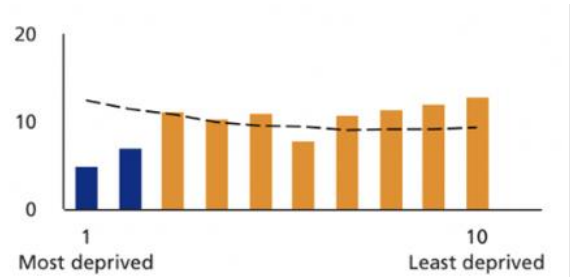


Figure 4: Children and Young People Deprivation Profile for mid and south Essex

Overall, Essex (data excludes Southend) is performing worse than national comparisons for proportion achieving GCSE pass (Grade 9-4) in English and maths creating a disadvantage for future schooling and future skills for work. The productivity gap is increasing between mid and south Essex and national comparators.

Homes have become up to 58% less affordable over the last decade.

More details on the health inequalities experienced in the MSE population can be found in the Health Inequalities Information Statement 2023/24 - Mid and South Essex Integrated Care System [hyperlinks]

Figure 5: Overview of Health Inequalities within mid and south Essex

UNDERSTANDING OUR WORKFORCE

The ICB has a diverse workforce that includes people of different sex, age, race, sexual orientation, religion or belief, disability, and marital status. We are committed to encouraging and supporting these diversities in all we do.

Based on our corporate workforce data, MSE ICB's workforce is made up of a majority of female employees (80%) (see figure 6). Whereas the gender split of the MSE population is 51% female, 49% male.

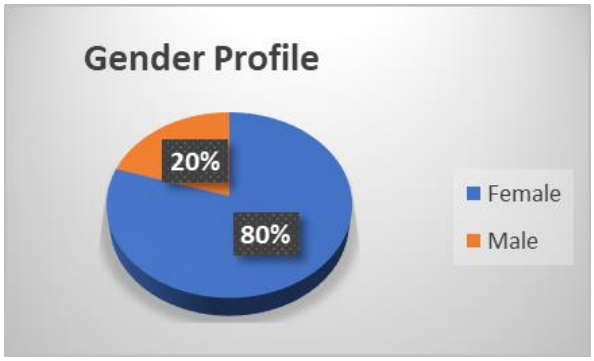


Figure 6: Distribution of MSE employees by sex

The majority of the ICB's workforce is aged between 36-60 (73%), with a fairly equal split between the age ranges 36-40 (11%), 46-50 (15%), 51-55 (14%) and 56-60 (13%). The larger element is 19% of our workforce being 41-45 years, as shown in figure 7.

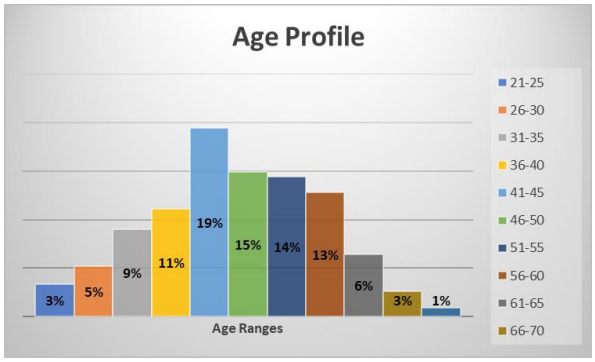


Figure 7: Distribution of MSE employees by age

A high level of ICB staff feel comfortable reporting their race, with 2% unknown (see figure 8). Much like the racial diversity across the population of MSE, the majority of our workforce are white. 81% of our workforce, compared to 83% of our population in MSE are white. Of the 17% of ethnically diverse groups, 52% were of Black African and 21% were of Indian origin.

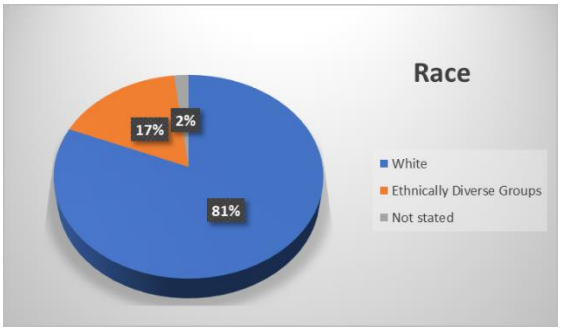


Figure 8: Distribution of MSE employees by race

Of the staff who responded to the most recent survey, 84% stated they were heterosexual, with 6% stating they were gay/lesbian/bisexual, 10% preferred not to disclose (see figure 9).

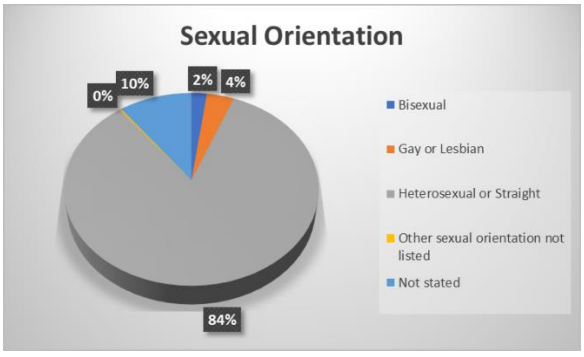


Figure 9: Distribution of MSE employees by sexual orientation

Christianity was the majority religion/belief at 49%, with atheism the second at 20% (see figure 10). A proportion (20%) of our workforce preferred not to disclose or left blank the data that records religion or belief.

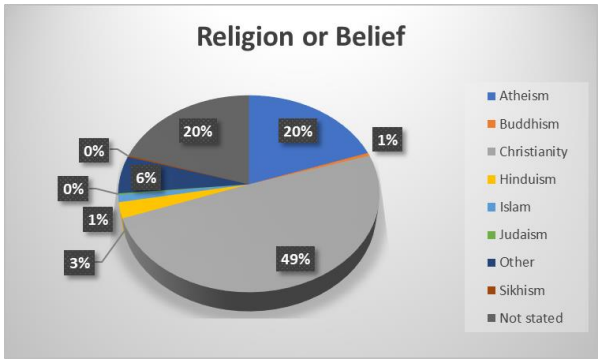


Figure 10: Distribution of MSE employees by religion or belief

8% of the ICB workforce stated they had a disability, with 9% recorded as 'disability unknown', 83% stated they did not have a disability (see figure 11).

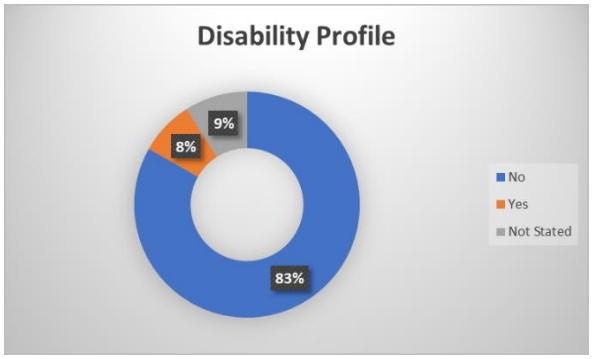


Figure 11: Distribution of MSE employees by disability

Supporting people to feel comfortable to declare their disabilities and religion is key to ensure that the ICB delivers effectively on our requirement to make reasonable adjustments to support our colleagues with a disability or need for support in following their faith. The ICB needs to work with staff so that everyone feels comfortable to declare whether they have a disability or not. This will ensure that anyone who has any kind of disability and requires reasonable adjustments can be supported to receive them as an employee of the ICB. The ICB needs to ensure that has truly inclusive recruitment processes and is recognised as an employer of choice for all.

60% of the workforce stated they were married, 26% stated they were single. 2% of our workforce did not provide information relating to their marriage or civil partnership (see figure 12).

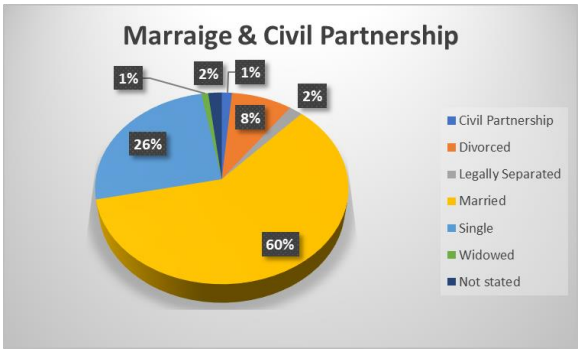


Figure 12: Distribution of MSE employees by marriage and civil partnership

The ICB respects individuals right to not disclose information they consider personal to them, but where this inhibits the ICBs ability to support staff with a protected characteristic, we will endeavour to understand why staff did not feel able to disclose such information and consequently what else the ICB could do to improve staff psychological safety to disclose and the ICB ability to support staff.

42% of staff who completed the 2023 staff survey declared that they have dependent children living at home for whom they care and 38% declared that they are a carer for someone with a disability or long-term condition. This is not representative of our full workforce as it was gathered from staff survey data that not all staff completed.

The ICB does not collect data on gender re-assignment or pregnancy and maternity, which includes elements such as parental leave / surrogacy / adoption etc. (which is in line with the NHS generally); which are the remaining two protected characteristics, furthermore it does not collect data on staff who are

neurodiverse, but has an ambition to collect data on all protected characteristics by 2028 and to consider the impact of collecting data on the neurodiversity of its staff.

Furthermore, the ICB will look to compare its data to other ICBs across the region and to its partners within MSE to ascertain any insights to support its People Management Strategy. In the meantime, robust human resource policies exist to protect all individuals working for the ICB, but we know there is more to be done for our workforce to feel able to be open and honest about certain protected characteristics.

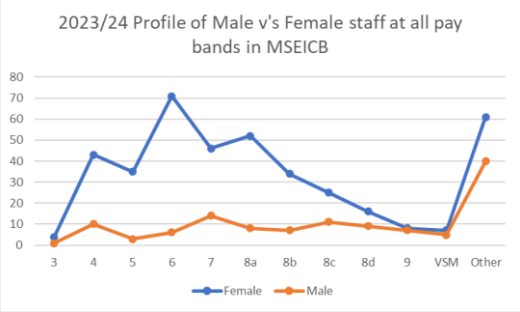


Figure 13: Gender profile within staff bands.

Of the senior managers within the ICB (band 8c and above), 56 were female (64%), and 32 male (36%). Data shows that overall, there are a higher proportion of men in higher banded positions in the ICB than in the lower bandings as shown in figure 13. Data further shows that women earn 10.6% less than men overall, according to the median pay gap data and 20% less than men according to the mean pay gap data. The ICB will therefore continue to monitor and take steps to address the gender pay gap (higher proportion of women paid at lower bands), as described in the detailed equality objectives from page 15.

In our endeavours to address the gender pay gap, the ICB will continue to ensure we conduct fair and equitable recruitment processes to senior posts within the ICB and all non-agenda for change pay changes are approved at the Remuneration Committee.

Annually, the ICB reports on the Workforce Race Equality Standards (WRES) the Workforce Disability Equality Standards (WDES) and the Gender Pay Gap; to comply with statutory reporting requirements and to better understand what further actions we may need to take to continue to address identified inequalities. The ICB has performed well in achieving a better representation throughout the ICB. For example, staff with a disability have an equal chance of being appointed but there remains disparity in terms of the appointment of staff from ethnically diverse backgrounds. There is also a new requirement to publish an Ethnicity Pay Gap Report. These will be reported to the ICB Board alongside a detailed action plan outlining the steps that will be undertaken to better understand equality of opportunity and ensure that the ICB takes every possible step to ensure equitable access, such as adjusting our recruitment processes to even up the likelihood of those from non-white heritage applying and being appointed to positions in the ICB.

Our latest published WRES, WDES and Pay gap reporting can be found here Gender pay gap - Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks]

As part of our strategy, we recognise that we can do more to interpret the data available regarding our staff and consequently, we will be looking at how we assess intersectionality; the experience of staff with more than one protected characteristic and what the ICB can do in the future to support staff in this respect.

Our Equality Objectives

The equality objectives have been developed in accordance with the mid and south Essex Integrated Care Strategy, which is furthered by our Joint Forward Plan. The objectives are set in the context of the legislation and what we set out to achieve in our strategies as well as our role as an Integrated Care Board.

The ICB has established two overarching equality objectives reflective of its dual role as a commissioner of health services and that of an employer as follows:

1. **To ensure equitable access, excellent experience, and optimal outcomes for all by addressing unwarranted variations in our services and moving towards an integrated health and care system.**

2. **To create an inclusive environment where our staff feel valued and are actively supported to achieve their potential, recognising that our culture values diversity and listens to the voice of our teams.**

These overarching equality objectives have been distilled into further objectives linked to the three equality aims. The detailed objectives (on the next page) are set out in terms of a statement of intent, what the ICB needs to do over the next four years and what success will look like for the ICB to achieve the objectives

Woven into who we are as an ICB, the objectives are also reflected directly in two of the ICB corporate objectives:

- To reduce health inequalities across mid and south Essex including access to, experience of and outcomes of the services we provide, and
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.

Demonstrating ownership at all levels of the ICB we have established equality objectives for each of our Board Members summarised below:

<u>Health Inequalities</u>

- Championing the women's health board.
- Improved oversight of actions to tackle health inequalities.
- Deliver awareness training to reduce inequality in access to eye health.
- EDI being a prioritised area of focus in Mental Health and Acute services.
- Raising the profile of cultural safety and trust within the primary / secondary care interface work.
- Ensuring visible leadership proactively supporting EDI.

<u>Staff</u>

- Chairing and supporting staff networks, engagement with community groups, and establishing an effective race equality network.
- Stretch assignments, mentoring and coaching to improve the number of ethnically diverse staff in senior roles.
- Mentorship for women from minority ethnic groups in digital health roles.
- Promoting inclusive physical and mental health and wellbeing, with a focus on male mental health.
- Oversight of and supporting HR processes that further the EDI agenda.
- Strengthening freedom to speak up.
- Create and encourage an inclusive environment at committee meetings.
- Reciprocal mentoring for non-executives.

Detailed Equality Objectives – as an Organisation / Commissioner

Equality Objective	What does success look like	What we need to do	Link to Equality Aim
1a. We will develop the organisational culture and governance arrangements within MSE to support embedding the principles of equality and inclusion	Decision making within the ICB will ensure consideration of Equity and Health inequalities, with Equality and Health Inequalities Impact Assessment (EHIIA) included in all relevant processes within the ICB - including financial recovery programme and commissioning and contracting decisions from April 2025. EHIIA will aim to include engagement with those population groups potentially affected and includes each protected characteristic. ImpactEQ, the digital EHIIA process will be implemented across the ICB by November 2025. All relevant staff to complete Equality and Health Inequalities Impact Assessment training by March 2026.	- Board and senior managers demonstrate their commitment to promoting equality - Mature our governance arrangements to ensure there is assurance and accountability for securing equity in all that we do. - Develop robust undertaking of equality impact assessments - From publication of this strategy, Board papers will highlight health inequalities impacts and associated mitigating actions. - Establish robust governance processes for reviewing EHIIAs through the Equity and Inclusion Panel	Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.
1b. We will monitor and review commissioned services to ensure delivery of an equitable health and care system which seeks to	We aim to include within all commissioned services a contractual obligation to consider and reduce gaps in inequity from April 2025.	- Utilise data intelligence and insights to close gaps in inequitable experience and access - Ensure that the services are equitably commissioned, procured, designed, and delivered to meet the needs of those groups	Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

Equality Objective	What does success look like	What we need to do	Link to Equality Aim
address healthcare disparities and poorer outcomes.	The ICB will monitor progress against specific equality and health inequalities objectives from April 2025.	most likely to experience inequalities in access, experience, and outcomes. - Set equality performance goals and develop a measurement framework to evidence how we are progressing in addressing inequalities.	
1c. We will work with communities as equal partners to develop local solutions and build resilient communities.	Place the voices of our communities and residents particularly those at risk of experiencing inequalities at the centre of how we design and implement services. As an organisation we can demonstrate how the insight of our residents informs our service commissioning and delivery.	- Utilise local intelligence and community insight (including from those who are digitally excluded) to improve our understanding of the health and social needs of our residents and local communities, ensuring we are better informed of the needs of under-served groups (via focus groups, virtual views, surveys, community alliance groups, Healthwatch and VCFSE partners). - Secure ICB resources to support and sustain community engagement. - Further adoption of Virtual Views as an effective platform to hear from digitally engaged local citizens and patients to inform future services from April 2024.Public and service user engagement is built into all ICB projects, including commissioning and transformation work by March 2025. - Continue to develop local and system-wide relationships with community and VCFSE partners through our Alliance networks from April 2025. Engaging with communities where they live. - Develop and maintain the ICB insight bank to ensure accessible community insights is available to all, to support delivery of equity informed plans from April 2025.	Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

DETAILED EQUALITY OBJECTIVES – AS AN EMPLOYER

Equality Objective	What does success look like	What we need to do	Link to Equality Aim
2a. We will ensure all staff (including our managers and senior leaders) understand their duties and required behaviours in the workplace and have mechanisms in place for staff to raise issues safely and confidently.	Staff will report lower rates of bullying and harassment by managers or colleagues in the workplace via our annual and quarterly staff surveys. This will result in significant improvements in our staff survey results by March 2026. We aim for mandatory training compliance to be at 75% by 2025, 85% or more by March 2028 and maintained thereafter. The East of England Anti-Racism Strategy will be delivered by 2028 in MSE. No bias in the number of suspensions, disciplinaries and dismissals for people with protected characteristics. Staff report results showing that staff feel confident to speak up about issues that concern them (25% increase in first year. 40% increase from baseline by 2028). Deliver the actions of the NHS sexual safety charter.	Provide learning opportunities and safe places through our staff networks for staff to feel confident about speaking up. Implement the East of England Anti-Racism Strategy within MSE. Better understand intersectionality and the impact on our staff. Develop and deliver the 10 actions of the sexual safety charter and report to the Executive Committee and raise staff awareness. All reported incidents of bullying and / or harassment will be investigated and managed using the ICB dignity at work and grievance policies. Ensure that all HR processes are fair and transparent, panels are appropriately diverse and there is external scrutiny to challenge and check due process. Make explicit the ICB work and intentions to include carers, neurodiversity, and menopause within its work alongside protected characteristics, raising awareness accordingly.	Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under this Act.

Equality Objective	What does success look like	What we need to do	Link to Equality Aim
2b. We will ensure our recruitment processes and promotion processes both internally and externally are inclusive and accessible.	Our WRES and WDES data will show improved statistics in relation to diversity in our workforce by March 2026. The ICB has a better understanding of neurodiversity within its workforce. By 2028 people of all races will have an equitable experience and opportunity to be appointed to roles within the ICB. Our goal is for 40% of staff to have completed (non-mandatory) EDI training programmes by 2026 and 60% of staff by 2028. Number of staff registered with a mentor / coach or using reciprocal mentoring will increase to 50 by 2028. 60% of staff will have had talent conversation by 2026 and this will have increased to 85% by 2028. 60% of staff will report (in the staff survey) that the organisation acts fairly in relation to career progression by 2026 and this will have increased to 85% by 2028.	Check our language in adverts and promotional materials and adjust our recruitment processes as required (as set out in the 'de-bias recruitment toolkit' used across MSE). Develop system talent pools, including stretch opportunities for staff to develop. Provide EDI training and support programmes. Implement succession planning and staff support. Review and update all relevant HR Policies Review available data and strengthen existing analysis/dashboards to support action plans to further equality and diversity among those with protected characteristics, including assessing intersectionality, and measures to address pay gaps such as recruiting more male staff into lower band, attracting younger people and supporting people to work longer where appropriate with reasonable adjustments. Complete training on ethnic diversity in recruitment and managing diverse teams. Produced a programme of EDI related training supplementary to mandatory training including areas such as unconscious bias, raising awareness through lived experience and build into a training needs analysis.	Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

Equality Objective	What does success look like	What we need to do	Link to Equality Aim
		Ensure that our recruitment processes support individuals with neurodiversity and ensure that reasonable adjustments are made to enable successful recruitment. To seek views of staff to better understand the profile of the ICB in terms of neurodiversity.	
2c. We will ensure our staff networks are working together to allow for intersectionality and ensure they are fully supported and part of the ICB accountability structures.	Staff networks are well attended, and the chairs are active participants of the Inclusion and Belonging Group. Staff identifying themselves on ESR improves by 25% by 2028.	Create safe space where staff feel comfortable to bring their whole selves to work. Allow staff time to participate in the networks and the Chairs have dedicated time to undertake their work. Maintain and further develop staff networks and collaborative working. In addition to the networks already within our ICB we are creating new staff networks for example on neurodiversity, men's health and for carers.	Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

How We Will Deliver on Our Objectives - Commissioning

Our vision is of 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. Addressing health inequalities plays a key role in that ambition. We are doing this by understanding and then addressing the drivers of those inequalities and supporting groups to enact a culture change to how services are accessed, for example by groups who struggle to actively engage with services because of their cultural background.

We will strengthen the organisational culture and maintain governance arrangements within MSE to support embedding the principles of equality and inclusion.

Governance

The Population Health Improvement Board (PHIB) was established with representation from partners across the system to drive an integrated approach to inequalities improvement. It uses JSNAs and data insights to set priorities and identify health inequalities. It links to Stewardship Groups (bringing teams of health and care staff and managers together to get the best values from our shared health and care resources) via the Health Inequalities Delivery Group that reports into PHIB. The diagram below depicts the complex structure of sub-groups that drive delivery through change. PHIB therefore brings together programmes of work across health inequalities, population health management, prevention, personalised care, and anchor programme. It reports up to both the MSE Integrated Care Partnership (ICP) to bring together the work around wider determinants of health and to the Integrated Care Board to drive improvements around specific healthcare priorities (see figure 14 below).

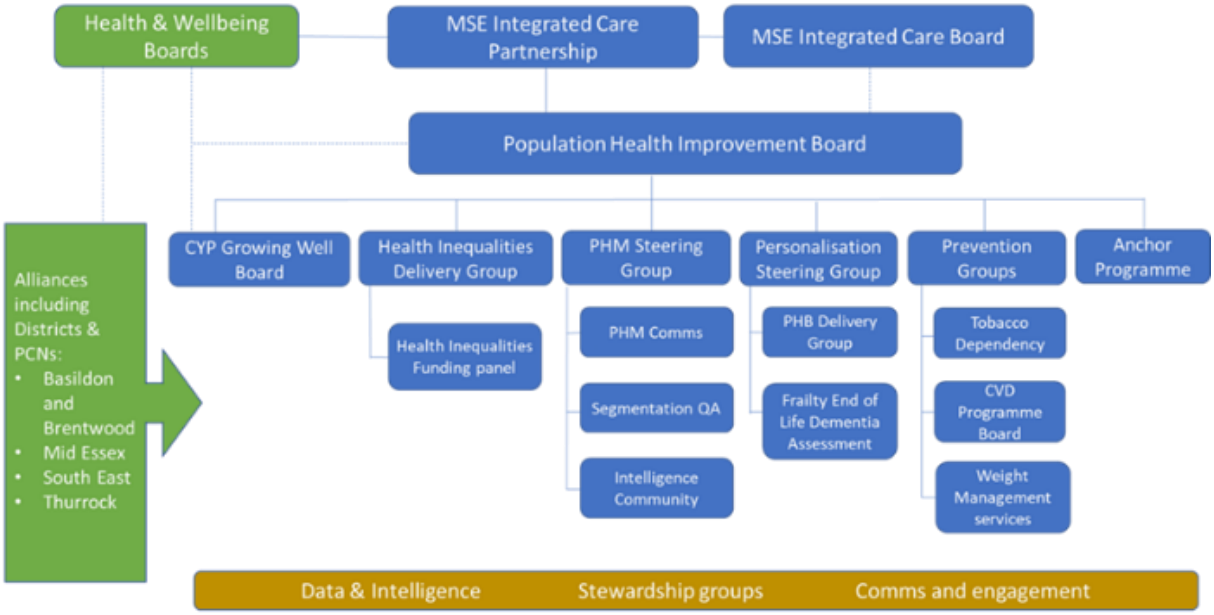


Figure 14: Population Health Improvement Board governance and reporting

Strategy and Framework

The Joint Forward Plan [Joint Forward Plan - Mid and South Essex Integrated Care System (ics.nhs.uk) [hyperlinks]] sets out the system strategy for addressing health inequalities across mid and south Essex.

This is accompanied by our population health framework which enables us to focus on delivering integrated care and reducing health inequalities. This goes further than treating ill health; moving towards a proactive, preventative model of care to address the causes of poor health outcomes and the wider socio-economic determinants of health (see figure 15 below).

Figure 15: Mid and South Essex Population Health Framework.

Our framework helps us ensure that each health inequalities activity, across the system, is:

- focused on a health gain for a defined group that contributes to a shared outcome in the MSE outcomes framework
- using appropriate evidence to identify the group in need, including integrated data, analytics, and intelligence (objective 1b on page 15 focusses the ICB understanding of inequalities in access, experience and outcomes).

- drawing on insight, resource, and commitment to design appropriate interventions.

The four identified enablers to drive improvements are:

1. *Resource allocation.* Developing sustainable funding strategies to address inequalities, allowing investment in transformation at a scale and intensity proportionate to the level of disadvantage.

2. *Population health management.* Accelerate the embedding of a Population Health Management (PHM) approach to help front line services understand current health and care needs and predicting what local people will need for the future.

3. *Leadership and organisational development.* Developing human learning systems that foster a culture of shared learning and innovation, supported by infrastructure to build capacity and leadership.

4. *Asset-based development.* Working closely alongside communities, using an asset and strength-based approach to develop local solutions and build resilience.

Digital Tools

The implementation of a digital Equality and Health Inequalities Impact Assessment tool 'ImpactEQ' alongside organisational training and development, will enable us to ensure high quality assessment are delivered consistently. Organisational development will embed an equity first approach in how we plan and implement services; it will encourage more consistent co-designing of services with residents and engaging those from vulnerable groups.

We will co-ordinate system planning to deliver an equitable health and care system which seeks to address healthcare disparities and poorer outcomes.

Operational Planning Guidance

Continued implementation of the five NHSE strategic priorities for tackling health inequalities are set out in the 2024-25 Priorities and Operational Planning Guidance, explained further below:

1. ***Restoring NHS services inclusively.*** Undertaking elective waiting list data analysis by ethnicity, sex, and deprivation will support the development of effective action plans to reduce barriers to access and outcomes. Progress with this action will be reported via the MSE Elective Care Board.

2. ***Mitigating against digital exclusion.*** Ensuring access to primary, secondary and community care continues to be offered via digital, face to face and by telephone for all. Embedding the Digital Inclusion Framework with principles being adopted by all partners within the Integrated Care System (ICS) will support digital infrastructure improvements.

3. ***Ensuring datasets are complete and timely.*** Continuing to make progress on recording and reporting against protected characteristics will enable identification of gap in health inequalities.

4. ***Strengthening leadership and accountability.*** Continuing to ensure there is clear leadership, governance, and accountability for health inequalities through the PHIB

reporting to ICB Board and the Integrated Care Partnership that supports the delivery of reductions in health inequalities across all levels with the system.

5. ***Accelerating preventative programmes.*** MSE ICB will continue to accelerate prevention programmes, that includes a major focus on prevention and early intervention across the wider determinants of health, as set via national targets or NHS England funded programmes, through the following actions:

- Improving early cancer diagnosis aiming for 75% of cases diagnosed at stage 1 or 2 by 2028. A focus will be maintained on increasing screening uptake in those groups known to be underrepresented.
- Improving the health outcomes of those with serious mental health illness (SMI) by increasing the uptake and quality of annual SMI health checks.
- Achieving at least 75% uptake of annual Learning Disability (LD) health checks with corresponding health action plans.
- Increasing Flu, Covid and Pneumonia vaccination rates in those groups likely to have poorer uptakes and experience poorer respiratory outcomes. Including increasing vaccination uptake for children and young people year on year towards the World Health Organisation (WHO) recommended levels.
- Increasing referrals into local authority commissioned smoking, weight management and alcohol cessation and other lifestyle and behavioural support programmes.
- Increasing referrals into the nationally commissioned digital weight management programmes and diabetes prevention programmes to support reducing cardiovascular risk, particularly for those most deprived quintiles of the MSE population.
- Supporting people to stop smoking, including through implementing opt-out treatment for patients in hospital and as part of maternity pathways.

<u>Local work on 'narrowing the gap'</u>

Our work on health inequalities is guided by the national NHS CORE20 PLUS5 frameworks (see figures 16 and 17). Narrowing the gap in health inequalities in our most deprived communities is a priority for all our four Alliance partnerships (Basildon & Brentwood, Mid Essex, South East Essex and Thurrock).

Each Alliance has tailored their approach and focused on specific areas, groups or conditions based on the needs of their local populations and the engagement work undertaken with their communities.

The CORE20PLUS5 frameworks set out five clinical priorities for adults (maternity, serious mental illness, respiratory, cancer and hypertension) and five for children and young people (asthma, diabetes, epilepsy, oral health, and mental health).

A number of core initiatives around cardiovascular disease, smoking cessation and tackling obesity will become enablers for us delivering against the CORE20PLUS5 frameworks.

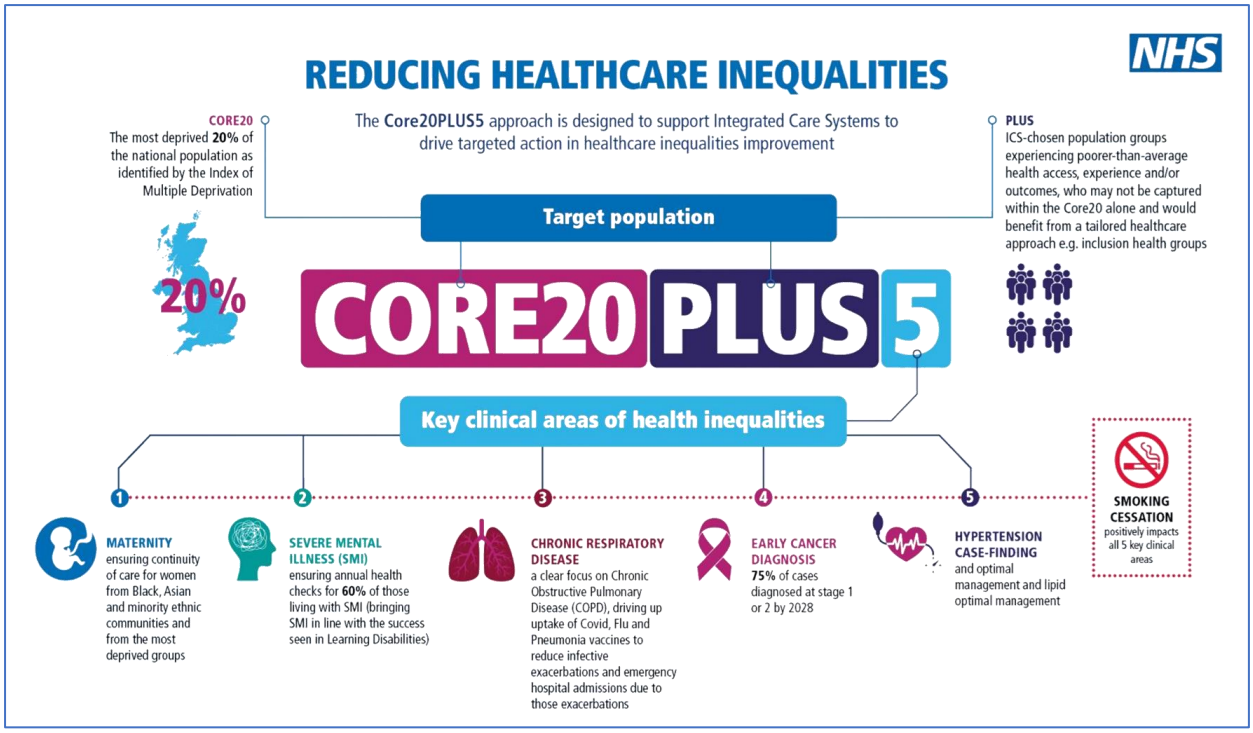


Figure 16: CORE20 PLUS5 framework for adults in MSE

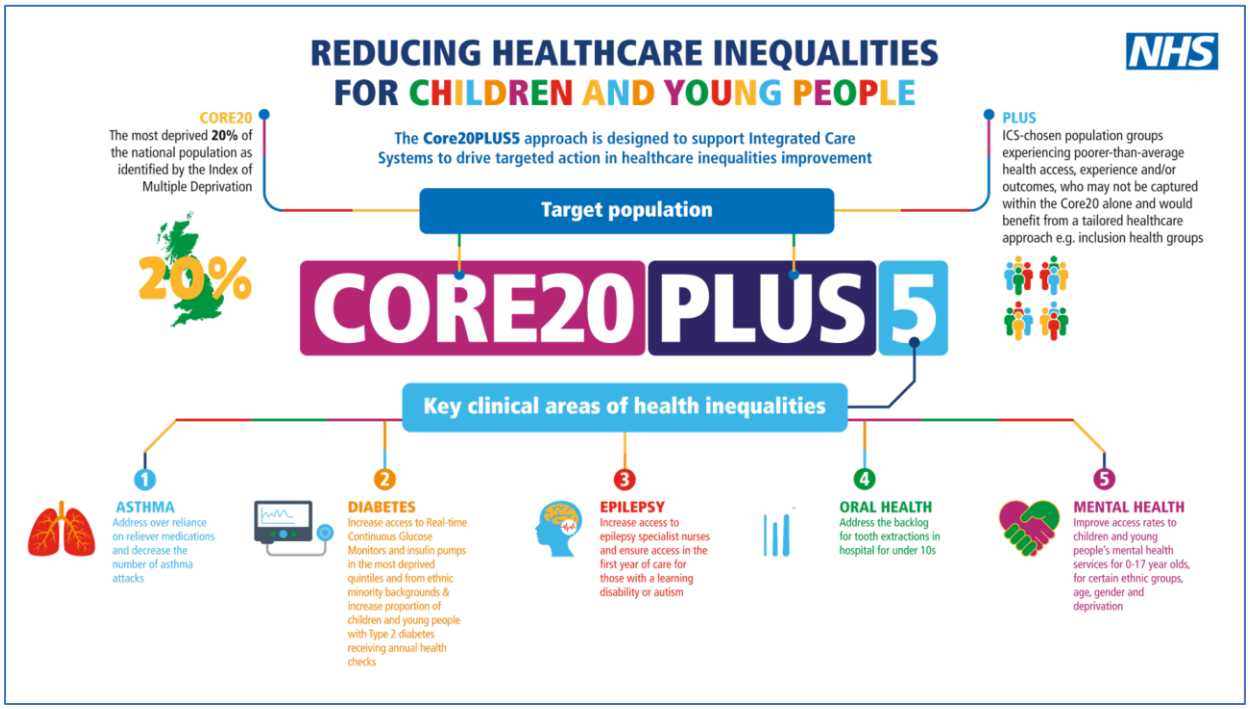


Figure 17: CORE20 PLUS5 framework for children and young people in MSE

The **CVD Prevention** programme has been identified as a system priority, with a focus on delivering improvements in hypertension and lipid management.

The ICB work collaboratively with partners towards the ICS commitment of a Smokefree 2030. This includes the launch of **tobacco cessation** programme for inpatient services and pregnant women.

Tackling increasing rates of overweight and obesity by taking a system wide approach that includes increasing access to Tier 2 weight management services, tackling the obesogenic environment and supporting children and young people to make health food choices.

We will work with communities as equal partners to develop local solutions and build resilient communities.

Our 'Working with people and communities' strategy continues to be the foundation of our engagement work to involve the public in developing NHS services. We will continue to deliver two of the core ICB duties of delivering improved services and reducing health inequalities by involving the public, particularly those from groups who experience worse health outcomes, have limited access to care and generally experience poorer quality of care.

MSE Virtual Views

Following the launch of our digital engagement platform MSE Virtual Views in November 2023, this web-based platform has developed our approach to public engagement and consultation. It features interactive capabilities like forums, polls, and workshops, accommodating both digital and face-to-face engagement. The platform's analytics enable us to craft engagement strategies that reflect the diverse makeup of our communities.

There is also a function for the participant to choose which language they would like it in, helping us reach those communities where English is not their first language.

Virtual Views allows us not only to target populations via postcode data, but those with specific disclosed health conditions, if they are a carer, or a member of staff for example. We also encourage people who sign up to provide their demographic characteristics, age, ethnicity, the more information provided the better targeted and more suitable our engagement can be.

Virtual Views will continue to play a large part in reaching out to those seldom heard groups so that we can continue to have more targeted conversations.

Research Engagement Network (REN)

We established the MSE REN in November 2023 to improve access to health and social care research to underserved groups. By focusing on marginalised groups, the REN project promotes research practices that effectively address health inequalities. Funding from NHS England has enabled us to train and support 18 community champions and their Voluntary, Community, Faith, and Social Enterprise (VCFSE) groups. These champions can now support engagement activity within their communities.

We are planning to expand the number of communities we engage with to include Chinese, Jewish, Eastern European and Gypsy, Roma, and Traveller (GRT) community, as well as expand our outreach into the LGBTQ+ community.

Our four Alliance partnerships (Basildon & Brentwood, Mid Essex, South East Essex, and Thurrock) have a collective purpose to help local people in their own communities and neighbourhoods by developing and championing cross sector collaboration to help transform our approach to the delivery of health and care. We recognise that inequalities are often rooted in unique cultural and environmental causes within communities and neighbourhoods, and by engaging directly with people and communities we can understand their specific needs. Working with local partners, approaches to joint working in our neighbourhoods are emerging, creating new and sustainable solutions which are truly reflective of the diverse communities they serve.

Health Inequalities funding has been delegated to each Alliance for local prioritisation, this funding opportunity targeted at the Faith, Voluntary, Community and Social Enterprise Sector endorses the adoption of a multi-year approach to support the development of a rolling programme of locally shaped projects. Each Alliance has identified a 'trusted partner' to manage and administer their Health inequalities funding, ensuring that funding is used effectively and efficiently to meet local needs, fostering transparency, trust, and delivery of the CORE20PLUS5 programmes.

PLUS groups are defined as those locally identified population groups who experience poorer access, experience, and outcomes. Our priority is to better engage and mature our data and intelligence which will allow us to co-design services which are more equitable and answer the needs of our identified PLUS groups. The ICB PHM team are developing local data and insight for the 'PLUS' groups within MSE to identify areas of greatest need and best practice interventions. Maturing of the ICB Insight Bank will support programs in accessible insight to PLUS groups to inform planning.

The MSE ICB has committed £3.4 million each year to reduce health inequalities. In each alliance, we are working through trusted partners – either community and voluntary sector infrastructure organisations or local councils – to identify and support projects that narrow the gap in health inequalities. Our funding is focused on the most deprived communities, PLUS groups, clinical priority areas or priority lifestyle behaviours such as smoking and weight management. The aim is to test new, innovative, and collaborative approaches to addressing the underlying causes of health inequalities.

How We Will Deliver on Our Objectives - Workforce

Through a sense of belonging, we aim to create an inclusive culture which encourages different perspectives and celebrates diversity. The ICB has developed its approach to EDIB in line with the NHS People Plan, NHS People Promise, its corporate objectives and similar plans established for the ICS.

Our approach is therefore consistent with and reflects the NHS EDI Improvement Plan introduced by NHS England in June 2023, which underpins and supports the NHS Long Term Workforce Plan. The improvement plan and indeed this strategy aims to:

- Address discrimination
- Increase accountability of all leaders
- Support the levelling up agenda
- Make opportunities for progression equitable.

This section outlines the governance, strategies, processes and reporting mechanisms in place to deliver our equality objectives for workforce.

Governance

The People Board (a sub-committee of the ICB Board) has representation from the ICB and wider system partners; it has oversight of how we achieve our workforce objectives; as an ICB and system. Sub-groups have been tasked with ensuring the objectives are delivered as shown in figure 18 (page 29).

The ICB website includes the terms of reference of the People Board and the minutes of the meetings are presented to the Board (which are also publicly available within ICB Board papers)

The Executive Committee also reports to the ICB Board and is responsible for oversight of the EDI Objectives.

The ICB has embedded and continues to strengthen inclusion as one of the key principles that runs through everything we do. To begin that journey, the Executive Committee has established a framework of staff networks (figure 19, overleaf), which will help to provide a safe space for colleagues from under-represented groups, as well as developing allies for these groups. The Executive Chief Nursing Officer chairs the ICB Inclusion and Belonging Steering Group to provide a mechanism for the steering groups to provide and link and feed back to the Executive Committee and the ICB Board. Further networks will be developed as we progress on our journey; advised by the steering group who will also revisit the effectiveness of the networks and the support they provide to staff.

At the heart of the workforce objectives is the ambition to become an employer of choice, creating an organisation culture that attracts and retains our workforce.

Strategy and Key Programmes of Work

The **People Management Strategy**, approved by the ICB Board in May 2024 is underpinned by a relevant and accessible set of HR policies and procedures that all embed a culture of EDI. It is centred around supporting four strategic pillars:

1. Culture and Leadership
2. Talent Management and Succession Planning
3. Recruitment and Retention, and
4. Data

The ‘what we need to do’ actions set out within the EDI objectives (page 15) ensure that we are taking actions to strengthen each of the strategic pillars to attract and retain our workforce as an employer of choice.

The ICB has signed up to the **sexual safety at work charter** and is implementing actions to comply fully with the charter.

Our commitment to delivering the **Anti-racism strategy** involves a programme of work to fully deliver the commitments set out by NHS England.

The ICB approach to delivering a programme of work on the **High Impact Actions** set by NHS England is provided in more detail on page 31.

Organisational Development

The ICB Organisational Development Plan sets out how we will achieve this and the key metrics for monitoring progress that are reported to the Executive Committee.

We want to create a working environment where colleagues feel comfortable and empowered to bring their whole selves to work, as this is how our workforce can deliver the very best to the population we service. We are committed to challenging discrimination and want the ICB to be a great place to work for all staff to feel they belong and are equally valued.

The ICB continues to strengthen its processes around Freedom to Speak Up and Allyship.

The Freedom to Speak Up (FTSU) Guardian (Non-Executive Board Member and Audit Committee Chair) is supported by FTSU Champions across the ICB and is linked into the Inclusion and Belonging Steering Group. Monitoring disclosures to the FTSU Guardian and the responses to the Staff Survey and Pulse surveys, the ICB can ensure that staff have avenues they can use to speak up and call out any poor behaviour that affects them and consequently is not reflective of ICB Values.

The ICB staff networks promote and encourage allyship and are supported by a structured programme of how to become an ally and the impact of the programme, which is set out on the ICB intranet ‘connect’.

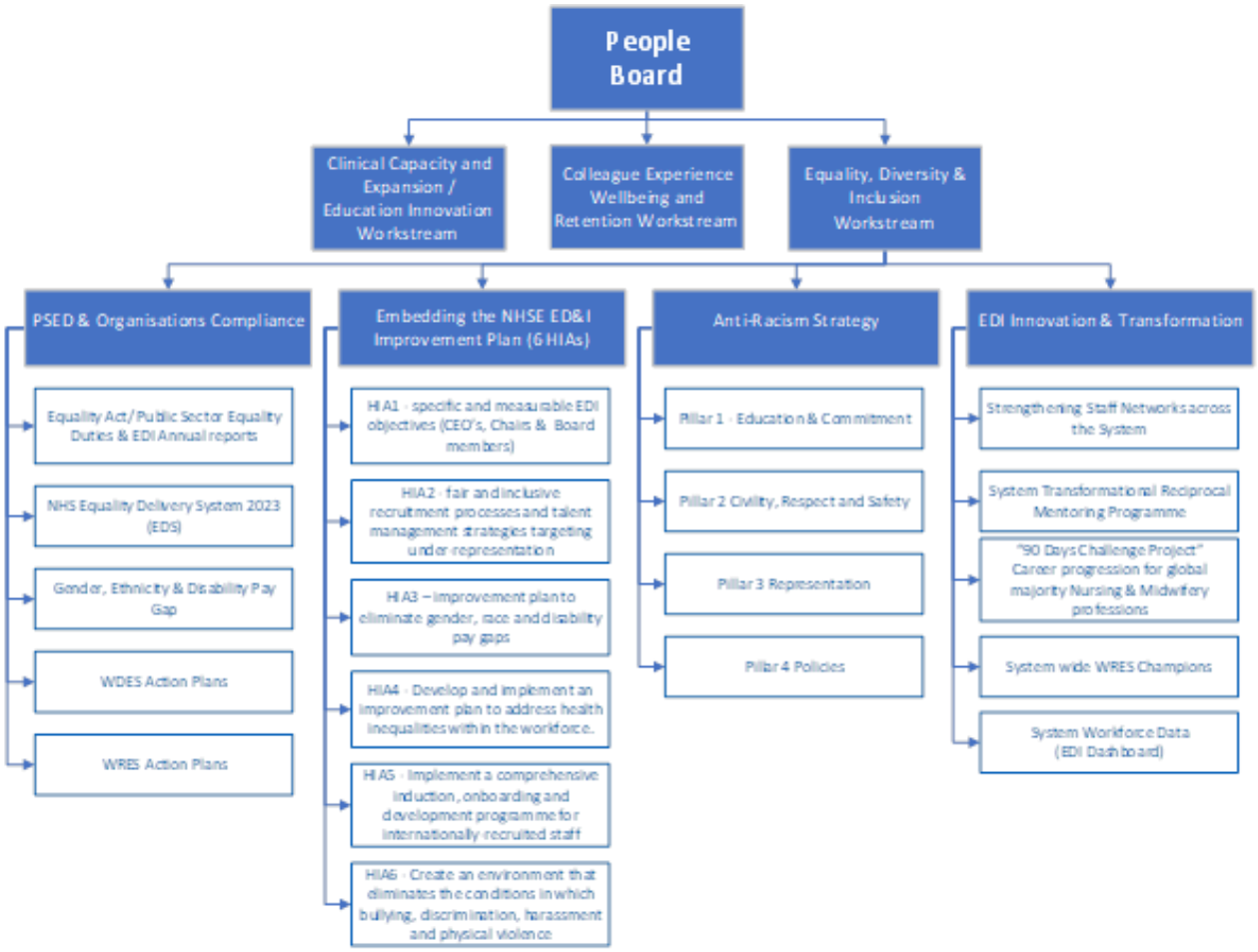


Figure 18: People Board governance structure.

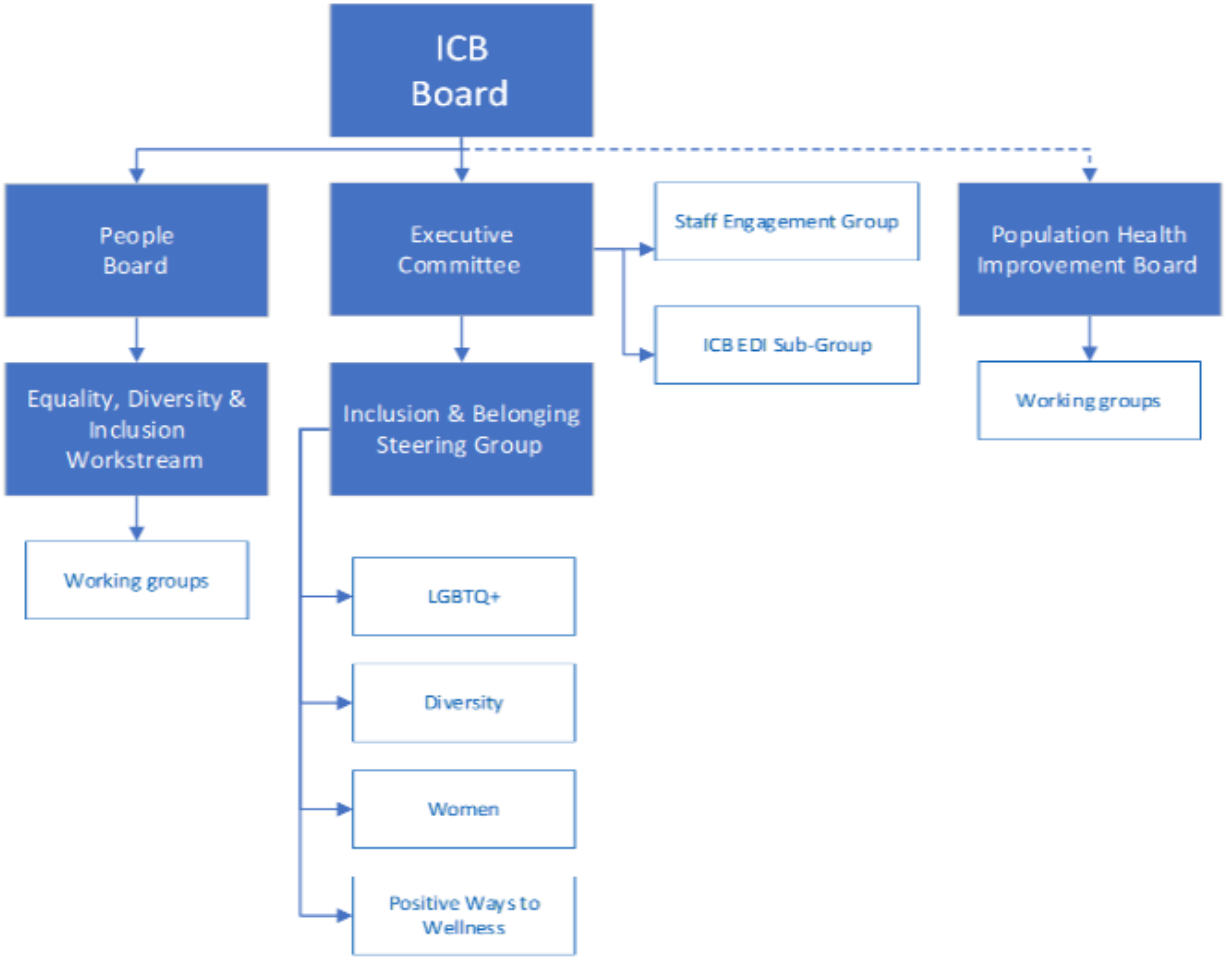


Figure 19: ICB EDI Governance and Staff Networks

Culture

Figure 20: MSE ICB Organisational Values

The culture of our organisation starts with our organisational values (see figure 20).

Our organisational values and expected behaviours each ensure that we have an inclusive workforce with a sense of belonging that promotes diversity and equality. The values are embedded through our recruitment, induction, and retention processes, how we conduct ourselves, and through our system of performance management and development.

The motivation and well-being of our staff is central to our ability to deliver our corporate and EDI objectives, and the level of recovery required across our system to meet our statutory and constitutional duties. This is measured by the annual staff survey, quarterly pulse surveys, our compliance with mandatory training, our ability to pro-actively manage our talent pool, succession planning and career development.

The 2024 staff survey results [National results across the NHS in England | NHS Staff Survey (nhsstaffsurveys.com)] reflected a period of significant organisational change and showed that we have a long journey ahead to become the organisation we want to be. We therefore must focus on equality, diversity and inclusion and use our staff networks to understand what this should look like going forward.

NHS England - Six High Impact Actions

In June 2023, NHS England published the *NHS equality, diversity, and inclusion improvement plan.* The Plan reflected on available data and the asks of the NHS People Plan and People Promise to support the 1.3 million people who work in the NHS and presented six high-impact actions to support equality, diversity, and inclusion. The ICB is committed to delivering these actions:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

We have already made progress in implementing the actions that will be monitored by the Executive Committee and the ICB Board, for example page 14

references the objectives for our Board members. We have also developed reporting dashboards to monitor continued performance and achievement of the actions in accordance with NHS England guidance.

Mandatory Reporting

In 2014, the NHS Equality and Diversity Council announced actions to ensure that employees from ethnically diverse backgrounds had equal access to career opportunities and receive fair treatment in the workplace. Thus, in April 2015 the WRES became a mandatory requirement, followed by the WDES, and GPG reporting and recently (2024) an Ethnicity Pay Gap report.

Each year the ICB completes assessments and publishes the results of the WRES, WDES and GPG alongside action plans to improve performance against the standards in the coming year. Compliance with these standards is included within this strategy to further the development of EDIB within the ICB.

Alongside those standards, NHS organisations (including the ICB and NHS Trusts within mid and south Essex) use the NHS Equality Delivery System 2022 (EDS2). This enables discussion with local partners including local populations, to review and improve performance for people with protected characteristics to deliver the requirements of the PSED.

EDS2 is aligned to NHS England's Long-Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. It consists of three domains:

- **Domain 1:** Commissioned or provided services
- **Domain 2:** Workforce health and well-being
- **Domain 3:** Inclusive leadership

The ICB, Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust (EPUT) work together to assess three services each year (on a cyclical basis). As a group, services are reviewed with patients, public, staff networks, community groups and trade unions, to review and develop our approach in addressing health inequalities through the three domains. The outcome of the assessment and resulting plans are reported to the ICB and Trust Boards and published on our websites Equality Delivery System 2022 Report for 2023/24 - Mid and South Essex Integrated Care System [hyperlinks].

How We Will Track Progress on Our Objectives

Working Groups

Within the governance sections of this strategy, we outlined working groups tasked with ensuring our programmes of work to deliver our objectives are achieved. Each working group will track and monitor progress against action plans and report back through the Executive Committee and PHIB where delays or risks to delivery are identified.

The existing staff networks (Staff Engagement Group; LGBTQ+; Diversity; Women; and Positive Ways to Wellness, alongside groups being developed for example for neurodiversity), will also oversee and hold to account the ICB for delivering on this strategy via the ICB Including and Belonging Steering Group (a sub-group of the Executive Committee).

Maturity assessments and mapping the delivery of actions

Through the NHS England [East of England] EDI maturity matrix, the ICB has assessed itself against three key areas of: compliance, the high impact actions, and the anti-racism strategy. This provides an in-depth understanding of how mature the ICB is and a mechanism to track its progress.

A detailed action plan has been established to guide the ICB through its journey of development. Updates of our progress are reported to the ICB Inclusion and Belonging Steering Group.

Reporting

The ICB will track progress on implementation across the actions it has committed to and how that work is contributing to our equality objectives through:

1. Reporting to the PHIB and the ICB Board on Health Inequalities objectives through:
   - Updates on Health Inequalities provided to the ICB Board (bi-annually)
   - Health Inequalities Information Statement (annual)
2. Reporting to the Executive Committee and ICB Board on workforce objectives through:
   - Staff pulse surveys (quarterly)
   - NHS staff survey (annual)
   - WRES, WDES and EDS2 reporting (annual)
   - Snapshot report on six high-impact actions (annual)
3. Annual review of progress against the strategy reported to the ICB Board.

Policy

The EDIB Policy, HR Policies and a suite of associated policies sit alongside this strategy to define the mechanisms by which the ICB complies with the Equalities Act and associated legislation and guidance. Each policy is assigned a sponsoring committee who has oversight of and monitors compliance with the policy.

Engagement & Awareness

The ICB will engage staff through established networks, lunch and learn sessions, through communications channels such as 'connect', staff briefings, and via training to raise awareness of the EDI agenda within the ICB and how we are progressing in implementing the various aspects of the strategy.

Culture

The Board will work with senior managers to improve visibility and organisation culture, tracking, scrutinising and monitoring progress against our actions and keeping a sense check on the culture of the ICB.

Oversight

The audit committee also has oversight of the EDI agenda and will receive updates on progress with various aspects of EDI compliance and progress with delivering the strategy. For example, the audit committee will receive reports from the Freedom to Speak Up Guardian on issues raised by staff (as outlined in the ICB Whistleblowing Policy).

Working within the MSE 'system'

The ICB will continue to work with our regional and local colleagues within the MSE ICS to better understand how we hold each other to account and deliver on the need to address inequalities and create and inclusive culture. The ICB EDIB strategy supports this journey and how we work with our colleagues, but collectively we need to ensure we are all pulling in the same direction.

An invitation to challenge

All staff members are encouraged to participate in the delivery of the EDIB Strategy and to hold themselves and others to account through line management, joining staff networks or through speak up initiatives.

All staff members are also welcome to become EDI Champions for any aspect of the EDI agenda to assist in holding the Executive and ICB Board to account for performance against our EDI objectives. Either a representative of HR or the governance team can guide you in becoming a champion.

GLOSSARY

Acronym	Definition
The 'Act'	Meaning the Equality Act 2010
COPD	Chronic Obstructive Pulmonary Disease
CORE20 PLUS5	Meaning the Core 20 Plus 5 national frameworks for narrowing the gap in health inequalities.
CVD	Cardiovascular Disease
EDI	Equality, Diversity and Inclusion
EDIB	Equality, Diversity, Inclusion and Belonging
EDS2	Equality Delivery System 2022
EHRC	Equality and Human Rights Commission
EPUT	Essex Partnership University NHS Foundation Trust
Global Majority	Is the collective term for people of Indigenous, African, Asian, or Latin American descent who constitute approximately 85% of the global population. It is increasingly used to replace language such as Black, Asian, Minority Ethnic (BAME).
GPG	Gender Pay Gap
GRT	Gypsy, Roma, and Traveller community
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ImpactEQ	Meaning the digital platform where Equality Impact Assessments are undertaken and recorded.
Intersectionality	Refers to the interconnectedness of social categories, such as race, gender, class, sexuality and ability, all of which shape an individual's experiences and opportunities.
JSNA	Joint Strategic Needs Assessment. JSNAs look at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.
LD	Learning Disability

Acronym	Definition
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, queer or questioning or another diverse gender identity
MASI	Mortality attributable to socioeconomic inequality [EXPLAIN WHAT THIS ACTUALLY MEANS]
MSE	Mid and South Essex
MSEFT	Mid and South Essex NHS Foundation Trust
NEM	Non-Executive Member of the ICB Board
PHIB	Population Health Improvement Board
PHM	Population Health Management
PSED	Public Sector Equality Duty
REN	Research Engagement Network
SED	Specific Equality Duties
SMI	Serious Mental Health Illness
VCFSE	Voluntary, Community, Faith, and Social Enterprise
WDES	Workforce Disability Equality Standards
WHO	World Health Organisation
WRES	Workforce Race Equality Standards

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 9

Winter Plan 2024/25

Summary Report

1. Purpose of Report

This report outlines the strategic and operational approach for managing the 2024/25 winter season within the Mid and South Essex Integrated Care System (MSE ICS). The plan aims to ensure the system can be resilient in handling increased demand and potential disruptions while maintaining patient flow and delivering timely care.

2. Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services

3. Report Author

Samantha Goldberg, Urgent Emergency Care System Director

4. Responsible Committees

The following meetings have reviewed and supported the approach for winter management:

- Integrated Care Board Executives Meeting
- Mid & South Essex Chief Executives Meeting

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:

- Note the risks and mitigations.
- Approve the 2024/25 winter planning approach.

Winter Plan 2024/25

1. Introduction

This report outlines the strategic and operational approach for managing the 2024/25 winter season within the Mid and South Essex Integrated Care System (ICS). The plan aims to ensure the system can be resilient in handling increased demand and potential disruptions while maintaining patient flow and delivering timely care.

Winter planning and delivery will be led by the Urgent Emergency Care System Director, with input from the Integrated Care System Winter Leads. The Mid & South Essex (MSE) Winter Planning group will meet weekly to provide operational updates, identify risks, and escalate issues to the Integrated Care Board (ICB) Executives.

The System Co-ordination Centre (SCC) serves as the operational hub, providing daily oversight. It utilises the Operational Pressures Escalation Level (OPEL) framework in conjunction with the daily OPEL status. During the morning MSE Situation Awareness meetings, actions related to the OPEL status are allocated. The actions are followed up in the afternoon to ensure continuation of patient flow across the system. Throughout the day, SHREWD Resilience database is monitored to track actions and system status/triggers. This ensures the correct measures are applied when the system becomes more pressured, and necessary escalation through provider organisations are fulfilled.

2. Main content of Report

Meeting national requirements

MSE's Winter Plan for 2024/25 aims to support the system in providing the best possible care to residents through the winter period. The plan provides a framework to maximise capacity across the system and to provide maximum resilience and oversight during periods of increased pressure.

The Winter Plan will help MSE deliver on the priorities set out in the Winter and half two (H2) priorities NHS England sent to systems in September 2024, which included:

- **Planning and financial framework**: delivering on our agreed 2024/25 operational plan.
- **Providing safe care over winter**: including delivering continued improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time (30 minutes) ambitions.
- **Supporting people to stay well**: by maximising uptake of vaccinations for flu, COVID-19 and respiratory syncytial virus (RSV).
- **Maintaining patient safety and experience**: system clinical and managerial leadership and oversight of winter plans, including providing alternatives to hospital attendance and admission, coordinated work to support Urgent Emergency Care (UEC) flow and implementation of the 10 high-impact interventions for UEC.

MSE's winter plan

MSE's winter plan, been developed around four pillars, which has been informed by the East of England (EoE) Regional Winter Risk Meeting held on 18 October 2024:

1. Operational resilience.
2. Improving co-ordination and collaboration & streamline patient flow and discharge.
3. Enhancing urgent emergency care.
4. Promoting preventative measures.

Plans also take account of the latest national evidence-based guidance on same day emergency care services (SDEC), single point of access hubs and the virtual ward operational framework.

1. Operational Resilience

MSE has implemented a robust approach to overseeing the day-to-day challenges the system may face through winter to ensure a focus on patient safety and experience alongside performance. This approach includes:

A 7 day a week SCC to provide oversight and co-ordination of the system, utilising real-time data to manage patient flow and capacity. The SCC is operational daily from 8am – 6pm, using the OPEL framework and SHREWD Resilience to help track actions and system status / triggers, working with system partners to apply appropriate measures during periods of increased pressure. The SCC is also supported by 24/7 operational and clinical leadership teams across the ICS to monitor and respond to operational pressures, ensuring timely decision-making and resource allocation to support in the management of patient demand or pressure.

2. Improving Co-ordination and Collaboration

A joined-up approach to enhance operational resilience will help support flow through UEC and the system as a whole. This will be delivered through:

- Creation and implementation of a System Discharge Cell operational from 18 November 2024, led by Michelle Stapleton, Discharge System Director. The Discharge Cell will incorporate representatives from partners and that will provide additional strategic and tactical capacity to coordinate and manage the safe movement of patients through and out of hospital this winter. It will co-ordinate discharge and flow across MSE hospital sites, community hospitals and virtual wards, social care and hospices, and mental health capacity. The Discharge Cell will have the authority make decisions and take actions that will have a tangible impact on the movement of patients across the healthcare system to support timely and effective patient care and manage system pressures.
- From 4 November 2024 multiple services that support flow and operational resilience (SCC, Unscheduled Community Care Hub (UCCH) and Discharge Cell) will be brought together in a single location on the first floor of Phoenix House, Basildon. This will enable real-time co-ordinated and transactional action

delivery, improve, and enhance communication and efficiency gains in streamlining referrals to support timely and effective care.

3. Enhancing Urgent Emergency Care

Strengthening services to provide timely and effective urgent and emergency care:

- Increasing the utilisation of SDEC at Mid & South Essex Foundation Trust (MSEFT) hospital by increasing the streaming of non-elective demand from the EDs into SDEC's to 20-30%, as per guidance to reduce admissions into core general and acute beds. The current utilisation is 10% of activity streamed, which will contribute toward mitigation of a negative acute bed position for winter. The risk to delivery is the SDEC facilities being utilised as escalation capacity, which will be monitored daily by the SCC.

- Increase utilisation of the UCCH, enabled through national funding to support the UCCH to be staffed in line with the EoE NHSE minimum viable product from 4 November 2024. The increased resources and skills within the multidisciplinary team will help enhance admission avoidance through:

  - NHS111 led 7-day virtual board rounds into care home, commencing with the top ten homes who are the greatest users of 999 resource.
    A virtual board round is an online meeting where healthcare staff discuss patients' care plans, progress, and next steps. Instead of gathering in one physical location, participants join remotely through a digital platform.
  - Incorporating the Frailty Consultant Hotline to strengthen resilience and gain efficiencies.
  - Opening the UCCH single point of access to general practice, commencing with the top general practices that are the greatest referrers to ED.

  Implementation of the East of England Ambulance Service NHS Trust (EEAST) 45-minute handover process (HO45) is designed to reduce the risk of patient harm caused by extended handover delays. These delays not only pose a risk to those waiting outside a hospital but also impact the ambulance service's ability to respond to others in the community. The HO45 will be implemented by EEAST as a standard procedure across all hospital sites, ensuring that waits for clinical handover are limited to 45 minutes. After this period, the patient will be left by the crew in the care of the ED.

  While some hospital trusts have initially found it challenging to adapt to the 45-minute handover process in other ambulance services, it is recognised at a system level that implementing HO45 will significantly improve EEAST's ability to respond to patients in the community. This, in turn, will enhance patient experience and outcomes by reducing avoidable harm associated with delayed response times. The process will be monitored and evaluated to ensure its effectiveness and to make any necessary adjustments.

4. Promoting Preventative Measures

The ICB has a number of initiatives in place to support people to stay well at home, these include:

- Increasing flu, COVID-19, and RSV vaccination rates across the system. The ICB Emergency Preparedness Resilience & Response team is working with teams across with Primary Care, community pharmacies and ICS providers to ensure widespread access to vaccines and encourage people to get vaccinated. Alongside this, the ICB is seeking opportunities to encourage 'every contact counts' with proactive vaccination.

- The ICB launched its winter communications campaign in September 2024 and covers the following three initiatives that aim to empower individuals and communities to take proactive steps to safeguard their health during winter:

    1. "Be Prepared for Winter" highlights actions individuals can take to care for themselves at home and potentially avoid the need to access NHS care. As part of this phase of work the community vaccination information bus visited Basildon, Southend, Thurrock, and Canvey in October 2024, vaccinating a total of 222 people across the four-day roadshow.
    2. "Get the right care" launched in October 2024 to inform individuals where to seek medical services, highlighting alternatives to ED.
    3. "Breathe Easier This Winter" launches in November 2024 to emphasise taking care of your lungs during colder months, especially for those with chronic respiratory conditions.

- The ICB is commissioning a Primary Care Winter Access Scheme for 2024/25 which builds on the successful scheme delivered in 2023/25. The scheme will operate at a Primary Care Network level, offering additional proactive longer appointments and reactive capacity to people with respiratory or seasonal demands at higher risk of exacerbation during winter.

Managing bed capacity

Throughout 2024/25, MSEFT has closed sixty-four core general and acute beds. Despite these closures, the hospital sometimes needs escalation capacity due to demand imbalances, activating the full capacity protocol (FCP) to facilitate patient flow and ambulance offloads.

The Trust has developed a monthly bed model that includes forecasted elective and non-elective activity, past year length of stay data, and improvement schemes to help the system understand and manage risk. This model, which can be adjusted to incorporate additional capacity or length of stay changes, aims for a minimum bed occupancy of 95%.

Based on the current system plan, from 1 November 2024 to March 31, 2025, MSEFT is facing a monthly average acute bed deficit of -168. However, a number of MSEFT and system initiatives are planned to increase system capacity and reduce the system bed deficit. If all schemes are successfully implemented, MSEFT's bed deficit would reduce to -40.

Hospital Site	MSEFT Bed Balance	Bed Balance with MSEFT Improvement Schemes Only	Bed Balance with MSEFT & ICB Improvement Schemes	Bed Balance with MSEFT, ICB & Community Collaborative Improvement Schemes
Basildon	-68	-50	-45	-26
Broomfield	-32	6	11	29
Southend	-68	-64	-59	-43
MSEFT	**-168**	**-108**	**-93**	**-40**

Table 1: MSEFT summary of bed model for winter 2024/25

The specific mitigating initiatives within the bed model are:

MSEFT:	SDEC utilisation: admission avoidance. Medical Model: admission avoidance. Board/ward rounds: length of stay reduction. Home for lunch: length of stay reduction. Red 2 Green: length of stay reduction.
Community Collaborative:	Frailty & Respiratory virtual wards: increase utilisation Stroke rehab: reduce length of stay Community beds: reduce length of stay
ICB:	Enhanced UCCH: attendance/admission avoidance Neuro-navigation pathway: reduction in length of stay

3. Risks

This winter presents risks in managing demand fluctuations and maintaining patient flow across the system whilst ensuring delivery of system interventions to mitigate the acute bed deficit. Interventions include enhancing the UCCH, implementing the Discharge Cell, and increasing SDEC activity to support ambulance offloads, reduce Emergency Department overcrowding and admissions avoidance.

In previous years, MSE received winter funds for short-term surge capacity investment, aiding demand management, ambulance offloads, emergency department performance, and patient flow. However, this year, no funds are available to expand capacity or workforce, jeopardising the already closed general and acute beds should mitigation schemes not be delivered.

Therefore, daily management, coordination, and oversight from the SCC are essential to maintain stability and resilience, enabling patient access to services and system flow. Partners must be dynamic in their responses to enact actions according to the OPEL framework. MSE ICB will utilise OPEL action cards to manage pressures, delivering specific guidance, action, and escalation at each level based on the System OPEL score.

The SCC will hold providers accountable for their actions, ensuring balanced risk across the system and supporting the reduction of OPEL scores for individual providers or the overall system.

Additional risks identified include performance, workforce, finance, health inequalities, and infection prevention control. These risks will be managed by individual providers within their respective operational and clinical management teams, and governance frameworks.

4. Recommendation(s)

The Board is asked to:

- Note the risks and mitigations.
- Approve the 2024/25 winter planning approach.

5. Appendices

Appendix A: Presentation: Mid & South Essex Foundation Trust 2024/25 Bed Model, Version 12 Bed Model – October 2024

Appendix B: Letter: NHSE Winter and H2 priorities

Appendix A

Mid and South Essex

Mid & South Essex Foundation Trust 2024/25 Bed Model

Version 12 Bed Model – October 2024

Bed Model Criteria

Mid and South Essex

The following criteria will be applied to the 2024/25 bed model:

Beds

- G&A adult beds only
  - Therefore excludes:
    Paediatrics
    Maternity
    Critical Care (ITU and HDU)
    SDECs

- Additionally excludes the ring-fenced tertiary beds:
  - CTC for Basildon site
  - Burns for Broomfield site

- Based on agreed G&A wards in line with Sitrep reporting

- Excludes day case admissions

Bed Model Proposed Assumptions

Mid and South Essex

Elective

- Forecast activity as agreed and signed off for the 2024/25 Planning to be triangulated into the bed model
- LOS to be based on 2023/24 month by month

Non Elective

- Activity forecast to be based on 2023/24 month by month with no growth applied
- LOS to be based on 2023/24 month by month.

It is important to note that whilst these reflect the initial baseline assumptions the bed model is dynamic and, as per the process throughout 2023/24, will be subject to review and any evidence-based changes to assumptions will be considered and applied accordingly.

LOS Scenarios

As above, whilst beds will be modelled against 2023/24 activity, the overall requirements for each site will be viewable for the following LOS scenarios so the impact of an improved/worsened LOS is apparent:

- 2023/24, month by month.
- 2022/23, month by month.
- 2021/22, month by month.
- 2019/20, month by month.

Bed Occupancy

- Bed balance calculations based on 92%, 95% and 98% occupancy

Bed occupancy assumption for winter 2024/25 is 95%

MSEFT Hospitals

Mid and South Essex

Assumptions based on:

- 95% bed occupancy
- Average monthly bed position from November 2024 to March 2025 (5 months)
- *Version 12 of the MSEFT Bed model*

Bed Closures:

- Basildon: 0
- Broomfield: 40 (+16 end of October) 56
- Southend: 22 (+9 in Sept and +5 in Nov = 14) 8

Hospital Site	MSEFT Bed Balance	Bed Balance with MSEFT Improvement Schemes Only	Bed Balance with MSEFT & ICB Improvement Schemes	Bed Balance with MSEFT, ICB & Community Collaborative Improvement Schemes
Basildon	-68	-50	-45	-26
Broomfield	-32	6	11	29
Southend	-68	-64	-59	-43
MSEFT	**-168**	**-108**	**-93**	**-40**
		60 bed opportunity	*15 bed opportunity*	*53 bed opportunity*

Opportunities to mitigate bed deficit across all of Mid & South Essex Foundation Trust Hospital sites with improved streaming of non-elective activity into Same Day Emergency Care (SDEC). SDEC improvement plans being compiled for the end of October 2024 to demonstrate improvement

MSEFT Hospitals

NHS
Mid and South Essex

G&A Requirement	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Non Elective Requirement		1571	1623	1617	1665	1674	1605
Elective Requirement		146	130	130	115	139	114
Total Requirement		1717	1753	1746	1780	1812	1720
Bed Base		1534	1539	1539	1539	1539	1539
Deficit at Modelled Occupancy		-183	-214	-207	-241	-273	-181
Deficit at 95% Occupancy		-129	-159	-152	-185	-216	-127
Deficit at 98% Occupancy		-78	-107	-100	-132	-162	-76

Bed Opportunities	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Frailty Assessment Units	LOS Reduction	0	0	0	0	0	0
Medical SDEC	Admission avoidance	0	0	0	0	0	0
Medical Model	Admission avoidance	0	0	0	0	0	0
AMRU	Southend Site	14	14	14	14	14	14
R2G (inc. P0 discharges/long length of stay reviews/medically optimised reduction)	LOS Reduction	0	0	0	0	0	0
Escalation bed closure x41 in April	**Impact not applied to model as escalation beds not included in core capacity.**						
LOS Reduction	LOS saving	76	63	53	53	28	27
QI – Board/ward round discipline		0	0	0	0	0	0
QI – Home for lunch		0	0	0	0	0	0
QI – Golden Hour/R2G		0	0	0	0	0	0
Total Bed Saving		**90**	**77**	**67**	**67**	**42**	**41**
Bed deficit at 95%		**-38**	**-82**	**-85**	**-118**	**-174**	**-85**
Bed deficit at 98%		**13**	**-30**	**-33**	**-65**	**-120**	**-34**

Main Ward Changes (For info)	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Ward Closures due to LOS improvements		-85	-80	-80	-80	-80	-80
Total Bed Saving		**-85**	**-80**	**-80**	**-80**	**-80**	**-80**
Bed deficit at 95%		**-38**	**-82**	**-85**	**-118**	**-174**	**-85**
Bed deficit at 98%		**13**	**-30**	**-33**	**-65**	**-120**	**-34**

System Partner Schemes	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Virtual Ward	Total bed base 15% optimisation	0	0	0	12	16	20
Stroke Rehab	LOS Reduction (47.6 LOS to 42 LOS)	0	5	5	5	5	5
Respiratory Virtual Ward	Move to 80% occupancy	0	12	14	14	14	14
Community Capacity	LOS Reduction (LOS down to 22.1 from 23.4)	0	16	16	16	16	16
UCCH	Attendance/admission avoidance	0	15	15	15	15	15
Neuro Navigation	Reduce LOS/Pathway improvement	0	0	0	0	3	3
High Intensity Users		0	9	9	9	9	9
Total Bed Saving		**0**	**57**	**59**	**71**	**78**	**82**
Bed deficit at 95%		**-38**	**-25**	**-26**	**-47**	**-96**	**-3**
Bed deficit at 98%		**13**	**27**	**26**	**6**	**-42**	**48**

Basildon Hospital

NHS
Mid and South Essex

G&A Requirement	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Non Elective Requirement		502	555	554	558	580	525
Elective Requirement		39	30	24	18	32	24
Non Elective Requirement		546	603	602	607	630	570
Elective Requirement		42	33	26	20	35	26
Total Requirement		587	636	628	627	665	596
Bed Base		542	542	542	542	542	542
Deficit at Modelled Occupancy		-45	-94	-86	-85	-123	-54
Deficit at 95% Occupancy		-27	-74	-66	-65	-102	-35
Deficit at 98% Occupancy		-9	-55	-47	-46	-82	-18

Bed Opportunities	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Frailty Assessment Units	LOS Reduction						
Medical SDEC	Admission avoidance						
Medical Model	Admission avoidance						
R2G (inc. P0 discharges/long length of stay reviews/medically optimised reduction)	LOS Reduction						
Escalation bed closure x11 in April	**Impact not applied to model as escalation beds not included in core capacity**						
LOS Reduction	0.26 day average LOS saving. Reduction in 8 due to Frederick Banting and SRU closures	18	18	18	18	18	18
QI – Board/ward round discipline							
QI – Home for lunch	1x patient per ward by lunch						
QI – Golden Hour/R2G							
Total Bed Saving		**18**	**18**	**18**	**18**	**18**	**18**
Bed deficit at 95%		**-9**	**-56**	**-47**	**-47**	**-84**	**-17**
Bed deficit at 98%		**8**	**-37**	**-29**	**-29**	**-64**	**0**

Main Ward Changes (For info)	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Frederick Banting	Bed closure due to LOS improvements	-4	-4	-4	-4	-4	-4
Surgical Referrals Unit	Bed closure due to LOS improvements	-4	-4	-4	-4	-4	-4
Other ward (Currently unknown)	Bed closure due to LOS improvements	-3	-3	-3	-3	-3	-3
Total Bed Saving		**-11**	**-11**	**-11**	**-11**	**-11**	**-11**
Bed deficit at 95%		**-9**	**-56**	**-47**	**-47**	**-84**	**-17**
Bed deficit at 98%		**8**	**-37**	**-29**	**-29**	**-64**	**0**

System Partner Schemes	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Virtual Ward	Total bed base 15% optimisation				4	6	7
Stroke Rehab	LOS Reduction (47.6 LOS to 42 LOS)		2	2	2	2	2
Respiratory Virtual Ward	Move to 80% occupancy		4	5	5	5	5
Community Capacity	LOS Reduction (LOS down to 22.1 from 23.4)		6	6	6	6	6
UCCH	Attendance/admission avoidance		5	5	5	5	5
Neuro Navigation	Reduce LOS/Pathway improvement					1	1
High Intensity Users			3	3	3	3	3
Total Bed Saving		**0**	**20**	**21**	**25**	**28**	**29**
Bed deficit at 95%		**-9**	**-36**	**-26**	**-22**	**-56**	**12**
Bed deficit at 98%		**8**	**-17**	**-8**	**-4**	**-36**	**29**

122

Broomfield Hospital

NHS
Mid and South Essex

G&A Requirement	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Non Elective Requirement 100%		463	447	439	469	449	462
Elective Requirement 100%		36	31	31	32	33	28
Non Elective Requirement		503	486	478	510	488	502
Elective Requirement		39	33	34	35	36	30
Total Requirement		542	519	511	544	524	532
Bed Base		478	478	478	478	478	478
Deficit at 95% Occupancy		**-47**	**-25**	**-17**	**-49**	**-30**	**-37**
Deficit at 98% Occupancy		**-31**	**-9**	**-2**	**-33**	**-14**	**-21**

Bed Opportunities	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Frailty Assessment Units	LOS Reduction						
Medical SDEC	Admission avoidance						
Medical Model	Admission avoidance						
R2G (inc. P0 discharges/long length of stay reviews/medically optimised reduction)	LOS Reduction						
Escalation bed closure x9 in April	**Impact not applied to model as escalation beds not included in core capacity**						
LOS Reduction	0.50 day LOS saving. Reduction in 30 due to Billericay Bay and Bardfield ward closure.	41	36	35	38	38	38
QI – Board/ward round discipline							
QI – Integrated Discharge Team scheme							
QI – Golden Hour/R2G							
Total Bed Saving		**41**	**36**	**35**	**38**	**38**	**38**
Bed deficit at 95%		**-6**	**12**	**17**	**-11**	**8**	**1**
Bed deficit at 98%		**10**	**27**	**33**	**5**	**24**	**17**

Main Ward Changes (For info)	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Billericay Ward	Closure of 4 beds to build a Wifi Hub	-4	-4	-4	-4	-4	-4
Bardfield Ward	Ward Closure	-26	-26	-26	-26	-26	-26
Rayne Ward	Closure of 11 beds	-11	-11	-11	-11	-11	-11
Feering Ward	Closure	-16	-16	-16	-16	-16	-16
Total Bed Saving		**-57**	**-57**	**-57**	**-57**	**-57**	**-57**
Bed deficit at 95%		**-6**	**12**	**17**	**-11**	**8**	**1**
Bed deficit at 98%		**10**	**27**	**33**	**5**	**24**	**17**

System Partner Schemes	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Virtual Ward	Total bed base 15% optimisation				4	5	7
Stroke Rehab	LOS Reduction (47.6 LOS to 42 LOS)		2	2	2	2	2
Respiratory Virtual Ward	Move to 80% occupancy		4	5	5	5	5
Community Capacity	LOS Reduction (LOS down to 22.1 from 23.4)		5	5	5	5	5
UCCH	Attendance/admission avoidance		5	5	5	5	5
Neuro Navigation	Reduce LOS/Pathway improvement					1	1
High Intensity Users			3	3	3	3	3
Total Bed Saving		**0**	**19**	**20**	**24**	**26**	**28**
Bed deficit at 95%		**-6**	**31**	**37**	**13**	**34**	**29**
Bed deficit at 98%		**10**	**46**	**53**	**29**	**50**	**45**

123

Southend Hospital

NHS
Mid and South Essex

G&A Requirement	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Non Elective Requirement 100%		480	491	494	505	511	491
Elective Requirement 100%		60	59	65	55	62	54
Non Elective Requirement		522	534	537	549	556	533
Elective Requirement		65	64	70	60	68	59
Total Requirement		588	598	607	609	623	592
Bed Base		514	519	519	519	519	519
Deficit at Modelled Occupancy		-74	-79	-88	-90	-104	-73
Deficit at 95% Occupancy		-55	-61	-69	-71	-85	-54
Deficit at 98% Occupancy		-38	-43	-51	-53	-66	-37

Bed Opportunities	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Frailty Assessment Units	LOS Reduction						
Medical SDEC	Admission avoidance						
Medical Model	Admission avoidance						
AMRU	Admission avoidance bed benefit	14	14	14	14	14	14
R2G (inc. P0 discharges/long length of stay reviews/medically optimised reduction)	LOS Reduction						
Escalation bed closure x21 in April	**Impact not applied to model as escalation beds not included in core capacity**						
LOS Reduction	Varying LoS not below avg of 5.9. Reduction in 21 due to Stambridge ward closure.	18	9	0	-3	-28	-28
QI – Board/ward round discipline							
QI – Home for lunch	1x patient per ward by lunch						
QI – Golden Hour/R2G							
Total Bed Saving		**32**	**23**	**14**	**11**	**-14**	**-14**
Bed deficit at 95%		**-23**	**-38**	**-55**	**-60**	**-99**	**-69**
Bed deficit at 98%		**-5**	**-20**	**-37**	**-42**	**-80**	**-51**

Main Ward Changes (For info)	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Stambridge Ward	Ward closure due to LOS improvements	-26	-26	-26	-26	-26	-26
Balmoral move to Stambridge		3	3	3	3	3	3
Estuary move to Balmoral		6	6	6	6	6	6
AMU Ward	Additional beds		5	5	5	5	5
Total Bed Saving		**-17**	**-12**	**-12**	**-12**	**-12**	**-12**
Bed deficit at 95%		**-23**	**-38**	**-55**	**-60**	**-99**	**-69**
Bed deficit at 98%		**-5**	**-20**	**-37**	**-42**	**-80**	**-51**

System Partner Schemes	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Virtual Ward	Total bed base 15% optimisation				4	5	6
Stroke Rehab	LOS Reduction (47.6 LOS to 42 LOS)		1	1	1	1	1
Respiratory Virtual Ward	Move to 80% occupancy		4	4	4	4	4
Community Capacity	LOS Reduction (LOS down to 22.1 from 23.4)		5	5	5	5	5
UCCH	Attendance/admission avoidance		5	5	5	5	5
Neuro Navigation	Reduce LOS/Pathway improvement					1	1
High Intensity Users			3	3	3	3	3
Total Bed Saving		**0**	**18**	**18**	**22**	**24**	**25**
Bed deficit at 95%		**-23**	**-20**	**-37**	**-38**	**-75**	**-44**
Bed deficit at 98%		**-5**	**-2**	**-19**	**-20**	**-56**	**-26**

Final Position	Notes	Oct	Nov	Dec	Jan	Feb	Mar
Bed deficit at 92%	124	**-41**	**-39**	**-56**	**-57**	**-94**	**-63**
Bed deficit at 95%		**-23**	**-20**	**-37**	**-38**	**-75**	**-44**
Bed deficit at 98%		**-5**	**-2**	**-19**	**-20**	**-56**	**-26**

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Winter and H2 priorities

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Content

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To:

- integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
  - integrated care partnership chairs
- all NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- regional directors

cc.

- Local authority:
    - chief executive officers

Dear colleagues

Winter and H2 priorities

Further to the meeting with ICB and provider chief executives on 3 September, we are now confirming operating assumptions for the remainder of this financial year.

This letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.

Planning and financial framework

You are all aware of the tight financial environment both across the NHS and for the government more widely; it remains essential in H2 that systems continue their work to return to their agreed 2024/25 plans.

Providing safe care over winter

As set out in our letter of 16 May, (https://www.england.nhs.uk/publication/urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24/) we are in the second year of the delivery plan for recovering urgent and emergency care (UECRP) (https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-urgent-and-emergency-care-services-january-2023/).

Colleagues across the country have worked incredibly hard to implement the priority interventions identified in the UECRP. This has delivered improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time ambitions, against an extremely challenging backdrop.

The delivery priorities for this winter remain unchanged from those agreed in system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

Given demand is running above expected levels across the urgent and emergency (UEC) pathway, ahead of winter we collectively need to ensure all systems are re-confirming that the demand and capacity plans are appropriate and, importantly, are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Supporting people to stay well

As a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign.

As well as eligible population groups, it is imperative that employers make every possible effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

More detail on eligible flu cohorts is on gov.uk:

- National flu immunisation programme 2024 to 2025 (https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan-2024-to-2025/national-flu-immunisation-programme-2024-to-2025-letter)
- COVID-19 autumn/winter eligible groups (https://www.gov.uk/government/publications/covid-19-autumn-2024-vaccination-programme-jcvi-advice-8-april-2024/jcvi-statement-on-the-covid-19-vaccination-programme-for-autumn-2024-8-april-2024)

We confirmed campaign timings for both vaccines in our system letter on 15 August (https://www.england.nhs.uk/long-read/flu-and-covid-19-seasonal-vaccination-programme-autumn-winter-2024-25/).

This year for the first time, the NHS is offering the respiratory syncytial virus (RSV) vaccine (https://www.gov.uk/government/publications/respiratory-syncytial-virus-rsv-vaccination-programmes-letter/introduction-of-new-nhs-vaccination-programmes-against-respiratory-syncytial-virus-rsv) to those aged 75 to 79 and pregnant women. This is a year-round offer but its promotion ahead of winter by health professionals is vital, particularly to those at highest risk.

To support vaccination efforts, NHS England will:

- ensure all relevant organisations receive information as quickly as possible for flu, COVID-19 and RSV
- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)

- continue to share communication materials to support local campaigns

ICBs are asked to work with:

- local partners to promote population uptake with a focus on underserved communities and pregnant women
- primary care providers to ensure good levels of access to vaccinations, ensuring that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
- primary care and other providers, including social care, to maximise uptake in eligible health and care staff

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

Maintaining patient safety and experience

We recognise this winter is likely to see UEC services come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable.

It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect.

This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

Evidence and experience shows the measures set out in the UECRP are the right ones, and systems and providers should continue to make progress on them in line with their local plans, with assurance by regional teams.

In addition, NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
    - providing capabilities 7 days a week, including situational reporting to respond to pressures in live time
    - this will be supported by a senior national clinical on-call rota to support local escalations
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
    - across all systems, and deploying improvement resources as appropriate, to support implementation of key actions within the UECRP, with a dedicated focus on ensuring patient safety
- convening risk-focused meetings with systems:
    - to bring together all system partners to share and discuss key risks and work together to agree how these can be mitigated
- expanding the Operational Pressures Escalation Levels (OPEL) framework:
    - to mental health, community and 111, and providing a more comprehensive, system-level understanding of pressures

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:
    - this will include materials and data for organisations to use, as well as a set of provider-led learning and improvement networks, to implement and embed a focused set of actions

ICBs are asked to:

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:
    - primary care and community services should be working with these patients to actively avoid hospital admissions

- provide alternatives to hospital attendance and admission:
    - especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting
    - this should include ensuring all mental health response vehicles available for use are staffed and on the road ahead of winter
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place:
    - the plan should include surge plans, and co-ordinate action across all system partners in real time, both in and out of hours
    - it should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC (https://www.england.nhs.uk/long-read/uec-recovery-plan-delivery-and-improvement-support/#annex-a-10-high-impact-interventions) published last year to ensure progress has been made:
    - systems have been asked to repeat the self-assessment exercise undertaken last year, review the output, consider any further actions required, and report these back through regions

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans:
    - with board assurance on delivery by the peak winter period
- review and test full capacity plans:
    - this should be in advance of winter
    - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member of the executive and at system level; and it is used for the minimum amount of time possible
- ensure the fundamental standards of care (https://www.cqc.org.uk/about-us/fundamental-standards) are in place in all settings at all times:
    - particularly in periods of full capacity when patients might be in the wrong place for their care
    - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces (https://www.england.nhs.uk/long-

read/principles-for-providing-safe-and-good-quality-care-in-temporary-escalation-spaces/)

- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
    - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
    - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Next steps

In addition to existing guidance in the UECRP Year 2 letter (https://www.england.nhs.uk/publication/urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24/) and elsewhere, we have recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- Same day emergency care service specification (https://www.england.nhs.uk/publication/same-day-emergency-care-service-specification/)
- Single point of access hubs (https://www.england.nhs.uk/publication/single-point-of-access-guidance/)
- Virtual wards operational framework (https://www.england.nhs.uk/publication/virtual-wards-operational-framework/)

As set out above, system risk discussions will follow during September.

We want to thank you and everyone across the NHS for your continued hard work this year.

Together, we are committed to doing everything we can to support the provision of safe and effective care for patients this winter, as well as continuing to improve services for the longer term.

Yours sincerely

Sarah-Jane Marsh, National Director for Urgent and Emergency Care and Deputy Chief Operating Officer
Dr Emily Lawson DBE, Chief Operating Officer

Professor Sir Stephen Powis, National Medical Director
Duncan Burton, Chief Nursing Officer for England

Date published: 16 September, 2024
Date last updated: 16 September, 2024

ICB Part I Board meeting, 14 November 2024

Communications and Engagement Strategy Refresh: 2025-2027

Summary Report

1. Purpose of Report

This report accompanies the refreshed 2025-2027 Communications and Engagement Strategy, which is submitted for Board review and approval. The strategy, developed in consultation with key stakeholders and partners, serves as a comprehensive roadmap to guide how the Mid and South Essex Integrated Care Board (ICB) communicates and engages with the communities, partners, and workforce we serve.

This strategy reflects both the changing needs of our communities and the financial and operational pressures facing our health and care system. It provides a robust framework for delivering clear, inclusive, and efficient communications that support transparency, foster trust, and enhance collaborative relationships across our system. Furthermore, this updated approach ensures that communication and engagement efforts align closely with our strategic priorities and adapt to emerging challenges, ensuring resilience and flexibility in meeting our goals.

By approving this strategy, the board will enable the ICB to strengthen how the organisation communicates and engages, build community trust, and enhance our system's overall effectiveness by meeting our statutory responsibilities in this area.

2. Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services

3. Report Authors

Claire Hankey, Director of Communications and Partnerships
Claire Routh, Head of Communications

4. Responsible Committees

Executive Committee

5. Link to the ICB's Strategic Objectives

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.

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

- To improve standards of operational delivery, supported by collaborative system working, to deliver patient-centred care in the right place at the right time and at the right cost to the NHS.

- To develop effective oversight and assurance of healthcare service delivery across Mid and South Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

N/A

7. Financial Implications

Not applicable to this report.

8. Details of patient or public engagement or consultation

Insight gathered via surveys and feedback – details within main report

9. Conflicts of Interest

None identified.

10. Recommendation/s

The Board is asked to approve the refreshed communications and engagement strategy for 2025-2027 set out at **Appendix A**.

Communications and Engagement Strategy Refresh: 2025-2027

1. Introduction

This draft Communications and Engagement Strategy (the strategy) provides a refreshed framework for how we, as an ICB, will work as part of a wider health and care system to communicate and engage with the public, our staff and our many stakeholders and partners. It recognises a need to refocus and adapt efforts to tackle significant financial pressures and resource constraints facing the health and care system today.

In this challenging environment, our approach to communication and engagement must be more efficient, targeted and innovative, building on what has worked well while actively listening to feedback on opportunities to do things better.

This strategy outlines how we will work differently to ensure that every communications effort maximises value, reaches the right audience and supports collaborative working to deliver the best possible solutions within the resources available.

The ICB has an obligation to explain, encourage, engage, consult, listen and respond to our multiple stakeholders and the Communications and Engagement Team has a critical role in achieving this.

The strategy takes, as its starting point, delivery of the Joint Forward Plan and the developing Medium-Term Plan that sets out system strategic priorities and actions that we have agreed with our partners.

The strategy will be reviewed and will change over time, although the core purpose of communications and engagement will not change.

It is important to recognise that communication and engagement, whether internal or facing outwards, is the responsibility of all who work in health and care, especially leaders and managers, and this will be an important feature in the culture we wish to build.

It also requires leaders and managers to be disciplined in both their expectations of and demands for communications and engagement, to ensure that what they are asking for is necessary and aligned to what is set out in this strategy.

Since the publication of the original ICS Communications Strategy in 2021, the ICB has had to respond to a national reduction in running cost allowances that has seen the communications and engagement function reduce in line with the organisational change process.

To support this shift, there have been several changes to how programmes of work are resourced outside of the core corporate communications team with wider teams asked to take on more responsibility for their own communication and engagement needs. To support this shift, all ICB staff are supported through a self-service portal on Connect (Intranet) that provides guidelines, templates, and resources. The team has also introduced a digital team handbook that includes links to key communications documents, ‘how to’ assets and important information that can be accessed quickly in a single space to support team resilience.

The new structure also now encompasses corporate communications, engagement, and a partnerships function.

This function supports the ICB's strategic objectives by fostering transparency, trust, and engagement through comprehensive strategies and initiatives. The team also provides a delivery and coordination role across the system partnership to support the work of the Integrated Care Strategy and other cross-cutting workstreams.

2. Main content of Report

Section 1 describes the purpose, vision, approaches and responsibilities of communications and engagement, i.e. the role of communications and engagement in our organisation; the vision for how the team will carry out that role, using professional and principled approaches; and clarifies what the ICB is responsible for communicating and engaging on and the responsibilities of others.

Section 2 contains a summary of how we have listened and adapted our approach in direct response to feedback from our key audiences. It sets out the variety of internal and external stakeholders and audiences that we need to reach, and the range of channels that we can use to reach them, in order to communicate and engage with them effectively – the right messages, through the right channels, at the right time.

Section 3 sets out the detailed plan for the wide range of activities that communications and engagement will be undertaking over the coming two years, which is based on the ICB's stated goals, agreed system strategic priorities and the actions that flow from them.

Communication and engagement activity during 2025-27 will therefore focus on three core areas:

1. supporting the system strategic priorities as set out in the Joint Forward Plan and developing Medium-Term Plan effective proactive communications campaigns, in partnership with other system stakeholders

2. supporting the ongoing business-as-usual activities in managing ongoing requests to support routine and urgent communications to key audiences

3. supporting the ICB's organisational development programme, especially in relation to engaging with our workforce to improve staff experiences.

In addition, the team will need to respond to any emerging issues, crises and new initiatives.

3. Recommendation

The Board is asked to approve the refreshed communications and engagement strategy for 2025-2027 set out at **Appendix A**.

4. Appendices

Appendix A – Refreshed Communications and Engagement Strategy 2025-27

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Appendix A

DRAFT Communications and Engagement Strategy REFRESH

2025-2027

October 2024 V2

1. Contents

Introduction by the Chief Executive

As we face an era marked by both unprecedented opportunities and challenges in healthcare, our commitment to a transparent and collaborative approach in how we communicate and engage with our population has never been more essential.

At the Mid and South Essex Integrated Care Board (ICB), we recognise that meaningful communication and engagement lie at the heart of achieving impactful health outcomes. Our collective journey toward a more coordinated, person-centred system of care requires clear, honest conversations with our communities, staff, and partners.

This refreshed Communications and Engagement Strategy for 2025-2027 serves as a foundational tool to strengthen those conversations and foster connections across the diverse network of individuals and organisations we serve.

In an environment shaped by financial and resource limitations, we aim to be intentional and data-driven, focusing on targeted, efficient communication that resonates.

As we move forward, we remain dedicated to integrating feedback, innovating with new technologies, and continuously refining our approach.

This strategy not only guides our communications but also embodies our commitment to inclusivity, transparency, and mutual respect.

I am confident that through this approach, we will build lasting trust and work collaboratively to realise our shared vision for a resilient, inclusive, and responsive health and care system.

Tom Abell, Chief Executive, Mid and South Essex Integrated Care Board

Executive Summary

The 2025-2027 Communications and Engagement Strategy for the Mid and South Essex Integrated Care System (ICS) outlines our renewed focus on fostering clear, effective communication with the people we serve, our workforce, and our broader healthcare network. With this strategy, the ICS commits to a proactive, audience-driven approach that leverages insights, transparency, and adaptability to address the evolving needs of our communities and stakeholders.

Key components of the strategy include:

- **Purpose and Vision**: The strategy reaffirms our commitment to delivering high-quality, accessible communication that builds trust, understanding, and partnership with our communities. We will prioritize inclusivity and accessibility to support a health system that is accountable, transparent, and grounded in the needs of those it serves.

- **Targeted Engagement**: By segmenting our audiences and refining our channels, we aim to deliver the right messages, in the right ways, at the right times. This approach will ensure that our communication efforts are not only efficient but also impactful, promoting engagement that is both genuine and effective.
- **Strategic Priorities and Flexibility**: This strategy aligns with the ICS's broader Medium Term Plan, focusing on three main areas—supporting system-wide priorities, enhancing business-as-usual communications, and fostering organizational development. A triaged approach will allow us to prioritize resources effectively and respond flexibly to emerging issues.
- **Performance Measurement**: Through a structured, evidence-led evaluation framework, we will track our impact, using data to refine and adjust our approach. Quarterly reports will provide insights into our progress, helping us demonstrate our commitment to accountability and continuous improvement.
- **Commitment to Innovation and Inclusivity**: The strategy embraces digital advancements and inclusive practices, ensuring our communications meet the diverse needs of our audiences. We will support our teams and leaders in fostering a culture of open, two-way communication to build a more resilient and community-centred healthcare environment.

With a structured yet adaptable approach, the 2025-2027 strategy represents our pledge to communicate effectively and engage authentically. We are committed to working alongside our communities and partners, listening to their insights, and building a healthcare system that reflects their needs and values.

Introduction

Since the publication of the original ICS Communications Strategy in 2021, the ICB has had to respond to a national reduction in running cost allowances that has seen the communications and engagement function reduce in line with the organisational change process.

To support this shift, there have been a number of changes to how programmes of work are resourced outside of the core corporate communications team, with wider teams asked to take on more responsibility for their own communication and engagement needs.

To support this shift, all ICB staff are supported through a self-service portal on Connect (Intranet) that provides guidelines, templates, and resources. The team has also introduced a digital team handbook that includes links to key communications documents, 'how to' assets and important information that can be accessed quickly in a single space to support team resilience.

The new structure also now encompasses a corporate communications, engagement, and partnerships function.

This function supports the ICB's strategic objectives by fostering transparency, trust, and engagement through comprehensive communication strategies and initiatives. The team also provides a delivery and coordination role across the system partnership to support the work of the Integrated Care Strategy and other cross-cutting workstreams.

This strategy has been drafted in collaboration with our NHS and wider system partners, who will share responsibility for supporting the delivery of the strategic objectives through a wide range of communications and engagement channels and techniques.

Section 1 describes the purpose, vision, approaches and responsibilities of Communications and Engagement; i.e. the role of communications and engagement in our organisation; the vision for how the team will carry out that role, using professional and principled approaches; and clarifies what the ICB is responsible for communicating and engaging on and what are the responsibilities of others.

Section 2 contains a summary of how we have listened and adapted our approach in direct response to feedback from our key audiences. It sets out the variety of internal and external stakeholders and audiences that we need to reach, and the range of channels that we can use to reach them, in order to communicate and engage with them effectively – the right messages, through the right channels, at the right time.

Section 3 sets out the detailed plan for the wide range of activities that Communications and Engagement will be undertaking over the coming two years, which is based on the ICB's stated goals, agreed system strategic priorities and the actions that flow from them.

Communication and engagement plans in 2025-27 will therefore focus on three core areas:

1. supporting the system strategic priorities as set out in the Joint Forward Plan and the developing Medium-Term Plan through delivery of effective **proactive communications campaigns**, in partnership with other system stakeholders
2. supporting the ongoing business as usual activities in **managing ongoing requests to support routine and urgent communications** to key audiences
3. supporting the **ICBs organisational development programme**, especially in relation to engaging with our workforce to improve staff experiences.

In addition, the team will need to respond to any **emerging issues, crises, and new initiatives**.

1. SECTION 1

Our purpose, vision, approaches and responsibilities

1.1 Our purpose

Communications and engagement do not exist for itself, but are an enabler and facilitator for others. The purpose of public sector communications is defined by the national Government Communications Service approach of 'CORE' activity:

- **Changing behaviours** – through planning and initiating campaigns that create desired positive behaviours among targeted audience groups, based on data, insight and behavioural science.
- **Operational effectiveness** – supporting services by providing the information that people need to access them; informing residents in a timely and co-ordinated way

about service decisions, actions and changes; being honest in recognising problems or failures; using engaging and accessible content.

- **Reputation** – of our organisation and the NHS in our area, by building positive relationships with partners and stakeholders; collaborating in how we communicate and engage genuinely with residents; promoting and celebrating what we do well; and dealing effectively with crises.
- **Explaining** – our decisions, priorities and policies, through honest and transparent communications via accessible channels, that set out the reasoning behind decisions and proposed changes, and any impact they have on finances, services and health and care outcomes.

We have a range of **statutory duties** that we must meet under the Health and Social Care Act 2012. Most relevant to this strategy is our statutory duty to involve people, whether directly

or through representatives, in:

- planning the provision of services
- the development and consideration of proposals for changes to the way services are provided
- decisions to be made affecting the operation of services.

The Act also places a specific duty to ensure that health services are provided in a way that promotes the NHS Constitution – and to promote awareness of the NHS Constitution. NHS organisations also have a duty under section 244 of the Health and Social Care Act to consult the local Health Scrutiny Committee on any proposal for 'substantial development or variation of health services'.

Other statutory duties relevant to this strategy are the Public Sector Equality Duty – Equality Act 2010 and the Accessible Information Standard.

These and other responsibilities are reflected in a dedicated 'Working with People and Communities' approach set out on the ICS website.

1.2 Our vision

The vision for our function is:

- to be seen as trusted advisers and respected by our colleagues to produce high-quality, accessible and strategically-aligned communications and engagement approaches, which are tailored for target audiences and enable two-way communications
- to support the organisation to facilitate relationships and build trust with staff, partners and communities, building and enhancing the ICBs reputation and providing contextual intelligence to help make sure communications are timely, relevant and resonate with key audiences.
- to be a leading in-house communications and engagement team, which delivers innovative approaches and attracts, retains and develops great communications and engagement professionals.

1.3 Our approaches

The fundamental approaches that the Communications and Engagement team will use to deliver our purpose, vision and the specific activities set out in section 3 are:

- we will maintain a **flexible communications approach** that allows for immediate reallocation of resources to address urgent and crisis situations. This will see less critical work temporarily paused as needed in line with agreed priorities.
- we will continue to build **trusted relationships** with leaders and managers inside the ICS and with alliance leads to ensure that we are fully informed about and engaged in issues, priorities and activities from the outset.
- we will directly link measurable **communications objectives and outcomes** to the ICB's strategic priorities
- we will **understand and segment audiences**, by making use of behavioural, demographic, public opinion and other relevant insights, to inform how we can best communicate and engage with them
- we will **develop the wide range of direct and indirect communication channels** available to us and identify which are the most effective to use for each audience and issue
- we will **provide trustworthy, timely, concise, consistent, clear, accurate and accessible information** for our audiences, focusing on what they need to know, not everything that we know
- we will develop and strengthen **structures, arrangements and processes for meaningful, effective and sustainable communication and engagement with key stakeholders**, including members, partners, patients, politicians, the public and local community groups, GP practices, community pharmacies, dental practices, general ophthalmic service providers and ICB staff
- we will **listen and respond to residents' and stakeholders' views**, promoting a culture where the experience of residents and our communities is at the centre of everything we do, through effective, two-way engagement, to ensure both that we meet our statutory obligations and that we genuinely seek their input in developing priorities and plans
- we will take a **campaigns-based communications and engagement approach** to support the ICB's priorities, adapting plans in line with contextual intelligence.
- we will establish and **continually improve communications and engagement standards** in our function by listening, learning and acting on feedback and insights
- we will continue to **strengthen the role and effectiveness of the communications network** from across the system to improve how we collectively plan and implement communications and engagement, exploring opportunities to support system efficiencies through joint procurements, maximising AI-generative opportunities, in line with the Government Communications Service generative AI policy and future ICB organisational policy.
- We will **continually evaluate** the effectiveness of our efforts and embedding a culture of continuous learning

1.4 Our communication and engagement responsibilities

While the ICB is responsible for governance, strategy and funding of health and social care in our area, the delivery of that care is the responsibility of the many health providers, from pharmacy to hospitals. This split of responsibilities is therefore similarly reflected in who is responsible for communicating what within our health and care system.

ICB Communications and Engagement is responsible for:

- working with system partners to embed a strategic approach to communications - building common ambition across the health and care system helping promote strong partnership working. Since the establishment of the ICS, communications leads from across the system have built strong relationships, identifying activities that can be jointly planned and delivered, including system-wide campaigns and programmes with an opportunity to build on shared ways of working and jointly procured tools to help demonstrate value. This collaborative approach minimises risk and optimises the use of resources, effort, and communications impact across the health and care.
- development of shared narrative linked to system-wide priority programmes.
- working with partners to adopt ensure continuous relationship building with key stakeholders.
- providing counsel, support and training to leaders and spokespeople for media, internal and public engagement events
- raising awareness and understanding of the work of the ICB and our system priorities among all staff and key stakeholders and ensuring that people are kept informed in a timely, appropriate and consistent way.
- supporting both proactive and reactive media relations in line with the ICB media policy and horizon scanning to widen understanding of and support for the work of the ICS and detect, prevent and contain issues.
- Providing an overarching framework for the use of social media within the Integrated Care Board. See ICB social media policy for more information.
- delivering the internal communications programme to colleagues directly employed by the ICB
- supporting the delivery of the key strategic programme objectives
- functional communications to ensure the timely cascade of messages and effective crisis management in line with our responsibilities as a Category 1 responder and the ICB Communications Incident Response Plan, see Appendix 1.
- planning and providing appropriate engagement activities that bring real opportunities for local people, communities, partners and staff to be involved and to ensure our communications and engagement work is coordinated across our partnership to avoid duplication. Please see this webpage for more information on the ICBs ‘Working with People and Communities’ approach.

However, it is important to recognise that communication and engagement, whether internal or facing outwards, is the responsibility of all who work in health and care, especially leaders and managers, and this will be an important feature in the culture we wish to build.

The **Mid and South Essex NHS Foundation Trust** is responsible for communications and engagement with their staff and patients about the work and performance of our three acute hospitals – Basildon, Broomfield and Southend and their satellite clinics and services.

Our three **community and mental health providers** individually and collectively– Essex Partnership University Foundation Trust, North East London NHS Foundation Trust and Provide Community Interest Company and via our **Community Collaborative** – are responsible for communicating with their staff and patients and about their services and performance.

Essex Partnership University Foundation Trust is responsible for communications to staff and patients about the work and performance of its adult and acute children's mental health services and **North East London NHS Foundation Trust** for its Emotional Wellbeing and Mental Health Service for children across Essex.

The **East of England Ambulance Services Trust** is similarly responsible for communications and engagement about its services and performance.

Our **partner local authorities** communicate with their residents on the social care services that they provide, and are also the communications lead, through their directors of public health, on a range of wider public health matters.

Our **Primary Care providers** communicate with their patient populations and for general practice in particular, must undertake community engagement through for example patient participation groups.

Finally, Healthwatch and our **voluntary and charitable sector partners** also communicate with their users and members and work closely with us to support how we engage effectively with different communities.

Who communicates what depends on a number of factors: what the organisation does; what statutory responsibilities it has; who its main stakeholders and users are; and the geographical level at which it works – from local neighbourhood to place to system.

This can be more easily understood in four simple communications categories, where an organisation has the following communications and engagement responsibilities, depending on the issue:

- **Own** – sole, direct (or statutory) responsibility to deliver
- **Lead** – lead responsibility to deliver, but must engage and agree with partners
- **Partner** – shared responsibility to deliver with one or more partners
- **Influence** – responsibility to engage and influence, but not directly to deliver.

The ICB communications and engagement team will ensure that we play our full role across the health system in our area, from delivering communications and engagement activities where we own or have statutory or lead responsibility for the issue, through to engaging with and influencing our partners, where they bear the specific responsibility for delivering communications and engagement.

We will also ensure that responsibility sits where it belongs, so that we do not take on the delivery of activities that should be done elsewhere.

2. SECTION 2

Our audiences and channels

2.1 Our audiences

Our ICS system covers 1.2 million residents. We have around 40,000 health and care staff across the NHS – around 400 of whom will work directly in the ICB, but tens of thousands more work in GP surgeries, local pharmacies, opticians, dental practices, hospitals, care homes and other partner organisations. We also work with local and national political audiences, regional and national NHS, the Department for Health and Social Care, local and national media, professional membership and regulatory bodies, voluntary, community and faith sector organisations, and trades unions. See Figure 2 for more information.

These audiences are not homogeneous – and especially our residents, who will have very different social and economic circumstances, demographics, culture, outlook, education, interests and needs.

We need to understand our audiences, so we can reach them in the right way, with the right messages, at the right time, through the right channels, so that they will hear, think and act on what we are telling them. Excellent communication and behaviour change relies on strong and sound datasets. Our work will use data and audience insight to shape our communications – both the messaging and the way in which it should be delivered.

2.2 Summary of findings from our 2024 communications surveys

To continually improve our communications strategy, it's essential to regularly evaluate what's working well and what isn't. To inform our strategy refresh, four separate surveys were issued to the below audiences:

- Staff
- Stakeholders
- Primary care
- General public

A summary of key findings and how we will adapt our approach is below. A more detailed breakdown of the feedback and methodology can be found in Appendix 2.

2.3 Key findings

There was good awareness of our corporate communications channels across the majority of internal and primary care audiences. The effectiveness and tone of communications also scored positively. Opportunities for improvement included promotion of the primary care

channels to staff and as part of primary care/PCN induction programmes, suggestions for how we might organise and better schedule communications, plus ideas for improving search functionality and clarity of content – removing acronyms wherever possible. Feedback also included a request to involve people more, with a less top-down approach to staff briefings and transformation programmes preferred.

Outputs of the public and stakeholder surveys demonstrated a perceived lack of both awareness and effectiveness in ICB corporate communications channels. While stakeholder emails were rated positively, certain social media channels such as X (Twitter), YouTube and Instagram consistently scored lower than other methods of corporate communications with concerns expressed about an overreliance on digital media and an overall preference for more face-to-face engagement. Opportunities for improvement include exploring how we can ensure more tailored and targeted messaging across the different channels, with less 'common sense' 'patronising' generic content. Themes of public feedback also demonstrated a perception of spin and a need for more transparency and honesty.

**It is important to note the responses of the survey are likely to have been impacted by the status of a public consultation that has attracted widespread objection to proposals that risk the closure of a community hospital.*

Observations about the frequency and clarity of some communications from the public and stakeholders were also consistent with feedback from internal audiences.

We will continue to develop what is working well to tailor our activities so that we reach the right audiences and will need colleagues who know those audiences best to help us to access data and insight into behaviours and preferences so that we have the best chance of getting this right.

Fairness will be integral to our approach, as we ensure that we tailor our communications well, working to avoid devoting our responsive resource to those who have the loudest voices, rather than the greatest need.

Figure 2 summarises the many different audiences that we need to engage with:

ICS Audience Wheel

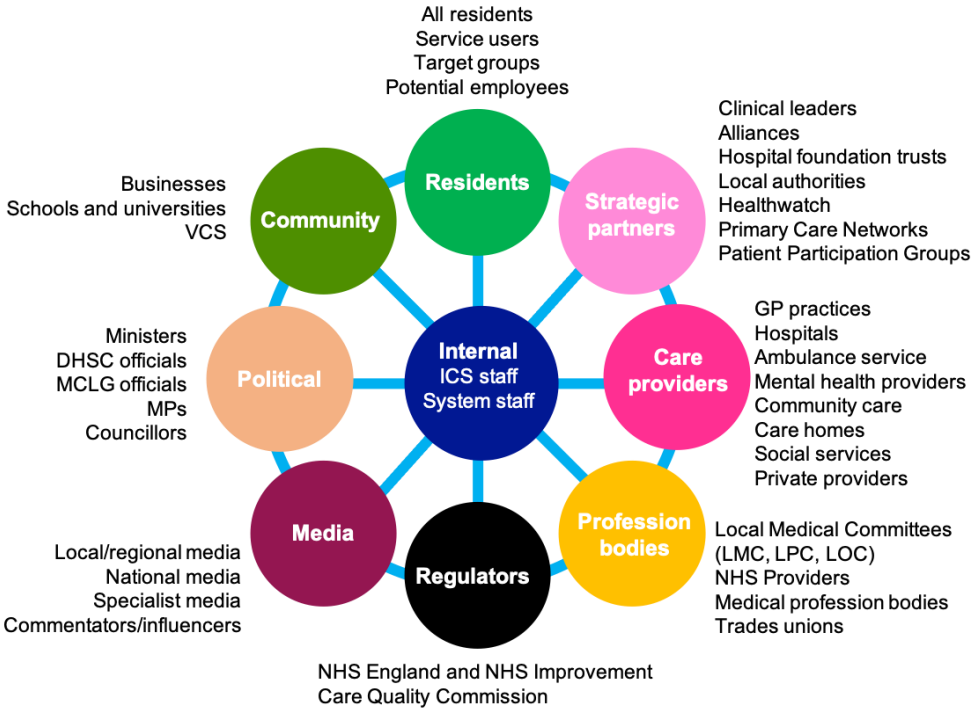


Figure 2

2.4 Our channels

Communications channels are the different ways by which we communicate and engage with our many audiences. Much of that we will do directly, although we will also communicate through third-party partners, such as hospitals and voluntary and charitable organisations, where they are best placed to reach specific audiences, and through other intermediaries, such as the media.

In selecting the right channel for the audience, we will always bear in mind both its effectiveness and cost effectiveness, and in most cases, this will mean a digital-first approach.

The main channels we use are:

- **Face-to-face** – one-to-one and group meetings, briefings, drop-ins, workshops, large events and exhibitions (either virtual or in person).
- **Media** – local and national print and online newspapers, local and specialist magazines, local and national radio and television and online-only media.
- **Print** – letters, leaflets, newsletters, print advertisements, posters, forms, magazines, printed reports, briefings and consultations.
- **Internal digital** – our own staff intranet, internal webchat, discussion forums, all-staff/team email announcements and briefings, email bulletins and lock-screen messages.

- **External digital** – our own websites, digital engagement platform, partner/campaign/interest group websites, blogs and vlogs.
- **E-marketing** – an established subscriber database continues to grow enabling us to target information to 000's of residents who have registered to receive information on specific topics.
- **Social media** – X, Facebook, Instagram and LinkedIn.
- **Marketing** – banner-type promotion messages on our website, external digital advertising, print, radio, television and out-of-home advertising, promotion via third-party/partner channels and direct mail to residents' homes

2.5 Some essential principles

Regardless of the channel we use, there are some essential principles of good communication that we will adhere to:

- write in **plain, accessible and inclusive language**, in short sentences, which are free from jargon and acronyms
- **focus on what people really need to know**, not on everything we might know
- **use data and insights** into audiences and areas to tailor communication to people and place
- **ensure messages are consistent and repeated** but tailored across channels and audiences
- **use the spokespeople most appropriate to the audience** and issue – especially recognising that clinicians are best placed to communicate to residents on health matters
- **Work with our communities** to help shape and inform our communications
- Ensure our communications are **inclusive and accessible**, avoiding a reliance on digital media using ALT text, subtitles and other means of ensuring accessibility in our communications
- **use well-designed images and photography** to bring concepts to live
- **use infographics, graphs and charts** to help with the understanding of complex numbers
- **use video** as a substitute for or supplement to documents, to engage those who prefer to watch and listen than read
- **empower and inform internal audiences** on what good communications look like, ensure relevant policies are kept up to date and adhered to
- **apply the organisation's brand, colour palette, font and house style** rigorously and consistently, so that audiences can recognise and trust what they are receiving
- **prioritise and schedule communications**, to avoid bombarding audiences with multiple messages and topics

- **communicate to colleagues first** (wherever possible) so they are equipped with accurate information, and are aware of the wider impact and how to handle queries from residents/patients
- **actively listen and respond** to stakeholder views.

3. SECTION 3

3.1. Our communication and engagement plans for 2025-2027

Our communication and engagement plans in 2025-27 will focus on three core areas:

1. supporting the system strategic priorities as set out in the Joint Forward Plan and developing Medium-Term Plan through delivery of effective **proactive communications campaigns**, in partnership with other system stakeholders
2. supporting the ongoing business as usual activities in **managing ongoing requests to support routine and urgent communications** to key audiences
3. supporting the **ICBs organisational development programme**, especially in relation to engaging with our workforce to improve staff experiences.

With limited resources, it will never be possible to meet everyone's expectations for communications and engagement support, so we will need to prioritise our work to these three areas, with a tiered level of support, depending on the level of priority and impact. We also need the capacity to respond to emerging issues and to deal with crises.

To ensure that we focus our resources and efforts on what is critical and important, we therefore triage communications and engagement work as red, amber and green rated, as follows:

Red rated **Critical – must do**	**Amber rated** **Important – should do**	**Green rated** **Nice to have – if possible**
• Primary strategic priority • Major incident response • Statutory obligation • High reputational risk to the organisation or system • High level of outcome or impact • High level of resource allocated	• Secondary strategic priority • Minor incident response • Medium level of reputational risk to the organisation or system • Medium level of outcome or impact • Medium level of resource allocated	• Not a strategic priority • Not time sensitive • Low reputational risk to the organisation or system • Low level of outcome or impact • Low level of resource allocated

Since the scope of our work is linked to the priorities established by the ICB and the resources we have available, we expect leaders, managers and colleagues to recognise and respect our responsibility to prioritise our work and engage with us collaboratively and as early as possible, so that we can plan ahead to deliver as much as possible.

While we cannot avoid a sudden and unexpected incident or crisis, we must avoid a situation in which requests and demands are brought to the team at a very late stage, leading to knock-on impacts on other critical or important activities. Communications and engagement must be involved early in projects and workstreams, so that we can provide advice and properly plan our activities and resource to support them.

3.2 System strategic priorities as set out in the Joint Forward Plan and Medium-Term Plan

The extensive actions, initiatives, programmes and projects which flow from these system strategic priorities will determine a large part of the Communications and Engagement team's activities. Each priority will need to have a planned and implemented communication and engagement plan with a detailed campaign plan, measurable objectives and intended outcomes (see 'Our campaigns approach in section 4).

Senior responsible officers and clinical leads are still developing the detailed objectives, outcomes, actions and activities that will underpin and deliver these system strategic priorities, so we are unable to provide a breakdown of the communications and engagement objectives and activities needed to support them currently.

However, we can predict that a proportion of the work of the Communications and Engagement Team will involve these priorities, and even if we cannot be clear about precisely what is needed and when, we know that they will draw on the breadth of the team's capabilities and the spectrum of channels that we use.

3.3 Supporting the ongoing business as usual activities

The day-to-day work of communications supports our health and care colleagues to deliver their services effectively. Keeping residents aware of how to access those services, involving, engaging and where appropriate consulting with them when things are changing and advising them about what they need to do because of those changes.

This is the bread and butter of operational communications, whether for internal or external audiences, delivered through, regular bulletins, media releases, social media posts and videos, keeping websites and intranets updated, advertising, posters, leaflets, newsletters and other channels.

While we undertake a huge volume of activity to support day-to-day health and care services, a lot is also delivered by our partners (see 'our responsibilities' in section 1). Below is a summary of the day-to-day corporate communications and the business-as-usual health and care communications on which we are currently engaged.

3.4 Corporate communications

We do a lot of corporate communications and engagement as part of our everyday work, which will continue, including:

- **internal communications** to colleagues about their role in delivering system strategic priorities, pay, HR, health and safety and other internal issues, actions needed.
- regular liaison with **system and regional communications teams** to ensure appropriate co-ordination and consistency of messaging.
- **drafting, editing and publishing** corporate publications including strategies, plans, consultations and reports.
- preparing **briefings and presentations** for ICS senior leaders.

- managing and developing the **ICS website, intranets (ICB staff and primary care) and corporate social media channels.**
- dealing with day-to-day media requests and **parliamentary requests** for information, statements and interviews.
- supporting **corporate governance/ transparency in decision making**, promoting access to board meetings, papers and opportunity to submit questions.
- preparing and **training spokespeople** for media interviews.
- ensuring regular flow of **proactive media releases and emails to our comprehensive subscriber list** to help communicate the work of the ICS and important information to support local health and care.
- design and delivery of **evidence-based system campaigns** to support local priorities e.g., winter preparedness.
- support and advice on designing and producing **graphics, branding and collateral.**
- planning, filming, editing and publishing **audio and video** material.
- regular **stakeholder engagement** including **MP enquiries and other briefing sessions** in partnership with system colleagues.
- supporting and promoting **staff recognition and reward events.**
- organising **events, conferences and webinars as necessary.**
- regular **bulletins to key audiences** and stakeholders.
- reputation and incident/**crisis management** communications.

3.5 GP/Primary care communications

We provide support, advice and day-to-day communications **assistance to GP practices** on a range of issues and topics in our role as delegated commissioners for these services, including:

- supporting **communication and engagement of merger/closure of practices** or moving to new premises
- changes in **contracts or performance related issues**
- **capital investment programmes** and **procurements**
- **cascade of information to practices** from ICB/system and regional and national NHS bodies through **bulletins, news sections on the primary care hub and webinars**
- **working with and supporting Primary Care Networks**
- managing the **publication of practice-level CQC reports and suspensions**
- **advising on feedback received on social media or reactive media enquiries**
- other reputational issues such as **serious incidents/outbreaks**

3.6 Public engagement

In line with our statutory duties, we lead **engagement activities**, including patient participation groups, Virtual Views citizens' panel and targeted outreach sessions. We have lead responsibility for the ICS engagement framework and provide advice, guidance and training to encourage a culture of co-production among wider teams to support its delivery as close to our communities as possible. Working with clinical leads, we will seek to ensure that we consult and engage with representative and targeted patient groups, so that we do not rely on the same voices.

3.7 Programme communications and matrix working

During the 2023/24 ICB restructure, the communications, engagement and partnerships team saw a staffing reduction of over 50%. To ensure sufficient focus on key priority programmes of work, a small number of dedicated communications posts are funded separately. This includes support for the ongoing delivery of; a system wide consultation, the MSE primary care access recovery strategy, health inequalities work and key digital programmes. These posts do however work closely with the main corporate communications team to ensure appropriate co-ordination, and specialist support where needed.

A digital communications team handbook has also been developed to support awareness and resilience of cascade of information via ICB corporate communications channels and partners.

3.8 Public health campaigns:

In delivering on the CORE framework and behaviour change, the function amplifies and supports key national public health programmes as well as developing and delivering locally led programmes including:

- **cancer awareness campaigns**, including Know the Symptoms, supporting Macmillan GPs, targeted lung health checks
- **mental health awareness campaigns**, including promotion of self-referral to adult psychological therapies, changes to local pathways (post procurement) and children and young people's support services in partnership with the SET CAMHS Communications and Marketing steering group
- **health campaigns aimed at parents and carers** e.g. Children's Health Matters

3.9 Service transformation and capital funding programmes:

The team supports across the organisation and wiser system to ensure communications and engagement is undertaken robustly and in line with our statutory responsibilities, including:

- **supporting patient insight to inform new procurements** e.g. MSK, dermatology
- **stewardship,** including changes of approach, public insight and promotion of successes

- **capital investment projects**, including Beaulieu Health Centre and Hedingham Medical Centre development in mid Essex

Supporting **business-as-usual services and function responsibilities**, including:

- **emergency preparedness, resilience and response (EPRR)** including role as Category 1 responder in the event of an incident, design and delivery of seasonal system-wide winter campaigns, supporting action during industrial/collective action and responding to weather alerts
- membership of the communications group **supporting the Local Resilience Forum (LRF)**
- **medicines management and optimisation**
- **quality improvement training and development**
- **performance and delivery of constitutional standards**
- **service restriction/prioritisation programmes**
- **quality assurance**, patient safety, regulatory compliance, reviews and audits and CQC registration/inspection
- **infection prevention and control**
- **safeguarding/ SEN**
- **operational planning cycles**
- **innovation and research**
- **anchor institutions programme**

3.10 Additional capacity and expertise

In addition to the permanent team, we recognise that at times we will need to draw on additional resources to supplement our in-house team, whether by employing temporary team members or outsourcing work to external providers.

For instance, specific, time-limited projects. And there will be instances in which we need to buy in design, audio and video skills for specialist products or capacity where we cannot meet the demand ourselves.

In order to ensure quality, consistency and value for money and governance, **the Director of Communications and Partnerships** is the accountable officer for all communications and engagement activities, which means that other departments and programmes are not permitted to employ or contract with communications and engagement resources independently of the unified team.

3.11 Our campaigns approach

To make the best use of our in-house communications skills and knowledge, we will take a ‘campaigns approach’ to communications planning and delivery against our agreed priorities, in line with the UK Government Communications Service (GCS) best practice model. In short this means implementing a planned sequence of communications and interactions that uses a compelling narrative over time to deliver a defined and measurable outcome.

Our campaigns will always have a beginning, a middle and an end. Each campaign will have set objectives, linked to the ICS's objectives, and a clear goal, to improve perception, increase understanding or change behaviour. Our campaigns will use the GCS 'OASIS' campaign planning model, as summarised below:

- **Objectives** – of the overall programme/project and SMART communications objectives
- **Audiences** – segmented with insight for appropriate targeting using the ICS 'audience wheel'
- **Strategy** – summarises resource requirement, key messages, the creative approach and the communications channels we will use
- **Implementation** – the detailed action plan of what and how we will do, and when we will do it
- **Scoring** – the evaluation of:
    - **inputs** (what we did)
    - **outputs** (the volume and reach of the activity)
    - **outtakes** (reactions and response of the target audiences to the activity) and
    - **outcomes** (effect of the communications on the audience in understanding, attitude, trust, advocacy and behaviours/actions)
    - **impacts** (the organisational outcomes that the campaign is intended to support).

3.12 Our standards and commitments

We are committed to the pursuit of excellence in our practice as a professional communications and engagement function. We will constantly seek to improve and refine our adopted operating processes and appoint the right communicators with the skills to be bold, creative and professional.

We are committed to team and individual continuous professional development, through self-learning, learning-by-doing, shared team learning and formal training.

Our team members join the Government Communications Service (GCS) and have access to the extensive professional resources and training available through the GCS website and its learning and development programmes.

We will use colleague, public and stakeholder insights to understand the attitudes, behaviours and needs of our internal and external audiences.

We will work in partnership across the organisation and with partners, sharing information and expertise freely to help services succeed.

Our communications will reflect our understanding of residents and will help to deliver sustainable change in their behaviour, in line with the ICB's objectives. It will always be relevant, targeted and accessible to those at whom it is aimed, communicating clearly and concisely, avoiding jargon and inconsistency, in tones that are helpful, informative and engaging to all our audiences. Our activities will be consistent and integrated across all channels.

We will be proactive in identifying and managing risks and issues that affect the ICB's and NHS's reputation and we will advise leaders and colleagues on the reputational impact of decisions and demonstrate the contribution that communications can make to support services, reputation and engagement.

We will respond quickly and decisively to crisis situations.

We will develop innovative and creative communications that meet the needs of all our stakeholders, which are based on evidence and result in behavioural change. We will actively promote the development and delivery of appropriate and cost-effective communications channels.

We will support the equalities and diversity agenda by ensuring our communications and information is accessible and in appropriate formats for those who need it, and by reflecting and celebrating the diversity of our communities and stakeholders. We will call out bias and discrimination.

We will ensure that our communications with communities are culturally competent and involve two-way communications when addressing health inequalities. It is particularly important to ask communities what is important to them, and to ensure that the message that we think we are sending is the same as the message that is received.

3.13 Measuring performance

The measurement of the effectiveness of the Communications and Engagement team is in three broad areas:

Campaign performance

This means setting clear objectives for each campaign and measuring and reporting on the inputs, outputs, outtakes, outcomes and impacts of the team's activities in support of the campaign (as set out in the OASIS campaigns approach above).

Organisational performance

This means measuring the contribution of the Communications and Engagement team to the success of broader organisational objectives, generally through the measurement of its channels and the perceptions of its audiences.

It is not easy to measure the direct impact of Communications and Engagement on an organisational objective, since the team's activities will only be one element of the factors contributing to the organisation's performance. For instance, the team can facilitate, enable and support leaders and managers to engage better with their teams through high-quality briefing materials, messages, presentations and events, but employee engagement is based on a much wider range of factors than the quality and timeliness of communication.

Similarly, reputation measures will be an amalgam of patient feedback data, stakeholder perceptions, media and stakeholder perceptions, political and partner perceptions and so on.

A quarterly impact report will be developed and presented to ICB executives to demonstrate delivery against the agreed ICB communications plans. The data presented will include a

breakdown of performance against key campaigns and our progress in reaching and effectively engaging with the below key audiences:

- **Internal:** ICB and key primary care audiences
- **Media and other key stakeholders**
- **External:** public facing digital channels
- **Wider community groups and those under-represented** through digital communications

Measures will include:

- **Media** – percentage of net positive, negative and neutral media coverage of the ICB
- **Stakeholder engagement** – number and percentage of external stakeholders say they feel well informed about the things that involve them; surveys of stakeholders on the quality, timeliness and relevance of communications with them and their awareness and understanding of key issues
- **Social media** – growth in reach and followers across platforms; growth in engagement rate in response to posts (eg likes/shares/comments)
- **Digital** – growth in web/intranet users; growth in subscriptions to information/news bulletins; increase in specific page hits in response to issues; increased page dwell time and reduced bounce rate (people leaving the page); increased take-up of online self-service tools, online surveys
- **Staff and primary care engagement** – number and percentage of leaders, managers and staff who access internal information (intranet news and page hits, email open-rates, online event attendance); percentage of staff who say they feel well informed about the things that affect them; intermittent sample surveys of staff on the quality, timeliness and relevance of communications with them
- **Events** – net positive feedback scores from attendees on events run, promoted or coordinated by Communications and Engagement

Financial performance

This means both the effective management of the team's budget, and its cost-effective stewardship of non-payroll activity costs. The team should demonstrate where such costs have been saved or reduced, whether by providing more cost-effective in-house services in place of external suppliers (such as for graphic design and video production), or by securing better value for money from external suppliers (such as for events, printing and advertising) by operating at a system level and applying central control and coordination of such costs

This is not an exhaustive list, and will be developed alongside the organisation's view of how it intends to measure its success as a whole.

4 APPENDIX 1

MSE communications incident plan (attached)

001 Media Policy - Mid and South Essex Integrated Care System (ics.nhs.uk)

002 Social Media Policy - Mid and South Essex Integrated Care System (ics.nhs.uk)

5 APPENDIX 2

Comms strategy survey - 26-9-24.pptx

Communications Incident Response Plan

Document Control:

Date: October 2024
Version: 1.2

1. Purpose

This Communication Incident Response Plan describes how NHS Mid and South Essex Integrated Care Board (ICB) will communicate with staff, patients and the population of mid and south Essex in the event of any incident, regardless of cause. This includes responses to emergency situations that occur externally and to those, which happen within the ICB.

It should be read in conjunction with the following national and regional EPRR plans/documents:

National:	NHS England National Incident Response Plan NHS England EPRR Framework 2022 The Civil Contingencies Act 2004
Regional:	East of England EPRR Communications Incident Response Plan
Local:	ERF Major Incident Communications Response Plan NHS Mid and South Essex Integrated Care Board Incident Response Plan NHS Mid and South Essex Integrated Care Board EPRR and BCM Policy NHS Mid and South Essex Integrated Care Board Business Continuity Plan Communications and Engagement Team Business Continuity Plan

This Communications Incident Response Plan (CIRP) is the overarching EPRR document that sets out: the transition from business as usual and step-up in operational procedures, the key responsibilities that the communications team will conduct in response to an incident affecting the mid and south Essex health and care system, and how these activities will support the overall aims and objectives of the ICB's Incident Management Team and wider structures.

It is noted that should a communications/media vacuum occur, misinformation (ignorance) and disinformation (malicious) become more prominent which makes management of the situation, the public or the message, difficult to manage. This is

why we have drafted this plan to ensure a regular flow of accurate information in the event of an emergency/crisis situation.

This plan applies the principles of integrated emergency management; anticipation, assessment, prevention, preparation, response and recovery and is supported by a range of operational plans and procedures within the ICB.

2. Incident Response Process

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies affecting health/patient care. This is underpinned by legislation contained in the Civil Contingencies Act (CCA) 2004 and Health & Social Care Act 2012.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 (supporting agencies). Category 1 responders are those organisations at the core of an emergency response and are subject to the full set of civil protection duties. These duties are set out in Chapter 8 of the EPRR framework. In terms of communications teams, the Act (section 2, paragraph 1(g)) requires organisations to:

> "***Maintain arrangements to warn the public, and to provide information and advice to the public, if an emergency is likely to occur or has occurred."***

Refer to the ICB EPRR and BCM Policy for information on the statutory requirements to maintain EPRR arrangements.

Further information on incident types and levels are detailed within the MSE ICB Incident Response Plan here.

3. Key roles, accountabilities and responsibilities

It is important to understand who is leading on the incident response. It is vital that the organisation leading the incident response is the primary source of information in relation to an incident and that requests for information or making announcements relating to the incident are made through the lead organisation.

The lead organisation, (usually the one that declared the incident) will likely be responsible for sharing information related to the incident. For example, if the incident is a large fire, the fire brigade leading the incident would be responsible. If

there was a public health related outbreak, the UK Health Security Agency would be the lead organisation.

Where an incident is health related, and action is required of the NHS, it is important to determine who would be responsible for communications within the NHS.

3.1.1 EPRR Team (Monday – Friday, 0800-1700hrs)

The MSE ICB EPRR Team are a small team of specialists who oversee and support the ICB and Providers to ensure that healthcare services are well-prepared for, can respond effectively to, and recover quickly from a wide range of incidents and emergencies such as terror attacks, cyber incidents, or pandemics for example.

In the event of an incident the EPRR Team may assume the role of Incident Manager (Tactical Commander) initially and, or provide Command Support including Subject Matter Advice.

The EPRR team also contribute to the 7 day a week System Coordination Centre (SCC) roster and the Associate Director for EPRR is nominated as the Corporate Health and Safety Lead.

Contact: mseicb-me.essex.cimt@nhs.net

3.1.2 System Coordination Centre (Monday – Sunday, 0800-1800hrs)

The System Coordination Centre (SCC) operates between 0800-1800hrs, 365 days a year, and provides a central co-ordination service for providers of care and UEC flow related services across the ICS footprint, with the aim to support patient access to the safest and best quality of care possible.

If an incident occurs during this time the SCC will initially lead on the coordination of the ICB and systems response until formal incident management arrangements are stood-up or other resources become available. The SCC Lead will initially assume the role of Incident Manager (Tactical Commander) and the SCC may undertake the role of an Incident Coordination Centre (ICC).

Contact: mseicb-me.essex.cimt@nhs.net

Telephone: 01268 594 552

3.1.3 ICB On-call

The ICB maintains a resilience and dedicated on-call system for incidents and emergencies. A Strategic Commander (Executive) is available 24/7 and a Tactical Commander (Senior Manager) is available 24/7 weekend and bank holidays, and when the SCC is closed.

Outside the SCC hours of operation, the Strategic and Tactical Commander will lead and coordinate the ICB and Systems response to an incident or emergency. If the

SCC is operational then a tripartite discussion will take place to agree roles and responsibilities based on the situation at the time.

Out of hours contact: 0345 600 0025

3.1.4 Incident Management Team (IMT)

An Incident Management Team may be established if the situation requires the coordination of a number of ICB services and/or system partners, and Incident Director appointed to lead the team, however the Incident Director may delegate authority to the Incident Manager.

The Communications Lead is a key member of this IMT and reports directly to the Incident Director (or Incident Manager) and to the team.

3.2 Communications team

3.2.1 Communications lead

The Communications Lead Officer will do the following, a full action list that may be undertaken in an incident is in Appendix I, and the Communications Action Card is in Appendix II.

- Engage with regional and national structures as appropriate.
- Develop a communications plan to help manage the incident, including aims and objectives which are aligned with those of the IMT.
- Ensure appropriate communications sign off routes are established and implemented, including delegated sign off if required.
- Co-ordinate information and communications to warn and inform public and their staff in liaison with the ECG as appropriate.
- Ensure that communication messages are aligned across these forums.
- Ensure initial media liaison and provision of a ‘talking head’ or support to the ‘talking head’ if required.
- Provide expert advice to the IMT and Incident Director/On Call Commander.
- Relay agreed communications to stakeholders such a patient groups and voluntary and third sector.
- Update key stakeholders such as councillors and MPs.
- Manage media enquiries.
- Develop social media messaging including proactive and reactive messaging.

3.2.2 On-call communications responsibility

Responsibility for on-call communications, with regard to media handling, currently sits with those on the on-call rota, 24/7 daily (including weekends and bank holidays).

Media training has been provided and is available on the ICB intranet here. Contact details and rota for the on-call Director are available through the System Coordination Centre (email the SCC or out of hours call 0345 600 0025). Information on which member of the team is on call is provided to the On Call Commander. Team members are paid an on-call allowance for providing this service.

The Director of Communications and Partnerships acts as Strategic (Gold) for the purposes of escalation for comms on-call in addition to taking on Tactical (Silver) rota duties.

There is no payment allowance for an on-call communications role. To mitigate the risk of a communications member being unavailable, a Communications guide is available via the staff intranet with guidance on communications principles and media relations, as well as key contacts in the Communications SMT.

4. Activating Incident Communications

Before starting communications in relation to an incident, it is important to understand who is leading on the incident response. It is vital that the organisation leading the incident response is the primary source of information in relation to an incident and that requests for information or making of announcements relating to the incident are made through the lead organisation.

This plan will be activated alongside the ICB Incident Response Plan or Business Continuity Plan.

The plan will be activated by the Director of Communications and Partnerships or Deputy following agreement by the ICB Incident Director (Strategic Commander), or Incident Manager (Tactical Commander).

The NHS England regional communications team will be briefed by calling their Regional Head of Strategic Communications or on-call lead via **01223 902 044** if out of hours. If this isn't possible, they will be emailed.

4.1. Brief – Who needs to know about the incident

The first step should be to check with the EPRR team to ensure they are aware of the incident and that the appropriate steps around incident response have been taken and incident leadership has been identified.

Any briefings and actions in relation to an incident are agreed with the incident leadership as follows.

Mid and South Essex EPPR colleagues
Check that EPRR colleagues are aware, sometimes information about incidents gets out in the media / social media faster than internal processes. Once this has been established, find out what steps the incident leadership are taking. Confirm set up of IMT and agree wider briefing process.

East of England Communications colleagues
If an incident has taken place, inform regional communications team through the on-call number 01223 902 044 if out of hours, or through regular daytime contact methods. Depending on the nature of the incident it may be necessary for regional colleagues to alert national colleagues to ensure that they are aware and advise of initial actions.

Provider/Partner Communications Team Relevant communications team(s) that are impacted made aware and briefed re. agreed actions.

NHSE National Communications
Regional teams are responsible for informing their national counterparts and escalating where appropriate for guidance and direction.

Key stakeholders/wider briefings
Depending on the incident, it would be appropriate to brief organisations including local government authorities, UKHSA, Directors of Public Health and Essex Resilience Forum via the Essex Communications Group.

It may be appropriate to contact other organisations who may be impacted by the incident. For example other regional and national (RAAC) trusts should be informed of a local RAAC issue for awareness, impact and information.

KEY POINT: All communications in relation to an incident need appropriate clearance. This is usually the normal clearance process with the addition of approval from the incident leadership (as this ensures accuracy and consistency).

It is vital that all communications are cleared by the Incident Communications Lead on behalf of the incident leadership (noting that key communications and sharing of new information may need to be cleared by incident leadership/national leadership).

Roles required may vary depending upon the level of response and the nature of the incident and in smaller scale or prolonged incident, roles may be adapted.

Structures will be instigated at the direction of the Incident Director with (dependent on severity of the situation) scaling variety, however it has been nationally noted the importance of robust communications in all instances.

Roles carried out by the Communications Lead Officer are outlined at Appendix I.

4.2. Strategic communications approach

Incidents are, by their nature, confusing and uncertain. The NHS has a role as a national body and a local anchor institution, that is trusted by the public. In an incident it is important that a primary source of information is created with information flowing into and out from this point. This helps to ensure accurate, clear and consistent messages are developed and shared.

A key objective during an incident is ensuring that communications reach appropriate audiences. To achieve this, it may be necessary to limit other unrelated communications. When sending out any communication during an incident, the first questions should be '**Is this necessary and does it help the NHS to respond?**' All communications should be cleared through the appropriate channels.

It is essential to establish a battle rhythm as early as possible during an incident. This allows the team to manage time effectively and manage the expectations of others.

The rhythm of the incident
The incident leadership will establish and manage incident calls. It is important to ensure communications team representation on these calls as well as any other points when data or information will be shared. This allows communications colleagues to be aware of information and remain close to key decision making.

The rhythm of the communications
It is important to establish within the Incident IMT what information will be released, by whom, when and how. This will allow for coordination across wider system communications colleagues.

All records, information, knowledge, and data should be captured and stored with running logs of decisions, key information, outstanding and completed actions maintained.

This forms the definitive record of the response and may be required at a future date as part of an inquiry process (judicial, technical, inquest or others). Such records are also invaluable in identifying lessons that would improve future response.

It is vital to ensure not only that records are captured and stored, but that information related to an incident is available to colleagues as the incident unfolds. This process will be set up by the EPRR team and maintained by a loggist.

The length of time that an incident can run will vary depending on its nature. It is important to maintain a running handover containing key information and actions. This will allow for others to take over if needed and where appropriate shift patterns are required.

4.3. Objectives

- Provide public reassurance that the incident is being managed effectively.
- Inform staff and partners of what is happening and what they should do.
- Inform accurate media reporting of the incident and correct any misinformation.
- Set timely rhythm of factual, timely information.

4.4. Single Point of Contact

Information should be shared via a single point of contact, which should be agreed within Incident IMT. This allows for information and messages to be coordinated and shared consistently.

This allows for a single, authoritative source of information to be established (which should be the Lead agency). And includes the clearance of any communications, regardless of channel.

4.5. Establishment of a Comms Cell

Where necessary, the communications lead officer would bring together a communications cell to help coordinate activity across different teams, ensuring colleagues have access to the appropriate information and understand agreed communications protocols.

4.6. Audiences and channels

It is important to consider tailoring messaging for specific audiences.

Anticipated audiences include:

- Internal audiences incl. primary care
- Media
- Digital media
- Key stakeholders
- Patients and the wider public, including vulnerable, marginalised groups

Lessons from COVID-19 demonstrated that targeted messages ensured marginalised/ vulnerable groups were reached and that messages are clearly understood.

Details of how to contact various audiences is provided via the Communications handbook.

4.6.1. Internal audiences incl. primary care

Staff will need to know what actions the ICB needs them to do. As the incident unfolds, shared internal messages will become more important as the organisation transitions through to the recovery and restoration phase.

All staff updates will be handled via the ICBs internal communications channels which is kept updated when the team is informed of starters and leavers (details via the Communications handbook). If the incident takes place out of hours, or it is necessary due to the nature of the incident, the SCC and On Call Incident Commanders will support communications to staff and through activation of the incident cascade using the Gov Notify platform.

The frequency of communications will be kept under regular review and will be determined by the pace and duration of the incident. More detailed weekly updates can be provided via the staff Intranet.

We'll also encourage staff to share messages with other members of staff whilst respecting those who are on annual/sickness/maternity/compassionate leave.

Primary care communications will be handled through the communications via the ICBs primary care communications channels and **in liaison with local Alliance colleagues**.

Where necessary, staff in partner organisations will be facilitated via a communications cascade to those in the Mid and South Essex Communications Network and /or the Essex Communications Group (ECG). These networks include partners from health services, local authorities and blue light services.

We have an ERF Major Incident Communications Framework which we will use. We can contact members of the group by email. This will be backed up by using the Mid and South Essex warn and inform WhatsApp group.

4.6.2. Media

In most incidents, the media will quickly become a key stakeholder to manage closely. The media will generally have the broadest reach for our communications, so we should consider using the media to cascade information and be ready to respond reactively to enquires.

It is important to:

- Establish media monitoring of key regional new bulletins and websites.
- Engage with any reactive media enquiries around the incident.
- Establish a list of journalists interested in the issue.
- Consider what proactive approach might be required.
- Identify a key spokesperson, ideally on the ground, for media interviews. This spokesperson would need to be sufficiently trained and not in a frontline role.

It is important to ensure there is a regular flow of information to avoid a communications vacuum. A holding line in the event of an incident unfolding is therefore important to confirm what we do know, provide reassurance and confirm where people can go for latest updates (lead agency).

Suggested holding line: *"We are aware of XX. We are currently assessing the situation, latest updates will be shared through XX. Our priority is the safety and wellbeing of all those involved."*

The role of the communications and engagement team functions in relation to media handling are detailed in the Media Policy.

4.6.3. Digital (social media, website and intranets)

- **Website**: keep website updated with latest information, including the date and time when last updated.

- **Social media**: keep all social media channels updated with the same latest information. Acknowledging the incident, providing an initial statement (in line with media statement) and then toning down content appropriately in line with the nature of the incident. Finally, declaring with the incident resolved.

- **Intranets**: Make sure internal audiences, i.e. staff and primary care receive latest information.

- **WhatsApp/Text Groups**: suggested content created to share via WhatsApp or other messaging platform cascades as appropriate.

The organisation has **four main social media channels** which can be updated with the latest information for the public. From these channels we can identify, monitor and track incidents that are happening. Via social listening tools it's possible to search key words to see what is happening and conversations around an incident.

On **Facebook** we can use local village/town/city Facebook groups to look at posts too. Additionally with Facebook we can link with the ICS's Essex Communities team

to support liaison with Facebook group administrators if an incident was in specific geographical area.

The front page of our **website** would be kept up-to-date with the most recent and relevant information. The page where more information is stored will include the time and date of when it was last updated to ensure people know they are looking at the most up to date information. Using website analytics, we would be able to look at the number of people accessing information on our website.

At times we receive **national toolkits** for communications from NHS England (East). We would use the content in these toolkits for social media, internal communications and external communications as appropriate. These toolkits would contain images, post text for social media, articles and news releases. We would use their toolkits for our own channels, only changing content when appropriate to make this localised for the public.

4.6.4. Key stakeholders

The ICB communications team already has in place a stakeholder database as well as separate methods to contact key stakeholders such as MPs, Cllrs, Health and Wellbeing Boards, Scrutiny officers etc. We can use established communication methods to keep stakeholders updated.

4.6.5. Patients and the wider public, including vulnerable, marginalised groups

Key partners including the voluntary, community and social enterprise sector will be provided with latest information and statements for them to share. Encourage them to signpost the public to our website/social media for latest updates.

To ensure consistent messages are shared, we would create a communications toolkit, including social media content, which can be shared and used by key partners. If required, we'll create a list of FAQs for the public for our website which our partners can link to.

Any such posters could be cascaded to ECG members, GPs, pharmacies and other partner organisations to display in their public places, as required.

5. Training

All on-call staff have been provided with media handling training. A recording is also available on Connect Online here.

6. Testing and Exercises

Testing every year tests our ability to contact key staff and other NHS/partners 24/7. These should test all communications methods such a telephone, email, and other communications.

These tests should be in and out-of-hours, unannounced and on a rotational basis. We need to undertake our own communications system exercise, but we can also participate in other organisations' exercises to test the plan.

7. Recovery

Recovery from any incident requires a co-ordinated approach from the affected organisation(s) and multi-agency partners, depending on the type and scale of the incident.

The recovery phase should begin at the earliest opportunity. The recovery phase does not end until all disruption has been resolved, demands on services have returned to normal levels and the physical and psychosocial needs of those involved have been met.

An emergency or disaster is a highly disruptive and stressful event. Access to quality information before, during and after an emergency can have a profound effect on the resilience and recovery of individuals and the community.

Following an emergency, people usually want to know:

- *What is happening/ what happens next?*
- *What support is available? How do they access and/or qualify for it?*
- *What to do /Where to go - if they have questions, concerns, or complaints.*

Be careful not to focus solely on those people directly affected in an emergency (for example, people whose properties were burned or those relocated due to a flood). people not directly affected can often experience significant trauma and stress following an emergency too.

An emergency can impact on a person's ability to take in information, think about it and remember it. Repetition, clear, concise information, and reassurance is vital. Inclusive communications need to consider a range of needs (age, ability, cognitive function, literacy, language, visual impairment etc) and should be provided in variety of formats and shared through multiple channels.

Debrief and learning lessons

To identify lessons from any incident, it is important to capture as much detail about the incident and the experiences of those involved as soon as is reasonably

practicable. A series of debriefs post incident is good practice. The process of debrief should also provide a support mechanism and identify staff welfare needs.

Lessons identified for communications teams during the debrief should be allocated a lead who is responsible for implementing the learning.

8. Plan Responsibility

The Audit Committee provides the Board with an independent and objective view of the ICB's compliance in relation Emergency Preparedness, Resilience & Response (EPRR).

APPENDIX I - COMMUNICATIONS LEAD OFFICER

Below are examples of actions that Communications Lead Officer may be required to undertake.

Remember to record all actions taken on the appropriate Major Incident Log. Blank templates are available here.

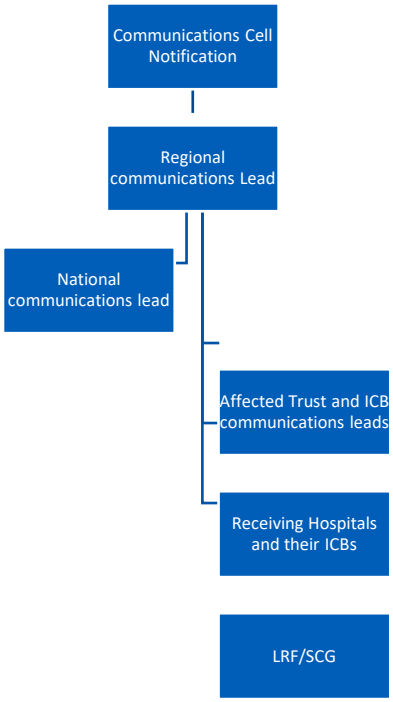
NB - If Strategic Co-ordinating Group (Gold) Media Support Group in operation, all instructions for dealing with the media locally will come from Media (Gold) and role of communications lead will be to carry out SCG (Gold) instructions.

	Action
	If in hours, contact Director of Communications and Engagement via Teams or mobile and email the Communications Team via: msepartnership.comms@nhs.net If out of hours: Contact Director on-call to notify of incident/ issue via 0345 600 0025
	Ensure NHSE regional communications are aware - england.eastcommunications@nhs.net If out of hours, notify NHSE Regional Comms on Call of incident and proposed plan of action via 01223 902 044
	Establish communications links between NHS organisations along with the admin support
	Establish communications links with local ECG to warn and inform the public
	Provide initial advice on media implications to the Incident Leader
	Develop a communications plan to help manage the incident, including aims and objectives which are aligned with those of the IMT.
	Draft initial media statements for approval.
	Get statements approved by Strategic Commander
	Ensure appropriate authorisations are established for information to be released
	Liaise with press offices in other organisations as necessary (e.g. police/fire/acutes) as part of SCG
	Organise and manage media briefings, interviews, statements, including provision of area to locate media representatives in liaison with partner agencies.

	Identify and brief spokespersons according to the position agreed by the Incident Management Team (or SCG (Gold) Media Support Group if in operation)
	Act as the point of contact between the Incident Management Team and the media.
	Comms to join briefings as required and provide expert advice and operate as part of tactical arrangements.
	Comms to escalate to Strategic (head of service) depending on complexity and scale of communications required.
	Update staff/internal audiences as required
	Consider welfare needs of staff
	Create and update posts for social media channels
	Ensure the website is kept up-to-date with information about the incident on the landing page of the website.
	Update key stakeholders as required.
	Liaise with other members of the Incident Management Team in providing appropriate advice, communication briefings etc (HR, medical leads etc)
	Undertake tasks as delegated by the Incident Leader.
	Where necessary, requesting assistance from other NHS communications leads or with the support of the NHS England
	Inform and link with SCC Manager of the Day (during days service operational)
	Set up and maintain a Media Log – this can be added as a tab or section of the Action Log. (It is essential to keep a list of everyone who has been called, all media contacts to the organisation, and all information given. Log times and dates throughout the incident).
	Monitor communications throughout the incident on social media, TV, radio and print.
	Evaluate communications activities after the incident**.**
	Participate in any debriefing following incident, as per the ICB EPRR Debrief and Post Incident / Exercising Learning Framework
	Maintain individual copy of Incident Notes and ensure that these are retained appropriately in case requested by EPRR Team for any future inquiry.
	Ensure all steps taken are documented in occurrence log (Appendix II) and all decisions captured in the Action Log.

Appendix II Communications Action Card

Communications Action Card **Communications Cell Activation and Operational Card**	
INITIAL ALERTING INFORMATION AND RESPONSE	
Aim:	**Accountable to:**
Purpose The communications cell is designed to work collaboratively to facilitate coordinated communications across the region and to the national team as part of the incident management response to an incident. **Aim, Roles, and Responsibilities**: • To ensure consistent media (including social media) and communications messaging across the region • Ensure delivery of key messages during an incident to enable ICBs/ systems/ Trusts to communicate to staff, stakeholders, and patients/public These messages are to guide a consistent message while allowing for local adaptations. • To ensure collaboration of colleagues regional/national/local comms networks as required • Develop and deliver key messages and alert/ involve other service providers who may be impacted and under intense scrutiny. • To provide assistance to, and air cover for, partners in the event of a major incident • To work with multiagency partners to delivery key messages via the LRF/SCG • Provide briefings to the regional incident management team via the incident director as required	Incident Director
Responsibilities / Actions:	**Completed (Time and date)**
Set up actions - Cell Lead	
Establish Comms Cell to complement Strategic level meetings/ instructions /strategy and set up initial meeting.	

	Cell membership to include: **Membership** • Regional communications lead/ deputy (cell lead) • Communications lead from affected organisations • Admin • Decision Loggist	
	Ensure set up of cell governance, including but not limited to: • Decision log/ action log • Meeting operational rhythm • Generic inbox • Filing	
	Operational actions – Response	
	Set agencies with roles/responsibilities within the communications cell. (Roles and responsibilities may need to be adapted in response to how the incident has been triggered)	
	Notify colleagues/national/local comms networks as required – based on location and contact availability. A notification tree is outlined below 	
	Determine and agree leadership of communications response.	
	Establish communications sign off routes	

	Provide membership if activated to other sub-group cells	
	Be ready for national team to establish and take over running of strategic direction	
	Set up action log and ensure action plan is kept updated with communications activity, and the decision log is kept	
	Monitor news and social media. Establish facts / verify / confirm what information is essential to support incident management	
	Develop a communications plan to help manage the incident, including aims and objectives which are aligned with those of the IMT	
	Develop initial statement – reactive / proactive – lines for media, social media, broadcast. Identify spokespeople and lead organisation	
	Establish communications links with local ECG to warn and inform the public	
	Establish operational rhythm for communications cell meetings / actions and proactive briefings	
	Capture questions and priorities how/who/when/whether we answer	
	Establish key audiences (internal/external) and record communications methods / frequency / content in action log	
	Agree engagement with MPs	
	Agree regional teams link to the LRF	
	Agree on site communications presence and remote presence from region and or national	
	Seek specialist expert advice as required	
	Provide briefings to the regional incident management team via the incident director as required	
	Consider staff rota and welfare issues	
	Support the recovery process including a phased return to business as usual	

	Stand down	
	Inform all involved in the response	
	Amend staff rota to reflect reduced hours staff working as cell closes down	
	Cancel all incident related meetings	
	Ensure all tasks that couldn't be completed while the cell was active (due to time constraints) are now complete.	
	Transfer all decision-making/important emails from the generic inbox to shared files	
	Record management spot check: to ensure all files are saved appropriately. Create map of folders.	
	Capture lessons learned – hold a Learning Event for all estates and facilities stakeholders to attend and provide feedback	
	Produce any necessary reports	

Appendix III Contact Groups

Group	Audience	Channel/Method
Internal	ICB Staff	E-shot distribution list
	PC – General Practice	Primary Care Hub E-shot distribution list
	PC – Pharmacy, Dental	E-shot distribution list
External	MPs/Cllrs	E-shot distribution list
	ICS Stakeholders (inc providers, Healthwatch, District and Local Authorities, CVS, LMC/LPC/LOC/LDC)	E-shot distribution list
	Parish & Town Councils	E-shot distribution list
	Essex Communications Group (inc healthcare, district and local authority, police and fire comms contacts)	Via chair of ECG) and co-chair
Public	Patients, media outlets	ICS website Social Media channels

Appendix IV Glossary

ABU	Accountable Business Unit
BCP	Business Continuity Plan
CCA	Civil Contingencies Act
CIRP	Communications Incident Response Plan
COMAH	Control of Major Accident Hazards Regulations
CPPE	Chemical Personal Protective Equipment
DOH	Department of Health
ECC	Essex County Council
EPO	Emergency Planning Officer
EPRR	Emergency Preparedness, Resilience & Response
HPU	Health Protection Unit
HSE	Health and Safety Executive
ICB	Integrated Care Board
ICC	Incident Co-Ordination Centre
ICP	Integrated Care Partnership
ICS	Integrated Care System
IRP	Incident Response Plan
JESIP	Joint Emergency Services Interoperability Principles

LA	Local Authority
MERIT	Medical Emergency Response Incident Team
METHANE	A Mnemonic used by the Ambulance Service and other NHS Organisations to assist in passing information regarding facts about a Major Incident (a form of SITREP)
MSE	Mid and South Essex
MSE ICB	Mid and South Essex Integrated Care Board
MSE FT	Mid and South Essex NHS Foundation Trust
NHS	National Health Service
NHSE	NHS England
OCC	On Call Commander
PPE	Personal Protective Equipment
REG	Resilience Escalation Guidance
RWG	Recovery Working Group
SBC	Southend Borough Council
SCG	Strategic Co-ordinating Group
SITREP	Situation Report
SPICE	Supporting People in Civil Emergencies
SPOC	Single Point of Contact
STAC	Scientific and Technical Advisory Cell

TCG	Tactical Coordination Group
TOC	Tactical Operational Cell
UKHSA	UK Health Security Agency and Office for Health Improvement and Disparities (Previously Public Health England)

Part I ICB Board meeting, 6 November 2024

Agenda Number: 11

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment 2024/25

Summary Report

1. Purpose of Report

The purpose of this report is to seek Board endorsement of the Mid and South Essex (MSE) Integrated Care Board (ICB) Emergency Preparedness, Resilience and Response (EPRR) Annual Core Standards self-assessment which remains unchanged in 2024/25 at a substantial level of compliance. The Core Standards have been reviewed and approved by the MSE ICB Audit Committee and validated with the NHS England (NHSE) regional team on 7 November 2024.

2. Chief Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services

3. Report Author

Jim Cook, Associate Director Emergency Preparedness, Resilience and Response

4. Responsible Committees

Audit Committee

5. Link to the ICB's Strategic Objectives

Improve outcomes in population health and healthcare and supporting System pressures.

6. Impact Assessments

Not applicable to this report.

7. Financial Implications

None.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

Members of the Board are asked to endorse the MSE ICB EPRR Annual Core Standards self-assessment of 'Substantial Compliance' as approved by the MSE ICB Audit Committee and validated by the NHSE regional team.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment 2024/25

1. Introduction

NHS EPRR Core Standards Assurance is an annual process to assure the Secretary of State for Health and Social Care of the NHS's readiness to respond to emergencies. The EPRR core standards provide a common reference point (or standards) for all organisations and are the basis of the annual assurance process.

2. Main content of Report

Overview of the EPRR Core Standards Assurance process

Providers and commissioners of NHS-funded services complete an assurance self-assessment based on the NHS EPRR core standards. The assurance process is led nationally and regionally by NHS England and locally by ICBs.

The NHS core standards for EPRR cover the following 10 domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiology nuclear (CBRN) and hazardous material (HAZMAT)

The applicability of each domain and core standard depends on the organisation's function and statutory requirements. For example, of the 73 core standards only 47 are applicable to the ICB.

Each year, alongside the annual assurance process, a 'deep dive' is conducted to gain valuable additional insight into a specific area. Following recent incidents and common health risks raised as part of last year's annual assurance process, the 2024/25 EPRR annual deep dive will focus on responses to cyber security and IT related incidents. The compliance ratings against individual deep dive questions do not contribute to the overall organisational EPRR assurance rating.

The outcome of the ICB's self-assessment generates an overall EPRR assurance rating based on the following:

- **Fully**: the organisation is fully compliant against 100% of the relevant NHS EPRR core standards
- **Substantial**: the organisation is fully compliant against 89-99% of the relevant NHS EPRR core standards
- **Partial**: the organisation is fully compliant against 77-88% of the relevant NHS EPRR core standards

- **Non-compliant**: the organisation is fully compliant up to 76% of the relevant NHS EPRR core standards

MSE ICB EPRR Assurance Rating 2024/25

Following the completion of the MSE ICB EPRR core standards self-assessment, the EPRR Team presented an overall assurance rating of 'substantially compliant' for 2024/25 to the MSE ICB Audit Committee on 15 October 2024, which was agreed by the committee. This represents no overall change to last year's rating, although the organisation is partially compliant with 5 core standards compared with 6 last year. The MSE ICB compliance rating was validated at a 'confirm and challenge' session with NHSE regional team England East of England on 7 November 2024.

The table below shows the front page from the MSE ICB self-assessment showing the overall compliance assessment and breakdown against each of the domains.

Please select type of organisation: Integrated Care Board
Click button to format the workbook: Format Workbook

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	8	5	3	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	6	6	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	0	0	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	47	42	5	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	4	7	0
Total	11	4	7	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: If you see a yellow ribbon at the top of the page and a button asking you to 'Enable Content' please do so
Step 2: Select the type of organisation from the drop-down at the top of this page
Step 3: Click on the 'Format Workbook' button.
Step 4: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 5: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 6: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 7: In the Action Plan tab, click on the 'Format Action Plan' button.

Work to improve compliance on these core standards will be factored into the 2025/26 EPRR workplan and updates provided quarterly to the MSE ICB Audit Committee.

3. Recommendation

Members of the Board are asked to endorse the MSE ICB EPRR annual core standards self-assessment of 'Substantial Compliance' as approved by the MSE ICB Audit Committee and validated by the NHSE regional team.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

MSE Integrated Care Board, 14 November 2024

Agenda Number: 12

Mid and South Essex Anchor Charter 2024-27

Summary Report

1. Purpose of Report

To recommend that the ICB Board sign up to the Mid and South Essex Anchor Charter for 2024-2027.

2. Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services, MSEICB

3. Report Author

Emily Hough, Executive Director, Strategy & Corporate Services, MSEICB

4. Responsible Committees

N/A

5. Impact Assessments

Not applicable to this report.

6. Financial Implications

No financial impact to signing the charter as commitments should already be being considered through the ICB's core business approaches.

7. Details of patient or public engagement or consultation

Engagement with system partners has been ongoing through the development of the MSE Anchor Charter.

8. Conflicts of Interest

None

9. Recommendation/s

That ICB Board are asked to confirm support for MSE ICB being a signatory of the MSE Anchor Charter for 2024-2027 and in doing so committing the ICB to work to apply the anchor principles to all it does.

Mid and South Essex Anchor Charter 2024-27

1. Introduction

Anchor institutions are those which are large organisations whose long-term sustainability is tied to the wellbeing of the populations that they serve. Since 2020 Mid and south Essex (MSE) health and care system has had an Anchor programme to consider how we can use our assets and resources to influence the health and wellbeing of our local communities, beyond the services we directly commission.

As part of this, an initial MSE Anchor Charter was established in 2021 (See **Appendix 1**). Through the Charter, signatories across the MSE health and care system committed to acting as 'anchors'. The MSE Anchor Charter is now being refreshed to update partner commitment to anchor principles and to reflect the breadth of members of the Integrated Care Partnership (ICP).

2. Purpose of the Report

The report seeks support from MSE ICB to sign the refreshed Mid and South Essex Anchor Charter for 2024-2027 (see **Appendix 2**). In doing so the ICB will be committing to consider the five anchor pillars in all it does.

3. Background

The NHS as an anchor institution was established from the Long-Term Plan, published in 2019. The anchor principles recognise that health, and other ICP partners, can have significant impact in their communities through the people they employ, the way they spend their money:

> *An anchor institution is one that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy. 'Anchors' tend to be large, spatially immobile and have a strong social ethos, and traditionally include bodies such as councils, universities, colleges, voluntary, community and social enterprise (VCSE) organisations, sports clubs, increasingly businesses and, of course, the NHS.*
>
> Unlocking the NHS's social and economic potential, NHS Confederation 2022

The MSE anchor programme was one of the first to be established and has been recognised for its successes, specifically in relation to employment and sustainability and active travel[1]. The 2021 MSE Anchor Charter committed signatories to a collective endeavour to act intentionally to target inequalities and ensure equality of opportunity for all and aligned Anchor to the Social Determinates of Health model and subsequently a national framework.

As a system we continue to support the anchor principles in MSE. We have refreshed the 2021-24 Charter using the national framework and its focus on employment, procurement, land and building and sustainability as its foundations.

[1] MSEFT and Essex Pedal Power are finalist for the HSJ Toward Net Zero Award,

Anchor and its principles have an existing and potentially important contribution to support reducing health inequalities and the ICB's objectives, acting as a bridge between different parts of the system. There is evidence that its principles are moving into the mainstream and can make a real difference to local communities in time of individual and organisational austerity.

1. **Social and economic development**

ICS Leaders who were surveyed by the HSJ in June 24 and the NHS Long Term Plan identify that inclusive employment is a priority in helping to transform services. As an exemplar North Bristol Foundation Trust has become the first to set a deprivation led workforce target.

2. **Tackling Inequalities**

Anchor principles can and are helping to enhance an institutional focus on specific cohorts and their opportunities, often aligning to the ICS' Core 20Plus5 approaches, including Care Leavers, Veterans, and at a time of growing concern, young people with additional needs, and MSE's changing demographics.

3. **Value for money**

Anchor support for intermediary provision such as the NHS England funded ICB Youth Work in Hospital pilots in Southend and Basildon will help to quantify efficiencies and secure longer-term investment.

4. **Population Health**

The MSE anchor programmes advocacy of active travel, air quality and quality work, in tandem, can help to reduce, for instance, the prevalence of childhood asthma where data identifies income as an important component.

4. Current position

MSE Anchor Charter

Recognising the value anchor principles can have to supporting population health and wellbeing, the MSE Anchor Charter has been updated with a refreshed set of commitments across the five areas of:

1. **Employment** – developing skills, creating opportunities and providing quality work for all.
2. **Procurement** – buying local where possible, ensuring procurements deliver social value and make it easier for suppliers to work with us.
3. **Land and buildings** – considering how to best use our assets to support our communities.
4. **Environmental sustainability** – ensuring emissions reductions and biodiversity remain a top priority across partners in line with the national Greener NHS programme.
5. **Leadership and partnership** – which is accountable, underpins and informs Anchor activity in individual organisations and across our partnership.

The MSE Anchor Charter was presented to the MSE Integrated Care Partnership Board in September 2024, where it received unanimous support. Partners, including the ICB, are now being invited to recommit to the charter for 2024-2027.

The ICB has already made progress in applying the Anchor principles and the commitments in the charter to the work that we do. Examples include:

1. **Employment:** the ICB's Health and Social Care Academy is increasing awareness of healthcare careers and supporting education and training for those who are not yet in employment. The ICB's community outreach work and the Anchor Pre-Employment Programme is supporting students, care leavers and unemployed adults to build their confidence to get back into work, with a focus on healthcare roles. These programmes are not only supporting local residents to find meaningful employment, they also support a more inclusive approach to recruitment in healthcare. Through the Anchor Ambition programme, 179 people have been supported into work including 21 people who identify as having a disability.
2. **Procurement:** Social value principles are embedded into all ICB procurements and the ICB has developed a separate scoring matrix to reflect the observations of the Model Award Criteria (MAC) that helps potential bidders understand the nuances in response requirements. Through this the ICB is taking account of broader aspects of Social Value such as Supporting Net Zero, eliminating wasteful or over packaging on products, the Modern Slavery Act 2015 and cheap labour and product miles.
3. **Land and buildings:** the ICB has developed an infrastructure strategy that recognises the need to maximise the use of estate across MSE. The development of the strategy will consider how to best use those assets to meet the needs of the local population in how we deliver services and support other partners.
4. **Environmental sustainability:** the ICB recently re-established the MSE Greener NHS Programme Board to oversee work the system is collectively doing to reduce its environmental footprint. In addition, the ICB is developing its own organisational plan to reduce emissions and minimise its environmental impact. ICB 'Greener NHS Champions' have stepped forward and are progressing initiatives such as improving active travel through the cycle-to-work scheme, increasing access to volunteering, reducing waste in ICB offices and reducing energy consumption.
5. **Leadership and partnership:** the ICB actively supports the system's Anchor Programme through local and system-wide partnership and co-production in service development. An example of this is the Basildon and Brentwood Alliance asset-based community mapping exercise that has identified the importance of prioritising mobility, community cohesion and opportunities for young people.

In addition to action within the ICB, the work of the wider anchor programme will continue to drive action and progress in ensuring that the health and care system in using its resources to best support the health and wellbeing of the local population.

Broader MSE Anchor Programme

Over the last year, MSE's Anchor programme has continued to focus on driving work across all five of the anchor pillars. In addition to this, the MSE programme has contributed to the development of a national framework, How Strong is Your Anchor: A measurement toolkit for health anchors[2] with activity closely aligned to the Social Determinates of Health model.

[2] The national UCLP led framework identifies actions, outputs and outcomes that focus on the following pillars: Employment, Procurement, Land and Buildings, Sustainability and Partnership and Leadership

More detail on the achievements of the MSE Anchor Programme can be found in the 2023/24 annual Anchor Report (see **Appendix 3**).

Priorities for the programme in 2024/25 include:

Employment

- To maintain and develop the system wide coordination of pre-employment activity.
- Developing, further, the multi-Anchor partner Social Spark, the Basildon Healthcare Innovation Incubator, to create a thriving social economy at a community level.

Procurement

- NHS Essex Anchors working collectively and with Essex Chamber for Commerce to encourage development of more diverse local suppliers and encourage more to apply to be part of our supply chains.
- Developing a tool to monitor implementation of supplier social value commitments to support communities in MSE, maximising broader value from contracts.

Land and buildings

- MSEFT's Values and Outcomes work will report on how its land and buildings are used by local/target organisations and actions that support that activity.
- MSEICS Infrastructure Strategy will help to identify opportunities for co-location and the mix of providers and help the system to consider future options.
- The development of Clinical Diagnostic Centres will be able to test the identification and reporting of anchor procurement, employment, and sustainability priorities.

Sustainability

- An Anchor partners' Climate Action Fund (Big Lottery) bid linking climate action to the everyday lives and interests of local communities, inspiring residents to act to increase climate activism and influence decision making.
- Extending the Hospitals Essex Pedal Power variation across geographies and partners through a combination of approaches including active travel.

Partnership and leadership

- The Values and Outcomes work that identifies and quantifies intermediary support that begins in hospital and reduces attendance, admission/ readmission and stays.
- The socialising, signing, and reporting of a Mid and South Essex Anchor Charter.

5. Recommendations

That ICB Board are asked to confirm support for MSE ICB being a signatory of the MSE Anchor Charter for 2024-2027 and in doing so committing the ICB to work to apply the anchor principles to all it does.

6. Appendices

Appendix 1 - Mid and South Essex Anchor Charter 2021-24.
Appendix 2 - Mid and South Essex Anchor Charter 2024-27.
Appendix 3 - Annual ICS Impact Report 2023-24.

Mid and South Essex Health and Care Partnership

Charter for the Mid and South Essex Partnership of Anchor Institutions

Mid and South Essex Health and Care Partnership has huge potential to add social value to the 1.2m people who live in our area, through:

- targeting inequalities
- creating the conditions to attract local investment and economic growth
- increasing educational aspiration and attainment among children and adults
- offering local employment opportunities
- addressing discrimination in all its forms
- creating a culture of diversity and inclusion - ensuring equality of opportunity for all
- leading the way in supporting the health and wellbeing of our workforce and our residents
- addressing concerning trends such as lowering aspirations of young people, and health disparities exacerbated by COVID-19.

An Anchor Institution commits itself to this cause, acting with intent and drive towards this goal.

As partners in our Health and Care Partnership we recognize the key role that we have to influence these areas, and the impact this will have on the health and wellbeing of our local communities. Evidence[1] has shown in the public sector we can make gains in considering our role in employment, education and life chances, procurement and estate, now and in the future through thinking about long-term impacts of our actions and sustainability.

We therefore sign below to recognize our commitment to consider, within our legal and regulatory limits, every opportunity to add social value through our decisions and actions as an organisation and as a Partnership. We will do this deliberately, and agree through this Charter to collaborate with partners to support our Anchor Institutions in this endeavour.

Our Anchor Partnership Principles

To work, an anchor needs a chain, and the Mid and South Essex Anchor Partnership will only succeed by having strong links and pulling together. We aim to build on existing relationships, engagement, intelligence and investment to deliver greater value and expand opportunity, leading to higher impact.

No single organisation can achieve as much on its own as an Anchor Institution as we can by drawing on, complementing and amplifying the strengths of each other. The Anchor Partnership will measure its success through the achievements of the partners below collectively against our shared goals.

[1] Building healthier communities: the role of the NHS as an anchor institution, Health Foundation, August 2019

As employers

Creating More Opportunity for Good Work

Between us we employ over 40,000 people, many of whom live in the Mid and South Essex area. This fact gives added emphasis when carrying out our statutory duties and responsibilities. As our legal and professional frameworks allow, we will review our approaches and policies to create more opportunity for meaningful, good work locally; ensuring employment practices are as inclusive and accessible as possible, focusing on the opportunity to add social value and reduce inequality.

We will build an ambition to add social value within Mid and South Essex into our education and training portfolio, including through targeted engagement with young people, apprenticeships and career programmes linking to the wider public sector and local business, through widening participation.

We will increase opportunities for local people to volunteer and gather work experience in our organizations where this has been shown to lead to improvements in rates of employment, and aim to make these opportunities as inclusive as possible of those with particular needs or protected characteristics or from under-represented groups. We will also encourage staff to volunteer within their communities, to improve their health and wellbeing and to increase their community assets.

Health and Wellbeing at Work

We will ensure inclusive, healthy workplace wellbeing schemes, aiming to build active workplaces and supporting those with highest needs. We will encourage staff to help us with this agenda and where appropriate will build health and wellbeing messages into our work with communities e.g. schools.

We also commit to supporting lower paid staff reaching their potential via inclusive personal and professional development, and supporting them more broadly in their health, wellbeing and financial security where possible.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

As purchasers

Supporting local enterprise
Insofar as is consistent with our statutory obligations or requirements from our regulators, we will procure locally and in line with good practice principles on procurement to maximize social value. This will include looking to develop routes for locally based micro, small and medium-sized enterprises to take on contracts from our organizations. This will also contribute to reducing our carbon footprint.

Social and environmental value from procuring goods and services
As regulatory processes allow, we will build social value into our supply chain contracts, expecting providers to quantify the social value returned to Mid and South Essex as part of the contracting process.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

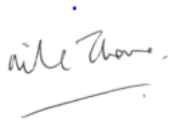
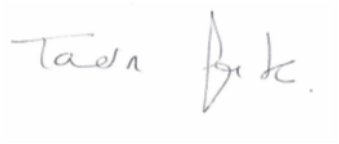
Leading by example for our environment

We will incorporate sustainability criteria into our contracts to reduce our environmental impact.

We will utilize our estate and facilities in support of staff and local communities e.g. through concepts such as green spaces, encouraging community groups and businesses to use our sites, and promoting active and green travel through and to our sites and processes.

We will work across sectors and industries to innovate and address inequality through access to resources such as energy, transport, housing, health and care and leisure for local communities including our own staff and their families.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

 Professor Michael Thorne CBE Independent Chair Mid & South Essex Health & Care Partnership	 Anthony McKeever Executive Lead, Mid & South Essex Health & Care Partnership Joint Accountable Officer for the 5 CCGs
 Clare Panniker Chief Executive Mid & South Essex NHS Foundation Trust	 Paul Scott Chief Executive Essex Partnership University NHS Foundation Trust
 Oliver Shanley Chief Executive North East London NHS Foundation Trust	 Mark Heasman Chief Executive Provide CIC
 Ian Wake Corporate Director of Adults, Housing & Health Thurrock Council	 Tandra Forster Executive Director (Adults & Communities) Southend-on-Sea Borough Council
 Nick Presmeg Director of Adult Social Care Essex County Council	 Juliet Beal Director of Nursing & Quality East of England Ambulance Service Trust
 Owen Richards Strategic Manager Healthwatch Southend	 Sam Glover Chief Executive Healthwatch Essex
 Kim James Chief Operating Officer Healthwatch Thurrock	 Kristina Jackson Thurrock CVS on behalf of CVS organisations in Mid & South Essex

Appendix 2

Mid and South Essex Integrated Care System

Mid and South Essex Anchor Charter 2024-2027

Mid and South Essex Integrated Care System, its partners, providers, and institutions have huge potential to add value by combing their size and spending to improve the health and wellbeing of the whole community including tackling embedded inequality.

Anchor institutions are large, often public-sector, bodies that are 'anchored' in place – in other words, unlikely to move – and linked to their local community. Anchors have a responsibility to improve the health, wealth and wellbeing of their local population and reduce inequalities. They also have multiple opportunities to do this, by managing their resources and operations strategically in support of the ICS requirement to support the development of social and economic wellbeing.

Anchors can have a positive impact on the social determinants of health by shifting and targeting the way they employ staff, procure goods and services, use their land and buildings, contribute to environmental sustainability and work in partnership. Anchors can also help support broader social and economic development.

The Mid and South Essex Charter is our collective commitment to act individually and collectively through these themes to improve life chances for our residents, patients, and their families.

The Mid and South Essex Anchor Approach

As Anchors we are committed to acting intentionally, by focusing on five key pillars that target inequalities, promote inclusion, and ensure equality of opportunity for all.

Our approach covers action to support:

- **Employment** – developing skills, creating opportunities, and providing quality work for all.
- **Procurement** – that is local, by preference, delivers social value and makes it easier for our suppliers to trade with us.
- **Land and Buildings** – sharing, our assets with our communities, and the opportunities new developments can deliver for communities.
- **Sustainability** – ensuring that it remains a top priority through a range of interventions and investment.
- **Leadership and Partnership** - that is accountable, underpins and informs Anchor activity across Mid and South Essex.

The MSE Anchor Charter builds on our collective experience in working together to address the health and wellbeing challenges facing our communities. Those signing this Charter are committing to both individual and collective action to use our assets to best serve the people living and working in MSE.

Together as Anchors we can make progress drawing on, complementing, and amplifying individual strengths. The Anchor call to action is for a multi sector approach at place and beyond with its pillar-based approach[1], common language and shared information to improve outcomes. As NHS Anchor institutions are new, the evolving learning[2] reveals that their activity can be across various dimensions.

1. Regionally (Greater Essex), anchors align wider relevant public policy and convening examples of good practice and lessons learnt through coordinated network.

2. At System /ICB level, anchors can lead social and economic development and cross sector partnerships and could identify and share funding opportunities.

3. At Place, stimulating local anchor networks and /or activity, local economies and community wealth building approaches and applying local intelligence.

4. Community Anchors such as schools, local libraries, GP surgeries and importantly place and/or cause focused voluntary and community organisations.

Since the first MSE Charter in 2021 Mid and South Essex has produced yearly Annual Impact Reports that have charted progress, and in 2024 confirms that;

- Its pre-employment work supported over 800 unemployed people into work.
- Procurement, specifically social value and its contractual management can contribute to the Mid and South Essex Anchor approach.
- Our physical assets are being used beyond clinical for an increasingly wide range of psychosocial support that deliver positive outcomes.
- Basildon and its hospital have a groundbreaking active travel project, Essex Pedal Power, that has received attention from national policy makers and leaders.
- That more organisations and people than ever are engaged in local Anchor networks and learning.

These are available at https://www.mse.nhs.uk/trust-publications-and-reports?smbfolder=126

Our 2024-2027 commitments

As a signatory of the Mid and South Essex Anchor Charter, we are committing to:

- Implementing anchor principles into our core business.
- Being explicit in how our work contributes to the ambitions of the Mid and South Essex Anchor mission, including tackling health Inequalities and the wider (social) determinates of health; and
- Developing a clear action plan and report on progress annually.

Organisations that sign the Mid and South Essex Anchor Charter are committing to this across the five anchor pillars.

[1] Employment, Procurement, Land and Buildings, Sustainability, and Partnership and Leadership - How Strong is Your Anchor (2023

[2] North West Anchor Network

The ambitions for how Charter members do this are set out below:

Employment

The Mid and South Essex Integrated Care System, including all of its members, is the `largest employer' in Essex with a workforce of 40,000 people, often residents. This demonstrates the scale of opportunities we have, as anchor institutions, to support employment opportunities for those in our communities.

As Anchor institutions, we will aim to:

1. Provide high quality work for local people, supporting local young people and adults, specifically those that are more vulnerable, to be aware of and introduced to opportunities to work in healthcare and public service.
2. Pay the people who work for us the real living wage, or at least the minimum wage,
3. Take an inclusive approach to recruitment and career development, seeking alternatives to traditional recruitment, incentivises and staff retention.
4. Work together to increase awareness of healthcare and public sector work opportunities, particularly in diverse communities.
5. Report on workforces from targeted groups (i.e. Care Leavers) and of those living in the 40% most disadvantage

Procurement

Across the system we spend a huge amount of money purchasing goods and services, in the region of £5 billion a year. We want to do that in a way that embeds social value and supports positive environmental, social and economic impacts for our communities.

As Anchor institutions we will aim to :

1. Embed social value principles into all purchasing and procurements.
2. Increase the proportion of spend that goes to existing local / target organisations such as community groups, creative industries, and female-owned businesses.
3. Be open to potential new suppliers, particularly local and/or target organisations, and supporting them to supply to the NHS and public sector; and
4. Report on annual addressable, spend that is with local and/or target organisations.

Land and Buildings

Partners across Mid and South Essex have access to a wide range of land and buildings. We want to use these assets in a way that allows us to go beyond providing core services, to explore additional ways that we can support the health and wellbeing of our communities.

As Anchor institutions we will aim to:

1. Explore ways to better use our land and buildings to support the local community.
2. Report on how land and buildings are used by local / target organisations and the specific actions taken to support that, such as Community Asset Transfer.
3. Ensure new development projects include anchor principles, and;
4. Identify and report anchor procurement, employment, and sustainability priorities in new developments.

Sustainability

The NHS is a major contributor of carbon emissions in England, as are many other public sector bodies. As Anchors in our community, we have a responsibility to ensure that we are taking action to reduce our carbon footprint and working to help protect the environment and biodiversity in our local communities.

As Anchor institutions, we will aim to:

1. Deliver on local and national commitments to reduce carbon emissions, including a focus on energy, active travel and reducing waste and, critically, the Greener NHS programme.
2. Protect and support local biodiversity in local communities.
3. Report annual emissions to track progress against relevant plans .
4. Take action to support active/ sustainable travel and food.

Leadership and partnership

Our focus as Anchor institutions is responding to the needs of our community. To do that we need to work in partnership with our communities and each other to help address local skills and maximise the benefits we can gain from our collective assets.

As Anchor institutions we will aim to:

1. Learn from each other and sharing best practice that is correlated with local evidence and priorities and shaped by lived experience.
2. Engage with Anchor Institutions Networks and learning, and;
3. Secure Board level support for anchor activities evidenced through an annual report and plan based on appropriate, recognised frameworks[3] and contribute relevant data to the Mid and South Essex Anchor Programme.

In signing the Charter, I commit my organisation to progressing its Anchor work in 2024-27 and understand that means doing the basics – sharing relevant information, reimagining and changing recruitment and procurement approaches to support residents and businesses, and increasingly, action to mitigate changes to our climate.

Tom Abell Chief Executive Officer Mid and South Essex ICB	Mike Thorne Chair Mid and South Essex ICP[4]	Paul Scott Chief Executive Officer Essex Partnership University Trust
Paul Calaminus Chief Executive Officer North-East London Foundation Trust	Gavin Jones Chief Executive Officer Essex County Council	Rick Hylton Chief Fire Officer Essex Fire and Rescue
Denise Brown Principal / Chief Executive Officer South Essex College	Neill Moloney Chief Executive Officer East of England Ambulance Trust	B.J Harrington Chief Constable Essex Police

[3] How strong is your Anchor (and its indicators), NHS Confed ICB Objective 4 Framework, Leeds or Essex Anchors Framework Civic organisations framework.

[4] As a committee of the ICB including MSE Alliances, H&WB Boards, the voluntary and community sector, Healthwatch's.

TBA Anglia Ruskin University	Dave Cope Essex Service Leader DWP /Job Centre Plus	Professor Maria Fasli Vice-Chancellor University of Essex
Dave Smith Chief Executive Thurrock Borough Council	Colin Ansell Chief Executive Southend City Council	Kim Bromley Derry Interim Chief Executive Basildon Council
Doug Wilkinson Chief Executive Maldon Council	Angela Hutchings Chief Executive Castlepoint Council	Dan Gascoyne Chief Executive Braintree Council
Jonathan Stephenson Chief Executive Brentwood and Rochford Councils	Nick Eveleigh Chief Executive Chelmsford City Council	Matthew Hopkins Chief Executive Officer Mid and South Essex Foundation Trust
Mark Heasman Chief Executive Provide		

Mid and South Essex Integrated Care System

Strengthening our Anchor

Our work in 2023/24

Introduction

2023/24 has been an important year for MSE Anchor.

We have considered and updated the programme to take account of national guidance **(How Strong is Your Anchor: A measurement toolkit for health anchors)**. We also ran a major event that brought together people from every sector across Mid and South Essex wanting to improve health outcomes.

Looking forwards to 2024/25, we are looking to refresh our system's Anchor Charter. This involves reaffirming our commitment to Mid and South Essex Anchor principles and outcomes, including measuring the collective achievements of all our partners against our shared goals.

Through the Charter, organisations are committing to individual and collective action to improve population health through a focus on the following five areas:

Employment

Procurement

Sustainability

Land and buildings

Leadership and partnership

The MSE Anchor programme is structured around these themes, with work in each area set out in this report.

What is an anchor institution?

Anchor institutions are large, often public-sector, bodies that are 'anchored' in place – in other words, unlikely to move – and linked to their local community.

Anchors use their assets to improve the health, wealth and wellbeing of their local population and reduce inequalities. They also have multiple opportunities to do this, by managing their resources and operations strategically and intentionally.

Anchors can have a positive impact on the social determinants of health by shifting and targeting the way they employ staff, procure goods and services, use their land and buildings, contribute to environmental sustainability and work in partnership.

How anchor complements our ICS priorities

As Mid and South Essex ICS moves into our second year, what has MSE Anchor brought to the system?

Integrated care is about seeing the bigger picture around the individual and building connections across the system. Anchor's aims – considering organisations' broader contribution to the economy and to society in general – also support these goals.

The two have different but complementary perspectives. Anchor focuses on the intentional, organisation-led actions that larger institutions can take – in addition to their traditional roles – to support specific populations and neighbourhoods. Meanwhile, the integrated care system aims to improve the health and wellbeing of the population – with a focus on prevention, better outcomes and reducing health inequalities.

They both have effectively the same goal, but each supports it in different ways.

The anchor approach has helped build shared understanding between partners across the integrated care system, from local authorities to the voluntary sector. Many of these players are not healthcare providers. They promote good health through active travel, healthy lifestyles, and work with education, veterans and others.

Working alongside them has helped many providers think differently about our civic responsibility.

Anchor is especially effective at building connections across and within sectors and organisations to tackle common issues. This enables partners to use their combined strengths to create value across the whole system, focusing on population health and social determinants of health.

It's early days. But MSE Anchor's role in making this happen is widely recognised as an example of good practice. And over time, our local residents will see organisations creating more opportunities for local people.

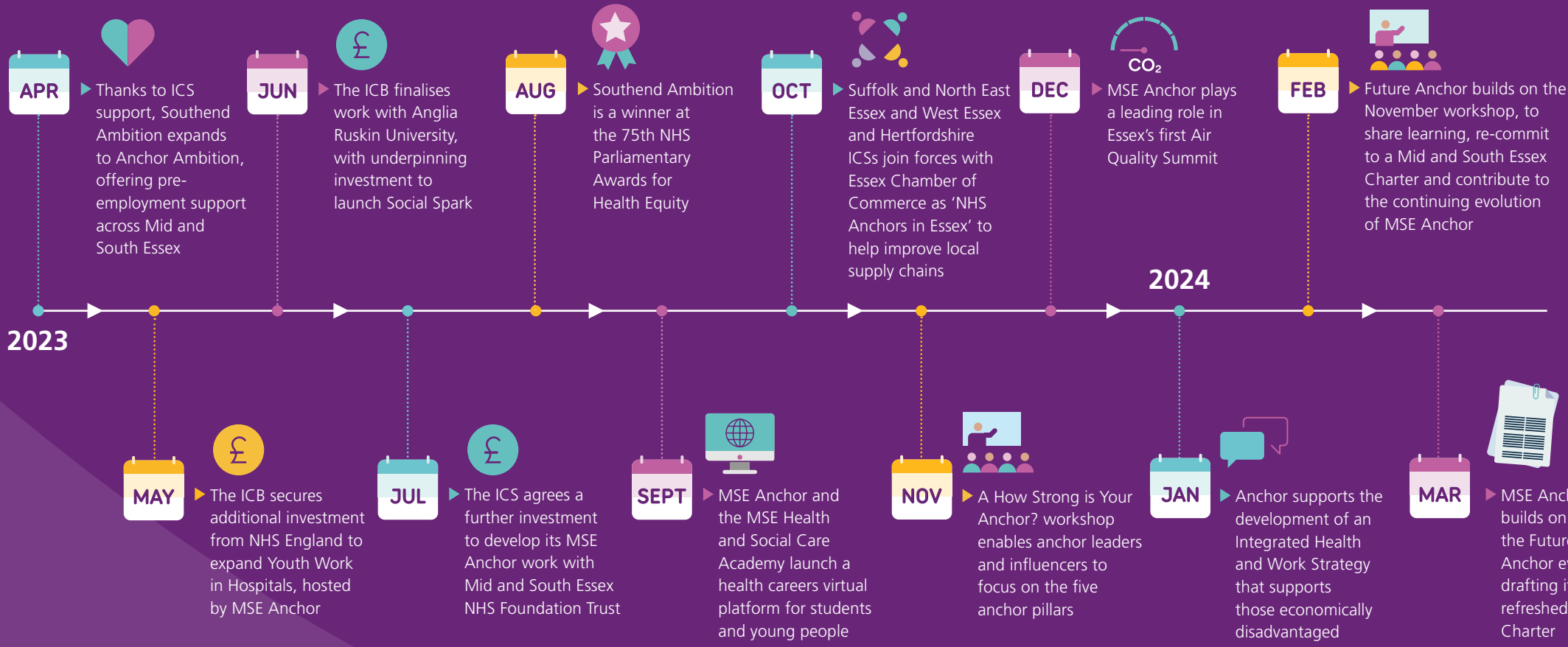
"By harnessing our combined efforts and financial resources at the local level across our health and care system, we have the potential to make significant strides in supporting our most at-risk residents and communities.

At the Future Anchor event, it was clear to see how partners across the system are using the anchor approach to actively address inequalities, bolster economic development and enhance overall health, well-being and sustainability."

Nigel Beverley, Chair, Mid and South Essex NHS Foundation Trust

Highlights

Our MSEICS Anchor Year 2023/24



Working to tackle inequalities across mid and south Essex

Employment

- **Conducting outreach and partnership work to increase awareness of healthcare careers and support education and training**
  Through its Health and Social Care Academy, the ICB has strategically communicated its pre-employment offers to support people into work.
- **Employment focused participation programmes and support**
  Anchor institutions across the ICS have developed a system-wide Pre-Employment Advisory Group. The network brings together organisations across the system to coordinate delivery activity and ensure that good work opportunities reach the people who will benefit most.
- **Developing recruitment policies, processes and programmes to help people into work**
  North East London Foundation Trust embarked on a project to test out a better way of reaching local people, through adapted communication, application and recruitment processes. It reached local people in Basildon and helped fill several 'difficult to fill' positions.

Procurement

- **Embedding anchor priorities into social value requirements**
  The MSE Anchor team worked alongside colleagues from MSE NHS Foundation Trust's sustainability team to deliver a series of webinars on social value and its development in mid and south Essex.
- **Developing partnerships at place, system, regional and national levels**
  MSE Anchor has worked with local partners and national support to meet its obligations to its armed forces community, upskilling 200 members of staff and creating a Service Champions Network to support its 38,000 veterans.
- **Building partnerships with other health anchors, at multiple levels**
  National numeracy support programme Multiply has brought ICS anchors work together to develop Every Carb Counts. The programme helps people with type 1 diabetes calculate their carbohydrate intake.

Sustainability

- **Supporting estate, fleet and waste to deliver sustainability programmes**
  Two MSE anchor organisations (Mid and South Essex NHS Foundation Trust and Essex Partnership University Trust) have jointly procured a linen and laundry service that will aim to reduce existing emissions by 80 per cent in 2032.
- **Supporting staff, patients and communities and being a good employer**
  MSE Anchor and Essex County Council are supporting Essex Pedal Power to test an E-bike loan scheme to support staff with commuting and outreach, resulting in reduced emissions, cost savings, and improved physical and mental wellbeing.
- **Creating green spaces for Southend's Victoria Ward residents**
  Greening Southend Queensway is a new programme improving the outdoor green spaces on the Queensway estate and providing targeted support to improve the health and care of local communities. The project is delivered by charity Trust Links and funded by the South East Essex Alliance Health Inequalities Grant.

Partnership

- **Partnerships and programmes reaching young people in schools and colleges**
  MSE Anchor has worked with further education colleges and Essex County Council (themselves anchor institutions) to deliver a gamified approach to support young people's work ambitions in health and care.
- **Supporting community co-production to design, deliver and evaluate anchor**
  Basildon and Brentwood Alliance carried out an asset-based community mapping exercise. This identified the importance of prioritising mobility, community cohesion, opportunities for young people and making the most of local space.
- **Developing participation programmes and support to local and target populations**
  Thurrock Alliance's tobacco control strategy and smoking cessation implementation plan is focusing on Thurrock's small businesses, providing training, stop-smoking packs and ongoing support to 16 participating companies.

  A common challenge for anchor programmes is devising ways of working with small businesses. This project is a good example of work with businesses on specific health initiatives.

Leadership

- **Developing strong place-based partnerships with other local organisations**
  Mid Essex Alliance Thriving Places work has generated place-based common outcomes and indicators and, importantly, two demonstrators: wealth creation and respiratory Illness and incidence.
- **Supporting partnerships, informing delivery and sharing learning**
  MSE Anchor plays a prominent role in the Essex Anchors Network – bringing individuals together across boundaries of profession, organisation and sector. Its anchor institutions membership includes 133 individuals from 39 different organisations.
- **Co-creating anchor projects alongside local and target communities**
  Community Connectors is a programme working to build a better understanding the lived experience of support and daily life for people living with COPD, to improve support and recognise what works. The programme is delivered with Healthwatch Southend and Southend Association of Voluntary Services and funded by MSE ICB with support from Southend City Council.

Showcasing activities from across the five anchor pillars

Good employment

Procurement

Sustainability

Land and buildings

Leadership and partnership

Supporting Mid and South Essex's response to the NHS Long Term Workforce Plan

Forging links between local communities and health and care employers opens up new possibilities in which everyone's a winner.

"When I was at school, careers days were spent sitting in a hall, listening to someone delivering a talk," says Rachel Sestak, Head of Systems Workforce at MSE ICS. "It's not like that now. At our events, you'll see young people wearing virtual reality goggles, taking part in online quizzes, or doing hands-on tasks with people from clinical backgrounds."

She continues: "Our community outreach work is important, partly because it helps us recruit and retain much-needed staff, but also because it changes lives. There are people within our local populations who would never think of working in healthcare if we didn't show them what's possible. We can broaden their horizons."

As well as students, Rachel and her team support care leavers or adults who have been unemployed and need to build their confidence to get back into work.

The Anchor Pre-employment Programme (in line with the anticipation of the NHS Long Term Workforce Plan) plays a specific role in broadening participation.

Applications for health and social care involve a lot of form-filling and checks – and not everyone finds that easy. This programme offers advice and support to steer people through the process.

"Our approach is closely aligned to anchor principles – providing health and care staff while levelling the playing field," says Rachel.

"Helping somebody into employment can transform other parts of their lives too, including their physical and mental health, lifestyle choices and economic wellbeing. This, in turn, affects their families, friends and wider communities – creating a positive cycle. It's very rewarding."

> **"By harnessing our combined efforts and financial resources at the local level, across our health and care system, anchor offers the potential to make significant strides in supporting our most at-risk residents and communities."**
>
> **Alan Tobias, Non-Executive Director and Anchor Champion, Mid and South Essex NHS Foundation Trust**

Good employment

Introducing our pre-employment schemes

Halo is a four-week programme delivered by Southend Council to help people prepare for healthcare work. It has supported 380 participants, of whom 165 have secured work.

MSE Prince's Trust programme has worked with 140 young people, securing 96 job offers.

Anchor Ambition supports unemployed people into health work. Of the 179 people who found work through the project in 2023/24, 21 identified as having a disability.

Over the same period, MSEFT increased the proportion of its employees from the most disadvantaged areas by 2%.

This work aligns with findings of a recent HSJ survey that asked ICB leaders about their priorities for transforming services. One of the key priorities highlighted was 'inclusive recruitment' to get long-term unemployed into stable jobs.

What else has been happening?

- **The College Enrichment Programme** runs regular events to recruit level 2 and 3 NVQ students for volunteering roles, building a pipeline for entry-level healthcare support workers.
- **The Healthcare Assistant Academy** is designed to tackle the high percentage of healthcare assistant candidates who drop out during the recruitment process – supporting them along the way and offering longer-term career advice.

Embedding social value principles into all purchasing and procurement

How Strong is Your Anchor clearly states the links between anchor activities and economic and social wellbeing. But it goes beyond this too – setting out how institutions can go beyond that – drawing on legislation, regulation and financial constraint to stimulate community wealth building and diverse supply chains.

£100 million

Mid and South Essex's Anchors social (local) value expertise has provided end-to-end support for the procurement of more than £100 million of outsourced contracts.

1 Making sure social value is an important and prominent component in the way goods and services are purchased

Since April 2021, all relevant NHS procurements have been required to include a minimum of 10 per cent social value weighting. Mid and South Essex's Anchors social (local) value expertise has provided end-to-end support for the procurement of more than £100 million of outsourced contracts – from support services to digital and clinical testing.

This includes framing the social value questions: most often, support for economic development and wellbeing and then supporting the process assessor with expert opinion.

Submissions have focused on:

- apprenticeships, training, work experience and support for basic skills
- avoiding modern-day slavery in supply chains and staff benefits
- support for community organisations, schools and mentoring local residents.

Mid and South Essex Anchor will continue to work with its supplier base to help localise, tailor and deliver successful proposals.

2 Welcoming small social business into the local health economy and investing their wealth locally for stronger, more diverse economies

In Basildon, the Social Spark healthcare innovation incubator is supporting residents, healthcare staff, students and local businesses to develop social and economic innovations that will benefit the local community. It assesses local need, delivers training and builds connections. Its ultimate goal is to build local capacity and harness ideas that will provide long-term solutions to local problems.

Building on ARU's NHS Clinical Entrepreneur Programme, the scheme is a collaboration between Basildon Council, Mid and South Essex NHS Foundation Trust, Essex County Council, Mid and South Essex ICS and Anglia Ruskin University (ARU), along with other higher education institutions.

- Social Spark and Anchor activities are perfectly aligned with the ICB's objective to support broader social and economic development.
- Social Spark is a place-based, multi-sector partnership that embraces and articulates many of the concepts of At the Helm to address the social determinants of health.

Drawing on her experience in youth and community work, local resident Miriam Chalkley identified a local need for an ethnically diverse youth organisation and founded a volunteer-led organisation Flex. Today, Flex reaches around 200 young people through weekly youth sessions, 'Mumma and Me' groups, tutoring and a teen café.

Reducing poor air quality-related illness among staff, patients and community

Anchor is supporting the ICS to meet its environmental and sustainability targets, through projects ranging from Pedal Power to advocating to improve air quality.

Many of the actions that reduce carbon emissions also strengthen communities, such as investing in local providers or encouraging walking or cycling, which also improve physical health.

One example is Essex Pedal Power and its Anchor-led work with Basildon Hospital. The initiative provides free bikes to people across Basildon, focusing on disadvantaged communities. In collaboration with Essex County Council, the Active Wellbeing Society and other partners, the project is improving people's physical and mental wellbeing, helping people commute affordably and improving air quality.

Overall, the scheme has distributed 620 bikes across Basildon, including 150 for Basildon Hospital staff on lower pay bands, alongside free learn-to-ride sessions, bike maintenance support and group bike rides.

The scheme has attracted the support of Olympic cyclist and Chair of Sport England Chris Boardman, who visited in October 2023.

Air quality is closely linked with health inequalities, deprivation and the wider determinants of health, so this is a key focus. Improving air quality – both outdoors and within the home – is an important way of improving health outcomes and reducing costs.

Staff travel is one of the biggest contributors to NHS emissions, so changing staff perceptions and enabling active and zero-emission travel is a focus to tackle hospital hotspots – particularly at points where there is greatest staff, patient and visitor exposure. Find out more at Essex Air.

> **Across our health and care systems, there is so much we can do to boost sustainability and social value.**
>
> **Becky Jones, Head of Sustainability, Mid and South Essex NHS Foundation Trust**

What's been happening on air quality?

- In December 2023, anchor representatives from across Essex came together for the first Essex Air Quality Summit.
- A new working group (part of the Essex Anchors Network's climate action working group) is taking the programme forward, such as supporting schools to reduce school-gate drop-offs.
- MSEFT is currently trialling a testing regime in its loading bays to monitor the impact of engines left running, site congestion and below-standard vehicles on site.

NHS land and buildings are being used by local organisations such as community groups and creative industries

Integrated work is never more evident than in our Youth Worker in Hospitals project, run by Essex County Council Youth Service in A&E departments and for long-term conditions.

Young people attending A&E often have underlying social needs, but they don't always find it easy to engage with healthcare professionals. Going to A&E can provide a 'reachable moment' when a youth worker can make a connection with them.

"This idea was at the heart of this work," explains senior youth and community worker Helen Newman. "The project was originally funded by the Violence and Vulnerability Unit, but most of the people we see are attending with mental health needs. Many are on waiting lists for CAHMS or don't quite meet their thresholds."

She continues: "Our staff are stationed either in A&E or at our desk space near the unit. We've worked hard to build relationships with the A&E, CAMHS, crisis and children's play teams and they will refer a young person they feel could benefit from our support."

The service is tailored to each young person. Importantly, some are signposted to community or youth services, but it also runs weekly groups and some have regular one-to-one sessions at school or a local café. The team also carry out advocacy work – for example, attending multi-disciplinary meetings with other providers.

Results have included improvements at home and school, including better ability to manage anxiety and stress and less risky behaviour such as drug use and self-harm. In 2023/24 the service supported 168 young people at Basildon and Thurrock University Hospital A&E.

"It's a really fabulous project," says Helen. "Before, I worked in education, as a deputy head and SENCO, so I've seen the level of need from the other side, too. Every young person needs someone in their corner."

168 young people supported

In 2023/24 we supported 168 young people at Basildon and Thurrock University Hospital A&E.

215

What else is happening?

- Mid and South Essex ICS is developing an infrastructure strategy that will need to consider the role of the NHS as an Anchor through its buildings and spaces.
- Mid and South Essex Foundation Trust is reviewing the current use of its land and buildings by the voluntary and community sector. For example, for many years the Helen Rollason Cancer Charity operated from a standalone site at Broomfield Hospital.

  The work will explore how far its land and buildings are used by the voluntary and community sector and whether increasing co-location will reduce admissions and length of stay and expedite discharge.

Anchor action is supported and sustained at an organisational level

In February 2024, MSE Anchor hosted people working across the health and care system from around mid and south Essex, at Chelmsford's Hylands House. The event, called Future Anchor, was funded by the ICS and brought together people across sectors and organisations.

Shammi Jalota
Head of Partnerships and Equalities, Essex County Council

The Essex Anchor Network faces some challenges – not least, because of the geography of Essex. In cities like Leeds, Bradford, Luton and Manchester anchor plans can be fairly contained. But in a wider geography, such as Greater Essex, it's hard to think about the system response and collective goals. For me, the next step is taking a strategic, system-wide approach so we can add up to more than the sum of our parts.

Liesel Kennedy
Intelligence and Research Programme Manager, Suffolk and North East Essex ICP Secretariat

I work closely with Anchor in Suffolk and North East Essex. In the spirit of sharing learning and good practice, it is really helpful to learn and share with other systems, particularly with our immediate neighbours. At the event, it was gratifying to see how similarly our ways of working and thinking are evolving, and how many opportunities there are to continue to share our learning and practice

Adam Seomore
Lead Nurse for Safeguarding Children, Provide Social Enterprise

I've been looking to create a role within our organisation for a care leaver. My colleague told me about the anchor programme so I wanted to come here and find out more. Anchor is definitely a different way of doing things. It feels more organic – that collective approach.

Toni Parrish
Employer Engagement, ACL Essex County Council

As an adult education provider, we have clear social development goals, so we're very aligned with anchor. For example, recently we've collaborated with community engagement and transport colleagues to help people in coastal communities gain qualifications. We've come here to spread the word about our work and find out what's needed and how to join it all together.

Anna Bokobza
Director of Strategy, EPUT

We look at the whole life experience for the Learning Disability and Autism community, so we work across all key themes of the Anchor programme. It was really refreshing to hear that the programme had teeth and was willing to challenge thinking. The learning was not about process or programmes: it was about ethos and the willingness of the programme to embrace partners, innovation and wider thinking, and deliver structural change.

Ru Watkins
CEO, Hamelin Trust

We look at the whole life experience for the Learning Disability and Autism community, so we work across all key themes of the Anchor programme. It was really refreshing to hear that the programme had teeth and was willing to challenge thinking. The learning was not about process or programmes: it was about ethos and the willingness of the programme to embrace partners, innovation and wider thinking, and deliver structural change.

David Slatter
Public policy and strategy manager, Essex County Council

I'm part of the levelling up team within Essex County Council. We tackle the underlying barriers to economic or personal development across Essex – so quite a similar mission to anchor. I have experience in education, skills and employment so I'm here to find out how these link with health-related wider determinants and how to bring them together.

Grant Taylor
Assistant Director for Communities and Health, Basildon Council

I'm working alongside the Anchor partnership on the Social Spark programme to enhance community enterprises and close the gap of active travel inequalities, through Pedal Power. Future Anchor delivered a chance to learn, collaborate and re-set our work together for the betterment of the place. It was an excellent opportunity to meet and collaborate with system partners who are driven to effect positive change with, and for, our communities.

Mid and South Essex Integrated Care System

For further information:

Go to our website at:
www.midandsouthessex.ics.nhs.uk

Watch our short film at:
tinyurl.com/MSE-Anchor

Contact us at:
mse.anchor@nhs.net

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Mid and South Essex Integrated Care System

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 14

MSE ICS Strategic Digital Benefits and Achievements

Summary Report

1. Purpose of Report

To provide the Board with an overview of the Mid and South Essex (MSE) Integrated Care System (ICS) Strategic Digital Benefits and Achievements.

2. Executive Lead

Barry Frostick, Executive Chief Digital and Information Officer

3. Report Author

Sadie Plunkett, Head of Assurance and Oversight

4. Responsible Committees

Digital Data and Technology Board

5. Link to the ICB's Strategic Objectives

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
3. To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.

6. Impact Assessments

Not applicable to this report.

7. Financial Implications

Not applicable to this report.

8. Details of system partner, patient or public engagement or consultation

The draft approach to compiling the MSE ICS Strategic Digital Benefits and Achievements pack was approved at the previous Digital Data and Technology Board

(DDaT). The first draft was shared and approved at DDaT on 12 September 2024. This version will also be shared at DDaT on the morning of 14 November 2024.

9. Conflicts of Interest

None identified.

10. Recommendation/s

The Board is asked to:

- Note the content of the the MSE ICS Strategic Digital Benefits and Achievements pack at **Appendix A**.
- To give consideration to the content and improvements which could be made to future reports moving forward.
- To support the promotion of these achievements within partner organisations, our regional and national teams.

MSE ICS Strategic Digital Benefits and Achievements

1. Introduction

At the inception of the Mid and South Essex Integrated Care Board (MSE ICB) in July 2022 there was a strong recognition of the need to strategically invest in the digital and data landscape. A commitment was therefore made to support an ambitious three-year investment plan to upshift our investment in digital and data capabilities for the benefit of our staff and residents.

Since that commitment, and through the governance of the Integrated Care System (ICS) Digital and Data Technology Board, teams worked in partnership to deliver against that ambition. The attached report provides an update to the ICB Board on the benefits and achievements to-date.

Following on from the endorsement for the approach to our MSE ICS Strategic Digital Benefits and Achievements pack in July 2024, the ask was progressed to include our key strategic programmes, partners and NHSE. This paper provides an overview of the MSE ICS Strategic Digital Benefits and Achievements (**Appendix A**).

2. Main content of Report

The attached report provides an update to the board and it separated into four main sections. These sections provide insight on the achievements and impact over the last 2 years in the digital and data space.

The first section covers our five strategic programmes across the system where we have worked in partnership to create the foundations required to enable the transformation of care provision across our partners. There are some significant milestone achievements including: approval of a Unified Electronic Patient Record (EPR) investment case; and go-live of both the Shared Care Record and Digital Patient Interface platforms.

Last year we saw the implementation of Athena – our strategic data platform with over 70 dashboards used to: underpin decisions from our flagship stewardship programme; visualisation of pressure points across the system; and creation of a comprehensive segmentation model to support improved insight for health inequalities and our Population Health Management teams.

Similarly, our Digital Social Care Records (DSCR) programme, hosted by Essex County Council, saw Essex exceed the national target of 80% of providers using an assured DSCR solution, which has improved data accuracy and resulted in a reduction of effort for our social care teams.

The second section highlights achievements by partner organisations which have made positive inroads in relation to Robotic Process Automation to alleviate repetitive tasks to support the move from legacy IT infrastructure to cloud based platforms, which will improve resilience.

In Primary Care we have seen a shift to Cloud Based Telephony, increased use of the NHS App both for view information, but also managing appointments. As with other

partners there are also other achievements such as the completion of our Lloyd George Digitisation programme.

The focus of our Local Authority partners has been on: improving residents' ability to claim benefits; using business intelligence to support greater community insight; and implementing online tools to reduce duplication and demand for referrals in areas such as safeguarding.

In the last two sections the report identifies the funding which has been made available to MSE in support of our programmes and our sub-groups which work to the Digital and Data Technology Board. A total of £33m of investment has been provided over the last two years. With a large proportion of that being focused on levelling up our infrastructure and supporting our Unified Electronic Patient Record Programme.

3. Findings/Conclusion

As a system MSE has made significant steps forward culturally around collective leadership and delivery of large-scale programmes. We have attracted a significant amount of investment to support and underpin our system strategy and partners have aligned their local ambitions.

This report includes achievements on our strategic system programmes and those transformation programmes within partners. It provides an important point of reflection and recognition for those programmes whilst also sighting the further improvements teams are striving to achieve.

Teams across our system should be immensely proud of those achievements and for the parts they collectively played in enabling these to happen. However, they are not sitting back and are already focusing on the next steps aiming to further enhance our system.

Looking forward as a system, we recognise the challenging environment we are working in. The next period will require continued resilience and a strong focus on realising the benefits which technology can enable. Over the coming months the output of this work will feed into the refresh of our digital and data strategy, where with partners we will look to confirm the next period of delivery.

4. Recommendation(s)

The Board is asked to:

- Note the content of the MSE ICS Strategic Digital Benefits and Achievements pack at **Appendix A**.
- To give consideration on the content and improvements which could be made to future reports moving forward.
- To support the promotion of these achievements within partner organisations, our regional and national teams.

5. Appendices

Appendix A – MSE ICS Strategic Digital Benefits and Achievements pack.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

MSE ICS Strategic Digital Benefits and Achievements

Foreword

In 2021 partners across Mid and South Essex (MSE) approved an ambitious digital strategy “Setting the North Star” and a Data and BI strategy. Together these strategies aimed to create the corner stone foundations which will enable the transformation of care provision across our partners. Working together we prioritised and shaped five transformational programmes of work which was underpinned by good governance and supporting expertise.

The Digital community has provided an exemplar of what system working could look like. They have overcome sometimes conflicting organisational priorities, historical difficult relationships and focused on what is achievable for the system. As a result MSE have made significant steps forward around collective leadership, delivery of large-scale change programmes and have attracted a significant investment to support and underpin our system strategy.

This year rewards MSE with some significant milestone achievements; the approval of a Unified EPR investment case, and go live of both the Shared Care Record and Digital Patient Interface platforms to name a few. Teams across our system should be immensely proud of those achievements and for the parts they have collectively played in enabling these to happen.

This report includes achievements on our strategic system programmes and those transformation programmes within partners. It provides an important point of reflection and recognition for those programmes whilst also sighting the further improvements teams are working hard to achieve.

Looking forward as a system, we recognise the challenges we are working in. The next period will require continued resilience and a strong focus on realising the benefits which technology can enable.

Paul Scott, EPUT CEO, and Chair of MSE ICS Digital Data and Technology Board

Barry Frostick, Executive Chief Digital and Information Officer at MSE ICB

MSE System-Wide Programmes

Overview of our ongoing digital programmes

	Shared Care Record	Digitising Social Care Records	Electronic Patient Record	Digital Patient Portal	Strategic Data Platform
	Shared Care Record Mid and South Essex	CARE	nova * Launching 2026/27	PATIENTS KNOW BEST® The Patient's Company	Athena Mid and South Essex Data and Analytics Platform
What it is	A digital system for securely accessing and sharing information across organisational boundaries	A digital record keeping system for managing and recording the delivery of care within a care home and/or a person's home	A digital system for managing and recording the delivery of care within a healthcare organisation	An online platform for patients to digital access some of their health records and communicate with healthcare providers	Provides insight and enables evidence-based decision making to improve health and wellbeing of residents and reducing inequalities
Who uses it	Healthcare professionals; Social care professionals; Admin teams	Social care professionals; Admin teams	Healthcare professionals; Admin teams	Patients; Carers	Healthcare professionals; Social care professionals; Admin teams
When it's used	Only when delivering care for a person	When delivering care for a person, managing a person's care, or for reporting and analytics	When delivering care for a person, managing a person's care, or for reporting and analytics	When communicating health information digitally with patients/carer	When generating intelligence to enhance population health, improve care quality, and optimise NHS resource use through data-driven insights and targeted interventions
Organisations involved	11 health and social care organisations in MSE, including Trusts, community providers, mental health, general practices, local authorities, NHS 111, and ambulance services	NHS England, Department of Health and Social Care (DHSC), Care Quality Commission Local Authorities, registered social care providers in Essex	NHS Essex Partnership University NHS Foundation Trust; 226; NHS Mid and South Essex NHS Foundation Trust	NHS Essex Partnership University NHS Foundation Trust; NHS Mid and South Essex NHS Foundation Trust	NHS Essex Partnership University NHS Foundation Trust; Essex County Council; GPs and PCNs, Southend City Council and Thurrock; NHS Mid and South Essex NHS Foundation Trust

Shared Care Record

About this programme

The implementation of our new Shared Care Record solution will provide functionality that enables joined up care across health, mental health, social care, Primary Care Networks (PCNs), community services, as well as voluntary, charity and third sector organisations. This will transform data integration and information flows between our partner organisations with MSE ICS.

Maximising value for our ICS

To date we have identified over **£1.7M of efficiencies** from wasted time within our system due to information not being available to staff at the point of need.

Benefits

The scope of benefits for this programme is broad. We have created a "Day in the Life" framework to help focus on those offering the most value to partners. This approach highlights specific moments in a care professional's typical day where the Shared Care Record can be utilised demonstrating the tangible benefits that directly impact both workforce and patients.

Through this programme, we aim to:

- Improve patient experience by reducing the need for patients to repeat information to different care professionals.
- Enhance a person's care by ensuring information is readily available, especially when people are unable to communicate.
- Support staff wellbeing by providing up-to-date information to aid decision-making.
- Reduce the time taken to make decisions about a person's care.
- Minimise wasted community visits.

Our impact in this first month live *(27/08/24 to 27/9/24)*

2,651 total no. of health and care professionals using the system

40,204 total no. of people cared for using this information

53,357 total no. of documents viewed using the Shared Care Record

15.5 average number of logins per individual user in the first month

387 average no. of logins per day

10,871 times data accessed from neighboring Shared Care Records (CHIE)

Stakeholder engagement

The programme has seen real system working with multiple organisation collaborating to provide joint approval of major strategies, involving data, user access, and training.

We have conducted system-wide:

- Testing phases, including a comprehensive review and testing of the single sign-on system
- An ICS-wide frailty pathway mapping event
- 45 engagement sessions across all organisations taking part in the Minimum Viable Specification (MVS) stage
- 'Train the Trainer' sessions
- An ICS-wide AHP pathway mapping event.

Over the past 15 months we have worked collaboratively as a system to:

- Complete procurement activities resulting in Orion Health being awarded the MSE ShCR contract.
- Finalise decisions on the systems design, and implementation plans as part of our Planning & Design phase.
- Execute key activities such as testing strategy approval and single sign-on during our initial Build & Configure phase.
- Complete:
  - User Acceptance Testing (UAT) preparations
  - Clinical safety report compilation
  - Final testing report preparations.

What's next

Through our gradual implementation of Phase 1 we will broaden the partner organisations accessing and providing data to our ShCR as well as increasing the data available above and beyond that shared in the MVS.

Shared Care Record
Mid and South Essex

Digitising Social Care Records (DSCR)

About this programme

NHS England is fronting the DSCR programme supporting Care Quality Commission (CQC) registered care providers to adopt a digital social care record system. Engagement was via direct communication with Providers and information is available on the Essex Provider Hub.

An important condition of funding is compliance to the NHS Data Security and Protection Toolkit, in an effort of improve data security alongside digitalisation.

Benefits

- 3-year match grant funding programme, totalling over £1.5m, available to all CQC registered providers in Essex to adopt an NHS assured Digital Social Care Record system.
- Average reduction in stationary costs of £977.91 per location
- Average cost saving of £2,425 within the first six months of implementation
- MSE grants paid totalling £538,249.38 to providers
- Funding secured £513,440
  (We also anticipate requesting further funding in September as we expect to exceed our allocated budget)

Our impact

84%
Of MSE providers using an assured DSCR, this is up from 40% and exceeds the national target of 80%

82%
Of those using and assured DSCR have reported better data accuracy

31 minutes
Admin time saved, per carer, per shift

80%
Of those using an assured DSCR reported data extraction was now easier and less time consuming

Challenges

60% of providers state the most significant challenge to adopting DSCR is the time needed to train staff. However, as 85% agree, they can adapt to changes in care more efficiently, the time invested is yielding very real benefits within the first six months of use.

Smaller providers who are not yet digital are proving hard to engage as they do not have the funds to invest, nor the time to research.

CQC insistence that good or outstanding ratings will be dependent on going digital has helped to persuade a few as the programme draws to a close.

What's next

Aspirations to digitalise 90%+ of providers
Extending investment to sensor-based falls technology benefitting at least 450 adults across Essex. The falls technology will give rise to avoided costs of £11.69 for every £1 invested

Nova Electronic Patient Record

About this programme

The Nova Electronic Patient Record (EPR) programme is a ground-breaking digital transformation programme that is a first in type in the UK. Essex Partnership University NHS Foundation Trust (EPUT) and Mid and South Essex NHS Foundation Trust (MSEFT) are united in an ambitious partnership programme driving substantial improvements in quality, safety, and patient-centred care.

Benefits

Secured funding through EPR Investment Board with financial benefits to the system equate to circa

- 200m cash releasing
- 700m non cash releasing
- 65m societal

NOVA is….

- Aligned with ICS Digital strategy
- Congruent with Patient Knows Best and Shared care record
- Integrating patient care
- Capacity to link on agreed pathways and develop new models of care

Our impact

In a healthcare landscape burdened by fragmented information systems and disjointed care pathways, patients and clinicians struggle to navigate a maze of data silos and inefficiencies, our Nova EPR Programme illuminates a path towards seamless, unified care delivery where healthcare information flows effortlessly across boundaries, empowering patients and clinicians alike.

- Our commitment to collaboration, innovation and patient-centricity sets us apart
- We prioritise user experience
- By engaging people at every step, we ensure alignment with evolving needs and foster a culture of continuous improvement

Our Achievements

- Successful **set up** of our programme, **establishing** good governance, Trust change networks (800 members) including system collaborative.
- Strong executive leadership and clinical engagement at a senior level.
- **Approval of** the full business case and supplier contract discussions underway
- **Launched** Nova Programme Brand **and** Launch of our Nova Digital Academy creating Digital leaders across the Trusts
- Change Management Strategy **published** considered exemplar by NHSE FD and shared across EoE
- **Organisational readiness** underway, mapped 32 services in MSEFT and 28 in EPUT
- Communication Strategy **published**
- Set up an EoE collaborative with other Trusts also undergoing EPR deployments to learn and share experiences and resource

Our Engagement

- **Events attended -** Paper picnic, Digital Event in a Tent, Southend Digi Fest, Monthly MSEFT All Staff Briefing
- There are **870 Digital Champions** across MSEFT and EPUT
- Our **329 strong Founders Community** is distributed broadly across health and social care, including our patients
- 8 members already part of our new Patient Partnership

What's next

Collaborate with NHSE FD and ICS as partners in this transformation
Recruit resources for the programme and **Develop** our people partnership approach and engage patients, carers and residents in our programme
Grow our digital leaders through the Nova academy preparing them for the change
Train for the change: We will develop MDTs of EPUT & MSEFT clinicians and operational leads. **Prepare the organisation for go live**
Deploy the EPR in Oct 2026

nova

Digital Patient Portal (PKB)

About this programme

The Digital Patient Portal Programme's purpose is two-fold:

(1) To provide patients with parts of their health record in an easily-accessible digital format

(2) To enable new ways for patients to interact digitally with their health and care teams.

The patient engagement portal is being implemented across Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust (EPUT). Patients Know Best (known as PKB) was procured in February 2023 as the Patient Portal for the Mid and South Essex system.

Benefits

PKB provides patients with access to their information held within our hospital systems. It is accessible anywhere, integrated with the NHS App and enables patients to share their information with friends, family and/or carers.

The first phase of our programme has enabled patients to digitally view their demographic information and documentation for MSEFT, and EPUT Mental Health appointments, and MSEFT discharge summaries in PKB.

With these elements available we are expecting to see

- A reduction in enquires across both MSEFT and EPUT, and an estimated 6% reduction in inbound calls for MSEFT.
    - Allowing staff to focus on care and improve patient experience
- Reduction in 'Did Not Attends (DNAs)' as patients now have digital access to their appointment information at any time.
    - Improving productivity, benefiting both staff and patients.

Our impact

172,592
total no. patients registered to use the system since launch

July 2024
First documents published to PKB and available to patients

68%
Average % of published documents read (last 3 months)

167,480
number of users registered through NHS App (97%)

4,544
Average no. daily active users (>1 login per day)

1,270,227
total no. of records created across EPUT and MSEFT

Our Progress

As the programme matures through its phases the information available to patients will increase, including appointments letters, MSEFT test results, EPUT Community data and much more.

Onboarding Clinical specialties -

- Specialties will be able to work differently and engage with patients more effectively by utilising PKB. Having a bespoke space for each, offering patients access to a library of information relevant for their care, the ability to receive questionnaires, develop care plans jointly or send and receive messages with their clinician.
- Patients will be able to access a library of information relevant to their care in a single place and, for certain teams, they will be able to directly communicate. This benefits staff as queries will be directed to one place and common questions can be resolved in the library.
- Clinics will use questionnaires to collect information from patients allowing them to utilise clinic appointments more effectively benefiting both staff and patients.

Bringing pathology and radiology results into PKB -

- Patients will be able to see their test results as soon as they are available giving them greater control of their health.
- They can also choose if they would like to share these with others, benefitting staff by reducing queries related to chasing test result information.

What's next

Bringing Clinical Specialties on board with bespoke PKB offerings, providing benefits to their patients

Increased data available to patients

Bi-directional patient and clinician engagement

PATIENTS KNOW BEST®
THE PATIENT'S COMPANY

Athena: MSE Data and Analytics Platform

About this programme

Establishing a virtual Business Intelligence (BI) hub and its overarching vision to have a single way of managing information, which can be manipulated and collated to provide a single source of truth. This enables 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.

New and Enhanced Dashboards (Jun 24 – Nov 24)

PHM
- Segment Drift
- Population Segmentation
- CVD Action (including re-id)
- Do our patients "Age Well"?

Urgent Care
- The impact of flow on bed occupancy
- Falls and Fractures

Maternity and Children
- Local Maternity and Neonatal System Quality
- SEND (combining 3 Essex ICSs)
- Neurodiversity PoC

Workforce
- Secure and dedicated area set up on Athena
- Workforce data migrated
- Initial Workforce PoC dashboard

Performance
- Essex Health and Wellbeing
- Better Care Fund Indicators
- Transfer Of Care Hubs(TOCH)

Financial Management
- Secure and dedicated area set up on Athena
- Budget Holder Reports
- ICB Financial Sustainability

Primary Care
- Estimating the Impact of Capping Daily GP Appointments
- GP Practice Appointments (Sub-Unit)
- Primary Care Metrics

Planned Care
- Pneumococcal Vaccinations (PPV)
- Waiting well case finding for GP practices

Other
- EPACCS data feed from all four hospices
- Housing dataset created
- Data Bricks installed on Athena
- Link to NHSE Analytics Hub

Stakeholder Feedback

"By making data-driven decisions and demonstrating their impact, we build trust with residents and stakeholders" Digital and Transformation lead at Central Basildon PCN

"The possibilities with this tool appear endless to help us target our PHM and transformation efforts far more intelligently, accurately and therefore more successfully and who knows maybe even influence nationally" Clinical Director, MSE

"*Less time spent sourcing data and more time to apply impactful interventions that can change lives*". Population Health Lead, MSE

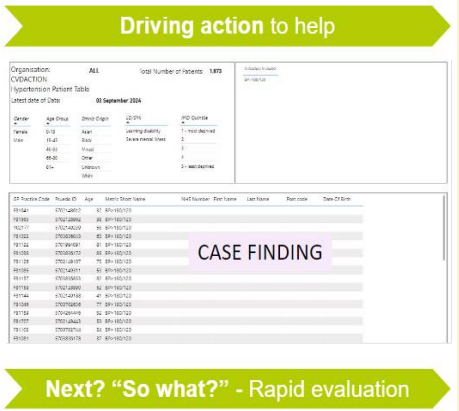
"…*Overall the Athena platform allows partners to access systemwide, linked data that hasn't been possible previously. Whilst still at an early stage in exploring the possibilities it does present many opportunities for ECC to work as a system partner with all organisations viewing the same data and working together on an evidence-based approach for improving population health"* Essex County Council Exec Office Analyst

CVD Action – The Opportunity

By increasing the % of hypertension patients whose blood pressure is treated to target, there are potential significant population (reduced heart attacks, strokes and deaths) and financial (between 1.3m and 2.5m) gains over 2 years

What we did

Whilst the "size of the prize" work gives us insight into the opportunity, through our work with UCL Partners we've been able to publish a case finding tool to support our clinicians in taking action.



Next? "So what?" - Rapid evaluation

Did it work? Have we seen those population and financial benefits?

What's next

- Athena Rapid Evaluation tool to understand return on investment relating to delivery of interventions across the alliances
- Integrated Neighbourhood Team prototypes
- Work with the Secure Data Environment to claim £100k funding from them for data harmonisation
- Work with Stewardship and Alliance teams together to agree key lines of enquiry on priory areas including NHT, Primary care and System Transformation with shared Data sets where possible to allow joined up working
- Redesign of the Athena front page to allow easier direction to existing information

Athena
Mid and South Essex
Data and Analytics Platform

Athena: MSE Data and Analytics Platform

Headline stats

Over 1 billion
rows of data loaded since Feb 2023, and available via subject-specific dashboards or for analytical research

95
national and local data feeds automatically loading to Athena and being linked together

1,330,720
ICB registered residents available for analysis through various segmented views

System usage

6,028
visits to Athena since our February 2023 launch

604
Dashboards viewed monthly on average following the closure of legacy reporting in May 24

71
dashboards currently being accessed across all directorates and ICS partners

ICS Usage

108
ICB staff registered

38
registered from MSEFT, EPUT, NELFT, ECC, Basildon, Southend and Thurrock

24
staff in PCNs and GP practices registering at a slower pace, but with some pockets of encouraging activity

Internal comms

15
presentations to alliance teams, wider ICS partners, PCNs and GPs

100
staff joined a recent Athena lunch and learn session, with 5 registering afterwards

5
positive sentiment from recent feedback and interviews, and published case studies

Training & guidance

13
report catalogues, plus online training and user group available on NHS Futures

12
training videos created on using PowerBI, accessing Athena and promoting Athena

7
Athena newsletters published by AGEM to all registered users across all their 160 customers

External comms

5
national and regional events where Athena has been presented by MSE

160
other ICBs, NHS Providers and Councils using Athena nationally

1
"Data driven transformation" HSJ award won

Athena
Mid and South Essex
Data and Analytics Platform

MSE Providers

MSEFT Digital Programmes slide 1

Microsoft Teams Premium Pilot (August 2024)

Programme Background

The MS Teams Premium pilot was launched to boost collaboration and productivity. Key benefits include intelligent meeting recaps with AI-generated notes and tasks, timeline speaker and subject markers, and live translated meeting captions.

MSEFT pilot selected 6 different non-clinical staff groups.

Key achievements & benefits

- **Access Process**: Staff can request access beyond the pilot with drafted approval criteria.
- **Pilot Expansion**: Increased from 20 to 70 staff.
- **Time Savings**: Average of 2.5 hours saved per person per week, as captured through MS Forms.
- **Licenses**: Potential access to 1,000 free licenses for 2024/25.
- **Productivity** : Expected FTE equivalent benefit of 33.3 to 60.0, supporting departments with natural attrition or reducing bank and agency spend.
- **Support Provided**: Multiple drop-in sessions and a SharePoint support site with guides, training resources, and FAQs.

Robotic Process Automation (RPA) - Outpatient Referral & Communication (September 2024)

Programme Background

Introduce RPA to ORC team and admin teams within the specialties automating manual repetitive tasks carried out by humans.

Repetitive low value tasks can be automated using RPA software.

Key achievements & benefits

- **Streamlined Processes**: Automates uploading GP referral documentation and managing the eRS 19-week drop-off process across all hospital sites.
- **Capacity Creation**: Frees up the ORC team to support centralisation of people and processes.
- **Workforce Efficiency**: Automation equates to 16-18 FTE, providing capacity release, productivity gains, and cash savings by reducing bank shifts.
- **Accuracy**: Eliminates human errors, ensuring consistent and precise task execution.

- These benefits collectively enhance operational efficiency and improve productivity and accuracy across the Trust.

eConsent (November / December 2024)

Programme Background

Implementing the EIDO e-Consent Suite will replace all paper consent forms with a standardised digital process, enhancing efficiency and consistency.

Key achievements & benefits

- **Improved Patient Experience**: Clear, accessible information enhances understanding and satisfaction.
- **Efficiency**: Reduces manual processes, freeing up clinician time.
- **Standardisation**: Ensures consistent information delivery and regulatory compliance.
- **Enhanced Data Quality**: Accurate and complete patient records improve planning and decision-making.
- **Accessibility**: Convenient digital review and signing of consent forms.
- **Security**: Advanced measures protect patient information.

- These benefits collectively enhance patient care, efficiency, and data management.

Digital Dictation and Speech Recognition (November 2024)

Programme Background

Implementation of a single Digital Dictation solution (Dictate IT /Dit3) and standalone speech recognition (Dictate IT Live) across the Trust.

Key achievements & benefits

- **Reduced Transcription Backlog**: Faster access to patient information.
- **Faster Document Turnaround**: Speeds up clinical workflows and reduced delays.
- **Technological Alignment**: Supports better outcomes, mobile device use adds flexibility.
- **Single System**: Streamlines processes across the Trust.
- **Improved User Satisfaction**: Fit for purpose systems
- **Staff Utilisation**: Frees up administrative and clerical staff.
- **Training**: Lowers cost and minimises disruption.
- **Centralised Statistics**: Trust view of dictation and transcription.
- **Cost Reduction**: Lowers outsourced transcription expenses.

- These benefits collectively enhance efficiency, security, and user satisfaction.

MSEFT Digital Programmes slide 2

Unified Communications (January 2025)

Programme Background

Replacement of multiple the current systems with a Trust-wide, cloud-based Unified Telephony solution.

Key achievements & benefits

- **Scalability**: Easily scale up or down based on demand.
- **Cost Efficiency**: Reduces the need for expensive hardware and maintenance.
- **Flexibility**: Supports remote and flexible working arrangements.
- **Enhanced Collaboration**: Integrates voice, messaging, video calls, and file sharing on a single platform.
- **Reliability**: Ensures consistent uptime and robust disaster recovery.
- **Improved Security**: Utilises advanced security measures to protect data.
- **Centralised Management**: Simplifies administration and management of communication systems.

- These benefits collectively enhance operational efficiency, reduce costs, and improve communication across the Trust.

Increased Depth of Clinical Coding – Pilot (March 2025)

Programme Background

Improving the recording of co-morbidities in the patients' health records will increase the quality of clinical coding resulting in improvement in Trust income for ERF activity.

Key achievements & benefits

Three schemes—Elective Clinical Documentation, Audit of Clinical Coding, and Awareness of Clinical Coding—the Trust can achieve:

- **Increased annual income:** £0.5m (£381k in 24/25)
- **Improved mortality statistics:** Better Trust performance metrics.
- **Enhanced data:** Improved planning, benchmarking, and PLICs.
- **Better patient care:** Complete records and accurate population health data.

- These benefits collectively enhance financial performance, data quality, and patient care.

Data Networks / Wi-Fi (Summer 2025)

Programme Background

Having a standardised single vendor wired and Wi-Fi network architecture across the trust. A full refresh of the trust's legacy data centre network architecture.

Key achievements & benefits

- **Broomfield Go-Live:** Moving from 400 access points to 1200 on the new network will allow EPMA (Electronic Prescribing & Medicines Administration) to be rolled out.
- **Security Posture**: Improved through the adoption of network-based security controls.
- **Enhanced Network Operations**: Using improved analytics capabilities.
- **Better User Experience**: Faster and more efficient network.
- **Better Patient Experience**: Greater NHS Wi-Fi coverage across the wards.

- These benefits collectively enhance operational efficiency and improve productivity and accuracy across the Trust.

Digital Contact Centre (Date TBC)

Programme Background

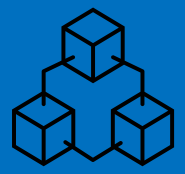
Implementing contact centre technology will increase the ORC team's capacity and reduce abandoned calls, ensuring patients connect with staff.

Key interventions include Chatbot, IVR Redesign, Live Web Chat, ASR, and Omnichannel Contact.

Key achievements & benefits

- **Increased Capacity:** Enhances the ORC team's capacity.
- **Reduced Abandoned Calls**: Ensures patients connect with staff, improving service quality.
- **Efficiency**: Expected benefits equivalent to 3.5 to 7 FTE, freeing up resources.
- **Improved Patient Experience**: Faster and more reliable responses through Chatbot, IVR Redesign, Live Web Chat, ASR, and Omnichannel Contact.
- **Expert Support**: Implementation and training supported by PWC, ensuring a smooth transition.

- These benefits collectively enhance patient care, operational efficiency and improve communication across the Trust.



Digital

New UEPR	Patient Portal	Cloud Migration	Electronic Observations	Digital Operations	Robotic Process Automation	Target Operating Model	Digital SOP's
The new UEPR is currently in procurement and progression of contract.	We have launched the Patient Knows Best (PKB) patient portal in partnership with MSEFT and MSEICB providing baseline demographic and patient appointment data.	The journey to cloud has begun; the shift of infrastructure service is steadily moving into the cloud to improve resilience, efficiency, accessibility and reduce spend on local datacentre hardware.	Launch of the Oxehealth electronic observations (e-obs) system as well as further rollout of the Oxevision solution to support faster, non-intrusive physical checks and interventions	Procurement, development and launch planning for a new IT support system (Hornbill)	Mobilisation of automation opportunities across the trust.	Development of a modernised, value stream operating model for digital and data services across EPUT.	Our Electronic Standard Operating Procedures (e-SOPS) programme is reaching the end of pilot phase.
Key achievements and benefits							
The UEPR will replace and unify EPUT legacy EPRs to support safer and joined up care pathways across both EPUT and MSEFT.	This is the first step towards improving our patient engagement and how they interact with their care.	Migration to the cloud will support improvements in resilience, efficiency, accessibility and reduce spend on local datacentre hardware.	Electronic observations improve the quality, efficiency and safety of patient observations in our mental health inpatient settings.	The new IT support system (Hornbill) will improve self-service, reduce IT support response times and enable opportunities to integrate with MSEFT (common system)	The use of RPA supports clinical care, synchronisation of EPR-to-EPR appointments between mental health practitioners and primary care to enable a single view of availability and appointment booking.	The new operating model will bring together the clinical digital oversight, alignment to organisation business partnering and modernise the digital services to reflect best practice and drive efficiency.	e-SOP's will bring digitally enabled operating procedures to all our staff making them more accessible, reportable and ensure that they are always current.

Data

Data Intelligence	Data Platform	Mental Health Crisis Prediction	Data Quality	Record Management Accreditation
We have launched Power BI as a standardised data intelligence solution across the trust with examples such as the IPR, accountability framework, Patient safety and perinatal dashboards live.	Implementation of a new data warehouse and the onboarding process has begun for all trust data sources into a single source of truth.	Using the Management and Supervision Tool (MaST) to support clinicians in identifying and intervening in crisis prevention.	Our new data quality framework supports us to ensure that our data is accurate, timely and assured.	We have achieved BS10008 certification in records management and governance.
Key achievements and benefits				
These dashboards are enabling improved organisational insight and oversight. Improved decision support for organisational leaders and identify areas for improvement.	A single source of truth will support data insight intelligence for both clinical and operational decision support. Bring together data types from multiple (clinical and non- clinical) source systems to deliver lateral data intelligence.	Predicting and preventing MH crisis and allow for earlier interventions to improve the quality of care and drive efficiency.	Level-up our data quality and data governance, identify gaps and remediate in partnership with the front-line services.	This is best practice assurance for how EPUT ensures the integrity, quality and availability of the clinical record.

Primary Care Digital Programmes

Providing NHS services

Improving our Digital offer

We are moving to Cloud Based Telephony (CBT)

- 55 Practices moved from analogue phones to cloud based
- 38 practices cloud-based system upgraded

We are using Online Consultation / Video Consultation (OCVC) tools as part of our new ways of working

- eConsult – 32,585 patients visited and 17,620 eConsult's submitted in September 24
- Patchs – 17,696 submissions to practices in September 24
- Accurx – huge take up by primary care on this recent contract. Only 7 practices not using the product.

Key Achievements & Benefits

- £1.5m investment into primary care telephony
- CBT – only anecdotal feedback (national data uploaded from October). Extremely popular with patients, GP patient survey results improved in 2024 for phone contact.
- Circa 800k patients now have improved access on the phone. Data to be released nationally end October. Anecdotal feedback extremely positive with staff and patients.
- OCVC software freeing up phones for patients who aren't digitally enabled and supporting staff to work smarter, not harder.

Modern General Practice Access

Utilising transition funding and moving practices over to a Total Triage model.

- 64 applications received
- 34 Approved
- 8 approved in principle subject to minor clarification
- 22 declined and Connected Pathways team working with these practices on total triage process to enable future successful application.
- Deadline for applying extended until end November and all practices contacted and encouraged to apply if struggling with capacity and demand planning.
- 13 practice taking part in NHSE GPIP
- Successful Lunch and Learn in September

Key Achievements & Benefits

- Modern General Practice Access - parity between online, phone and walk ins.
- Many patients submitting requests can be dealt with remotely without the need of visiting the surgery. Assisted by the digital tools provided.
- 25 practices with declined / AIP submissions now approved following work with Connected Pathways team
- ~400k patients now have modern general practice access.

367,158
Record views, exceeding our target of 304,605

NHS App

5,133
MSE appointments managed in the NHS App

81,949
Repeat prescriptions, exceeding our target of 71,074

90,000
Phone calls saved per month

2,768
MSE Appointments cancelled using the NHS App

What's Next

- Continue promotion of NHS App, including messaging function
- Prepare for OCVC procurement, once budget for 25/26 known
- Continue to work with practices and Procurement hub for invoicing
- Collect and analyse CBT data once released and provide support to outlying practices
- Ensure that practices have signed up to the CBT DPN.
- Continue to work with practices to implement total triage / modern general practice access

Provide community

Smart Referral System (SRS)

The Smart Referral System (SRS) aims to enhance the accuracy, efficiency, and equity of patient referrals within the MSK Service. Key components of the digital platform consist of a web portal for patients to complete a self-referral, an AI-assisted triage application to provide real-time inputs/recommendations to the patients and clinical team by using data-driven insights from various sources of data, and a digital pathway for data collection to support triage.

Key Achievements & Benefits

- **Cost and time efficiencies:** proven to reduce the number of clinical contacts and save significant administrative and clinical time (over 2,100 hours annually for care navigator staff*) through semi-automated triage and assigning service users to the correct urgency and caseload.
- **Health Recovery Outcomes:** the MSK-HQ score (a key determinant of health recovery outcome) for SRS pathway patients increased by 18.7 points compared to 16.9 points for non-SRS pathway patients.*
- **Reduced need for GP appointments:** the SRS algorithm allows patients to refer to the service directly and be effectively signposted based on their condition in real-time.
- **Improved Patient experience:** quicker and more transparent service delivery.
- **Expansion:** plan to extend into other services.

Smart Referral System

*Optimizing Patient Care Pathways: Impact Analysis of an AI-Assisted Smart Referral System for Musculoskeletal Services https://ieeexplore.ieee.org/document/10645842

RealWear Headsets

Realwear Headsets are rugged, voice controlled, wearable hands free video/audio devices, currently being trialed with Virtual Frailty Wards and the Urgent Community Response Team (UCRT) across the MSE Community Collaborative. The headsets allow clinicians working with patients in their own homes to connect virtually with other team members in real time with a live interactive audio and video feed, introducing additional support for clinical care and decision making. Used with patients with increasing acuity, the clinical staff using the headsets will be connected with the Frailty hotline to support care delivery in people's homes, with the aim of reducing escalation and additional direct visits.

Key Achievements & Benefits

- **Community Collaborative Sign off:** complex process requiring engagement with various stakeholders across the Community Collaborative. Final sign off achieved April 2024.
- **Training:** Train the trainer sessions have been delivered remotely by Realwear and SimplyVideo, to overcome the challenges of teams dispersed across Essex and the complexities of delivering face to face sessions. All sessions have now been completed.
- **Clinical Go-Live:** 19th of September 2024 following sign off from the Joint Clinical Operational Group (JCOG). Templates have been implemented across all TPP SystmOne units to capture clinical activity looking at specific outcomes such as admission avoidance and preventing delays to prescribing. Benefits will start to be assessed at the end of Q3.

AssetVoice

AssetVoice is an equipment management system undergoing testing within Integrated Care teams to monitor the allocation and movement of syringe drivers, small devices critical to supporting end of life care. Its application is a mobile app to scan QR codes on assets and a back-end data system. The aim of the AssetVoice pilot is to understand how this new system helps teams to keep track of assets in the community, ensuring that essential equipment is always available when needed.

Key Achievements & Benefits

- **Streamlined process and time efficiencies:** it takes approximately 20 seconds to scan an asset and make an action within the app, vs the previous manual sign out process which was time consuming and open to human error. Since the start of the pilot in August, 100% of syringe drivers have been accounted for 100% of the time, enabling responsive and efficient planning and deployment in the end of life pathway.
- **Accessibility & Ease of Use:** over 80% of ICT clinical and admin staff are signed up and trained on the mobile/web apps. Early adopters were identified to promote use across the team and provided essential feedback to the workflow.
- **Expansion:** VAC pumps have recently been added to AssetVoice, with Dopplers planned for the next phase.

Adult's and Children's Social Care

Our Liquid Logic Portals; The public and professionals' complete online referrals / access information.
Nov 24 – We are reducing complexity of forms creating easier self-referral and assessments. Residents will have direct access to their own information. We are also making improvements to our internal processes

Southend-on-Sea City Council

Adult Social Care

LIFT	Livewell	Social Prescribing
LIFT uses data from Southend County Council and the Department of Work and Pensions to identify residents who are potentially missing benefits.	Livewell is the relaunch of our Health and Wellbeing Website. This was co-designed with community stakeholders.	Phase 1; Link workers with GP Practices digitally prescribing
Key achievements and benefits		
This went live in July 2024 and has already identified and notified 417 residents that were missing out on Pension Credits. A further 315 residents are due to receive letters following recent identification.	Thanks to the engagement with stakeholders, the system is now easier to navigate, accessibility compliant and has received positive resident feedback.	By Jan 25 – Link workers digitally prescribing and booking with accredited local providers. In 2025 – Via Livewell, residents will be able to self-refer to accredited local providers, giving faster access to local support, and improving health and wellbeing.

What's next?

Ask Sara is our outcome-based self-assessment smart form for aids/disability equipment products. By **Jan 25** we will be linking to equipment providers relevant to recommended products, reducing need to wait for Occupational Therapy assessments, speeding up the support provision.

The ICS Shared Care Record links data across our ICS partner organisations sharing patient/resident information. In Nov 24 SCC Data will be shared with the System. SCC Social Care Staff accessing wider data will support better informed decisions and support process efficiencies.

Children's Social Care

Family Centres

Our new operating model focusing on three main family centres and five outreach sites. Leveraging technology to support efficiencies.

Key achievements and benefits

Live Sept 24 –
New operating model supporting the needs of children in the city and target support where required.

July 25 – rationalisation of systems, utilising Liquid Logic EHM, improving reporting and providing operational efficiencies.

What's next?

Child Protection Information Sharing (CP-IS)	Review of SEN System	Digital Inclusion Support	Youth Justice System	Joint Strategic Needs Assessment (JSNA)	Pharmaceutical Needs Assessment –
By March 25 We will be sharing 0 – 19 information. This will support early intervention to reduce future harm to children and young people.	**In 2025** we will leverage the potential of our existing children's systems, rationalise our Application Estate, improve our processes and our use of data and reporting.	Working with partners, and the voluntary sector to bridge the digital divide, via digital inclusion support and training we will address the digital disparities with our communities **by Jan 25.**	Procurement, transition of data, and improving processes **by Apr 25**. This will bring continuity of service, operational efficiencies through improved system utilisation and electronic sharing of case data with partners.	We are in the final stages of the SEN joint Strategic Needs Assessment with ICB colleagues. By **Dec 25** we expect to have the first ever JSNA. This will focus on Special Education Needs (SEN), supporting both Health and LA's to effectively meet their needs.	Collaboration between Thurrock and Southend to align the Assessment. By **Sept 25** we will understand the pharmaceutical needs of the area, what is commissioned and where there are gaps to be addressed.

Southend-on-Sea City Council

Corporate

My Southend & Front Door Review	ERP Modernisation	SEC Dark Fibre
In July 2024 we transitioned to a new platform and completed a Channel Review.	In Aug 24 we modernised our ERP. ERP is used for managing our core business processes.	Throughout 2024 we have been working to roll-out Dark Fibre.
Key achievements and benefits		
Our new platform is Accessibility Compliant supporting digital inclusion. **By Dec 26** we are hoping to realise operational efficiencies, automation, Customer Relationship Manager, improved customer experience, end to end management.	This provides more flexible access through deployment of web client and removing the need for desktop. By **April 25** this will support us to we improve operational efficiency, MI rollout Position Management, Absence, Budgeting, Payroll & Pensions.	We will have the ability for SCC and partners to deploy Internet Of Things (IOT) i.e. Pollution Monitoring, Falls, Water use, Traffic etc. Phased **throughout 2025** we are expecting significant operational savings.

What's next?	
Data Strategy	**Artificial Intelligence**
Our 5 year plan will support better use of data & delivery of intelligence across SCC, including Partners who access & supply data. It will enable better targeted services & early intervention by leveraging modern open data platform, improved data literacy, system integration and process efficiencies.	Utilising AI to process audio file recordings of meetings then populating social worker templates By early **2025 o**ur proof of concept will realise operational efficiencies of 30%, releasing resource to front end care by reducing administration.

Adult Social Care

Quality Commission Inspection Regime Preparation	Portals	Financial Insights Dashboard	MSE Shared Care Record
Created and implemented a self-assessment and improvement quality assurance process implemented.	Our Safeguarding Referrals & Carers Assessments portals enable referral and submission of Carers Support by our Commissioned Carers Support Service.	Agreement for a 'try before you buy' pilot of the dashboard carried out by our Corporate and Customer Finance Teams.	Initial planning and implementation of the SCR into our system.
Key achievements and benefits			
Provides greater Clarity for Council Officers on what is required of them. Improving experience and involving our residents in development and improvement of our practice and processes.	Visibility of support provided by our Carers Support Service Portal forms pre-populate case management system thereby reducing processing time and expediting decisions for the resident.	Increased oversight and accuracy of finance data relating to Council commissioned and funded service provision; enabling improved analytics and decision making.	Hospital and care workers will have immediate access to the entire scope of an individual's needs.
What's next			
Cycle of continuous improvement to further develop our practice and processes following the audit outcomes.	Update Safeguarding Referral following review and to plan implementation of the public facing referral.	Business case to be drafted to secure use of the portal for the next 12 months.	Testing and fully implementing the ShCR and rolling the system out to our users.

Childrens Social Care and Education

Portals	Education Case Management System	Special Education Needs (SEN) system	School Data Daily Feed
We have implemented base portal functionality across Childrens Social Care with our Initial Health Assessment, Safeguarding Referrals and Education & Health Care Plans portals.	We have issued a tender for the replacement of our Education Case Management application with view to creating a single view of the child and family across Social Care.	We have implemented a new system for the management of SEN cases.	Around 85% of Thurrock schools are now feeding attendance data directly into our internal systems once a day.
Key achievements and benefits			
This additional front door allows service users to access our key services directly.	Centralisation of Social Care and Education data for integrated use across teams.	Centralisation of Social Care and Education data for integrated use across teams.	More up to date data is now available to users, this improves oversight of the child and any perceived concerns to ensure support is offered.
What's next			
Rollout of specific forms to the public, looking at EHCP requests, safeguarding referrals and Initial Health Requests.	Implementation of and migration to the newly procured system.	Data migration from the old system to the new system.	To bring the remaining borough school on board and to on board out of borough schools into the feed.

Corporate

Business Intelligence Transformation	Customer Relationship Management System	Robotic Process Automation	Artificial Intelligence
We have moved BI into the Assistant Chief Executive Office. Gathering information from other Local Authority models. Successfully gained support from our Senior Leadership Team on the change principles for transformation.	Requirements gathering and initial vendor discussions have been held.	Several repetitive manual tasks have been automated, with the ability for workers to request this service as needed	Identified business requirements of a voice AI product to inform a business case and tender process
Key achievements and benefits			
Enabling use of our data in a collective way enabling improving business intelligence from a Community Insights perspective, supporting our shift to a Community Leader Council in line with our Corporate Plan.	Access to core data on our citizens will be available to all staff to enhance customer experience	Saved hours of workers time by automating repetitive tasks and improving data quality	Enhance customer experience and staff efficiencies
What's next			
Identification and centralisation of cross organisation resources/funds. Confirmation of the remit and responsibilities for our BI function, launching it as an organisation wide corporate function	Define requirements, undertake procurement exercise and start implementation	Ongoing work to realise the benefits of RPA. Recent examples include resolving of data quality issues impacting reporting / Business Intelligence	To secure Voice AI contract (imminent) and begin implementation. Considering other use cases for AI.

Essex County Council

Adult Social Care

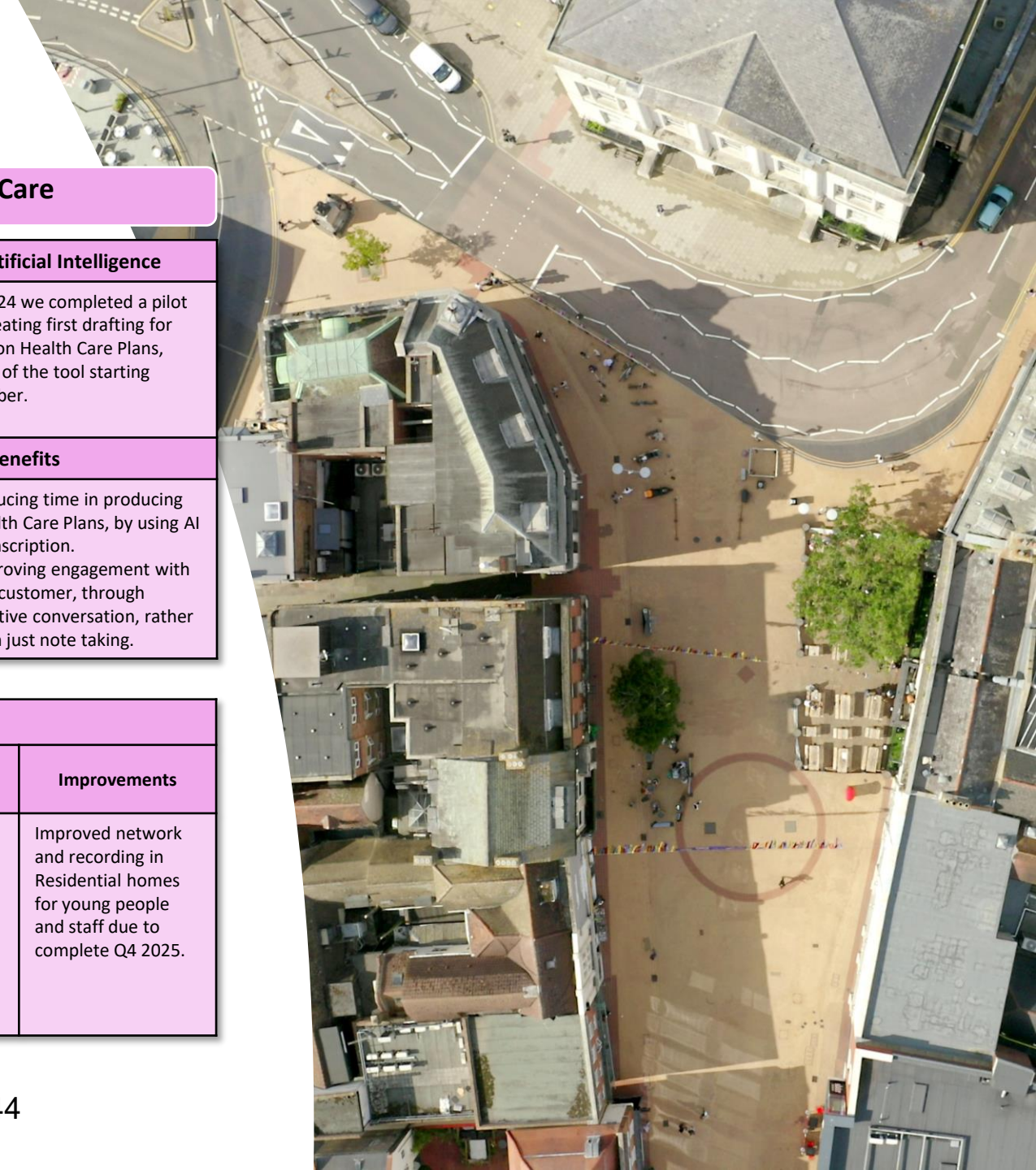
Online Safeguarding Form	MSE Shared Care Record	CQC Inspection
In March 24 we delivered an online Safeguarding form for referrals.	In August 24 we successfully implemented the MSE Shared Care Record.	Successfully completed the CQC onsite inspection in July 2024.
Key achievements and benefits		
The online referral form will reduce duplication and demand on referrals.	This will improve care of our residents.	Stage 1 of inspection completed virtually, with feedback due early Nov, for onsite inspection TBC.

What's next?	
Social Care Platform Programme	**Safeguarding Portal**
Over the next 12 months our Social Care Platform Programme is looking for Digital Technology to implement fit for purpose Systems for the workforce.	To develop and improve the Safeguarding Portal, we are undertaking Discovery and Innovation for Front Door/Information, Advice, and Guidance for Residents. Enabling self-serve options for residents.

Children's Social Care

Family Centres	Artificial Intelligence
In August 24 we completed the procurement for the Education Case Management System (Capita One).	In June 24 we completed a pilot of AI creating first drafting for Education Health Care Plans, phase 2 of the tool starting September.
Key achievements and benefits	
• Information, advice and guidance for young people and adults in education. • Funding for SEND support and managing schools' admissions for intakes.	• Reducing time in producing Health Care Plans, by using AI Transcription. • Improving engagement with our customer, through positive conversation, rather than just note taking.

What's next?		
Our Front Door	**Foster Carer Digital Experience**	**Improvements**
Discovery for digital opportunities for front door/information, advice and guidance (Family Hub)	Exploring opportunities for improved digital experience for Foster Carers to support increased recruitment and retention.	Improved network and recording in Residential homes for young people and staff due to complete Q4 2025.



Essex County Council

Corporate

In the early part of 2024, we established a M365 Product Team, to support with product skills and learning pathways, along with secure and safe access for our workforce.

Key achievements and benefits

- Development of Learning Pathways to improve the Employee skills and literacy in using the technology available to them.
- Information, Advice, & guidance in one location, for the Employee to self-serve
- Varying training offerings, for the employee to use, giving them a good employee experience that suits their way of learning.

What's next?

Over the next 12 months we will be:

- Developing plans for using AI within the business functions:
- Magic Notes for Transcription, Adults Proof of Concept.
- Access to free version of CoPilot on Microsoft Edge Browser.
- Opportunity to apply for CoPilot License.
- For driving through efficiencies & saving on time.

Regional

In FY23/24 approximately **£21m was invested in digital programmes** across MSE.

Programme Name	Organisation	FY 23/24 £s		FY 24/25 £s	
		Cap	Rev	Cap	Rev
Frontline Digitisation: Electronic Patient Record (EPR)	EPUT	£3,000,000	£900,000	£2,206,000	£391,866
AI Diagnostics Fund	MSEFT	£149,000	£64,000	n/a	£30,000
Frontline Digitisation: Electronic Patient Record (EPR)	MSEFT	£8,800,000	£500,000	£5,376,000	£685,766
Future Connectivity – Gigabit Pathways	MSE ICB	£114,000	-	n/a	n/a
	EPUT	-	£112,000	n/a	n/a
GPIT Funding (BAU Capital)	MSE ICB	£1,987,000	n/a	£1,988,000	n/a
Patient Engagement Portals (Wayfinder)	MSEFT	n/a	£500,000	n/a	n/a
	EPUT	n/a	£147,000		
Shared Care Record		£350,000	n/a	tbc	Tbc
Health Adoption and Accelerator Fund (HTAAF)	Various	n/a	£641,000	tbc	tbc

Through HTAAF funding, MSE are piloting five products supporting Elective Recovery and Virtual Wards. The technology will support optimising clinician time and improve patient experiences through AI and smartphone applications, reduce the number patient referrals for hearing loss and provide and Palliative and End of Life Care website.

Programme Name	Org	FY 23/24 £s		FY 24/25 £s	
		Cap	Rev	Cap	Rev
Business Case Development Funding	MSE ICB	n/a	£1,649,557	n/a	n/a
Care Coordination Solution	MSE ICB	n/a	£42,000	n/a	n/a
Cloud Based Telephony (CBT) - Phase 1 and 2	MSE ICB	n/a	£1,649,557	n/a	n/a
Cyber Risk Reduction Funding		£197,980	£39,596	tbc	tbc
Cyber Improvement Programme - System Support Funding				tbc	£171,801
PCARP Digital Tools (formerly Digital Pathways Framework)				£959,635	tbc
Digitising Social Care	MSE ICB	n/a	£98,810	£0	£587,620
Regional Underspend - Frontline Digitisation Support	MSE ICB	n/a	£47,000	n/a	n/a
Secure Data Environments ICB Strategic Alignment	MSE ICB	n/a	£20,000	tbc	tbc
Secure Data Environments - MVP for the Heart Failure Admission Prevention Use Case	MSE ICB	n/a	£20,000	tbc	tbc

Digitising Social Care
Since 2022, funding has supported over 135 adult social care providers in MSE to adopt digital record systems (35% increase) and helped +400 people to access falls detection and prevention technology. Digital literacy of the workforce continues to increase and the relationships between providers, local authorities and the ICB strengthened.

EPR
Frontline Digitisation investment has supported readiness activity and business case development for the Unified EPR across MSEFT & EPUT. This will be a national first of type solution supporting patients across acute, mental health and community care settings.

In FY24/25 there is over £12m allocated with some programmes still to confirm what funding will be available

Governance

Mid and South Essex Integrated Care System

Our ICS Groups

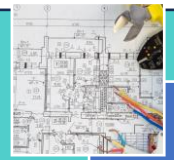
ICS IG Steering Group

- The ICS IG Steering Group was established as a decision-making group for ICS Projects/Programmes.
- Originally set up to ensure IG Leads from all system partners are aware of system wide projects that may affect their organisations.
- The group meet monthly with the following purpose
  - Agree template documents for all organisations to accept for any system wide project.
  - Approving (on behalf of their organisations) all IG related documents for the Shared Care Record programme.
  - In addition to discussing system wide projects/programmes the group acts as a support network to discuss other issues faced by individual IG teams within the ICS.
- During 24/25 the group will continue to look at ICS wide projects/programmes and will use the monthly meetings to provide support to those organisations that are implementing the new CAF aligned DSPT in this and future years.

We now have a suite of IG templates that are used to save time and effort in completing multiple versions of the same documents for each organisation.

ICS Cyber Security Steering Group

- The ICS Cyber Group is a decision-making body and forum that brings together Cyber Security Subject Matter Experts (SMEs) from across the Health and Social Care settings in Mid and South Essex.
- The group's focus is on "levelling up" cyber security maturity in Mid and South Essex to ensure robust practice to secure systems that prevent cyber-attacks.
- The role of the ICS CSSG is to:
  - Provide oversight on behalf of the MSE ICS; it will provide collective strategic leadership and act as the approval body for all matters of cyber security for all ICS related programmes/projects.
  - Create specialist advisory Cyber Groups or nominate individuals to support major ICS programmes and projects
  - Promote effective and timely engagement and collaborative working across MSE ICS. Where needed liaison across other regional ICSs and their equivalent functions.
  - Manage the ICS wide allocated budget for cyber security. Ensuring that the resource and funding provides the system with best value solutions and function.



Digital Design Enablement Group

- Linked in with other subgroups such as Cyber and IG, DDEG is supporting positive and progressive system working.
- DDEG's purpose is -
  - To work as a Technical Design Authority (TDA) to the system, with bi direction links to sovereign organisational TDAs. – a place where all partners can agree standards and principle to support system partner working.
  - Working with the DTPG they will be a conduit for national opportunities, collectively shaping offers, and maximising investments into the system.
  - Provide a collective compliance view for the ICS and its system partners on adherence to standards such as Information Standard Notices
  - A place to support procurements and investment cases
  - Act as a place of escalation and resolution on agreement for core technology programmes such as HSCN replacement.

Digital Transformation Programme Group

- DTPG is an open forum with system wide attendance and input.
- It is a collaborative space for shared learning, updates and open discussions.
- The group focuses on hot topics that are proposed by members alongside updates on our key strategic programmes.
- The group is used to 'test the water' with several ideas and proposals prior to these being worked up through governance.
- Recently the group has been used to support the shaping of our ICS Digital and Data Strategy refresh

Essex County Council

Southend-on-Sea City Council

thurrock.gov.uk

NHS Mid and South Essex NHS Foundation Trust

Mid and South Essex Integrated Care System

NHS England East of England

NHS Mid and South Essex Integrated Care Board

Provide community

NHS Essex Partnership University NHS Foundation Trust

Part I ICB Board meeting, 14 November 2024

Agenda Number: 15

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

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

Chief Executive's Report

1. Introduction

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

2. Main content of Report

2.0 Key activities since the last Board meeting

My induction period has continued since the last Board meeting, including meeting with a wide variety of colleagues within the ICB alongside our partners. I have also attended several key events including:

- The commencement of the Essex Caring Communities Commission, which I was invited to join as a commissioner. This is an exciting initiative taken forward by Essex County Council (ECC) made up of elected members and an independent group of experts to look at how outcomes can be transformed across health and social care. More detail around the work of the commission is available here.

- The Essex and Southend Health and Wellbeing Boards.

- Participation in the NHS England led Recovery Support Entry Programme meeting for Mid and South Essex NHS Foundation Trust (MSEFT).

- Our first quarterly ICB review meeting with NHS England as part of new oversight arrangements that are being introduced for ICBs, which I reflect on in more detail below.

- Participation in the Winter Risk roadshow, which is currently being undertaken by NHS England, at which Sam Goldberg, Urgent Emergency Care System Director, presented to members of the national leadership team on the good work being undertaken to establish and optimise our Unscheduled Care Co-ordination Hub (UCCH).

- A collaborative meeting held between the ICB and the University of Essex exploring opportunities for joint working.

- The launch of the 'change NHS' engagement campaign being led by the Department of Health and Social Care alongside NHS England (NHSE) to help inform the development of the 10-year plan for the NHS.

2.1 Quarterly review meeting

I attach the letter, dated 22 October 2024, received following the quarterly review meeting held with NHSE on 11 October 2024 **(Appendix A)**. The key areas identified for the Boards' attention and the work underway in these areas is detailed below:

2.1.1 Financial Performance

The Board is well aware of the financial challenge faced by our system and this remains a key focus. As reflected within the finance report being presented on the agenda today, there was some improvement in the run rate during month 6, although we will need to see significant further improvement in month 7 to have confidence of the system's ability to deliver to plan for the year.

2.1.2 Cancer Performance

Cancer performance remains of significant concern and is well understood as having been a long-standing issue for our system.

To this end, we held an ICB / MSEFT roundtable on cancer performance on 28 October 2024 to agree the next steps that could be taken to address performance now, alongside the longer term actions required to underpin future sustainability of cancer performance and services.

Within this work we identified that there were actions underway within MSEFT to tackle key concern areas of skin and colorectal services in-year but there were several other services which will require more significant change and transformation across the entire pathway, including our current breast service pathway alongside head and neck services.

To assist in this, we will alter our current governance and oversight arrangements within the system to reduce duplication of monitoring between the 'Tier 1' cancer meetings convened by NHS England and the system wide Cancer Oversight and Assurance Committee. These changes will allow the Tier 1 meetings to focus on day-to-day performance, with the Oversight and Assurance Committee focusing on service change and transformation work.

2.1.3 Workforce

It was identified and agreed that more work is required to develop a system owned long term workforce strategy, to be incorporated within the Medium Term Plan work currently being initiated (more detail below).

2.1.4 Elective

The good progress that has been made was noted, but the need for maintained focus on elective waiting times will continue.

2.2 ICB development and focusing on delivery and planning for the medium term

Since starting at the ICB, I have received feedback from team members as well as others on the need for the ICB to be clearer on the priorities for the organisation and system, alongside starting the work to set out the medium-term plan for system sustainability.

To achieve this, I have been working with leaders across the ICB to set out our priorities and key deliverables for the remainder of the financial year, with the aim for this work to be concluded and the priorities set during November, with the intention of routinely reporting progress against these to Board.

Secondly, we are receiving support through the Recovery Support Programme to undertake a medium-term planning exercise to set out the change required to move our system to a more sustainable operating model in terms of the care we deliver to our communities, the workload on our people and for taxpayers. The first phase of this work will launch in November, with the completion of the first phase being in January.

To support this work, we have identified a need to develop an Organisational Development plan for the ICB to clarify how the ICB works and delivers for patients, alongside creating the ICB as a great place to work. To support this, we are focusing on securing a good uptake of the NHS Staff Survey which will give us good data on our areas of focus, at the time of writing ICB staff uptake was 52% against an ICB average of 49% (range of 38%-65%).

2.3 Community Services Consultation

The Working Group on the Community Services Consultation has now commenced with the first meeting held on 28 October 2024. We have had a good response from partners and community organisations with over 30 participants now involved within the group.

The first meeting provided an opportunity to brief participants on the proposals which were included within the consultation, the consultation feedback and an initial conversation on estates considerations. A minute of each meeting will be published, and I will also provide updates to the Board through this report.

2.4 Winter

The risks associated with winter pressures are significant and there is a briefing to the Board on the plans which are in place elsewhere on the agenda today. However, I wanted to use this report to draw the Boards' attention to the five areas of focus that were discussed and agreed by Chief Executive Officers (CEOs) across the system at our most recent CEO meeting:

- **Escalation beds within acute hospitals**: Within the agreed bed model there is a risk of a circa 40 peak bed deficit during February 2025 within the bed model assuming the full delivery of a range of internal and system wide mitigation schemes. Should these schemes not deliver there will a further pressure on hospital beds across our system.

- **Community capacity:** Alongside the risk to acute beds, there are also risks associated with ensuring appropriate support is in place to support community service providers to maintain flow to support safe and effective care.

- **Mental health inpatient flow:** The system is experiencing significant pressure on mental health inpatient capacity, resulting in high numbers of out of area placements. This is alongside mental health community teams managing increased risk within the community, and delays for mental health patients who present at acute hospital services.

- **Discharge to Assess:** The system currently has high reliance on discharge to assess pathways to support flow. The current model operated by the ICB is leading to poor outcomes for patients and very high costs.

CEOs acknowledge the above risks and have agreed to several steps to facilitate the system to best manage these during the winter period, as follows:

- Support the establishment of the System Discharge Cell to bring together senior leaders under single leadership to support patient flow across all settings and fill the current gap we currently have, and to lead tactical response and management of system pressures (supporting the current daily operational response mechanism which is in place).

- To undertake scoping and provision of additional support to community beds to help identify blockages and support flow through the existing capacity.

- To build on the learning from the recent multi-agency discharge event (MADE) event and support Essex Partnership University Hospitals NHS Trust (EPUT) in any work requiring system action to support mental health inpatient flow, alongside agreement for joint work between EPUT and MSEFT to identify the most effective support model for mental health patients within acute settings.

- To acknowledge the work currently being led by the ICB to improve the Discharge to Assess model with proposals being developed in the next few weeks to optimise capacity and support for patients who are discharged from hospital through this pathway.

2.5 Focus on winter vaccinations

The NHS has launched the winter vaccination campaign, and I am particularly keen for us to focus on uptake this winter as one of the best ways we can support people at risk from illness. As such our System Co-ordination Centre has taken on responsibility for co-ordinating and supporting work to drive the update of vaccines across our system over the coming months.

There is significant work to be undertaken in this area, uptake across the key vaccine areas for our eligible populations (both patients alongside health and care workers) are shown in the table below:

	Eligible population (patients, HSCW)	Vaccinated (as of 29/10/24)	Uptake %
COVID Booster	382,871	135,667	35.4%
Flu	679,171	228,552	33.7%
RSV Catch-up	57,408	18,455	32.4%

3. Executive Committee

Since the last report, there have been nine weekly meetings (from 3 September to 28 October 2024)

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

- Review of delivery plans across each of the four Alliances within mid and south Essex (MSE).
- Review of clinical record storage across the ICB, including physical storage.
- Agreed the ICBs commissioning intentions across 2025-2026.
- Review of the draft system Equality, Diversity and Inclusion Strategy.
- Agreed the rollout of a 12-month project which will see the introduction of Pharmacy Primary Care Network Engagement Leads across MSE.
- Creation of an internal Legal Services Panel which will form part of the ICBs Triple Lock arrangements.
- Review of APMS / GP Contracts across the patch.
- Agreement for a re-introduction of the MSE Community Assembly.
- Weekly review of the ICB Pulse Staff Survey Results.
- Approval of revised utilisation for Mid Essex Health Inequalities funding, as a result of underspend.
- Establishment of the Learning and Development Steering Group which will manage internal requests for training and development across the ICB.
- Agreement to explore the creation of several new staff schemes to support the learning, development, and wellbeing of staff. These schemes will continue to be formally developed with staff prior to final ratification.
- Review and approval of our System Winter Plan, with a weekly update brought on our performance over the winter period.
- Development of our ICB Contractual Management Approach for all clinical contracts across the ICB.
- Approval of the revised Service Restriction Policy for Uterine Artery Embolisation Procedure (UAE).
- Review of the draft Communications & Engagement Strategy.
- Approval of an ICB Staff Network proposal, which will support staff dedicated time to engage with staff networks and support work required across the groups.

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

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

4. Conclusion

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

5. Recommendation

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

6. Appendices

Appendix A - Letter dated 22 October 2024, received following the quarterly review meeting held with NHSE on 11 October 2024.

NHS England
East of England

To: Tom Abell
Chief Executive
Mid & South Essex ICB

Mike Thorne
Chair
Mi& South Essex ICB

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

22 October 2024

Dear Tom and Mike,

Mid & South Essex ICB Review Meeting – 11th October 2024

Thank you to you and your team for meeting with us for the ICB's Quarterly Review and for the supporting slide deck which supported the meeting. I do not propose to go into the detail of the discussion in this letter as this can be found in the notes taken during the meeting, which are enclosed.

It was positive to hear of the progress being made in a number of areas and you recognised the need to build on this good work. As an ICB you appear better sighted on the problems within the system and are taking a proactive approach to identifying and managing risk, specifically in relation to quality concerns. This has been evidenced through your risk summit approach, reacting quickly and robustly.

You and the team were able to take us through the changes being implemented in response to the development areas highlighted in the ICB's Annual Assessment feedback.

The ICB continues to face a number of challenges, not least the financial deficit. The pace of progress remains stubbornly slower than planned (or required), despite some recent signs of improvement.

We identified a number of areas that require the Board's attention over the coming months.

These included:

- **Cancer performance** - Access must be improved to deliver the outcomes patients deserve. A further meeting to focus on Cancer performance will be convened in 6-8 weeks' time. This will need to consider the support required to make meaningful and sustained progress in key, challenged specialities. The work of the stewards is showing positive change, and we would ask the ICB to look at what more can be achieved through the stewardship model.

- **Workforce** - Recognition that this requires significant work. A system owned Long-Term Workforce Strategy is fundamental to the system's clinical and financial sustainability.
- **Finance** - whilst there are early signs of progress, we challenged the pace of improvement. Run rate has to increase significantly to put the system in a position to deliver plan. Work on financial sustainability (MTFP) needs to be progressed.
- **Elective** – 65ww performance is positive and we expect to see that improvement sustained and built upon.

I would like to take this opportunity to thank the team for their hard work in trying to address these significant system challenges. We do not underestimate how difficult it is for the Board to balance these challenges with other priorities, whilst ensuring the provision of safe services. We note the work already underway in these key areas and look forward to hearing about progress at future meetings.

If you have any questions regarding this letter, please do not hesitate to contact your Regional SRO or my office.

Yours sincerely,

Clare Panniker
Regional Director
NHS England – East of England

Enc.

Part I ICB Board meeting, 14 November 2024

Agenda Number: 16

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response. This Quality Report provides a focus on the learning disability, autism and mental health inpatient improvement work which has been undertaken in response to national guidance and reviews into specific populations requiring intensive and assertive outreach.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Dr Giles Thorpe, Executive Chief Nursing Officer.

4. Responsible Committees

Quality Committee.

5. Link to the ICB's Strategic Objectives

To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.

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

6. Impact Assessments

None required for this report.

7. Financial Implications

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is asked to:

- Note the development of the Learning Disabilities, Autism and Mental Health Inpatient Quality Transformation Programme for MSE ICB.
- Note the response to the request from the NHS England regarding the provision of Intensive and Assertive Community Outreach for MSE ICB.
- Note the continued focus on quality improvement of services for people with mental health needs, autistic people, and people with a learning disability.

Mid and South Essex Quality Report

1. Introduction

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

1.2 The report for this Board will focus on mental health and the importance of ensuring that the Board meets its statutory duties to understand and support the improvement work being undertaken within the sphere of mental health, learning disabilities and autism services. NHS England (NHSE) requires ICBs to be sighted on plans to improve services via the development of the Learning Disabilities, Autism and Mental Health Quality Transformation Programme.

1.3 NHSE has also asked all ICBs to review policies and practices in place to support people with Severe Mental Illness (SMI) who require treatment but where engagement is a challenge. This has been in the wake of the recent incident resulting in the deaths of three people in Nottingham and the subsequent review of mental health care undertaken. A defined cohort of people was identified for review, with action plans developed to understand the provision of intensive and assertive outreach services. The findings of the review are now presented below.

2. Learning Disabilities, Autism and Mental Health Inpatient Quality Transformation Programme

2.1 All Integrated Care Systems (ICSs) aim to improve population health, healthcare and tackling inequalities in outcomes, experience, and access for all. This means that they need to plan with all partners for improvements for their citizens, including people with a mental health need, people with a learning disability and autistic people.

2.2 A Mental Health, Learning Disability and Autism (LDA) Inpatient Quality Transformation Programme (2022) was aimed at primarily supporting cultural change and a new model of care for the future across all NHS-funded mental health, LDA inpatient settings, focussing on the following:

- Care that is personalized
- Admissions which are timely and purposeful
- Hospital stays which are therapeutic.
- Discharges that are timely and effective
- Services which actively identify and address inequalities
- A Pathway which is continuously improving.

2.3 The NHS England 2023/24 Priorities, and associated Operational Planning Guidance, set out a requirement for ICBs “to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three-year period”. Draft plans were shared with regional teams by end of March 2024 with final, agreed, and published plans by end of June 2024.

2.4 As a minimum, these plans needed to describe the interventions that will be put in

place to address the issues summarised in the NHS England Commissioning Framework.

Areas of Focus

2.5 An extensive engagement exercise with key stakeholders to gather views and expertise of individuals concerned with the commissioning, delivery, and improvement of mental health inpatient services was carried out through a national programme. This included clinicians, people with lived experience of inpatient services and their families, identifying key themes and priorities where intervention and support to improve quality could be employed to best effect in the following:

- Localising and realigning inpatient services
- Harnessing the potential of people and communities
- Improving the culture of care and supporting staff
- Supporting systems and providers facing immediate challenges
- Making oversight and support arrangements fit for the sector; and
- Supporting least Coercive Care through Reducing Restrictive Practices.

2.6 The approach by mid and south Essex (MSE) has been to prioritise the first three points above, whilst ensuring the other themes are linked throughout the plan. The ICB Mental Health and LDA team have evidenced in the plan how the ICB has, or will ultimately, achieve/deliver improvements against all key themes below:

- Purposeful Admissions
- Therapeutic Inpatient Care
- Proactive Discharge Planning
- Personalised Care and Shared Decision Making
- Trauma Informed Care
- Care that Advances Health Equality
- Joined Up Partnership Working.

2.7 The commitments outlined in the three-year plan to transform the quality and experience of care within mental health and learning disabilities inpatient services has been aligned to the ICB's Joint Forward Plan, by engagement with our provider organisations and respective stakeholders.

2.8 Oversight by the ICB will be delivered through its Quality Committee, where sufficient scrutiny will be applied to seek assurance on delivery against the plan. Escalations and progress will be shared through the Quality Report for the Board's consideration. Provider level oversight on commitments to act will be delivered through quality and contract performance meetings, with ICB Executive Director oversight.

3 Mental Health Intensive and Assertive Outreach Review

3.1 Following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber in Nottingham, the former Secretary of State for Health and Social Care commissioned the Care Quality Commission (CQC) to conduct a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008, which was published on 13 August 2024.

3.2 A requirement in the 2024/25 Operational Planning Guidance was for ICBs to review their mental health community service provision by the end of Quarter 2. On 26 July 2024 NHSE published guidance to ICBs on intensive and assertive community mental health care and directed them to review policies and practices regarding the care of people with SMI who require treatment but where engagement is a challenge and/or they face barriers to accessing services.

3.3 NHSE provided a 'Maturity Index' tool for local areas to measure current service provision and practice against the Intensive and Assertive Outreach service model. In August NHSE asked systems to confirm that non-attendance at appointments is never used as the reason to discharge a patient from this cohort from a service. The ICB and Trusts confirmed this to NHSE as per request.

3.4 The local review continues and the accompanying presentation to this paper (**Appendix A**) sets out progress and findings to date in detail. As part of the review, ICBs are asked to report any gaps and barriers to delivering care that they have identified (such as resourcing and workforce implications) to regional NHS England teams with the submission due on 30 September 2024. MSE ICB submitted their review and met with the NHS England regional team on 6 October 2024, alongside colleagues from Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWE) ICBs, in order to provide oversight of an Essex-wide footprint.

Findings to date

3.5 Service structures and functions vary across the ICB areas. For MSE ICB, whilst EPUT as the Mental Health Trust operates across the system, the delivery for community intensive and assertive outreach provision is different between south east, south west and mid Essex, so assessment and developments vary in each of these contexts.

3.6 There is a lack of dedicated assertive outreach teams across the entirety of MSE, although some functions and approaches of the Assertive Outreach Model remain in place. In areas where there is no dedicated team, they:

- do not operate, and are not commissioned to, at the level of intensity of Intensive and Assertive Outreach provision.
- the functions are dispersed across services/teams.
- current caseload sizes are higher than indicated in the Dartmouth Assertive Community Treatment Scale (DACTS).
- community Teams are not currently resourced to meet the level of intensity to be fully compliant with the standards.

3.7 Positively, recognised and robust approaches to risk management are in place with clinicians working with multi-disciplinary teams to identify and manage risks and make decisions about the right patient care and pathways. This includes the standardised tools and techniques for identifying and managing risk such as the use of early warning signs, and risk formulation techniques.

3.8 There are examples of good relationships and joint working across organisations and agencies where those exist; adult care services, criminal justice partners, substance use services, and voluntary, community faith and social enterprise (VCFSE) partners. There are already initiatives underway to improve joined-up interventions for this group of people, such as complex multi-disciplinary teams (MDTs) as part of complex care pathway development, and primary care network (PCN) level meetings as part of community mental health transformation. However, there is a need for continued development of:

- Information sharing and risk formulation processes across agencies involved in a person's care.
- Identification of people at risk, identifying non-engagement or relapse often relies upon key individuals working with the person and more systemic processes need to be considered, particularly when multiple agencies are involved.
- Better integration with housing, complex needs, and substance misuse services.

3.9 There are established policies and mechanisms for patient and carer feedback in the delivery and development of services, but consistency in the approach, recording, communication and demonstrating involvement needs to be an area of focus.

3.10 The Patient and Carer Race Equality Framework (PCREF) process needs to continue, and there is a call to consider new ways of working as a system to engage creatively with people with specific needs and characteristics, including neurodiversity, who may experience psychotic symptoms and disengagement from services.

Resource Implications

3.11 The potential resource implications are currently not quantified. The review to-date has highlighted that caseload sizes are too high to provide the targeted work required for full compliance with the DACTS model and this will have resource or service structure implications.

3.12 Beyond reducing caseloads for care co-ordinators for this patient group, there are other resource implications in terms of psychology, social work, occupational therapy, nursing, and psychiatry. To fully meet DACTS standards, staff in these disciplines need dedicated time to be able to work flexibly to effectively reach out to people in this cohort.

3.13 The further work to develop options for the provision of intensive assertive outreach for this cohort will also consider the training and supervision of staff and MDT requirements. The review to date has noted skills gaps, or the volume of these skills in intensive outreach needed across the current workforce is not sufficient, as those ways of working have reduced over time.

3.14 There are other groups as well as those presenting with psychosis who may also require and respond to more intensive support, such as people with personality disorders and / or autism and mental health conditions. There will be a need to consider resource allocation to people with complex needs in totality to ensure resource is allocated effectively across our populations.

3.15 NHSE have not mandated that areas should reintroduce the full Intensive Assertive Outreach Team model. The requirement is that patients' needs are identified and provided for, and that people can access treatment and are kept safe. As the future service model options are developed there will be a need for system partners, people who access services, and their carers to consider whether the full Intensive Assertive Outreach Team model is appropriate, or indeed possible across the ICB, and what the alternative options are to meet patient needs better.

3.16 In the response from MSE ICB the team have presented the recommended actions as short and long-term, with a focus on areas that need to be progressed as a system, alongside areas that provider Trusts will take forward.

3.17 NHSE have confirmed that high level action plans are required at this stage, which will be refined and developed as work continues.

4 Recommendations

The Board is asked to:

- Note the development of the Learning Disabilities, Autism and Mental Health Inpatient Quality Transformation Programme for MSE ICB.
- Note the response to the request from NHS England regarding the provision of Intensive and Assertive Community Outreach for MSE ICB.
- Note the continued focus on quality improvement of services for people with mental health needs, autistic people, and people with a learning disability.

5 Appendices

Appendix A – Intensive and Assertive Community Treatment Review Presentation

Appendix A

Mid and South Essex

Intensive & Assertive Community Treatment Review

Presentation to:

ICB Public Board

November 2024

We are collaborative

We are compassionate

We are innovative

We are living well

Context: Intensive & Assertive Outreach - Community Treatment Review

- NHS England has asked all Integrated Care Boards (ICBs) to review policies and practices regarding the care of people with Severe Mental Illness (SMI) who require treatment but where engagement is a challenge.

- The review has taken place in the wake of the recent incident in Nottingham, and the subsequent CQC review of the incident and the mental health care provided.

- In July 2024 NHSE issued guidance to all ICBs requesting that policies and practice relating to a defined cohort of people are reviewed, an action plan developed, and for the findings of this process to be presented to a public ICB board meeting.

- This presentation and accompanying paper sets out the work completed and findings to date and details the next steps for implementing improvements in the way we support people with an SMI.

People in scope of the review

The aim of local reviews is to identify and meet the needs of a particular group of people with severe mental health illness, focussing on people who:

- Are presenting with psychosis, but do not necessarily have a diagnosis of a psychotic illness.
- May not respond to, want, or may struggle to access and use ‘routine’ monitoring, support and treatment that would minimise harms.
- Are vulnerable to relapse and/or deterioration with serious related harms associated (especially, but not limited to, violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation)
- May be presenting with co-occurring problems (e.g. drug and alcohol use)
- May have had negative (harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice system).
- Concerns may have been raised by families and carers.

Content of the Review

The Review asks ICBs to confirm:

Following your review are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?

- NHSE has already asked local areas to confirm that non-attendance at appointments is never used as the reason to discharge a patients from this cohort from a service - the ICB and partner Trusts were able to confirm this to NHSE in August.
- The review has initially focussed on work with our NHS mental health trust (EPUT) to identify existing practice with this cohort, together with an action plan of both short- and long-term work in and outside of the trust to improve the quality of care.
- The trusts have used the ‘Maturity Index’ tool recommended by NHSE, which has guided a detailed review of policy and practice for this group of people.
- The initial review has shown that care for this vulnerable group requires sustained working across NHS Trusts, Primary Care, Voluntary, Community, Faith, Social Enterprise (VCFSE) partners, drug and alcohol, housing, and criminal justice partners. Multi-agency partner workshops will be convened to take this work forward.

Findings so far – Good practice

- Whilst EPUT as our Mental Health Trust has dedicated Intensive Assertive Outreach Teams, this is not reflective of MSE. South West and South East have dedicated teams whilst Mid Essex does not. However, the current practices identified that:
  - There remains robust approaches to risk management with individual clinicians supported by multi-disciplinary teams to identify and manage risks, and to make the right decisions about patient care and pathways.
- There are policies in place to manage transfer of care between teams, and examples of good local relationships with partners, including escalation processes and processes for safe discharge from mental health services, such as:
  - Multi-Disciplinary Teams with Primary Care Network Meetings in some areas which provide a helpful space for managing well-known complex patients who attend GP surgeries
- Training compliance is regularly audited, and the PSIRF patient safety process for learning from serious incidents was felt to be robust.
- There are established policies and mechanisms for patient and carer feedback and involvement in the delivery and development of services.
- There are a range of transformation programmes underway within trusts and across the system which seek to further improve the quality of care this cohort of people receive.

Findings so far – Areas for Development 1

- **Service model –** While services flex to meet the needs of patients currently, the review shows as a system we face considerable challenges in creating the capacity to fully deliver the principles of Intensive Assertive Outreach.
- **Caseloads** – EPUT as our MH trust has procedures for monitoring and adjusting caseloads across clinicians to meet patient needs. However, to achieve full fidelity to the nationally recognised Dartmouth standards for Intensive and Assertive Outreach teams, caseloads would need to drop significantly. This represents a significant challenge in the current environment.
- **Carer and family member communication & engagement** – there are well developed and established policies and processes to promote communication and involvement of carer and family members, but consistency in the approach, recording communication and demonstrating involvement needs to be an area of focus.
- **Identification of people at risk** – There is training and processes for identifying and escalating risks and/or disengagement, however;
  - This often relies on individual staff noticing disengagement and is not systematised within the Electronic Patient Record system.
  - Between the Trust and external partners, the challenge is even greater and often relies on relationships between local services.
- **Roles and Responsibilities** – needs clarity across local pathways with better communication and links with neurodiversity services etc.

Findings so far – Areas for Development 2

- **Better integration with housing and complex needs provision**; continued work is needed to support housing teams and providers to continue supporting this cohort of service users.

- **Health inequalities** – the Patient and Carer Race Equality Framework (PCREF) process needs to continue and there is a call to consider new ways of working as a system to engage creatively with people with specific needs and characteristics.

- **Training & skill mix** – Across Essex, there is variable assertive outreach provision, either absent or not delivering fidelity to the model. We do not have the required workforce with the right training, the right team culture or resources to deliver a full assertive outreach approach.

- **Joining up risk assessment planning with partners** – it is difficult for organisations to share risk planning information effectively across partners - this is a joint working challenge as well as an ICT systems challenge.

Action Planning – System Actions

Shorter Term

- Develop options for enabling intensive/assertive working - early indications from the review suggest there are significant gaps against full fidelity of model, and significant resource constraints
- Run partner workshops to identify further support needed by voluntary, community faith and social enterprise (VCFSE) services, primary care, drugs and alcohol (D&A), housing teams regarding identification and support for this cohort, including those with neurodiversity
- Review the caseloads of mental health clinicians deployed to preventative/early intervention services, to ensure expertise is appropriately directed to people.
- Crisis Care Partnerships in MSE continue working to support to this cohort of individuals, including support from Street Triage and crisis response services.

Longer Term

- Continue our transformation of community mental health services, so that the role of system partners in supporting SMI patients is clarified and supported, and SMI patient contact is balanced across the system
- Work with business intelligence (BI) and public health management (PHM) colleagues to develop our ability to identify people at risk of disengagement and integrate into follow up services, e.g. Emergency Department (ED) attendances.
- Review the current pathway for D&A induced psychosis and develop support options.
- Commissioners to reflect learning from this review in future commissioning strategies and service design for secondary services, VCSFE services, and primary care

Action Planning – Provider Actions

Shorter Term

- Continue developing and implementing post Care Programme Approach (CPA) care pathways in Trust, ensuring this cohort is supported appropriately.
- Continue developing and implementing the psychosis pathway to support this cohort.
- Review and embed clinical guidance in pathways for people with a history of violence and/or offending.
- Include the person's Mental Health Act (MHA) detention history in appropriate risk protocols.
- Ensure learning from Early Intervention in Psychosis and Psychosis: Prevention, Assessment and Treatment services is brought into Community Mental Health Teams.

Longer Term

- Continue family and carer engagement work, focussing on improving consistency and recording communication.
- Continue PCREF and related work to improve data and understanding of health inequalities for this group.
- Further expand and embed the role of experts by experience in service development programmes.
- Further refinement of Electronic Patient Record systems to flag disengagement and barriers to engagement.

NHS
Mid and South Essex

Intensive & Assertive Community Treatment Review

Alfred Bandakpara-Taylor, Deputy Director Mental Health, LD & Spec Comm

www.midandsouthessex.ics.nhs.uk

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I Board Meeting,14 November 2024

Agenda Number: 17

Month 6 Finance and Performance Report

Summary Report

1. Purpose of Report

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

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

2. Executive Lead

Jennifer Kearton, Executive Chief Finance Officer.

Report Author

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

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance & Performance Committee on 5 November 2024.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to receive this report for information.

Finance & Performance Report

1. Introduction

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

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

As part of the M6 position NHS England (NHSE) have provided the Deficit Allocation Funding which has adjusted the £96m deficit to breakeven. The system is now being measured against a breakeven plan. This additional funding is repayable in future years.

2. Key Points

2.1 Month 6 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB, has increased by £106.05m of allocation, all of which was expected. £96m of this change is the Deficit funding.

Table 1 – Allocation movements between month 5 and month 6

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
Recurrent	Programme	2,217.10	2,217.09	0.01
	Delegated - Specialised	279.92	279.92	0.00
	Co-Comm	228.24	220.21	8.03
	Delegated - DOP	104.47	104.47	0.00
	Running Costs	19.88	19.88	0.00
	Total	**2,849.60**	**2,841.56**	**8.04**
Non-Recurrent	Programme	198.58	100.57	98.01
	Delegated - DOP	2.34	2.34	0.00
	Delegated - Specialised	(51.03)	(51.03)	0.00
	Total	**149.89**	**51.88**	**98.01**
Total		**2,999.48**	**2,893.43**	**106.05**

The ICB has a £4.15m adverse variance at month 6 which reflects the additional growth we are experiencing in All Age Continuing Care. We have managed to offset an element of this increase due to in-year benefits across other spend areas which are non-recurrent in nature. The ICB has efficiency plans in this area and has redirected resource into supporting the mitigation of both the operational and financial impacts of the continued growth.

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

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

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

Table 2 – summary of the position against the revenue resource limit for month 6.

Summary of ICB Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m	Full Year Budget £m	Full Year Forecast £m	Full Year Variance £m	Full Year Variance Mth on Mth Change £m
Allocation	(1,526.12)	(1,526.12)	(0.00)	(2.57)	(2,999.48)	(2,999.48)	(0.00)	(0.00)
Acute	753.95	752.34	1.61	1.89	1,460.22	1,457.30	2.92	4.00
Community Health Services	117.82	118.75	(0.93)	(0.62)	233.39	235.18	(1.78)	(0.25)
Continuing Care	79.41	88.91	(9.50)	(2.70)	158.82	176.30	(17.48)	(2.64)
Mental Health	141.49	139.85	1.64	(0.16)	283.90	281.99	1.91	1.03
Other Commissioned Services	2.36	(1.35)	3.71	(0.16)	4.73	(11.71)	16.43	(1.42)
Other Programme Services	9.84	9.78	0.06	0.06	19.11	19.11	(0.00)	(0.00)
Primary Care	294.35	295.60	(1.25)	(0.38)	588.76	590.76	(2.00)	(0.73)
Programme Reserve & Contingency	0.00	0.00	0.00	(0.00)	2.29	2.29	(0.00)	(0.00)
Specialised Commissioning	117.14	117.14	(0.00)	(0.00)	228.89	228.89	(0.00)	(0.00)
Corporate	9.55	9.03	0.52	0.50	18.99	18.97	0.02	(0.00)
Hosted Services Admin	0.19	0.21	(0.02)	0.00	0.39	0.41	(0.02)	0.00
Total	**0.00**	**4.15**	**(4.15)**	**(4.15)**	**(0.00)**	**0.00**	**(0.00)**	**0.00**

2.2 ICB Finance Report Conclusion

The ICB is showing further divergence from plan at month 6 and understands the drivers for the challenge and is taking deliberate steps to mitigate. The Finance and Performance Committee will continue to receive 'deep dive' reports on progress across these areas with escalation to the System Oversight Assurance Committee and the ICB Board.

2.3 Month 6 System Financial Performance

At month 6 the overall health system position is a deficit of £28.6m against the revised plan of breakeven.

Table 3 – summary of the System position against the revenue resource limit for month 6.

Organisation	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m	FY F/Cast £m	FY Variance £m
⊟ ICB						
Allocation	1,526.12	1,526.12	0.00	2,999.48	2,999.48	0.00
Expenditure	(1,526.12)	(1,530.26)	(4.15)	(2,999.48)	(2,999.48)	(0.00)
⊟ Provider						
Income	1,066.23	1,074.72	8.49	2,096.59	2,117.62	21.03
Non-OP Expenditure	(23.34)	(22.16)	1.18	(48.05)	(45.41)	2.64
Expenditure	(1,042.89)	(1,077.04)	(34.15)	(2,048.54)	(2,072.21)	(23.67)
Total	**(0.00)**	**(28.63)**	**(28.63)**	**(0.00)**	**0.00**	**0.00**

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

Both our system providers implemented grip and control actions during 2023/24 and continue to work collectively with the ICB to reduce the run rate during 2024/25. The whole system continues to operate in Triple Lock with regional oversight of expenditure items greater than £25k.

2.4 System Efficiency Position

At month 6 the system has delivered £46.7m of efficiencies against a year-to-date plan of £62.1m reflecting the revised planning submission made to NHSE in June 2024. The system is still forecasting delivery of the full requirement of £167.8m.

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

Table 4 – System Efficiency summary

Organisation	Plan £m	Actual £m	Variance £m	Full Year Plan £m	Forecast £m	Full Year Variance £m
ICB	20.89	20.35	(0.54)	47.62	47.62	0.00
EPUT	13.00	8.68	(4.32)	28.65	28.65	(0.00)
MSEFT	28.23	17.66	(10.57)	91.50	91.50	0.00
SYSTEM	**62.12**	**46.69**	**(15.43)**	**167.77**	**167.77**	**(0.00)**

2.5 System Capital Position

The forecast capital spend for the system is £131.2m, £6.7m below plan due to electronic patient record (EPR) spend being re-phased. Our actual YTD spend is £31.7m against a planned position of £45.6m. It is expected that delivery will gain pace throughout the year and prioritised capital commitments will be fulfilled.

Table 5 – Capital Spend Summary

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
Externally Financed						
MSEFT	21.86	11.13	10.74	72.85	68.82	4.02
EPUT	5.79	2.91	2.88	14.46	7.72	6.73
ICB	0.00	0.00	0.00	0.00	0.00	0.00
Total	**27.65**	**14.04**	**13.62**	**87.30**	**76.55**	**10.76**
Internally Financed/System CDEL						
MSEFT	13.65	13.99	(0.34)	38.73	42.73	(4.00)
EPUT	3.71	2.88	0.84	9.92	9.92	0.00
ICB	0.53	0.81	(0.27)	1.99	2.03	(0.04)
Total	**17.89**	**17.67**	**0.23**	**50.64**	**54.68**	**(4.04)**
Total	**45.55**	**31.70**	**13.84**	**137.94**	**131.23**	**6.71**

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

2.6 System Finance Report Conclusion

At month 6 the System is working toward a revised planned year end position of breakeven having received £96m in deficit funding. As in previous years this funding is repayable in line with the business rules in respect of deficit repayment.

The system is focused on delivering its Operating Plan for 2024/25, ensuring financial efficiencies are delivered whilst mitigating any potential risks to the plan in-year. Action is being taken to deliver a route back to plan in this financial year and we should see the financial impact of these actions during quarter 3 and into quarter 4.

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

2.7 Urgent and Emergency Care (UEC) Performance

The UEC Strategic Board oversees performance and planning for all UEC services (East of England Ambulance Service (EEAST), NHS 111, A&E, Urgent Community Response Team (UCRT), Mental Health Emergency Department (ED) and has members from both health and social care.

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

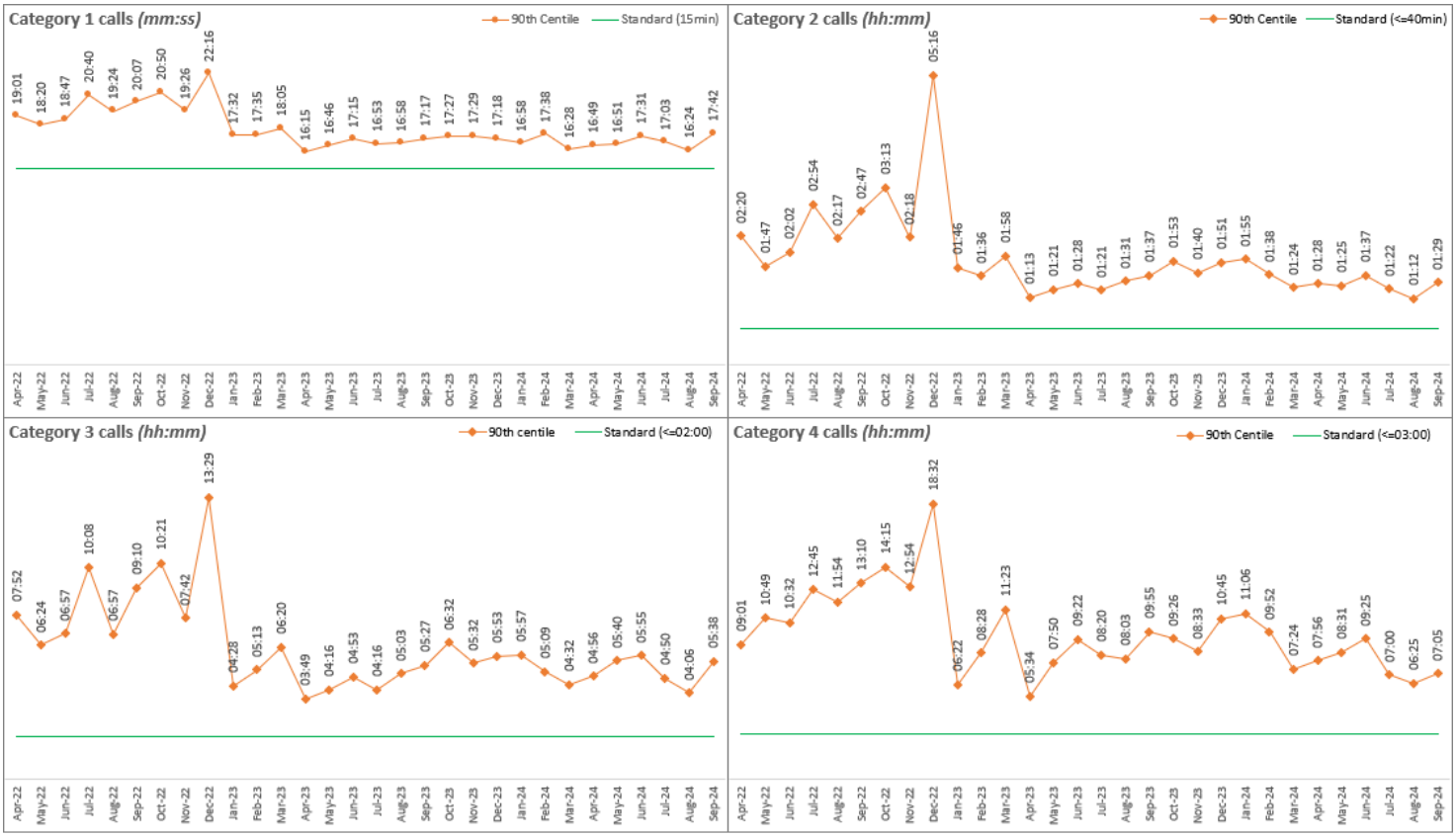
Our current performance is below the standard required as outlined below:

Ambulance Response Times

Standards:

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

The 90th centile response times for East of England Ambulance Service for all four categories of calls are above their respective standards as shown in the following graphs.

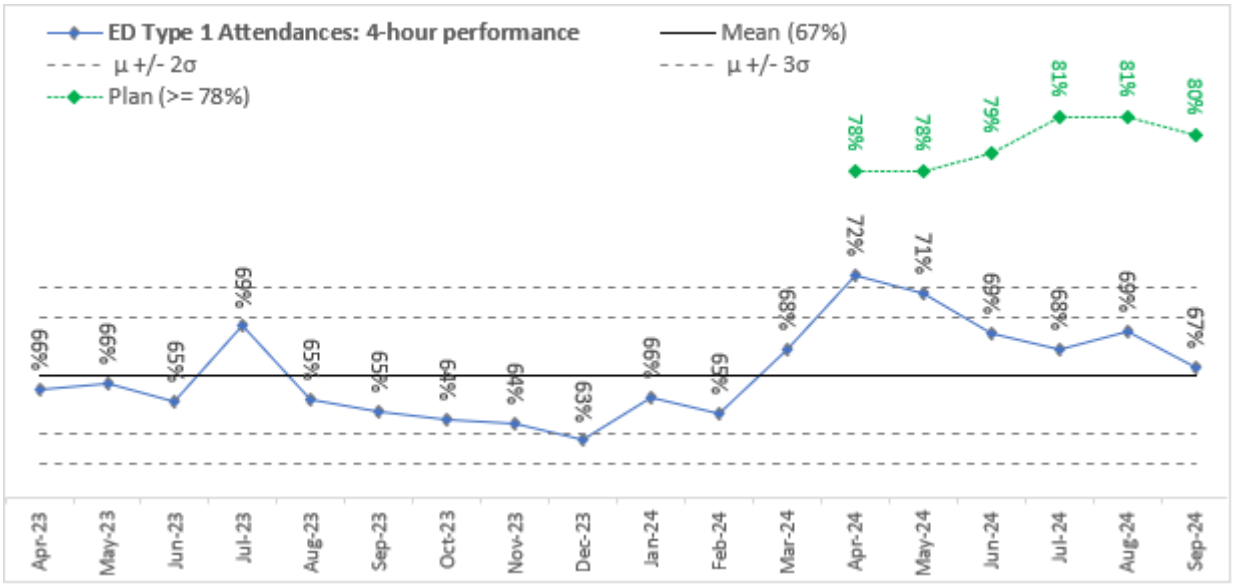


Emergency Department – waiting times

2024/25 priorities and operational planning guidance ask:

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

Performance is below operational plan to meet the 2024/25 priorities and operational planning guidance across all three MSEFT sites as per the following graph. Performance increased significantly in April 2024, but then decreased, remaining above average to September 2024. September 2024 achievement of 67% remains below the Operational Plan of 80%. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

Performance against the Operational Plan for Mid and South Essex NHS Foundation Trust is overseen via the new Quality Contract Performance Review Meeting (QCPM). There is oversight via the National Team through the Tier 1 fortnightly meetings. MSE Integrated Care System (ICS) continue to oversee cancer and diagnostics via the relevant committees.

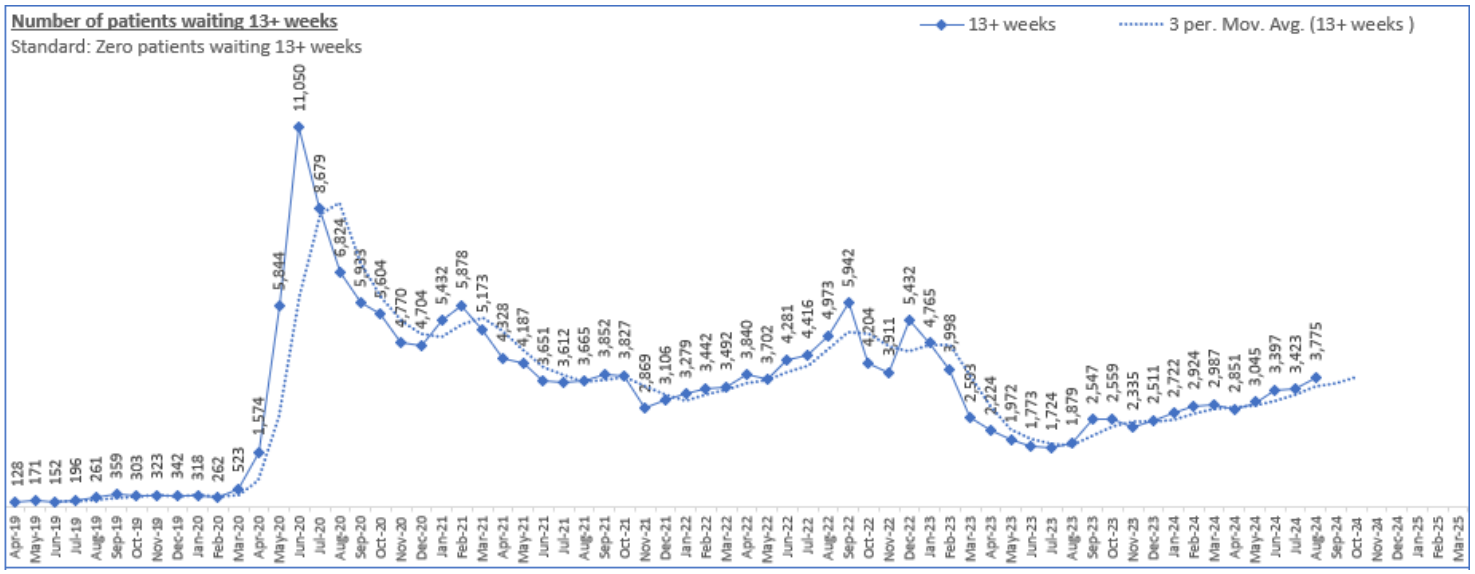
Our current performance is below the targeted national standard as set out below.

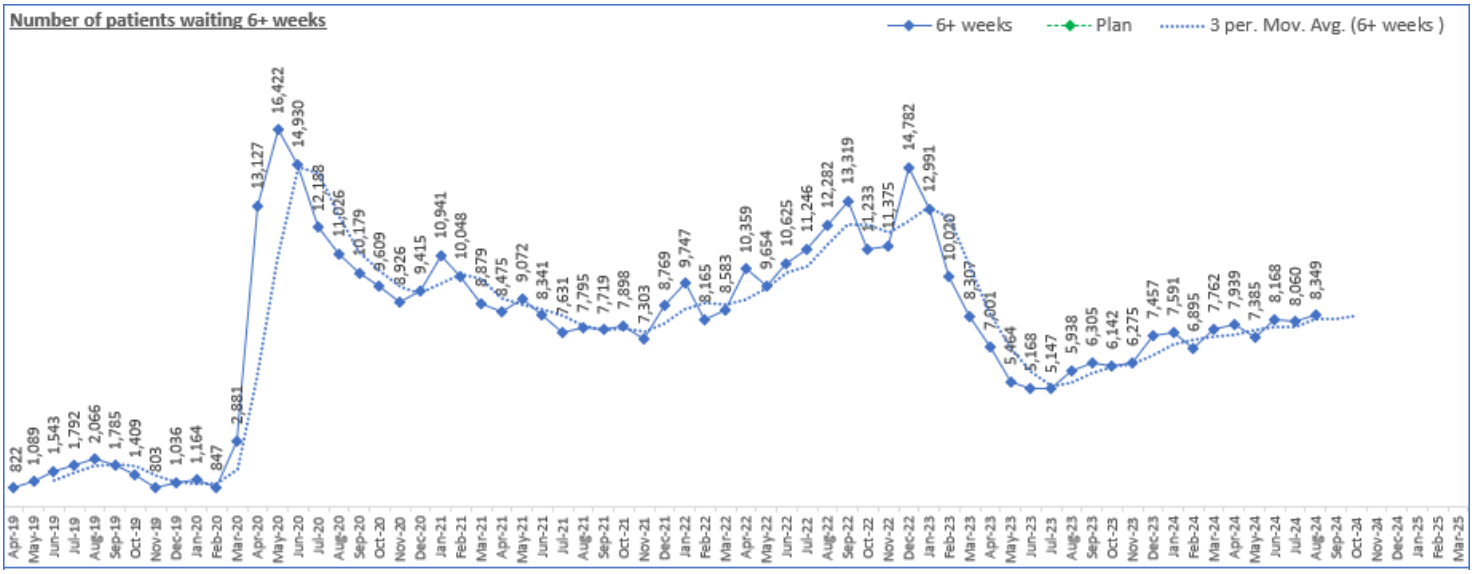
Diagnostics Waiting Times

Standard:

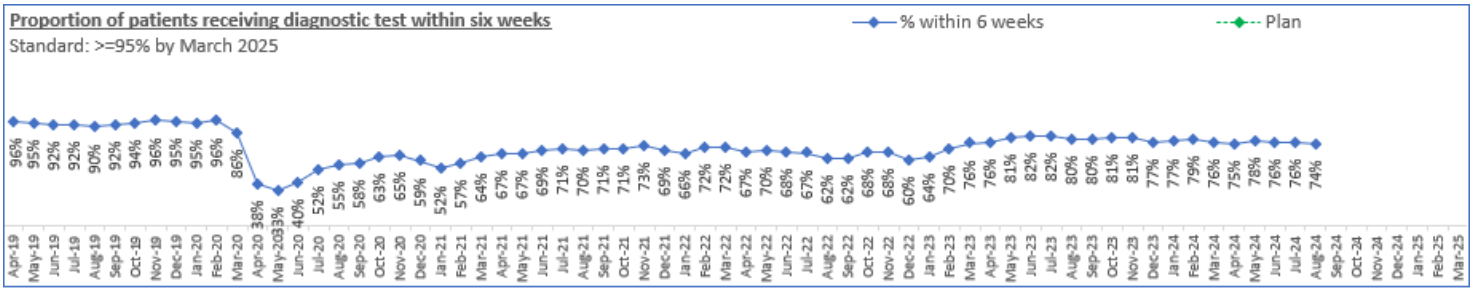
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

The below tables show the total number of MSE residents waiting 13+ and 6+ weeks across all providers to August 2024.





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



As of August 2024, 3,775 people waited over 13 weeks (standard: zero) and 74% of all people waiting for their diagnostic test were seen within six weeks (standard: >=95%).

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

- Imaging: Non-obstetric Ultrasound and Magnetic Resonance Imaging (MRI).
- Physiological measurements: Echocardiology and Neurophysiology.
- Endoscopy: Colonoscopy and Gastroscopy.

Mid and South Essex: Diagnostic DM01 waiting list summary for Aug-24

Diagnostics		Number of patients waiting 13+ weeks Standard: 0
Test		**Total**
Imaging	Barium Enema	1
	CT	8
	DEXA Scan	68
	MRI	48
	Non-Obstetric Ultrasound	1,109
Physiological Measurement	Audiology Assessments	20
	Cardiology Echocardiography	1,197
	Peripheral Neurophysiology	180
	Respiratory Physiology Sleep Studies	39
	Urodynamics - Pressures & Flows	6
Endoscopy	Colonoscopy	502
	Cystoscopy	56
	Flexi sigmoidoscopy	147
	Gastroscopy	392

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

Diagnostics		Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%
Test		Total
Imaging	Barium Enema	92.3% (1)
	CT	93.1% (245)
	DEXA Scan	85.3% (184)
	MRI	85.2% (657)
	Non-Obstetric Ultrasound	82.8% (2,150)
Physiological Measurement	Audiology Assessments	90.7% (85)
	Cardiology Echocardiography	41.8% (2,725)
	Peripheral Neurophysiology	45.1% (307)
	Respiratory Physiology Sleep Studies	45.6% (216)
	Urodynamics - Pressures & Flows	69.2% (20)
Endoscopy	Colonoscopy	57% (806)
	Cystoscopy	68.1% (117)
	Flexi sigmoidoscopy	51.7% (226)
	Gastroscopy	61.1% (608)

Cancer Waiting Times

Standards: For people with suspected cancer:

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

The waiting times for patients on a cancer pathway remain below the NHS constitutional standard. The tables below reflect the NHS Constitution and 2024/25 operational planning requirements.

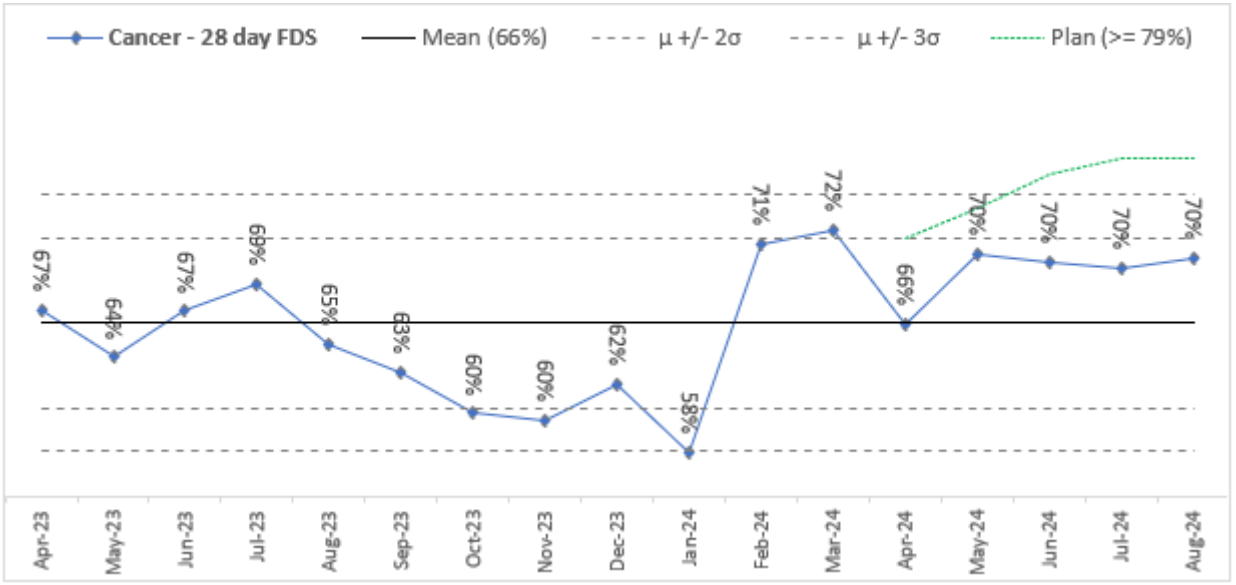
The following table shows the latest MSEFT position (August 2024) for each of the waiting time standards by site.

Tumour Site	28 Day Faster Diagnosis Standard	31 day first treatment	31 day subsequent treatment Drug Treatments	31 day subsequent treatment Radiotherapy Treatments	31 day subsequent treatment Surgery	62 day general standard	62 day standard (Urgent Suspected Cancer)	62 day standard (Screening)	62 day standard (Upgrade)
	Standard (>=75%)	Standard (>=96%)	Standard (>=98%)	Standard (>=94%)	Standard (>=94%)	Standard (>=85%)	Standard (>=85%)	Standard (>=90%)	
Total	70.2%	86.4%	92.1%	66.4%	57.5%	50.2%	43.7%	58.3%	65.5%
Acute leukaemia		100.0%				100.0%			100.0%
Brain/Central Nervous System						100.0%			100.0%
Breast	90.2%	90.8%				61.1%	55.3%	65.9%	85.7%
Children's	92.0%								
Exhibited (non-cancer) breast symptoms	94.1%								
Gynaecological	64.4%	73.3%				42.9%	28.6%		85.7%
Haematological	50.0%	94.6%				53.8%	47.1%		66.7%
Head & Neck	51.4%	47.4%				26.3%	14.3%		60.0%
Lower Gastrointestinal	49.1%	89.5%				51.3%	46.2%	50.0%	71.4%
Lung	76.2%	90.4%				46.9%	50.0%	28.6%	48.5%
Other	100.0%	80.0%				20.0%	0.0%		100.0%
Sarcoma		0.0%				0.0%	0.0%		0.0%
Skin	76.8%	81.1%				53.6%	55.9%		25.0%
Testicular	85.7%	100.0%				100.0%	100.0%		
Upper Gastrointestinal	72.0%	92.3%				58.3%	33.3%		73.3%
Urological	54.0%	88.6%				43.0%	35.1%		65.4%

The following table benchmarks the performance to all trusts nationally.

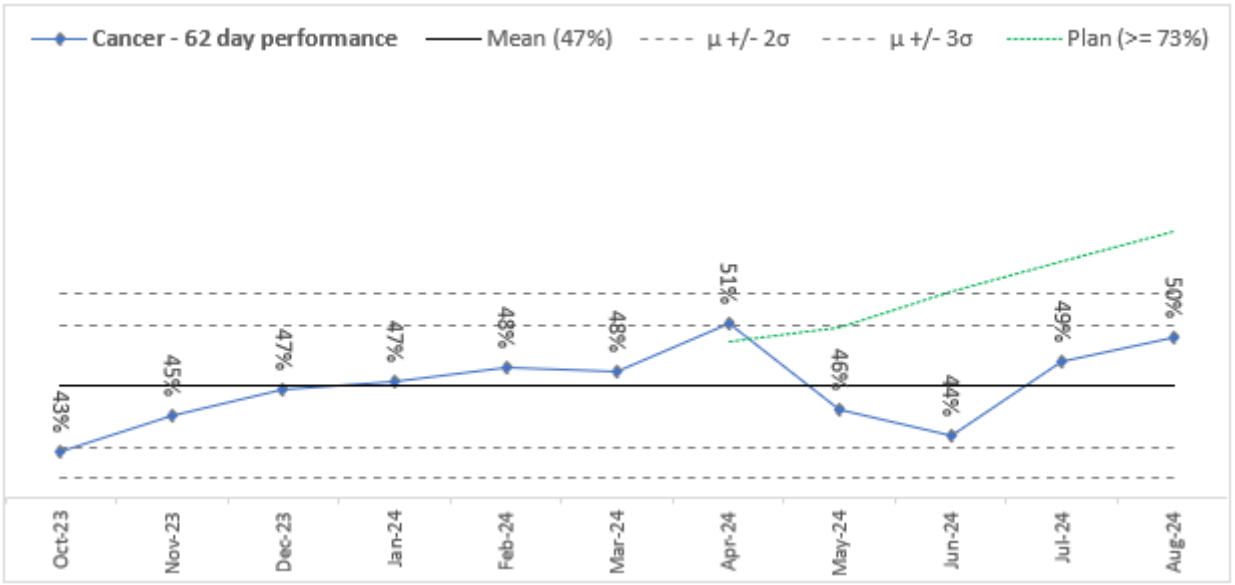
Pathway	Standard	Metric	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
28 Day Faster Diagnosis Standard	>=75%	Performance %	72.0%	66.0%	70.4%	70.0%	69.5%	70.2%
		Rank (1= highest)	121	130	123	123	128	116
		No. of Trusts	141	144	142	140	140	141
		National Performance %	**77.3%**	**73.5%**	**76.4%**	**76.3%**	**76.2%**	**75.5%**
31 Day First Treatment	>=96%	Performance %	80.3%	82.4%	82.4%	77.8%	85.0%	86.4%
		Rank (1= highest)	136	125	135	136	129	127
		No. of Trusts	139	139	140	138	139	141
		National Performance %	**91.5%**	**89.6%**	**92.4%**	**91.3%**	**92.4%**	**92.2%**
31 Day Subsequent Treatment: Drug Treatments	>=98%	Performance %	94.9%	85.8%	90.4%	92.4%	92.7%	92.1%
		Rank (1= highest)	105	119	116	102	117	114
		No. of Trusts	122	121	121	120	123	120
		National Performance %	**97.9%**	**97.4%**	**98.0%**	**97.1%**	**98.0%**	**98.1%**
31 Day Subsequent Treatment: Radiotherapy Treatments	>=94%	Performance %	57.3%	60.4%	51.4%	61.0%	67.9%	66.4%
		Rank (1= highest)	58	58	61	54	59	58
		No. of Trusts	60	66	63	58	64	63
		National Performance %	**89.8%**	**86.4%**	**89.1%**	**89.1%**	**90.2%**	**89.4%**
31 Day Subsequent Treatment: Surgery	>=94%	Performance %	45.1%	58.4%	57.4%	51.5%	55.0%	57.5%
		Rank (1= highest)	131	120	123	129	125	123
		No. of Trusts	133	133	131	131	129	130
		National Performance %	**78.6%**	**77.2%**	**81.6%**	**80.4%**	**81.5%**	**81.0%**
62 Day General Standard	>=85%	Performance %	48.0%	51.1%	45.6%	43.9%	48.7%	50.2%
		Rank (1= highest)	136	133	141	138	144	140
		No. of Trusts	145	149	149	149	150	149
		National Performance %	**68.7%**	**66.6%**	**65.8%**	**67.4%**	**67.7%**	**69.2%**
62 Day Standard (Upgrade)	N/A	Performance %	66.7%	67.4%	68.9%	61.6%	64.7%	65.5%
		Rank (1= highest)	124	117	114	130	129	127
		No. of Trusts	142	145	143	140	143	144
		National Performance %	**77.2%**	**76.8%**	**76.4%**	**78.1%**	**78.2%**	**79.0%**

The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. The August 2024 performance at 70% was below operational plan to meet the 2024/25 priorities and operational planning guidance requirement of >= 77% by March 2025 from September 2024.



The following graph shows the 62-day general standard performance. The August 2024 performance was 50%. MSEFT plan to meet the 2024/25 Operational Planning guidance ask to improve performance to >= 70% by March 2025. The Constitutional requirement is 85%.

The Trust is in national oversight Tier 1 for Cancer.



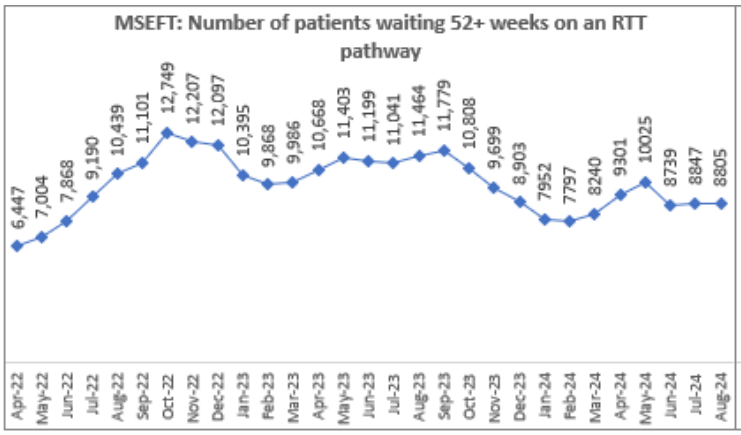
Referral to Treatment (RTT) Waiting Times

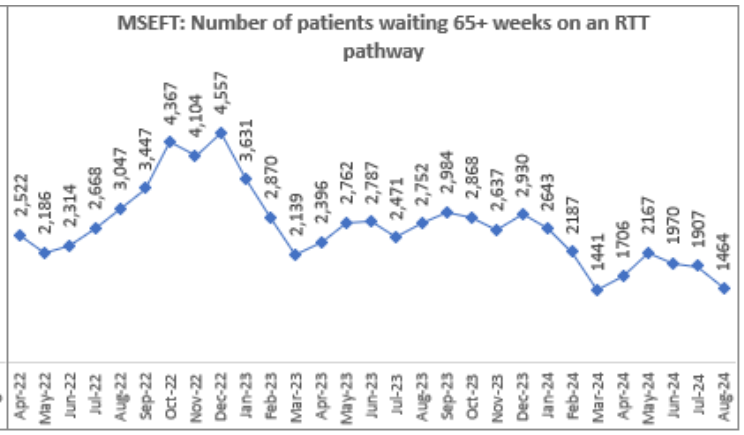
Standards:

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

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

- 1,464 patients waiting 65+ weeks.
- 8,805 patients waiting 52+ weeks.





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

The following table summarises the latest MSEFT referral to treatment (RTT) position (August 2024) by specialty.

Specialty	Total waiting list size	Average (median) waiting time in weeks	92nd percentile waiting time in weeks	Total number of patients waiting 52 plus weeks	Total number of patients waiting 65 plus weeks
Total	**168,967**	**17**	**48**	**8,805**	**1,464**
General Surgery	8,754	20	50	527	80
Urology	9,164	18	47	465	76
Trauma and Orthopaedic	17,308	19	52	1,348	253
Ear Nose and Throat	15,129	24	52	1,225	248
Ophthalmology	13,943	17	48	643	86
Oral Surgery	4,736	30	59	814	180
Neurosurgical	107	23	44	5	0
Plastic Surgery	5,313	15	49	321	61
Cardiothoracic Surgery	13	-	-	1	0
General Internal Medicine	2,075	13	34	12	3
Gastroenterology	9,357	16	47	446	72
Cardiology	11,530	16	39	227	34
Dermatology	12,640	15	49	660	1
Respiratory Medicine	5,155	16	35	49	15
Neurology	5,389	20	45	245	65
Rheumatology	2,916	15	39	61	8
Elderly Medicine	876	10	29	1	0
Gynaecology	12,497	18	42	340	46
Other - Medical s	16,409	15	43	556	90
Other - Mental Health	0	-	-	0	0
Other - Paediatric s	4,281	20	53	360	45
Other - Surgical s	6,618	16	49	421	89
Other - Other s	4,757	9	41	78	12

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

2.9 Mental Health

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

Improving access to psychology therapies (IAPT)

Standards include:

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

This standard is being sustainably achieved across MSE (latest position: August 2024).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across MSE (latest position: August 2024).

3.0 System Performance Report Conclusion

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

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

4.0 Recommendation

The Board is asked to receive this report for information.

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 18

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

To update Board members of the development of services by the Alliance teams including the Primary Care Team.

2. Executive Lead

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

3. Report Author

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

4. Responsible Committees

Primary Care Commissioning Committee

5. Impact Assessments

Not applicable

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation

The Board is asked to note this update.

Primary Care and Alliance Report

1. Main content of Report

Primary Care – General Practice

Updates have been provided to the Executive Committee and Audit Committee on the early impact of Collective Action being undertaken by general practices. Initial impact is particularly focussed on elements of prescribing that are being undertaken by general practice that could be undertaken within other services. Work is underway with the Community Collaborative to mitigate this. The ICB is working closely with stakeholders on other emerging issues.

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

Primary Care – Pharmacy

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

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

Primary Care – Dentistry

The PCCC approved two important business cases in the last period. This includes the extension of the Access Pilot where we are seeking to expand an already successful scheme. A business case to embed the Care Homes Service as a core service was also approved. Both schemes will require further governance approval.

Estates

Alliance Teams have been progressing several smaller Section 106 estates developments working with a range of practices across MSE. This includes development of premises at Sutherland Lodge and Halstead X-Ray block.

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

Focus of Alliance Teams

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

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

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

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

South East Essex Alliance have recently seen the approval of their Alliance Delivery Plan for 2024-26, which endorses the Healthy Neighbourhood approach.

Better Care Fund (BCF)

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

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

Transfer of Care Hubs (TOCH)

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

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

2. Recommendation

The Board is asked to note this update.

3. Appendices

Appendix A - Primary Care and Alliances Highlight Report, November 2024.

NHS
Mid and South Essex

MSE ICB - Primary Care and Alliances Highlight Report

November 2024

We are collaborative

We are compassionate

We are innovative

We are living well

Primary Care - General Practice

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

Overall Summary

BMA Collective Action

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

Financial Recovery Programme

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

Primary Care Strategy

- The Primary Care Team and Alliances are progressing the development of the Primary Care Strategy
- A workshop with the Primary Care Commissioning Committee (PCCC) was undertaken at the beginning of October. This has identified aims for the strategy.
- The detail on how these aims will be delivered is now underway.

Emerging GP Primary Care Collaborative

- The ICB are continuing to work closely with the GP Primary Care Collaborative. Priorities have been identified by the collaborative.

Primary Care – Access Recovery Programme/Connected Pathways

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

Overall Summary

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

Development	Progress	Status
Cloud Based Telephony - "we will establish Cloud Based Telephony across 45 practices identified as critical"	All sites have either a compliant solution fully installed or have their install booked within the next quarter.	Completed
Communication of Modern General Practice and various aspects of the Recovery Plan to stakeholders	PR/Comms agency appointed for MSE campaign. The remit includes: - Promotion (to public) of NHS App and messaging function to reduce cost to ICB of text messages. -Promotion (to practices and public) to consent to use email function into reduce cost to ICB of text messages. - Promotion to use practice/Primary Care Network (PCN) websites. - Improved awareness of self-referral pathways/frontline. - Improve the public's understanding of the new model of primary care, including impactful promotional campaign on the new model, new roles, alternative provision. - Increase public awareness of community pharmacy services, as part of our Integrated Neighbourhood Team (INT) model.	On Track
Digital Tools – supporting implementation of Modern General Practice through digital tools	136/145 practices using AccuRx (including 65% using Floreys, 90% using SMS and 48% using booking functions). E-Consult and Patchs also being used. Practice website audit underway – discussions with practices on how to improve. 1800 referrals through Frontline and 7000 signposts.	On Track
Pharmacy/Dental/Optom - strengthen the role of other primary care services to help manage patient need	Vast majority of community pharmacies now delivering Pharmacy First. Community Optometry Services being further promoted to practices/PCNs including self-referral pathways. Dental access pilot now fully integrated into 111	On Track
Self-Referral Pathways – By March 24 we will establish at least 10 self-referral pathways	11 Self Referral pathways are now available to all patients across MSE. Further opportunities being scoped.	Completed
Total Triage – By March 2024, 5 practices will have implemented a total triage model in line with Modern General Practice	57 Applications for Transitional Funding reviewed (up from 47 in previous report). 12 practices have signed up to the GPIP programme (national support programme for practices).	On Track

Primary Care – Community Pharmacy & Optometry

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

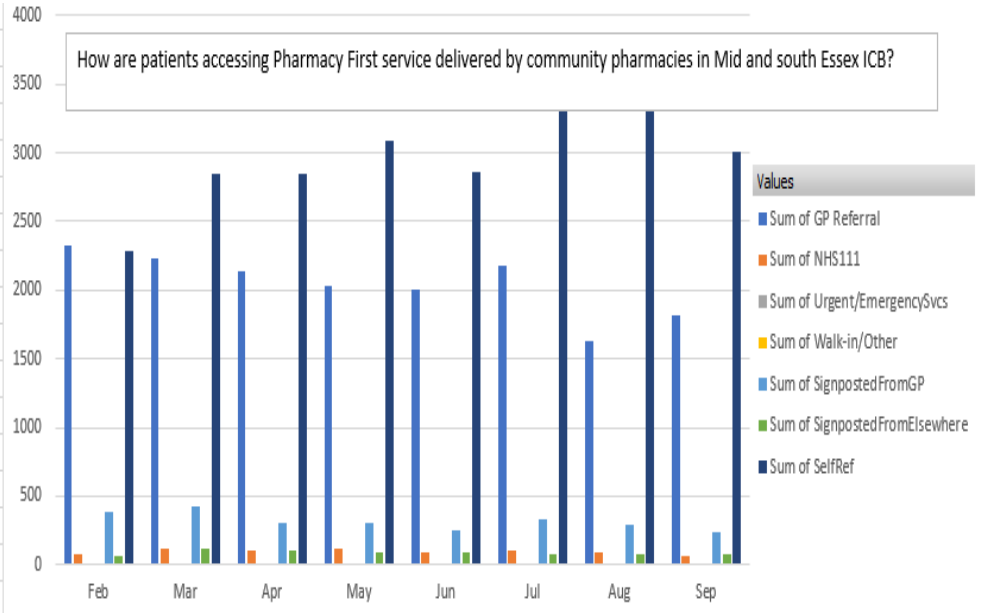
Community Pharmacy

Community pharmacy 'Pharmacy First' (minor ailments and seven common conditions) activity continues to support access to Primary Care. Around 3,000 people per month are self-referring to community pharmacies and over 2,000 people per month are being referred by GP practices.

Our four Community Pharmacy Independent Prescribing Pathfinder sites are now live-Essex pharmacy in Tilbury started in November. The pharmacists are supporting patients with immediate care needs who are not eligible for the Pharmacy First service. Prescribing data to August 2024 shows that 444 patient have accessed this service and avoided the need to visit their GP.

Expressions of interest have gone out for our 24 Community Pharmacy PCN Engagement Leads across the MSE. This expands upon an existing pilot of six leads and aims to enhance the role community pharmacy play within Integrated Neighbourhood Teams. This initiative is being funded from Community Pharmacy Integration Money and delivered in conjunction with Essex Local Pharmaceutical Committee's provider arm "Healthy Living Partnership".

Community pharmacy Independent Prescribing Activity	Prescription items
May-24	95
CHRISTCHURCH PHARMACY	5
CROSS CHEMIST	90
Jun-24	92
CHRISTCHURCH PHARMACY	15
CROSS CHEMIST	77
Jul-24	162
CHRISTCHURCH PHARMACY	37
CROSS CHEMIST	124
KALSONS CHEMIST	1
Aug-24	95
CHRISTCHURCH PHARMACY	20
CROSS CHEMIST	71
KALSONS CHEMIST	4
Grand Total	444



Community Optometry

The Primary Care Commissioning Committee received an update from the Local Optometry Committee lead and primary care team on the development of Optometry services locally.
The Optometry Team hosted by Herts and West Essex ICB continue to provide a comprehensive contract management function on behalf of all ICBs in the East of England.
Optometry continues to play an important role in the wider transformation of ophthalmology services across Mid and South Essex. The Connected Pathways Team are working closely with the LOC to try and better promote the pathways available to patients (many of which are available via self-referral).
The Primary Care Commissioning Committee are seeking to resolve a current pathway issue in-regards to enabling independent prescribers to prescribe without the need to refer patients back to their GP or the Hospital Eye Service.

Primary Care – Dentistry

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

Dentistry

- The Primary Care Commissioning Committee have approved extending the Dental Access Scheme for a further two-year period. This model is proving successful at improving access to dental services, particularly for urgent access. Further detail is anticipated with regard to the national commitment to increase Units of Dental Activity by 700k in 2024/25. This may require further refining of the ICB's scheme.
- The Primary Care Commissioning Committee have approved integrating the Care Home Scheme into core provision for up to five years. This scheme has successfully improved the oral health of people in several care homes across MSE. The ambition is to improve oral health across all care homes.
- The hypertension case finding service is going live. This aims to increase the number of patients identified as having hypertension by testing blood pressure in dental practices.
- Our urgent access pilot continues to be successful. This aims to improve access to dental services by utilising capacity in the evenings and at weekends. Recently developments have included a software integration with 111 which allows for the direct booking of patients into available slots.
- The new pilot service for cardio-vascular disease went live in May 2024. At present only limited numbers of referrals have been made to this service. Further pathway refinement work continues.

Estates

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

Estates

Section 106 Funding

- **Over the coming months, Alliance Level estates plans will be drawn-up to inform the spending of available Section 106 (S106) funding.**
- **£272,119 of available S106 funding has been released in the last few months to help fund several projects spread across the Mid-Essex Alliance area (Braintree, Chelmsford & Maldon).**
- **£204,595 of available S106 funding will be released in the next few months to help fund more projects spread across the Mid-Essex Alliance area.**

Sutherland Lodge

- **Significant Community Infrastructure Levy (CIL) and S106 funding used in addition to ICB BAU Primary Care Estates funding.**
- **Refurbishment and reconfiguration of the premise to provide additional clinical space.**
- **Improvement of infection control, Equality Act 2010 access and compliance.**
- **Premises more user and patient friendly.**
- **Estimated completion Nov 2024.**

Halstead – X Ray Block

- **NHS Property services owned premises.**
- **An NHS ICB long term void premises.**
- **Utilising S106 funding to refurbish the premises to current standard to provide additional clinical capacity for a local practice.**
- **NHS Property Services (NHSPS) has also secured Department of Health & Social Care (DHSC) funding to fund the additional costs of the refurbishment over and above the S106 funding available.**
- **Returns a void space back to support delivery of local GP services.**
- **Estimated Completion Spring 2025.**

PCN use of ICB Void estate Thurrock

Corringham Health Centre

- **PCN utilising void space within the Health centre using Five clinical rooms and support space.**
- **Funding sourced to carry out minor refurbishment or the area.**
- **Services delivered Physio, PCN Care coordinator, Social Prescriber, Advanced Clinical Practitioner.**

South Ockenden Health Centre

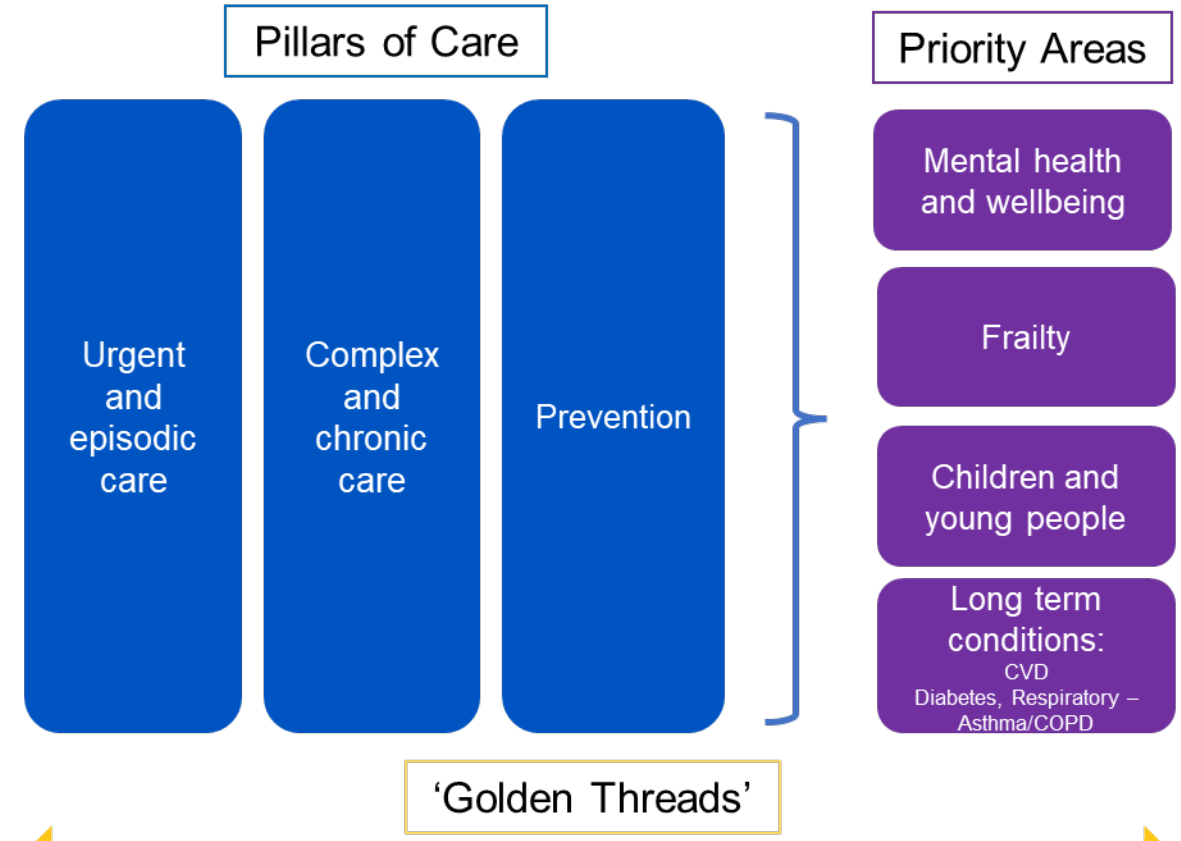
- **PCN utilising 4 Void rooms.**
- **Services Provided Children and young person's mental health practioners, Clinical Pharmacist, Paramedics base between home visits and additional hours for an Advance Nurse Practitioner (ANP).**

Stifford Health Centre

- **8 rooms available for PCN use.**
- **Minor refurbishment to be carried out.**
- **Services delivered flu and covid vaccination programme, paramedic hub, Cancer screening campaigns, cardiovascular disease (CVD) Local Enhanced Scheme (LES), Obesity screening, Respiratory hub, PCN Phlebotomy service.**

Integrated Neighbourhood Teams (INTs)

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



- This INT graphic, developed in partnership by the 4 Alliances, is based upon ICB and ICP priorities to focus INT development
- 23 of 24 INTs now in place with differing levels of maturity
- Metrics are currently being developed and agreed (to include areas such as reduction in GP appointments by high intensity users, reduction in A&E attendance).
- Oversight of INT development is provided through the Primary Care Commissioning Committee
- First ICS meeting took place in October to ensure alignment of understanding, priorities and partners. This will be a forum for sharing good practice and unblocking issues going forward.

Integrated Neighbourhood Team (INT) development

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

Overall Summary

The current INT position:
There are 23 live INTs across MSE with varying levels of maturity.

Basildon and Brentwood - Central Basildon, West Basildon, Brentwood, Billericay and Wickford are all live. East Basildon will be live by December 2024.

Mid Essex - All 6 live, Braintree North (INT 1), Braintree South (INT2), Maldon North, Chelmsford East & Witham (INT 3), Chelmsford Outer (INT 4), Chelmsford Central (INT 5), Maldon Central, Dengie & Woodham (INT 6)

South East Essex - SS9, Southend West Central, Southend East, Benfleet, Rayleigh, Canvey Island, Southend Victoria and Rochford are all live.

Thurrock - All 4 now live

Planned activities

- Establish system wide strategic group including senior representatives from all Councils, voluntary sectors and health organisations – 1st meeting occurred in October with agreed purpose and organisational priorities
- Consistent reporting with support from Public Health Management (PHM) team and potential use of Eclipse
- Introducing frailty, dementia and end of life focus across all
- Define project areas for each INT.

Alliance Summary

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

Thurrock

•Thurrock has 5 GP Fellows in practices in the borough. Additionally, there are now 7 GP practices and 1 PCN which are approved as training practices. This step has been taken to provide a solid foundation for attracting more GPs into Thurrock.

•Additional Roles Reimbursement Scheme (ARRS) roles in the borough have been strengthened. There are now 82 WTE roles including 16 Pharmacists, 11 Physios, 8 Paramedics and 6 Mental Health Practitioners. This provides a more holistic approach to the provision or primary care services.

•The Alliance in Thurrock is working closely with Thurrock Council to support developments within the CVFSE sector and will be joining a sector conference in November to launch the new charter. The charter contains a series of agreed principles for how the ICB and Local Authority will work with the sector going forward.

•Thurrock Alliance is leading a new piece of work on behalf of the 4 Alliances on improving the quality of physical health checks for people with serious mental illness. This work is being supported by NHSE EoE regional team. A new SOP is in development which will support standardization of the quality and reporting of SMI health checks and reflects the Alliances' prioritisation work under the financial recovery programme.

•The recent clinical leadership restructure saw the 3 clinical leads in Thurrock re-appointed to the roles. The Alliance Director and Deputy Director are working with the clinical leads to identify priorities within the clinical leadership roles and to support the focus of the ICB on FRP.

•The Alliance is about to launch a new programme which will bring local council elected members and primary care together on a regular basis to build improving relationships.

Basildon and Brentwood

The October Alliance Committee focussed on the Alliance Delivery Plan and the key deliverables from each domain within our Live Well strategy. This ranged from our Start Well domain and school readiness, via Be Well and losing weight and stopping smoking strategies, through to our Die Well domain and individuals being able to make informed choices at their end of life.. Alongside these key priorities it was agreed that our key Alliance principles such as reducing health inequalities and promoting physical activity need to be the golden thread across each domain.

The Committee received a report that highlighted where health inequality funding has been utilised. It was well received and noted a wide spread of supported initiatives including in some of the most deprived communities, a focus on young people, global majority communities and dementia projects.

INTs continue to gather traction and our original INT in Central Basildon presented at the Grand Round in Basildon hospital during October. They were able to illustrate how taking a proactive approach to support individuals with complex needs, making full use of the community assets and integrated working, had resulted in a decrease in the number of GP appointments for this group as well as a reduction in A&E attendances. This generated much interest from secondary care colleagues and as a result we will be returning to present data and information on primary care access and the many improvements that have been implemented and continue to develop.

The team continue to support the financial recovery programme with specific focus on diabetes, virtual wards, community equipment and MSK procurement.

Alliance Summary

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

Mid Essex

The focus of the last Alliance Committee in October was the Essex Healthy Weight Strategy. The Alliance were asked to discuss and input into how partners can support any current/ongoing local place-based areas of work. There was also a review of the committee effectiveness, which recognised there had been limited feedback from members of the Alliance, and therefore more work was needed to agree how we develop the Alliance over the next 12 months. Work has started on this with the Alliance Executive Steering Group

The Alliance team continue to work on the development and delivery of the Thriving Places Index work, working with local authorities in Chelmsford, Maldon and Braintree, and system partners. There are focus groups looking at respiratory and housing and how we can reduce inequalities in these areas in each district and work in all areas is progressing. The team also continue to work to deliver in key priority areas for the Alliance, including supporting with multiple estates projects in mid Essex, the ongoing development on the Transfer of Care Hub, plans for continued use of Health Inequalities funding, and ongoing support of financial recovery schemes.

11 INT forums have taken place over the last couple of months with over 300 partners in total in attendance with topics covering primary care, children's early help, mental health system, adult social care, carers and the next forum will focus on neurodiversity. Over 500 people are now members of the neighbourhood handbook, including GPs surgeries, pharmacies, care homes and youth provisions. There are 6 neighbourhood leadership groups with recent launches of mental health pathway tool working with EPUT and NELFT colleagues.

The team remain heavily involved in supporting the Community elements of financial recovery

South East Essex (SEE)

The focus of the last SEE Alliance Committee in October;

The Alliance Delivery Plan (ADP) for 2024/26 was reviewed and approved by the Committee, endorsing the overarching Healthy Neighbourhood outcome and supporting domains (Healthy Start, Healthy Living, Healthy Mind and Healthy Ageing). The Committee noted the importance of place and the collective responsibility of partnership delivery and the relevance of focussed projects in particular neighbourhoods, ensuring an equitable balance across the Southend and Castle Point & Rochford footprints.

A progress overview of the SEE Transfer of Care Hub (TOCH) was presented, outlining the purpose and remit. Successes and challenges were noted with a detailed discussion on priority actions, namely provision of Co-ordinator and admin resource and increased awareness among the wider workforce. Interdependencies were recognised with other key workstreams and specifically the evolving maturity of Integrated Neighbourhood Teams (INTs). Decisions made included developing a Training Toolkit and identifying champions within partner organisations to cascade awareness and information. Healthwatch also committed to supporting the development of a mechanism to gather patient/family/carer feedback on their experience.

A detailed overview of the CVD element of the Healthy Living domain was presented, emphasising the correlation with the wider determinants of health and the value of preventative approaches and healthy behaviours i.e. physical activity and weight management. A spotlight was given to the mobilisation of the Sport England place-based partnership work in Canvey Island (Castle Point), a partnership programme dedicated to increasing the levels of physical activity. Through this programme the SEE Alliance are leading a defined programme of work around CVD prevention, plans for a small funded partnership pilot, targeting certain patient cohorts were shared and endorsed.

The Mid & South Essex Foundation Trust (MSEFT) presented a high-level overview of their plans to develop a 10-year strategy, aiming to developing an approach and framework to future planning and delivery. Integrated approaches and the significant added value of working with Primary Care and Community partners was discussed and recognised, highlighting the need to link this to the visioning of the whole system and the Alliance ADP.

Essex County Council (ECC) provided an overview of the Better Care Fund (BCF) and Improved Better Care Fund (iBCF), both of which were introduced to support integration and partnership working. Time was also given to discuss additional elements of the programme including the Discharge fund, providing focussed additional capacity into the health and care system to support effective discharge and the Disabled Facilities Grant (DFG). Noted the Castle Point & Rochford improved BDF (iBCF) currently has some available funding to support short term initiatives over winter, with an ask of all Committee members to support their organisations to bring forward innovative and creative ideas.

Better Care Fund/Discharge Fund

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

BCF and Discharge fund

BCF - All 4 Alliances maintained partnership BCF governance groups with LA partners in addition to this:

An MSE wide BCF Quarterly meeting was held in October in which we had an overview of projects for shared learning with all three LA partners. These included:

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

An ECC MSE BCF meeting was also held in October the agenda covered:

- A presentation on the welfare call service interim evaluation from the Provide team, including case studies
- A presentation detailing the end of project evaluation in from the Ward led Reablement project
- A review of the spend against the ECC and ICB Discharge fund and wider BCF finance update.
- A BCF planning update was also discussed.

The ICB discharge fund spend remains on target currently to be fully utilised by year end.

The Q2 BCF update was submitted to NHSE in late October – this is focused on the activity and spend at the Discharge fund, the wider BCF and includes a wider update on capacity and demand modelling which was refreshed as part of the submission.
We are broadly on track to achieve the 3 core data metrics for the BCF across MSE.

Thurrock: The BCF review is now in its 3rd and final phase – this phase covers a line-by-line evaluation of areas of expenditure, using a value for money (VfM) tool to identify any potential areas of investment/disinvestment in the coming financial year. The final report is expected in January 2025. The findings and recommendations from the evaluation will be aligned to the discharge fund expenditure and profile.

Southend – The Group discussed refreshing the TOR to further reflect the groups aims and ambitions for the BCF. Discussed the Equipment service and pressures being experienced and planned a drill down into the falls data for the locality to understand impacts from the current work.

DUPR Data includes 2024-04 to 2024-09

Measure	Basildon	Castle Point and Rochford	Mid Essex	Southend	Thurrock	MSE
% Discharged Usual Place Of Residence - Actual YTD	93.50%	93.70%	92.20%	93.80%	94.00%	93.30%
% Discharged Usual Place Of Residence - 24/25 Target	93.50%	93.50%	93.50%	95.00%	95.00%	93.50%
Difference From Target	0.00%	0.20%	-1.30%	-1.20%	-1.00%	0.30%

Falls Data includes 2024-04 to 2024-06

Measure	Basildon	Castle Point and Rochford	Mid Essex	Southend	Thurrock	MSE
% Falls - 24/25 YTD	14.30%	12.20%	9.30%	12.20%	14.90%	12.20%
% Falls - Annual Plan	18.20%	18.20%	18.20%	7.80%	8.10%	13.00%
Difference From Target	-3.90%	-6.00%	-8.90%	4.40%	6.80%	-0.80%

ACS Data includes 2024-04 to 2024-06

Measure	Essex	Southend	Thurrock	MSE
ACS	2097	648	494	3239
ACS Plan	3358	578	416	4352
Difference From Plan	-1261	70	78	-1113

Transfer of Care Hubs (TOCH)

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

Transfer of Care Hubs

- We continue to work on a maturing the Matrix of areas of good practice in each hub that should be standard across the 4 hubs this is supporting learning across the hubs.

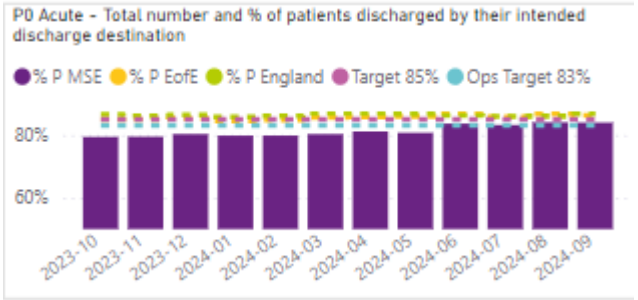
- The Outcomes from the discharge experience report produced in Thurrock by Healthwatch has been shared with the Leadership group for joint learning. Communications team colleagues are working with hub leads to support development of a newsletter to share the work across wider staff groups and to support the update of the MSEFT Discharge booklet to address some of the issues raised in the report.

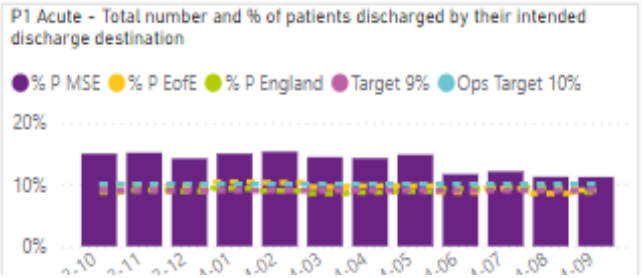
- **Mid** - Overall positive feedback to date from Provide and Trust regarding the recent 3- month pilot. 3 x wards now accessing Systm1 and printing Admission Information sheet. Evidence of impact via case studies being collected. Provide have instigated 3 x mobile phones for direct access to District community matrons – to enable swift communication between ICT and Wards. Further 3 wards being planned to support work. Acknowledged need stronger Mental Health (MH) link – Project teams are linking with team from MH to make connections.
- **BB** Pilot now looking at how MH services link into the complex cases review including supporting individuals accessing services multiple times.
- **SE** - Pilot in development to mirror Mid ward mode aiming to be live in the next 2 weeks, daily admission lists are being reviewed and followed up by the pathway co-ordinators and clerks, and CC have a front door team in place networking with wider teams to support facilitated discharge. Leadership discussion has moved on with BCF agreed to support a post.
- **Thurrock** - Have agreed BCF funding for an 8a and B4 post to support TOCH development and capacity. And are focused on alignment of ILT and TOCH functions to maximise community assets in both Admission Avoidance and Discharge support

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

Discharges vs operational plan (September TOCH Data)

- Pathway zero: Target 83% - Actual 83.97% - Improvement sustained for 4 months
- Pathway One: Target 10% - Actual 11% - Improvement sustained for 4 months
- Pathway Two: Target 4% - Actual 4.8% - Increase in P2 seen over the last 3 months despite the HD2A panel work however remains lower than earlier in the year
- Pathway Three: 3% - Actual <1%





Mid and South Essex

Alliance Directors

Dan DOHERTY
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Rebecca JARVIS

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Key for project updates

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

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 19.1

Changes to ICB Constitution

Summary Report

1. Purpose of Report

To present for approval changes to the ICB Constitution required because of the updated model constitution guidance from NHS England (NHSE). Proposed changes were made and approved at the May Board meeting. However, the guidance issued subsequently required changes to incorporate the role of the Senior Non-Executive Member, which hadn't been included within the draft in May.

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

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

5. Impact Assessments

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

6. Financial Implications / Engagement / Conflicts of Interest

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

7. Recommendation(s)

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

Mid and South Essex
Integrated Care Board

NHS Mid and South Essex Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
v1.0	N/A	1 July 2022
V1.1	N/A	Minor changes
V1.2	9 May 2024	1 December 2022
V1.3	N/A	Minor changes
V1.4		

CONTENTS

1 Introduction

1.1. Foreword

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

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

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

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

1.2 Name

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

1.3 Area covered by the Integrated Care Board

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

1.4 Statutory Framework

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

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

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

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

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

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

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

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

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

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

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

1.5 Status of this Constitution

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

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

1.6 Variation of this Constitution

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

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

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

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

1.7 Related Documents

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

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

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

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

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

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

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

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:
   - The above documents a) – c).
   - Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
   - Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
   - Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
   - The up-to-date list of eligible providers of primary medical services under clause 3.7.2.
   - Detailed arrangements for the nomination and selection process of board members, as required.

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

2 Composition of the Board of the ICB

2.1 Background

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

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

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

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

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

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

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

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

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

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

2.2 Board membership

2.2.1 The ICB has 6 Partner Members:

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

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

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

2.2.3 The board is therefore composed of the following members:

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

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

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

2.3 Regular participants and observers at board meetings

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

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

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

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

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

3 Appointments Process for the Board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

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

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

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

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

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

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

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

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

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

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

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

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

3.2.8 A person who is subject to:

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

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

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

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

3.3 Chair

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

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

a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

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

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

3.4 Deputy Chair and Senior Non-executive Member

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

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

3.4.3 The Senior Non-executive Member is to be appointed from amongst the non-executive members by the board subject to the approval of the Chair.

3.5 Chief Executive

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

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

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

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

3.5.4 Individuals will not be eligible if:

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

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

3.6.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs that provide services for the purposes of the health service within the ICB's area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

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

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

a) Be a CEO or Executive Director of one of the NHS Trusts or FTs within the ICB's area.
b) One member must provide current and on-going experience of the acute hospital sector.

c) One member must provide current and on-going knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.
d) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.6.3 Individuals will not be eligible if:

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

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

3.6.5 The appointment process will be as follows:

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

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

c) Chair's approval:

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

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

3.7 Partner Member - providers of primary medical services

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

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

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

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

3.7.4 Individuals will not be eligible if:

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

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

3.7.6 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation described at 3.7.1 and listed in the Governance Handbook will be invited to make one nomination.
   - Each nomination must be seconded by one of the other eligible organisations described at 3.7.1 and listed in the Governance Handbook.
   - Eligible organisations may nominate an individual from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals,

with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

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

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

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

3.8 Partner Members - local authorities

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

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

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

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.8.1.

b) The ICB is seeking knowledge and experience covering the full breadth of the ICB geography, its range of health and care services and professions.

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

3.8.3 Individuals will not be eligible if:

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

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

3.8.5 The appointment process will be as follows:

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

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

c) Chair's approval:

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

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

3.9 Medical Director

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

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

3.9.1 Individuals will not be eligible if:

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

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

3.10 Director of Nursing (known as the Chief Nurse)

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

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

3.10.2 Individuals will not be eligible if:

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

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

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

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

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

3.11.2 Individuals will not be eligible if:

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

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

3.12 Non-Executive Members

3.12.1 The ICB will appoint three Non-executive Members.

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

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

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

3.12.4 Individuals will not be eligible if:

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

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

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

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

3.13 Other Board Members – Chief People Officer

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

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

3.13.2 Individuals will not be eligible if:

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

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

3.14 Board Members: Removal from Office

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

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

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

f) If they are deemed to have failed to uphold the principles of the East of England Leadership Compact.

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

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

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

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

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

3.15 Terms of Appointment of Board Members

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

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

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

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

4 Arrangements for the exercise of our functions

4.1 Good Governance

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

4.2 General

4.2.1 The ICB will:

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

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

4.3 Authority to Act

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

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

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

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

4.4 Scheme of Reservation and Delegation (SoRD)

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

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

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

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

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

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

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

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

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

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

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

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)

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

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

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

6.1 Conflicts of Interest

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

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

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

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

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

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

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

6.2 Principles

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

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

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

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

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

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

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

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

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

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

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

6.4 Standards of Business Conduct

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

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

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

7 Arrangements for ensuring Accountability and Transparency

7.1 Principles

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

7.2 Meetings and publications

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

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

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

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

7.2.6 Information will be provided to NHS England as required.

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

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

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years (the “Joint Forward Plan”). The plan will, in particular:

a) Describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
b) Explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards), and sections 223GB and 223N (financial duties).
c) Set out any steps that the ICB proposes to take to implement the three joint local health and wellbeing strategies.
d) Set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.

e) Set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.3 Scrutiny and Decision Making

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

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

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

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

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

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

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

7.4 Annual Report

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

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

under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees.

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

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

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

a) HR advisers being in attendance at meetings.

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

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

8.1.6 The duties of the Remuneration Committee include:

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

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

9 Arrangements for Public Involvement

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

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

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

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

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

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

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

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

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

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

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
ICB board	Members of the ICB.
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders. In Mid and South Essex these are also referred to as 'Alliances'.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in

	accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description. • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description. • The local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Director of Finance	Known locally as the Chief Finance Officer.
Health Service Body	Health Service Body as defined by (a) section 9(4) of the NHS Act 2006 or (b) NHS foundation trusts.
Health Care Professional	An individual who is a member of a professional regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Appendix 2: Standing Orders

1 Introduction

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

2 Amendment and review

2.1 The Standing Orders are effective from 1 July 2022.

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

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

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

3 Interpretation, application and compliance

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

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

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

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

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

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

4 Meetings of the Integrated Care Board

4.1 Calling Board Meetings

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

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

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

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

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

4.2 Chair of a meeting

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

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

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

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

4.3 Agenda, supporting papers and business to be transacted

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

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

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

4.4 Petitions

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

4.5 Nominated Deputies

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

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

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

4.6 Virtual attendance at meetings

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

4.7 Quorum

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

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

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest shall no longer count towards the quorum.
c) A nominated deputy permitted in accordance with standing order 4.5 will not count towards quorum for meetings of the board.

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

4.8 Vacancies and defects in appointments

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

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

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

4.9 Decision making

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

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

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

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

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

Urgent Decisions

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

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

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

4.10 Minutes

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

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

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

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

4.11 Admission of public and the press

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

4.11.2 The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies

(Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

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

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

5 Suspension of Standing Orders

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

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

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

6 Use of seal and authorisation of documents

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

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

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

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

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

Part I ICB Board meeting, 14 November 2024

Agenda Number: 19.2

Board Assurance Framework

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer and named Directors for each risk as set out on the BAF.

3. Report Author

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

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

5. Conflicts of Interest

None identified.

6. Recommendation/s

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

Board Assurance Framework

1. Introduction

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

2. Risks currently on the Board Assurance Framework

The current BAF, provided at **Appendix 1**, includes the following strategic risks, all of which are rated red (scored between 15 and 25) with the exception of Health Inequalities which is scored 12 (Amber). The risk rating for each risk has remained the same since the last Board meeting.

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

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

3. Review of ICB Risk Management Arrangements

The Associate Director of Corporate Services has contacted the Quality Team at NHSE to request a meeting to progress the introduction of dynamic/complex risk assessments so that proposals for revised ICB risk management arrangements can be finalised.

4. Recommendation

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

5. Appendices

Appendix 1 - Board Assurance Framework, November 2024.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Board Assurance Framework

November 2024

Contents

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

BAF Risks – Summary Report

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

Risk Narrative:	**WORKFORCE:** Risks associated with the ICB and partner organisations not taking effective action to improve recruitment and retention of permanent staff to reduce reliance on bank/agency staff; and not taking effective action to ensure there is a reliable pipeline of staff to fill future vacancies. Inaccuracies in data reporting for HCAs has been identified as a concern.	**Risk Score: (impact x likelihood)**	**4 x 4 = 20 (based on highest rated risks on Datix which are rated between 16 and 20.)**
Risk Owner/Lead:	Kathy Bonney, Interim Chief People Officer.	Directorate: Committee:	People Directorate System Oversight & Assurance
Impacted Strategic Objectives:	Diverse and highly skilled workforce	Associated Risks on Datix:	ID Nos 4, 53, 54, 55 and 56.

Current Performance v's Target and Trajectory

RECRUITMENT MSEFT: Against target of 11.55%, vacancies have been improving month on month for 6 months down to 8.3% in April 2024 (from high of 12.3% in April 23), July vacancy rate is 8.8%. Nursing and midwifery vacancies down to 7.8% (from significant high of 13% for nurses & 17% for midwives July 23). Medical & dental vacancies down to 9.5% in July 2024 against target of 11.5%. **EPUT:** overall vacancy rate now at 12.6% against 12% target..
TURNOVER: **MSEFT:** Continued downward trend from a peak of 15.6% in August 2022 to 10.7% in Jun 2024, July 2024 turnover 10.5% against 13% target. Nursing turnover down to 8.3%, midwifery 6.5% (10.8% in July 2023). Medical and dental improvement 11% against target of 12% (15% in July 2023 **). EPUT:** Staff Turnover down to 9.3% in July 2024, Jun 2024 turnover 9.3% against 12% target.
BANK & AGENCY: Both EPUT and MSEFT remain on a significant downward trajectory for their bank spend, however, at M5 they remain below plan - EPUT 210 below plan and MSEFT 372 below.

How is it being addressed? (Current Controls)

Whilst the trajectory of the reduction in Bank and Agency Spend is going in the right direction, pace is an issue. MSEFT is undertaking a deep dive in the usage of Bank and Agency in the Emergency Departments which is a real hot spot and work is being undertaken with Care Group Managers to encourage better staffing models across all departments. Establishment Control Processes are being tightened to include overtime requests. MSEFT have undertaken a review of all active tiles on the roster which is 80% complete resulting in savings. MSEFT are moving their temporary staffing service to Litmus for a 1 year period to run and manage the service. The MSEFT bank team will be TUPE across to Litmus for 1 year. The ICB continues to scrutinise all vacancy fill, contract extension requests, against a set of predetermined criteria. Reducing headcount remains a challenge for MSEFT. Scrutiny for both organisations is on the following:

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

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

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

Barriers (Gaps)

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

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

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

Next Steps: (Actions)

1. Ongoing compliance and control tracking.
2. 2025/26 operational planning to agree affordable staffing levels and commitment to manage to that workforce plan (commencing December 2024).
3. Scoping for system and region agency price cap compliance pilot project (January 2025).

Risk Narrative:	**PRIMARY CARE:** As a result of workforce pressures and demand outstripping capacity, patient experience and pathways may not adequately meet the needs of our residents.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (no change since September BAF report)**
Risk Owner/Lead:	Pam Green – Basildon & Brentwood Alliance, Executive Lead for Primary Care William Guy, Director of Primary Care.	Directorate: Board Committee:	Basildon and Brentwood Alliance Primary Care Commissioning Committee
Impact on Strategic Objectives/ Outcomes:	Patient Experience, Harm, Access, Additional Roles Reimbursement Scheme (ARRS), Hospital performance, reputational damage.	Associated Risks on Datix:	ID Nos 3, 21

Current Performance v's Target and Trajectory

Workforce:

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

Demand/Capacity:

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

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- Access Recovery Plan – 10 Self-referral pathways established, roll out of Cloud Based Telephony delivered. Digital tools being widely used by Primary Care providers.
- Workforce development e.g. ARRS optimisation.
- Primary/Secondary Interface – programme of work to improve effectiveness
- Initiatives for new GPs / Partners and to support other roles in practice teams.
- Refresh of the Mid and South Essex Primary Care Strategy.
- Development of services in other primary care disciplines (i.e. Pharmacy First, minor eye condition pathways, dental access pathway)

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

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

Next Steps (Actions)

- Integrated Neighbourhood Teams – all INTs expected to go live by March 2025. (23 of 24 in place)
- Digital tools solution for 25/26 (provision now in place for 24/25)
- Transitional funding for practices – scheme in place, all practices expected to apply by end of November 2024 (54 practices have submitted requests to-date).
- BMA Contract Dispute – continue engagement with Essex Local Medical Committee - timeline outside of local control).

Risk Narrative:``````	**Urgent Emergency Care (UEC) and System coordination** Risk that ICB and providers organisations are unable to effectively manage / coordinate capacity across the system, impacting on the system's ability to deliver effective care to patients.	**Risk Score:** **(impact x likelihood)**	**4 x 4 = 16 (no change since September BAF report)**
Risk Owner/Lead:	Emily Hough, Director of Strategy and Corporate Affairs. Samantha Goldberg, Urgent Emergency Care System Director.	Directorate: Committee:	Strategy & Corporate Services MSE Strategic UEC Board and Finance & Performance Committee

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

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

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

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

Next Steps

- Compilation of the 2024/25 winter plan, incorporating the OPEL framework triggers and actions. *18 November 2025.*
- Quality Improvement programmes at MSEFT to improve ED performance and ambulance handover delays, reduce length of stay, improve flow and retain escalation bed and G&A bed closures by focusing on: 1) Board and ward rounds, 2) Home before lunch, 3) Red 2 Green and 3+ LOS daily reviews. *Ongoing for 2024/25*
- MSEFT will commence Same Day Emergency Care (SDEC) plans to increase streaming patients to SDEC to reduced contribute toward ED performance reduce admission avoidance by supporting same day interventions for patients. *1 November 2024*
- Introduction of the System Discharge Cell to improve discharge and flow from MSEFT into community virtual and physical capacity. *14 November 2024.*
- Unscheduled Care Co-ordination Hub has received from NHSE to deliver the minimum viable product winter model. Incorporating enhanced roles and service provision to increase attendance avoidance to MSEFT and maximising UEC pathways. *1 November 2024.*
- Co-location of the System Co-ordination Centre (SCC), UCCH and Discharge Cell to enhance communications and real time actions to improve patents discharge and flow. *1 November 2024*

Risk Narrative:	**CAPITAL:** Insufficient capital to support all system needs, necessitates prioritisation and reduces our ability to invest in new opportunities, for transformational impact.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (no change since September)**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer. Ashley King, Director of Finance and Estates	Directorate: Board Committee:	System Resources Finance & Performance Committee Primary Care Commissioning Committee
Impacted Strategic Objectives / Outcomes:	Patient Experience, Equality of Access, Workforce, Harm	Associated Risks on Datix:	ID 58

Current Performance v's Target and Trajectory

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

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- Evolving Infrastructure Strategy and revised medium term prioritisation framework for pipeline of investments.
- Oversight by Finance Committee, System Finance Leaders Group and Executive / Senior Leadership Team.
- System Investment Group sighted on 'whole system' capital and potential opportunities to work collaboratively.
- Working with NHSE / Trusts to deliver the benefits associated with the sustainability and transformation plan capital.
- Prioritisation framework for Primary Care Capital now established and under regular review.
- Alliance level estates plans being developed to support prioritisation.

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

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

Next Steps: (Actions)

- Primary Care Projects Review on-going.
- Promotion of available developer contributions to support eligible affordable developments.
- Training for Board members & executives (senior managers) on capital funding f/wk (post approval of Infrastructure Strategy) and consideration of future Capital requirements.

Risk Narrative:	**DIAGNOSTICS, ELECTIVE CARE AND CANCER PERFORMANCE:** Risk of not meeting relevant NHS Constitutional or Operational Performance Standards.	**Risk Score:** **(impact x likelihood)**	**5 x 4 = 20 (based on highest rated risk score for diagnostic risk)**
Risk Owner/ Lead:	Matt Sweeting, Executive Director of Clinical Leadership and Innovation Mike Thompson, Interim Alliance Director Thurrock, Diagnostic SRO Karen Wesson, Director Oversight & Assurance (Elective & Cancer)	Directorate: Committee:	Clinical Leadership and Innovation, Thurrock Alliance, Resources MSE ICS Cancer Committee, MSE Diagnostic Board
Impacted Strategic Objectives:	Delivery of Operational Planning commitments/Recovery of constitutional standards for diagnostics, cancer and Referral to Treatment (RTT).	Associated Risks on Datix:	ID Nos 1, 2 and 13.

Current Performance v's Target and Trajectory

Diagnostics: Current plans on track to deliver operational planning commitment currently performance 63% (ask increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%)
Cancer: Cancer Plan currently off track for delivery against operational performance Faster Diagnostic Standard 70.2% vs plan 76.6%, 62 day performance 50.2% vs plan of 56.8%
Referral to Treatment:

- 65+ week wait: MSEFT updated trajectory to achieve operational plan commitment, in response to National ask MSEFT have confirmed the plan to achieve zero 65 weeks waiting patients at 30 September 2024 reported position was 170

Barriers (Gaps)

- **Cancer -** requires best practice pathways in place – System Delivery Fund (SDF) funding approved, MSEFT recruiting to the posts to support pathway delivery, Pathway analyser being completed to identify where there are opportunities for pathway improvement
- **Diagnostic Capacity –** capacity across diagnostics is impacting delivery of the Faster Diagnostic Standard, this is being reported and overseen in terms of actions taken via the Diagnostic Performance Sub-Group of the MSE System Diagnostic Board and the Tier 1 Cancer meeting.
- **Elective –** Delivery of capacity and optimisation of the Surgical Hub at Braintree, recovery plans for 65 weeks being prepared for National Team (meeting 24 October 2024).

How is it being addressed? (Current Controls)

Diagnostics:

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

Cancer:

- Daily review of patient tracking list (PTL) and next steps with all tracking focused on trajectory compliance. Weekly "huddle", monthly Cancer Transformation and Improvement Board, Cancer Committee and via the National Tier 1 meetings.

Referral to Treatment (RTT):

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

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

- ICB maintains oversight of performance against all NHS Constitutional Standards/Operational Plan asks**.**
- **Diagnostics:** MSE Diagnostic Reporting to System Diagnostic Board & Diagnostic Performance Sub-Group.
- **Cancer:** MSEFT Cancer performance report: Fortnightly meetings with National Team as a Tier 1 Trust.
- **RTT:** MSEFT RTT Long Wait Report. Fortnightly meetings with National Team as a Tier 1 Trust.

Next Steps (Actions)

RTT and Cancer:

- Fortnightly Tier 1 meetings with the national and regional team with oversight of actions, recovery and performance position.
- Executive Teams at ICB and MSE FT and Cancer Stewards meeting to discuss urgent prioritisation and plan for poor cancer performance. Planned 28.10.2024

Quality, Contract, Performance Meeting (QCPM)

- Will oversee operational performance delivery vs plan.

Risk Narrative:	**INEQUALITIES**: Identification of groups at most risk of experiencing health inequalities and taking action to reduce these by improving access and outcomes.	**Risk Score: (impact x likelihood)**	**4 x 3 = 12 (no change since September)**
Risk Owner/Lead:	Emily Hough, Executive Director of Strategy and Corporate Affairs Emma Timpson, Associate Director of Health Inequalities and Prevention	**Directorate: Committee:**	Strategy and Corporate Services. Quality Committee, Audit Committee and Population Health Improvement Board.

Current Performance v's Target and Trajectory

- Basildon, Southend-on-Sea and Thurrock identified as having lower life expectancy and a greater inequality in life expectancy within their populations (source ONS 2020) .
- Core20PLUS5 (Adult and Children & Young People) inequalities data packs are being actioned by the Alliances and via Growing Well Board.
- PLUS group insights from Population Health Management team that identifies inequalities in health outcomes for certain groups circulated to Alliances highlighting opportunities for improvement in data capture.
- Health Inequalities dashboard complete and in final sign off phase. Population Health Improvement Board (PHIB) reviewing system ambitions based on JSNAs and PHM data and insights.

Barriers (Gaps)

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

How is it being addressed? (Current Controls)

- PHIB provides system wide co-ordination and oversight for reducing health inequalities. PHIB along with Alliances will provide oversight and direct priorities for health inequalities funding.
- Equality and Health Inequalities Impact Assessments (EHIIA) undertaken for each project including those part of financial recovery programme. EHIIA Policy and EHIIA panel terms of reference approved by Quality Committee in October 2024. Digital EHIIA tool under review and final testing.
- Equality Delivery System (EDS) areas for review in 2024/25 commenced and collective scoring event planned for November 2024.
- Health inequalities annual statement for 2023/24 published on the ICB website. "Narrowing the gap" report published on ICS website highlighting work undertaken. Bi-annual reports to the MSE ICB Board and ICP undertaken, last reports were September 2024.
- Targeted health inequalities funding in 2024/25 is supported Alliance level investment through trusted partners and system-wide strategic initiatives to address health inequalities for agreed priorities groups. All investments are subject to appropriate financial controls and triple lock.

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

- Internal audit report on ICB health inequalities arrangements provides substantial assurance
- Monitoring of Slope Index of Inequality (measure of social gradient in life expectancy) in MSE.
- Improvement in access and reduction of health inequalities as shown in the performance metrics with HI dashboard.
- Continued restoration of NHS services inclusively resulting in improved access to services and patient outcomes for the MSE population.

Next Steps (Actions to be implemented by March 2025)

- Launch of digital EHIIA tool (December 2024)
- Health inequalities dashboard Phase 2 launch (December 2024)
- Development of 2025/26 Health inequalities funding programme (January 2025)
- Development of MSE ICS Ambitions for improving Population Health (March 2025).

Risk Narrative:	**SYSTEM FINANCIAL PERFORMANCE:** MSE is a system facing significant financial challenges, agreeing a £96m deficit plan with NHSE for 2024/25. As part of the M6 position NHSE provided repayable Deficit Allocation Funding which adjusts the £96m deficit to breakeven. Failure to deliver the financial plan will place increased pressures across the whole system, impacting on our ability to deliver our intended outcomes.	**Risk Score: (impact x likelihood)**	**5 x 4 = 20**
Risk Owner/Dependent:	Jennifer Kearton, Executive Chief Finance Officer	Directorate: Committee:	System Resources Finance Committee
Impacted Strategic Objectives:	Financial sustainability	Associated Risks on Datix	ID Nos 7, 10, 14, 42.

Current Performance v's Target and Trajectory	**Barriers (Gaps)**
The System has agreed its plan for 2024/25 submitting a revised profile in June 2024. At month 6 the overall health system position is a deficit of £28.6m against the revised plan of breakeven.	- New and emerging financial challenges being driven by workforce challenges, performance, quality and delivery. - System pressures to manage delivery (capacity). - Capacity due to vacancy chill.

How is it being addressed? (Controls)

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

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

Risk Narrative:	**MENTAL HEALTH QUALITY ASSURANCE:** MSE Mental Health (MH) services have been identified as experiencing significant issues impacting on patient safety, quality and access which could result in poor patient outcomes.	**Risk Score: (impact x likelihood)**	**4 x 4 = 16 (based on the highest rated risk referred to below, rated between 12 and 16)**
Risk Owner/Lead:	Dr Giles Thorpe, Executive Chief Nurse	Directorate: Committee(s):	Nursing & Quality Quality / System Oversight & Assurance
Impacted Strategic Objectives:	Patient Experience, Workforce, Reputational Damage	Risks on Datix:	ID Nos 5, 8, 22 and 23.

Current Performance v's Target and Trajectory

- Sub-Optimal performance against several quality and contract indicators including SMI health checks and Out of Area (OOA) placements with 42 people placed out of area against a plan of 5 for September and SMI performance currently at 58% against 75% of achievement in 12 months to end of the period (total percentage to get full check)
- Demand, capacity and flow issues resulting in long length of stay and continued out of area (OOA) placements of patients above the Long Term Plan (LTP) expectation.
- Significant external scrutiny from media, Care Quality Commission (CQC) / Regulators.
- Ongoing HM Coroners cases with possibility of Regulation 28 Prevention of Future Deaths Reports (PFDR).
- Lack of equitable offer of services across MSE e.g. Autistic Spectrum Disorder (ASD) and wider neuro divergent pathway (NDP).

Barriers (Gaps)

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

How is it being addressed? (Controls)

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

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

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

Next Steps (Actions):

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

Partner Organisation Self Identified Red Risks (and scores)

MSEFT - 10 Red Risks (as of October 2024*).

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

*MSEFT's Board paper 10 October 2024.

Partner Organisation Self Identified Risks

EPUT red risks, as of October 2024

- Capital resource for essential works and transformation programmes.
- Use of Resources (control total target / statutory financial duty)
- Engagement and Supportive Observation (CQC found observation learning not embedded)

Mid and South Essex Integrated Care System

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ICB Board Meeting, 14 November 2024

Agenda Number: 19.3

Establishing the Digital, Data and Technology Board as a sub-committee of the ICB Board and approval of the People Board Terms of Reference

Summary Report

1. Purpose of Report

To present for approval, the establishment of the Digital, Data and Technology (DDaT) Board as a sub-committee of the ICB Board and therefore approve its terms of reference and the consequent change to the ICB Scheme of Reservation and Delegation (SoRD). The DDaT is a group consisting of colleagues from partners across MSE, but currently the group does not formally report into the Board or another body. Becoming a sub-committee of the ICB Board will therefore strengthen governance and accountability in this area.

To also present for approval the updated terms of reference of the People Board that was constituted as a formal sub-committee of the ICB Board in January 2024.

Note: The SoRD has also been updated to meet the accessibility standard and therefore may look different to previous versions (in the schedule of detailed delegated financial limits) where tables are presented differently. No other changes have been made to the SoRD, other than the inclusion of DDaT.

2. Executive Lead

Barry Frostick, Executive Chief Information Officer
Kathy Bonney, Interim Chief People Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The DDaT has approved its terms of reference and has recommended its approval at the Board.

The People Board has approved its terms of reference and has recommended its approval at the Board.

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

Not applicable to this report.

6. Conflicts of Interest

None identified.

7. Recommendation(s)

The Board is asked to approve:

- The Digital, Data and Technology Board becoming a sub-committee of the ICB Board.
- The updated Digital, Data and Technology Board terms of reference.
- The amended Scheme of Reservation and Delegation (to include DDaT)
- The People Board terms of reference.

Appendices

A – DDaT terms of reference

B – Updated Scheme of Reservation and Delegation

C – Updated People Board terms of reference

Mid & South Essex Integrated Care Board

Digital Data and Technology Board (DDaT)

Terms of Reference

1. Constitution

1.1 The Digital Data and Technology Board (DDaT) is established by the Integrated Care Board (the Board or ICB) and is a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

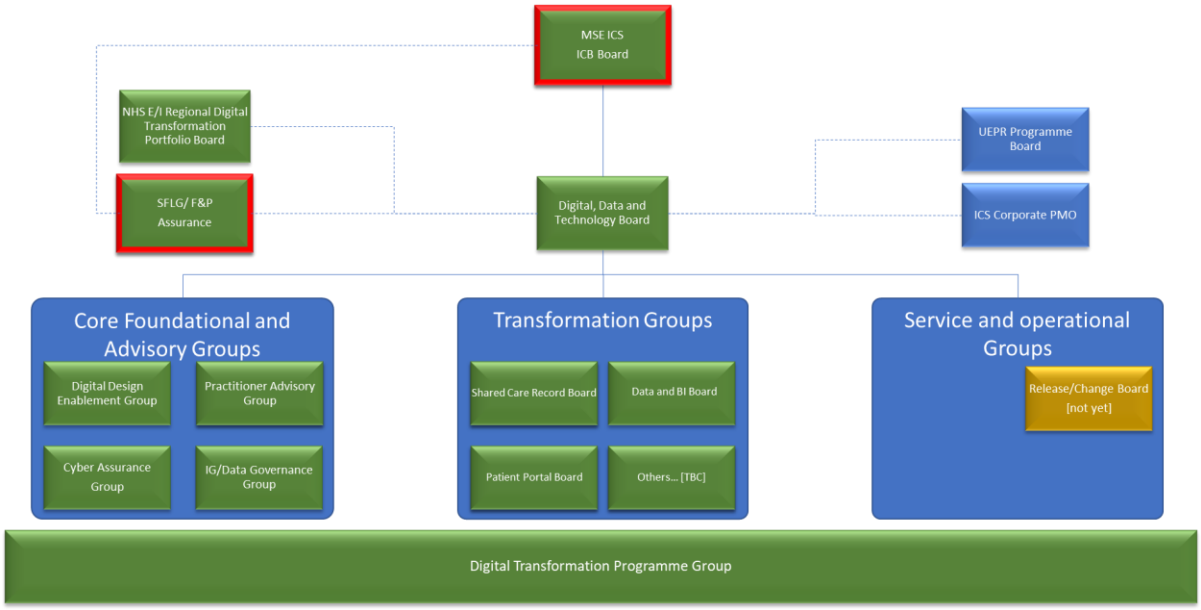
1.3 The Committee is an executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The DDaT Board is a formal Committee of the ICB, which has delegated authority from the ICB details of which are set out in the Scheme of Reservation and Delegation. The DDaT Board holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Establish sub-committees.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may not delegate any decisions to such groups.



2.3 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

3.1 The purpose of the Committee is as follows:

3.2.1 To provide oversight and assurance to the Board in the development and delivery of DDaT in relation to services commissioned by the ICB, mitigating risk as appropriate in the context of system working.

3.2.2 To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and assurance to the ICB Board on the following areas:

- Providing the strategic oversight for all ICS Priority Digital Programmes.
- Objective oversight and scrutiny of DDaT and decisions.
- Review system performance against digital priorities.
- Identify key system issues and system risks requiring discussion or escalation to the Board.

3.3 The duties of the Committee will be driven by the ICB's objectives and the associated system risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.4 The DDaT Board's remit is to align the strategic goals of the ICS (in line with national and regional priorities) to the appropriate use of digital and business intelligence systems, and the deployment of technology, enabling partner organisations to maintain effective programmes and services to support the reduction in health inequalities across MSE.

3.5 DDaT will further ensure that information standards and sharing of information for the purpose of health and social care within MSE ICS function is undertaken in accordance with relevant legislation. DDaT will be held to account for compliance

with the standards and as part of the Digital and Data 'What Good Looks Like' requirements issued on the 31 August 2021.

3.6 The DDaT Board will oversee and ensure achievement of the overall digital delivery plan and services (including risk management) for the system. It will bring together digital and data/BI leads, executive leads, communications and other relevant individuals to enable delivery from across the M&SE system.

3.7 The Committee will create assurance links with other digital and data local care systems governance as required.

3.8 The DDaT Board has no executive powers, other than those delegated in the SoRD and specified in these ToR or by virtue of its attending Members.

4. Membership and attendance

Membership

4.1 The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

4.2 The Board will appoint no fewer than 16 members of the Committee, including at least 1 Member of the ICB Board/external Chair, based on their specific knowledge, skills and experience. Other members of the Committee need not be members of the Board.

4.4 Membership will comprise:

- ICB Partner Member (External Chair)
- ICS Chief Digital Information Officer (Vice Chair)
- ICS Practitioner Advisory Group Chair
- NHS and Partner Executive Digital Lead/Chief Information Officer x 4 (MSEFT, EPUT, NELFT, Provide CIC
- Local Authority Digital Lead x 3 (Southend, Essex, and Thurrock)
- ICS Finance Lead
- ICS Information Governance Lead
- ICS Communications Lead
- Primary Care Digital Lead
- ICB Strategy / Transformation Lead
- NHS England Regional Digital Representative

4.5 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may vote on behalf of the absent Committee member.

Chair and vice chair

4.6 The Chair of the ICB will appoint a Member of the ICB Board, with the relevant skills and experience, to chair the DDaT Board. This will be the ICB Partner Member.

4.7 The DDaT Board may appoint a Vice Chair of the Committee from amongst its members. This shall be the ICS Chief Digital Information Officer.

4.8 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

4.10 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended by the following individuals who are not members of the Committee by invitation:

- Emergency Preparedness, Resilience and Response Lead
- Digital Contracts Lead
- Procurement Lead
- Programme Leads
- Local Authority Leads
- Head of Assurance and Oversight
- ICS Programme Director Data and Digital
- Data and BI Board Chair/Deputy Chair

4.11 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.12 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from health partners.

Attendance

4.13 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least 6 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned bi-monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 5 Members of the Committee are required, including the Chair or Vice Chair of the Committee, Information Governance Lead, one representative from the Local Authority and one Chief Information Officer from a Provider.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

5.11 Any agenda items that have a wider ICS implication will need to obtain approval and recommendations from the Finance and Performance Committee prior to it being discussed at DDaT.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for ratification.

6. Responsibilities of the Committee

6.1 The Committee's duties are as follows:

- focus on ensuring the implementation of the Digital and Data Strategies, including the prioritisation of system work/projects across the ICS based on capacity.
- Offer a forum where change, escalation of issues and risks can be discussed and managed.
- test and ensure there is a robust framework that endorses, enables and supports delivery of the ICS Digital and Data strategies.
- Through its members prioritise resources with partner organisations to support key system wide programmes and objectives.
- offer a horizon scan for external influences and strategic initiatives which the

system may need to consider not manage the detail of projects.

The following areas are not within the scope of the DDaT

- Specific locally commissioned technical and digital projects undertaken by individual organisations will not be delivered through this mechanism but will be subject to its governance.
- Digital programmes that are delivered outside of the pre-agreed priorities.
- Detailed delivery of projects.

6 Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy.

Confidentiality

7.6 Issues discussed at Committee meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

7 Accountability and reporting

8.1 The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

8.4 The Chair of the committee may be invited to attend the ICB as requested by the Chair of the ICB.

8.5 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.6 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.7 The Committee Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8 Secretariat and Administration

9.1 The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained, and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

9 Review

10.1 The Committee will review its effectiveness at least annually.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Date of approval: 14 Nov 2024

Date of review: 14 Nov 2025

Decisions and functions reserved to the Board

Functions will be exercised by the Board unless they are delegated. This is the default position for any function that is not expressly delegated. The Board has set out specifically those matters it is choosing to reserve. The Board, regardless of any delegation arrangements it has made, remains legally accountable for the exercise of its functions.

	Decisions and functions reserved to the Board	Reference
The Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.	
	The Board will establish the necessary systems and processes to comply with relevant law and regulations, directions issued by the Secretary of State, directions issued by NHS England, statutory guidance and advice issued by NHS England and relevant authorities and respond to reports and recommendations made by Healthwatch organisations in the ICB area.	Constitution 4.2.2
The Board	**Regulations and Control** Consider and approve proposed amendments to the ICB Constitution by the Chief Executive prior to making an application to vary the constitution to NHSE.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Approve Standing Orders (SOs), a schedule of matters reserved to the Board (Scheme of Reservation and Delegation (SoRD)) of powers delegated from the Board to the Executive Team and other Committees, Functions and Decisions Map, Standing Financial Instructions (SFIs) and the Governance Handbook for the regulation of its proceedings and business.	Constitution 1.6.2, 1.7.2, 4.4.2, Standing Orders 2.1.3, 2.1.4
	Approve to vary or amend the Standing Orders in accordance with the procedures for amending the Constitution as described above.	Constitution 1.6.2; Standing Orders 2.1.3
	Approve delegation arrangements to ICB Committees, Joint Committees, to other Statutory Bodies, individual Board Members and employees is reserved to the Board. Including approval of committee terms of reference.	Constitution 4.6.1, 4.6.3, 4.6.6, 4.7.1
	The power to approve arrangements for Pooled Funds is reserved to the Board.	Constitution 4.7.3

	Decisions and functions reserved to the Board	Reference
	Approve arrangements for the management of conflicts of Interest defined within the Conflicts of Interest Policy, including publication of registers of interest.	Constitution 6.1.1, 6.3.2
	Require and receive the declaration of Board members' (and others as required) interests to discharge its duty to manage conflicts of interest.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	Approve arrangements for dealing with complaints and ensure a clear complaints process is published.	Constitution 7.2.4
	Ensure the ICB Complies with the Freedom of Information Act 2000 and Information Commissioner Office requirements.	Constitution 7.2.5
	Ensure systems and processes exist to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	Comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.3.4
	Ensure the ICB complies with all relevant procurement regulations.	Constitution 7.3.5
	Adopt the Executive structure to facilitate the discharge of business by the ICB and to agree modifications thereto except where these functions have been delegated to a Joint Committee.	
	Receive reports from committees including those that the ICB is required by the Secretary of State or other regulation to establish and to action appropriately.	
	Confirm the recommendations of the ICB's committees where the committees do not have executive powers.	
	Approve arrangements relating to the discharge of the ICB's responsibilities as a corporate trustee for funds held on trust.	
	Discipline members of the Board who are in breach of statutory requirements or SOs.	

	Decisions and functions reserved to the Board	Reference
The Board	**Appointments/Dismissal** Appoint the Ordinary Members of the Board, exercised by the Chair.	Constitution 2.1.5, 2.2.2, 2.2.4
	Approve removal of members of the Board (other than the Chief Executive and Executive Members) at the recommendation of the Chair, to be executed by the Chair.	Constitution 3.13
	The Chair of the ICB will be appointed by NHS England as set out within legislation. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board.	Constitution 4.6.1
	Appointment of Internal or External Auditors and the Counter Fraud officer following recommendations from the Audit Committee.	Constitution 4.6.8
The Board	**Strategy, Annual Operational Plan and Budgets** Approve a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years.	Constitution 7.2.8
	Approve and publish an Integrated Care System Plan and Capital Resource use Plan.	Constitution 7.2.8, 7.4.1
	Define the strategic aims and objectives of the ICB.	
	Oversee and maintain accountability for the management of the ICB Risk Management Framework.	
	Approve plans in respect of the application of available financial resources to support the agreed Annual Operational Plan (Financial Framework and Annual Budgets).	
	Approve proposals for ensuring quality and developing clinical governance in services provided by the ICB or its constituent practices (ICB Quality Strategy), having regard to any guidance issued by the Secretary of State.	Constitution 1.4.7
	Approve annually (with any necessary appropriate modification) the annual refresh of system plan.	

	Decisions and functions reserved to the Board	Reference
	Approve and publish the ICB Engagement Framework setting out how the ICB complies with and delivers its duties to engage with the public. Approve Outline and Final Business Cases for Commissioning Investment if this represents a variation from the Plan, in line with the ICB SFIs and Schedule of Detailed Delegated Financial Limits.	Constitution 9.1.7
The Board	**Policy Determination** Approve ICB Policies, except where delegated to specific committees for approval in accordance with the Committee Terms of Reference.	
The Board	**Audit and Counter Fraud** Receive the annual management letter from the External Auditor and agreement of the Executive Team's proposed action, taking account of the advice, where appropriate, of the Audit Committee. Receive an annual report (and Head of Internal Audit Opinion) from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee. Receive an annual report from the Counter Fraud officer and agree action on recommendations where appropriate of the Audit Committee.	
The Board	**Annual Reports and Accounts** Receive and approve the ICB's Annual Report and Annual Accounts, to be externally audited and published. Receive and approve the Annual Report and Accounts for funds held on trust.	Constitution 7.2.3, 7.4.1
The Board	**Monitoring** Receipt of such reports as the Board sees fit from the Executive Team and other committees in respect of its exercise of powers delegated.	

Decisions and functions delegated by the Board to the ICB committees

Committee	Decisions and functions reserved to the Committee	Reference
Audit Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the adequacy of the governance, risk management and internal control processes within the ICB including: - Integrated governance, risk management and internal control - Internal Audit, External Audit and Counter Fraud - Freedom to Speak Up - Information Governance - Financial Reporting - Conflicts of Interest - Security - Governance - Emergency Planning, Preparedness and Resilience	Constitution 4.6.8
	The Committee shall have oversight of and responsibility for approving the governance arrangements of the ICB (including the delegation of functions to and from the ICB). The Audit Committee shall review instances of non-compliance with Standing Orders. The Audit Committee shall approve policies for which it is the sponsoring committee. The Audit Committee shall receive a report of any decisions made using Constitutional provision for 'urgent decisions'.	 Standing Orders 3.1.6 Standing Orders 4.9.6
Remuneration Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 and implement NHSE guidance, including: - Determining the remuneration of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members).	Constitution 3.14.1, 8.1.6

Committee	Decisions and functions reserved to the Committee	Reference
	- Determining arrangements for the termination of employment and other contractual and non-contractual terms of the Chief Executive, Directors and other Very Senior Managers and Board members (other than non-executive members). - Agreeing the pay framework for clinical staff working within the ICB but outside of Agenda for Changes Terms and Conditions. - Determining the arrangements for termination payments and any special payments for all staff. The Remuneration Committee shall establish a Non-Executive Remuneration Panel to consider and agree arrangements for remuneration of Non-Executive Members. The Remuneration Committee shall approve policies for which it is the sponsoring committee.	Constitution 3.14.1
Non-Executive Remuneration Panel	The Panel will, in accordance with the terms of reference of the Remuneration Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution exercise the function of setting the remuneration of Non-Executive Members of the Board.	Constitution 3.14.1
Finance & Investment Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution provide oversight and assurance to the Board in the development and delivery of a robust viable and sustainable financial plans and associated financial performance in relation to services commissioned by the ICB, mitigating risk as appropriate in the context of system working, including: - Agree the financial framework including annual budgets and commissioning intentions. - Make investment and disinvestment decisions /recommendations - Receive assurance on delivery of financial performance - Investigate any activity within its terms of reference.	

Committee	Decisions and functions reserved to the Committee	Reference
	The Finance & Investment Committee shall approve policies for which it is the sponsoring committee. The Finance & Investment Committee has established sub-groups for the oversight of medicines optimisation, commissioning prioritisation and for processing appeals to procurement decisions made under the Provider Selection Regime.	
Executive Team (Committee)	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution: - Make investment and disinvestment decisions / recommendations in accordance with the Detailed Delegated Financial Limits - Oversee the operational functions of the ICB - Provide assurances to the ICB Board and relevant sub-committees as required - Approve minor changes to service restriction policies as recommended by the Medical Director and refer complex / controversial changes for decision at appropriate committee / ICB Board.	
Quality & Safety Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance that the ICB is delivering its functions in a way that secures continuous improvement in the quality of services (section 14Z34 of the Act) against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This shall be reported within the ICB Annual Report. The committee is responsible for the development and implementation of the ICB's Quality Strategy, which sets out its plan for quality and safety and for assuring the Board of quality, safety and performance standards. The Quality Committee shall approve policies for which it is the sponsoring committee.	Constitution 7.4.1

Committee	Decisions and functions reserved to the Committee	Reference
System Oversight and Assurance Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight on the delivery of performance and standards, key system programmes, enabling mutual accountability and providing assurance to the Board. The Group has no specific delegated powers for decision making but shall establish system leadership and partner groups to ensure the delivery of the system plan. It will assure system performance relating to agreed outcomes, quality and safety and operational performance against constitutional standards.	
Primary Care Commissioning Committee	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide oversight and assurance to the ICB Board on the exercise of the ICB's delegated commissioning functions and any resources received for investment in primary care. The Committee will enable collective decisions on core contractual, quality and procurement of primary care services and oversee the Contracting framework for primary care, within their delegated budget approved by the ICB. The Primary Care Commissioning Committee shall approve policies for which it is the sponsoring committee.	
Basildon & Brentwood Alliance Mid Essex Alliance South East Essex Alliance Thurrock Alliance	The Committee will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, contribute to the overall delivery of the ICS's objectives, create opportunities for the benefit of residents of the Alliances in accordance with Alliance Plans, to support health and wellbeing, bring care closer to home and to improve and transform services, undertaking appropriate local engagement and propose, co-ordinate and deliver local elements of the estates strategy.	

Committee	Decisions and functions reserved to the Committee	Reference
	The committee has specific delegated responsibility for managing the ICB element of the Better Care Fund (BCF) and associated iBCF investment, in accordance with the schedule of detailed financial delegated limits.	
Clinical & Multi-professional Congress ("The Congress")	The Congress will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, act as an advisory committee providing clinical and multi-professional leadership to the system as well as involvement, advice and support to service development and transformation programmes. The Congress shall lead on Stewardship. The Congress has no delegated authority for decision making, however, must provide its oversight in order for decisions to be approved by the relevant Committee (such as the Finance & Investment Committee). The Congress shall approve policies for which it is the sponsoring committee.	
People Board	The Committee (Board) will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide strategic leadership to ensure the implementation of the People Plan and Integrated Health & Care Workforce Strategy and associate workforce plans.	
Digital, Data and Technology Board	The Committee (Board) will, in accordance with the terms of reference of the Committee as approved by the Board as if written into the Scheme of Reservation and Delegation and ICB Constitution, provide strategic leadership and oversight of overall digital delivery plan for the system.	
System Leadership / Partner Groups	The system has established the following system leadership/partner groups (for example): • Chief Executive Forum • ~~System Transformation and Investment Group~~	

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Committee	Decisions and functions reserved to the Committee	Reference
	• System Finance Leaders Group • Clinical Leaders Forum • Transformation & Improvement Boards • System Quality Group • ~~Digital and Data~~ • System Projects, Programmes & Performance The groups have no delegated powers beyond those delegated to officers by their respective organisations, but function with the commitment that as a system all partners work to achieve the system plan as expected and that system aims and objectives are met. ~~The groups report to the System Oversight and Assurance Committee and thus maintain an accountability to the ICB and partners.~~	

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Decisions and functions delegated to be exercised jointly

Committee/entity that will exercise the function/decision	Decisions and functions delegated by the Board	Legal power	Governing arrangements
ICB/Essex County Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement
ICB/Thurrock Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging	Section 75, NHS Act 2006	Section 75 Agreement

	the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.		
ICB/Southend Council	**Better Care Fund** In accordance with Section 75 of the 2006 Act as amended the ICB and Council have entered into arrangements to established pooled budgets for the purpose of discharging the duties set out within the Act. All governance arrangements are defined within Section 75 Agreements as if written into the SORD.	Section 75, NHS Act 2006	Section 75 Agreement

Decisions and functions delegated by the Board to other statutory bodies

Body	Decisions and functions delegated by the Board	Legal power	Governing arrangements
Hertfordshire and West Essex Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Community Pharmacy and Optometry Contract Management - Children and Young People Mental Health Services - Home Oxygen Service	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Children's Commissioning Collaborative Agreement via the Executive Children's Commissioning Collaborative Forum.
Bedfordshire, Luton and Milton Keynes Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Specialised commissioning of services not retained by NHS England.	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Collaborative working agreement for specialised services.

Suffolk and North East Essex Integrated Care Board	For the operational management of the following services as defined within supporting delegation agreements / memorandum of understanding, as approved by the Board as if written into the Scheme of Reservation and Delegation: - Individual Placement Team - Contract management of the East of England Ambulance Service NHS Trust	S65Z5 of the 2006 Act	Memorandum of Understanding and delegation agreement. Collaborative working agreement for specialised services.

Decisions and functions delegated by the Board to individual Board Members and employees

Board Member / employee	Decisions and functions delegated by the Board	Reference
Chair	**Regulations and Control**	
	Authenticate use of the seal.	Standing Orders 6.1.3
	Suspend Standing Orders in conjunction with 2 other Board members.	Standing Orders 5.1.1
	In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the relevant Director, will provide a settled view which shall be final.	Standing Orders 3.1.4
	To call meetings of the Board and preside over Board meetings.	Standing Orders 4.1.2, 4.2.1
	In conjunction with the Chief Executive (or relevant lead Director in the case of committees) and one other member, make an urgent decision on behalf of the Board/Committee.	Standing Order 4.9.5
	Discipline members of the Board (other than Executive Directors) who are in breach of statutory requirements or SOs.	
	Appointments/Dismissal	
	Appoint the Chief Executive of the ICB subject to the approval of NHS England.	Constitution 3.4.1
	Approve the appointments of the Partner Members of the Board.	Constitution 2.2.1, 3.5.4, 3.6.5, 3.7.4
	Approve the appointment of Executive Members of the Board.	Constitution 2.1.5, 2.2.2, 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Approve the appointment or re-appointment of Non-Executive Members of the Board.	Constitution 3.11.2
	Appoint the Vice Chair of the Board.	Constitution 3.11.8

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Approve appointment of members of any committee	Constitution 4.6.6; Standing Orders 4.2.3
	With the exception of the Executive Board Members, suspend or terminate members of the Board, as approved by the Board.	Constitution 3.13.3
Chief Executive	**Regulations and Control** Propose amendments to the Constitution to be considered and approved by the ICB prior to making an application to vary the Constitution to NHS England.	Constitution 1.6.2, Standing Orders 2.1.3, 2.1.4
	Establish a procedure for the use of the seal and keep (or nominate a manager to keep) the seal secure.	Standing Orders 6.1.1, 6.1.3
	Propose to the Board the adoption of the Executive structure to facilitate discharge of ICB business.	
	Discipline the Executive Director members of the Board who are in breach of statutory requirements or SOs.	
	Appointments/Dismissal Subject to the approval of the ICB Chair, appoint the Partner Members of the Board.	Constitution 3.5.4, 3.6.5, 3.7.4
	Subject to the approval of the ICB Chair, appoint the Executive Members of the Board.	Constitution 3.8.2, 3.9.3, 3.10.3, 3.12.3
	Subject to the recommendation of the selection panel, approve the appointment of the Non-Executive Members and their re-appointment (within the limit of terms of office)	Constitution 3.11.2, 3.11.7
	Statutory Functions / Duty In accordance with section 252A of the 2006 Act (as amended) act as the Accountable Emergency Officer (AEO) and Gold Commander for responding to Emergency Planning Resilience and Response events and declared incidents.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Operational Responsibilities To approve and be the signatory of delegation agreements on behalf of the ICB.	
Chief Finance Officer	**Regulations and Control** Authenticate use of the seal.	Standing Orders 6.1.3
	Develop systems and processes to comply with the requirements of the NHS Provider Selection Regime.	Constitution 7.3.2, 7.3.3
	Establish processes to ensure compliance with all relevant procurement regulations.	Constitution 7.3.5
	Annual Reports and Accounts Preparation of the annual accounts and accounting tables within the Annual Report in accordance with relevant guidance and regulations, including those for funds held on trust.	Constitution 7.2.3
	Arrange for annual accounts to be externally audited and published.	
	Statutory Functions / Duty Ensure systems are in place to deliver the financial duties of the ICB (Sections 223GB, 223N, 223H and 223 J). Including establishing the annual budget and budget management processes.	Constitution 1.4.7, 7.2.8
	Develop the Capital Resource Use Plan for approval by the Board and report how the ICB has exercised its functions in accordance with the Plan within the Annual Report.	Constitution 7.4.1
	Operational Responsibilities To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation, and best practice: Financial Strategy; Financial Operations; Planning and Reporting; Estates; Purchase of Healthcare; Digital Technology; Data and System Technology.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Finance & Investment Committee. To be the Senior Information Risk Owner (SIRO) for the ICB. Maintain and refresh (where appropriate and subject to approval of the Board) the Schedule of Detailed Delegated Financial Limits. Establish and maintain the financial framework of the ICB as defined within Standing Financial Instructions as if written into the SoRD. Respond to the annual management letter from External Audit preparing proposed actions for to present to the Board after review by the Audit Committee. The Director of Resources may temporarily delegate functions to be undertaken in their absence to an appropriate deputy. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Medical Director (Chief Medical Officer)	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Development (Clinical and Professional Leadership and innovation); clinical and multi-professional leadership support; Stewardship; Individual Funding Requests; Quality and Governance (Clinical and Multi-Professional Congress); Clinical Pathways and Medicines Optimisation. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Clinical & Professional Congress. To ensure that adequate processes are in place for the management of Specialised Commissioning as delegated by NHS England, providing assurance in that regard to the Board.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To oversee, review, advise upon and recommend changes to service restriction policies for approval by the Executive Team or wider committees / Board accordingly. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Chief Nursing Officer (Chief Nurse)	**Strategy, Annual Operational Plan and Budgets** Develop and propose to the Board the ICB Quality Strategy. **Statutory Functions / Duty** Ensure systems are in place to deliver improvement in quality of services (Section 14Z34) and report on the discharge of these duties within the Annual Report. Establish and publish clear arrangements for dealing with complaints in accordance with the Complaints Regulations including publishing an annual complaints report. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Patient Safety; Patient Experience; Safeguarding and Continuing Health Care. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Quality & Safety Committee. To act as the Board designated lead (and supported by other Executive Officers) for: - Children and young people (aged 0-25) - Children and young people with special education needs and disabilities (SEND) - Safeguarding (all-age), including looked after children - Learning disability and autism (all-age) - Down syndrome (all-age) To act as the System Director of Infection Prevention and Control.	Constitution 1.4.7, 7.2.8, 7.4.1 Constitution 7.2.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To manage the commissioning Teams responsible for Mental Health and Babies, Children and Young People services focussing on workstreams to oversee contractual performance (alongside the quality Team) and work collaboratively for service transformation. To act as the Caldicott Guardian and the Designated Safeguarding Lead. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Chief People Officer	**Strategy, Annual Operational Plan and Budgets** Develop and present to the Board for approval, proposals for organisational development. Develop and present to the Board for approval, the Equality and Diversity Strategy; having overarching responsibility for the delivery of employer responsibilities for equality, diversity and inclusion (and associated national reporting) as well as the co-ordination of wider equality, diversity and inclusion responsibilities delivered by the Strategy and Corporate Services Directorate. **Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Human Resources (ICB internal function); System Workforce, designed to fulfil the ten designated people functions. Ensure arrangements in place to provide an adequate workforce for the system. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Remuneration Committee. To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Executive Director of Strategy and Corporate Services	**Regulations and Control** Ensure processes are in place to comply with Local Authority Health Overview and Scrutiny Requirements.	Constitution 7.3.4

Board Member / employee	Decisions and functions delegated by the Board	Reference
	Report urgent decisions to the Board for ratification.	Standing Order 4.9.6
	Annual Reports and Accounts Preparation of the Annual Report in accordance with relevant guidance and regulations.	Constitution 7.4.1
	Statutory Functions / Duties In accordance with section 14Z30(2) of the 2006 Act establish systems and processes (defined within the Conflicts of Interest Policy) to manage conflicts of interest (including gifts and hospitality) and publish the registers of interest on the ICB website.	Constitution 6.1.3, 6.1.4, 6.1.5, 6.3.1, 6.3.2, 6.3.7
	To ensure that key governance documentation (Constitution, Standing Orders, Governance Handbook, Register of Interests and other key documents and policies as appropriate) are considered annually, reviewed and updated as necessary and published on the ICB website.	Constitution 7.2.7, Standing Orders 2.1.2
	Publish agenda's, papers and minutes for meetings held in public, including details about meeting dates, times and venues.	Constitution 7.2.2; Standing Orders 4.1.4, 4.3.3
	Ensure adequate arrangements are in place to govern Board and Committee meetings in accordance with the Constitution, Standing Orders and best practice, including the development of committee terms of reference.	Constitution 4.6.3, 4.6.6; Standing Orders 4.10, 4.11
	In accordance with section 14Z45 of the Act establish processes for public involvement and consultation in relation to commissioning arrangements and report on the discharge of these duties within the Annual Report; ensuring the ICB meets the ten principles set out by NHSE for working with people and communities.	Constitution 1.4.7, 7.2.8, 7.4.1, 9.1.1, 9.1.2, 9.1.3
	In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7
	Ensure systems are in place to reduce inequalities (Section 14Z35) and report on the discharge of these duties within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1

Board Member / employee	Decisions and functions delegated by the Board	Reference
	In accordance with section 14Z38 of the Act establish arrangements for obtaining appropriate advice.	Constitution 1.4.7
	In accordance with section 14Z43 of the Act meet the duty to have regard to wider effect of decisions and report of the discharge of this duty within the Annual Report.	Constitution 1.4.7, 7.2.8, 7.4.1
	In accordance with section 116B(1) of the Local Government and Public Involvement in Health Act 2007 ensure that due regard is given to assessments and strategies.	Constitution 1.4.7
	Operational Responsibilities To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the Audit Committee.	
	To have oversight of and ensure the correct functioning of the ICB and its Committees.	
	Ensure that non-compliance with Standing Orders are reported to the next formal meeting of the Board for action or ratification.	Standing Orders 3.1.6
	Establish a robust system for the management of risk (including defining the strategic aims and objectives; identify, evaluate and report on risks, establishment of a risk management policy).	
	Management the policy framework of the ICB ensuring that policies are reviewed, updated and approved in a cyclical manner.	
	To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: ICB Strategy: Community Resilience and Mobilisation; contribute to the development of a successful ICP and Strategic Partnerships; System Development Plan; MSE Partners; Communications and Engagement.	
	Ensure the ICB discharges its responsibilities to lead the ICS Engagement Framework.	Constitution 9.1.7

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To act, on behalf of the Chief Executive, as the Gold Commander where necessary. To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice: Community Pathways; Acute Delivery; Performance and Analytics; Emergency Planning; and Operations and Resilience.. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to the System Oversight and Assurance Committee and any other relevant committees to which it reports. **Strategy, Annual Operational Plan and Budgets** Develop and publish a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. Develop the Integrated Care System Plan for approval by the Board reviewing, within the annual report, the extent to which the ICB has exercised its functions.	Constitution 7.2.8 Constitution 7.2.8
Executive Chief Digital and Information Officer	**Operational Responsibilities** To undertake the role of Chief Information Officer. To ensure the ICB complies with legislation and guidance related to the protection of data, working alongside the SIRO and Caldicott Guardian. Establish adequate arrangements to discharge ICB duties in relation to the Freedom of Information Act 2000 and Information Commissioner Office requirements. To provide the operational services for Corporate IT and Primary Care Digital Services. To work collaboratively with partners to deliver the digital transformation agenda and national asks. To provide ongoing assurance of cybersecurity, business continuity, privacy, and data protection. To ensure the efficient collection, and the timely and appropriate distribution	Constitution 7.2.5

Board Member / employee	Decisions and functions delegated by the Board	Reference
	of information to support operational and strategic decisions.	
Alliance Directors	**Operational Responsibilities** To ensure that adequate arrangements are in place to manage in accordance with legislation, regulation and best practice at place: Transformation and Engagement; Performance and Planning; Alliance Clinical Leadership with responsibility for tackling health inequalities at a local level. Be accountable for delivery of Alliance Plans and the ICB element of the Better Care Fund and the way in which BCF funds are utilised. To be the lead Executive Officer ensuring appropriate advice and explanations are provided to their respective Alliance and the ICB. Being responsible for local partnership working, engagement with communities and the delivery of public health, early intervention models of prevention. The Basildon and Brentwood Alliance Director has specific responsibility for Primary Care Development and the management of Primary Care Commissioning including GPs, Pharmacy, Optometry and Dental Services (Primary Care Delegated functions and Primary Care Networks Development); To act, on behalf of the Chief Executive, as the Gold Commander where necessary.	
Audit Committee Chair	To act as the Conflicts of Interest Guardian. To act as the Freedom to Speak Up Guardian.	Constitution 6.1.6
On Call Director	To fulfil the duties required as set out by the Emergency Planning Team for managing escalations, incidents and out of hours cover as set out within associated ICB Policies.	
Budget Holders	To fulfil budget holder duties as set out within the Standing Financial Instructions and in accordance with the delegated limits set out within.	

Board Member / employee	Decisions and functions delegated by the Board	Reference
	To be accountable for and sign contracts within their budgetary remit (Directors and above), where approval for the contracted service is complete in accordance with this scheme of reservation and delegation e.g. The Director of Primary Care signing primary care contracts.	

Decisions and functions delegated to the Board by other statutory bodies

Body making the delegation	Decisions and functions delegated to the Board	Reference
NHS England	In accordance with its statutory powers under section 65Z5 of the NHS Act, NHS England have delegated the exercise of Delegated Functions (for Primary Medical Services, Pharmacy, Optometry and Dentistry and Specialised Services) to the ICB to commission a range of services for the people of the area as follows: • Decisions in relation to the commissioning, and management of Primary Medical Services, Pharmacy, Optometry and Dentistry. • Planning Primary Medical Services, Pharmacy, Optometry and Dentistry in the Area, including carrying out needs assessment. • Undertaking review of Primary Medical Services, Pharmacy, Optometry and Dentistry in respect of the Area. • Management of Delegated Funds in the Area. • Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services, Pharmacy, Optometry and Dentistry with other health and social care bodies in respect of the Area where appropriate; • For the operational management of those specialised services delegated by NHS England; and • Such other ancillary activities that are necessary in order to exercise the Delegated Functions. Such arrangements have been set out in the 'delegation agreement' and shall prevail as if written into the SORD.	Delegation Agreement (Primary Care). Delegation Agreement for Specialised Services.

Schedule of Detailed Delegated Financial Limits

Provision	Who can authorise	Notes
1. Virements *Movements between care areas to be signed off by the Medical Director or Executive Chief Finance Officer*		
a. Within cost centre	Budget Holders	Note 1
b. Between cost centre in same directorate and care area	Budget Holders	Note 1
c. Between directorates but in same care area	Executive Directors	Or nominated deputy
d. Between care areas	Executive Chief Finance Officer and Medical Director	
e. New allocations (specified use)	Executive Directors	Or Senior Finance Manager
f. New allocations (general)	Executive Directors	Or nominated deputy

Provision		Who can authorise	Notes
2. Approval Limits for committing expenditure and service contracts, including variation of contracts, but excluding staff pay costs (see notes 2 & 3)			*Business cases to be presented in accordance with the Decision Making Policy.*
a. Within existing agreed budgets			
i.	< £100,000 (and within budget holder limits)	Budget Holders	Note 1
ii.	< £250,000	Executive Director	
iii.	£250,000 - £5,000,000	Executive Team	
iv.	£5,000,000 - £10,000,000	Finance and Performance Committee	
v.	> £10,000,000	ICB Board	
b. In-year proposals with no budgetary provision			
i.	< £100,000 (and within budget holder limits)	Executive Team	
ii.	£100,000 - £2,500,000	Finance and Performance Committee	
iii.	> £2,500,000	ICB Board	
c. Approval of invoices within approved contract values:			
i.	< £1,000,001	Budget Holders	Note 1
ii.	£1,000,001 - £10,000,000	Executive Director	
iii.	£10,000,000 - £25,000,000	Executive Chief Finance Officer	Or Deputy Director of Finance
iv.	> £25,000,000 to NHS providers with MSE system	Executive Chief Finance Officer	Or Deputy Director of Finance
v.	> £25,000,000 with other providers	Executive Chief Finance Officer	
d. Approval of expenditure greater than tender price / business case. Subject to remaining within approval and tender limits identified above			
i.	< 10% of approved tender	Chief Executive Officer or Executive Chief Finance Officer	
ii.	> 10% of approved tender or business case would require review of need and affordability in accordance with the business case process identified in 2 (above).	Follow the limits as per business case section 2. Above.	

Provision	Who can authorise	Notes
3. Quotation, tendering and contract procedures for expenditure / income proposals, whether capital or revenue, purchases or disposals of non-clinical services / products procured in accordance with the Public Contract Regulations (2015)	*To clarify, these limits relate to contracts where the ICB is the contracting authority. Where another system partner is the contracting authority, that organisations limits and processes will apply.*	The value of the goods and services should be the total contract value, not the annual value and should be inclusive of fees but exclusive of VAT. Where the number of years is not specified or is open ended from year to year, a 3-year period should be assumed for the purpose of this calculation).
a. £501 - £5,000 (minimum of 2 verbal quotations)	Budget Holders	Note 1
b. £5,001 - £50,000 (minimum 3 written quotations)	Budget Holders	Note 1
c. NON-CLINICAL GOODS / SERVICES (inc VAT)		
i. £50,001 - £213,447	Executive Director	
ii. > £213,447	Executive Director	
d. CLINICAL GOODS / SERVICES (inc VAT)		
iii. £50,001 - £663,540	Executive Director	Note 1
iv. < £663,540	Executive Director	
e. Waiving of quotations and tenders subject to SOs and SFIs	Executive Chief Finance Officer	All waivers to be reported to Audit Committee.

Provision	Who can authorise	Notes
4. Arrangements for the discharge of responsibilities under the Health Care Services (Provider Selection Regime) Regulations 2023.	*All provisions set out below may be authorised in accordance with the thresholds set out under section 2.*	
a. Complete and approve direct award without competition	Executive Directors	Or Budget Holders or Attain
b. Approval of 'most suitable provider'	Executive Directors	Or Budget Holders or Attain
c. Approval of PSR competitive process	Executive Directors	Or Budget Holders or Attain
d. Review and response to Provider representations	Provider Selection Regime Review Group	
e. Secondary review subsequent ICB response to Provider representations	NHS England Independent Panel	

Provision		Who can authorise	Notes
5. Management of Budgets/Expenditure for Staff Pay, Agency and Consultancy			
a.	Engagement of staff not on the Establishment (within available budget and full year cost) – costs per employee:		
i.	> £50,001	Executive Director	
ii.	£50,001 - £100,000	Chief Executive Officer or Executive Chief Finance Officer	Prior approval required from NHSE for contract appointments
iii.	£100,001 - £250,000	Chief Executive Officer AND Executive Chief Finance Officer	Prior approval required from NHSE
iv.	> £250,001	Chief Executive Officer AND Executive Chief Finance Officer Reported to Remuneration Committee for information and scrutiny EXCEPT, if the appointment relates to CEO or CFO (in iii or iv above) the process will be reviewed by Remuneration Committee and recommended to the ICB Board for approval.	Prior approval required from NHSE
v.	IN ADDITION, for the recruitment agency / contract staff, all contract with either a total value of £50,000 or above, a day rate of £600 or greater and/or contracts that exceed 6 months.	> £600 per day – NHSE Regional Rep > £800 per day – NHSE CFO > £900 per day – NHSE Regional & National	Require NHSE prior approval.

Provision	Who can authorise	Notes
6. Signing of Contracts and contract variations		
a. Signing of contracts (including Grants, MOUs and LOAs) where due process has been followed i.e. procurement / funding approved / business case processes (as evidence in the contract governance form).	Budget Holders, or Executive Directors, or Executive Chief Finance Officer, or Chief Executive Officer.	Note 1
b. Signing of contracts or documentation related to services that are delegated to another ICB to deliver on behalf of Mid and South Essex ICB.	Executive Directors	

Provision	Who can authorise	Notes
7. Primary Care Commissioning		
a. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) within existing budgets or nationally defined entitlement:		
i. < £250,000	Executive Director	Director of Primary Care
ii. £250,000 - £1,000,000	Executive Team or Executive Chief Finance Officer of Chief Executive Officer	
iii. £1,000,000 - £5,000,000	Primary Care Commissioning Committee	
iv. £5,000,000 - £10,000,000	Finance and Performance Committee	
v. > £10,000,000	ICB Board	
b. Investment in Primary Care Contractors (General Medical Services, Pharmacy, Optometry and Dentistry) outside of existing budget:		
iv. < £250,000	Executive Team or Executive Chief Finance Officer or Chief Executive Officer	
v. £250,000 - £1,000,000	Primary Care Commissioning Committee	
vi. £1,000,000 - £5,000,000	Finance and Performance Committee	
vii. > £5,000,000	ICB Board	
c. Investment in Primary Care outside of contractual entitlements will require the relevant business case and financial approvals process described in sections 2 and 5 to be followed.	As per business case process (and reported back to the Primary Care Commissioning Committee.	

Provision	Who can authorise	Notes
8. Better Care Fund (see note 4)		
a. Approval of the ICB element of BCF investment within existing budgets:		
i. < £250,000	Executive Directors	Alliance Director
ii. £250,000 - £1,000,000	Executive Directors	2 x Alliance Directors
iii. £1,000,000 - £3,000,000	2 x Executive Directors **AND** Executive Chief Finance Officer or Chief Executive Officer	
iv. > £3,000,000	To follow section 2 above.	
b. Approval of the ICB element of BCF investment outside of existing budgets.	To follow section 2 above.	

Provision	Who can authorise	Notes
9. Continuing Healthcare		
a. Approving Continuing Healthcare packages of care:		
i. Up to agreed standard rate per week	CHC Business Manager	
ii. Up to annual equivalent £100,000	Operational Lead	
iii. Up to annual equivalent £150,000	Head of CHC / Deputy Chief Nurse	
iv. Over annual equivalent £200,000	Executive Chief Nursing Officer	
b. Patient Transport (journeys outside of contract)	Any posts identified in 9a.	

Provision	Who can authorise	Notes
10. Losses, Write Off and Compensation		
a. Losses due to theft, fraud, overpayment, fruitless payments, non-contracted activity, compensation payments:		
i. < £5,000	Executive Chief Finance Officer **OR** Chief Executive Officer	
ii. £5,000 - £25,000	Executive Chief Finance Officer **AND** Chief Executive Officer	
iii. £25,000 - £100,000	ICB Board	
iv. > £100,000	ICB Board	And reported to NHSE at year-end
b. Redress payments made in respect of Continuing Healthcare costs (except for routine reimbursement of care costs incurred due to delay in package set-up over permitted 20 days):		
i. < £10,000	Chief Executive Officer **OR** Executive Chief Finance Officer **AND** Executive Chief Nursing Officer	
ii. > £10,000	Chief Executive Officer **AND** Executive Chief Finance Officer **AND** Executive Chief Nursing Officer	
c. Write off of non-NHS debtors:		*All instances of losses or write off will be reported to the audit committee.*
i. < £500	Executive Directors	
ii. > £500	Chief Executive Officer **OR** Executive Chief Finance Officer	
d. Special severance or retention payments	Reserved by NHS England	

Notes:

1. Limits for Budget Holders will be set on a case-by-case basis up to the maximum limits shown in the schedules.
2. Approval limits include commitment of expenditure (approval of business cases), authorising requisitions / order / invoice and the signing of contracts and grants.
3. Approval of commitment of expenditure relates to the total and aggregate value of any contracts over its full term.
4. Approval of BCF investments for Essex will need to be signed by at least two Ads to reflect the arrangements of the Essex BCF impacting on three Alliances.

Definitions:

Full Title	Short Title	Description
Executive Directors	Exec Dir	All Executive Directors of the ICB with a line report to the Chief Executive Officer
ICB Chief Executive Officer	CEO	The ICB Chief Executive Officer
Executive Chief Finance Officer	CFO	The ICB Executive Chief Finance Officer
Medical Director	MD	The ICB Executive Medical Director
Executive Chief Nursing Officer	CN	The ICB Executive Chief Nursing Officer
Deputy Director of Finance	DDoF	Named Directors and Deputy Directors of Finance within the Finance and Estates Directorate
Director of Primary Care	Dir PC	Director of Primary Care
Deputy Director for Primary Care Development	DD PC	Deputy Director for Primary Care Development
Alliance Director	AD	Alliance Directors for Basildon & Brentwood, Mid Essex, South East Essex and Thurrock
Deputy Chief Nursing Officer	Deputy CN	The ICB Director of Nursing reporting to the CN.
Head of Continuing Healthcare	Head of CHC	The Deputy Director for All Age Continuing Care
Continuing Healthcare Business Manager	CHC Business Manager	Nominated CHC Business Managers, CHC team to maintain register.
Operational Lead	Operational Lead	Nominated CHC Operational Leads. CHC team to maintain a register.
Budget Holder	Budget Holder	Any nominated budget holder. The limits in this SoDDFL are the maximum limits. Each budget holder will be granted a specific limit based on need and responsibility, see note 1.
Senior Finance Manager	SFM	Deputy Directors of Finance or their line reports. For allocation of new budget allocations (virements) where the use is specified and thus no decision on which are area the funding is to be allocated to is needed.
Nominated Deputy	ND	A deputy can be nominated by the authorising officer.
Committee Name:		
The ICB Board	Board	
Finance and Performance Committee	FPC	
Audit Committee	Audit	
Primary Care Commissioning Committee	PCCC	
Remuneration Committee	RemCom	
Executive Team	Exec	

Mid & South Essex Integrated Care Board

People Board

Terms of Reference

1. Constitution

1.1 The People Board is established by the Integrated Care Board (the Board or ICB) and is a Committee of the Board in accordance with its Constitution.

1.2 These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

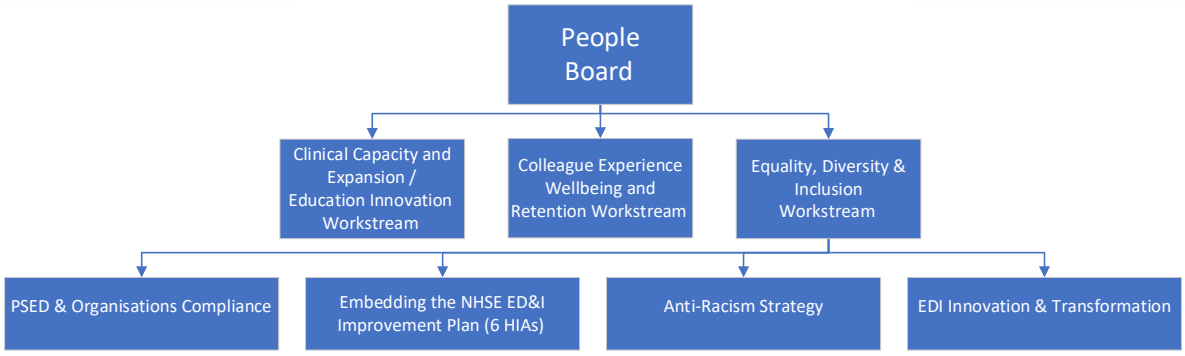
1.3 The People Board is a non-executive chaired committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Authority

2.1 The People Board is a formal committee of the ICB, which has delegated authority from the ICB details of which are set out in the Scheme of Reservation and Delegation. The People Board holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

2.2 The Committee is authorised by the Board to:

- Investigate any activity within its terms of reference.
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference.
- Create task and finish sub-groups to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups. The sub-structure of the People Board workstreams are shown below:



2.3 For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions, and the SoRD.

3. Purpose

3.1 The People Board has been established to provide the ICB with assurance that it is delivering its functions and undertaking its responsibilities to deliver the workforce related activities that are carried out by the ICB as an employer itself and to work collaboratively with other partners across the Integrated Care System (ICS). To contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services.

3.2 The People Board will agree system implementation of people priorities including delivery of the People Plan, People Promise and Workforce Plan (2023) by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, and the voluntary, community, faith, and social enterprise (VCFSE) sector.

3.3 The People Board will ensure that the ten people functions are delivered and that the ICB and system partners are meeting the strategic workforce priorities in the NHS, as set out in the People Plan. These include improving people's experience of working within the NHS, enabling them to provide the best possible care and health outcomes for patients and citizens; transforming and growing the workforce to make use of the skills of staff and meet changing health needs; and developing a compassionate and inclusive culture that drives positive change for staff.

3.4 The People Board will provide regular assurance updates to the ICB and system partners, in relation to activities and items within its remit and linked to the areas above as well as identifying any key system issues and/or risks requiring discussion to escalation to the Board.

3.5 The duties of the People Board will be driven by the ICB's objectives and the associated system risks. An annual programme of business will be agreed before the start of the financial year, however this will be flexible to new and emerging priorities and risks.

3.6 The People Board has no executive powers, other than those delegated in the SoRD and specified in these ToR or by virtue of its attending Members.

4. Membership and attendance

Membership

4.1 The People Board members shall be appointed by the ICB Board in accordance with the ICB Constitution.

4.2 The ICB Board will appoint no fewer than 8 members, including at least one independent Non-Executive Member who shall be the Chair of the People Board. Other members of the Committee need not be members of the Board.

4.3 When determining the membership of the People Board, active consideration will be made to equality, diversity and inclusion.

4.4 Membership will comprise:

- Non-Executive Member (Chair)
- ICB Chief People Officer (Vice Chair)
- ICB Executive Chief Nursing Officer
- NHS Provider Chief People Officers x3 (MSEFT, EPUT and Provide CIC)
- NHS Provider Chief Nurses x3 (MSEFT, EPUT and Provide CIC)
- Local Authority Workforce / People Director(s) x3 (Southend, Essex and Thurrock)
- MSE Hospice Collaborative Representative
- Primary Care Lead
- Staff Side Representative
- System EDI Senior Responsible Officer (SRO)

4.5 Where a member of the Committee is unable to attend a meeting, a suitable deputy may be agreed with the Committee Chair. The deputy may vote on behalf of the absent Committee member.

Chair and vice chair

4.6 The Chair of the ICB will appoint a Non-Executive Member of the Board, with the relevant skills and experience, to chair the People Board.

4.7 The People Board may appoint a Vice Chair of the Committee from amongst its members.

4.8 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

4.9 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

Attendees

4.10 Only members of the Committee have the right to attend Committee meetings, however meetings of the Committee may also be attended by the following individuals who are not members of the Committee by invitation:

- Workstream Chairs (or members)
- Heads of Service
- EDI Leads across the system

4.11 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

4.12 Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with its discussions on any particular matter including representatives from health partners.

Attendance

4.13 Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

5. Meetings Quoracy and Decisions

5.1 The Committee will meet at least 6 times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Meetings will be planned bi-monthly subject to there being necessary business to transact. Additional meetings may take place as required.

5.2 The ICB Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

5.3 In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Quorum

5.4 For a meeting to be quorate a minimum of 4 Members of the Committee are required, including the Chair or Vice Chair of the Committee and a Chief People Officer and two members who are representing other organisations or sectors within the Integrated Care System.

5.5 If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

5.6 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

5.7 Decisions will be taken in according with the Standing Orders. The People Board will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

5.8 Only members of the People Board may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

5.9 Where there is a split vote, with no clear majority, the Chair of the People Board will hold the casting vote.

5.10 If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

Urgent Decisions

5.11 In the event that an urgent decision is required, every attempt will be made for the Committee to meet virtually.

5.12 Where this is not possible an urgent decision may be exercised by the Committee Chair and relevant lead director subject to every effort having been made to consult with as many members as possible in the given circumstances (minimum of one other member).

5.13 The exercise of such powers shall be reported to the next formal meeting of the Committee for ratification.

6. Responsibilities of the Committee

6.1 The People Board's duties are to ensure that strategies and delivery plans are in place to:

- Support the health and wellbeing of staff across the Integrated Care System
- Build / develop the workforce for the future and enable adequate workforce supply, ensuring that the 'one workforce' across the Integrated Care System is representative of the local communities served.
- Support inclusion and belonging for all and create a great experience for staff across the Integrated Care System, addressing issues of inequality and inequity.
- Value and support leadership at all levels and lifelong learning, ensuring that leaders at every level live the behaviours and values set out in the People Promise
- Lead workforce transformation and new ways of working.
- Educate, train and develop our people and manage our talent.
- Drive and support broader social and economic development, leveraging roles as anchor institutions and networks, and supporting all ICS partners to address the wider determinants of health and inequalities.
- Transform our people services and support the people profession.
- Lead on coordinated workforce planning using analysis and intelligence, aligning this to the needs to our current and future population, and our service and workforce needs.
- Support system design and development, using organisational and cultural development principles to support the establishment and evolution of the ICB and the Integrated Care Partnership.

6.2 The People Board will:

- Review and monitor those risks on the BAF and corporate risk register which relate to people and identify operational risks which could impact on care.
- Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.
- Ensure oversight, and implementation, of national policy developments relating to the health and care workforce.
- Have oversight of, and approve the Terms of Reference and work programmes for, any groups reporting into the People Board.

6.3 The People Board must be assured that:

- There are robust processes in place for the effective delivery of a high-quality people function for the ICB.
- There are robust processes in place to ensure effective collaborative working across partners.
- A culture which considers Equality, Diversity and Inclusion (EDI) is embedded and actively promoted, and that consideration of EDI is demonstrably present across the ICB and its partners.

7. Behaviours and Conduct

ICB values

7.1 Members will be expected to conduct business in line with the ICB values, objectives and Code of Conduct set out including the East of England Leadership Compact.

7.2 Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity

7.3 Members must demonstrably consider the equality and diversity implications of decisions they make in accordance with the equality impact assessment process established by the ICB.

Conflicts of Interest

7.4 Members of the Committee will be required to declare any relevant interests to the ICB in accordance with the ICB's Conflicts of Interest Policy.

7.5 A register of Committee members' interests and those of staff and representatives from other organisations who regularly attend Committee meetings will be produced for each meeting. Committee members will be required to declare interests relevant to agenda items as soon as they are aware of an actual or potential conflict so that the Committee Chair can decide on the necessary action to manage the interest in accordance with the Policy. This could mean excluding an individual from access to or participation in an agenda item or meeting, at the discretion of the chair.

Confidentiality

7.6 Issues discussed at People Board meetings, including any papers, should be treated as confidential and may not be shared outside of the meeting unless advised otherwise by the Chair.

8. Accountability and reporting

8.1 The People Board is accountable to the ICB Board and shall report to the Board on how it discharges its responsibilities.

8.2 The Chair of the People Board may be invited to attend the ICB Board as requested by the Chair of the ICB.

8.3 The Chair of the Committee will be accountable to the Chair of the ICB for the conduct of the committee.

8.4 The minutes of the meetings, including any virtual meetings, shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

8.5 The People Board Chair will provide assurance reports to the Board at each meeting and shall draw to the attention of the Board any issues that require disclosure to the Board or require action.

8.6 The People Board will have regard to the Integrated Care Strategy and the Joint Forward Plan. It will take direction and provide relevant updates to the ICP in this regard.

9. Secretariat and Administration

9.1 The People Board shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements.
- Records of members' appointments and renewal dates are maintained and the Board is prompted to renew membership and identify new members where necessary.
- Good quality minutes are taken in accordance with the standing orders, including a record of all decisions, and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports to the Board.
- The Committee is updated on pertinent issues/ areas of interest/ policy developments.
- Action points are taken forward between meetings and progress against those actions is monitored.

10. Review

10.1 The People Board will review its effectiveness at least annually and complete an annual report submitted to the ICB Board.

10.2 These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the ICB Board for approval.

10.3 The People Board will utilise a continuous improvement approach and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: XX XXX 2023

Date of review: XX XXX 2024

Part I ICB Board Meeting, 14 November 2024

Agenda Number: 19.4

Revised Policies

Summary Report

1. Purpose of Report

To update the Board on policies that have been revised and approved by sub-committees of the Board.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.
Jo Cripps, System Recovery Director

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Audit Committee and Quality Committee

5. Link to the ICB's Strategic Objectives:

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement in staff survey results by March 2026.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

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

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on revised policies which have been approved by the relevant committees since the September Board meeting.

2. Revised Policies

The following policies have been revised and approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit Committee 15 October 2024.	The committee further extended the review date of the Incident Reporting Policy (Ref 024) to January 2025 as this will need to be updated to take account of implementation of the RLDatix incident reporting module which is being progressed (anticipated completion is end December).
Quality Committee 25 October 2024.	The committee approved amendments to the following policies: • 032 Equality and Health Inequalities Impact Assessment Policy • 063 Safeguarding Adults and Children Policy • 073 Mental Capacity Act 2005 Policy The committee also extended the review dates of the following policies due to workload capacity issues within relevant teams: • 065 Management of Allegations Against Staff Policy (extended to December 2024) • 068 All Age Continuing Care Policy (extended to March 2025) • 074 Communicable Disease Outbreak and Incident Management Policy (extended to December 2024)

3. Findings/Conclusion

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

4. Recommendation

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

Part I ICB Board meeting, 14 November 2024

Agenda Number: 19.5

Committee Minutes

Summary Report

1. Purpose of Report

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

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

2. Chair of each Committee

- George Wood, Chair of AC.
- Joe Fielder, Chair of F&P.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

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

Committee Minutes

1. Introduction

Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of the meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on the functions and decisions delivered on its behalf.

2. Main content of Report

The following summarises the key items that were discussed / decisions made by committees as recorded in the minutes approved since the last Board meeting.

Audit Committee, 23 July 2024

The committee received reports on the following:

- The ICB's corporate risk register and latest iteration of the Board Assurance Framework.
- A deep dive into mental health services.
- A report on the committee's effectiveness during 2023/24.
- An update on sustainability initiatives, noting that the ICB's responsibilities would be included within a refreshed 'Green Plan'.
- A report on mandatory training compliance.
- Information Governance update.
- Emergency Preparedness, Resilience and Response update.
- Health & Safety Update.
- Contract Governance and Procurement Register.
- Waiver Report.
- Losses and Special Payments.
- Internal Audit update report.
- Local Counter Fraud Specialist and Local Security Management Specialist update.
- External Audit update.
- Service Auditor reports were also provided for information.
- Minutes of other ICB main committees.

The committee also approved:

- Seven revised policies within its remit and extended the review dates of several other policies.
- The updated Business Continuity Plan.

Finance & Performance Committee, 3 September 2024

The Committee considered reports on the following:

- Update report on progress since mobilisation of the Fracture Liaison Service at Southend Hospital.
- System Finance and Performance Report for month 4.
- System Recovery.

- Risks within the remit of the committee and financial Board Assurance risks.
- Minutes of the System Finance Leaders Group meeting on 22 July 2024.

Primary Care Commissioning Committee, 14 August 2024

The committee received reports on:

- Primary Medical Services Contracts update.
- Primary Dental Services – Care Home Pilot, highlighting the positive impact this was having on care residents.
- Additional Dental activity performance.
- Primary Optometry services.
- Community Pharmacy engagement.
- Primary Care Performance reporting update.
- Primary care risk register and relevant BAF risk.
- Primary Care quality updates
- Minutes of the Dental Commissioning and Transformation Group meetings held on 5 June 2024 and 3 July 2024.

Quality Committee, 30 August 2024

The committee received reports / presentations on the following:

- An update on 3 risks relating to mental health quality assurance, compliance with the Mental Health Act and Autistic Spectrum Disorder.
- The Executive Chief Nurse report confirmed there were no escalations from Safety Quality Group, provided an update on emergency safety concerns and advised of concerns highlighted via the ICB Board and System Oversight and Scrutiny Committee.
- Essex Partnership University Hospitals NHS Foundation Trust (EPUT) update on mental health services,
- Local Maternity and Neonatal System update
- Safeguarding – Children and Young People update.
- Neurodiversity (Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder) Update
- Infection Prevention and Control update
- Patient Safety and Quality Risks
- Update on the status of policies within the committee's remit.

The committee also approved the following:

- The revised Serious Incidents Policy, Safeguarding Case Review Procedure and extension of review dates of two other policies.

3. Recommendation

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

Minutes of the Audit Committee Meeting

Held on 23 July 2024 at 1.00pm

via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.

Other attendees

- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Head of Financial Services, MSE ICB.
- Jane King (JKi), Corporate Services and Governance Support Manager (minute taker), MSE ICB.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB (for Item 4-6).
- Rachel Stinson (RS), HR Manager, MSE ICB (for Item 9).
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB (for Items 11 & 12).
- Barry Frostick (BF), Chief Digital & Information Officer, MSE ICB (for Item 12).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (for Items 13 and 14).
- Emma Larcombe (EL), Director, KPMG.
- Nathan Ackroyd (NAc), Senior Manager, KPMG.
- Clarence Mpofu (CM), Director – Healthcare Sector, TIAA.
- Jonathan Gladwin (JG), Director of Anti-Crime Services, TIAA.
- David Kenealy (DK), Senior Anti-Crime Specialist, TIAA.
- Hannah Wenlock (HW), Anti-Crime Specialist, TIAA.
- Alfred Bandakpara-Taylor (ABT), Deputy Director of LD, Mental Health and Specialised Commissioning, MSEICB (for item 5).
- Maria Crowley (MC), Director for Children, Mental Health and Neurodiversity, MSEICB (for item 5).
- Michelle Angell, Director of Corporate Services, MSEICB (for item 8).

Apologies

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

1. Welcome and Apologies

GW welcomed everyone to the meeting. Apologies were noted, as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the ICB Extraordinary Audit Committee on 19 June 2024 were received.

The action log was discussed and noted that with the exception of action 62, all were complete.

Outcome: The minutes of the meeting held on 19 June 2024 were approved as an accurate record.

4. Board Assurance Framework & Corporate Risk Register

SOC presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 11 July 2024. The latest BAF would be submitted to the next Part I ICB Board meeting on 12 September 2024. SOC thanked Chris Cullen for compiling the accompanying report for the Audit Committee.

There were 8 ICB red rated risks outlined in the BAF. A summary of Mid and South Essex Foundation Trust (MSEFT) and Essex Partnership University Trust's (EPUT) red rated risks were also included.

A copy of the Corporate Risk Register was also presented to the committee, which detailed 55 active risks. At the time of writing, updates for 11 risks remained outstanding. From late July, the Executive Team would receive regular performance reports on progress with the bi-monthly updating of risks.

SOC advised that since the last committee meeting 4 risks had been closed and 8 new risks had been opened.

The RLDatix DCiQ risk module was in daily use by risk leads. There were software issues which Datix were working to resolve to enable improvements in reporting.

NA explained that the National Quality Board had issued guidance on dynamic and complex system risk assessments. Working with NHSE as a pilot site the governance team would develop a new process for the Board Assurance Framework, but this would take significant time as the intention was to create a system risk process and therefore the journey ahead included engagement with partners to develop a consistent approach to risk management as well as a collaborative approach to undertaking complex, dynamic risk assessments across the system for the BAF. In the interim, the team were maintaining the current board assurance framework format.

CM advised that TIAA had clients using a similar approach and offered to connect NA with them.

GW sought assurances over the Primary Care BAF risk and what effect the actions on the risk were having on acute services and the wider system e.g., were A&E admissions going up or down. NA reminded members that the risk was owned by the Primary Care Commissioning Committee and was regularly reviewed and suggested a deep dive on the topic. GW requested data to show the impact of treating the Primary Care Risk across the system.

ACTION: A deep dive review on the primary care risk to be scheduled for the next Audit Committee meeting.

The following areas were raised by GW and GO:

- Urgent, Emergency Care (UEC) risk – whether the system had enough capacity to take patients from the acute into the community setting.
- Cancer Diagnostics risk - waiting times were not met, but the trajectory showed it was on track.
- Workforce risk - when updated data would be provided.
- Primary Care / Capital risks – how the development of the Infrastructure Strategy was progressing and whether it included consideration of the system estate as well as Primary Care. Also, to what extent the ICB was prepared for industrial action.

NA provided assurance that the issues raised were being addressed through sponsoring committees e.g., workforce within the People Board, performance within the Finance & Performance Committee.

NA confirmed that the proposed Infrastructure Strategy would be presented at the Board Seminar in July. And that the use of estate was discussed at both the Finance & Performance Committee and the Primary Care Commissioning Committee.

IGe informed members that the new data system 'Athena' presented A&E data as questioned by GW and confirmed that whilst the ICB was prepared for any incidents (e.g., Industrial Action), there could never be absolute preparedness for every resulting situation.

Outcome: The Committee NOTED the Board Assurance Framework and Corporate Risk Register update.

5. Mental Health Risk Update

GW welcomed ABT and MC to the meeting to present the update on the mental health risk deep dive.

MC and ABT explained the data, performance and service delivery associated with the mental health risk, the impact on patients and the population and the action plans and milestones in place to manage associated risks.

It was noted that out of area placements and workforce remained challenging and that there was work being undertaken to re-base the financial risk share arrangements working with neighbouring ICBs.

GW sought clarification on the inappropriate Out of Area placement projection. ABT explained the NHS mandate stated it was better for patients to be treated locally, but some patients were placed out of area because of clinical need or a lack of capacity within the system. ABT confirmed that data relating to children was not included as children's commissioning was delegated to Hertfordshire and West Essex ICB. ABT explained the actions being taken to address adult placements.

ACTION: ABT to provide children's mental health data for out of area placements to the Audit Committee.

Members and ABT discussed actions relating to early intervention and prevention, noting that the new standards focus on reliable improvement and reliable recovery.

Following a question from GW, MC concluded that the neurodiversity programme was not included within the mental health portfolio, but there was variation in provision of Autism and ADHD services across MSE, with a focus on diagnostics, but a drive to move to a more needs led provision of services. This was monitored by the Quality Committee. MC noted that the 'right to choose' was challenging service provision, but there was a clear plan of action within the community collaborative. MC further noted that there was improved access to perinatal mental health services, but there were challenges recruiting midwives.

GW noted variances within the mental health scorecard and NA invited ABT to explain how work with the Alliances was addressing that. ABT provided assurances that there was joined up functions between mental health commissioning and delivery at place through the Alliances.

GW thanked ABT and MC for an insightful and detailed presentation on the Mental Health risk.

Outcome: The Committee NOTED the update on the deep dive Mental Health risk.

6. Policy Approval & Update

SOC presented the policy review update noting that the following policies had been updated and were presented to the committee for approval:

- Accounting & Financial Management Policy
- Banking Cash Management Policy
- Creditor and Purchase Policy
- Debtor and Sales Order Policy
- Policy for Developing Policies
- Legal Services Policy
- Counter Fraud, Bribery & Corruption Policy

SOC noted that the Incident Reporting Policy was in the process of being updated to reflect the implementation on the Datix system for reporting and therefore an extension to the policy review date to 30 September 2024 was sought.

Outcome: The Committee APPROVED the Accounting & Financial Management; Banking Cash Management; Creditor and Purchase; Debtor and Sales Order; Policy

for developing policies; Legal Services; and Counter Fraud, Bribery Corruption Policies.

Outcome: The Committee APPROVED an extension to the review date of the Incident Reporting Policy to 30 September 2024.

7. Committee Effectiveness Report

NA explained each sub-committee of the Board was required to undertake an annual self-assessment of its effectiveness to determine whether it had met its objectives as set out within its terms of reference (TOR). The process included a desktop review, a questionnaire sent to its members and a review of its TOR to ensure its currency and appropriateness. NA presented a summary report of committee effectiveness reviews to the Audit Committee as the committee responsible for oversight of governance arrangements across the sub-committees of the ICB Board.

Members noted that the most significant changes following the review related to the Finance & Investment Committee, which would take responsibility for performance management and thus be named the Finance & Performance Committee; and the System Oversight and Assurance Committee, which had a revised focus on escalations and management of the National Oversight Framework 4 process led by NHS England.

NA explained that largely the sub-committees of the Board had met their objectives, but all had developed action plans to strengthen their operation for the coming year. Consequently, each committee TOR had been updated and approved at the last Board meeting, subject to the Individual Funding Request process being aligned to a new committee (rather than the Quality Committee).

NA further explained that the review of ICB Board effectiveness would consider the effectiveness of sub-committee arrangements, but would be undertaken once the new Chief Executive Officer was in post.

NA confirmed to GO that the minutes of the Health and Safety Group would be shared with the Audit Committee alongside the report from the group.

Following a question from GO, NA confirmed that the ICP would review its effectiveness, but that there was no accountability to report it to the ICB.

Outcome: The Committee NOTED the report on committee effectiveness.

8. Sustainability Update

MA shared a presentation setting out the key deliverables of the plan to develop sustainability responsibilities within the ICB, noting that this would be reflected in a refreshed 'Green Plan.'

Members were pleased to note the initiatives taking place and that green champions had been established across the ICB, alongside close working relationships on the subject with ICB partners.

CM noted that TIAA had a specialist in sustainability who could provide support where required.

GO asked whether work on sustainability included engagement with residents and patients. MA confirmed this was the case, particularly with initiatives such as Active Essex and volunteering initiatives that would link with our elderly residents and children with special needs. The work would also link to that of the Alliances.

Outcome: The Committee NOTED the update on sustainability.

9. Mandatory Training Compliance

RS presented an improved position on mandatory training compliance.

GW expressed concern regarding compliance with resuscitation training. Through discussion, RS agreed to determine the requirements of the training and whether it was an ICB training requirement. GW further queried safeguarding training and how this applied to Non-Executive Members.

ACTION: RS to review the appropriateness of resuscitation training and whether it should be ICB mandated training or not. A further review of the rationale for safeguarding training for NEMS should be fed back to the committee.

Outcome: The Committee NOTED the update on progress with mandatory training compliance.

10. Information Governance Update

IGe provided the committee with an overview of the work undertaken towards the Data Security Protection Toolkit (DSPT) submission, the associated DSPT audit, and wider Information Governance (IG) related work across the ICB and ICS.

The ICB submitted a DSPT 2023/24 'Standards Met' self-assessment by the deadline of 30 June 2024. The DSPT 2024/25 would adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

A request was made to the committee to extend the review date of the current IG policies in recognition of additional audit recommendations feeding into the Information and Cyber Security Policy, the change in DSPT to reflect the CAF (further guidance on CAF was due in September 2024), potential strengthening of the Records Management policy and associated processes and future adoption of Artificial Intelligence. Rewritten policies would be presented to the Audit Committee in January 2025 for consideration.

Outcome: The Committee APPROVED the extension of the Information Sharing Policy, Records Management and Information Lifecycle Policy, Access to Information Policy, Cyber Security Policy and Forensic Readiness Policy by six months to January 2025.

Outcome: The Committee NOTED the quarterly report on Information Governance.

11. Emergency Planning, Resilience and Response Update

JC presented an update on Emergency Preparedness Resilience & Response (EPRR) and the System Co-ordination Centre (SCC).

The Business Continuity Plan (BCP) was updated to reflect changes introduced following the organisational restructure in early 2024 and subject to a full review within the next 12 months.

Following a consultation process with affected staff, changes to on-call arrangements were implemented from 1 July 2024.

The risk of industrial action affecting the NHS remained an ongoing risk to patient safety and delivery of patient care, with possible collective GP action from 1 August 2024. The ICB continued to work with partners in preparedness.

The ICB was due to undertake the annual NHSE EPRR Core Standards Assurance process, an update would be provided to the committee at the next meeting in October 2024.

Outcome: The Committee SUPPORTED the updated Business Continuity Plan and NOTED the quarterly EPRR Update.

12. Health & Safety Update

JC presented the Health and Safety (H&S) report to the Audit Committee. Following a review of the Health and Safety Working Group's terms of reference, meetings had reduced from monthly to bi-monthly, and membership had expanded to include the H&S Competent Person and Corporate Risk lead.

Minor changes had been made to the following policies and were presented to the committee for approval:

- **Security and Lockdown Policy** – minor amendments following the ICB restructure and subject to a full review within the next 12 months.
- **Management of Violence, Aggression and Vexatious Behaviour Policy** – minor amendments following the ICB restructure.

Compliance rates for ICB staff completing the annual working from home / display screen equipment risk assessment was poor at 35%. The risk was shared with the ICB Executive Committee and the HSWG was focusing on increasing compliance.

In response to GO, JC explained that although there was no target number for Fire Marshall and First Aid training, a number of staff had undertaken the training, and a rota was in place to ensure appropriate coverage at the ICB HQ. To date, no gap in cover had been flagged.

GW queried how the weaknesses identified in the TIAA Security Review (presented under Item 17) would be incorporated into H&S plans. JC confirmed he was in contact with TIAA regarding the security management risk assessment findings and was preparing a paper to go to the Executive Committee.

BF commented that no incidents or accidents had been formally reported to the ICB so far in 2024, however the HSWG were aware anecdotally of 'incidents' and 'near misses' and were working to ensure these were formally reported.

Outcome: The Committee APPROVED the minor amendments to the Security and Lockdown Policy and Management of Violence, Aggression and Vexatious Behaviour Policy and NOTED the Health & Safety update.

13. Contract Governance & Procurement Register

JJ presented the Register of Procurement Decisions detailing the 14 decisions (which have a published Contract Award Notice (CAN) on the Find a Tender service, for Mid and South Essex Integrated Care Board) for contracts awarded between the 1 April 2024 and 15 July 2024. From 1 April 2024, the ICB's procurement specialists, Attain, had taken over the responsibility of maintaining and producing the Register of Procurement Decisions.

At the Audit Committee meeting on 16 April 2024, JJ advised that any contract extensions that had been clearly and unambiguously provided for within the original contract award and a report on grants would not be included in future reports submitted to the committee.

Under the Provider Selection Regime (PSR), which came into force on 1 January 2024, transparency of decision making was a key component of the regulations. Training had been, and continued to be, provided to all staff with responsibilities for contracts to ensure compliance with the requirements of PSR.

Evidence of contract governance was now being managed locally by the responsible contract owners and recorded within the Atamis contract management system. Once fully rolled out, further assurance and reporting from Atamis to the Audit Committee could be considered.

There were a small number of procurement decisions made by the Finance and Investment Committee (FIC) and Board under the Provider Selection Regime in January and March 2024 that required publication of a CAN. Additionally, the CANs for Acute contracts to which Mid and South Essex ICB was an Associate, would both be included in the next quarters report.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

Outcome: The Committee NOTED the Contract Governance update.

14. Waiver Report

JJ presented the Waiver Report. There were 2 new waivers authorised during the period 1 April 2024 – 15 July 2024, totalling £77,059.

There were no questions from the committee.

Outcome: The Committee NOTED the Waiver Report.

15. Losses & Special Payments

There were no losses and special payments to report.

Outcome: The Committee NOTED there were no losses or special payments.

16. Internal Audit

CM presented the Internal Audit update, detailing the progress of work undertaken against the 2024/25 Internal Audit Plan. The report also provided an update on progress in implementing the previous internal Auditor's recommendations.

Draft reports had been issued for the recent Addressing Health Inequalities and Population Health Management, Collaboration and Partnerships and Primary Care Estates (Part 1) audits. Detailed reports would be presented at the next meeting.

GW suggested the Primary Care Estates Part 1 report should be received prior to planning for the Primary Care Estates Part 2 audit. Additionally, as work was still needed on the ICB's Primary Care Strategy, it was preferable to defer the Part 2 audit until it was complete.

GO noted the outstanding audit recommendations and queried whether any were of concern. CM confirmed that since the paper was issued, updates for 2 of the 3 overdue recommendations had been received and closed and 1 recommendation remained overdue which was being followed up by the Governance Team.

Outcome: The Committee NOTED the Internal Audit update.

17. LCFS/LSMS

HW and DK presented the Anti-Crime progress report which summarised the proactive work completed against the 2024/25 work plan and in accordance with NHS Counter Fraud Authority Government Functional Standards. The report also included a summary of the status of investigations and referrals since 1 April 2024.

The Counter Fraud Functional Standard Return (CFFSR) was completed by the previous Counter Fraud provider on 30 May 2024, in advance of the revised NHS CFA deadline of 14 June 2024. The provisional overall rating for 2023/24 was 'Green'.

GO noted there had been an in-person fraud awareness session delivered to identified staff groups but queried whether more could be done in this area. HW advised that she regularly met with NB in her role as Fraud Awareness Champion and that fraud awareness information packs would be sent out to targeted staff groups. HW also planned to work on-site at the ICB headquarters. DK added there was time set aside to support the International Fraud Awareness week in November 2024 to raise awareness amongst staff.

In relation to a fraud referral recently opened, GW enquired whether the ICB had spoken to the subject to establish whether there was an indication of possible fraud and whether the case should be referred to LCFS. HW would seek confirmation of whether the meeting had taken place.

ACTION: HW to follow up on whether the ICB had contacted the subject of the fraud referral and whether it was necessary to refer the case to LCFS.

The TIAA Security Review was discussed under Item 12, there were no further questions.

Outcome: The Committee NOTED the update from the Local Counter Fraud and Security Management Services.

18. External Audit

EL confirmed that the final audited and signed Mid and South Essex ICB Annual Report and Accounts for 2023/24 were successfully submitted to NHS England within the deadline, noting the Mental Health Investment Standard (MHIS) assurance statement for 2022/23 was disclaimed, as previously reported to the Audit Committee on 19 June 2024.

Planning for the 2024/25 audit would be undertaken later in year.

GW extended thanks to all involved in the Annual Report and Accounts work.

Outcome: The Committee NOTED the update from External Audit.

19. Service Auditor Reports

NA noted that the Service Auditor Reports, referenced in the Annual Report, were provided to the committee for information.

Outcome: The Committee NOTED the Service Auditor Reports.

20. Minutes of other ICB Committees

The following minutes were presented to the committee:

- Finance & Investment Committee – 11 April 24, 1 May 24.
- Quality Committee - 26 April 24.
- Primary Care Commissioning Committee - 10 April 24, 7 May 24.
- Clinical & Multi Professional Congress - 24 April 24.
- Information Governance Steering Group - 20 March 24, 3 June 24.
- Health & Safety Group - 20 May 24.

Outcome: The Committee NOTED the minutes of the sub-committees.

21. Any other Business

No matters of any other business were raised.

22. Date of Next Meeting

1.00pm – 3.00pm, Tuesday 15 October 2024.

Minutes of the ICB Finance and Performance Committee Meeting Held on 3 September 2024 at 2.00pm

Boardroom, ICB Headquarters and via Microsoft Teams.

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, MSE ICB, **Chair**
- Mark Bailham (MB) Associate Non-Executive Member, MSE ICB
- Emily Hough (EH) Executive Director of Strategy and Corporate Services, MSE ICB
- Loy Lobo (LL) Finance and Performance Committee Chair, Essex Partnership University NHS Foundation Trust (EPUT) - (via Microsoft Teams)
- Julie Parker (JP) Mid and South Essex NHS Foundation Trust (MSEFT)
- Matt Sweeting (MS) Executive Medical Director, MSE ICB (via Microsoft Teams)
- Ashley King (AK) Director of Finance and Estates, MSE ICB – attending on behalf of Jennifer Kearton

Other attendees

- Karen Wesson (KW) Director Oversight and Assurance, MSE ICB (via Microsoft Teams)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB (via Microsoft Teams)
- William Guy (WG) Director of Primary Care, MSE ICB (for agenda item 6 - Special Allocation Service and APMS/GMS Contract (via Microsoft Teams)
- Barry Frostick (BF) Chief Digital and Information Officer, MSE ICB (for agenda item 7 - TPP SystmOne contract extension) (via Microsoft Teams)
- Dr Way Main Wong (WW), MSEFT (for agenda item 8 - Fracture Liaison Service Evaluation Report) (via Microsoft Teams)
- Jayne Mason (JM) Deputy Director of Stewardship & Transformation, MSE ICB (for agenda item 8 - Fracture Liaison Service Evaluation Report) (via Microsoft Teams)
- Emma Seabrook (ES) Business Manager - Resources, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate. Apologies were received from Jennifer Kearton, Executive Chief Finance Officer, MSE ICB, noting that AK was attending on her behalf. Apologies were also received from Tom Abell (TA), Chief Executive Officer, MSE ICB.

2. Declarations of interest

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

JF had a technical adjustment to his Declaration of Interest, it was clarified the change was not pertinent to any items on the agenda.

JP and LL had a potential conflict for agenda item 5 (Community Dermatology Procurement, Financial Envelope) as employees of MSEFT and EPUT, and therefore recused themselves from the meeting at the point the agenda item was discussed.

MS declaration has not been included within the register (as a new member), but clarified he had no direct conflicts on any agenda item. NA confirmed an updated Register of Interests would be available for the October meeting.

ACTION: Updated committee Register of Interest to be provided for the October meeting.

3. Minutes of previous meetings

The minutes of 6 August 2024 were agreed as an accurate record subject to the following amendments:

- (Agenda item 6, paragraph 3) sentence amended for clarity to: YTD efficiencies for the System were £5.2m off-plan, which was contributing to the overall YTD adverse variance of £9.74m.
- (Agenda item 7, last paragraph) – insupportive amended to 'in support'.

Outcome: The minutes of 6 August 2024 were approved subject to the amendments above.

4. Action Log / Matters arising

Members discussed the approach to recording the status against actions. An update on actions was provided. It was agreed JF/NA would agree an approach outside of the meeting to ensure tighter control and to provide the Committee with the necessary assurance.

Outcome: The action log was discussed and noted.

Business Cases

5. This item has been minuted confidentially.

Minute redacted in response to managing conflicts of interest.

6. This item has been minuted confidentially.

7. This item has been minuted confidentially.

8. Fracture Liaison Service Evaluation Report

The report provided an update on progress since mobilisation of the Fracture Liaison Service (FLS) at the Southend Hospital site following approval of the Business Case in August 2023.

MS spoke of the longer-term aim to improve bone health and queried when outcomes of fracture reduction would be known. WW explained it was difficult to measure the fractures that do not happen but expected proxy data would help outline outcomes in the next 2 years.

Data showed the identification level was above national average in the first 3 months of the service going live. Prior to the establishment of the service minimal number of patients were known to services and accessed the required assessments.

The Committee was advised recruitment of administration would enable the uploading of data to the national database. JF suggested consideration of volunteers in future to add value from both a patient voice perspective and to reduce costs.

The Committee recognised the huge amount of work that had taken place to improve bone health for Southend patients and noted the next step was to the roll the service out in Basildon and Broomfield Hospitals.

JF highlighted the projected savings for £1 invested in Fracture Liaison Services that would generate £3.26 in costs avoided in NHS and Social Care and would look to see this validated in future reporting.

JP suggested the use of other intel to identify people who were more likely to have a fracture such as targeted work on housing estates or those less likely to attend an appointment.

The Committee welcomed a further update in March to understand how the project was progressing to support prevention.

WW would share an invite for a Royal Osteoporosis Society regional FLS Event on 29 October 2024 for commissioners.

Outcome: The Finance and Performance Committee noted the report and that the Fracture Liaison Service would submit a further report to the Committee in March 2025.

9. System Finance and Performance Report – Month 4

The ICB was reporting an adverse year to date position of £2.6m off plan and a forecast position of £0.25m deficit. The £0.25m deficit related to unexpected costs associated with phase 1 of the Investigation and Intervention process mandated by NHS England.

AK outlined that all age continuing health care continued to be an area of extreme pressure for the ICB. The team continued to work on delivering £8.7m in efficiencies but this was significantly impacted by an increase in growth above what was originally planned.

High-cost drugs and device costs was a further area of pressure, work was taking place within the ICB to mitigate costs. Spend and recruitment controls continued to be in place.

At Month 4, the System was reporting a £16m deficit from its planned position across the three organisations, this was an increase from Month 3 of £9.7m. The net risk had reduced to £82m because a number of risks had crystalised.

The non-delivery of efficiencies had deteriorated from £5.2m at Month 3 to £9.4m at Month 4.

Following a query from MB on early indication of Month 5, AK expected the position to worsen as planning risks on contract value and growth crystalised.

LL suggested a separate forecast to provide a sense of where the System would deliver at year end with the current suite of interventions. He raised the balance between recurrent and non-recurrent measures had not improved. It was queried how much could be improved locally and how much was a national issue and outside of the Systems control.

JP was assured the right systems and mechanisms were in place within MSEFT with escalation to the MSEFT Board where appropriate.

MS highlighted the need to consider the quality element in accordance with safter staffing standards and ensure grip on the funded establishment and benchmarking of bank and agency spend.

Following a query from JP on the risk of a lease within the ICB not being finalised until Month 10, AK clarified discussions were taking place with NHS England on funding and where this would be captured on balance sheets. JF referred to discussions at the August meeting on Capital and the concern the financial envelope did not meet the System requirements, he welcomed assurance regarding the prioritisation of Estate.

Performance

The Performance section of the report outlined delivery against the 2024/25 National Operational Planning commitments and Constitutional Standards. The Committee were presented with performance on Stroke, Palliative and End of Life Care.

KW highlighted a number of escalation beds remained open to support urgent emergency care and discharge and flow. It was reported diagnostics were on plan (at 76%) to achieve the 95% performance standard by March 2026.

It was noted Cancer and referral to treatment (RTT) performance was being reported fortnightly to NHS England.

Patients waiting over 65 weeks was flagged as a risk. MSEFT were reporting between 20-50 people were likely to exceed waiting 65 weeks at the end of September.

In response to a query from JP on the wider reporting of primary care metrics, NA clarified those outside of the constitutional and operational delivery were reported to the Primary Care Commissioning Committee.

MB welcomed inclusion of a summary page on overall performance of Operational and Constitutional standards.

Following an ask if the Committee wished to have oversight of all operational metrics (not included in the Performance report) JF suggested presentation at a separate Committee Seminar 2 or 3 times a year would be helpful to provide additional assurance.

MS highlighted the standard for Dementia Diagnosis had been achieved for the first time.

Outcome: The Committee noted the Month 4 Finance and Performance Report.

10. System Recovery Report

A report on the first phase of the Investigation and Intervention process had been received and was with organisations for points of accuracy, this would then be shared with NHS England. Price Waterhouse Coopers (PwC) identified scenarios within the report they believed could deliver self-grip and control. The ICB was presented with four recommendations, two of which would require a longer-term focus; an action plan was being developed from the report.

EH advised support from PwC would help to strengthen grip and control on Project Initiation Documents (PIDs) and immediate actions required collectively to improve the in-year gap. The second challenge was to link this with the Medium-Term Financial Plan to drive improvements beyond 2024/25. JP hoped the focus on improving 2024/25 would not have a detrimental impact longer term.

Following a query from JF, it was expected the PwC report would be shared with Board Members in due course.

Outcome: The Committee noted the System Recovery Report.

Financial Governance

11. Board Assurance Framework / Finance Risk Register

NA presented the July Board Assurance Framework and finance risk register. It was noted the request to close risk 19, hospital discharge would be reviewed.

JP queried why the risk of cyber-attack was not included as a risk on the Body Assurance Framework. NA clarified this was captured on the risk register and had not been escalated to the

Body Assurance Framework due to the control frameworks in place to manage the risk. NA would however feedback to BF.

LL added the NHS had made good progress to mitigate cyber-attacks and recommended BF consider working with suppliers to ensure adequate protection against cyber-attacks.

Outcome: The Committee noted the Board Assurance Framework and Finance Risk Register.

ACTION: NA to feedback comments on the Cyber risk to the Chief Digital and Information Officer.

12. Triple lock ratification

Nothing this meeting

13. Feedback from system groups

The minutes of the System Finance Leaders Group (SFLG) held on 22 July 2024 were presented for information.

Outcome: The minutes of the System Finance Leaders Group were noted

14. Any other Business

JF invited members to consider the effectiveness of the meeting. Following discussion JF asked that the 'responsible committee' section of committee cover papers be fully completed describing the role of the Finance and Performance Committee.

NA confirmed a review of Committee templates was being undertaken and AK would raise at the ICB Operational Group (IOG).

ACTION: AK to raise the expectation of the standard of reports at the ICB Operational Group (IOG).

15. Items for Escalation

To the ICB Board:

- Item 5 - for approval

To the Executive Committee:

- Review of business continuity arrangements within suppliers (reference cyber security)15.

16. Date of Next Meeting

Tuesday, 1 October 2024, 2.00pm - 4.30pm.

Microsoft teams meeting.

Minutes of ICB Primary Care Commissioning Committee Meeting

Tuesday, 14 August 2024, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- William Guy (WG), Director of Primary Care.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood (nominated deputy for Pam Green).
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Dr Anna Davey (AD), ICB Primary Care Partner Member.
- Dr James Hickling (JH), Deputy Medical Director (nominated deputy for Dr Matt Sweeting).
- Ashley King (AK), Director of Finance Primary Care, Financial Services and Infrastructure (nominated deputy for Jennifer Kearton).
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality (nominated deputy for Viv Barker).

Other attendees

- Jennifer Speller (JS), Deputy Director for Primary Care Development.
- David Barter (DBa), Head of Commissioning.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Sarah Cansell (SC), Contracts Manager
- Jane King (JKi), Corporate Services & Governance Support Manager (minutes).
- Karen Samuel-Smith (KSS), Chief Officer, Community Pharmacy Essex.
- Sheila Purser (SP), Chairman, Local Optical Committee.
- Emma Spofforth (ES), Secretary, Local Optical Committee.
- Dr Brian Balmer (BB), Chief Executive Essex Local Medical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee.
- Tony Clough (TC), Secretary, Essex Local Dental Committee.
- Jackie Graham (JG), Dental Manager (Item 7).
- Michelle Cleary (MC), Alliance Delivery & Engagement Lead for South East Essex.
- Dr Stephen Denny (SD), General Dentist, South East Essex (for Item 7).
- Umaiyal Ravindran (UR), Associate Operations Director, Community Dental Services CIC (for Item 7).

Apologies

- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that the meeting was quorate.

2. Declarations of Interest

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

Members noted the register of interests.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 10 July 2024 were received.

Outcome: The minutes of the ICB PCCC meeting on 10 July 2024 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (111, 116, 120, 121, 122 and 126) were all within timescales for completion.

Under matters arising it was noted that the Optometry FP10s update would be covered under item 9 on the agenda.

At the PCCC on 10 July 2024, the Committee considered a proposal for a Children and Young People Dental access pilot, which was supported by the Committee, subject to some amendment suggested at the meeting. The Committee delegated final approval of the paper to the Chair. The Committee noted that this was approved by the Chair in between meetings. AK advised that the recommendation was also approved by the Executive Committee and Finance & Performance Committee.

5. Primary Medical Services Contracts Report

JS provided an update on primary medical service contract activity since the last paper was presented to the Committee in June 2024. The paper included an update from the Connected Pathways team on the work undertaken to support practices to move to a modern general practice access model and raise public awareness on the changes to general practice. The following key points were highlighted:

Work was underway on reviewing previous practice mergers.

Three paragraphs in this section have been minuted confidentially.

WG provided an update on the branch closure application of two practices in South East Essex, advising that the practices involved were unable to agree new lease terms with the current landlord. Consequently, the landlord was no longer allowing the practices to remain in premises from 1 September 2024. A process was underway to make a recommendation to the Committee on the branch closure. The Committee agreed, that due to timing of the closure, the recommendation would be shared virtually for consideration.

ACTION: Recommendation in relation to branch closure of two practices in South East Essex to be presented to the Committee for virtual consideration.

WG confirmed the practice had a number of other sites for patients to attend for appointments and there were other practices nearby if patients wanted to reregister. The closure would present minimal risk to patient care. Clarity was being sought for patients with protected characteristics registered at the practice to ensure any potential impact upon them from the closure was mitigated.

JS advised that a number of PCNs were looking at their configuration and reported the ICB would ensure a consistent approach was taken to any proposed changes. National guidance did not allow for in-year changes unless in exceptional circumstances, therefore any changes would need to be from April 2025.

The Primary Care team were considering the potential impact that the GP Collective Action (which commenced on 1 August 2024) would have on various ICB work programmes.

An identified preferred and reserve bidder had been identified for the Beaulieu Park Scheme in Mid Essex. The new Beaulieu Health Centre was expected to open to patients on 1 November 2024, as planned.

The Connected Pathways programmes were all progressing well, including the Cloud Based Telephony and Total Triage projects. JS suggested a Primary Care / Secondary Care interface report could be incorporated within future Connected Pathways updates.

Work was ongoing in relation to the Autumn COVID and Flu Vaccination Programmes and the implementation of the new RSV (Respiratory Syncytial virus) pilot Vaccination Programme.

JH applauded the results of the mid and south Essex GP patient survey which showed overall that patient satisfaction had increased from 66% in 2023 to 71% in 2024. WG explained there had not been the opportunity to analyse the results in detail but it was thought the increase was in part due a combination of changing patient expectations and the introduction of a series of measures such as cloud based telephony and total triage.

AD agreed that the increase in patient satisfaction was very positive but flagged this was also as a result of significant changes to primary care workloads, e.g., many GPs were undertaking additional clinics. It was important to remember the impact the increased workloads were having on workforce and how increased access was being delivered.

JS agreed, adding that once NHS Staff Survey results were available in April 2025, work was needed to triangulate the results with the Patient Survey results, the access recovery actions taken and the outcomes.

The report stated that wider awareness was required amongst some providers on Freedom to Speak Up (FTSU) processes, employee wellbeing and Occupational Health (OH) support services. SA queried whether the ICB were looking at wellbeing issues of ICB staff, rates of attrition and uptake of occupational health (OH) services in primary care and whether discussion at PCCC around staff experience and attrition was required.

JS responded that Staff Survey findings and publication of the FTSU guidance could potentially flag issues in primary care that were not within the ICB's gift to resolve. The ICB would need to consider carefully how it could influence or address any issues. SA requested that JS & WG considered an approach to staff wellbeing for primary care and what was within the ICB's scope. SA was happy to discuss further at the face-to-face event in October 2024.

ACTION: Consider an approach to staff wellbeing for primary care and what is within the ICB's scope.

ES highlighted for accuracy that the Community Glaucoma Service was not a pilot as stated in the paper, but had been running for 10 years. ES said that the ongoing problems with the issue of FP10 forms (prescription forms for patients in community settings which could be taken by the patient to a community pharmacist for dispensing) was still not resolved resulting in patients having to attend another service (GP or hospital to get a valid prescription. If resolved, this could alleviate some work pressures experienced by GP and Trust colleagues. This matter was also for discussion under item 9.

DD commented that the Maslach Burnout Inventory (MBI), used to measure GP Burnout, was used in the previous Primary Care Strategy. The samples taken prior to the Covid-19 pandemic, and analysed by Anglia Ruskin University (ARU), would provide a benchmark to compare GP Burnout post-pandemic.

SA was supportive of using the MBI if it could be easily mobilised and asked JS and WG to consider this being part of the refreshed Primary Care Strategy and to include all professional groups. The Committee agreed that it was important to understand what would be done with the results.

ACTION: Consider using the Maslach Burnout Inventory (MBI) in the refreshed Primary Care Strategy to benchmark against samples taken prior to the Covid-19 pandemic.

Outcome: The Committee NOTED the Primary Medical Services and Connected Pathways updates.

6. This item has been minuted confidentially.

7. Primary Dental Services – Care Home Pilot

DB introduced Dr Stephen Denny and Umaiyal Ravindran who were both part of the Care Home Dental Pilot Steering Group and invited them to give an update on the progress of the pilot and the impact it was having on care home residents.

Prior to the pilot, care home resident dental referrals were received by the Community Dental Service (CDS), however with over 8,000 beds in mid and south Essex it was a huge task for CDS to manage the demand on the service. Evidence had shown that poor oral health and hygiene was linked to general chronic health and systemic diseases.

The pilot involved local dentists sharing the distribution of care home patients more equitably. The programme provided oral care to residents and oral hygiene training for staff, achieving better outcomes for patients and helping homes comply with NICE guidelines and CQC standards. The pilot had reduced inappropriate referrals to the CDS and reduced CDS waiting times, resulting in the CDS treating more patients and able to upskill care home staff.

Since January 2024, SD had visited 1,500 care home residents. Some of the visits had found a lack of oral hygiene, prevalence of gum disease, patients not able to chew properly, inadequate training for carers to spot early signs of dental problems and dementia patients not able to communicate when they were in pain. A selection of patient case studies was shared with the Committee. A variety of treatments were provided in the care home setting including extractions and fillings. The pilot provided the right dental care, at the right time in the right place and provided better pathways for priority dental patients with complex cases, being appropriately and quickly referred to the CDS.

SD said that engagement with care homes varied and reported challenges in gaining access to some care homes, as many were not aware of the pilot.

Dental teams involved in the pilot reported they found the care home work extremely rewarding and had provided the opportunity to work differently, providing increased job satisfaction.

SA thanked SD and UR for the inspiring presentation and the good work undertaken, commenting that it was great to see that intervention can make such a profound difference to the experience of individuals. The Committee unanimously agreed with SA's comments.

RJ said she and Alliance representatives would be very happy to help break down any barriers to accessing care homes and would help the team build connections, including with the local authorities.

AD stressed the importance of the pilot, commenting that it was necessary and important. AD added that it was important that all partners were engaged in order to offer an equitable service across the system.

KSS queried whether there had been any engagement with local authorities, system partners and community partners to join up communication to raise awareness and if there was any work looking at the overall health benefits to residents having access to the service and the impacts on their broader health conditions as a result of dental visits.

TC advised that the Local Dental Committee was in support of pilot and asked how they could support the team. SD explained that training was always welcome, potentially around patients nearing end of life and with advanced dementia.

BH suggested a presentation on the pilot could be given at the next Licence in Dental Surgery (LDS) study day which would help get the pilot out to a wider audience.

DB advised that a paper would be presented at the October 2024 for the Committee to consider forward plans for the pilot to become a commissioned service.

Outcome: The Committee NOTED the Care Home Dental Pilot presentation and progress update.

8. Additional Dental Activity Performance

DB presented the paper which set out an authorisation request for dental providers to deliver up to 110% of their contracted units of dental activity (UDAs) and Units of Orthodontic Activity (UOA) in 2024/25. It was estimated that the additional UDA activity would provide an additional circa 39,244 band 1 (basic checkup) appointments and additional UOA's would deliver an additional 242 courses of orthodontic treatment.

The additional dental activity would be funded from identified ring-fenced dental budgets. DB commented that it was sensible to consider this proposal now to allow enough time for practices to undertake the additional activity to benefit patients. The delivery of additional UDAs would increase dental access for the population outside of the care home pilot, dental access pilot, and children and young people's dental pilot.

JH enquired whether there was any risk attached to the proposal, e.g., was there a possibility of overspending. DB advised there was no risk of an overspend and confirmed the budget was available. In response to AK, DB clarified that the dental underspend available for additional UDAs and UOAs was unallocated expenditure and there was adequate funding available.

SA enquired whether dental ringfencing would continue into the following year. AK commented that dental funding was agreed by NHSE and was not aware if the ringfencing position would change. AK agreed to update the Committee should there be any changes made to dental funding.

Outcome: The Committee APPROVED the request as detailed, subject to ringfenced dental budgets.

9. Primary Optometry Services

WG presented the quarterly Primary Optometry Services report, thanking ES for her input. The paper included an update from Hertfordshire and West Essex ICB who host the General Ophthalmic Services (GOS) contracting function on behalf of the six ICBs in the East of England.

There were a number of issues affecting optometry services currently being progressed within the MSE Ophthalmology Transformation Board. This included an options appraisal to identify the local approach to take forward the triaging of cataract referrals which currently sits outside other triage arrangements. The Connected Pathways Team would work closely with the Local Optometry Committee to improve self-referral into Minor Eye Conditions pathways.

The ICB was seeking clarification from NHS England on the likely timeline for the roll out of Eye Screening Services to Special Schools which was a national requirement for 2024/25 but for which the publication of national guidance was awaited.

There was discussion around the ongoing difficulties with Optometry FP10 prescriptions, however, as the issues were not currently fully understood by the Committee, SA requested a paper to make clear the issues and challenges in order to seek a suitable solution and, if necessary, raise the issue as a risk. SA was happy with JS's suggestion to include within the primary/secondary care update.

ACTION: FP10 issues and potential solutions to be added to the next Primary/Secondary care interface update within the Connected Pathways report.

Outcome: The Committee NOTED the Primary Optometry Services.

10. Community Pharmacy Engagement

PW presented the Community Pharmacy Engagement paper, proposing to use Community Pharmacy integration funding (from the 2024/25 allocation) to support Primary Care Network (PCN) engagement leads to deliver engagement across mid and south Essex, building on the work already undertaken by the current 6 engagement leads who were due to finish in October 2024.

The community pharmacy PCN engagement lead role had been established to support the regional implementation of the Pharmacy Primary Care Access Recovery Plan (PCARP) requirements, including implementing the Pharmacy First Service and expanding the Blood Pressure Checks Service and Pharmacy Contraception Service.

AK highlighted that the funding was non-recurrent, therefore an exit strategy must be considered if funding was not continued. SA commented that it was not clear that funding was non-recurrent and requested that the paper was amended to show this.

SA agreed that an exit strategy and evaluation of the work undertaken was important. PW agreed to amend the paper before it was presented to the Executive Committee for consideration and recirculate the updated paper to the Committee for information.

ACTION: Updated Community Pharmacy Engagement paper to be recirculated to the Committee for information.

Outcome: The Committee APPROVED the Community Pharmacy Engagement proposal.

11. Primary Care Performance Reporting update

WG advised that work was continuing on a national dashboard for primary care services and that ICBs had been given opportunity to feedback the proposed dashboard. It was expected that changes would be made to the national dashboard and a timeline for publication was awaited. While national work was taking place, the Primary Care team were working with the Business Intelligence (BI) team to collate a number of key metrics for local reporting. A draft Primary Care Performance dashboard would be presented to a future meeting.

ACTION: Draft Primary Care Performance dashboard to be presented to future meeting.

Outcome: The Committee NOTED the Primary Care Performance Reporting update.

12. Primary Care Risks

WG presented an overview of the primary care risks included on the ICB's risk register and Board Assurance Framework. There were currently 54 risks on the ICB Risk Register, 10 of which were relevant to the work of the Committee. There was 1 red rated risk related to Primary Care Demand and Capacity and Prescribing Costs and 9 amber rated risks.

WG was working with risk owners to review the risk ratings to see whether the actions to mitigate the risks had any impact on the ratings, particularly those that were long standing. It was expected that the next risk report would see risk ratings reduce.

JS queried whether the lack of national Freedom To Speak Up (FTSU)/whistleblowing guidance in relation to Primary Care should be added to risk register as ICB's role still unclear. WG agreed as had been approached by many practices on FTSU but still not aware what role was and would discuss with the Governance Lead. AD commented that FTSU guidance was needed as a priority in order to appropriately support the FTSU Guardian role.

Outcome: The Committee NOTED the Primary Care risk update.

13. Primary Care Quality Updates

The ICB Quality Committee was responsible for oversight of Primary Care quality issues and received a report on a quarterly basis. The Primary Care Quality Committee paper was provided to the Committee for information.

There were no questions.

Outcome: The Committee NOTED the Primary Care Quality Updates.

14. Minutes of the Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group meeting held on 5 June 2024 and 3 July 2024 were received.

Outcome: The Committee NOTED the minutes of the Dental Commissioning and Transformation Group.

15. Items to Escalate

There were no items to escalate to Board or other Committees.

16. Any Other Business

Following the presentation on the Care Home Dental Pilot, JH queried how the level of concern around widespread neglect of oral health and care in care homes could be most appropriately raised.

VK advised that the ICB was not responsible for commissioning care homes, therefore the concerns would have to be redirected to the local authorities safeguarding teams. VK agreed to discuss with the dental team a suitable approach to raising the concerns.

SA highlighted the purpose of the pilot was to address poor oral health in care homes. SA requested that VK feedback to the Committee on her contact with the local authority safeguarding teams regarding oral health concerns in care homes.

JS added there was work that could be done to bring together information sources regarding primary care that could highlight care home concerns. However, there would also be other teams within ICB and ICS who could inform the paper. SA requested that

information was collated and consideration was given around how to hand over to the responsible authority for appropriate action.

ACTION: VK to feedback to the Committee on her contact with the local authority safeguarding teams regarding oral health concerns in care homes. The Primary Care team to collate information provided on care home concerns and give consideration around how to hand over to the responsible authority for appropriate action.

ES stated it was important that care homes engaged with other primary care practitioners e.g. Optometry Services. It was noted that it was difficult for other services to access care homes.

This paragraph has been minuted confidentially.

MA raised a further AOB in relation to local authority commissioned services from Primary Care. JS agreed to speak to MA separately to mature the conversation and agree the appropriate forum for discussion.

17. Date of Next Meeting

9.30am-11.30am, Wednesday 11 September 2024
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 30 August 2024 at 10.00 am – 12.15 pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member & Chair of Committee, MSE ICB.
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex (from item 6), MSE ICB.
- Joanne Foley (JF), Patient Safety Partner, MSE ICB.
- Diane Sarkar (DS), Chief Nursing and Quality Officer, MSEFT.
- Ann Sheridan (AS), Executive Nurse, EPUT.
- Geraldine Rodgers (GR), Director of Nursing, Leadership and Quality, NHS England.
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company.

Attendees

- Claire Angell (CA), Deputy Director Children, Mental Health & Neurodiversity, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- Yvonne Anarfi (YA), Deputy Director of Nursing for Safeguarding, MSE ICB.
- Gemma Hickford (GH), LMNS Consultant Midwife, MSE ICB.
- Sara O'Connor (SOC), Senior Corporate Services Manager, MSE ICB.
- John Swanson (JS), Lead Nurse for Infection Prevention and Control, MSE ICB.
- Sarah Paxman (SPa), Maternity and Neonatal Independent Senior Advocate, MSE ICB.
- Christine Blanshard (CB), Chief Medical Officer, MSEFT.
- Sarra Bargent (SB), Deputy Director of Nursing, Suffolk and North East Essex ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Alison Clark, Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Victoria Kramer, Senior Nurse for Primary Care Quality, MSE ICB.
- Stephen Mayo, Director of Nursing for Patient Experience, MSE ICB.
- Dan Doherty, Alliance Director, Mid Essex, MSE ICB.
- Wendy Dodds, Healthwatch Southend.
- Gemma Stacey, Designated Clinical Officer for SEND, MSE ICB.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate.

2. Declarations of Interest

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

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 28 June 2024 were reviewed and approved, subject to Dr Sarah Crane's job title being amended to Associate Medical Director in the list of attendees.

NIB requested assurance on three risks, detailed below, that were not near the target rating. GT provided assurance that the three risks were not uncontrolled and an update as follows:

The provider mental health quality assurance risk could be reduced following the ongoing work with AS. Greater assurance was provided through weekly safety huddles, governance oversight and assurance meetings with mental health providers, mental health strategic implementation group and System Investment Group (SIG) that reviewed the pan Essex approach to mental health services.

Strong controls were in place for the Mental Capacity Act (MCA) risk and no issues had been identified with MCA compliance. The risk would be reviewed following the work completed by the Safeguarding Teams across the system.

The Autism Spectrum Disorder (ASD) risk was a national challenge, with significant capacity and demand challenges in the system. Strong commissioning arrangements were in place and the backlog was being reduced, although concerns continued to be raised by local authorities and MPs which were potentially were due to miscommunication. The programmes of work to support children and young people (CYP) and their families whilst waiting for assessment continued. NIB advised any change to the risk rating would require clear evidence and rationale. CA advised that the wording of the risk required review as it was misleading in assuming that because a child does not have a diagnosis their needs could not be met. Work was ongoing on the system response as there were groups of children that would have had their outcome impacted without diagnosis and treatment.

SP requested an update on the sodium valproate risk. PW advised that the risk was included within the patient safety workstream. GT advised that the medicine element would be specific to the medicine pathway and the sodium valproate in pregnancy would form part of the wider safety work in the system under the Local Maternity and Neonatal Safety (LMNS) Board. It would be multifunctional in terms of prescribing practice and education for those pregnant people with epilepsy who utilise appropriate medication. The governance route could come through LMNS but should link in with PW for medicine management.

SOC confirmed that risk leads were asked to provide a clear rationale if there was a change in the risk rating/score. The datix system would be able to provide improved reporting and further training was being provided to the datix administrators in September.

GT advised that there would be an expectation that the current risk rating would be less than the initial risk rating if appropriate controls were in place. The risk register required a full review, including looking at the effectiveness of controls. The Board had discussed dynamic risk assessments as part of the risk improvement programme, which would be a huge change in the direction of travel, and required time to be implemented across the system. SOC explained that when the risks were initially input onto the datix system, the risk ratings were reset as they were on 1 April 2024, so may not have changed much in that short period of time.

Resolved: The minutes of the Quality Committee meeting held on 28 June 2024 were approved.

Action: GT and SOC to review the full risk register, including multi-functional risks.

Action: CA to review wording of the ASD risk (Ref ID 5) to reflect that just because a child does not have a diagnosis, it does not mean their needs cannot not be met.

4. Action log

The action log was reviewed, and the following updates were noted.

Action 60: Initial discussions had been held with Emily Hough/Nicola Adams on the information required on delegation arrangements and an update would be provided at the next committee meeting.

Resolved: The Committee noted the Action Log.

5. Executive Chief Nurse Update

5.1 Safety Quality Group - Escalations

GT confirmed there were no escalations to raise from the Safety Quality Group.

5.2 Emerging Safety Concerns/National Update

GT advised that the completion of MCA, Court of Protection and Deprivation of Liberty (CoPDoL) safeguards within the ICB under All Age Continuing Care (AACC) was an emerging issue. Following a review, a report would be presented to Executive Committee, noting the significant financial legal costs. A safeguarding risk was being drafted and would be discussed at Executive Committee to determine how to bridge the gap. There would be people discharged, that required a DOLS assessment, which would not have been completed within the statutory timeframe.

Work was underway to consider a regional approach to AACC. Every integrated care system in the country recognised the challenge around capacity and demand in being able to deliver the service in a timely fashion.

There was a challenge with mental health (MH) inpatient beds across the system, with 16 people currently in the acute setting and several people in community awaiting inpatient

support. A roundtable discussion with local authority partners was being held relating to providing support for discharges under Section 117 arrangements.

There had been several recent serious incidents within the MH setting resulting in patient deaths which were under investigation.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

5.3 ICB Board/SOAC concerns and actions

The Board had requested further detail on the deficit and backlog position of AACC which would be addressed within the Finance and Performance report.

The National Oversight Framework, Level 4 (NOF4) meetings continued with regional colleagues.

Notification had been received by Care Quality Commission (CQC) to remove the Section 31 (S31) notice from Basildon Hospital maternity services, with no immediate safety concerns noted at the follow-up inspection.

DS advised that the S31 notice was still in place at Broomfield, however, following the reinspection the Trust was hoping to apply for the conditions of notice to be removed. The CQC inspection reports for Basildon, Southend and Broomfield sites were still awaited. A maternity improvement plan was in place, with a robust system for monitoring, checking the evidence and sign off following three months of sustained improved performance. The Maternity Assurance Committee gave greater oversight and scrutiny by Non-Executive Directors to ensure performance against the improvement plan and the maternity safety dashboard. The provision of maternity improvement support from the national team was ongoing and had been helpful to direct and support the Trust with a national benchmarking perspective to maintain a sustainable position. Lessons learnt were duplicated on all three sites and the Director and Head of Midwifery participated in the East of England maternity system meetings.

DS confirmed that the CQC had been regularly contacted to request the outstanding reports. The biggest challenges to sustainability were people, culture and operational capacity driven. A deep dive would be provided on the overarching maternity improvement plan.

GT confirmed that data within maternity services was produced on Statistical Process Control (SPC) charts within reports reviewed by several maternity groups and the LMNS Board to ensure that improvements were sustained over a period of time.

PW advised that discussions had been held relating to access to medicines for pregnant people booked into clinics, to improve integration between primary care prescribing and maternity. The maternity guidelines would be taken through MSE Medicine Optimisation Committee (MOC) in order to ensure that people had access to prescribed medications earlier in the process.

Outcome: The committee noted the verbal update on ICB Board/SOAC concerns.

Action: DS to provide a deep dive report on the overarching maternity services

improvement plan, including challenges and achievements, in place of LMNS Board update.

6. EPUT/Mental Health Update

AS reported that several serious incidents (SI) had occurred in the last four weeks, including two inpatient deaths. The first death appeared to be cardiac related but was to be confirmed. The second death related to a patient who was found unresponsive. The police were called, and subsequent investigations ruled out any suspicious circumstances, however the cause of death was to be confirmed. Support had been provided to the patients' families and staff involved.

AS summarised the SIs that had occurred recently and the learning and action that would be taken as a result of them.

There had been high acuity on wards, particularly in the Linden Centre, resulting in additional staff on site, including senior staff. A staff member had sustained a serious injury during an incident.

The challenges with patient flow continued. There were 52 out of area (OOA) placements. Several people were medically optimised and were waiting to be moved back into the community. Discussions were being held with regards to patient flow as the longer someone stayed in hospital there was potential for them to deteriorate, hindering their recovery.

The ratio of formal and informal complaints was 1:5 and the main theme was communication. Work was ongoing to review how people were communicated with.

The Lampard Inquiry opening statements would begin shortly and corporate disciplines had been identified on the website, along with several issues which would continue to be updated as the Inquiry progressed. EPUTs Project Team would be supporting staff members and families.

The importance of the Patient Safety Partners' role was highlighted, who had lived experience working with frontline staff, visiting services, and talking to patients. EPUT continued to work with system partners to ensure patients had a voice.

The Resilience Intelligence Strength and Excellence (RISE) programme and the Fundamentals of Care programme had been held which related to ensuring the gap analysis basics were right in terms of clinical practice and ensuring the clinical voice was at the centre of everything.

MS asked if there was any formal or informal support provided from medical services for those patients with non-mental health issues rather than hospital when under section. AS advised that some international nurses and others who worked on wards had received physical health training. Some people had a long history of mental illness where physical health had not been as prominent, so consideration was being given as to how physical health checks were completed. There was now greater visibility of physical health issues on wards and a physical health clinic was held on the Rochford site.

SP & NIB queried whether processes were in place to ensure sustainability of lessons learnt. GT advised that a risk summit was being held with all partners and the outcome

would be reported back to a future Quality Committee meeting to provide the level of detail requested.

NIB asked if an internal review or investigation had been completed. NIB noted there was often an element of staff fatigue, lack of training, staff changeover or staff capacity identified and should be included in the investigation report narrative where relevant. AS confirmed that at the point of scoping the investigation, there would be the opportunity to include the multiagency perspective. When someone was optimised within the acute hospital, they should be moved into a MH bed or discharged as quickly as possible. Anyone detained under the Mental Health Act would be under observation and processes would be reviewed as part of the investigation process.

Resolved: The Committee noted the EPUT Mental Health update report.

Action: AS to provide further information on the sustainability of lessons learnt for the mental health incidents following the risk summit.

7. Local Maternity and Neonatal System (LMNS) Update

GH advised that the report provided the perinatal mortality data, in particular safety and quality metrics considered by the LMNS and addressed action 52 on the committee action log.

Stillbirths had fallen nationally in 2022, but neonatal deaths increased. The neonatal figures could have been attributed to the more survival focused provisions of care for babies from 21-23 weeks. The perinatal mortality data for MSEFT reported that stillbirths and neonatal deaths were 5-15% lower than the group average.

The Trust performance dashboard for maternity services provided insight to several areas. There had been an increase in both metrics for 2023 which had raised concern for the Trust and the LMNS. A thematic review for stillbirths had been completed in 2022, led by Maternity Improvement Advisor from NHSE, LMNS lead and NHSE colleagues. The reduction in stillbirth rates was welcomed, which could partly be attributed to the actions completed from the review. A repeat thematic review was undertaken in July and it was anticipated that the improvements were sustained. The saving babies care bundle was being implemented, and was part of Clinical Negligence Scheme for Trusts (CNST), a program aimed at improving maternity care safety.

The recent Lucy Letby case had prompted a deep dive on neonatal deaths by the Trust and key themes associated with pre-term birth and ethnicity had been recognised. A report would be provided to the LMNS Board in September, focusing on the pre-term birth element and areas addressed to improve outcomes, such as the smoke free pathway. The implementation of nicotine replacement therapies and funding for midwife leads on each site to drive the programme forward resulted in positive progress. Consideration was also given to improve equity and equality on access to services and the ethnicity factors of those neonatal deaths. Broomfield's enhanced continuity of care team targeted services for groups of women from both global majorities and areas that were considered the most deprived, where outcomes are thought to be poorest. Work was ongoing in Thurrock to review the provision of focused support for families, particularly perinatal MH, and supporting families during and post pregnancy, such as feeding choices or antenatal education. There was good collaboration from the local authorities. Southend was working

on the implementation of different peer support programmes for perinatal MH and feeding, and how the ‘Better Start’ programme could be sustained.

The opportunities to implement continuity had been paused due to workforce challenges, however, these should be significantly reduced in September and would provide the opportunity to revisit and understand whether those targeted teams could be implemented and be more feasible and safe.

SPa provided an update on the Maternity and Neonatal Independent Senior Advocate (MNISA) pilot project. Working currently with four families and a total of seven referrals had been received since April. MSEFT and the Maternity and Neonatal Voices Partnership (MNVP) provided support to increase the number of referrals. The best way to connect with families was through contact with healthcare professionals already working with families.

The learning from cases was detailed in the report around the emerging issues and themes and the report also included quotes from women and parents which provided a valuable insight. The Safety Champions Forum and LMNS Safety Board received regular reports. The helpful and professional response from Trust staff was welcomed when resolutions were needed to be found for families. Cases were under investigation by the Trust either through the formal complaints route or investigation as part of the Patient Safety Incident Response Framework (PSIRF).

In response to a query from SP, GH advised that the summary of the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) UK data included all ICBs, however it was necessary to be mindful that the data was from 2022. With regard to achieving the previous figure, there were several cases where no direct care related issue was identified and the post mortem had not identified anything either, which hindered the ability to implement action to prevent a future occurrence. The quality of data needed to remain good to ensure learning was realised, but GH would be cautious to set a target that was not currently being achieved nationally.

SP asked how the good learning was communicated to families and parents to reduce that risk. SPa explained that working alongside the MNVP should increase the number of referrals and she would be attending their regular meetings with service user representatives to share learning. Regular reports would also be provided to Trusts to amplify the voices of families.

MS queried the definition of special cause variation. GH advised that MMBRACE data would only normally define a neonatal death after 24 weeks, however, it was a grey area, as babies that showed signs of life should be classed as a neonatal death. A greater number of women had been moved to a location where tertiary care could be provided which could have attributed to the low numbers. GT advised that special cause variation was a Statistical Process Chart (SPC) terminology based upon movement of data points and was an automated process.

NIB suggested referring patients who had experienced stillbirth and neonatal deaths to charities and organisations that specifically undertook research on lowering neonatal and stillbirth rates, as the sample size was small.

SP asked if the cessation of funding would cause a challenge for sustainability.
GH explained that the funding for Better Start had not yet ceased, and was national lottery

funded for a set period. Conversations were being held with the local authority and public health leads about the type of provision which could be made sustainable and long term. It was noted that the pilots provided the opportunity to test approaches rather than being built into a permanent long-term system and would be able to identify what had worked well and needed to continue as a definitive requirement. RJ advised that there was collaborative working on the 'A Better Start Southend' (ABSS) programme to understand sustainability of services and manage transition when the programme ended.

Resolved: The Committee noted the Local Maternity and Neonatal Safety Board Update report.

8. Safeguarding – Children and Young People Update

YA advised that the paper would be taken as read but she would highlight areas relating to the ICB's statutory responsibilities.

The government provided a statutory timeframe of 20 days to complete initial health assessments (IHAs) for any child taken from their parents and in the care of a local authority. The timeframes were currently not being met and was a local and national concern. Locally, funding was provided to one healthcare provider to clear the backlog, however due to the increase in the number of IHA requests during May and June, only 5% were completed during this period. Discussions were ongoing with partners. A response was awaited from region to the proposal for Advanced Nurse Practitioners to complete the IHAs following appropriate training and development., as this had been successful in other areas, GT advised that the capacity of paediatric colleagues was challenged in both acute and community settings. This issue had been escalated to national level, however, by law IHAs must be completed by a paediatric consultant. The Royal Colleges, including the Royal College for Paediatrics and Child Health and Royal College of Nursing, were supportive of other appropriately qualified professionals completing IHAs. The ongoing issue would be raised again at Regional Quality Group, however, unless legislation changed, ultimately place children at risk.

NIB asked this issue was highlighted to the Board.

YA advised that concerns regarding the Sexual Assault Referral Centre (SARC) capacity continued. However, a meeting took place with NHS England and concerns had also been highlighted to the CQC, via the regional team who are taking the lead on managing this with the police.

The Child Protection Information Service (CP-IS) was progressing. The MSEICB Executive Chief Nursing Officer was the senior responsible officer to ensure roll out of CP-IS with the local authorities and health providers. The system would highlight if a child had a child protection plan or was a looked after child so any health or social care services coming into contact with the young person would know immediately and should inform the way assessments were completed.

Notification of a joint targeted inspection with Ofsted, CQC, Probation Service and police and Fire Services, had been received to occur between November 2024 and December 2025 and would be focused on domestic abuse. In preparation, a multiagency audit was conducted in the Mid Essex area. Several areas for improvement were highlighted and detailed in the report, including the limited focus on the role of fathers.

YA provided an update from the Safeguarding Children Board / Partnerships for Southend, Essex and Thurrock as detailed in the report.

MS asked if the Shared Care Record (SCR) had the ability to support the sharing of information across the system, particularly with respect to safeguarding, as primary care had advised that it would be beneficial. YA agreed and highlighted that the accessibility of health records would need to be considered, particularly when a child reached the age of 17/18 and attained the right to challenge what information was shared. Children in need or with Special Educational Needs and Disabilities (SEND) would not be on the CP-IS flagging system. NIB suggested that it could be beneficial for these limitations to be highlighted to the Digital Team. GT advised that the information governance team and Caldicott Guardians would be heavily involved to ensure that any data sharing would meet Caldicott principles. The same issue would also apply to the Electronic Patient Record and Shared Care Record.

GT advised that the quality report to Board would include an update on IHAs to highlight the clear and emerging risk to the system.

In response to a query from SP, YA advised that it was difficult to confirm the numbers of cases of concern in relation to SARC, but primary care GPs were extremely concerned with the new contract and pathway as currently GPs could not refer directly into SARC, as referrals were made through social care and police. However, the data would be collected from telephone calls to GPs in MSE and escalated if required. GT advised that data for the system would be picked up offline in terms of where the data needed to go for wider partnership.

Resolved: The Committee noted the Safeguarding – Children and Young People Update report.

9. Neurodiversity (ASD/ADHD) Update

CA took the report as read and highlighted the following points.

Following the neurodiversity demand and capacity review, six recommendations were presented to committee earlier this year.

The development of new partnership models of delivery sat within the system programme of work and the health education system. Neurodiversity was a challenge for other local ICBs and regionally, due to the rise in requests for ‘right to choose’ assessments. MSEICB would be required to meet their responsibilities as a commissioning body, but recognised that other workstreams were in place across the region.

CA advised she was currently working with the ICB MH team to recruit into a neurodiversity post to drive forward programmes of work, such as setting a quality benchmark for assessment experience for children, young people and adults and ensuring clarity of expectation across the NHS and independent providers landscape about how and when children should be seen, and what would be expected as part of the treatment. The patient carer forums were keen to improve communication with families and stakeholders, in particular to ensure that children at risk of not receiving help, were seen in a timely manner to prevent any disruption to their education or care.

With regards to the national strategic prioritisation programme, work was ongoing with

regional leads with two workstreams, ADHD pathways and the provision of better information to GPs on right to choose.

With regards to the right to choose recommendation, the conflict of utilising the independent sector needed to be managed appropriately. There were challenges with consultant paediatrics and capacity within the clinical sector, and how could that be managed against the commercial interests of those organisations that were seeking to make a profit. The expectations across the system needed better management, only those at real risk should be prioritised for assessment, but required greater partnership working.

An MSEICB SEND dashboard was being populated and would allow activity to be reviewed and analysed which would then feed into a pan Essex dashboard which should be ready to launch in September.

Engagement was occurring with colleagues at Southend and Thurrock regarding the ICB led system oversight and redesign of models of support.

With regards to a recommendation regarding support in education models, children would need to be identified and their needs accommodated to maintain their access to school and improve their wellbeing. It was a complex piece of work and there were financial and quality risks, but assurance had been provided by the level of partnership working for those risks to be addressed.

NIB noted there were recurring themes with this and the safeguarding update, so colleagues should not lose sight of that link.

MS commented that ethical dilemmas were arising in other areas, such as Foetal Alcohol Syndrome Disorder discussed at the Clinical and Multi-professional Congress recently. The difference with ADHD was that medications were available. CA advised that in recent years the focus was on addressing the Referral to Treatment (RTT) waits, with an additional level of funding nationally towards improvement, although not much difference had been made due to the significant increase in demand. A level of funding should be provided towards early intervention and prevention of escalation because regardless of diagnosis, a patient's needs could be met.

Resolved: The Committee noted the Neurodiversity (ASD/ADHD) Update report.

10. Infection Prevention and Control (IPC) Update

JS took the report as read and highlighted the following key points.

There had been improvement in the bacteraemia rates across MSE in the last quarter. Discussions were ongoing with NHSE and the 'making data count' team to review how data could be demonstrated more effectively with SPC charts. The Cdiff numbers had decreased slightly compared to the same time last year. The annual thresholds for Cdiff were much more lenient than previously as they were based on 2023/2024 data rather than 2019 data.

There had been an outbreak of Group G Strep affecting community tissue viability services through EPUT, which were currently on a surveillance period of 6 months. No further cases had been reported. There was a peak of norovirus in Quarter 1 in MSEFT and a substantial amount of bed days were lost due to ward and bed closures.

The IPC team had continued to provide support to primary care colleagues with IPC audit. Education and engagement had improved and was a positive process to support improving how patients received care and ensured that regardless of where care was delivered, the same level of environment and infection prevention was provided as expected in an acute trust.

There had been a period of increased incidence of Enterobacter colonisation affecting the neonatal unit at Southend, which had been identified through routine screening. Currently 11 babies identified with colonised Enterobacter and typing results were awaited to ascertain whether this was identical strains or strains of concern. There had been no confirmed cases of active infection or babies becoming unwell to date. A quality assurance visit would be undertaken by the ICB to identify if anything could have been done differently and to ensure that learning from the MRSA outbreak was embedded and sustained.

Resolved: The Committee noted the Infection Prevention and Control Update report.

11. Patient Safety & Quality Risks

SO took the report as read and advised that lots of work was ongoing relating to the risk management module on datix, such as new risk hierarchy and arrangements for reporting.

Resolved: The Committee noted the patient safety and quality risk report.

12. Nursing and Quality Policies and Procedures:

12.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the revised Serious Incidents Policy (Ref 067) and the new Safeguarding Case Reviews Procedure.

YA advised that the Safeguarding Case Reviews Procedure was a new procedure for the ICB and related to case reviews of domestic abuse, domestic homicide and child and adult safeguarding. The procedure would improve the way the ICB contributed and participated in case reviews across the system.

Resolved: The committee approved the following revised documents:

- **067 Serious Incidents Policy.**
- **Safeguarding Case Reviews Procedure.**

12.2 Extension of review dates of existing policies:

Committee members were asked to extend the review dates of the following policies:

- 066 Safeguarding Adults and Children at risk of Domestic Abuse (to 31 October 2024).
- 068 All Age Continuing Care Policy (to 31 October 2024).

Resolved: The committee agreed to extend the review dates of the above policies as detailed above.

12.3 Status of Policies within remit of Quality Committee

SOC presented the policy update paper highlighting that all policies within the remit of Quality Committee had been reviewed or that review dates had been extended where necessary.

The full schedule of policies had been shared with Executive Committee.

Resolved: The committee noted the update on the status of policies within the remit of Quality Committee.

13. Discussion, Escalations to ICB Board and agreement on next deep dive.

NIB asked members for any items of escalation to the Board, noting that the positives reported should also be highlighted.

No further comments were received.

14. Any Other Business

No items of other business were raised.

15. Date of Next Meeting

Friday, 25 October 2024 at 10.00 am to 1.00 pm via MS Teams.