

Title	NHS Suffolk and North-East Essex Integrated Care Board Meeting
Date	21 March 2023
Place	Elizabeth Frink room, Endeavour House, 8 Russell Road, Ipswich, IP1 2BX
Time	1400-1700 hrs

Members of the public are welcome to attend to observe the meeting and the meeting will also be 'live streamed'. (a link for the live streaming will be available on the ICB website).

Questions relating to agenda items can be submitted via the following means;

1. Please submit questions no later than 12 noon on the 16 March 2023, via email to jo.mael@suffolk.nhs.uk
2. During the live streaming when they will be collated and asked at the appropriate time on the agenda at the discretion of the Chair
3. For those attending in person at the appropriate time on the agenda at the discretion of the Chair.

The minutes of the meeting which will include answers to any questions submitted by the public will be published on the CCG website at a future date.

AGENDA

Time	No	Agenda item	Purpose	Lead
GENERAL BUSINESS				
1400	1	Notification of any questions from members of the public for response at the appropriate time on the agenda.	Note	Will Pope (Chair)
1402	2	Welcome and Introductions and apologies for absence	Note	Will Pope (Chair)
1404	3	Declarations of Interest <i>Declarations of interest made by members of the Integrated Care Board - Board declarations are listed in the Register of Interests which, along with the Hospitality and Gifts Register will be available on the ICB website.</i>		All
1406	4	Minutes of the previous ICB Board meeting held in public on 24 January 2023. <i>To approve as a correct record the minutes of the ICB Board meeting held in public on 24 January 2023.</i>	Approve	Will Pope (Chair)
1410	5	Matters arising from the ICB Board meeting of 24 January 2023 and review of outstanding actions. <i>To note and endorse how we have responded to the</i>	Note	Will Pope (Chair)

		<i>outstanding issues which arose at the last meeting.</i>		
1415	6	General update to include update on Industrial Action To receive an update from the ICB's Chief Executive and Director of People and Workforce.	Note	Ed Garratt/ Amanda Lyes (Chief Executive)
STRATEGY				
1420	7	West Suffolk NHS Foundation Trust – Maternity Service – Quality, Safety and Culture Improvements	Note	Justyna Skonieczny/ Susan Wilkinson Report No: ICB 23-17
1440	8	Suffolk and North-East Essex (SNEE) Alliances – focus on West Suffolk Alliance - Physical Activity Pathways and Health To receive and note a report from the West Suffolk Alliance Director	Note	Peter Wightman/ Warren Smyth Report No: ICB 23-18
1455	9	Suffolk and North-East Essex (SNEE) Joint Forward Plan To receive and note a report from the ICB's Director of Strategy and Transformation	Note	Richard Watson Report No: ICB 23-19
1510	10	Integrated Performance Report. To receive and note a report from the ICB's Director of Performance Improvement.	Note	Paul Gibara Report No: ICB 23-20
1520	11	Governance Updates for Delegation of Pharmacy, Optometry and Dental To receive and approve a report from the ICB's Ipswich and East Suffolk Alliance Director	Approve	Maddie Baker-Woods Report No: ICB 23-21
1530	12	Establishment of the Suffolk Mental Health Collaborative To receive and approve a report from the ICB's Director of Strategy and Transformation	Approve	Richard Watson/ Andy Vowles Report No: ICB 23-22
1540	13	Suffolk and North-East Essex Integrated Care Partnership Update To receive and note a report from the ICP Director	Note	Susannah Howard Report No: ICB 23-23
FINANCE, PERFORMANCE AND SCRUTINY				
1550	14	Suffolk and North-East Essex (SNEE) ICB Financial Planning To receive and note the following reports from the ICB's Director of Finance a) Finance Dashboard b) SNEE ICB Draft Financial Planning Update	Note	Howard Martin Report No: ICB 23-24
1600	15	Board Assurance Framework To review and approve the current Board Assurance	Approve	Amanda Lyes Report No:

GOVERNANCE AND CORPORATE BUSINESS

1610	16	Review of the ICB Constitution <i>To receive and note the ICB Constitution</i>	Note	Amanda Lyes Report No: ICB 23-26
1615	17	Review of ICB Board Sub-Committee Terms of Reference <i>To receive, review and approve current and revised sub-committee terms of reference.</i>	Review/ Approve	Amanda Lyes Report No: ICB 23-27
1620	18	Delegation of Direct Commissioning for Specialised Services <i>To receive and approve a report from the ICB's Director of Strategy and Transformation</i>	Approve	Richard Watson Report No: ICB 23-28
1630	19	Committee Minutes and Highlight Reports <i>To receive and note minutes and highlight reports from the following ICB Sub Committees:</i> a) Audit Committee <i>The unconfirmed minutes of a meeting held on 16 February 2023</i> b) Remuneration and HR Committee <i>The unconfirmed minutes of a meeting held on 7 March 2023</i> c) Quality Committee <i>The minutes of a meeting held on 12 January 2023 and unconfirmed minutes of a meeting held on 9 March 2023.</i> d) Finance Committee <i>The minutes of meetings held on 17 January and 14 February 2023</i> e) People Committee <i>The minutes of a meeting held on 15 February 2023</i> f) People and Communities Committee <i>No report received</i> g) Estates Committee <i>Highlight report from January and February 2023 meetings</i> h) Strategic Digital Investment and Assurance Board <i>A summary of minutes of a meeting held on 3 February 2023</i>	Note	Amanda Lyes Report No: ICB 23-29
1640	20	Attendance Log <i>To note and review attendance at ICB Board meetings.</i>	Note/ Review	Will Pope (Chair)
1645	21	Any Other Business		All

1648	22	Date and Time of Next Meeting: <u>Scheduled Date:</u> 23 May 2023		
1650	23	Questions from the public – Maximum 10 minutes <i>Please note questions should relate to the items under discussion and must be a question rather than statement. Where individuals deviate from this requirement they will be asked to stop and will not be invited to take any further part in the meeting.</i>		

Exclusion of the Press and Public

The ICB Board is recommended to exclude representatives of the press, and other members of the public, from the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest; Section 1(2), Public Bodies (Admission to Meetings) Act 1960

Integrated Care Board - Board Members												
Title	First Name	Last Name	Declared Interest	Type of Interest			Direct or Indirect	Date of Interest		Date of Receipt	Action Taken to Mitigate	Consent to Publish
				Financial Interests	Non Financial Interests	Non Financial Interests		From	To			
VCSSE Sector Assembly	Kirsten	Alderson	SFC II commissioned by SCC and Health in Suffolk and frequently submits bids that have been competitively tendered.	✓			Direct		Ongoing	28/10/2022	To be declared when necessary	Yes
Interim Director of Finance	Chris	Armit	Nil							04/10/2022	To be declared when necessary	Yes
Primary Care Essex Partner	Freda	Bhatti	GP partner, Gt Bentley Surgery, Colchester, cC078PJ							04/10/2022	To be declared when necessary	Yes
			NEE LMC Member							04/10/2022	To be declared when necessary	Yes
			Spouse Consultant Gastroenterologist							21/02/2023	To be declared when necessary	Yes
Provider Partner - Community	Ewen	Cameron	Nil									
Non Executive - Finance and Audit	Steve	Clarke	Strategic Adviser to Liaison Group, which provides financial services, human resource management and clinical services to the NHS	✓			Direct	Apr-22	Ongoing	06/10/2022	To be declared when necessary	Yes
			Independent Board Director, University of Suffolk		✓		Direct	Aug-19	Ongoing	06/10/2022	To be declared when necessary	Yes
			Strategic Advisor, Royal College of Physicians		✓		Direct	Dec-21	Ongoing	06/10/2022	To be declared when necessary	Yes
			Trustee and Hon Treasurer, Dementia UK		✓		Direct	Jul-16	Ongoing	06/10/2022	To be declared when necessary	Yes
			Trustee and Hon Treasurer, Young Dementia UK		✓		Direct	Nov-20	Ongoing	06/10/2022	To be declared when necessary	Yes
Suffolk County Council Partner	Sue	Cook	Nil							19/10/2022	To be declared when necessary	Yes
Non Executive - People, Remuneration and Diversity	Tanya	Curry	CEO for the Motor Neurone Disease Association		✓		Direct	Jul-22	Ongoing	24/01/2023	No further action required	Yes
Chief Executive	Ed	Garatt	Visiting Professor of Integrated Care - University of Suffolk		✓		Direct	Apr-21	Ongoing	05/10/2022	To be declared when necessary	Yes
Non Executive - Quality and Safety	Steven	Feast	Honorary Professor, University of East Anglia	✓			Direct	Jun-19	Ongoing	04/10/2022	To be declared when necessary	Yes
			Mainly teaching on the MBA programme									
			Senior Advisor, Lexington Communications	✓			Direct	Feb-20	Ongoing	04/10/2022	To be declared when necessary	Yes
			Ad hoc advice for engaged clients in relation to government affairs									
			Ad hoc work for innovative UK, part of UKRI Assessing applicants for government funding				Direct	Jan-18	Ongoing	04/10/2022	To be declared when necessary	Yes
			Owner and director, Steve Feast Ltd, ad hoc coaching, mentoring and provision of strategic advice to clients	✓			Direct	Jan-18	Ongoing	04/10/2022	To be declared when necessary	Yes
Provider Partner - Acute	Nick	Hulme	CEO of East Suffolk and North Essex NHS Trust, an organization that could benefit from commissioning decisions	✓			Direct	Apr-13	Ongoing	05/10/2022	To be declared when necessary	Yes
Medical Director	Andrew	Kelso	Member Association of British Neurologists		✓		Direct	Jan-04	Ongoing	05/10/2022	To be declared when necessary	Yes
			Master, Essex Association of Change Ringers (Registered Charity No 292250)			✓	Direct	Jan-18	Ongoing	05/10/2022	No further action required	Yes
			Trustee, Music in Hospitals and Care (Registered Charity No 1051659)			✓	Direct	Jan-17	2020	05/10/2022	No further action required	Yes
			Consultant Neurologist at West Suffolk Hospital (holding clinics the first and third Wednesday morning of each month)		✓		Direct	Oct-22	Ongoing	05/10/2022	To be declared when necessary	Yes
Director of Finance	Howard	Martin	Nil							08/11/2022	To be declared when necessary	Yes
Acting Non-Executive Member	Pharuel	Mutumbut	Director for Ipswich and Suffolk Council for Racial Equality (SCRE)	✓			Direct	Aug-20	Ongoing	10/10/2022	To be declared when necessary	Yes
			Partnership project between SCRE and IESCCG/IES Alliance for support for the multicultural communities health and wellbeing programme									
			Chair IES Alliance Primary Care Commissioning Committee		✓		Direct	Dec-20	Ongoing	10/10/2022	To be declared when necessary	Yes
			Chair IES Alliance Executive Delivery Group		✓		Direct	Jul-22	Ongoing	10/10/2022	To be declared when necessary	Yes
			Finance Director for the Suffolk Law Centre	✓			Direct		Ongoing	10/10/2022	To be declared when necessary	Yes
			Trustee at Asset Education Trust		✓		Direct		Ongoing	10/10/2022	No further action required	Yes
			Trustee at Gecko Theatre		✓		Direct		Ongoing	10/10/2022	No further action required	Yes
Director of Nursing	Lisa	Nobes	Clinical visiting fellow at University of Suffolk	✓			Direct	2018	Ongoing	30/01/2023	To be declared when necessary	Yes
Chair	William	Pope	Professor at the University of Suffolk	✓	✓		Direct	Jan-20	2020	09/02/2023	To be declared when necessary	Yes
			Joint Chair SNEE Integrated Care Partnership Board				Direct	Jul-22	Ongoing	09/02/2023	To be declared when necessary	Yes
Primary Care Suffolk Partner	Nick	Rayner	Director of online pharmacy, L&R Pharma Ltd	✓			Direct	Apr-17	Ongoing	04/10/2022	To be declared when necessary	Yes
			GP Partner at Suffolk Primary Care	✓			Direct	Jan-13	Ongoing	04/10/2022	To be declared when necessary	Yes
			Non-exec Director, Suffolk GP Federation CIC Ltd							04/10/2022	To be declared when necessary	Yes
Provider Partner - MH	Siward	Richardson	Nil							04/10/2022	To be declared when necessary	Yes
Essex County Council Partner	Patrick	Warren-Hogg	Nil							04/10/2022	To be declared when necessary	Yes
Other Regular Attendees:												
Director Ipswich and East Suffolk Alliance	Maddie	Baker-Woods	Trustee of Suffolk ArtLink		✓		Direct	Mar-20	Ongoing	10/10/2022	Declaration when necessary	Yes
Director of Performance and Improvement	Paul	Gibara	Nil							12/10/2022	To be declared when necessary	Yes
Integrated Care Partnership Director	Suzannah	Howard	My daughter is an employee of Healthwatch Suffolk			✓	Indirect	Jan-20	Ongoing	06/01/2023	To be declared when necessary	Yes
			My daughter is an employee of Capsule Marketing Ltd who provide occasional services to the ICB and other health and care organizations			✓	Indirect	Jan-20	Ongoing	06/01/2023	To be declared when necessary	Yes
			My step-son is an employee of St Elizabeth Hospice			✓	Indirect	2007	Ongoing	06/01/2023	No further action required	Yes
			My step-daughter is a community nurse employed by Virgin in NEE			✓	Indirect	2021	Ongoing	06/01/2023	No further action required	Yes
			I am an advocate for people living with obesity and a member of the APPG and national strategic council for obesity		✓		Direct	Jan-14	Ongoing	06/01/2023	To be declared when necessary	Yes
			I am a director and shareholder of East Harbour Group Ltd, which supplies speciality chemicals to commercial end users and to the Ministry of Defence	✓			Direct	2017	Ongoing	06/01/2023	To be declared when necessary	Yes
			I am a director and shareholder in East Harbour Property Ltd which invests in commercial properties.	✓			Direct	2022	Ongoing	06/01/2023	To be declared when necessary	Yes
Director of People and Workforce	Amanda	Lyles	Director of Workforce & People for Suffolk & North East Essex ICB	✓			Direct		Ongoing	10/01/2023	No further action required	Yes
			Visiting Senior Fellow in Integrated Care, University of Suffolk		✓		Direct	Jan-23	Ongoing	10/01/2023	To be declared when necessary	Yes
ICP Chair Suffolk	Andrew	Reid	Nil							04/10/2022	To be declared when necessary	Yes
ICP Chair Essex	John	Spence	Chairman Spicer Haart Group Ltd (Estate Agency)	✓			Direct	2021	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Business Banking Resolution Service	✓			Direct	2021	Ongoing	19/10/2022	To be declared when necessary	Yes
			Chairman Cambridge Building Society	✓			Direct	2021	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member and Joint Chair Suffolk and North-East Integrated Care System (ICS)	✓			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member and Vice-Chair Mid- and South-Essex ICS	✓			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Herts and West Essex ICS	✓			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Chelmsford Business Improvement District Ltd	✓			Direct	Ongoing	Ongoing	19/10/2022	To be declared when necessary	Yes
			Membership or other Roles in Charities/Political Parties/Pressure Groups/Public Bodies/Trade Unions.				Direct	Jan-13	Ongoing	19/10/2022	To be declared when necessary	Yes
			•Church of England Archbishops Council - Finance Chairman (involves inter alia Church of England Central Services Ltd & numerous other CofE bodies)									
			•Essex Community Foundation - Life Vice President									
			•Chelmsford Constituency Conservative Association - Member									
			•Royal Zoological Society of Scotland - Fellow									
			•The J's Hospice - Honorary Patron									
			•Chelmsford Cathedral Council - Member									
			•Royal Society of Arts - Fellow									
			•Chartered Institute of Bankers (Scotland) - Fellow									
			•Conservative Councillors Association - Member									
			•Anglia Ruskin University Philanthropic Foundation - Member									
Director of Strategy and Transformation	Richard	Watson	Director of Strategy and Transformation for SNEE ICB	✓			Direct	Jul-22	Ongoing	10/01/2023	No further action required	Yes
			Husband is employee of Hadleigh Group Practice			✓	Direct	Oct-19	Ongoing	10/01/2023	To be declared when necessary	Yes
			Deputy Chief Executive SNEE ICB	✓			Direct	Jul-22	Ongoing	10/01/2023	No further action required	Yes
			Trustee Anglia Ruskin University Students Union			✓	Direct	Aug-22	Ongoing	10/01/2023	To be declared when necessary	Yes
			Senior Research Fellow for Integrated Care, University of Suffolk			✓	Direct	Jan-23	Ongoing	10/01/2023	To be declared when necessary	Yes
Director of West Suffolk Alliance	Peter	Wightman	Nil							18/10/2022	To be declared when necessary	Yes
Director of North East Essex Alliance	Laura	Taylor-Green	Brother-in-law works for SilverCloud UK LTD as a product manager			✓	Indirect	Ongoing	Ongoing	09/11/2022	No further action required	Yes
			Close friend is employed by Tiptree Medical Practice (part of COLT PCN)			✓	Indirect	Ongoing	Ongoing	09/11/2022	To be declared when necessary	Yes
			NEE Alliance director with role accountability to Tending District Council, Colchester Borough Council and Essex County Council			✓	Direct	Aug-22	Ongoing	09/11/2022	To be declared when necessary	Yes
			Mother is a healthwatch Essex ambassador and member of the West Mersea GP patient participation group			✓	Indirect	Nov-22	Ongoing	09/11/2022	To be declared when necessary	Yes

**Integrated Care Board meeting held on 24 January 2023 at St Edmundsbury Cathedral,
Angel Hill, Bury St Edmunds and live streamed for members of the public**

PRESENT:

Prof. Will Pope	Integrated Care Board (Chair)
Kirsten Alderson	Partner Member, Voluntary Community and Social Enterprise (VCSE)
Dr Freda Bhatti	Partner Member Primary Care Essex
Craig Black	Provider Partner Member – Acute
Sue Cook	Partner Member Suffolk County Council
Tanya Curry	Non-Executive, People, Remuneration and Diversity
Steve Feast	Non-Executive, Quality and Safety
Ed Garratt	ICB Chief Executive
Howard Martin	ICB Director of Finance
Nick Hulme	Provider Partner Member – Community
Dr Andrew Kelso	ICB Medical Director (Part)
Lisa Nobes	ICB Director of Nursing
Dr Nick Rayner	Partner Member Primary Care Suffolk
Patrick Warren-Higgs	Partner Member Essex County Council

REGULAR ATTENDEES:

Maddie Baker-Woods	Director Ipswich and East Suffolk Alliance (Part)
Susannah Howard	Integrated Care Partnership Director
Amanda Lyes	ICB Director of People and Workforce
Laura Taylor Green	Director North-East Essex Alliance
Richard Watson	ICB Director of Strategy and Transformation
Peter Wightman	Director West Suffolk Alliance

OBSERVERS:

Edward Creasy	Ipswich and East Suffolk Alliance Chair
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IN ATTENDANCE:

Ganesh Baliah	Chief AHP and system AHP Programme Director
Jo Mael	Corporate Governance Manager (Minutes)
Simon Morgan	Head of Communications

**23/001 NOTIFICATION OF ANY QUESTIONS FROM MEMBERS OF THE PUBLIC FOR
RESPONSE AT THE APPROPRIATE TIME ON THE AGENDA.**

No questions had been received prior to the meeting.

23/002 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and apologies for absence were received from:

Steve Clarke	Non-Executive, Finance and Audit
Stuart Richardson	Provider Partner Member - Mental Health

Other Regular Attendees:

Paul Gibara ICB Director of Performance and Improvement
Cllr Andrew Reid Integrated Care Partnership Chair, Suffolk

Observers

Sam Glover Healthwatch, Essex
Andy Yacoub Healthwatch

23/003 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations were received.

23/004 MINUTES OF THE PREVIOUS ICB BOARD MEETING HELD IN PUBLIC ON 22 NOVEMBER 2022.

The ICB Board approved the minutes of its meeting held in public on 22 November 2022, **subject to** the first sentence in the second paragraph of Minute 22/069 being amended to read (It was highlighted that the Executive Committee had a role to 'execute strategy' as set by the Board to achieve best possible outcome) rather than 'set strategy' as had been written.

23/005 MATTERS ARISING FROM THE ICB BOARD MEETING OF 22 NOVEMBER 2022 AND REVIEW OF OUTSTANDING ACTIONS.

There were no matters arising and the action log was reviewed and updated.

23/006 GENERAL UPDATE

The ICB Chief Executive paid tribute to Dame Clare Marx who had sadly passed away in November 2022. She had been a great leader and would be a considerable loss to the NHS both at a national and local level. She had been the first female President of the Royal College of Surgeons and the first female Chair of the General Medical Council. A remembrance service had been held at ESNEFT last week. When she had stepped down from her role at the General Medical Council, Dame Clare Marx had written an open letter to all doctors that the ICB's Chief Executive proceeded to read out to the Board.

The ICB Chief Executive also reported;

That the major increase in December of demand on urgent and emergency care services was largely a result of Strep A, Covid and flu. In addition, there had been industrial action in January, which had been approached in a well-planned and collaborative way by the System. There was additional funding support of £200m in respect of discharge.

As Chair of Suffolk Primary Care (SPC), Dr Nick Rayner was congratulated on SPC recently being awarded a 'Good' overall rating by the Care Quality Commission with an 'Outstanding' rating in respect of leadership.

As had been carried out in Gloucestershire, the Suffolk and North-East Essex Integrated Care System had recently set up recruitment fairs to attract potential care support workers. As a result of those fairs, 179 individuals had received offers of employment.

Two 'Steam Cafes' had recently opened in Suffolk. The Cafes sought to provide access support to mental health crisis and community services.

Having questioned staff morale in light of current system pressures, the Board was informed that whilst the current situation was challenging and there was unrest in respect of pay,

individuals continued to work hard and there was a lot of collaboration which was resulting in the identification of new ideas that could be moved forward.

The Board noted the update.

23/007 PATIENT EXPERIENCE

The Integrated Care Partnership Director introduced the next two agenda items that were related to development of the Integrated Care Strategy.

The first item was a short film which identified key messages that had been highlighted from engagement with the local population in respect of the Integrated Care Strategy. The Board was being asked to formally receive the Strategy following its approval by the Integrated Care Partnership on 13 January 2023.

The film included a number of clips recorded from a 'pop up' video booth that had been set in 16 locations across Suffolk and North-East Essex. The booth had captured 300 clips where people had used the opportunity to share their thoughts of what was important to them and how the integrated care system might think differently going forward.

23/008 SUFFOLK AND NORTH-EAST ESSEX INTEGRATED CARE STRATEGY

A key role for the Integrated Care Partnership (ICP) was to develop a single Integrated Care Strategy that set the direction of the system across the whole ICS footprint, setting out how commissioners in both the NHS and local authorities, working with providers and other partners, could deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. National statutory guidance on the development of Integrated Care Strategies was published by the Department of Health and Social Care in late July 2022.

Under the Health and Care Act 2022, the Integrated Care Partnership (ICP) must give a copy of the integrated care strategy to each responsible local authority and the integrated care board and must publish the integrated care strategy. The Integrated Care Partnership must ensure that the strategy was readily available to people throughout the integrated care system through routes that were most meaningful to people, including those with accessibility needs and low levels of health and care literacy. It was important that the people, their communities, and organisations who had contributed to the strategy were able to see the impact of their contributions reflected in the strategy and, in turn, the effect of their contributions on the provision of services.

An initial Integrated Care Strategy for Suffolk and North-East Essex ICS was published on 31 December 2022 and submitted for approval by the Suffolk and North-East Essex ICP in January 2023. The report provided:

- a summary of the key messages from engagement with people living and working in Suffolk and North-East Essex, and;
- a summary of the Integrated Care Strategy was available at www.sneeics.org.uk.
- an overview of next steps for continued development of the Integrated Care Strategy

At its meeting on 13 January 2023, the Suffolk and North-East Essex ICP had approved the Suffolk and North-East Essex Integrated Care Strategy. Members of the NHS Integrated Care Board were therefore asked to:

- formally receive the Integrated Care Strategy from the ICP.
- note the requirement for the NHS Integrated Care Board alongside both Suffolk County Council and Essex County Council to have regard to the relevant integrated care strategy

- when exercising their functions, so far as relevant. That included commissioning functions, plans and strategies and working with system partners;
- continue to work with the ICP to ensure alignment between the Integrated Care Strategy and the NHS Integrated Care Board Joint Forward Plan (JFP) currently in development.
 - continue to contribute to the ongoing development and evolution of the Integrated Care Strategy.
 - note the key themes from our engagement with people living and working in Suffolk and North-East Essex that had informed the development of the Integrated Care Strategy.

Healthwatch in Suffolk and Essex were thanked for their support with engagement and communications which had resulted in approximately 600 people having put forward their views as part of the engagement. Key issues highlighted had been access to local services and GPs; access to urgent and emergency care; waiting times for diagnosis and treatment and its impact; the requirement for joined up care and inclusivity.

The Board was informed of the intention to include a dashboard and further case studies to the Strategy going forward.

(Dr Andrew Kelso left the meeting)

The Chair advised that the next agenda item on the Joint Forward Plan would be received prior to seeking questions.

The Board received and noted the report and Strategy and, whilst understanding the need to show the difference of the mechanics of delivery which included prioritisation as part of work associated with the Joint Forward Plan, **broadly supported overall** the report and recommendations as set out above.

23/009 SNEE JOINT FORWARD PLAN (JFP) UPDATE

The report provided an update on the development of the Joint Forward Plan (JFP) from 2023 to 2028 for SNEE ICB.

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP described how SNEE ICB and its partner trusts intended to arrange and provide NHS services to meet its population's physical and mental health needs. That included consideration for the delivery of universal NHS commitments and addressing the ICSs' four core purposes.

The JFP sets out key ambitions for the ICB over the period 2023 to 2028. JFPs must be reviewed and updated or confirmed annually before the start of each financial year. NHSE shared guidance on the development of JFPs with ICBs on 24 December 2022.

The report went on to provide an overview of the JFP and key activities; patient and public involvement; and to outline next steps which included;

- NHSE expected ICBs to have commenced the process of consulting on a draft of their plans. A first draft of the JFP should be prepared by 31 March 2023.
- Consultation on further iterations would continue from April to June 2023, prior to the plan being finalised in time for publication by 30 June 2023.
- The JFP development team at SNEE ICB had previously anticipated a final deadline of 31 March 2023 for completion of the document. Therefore, key timelines for the SNEE ICB JFP were proposed to finalise the JFP for approval at the March ICB Board.

(Dr Andrew Kelso returned to the meeting)

Comments and discussion included:

There should be an aim for the reduction of health inequalities and inclusion and diversity to be common themes throughout both the Integrated Care Strategy and Joint Forward Plan.

The ICB's Patient Engagement and Communications teams were thanked for their work regarding engagement and involvement, and in seeking identification of the number one priority for each participating individual. The aim was to use the feedback to set out 10 areas of focus for the ICB. Further face to face events were planned and would be publicised on the website and feedback was being sought from Alliance forums. Further report would be made to the Board in March 2023.

The work to date was commended and the importance of framing the work recognised. It was questioned what made the ICB different and what would make people wish to live within Suffolk and North-East Essex (SNEE). There should be ambition to make SNEE the place that people wished to live.

It was queried how the work would feed down into the ICB's sub-committees and, given workforce challenges, when would discussions with regard to what could not get done take place? How would discussion by the Board be facilitated?

It was explained that 8-10 key commitments framed by the general public feedback would be identified and the Board could be asked to focus on 1-2 of those at each development session or Board meeting. It was agreed that initially a conversation take place at the Board Development Session scheduled to take place on 21 February 2023 as to how the Integrated Care Strategy might be linked to the Joint Forward Plan to confirm commitments.

There was concern, when setting high standards, as to how the expectation of the workforce might be managed when they were struggling day to day with capacity and demand.

The overall principles were to protect and enable good health.

The Partner Member for Essex County Council queried whether the documents related to NHS services or SNEE as a whole and the need for focus to be on delivery was emphasized. As enablers were digital and workforce it was questioned how that would be done across the three Alliances. With regard to the Health and Wellbeing Board there was likely to be a requirement for consistency across Essex. Thought was required as to how to bring the Strategy alive for members of the public and there was a need to review the language with regard to inclusivity.

In response it was reported that the Joint Forward Plan was the ICB's response to specific requirements and it sat alongside local authority plans. With regard to delivery **the ICB's Director of Strategy and Workforce agreed** to discuss the matter further with the Partner Member for Essex County Council outside of the meeting. There was a recognised need for sections on digital and workforce to be linked into neighbouring ICBs and discussions had already taken place to ensure an aligned response. Delivery plans would be important in bringing the plans alive for the local population and language within the document would be reviewed. Three Integrated Care Partnership (ICP) Strategies were to be presented to the Essex Health and Wellbeing Board next week.

It was felt that the Strategy was good and should connect people across the organisations by facilitating decision making. There was a risk that the Strategy was so broad there was no clarity which could cause morale difficulties in trying to do everything without the available resources. The Strategy should facilitate decision making with regard to what could not be done as currently there was inconsistency with regard to financial and workforce resource.

There was a need to identify actions that could be taken forward within practicalities and to consider how the Strategy and Plan might interact with the devolution process.

The Board received and noted the update.

23/010 INTEGRATED CARE BOARD (ICB) REPORT AND SYSTEM OVERSIGHT FRAMEWORK (SOF) PERFORMANCE INDICATORS AND WINTER PRESSURES

The report provided information on:

- Performance priorities as identified in the recently published operational guidance.
- Development of infographics to support the identified priorities.
- A focus on current performance and system pressures relating to urgent care.
- A summary of the System Oversight Assurance Committee in December 2022.
- A summary of System Oversight Key performance indicators.

Key points highlighted included;

At quarter three System performance was not where we would want it to be and there was a need to reset the approach going into quarter four. A joined up approach with regard to pre-hospital services was required which should include support for patients within the ambulance stack, and within the community. A team had visited Leicester to review its hub model. There was increased focus on safety and greater collaboration, as seen during the pandemic, in respect of the recent industrial action.

The national Emergency Care Improvement Support Team (ECIST) had been engaged to bring new ideas to improve Urgent Care performance, and this was being taken forward by Dr Andrew Kelso.

Comments included;

With regard to urgent and emergency care it was suggested there was a need to change the narrative away from chasing performance numbers to improving patient safety and quality. There should be emphasis on 'reason to reside' rather than 'right to reside'. Patients' health can deteriorate in hospitals and so we need to support people more in the community through greater integration of services. The workforce needed to come together.

The Board noted the report and need for cultural change and importance of system working embedded in ambition of Strategy discussion.

23/011 SUPPORT AVAILABLE TO CHILDREN AND YOUNG PEOPLE (CYP) PRESENTING IN CRISIS IN SUFFOLK AND NORTH-EAST ESSEX (SNEE).

The Board was in receipt of a report which provided an update on the current position of CYP presenting in mental health crisis within SNEE and the impact of the new approaches and services commissioned in the last 12 months.

Key points highlighted included;

In December 2021 there had been 13 children and young people waiting for Tier 4 beds. The number of beds available had been decreased due to range of reasons and there were increased numbers of children and young people reporting to Accident and Emergency services in need which had created anxiety within the system. As a result, a crisis protocol had been developed with agreed principles for working together. Use of the protocol and seen a decrease of numbers, improved care from hospitals and improvements re inreach and peripatetic offers. Length of stays had also been decreased.

There was a senior nurse within each hospital to support the workforce with regards to childrens mental health and the mental health Trusts had led on training and development.

There was now an aim to introduce more early intervention services to prevent children and young people getting into crisis. At present there was approximately 48% coverage of mental health support within schools, and it was recognised that the voluntary care and social enterprise sector could provide greater support. There was an aim to join up the work through peripatetic collaboratives.

The Board was informed that there was now a flexible resource that provided a good example of personalised care in an integrated way across system partners. Challenges remained for some such as those with autism and it was recognised that more work was required in that area.

Places of safety were also an area of focus, and it was hoped that the launch of 'Steam Cafes' would provide opportunity to progress that work.

Support for families and carers was questioned together with transition into adult services and suicide prevention. It was explained that the peripatetic offer looked at families and carers, transition was key and suicide prevention was part of the work being carried out in conjunction with Public Health teams.

In North-East Essex there had been investment for mental health practitioner and counsellor posts which was very positive for local general practice.

The Board noted the report **and thanked** the team for the encouraging work in progress.

23/012 NEW SPECIAL EDUCATION NEEDS AND DISABILITY (SEND) INSPECTION FRAMEWORK

The Children and Families Act (2014) introduced the requirement for education, health and social care agencies to work together more closely than they had previously. That included integrated practices in identification and assessment of needs, and integrated planning to meet needs. It also included joint commissioning of services for children and young people with Special Educational Needs and/or Disabilities (SEND) and their families. Additionally, the Act extended the SEND system from birth to 25, giving children, young people and their parents, greater control and choice in decisions and ensuring needs were met.

The SEND Code of Practice was statutory guidance, which came into force in September 2014. It set out the duties, policies and procedures following on from legislation set out in the Children and Families Act (2014). That statutory guidance was produced by the Department for Education and the Department for Health and Social Care.

Ofsted and the Care Quality Commission had in November 2022 published details on how they would inspect services for children and young people with SEND in a local area. The new inspection framework came into force in January 2023.

Key issues were set out in Section 2 of the report.

The updated SEND inspection framework was open to public consultation from June to September 2022.

Having queried whether the report would be provider specific or include recommendations for the ICB Board, it was explained that the report would be for the System with specific matters for health to address.

The Board noted the report.

(The Chair advised that the update from Ipswich and East Suffolk Alliance associated to Agenda item 15 would be taken next to allow Maddie Baker-Woods, Ipswich and East Suffolk Alliance Director to depart for another meeting).

23/013 SUFFOLK AND NORTH-EAST ESSEX (SNEE) ALLIANCES – HIGHLIGHT REPORT – IPSWICH AND EAST SUFFOLK ALLIANCE

The Ipswich and East Suffolk Alliance Director reported that the Alliance had agreed its 10-point plan for the coming quarter.

Areas of focus included stabilising and improving operational resilience with focus on urgent and emergency care; focus on integrated neighbourhood plans; Integrated Care Partnership and identification of work to progress with the voluntary sector; work with colleagues across the System to look at forward strategy in respect of primary medical care; to receive safe accountability of pharmacy, dental and optometry commissioning; retain focus on the mental health commissioning model; ensure response as an Alliance to workforce and estates operational groups; to look forward with regard to financial strategy; to plan for 2023/24 within framework of ICS Strategy.

The importance of ensuring that the voluntary sector was treated as a partner within the Alliance was emphasized.

The Board received and noted the update.

(Maddie Baker-Woods left the meeting)

23/014 EMBEDDING ALLIED HEALTH PROFESSIONAL (AHP) LEADERSHIP ACROSS SUFFOLK AND NORTH-EAST ESSEX INTEGRATED CARE SYSTEM.

Ganesh Baliah was welcomed to the meeting and the ICB Board received a presentation with regard to embedding AHP leadership across the integrated care system.

The presentation included information on the diversity of AHP leadership; benchmarking information; key areas of focus; AHPs Councils purpose; areas to explore for AHP faculties; funding; and deliverables.

Comments included:

There were a rising number of AHPs within primary care together with physician associates and it was suggested that it would be beneficial to have a conversation with regard to leadership to assist recruitment and retention. **The Chief AHP and system AHP Programme Director agreed** to make contact with the Partner Member for Primary Care Suffolk outside of the meeting.

Mental Health services included a high number of AHPs and it was suggested there was a need to think innovatively with regard to directing referral pathways through community hubs, together with considering how the System might build on the dentistry social enterprise structure to seek how doors might be opened to treat patients in a different way.

The Board was informed there was close engagement with professional bodies and it was recognised that a lot of service users did not understand the various different roles.

If there was potential to use the AHP workforce to supplement alternative pathways there was a need to also consider the most appropriate social care workforce based on what made sense for the pathways.

The Board welcomed the presentation, **noted** the comments made **and requested** that the Executive Committee bring back to a future development session or Board meeting a proposal to further improve understanding and integration.

23/015 SNEE ORAL HEALTH AND DENTAL SERVICES COMMISSIONING PROPOSALS

SNEE ICB had been working with local providers, Public Health Suffolk and Public Health Essex and in partnership with the University of Suffolk, regional dentists, Health Education England, NHSE and our region's MPs over the past 12 months to develop solutions to the present oral health crisis in the short, medium and longer term.

As the current responsible commissioner, NHS England was providing funding to support:

- improvements in the oral health of the population.
- the development of dentistry service provider(s) in Suffolk and North-East Essex.
- the development of primary ophthalmic and pharmacy services in Suffolk and North-East Essex.

NHS England had delegated the funding to NHS Suffolk and North-East Essex ICB for distribution.

NHS Suffolk and North-East Essex ICB was required to issue funding grants to organisation(s) including but not limited to; Local Authorities (Public Health), Higher Education organisation(s), Community Interest Companies and Charitable organisation(s) by 31st March 2023 in line with the aims of the funding.

Proposed grants were detailed in Section 2 of the report.

Poor dental health was often linked to poverty. It was suggested that the voluntary sector could provide support with regard to products and educational material.

It was reported that the report was about issuing the grants and, as such, outlined broad areas of focus. A Dental Taskforce had been established.

The Chief Executive advised that a meeting would be set up with the Partner Member, Voluntary Community and Social Enterprise (VCSE) to explore opportunities within the voluntary sector.

The Board noted the agreement of the ICB Executive to the additional funding set out for oral health and dental services and commencement of the commissioning of services within Suffolk and North-East Essex.

23/016 SUFFOLK AND NORTH-EAST ESSEX (SNEE) ALLIANCES – HIGHLIGHT REPORTS

The Board was in receipt of highlight reports from the following Alliances:

- Ipswich and East Suffolk Alliance
- North-East Essex Alliance
- West Suffolk Alliance

Key points highlighted included:

Ipswich and East Suffolk Alliance – update received earlier on the agenda – see minute 23/013 above.

North-East Essex Alliance – the Alliance had appointed Cllr Mark Cory as its new Chair. The Alliance was reflecting on the way forward in light of the Essex Health and Wellbeing

Strategy, Public Health Strategy and ICP Strategy and Joint Forward Plan. The Alliance had secured support from the Local Government Association to facilitate workshops in Feb/March 2023 to focus on work to date and opportunities regarding an outcome based approach; organisation strategies and priorities; and new ways of working as a partnership.

West Suffolk Alliance – a key issue for the Alliance was primary care sustainability. It had received a paper on primary care estate which reported that West Suffolk currently had 75% of its recommended estate for general practice with significant growth expected over the next 16/17 years. Other areas of focus included workforce, prescribing levels and antibiotic use. Prescribing remained high and work had continued with practices to improve.

It was suggested that future reports might include common identified themes for discussion and support from the Board.

The Board noted the highlight reports.

23/017 INTEGRATED CARE ACADEMY ANNUAL REPORT

The Board was in receipt of a link via the agenda to the Integrated Care Academy Annual Report.

It was recognised that there was a need to ensure the Academy was aligned to priorities going forward.

The Board noted the report.

23/018 SUFFOLK AND NORTH-EAST ESSEX ICB FINANCE REPORT

The Board was in receipt of the ICB finance report for Month 8. Key points highlighted included;

- The year to date and forecast position remained on plan for break-even. The risk against delivery was assessed as low. The situation was reflected in other ICS NHS partners.
- Efficiency forecast was at £15.1m of the £17.3m target (87%). The under delivery remained manageable within the financial position
- The forecast was an underspend against of £1.1m against the annual limit.
- The forecast was for an overachievement; £149.1m vs a target of £148.3m (0.5%).
- It was anticipated that remaining reserves for inflationary pressures were sufficient to offset risks for the remainder of the financial year.
- Some neighbouring ICBs were under financial pressure and, as such, we should not take our position for granted. It was testament to the hard work that had taken place and was likely to attract a £5m capital bonus going into 2023/24.
- The financial position had been delivered through application of non-recurrent solutions and there was likely to be an underlying financial challenge going into 2023/24.
- 2023/24 planning was underway with guidance currently being worked through. The total allocation was likely to grow to over £2bn. As Covid-19 funding was now out of the system allocations were expected to cover inflation only and focus would return to productivity improvement.
- Adjustments were non-recurrent although SNEE was in a better position than most others and was well served by good relationships across the finance community in order to address challenges.
- A more detailed report on financial plans would be presented to the March 2023 meeting.

Comments included;

Having noted slippage on cost improvement programmes and queried what could be done to diminish the problem in future years, the Board was informed that would be worked through as part of the planning for next year.

The Interim Chair of the ICB's Finance Committee reported establishment of the Committee which had met twice. To date, it had defined its terms of reference and reviewed financial performance. It was clear that the meeting would be effective, honest and open. Whilst 2022/23 targets would be met, some had been affected by reducing balance book strength which put pressure on the 2023/24 process. Assurance was provided that the governance process was in place and working well.

It was highlighted that as over the last three years the System had received additional funding partners, it might have de-prioritised their responsibility with regard to financial restraint. There was a need to consider and review system wide waste reduction rather than on an individual organisation basis.

The Board was informed there was a willingness amongst Directors of Finance to develop a system approach and to challenge each other with regard to delivery of internal cost improvement plans. The Finance Improvement Group was tasked to hold to account and potentially take a role in respect of the financial evaluation of investments.

The Board noted the report and challenge in 23/24

23/019 BOARD ASSURANCE FRAMEWORK (BAF)

The Director of People and Workforce presented the most recent Board Assurance Framework (BAF).

Key issues were detailed within Section 2 of the report.

Further to discussions at the Audit Committee meetings in September and December, a number of issues were highlighted which included that wider system assurance was now necessary with regard to risks that impacted across both health and social care.

A process change had already been initiated with the risks for Referral to Treatment, Cancer Targets and A&E waiting times being addressed as system risks rather than separate provider risks in the current iteration of the BAF.

Further to discussion at the Board meeting on 22 November 2022, it was suggested that more generally risks should be presented in a strategic system wide context rather than with an operational focus and also reflect risks identified by the ICP. Also, arising from discussion at the November Board meeting, there was a takeaway for Partner Members to ensure that where appropriate, their own strategic risks were aligned with those of the ICB.

The format of the BAF document had been revised and was reliant upon Directors populating the document with relevant risks with those being regularly addressed at the Executive Committee.

As the Audit Committee regarded Board assurance as one of its most important functions the BAF would be the first substantive item on future agendas.

The Board was informed that, as a result of an offer by Internal Audit, it was intended there be a session on risk management at the April 2023 Board Development Session.

Although absent from today's meeting, the following questions had been posed by the Non-Executive for Finance and Audit:

Risk 8 and 9 re Norfolk and Suffolk NHS Foundation Trust (NSFT) – was there any update?
Risk 11 re cyber security – was there an impact from recruitment of a programme director?
Risk 25 re finance – was there an update?

In response it was noted that NSFT was currently considering the Care Quality Commission's draft report and the risk would be updated when wider intelligence was available. There was no ability to reduce the cyber security risk at present and work was underway to link up cyber security across the System. There had been a conscious effort to update the finance risk for the Board meeting, the Finance Committee had now been established which concluded one action.

The Audit Committee had been content with the version of the BAF and was pleased there was commitment to review. Auditors had highlighted that it contained a large number of risks whilst others contained a smaller number of more strategic risks.

The ICB Board accepted the Board Assurance Framework as presented as a 'working document' **and noted** that it was under continuous review and development.

23/020 REVIEW OF THE ICB CONSTITUTION

The Board endorsed the ICB Constitution at its inaugural meeting on 1 July 2022, the former Clinical Commissioning Groups (CCGs) having previously approved the document. That was in accordance with the Health and Care Act 2022 which stated that the CCGs must propose to NHS England the Constitution for the first Integrated Care Board (ICB) to be established for the ICB area of Suffolk and North-East Essex.

Prior to its approval, the Constitution, in line with NHS England guidance, was developed in consultation with system partners and key stakeholders.

Subsequent to initial approval and endorsement, the ICB Constitution was subject to a number of technical amendments mandated by NHS England with those being endorsed by the Board at its meeting in November 2022.

Now, some six months after establishment of the ICB, was an opportune moment for Board Members to review the Constitution and if appropriate, suggest any necessary amendments. Any such amendments would, however, be subject to approval by NHS England.

Also, in accordance with the initial approval and endorsement, the Constitution would be subject to a full review after one year, that being set for July 2023.

Board Members were invited to reflect on the document and feedback any comments to the ICB's Director of People and Workforce within two weeks prior to the Constitution being presented back to the Board in March 2023.

The Board noted and reviewed the ICB Constitution as presented.

23/021 DEVELOPING A HEALTH INEQUALITIES AND PREVENTION COMMITTEE

The report set out a proposal for a system-wide approach to addressing health inequalities across the Suffolk and North-East Essex (SNEE) Integrated Care System (ICS).

The report recommended the establishment of a Health Inequalities and Prevention Committee (HIPC) reporting into the Integrated Care Board (ICB) and set out the suggested remit, membership, and terms of reference of the committee for endorsement by the Board. It also recommended the establishment of an Operational Delivery Group, which would report to the HIPC and drive the agenda and programmes of work.

The report additionally sought to inform the Board of a proposal to establish a system-wide Integrated Care Partnership Equality and Prevention Sub-Committee (EPSC) reporting into the Integrated Care Partnership (ICP).

It was explained that nominations for membership would be followed up with partners.

Having queried whether there was opportunity for increased voluntary sector representation, and inclusion of representation in relation to the maternity equity plan, it was reported that there was a need to review the broader membership offline in order to ensure that the Committee served its purpose in an integrated system way but did not become too large.

The Board requested that, whilst carrying on in the meantime, the Executive Committee review the correct way forward regarding membership and return with a proposal for approval to the next meeting. A specific conversation with regard to voluntary sector membership would be facilitated.

The Board:

- 1) **supported** the establishment of a Health Inequalities and Prevention Committee (HIPC) which would report into the SNEE Integrated Care Board (ICB) **and endorsed** its proposed function and governance.
- 2) **supported** the establishment of an Operational Delivery Group, which would report to HIPC and drive the agenda and programmes of work.
- 3) **noted** the establishment of a system-wide Integrated Care Partnership (ICP) Equality and Prevention Sub-Committee (EPSC) which would report into the ICP Committee and act as an advisory group to the ICB HIPC.

23/022 POLICY ENDORSEMENT

Through the ICB Joint Staff Partnership Group, four key HR policies had been developed from legacy CCG policies. To date, new policies had been developed across the following subject areas:

- Change Management
- Grievance
- Absence
- Working in partnership with trade unions

Changes to the policies were detailed in Section 2 of the report.

The policies had been presented to the ICB's Remuneration and HR Committee via virtual (by email) meeting on 13 December 2022 and that Committee had approved the policies and recommended they be endorsed by the ICB Board, hence today's report.

It was suggested that attempt be made to align policies across the System where appropriate. It was explained that these were legacy policies but going forward it was recognised there was a need to better align policies and the **ICB's Director of People and Workforce agreed** to take the suggestion forward via the People Committee.

As recommended by the ICB's Remuneration and HR Committee the Board approved the above policies.

23/023 COMMITTEE MINUTES AND HIGHLIGHT REPORTS

The Board received and noted minutes and highlight reports from the following ICB Sub Committees:

- a) **Audit Committee**
The unconfirmed minutes of a meeting held on 15 December 2022
- b) **Remuneration and HR Committee**
Decision Notice from a virtual meeting held on 13 December 2022
- c) **Quality Committee**
The minutes of a meeting held on 10 November 2022.

The Committee Chair reported that, at the November meeting, there had been a real sense of moral injury to staff that were experiencing dealing with pressures of work and that leaders were asking for help from the ICB. The Quality Committee Chair advised that he had taken a commitment to pass the message on to the ICB Board.

- d) **Finance Committee**
No minutes to present this time.
- e) **People Committee**
No minutes to present – December meeting postponed
- f) **People and Communities Committee**
No report received.
- g) **Estates Committee**
Highlight report from November and December 2022 meetings.

It was reported that SNEE was one of 10 Systems working on an estates infrastructure pilot which was due to conclude at the end of March 2023.

- h) **Strategic Digital Investment and Assurance Board**
A summary of minutes of a meeting held 29 November 2022

23/024 ATTENDANCE LOG

The Board received and noted the current attendance log.

23/025 ANY OTHER BUSINESS

No items of other business were received.

23/026 DATE AND TIME OF NEXT MEETING

Scheduled Dates:

21 March 2023

23/027 QUESTIONS FROM THE PUBLIC – MAXIMUM 10 MINUTES

The following questions were received;

Question 1

The Health Overview and Scrutiny Committee had recently carried out a 'deep dive' into clinical strategy related to the ambulance service which it was felt had become the 'fall guy' for failures in other parts of the system. It was questioned whether the East of England Ambulance Service NHS Trust was to receive additional funding from the national allocation and how it might be used.

Response

The ICB Chief Executive reported that there were two £200m national pots of funding, one for discharge from hospital into the community for which SNEE's allocation was anticipated to be approximately £3.4m, and an additional £200m for additional capacity for the ambulance service. It was not yet known how much of that £200m would be allocated to the SNEE System. There was a need to resolve the best use of funding ie whether it was best to spend on the recruitment of more paramedics or on admission avoidance schemes to take pressure off the ambulance service. Notification of the final allocation was awaited and would be reported to the Health Overview and Scrutiny Committee when known.

Question 2

The Board was reminded that it had previously been asked why the NHS was not utilising developer contributions to support expansion of the Grove surgery in Felixstowe to meet the needs of the growing population. Several new housing developments were planned which could result in primary care experiencing a 130% increase in demand. There remained continuing concern that developer contributions were not being utilised to support the expansion of the Grove and Haven Health to meet the needs of the local population.

Response

The ICB's Chief Executive reported that the Ipswich and East Suffolk Alliance Director had left the meeting earlier to attend a meeting in Felixstowe to launch a review of demand and capacity within the town and surrounding area for conclusion in June 2023. The challenge for the ICB Board was how to respond in that respect across communities within SNEE within available resources. There was concern that use of developer contributions was not taking place and the **Chief Executive agreed** to identify any block in process and report to a future Board meeting.

Questions received during the live stream

The Board was informed that the following questions had been received via the live stream:

- 1) Will the ME Service work be eligible for full public consultation and possible referral to an Independent Reconfiguration Panel process?
- 2) Can the board please ensure in future, that all works towards reconfiguring of services and Joint Needs assessment work are done with full public patient involvement before works are made public? Some progress is being made on this, however, some aspects of the work, particularly in relation to SCC Public Health Management processes and public engagement have been problematic.

The Board agreed that a written response to these questions would be provided and appended to the minutes.

ICB BOARD
ACTION LOG: 24 January 2023 (updated)

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
Meeting of: 22 November 2022				
22/060	Digital Care Technology Services	The Board noted the report and was impressed with the work taking place. The Board welcomed the initiatives and the ICB's Medical Director was requested to explore how the work might be taken forward within the ICB prior to presenting a plan of action to a future Board meeting.	Andrew Kelso	30/12/22 - Andrew Kelso meeting with Sue Cook (Executive Director for People Services – SCC) and Patrick Warren Higgs (Director of ASC Essex Operations, Deputy to the DASS) on 30 th January to explore further.
22/066	Board Assurance Framework	Having queried local authority risks and how they might be reflected within the framework the Partner Members for both County Councils agreed to reflect on that issue and feed into future discussions.	Sue Cook/Patrick Warren-Higgs	Ongoing
22/076	Questions from Members of the Public	1) Question 1 re national contract to Palantir to handle patients' NHS data. The ICB Chief Executive advised that as the issue was related to a national contract there was a need to liaise with NHSE to obtain an appropriate response to the question.	Ed Garratt	The CEO had liaised with NHSE but there was no response at present.
Meeting of: 24 January 2023				
23/009	Joint Forward Plan Update	1) It was explained that 8-10 key commitments framed by the general public feedback would be identified and the Board could be asked to focus on 1-2 of those at each development session or Board meeting. It was agreed that initially a conversation take place at the Board Development Session scheduled to take place on 21 February 2023 as to how the Integrated Care Strategy might be linked to the Joint Forward Plan to confirm commitments. 2) In response it was reported that the Joint Forward Plan was the ICB's response to specific requirements and it sat alongside local	Richard Watson Richard Watson/ Patrick Warren-Higgs	For Board Development Session 21 February 2023

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
		authority plans. With regard to delivery the ICB's Director of Strategy and Workforce agreed to discuss the matter further with the Partner Member for Essex County Council outside of the meeting.		
23/014	Embedding Allied Health Professional (AHP) Leadership Across Suffolk and North-East Essex Integrated Care System.	<p>1) There were a rising number of AHPs within primary care together with physician associates and it was suggested that it would be beneficial to have a conversation with regard to leadership to assist recruitment and retention. The Chief AHP and system AHP Programme Director agreed to make contact with the Partner Member for Primary Care Suffolk outside of the meeting.</p> <p>2) The Board welcomed the presentation, noted the comments made and requested that the Executive Committee bring back to a future development session or Board meeting a proposal to further improve understanding and integration.</p>	<p>Ganesh Baliah/Dr Nick Rayner</p> <p>Executive Committee</p>	
23/015	SNEE Oral Health and Dental Services Commissioning Proposals	The Chief Executive advised that a meeting would be set up with the Partner Member, Voluntary Community and Social Enterprise (VCSE) to explore opportunities within the voluntary sector.	Ed Garratt/Kirsten Alderson	Lizzie Mapplebeck & Greg Brown will be taking this forward with Kirsten Alderson
23/020	Review of the ICB Constitution	Board Members were invited to reflect on the document and feedback any comments to the ICB's Director of People and Workforce within two weeks prior to the Constitution being presented back to the Board in March 2023.	All/Amanda Lyes	March 2023
23/021	Developing a Health Inequalities and Prevention Committee	The Board requested that, whilst carrying on in the meantime, the Executive Committee review the correct way forward regarding membership and return with a proposal for approval to the next meeting. A specific conversation with regard to voluntary sector membership would be facilitated.	Executive Committee	A meeting was held including the Director of Workforce & People, Director of Nursing, VCSE Board Member & Governance Advisor on 14 February to discuss membership of the committee. It is now proposed & agreed that the Director of Nursing will replace the Medical Director on the committee in order to ensure comprehensive maternity & LD&A representation. In addition, a further VCSE representative will be added to the membership & it has been suggested that in the first instance this should be Andrea Clarke, CEO of Ace Anglia. In summary, committee membership has only been increased by one & it is felt that the membership is now more representative.
23/022	Policy Endorsement	It was suggested that attempt be made to align policies across the System where appropriate. It was explained that these were legacy policies but going forward it was recognised there was a need	Amanda Lyes	

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
		to better align policies and the ICB's Director of People and Workforce agreed to take the suggestion forward via the People Committee.		
23/027	Public Questions	<p>1) <u>Felixstowe Demand</u></p> <p>There was concern that use of developer contributions was not taking place in Felixstowe primary care and the Chief Executive agreed to follow up on the issue.</p> <p>2) <u>The Board was informed that the following questions had been received via the live stream:</u></p> <ul style="list-style-type: none"> • Will the ME Service work be eligible for full public consultation and possible referral to an Independent Reconfiguration Panel process? • Can the board please ensure in future, that all works towards reconfiguring of services and Joint Needs assessment work are done with full public patient involvement before works are made public? Some progress is being made on this, however, some aspects of the work, particularly in relation to SCC Public Health Management processes and public engagement have been problematic.) <p>The Board agreed that a written response to these questions would be provided and appended to the minutes.</p>	<p>Ed Garratt</p> <p>Executive Committee</p>	<p>Maddie Baker-Woods visited Felixstowe on 1 Feb where the issue was to be discussed and more broadly included in the Forward Plan for Felixstowe assessment of demand and capacity.</p>

ICB BOARD

Agenda Item No.	07
Reference No.	ICB 23-17
Date.	21 March 2023

Title	West Suffolk NHS Foundation Trust – Maternity Service – Quality, Safety and Culture Improvements
Lead Director	Lisa Nobes, ICB Director of Nursing Karen Newbury, Head of Midwifery, West Suffolk NHS Foundation Trust
Author(s)	Justyna Skonieczny, West Suffolk NHS Foundation Trust Susan Wilkinson, West Suffolk NHS Foundation Trust
Purpose	To present information on the West Suffolk NHS Foundation Trust's Maternity Service.
Recommendation:	
To note the presentation.	

WSFT Maternity Service; Quality, safety and culture improvements



Background

- WSFT was placed on the Maternity Safety Support Programme (MSSP) following the CQC inspection in September 2019 and subsequent issue of a Section 29A warning in October 2019.
- June 2020 new Chief nurse for the Trust
- A Maternity Improvement Advisor (MIA) was allocated to WSFT in 21st Oct 2020 and worked closely with the maternity triumvirate, providing feedback to the executive, regional and national team.
- Additional support was gained from an independent midwifery advisor to primarily support the HOM and a project midwife, who had extensive knowledge and experience regarding Maternity Governance.
- An obstetric MIA visited the unit twice to guide the obstetric team.
- 2021 new Medical Director for the Trust & Clinical Director for the Division
- Following further CQC unannounced inspections in April 2021, the CQC revised the ratings for the WSFT in the Well-led domain from inadequate to requires improvement. All other domains reviewed remained the same, however the CQC reported they had seen evidence of progression, significant change and culture improvement. The triumvirate were aligned on the challenges of quality and sustainability within the service and had plans in place to address them.
- 10th November 2022 Professor Jacqueline Dunkley-Bent confirmed that the WSFT had formally exited the MSSP

Summary of Progress

The following bullet points summaries the achievements against various improvement notices to date:

- The CQC are assured that the concerns relating to the Section 29A warning were adequately addressed and are now 'business as usual'.
- The CQC visit in April 2021 reported they had seen evidence of progression, significant change, and culture improvement. A clear management and leadership structure were observed to be in place.
- All actions arising from both CQC inspections and other external visits have been captured on an overarching Quality and Safety Plan which is reviewed fortnightly by the Maternity Improvement Board to enable scrutiny and oversight of any incomplete actions.
- Implementation of Professional Midwifery Advocate (PMA) service to support staff to develop and provide constructive clinical supervision.
- A revised Maternity Risk and Governance Framework in place.
- Significant investment has been provided to the maternity service to address previous concerns and enable the service to progress with key elements in line with the NHS Long Term Plan.
- Triumvirate attend Trust Board Meetings to present maternity and neonatal papers.
- HSIB acknowledgement of transparency, robust report writing/investigations and learning from incidents.

The divisional team have the support of executive colleagues

Robust Safety Champion forum and roles; including Executive, NED, Midwifery, Obstetrician, Anaesthetic and Neonatal representation.

Structured oversight of the service from the LMNS is in place via the Strategic Group and Safety Forums.

Periodical attendance of the regional NHSE/I team, MVP and LMNS to our Maternity Improvement Board.

The Perinatal Surveillance Model is fully embedded to provide local and regional oversight of quality and any issues that require intervention or escalation.

Quarterly meeting with HSIB

Staff/ student/ service users feedback

Our success factors

- Fully engaged and supportive chief nurse and medical director
- Robust Mat/Neo Safety Champions (inc. NED)
- Direct access to the board
- Trust Board support
- Open and Transparent governance (including clear framework)
- Alignment of governance process with the overall Trust
- Adoption of a restorative Just Culture particularly in relation to learning from incidents
- Co-production with MVP
- Close work with FTSUG
- Listening to staff
- Embedded perinatal surveillance model
- Structured oversight of the service from the LMNS is in place via the Strategic Group and Safety Forums.
- Maternity Improvement Board.

AOB and Questions

ICB BOARD

Agenda Item No.	08
Reference No.	ICB 23-18a
Date.	21 March 2023

Title	Physical Activity Pathways and Health
Lead Director	Peter Wightman, West Suffolk Alliance Director
Author(s)	Peter Wightman, West Suffolk Alliance Director
Purpose	To present work being carried out in West Suffolk.
Recommendation:	
The ICB Board is asked to note the report.	

Physical Activity, Pathways and Health

A system approach – why it works. Philosophy and Business Model

Jill Korwin, Strategic Director West Suffolk Council

Warren Smyth, Chief Executive Abbeycroft Leisure



ACTIVE LIVING

SUPPORTING PEOPLE TO MOVE MORE

**To share
today**

- **Reinforce our shared commitment** to Empower people to live healthy and connected lives.
- **Reflect on the foundations** we have in place to create the system conditions for the West Suffolk approach
- **Showcase** what we have delivered
- **Explore future opportunities;** Hubs, Healthy Behaviours, pathways and funding

We know we need to get this right



Promoting Resilience

Being active

Being physically active can help to keep us safe from illness and disability, develop a sense of belonging when we are active alongside other people, and give us purpose through achieving our goals.

Physical activity is essential to human health. Not moving leads to damage from free radicals released by mitochondria in human cells. This causes premature aging and diseases such as cancer, heart disease, diabetes, dementia and depression. There is no medication or diet that will prevent this damage. There is a simple cure though – being more active!

[Building Resilience - Suffolk & North East Essex Integrated Care System \(sneecs.org.uk\)](http://sneecs.org.uk)

The West Suffolk Foundations

- **Strategic Alignment**

Ambition 1 - Strengthening the support for people to stay well and manage their wellbeing and health in their communities

- **People-** Integrated teams, pathways, collaboration, shared learning
- **Place** – Hubs



CAN DO HEALTH & CARE
Suffolk & North East Essex Integrated Care System

Our Collective Ambition is to enable the **'Best Health and Wellbeing'** to be a genuine reality for everyone living in Suffolk and North East Essex.

VISION
Inspiring Healthier Active Communities through Excellent Facilities and Services, Great Experiences and Strong Partnerships.

Resilient families and communities that are healthy and active.



Reflection: Experience from Covid

Breadth and Depth

Acute	Prevention	Infrastructure/Co-Location
Pulmonary Rehab Pathway	NHS Health Checks	Community Health Team
Frailty Pathway	Locality Based Physical Activity Pilot	Children's Centre
Cancer Rehabilitation	Mental Health Community Connector	Library
Exercise on Referral	Stand Tall Mental Health Programme	DWP/CAB
Care Home Support	Active Mums	Visiting Clinics
Waiting Well Pathway	Move More Outdoors Free Access to Exercise	MSK Physio
	Family Park Cooking	Community Midwifery Service
	Forest Schools	NHS Pulmonary Rehab Pathway
	Healthy Lifestyles Support	NHS Cardiac Rehab Pathway
	Free Access Pilots	Weight Management
		Children's Physio
		Fibromyalgia Integrated Pain Management
		Sexual Health Clinics

Showcase

- Stand Tall <https://youtu.be/5j3CJ8ixGFc>



STAND TALL

A free 8-week programme for 11-19 year olds designed to support health and wellbeing.

FIND OUT MORE



KEEP ACTIVE

We run weekly sessions to encourage physical activity for **over 55's**. All sessions include refreshments and a chance to socialise.

FIND OUT MORE



ACTIVE LIVING

Our accredited 'exercise on referral' programme for people living with long term health conditions.

FIND OUT MORE



ACTIVE MUMS

Antenatal care programme developed by midwives & health professionals, to support women to make healthy choices during pregnancy.

FIND OUT MORE



REDUCING ISOLATION

Sessions to help isolated people feel connected, dementia friendly for individuals & carers.

FIND OUT MORE

Evaluation of Abbeycroft Leisure's referral and exercise pathways 2021 to 2022

1924
people referred

Council's role

West Suffolk residents can take advantage of physical activity health pathways thanks to joined up working between health practitioners from West Suffolk NHS Foundation Trust, West Suffolk Council which owns five leisure centres and Abbeycroft Leisure, the not for profit social enterprise which delivers leisure activities on the council's behalf.

Cross working

Between West Suffolk NHS Foundation Trust, West Suffolk Council, Abbeycroft Leisure (ACL), residents.

Co-location

Health and leisure services are co-located at Brandon, Haverhill, Mildenhall and Newmarket Leisure Centres

What it's delivered

Social and wellbeing benefits

61% participants wellbeing score improved over **12 weeks**

Physical benefits

From 1695 MET* minutes to 2757

From 408 minutes sitting to 355

From low activity level to moderate at the end of 24 weeks

Strong participation

June 21 to Aug 22

85% successful



14% unable to attend for health or travel reason

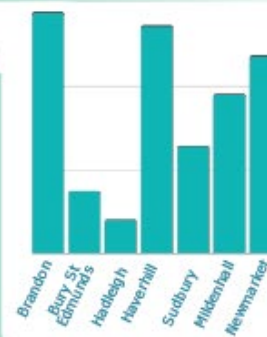
Promising level of continuing participation

Nearly a quarter who finished the ACL 24 week programme became members, and that doesn't include alternative activities



Effective exercise

Studies show that experienced supportive staff and peer support increase the effectiveness of exercise.



Shift from inactive to active

Age ranges

Age range of people referred to ACL (from April 2021 to September 2022) was

14-95

55% of all referrals were over the age of

60

15.9% of all referrals were over the age of

75

Reasons for participation

- Weight loss – most expressed motivation – but often second or third reason
- Breathlessness
- Improve mobility
- Osteoarthritis
- 12.4% of referrals for mental health, anxiety or depression

Activity choice

86.9%

of people who signed up to ACL started an activity. Most common activities that people attend were:

79 supervised gym session attendances



735 strength and balance class attendances

3291 unsupervised gym session attendances



624 breathe better class attendances

1808 swimming open session attendances



Social motivation



"Grateful to be using this service and am strongly contemplating becoming a member when I'm finished."

"The trainer had a very warm personality and I felt very well supported in setting goals to improve my mobility through exercise. I'm looking forward to starting my programme."

"I really enjoy doing the exercises. I never would have done this without the help of Active Living."

*Activity measured in metabolic equivalents (METs.) One MET is the energy it takes to sit quietly, on average about one calorie for every 2.2 pounds of body weight per hour.

Opportunities

Systems and Pathways

- Healthy Behaviours
- Value in investing in approach from multiple lenses - true system benefit
- Build on local model - and asset based approach
- Streamline commissioning and outcomes frameworks
- Standardise evaluation approach
- Maximising benefit of funding streams

Place

- Colocation - Creating a wider system benefit and offer

People

- Addressing multiple needs
- Developing an extended workforce model
- Improving wellbeing, connections, physical activity and health



ICB BOARD

Agenda Item No.	09
Reference No.	ICB 23-19
Date.	21 March 2023

Title	SNEE Joint Forward Plan Update
Lead Director	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Purpose	To provide an update on the development of the Joint Forward Plan (JFP) from 2023 to 2028 for SNEE ICB.
Recommendation:	
To continue at pace, progressing delivery of a robust five-year JFP for SNEE ICB and bringing back to final version for agreement to the May meeting of the ICB.	

1. Background

1.1 As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP describes how Suffolk and North East Essex Integrated Care Board (SNEE ICB) and its partner trusts intends to arrange and provide NHS services to meet its population's physical and mental health needs and how it will work with partners across the Integrated Care System to achieve this. This includes consideration for the delivery of universal NHS commitments and addressing the ICS's four core purposes.

1.2 Archus - a team of experts who provide strategic and infrastructure advice to health and social care organisations - has been supporting SNEE ICB since October 2022 in the preparation of its JFP which sets out key ambitions for the ICB over the period 2023 to 2028. National guidance states that JFPs must be reviewed and updated or confirmed annually before the start of each financial year. NHSE shared guidance on the development of JFPs with ICBs on 24 December 2022. Key components noted by the guidance for inclusion in the Plan are:

- Purpose of the JFP
- NHS mandate
- Alignment to the Integrated Care Strategy
- System capital plans
- Summary of views expressed by anyone the ICB/partner trusts have a duty to consult
- Describe the health services for which the ICB proposes to make arrangements
- Duty to promote integration
- Duty to have regard to wider effect of decisions
- Financial duties
- Implementing Joint Local Health and Wellbeing Strategies (JLHWSs)
- Duty to improve quality of services
- Duty to reduce inequalities
- Duty to promote patient involvement
- Duty to promote public involvement
- Duty to patient choice
- Duty to obtain appropriate advice
- Duty to promote innovation
- Duty in respect of research
- Duty to promote education and training
- Duty as to climate change
- Addressing the particular needs of Children and Young People (CYP)
- Addressing the particular needs of victims of abuse

The JFP that SNEE ICB is producing encompasses these areas as well as much of the additional content recommended by NHSE in its guidance. These supplementary items are noted below:

- Workforce
- Performance
- Digital/data
- Estates
- Procurement/supply chain
- Population Health Management (PHM)
- System development
- Supporting wider social and economic development

2. Overview of JFP and Key Activities

2.1 The JFP proposed vision is for everyone at all stages of their life to be able to **Live Well** across SNEE.

2.2 We have therefore adopted, organised ourselves and defined the outcomes we wish to achieve using the six domains of the Live Well model:

- **Start Well** – Giving children and young people the best start in life

- **Feel Well** – Supporting the mental wellbeing of our local population
- **Be Well** – Empowering adults to make healthy lifestyle choices
- **Age Well** – Supporting people to live safely and independently as they grow older
- **Stay Well** – Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives
- **Die Well** – Giving individuals nearing end of life choice around their care

2.3 Our six Live Well Domains and the outcomes there within are underpinned by a focus upon reducing health inequalities for our local population. To support our vision and achievement of our outcomes we are committed to collaborating with the people and communities of SNEE at every stage of our work, and this is a fundamental part of the successful delivery of the Plan.

2.4 The Live Well priorities have been developed by partners across a wide range of established arrangements and will contribute to the ICB’s delivery against the domains. Key components of each of the domains are shown below:

Table 1: Joint Forward Plan Live Well Domains

Start Well	Feel Well	Be Well	Stay Well	Age Well	Die Well
<ul style="list-style-type: none"> • Maternity & Neonatal Care • Children & Young People incl. CAMHS, Neuro Developmental, SEND, Community and LTCs 	<ul style="list-style-type: none"> • Mental Health & Wellbeing • Suicide Prevention • Addictions • Trauma and Abuse 	<ul style="list-style-type: none"> • Healthy Behaviours • Personalised Care • Women’s Health • Dental / Oral Health • Eye Health 	<ul style="list-style-type: none"> • Elective Care & Diagnostics • Urgent & Emergency Care incl. community • Cancer • Diabetes • Respiratory • Cardiovascular Disease • Stroke & Stroke Rehab • ME and CFS • Neuro Rehab • Learning Disabilities & Autism 	<ul style="list-style-type: none"> • Ageing Well Programme • Dementia • Carers 	<ul style="list-style-type: none"> • End of Life

Each of the areas identified above will follow a common methodology through setting out:

- Why is it important for the people of SNEE
- What do we know about people’s local experiences
- How do we plan to make a difference
- How we will know we are making a difference
- Case study for the area

Underpinning our key outcomes, we are in the process of developing a small set of top commitments the ICB will make to the population it serves to deliver by 2028. The methodology for developing these takes account of:

- Public engagement feedback
- Partner engagement feedback
- Joint Strategic Needs Assessment (JSNA) findings
- ICS Strategy and Health and Wellbeing Board Strategies
- NHS Long Term Plan and other key national priorities and guidance

The commitments we give will be framed in the following way:

Outcome	Commitment Theme	Five Year Commitment	Why Is it Important?	Indicators of Success	Big Ideas for 23/24
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Further engagement with partners is ongoing throughout March and April to develop these in time to be included within the JFP for the May meeting of the ICB Board.

Alongside the six Live Well Domains and the top commitments, the JFP will also have key sections covering:

- Why do we need a JFP?
- How we will work differently to achieve our priorities including:
 - ICB Governance
 - Alliances and Localities
 - GP Primary Care
 - Collaboratives
 - Population Health Management
 - Demand and Capacity Planning
 - Medium Term Financial Planning
 - Quality and Safety
 - Clinical and Professional Leadership
- Our enablers to success
 - Working in partnership with people and communities
 - Workforce
 - Estates
 - Digital
 - Intelligence
 - Communication and Engagement
 - Research and Innovation
 - Sustainability
- Managing the JFP including how we report progress and our performance

Our Plan will be delivered through our three place-based Alliances, Ipswich and East Suffolk, North East Essex and West Suffolk, and each is commencing work on their own localised delivery plan.

We now have a strong draft of the JFP at circa 100 pages with a circa 10 page executive summary and a 'plan on a page' under development.

3. Patient and Public Engagement

- 3.1 As part of this work, ICBs and their partner trusts must consult with those for whom the ICB has core responsibility. SNEE ICB has therefore been engaging with a range of partners and stakeholders from across the system to both draft and review the JFP. Leads from the ICB, ICP, Healthwatch, primary care, community and acute trusts, mental health trusts, Suffolk County Council, Essex County Council, collaboratives, networks, alliances and the VCSE sector have been involved in the drafting of key sections to date to ensure a robust and complete JFP is produced for the ICB.
- 3.2 A JFP Communications and Engagement Sub-Group was established to plan out key activities to support the promotion of the public engagement exercises. This involved use of newspaper advertisements, social media promotion, press releases, articles in stakeholder briefings and website content.
- 3.3 Rather than starting a fresh gathering insight and experience for the JFP, the ICB was able to refer back to priorities and issues raised in numerous engagement and coproduction activities that have taken place across Suffolk and NEE. On this basis the aim of engaging people and communities in the JFP was to enable effective and meaningful involvement and to ensure all people and communities have the opportunity to comment, either on the sections most important to them or the whole document. In planning how to involve people meaningfully.

- 3.4 The engagement was designed to follow the domains, mirroring the format of the plan itself. Using the engagement platform LetsTalkSnee.co.uk a series of web pages were developed to define and break down each domain, outlining the key priorities. A series of public meetings were held for people who preferred to take part in person.
- 3.5 The engagement activity ran from Monday 16th of January until Wednesday 22nd February. During which time there were over 1000 visits to the engagement platform, 340 voted using quick polls, 280 ideas were submitted and there were 330 downloads of the draft document and executive summary. Approximately 100 people attended an in person meeting.
- 3.6 There were eight core themes raised through the engagement activity:
1. **Access** – This related to access to any service, primary care, secondary care, specialist care and community services, or to opportunities and activities to support healthy living. It also included the ability to get to and from appointments and activities
 2. **Mental health** – This included services for both children and young people and adults
 3. **Prevention, health education and information** – Supporting and enabling people and communities to manage their own health, stay health and know how to access support
 4. **Personalisation and reasonable adjustments** – Both personalised care in response to a person's specific conditions and the adjustments made to support good health outcomes This might include communication, physical access or cultural competence
 5. **Digitalisation** – To be aware of both the innovation and progress that can be provided through the use of new technology, whilst also recognising that not everyone is willing or able to use technology
 6. **Workforce** – This included recruitment, retention, training and wellbeing
 7. **Primary Care** – Further development of primary care across Suffolk and North east Essex
 8. **Children and Young people with Special Educational Need** – services, support and interventions to support young people with a special educational need

4. Next Steps

- 4.1 Key timelines for the JFP as detailed within the NHSE guidance documents are noted below:
- Further development of the JFP and top commitments - March-April 2023
 - SNEE ICP consideration of the JFP – 14 April 2023
 - NHSE feedback on the JFP – 17 April 2023
 - Essex Health and Wellbeing Board consideration of the JFP – 17 May 2023
 - Suffolk Health and Wellbeing Board consideration of the JFP – 18 May 2023
 - SNEE ICB Board consideration and approval of the JFP – 23 May 2023
 - JFP publication – June 2023

5. Recommendation

- 5.1 To continue at pace, progressing delivery of a robust five-year JFP for SNEE ICB and bringing back to final version for agreement to the May meeting of the ICB.

ICB BOARD

Agenda Item No.	10
Reference No.	ICB 23-20
Date.	21 March 2023

Title	Integrated Care Board (ICB) Performance Report
Lead Director	Paul Gibara, ICB Director of Performance Improvement
Author(s)	Ed Garratt, ICB Chief Executive Maddie Baker-Woods, Ipswich and East Suffolk Alliance Director Andrew Kelso, ICB Medical Director Amanda Lyes, ICB Director of People and Workforce Howard Martin, ICB Director of Finance Lisa Nobes, ICB Director of Nursing Laura Taylor-Green, North East Essex Alliance Director Richard Watson, ICB Director of Strategy and Transformation Peter Wightman, West Suffolk Alliance Director
Purpose	The paper covers several areas: <ul style="list-style-type: none"> • ICB Quarterly Performance 27th January 2023 • A summary of System Oversight Assurance Committee. • Summary of System Oversight Key performance indicators.
Recommendation:	
The ICB Board is asked to note the report.	

Suffolk and North East Essex Integrated Care Board Performance Report

ICB Quarterly performance review

27th January 2023

The ICB had its second quarterly review meeting

The ICB acknowledged the challenging period experienced in quarter 3 and that it would continue its focus on recovery throughout quarter 4

Progress on the development of the Joint Forward plan ICP strategy were discussed

Detailed update of our work with voluntary care sector was well received with a commitment to discuss progress on collaboration with district borough council in more detail at the next quarterly review

A number development areas were discussed:

- Progress and plans for dentistry
- Development of CDCs training academy model
- Supporting mental health through investment in voluntary care sector
- Development of digital health and social care solutions to support independence and targeted home based care.
- Support of primary care and the need to ensure resilience of services
- Progress on planning and the need to ensure delivery of key recovery priorities.

ICB Quarterly performance review

27th January 2023

Key recovery actions were discussed:

- Elective recovery
- Cancer
- Urgent care
- Maternity services

Finance

- Current forecast outturn and planning for 23/24

This was a positive meeting with regional colleagues committed to reviewing cadence of reviews and expand membership to all ICB members

System Oversight Assurance Committee

A recommendation should be taken to the March Regional Support Group (RSG) meeting to review the SOF rating for WSHFT from SOF3 to SOF2

Update was received on the successful recruitment campaign held in January for Health & Social care workers with 175 offers of employment had been made, and a further 329 interviews scheduled. focus on employment distribution would be continually monitored and further work will be taken through the people committee.

Discussion regarding lessons learnt from recent industrial action would be shared to ensure readiness and preparedness for any future planned dates. A plan of action

The Committee were appraised of the new SEND Framework and noted good preparations were underway for imminent re-inspection in Suffolk, and the areas where further work was required.

Urgent Emergency Care high impact strategic ideas were considered to support improvement in quality and performance and the Committee was supportive of taking forward:

- Initiatives from 'Learning from the highest performing trusts and systems on hospital handover delays'
- Grand rounds – to understand discharge profile across medical wards, generating high level thinking around discharge
- Development of a single community hub involving multi disciplinary team of clinicians based in one location, ensuring each patient accessed the right pathway and avoid ambulance dispatch and visits to emergency departments wherever safe and possible

Performance:

Cancer 62 week wait remained a concern, although improvement seen

52 week RTT had improved

Access to community mental health services for adults with SMI had decreased, with last 3 months activity falling below SPC control limits

General surgery remained a concern but insourcing capacity was making a difference. The orthopaedic trajectory had been revised & the target should be achieved by the end of the year, although industrial action could have a significant impact

ICB Priorities 23/24

[View in Power BI](#) ↗

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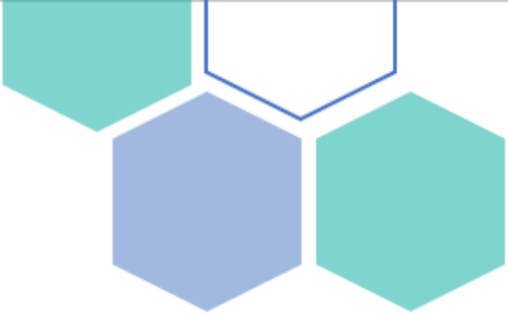
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					Assurance			
Variation		Special cause variation of an IMPROVING nature where the measure is significantly HIGHER . This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER . This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER . This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER . Assurance cannot be given as there is no target.			
		Special cause variation of an IMPROVING nature where the measure is significantly LOWER . This process is capable and will consistently PASS the target if nothing changes.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER . This process will not consistently HIT OR MISS the target as the target lies between process limits.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER . This process is not capable and will FAIL the target without process redesign.	Special cause variation of an IMPROVING nature where the measure is significantly LOWER . Assurance cannot be given as there is no target.			
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					Special cause variation of an increasing nature where UP is not necessarily improving or concerning, Assurance cannot be given as there is no target.			
					Special cause variation of an increasing nature where DOWN is not necessarily improving or concerning, Assurance cannot be given as there is no target.			
					There is insufficient data to determine either special cause or common cause variation. Assurance cannot be given as there is no target.			

23/24 Planning & Priorities

Area	Metric	Data Source	Month	Current Value	Variation	Assurance	Target	LPL	Mean	UPL
Urgent and emergency care	A&E 4 Hour Waiting Times	National Monthly Reporting	Dec-22	66.0%			76%	70.7%	77.4%	84.1%
Urgent and emergency care	Ambulance response times - C2 Mean	EEAST	Jan-23	00:43:00			00:30:00	00:10:52	00:57:49	01:44:46
Urgent and emergency care	G&A Bed Occupancy	Local Daily Trust Report	Mar-23	96.1%			92%	90.3%	93.5%	96.7%
Urgent and emergency care	Ambulance handover delays	EEAST	Feb-23	74.1%			95%	64.8%	77.5%	90.3%
Urgent and emergency care	12 hour waits in ED	Local Trust Report	Feb-23	3,674 (9.7%)			0%	1.32%	5.43%	9.53%
Community health services	UCR Referrals in 2 hours	CSDS	Dec-22	71.0%			70%		67.1%	
Primary care	Number of general practice appointments	NHS Digital	Jan-23	520,004				374,562	487,786	601,010
Elective care	65 weeks wait	National RTT	Dec-22	2,341					1,894	
Elective care	Elective Day Case	Faster SUS	Feb-23	8,811				8,582	10,861	13,140
Elective care	Elective Ordinary	Faster SUS	Feb-23	1,334				1,263	1,591	1,918
Elective care	First outpatients - F2F	Faster SUS	Feb-23	26,314				26,303	36,159	46,014
Elective care	Follow up outpatients - F2F	Faster SUS	Feb-23	43,710				47,311	64,259	81,208
Elective care	First outpatients - Virtual	Faster SUS	Feb-23	3,523				3,952	5,375	6,797
Elective care	Follow up outpatients - Virtual	Faster SUS	Feb-23	12,582				15,728	21,649	27,570
Cancer	62+ day waiting list	Trust Local PTL	Feb-23	749				732	818	905
Cancer	28 day faster diagnosis	National CWT	Dec-22	66.9%			75%	59.1%	64.8%	70.5%
Cancer	Increased first cancer treatments	National CWT	Dec-22	493				397	537	677
Diagnostics	Diagnostic Tests within 6 weeks	DM01	Dec-22	75.9%				67.0%	75.1%	83.2%
Diagnostics	Diagnostic Tests	DM01	Dec-22	27,857				21,809	27,087	32,365
Maternity	Stillbirth rate (per 1,000)	Civil Registration of Births	Oct-22	4.20				-2.64	3.80	10.2
Maternity	Neonatal mortality rate (per 1,000)	Civil Registration of Deaths	Oct-22	0.00				-6.74	2.77	12.3
Mental health	CYP accessing MH services	MH Core Data Pack	Nov-22	12,735				10,790	11,465	12,140
Mental health	IAPT Access	MH Core Data Pack	Nov-22	2,280				1,611	2,197	2,784
Mental health	Community MH services access (older adults/SMI)	MH Core Data Pack	Nov-22	5,530				6,008	6,179	6,350
Mental health	Inappropriate OOA placement bed days	MH Core Data Pack	Nov-22	1,140				321	656	990
Mental health	Dementia diagnosis rate	NHS Digital	Dec-22	60.5%			66.7%	59.8%	60.5%	61.2%
Mental health	Perinatal Access - YTD	MH Core Data Pack	Nov-22	740					464	
People with a learning disability and autistic people	LD health checks	NHS Digital	Jan-23	62.7%					30.5%	



Cancer

Issues & Root Cause

New recovery trajectories developed by the providers with both reporting 62 back log recovery by March 2023.

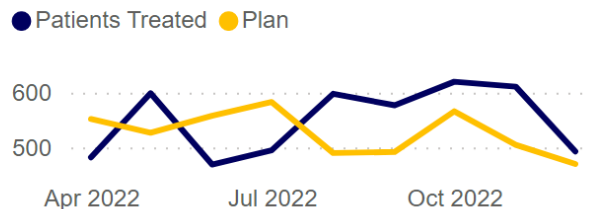
ESNEFT current 62 backlog position (w/e 20/1) is 13.7% of their PTL and WSFT is 13.6% of their PTL.

Increase in backlogs noted over the Christmas period due to annual leave and sickness absence.

WSFT skin pathway remains 60% of their PTL, delays in histology has resulted in patients remaining on the pathway following treatment.

ESNEFT LGI PTL is currently 52% and growing week on week. Red to Green supporting removing patients of the pathway, delays over Christmas due to annual leave and sickness.

Patients Treated for Cancer



First cancer treatments

are currently **104.2%**

against plan for 22/23

62+ Day Cancer Waits

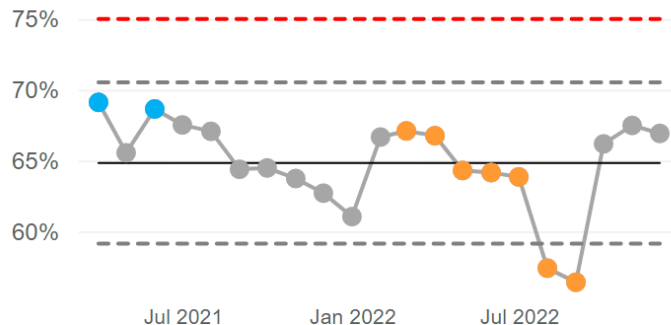
749

ESNEFT/WSFT patients are currently on the waiting list who have been waiting more than 62 days

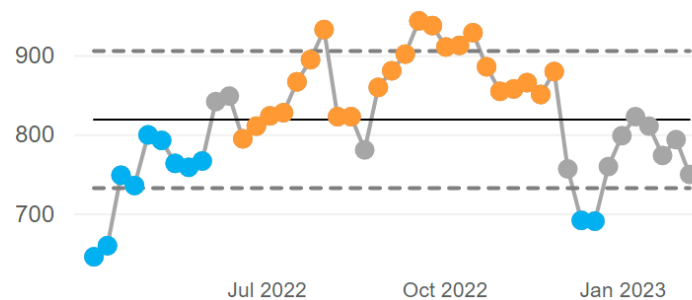
593 at ESNEFT **12.6%** of all waiters

156 at WSFT **9.4%** of all waiters

28 Day Faster Cancer Diagnosis



62+ day waiting list: Cancer



Proportion of ESNEFT/WSFT patients meeting the faster cancer diagnosis standard

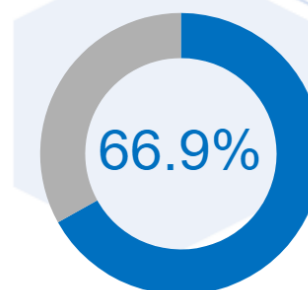
Recovery Actions

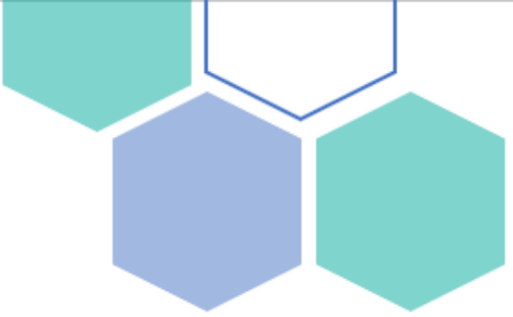
Red to Green on going at ESNEFT on the most challenged pathways, daily reviews of cancer PTL

Extra sessions in challenged pathways to support backlog recovery

New Skin pathway launched to support front end of the skin pathway - reduction in days waiting noted.

WSFT new CT live from Jan 15th supporting recovery of the colorectal CTC pathway.





Urgent & Emergency Care

Issues & Root Cause

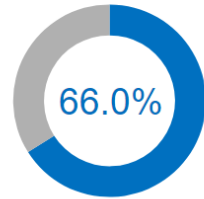
Ambulance response times remain above expected for both C1 & C2 priority categories, however there was a significant improvement in Jan-23 back to response times not seen since summer 2021

Response times vary across SNEE, with an average C1 waiting time of just over 8 mins in North East Essex, but over 10 mins in West Suffolk

The % of ambulance handovers in 30 mins improved in Jan-23 from the recent steep decline but still remains well below the target of 95%

The number waiting over 12 hours in ED is significantly above the SPC control limits and at 11.3% in January, remains significantly above the 2% max target

A&E 4 Hour Waits



Proportion of ESNEFT patients waiting in A&E for less than 4 hours

WSFT currently not reporting against this metric

G&A Bed Occupancy



96.05% of G&A beds are currently occupied in ESNEFT/WSFT

97.98% at Colchester Hospital

96.94% at Ipswich Hospital

92.17% at West Suffolk Hospital

Recovery Actions

Significant pressure remains across the UEC system.

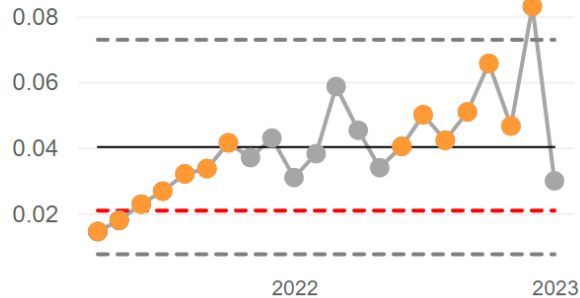
Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Ambulance Cat 2 Responses

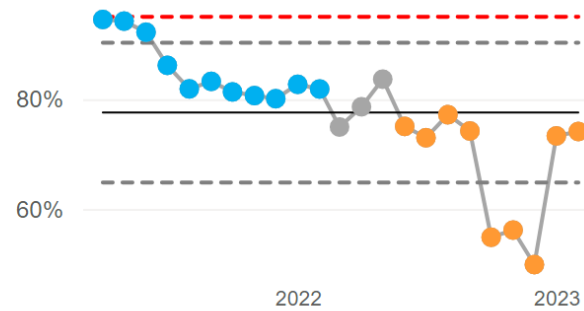


00:43:00

Mean category 2 ambulance response time (target 30 mins)



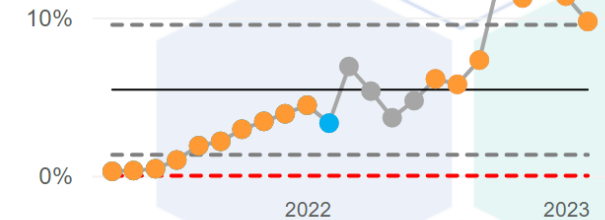
Ambulance Handover Delays



Handovers within 30 mins (target 95%)

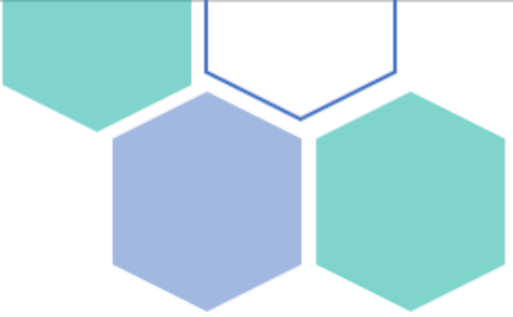
74.1%

ED 12 Hour Waits



Reduce towards 0 with no more than 2%

3,674 (9.7%)

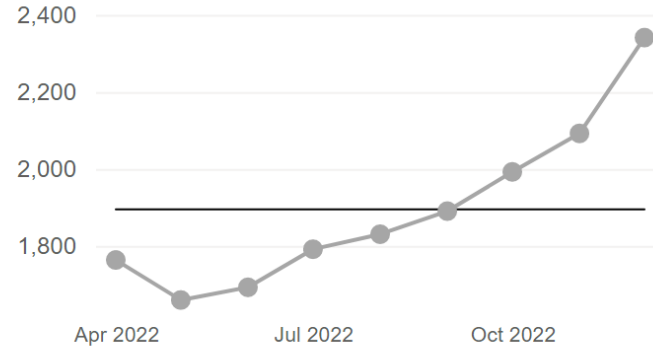


Elective Care & Diagnostics

Issues & Root Cause

ESNEFT showing strong activity figures. Key concerns are General Surgery and Gastroenterology where we are reliant on insourcing and locums for recovery. The growing waiting list and forecast increases in 52 week waits remain a concern. For diagnostics, all areas are either improving or are on plan for recovery. WSFT successfully reducing the longest waiters including 52 week breaches. Urogynaecology remains a challenge as there is a lack of local and national capacity. For diagnostics, MRI and endoscopy are the key concerns due to insufficient capacity/activity. We are seeking additional mitigations for endoscopy in particular.

RTT - 65 weeks waits



There are currently **2,341**

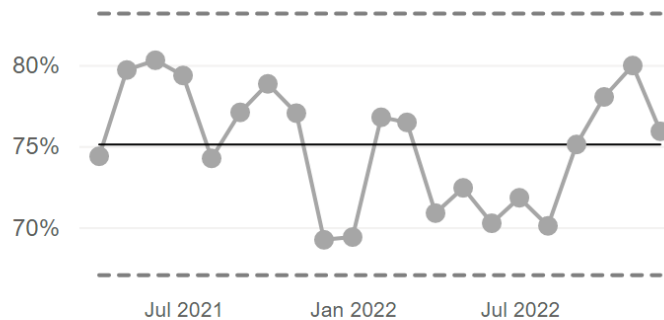
ESNEFT/WSFT patients who have been waiting more than 65 weeks to start treatment

Recovery Actions

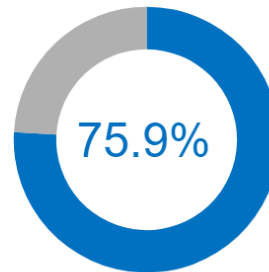
Key focus for both trusts is on outpatient productivity including increasing the rates of: patient initiated follow up; use of advice and guidance; use of virtual clinics (particularly at ESNEFT) and reducing the demand for face to face follow up attendances. Improving theatre efficiency and daycase rates are a system priority. Joint working opportunities are being utilised in some areas and scoped in others where mutual support would be beneficial. A diagnostics plan has been developed and is being implemented.

MetricName	Date	Actual	Var.	Target	LPL	Mean	UPL
Elective Day Case	Feb-23	8,811	🟡	10,875	8,582	10,861	13,140
Elective Ordinary	Feb-23	1,334	🟡	1,585	1,263	1,591	1,918
First outpatients - F2F	Feb-23	26,314	🟡	35,604	26,303	36,159	46,014
Follow up outpatients - F2F	Feb-23	43,710	🔴	83,579	47,311	64,259	81,208
First outpatients - Virtual	Feb-23	3,523	🔴	11,354	3,952	5,375	6,797
Follow up outpatients - Virtual	Feb-23	12,582	🔴	28,659	15,728	21,649	27,570

Diagnostic Tests within 6 weeks

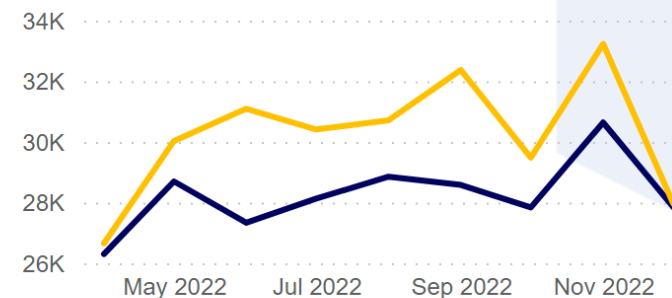


Proportion of ESNEFT/WSFT patients waiting less than 6 weeks (target 95%)

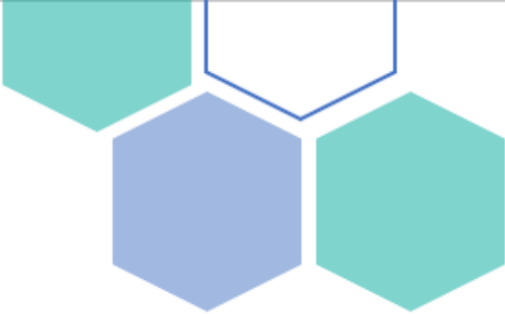


Diagnostic Tests

● Tests ● Plan



Diagnostic tests are currently **93.5%** against plan for 22/23



Mental Health

Issues & Root Cause

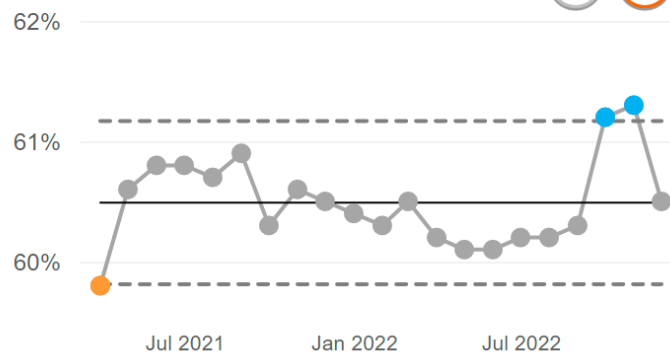
The number of children & young people accessing MH services with 1+ contacts has increased steadily for well over a year, with the target being met continually since Dec-21

Access to community MH services has been decreasing steadily since Dec-21, with the last 3 months activity falling below the SPC control limits

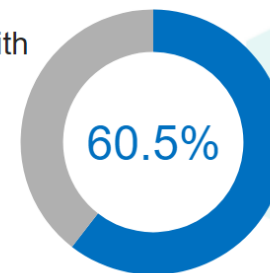
The number of out of area bed days had been declining steadily since Feb-22. However there has been a sharp increase since Jun-22, with bed days back to levels last seen in Jul-21.

Dementia diagnosis rates remain relatively consistent, but still some way off the national target of 66.7%. They are 1.4% off of the local plan for the current period

Dementia Diagnosis Rate

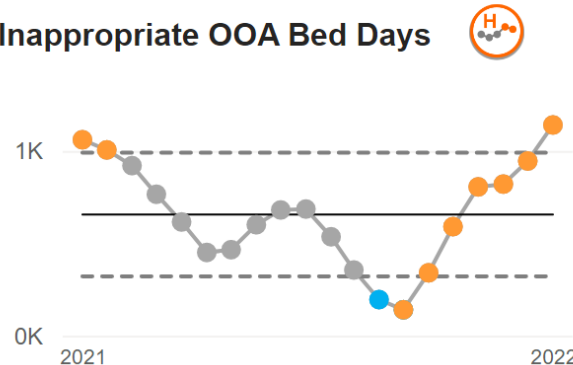


% diagnosed with dementia compared to estimated prevalence (target 66.7%)

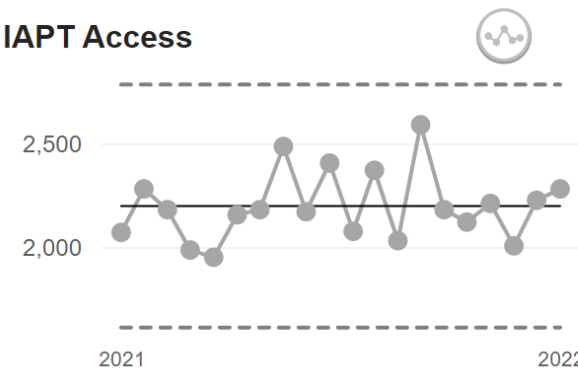


MetricName	Date	Actual	Var.	LPL	Mean	UPL
CYP accessing MH services	Nov-22	12,735		10,790	11,465	12,140
Community MH services access (older adults/SMI)	Nov-22	5,530		6,008	6,179	6,350
Perinatal Access - YTD	Nov-22	740			464	

Inappropriate OOA Bed Days



IAPT Access



Recovery Actions

Development of recovery plans to reduce wait list backlogs focusing on ADHD, Children & family and dementia assessment services.

Business case for West Suffolk MATS service to be progressed through ICB/Trust Governance processes

Additional investment made into SMI teams to deliver additional checks within primary care.

90 day waits continue to increase in the IAPT NEE service provided by EPUT. The Trust is working with Xyla and utilising temporary staff via bank and agency to bolster both assessment and treatment capacity.

Focus on ensuring appropriate community response to reduce Inappropriate OOA placements to zero by Nov 2023 within NSFT

ICB System oversight framework

[View in Power BI](#) ↗

Last data refresh:
23/02/2023 14:54:09 UTC

Downloaded at:
06/03/2023 20:57:42 UTC

Cancer & Rapid Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
62+ day waiting list	Reduction of waiting list to pre-pandemic levels by Mar 2023	Trust Local PTL	Feb-23	●			749	📈	
62+ day waiting list - over 104 days		Trust Local PTL	Feb-23	○			189	📈	
Increased first cancer treatments	Reduce shortfall	National CWT	Dec-22	●		470	493	📈	
28 day faster diagnosis	75% by Mar 23	National CWT	Dec-22	●	75.0%	75.0%	66.9%	📈	🚩
31 day wait diagnosis to treatment	Improve performance	National CWT	Dec-22	○	96.0%		95.1%	📈	🔍
Patients treated within 62 days	Improve performance	National CWT	Dec-22	○	85.0%		72.8%	📉	🚩
Screening uptake - Cervical (25-49)	Maintain and restore cancer screening programmes	NHS Digital	Sep-22	●			72.9%		
Screening uptake - Cervical (50-64)	Maintain and restore cancer screening programmes	NHS Digital	Sep-22	●			77.4%		
Screening uptake - Breast (50-70)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-22	●			67.8%		
Screening uptake - Bowel (60-74)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-22	●			73.7%		

Key performance issues & root cause summary

New recovery trajectories developed by the providers with both reporting 62 back log recovery by March 2023.

ESNEFT current 62 backlog position (w/e 20/1) is 13.7% of their PTL and WSFT is 13.6% of their PTL.

Increase in backlogs noted over the Christmas period due to annual leave and sickness absence.

WSFT skin pathway remains 60% of their PTL, delays in histology has resulted in patients remaining on the pathway following treatment.

ESNEFT LGI PTL is currently 52% and growing week on week. Red to Green supporting removing patients of the pathway, delays over Christmas due to annual leave and sickness.

Key performance recovery actions

Red to Green on going at ESNEFT on the most challenged pathways, daily reviews of cancer PTL

Extra sessions in challenged pathways to support backlog recovery

New Skin pathway launched to support front end of the skin pathway - reduction in days waiting noted.

WSFT new CT live from Jan 15th supporting recovery of the colorectal CTC pathway.

Cancer & Rapid Diagnostics Committee

Narrative submitted:

16/02/2023

Key activities completed in the previous 2 months

- 62 day backlog recovery remains a key priority within SNEE and improved backlog positions noted.
- Patient engagement session held focusing in on the faster diagnosis pathway in Cancer.
- Quality of Life deep dive held to review available data, sleep identified as the largest consequence of cancer treatment, task and finish group established.
- New Upper GI pathway live in WSFT, streamlining the referral pathway and supporting the faster diagnosis of Oesophageal (OG) cancer.
- Remote Monitoring System (RMC) now live for Personalised Stratified Follow-Up (PSFU) pathways in SNEE, which has resulted in breast, colorectal and prostate PSFU pathways now in place with COSD data collection.
- Community Cytosponge pathway now live in East Suffolk PCN in partnership with Heart burn cancer UK, the pathway is a pilot to support the identification of early OG cancer

Key activities planned for the next 2 months

- ESNEFT Non Site Specific pathway to give live in Cancer & Diagnostics division 3rd April 2023, MDT clinical lead out as an expression of interest
- Cancer service development funding for 23/24 due to be agreed at March ICS cancer programme committee.
- Cancer delivery plan to be completed for 23/24 and signed off by national team.
- Two community cancer champions to be recruited and hosted in the community.
- Open access breast pathway to be piloted in I&E Suffolk.
- New starter within Cancer team, starting May 2023. They will be the Cancer project officer.
- Psychological support in cancer event planned for March 2023, sharing plan for new L4 service.
- Improving Cancer Journey event planned for March 2023

We have learned this and need to share...

Following a series of patient engagement sessions and one of first large face to face session with patients and partners, we have learnt to develop a function to support the communication between partners as a continuous discussion, therefore we are going to further develop our let's talk SNEE platform

We need help with..

Transformation capacity within providers to support implementing deliverables from the cancer programme

Key Issues

Within the system we have a shortage of specialist roles, including Consultant radiologists and Specialty Consultants, this results in vacancies and high locum workforce

Key Risks

Targeted Lung Health Checks (TLHC) procurement is delaying go live date, the delay has resulted in the TLHC go live being delayed for five months

Strategic Programmes, Elective Care and Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
RTT Admitted Pathways	110% of 19/20 baseline	National RTT	Dec-22	○		3,458	2,604	📉	
RTT Non-Admitted Pathways	110% of 19/20 baseline	National RTT	Dec-22	○		15,987	14,690	📉	
104 weeks wait	0 by 31 Jul 2022	National RTT	Dec-22	●	0		17	📉	🚨
78 weeks wait	0 by 31 Mar 2023	National RTT	Dec-22	●	0		748	📉	🚨
52 weeks wait	Reduction on Apr 22 baseline	National RTT	Dec-22	●	0		5,720	📉	🚨
Diagnostic Tests	Increase diagnostic capacity to 120% of pre-pandemic activity	DM01	Dec-22	●		27,973	27,857	📈	
Elective Day Case		Faster SUS	Jan-23	○		11,006	10,979	📉	
Elective Ordinary		Faster SUS	Jan-23	○		1,458	1,405	📉	
First outpatients - F2F		Faster SUS	Jan-23	○		37,147	31,820	📉	
Follow up outpatients - F2F	25% reduction in outpatient follow-ups by 2023	Faster SUS	Jan-23	●		89,300	54,898	📉	
First outpatients - Virtual		Faster SUS	Jan-23	○		11,841	4,444	📉	
Follow up outpatients - Virtual	25% reduction in outpatient follow-ups by 2023	Faster SUS	Jan-23	●		30,718	18,073	📉	

Key performance issues & root cause summary

ESNEFT showing strong activity figures. Key concerns are General Surgery and Gastroenterology where we are reliant on insourcing and locums for recovery. The growing waiting list and forecast increases in 52 week waits remain a concern. For diagnostics, all areas are either improving or are on plan for recovery. WSFT successfully reducing the longest waiters including 52 week breaches. Urogynaecology remains a challenge as there is a lack of local and national capacity. For diagnostics, MRI and endoscopy are the key concerns due to insufficient capacity/activity. We are seeking additional mitigations for endoscopy in particular.

Key performance recovery actions

Key focus for both trusts is on outpatient productivity including increasing the rates of: patient initiated follow up; use of advice and guidance; use of virtual clinics (particularly at ESNEFT) and reducing the demand for face to face follow up attendances. Improving theatre efficiency and daycase rates are a system priority. Joint working opportunities are being utilised in some areas and scoped in others where mutual support would be beneficial. A diagnostics plan has been developed and is being implemented.

Strategic Programmes, Elective and Diagnostics Committee (1 of 2)

Narrative submitted:

21/02/2023

Key activities completed in the previous 2 months

The system has continued to push hard to clear all 78 week waits due to capacity reasons. It is likely there will be 50 breaches in Urogynaecology at WSFT despite the Trust having reached out nationally for support. ESNEFT have some risk in clearing all Gastroenterology cases, WSFT are supporting, and ESNEFT are exploring all options for insourcing or outsourcing.

ESNEFTs diagnostic performance remains strong, WSFT working on improvements on MRI and endoscopy in particular.

WSFT have seen significant improvement in the use of patient initiated follow up and ESNEFT have seen a significant improvement in their Daycase rate.

Planning for 2023/24 continues, achieving 65 weeks by the end on 23/24 is likely to be high risk due to constraints on staffing, bed base and funding.

Key activities planned for the next 2 months

In February and March the system has a Getting it Right First Time (GIRFT) review for general surgery and a follow up High Volume Low Complexity (HVLC)/GIRFT review with the National Director for Clinical Improvement and Elective Recovery.

Outsourcing of endoscopy work from WSFT to InHealth is expected to commence which will be a key element to WSFT recovery.

Theatre productivity, outpatient programmes and other productivity initiatives continue.
23/24 planning will conclude and recovery trajectories will be monitored.

We have learned this and need to share...

The trusts have established an elective recovery meeting which is proving to be an effective means of sharing best practice, opportunities to support each other and building networks. Clinical leadership of the musculoskeletal programme has been effective and we will seek to roll out this approach into General Surgery.

We need help with..

As demand and capacity modelling evolves, a review of key services and approach required to meet the reduction in waiting times and waiting list will be required.

We are seeking mutual aid for Urogynaecology for WSFT, and Gastroenterology and Oral Maxillo Facial Services for ESNEFT.

Key Issues

Our key issues are: staffing availability and industrial action resulting in cancellations; availability of mutual aid for some of our hard-pressed specialties and sub-specialties; bed pressures.

Key Risks

Our key risks are: ongoing and heightening industrial action, absence of sufficient funding to increase capacity; insufficient beds to meet demands of UEC and elective programmes; staff resilience; escalating cancer demand.

Strategic Programmes, Elective and Diagnostics Committee (1 of 2)

Narrative submitted:

16/02/2023



Key activities completed in the previous 2 months

Asthma - Sentenil plus pilot in 2 NEE Primary Care Networks continues and progress has been made to support data requirements and clinical educational support to review the number of patients switched to maintenance and reliever therapy where clinically appropriate. Community engagement officer posts have been advertised to support increase in smoking cessation particularly to address health inequalities.

Neuro - rehabilitation - Level 2b procurement working on getting spec sign off, and starting procurement process.
Stroke - Re focus of InHip Atrial Fibrillation (AF) project due to technology issues surrounding AF detection devices. Finalising SQuIRe secondment, background for catalyst project

Diabetes - West Suffolk at 100% usage of Eclipse (like NEE). Concerns that IES practices uploading to Eclipse has dropped off + Local Enhanced Services needs updating as a matter of urgency. Healthy.io pilot2 has started in West Suffolk

Key activities planned for the next 2 months

ICS respiratory committee to discuss future planning options to support delivery of the spirometry service across SNEE 23/24.
Long covid workforce plan 23/24 and pathway to be submitted to Strategic Programmes, Diagnostics and Elective committee (SPED) for approval.
NHS tobacco funding appraisal to support delivery and evaluation of the programme will be submitted to SPED committee for approval.

Stoke and Neuro:L2b beds, will go out to procurement, Finalise inhip AF project. Commencement of Catalyst funded project for Stroke Improvement on workforce, training, 6 month reviews.

Diabetes:Work on upgrading diabetes IES Local Enhanced Service(LES) + Diabetes funding for HCAs to support Care Processes. Resolve ESNEFT DISN/Podiatrist ongoing payment issue. Develop National Diabetes Prevention Programme (NDPP) LiberatePro pack and deploy.

CVD:Put out Expression of Interest (EOI) for CVD clinical lead and hire of supporting project manager. Initial funding for Healthy Hearts Together programme for SMI/LD lipid reviews to be transferred to the relevant providers so they can begin hiring against the project

We have learned this and need to share...

We need help with..

Diabetes - Support on completing the Diabetes LES in IES would be helpful

Key Issues

Tobacco dependency treatment programme and pulmonary rehabilitation funding 23/24 is yet to be confirmed.
Diabetes - no further service development funding for 23/24, so a review of current funding arrangements ongoing

Key Risks

Tobacco - potential temporary impact on the delivery of the NHS tobacco treatment programme in the community due to procurement processes. Working with Public Health colleagues to mitigate the risk

Urgent & Emergency Care

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Ambulance response times - C1 Mean	7 mins	EEAST	Jan-23	●	00:07:00		00:09:16		
Ambulance response times - C1 90th percentile	15 mins	EEAST	Jan-23	●	00:15:00		00:18:21		
Ambulance response times - C2 Mean	18 mins	EEAST	Jan-23	●	00:18:00		00:43:00		
Ambulance response times - C2 90th percentile	40 mins	EEAST	Jan-23	●	00:40:00		01:34:38		
Ambulance handover delays	95% within 30 mins	EEAST	Jan-23	●	95.0%		73.3%		
A&E Attendances - Type 1&2		Faster SUS	Jan-23	○		20,305	18,512		
12 hour waits in ED	Reduce towards 0 and no more than 2%	Local Trust Report	Jan-23	●	0	2.0%	2,182 (11.3%)		
NEL Spells		Faster SUS	Jan-23	○		9,822	8,558		

Key performance issues & root cause summary

Ambulance response times remain above expected for both C1 & C2 priority categories, however there was a significant improvement in Jan-23 back to response times not seen since summer 2021

Response times vary across SNEE, with an average C1 waiting time of just over 8 mins in North East Essex, but over 10 mins in West Suffolk

The % of ambulance handovers in 30 mins improved in Jan-23 from the recent steep decline but still remains well below the target of 95%

The number waiting over 12 hours in ED is significantly above the SPC control limits and at 11.3% in January, remains significantly above the 2% max target

Key performance recovery actions

Significant pressure remains across the UEC system.

Demand & Capacity work has been undertaken (linked to national funding) with a number of schemes being implemented to support flow. This should improve the ED performance and support improved patient arrival to handover performance.

Urgent & Emergency Care Committee

Key activities completed in the previous 2 months

Significant planning and response to manage industrial action in nursing and ambulance groups.
The latest draft of the ICB Joint Forward Plan agreed by system partners and submitted
Daily Clinical Huddle continues to further enhance the System Control Centre operation with the coolation of the EEAST Local operational oversigth cell (LOOC).
Submitted schemes to NHSE for the supporting the UEC recovery plan.
Learning from the best performing hospital for ambulance handover has been mapped against the UEC recovery plan.
Reasonable utilisation of the additional £200m discharge fund. Expect to utilise around £1.7m by 31 March 23.

Key activities planned for the next 2 months

Further development of the 'Community Hub' principles to improve our ability to manage patients in the right place firs time, every time. with learning from the Cleric Stack model to its maxinium potential with the URCS teams asked to go further faster.
Forward planning to manage further industrial action and Easter
Continue to work with providers to develop a live data visibility for system pressures inline with requirement for SCC/UEC deliverables.
Continue planning to implement the right model to utilise the £500m discharge fund

We have learned this and need to share...

We have had excellent response to our community hub proposal with all agreement for all system partners that this is the correct future model.

We need help with..

The agreed data and sharing of key metrics to support the System Control centre function, particularly focussed on discharge

Key Issues

Expected escalation of IA and significant impact on ability to provide UEC services. Reintroduction of the 4hr performance in WSFT. Expected MAY 23.
C2 performance has improved but is still below the 18 min standard and significant pts handover delays

Key Risks

Continued challenge with UEC demand and utilisation of surge capacity
On-going and escalating industrial action
Workforce fatigue

Narrative submitted:

20/02/2023

Maternity & Neonatal

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Number of live births		Trust Local Data	Dec-22	○			714		
Preterm Births (<37 weeks)	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Dec-22	○			54		
3rd/4th Degree Tears	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Dec-22	○			12		
Postpartum haemorrhage (PPH) >=1500mls	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Dec-22	○			19		
Smoking at time of delivery		Trust Local Data	Dec-22	○			7.8%		
Stillbirth Rate (per 1,000)		Civil Registration of Births	Oct-22	●			3.28		
Neonatal Mortality Rate (per 1,000)		Civil Registration of Deaths	Oct-22	●			0.00		

Key performance issues & root cause summary

Stillbirth and Neonatal mortality is not seeing the downward trend that is required to meet the national ambition of 50% reduction before 2025. Root cause is under investigation. Performance metrics are currently being reported from combined local reports for ESNEFT and WSFT. There are known DQ issues with ESNEFT's submission to the national Maternity Services Data Set (MSDS). When these are rectified, reporting will be switched to using the national flows, which will also provide more detail behind some of these metrics.

The percentage of women smoking at time of delivery has started to reduce but the SNEE average is still above the national target. NEE commenced new model of care on 7th Nov, East Suffolk will commence 9th Jan and West will follow in Feb 23. Preterm births are higher than national benchmark and have risen during 22/23 ,clinical audit showed deprivation and smoking as indicators.

Key performance recovery actions

Preterm births - clinical workstream established and drafted best practice pathway for all 3 services to follow. Gap analysis underway to identify where we are not currently delivering the pathway. Preconception services under development to reduce risk as early as possible, VCSE partnerships in place to assist with addressing deprivation and diverse groups access support, new smokefree pathway started, clinical triage model in place Ipswich and in development Colchester and WSFT.

*there is a known lag in the completeness of both births and deaths monthly data, so these figures are likely to change on refresh

Maternity Committee

Key activities completed in the previous 2 months

Post partum haemorrhage workstream monthly. WSFT risk assessment tool commended by Region as good practice. Regional team congratulated SNEE LMNS on workstream and it's approach.

Negotiations with NHSE National Retention Team concluded, and actioned.

VCSE workshop held to map areas for change within maternity and system. Paper presented to ICP Board.

Significant challenges to commence smokefree pregnancy within Suffolk due to prescribing issues with NRT and vape provision.

LMNS review of evidence and compliance by both Trusts for CNST submissions. Both trusts submitting non-compliance, WSFT non compliant with 2 of 10 and ESNEFT non compliant with 3 of 10.

Declaration forms submitted.

Key activities planned for the next 2 months

Finalise antenatal education specification and commence procurement LMNS and ICB Workforce team workshop held on 1st Feb, actions to be taken forward.

Smokefree pregnancy pathway to go live in IES

Contractual and financial planning discussions with all providers

Business case for pan ICS Perinatal Mental Health review

Rollout retention schemes

Independent Senior Advocate role progressed with 3 other LMNS within EoE. Proposal to now recruit directly into the role. Case to be shared with LMNSB for approval.

We have learned this and need to share...

National oversight of Entonox commenced, Ipswich commended for their level of engagement.

ESNEFT staggering their admission times for EC/S

Regional "toolkit" under development for elective c-sections which we will be strongly recommended to adopt PPH - new improvement trend in overall LMNS figures for vaginal birth PPH since July 22. WSH improvement in vaginal birth PPHs over several consecutive months.

We need help with..

Issues outlined below

MSDS not accurate re ESNEFT data, unable to create reliable SPC's or complete historical analysis to identify trends and impacts of any QI measures, therefore dependent on ESNEFT to provide data required. This puts pressure on ESNEFT BI team.

Key Issues

ESNEFT 6 monthly workforce Board reports not yet delivered (national deliverable)

Both Trusts having difficulty with full MDT ward rounds, 12 hours apart MDT training compliance a challenge for both Trusts.

Key Risks

Poor data quality within ESNEFT resulting in limited understanding of clinical outcomes.

Ipswich Hospital national outlier for term admissions to neonatal unit
LMNS regional outliers for preterm birth, PPH, smoking at time of delivery.
Stillbirth and neonatal mortality rates not reducing as per national ambition
NEWTT trigger tool in Ipswich maternity service to be implemented.

Narrative submitted:

21/02/2023

Mental Health & CYP

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
CYP accessing MH services		MH Core Data Pack	Nov-22	●	12,341		12,735		
SMI full annual physical health checks		MH Core Data Pack	Dec-22	●	5,386		4,304		
IAPT Access		MH Core Data Pack	Nov-22	●	2,342		2,280		
Community MH services access (older adults/SMI)		MH Core Data Pack	Nov-22	●			5,530		
Inappropriate OOA placement bed days		MH Core Data Pack	Nov-22	●			1,140		
Dementia diagnosis rate		NHS Digital	Dec-22	○	66.7%	63.0%	60.5%		
Perinatal Access - YTD		MH Core Data Pack	Nov-22	○			740		
EIP - Waiting Times	Treatment within 2 weeks of referral	MH Core Data Pack	Nov-22	○			86.7%		
CYP Eating Disorders - Routine	Treatment within 4 weeks of referral	MH Core Data Pack	Dec-22	○			67.5%		
CYP Eating Disorders - Urgent	Treatment within 1 week of referral	MH Core Data Pack	Dec-22	○			52.4%		

Key performance issues & root cause summary

The number of children & young people accessing MH services with 1+ contacts has increased steadily for well over a year, with the target being met continually since Dec-21

Access to community MH services has been decreasing steadily since Dec-21, with the last 3 months activity falling below the SPC control limits

The number of out of area bed days had been declining steadily since Feb-22. However there has been a sharp increase since Jun-22, with bed days back to levels last seen in Jul-21.

Dementia diagnosis rates remain relatively constant, but still some way off the national target of 66.7%. They are 1.4% off of the local plan for the current period

Key performance recovery actions

Development of recovery plans to reduce wait list backlogs focusing on ADHD, Children & family and dementia assessment services.

Business case for West Suffolk MATS service to be progressed through ICB/Trust Governance processes

Additional investment made into SMI teams to deliver additional checks within primary care.

90 day waits continue to increase in the IAPT NEE service provided by EPUT. The Trust is working with Xyla and utilising temporary staff via bank and agency to bolster both assessment and treatment capacity.

Focus on ensuring appropriate community response to reduce Inappropriate OOA placements to zero by Nov 2023 within NSFT

Mental Health Committees (Suffolk & North East Essex)

Key activities completed in the previous 2 months

SNEE

- Mental Health Committee's held in Suffolk (20.01) and NEE (23.01).
- Suffolk Committee covered PD& Complex Needs evaluation, suicide prevention plan update working with Suffolk Public Health, agreement of new maternal mental health business case and dementia deep dive.
- NEE Committee covered community mental health model update, dementia update, winter pressures funding agreement and confirmation of a dedicated 12 month suicide prevention post.
- MH Collaborative Development- Suffolk MH Collaborative is due to go live from April 2023. NEE and Essex wide conversations continue on supporting increased joint working across the geography.
- 23/24 NHSE Planning-meeting held with NHSE MH team in support of first mh planning submission on 23.02 covering finance, activity and workforce

Key activities planned for the next 2 months

SNEE

- 23/24 NHSE Planning- Joint Forward Plan engagement to close and narratives to be completed for mental health, suicide prevention and dementia. Finance, Activity and workforce plans to be finalised with NHSE.
- Southend Essex Thorrock MH Strategy- due 31.03.23.
- Suffolk Public Health Mental Health Prevention Strategy- due 31.03.23.
- Joint working- appointment of tripartite funded head of Mental Health Service Change across SNEE ICB, ECC and EPUT.
- agreement of 23/24 joint mh work plan across ICB and SCC including future plans for the mental health pooled fund including supported housing.
- Eating Disorders- Update to be taken through Collaboratives.
- ASD and ADHD- Proposal for high ASD and ADHD waiting times

We have learned this and need to share...

SNEE

SMI Physical Health Checks at 58.7% for SNEE at Q3 22/23. Highest in East of England ICB's- our thanks to everyone's hard work who have helped achieve this- especially primary care. We are supporting the development of the 'Live Well' domains in Ipswich and East Suffolk and West Suffolk Alliances- in line with work to date in NEE

We need help with..

SNEE

Request Alliance support in developing relationships with district and borough colleagues in respect of housing agenda and broader community wellbeing conversations. We seek views on the development of our Mental Health Collaboratives to ensure that they will deliver for our local populations. Seek opportunities to join up mental health services with our physical health programmes of work

Key Issues

Increasing demand for MH services in light of covid pandemic and cost of living crisis.
Recruitment and retention of workforce challenges

Key Risks

NSFT CQC 2022 visit and delivery of the associated Improvement Plan. Final CQC Report expected Feb 23.
EPUT CQC visit and outcome- December 2022. Final CQC Report expected April 23.
System financial challenges could create the conditions for silo working and inhibit organisations from integrated working

Narrative submitted:

22/02/2023

Children & Young People Committees (Suffolk & North East Essex)

Key activities completed in the previous 2 months

1. Integrating delivery of paediatric services, initial meeting has taken place with WSFT to scope the challenges and how to approach from an acute and community perspective
2. Re-established NDD Oversight group NEE & supporting provider to address the backlog challenges re assessments, contributing to SNEE wide NDD Deep dive looking at referrals, pathways, triage to be completed by March 23
3. NEE Community Paediatric services, supporting review of Contract
4. VCSE mental health support in Suffolk, recurrent funding now awarded. Contracts mobilised for Kooth, Barnardo's and Green Light Trust.
5. Admission Avoidance now agreed with Noise Solutions, Kooth and Helios.
5. Suicide prevention action plan
6. NEE NDD Pathway - Focus on addressing the ADHD/ASD Effectiveness measures

Key activities planned for the next 2 months

1. Business case for Avoidant/restrictive food intake disorder (ARFID) now in co-production working with system leads and families to co-produce a new pathway and support. To be shared at Exec Boards in March/April
2. CYP Mental Health Crisis offer in Suffolk will be mapped for professionals and system leads, communication plan for CYP and Families will then be co-produced
3. NDD - Embedding process and feedback from review, system partners. SNEE deep dive
4. Embedding steering group for Acute and Community paediatric services review
5. Re-launch of mental health and emotional wellbeing resources and webpages

Narrative submitted:

22/02/2023

We have learned this and need to share...

1. Mapping of mental health crisis in Suffolk has demonstrated complexity & hand offs within current pathways that must be reviewed. INT approach & connections need to be replicated within CYP to ensure better join up and sharing of resources
2. Importance of co-production in service transformation highlighted across SNEE
3. CYP being further embedded in alliances frameworks is supporting join up and preventing duplication

We need help with..

1. Ensuring both NDD pathways continues to be raised across the system, support and engagement from system partners on deep dive
2. Continuing to work together across the system teams to ensure we can support CYP effectively to 'Wait Well' whilst waiting for assessment and treatment. Ensuring we can share key information and resources across all system areas to support CYP more consistently
3. Education leadership being more engaged with provision and support that is available to all our schools

Key Issues

1. Residual waiting lists for autism & ADHD diagnostic services, alongside the backlog in referrals
2. Increasing demand in need and provider recruitment challenges in key roles
3. Staff recruitment into roles is an ongoing challenge across the system
4. Continuing high level of demand for all level of emotional health & wellbeing services and support

Key Risks

1. Lack of financial support for non-mental health long term investment
2. Gaps in full engagement by all system partners in all programmes
3. Identification of resource to support current demands on service
4. CYP not able to access support quickly causing escalation in some cases to crisis or more complex needs. Wait times for treatment high

Learning Disabilities & Autism

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
LD health checks		NHS Digital	Dec-22	●	75.0%	56.3%	53.1%		
Adult Inpatients - Suffolk TCP (Rate per million)		NHS England	Dec-22	○			10.80		
U18s Inpatients - Suffolk TCP (Rate per million)		NHS England	Dec-22	○			0.00		
Adult Inpatients - Essex TCP (Rate per million)		NHS England	Dec-22	○			16.15		
U18s Inpatients - Essex TCP (Rate per million)		NHS England	Dec-22	○			0.00		
Flu Vaccination Uptake		CQRS	Jan-23	○			77.6%		
COVID-19 Vaccination Uptake - Autumn Booster		SystemOne	Feb-23	○			47.6%		

Key performance issues & root cause summary

Healthchecks – December figures show that in Ipswich and East Suffolk, 55.6% of healthchecks have been completed compared to 50.7% on the same period as last year. West Suffolk 47.5% compared to 46.8% on the same period as last year.

Key performance recovery actions (NEE)

NEE at 53.7% for LDHCs as at end Dec (Regional average 45.9%). 2 practices previously with 0% activity are now reportedly at 75%. Practices are being supported with coding issues, info on funding sources, best practice models, templates and tools. Promotion at CDs meeting in Jan. Specialist nursing team arranging PCN group training sessions. Evidence of PCN working now coming through. Practice level activity continues to be shared monthly to all practices, as peer pressure seems to be affective. Collaborative working continues at the NEE LD&A Steering Group with positive actions resulting. eg The charity Summit, which provides advocacy support is attending a practice managers meeting with an LD patient and a specialist LD nurse to present on challenges experienced and suggestions on future ways of engaging to deliver LDHCs.

Key performance recovery actions (Suffolk)

Work continues to provide support to those practices who are the least well performing. The NSFT LD Liaison team continue to reach out to those practices to offer support. An issue with the data has been identified; the data received from NHSE/Digital is not refreshed and so any changes that practices may make are not captured. For most, these changes will be insignificant (one or two checks), however a small number of practices have completed significantly more checks than what the data is suggesting. Conversations are underway with the Business Intelligence team, who can access a more accurate source of data (CQRS). The ICB will be able to use this when reviewing our practice level activity. This issue will be raised with the NHSE regional team as we need to ensure that they can also see the accurate data.

Learning Disabilities & Autism Committee (Suffolk)

Narrative submitted:

22/02/2023

Key activities completed in the previous 2 months

LD&A and partnership working presentation given to the WS TED event
National LDA Director, Tom Cahill, and Wendy Hicks, Regional Housing Lead visited Suffolk. Met members of the Suffolk LD Partnership Board, annual healthcheck peer educators, LD health facilitators, SCC colleagues, Intensive Support Team
My Health Focus Group main topic was Mental Health and emotional wellbeing
Work has begun to ensure that the new C(E)TR/DSR policy criteria is met
LD register deep dive started. An in depth view of the registers practice-by-practice level, developing a granular list to understand the LD population and how we as a system can best support them
Training for health and care staff in Advanced Care Planning for people with learning disabilities. Early feedback has been excellent

Key activities planned for the next 2 months

Exploring PHBs for people with LD as part of their annual health check and health action plan, funding has been identified to undertake a pilot. Discussions through the SNEE Oliver McGowan Steering Group to develop a plan for the training across health organisations. First phase will be for Tier 1
Discussions underway to develop a waiting list initiative to help clear the ASD/ADHD backlog. A service user workshop planned to listen to people with lived experience to help shape what a service should look like in order to support people whilst waiting for a diagnosis
Procurement to begin, led by SCC, to identify a provider to deliver the proactive support service
Development of the All Age Autism Strategy has now commenced and will be led by 31Ten Consulting

We have learned this and need to share...

We now have the workforce in place to rollout the train the trainer model for the Oliver McGowan Training. We need to share that our experts with experience require us, as an ICB, as a safe space to practice delivering initially the tier 1 1 hour online training

We need help with..

Continue emphasis with practices on the importance of completing LD annual health checks and Health Action Plans for people with a learning disability prior to the end of March 23. Particular push is requested on those practices who have only completed a few health checks.

Key Issues

Not meeting the LTP target for ASD diagnosis and provide no pre and post support
Diagnosis of ASD on patient records not NICE compliant

Key Risks

Healthchecks – young people not having a LD code are not being identified to be added to the LD register and are therefore not receiving an annual healthcheck
Funding to rollout the training of the OMMT is non recurrent
ASD waiting lists are long and demand is not being met.

Learning Disabilities & Autism Committee (North East Essex)

Narrative submitted:

23/02/2023

Key activities completed in the previous 2 months

- PCN CDs' meeting 5 Jan - Jackie Bland and Sally Harrington raised awareness of issues relating to leaving most of LDHCs until Q4 every year. Group training was requested.
- LeDeR report evidence. Shared with all practices that most LD patients are dying of pneumonia related illnesses in Essex, that NHS vaccinations are available and suggested combining LDHCs with the pneumonia jab in the Autumn.
- the 2 practices previously at 0% now reportedly at 75%
- Updated Practice level activity data shared with all practices.
- Support meetings; action planning, addressing coding issues; sharing best practice models, funding sources, info on their specialist LD nurses are; encouraging PCN working.
- Liaising with the specialist LD nursing team re joint strategy.

Key activities planned for the next 2 months

- The specialist LD nurses are providing group training sessions to PCNs, as a result of attendance at the PCN CDs' meeting.
- The charity Summit, which provides advocacy support is attending a practice managers' meeting with an LD patient and a specialist LD nurse to present on challenges experienced and suggestions on future ways of engaging to deliver LDHCs.
- Investigate further how NEE can adopt best practice models that employ co-ordinator roles to support LD patients to receive their LDHCs, as identified from an LDHC best practice webinar on 24 Jan.
- Continuing with the above support activities.

We have learned this and need to share...

The Essex LeDeR report highlighted that a very significant proportion LD patients are dying of pneumonia related illnesses in Essex, that Pneumonia vaccinations are available on the NHS and to suggest that practices consider carrying out the LD health check when they provide the pneumonia jab in the Autumn.

We need help with..

- Getting practices to gradually shift doing their LD health checks, from mostly towards the end of the year, to spreading them more evenly throughout the year.
- Whilst the IIF funding encourages PCNs as a whole to achieve LDHCs, there is currently no mechanism to make individual practices complete the health checks.

Key Issues

- Many practices leaving most of the LDHCs until the last 2 quarters. This has been a problem since inception of the scheme.
- Not having anyone within the ICB who understands the GP clinical systems and can help them resolve coding issues.
- Performance data does not tell us whether people who did not receive a health check last year have received one this year or not.

Key Risks

- Some hard to reach patients may not be receiving a health check on a rolling basis. We do not have the data to monitor/manage this, so there may be patients with worsening conditions who are not being monitored.
- LD patients not proactively monitored, are at higher risk of exacerbating conditions, leading to unplanned care incidents, greater demand on carers, poor quality of health/patient experience.

Quality

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Summary Hospital Mortality Index rate - ESNEFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Sep-22	●			1.0812 (2)	📉	
Summary Hospital Mortality Index rate - WSFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Sep-22	●			0.8877 (3)	📈	
CQC rating - ESNEFT		CQC	Jan-20	●			Requires improvement		
CQC rating - WSFT		CQC	Jan-20	●			Requires improvement		
CQC rating - NSFT		CQC	Apr-22	●			Inadequate		
Safety culture in NHS - raise concerns (ESNEFT)		NHS Staff Survey	Mar-21	●			74.5%		
Safety culture in NHS - raise concerns (WSFT)		NHS Staff Survey	Mar-21	●			68.7%		
MRSA rate (current month)		GOV.UK	Dec-22	●	0		1	📉	?
C Diff rate (current year - cumulative)		GOV.UK	Dec-22	●	157		126		
E-coli rate (current year - cumulative)		GOV.UK	Dec-22	●	155		145		

Key performance issues & root cause summary

The mortality index for ESNEFT & WSFT are as expected and below expected respectively in the rolling 12 months up until Sep-22

Both Trusts were rated as overall requiring improvement in Jan-20. ESNEFT required improvement in the responsive and safe domains, but was rated good for being caring, effective and well-led. WSFT were rated good for being caring and effective, but required improvement in all other domains

There was 1 MRSA breach in Dec-22 at ESNEFT. C. diff and E. coli are monitored against an annual cumulative threshold based on infection rates for the 12 months up to Nov-21. At current rates, E.coli and C. diff figures are projected to be well above threshold at year end

Key performance recovery actions

NSFT CQC rating: ICB executives fully engaged in improvement work within NSFT, as well as triangulating at regional level with colleagues from N&W ICB. Evidence groups underway with ICB commitment. Re-inspection expected September 2022.

MRSA: All MRSA cases investigated at provider level with oversight from ICB IPC team. PIRs underway, performance on timely completion improving, and resulting actions are followed through. IPC inspections have identified further areas for improvement (cleaning) and are working with providers to implement them.

Quality Committee

Key activities completed in the previous 2 months

On the 12 Jan 2023 the Quality Committee held its fourth meeting. The Quality Committees Terms of Reference were reviewed and agreed. Reports were presented on Continuing Healthcare, Infection Control and the Public Involvement and Experience Team. Discussions were had with regard to resilience and the fatigue and stress on staff of current working conditions.

Attain presented an updated list of the proposed Quality Data Set at the second meeting of the Dashboard Task & Finish Group. Discussions included the right data from EEAST, People measures and Childrens Health.

The Collective Accountability Framework was reviewed at the Development session held on the 09 Feb 2023. Next steps included the production of the framework for circulation to members prior to the March Quality Committee.

Key activities planned for the next 2 months

The next Quality Committee will be held on the 09 Mar 2023.

The next and final Dashboard Task & Finish Group meeting will be held on the 10 Mar 2023, where it was hoped that a working model would be ready for review.

The next Development Session will be held on the 13 Apr 2023.

We have learned this and need to share...

There was a requirement for ICB organisations to develop a five year Joint Forward Plan by the end of March 2023.

Recognition of local authorities' dual responsibility for quality assurance and statutory responsibility for safeguarding.

It was important that the flow of information was open and honest.

We need help with..

Five year Joint Forward Plan.
Draft the plan, hold workshops and engagement exercises.

Collective Accountability Framework.
Provide assurance and improvement across the ICB.

ICB Quality Dashboard.
Reviewing and providing feedback on the Dashboard.

Key Issues

The impact of Cost of Living issues.
Refugee and Asylum Seeker issues.
CQC Ratings for NSFT, EPUT & EEAST.
CYP access to Tier 4 Beds.
Dementia is excluded from MH D2A pathways.

Key Risks

EEAST delays and off loading waits.
NSFT Special Measures.
CYP access to MH treatment.
Covid Incident Level 3.
Special Schools in NEE do not have access to the Universal School Nursing Service.
Refugees and Asylum Seekers unable to access Primary Care.

Narrative submitted:

21/02/2023

Alliance - Ipswich & East Suffolk

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	Dec-22	●	70.0%		81.4%		
Hospital discharge to usual place of residence		SUS	Jan-23	●			96.3%		
GP appointments per 10k weighted pop		NHS Digital	Dec-22	●			4,570		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22	●			67.6%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Nov-22	●	0.871		0.930		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Nov-22	●	10.0%		7.95%		
All 8 diabetes care processes		Eclipse	Feb-23	●			48.09%		
Supported through NHS diabetes prevention programme		Eclipse	Jan-23	●			1,793		
Referrals to NHS weight mgmt services per 100k pop		SystemOne	Feb-23	●			1,239		
Seasonal flu vaccination (over 65s)		CQRS	Jan-23	●			93.7%		
MMR 2 doses (5 year olds)		GOV.UK	Sep-22	●			91.07%		

Key performance issues & root cause summary

The reported UCR % is well above the target of 70%. DQ work remains on-going to ascertain whether the currently reported UCR % is accurate

Those who had a good experience of making a GP appointment is considerably higher than the 56% reported nationally and the highest in SNEE

In regards to reducing antibiotic usage, the number of items per STAR-PU remains above the target of 0.871 and the prescribing of broad spectrum antibiotics are well below the 10% Target

Key performance recovery actions

An updated antibiotic formulary in final stages of ratification & will be launched early next year. This is based on NICE guidance and will cover primary care and A&E prescribing across the whole ICS. The medicines team also review the data at practice level monthly and are working to support those practices who are exceeding either target.

8 Care Processes – Pre-Covid target remains 70% by 2023. Current live data is unreliable as only 8 of 34 practices are uploading their data to Eclipses. Subject to governance requirements we hope to employ a new more robust way of gathering this data that minimises any work on the practices. There is also a possibility that the IES diabetes LES could be modified to encourage practices to install Eclipse for the wider benefit of the system. The data from the NDPP has not yet been refreshed yet. Last reported figure was 34% of trajectory of a possible 40% so remains below target.

Ipswich & East Suffolk Alliance Committee

Key activities completed in the previous 2 months

Be Well: Proposal discussed with Suffolk Community Foundation and BSC Multicultural Services to enable CORE20PLUS5 approach for people living within multicultural communities in Ipswich West and East who are diagnosed with hypertension.

Stay Well: Development of primary care strategy forward planning initiated, review of enhanced services for 2023/24 ahead of April commissioning, interim phlebotomy LES commissioned for 8 months

Age Well: Cohere Arts and Suffolk Art Link providing pilot sessions in 2 care homes.

Die Well: Roll-out of ReSPECT on track, series of webinars underway, go live date is 1st March 2023

Key activities planned for the next 2 months

The Alliance has identified ten priorities for action for the period January to end March as follows:

1. Stabilised and improved operational resilience
2. 8 completed forward INT plans based
3. Initiated development of dedicated plans for Ipswich and Felixstowe
4. Co-produced an IES voluntary sector working model (within ICB framework)
5. Progressed the Primary Medical Care forward strategy (within system context)
6. Received safe accountability for POD
7. Concluded and implemented agreed community MH model
8. Established the refreshed Alliance Workforce Operational Group
9. Agreed a forward financial strategy
10. Completed the Alliance's refreshed forward delivery plan

We have learned this and need to share...

- COVID continues to impact on workforce within primary care
- Operational resilience and performance requires consistent, collective effort –
- Planning for seasonal variation in 23/24 needs to (and is) starting now, specifically including supporting management of the most complex patients
- INT plans likely require two-three absolute priorities for action to ensure focus and delivery
- PHM Band 8a IES Alliance programme manager post has been re-advertised

We need help with..

- Cohesive joint estates plan
- Further discussions to reduce demand and duplication across the system

Key Issues

- Workforce – recruitment and retention in some key professions continues to be a priority
- Estate issues unresolved that impacts on workforce for primary and community staff
- Current capacity issues within primary care significantly limit their ability to undertake programmes of work recommended by the Medicines optimisation team
- Current Price Concessions are resulting in significant cost pressures, impacting the GP prescribing budget
- Medicines shortages
- Senior INT roles vacant
- ESNEFT resource allocated to take forward iCare Frailty Toolkit enhancements/changes will be leaving their role and have been asked to stop work with immediate effect

Key Risks

- Workforce
- Practice resilience
- The prioritisation toolkit process for financial pressures will not be completed until February 2023 leaving the Compassionate Companions scheme's workforce vulnerable

Narrative submitted:

23/02/2023

Alliance - North East Essex

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	Dec-22	●	70.0%		50.6%		
Hospital discharge to usual place of residence		SUS	Jan-23	●			94.9%		
GP appointments per 10k weighted pop		NHS Digital	Dec-22	●			4,427		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22	●			57.0%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Nov-22	●	0.871		1.025		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Nov-22	●	10.0%		8.35%		
All 8 diabetes care processes		Eclipse	Feb-23	●			71.39%		
Supported through NHS diabetes prevention programme		Eclipse	Jan-23	●			1,949		
Referrals to NHS weight mgmt services per 100k pop		SystemOne	Feb-23	●			351		
Seasonal flu vaccination (over 65s)		CQRS	Jan-23	●			86.2%		
MMR 2 doses (5 year olds)		GOV.UK	Sep-22	●			89.84%		

Key performance issues & root cause summary

ESNEFT has reported data quality issues on CSDS, which may be affecting performance figures. This is being actively looked at. Prior to CSDS the response was generally around the 80% mark but since the introduction of CSDS performance has dropped to be constantly in the 50 – 60% bracket for 2 hour response.

Other issues impacting performance include referrals coming into the service that do not need a 2 hour response but still need an urgent response (within 4 hours) and referrals coming in from the discharge pathway that are delayed with transport to get the patient home.

In regards to reducing antibiotic usage, the number of items per STAR-PU remains considerably higher than target, however prescribing of broad spectrum antibiotics are below the 10% Target

Key performance recovery actions

The team are looking at resolving data quality issues in CSDS submissions and reporting, which has been affecting UCRS performance figures.

Further information may need to be shared with referrers to ensure only referrals requiring a 2 hour response are sent to UCRS and to ensure patients not suitable for UCRS are signposted to more appropriate services.

Transport delays are being discussed with the NEE transport provider to improve timeliness of discharge.

NDDP - 2 engagement officers working with practices to encourage referral of pre-diabetic patients. Also supporting more searches of pre-diabetic patients and contacting about free life changing course Diabetes care processes – NHSI asked to restore % to above national average of 57%, funding to help with improvement plan across the ICS. NEE were best recovered service for care processes in the country

North East Essex Alliance Committee

Narrative submitted:

20/02/2023



Key activities completed in the previous 2 months

The Committee received the Breaking Barriers Innovation (BBI) project report, detailing the work underway to address the inequalities in coastal communities in Tendring and planned next steps.

The Be Well domain presented their spot light report, which highlighted the proposed areas of focus including healthy eating supporting both weight management and cost of living crisis and quality of housing stock.

The Committee was updated that Councillor Lynda McWilliams from Tendring District Council will be put forward as the Political representative for NEE on the Essex Wide Health and Wellbeing board.

Highlight reports were received from the Board sub-committees - Alliance Executive Group, Alliance Operational Group, with a focus on post Christmas debrief as well as evaluation of winter projects.

Key activities planned for the next 2 months

Continuing the Alliance development workshops, facilitated by the LGA.

Update on the future of the neighbourhood model to be shared with Feb Alliance Executive Group.

Evaluation of Start Well grant applications received, focusing on emotional health and wellbeing to be undertaken.

Age Well and Be Well bids to be received and issued to evaluation panel for review.

Review of joint forward plan, supported by engagement sessions to help inform Alliance Local Delivery Plan.

Circulation of the End of Year review.

Updated WELL group report to be shared with partners for comment.
Alliance Local Delivery plan outline to be shared with partners for comment.

Age Well spotlight report to be shared with the Committee.

Winter discharge funding review.

Stay Well Community Asset mapping report to be presented.

We have learned this and need to share...

The importance of taking time to reflect on progress to date to inform future model to support the Alliance. A reflection period has taken place within the neighbourhoods programmes with suggested recommendations to be presented to support the ongoing roll out of the model.

Alliance development sessions continue through March as an opportunity to review Alliance priorities and ways of working.

We need help with..

No new requests of SOAG.

Key Issues

Sustained operational pressures place competing demands on some of the domain leads/ Alliance partners.

Key Risks

No current risks to escalate.

Alliance - West Suffolk

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	Dec-22	●	70.0%		91.8%		
Hospital discharge to usual place of residence		SUS	Jan-23	●			95.3%		
GP appointments per 10k weighted pop		NHS Digital	Dec-22	●			4,386		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22	●			59.7%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Nov-22	●	0.871		1.020		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Nov-22	●	10.0%		9.53%		
All 8 diabetes care processes		Eclipse	Feb-23	●			43.97%		
Supported through NHS diabetes prevention programme		Eclipse	Jan-23	●			1,437		
Referrals to NHS weight mgmt services per 100k pop		SystemOne	Feb-23	●			749		
Seasonal flu vaccination (over 65s)		CQRS	Jan-23	●			88.6%		
MMR 2 doses (5 year olds)		GOV.UK	Sep-22	●			91.48%		

Key performance issues & root cause summary

The reported UCR % is significantly above the target of 70%. DQ work remains on-going to ascertain whether the currently reported UCR % is accurate. Antibiotic usage has been rising steadily and the number of items per STAR-PU is higher than the target of 0.871. The trend is similar to other systems regionally. However, the prescribing of broad spectrum antibiotics remains below the 10% Target. Diabetes metrics (people on the prevention programme and the 8 care processes) are both improving.

Key performance recovery actions

Antibiotic improvement: formulary being updated, finalised and communicated; recurrent UTI guidelines being updated; purple book for use with care homes being updated; structured medication review covering antibiotic use for UTI, Acne and COPD; joint working with WSFT to review inappropriate antibiotic usage; improved intelligence reporting for practices in place; establishing a SNEE Antimicrobial Stewardship working group (with representative from medicine optimisation teams, infection prevention & control, LPC, LMC, PCNs, primary and secondary care nursing) to help with the delivery of training using the TARGET antibiotics toolkit. Diabetes programme looking at practice level data and targeting support.

West Suffolk Alliance Committee

Narrative submitted:

22/02/2023



Key activities completed in the previous 2 months

- Seasonal planning and system tracking of impact
- Ageing well evaluation for release of 23/24 funding allocations
- Engagement of Joint Forward Plan
- Alliance Delivery Plan on track for sign off at WS Committee in April
- Cassius + Go Live
- Latest diabetes data shows significant improvement
- Community mental health change facilitation service begun by Suffolk GP Fed with NSFT & practices
- Partner input to WSDC housing development planning

Key activities planned for the next 2 months

- ACS Discharge funding planning for 23/24
- System integrated reablement modelling
- Exit strategy from non recurrent discharge funding
- CORE 20PLUS Task and Finish Group linking inequalities groups as a theme across the Alliance.
- Contuning to engage and connect with VCSE in WS
- Sign off of Live Well Domains into the Alliance Delivery Plan and alignment to JFP
- Development model in respect to integration with partnership organisations.
- Implementation of Live Well domains
- Development of Cassius+, including approach to digital change and Social Prescribing business case
- Review of approach to prescribing in WS to better understand why WS has higher costs
- Digital change proposal shared with WSFT SLT
- Codesign of Healthy Behaviours offer to WS

We have learned this and need to share...

- Engagement with local community demonstrates qualitative needs at place and directly fed into Neighbourhood Teams to shape our focus on outcomes.
- Acuity of acute activity has changed requiring a more radical shift in out of hospital care.
- WSA Digital Enabler: Cassius: National exemplar could enable prioritisation of prevention

We need help with..

N/A

Key Issues

Operational:

- Industrial action
- Workforce is biggest system challenge to resilience planning

Planning

- Working as partners to agree alliance plans

Key Risks

- Planned spend for Mental health is on track and likely to exceed. Mitigations and risk management plans in place include the Primary Care Commissioning Group being stood up to review actions and workplans to consider savings and resource requirements.
- Workforce challenges within clinical and health settings to be noted

Workforce

Metric	Planning Requirement	Data Source	Latest Date	S O F	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Leadership culture - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-21	●			6.64		
Leadership culture - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-21	●			6.89		
CQC well-led rating - ESNEFT		CQC	Jan-20	●			Good		
CQC well-led rating - WSFT		CQC	Jan-20	●			Requires improvement		
Engagement - staff survey (ESNEFT)	Score out of 10	NHS Staff Survey	Mar-21	●			6.67		
Engagement - staff survey (WSFT)	Score out of 10	NHS Staff Survey	Mar-21	●			6.99		
Bullying and harrassment (never experienced) - staff survey (ESNEFT)		NHS Staff Survey	Mar-21	●			78.0%		
Bullying and harrassment (never experienced) - staff survey (WSFT)		NHS Staff Survey	Mar-21	●			82.0%		
FTE GPs per 10k weighted pts		NHS Digital	Dec-22	●			5.2		
Direct pt care staff per 10k weighted pts		NHS Digital	Dec-22	●			5.7		

Key performance issues & root cause summary

The latest results from the NHS staff survey show that in regards to compassionate leadership both ESNEFT and WSFT staff responses were broadly in line with the national average, with WSFT matching the 6.9 (out of 10) sub-score and ESNEFT only just below

In relation to staff engagement, both Trusts reported similarly to the national average of 6.8 (out of 10), with WSFT above the average and ESNEFT just below

There are 3 survey questions in relation to bullying and harrassment, from patients, from managers and from colleagues. The metric score shown is the average of these 3 percentages

Key performance recovery actions

On going engagement with system partners

Linking with East of England Leadership Academy/ Looking at the system leadership programme

Utilising national staff survey engagement schemes

Developing Health and Wellbeing strategy and action plan

Continuing to develop the Training hub recruitment and retention programmes

West Suffolk Alliance Committee

Key activities completed in the previous 2 months

Healthcare Support Workers Recruitment Campaign - events held in Colchester, Ipswich and BSE: over 175 conditional offers made. This intervention was designed to decrease the vacancies in HCSW across health and care providers.

System Leadership Programme - agreement to proceed with the NHS Leadership Academy offer to partners for this program. This will help system engagement with 'wicked issues'.

Industrial Action Support - provided support to ESNEFT/WSFT on the RCN Industrial action days.

Reservists Programme - programme is now live and reservists are now able to work within the providers to support immediate staffing issues.

West Suffolk Workforce Alliance - the workforce plan for the alliance is being produced

Key activities planned for the next 2 months

We are planning on running a series of workforce planning workshops during February/March (subject to industrial action): these incl: Maternity, EDI, Community Services (for WSFT), Frailty, AHP. The Priorities and Operational Planning 23/24 process and the alignment between activity and finance will be a key activity until the end of March

We have learned this and need to share...

The industrial action process demonstrated a clear plan and alignment between workforce team and operational planning which proved important in supporting the system and ensuring good collaboration through a calm, measured way

We need help with..

Embedding workforce within other committees and programmes

Key Issues

Workforce issues still current

Key Risks

Workforce risks are still current

Narrative submitted:

27/01/2023

Finance

Financial Position: Performance against Key Targets

- Revenue (YTD and Forecast Outturn) Break-even

Month 10	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	Forecast outturn £000s	Forecast Variance £000s
SNEE ICB (CCGs Q1)	0	0	0	0	0	0
ESNEFT	0	161	161	0	0	0
WSFT	840	670	-170	1,008	1,008	0
Sub-total	840	831	-9	1,008	1,008	0
EEAST	-1,517	-1,566	-49	-1,000	-1,000	0
NHS Sub-total	-677	-735	-58	8	8	0

- System Capital and Capital Departmental External Limit (not to exceed, but deliver close)

Year to Date Month 10	ESNEFT			WSFT			EEAST			System Total		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
System Capital	22,230	14,557	-7,673	24,135	20,608	-3,527	8,850	3,614	-5,236	55,215	38,779	-16,436
CDEL	80,595	41,342	-39,253	26,910	22,776	-4,134	20,820	4,443	-16,377	128,325	68,562	-59,763
Forecast	Plan	Forecast	Variance	Plan	Forecast	Variance	Plan	Forecast	Variance	Budget	Actual	Variance
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
System Capital	23,311	23,311	0	30,250	31,750	1,500	10,618	10,345	-273	64,179	65,406	1,227
CDEL	99,267	78,841	-20,426	33,201	39,741	6,540	29,645	17,691	-11,954	162,113	136,274	-25,839

- Mental Health Investment Standard

The ICB forecast MH spend of £148.455m against a target of £148.310m; exceeding the MHIS target by 0.10% (0.05% last month).

The YTD overspend in NHS organisations continued to reduce, reaching £0.735m in m10 (£1.054m in m9). The variance from plan also reduced, from £0.280m to £0.058m. The forecast for the system and each component organisation remains on plan.

The Table reflects month 10 reported position against plan. The position reported in respect of system (BAU) capital is little changed from last month. Organisations are working to resolve year to date slippage (£16.436m), and continue to forecast that this will be achieved. The forecast position for YTD capital shows a small overspend (£1.227m); this is caused by the agreement (by NHSE) of additional RAAC expenditure at WSFT (£1.5m) that has not been reflected in a revised plan.

Changes in the wider (CDEL) capital target are more significant. In the period since report submission the long-standing issue of ESNEFT capital slippage against national programme projects has been resolved, with £30m of capital resource to be made available in 2023/24. Organisations are now working to manage within a revised capital envelope, including the need to accommodate any potential late changes to capital resources (e.g. diagnostic capital).

Finance

Financial Position: Other Issues

Risks and Mitigations

- Following further reviews the system is now reporting a balanced risk position (i.e. risks = mitigations). The confirmation of additional revenue resources for ERF and prescribing add to the confidence that an on-plan position will be delivered at the year-end.

Efficiency Savings

	Year to Date			Forecast Outturn			Forecast Outturn Memorandum		
	YTD Bud £000s	YTD Act £000s	YTD Var £000s	YTD Bud £000s	YTD Act £000s	YTD Var £000s	Recurrent £000s	Non-Rec't £000s	Total £000s
ESNEFT	21,869	15,684	-6,185	27,567	19,537	-8,030	14,874	4,663	19,537
WSFT	6,275	6,275	0	7,500	7,500	0	6,500	1,000	7,500
EEAST	9,313	4,270	-5,043	13,200	5,202	-7,998	2,104	3,098	5,202
ICB	14,409	12,363	-2,046	17,293	14,739	-2,554	7,658	7,082	14,740
Total	51,866	38,592	-13,274	65,560	46,978	-18,582	31,136	15,843	46,979

- Changes in the year to date and forecast efficiency savings performance are relatively small. Forecast slippage has increased slightly from £18.123 m to £18.582.
- Organisations continue to forecast break-even. However, both the slippage, and the level of non-recurrent savings achieved highlight the challenge to be faced in 2023/24 when the level flexibility to address these figures will be much reduced.

Agency Cap

Systems are required to deliver a 10% reduction in agency spend (c/w 2021/22). This remains a desirable outcome, but it has become apparent from discussions with the Regulator that the emphasis on this target has been reduced. Delivery of the target would risk impacting on elective recovery and other operational targets. On-going industrial action in key working groups not foreseen at the time the target was set also has impacted the ability to delivery reductions in agency. This is recognised nationally; reporting of performance against this target has been suspended.

Targets are, however, being set for 2023/24.

ICB BOARD

Agenda Item No.	11
Reference No.	ICB 23-21
Date.	21 March 2023

Title	Governance Updates for Delegation of Pharmacy, Optometry and Dental
Lead Director	Maddie Baker-Woods (POD) Amanda Lyes (Governance)
Author(s)	Lizzie Mapplebeck, Associate Director of Strategic Change
Purpose	For Approval
Recommendation:	
It is recommended the ICB Board approve the updates to the ICB governance documentation (Scheme of Reservations and Delegations and Functions and Decisions Map) to reflect the new delegated responsibilities for pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) on 1 st April 2023.	

1. Background

- 1.1 In May 2022, NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023.
- 1.2 Hertfordshire & West Essex ICB (HWE) will be hosting Pharmacy and Optom (P&O) for the East of England. This means they will host the team that manage P&O market entry and contract management (including complaints and communications) and P&O finances on behalf of all 6 East of England ICBs.
- 1.3 Suffolk and North East Essex ICB will lead (in house) management of Suffolk and North East Essex dental contracts (and wider functions), dental transformation, pharmacy transformation and optom transformation.
- 1.4 As part of the programme to manage the safe delegation of POD services to SNEE a number of governance documents are required to be updated, approved and published. This report details the changes we have been required to make to the key ICB governance documentation to provide assurance to the Executive Committee regarding adherence to good governance.

2. Key Issues

2.1. ICB Constitution

There is no obligation in the Delegation Agreement to alter ICB constitution. Therefore no updates will be made to the ICB Constitution, this has been confirmed (in writing) by NHS England as acceptable.

2.2. Governance Handbook

The NHS Suffolk and North East Essex Integrated Care Board Governance Handbook supports the NHS Suffolk and North East Essex Integrated Care Board Constitution by bringing together a range of corporate documents into one place.

Whilst it is not a legal requirement to have a Governance Handbook, it supports SNEE ICB to build a consistent corporate approach and brings relevant corporate documents together.

It is a requirement that the Governance Handbook is published on the SNEE ICB website as it includes the Terms of Reference for the statutory committees of the ICB.

The Governance Handbook includes the following key documents.

- Suffolk and North East Essex Integrated Care Board Functions and Decisions Map
- Scheme of Reservations and Delegations (SoRD)
- Committee Terms of Reference for the following Committees:
 - ICB Audit Committee
 - ICB Remuneration and Human Resources Committee
 - ICB Quality Committee

- ICB People Committee
- ICB Finance Committee
- Ipswich and East Suffolk Alliance
- North East Essex Alliance
- West Suffolk Alliance
- Suffolk and North East Essex Integrated Care Partnership
- Standards of Business Conduct and Conflicts of Interest Policy
- Detailed Financial Policies (SFIs)
- ICB People and Communities Strategy
- Primary Care Partner Members – Eligible Nominating Practices

To ensure the Governance Handbook reflects the delegation of POD, the documents in sections 2.3 and 2.4 have been updated.

The Governance Handbook will be updated once the below updated documents have been approved by the ICB Board on 21st March, the revised version will be updated on the ICBs website.

2.3. Scheme of Reservation and Delegation

The purpose of the Scheme of Reservation and Delegation (SoRD) is to provide information on the 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.

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.

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.

The SNEE ICB SoRD is detailed within Appendix A with changes highlighted in red.

The Ipswich and East Suffolk Alliance and West Suffolk Alliance SoRDs are detailed within Appendix B and C respectively with changes highlighted in red (note: there is no change relating to POD as wording was incorporated on 1st July 2022, the change highlights the new 'Suffolk Mental Health Collaborative Committee')

The North East Essex Alliance SoRD has not been amended and is therefore not attached.

2.4. Functions and Decisions

It is a requirement of ICBs to have a Functions and Decision Map which is 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 including POD.

The Suffolk and North East Essex Functions and Decision Map sets out the governance for the integrated NHS landscape.

The Suffolk and North East Essex Functions and Decisions Map sets out the governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance, it relates to the delegation of NHS ICB resources.

The purpose of the Functions and Decisions Map is to facilitate transparent decision-making and foster the culture and behaviours that enable system working. It details the health commissioning duties of NHS Suffolk and North East Essex Integrated Care Board, it does not detail the wider system duties of the Integrated Care Partnership or the Integrated Care System.

The full Functions and Decisions Map can be found within Appendix D with changes highlighted.

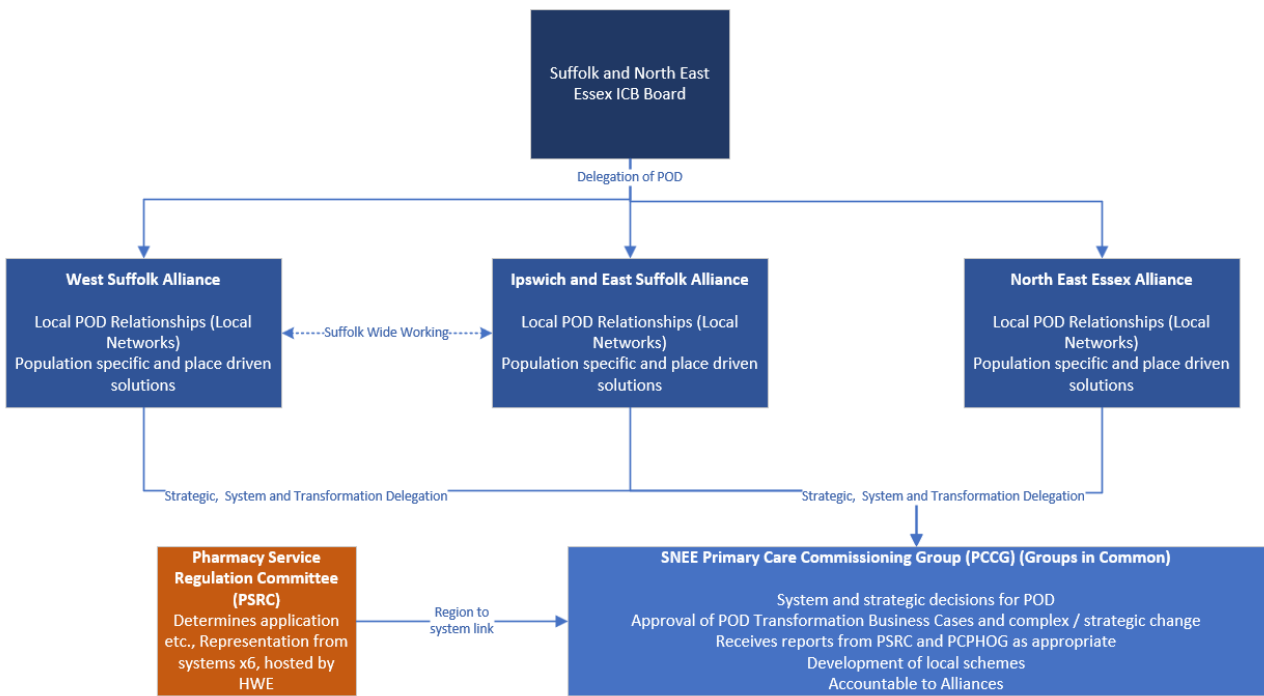
2.5. Terms of Reference

Terms of Reference for the Quality Committee, People Committee, Alliances (x3), and SOAC have all been reviewed in relation to the new functions. There are no changes to the Terms of Reference found within the Governance Handbook or those listed above.

The only Terms of Reference that requires updating is the Primary Care Commissioning Group, as this does not form part of the Governance Handbook and does not require approval from the ICB Board (approval is sought from the Alliances) it is not appended to this report.

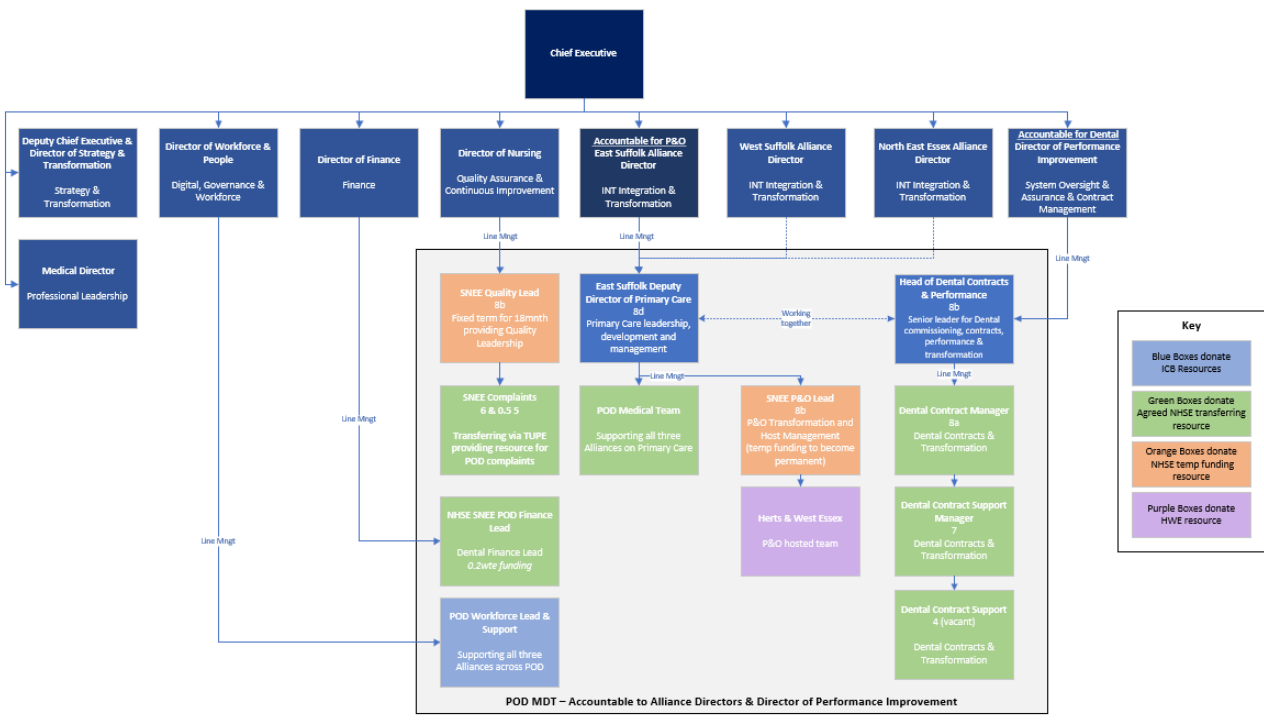
2.6. Governance Structure

The Governance Structure has been developed and approved by the Executive Committee (on 23rd January 2023); this is below for information.



2.7. Management Structure

The Management Structure has been developed and approved by the Executive Committee (on 23rd January 2023); this are below for information.



3. Recommendation

3.1 It is recommended the ICB Board approve the updates to the ICB governance documentation (Scheme of Reservations and Delegations and Functions and Decisions Map) to reflect the new delegated responsibilities for pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) on 1st April 2023.

Appendix A: ICB SORD

SUFFOLK AND NORTH EAST ESSEX ICB – SCHEDULE OF MATTERS RESERVED TO THE ICB AND SCHEME OF DELEGATION – (SoRD)

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
1. REGULATION AND CONTROL	Determine the arrangements by which the Members of the Board approve those decisions that are reserved for the Board.	✓																					
2. REGULATION AND CONTROL	Consideration and approval of applications to NHSEI on any matter concerning changes to the ICB Constitution, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and standing financial instructions.	✓																					
3. REGULATION AND CONTROL	Approve recommendations to NHSEI to change the Constitution, name of the ICB, to merge, federate or amalgamate, or to re-organise boundaries or organisational structures of the ICB.	✓																					

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
4. REGULATION AND CONTROL	Exercise or delegation of those functions of the Board which have not been retained as reserved by the Board, delegated to the Board, delegated to a committee or sub-committee of the Board or to one of its Members or employees.			✓																			
5. REGULATION AND CONTROL	Prepare the ICB's overarching scheme of reservation and delegation, which sets out those decisions of the Group <u>reserved</u> to the membership and those <u>delegated</u> to the: <ul style="list-style-type: none"> Board Committees and Sub-Committees An individual who may not be a Member of the Board or a specified person For inclusion in the ICB Constitution	✓																					
6. REGULATION AND CONTROL	Approval of the ICBs overarching scheme or reservation and delegation	✓																					
7. REGULATION AND CONTROL	Prepare the ICB's operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the ICB,			✓																			

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
8. REGULATION AND CONTROL	Approval of the ICB's operational scheme of delegation that underpins the overarching scheme of reservation and delegation' as set out in its Constitution			✓																			
9. REGULATION AND CONTROL	Prepare standing financial instructions & detailed financial policies that underpin the ICBs prime financial priorities				✓																		
10. REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests.			✓	✓																		
11. REGULATION AND CONTROL	Set out who can execute a document by signature	✓																					
12. REGULATION AND CONTROL	Approve proposals for primary care development, proposed GMS Local Development Scheme, proposed practice incentive schemes, and proposed new changes in existing GMS infrastructure									✓	✓	✓											
13. REGULATION AND CONTROL	Approve arrangements for identifying and appointing the ICB's proposed Chief Executive Officer		✓																				
14. REGULATION AND CONTROL	Approve arrangements for identifying and appointing the ICB's proposed Executive and Non-Executive Members	✓																					

Policy Area	Decision	DELEGATED TO																				
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee
15. REGULATION AND CONTROL	Confirm the appointment of Executive and Non-Executive Board Members		✓																			
16. REGULATION AND CONTROL	Approve arrangements for identifying and appointing the ICB's proposed Partner Board Members	✓																				
17. REGULATION AND CONTROL	Confirm the appointment of Partner Board Members		✓																			
18. REGULATION AND CONTROL	Approve arrangements for the reporting of conflicts of interest and the declaration process	✓																				
19. REGULATION AND CONTROL	Ensure that Registers of Interests are maintained and published on the ICB's web site			✓																		
20. REGULATION AND CONTROL	Oversight of both performance, including quality of care outcomes and relative development of the ICB													✓								
21. REGULATION AND CONTROL	Responsibility for ICB interface with place based Alliances and core commissioned services													✓								

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
22. STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the ICB in delivery of the ICP Integrated Care Strategy	✓																					
23. STRATEGY AND PLANNING	Approval of the ICB's operational structure	✓																					
24. STRATEGY AND PLANNING	Approval of the ICB's commissioning plans	✓																					
25. STRATEGY AND PLANNING	Approval of the ICB's corporate budgets that meet the financial duties as set out in the relevant section(s) of the Constitution	✓																					
26. STRATEGY AND PLANNING	Approval of variations to the approved budget where variation would have significant impact on the overall approved levels of income and expenditure or the ICB's ability to achieve its agreed strategic aims	✓																					
27. STRATEGY AND PLANNING	<p>Oversight and scrutiny of financial performance in relation to:</p> <ul style="list-style-type: none"> The current and forecast in year financial position receiving detailed reports including progress towards meeting targets agreed within the ICB's financial plan 									✓													

		DELEGATED TO																						
Policy Area	Decision	Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee		
	<ul style="list-style-type: none"> Implementation of QIPP schemes and receiving updates on both the financial and performance activity for each Achievement of any ICB incentive schemes and receiving reports of the actual and forecast performance for each Reviewing the ICB's medium term financial plans Implementation of any investments and/or transformation schemes and forecast performance for each Receiving and reviewing departmental financial delivery plans 									✓														
28. ANNUAL REPORT AND ACCOUNTS	Approval of the ICB's annual report and annual accounts	✓																						
29. ANNUAL REPORT AND ACCOUNTS	Approval of arrangements for discharging the ICB's statutory financial duties	✓																						
30. HUMAN RESOURCES	Approve the terms and conditions, remuneration and allowances for Board members, including pensions							✓																
31. HUMAN RESOURCES	Recommend terms and conditions of employment for all																							

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
	employees of the ICB including pensions, remuneration, fees and travelling or other allowances payable to the employees and to other persons providing services to the ICB							✓															
32. HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Chief Executive and for other persons working on behalf of the ICB							✓															
33. HUMAN RESOURCES	Recommend for approval the arrangements for discharging the ICB's statutory duties as an employer							✓															
34. HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the ICB							✓															
35. HUMAN RESOURCES	Approve system wide workforce plans linked to population health management																✓						
36. HUMAN RESOURCES	Approve plans and initiatives aimed at measuring and improving equality,																✓						

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
	diversity and inclusion																						
37. HUMAN RESOURCES	Measuring and analysing workforce data supported by agreed metrics																✓						
38. HUMAN RESOURCES	Responsibility for improving capability and capacity to undertake workforce planning, development and transformation																✓						
39. QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes							✓															
40. QUALITY AND SAFETY	Approve arrangements for discharging the ICB's responsibilities in relation to inspection and review of the ICS by the CQC					✓		✓															
41. QUALITY AND SAFETY	Provide assurance to the ICB that it is delivering its functions in a way which secures continuous improvement in the quality of services against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021					✓		✓															

		DELEGATED TO																					
Policy Area	Decision	Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
42. QUALITY AND SAFETY	Provide assurance regarding the implementation of all statutory duties in relation to the safeguarding of adults and children					✓			✓														
43. QUALITY AND SAFETY	Monitoring and management of Safeguarding arrangements					✓			✓														
44. QUALITY AND SAFETY	Responsibility for monitoring the continuous improvement in the quality of primary care services								✓		✓	✓	✓										
45. QUALITY AND SAFETY	Through patient and public involvement, responsibility for influencing discussion about quality and commissioning processes, decision making, planning and prioritising															✓							
46. OPERATIONAL AND RISK MANAGEMENT	Responsibility for day to day management and the ICBs key operations forum																				✓		
47. OPERATIONAL AND RISK MANAGEMENT	Executive oversight and assurance to the Board regarding delivery of the ICBs statutory functions																				✓		

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
48. OPERATIONAL AND RISK MANAGEMENT	Responsibility for approval of expenditure up to and including £3m																				✓		
49. OPERATIONAL AND RISK MANAGEMENT	Approve the ICB's counter fraud and security management arrangements						✓																
50. OPERATIONAL AND RISK MANAGEMENT	Approval of the ICB's risk management arrangements						✓																
51. OPERATIONAL AND RISK MANAGEMENT	Approve arrangements for risk sharing and or risk pooling with other organisations under section 75 of the NHS Act 2006)	✓								✓	✓	✓											
52. OPERATIONAL AND RISK MANAGEMENT	Approval of a comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the ICB						✓																
53. OPERATIONAL AND RISK MANAGEMENT	Responsibility for the Auditor Panel in the selection and appointment of internal and external auditors	✓																					
54. OPERATIONAL AND RISK MANAGEMENT	Approve proposals for action on litigation against or on behalf of the ICB	✓																					

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
55. OPERATIONAL AND RISK MANAGEMENT	Approve the ICB's arrangements for business continuity and emergency Planning	✓					✓																
56. INFORMATION GOVERNANCE	Approve the ICB's arrangements for handling complaints	✓																					
57. INFORMATION GOVERNANCE	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data															✓							
58. INFORMATION GOVERNANCE	Determining and approving arrangements for handling Freedom of Information requests			✓																			
59. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the ICB's statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public	✓																					

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
	engagement and consultation																						
60. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approve arrangements for co-ordinating the commissioning of services with Alliances and/or with the local authority(ies), where appropriate	✓																					
61. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Providing joint system leadership for LD&A service commissioning									✓	✓	✓											
62. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Providing joint system leadership for Mental Health service commissioning									✓											✓		
63. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Providing joint system leadership for Children and Young People service commissioning									✓	✓	✓											
64. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Exercise commissioning responsibility for a proportion of specialised services with national standards and access policies remaining at a national level																						✓
65. COMMISSIONING AND CONTRACTING	Approval of the arrangements for discharging the ICB's statutory duties associated																						

Policy Area	Decision	DELEGATED TO																				
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee
FOR NON-CLINICAL SERVICES	with its commissioning functions for non-clinical services, including but not limited to probity in the procurement process and assurance of value for money	✓																				
66. COMMISSIONING AND CONTRACTING FOR CLINICAL AND NON-CLINICAL SERVICES	Responsibility for providing oversight and challenge to ensure procurement policy and process is delivered appropriately													✓								
67. COMMISSIONING AND CONTRACTING FOR CLINICAL AND NON-CLINICAL SERVICES	Responsibility to secure quality and value for money services through procedures which are transparent, proportionate, fair and non-discriminatory													✓								
68. PRIMARY CARE COMMISSIONING	Make collective decisions on the review, planning and procurement of primary care services										✓	✓	✓									
69. PRIMARY CARE COMMISSIONING	Exercise such functions as specified by the ICB under delegated arrangements from NHS England and NHS Improvement for Primary Medical Services but continuing to exclude Section 7A Public Health functions										✓	✓	✓									
70. PRIMARY CARE COMMISSIONING	Exercise responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance										✓	✓	✓									

Policy Area	Decision	DELEGATED TO																					
		Reserved to Board	Chair	CEO	DoF	DoN & MD	Audit Committee	Rem & HR Committee	Quality Committee	Finance Committee	NEE Alliance Committee	I&ES Alliance Committee	WS Alliance Committee	Procurement Committee	System Oversight & Assurance Committee	Patient & Public Involvement Committee	People Committee	Digital Committee	Estates Committee	Executive Committee	Suffolk Mental Health Collaborative Committee	Specialist Services Commissioning Committee	
	contractors)																						
71. DIGITAL SERVICES	Coordinate the development and implementation of system wide Digital Strategy together with cross cutting programmes																	✓					
72. DIGITAL SERVICES	Provide assurance and accountability for ICB digital investments in order to deliver priority outcomes																	✓					
73. DIGITAL SERVICES	Provide strategic leadership, including prioritisation for the ICB Digital Agenda																	✓					
74. ESTATES	Develop, implement and monitor ICB strategic infrastructure strategy																		✓				
75. ESTATES	Prioritisation and oversight of infrastructure strategy and associated work programme																		✓				
76. ESTATES	Ensure effective estates utilisation																		✓				
77. ESTATES	Development and maintenance of of estates data set and monitor system wide estates metrics																		✓				

Appendix B: Ipswich and East Suffolk Alliance SoRD

IPSWICH AND EAST SUFFOLK ALLIANCE COMMITTEE – SCHEDULE OF MATTERS RESERVED TO THE COMMITTEE AND SCHEME OF DELEGATION – (SoRD)

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
78. REGULATION AND CONTROL	Determine the arrangements by which the Members of the Committee approve those decisions that are reserved to the Committee.	✓													
79. REGULATION AND CONTROL	Consideration and approval of applications to SNEE ICB on any matter concerning changes to the Alliance terms of reference, its groups, membership of groups, the overarching scheme of reservation and delegated powers and arrangements for taking urgent decisions.	✓													
80. REGULATION AND CONTROL	Exercise or delegation of those functions of the Committee which have not been retained as reserved by the Committee, delegated to the Committee, delegated to a group of the Committee or to one of its Members or employees.			✓											

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
81. REGULATION AND CONTROL	Prepare the Committees overarching scheme of reservation and delegation, which sets out those decisions of the Committee <u>reserved</u> to the membership and those <u>delegated</u> to the: <ul style="list-style-type: none"> Committees Groups An individual who may not be a Member of the Committee or a specified person For inclusion in the Committee terms of reference	✓													
82. REGULATION AND CONTROL	Approval of the Committees overarching scheme or reservation and delegation	✓													
83. REGULATION AND CONTROL	Prepare the Committees operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the Committee			✓											
84. REGULATION AND CONTROL	Approval of the Committees operational scheme of delegation that underpins the overarching scheme of reservation and delegation' as set out in its terms of reference			✓											
85. REGULATION AND CONTROL	Prepare standing financial instructions & detailed financial policies that underpin the Alliance financial priorities				✓										

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
86. REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests.	✓			✓										
87. REGULATION AND CONTROL	Set out who can execute a document by signature	✓													
88. REGULATION AND CONTROL	Approve proposals for primary care development, proposed GMS Local Development Scheme, proposed practice incentive schemes, and proposed new changes in existing GMS infrastructure	✓													
89. REGULATION AND CONTROL	Approve arrangements for identifying and appointing the Committees proposed Director		✓												
90. REGULATION AND CONTROL	Confirm the appointment of Committee Members		✓												
91. REGULATION AND CONTROL	Approve arrangements for the reporting of conflicts of interest and the declaration process			✓											
92. REGULATION AND CONTROL	Ensure that Register of Interests is maintained and published on the Committees web site			✓											

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
93. STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the Committee in working with the ICB to deliver the ICP Integrated Care Strategy	✓													
94. STRATEGY AND PLANNING	Develop and manage delivery of the Alliance strategy and supporting delivery plan											✓			
95. STRATEGY AND PLANNING	Approval of the Committees operational structure	✓													
96. STRATEGY AND PLANNING	Approval of the Committees delegated budgets that meet the financial duties as set out in the relevant section(s) of the ICB Constitution	✓													
97. STRATEGY AND PLANNING	<p>Oversight and scrutiny of financial performance in relation to:</p> <ul style="list-style-type: none"> The current and forecast in year financial position receiving detailed reports including progress towards meeting targets agreed within the ICB's financial plan Implementation of QIPP schemes and receiving updates on both the financial and performance activity for each Achievement of any Alliance incentive schemes 	✓													

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
	and receiving reports of the actual and forecast performance for each <ul style="list-style-type: none"> Implementation of any investments and/or transformation schemes and forecast performance for each Receiving and reviewing departmental financial delivery plans 	✓													
98. STRATEGY AND PLANNING	Ensure integrated clinical pathways across prevention, physical and mental health												✓		
99. STRATEGY AND PLANNING	Provide clinical recommendations to the Alliance Committee linking with the ICB Clinical Professional Forum and other SNEE system Alliances												✓		
100. ANNUAL REPORT	Approval of the Committees annual report	✓													
101. HUMAN RESOURCES	Approve the terms and conditions, remuneration and allowances for Committee members									✓					

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
102. HUMAN RESOURCES	Recommend terms and conditions of employment for all employees of the Alliance including pensions, remuneration, fees and travelling or other allowances payable to the employees and to other persons providing services to the ICB									✓					
103. HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Director and for other persons working on behalf of the Alliance									✓					
104. HUMAN RESOURCES	Recommend for approval the arrangements for discharging the Alliance's statutory duties as an employer									✓					
105. HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the Alliance									✓					
106. HUMAN RESOURCES	Monitor plans and initiatives aimed at measuring and improving equality, diversity and inclusion	✓													

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
107. QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes			✓		✓									
108. QUALITY AND SAFETY	Approve arrangements for discharging the Alliance's responsibilities in relation to securing continuous improvement in the quality of clinical services			✓		✓									
109. QUALITY AND SAFETY	Provide assurance to the ICB that it is delivering its functions in a way which secures continuous improvement in the quality of services against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021			✓											
110. QUALITY AND SAFETY	Monitor the continuous improvement in the quality of primary care services										✓			✓	

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
111. QUALITY AND SAFETY	Ensure fundamental standards of quality are delivered including the management of quality risks and addressing inequalities										✓				
112. OPERATIONAL AND RISK MANAGEMENT	Ensure the Alliances risk register is maintained and appropriately managed			✓											
113. INFORMATION GOVERNANCE	Approve the Alliance's arrangements for handling complaints	✓													
114. INFORMATION GOVERNANCE	Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data	✓													
115. INFORMATION GOVERNANCE	Determining and approving arrangements for handling Freedom of			✓											

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
	Information requests														
116. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approval of the arrangements for discharging the Alliance's delegated duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation	✓													
117. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approve arrangements for co-ordinating the commissioning of services with Alliance Groups	✓													
118. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for LD&A service commissioning						✓								
119. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for Mental Health service commissioning								✓						

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
120. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for Children and Young People service commissioning							✓							
121. COMMISSIONING AND CONTRACTING FOR NON-CLINICAL SERVICES	Approval of the arrangements for discharging the Alliance duties associated with its delegated commissioning functions for other non-clinical services, including but not limited to probity in the procurement process and assurance of value for money	✓													
122. PRIMARY CARE COMMISSIONING	With the ICB, make collective decisions on the review, planning and procurement of primary care services	✓													
123. PRIMARY CARE COMMISSIONING	Providing decision making on all primary care delegated functions as per the Primary Care Delegation Agreement signed between NHSEI and the ICB													✓	
124. MEDICINES MANAGEMENT	Manage medicines and pharmacy governance in regard to strategic planning and assurance in accordance with the NHS Long Term Plan, NHSE Integrated Pharmacy and Medicines Optimisation Programme and DHSC Overprescribing Review														✓

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Alliance Quality group	Executive Delivery Group	Alliance Clinical Professional forum	Primary Care Commissioning Group	Area Prescribing Committee
125.	Manage medicines budget, quality agenda and QIPP in line with local Alliance strategy	✓													

Appendix C: West Suffolk Alliance SoRD

WEST SUFFOLK ALLIANCE HEALTH, CARE AND WELLBEING COMMITTEE – SCHEDULE OF MATTERS RESERVED TO THE COMMITTEE AND SCHEME OF DELEGATION – (SoRD)

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
126. REGULATION AND CONTROL	Determine the arrangements by which the Members of the Committee approve those decisions that are reserved to the Committee.	✓													
127. REGULATION AND CONTROL	Consider and approval of applications to SNEE ICB on any matter concerning changes to the Alliance terms of reference, its groups, membership of groups, the overarching scheme of reservation and delegated powers and arrangements for taking urgent decisions.	✓													
128. REGULATION AND CONTROL	Exercise or delegation of those functions of the Committee which have not been retained as reserved by the Committee, delegated to the Committee, delegated to a group of the Committee or to one of its Members or employees.			✓											

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
129. REGULATION AND CONTROL	Prepare the Committees overarching scheme of reservation and delegation, which sets out those decisions of the Committee <u>reserved</u> to the membership and those <u>delegated</u> to the: <ul style="list-style-type: none"> Committees Groups An individual who may not be a Member of the Committee or a specified person For inclusion in the Committee terms of reference	✓													
130. REGULATION AND CONTROL	Approve the Committees overarching scheme or reservation and delegation	✓													
131. REGULATION AND CONTROL	Prepare the Committees operational scheme of delegation, which sets out those key operational decisions delegated to individual employees of the Committee			✓											
132. REGULATION AND CONTROL	Approve the Committees operational scheme of delegation that underpins the overarching scheme of reservation and delegation' as set out in its terms of reference			✓											
133. REGULATION AND CONTROL	Prepare standing financial instructions & detailed financial policies that underpin the Alliance financial priorities				✓										

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
134. REGULATION AND CONTROL	Approve arrangements for managing exceptional funding requests.			✓	✓										
135. REGULATION AND CONTROL	Set out who can execute a document by signature	✓													
136. REGULATION AND CONTROL	Approve proposals for primary care development, proposed GMS Local Development Scheme, proposed practice incentive schemes, and proposed new changes in existing GMS infrastructure	✓													
137. REGULATION AND CONTROL	Approve arrangements for identifying and appointing the Committees proposed Director		✓												
138. REGULATION AND CONTROL	Confirm the appointment of Committee Members		✓												
139. REGULATION AND CONTROL	Approve arrangements for the reporting of conflicts of interest and the declaration process			✓											
140. REGULATION AND CONTROL	Ensure that Register of Interests is maintained and published on the Committees web site			✓											
141. STRATEGY AND PLANNING	Agree the vision, values and overall strategic direction of the Committee in working with the ICB to deliver the ICP	✓													

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
	Integrated Care Strategy														
142. STRATEGY AND PLANNING	Approve the Committees operational structure	✓													
143. STRATEGY AND PLANNING	Approve the Committees delegated budgets that meet the financial duties as set out in the relevant section(s) of the ICB Constitution	✓													
144. STRATEGY AND PLANNING	<p>Oversight and scrutiny of financial performance in relation to:</p> <ul style="list-style-type: none"> • The current and forecast in year financial position receiving detailed reports including progress towards meeting targets agreed within the ICB's financial plan • Implementation of QIPP schemes and receiving updates on both the financial and performance activity for each • Achievement of any Alliance incentive schemes and receiving reports of the actual and forecast performance for each • Implementation of any investments and/or transformation schemes 	<p>✓</p> <p>✓</p>													

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
	and forecast performance for each <ul style="list-style-type: none"> Receiving and reviewing departmental financial delivery plans 														
145. STRATEGY AND PLANNING	Deliver the Health Infrastructure Programme										✓				
146. STRATEGY AND PLANNING	Provide strategic leadership for the delivery of integrated health and care services including physical health, primary care, mental health, children and young people and the wider voluntary sector											✓			
147. STRATEGY AND PLANNING	Development and delivery of investment plans for wellbeing in West Suffolk											✓			
148. ANNUAL REPORT AND ACCOUNTS	Approval of the Committees annual report	✓													
149. HUMAN RESOURCES	Approve the terms and conditions, remuneration and allowances for Committee members									✓					
150. HUMAN RESOURCES	Recommend terms and conditions of employment for all employees of the														

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
	Alliance including pensions, remuneration, fees and travelling or other allowances payable to the employees and to other persons providing services to the ICB									✓					
151. HUMAN RESOURCES	Approve disciplinary arrangements for employees, including the Director and for other persons working on behalf of the Alliance									✓					
152. HUMAN RESOURCES	Recommend for approval the arrangements for discharging the Alliance's statutory duties as an employer									✓					
153. HUMAN RESOURCES	Approve human resources policies for employees and for other persons working on behalf of the Alliance									✓					
154. HUMAN RESOURCES	Monitor plans and initiatives aimed at measuring and improving equality, diversity and inclusion	✓													
155. QUALITY AND SAFETY	Approve arrangements, including supporting policies, to minimise clinical risk, maximise			✓		✓									

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
	patient safety and to secure continuous improvement in quality and patient outcomes														
156. QUALITY AND SAFETY	Approve arrangements for discharging the Alliance's responsibilities in relation to securing continuous improvement in the quality of clinical services			✓		✓									
157. QUALITY AND SAFETY	Provide assurance to the ICB that it is delivering its functions in a way which secures continuous improvement in the quality of services against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021			✓											
158. QUALITY AND SAFETY	Responsibility for monitoring the continuous improvement in the quality of primary care services	✓													
159. QUALITY AND SAFETY	Ensure fundamental standards of quality are delivered including the management of quality risks and addressing inequalities												✓		
160. INFORMATION GOVERNANCE	Approve the Alliance's arrangements for handling complaints	✓													

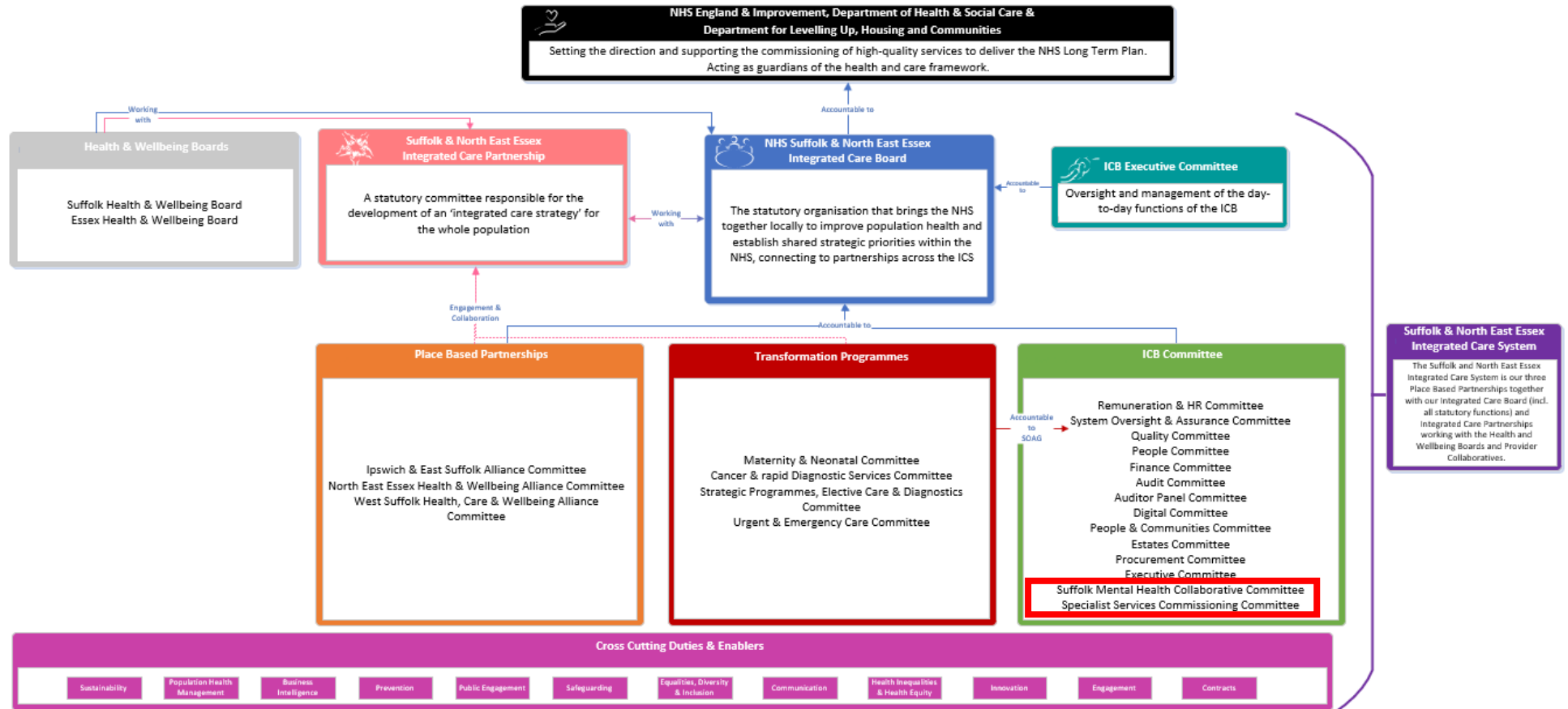
		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
161. INFORMATION GOVERNANCE	Approve the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data	✓													
162. INFORMATION GOVERNANCE	Determine and approve arrangements for handling Freedom of Information requests			✓											
163. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Approve the arrangements for discharging the Alliance's delegated duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation	✓													
164. COMMISSIONING AND CONTRACTING FOR CLINICAL	Approve arrangements for co-ordinating the commissioning of services with Alliance Groups	✓													

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
SERVICES															
165. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for LD&A service commissioning						✓								
166. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for Mental Health service commissioning								✓						
167. COMMISSIONING AND CONTRACTING FOR CLINICAL SERVICES	Lead for Children and Young People service commissioning							✓							
168. COMMISSIONING AND CONTRACTING FOR NON-CLINICAL SERVICES	Approve the arrangements for discharging the Alliance duties associated with its delegated commissioning functions for other non-clinical services, including but not limited to probity in the procurement process and assurance of value for money	✓													
169. PRIMARY CARE COMMISSIONING	With the ICB, make collective decisions on the review, planning and procurement of primary care services	✓												✓	

		DELEGATED/RESERVED TO													
Policy Area	Decision	Reserved to Committee	Chair	Alliance Director	ICB Director of Finance	ICB Director of Nursing & Medical Director	Suffolk Learning Disabilities & Autism Group	Suffolk CYP Group	Suffolk Mental Health Collaborative Committee	ICB RemCom	Future Systems Programme Group	Alliance Delivery Group	Alliance Quality Group	Primary Care Commissioning Committee	Area Prescribing Committee
170. PRIMARY CARE COMMISSIONING	Oversight of the development of the primary care networks, newly designed enhanced services and design of local incentive schemes. Providing decision making on whether to establish new GP practices in an area, approving practice mergers and making decisions on 'discretionary' payments													✓	
171. MEDICINES MANAGEMENT	Manage medicines and pharmacy governance in regard to strategic planning, assurance and resources allocated for the provision of medicines in accordance with the NHS Long Term Plan, NHSE Integrated Pharmacy and Medicines Optimisation Programme and DHSC Overprescribing Review														✓

Appendix D: ICB Functions and Decisions Map

Full ICB F&D Map (Simplified)



ICB F&D Map: Grouping Two Committees (expanded)

NHS Suffolk & North East Essex Integrated Care Board
 The statutory organisation that brings the NHS together locally to improve population health and establish shared strategic priorities within the NHS, connecting to partnerships across the ICS

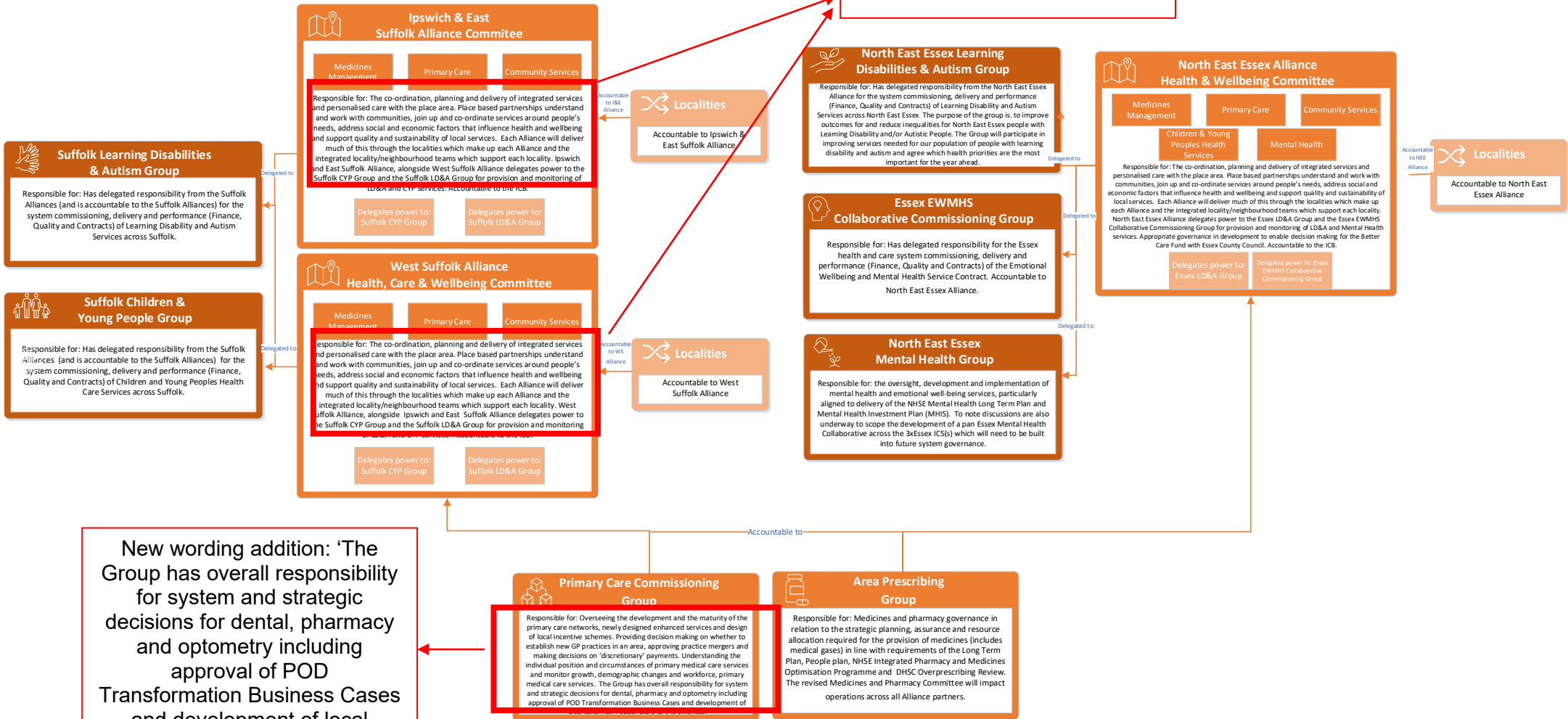
Accountable to

ICB Committees



ICB F&D Map: Grouping Two Alliances (expanded)

Wording Update: Removed reference to Mental Health delegation. This has been replaced by the Suffolk Mental Health Collaborative Committee



New wording addition: 'The Group has overall responsibility for system and strategic decisions for dental, pharmacy and optometry including approval of POD Transformation Business Cases and development of local schemes.'

ICB BOARD

Agenda Item No.	12
Reference No.	ICB 23-22
Date.	21 March 2023

Title	Establishment of the Suffolk Mental Health Collaborative
Lead Director	Richard Watson, Deputy ICB Chief Executive and Director of Strategy and Transformation
Author(s)	Andy Vowles
Purpose	For decision

Recommendation:

The Board is asked to:

- Agree to the establishment of the Suffolk Mental Health Collaborative from April 2023
- Agree to establish the Suffolk Mental Health Collaborative Committee as a sub-committee of the Integrated Care Board
- Agree to delegate mental health service commissioning functions into the Suffolk Mental Health Collaborative Committee
- Note that the detailed Terms of Reference of the Collaborative Committee will be presented for approval at the June 2023 ICB Board
- Note that, subject to the Terms of Reference of the Collaborative Committee being approved by the ICB Board, responsibility for relevant mental health budgets will move from the Alliances to the Collaborative from July 2023
- Agree to receive regular progress updates from the Suffolk Mental Health Collaborative Committee and to note that the minutes of the Committee will be reported to the ICB Board
- Endorse the direction of travel set out in this paper

1. **Background**

- 1.1 In 2019 partners from across Suffolk published the *East and West Suffolk Mental Health and Emotional Wellbeing 10 Year Strategy (2019-2029)*. This document was the culmination of an extensive period of co-production with service users, families and carers, staff and the wider public.
- 1.2 Since 2019, considerable further work has been completed to implement the service model outlined in the Strategy. This has involved an inclusive, partnership approach, in recognition of the fact that promoting good mental health is not the preserve of any one organisation.
- 1.3 To date, work to implement the Strategy has largely been co-ordinated through the Suffolk Mental Health Committee. This Committee, which is chaired by the Deputy Chief Executive of the ICB, encompasses a wide range of members, including the ICB, Suffolk County Council, Norfolk and Suffolk NHS Foundation Trust (NSFT), East Suffolk and North East Essex Foundation Trust (ESNEFT) West Suffolk Foundation Trust (WSFT), Suffolk GP Federation, Healthwatch, NHS England and a wide range of VCSE partners.
- 1.4 To further accelerate implementation of the Strategy and improve outcomes for local people, the Suffolk system has in recent months been considering changing the way in which decisions about mental health are made, through the development of a formal Suffolk Mental Health Collaborative. The proposed Collaborative will for the first time create a single forum where all decisions about mental health in Suffolk – setting strategy and outcomes, determining how resources should be deployed and how services are delivered – are brought together in one place.
- 1.5 This paper sets out in more detail why the establishment of the Collaborative is the recommended way forward, how it has been shaped, what its proposed scope is and how it will operate.

2. **Key Issues**

2.1 **Why establish a Suffolk Mental Health Collaborative?**

Achieving the best possible mental health outcomes for local people requires the active contribution of partners from right across the system. A comprehensive approach needs to focus on prevention and the promotion of wellbeing and resilience, right through to treatment for people with serious mental health conditions. As a result, traditional commissioning models (which tend to be bilateral between a single commissioner and provider) are unlikely to be effective.

Learning from the existing Suffolk Mental Health Committee suggests that simply bringing partners together is not enough to make progress at the pace desired. Although sharing and alignment of existing work between system partners and agencies (the current model) is very helpful, this is not as powerful as having a single system focal point for mental health decisions.

Such a forum would enable all local partners to come together to collectively take decisions on strategic plans and priorities, how to invest the available funds to deliver agreed outcomes, and how to configure and provide services. It is this space that the proposed system Collaborative is intended to fill.

It is also clear that taking a county-based approach is likely to be the optimal model for organising many elements of mental health, given the high degree of inter-dependency between services funded and organised by the NHS and those that are the responsibility of councils. The approach being proposed for Suffolk is largely mirrored by emerging

arrangements in Essex and Norfolk and Waveney and is in line with the emerging thinking within the national NHSE mental health team.

Establishing this Suffolk Mental Health 'board' is, partners agree, the logical next step in the evolution of local arrangements and will be central to accelerating progress.

2.2 Shaping the Collaborative

There has been extensive engagement with partners from across the system on whether to now develop a Suffolk Mental Health Collaborative, what its scope should be and how it might operate.

This has included 1:1 interviews with a wide range of stakeholders, discussion at a number of existing fora, and a major development workshop in January 2023 that included senior representatives from:

- The ICB (including clinical leads)
- Suffolk County Council
- NSFT
- ESNEFT
- WSFT
- NSFT
- VCSE partners including Suffolk Mind, Suffolk Family Carers and Suffolk Users Forum
- GP Federation and PCNs
- User voice organisations
- Suffolk Healthwatch

The work to develop the Collaborative has been guided by a small, senior sub-group of the existing Suffolk Mental Health Committee. This includes a Director level representative from NSFT, ESNEFT, WSFT, Suffolk GP Federation and a VCSE partner, as well as from Norfolk & Waveney ICB.

2.3 Proposed scope of the Collaborative

As part of the engagement work undertaken to develop these proposals, the broad 'shape' of the Collaborative has been discussed and agreed. The key elements are outlined below.

Delegated authority

As outlined above, the proposed model for the Collaborative is that it is decision making (rather than consultative or simply aligning activities), empowered to set direction on all relevant mental health issues and to determine how relevant financial resources are invested.

To facilitate this, it is proposed that the Committee that sits at the heart of the wider Collaborative is established as a sub-committee of the Suffolk and NE Essex Integrated Care Board¹. This will enable responsibility for mental health to be increasingly delegated as the Collaborative matures and becomes fully operational.

¹ The proposed establishment of the Collaborative Committee will, if agreed, necessitate some changes to SNEE ICB's Scheme of Reservation and Delegation and its Functions and Decision Map. These are detailed in the accompanying paper 20230321 ICB Board Governance Updates Report.

As a consequence of establishing the proposed Collaborative, responsibility for a number of budget lines will move from the two Suffolk Alliances to the Collaborative Committee. These are set out at Annex 1. It is proposed that this change is implemented from 1 July 2023, after the detailed Terms of Reference of the Collaborative Committee have been approved by the ICB. In addition, in common with all other SNEE Committees that have delegated authority for commissioning, the proposed Collaborative Committee will have a decision-making cap of £3m; changes above this level will revert back to the ICB Board.

It is proposed that the membership of the Collaborative Committee is of sufficient seniority to enable members to take decisions on behalf of their organisations. This is a key enabler for increasingly aligning and pooling financial resources, with the Collaborative being able to retain an overview of the whole financial envelope, and collectively take decisions on where best to invest the Suffolk 'mental health pound'.

Age range

It is proposed that the Suffolk Mental Health Collaborative is all age, bringing together services for children and young people, adults and older people. This, it is considered, is the best way of ensuring that there is an overview of all service provision, of managing transitions between service areas (for example from youth to adult services) and of assessing opportunity costs.

Scope of services

Similarly, it is proposed that the Collaborative should be 'end-to-end', with a role in shaping the full range of services and support from prevention, resilience and wellbeing through to the provision of secondary mental health care.

This is because stakeholders recognise that mental health is a continuum from prevention through to treatment, and that there are always opportunity costs that need to be considered when organising support or services (for example, an increased investment in secondary care provision reduces the level of resource available for prevention support, and vice versa).

There are a small number of services which, it is proposed, remain out of scope of the Suffolk Collaborative, in general because there are existing arrangements in the county which work well. The main exceptions are neurodevelopmental services (NDD) and the more specialist mental health services that are provided by the East of England Mental Health Collaborative.

In addition, while the intention is for the Collaborative to be responsible for taking decisions on most 'core' mental health planning and delivery issues within Suffolk, there are a number of areas in which the Collaborative will wish to take a close interest in – in order to promote alignment and integration – but over which it will not have decision making authority. These two categories (core and non-core) will be mapped during the first phase of the Collaborative's operation, but examples of the latter are likely to include dementia and a number of public health programmes.

Waveney

One area that requires clarity in defining the remit of the Suffolk Collaborative is the position of Waveney. Whilst this area falls within the county of Suffolk, all NHS funded services are the responsibility of the Norfolk & Waveney ICB.

In developing these proposals, there has been extensive engagement between colleagues from the Norfolk and Waveney and Suffolk and NE Essex systems to determine how best to establish arrangements that are clear and practical, whilst taking into account the need to achieve consistent delivery arrangements for some integrated services.

The position that has been identified by partners as logical and pragmatic is for all NHS funded mental health support for children and young people in Suffolk (including for Waveney) to be in scope for the Suffolk Collaborative. This model reflects the recognition among partners of the key role county councils play in organising and delivering wider children's services (social care, education, public health etc) and the resulting importance of ensuring there are consistent county-based models.

Decisions about NHS funded mental health services for adults and older people in Waveney that are the responsibility of Norfolk and Waveney ICB are not within the scope of the Suffolk Mental Health Collaborative. Decision making for these services will be within the proposed Norfolk and Waveney Adult and Older People Mental Health Collaborative, which will likely include senior representation from Suffolk County Council.

The two ICBs are working together to develop and agree the best way of implementing these arrangements, and to address any final outstanding issues. The detailed arrangements will be confirmed in the final Terms of Reference of the Collaborative Committee.

2.4 Development of the Collaborative

In developing the proposed approach to the Suffolk Mental Health Collaborative, partners have recognised that having a structure which has at its core a model of collective decision making is a different way of working and is one which will take time to fully mature. It is anticipated that there will be a number of phases, and that an ongoing programme of development to ensure that appropriate value, behaviours and culture are instilled will be required.

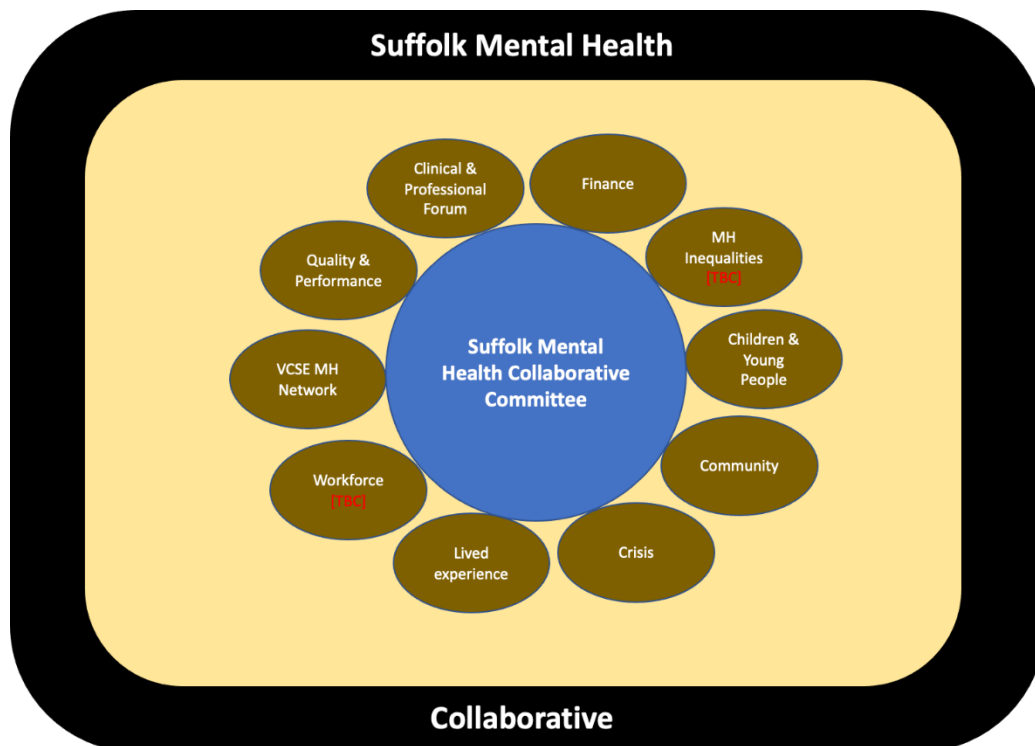
A number of potential priorities for the first phase (six months) of the Collaborative have been identified, and include:

- A stocktake of progress in implementing the existing ten-year strategy
- Development of the proposed supporting groups which will report into the proposed Collaborative Committee (see figure 1 below)
- Decisions on service priorities, including:
 - Integration of children and young people's mental health services
 - Future model of IAPT
 - Future model of PCN Mental Health Practitioners

2.5 Operation of the Collaborative

It important to reiterate that the Mental Health Collaborative is viewed as the broad concept, encompassing the organisations within it, the supporting groups and the core Collaborative Committee itself:

Figure 1 – Proposed Collaborative and supporting Groups



The key elements of the Committee that sits at the heart of the Collaborative are set out below.

Membership

As it is proposed that the Collaborative Committee will operate as (in effect) the system 'Board' for Mental Health, its core membership will be relatively small, including senior (Director-level or above) representation from:

- SNEE ICB (including Alliance Directors)
- Norfolk and Waveney ICB (in relation to mental health services for children and young people)
- Suffolk County Council
- Suffolk Police
- NSFT
- ESNEFT
- WSFT
- VCSE partners (including Chair of the proposed VCSE Mental Health Network)
- GP Federation and PCNs
- Clinical and Professional Forum – Chair of the proposed Forum
- Lived Experience Forum – Chair of the proposed Forum
- Children and Young People Lived Experience lead
- Healthwatch Suffolk

There are a number of options for chairing the Collaborative Committee that have been considered. However, in order to ensure that there is continuity and that momentum is maintained, during the first phase the Committee will be chaired by the Deputy Chief Executive of the ICB.

Sub-groups

Although the core Collaborative Committee will necessarily be a relatively small group, the overall Collaborative is intended to be highly inclusive. To enable this, as outlined above it is proposed that a number of supporting groups will be established (or, in some cases, existing groups repurposed), each of which will directly connect with the Collaborative Committee.

There are broadly three types of supporting group:

1. Functional / service development:

- Children and Young People – focusing on the development and delivery of the existing Thrive model for children and young people’s mental health
- Community – focusing on the new community mental health model including the integration within the integrated neighbourhood teams and PCNs
- Crisis – focusing on the further development of the 24/7 mental health crisis model including further integration with blue light services (EEAST and police)

2. Advisory:

- Clinical and Professional Forum – bringing together clinical and professional leads from partner members to support the development and delivery of mental health services
- Lived Experience Forum – bringing together a representative group of people with lived experience to support the work of the Suffolk Mental Health Collaborative
- VCSE Mental Health Network - bringing together VCSE organisations who are either directly delivering mental health commissioned services in Suffolk and others who have an interest in or are providing mental health support services

3. Operational groups:

- Quality and performance – focusing on an system overview of quality and performance of mental health services across the Suffolk Mental Health collaborative
- Finance – focusing on financial planning and monitoring of budgets and expenditure related to mental health services
- Workforce – focusing on workforce planning, recruitment and development as related to mental health

Relationship with the Alliances

Getting the relationship right between the Suffolk Mental Health Collaborative and the two Suffolk Alliances (and the Integrated Neighbourhood Teams) will be vital. It is not the intention of the Collaborative to centralise planning or delivery of mental health.

Although some mental health services are best organised and delivered on a county footprint, many – in particular those focused more on prevention, wellbeing and early intervention (Feel Well) – need to be designed and delivered locally.

In order to help to strike this balance, the Directors of both the Suffolk Alliances will be full members of the proposed Collaborative Committee, and it is explicit in the draft Terms of Reference of the latter that (where appropriate) decisions about the planning and delivery of mental health services will rest at Alliance level. There are also other strong connections between the proposed Collaborative and the Alliances – for example key provider partners (NSFT, WSFT, ESNEFT) are represented at both. It is also the intention to keep this balance under review as the Collaborative develops.

Resourcing the Mental Health Collaborative

It is clear that to be effective the overall Collaborative (i.e. the supporting groups as well as the core Collaborative Committee itself) will need to be appropriately resourced. A number of skills will be required, including programme and project management, clinical, finance, quality and administration, as well as key skills and experience such as coproduction.

Over time, it is the intention that an informal 'executive' will sit under the Collaborative Committee, bringing together skills, expertise and capacity from across the wider system. In its first phase, however, the Collaborative will be largely supported by existing resources from within the ICB. Further work is currently underway to map the required level of resource, and highlight any gaps with a plan developed by the end of April 2023 for consideration and agreement by the proposed Collaborative Committee.

3. Patient and Public Engagement

3.1 The proposals set out in this paper have been developed with the contribution of key existing patient, user and carer groups, including:

- Healthwatch Suffolk
- Suffolk Mind
- Suffolk User Forum
- Suffolk Family Carers

3.2 The ICB People and Communities team has also been engaged in the development work, including considering how the proposed Collaborative might in future link into the ICB People and Communities Committee.

3.3 One of the key supporting groups outlined above is the proposed Lived Experience Forum, which will have a vital role in ensuring that the views of service users and carers are core to the work of the Collaborative. It is intended that the existing Suffolk Mental Health and Emotional Wellbeing Focus Group will be able to take on this role with the chair becoming a member of the core Collaborative Committee.

4. Recommendations

4.1 The Board is asked to:

- Agree to the establishment of the Suffolk Mental Health Collaborative from April 2023
- Agree to establish the Suffolk Mental Health Collaborative Committee as a sub-committee of the Integrated Care Board
- Agree to delegate mental health service commissioning functions into the Suffolk Mental Health Collaborative Committee
- Note that the detailed Terms of Reference of the Collaborative Committee will be presented for approval at the June 2023 ICB Board
- Note that, subject to the Terms of Reference of the Collaborative Committee being approved by the ICB Board, responsibility for relevant mental health budgets will move from the Alliances to the Collaborative from July 2023
- Agree to receive regular progress updates from the Suffolk Mental Health Collaborative Committee and to note that the minutes of the Committee will be reported to the ICB Board
- Endorse the direction of travel set out in this paper

Annex 1

Changes to the delegation of budgets

Responsibility for a number of budgets will, as a consequence of establishing the proposed Collaborative, change, once the Terms of Reference of the Collaborative Committee are approved by the ICB.

An overview of the main proposed changes is set out below:

Cost centres formally delegated to the MH collaborative		Draft Budget 2023/24		
Cost Centre	Cost Centre Name	IES Alliance £'000	WS Alliance £'000	Total £'000
925042	MENTAL HEALTH SDF/NON RECURRENT FUNDS	6,802	0	6,802
925044	MENTAL HEALTH SERVICES OTHER	13	13	26
925046	MENTAL HEALTH NCA	0	0	0
925047	CYP MENTAL HEALTH (EXC LD)	781	461	1,242
925048	CYP EATING DISORDER	8	0	8
925054	AMBULANCE RESPONSE SERVICES	15	10	25
925055	COMMUNITY A NOT BED-BASED NOT PLACEMENTS	4,857	3,003	7,860
925057	MENTAL HEALTH PLACEMENTS IN HOSPITALS	595	605	1,200
925058	MENTAL HEALTH ACT	4,273	1,797	6,070
925060	SUKIDE PREVENTION	169	110	279
925061	LOCAL NHS ACUTE MH & REHAB IP SERVICES ADULT	27	12	39
Total		17,539	6,011	23,551

Cost centres formally delegated in part to the MH collaborative with some specific exclusions *		Draft Budget 2023/24		
Cost Centre	Cost Centre Name	IES Alliance £'000	WS Alliance £'000	Total £'000
925041	MENTAL HEALTH CONTRACTS	62,677	32,362	95,039
Total		62,677	32,362	95,039

* For investment decisions relating LD & Autism, Dementia and ADHD included within the Mental Health Contracts the delegation still resides with the Alliance.

Cost centres which are not formally delegated to the MH collaborative Delegation still resides with the Alliance		Draft Budget 2023/24		
Cost Centre	Cost Centre Name	IES Alliance £'000	WS Alliance £'000	Total £'000
925043	LD & AUTISM SDF/NON RECURRENT FUNDS	0	0	0
925081	LD AND AUTISM	4,226	2,042	6,268
925082	DEMENTIA	883	503	1,386
925083	ADHD	89	44	133
Total		5,198	2,589	7,787
Grand Total		85,414	40,963	126,376

Note: 2023/24 budgets are still in draft, subject to change, and ICB approval.

ICB BOARD

Agenda Item No.	13
Reference No.	ICB 23-23
Date.	21 March 2023

Title	Suffolk & North-East Essex Integrated Care Partnership (ICP) Update
Lead Director	Susannah Howard, Integrated Care Partnership (ICP) Director
Author(s)	Susannah Howard, Integrated Care Partnership (ICP) Director
Purpose	Update
Recommendation:	
Members of the NHS Suffolk and North-East Essex ICB Board are asked to note this brief general update report on the work of the ICP.	

1. Background

- 1.1 This report provides a brief general update on the current work of the Suffolk and North East Essex ICP.

2. Key Issues

a. ICP Meetings Held in February and March 2023

Key items discussed at the last two meetings held in February and March 2023 were as follows:

ICP Committee Meeting – Friday 10 February 2023	
Chair: Cllr. Andrew Reid, Suffolk County Council	
Update on the NHS ICB Joint Forward Plan	An update from Richard Watson, Deputy CEO at the ICB on progress
Equality, Diversity and Inclusion in our Health and Care Workforce	An update from Ganesh Baliah from the ICB on a planned system summit meeting
Examining the costs on the NHS of delayed Child Sexual Abuse disclosures in England and Wales	Members of the ICP agreed to incorporate conclusions from a report by Survivors in Transition into the Integrated Care Strategy
Updated Memorandum of Understanding (MoU) and Terms of Reference for the Suffolk & North East Essex ICP	Review of MoU and ToR for the ICP – members of the ICP agreed some minor amendments
<i>Thinking Differently Together... Belonging, Safety and Purpose</i>	Report from ICS event and decision by members of the ICP to incorporate conclusions into the Integrated Care Strategy
NHS England Delivery Plan for Recovering Urgent and Emergency Care Services	Brief update on the publication of this plan and discussion about relevant letter from the LGA
Learning from VCFSE Partners Working with Maternity Services	Report from a workshop held to explore the experience of VCFSE partners delivering maternity services projects
Draft Essex Disability Strategy	Engagement with the SNEE ICP on the draft strategy
ICP Committee Meeting – Friday 10 March 2023	
Chair: Cllr. John Spence, Essex County Council	
Essex and Suffolk Safeguarding Boards - Learning from Covid19	Presentations from the Chairs of Essex Adult Safeguarding Board and Suffolk Safeguarding Partnership highlighting their learning from Covid19. ICP agreed to incorporate into central resource on system learning from Covid19.
Launch of ReSPECT - The Recommended Summary Plan for Emergency Care and Treatment	Presentation by ICS Clinical Lead on End of Life Care of the new ReSPECT plan in Suffolk and North East Essex. Members of the ICP agreed to support roll out across all sectors.
System Learning from the Community Ambition Programme. <i>Project themes include: population health, men with mental health problems, suicide prevention, refugees and survivors of trauma and abuse, maternity, families, activity, health and nutrition.</i>	Presentation on progress made by projects led by grass-roots ethnic minority organisations in the ICS funded by NHS Charities Together. The report also summarised and system learning from their experiences. Members of the ICP agreed to establish a task and finish group to look at supporting the transition from the 2 year period of funding which ends in May 2023.
ICS VCSE Sector Workforce Review	Key highlights from a review of the VCFSE sector workforce across Suffolk and North East Essex. Members of the ICP approved the report and next steps which will be taken forward through the ICP work on VCFSE sector resilience and the ICS People Board.

b. Further Development of our Integrated Care Strategy

Work has continued to further develop the initial Integrated Care Strategy approved by the ICP in January 2023. A key area of development has been the addition of dashboard pages for each of the key sections in the strategy providing an overview of population health outcome measures associated with each section. With support from public health in Suffolk we are also identifying a proposed 'barometer indicator' for each section for discussion by the ICP in April 2023.

c. 'Community Connect' North East Essex

The ICP meeting in March 2023 took place in person at Firstsite in Colchester as part of a wider event 'Community Connect' North East Essex hosted by the North East Essex Health and Wellbeing Alliance. The wider event included an exhibition of stalls by around 30 organisations and a showcase presentation of some of the achievements of the Alliance highlighting in particular the work of the Alliance in local communities. The event was attended by Will Quince MP for Colchester and Minister of State for Health and Secondary Care who met local stakeholders and made a short speech at the end of the showcase presentation.

d. System Learning and 'Thinking Differently Together' Events

'Thinking Differently Together' about... The Essential Role of the VCFSE Sector in Health and Care took place on Wednesday 22 February 2023 as an online event organised in partnership with Norfolk and Waveney ICS. The event was co-chaired by Kirsten Alderson, Chair of the SNEE ICS VCFSE Assembly and Emma Ratzer, Chair of the Norfolk and Waveney ICS ACSE Assembly. The event included a range of speakers from the VCSE sector and the NHS ICB Chief Executives from both systems. The event was attended by more than 100 people and a written report is in preparation.

ICS System Learning 'A Community Powered NHS' – this online event will take place on Thursday 30 March 2023 led by New Local an independent think tank and network of councils, with a mission to transform public services and unlock community power. The workshop will look at three routes to achieving a more community-powered NHS and will include panel members from across our three local Alliances.

3. Patient and Public Engagement

- 3.1 As an ICP we continue to work closely with Healthwatch and wider members of the public. The last meeting of the ICP in March 2023 was attended by around 30 members of the public and included questions from the public at the end of the agenda. Information about how to access ICP meetings is available on the ICS website together with written reports of our work.
- 3.2 An ICP Sub-Committee on Health Equality is currently in development which will directly engage representatives of a broad range of groups who experience inequalities and marginalisation.

4. Recommendation

- 4.1 Members of the NHS Suffolk and North East Essex ICB Board are asked to note this brief general update report on the work of the ICP.

ICB BOARD

Agenda Item No.	14
Reference No.	ICB 23-24
Date.	21 March 2023

Title	Suffolk and North-East Essex (SNEE) Integrated Care Board Finance Planning
Lead Director	Howard Martin, ICB Director of Finance
Author(s)	Howard Martin, ICB Director of Finance
Purpose	To present the following to the Board: a) Finance Dashboard b) SNEE ICB Draft Financial Planning Update

Recommendation:
To note the reports.

Finance Dashboard

Month 10 (December 2023)

- At month 10 the adverse variance on plan of SNEE hosted NHS organisations continued to narrow (to £58k), and now shows and overspend of £735k, against a planned overspend at this stage for the year of £677.
- Following review of the risks, the system financial risks remain unchanged from the figure reported at month 9. Unmitigated risk reported by SNEE hosted NHS organisations remains £nil, with organisations confident that a financial plans will be achieved. However, financial performance is being supported by non-recurrent resources/use of balance sheet flexibility.
- NHS organisations continue to account for Elective Recovery Funding based on planned levels, in line with NHSE guidance that there will be no net ERF clawback. It is also assumed that there will be no clawback of community diagnostic centre (CDC) funding.
- The significant slippage in the ESNEFT national capital programme has been resolved, although after the submission of month 10 organisational positions and therefore not reflected in the tables in the dashboard. ESNEFT has received confirmation that £30m of capital resource can be transferred (brokered) into 2023/24. This addresses the issues of availability of raw materials and supply chain interruption that ESNEFT has been reporting since August 2022. This would appear based on the reported m10 position to leave national programme resources in an overspend position, although discussions with providers assure that the CDEL position can be managed to planned levels. Whilst there is slippage YTD, the forecast for business as usual, or 'system' capital is broadly in line with plan.
- Both County Councils are showing current and forecast overspends driven in both cases by children's social care costs running significantly ahead of schedule. The overspends at the year-end will be resourced by transfers from reserves.

Month 10	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	Plan £000s	Forecast outturn £000s	Forecast Variance £000s
SNEE ICB (CCGs Q1)	0	0	0	0	0	0
ESNEFT	0	161	161	0	0	0
WSFT	840	670	-170	1,008	1,008	0
Sub-total	840	831	-9	1,008	1,008	0
EEAST	-1,517	-1,566	-49	-1,000	-1,000	0
NHS Sub-total	-677	-735	-58	8	8	0
SCC	301,470	305,829	-4,359	361,765	366,995	-5,230
ECC	146,499	147,700	-1,201	176,304	177,505	-1,201
Total	447,292	452,794	-5,618	538,077	544,508	-6,431

- NHS performance is reported in the table above on an income and expenditure basis; County Council submissions record expenditure only, as they have a fixed (budget) level of income with any surplus or deficit transferred to or from reserves.
- The (small) overspend in NHS organisations continues to reduce. Year to date the NHS organisations have a combined deficit of £0.735m, against a plan figure of £0.677m). The variance (£0.058m) is reduced from month 9 (£0.280m). Only EEAST remains overspent at this stage. All organisations are reporting that they expect to be on plan by the end of the financial year.
- Although the position reported by the system continues to improve, it is not without its challenges. The combination of 'normal' winter pressures, elevated rates of Covid in addition to influenza, and difficulty in discharging medically fit patients due to social care capacity issues is placing pressure on financial positions as providers seek to create additional capacity. In addition the impact of inflation is rising, as contract renewal discussions/price negotiations become due.
- Suffolk and Essex County Councils are currently forecasting overspend positions (£5.230m and £1.201m respectively) with children's social services accounting for the majority of the overspend.

Organisation	RAG Status	Key Financial Risks
Suffolk and North East Essex ICB	Green	Inflation risk (funded at 5.3%). Covid Impact (c/w planning assumption of negligible impact after Q1). Under-delivery of cost improvement/efficiency savings programmes.
East Suffolk and North Essex NHS FT		COVID prevalence and price inflation are notable risks to the Trust's revenue position. The Trust currently estimate that price growth exceed the 5.3% nationally funded. Delayed discharge due to social care capacity is a significant risk World events impacting supply chains mean that goods and materials are sometimes not available or delivery is delayed. This is driving up costs and creating operational risks in some instances. Previously reported risks of the impact on the Trust's significant capital programme have been addressed since the submission of monthly reports with the agreement of brokerage of capital resource into 2023/24.
West Suffolk NHS FT		Inflation and Covid risks. Supply chain risks on services and capital developments risk impacting financial plans. The continuing RAAC project presents additional risk.
East of England Ambulance Service NHS Trust		Inflation risk is particularly acute, due to volatile and high fuel prices although these have started to subside. Covid impact on both operations and staffing levels. Handover delays impact on flexible staffing requirements; whilst the recruiting market remains challenging. Under-delivery of efficiency plans.
Suffolk County Council	Yellow	Domiciliary care market capacity, inflationary pressures (impacting cost base and workforce recruitment and retention), uncertain demand for adult social care
Essex County Council		Domiciliary care market capacity, inflationary pressures (impacting cost base and workforce recruitment and retention), uncertain demand for adult social care, social care (fair cost) reform and increased high cost unregulated placements for Children and Families.

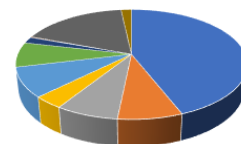
Key	
Red	Financial plan targets unlikely to be delivered without external support
Yellow	Risk of financial plan targets not being delivered
Green	Financial plans targets expected to be delivered

- Across the health and care system inflation is identified as a significant risk despite recent reduction in fuel costs and the capping of energy prices. Organisations report that the impact of inflation on non-pay costs has effectively been delayed by contracting arrangements with suppliers, but as contracts are renegotiated/annual price reviews finalised that increase in cost is filtering through. Inflation impacts both the delivery of the financial position and the ability of recruit and retain staff to manage operational performance given sub-inflationary wage rises.
- The previously reported risk that NHS organisations faced a potential underspend (and consequent loss) of capital resource has been addressed in the last few days, with the agreement of capital brokerage into 2023/24. Organisations are confirming an ability to deliver the planned system and CDEL positions, subject to this brokerage.
- County Council risk summaries show an amber rating, as neither is forecasting delivery of plan, but the overspend is affordable as sufficient reserves exist to offset the deficit.

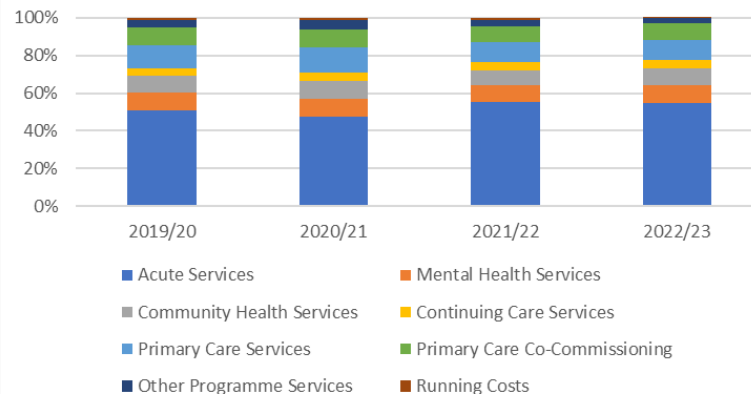
Commissioning Spend Month 10	System Total		2021/22	2020/21	2019/20
	£000s	%	%	%	%
Acute Services	894,335	54.5%	55.5%	47.4%	50.8%
Mental Health Services	154,575	9.4%	8.9%	9.6%	9.5%
Community Health Services	150,379	9.2%	7.8%	9.3%	8.8%
Continuing Care Services	72,760	4.4%	4.3%	4.8%	4.1%
Primary Care Services	175,745	10.7%	10.4%	13.3%	12.3%
Primary Care Co-Commissioning	149,172	9.1%	8.5%	9.5%	9.4%
Other Programme Services	38,231	2.3%	3.6%	5.0%	3.7%
Running Costs	4,723	0.3%	0.9%	1.1%	1.4%
NHS Sub-total	1,639,920	100.0%	100.0%	100.0%	100.0%
Social Care	356,945				
Public Health	35,403				
System Total	2,032,268				

- The NHS commissioning position is the aggregation of CCG reported (m1-3) and ICB (m4-10) figures.
- Analysis for 2022/23 has been switched to longitudinal approach: results show the comparative growth of service lines.

Commissioned Health and Social Care Expenditure 2022/23



NHS Share Expenditure 2019/20 to current



Month 10	YTD			Forecast		
	Budget £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Revenue Resource Limit (in-year)	1,650,229	1,650,229	0	1,986,144	1,986,144	0
Acute Services	-895,955	-894,335	-1,620	-1,073,185	-1,072,248	-938
Mental Health Services	-156,785	-154,575	-2,210	-188,390	-187,254	-1,136
Community Health Services	-152,123	-150,517	-1,606	-185,930	-185,059	-871
Continuing Care Services	-72,760	-72,938	178	-87,342	-87,528	186
Primary Care Services	-175,344	-175,745	401	-210,281	-211,995	1,714
Primary Care Co-commissioning	-149,532	-149,172	-360	-180,137	-181,936	1,799
Other Programme Services (inc Reserves)	-30,276	-37,076	6,800	-40,187	-40,696	508
Total Commissioning Services	-1,632,775	-1,634,357	1,583	-1,965,453	-1,966,716	1,263
Running Costs	-17,454	-15,872	-1,583	-20,691	-19,427	-1,263
Total CCG Net Expenditure	-1,650,229	-1,650,229	0	-1,986,144	-1,986,144	0
In Year Underspend/(Deficit)	0	0	0	0	0	0

- The financial position above is an aggregation of the CCG and ICB positions (months 1-3 and 4-8 respectively).
- The ICB continues to record a position that is on-plan both year to date and forecast. Increases in prescribing costs in the month have resulted in changes to the projected year-end position, which show an overspend (in primary care services) offset by underspends in mental health, acute and community services.

Performance YTD v Plan Month 10	ESNEFT			WSFT			EEAST			System Variance £000s
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	
Operating Income (Patient)	730,089	752,723	22,634	261,950	275,989	14,039	317,653	325,338	7,685	44,358
Operating Income (Other)	43,730	48,202	4,472	21,233	21,550	317	3,856	4,080	224	5,013
Employee Expenses	-473,375	-483,431	-10,056	-186,615	-197,570	-10,955	-231,910	-238,506	-6,596	-27,607
Other Operating Costs	-286,814	-305,424	-18,610	-90,371	-94,924	-4,553	-90,040	-91,973	-1,933	-25,096
Operating Surplus/(Deficit)	13,630	12,070	-1,560	6,197	5,045	-1,152	-441	-1,061	-620	-3,332
Net Finance Costs	-11,031	-9,617	1,414	-6,530	-5,557	973	-1,076	-696	380	2,767
Other Operating Costs	0	-2,442	-2,442	333	342	9	0	70	70	-2,363
Surplus/Deficit in year	2,599	11	-2,588	0	-170	-170	-1,517	-1,687	-170	-2,928
Impairments	0	0	0	0	0	0	0	0	0	0
Less gains on disposal of assets	0	0	0	0	0	0	0	0	0	0
Other technical adjustments	-2,599	150	2,749	840	840	0	0	121	121	2,870
Adjusted Financial Performance	0	161	161	840	670	-170	-1,517	-1,566	-49	-58

- Phasing of plans results in a combined provider overspend of £0.735m (£1.054m at m8) compared with a planned deficit of £0.677m (£0.774m at m8)
- Individual organisations are all close to plan Year to Date, with an aggregate adverse variance of £0.058m (£0.280m at m8).

Performance Forecast Outturn v Plan	ESNEFT			WSFT			EEAST			System Variance £000s
	Plan £000s	Forecast £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s	
Operating Income (Patient)	876,715	899,349	22,634	315,268	322,468	7,200	381,108	387,426	6,318	36,152
Operating Income (Other)	52,503	58,163	5,660	25,489	25,699	210	4,604	4,604	0	5,870
Employee Expenses	-568,246	-578,301	-10,055	-224,662	-231,862	-7,200	-278,299	-283,917	-5,618	-22,873
Other Operating Costs	-344,614	-363,786	-19,172	-108,659	-110,526	-1,867	-107,123	-108,086	-963	-22,002
Operating Surplus/(Deficit)	16,358	15,425	-933	7,436	5,779	-1,657	290	27	-263	-2,853
Net Finance Costs	-13,237	-11,422	1,815	-7,834	-6,177	1,657	-1,290	-1,222	68	3,540
Other Operating Costs	0	-2,442	-2,442	398	398	0	0	70	70	-2,372
Surplus/Deficit in year	3,121	1,561	-1,560	0	0	0	-1,000	-1,125	-125	-1,685
Impairments	0	0	0	0	0	0	0	0	0	0
Less gains on disposal of assets	0	0	0	0	0	0	0	0	0	0
Other technical adjustments	-3,121	-1,561	1,560	1,008	1,008	0	0	125	125	1,685
Adjusted Financial Performance	0	0	0	1,008	1,008	0	-1,000	-1,000	0	0

- System providers Continue to forecast an 'on-plan' £8k surplus.
- The forecast reflects organisational assessments of risks including the continuing impact of Covid19 (although based on NHSE guidance there is no clawback of elective recovery) and inflation. All organisations are providing a narrative that the underlying position is deteriorating caused by the increasing impact of non-pay inflation and winter pressures, and the inability to discharge medically fit patients.
- Previously reported risk/NHSE concerns that EEAST may be unable to deliver its planned position have been addressed, with all organisations providing assurance that plans will be delivered, and no remaining unmitigated risk.

Staffing Costs Month 10	ESNEFT			WSFT			EEAST		
	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s	YTD Budget £000s	YTD Actual £000s	YTD Variance £000s
Substantive	407,709	422,806	-15,097	167,332	176,253	-8,921	228,502	226,534	1,968
Bank	47,611	45,168	2,443	15,477	17,123	-1,646	387	3,783	-3,396
Agency	18,055	16,089	1,966	3,086	4,317	-1,231	2,255	7,267	-5,012
Other	0	0	0	0	0	0	0	0	0
Total	473,375	484,063	-10,688	185,895	197,693	-11,798	231,144	237,584	-6,440

Agency Spend YTD Month 10	ESNEFT £000s	WSFT £000s	EEAST £000s	Total £000s
2021/22	17,671	4,071	9,532	31,274
Agency Cap	15,904	3,664	8,579	28,147
Extrapolated Spend	19,306	5,180	8,720	33,207
Forecast Spend	19,931	5,115	8,384	33,430

- Following the submission of 2022/23 plans NHSE introduced additional agency expenditure targets, requiring systems to deliver a 10% reduction in agency spend (compared with 2021/22 outturn). The risk ratings table compares the agency cap with the Trust submitted forecast, and with a simple extrapolation of current YTD spend. Green RAG rating represents projected achievement of the agency cap target, whilst amber reflects a reduction from prior year spend.
- Achievement of target was always going to be challenging as changes in the labour market are limited. In addition the target did not reflect the full year effect of ESNEFT's acquisition of community services formerly provided by ACE. The pay settlement for 2022/23 was also higher than the estimate at the point that the target was set. Recent industrial action also casts some doubt on the ability of healthcare more widely to deliver the agency cap target.
- It is fair to note that Regulator focus on this target has diminished for the reasons noted above. New targets have been set for next year.

ICB Efficiency Savings Performance Month 10	YTD			Forecast		
	Budget £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Pathway Transformation	4,160	3,774	-386	5,000	4,613	-387
Continuing Healthcare - cost per case review	2,662	2,479	-183	3,188	3,002	-186
Primary Care Prescribing	4,720	2,375	-2,345	5,672	2,850	-2,822
Transforming community-based primary care	1,272	1,318	46	1,524	1,669	145
Running cost review	831	1,236	405	1,000	1,218	218
Other	764	1,181	417	909	1,387	478
Total Efficiencies - by scheme	14,409	12,363	-2,046	17,293	14,739	-2,554
Recurrent savings	5,992	6,276	284	7,196	7,658	462
Non Recurrent savings	8,417	6,086	-2,331	10,097	7,082	-3,015
Total Efficiencies - by type	14,409	12,363	-2,046	17,293	14,739	-2,554

- The month 10 report identifies some slippage YTD; £2.046m (compare with £1.597m at month 9). Primary care prescribing accounts for the shortfall, with other schemes broadly on schedule.
- Updated forecasts this month suggest that the ICB will fall short of delivering its efficiency target by £2.554m. The slippage can be attributed to prescribing budgets (£2.345m) with variances in other areas broadly cancelling each other out. Options for external support are being considered to assist in future delivery of prescribing cost improvement targets.

Month 10	ESNEFT			WSFT			EEAST		
	YTD Bud £000s	YTD Act £000s	YTD Var £000s	YTD Bud £000s	YTD Act £000s	YTD Var £000s	YTD Bud £000s	YTD Act £000s	YTD Var £000s
Pay Efficiencies									
Agency - improved procurement	281	72	-209	0	0	0	0	0	0
Bank - collaborative working	0	0	0	850	850	0	0	0	0
Skill mix reviews	2949	4394	1445	2200	2200	0	0	17	17
E-Rostering	9	4	-5	300	300	0	0	0	0
Corporate services transformation	310	443	133	0	0	0	0	0	0
Digital transformation	21	16	-5	0	0	0	0	0	0
Service re-design	3348	331	-3017	0	0	0	0	0	0
Managing sickness and absences	0	0	0	0	400	400	7380	2182	-5198
Pay Other	0	0	0	400	0	-400	421	0	-421
Total Pay	6918	5260	-1658	3750	3750	0	7801	2199	-5602
Non-pay Efficiencies									
Medicines optimisation	2526	1512	-1014	560	560	0	0	0	0
Procurement (excl drugs) -non-clinical	1921	4641	2720	750	750	0	0	0	0
Procurement (excl drugs) - medical dev/cons	2651	1902	-749	500	500	0	86	53	-33
Estates and Premises transformation	3371	310	-3061	300	300	0	597	202	-395
Fleet optimisation	171	208	37	0	0	0	185	1397	1212
Pathology & imaging networks	346	302	-44	0	0	0	0	0	0
Net zero carbon	128	46	-82	0	0	0	220	134	-86
Corporate services transformation	268	306	38	0	0	0	0	0	0
Non-pay Other (bal)	1691	206	-1485	0	0	0	424	199	-225
Total Non-Pay	13181	9600	-3581	2110	2110	0	1512	2071	559
Income Efficiencies									
Income Private Patient	428	202	-226	249	249	0	0	0	0
Income Overseas Visitors	0	0	0	166	166	0	0	0	0
Income Non-Patient Care	935	560	-375	0	0	0	0	0	0
Income Other (bal)	407	62	-345	0	0	0	0	0	0
Total Income	1770	824	-946	415	415	0			
Total Efficiencies	21869	15684	-6185	6275	6275	0	9313	4270	-5043

Provider Efficiency Plans by Type:
Year to Date



- Agency - improved procurement
- Bank - collaborative working
- Skill mix reviews
- E-Rostering
- Corporate services transformation
- Digital transformation
- Service re-design
- Managing sickness and absences
- Medicines optimisation
- Procurement (excl drugs) -non-clinical
- Procurement (excl drugs) - medical dev/cons
- Estates and Premises transformation
- Fleet optimisation
- Pathology & imaging networks
- Net zero carbon
- Corporate services transformation
- Non-pay Other (bal)
- Income Private Patient
- Income Overseas Visitors
- Income Non-Patient Care

- Slippage has been identified by two providers; ESNEFT and EEAST. In both cases operational pressure caused by ongoing incidence of Covid 19 is cited as a reason for slippage, although at this stage the shortfall is not currently preventing the reporting of (near) balance financial positions for this year. Slippage is, however a cause for concern for future years.

	ESNEFT			WSFT			EEAST		
	Plan £000s	FOT £000s	Var £000s	Plan £000s	FOT £000s	Var £000s	Plan £000s	FOT £000s	Var £000s
Pay Efficiencies									
Agency - improved procurement	337	95	-242	0	0	0	0	0	0
Bank - collaborative working	0	0	0	1000	1000	0	0	0	0
Skill mix reviews	3622	5111	1489	2500	2500	0	0	20	20
E-Rostering	11	5	-6	500	500	0	0	0	0
Corporate services transformation	352	474	122	0	0	0	0	0	0
Digital transformation	27	19	-8	0	0	0	0	0	0
Service re-design	4310	467	-3843	0	0	0	0	0	0
Managing sickness and absences	0	0	0	0	500	500	10044	2555	-7489
Pay Other	0	0	0	500	0	-500	500	76	-424
Total Pay	8659	6171	-2488	4500	4500	0	10544	2651	-7893
Non-pay Efficiencies									
Medicines optimisation	3114	1832	-1282	700	700	0	0	0	0
Procurement (excl drugs) -non-clinical	2770	5266	2496	800	800	0	0	0	0
Procurement (excl drugs) - medical dev/cons	3219	2570	-649	500	500	0	102	60	-42
Estates and Premises transformation	4113	581	-3532	500	500	0	1561	218	-1343
Fleet optimisation	193	222	29	0	0	0	187	1765	1578
Pathology & imaging networks	434	370	-64	0	0	0	0	0	0
Net zero carbon	154	148	-6	0	0	0	300	164	-136
Corporate services transformation	336	582	246	0	0	0	0	0	0
Digital transformation	255	325	70	0	0	0	0	115	115
Non-pay Other (bal)	2083	265	-1818	0	0	0	506	229	-277
Total Non-Pay	16671	12161	-4510	2500	2500	0	2656	2551	-105
Income Efficiencies									
Income Private Patient	518	333	-185	300	300	0	0	0	0
Income Overseas Visitors	0	0	0	200	200	0	0	0	0
Income Non-Patient Care	1207	797	-410	0	0	0	0	0	0
Income Other (bal)	512	75	-437	0	0	0	0	0	0
Total Income	2237	1205	-1032	500	500	0	0	0	0
Total Efficiencies	27567	19537	-8030	7500	7500	0	13200	5202	-7998

- Forecast slippage increased to £16.028m in month 10 from £15.749m, following a large increase reported last month (due to presentational reasons at EEAST)

Year to Date Month 10	ESNEFT			WSFT			EEAST			System Total		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
System Capital	22,230	14,557	-7,673	24,135	20,608	-3,527	8,850	3,614	-5,236	55,215	38,779	-16,436
CDEL	80,595	41,342	-39,253	26,910	22,776	-4,134	20,820	4,443	-16,377	128,325	68,562	-59,763
Forecast	ESNEFT			WSFT			EEAST			System Total		
	Plan £000s	Forecast £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
System Capital	23,311	23,311	0	30,250	31,750	1,500	10,618	10,345	-273	64,179	65,406	1,227
CDEL	99,267	78,841	-20,426	33,201	39,741	6,540	29,645	17,691	-11,954	162,113	136,274	-25,839

- System Capital (or BAU) expenditure is expected to be in line with plan by March 2023, although YTD there are underspends at all three providers (£16.436m in total). WSFT is expecting to overspend it's BAU capital figure by £1.5m. This relates to RAAC, and has been approved by NHSE, but is not reflected in an adjusted plan.
- There is significant slippage against the wider CDEL target as shown in the table above, which includes National Programmes. The acute reconfiguration project is affected by global supply chain issues, and is expected to underspend by £30m this year. Following the submission of month 10 returns the issue of brokerage referred to in previous returns has been favourably resolved, with ESNEFT receiving confirmation from DHSC that £30m of the resource will be made available in 2023/24. Organisations are working to manage their current positions and any further allocations (associated with diagnostic equipment) to ensure that this revised target will be delivered.

Balance Sheet	ESNEFT £000s	WSFT £000s	EEAST £000s	Total £000s
Non -Current Assets	462,059	252,021	124,581	838,661
Current Assets Exc Cash and equivalents	43,541	26,559	18,026	88,126
Cash	55,659	9,927	27,438	93,024
Current liabilities	-129,022	-51,121	-63,835	-243,978
Non-Current Liabilities	-87,219	-50,161	-60,176	-197,556
Net Assets	345,019	187,225	46,034	578,278
Public Dividend Capital	385,614	220,331	77,899	683,844
Revaluation Reserve	33,041	11,704	4,800	49,545
Income and Expenditure Reserve	-74,390	-44,810	-35,252	-154,452
Other Reserves	754	0	-1,413	-659
Tax Payers' Equity	345,019	187,225	46,034	578,278
NHS Suffolk and North East Essex ICB				6,530
BPC Performance (non-NHS, £Value)	ESNEFT	WSFT	EEAST	
Current Month	80.6%	89.7%	86.7%	
YTD	83.6%	87.1%	86.4%	

- The system is currently reporting £99.6m of cash balances (£111.8m at m9).
- Having taken advice, the BPC performance tables have been modified slightly. The figures provided now note non-NHS expenditure only (as intra-NHS payment delays are caused by the dispute process, and are of little consequence to external providers who are the key stakeholders for this KPI). Although performance remains below the target 95%, at reported levels pressure to improve is relatively limited. The improvement in WSFT from prior years is significant.

System cash and cash equivalent holdings at month end



- CC - County Council
- CCG – Clinical commissioning group
- CDEL – Capital Departmental Expenditure Limit
- DOFs – Directors of Finance (group)
- EEAST – East of England Ambulance Service Trust
- EPUT – Essex Partnership University Foundation Trust
- ERF – Elective Recovery Fund
- ESNEFT – East Suffolk and North Essex Foundation Trust
- FOT – Forecast Outturn
- ICB – Integrated Care Board
- ICS – Integrated Care System
- IPC – Infection Prevention and Control
- NHSE – NHS England (NHS regulator)
- NSFT – Norfolk and Suffolk Foundation Trust
- RAAC – Reinforced Autoclaved Aerated Concrete
- SNEE – Suffolk and North East Essex
- TIF – Targeted Investment Fund (Elective Recovery Capital and additional Digital Capital)
- WSFT – West Suffolk Foundation Trust
- YTD – Year to date

NHS Suffolk and North East Essex ICB DRAFT Financial Planning Update

ICB Board

March 2023



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Suffolk and
North East Essex

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Financial Planning – Key Dates

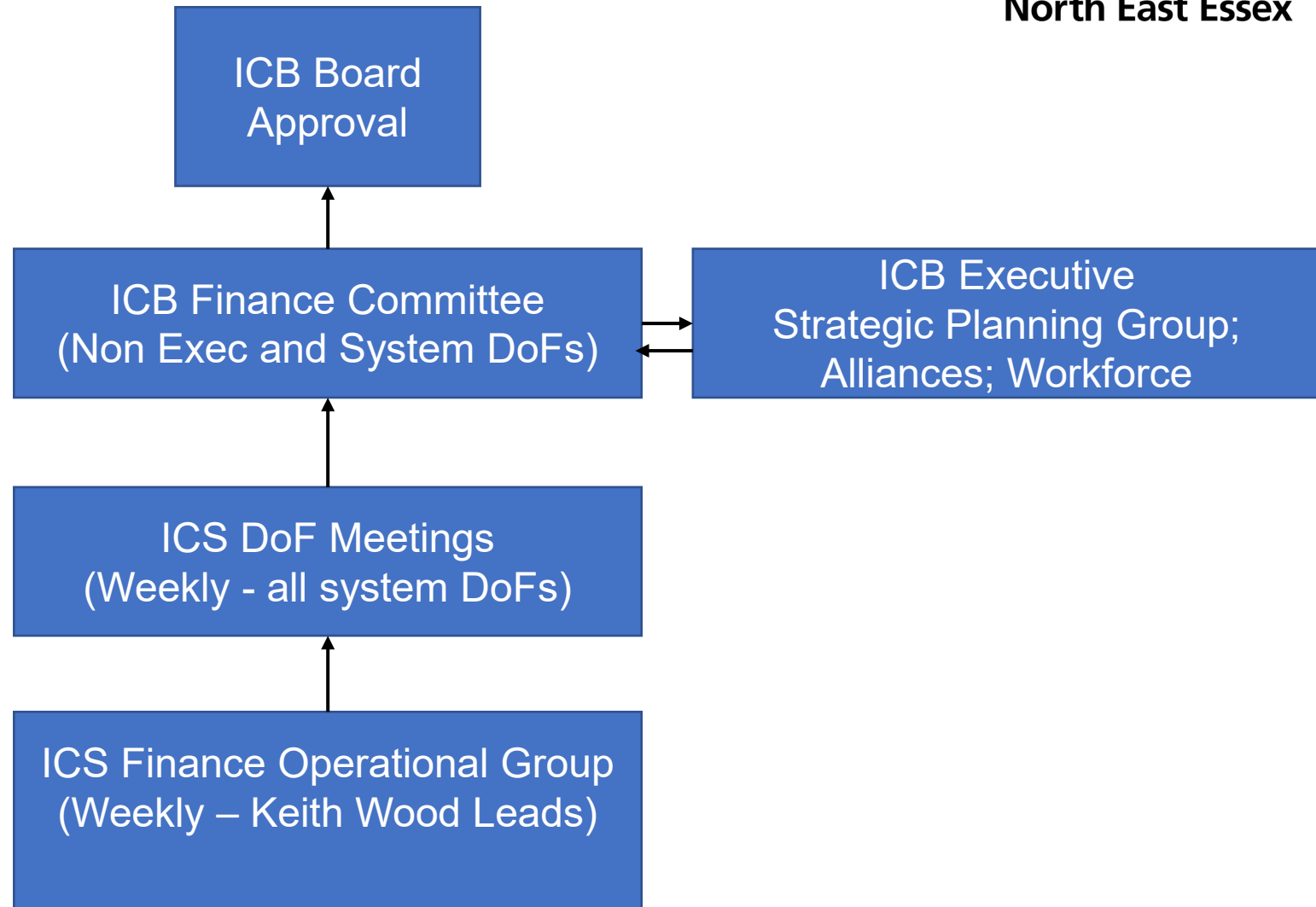
Key Date	Local/NHSE	
Thursday 2nd February	Local	Local Deadline: submission of (I+E elements)
Monday 6th February	NHSE	NHSE Checkpoint summary submission
Thursday 16th February	Local	Organisational submission deadline
Thursday 16th February	NHSE	NHSE Checkpoint summary submission
Thursday 23rd February	NHSE	National Draft Plan Submission Deadline
Friday 24th February	Local	ICB Internal CIP and Investment Review
Tuesday 14th March	Local	ICB Finance Committee
Wednesday 15th March	Local	Local deadline: Updated Financial plan
Wednesday 15th March	Local	Aggregation of system financial plan,
Tuesday 21st March	Local	ICB Board review
Friday 24th March	Local	Organisational Final Plan submission
Thursday 30th March	NHSE	National Final Plan Submission Deadline

Work is progressing to ensure aligned timetables for Finance / Activity / Workforce. This is being coordinated in SNEE through the Strategic Planning Group. Finance expected to have to provide bi-weekly 'flash reports' to NHSE from February.

Financial Planning – Governance

Key Principles to work to:

1. Transparency of position with all partners.
2. Fairness and realism in application of funding.
3. Challenge in delivery of cost improvement and productivity for all partners.
4. Where possible protect funding which supports our most deprived communities and prove this generates a return on our investment.



Financial Planning – Missing Pieces

Further elective guidance on Elective Recovery Funding clawback and response to current inequitable targets and funding.

GP contract guidance including prices.

ICB 24/25 running cost allocations.

SDF Allocations – Some still awaiting confirmation (current model assumes status quo, or where no notification cost has been removed).

Historic drawdown - £7m was guaranteed

Financial Planning – Allocations



Suffolk and
North East Essex

	EM	
ICB Recurrent Allocation	2023/24	Comments
ICB Programme Allocation	1,715	Headline growth of £89m, offset by £12m convergence
Primary Medical Care Services	187	
Running costs	19	Flat cash in 2023/24; expected 20% red'n in 2024/25
COVID Funding	7	Net reduction of £32.5m from SNEE system in 2023/24
Additional discharge allocation	4	Recurrent in baseline
Additional physical and virtual bed capacity funding	11	Recurrent in baseline
Total ICB recurrent Allocation	1,944	
Elective Recovery Funding	43	£9m increase on 2022/23; allocation dependent on activity delivery, targets TBC
Service Development Fund (SDF)	43	ERF still TBC, assume similar/same levels to 2022/23
Additional physical and virtual bed capacity funding	TBC	£590m national pot, details TBC
Ambulance capacity funding	TBC	£200m national pot, details TBC
Total ICB Non-Recurrent Allocation	86	
Total ICB allocation	2,030	

Some allocations TBC, but overall SNEE allocation is now just over £2bn...

Doesn't include POD delegation of circa £83m

Table below indicates level of challenge in 2023/24, essentially allocation growth allows only for inflation, and overall appears overcommitted by £1.3m.

Allocation Growth Em	89.19
less net inflation (inc CNST)	(29.48)
less other inflation (presc/CHC/BCF)	(10.51)
less add'l capacity (acute/EEAST)	(9.86)
less MHIS	(7.90)
less u/lying growth to providers	(30.29)
less funding shifts	(2.48)
Total calls on growth	(90.52)
Balance Remaining	(1.33)

- SDF includes £583k of indicative (GP fellowships and GP Mentors)
- Indicative Values for Bed Capacity £4.4m, Ambulance Capacity £30.1m

Financial Planning – Inflation & Growth

National notifications



Suffolk and
North East Essex

Inflation	2.90%
Efficiency	-1.10%
Net Inflation	1.80%
National underlying growth assumptions (All non compound)	
Covid Uplift NHS exc Ambulance	0.60%
Covid Uplift Ambulance	1.20%
Additional Capacity Acute/Ambulance (exc community/PTS)	0.90%
Acute Growth	2.10%
Ambulance Growth	2.60%
Community Growth	4.10%
CNST (not clear if differential by org type at this stage)	0.20%
Mental Health Investment Standard (inclusive of inflation)	7.10%
Continuing Healthcare (inclusive of inflation)	7.30%
Funded Nursing Care (inclusive of inflation)	8.50%
Prescribing (inclusive of inflation)	2.40%
Better Care Fund (inclusive of inflation)	5.70%

Financial Planning – Draft System Plan



Suffolk and
North East Essex

Draft Plan at 20 Feb 23

Organisation	Allocation/ Turnover	Surplus/ (deficit) pre- CIP	CIP	CIP	Surplus/ (deficit) post-CIP	Deficit % post-CIP
	£m	£m	£m	%	£m	%
SNEE ICB	2,035.4	(27.0)	13.5	0.69/3.1*	(13.5)	1.14
EEAST	400.8	(13.6)	13.6	3.39	0.0	3.42
WSFT	354.2	(30.6)	10.7	2.82	(19.9)	5.62
ESNEFT	944.7	(49.9)	24.5	2.59	(25.4)	2.69
System Total		(144.2)	62.1	3.05#	(58.8)	4.03#

* CIP expressed as a percentage of 'manageable spend' (excluding NHS contracts, mental health spend)

Expressed as a percentage of system allocation

Figures included above are extracted from a partially complete IFR submission 20 February 2023.

Financial Planning – Risks



Suffolk and
North East Essex

- Elective Service Recovery Fund.
 - Income assumed to equal expenditure in current draft plan
 - Activity and Income alignment has not been tested (Costs of 113.5% activity target subject to baseline changes)
 - Rules of ERF clawback to be resolved
- Ambulance Capacity Funding clawback/performance requirement still unknown
- CIP delivery risk
- PPE 'run-out' risk. PPE will continue to be provided centrally free of charge until 'it runs out'. No clarity has been provided for when this might be.
- Convergence reductions to contracts from other systems
- Non-pay inflation exceeds funded levels, 4.5% (noting that assurance have been received regarding funding of any pay settlement exceeding 2%)
- Industrial Action

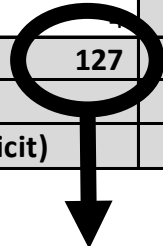
Financial Planning – Draft ICB plan



Suffolk and
North East Essex

- Against an allocation of £2.03bn, the draft plan is a deficit position of £13.5m or 0.7% of allocation.
- Non delivery of CIP increases the gap to a £27m deficit or 1.3% of allocation.

Budget Area (£Million)	Adjusted FOT	Inflation	Efficiency	Growth (All)	R/NR Pressures & Investments	Total Before CiP	ICB Cost Improvement Saving	Total 2023/24	Change to 2022/23 %	CIP % of Budget
ACUTE	972	30	(11)	34	56	1,082	-	1,082	11%	
COMMUNITY HEALTH SERVICE	179	5	(2)	7	6	196	-	196	9%	
CONTINUING CARE	91	7	-	3	-	101	(3.20)	98	7%	3.18%
CORPORATE	19	-	-	-	-	19	(2.00)	17	-11%	10.80%
DELEGATED GP	183	11	(0)	0	-	194	-	194	6%	
MENTAL HEALTH	176	5	(2)	1	26	205	-	205	17%	
OTHER PROGRAMME	15	0	-	-	37	52	(2.80)	49	225%	5.39%
PRIMARY CARE	200	5	(0)	6		215	(5.50)	209	5%	2.56%
Total ICB Projected Spend	1,835	63	(15)	52	127	2,062	(13.5)	2,049	12%	0.65%
Total Allocation						2,035		2,035		
Projected Surplus / (Deficit)						(27)		(14)		



£127m pressures includes: £30.8m net notified pressures (see next slide), £49m SDF, £42m ERF, £2.5m CEOV, £2.7m Health Inequalities...challenging this will be a priority over the next few weeks.

Note: 11% acute growth includes non recurrent ERF funding, 17% MH growth includes SDF funding

Financial Planning – ICB Cost Improvement

Suffolk and
North East Essex

Budget Area (£Million)	Total Before CIP	ICB Cost Improvement Saving	CIP % of Budget
ACUTE	1,082	-	
COMMUNITY HEALTH SERVICES	196	-	
CONTINUING CARE	101	(3.20)	3.18%
CORPORATE	19	(2.00)	10.80%
DELEGATED GP	194	-	
MENTAL HEALTH	205	-	
OTHER PROGRAMME	52	(2.80)	5.39%
PRIMARY CARE	215	(5.50)	2.56%
Total ICB Projected Spend	2,062	(13.5)	0.65%
	2,035		
	(27)		

- After adjusting for mandated contracts and spend (NHS blocks, MHIS, GP contract) the CIP is 3.1% of influenceable spend.
- CIP targets for CHC and Prescribing have been allocated essentially on basis of mitigating growth in 2023/24.
- £2m of savings assumed for Running Costs, this results in a 10% saving. Expected running cost reductions of 20% equal circa £4m required saving for 2024/25
- We currently have £2.8m of unallocated CIP
- We are sourcing additional support for a review of programs and to scope additional opportunities.

Financial Planning – ICB Cost Pressures



Suffolk and
North East Essex

Description	£m
Cost Pressures at last checkpoint	44.3
Moved to MHIS Prioritisation	(5.9)
Abated through contract settlements	(3.4)
Reduction in Pressures/Investment proposals 23/24	(4.1)
Remaining Pressures	30.8
Of Which	£m
Non Discretionary Cost Pressures	16.7
Investment proposals (part year effect)	14.1
Total	30.8

Included in the draft plan are £30.8m of notified pressures of which:

- £16.7m is non-discretionary
- £14.1m are investments which are being reviewed through a prioritisation process. It is assumed mental health pressures will be managed with the MHIS envelope.

Of the £16.7m non discretionary pressures key items are:

- Prescribing national price concessions have been included per the 22/23 forecast at £7m.
- CHC inflation has been partially offset through a CIP target to stay within national growth and inflation assumptions.
- IT increases are as a result of existing contracts coming to their end and the estimated costs of new procurements are expected to be higher as a result of significant changes during covid.

Non Discretionary Cost Pressures	£m
Prescribing - National Price Concessions	7.0
Prescribing - Oxygen Utilities Prices Increase	0.7
Prescribing - NICE Policy Impact	0.4
Subtotal Prescribing	8.1
CHC Inflation	7.1
IT - Contract changes	0.7
IT - Inflation	0.4
Subtotal IT	1.0
Estates - Rent Increases	0.2
Contracts Renewals/Increases	0.1
LD - Funding Changes	0.1
Total	16.7

Financial Planning – Running Costs



Suffolk and
North East Essex

- **Every year ICBs (as did CCGs) receive a separate allocation to cover its running/administration costs**
- **Allocations have now been confirmed for 2023/24 to 2025/26**
- **Our current allocation is £18.8m, by 2025/26 it will be 14.2m**
- **In cash terms this is a c25% reduction, but after allowing for pay inflation the impact is 30%**
- **Flat in 2023; 20% reduction in 2024/25; 10% reduction in 2025/26**
- **The ICB will have needed to transition to the full 30% reduction before the end of 2024/25**

ICB BOARD

Agenda Item No.	15
Reference No.	ICB 23-25
Date.	21 March 2023

Title	Board Assurance Framework
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Tony Buckle (Risk Manager)
Purpose	To approve the Board Assurance Framework
Recommendation:	
The ICB Board is asked to approve the Board Assurance Framework for March 2023.	

1. Background

- 1.1 Content of the BAF document is reviewed by the Executive Committee (EC) every month and by the Board, Quality and Audit Committees at each of its meetings. All BAF updates have been received and are up to date.
As agreed with the Directors, the BAF document is available for examination with this report.

2. Key Issues

- 2.1 A brief overview of the amendments is included in separate table along with this report.
- 2.2 Further to discussions at the Audit Committee meetings in September and December, a number of issues were highlighted, particularly that wider system assurance was now necessary in regard to risks that impact across both health and social care.
- 2.3 A process change has already been initiated with the risks for Referral to Treatment, Cancer Targets and A&E waiting times being addressed as system risks rather than separate provider risks in the current iteration of the BAF.
- 2.4 Further to discussion at the Board meeting in November, it was suggested that more generally, risks should in future be presented in a strategic system wide context rather than with an operational focus and also reflect risks identified by the ICP.
- 2.5 Also, arising from discussion at the November Board meeting, there was a takeaway for Partner Members to ensure that where appropriate, their own strategic risks are aligned with those of the ICB.
- 2.6 Finally, and perhaps most importantly, the Audit Committee regard Board assurance as one of its most important functions and as such, the BAF will be the first substantive item on future agendas.

3. Recommendation

- 3.1 The ICB Board is requested to review the BAF document.

4. Risk Registers

- 4.1 A summary table of the top directorate risks accompanies this report.

Suffolk and North East Essex BAF

Risk No and Owner	Risk description and actions update
<p>System A&E Risk 1</p> <p>Paul Gibara</p>	<p><i>The ICB continues to be under significant pressure and whilst benchmarks well against other regional systems it continues to fail several established standards.</i></p> <p>Current risk rating 16. March 2023 update.</p> <p>Some improvement in performance through January but remain below national standards. Several funding opportunities from NHSEI now available and alliance teams working through prioritisation of schemes to support performance improvements.</p>
<p>System RTT Risk 3</p> <p>Paul Gibara</p>	<p><i>System is not meeting Constitutional Referral to treatment Target of 18 weeks.</i></p> <p>Current risk rating 16. March 2023 update.</p> <p>System is on track to reduce 78 week waits to less than 100 by April 2023. Risks of not delivering this are growing as a result of strike action and BMA rate card rates being unaffordable.</p> <p>Long term sustainability risk identified in some specialties, specifically General Surgery, Gastroenterology and Urogynaecology.</p> <p>New action – Carry Out Getting It Right First Time actions in General Surgery.</p>
<p>NSFT CQC Risk 8</p> <p>Lisa Nobes</p>	<p><i>Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout its services present significant patient safety risks to the population of Suffolk.</i></p> <p>Current risk rating 20 March 2023 update.</p> <p>We continue to take part in the Quality Safety reviews but the challenges continue. Walker Close is currently closed to new admissions.</p>
<p>NSFT Performance Risk 9</p> <p>Richard Watson</p>	<p><i>Unsatisfactory performance of mental health services.</i></p> <p>Current risk rating 20 CQC Rating 'requires improvement' in February 2023. March 2023 update.</p> <p>Mental Health Committees overseeing recovery plans on a county basis.</p> <p>Suffolk system taking forward the development of a Mental Health Collaborative to go live from 01.04.23.</p> <p>Significant reform programme in place across four priority areas: Crisis, Community, Children and Young People and Learning Disabilities & Autism.</p> <p>Five actions in place.</p>
<p>Access to Primary Care Risk 10</p> <p>Maddie Baker-Woods Peter Wightman Laura Taylor-Green</p>	<p><i>Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).</i></p> <p>Current risk rating 16. No March 2023 update.</p>
<p>Cyber Security Risk 11</p> <p>Andrew Kelso</p>	<p><i>Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.</i></p> <p>Current risk rating 20 March 2023 update</p> <p>No applicants for Programme Director Security and Standards position. Exploring alternative options with system partners.</p> <p>SNEE have engaged the services of a qualified Cyber security professional and the in-house domain/tenant has been built with security in mind. The onboarding of NEE colleagues and the unification of services onto one tenant will lower the likelihood to a 3 (note that this transition now has verbal NHSE approval and there is a kick off meeting being planned for this project).</p> <p>The ICB are seeking the assistance from an external supplier (MTI, used by NHSd) in order to undertake an CE+ audit and vulnerability assessment prior to the next DSPT audit, including any remedial action required. This activity is dependent on Frontline Digitisation funding being allocated. An initial exploratory meeting was held 17th February and a follow up with MTI present is being arranged.</p>
<p>Provider Workforce Risk 12</p> <p>Amanda Lyes</p>	<p><i>Workforce challenges across the system.</i></p> <p>Risk rating increased to 20 (from 16).</p> <p>This is due to the continued increase in demand on services and on-going workforce challenges such as staff retention, burnout and resilience. Also, the potential risk of industrial action, especially the forthcoming Junior Doctors (13th-15th March) along with any other industrial action should talks between unions and government break-down.</p> <p>March 2023 update.</p> <p>Over 100 Reservists are now being deployed across ESNEFT/WSFT to support workforce pressures. Feedback from providers is very positive.</p> <p>System and ICB IMTs established to support Industrial Action for Junior Doctors (13th-15th March) Workforce Cell (as part of the EPR Oversight) meet weekly to ensure system</p>

	<p>oversight of workforce challenges. SNEE Industrial Action Meetings continuing and establish actions as required. IA meetings continue with HR and OPs leads. Lessons learnt from first round of IA being reflected into the next scheduled dates in March.</p> <p>Two additional actions.</p>
<p>Covid-19 Outbreak Risk 13</p> <p>Lisa Nobes</p>	<p><i>The Incident Level is currently at Level 3.</i></p> <p>Current risk rating 20. March 2023 update. Demand for UEC remains challenging across multiple providers - with Covid + inpatients relatively stable - reported as 145 cases across ESNEFT & WSFT as @6/2/23. No significant impacts on ICB staffing.</p>
<p>WSFT Infrastructure Risk 14</p> <p>Paul Gibara</p>	<p><i>WSFT have identified and alerted the CCGs to risks associated with the Trusts Reinforced Autoclaved Aerated Concrete (RAAC) infrastructure.</i></p> <p>Current risk rating 12 No further update.</p>
<p>EEAST Quality/Performance Risk 16</p> <p>Ed Garratt</p>	<p><i>EEAST is not meeting performance targets against ambulance response categories.</i></p> <p>Current risk rating 20 March 2023 update.</p> <p>a. NHSE/I and Lead commissioner working with EEAST to see how capacity can be increased and linking this with increased funding via £30m additional investment through national 'pot', primarily through reducing abstraction rates, and how new models of care can reduce inappropriate 999 pathway responses with C3 – C5 call categories. Plans in development to create ICB hubs and increase schemes such as access to stack EEAST have delivered draft Operational Improvement Plan, feedback has been given including has this is linked to the additional £30m fund available, focus on targets not benchmarking and individual areas should include pushing targets not 'safe'.</p>
<p>CYP Access to MH Therapy & Treatment Risk 17</p> <p>Lisa Nobes</p>	<p><i>CYP are unable to access MH therapy and treatment. As a result, YP have been admitted into paediatric wards in acute hospitals across the ICS. This creates a risk to staff, patients and families on these wards.</i></p> <p>Current risk rating 16 March 2023 update.</p> <p>Local Protocol for managing, escalating need in acutes in place. Review taking place based on practice-based evidence across CYP system agencies and led by ICB through a Task and Finish Group considering development of "place of safety" locally Dynamic Support Register for CYP with LD and/or A in place for proactive and support and monitoring where CYP at risk of admission. SCC leading on a forum where cases of concern locally across care, education and health are reviewed for proactive support and monitoring. Potential funding being accessed to improve/provide better environments for CYP with acutes needs. Peripatetic offer is now in place. Applied for Medium term funding to extend pilot offer and CATAT hosted by NSFT.</p>
<p>Clacton Hospital Redevelopment Risk 18</p> <p>Amanda Lyes</p>	<p><i>Delay in progressing the Clacton Hospital site redevelopment in accordance with the original bid criteria and stated spend profile could result in withdrawal of STP capital for the project.</i></p> <p>Current risk rating 20 No further update.</p> <p>The OBC development has been taken over by ESNEFT.</p>
<p>System Cancer Standards Risk 19</p> <p>Richard Watson</p>	<p><i>System not meeting the outcomes within the NHS constitution in regard to cancer standards</i></p> <p>Current risk rating 16 March 2023 update</p> <p>New recovery trajectories developed by the providers with both reporting 62 back log recovery by March 2023. Currently SNEE are over 100 pts over trajectory. 23/24 62-day backlog reductions have been published with ESNEFT to recover to 276 and WSFT to 93. ESNEFT current 62 backlog position (w/e 13/2) is 12% of their PTL and WSFT is 10.4% of their PTL. Which is an improved position from previous weeks. WSFT skin pathway 47% of their PTL, which has reduced from 60%, the pathway still has significant delays. ESNEFT LGI PTL is currently 54% and growing week on week. Red to Green supporting removing patients off the pathway, new clinical lead has been appointed at ESNEFT. Urology across the system has a declining performance, red to green has recently started to support actions to recover the pathway. 2WW delays on breast pathway on all 3 sites due to high numbers of referrals, Colchester currently polling at 24 days. Tertiary centres remain impacting local pathways, N&N dermatology consultant has recently retired resulting on skin delays at Ipswich – a new one has been appointed. Mid Essex have deploys in their skin pathway resulting in delays for Colchester patients referred. Escalated to Quality & Patient Safety Lead. Recent guidance published by NHSE has confirmed these patients can be removed from our PTL.</p>
<p>EPUT Fixed Ligature Points</p>	<p><i>Patient safety risk in relation to Fixed Ligature Points and clinical governance of EPUT Ligature process.</i></p>

<p>Risk 20</p> <p>Lisa Nobes</p>	<p>Current risk rating 15 March 2023 update No ligature deaths in reporting period. Datix data held within EPUT suggests increase in number of non-anchored ligature attempts on wards, particularly amongst females. Action plan not yet available. Keep watching brief and raise through Essex Quality Collaborative QCPM meetings.</p>
<p>NEE Special Schools Risk 21</p> <p>Lisa Nobes</p>	<p><i>The 5 Special schools across NEE do not have access to the Universal School Nursing commissioned offer and as such, the healthy Child Programme.</i> Current risk rating 16 March 2023 update – additional action 6. ESNEFT have raised a concern about the health needs of children being met in a specific special school which has been shared with ECC. A sample audit of IHCP's to identify the required level of need and how this is being met being planned between ICB/ECC and school.</p>
<p>Covid Patient Public Access Risk 22</p> <p>Lisa Nobes</p>	<p><i>Patient & Public access to a significant number of NHS services has been disrupted due to Covid 19 pandemic with an increased demand on all commissioned services.</i> Current risk rating 15 March 2023 no further update.</p>
<p>Dementia Environment Risk 24</p> <p>Lisa Nobes</p>	<p><i>Dementia is excluded from MH D2A pathways.</i> Current risk rating 16 March 2023 no further update. A business proposal has been shared with the MH Transformation team for Step Up and Step Down.</p>
<p>Financial targets Risk 25</p> <p>Howard Martin</p>	<p><i>Failure to meet statutory ICB financial targets.</i> Current risk rating 15. March 2023 update. The risk of non-delivery of financial statutory targets in 2022/23 is now low. However, the restricted financial settlement in 2023/24 alongside operational imperatives has resulted in a higher risk (likelihood) as we go into the next financial year. An overall system deficit of £59m was posted in February. System partners are working towards the delivery of a challenging but credible break-even plan. Two actions complete.</p>
<p>Primary care access to Afghan nationals, asylum seekers, and refugees. Risk 26</p> <p>Andrew Kelso</p>	<p><i>Reduction in access to, experience of and outcomes in primary care due to capacity.</i> RAG rating reduced to target score (6). RISK CLOSED Risk largely mitigated by current measures but requires ongoing monitoring and may increase in future should further hotels be commissioned.</p>

Suffolk and North East Essex ICB Board Assurance Framework: Overview



The Suffolk and North East Essex Integrated Care Board Assurance Framework (BAF hereafter) provides the NHS Suffolk and North East Essex Integrated Care Board (ICB) with a simple but comprehensive method for the effective and focused management of risk. Through the BAF the ICB Board gains assurance that risks are being appropriately managed throughout the organisation.

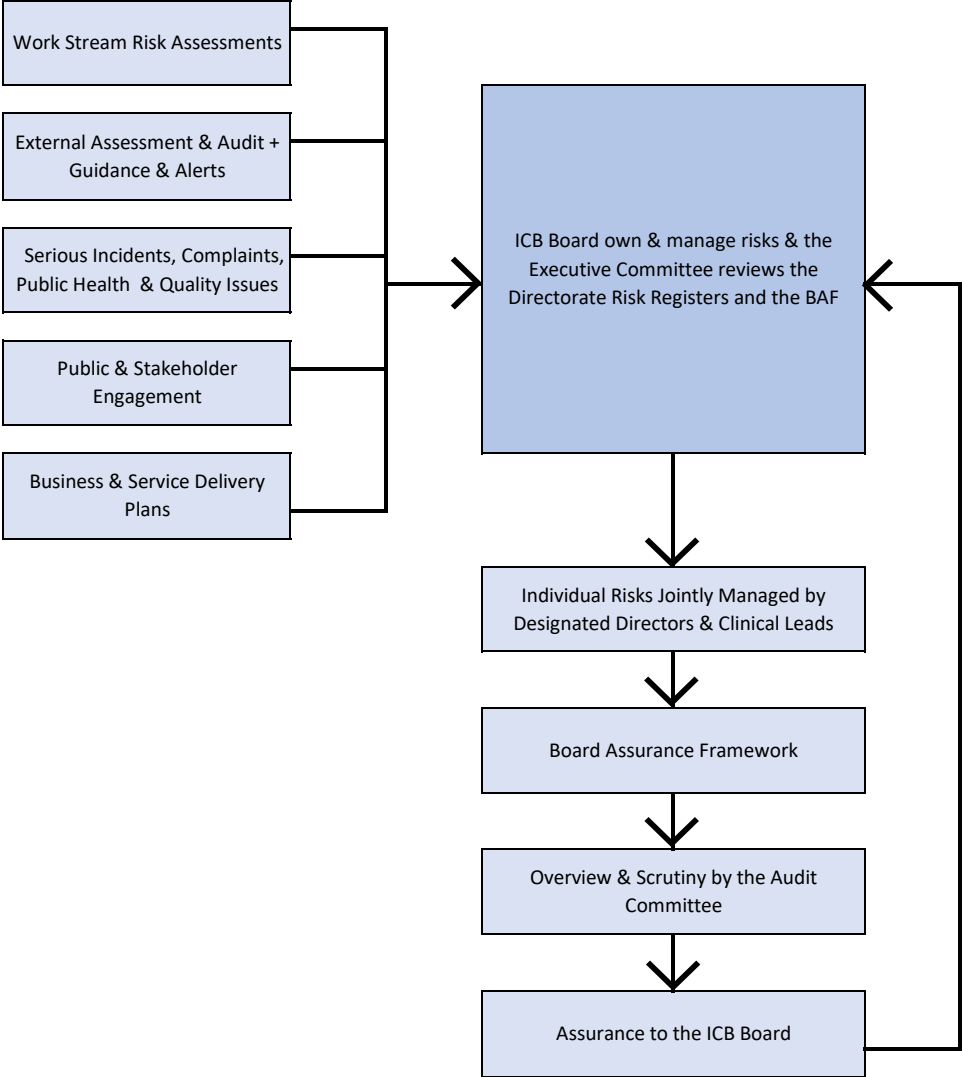
The BAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the ICB has insufficient assurance. At the same time, it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the ICB Board to determine how to make the most efficient use of resources and address the issues identified to improve the quality and safety of care. The BAF also brings together all the evidence required to support the Annual Governance Statement.

The BAF should be a working document and will be updated regularly by the Executive Management Team, monitored by the Audit Committee and reported to the ICB Board at each of its meetings. The BAF is linked to the Directorate Risk Register's, the content of which is also provided for review by the Executive Management Team. A flow chart setting out how risks are identified and managed is set out on the Risk Identification and Management tab.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Risk Register are assessed against the former National Patient Safety Agency (NPSA) 5X5 risk matrix and those scoring 15 and above and are of strategic concern migrate to the BAF and thereby inform the ICB Board agenda. Once added to the BAF, a risk should remain in place until its RAG rating has been mitigated to a score of 1-6 when it is considered manageable and therefore no longer a strategic concern.

The 5X5 risk matrix and subsequent red, amber, green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action and determines whether risks are to be accepted based on the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

**Suffolk and North East Essex ICB Board Assurance
Framework: Risk Identification & Management**



Risk Scoring Matrix

The subsequent red, amber, green (RAG) scores identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action and determines which risks are to be accepted on the basis of the colour banding and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating within the Risk Appetite classification:

		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Consequence	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Catastrophic	5	10	15	20	25

Risk Appetite

For all risks that have been agreed and then assessed and rated, an action plan should be drawn up containing the actions that will be taken, with timescales, in order to either totally eliminate the risk or to reduce its consequences to a level that the IC is prepared to accept. It is useful to consider the 'Three T's' when considering the management of risks:

Tolerate	Where the IC accepts the risk and lives with it
Treat	Where the IC takes action to reduce the risk
Transfer	Where the IC has someone else carry the risk such as by passing the responsibility for the risk to a contractor
Terminate	Where the IC feels that the risk is too great and does not continue with the activity going near to it

In order to determine the likely consequence arising from an identified risk and using the RAG matrix:
 • Define the risk explicitly in terms of the adverse consequence or consequences that might arise
 • Use the table below for example, to determine the consequence score relevant to the risk identified

Consequence score (severity level) and example of descriptions

Risk Domain	Consequence score (severity level) and example of descriptions				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Impact on the safety of patients, staff or public (light/low/psychological harm)	Minor injury or illness requiring intervention or treatment	Moderate injury requiring professional intervention	Major injury leading to long term disability	Multiple permanent injuries or deaths	At least one death
Impact on the safety of patients, staff or public (light/low/psychological harm)	Requiring time off work for 1-3 days	Requiring time off work for 4-6 days	Requiring time off work for 7-14 days	Multiple permanent injuries or deaths	At least one death
Operational issues of treatment or service delivery	Disrupts treatment or service delivery	Treatment or service delivery significantly reduced	Non-compliance with national standards with significant risk to patients if continued	Major incident	At least one death
Internal compliance/regulatory	Normal compliance (Stage 1)	Partial compliance (Stage 2)	Multiple (significant) independent reviews	At least one death	At least one death
Quality / complaints / audits	Local resolution	Local resolution with potential to go to independent review	Local resolution with potential to go to independent review	Critical report	At least one death
Human resources/ organisational development / staffing / competence	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Human resources/ organisational development / staffing / competence	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Human resources/ organisational development / staffing / competence	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Statutory duty/ inspection	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Statutory duty/ inspection	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Statutory duty/ inspection	Local resolution	Repeated failure to meet national standards	Major patient safety implications, if findings are not acted on	Critical report	At least one death
Adverse publicity/ reputation	Local media coverage	Local media coverage	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation
Adverse publicity/ reputation	Local media coverage	Local media coverage	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation
Adverse publicity/ reputation	Local media coverage	Local media coverage	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation	National media coverage with 10 days service and below reasonable public expectation
Business objectives/ projects	10-15 per cent over project budget	15-20 per cent over project budget	20-25 per cent over project budget	25-30 per cent over project budget	30-35 per cent over project budget
Business objectives/ projects	10-15 per cent over project budget	15-20 per cent over project budget	20-25 per cent over project budget	25-30 per cent over project budget	30-35 per cent over project budget
Business objectives/ projects	10-15 per cent over project budget	15-20 per cent over project budget	20-25 per cent over project budget	25-30 per cent over project budget	30-35 per cent over project budget
Finance including claims	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Finance including claims	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Finance including claims	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Service/ business interruption	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Service/ business interruption	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Service/ business interruption	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Environmental impact	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue
Environmental impact	Less than 10% of total revenue	10-15% of total revenue	15-20% of total revenue	20-25% of total revenue	25-30% of total revenue

Risk 1 SYSTEM A&E

Detail				Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Completion
Urgent and Emergency Care Committee	Paul Gibara	The ICB continues to be under significant pressure whilst benchmarks well against other regional systems it continues to fall several well established standards namely the wait 12 hour delay (new standard) Ambulance off load delays Ambulance response times Cause - demand to the department insufficient flow through the department Delay to discharge medically fit patients Effect - poor patient experience and heightened safety risk.	Compounding these difficulties remains the prevalence of Covid-19. Workforce and bed occupancy relating to system flow and operational delivery plans exceed 19/20 activity thresholds for elective recovery.	4	4	16	Daily system operational system flow meeting to support effective use of available capacity. Routine weekend planning and on call arrangements. Admission avoidance schemes aimed at reducing ambulance converging.	Performance dashboard established together with live data feed to monitor system pressures and support appropriate actions Tactical reviews of system performance and actions UECC oversight of system performance and programme development. SD&E oversight of performance and risks Regional oversight of performance and risks	Treat	4	4	16	16	Amber	March 2023 update: Some improvement in performance through January but remain below national standards. Several funding opportunities from NHSEI now available and alliance teams working through prioritisation of schemes to support performance improvements.		

Suffolk and North East Essex ICB Board Assurance Framework
Risk 11 Cyber Security



Committee	Accountable Director	Detail		Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action			
		Description of Strategic Risk	Granular Operational Risks	Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Completion	
	Andrew Kelso	<p>Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.</p> <p>Cause Cyber security attack.</p> <p>Effect Wide scale IT system outages, meaning no access to patient records, e-dispensing services etc</p>	<p>National requirements have increased, in respect of the need to achieve cyber essentials + accreditation.</p> <p>No national funding has been identified specifically for cyber security work to mitigate against the increased risk, and the increased requirements.</p> <p>No access to systems – would require frontline services to fully enact Business Continuity and Disaster Recovery procedures.</p> <p>Potential for lack of access to relevant IT skills and insight to develop a recovery plan (dependent on type of attack).</p> <p>Restoration of services complex, would involve multiple vendors and take a significant period of time</p>	4	5	20	<p>Service provider (NEL) have achieved cyber essentials accreditation and cyber essentials + accreditation. ICB has own domain and has achieved cyber essentials.</p> <p>RSM reviewed cyber controls. Assurance received.</p> <p>Additional ETTF funds have been successful to implement a NAC solution, details being worked up with NEL. W10 rollout 99.95% complete. Handful of remaining W10 PCs will be decommissioned in service transition, they remain supported.</p> <p>Improved access controls and enabling multi-factor authentication with OKTA.</p> <p>Implementation of effective incident response plan via ICC. Regular patch of systems and planned forced machine restarts.</p> <p>Ensure that backups, restore mechanisms and online defences are working as BAU, monthly reporting and live dashboards.</p> <p>NEL have team to keep up to date with latest threat and mitigation information.</p>	<p>External Audit.</p> <p>Internal audit complete</p> <p>Monthly SLA provider meetings.</p> <p>Monthly service review provider meetings.</p> <p>Monthly Joint Digital and IT Services Board.</p> <p>Audit Committee review.</p> <p>SNEE ICB will be working towards Cyber Essentials plus accreditation in the first half of 2023. Funds have been identified for this.</p> <p>NEL's OKTA solution has been removed through the migration process and MFA is being introduced in Jan 2023.</p> <p>Location based authentication is now active so a log on from an unexpected location will be treated by the system as a threat</p> <p>All backups are now cloud based and data is located in more than one datacentre</p> <p>Restoration of services is now easier to manage and control. Once NEE is onboarded SNEE will have full autonomy on this and not share resources with other NHS organisations in the event of a disaster</p>	Treat	4	5	20	Same	20	Amber	<p>March 2023 update:</p> <p>No applicants for Programme Director Security and Standards position. Exploring alternative options with system partners.</p> <p>SNEE have engaged the services of a qualified Cyber security professional and the in-house domain/tenant has been built with security in mind. The onboarding of NEE colleagues and the unification of services onto one tenant will lower the likelihood to a 3 (note that this transition now has verbal NHSE approval and there is a kick off meeting being planned for this project).</p> <p>The ICB are seeking the assistance from an external supplier (MTI, used by NHSd) in order to undertake an CE+ audit and vulnerability assessment prior to the next DSPT audit, including any remedial action required. This activity is dependant on Frontline Digitisation funding being allocated. An initial exploratory meeting was held 17th February and a follow up with MTI present is being arranged.</p>		

Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
				Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB People Committee	Amanda Lyes	<p>Workforce challenges across the system.</p> <p>Cause</p> <p>Staff burnout.</p> <p>Acuity of patients.</p> <p>Increased demand.</p> <p>Seasonal pressures.</p> <p>Industrial Action.</p> <p>Cost of living.</p> <p>Effect</p> <p>Leading to risks to patient safety, care and services.</p>	Retention of staff continues to be an issue, particularly HCSWs to nursing and adult care.	4	5	20	SNEE People Committee established to implement the system People Plan and associated initiatives.	SNEE People Committee, IES, NEE and WS Local Workforce Transformation Groups established in each Alliance.	Treat	5	4	20	Risk Increased	Green	<p>RAG increased to 20.</p> <p>This is due to the continued increase in demand on services and on-going workforce challenges such as staff retention, burnout and resilience. Also, the potential risk of industrial action, especially the forthcoming Junior Doctors (13th-15th March) along with any other industrial action should talks between unions and government break-down.</p> <p>March 2023 update:</p> <p>Over 100 Reservists are now being deployed across ESNEFT/WSFT to support workforce pressures. Feedback from providers is very positive</p> <p>System and ICB IMTs established to support Industrial Action for Junior Doctors (13th-15th March) Workforce Cell (as part of the EPR Oversight) meet weekly to ensure system oversight of workforce challenges</p> <p>SNEE Industrial Action Meetings continuing and establish actions as required.</p> <p>IA meetings continue with HR and OPS leads.</p> <p>Lessons learnt from first round of IA being reflected into the next scheduled dates in March.</p>	1. Cost of Living Workshops are currently running. Work continues H&WB interventions.	Actions, target date Mar 23
			Staff absence due to Mental Health and MSK.				Plans for Retention in place incl. workshop in Spring/Summer '23, and associated system oversight group.	Workforce Intelligence & Planning. Workforce workshops for challenged areas such as maternity and EoL Care.								3. Attracting people into health and care through school and college activities.	
			Staff absence due to seasonal flu and Covid-19.				Targeted groups established to identify system oversight and intervention such as Cost of Living Group.	Strategies in place for: Pharmacy, Nursing, Healthcare Science. Cost Living 'Mindful Money' series.								4. Retention Summit to be arranged (postponed due to IA)	
			Cost of living pressures and impact especially staff in lower paid roles.				H&WB team Cost of Living initiatives. Health and Care Academy and Apprenticeship strategy in place to support grow your own.	Cost of living resource pack – internal and external. SNEE Industrial Action and EPRR Industrial Action Plan.								5. Workforce Workshops arranged for: Maternity/EoL/Frailty and Community Services	
			Risk of breaching constitutional obligations.				Reservist Programme now launched.	SNEE Industrial Action SOP.								6. BMA rate card – Negotiations still ongoing.	
			Primary care risk of some practices not being able to function and list closures.				System Cost of Living Working Group established.	Reports to Health and Wellbeing Collaborative Group (sub-group of People Committee)								7. Junior Doctors Industrial Action (13th - 15th March) - System meetings established x3 a week - Workforce HR Meetings in-between these to focus on specific issues and feedback	
			Industrial action and the impact on operations activity and elective care. All unions apart from BMA in negotiations with Government, currently IA on hold except for Junior Doctors, due to take IA - 13th-15th March '23				System IA meetings now established weekly and now have internal daily calls.	EPR Processes and Oversight Group								8. Attraction and screening for Reservists continues	
			BMA rate card, this is non contractual rate of pay for consultants.				On-going discussions internally with providers	Regular calls with Medical Director and with HRDs									

Suffolk and North East Essex ICB Board Assurance Framework

RISK CLOSED

Risk 26 Primary care access to Afghan nationals, asylum seekers, and refugees



Committee	Accountable Director	Description of Strategic Risk	Granular Operational Risks	Initial Risk Rating			Mitigation			Revised Risk Rating			RAG Progress		Update and Action		
				Likelihood	Consequence	Score	Key Controls Established	Assurance of Controls	Risk Appetite	Likelihood	Consequence	Score	RAG Score Last Month	Target Risk Score	Update	Action Points	Target Date for Competition
ICB Board	Andrew Kelso	Reduction in access to, experience of and outcomes in primary care due to capacity. Cause Home office policy to stand up sites at short notice to reduce the backlog of people held at receiving/holding sites for people entering the country. Effect High expectation of local health services to respond to the needs of hotel residents. The scale and complexity of cases leading to impact of demand and capacity for primary care contractors already under pressure within existing resources.	Delay in patients being registered Reputational risk of ICB for perceptions of lack of access	4	5	20	Commissioned service (Enhanced Assessments). Commissioned Service (GP open access).	ICB governance followed inc. due diligence. Contract variation and contracting.	Treat	2	3	6	Same	Green	March 2023 update. Nearly all residents have been registered with GP Practice, confirmation of exact numbers awaited	Vaccination bus to visit hotel to support	31/01/2023
			Health and wellbeing of primary care staff, increased workforce pressures				Local working groups with system partners. Clinical and governance processes underpin preferred models.	Engagement with primary care via ICB GP lead and LMC							Public Health have met with provider to provide reassurance that infection control measures are robust within hotel	Continue to register & support refugees as they arrive & manage their health needs	Ongoing
			Opportunity costs of enhanced investment redirected from other budget areas				Meetings with Hotel to monitor emerging risks for mitigation and review. Additional support commissioned from voluntary sector e.g Colchester Refugee Action.								Risk largely mitigated by current measures, but requires ongoing monitoring and may increase in future should further hotels be commissioned.		
			Where patients not registered risk of duplicate records by supporting providers												RISK CLOSED		
			Lack of workforce to be deployed to preferred model.														

Directorate Risk Register summary of top risks

Date: March 2023

Department	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Corporate Services	Lack of access to NEE / Suffolk tenancy	NEE staff are reliant of Suffolk colleagues to assist	16	Actions taken by NHSE will prevent any work being progressed on this until after the transition work is completed, Suffolk complete, awaiting NEE.	June 2023	Amanda Lyes
2. Corporate Services	The risks of climate change and severe weather on the ICBs business functions and staff.	Climate Change is happening and the ICB is focusing on the consequences. National PHE heatwave and cold weather plan. Response plans in place for extreme weather events.	12	The ICS Green Plan is the adaptation plan acknowledging the headline threats, this work is ongoing. A more detailed granular risk assessment is being worked through.	March 2024	Amanda Lyes
	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. COO Ipswich & East and West	A practice in IES have encountered significant GP staffing issues which may impact on their ability to see patients in a timely manner	ICB is working with local practices and the current provider to develop a plan to deal with this issue.	12	Work on the way with the practice in respect of building project. Staffing issues have stabilised	Ongoing	Caroline Procter
	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Performance Improvement	Suffolk CYP Community services There have been longstanding concerns around the waiting times for autism spectrum disorder assessment & diagnosis for CYP up to 11 yrs. The pandemic has exacerbated waiting times. >400 CYP are waiting over 12 months for an autism assessment vs NICE guidance which is assessment/diagnosis within 6 months	A progress summary paper was shared by the trust in April 2022 and several areas of concern have been identified. Concerns have been shared with the trust and a meeting has been scheduled for 27 April to discuss the concerns. Concerns were raised at the April Community contract meeting and on-going discussions with the trust will be supported by colleagues from clinical quality and transformation. Concerns will be summarised at the CYP MDT in April to understand any other mitigation options.	16	Waiting list restoration plan developed and ICB investment agreed in October 2021. Restoration plan implemented by WSFT. A progress summary paper was shared by the trust in April 2022 and several areas of concern have been identified. These concerns have been shared with the trust Families have been provided with information/signposted to support resources. Additional resources due to be available from summer 2021 following the	No end date	Nicola Brunning

		There is currently limited assurance that WSFT has implemented the service restoration plan.		completion of the NDD procurement. Service has contacted all families to support signposting.		
2. Performance Improvement	<p>Pandemic Disease Hazard:</p> <p>On both the Suffolk and Essex Community Risk Registers Pandemic Influenza is the highest noted. During an outbreak we could see significant staff shortages from the ICB and provider organisations, disruption to supply chains. Changes in both local and national priorities for NHS Care that will translate in to changes within teams to deliver them.</p> <p>Consequences include inability to provide services, temporary loss of staff (through sickness/ caring for relatives), permanent loss of staff. Inability to discharge from hospitals due to lack of care facilities (inclusive of domiciliary care, residential and nursing homes). Increase in deaths likely to create significant pressure on hospital mortuaries and wider fatality management services (funeral homes etc). Impacts of the pandemic linked to changes in elective programs (both urgent and non-urgent) will involve a recovery plan, while potentially mitigating subsequent pandemic waves.</p> <p>Any prophylaxis or vaccination program will also add a huge demand on NHS services.</p>	<p>UKHSA monitoring for potential outbreaks.</p> <p>Resilience Forum Pandemic Plans.</p> <p>Resilience Forum Mass Fatality and excess death plans.</p> <p>ICB Business Continuity Plan, ICB Emergency Response Plan, Provider business continuity plans.</p> <p>NHS EPRR Core Standards process.</p>	15	<p>Annual ICB Business Continuity exercise.</p> <p>Annual flu vaccination campaign.</p>	01/04/2023	Chris Chapman
3. Performance Improvement	<p>Practice Plus Group are unable to deliver the 20 second response target for 111</p> <p>The risk is that patients with urgent needs are delayed or</p>	<p>Regular monitoring and action meetings are in place, Director Level conversations occurring.</p>	16	<p>Additional funding for Think 111 First given to PPG.</p> <p>Regular System Escalation conversations occurring</p>	March 2023	Greg Brown

	missed due to the longer than standard waits.					
	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Nursing	Due to unprecedented system pressure in the Eastern Region causing ambulance response delays, there is a risk an ambulance resource cannot be immediately deployed to Category 2 calls, which require an average response time of 18 minutes.	Reporting of Serious Incidents to Commissioner and Lead Commissioner oversight. ICB seek assurance on any immediate actions following each incident raised. Standing agenda item at regional QSM. EEAST are creating a single action plan to address findings from system delays SI's. ICB co-ordinating system response to facilitate improved response times across the region.	25	EEAST are updating their single action plan to address findings from system delays SI's. ICB remain developing the system response UEC meetings to help facilitate improved response times across the region. Included in BAF EEAST risk 16	March 2023	Joe Allen
2. Nursing	Risk of reputational impact as the lead commissioner of NSFT services, which show organisational risks in relation to clinical safety of services, timeliness of access to commissioned clinical services and the quality of care planning and risk assessments. This also create a risk of lack of public confidence including stakeholders in the ability of NSFT to provide the service.	Quality assurance reviews of all 41 service lines within Suffolk NSFT. Actions from visits shared with NSFT, progress monitored through CQRM. ICB support with trust quality and safety review process. Monthly CQRM meetings focus on quality / contractual requirements / appropriate actions / trajectories to meet required quality and contractual requirements. Joint support process from alliance system, with the allocation of SRO and project lead roles to support NSFT with progress for operational delivery to enable MCP process in 2022.	15	Safe and Wellbeing reviews for LD inpatients completed. Minor learning points very positive feedback from patients and families. Currently waiting for the CQC inspection report to be published.	March 2023	Wendy Scott
	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Transformation	Failure to achieve national Dementia diagnosis target for WS of 67% in line with the Prime Minister's Challenge on Dementia 2020. Length from referral to diagnosis currently c. 6 months with	System recovery funding in place with both diagnostic services as well as support agencies which also pick up pre-diagnosis. Recovery plan in place with projected achievement of 66.7% come March 2023 Current attainment for locality 56.7% at January 23	9	Update: West Suffolk Memory Assessment service business case derived with demand and capacity modelling to clear backlogs and sustain an MSNAP accredited service. Pending ICB finance prioritisation process.	March 2023 Update: Trajectory in the process of review following NHS Digital amending	Rob Chandler

	scanning across the locality being a key issue for delays.				prevalence calculations	
	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. NEE – Meds Mgmt	NICE issued updated guidance relating to the monitoring of blood glucose monitoring in all patients (adults and children; type 1 and 2 diabetes mellitus) on 31st March 2022. A significant and substantial impact on both Alliance and ICB medicines and devices budgets.	Joint ICB task and finish group is working on pathways and list of approved cost-effective options for CGMs.	9	Pathway completed by task and finish group, led by ICB Diabetes lead Pharmacist, agreement has been reached by all from clinical leads in ESNEFT, WSFT and NEEDS. ICB executive team has approved funding.	31 March 2023	Olubusola Daramola
2. NEE – Meds Mgmt	Minimising health inequalities by creating a SNEE wide insulin pump formulary with all patients being subject to common Approval criteria. NEE supports an insulin pump formulary based on lower acquisition cost options in the market, while Suffolk does not have a formulary. This creates a disparity and increases cost pressure in NEE with patients on the border or transferred to NEE from Suffolk.	Joint ICB task and finish group is working on a joint ICS-wide approval process and insulin pump formulary which takes into account a forecast of increase in use and a budget impact assessment, in view of the current financial recovery position without a negative impact on patient outcomes.	15	Pathway completed by task and finish group, led by ICB Diabetes lead Pharmacist, final agreement required from clinical leads in ESNEFT and NEEDS.	31 March 2023	Olubusola Daramola

ICB BOARD

Agenda Item No.	16
Reference No.	ICB 23-26
Date.	1 March 2023

Title	Review of the ICB Constitution
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Colin Boakes – Independent Governance Advisor
Purpose	Review of the ICB Constitution
Recommendation:	
The ICB Board is asked to note the review the ICB Constitution.	

1. Background

- 1.1 The Board endorsed the ICB Constitution at its inaugural meeting on 1 July 2022, the former Clinical Commissioning Groups (CCGs) having previously approved the document. This was in accordance with the Health and Care Act 2022 which stated that the CCGs must propose to NHS England the Constitution for the first Integrated Care Board (ICB) to be established for the ICB area of Suffolk and North-East Essex.

2. Key Issues

- 2.1 Some six months after establishment of the ICB, it was considered an opportune moment for Board Members to review the Constitution and if appropriate, suggest any necessary amendments.
- 2.2 Further to discussion at the Board meeting in January 2023, members were invited to reflect on the document and provide any comments or feedback to the Director of Workforce and People within the following two weeks.
- 2.3 Only one comment was received suggesting the addition of a section that sets out what patients can expect from us, in language they can access. However, as NHS England guidance states that ICB Constitutions cannot ordinarily be amended and no amendments can come into effect without NHS England having approved them in accordance with the Health and Care Act, the suggestion would not be considered approvable. As such, the Constitution remains unchanged.
- 2.4 It should be noted too that unlike the former CCG Constitutions, for ICBs, much of the amendable content has now been included within the Governance Handbook, changes to which are not subject to approval by NHS England.
- 2.5 In accordance with the initial approval and endorsement, the Constitution will be subject to a further review after one year, this being set for July 2023.
- 2.6 However, it should be reiterated that within the power given to NHS England by each ICB Constitution (which is a mandatory provision in all ICB Constitutions pursuant to the Act) to make amendments, they expect to use that power only in exceptional circumstances.

3. Recommendation

- 3.1 The Board is requested to note, that following interim review, the ICB Constitution remains unchanged.

ICB BOARD

Agenda Item No.	17
Reference No.	ICB 23-27
Date.	21 March 2023

Title	Review of ICB Board Sub-Committee Terms of Reference
Lead Director	Amanda Lyes, ICB Director of People and Workforce
Author(s)	Colin Boakes, ICB Governance Advisor
Purpose	For the Board to review and approve terms of reference for its sub-committees.
Recommendation:	
The Board is asked to review and approve the attached sub-committee terms of reference.	

1. Background

The ICB Board is reminded that it had previously approved a number of sub-committee terms of reference at its inaugural meeting held on 1 July 2023 and agreed that, going forward, only substantial or material changes should be presented to the Board for future approval.

At its meeting on 27 September 2022, the ICB Board agreed that its sub-committee terms of reference be reviewed in six months hence today's report.

2. Key Issues

Please see below the list of sub-committee terms of reference appended to the report for review and approval:

ICB Board Sub-Committees	Review date	Revisions since initial approval.
Statutory Committees:		
Audit Committee	March 2023	Yes - with regard to membership and inclusion of Freedom of Information oversight.
Auditor Panel	March 2023	No
Remuneration and HR Committee	March 2023	No
Others:		
Quality Committee	March 2023	Yes – with regard to quorum
Finance Committee	March 2023	Yes – with regard to membership
People Committee	March 2023	Yes – with regard to membership
People and Communities Committee	March 2023	No
Estates Committee	March 2023	Yes – to include reference to sustainability and change of job title of Chair.
System Oversight and Assurance	March 2023	No
Strategic Digital Investment and Assurance Committee	March 2023	Yes – with regard to membership
Executive Committee	March 2023	No
Commissioning Governance Process Group	New Terms of Reference	New Terms of Reference for approval.

3. Recommendation

The Board is asked to:

- 1) Review and approve the presented terms of reference
- 2) Approve that going forward, only substantial or material changes should be presented to the Board for future approval.

Audit Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The Audit Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its constitution. It shall provide the Board with an independent and objective review of the adequacy and effective operation of the organisation's overall internal control system including its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference are based on the specimen terms of reference set out in the *HFMA NHS Audit Committee Handbook*, as well the NHS model ToR for an audit committee, amended as necessary, and are approved by the ICB.

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.

The Committee is a non-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. It has no executive powers, other than those specifically delegated in these terms of reference or the scheme of reservation and delegation in the ICB's constitution.

2 Authority

The Audit 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;

Commission any reports it deems necessary to help fulfil its obligations;

Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice;

Create task and finish sub-groups in order 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.

For the avoidance of doubt, the Committee will comply with, the ICB Standing Orders, Standing Financial Instructions and the SoRD, other than for the following exceptions:

3 Relationship with the ICB Board

The Audit Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders. The 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.

The Audit Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

The fitness for purpose of the assurance framework;

The completeness and 'embeddedness' of risk management in the organisation;
The integration of governance arrangements;
The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
The robustness of the processes behind the quality accounts.

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

4 Membership

The Audit Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Independent Non-Executive Members of the Board. Other members of the Committee need not be members of the Board, but they may be.

Neither the Chair of the Board, nor employees of the ICB will be members of the Committee. Individuals who claim a significant proportion of their income from the Integrated Care Board will not be Members of the Committee

Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to the ICB's business.

When determining the membership of the Audit Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

The Audit Committee will be chaired by an Independent Non-Executive appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

The Chair of the Committee shall be independent and therefore may not chair any other committees. In so far as it is possible, they will not be a member of any other committee.

The Audit Committee members may appoint a Vice Chair who has the appropriate skillset, in order to lead the meeting if the Chair is unavailable.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

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

Only members of the Committee have the right to attend Committee meetings, however all meetings of the Committee will also be attended by the following individuals who are not members of the Committee:

Director of Finance or their nominated deputy;

Director of Corporate Services and System Infrastructure (or their nominated deputy)

Representatives of both internal and external audit;
Individuals who lead on risk management and counter fraud matters;
Individuals who lead on Governance and Financial Governance

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.

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 the Health and Wellbeing Board(s), Secondary and Community Providers.

The Chief Executive should be invited to attend the meetings and should discuss at least annually with the audit committee the process for assurance that supports the Governance Statement. They (or their nominated deputy) should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

The Chair of the ICB may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

5 Attendance

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.

6 Access

Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Audit Committee.

At least once per year the Committee should meet privately with the external and internal auditors.

7 Secretary and Administration

The organisation's governance lead shall be secretary to the Audit Committee and they, or their representative, shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members. The secretariat function 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 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 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 Audit Committee is updated on pertinent issues/ areas of interest/ policy developments

Action points are taken forward between meetings.

Committee members receive the development and training they require.

Meetings are arranged for the Chair where required.

8 Meeting Quoracy and Decision

Meetings

The Audit Committee will meet at least four times a year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Audit Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

Additionally, the Audit Committee Chair, external auditors or Head of Internal Audit may request an additional meeting if they consider one necessary, or the Audit Committee members may collectively agree to hold an additional meeting.

The agenda and supporting papers will be sent out at least 5 days in advance of the meetings to allow time for due consideration of issues.

Meetings will be timetabled and agreed in advance.

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.

Meetings will ordinarily be held in person or via video conference. However, meetings may be conducted on a 'virtual' basis through the use of e-mail or teleconference communication if necessary.

The Committee may meet 'in common' with other Audit Committees where the Audit Committee deems this appropriate. However, when meeting in common, the committee will have the ability to take its own decisions that might differ from those of the other committee(s) and regardless of any arrangements permitting decisions to be made following discussions by the committees in common, each ICB retains individual accountability for any decisions taken on behalf of their local populations and a consensus decision will only be binding if each individual ICB consents to that decision.

Quorum

For a meeting to be quorate a minimum of two members of the committee are required, including the Chair or Vice Chair of the Committee.

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.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. A decision may be finalised by the agreement of members not present by means of email or a "virtual" decision.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

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.

9 Remit and Responsibilities

The Committee's purpose is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

The duties of the Committee will be driven by the organisation's objectives and the associated 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.

The Audit Committee has no executive powers, other than those delegated in the SoRD and specified in these terms of reference.

The Committee's duties are set out in sections 11 to 21 below.

10 Integrated governance, risk management and internal control

To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the ICB's activities that support the achievement of its objectives, and to highlight any areas of weakness to the Board.

To ensure that financial systems and governance are established which facilitate compliance with DHSC's Group Accounting Manual.

To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of the ICB's objectives, the effectiveness of the management of principal risks.

To have oversight of system risks where they relate to the achievement of the ICB's objectives.

To have oversight of ICB Freedom of Information requests to achieve the ICB's obligations regarding the Freedom of Information Act 2000.

To ensure consistency that the ICB acts consistently with the principles and guidance established in HMT's Managing Public Money.

To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

To identify opportunities to improve governance, risk management and internal control processes across the ICB.

In particular, the committee will review the documents supporting the ICB's risk management framework, to ensure the adequacy and effectiveness of:

- The completeness and relevance of the controls described within the documents and that they relate to the organisation's strategic objectives.

- The reliability of the assurances within the documents and that they are of good quality; taking into account their source, the skills of those providing them and the extent of the work that lies behind them.

In addition:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the ICB.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (previously NHS Protect).
- The effectiveness and controls of key outsourced providers of financial services, including assurance statements from those providers where available.

In carrying out this work the Committee will utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example the committee charged with clinical quality) so that it understands processes and linkages. However, these other committees must not usurp the Committee's role.

11 Internal audit

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Board. This will be achieved by:

Considering the provision of the internal audit service and the costs involved, and any questions of resignation and dismissal;

Reviewing and approving the annual internal audit strategy, plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;

Considering the major findings of internal audit work, including the Head of Internal Audit Opinion (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources;

Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

Monitoring the effectiveness of internal audit and carrying out an annual review.

12 External audit

To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process.

In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit, and make recommendations to the Board when appropriate;

Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;

Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee;

Reviewing all external audit reports, including to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

13 Other assurance functions

To review the findings of assurance functions in the ICB, and to consider the implications for the governance of the ICB.

To review the work of other committees in the ICB, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.

To review the assurance processes in place in relation to financial performance across the ICB including the completeness and accuracy of information provided.

To review the findings of external bodies and consider the implications for governance of the ICB. These will include, but will not be limited to:

Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).

In reviewing the work of committees charged with clinical quality, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from clinical assurance sources such as clinical audit, where appropriate.

14 Counter fraud

To assure itself that the ICB has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

In accordance with 3.2 of NHSCFA's Fraud Commissioners Standards, the audit committee has "*stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHSCFA's quality assurance programme*".

15 Freedom to Speak Up/Whistleblowing

To review the adequacy and security of the ICB's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

It is worth noting that NHS England is a prescribed person, meaning that primary care service staff working at GP surgeries, opticians, pharmacies and dental practices can raise concerns about inappropriate activity directly to NHS England, which provides additional protections as set out in the Whistleblowing Policy.

16 Information Governance (IG)

To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

17 Financial reporting

To monitor the integrity of the financial statements of the ICB and any formal announcements relating to its financial performance.

To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

To review the annual report and financial statements (including accounting policies) before submission to the Board focusing particularly on:

The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

Changes in accounting policies, practices and estimation techniques;

Unadjusted mis-statements in the Financial Statements;

Significant judgements and estimates made in preparing of the Financial Statements;

Significant adjustments resulting from the audit;

Letter of representation; and

Qualitative aspects of financial reporting.

18 Conflicts of Interest

The chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

19 Management

To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the ICB as they may be appropriate to the overall arrangements.

To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the ICB's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

20 Communication

To co-ordinate and manage communications on governance, risk management and internal control with stakeholders internally and externally.

To develop an approach with other committees, including the Integrated Care Partnership, to ensure the relationship between them is understood.

21 Conduct of the Audit Committee

Benchmarking and Guidance

The Audit Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Audit Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

22 Review

The Audit Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 th September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)



**Suffolk and
North East Essex**
Integrated Care Board

Auditor Panel Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The Auditor Panel is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to provide an independent and objective recommendation of the external auditors to be appointed for the organisation. They shall provide this recommendation to the Board, which shall be in charge of the appointment of the external auditors.

2 Authority

The Auditor Panel is authorised by the Board to:

Carry out the functions specified below and can seek any information it requires from any employees or relevant third parties. All employees are directed to co-operate with any request made by the Auditor Panel.

Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such advice must be obtained in line with the organisation's existing rules.

3 Remit and Responsibilities

The Auditor Panel is responsible for:

Advising the organisation's Board on the selection and appointment of the external auditor. This includes:

Overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules.

Making a recommendation to the Board as to who should be appointed.

Ensuring that any conflicts of interest are dealt with effectively.

Advising the organisation's Board on the maintenance of an independent relationship with the appointed auditors.

Advising, if asked, the organisation's Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

Advising on, if asked, the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor.

Advising, if asked, the organisation's Board on any decision about the removal or resignation of the external auditor.

4 Relationship with the ICB Board

The Auditor Panel is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

5 Membership

The Auditor Panel members shall be appointed by the Board in accordance with the ICB Constitution. The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference or the scheme of reservation and delegation in the ICB's constitution.

When determining the membership of the Auditor Panel, active consideration will be made to diversity and equality.

The membership comprises of:

- A majority of lay members from the Board.
- Not less than three members.

Chair and Vice Chair

The Auditor Panel will be chaired by the lay member on the Board, with a lead role for overseeing key elements of governance

The Auditor Panel members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

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

Only members of the Auditor Panel have the right to attend Auditor Panel meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Auditor Panel. These invitees are not members of the Auditor Panel.

6 Secretary and Administration

The Auditor Panel 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

Records of members' appointments and renewal dates 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 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 Auditor Panel is updated on pertinent issues/ areas of interest/ policy developments

Action points are taken forward between meetings

7 Meeting Quoracy and Decision

For a meeting to be quorate it shall consist of two of three members, or 50% of members if the committee has more than three members.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

8 Decision Making and Voting

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Auditor Panel will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Auditor Panel may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Auditor Panel will hold the casting vote.

9 Meetings

The Auditor Panel shall consider the frequency and timing of meetings needed to discharge its responsibilities and will arrange them accordingly. The Auditor Panel may wish to meet on the day of the Audit Committee meetings.

Auditor Panel meetings MUST be held and minuted as separate meetings from Audit Committee meetings.

The Auditor Panel chair shall ensure it is clear to all attending that auditor panel meetings are not Audit Committee meetings.

Meetings will ordinarily be held in person or via video conference. However, meetings may be conducted on a 'virtual' basis through the use of e-mail or teleconference communication if necessary.

The Committee may meet 'in common' with the Auditor Panel of other ICBs. However, when meeting in common, the committee will have the ability to take its own decisions that might differ from those of the other committee(s) and regardless of any arrangements permitting decisions to be made following discussions by the committees in common, each ICB retains

individual accountability for any decisions taken on behalf of their local populations and a consensus decision will only be binding if each individual ICB consents to that decision.

10 Conduct of the Auditor Panel

Benchmarking and Guidance

The Auditor Panel will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Auditor Panel shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Conflicts of Interest

Conflicts of interest must be declared and recorded at the start of each meeting of the Auditor Panel.

A register of the Panel's interests must be maintained by the Panel's chair (or delegated to the person supporting the Panel's administration). It must be submitted to the Board in accordance with the ICB's existing requirements for conflicts of interest.

If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.

11 Review

The Auditor Panel will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)



**Suffolk and
North East Essex**
Integrated Care Board

Remuneration and Human Resources Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The Remuneration Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary, to confirm the ICB Pay Policy including adoption of any pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors.

These terms of reference, which are published on the ICB website as an appendix to its Constitution, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-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

The Remuneration 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

Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

Create task and finish sub-groups in order 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 SoRD but may /not delegate any decisions to such groups

For the avoidance of doubt, in the event of any conflict, the ICB's Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference.

3 Remit and Responsibilities of the Committee

For the Chief Executive, Directors and other Very Senior Managers:

Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars

Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

Determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change)

Oversee contractual arrangements

Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

The Committee shall review as required, the Chief Executive's performance.

The Committee shall establish arrangements for monitoring and evaluating the performance of individual senior officers and managers, as approved by the ICB Board.

The Committee shall advise on and oversee contractual arrangements for staff by developing policies for recommendation to the Board, to ensure an equitable and consistent approach.

The Committee shall receive and approve HR, Organisational Development and Learning and Development policies and procedures.

The Committee shall receive and approve reports and have oversight of the work of the Health and Safety Committee.

The Committee shall receive the minutes of any sub-groups that may be formed and receive and approve reports on Organisational Development and Learning and Development.

By reference to the Board Assurance Framework, the Committee shall monitor allocated risks and satisfy itself and assure the Audit Committee that the mitigating actions proposed for each allocated risk are reasonable and that each mitigating action is being undertaken.

In making its recommendations the Committee will take into account:

- Provisions of any national guidance and arrangements
- Relevant legislation (in particular anti-discrimination and equal pay legislation)
- Best practice and affordability
- Employee relations and relevant staffing matters within the Integrated Care Board
- Remuneration levels elsewhere within the NHS and other relevant labour markets
- Trends and development in non-pay benefits and terms and conditions
- Organisational performance
- Auditor requirements
- Existing terms and conditions of service
- Statutory health and safety legislation and best practice

The Committee will retain the right to place specific reports, on an exception basis and with the agreement of the Chair, in a closed agenda whereby the content of the report and subsequent discussion, will not be accessed under the Freedom of Information Act 2000. Reports placed in a closed agenda will be returned to the Board Secretary or nominated deputy at the meeting for shredding. Committee members will be responsible for deleting the relevant electronic records from their own computer systems.

4 Relationship with the ICB Board

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Chair of the Committee in consultation with colleagues on the Committee and senior officers of the ICB will make decisions that are required urgently.

The Committee has delegated powers from the ICB Board for all Human Resources policies and procedures and issues that may impact on the terms and conditions of employment for all staff, for instance lease cars and travel policies.

The Committee has delegated powers from the ICB Board for all matters of health and safety.

Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

The Committee will submit copies of its minutes and a report to the Board following each of its meetings. Where minutes and reports identify individuals, they will not be made public and will be presented at a meeting of the Board in private session. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

The Chair of the Committee shall draw to the attention of the ICB Board any issues that require disclosure in a specific report to the full Board or require executive action.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

5 Membership of the Committee

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than three members of the Committee including two independent members of the Board. Other members of the Committee need not be members of the board, but they may be.

The Chair of the Audit Committee may not be a member of the Remuneration Committee.

The Chair of the Board may be a member of the Committee but may not be appointed as the Chair.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by an independent non-executive member of the Board appointed on account of their specific knowledge skills and experience making them suitable to chair the Committee.

Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

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

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by the following individuals who are not members of the Committee for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:

The ICB's most senior HR Advisor or their nominated deputy
Director of Finance or their nominated deputy
Finance Department Observer
Chief Executive or their nominated deputy

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.

No individual should be present during any discussion relating to:

Any aspect of their own pay
Any aspect of the pay of others when it has an impact on them.

6 Secretary and Administration

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

Records of members' appointments and renewal dates 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 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.

7 Meeting Quoracy and Decisions

The Committee will meet in private.

The Committee will meet at least twice each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, Chair or Chief Executive may ask the Remuneration Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

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

For a meeting to be quorate a minimum of two of the non-executive members is required, including the Chair or Vice Chair.

If any member of the Committee has been disqualified from participating on item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

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

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

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.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

8 Conduct of the Committee

Benchmarking and Guidance

The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

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, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

9 Review

The Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	1st July 2022
Next Review:	March 2023

Quality Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The Quality Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to provide the ICB with assurance that is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2021. This includes reducing inequalities in the quality of care.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

2 Authority

The Quality Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Quality Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3 Remit and Responsibilities

The Quality Committee will:

Be assured that there are robust processes in place for the effective management of quality.

Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern.

Agree and put forward the key quality priorities that are included within the ICB strategy/annual plan, including priorities to address variation/inequalities in care.

Oversee and monitor delivery of the ICB key statutory requirements.

Review and monitor those risks on the BAF and Quality Risk Register which relate to quality, and high-risk operational risks which could impact on care. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner.

Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI and other regulatory bodies / external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.

Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites.

Oversee and seek assurance on the effective and sustained delivery of the ICB Quality Improvement Programmes.

Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and place, this includes reviewing patient experience data.

Receive assurance that the ICB identifies lessons learned from all relevant sources, including incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

Receive assurance that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports).

To be assured that people and communities are systematically and effectively involved as equal partners in quality activities.

Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for safeguarding adults and children.

Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control.

Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity working in partnership with people and communities.

Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for medicines optimisation and safety.

Have oversight of and approve the Terms of Reference and work programmes for the groups reporting into the Quality Committee (e.g. Alliance Quality Groups, Alliance Engagement forums, Infection Prevention and Control, Safeguarding Boards / Hubs, people and communities committee of the ICB etc.).

4 Relationship with the ICB Board

The Quality Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The Quality Committee has delegated powers from the ICB Board as delegated in these Terms of Reference as determined by the ICB Board.

Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

5 Membership

The Quality Committee members shall be appointed by the Board in accordance with the ICB Constitution.

When determining the membership of the Quality Committee, active consideration will be made to diversity and equality.

The membership comprises of:

- Non-Executive Member (Chair)
- ICB Director of Nursing
- ICB Medical Director

- Local Authority Directors
- Alliance representatives
- Provider representatives
- Healthwatch Suffolk and Healthwatch Essex
- At least two lay members with lived experience (People and Communities Group and Patient Safety Partner)
- Other representatives where required

Chair and Vice Chair

The Quality Committee will be chaired by a Non-Executive Member

The Quality Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

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

Only members of the Quality Committee have the right to attend Quality Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Quality Committee.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

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.

6 Secretary and Administration

The Quality 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
- Records of members' appointments and renewal dates 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 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 Quality Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings

7 Meeting Quoracy and Decision

For a meeting to be quorate there will be a minimum attendance of two Board Members comprising either the Non-Executive Member, Director of Nursing or Medical Director,

together with one provider representative, one Local Authority representative and at least one other representative.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Where members are unable to attend, they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

Decision Making, Voting and Frequency

Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

Decisions will be taken in according with the Standing Orders. The Quality Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Quality Committee may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Quality Committee will hold the casting vote.

The exception to this will be Healthwatch Suffolk and Healthwatch Essex. The impartiality and independence of Healthwatch organisations is critical to their role. Therefore, it has been agreed mutually that they will not have voting membership on the group. They will be fully involved and collaborate within the partnership, but without voting rights.

The Quality Committee will convene bi-monthly, rotating via each of the ICB Alliance main offices

8 Conduct of the Quality Committee

Benchmarking and Guidance

The Quality Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Quality Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Declarations of Interest

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

9 Review

The Quality Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	01 July 2022
Next Review:	March 2023

Financial Performance Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The Financial Performance Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

Its main purpose is to contribute to the overall delivery of the ICS objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan. This includes:

- Financial performance of NHS organisations within the formal ICS footprint (system control total) (part 1a)
- Financial management of the Integrated Care Board (part 1b)

2 Authority

The Financial Performance 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) as outlined in these terms of reference

Commission any reports it deems necessary to help fulfil its obligations

Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

Create task and finish sub-groups in order 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.

Authorise expenditure on behalf of the ICB Board up to the value set out in the scheme of delegation.

3 Remit and Responsibilities

The Committee will have a part 1a meeting which considers system financial issues, and **separate** part 1b meeting which considers issues specific to the internal management of the ICB. The committee's duties are as follows:

Part 1a

System financial management framework

To set strategic financial framework for ICB and ICS partners where appropriate

To develop the system financial planning processes to be used to make recommendations to the Board on the system financial plan in line with the strategy and national guidance

To ensure health and social inequalities are taken into account in financial decision-making

Resource allocation (revenue)

to develop an approach to distribute resource allocations through commissioning and direct allocation to drive agreed change based on the ICS strategy

to advise on the process regarding the deployment and monitoring the impact of system wide transformation funding

to work with ICS partners to identify and allocate resources where appropriate to address finance and performance related issues that may arise

to work with ICS partners to consider major investment/disinvestment business cases for material service change or efficiency schemes and to agree a process for sign off.

National framework

to advise the ICB and ICS partners on any changes to NHS and non-NHS funding regimes and consider how the funding available to the ICS can be best used within the system to achieve the best outcomes for the local population

to oversee national system level financial returns

to ensure the required preparatory work is scheduled to meet national planning timelines

Financial monitoring information

to articulate the financial position and financial impacts (both short and long-term) to support decision-making

to work with ICS partners towards common approaches across the system such as financial reporting, estimates and judgements

to work with ICS partners, including their non-executive members, to seek assurance over the financial performance from system bodies

to oversee the development of financial, activity and workforce modelling to support the system wide priority areas

to assure the development of a medium- and long-term financial plan which demonstrates ongoing value and sustainability

to ensure the system develops an understanding of where costs sit across a system, including its cost drivers and the impact of service changes

to ensure appropriate information is available to enable the system to manage financial issues, risks and opportunities across the ICS

to ensure visibility and reporting of system financial and associated risks as part of the overall review of system finances

Financial Performance

to oversee the management of the system financial target

to agree key outcomes to assess delivery of the system wide financial strategy

to monitor and report to the ICB, and to the Integrated Care Partnership as required, the overall financial performance against national and local metrics, highlighting areas of concern

to monitor and report to the ICB key service performance which should be taken into account in assessing the financial position

System efficiencies

to ensure system efficiencies are identified and monitored across ICS partners, in particular opportunities at system level where the scale of the ICS partners together and the ability to work across organisations can be leveraged

to ensure financial resources are used in an efficient way to deliver the objectives of the ICS

to review exception reports on any material breaches of the delivery of agreed efficiency plan including the adequacy of proposed remedial action plans

Communication

to co-ordinate and manage communications on financial governance with stakeholders internally and externally

to develop an approach with partners, including the Integrated Care Partnership, to ensure the relationships between cost, performance, quality and environmental sustainability are understood

People

to ensure an ICS wide finance staff development strategy is in place to ensure excellence by attracting and retaining the best finance talent

Capital

to seek assurance that the system capital strategy and associated plan properly balances clinical, strategic and affordability drivers

to ensure effective oversight of future prioritisation and capital funding bids

to monitor the system capital programme against the capital envelope and take action to ensure that it is appropriately and completely used

to gain assurance that short, medium and long term commitments are built into the overall system capital plan

Part 1b – Internal ICB finances

to ensure development of a reporting framework for the ICB (using the chart of accounts devised by NHS England and the integrated single financial environment (ISFE))

to oversee the management of the ICB's own financial targets.

to oversee the development of the ICB financial strategy and agree key outcomes to assess delivery

to ensure that suitable financial policies and procedures are in place for the ICB to comply with relevant regulatory, legal and code of conduct requirements

to approve expenditure within the committee's delegated limit, as listed in the Scheme of Reservation and Delegation.

4 Accountability and Reporting

The Financial Performance Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

Formal minutes shall be recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will draw to the attention of the Board any issues that require disclosure to the Board or require the Board to take action.

The Committee will provide an annual report to the Board to describe how it has fulfilled its terms of reference and give details on progress and a summary of key achievements in the delivery of its responsibilities.

5 Membership

The Financial Performance Committee members shall be appointed by the Board in accordance with the ICB Constitution.

When determining the membership of the Financial Performance Committee active consideration will be made to diversity and equality. Members of the committee may be co-opted to ensure diversity of thinking in decision making.

The board will appoint no fewer than four members of the Committee including one who is an Independent Non-Executive Member of the Board. Other members of the committee need not be members of the board but may be.

Members should possess between them knowledge, skills, and experience in:

- Accounting
- Risk management
- And technical or specialist issues pertinent to the business of the committee

Core membership for Part 1a and Part1b includes:

Part 1a – System Financial Management Framework

- Independent Chair - The chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB Finance and Audit)
- Non-Executive Member (Nominated by Provider Partners)
- Primary Care ICB Board representative
- Suffolk and North-East Essex ICB Director of Finance
- Suffolk and North-East Essex ICB Director of Performance Improvement
- ESNEFT Director of Finance
- WSFT Director of Finance
- EEAST Director of Finance
- NSFT Director of Finance (non-voting member)*
- EPUT Director of Finance (non-voting member)*
- Section 151 Officer, Suffolk County Council (non-voting member)
- Section 151 Officer, Essex County Council (non-voting member)
- Suffolk and North-East Essex ICB Deputy Director of Finance (non-voting member unless deputising for the Director of Finance)

* Mental health representation and logistics to be agreed at the start of each meeting.

Part 1b – Internal ICB Finances

- Independent Chair - The chair will be selected to ensure that the Audit Committee and the Finance Committee are chaired by different members
- Non-Executive Member (ICB Finance and Audit)
- Primary Care ICB Board representative
- Suffolk and North-East Essex ICB Director of Finance
- Suffolk and North-East Essex ICB Director of Performance Improvement
- Suffolk and North-East Essex ICB Deputy Director of Finance (non-voting member unless deputising for the Director of Finance)
- ICB Alliance Directors

Other Directors of the ICB will be expected to attend part 1b when required to report on significant expenditure areas within the ICB.

Other appropriate representatives from system partners may be invited or may request to attend in agreement with the chair.

Members are expected to attend at least 75% of meetings held each year to ensure consistency.

Where a member is unable to attend, efforts should be made to ensure that a suitable representative attends, as nominated by the member and agreed by the Chair.

Chair and Vice Chair

In accordance with the constitution, the Committee will be chaired by an Independent Non-Executive Member of the Board appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

The Financial Performance Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.

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

Only members of the Financial Performance Committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee. Other individuals may be invited to attend all or part of any meeting as and when appropriate to assist it with discussions on any particular matter.

The Chair may ask any or all of those who normally attend, but are not members, to withdraw to facilitate open and frank discussion on particular matters.

The Chair and the Chief Executive of the ICB may also be invited to attend one meeting a year in order to gain an understanding of the committee's operations.

6 Frequency, Secretary and Administration

The Financial Performance Committee shall meet at least quarterly, with meeting frequency increased to monthly where the operating landscape means this would be most appropriate.

The Financial Performance Committee shall be supported with a secretariat function, which will ensure 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
- Records of members' appointments and renewal dates and the Committee is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders 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 Financial Performance Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those is monitored
- Attendance of those invited to each meeting is monitored and the Chair is made aware as soon as possible of those meetings that do not meet the minimum quoracy requirements

7 Meetings, Quoracy and Decision

The Committee will ordinarily be held in person or via video conference. However, meetings may be conducted on a 'virtual' basis through the use of email or teleconference communication if necessary.

The Committee may meet 'in common' with other Finance Committees where the Committee deems this appropriate. However, when meeting in common, the committee will have the ability to take its own decisions that might differ from those of the other committee(s) and regardless of any arrangements permitting decisions to be made following discussions by the committees in common, each Committee retains individual accountability for any decisions taken on behalf of organisation: a consensus decision will only be binding if each individual committee consents to that decision.

For a meeting to be quorate a minimum of 50% of the voting members is required, including the Chair or Vice Chair and the ICB Director of Finance (or nominated deputy). Given the differing membership of part a and part b, the members required to reach a quorum for part a and part b may be different.

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum for that item.

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

Decisions will be taken in according with the Standing Orders. The Financial Performance Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Financial Performance Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Financial Performance Committee will hold the casting vote.

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. Where such action has been taken between meetings, then these will be reported to the next meeting.

8 Conduct of the Financial Performance Committee

Benchmarking and Guidance

The Financial Performance Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

Conflict of Interest

In discharging duties transparently, conflicts of interest must be considered, recorded and managed. Members should have regard to the NHS guidance on managing conflicts of interest.

All conflicts of interest must be declared and recorded at the start of each meeting. A register of interests must be maintained by the Chair and submitted to the Board. If a conflict of interest arises, the Chair may require the affected member to withdraw at the relevant point, refrain from voting in any votes on the particular matter, or taking part in discussions at the point, depending on the Chair's view of the best way to manage this conflict of interest.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members must agree that this overrides all individual or organisational self-interest. Members will be expected to abide by the duty to collaborate and the principles set out by the ICS.

Members of, and those attending, the Financial Performance Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make. They should also consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

9 Review

The Financial Performance Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	1 st July 2022 (ICB Board)
Next Review:	21 March 2023

People Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

The People Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution and Functions and Decisions arrangements. The Committee's main purpose is to oversee, support and advise on the implementation of priorities for the current and future system workforce, ensuring that Suffolk and North East Essex has an ambitious strategy for its people.

2 Authority

The People Committee is authorised by the Board to:

Ensure delivery of the Suffolk and North East Essex People Plan through the three Alliances, providers and commissioners.

Improve equality, diversity and inclusion for the current and future system workforce, maximising potential for using work to improve the health and wellbeing of local communities.

Promote integrated system working and ensure consistency to support collaborative working at scale.

Support relevant infrastructure groups to ensure the People Plan workstreams have clear leadership.

Work in partnership with the East of England People Board to ensure that system priorities are delivered in areas where a region wide approach is appropriate.

3 Remit and Responsibilities

The People Committee is responsible for

Increasing diversity across the ICS and developing a leadership culture that embraces equality, diversity and inclusion.

Developing and embedding a health and wellbeing agenda for staff.

Building and developing workforce capacity and capability.

Developing innovative methodologies to ensure the supply of the right workforce with the right knowledge and skills at the right time to deliver high quality care.

Enabling innovation and encouraging new ways of working.

Supporting and valuing leadership at all levels with lifelong learning.

Leading coordinated workforce planning using intelligence and analysis.

Supporting system design and development with appropriate workforce inputs.

Contributing to wider local social and economic growth and an available local labour market through collaboration with partner organisations.

Promoting positive cultures and developing system organisations as agile, inclusive and modern employers to attract, recruit and retain the people needed to deliver plans.

Committing to subsidiarity to ensure care is delivered as close to the patient as is possible.

4 Relationship with the ICB Board

The People Committee is accountable to the Board and to the East of England Regional Board and shall report to both Boards on how it discharges its responsibilities.

The People Committee has delegated powers from the ICB Board as set out in the ICB Scheme of Reservation and Delegation.

Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board. Where minutes and reports identify individuals, they will not be made public and will be presented at a meeting of the Board in private session. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure.

The Chair of the Committee in consultation with colleagues on the Committee and senior officers of the ICB will make decisions that are required urgently.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

5 Membership

The People Committee members shall be appointed by the Board in accordance with the ICB Constitution.

When determining the membership of the People Committee, active consideration will be made to diversity and equality.

The membership comprises of:

ICB Board Non-Executive Member, People, Remuneration and Diversity
ICB Director of People and Workforce
ICB Medical Director
ICB Executive Chief Nurse
ICB Head of Workforce Transformation
ICB Digital & Workforce – Programme Lead
ICB Strategic AHP Workforce Lead
Integrated Care Partnership (ICP) Director
SNEE Primary Care Training Hub Lead
Primary Care Representatives
ESNEFT Representative – Director of People and Organisational Development
WSFT Representative – Executive Director of Workforce and Communications
NSFT Representative - Deputy Chief Executive Officer & Chief People Officer
EPUT Representative
East of England Ambulance Service NHS Trust Representative - Business & Partnerships Lead (Suffolk & North Essex)
Suffolk County Council Representative – Head of HR
Essex County Council Representative - People Business Partner
Local Authority (District/Borough) Representative
Health Education England (HEE) Representative
Skills for Care (SfC) Representative
Voluntary, Community and Social Enterprise (VCSE) Representative
Further Education (FE) Representative
University of Essex Representative
University of Suffolk/HEI Representative
Integrated Care Academy (ICA) Representative
Chairs of the Alliance Workforce Transformation Groups

Chair and Vice Chair

The People Committee will be chaired by a member of the Committee identified by the ICB Chief Executive.

The People Committee members may appoint a Vice Chair from amongst the members.

In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.

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

Only members of the People Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

6 Secretary and Administration

The People 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

Records of members' appointments and renewal dates 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 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.

7 Meeting Quoracy and Decision

For a meeting to be quorate a minimum of five members is required, including the Chair or Vice Chair.

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

The People Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

Any member of the committee shall be entitled to nominate a deputy on his/her behalf in the event he/she cannot attend a meeting. In the absence of an individual, their nominated deputy shall assume their voting rights.

In those circumstances the Chair should be informed one week prior to the meeting.

Deputies will be expected to have been fully briefed by the substantive member.

8 Conduct of the Committee

Benchmarking and Guidance

The People Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

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, Diversity and Inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

9 Frequency of Meetings

The People Committee will meet every two months. However, it may meet more or less frequently as circumstances dictate.

10 Review

The People Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	1 st July 2022
Next Review:	1 st July 2023



**Suffolk and
North East Essex**
Integrated Care Board

**Suffolk and North-East Essex People and Communities Committee
Terms of Reference**

NHS Suffolk and North East Essex Integrated Care Board

1 Purpose

The People and Communities Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to ensure the duties related to 'Working in partnership with people and communities' are delivered in collaboration with system partners. Providing assurance that people and communities are included, their voices and experiences are heard, and that there is comprehensive infrastructure in place across the system to support this work.

2 Authority

The People and Communities Committee is authorised by the Board to:

- 2.1 Work in partnership to support the health and care systems in Suffolk and north East Essex to work effectively with their communities and ensure that people are involved in decisions about health and care services.
- 2.2 Bring together significant opportunities that will strengthen how people and communities are involved at all levels, from neighbourhoods to system wide, in supporting the 'Triple Aim duty' for health and care
- 2.3 Oversee the delivery of the ICB People and Communities Strategy and embed the 10 guiding principles of how to work with people and communities.

3 Remit and Responsibilities

The People and communities Committee is responsible for

- 3.1. identifying collective priorities and common themes and identify opportunities for system responses.
- 3.2. Identify areas of concern and issues being raised across different parts of the system (organisation, neighbourhood, Alliance) and bring these to the attention of the Board.
- 3.3. Use insight and work in collaboration with communities to provide a better understanding and response to improving health equity and reducing inequalities.
- 3.4. Respond to system priorities identified at the Board with insight and voices of experience, drawing on the range of expertise and experience of the committee partnership.
- 3.5. Look ahead at potential issues or areas of work and work together with people and communities to influence strategy and decision making.
- 3.6. Understand collective feedback loops and system communications about engagement, making sure opportunities are transparent and open and outcomes shared widely. Understand your community's needs, experience and aspirations for health and care.
- 3.7. Assuring processes are in place to ensure citizen involvement in design, development and procurement of services to ensure they are provided at the right time, in the right place and by the right people.
- 3.8. Act as a centre where all engagement activity across Suffolk and North East Essex will be collated.
- 3.9. Oversee clear reporting and feedback mechanisms between people and communities and the ICB.
- 3.10. Ensure the Alliances and the ICB is communicating with people and communities in a range of ways appropriate to the people within them.
- 3.11. Members sharing feedback from the groups they represent on service experience and views of proposed changes/transformation
- 3.12. Monitor and evaluate community involvement activity undertaken and how inclusive it has been (for example Equality Impact Assessments)
- 3.13. Assure that all engagement is representative of the population.

4. Relationship with the ICB Board

- 4.1. The People and communities committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 4.2. The People and communities committee has delegated powers from the ICB Board for delivery of duties associated with the stat
- 4.3. Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

5. Membership

- 5.1. The People and communities committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 5.2. When determining the membership of the People and communities committee, active consideration will be made to diversity and equality.

The membership comprises of:

- Healthwatch Suffolk (non voting membership)
- Healthwatch Essex (non voting membership)
- The Chair of the Alliance Engagement Forums x3
- Representative from strategic programmes
- West Suffolk Foundation Trust – Head of Patient Experience and Engagement
- East Suffolk and North Essex Foundation Trust – Head of Patient Experience
- Norfolk and Suffolk Foundation Trust – Head of Patient Experience
- Essex Partnership University Trust – Director of Patient Experience
- Public Health Suffolk
- Public Health Essex
- Adult Social Care – Suffolk County Council
- Adult Social Care – Essex County Council
- Voluntary, Community and Social Enterprise Sector Assembly Representative
- District and Borough Council x6 – Community Engagement or involvement leads
- ICB Head of Patient and Public Involvement and Experience

Chair and Vice Chair

- 5.3. The People and Communities Committee will be chaired
- 5.4. The People and Communities Committee members may appoint a Vice Chair from amongst the members.
- 5.5. In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
- 5.6. 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

- 5.7. Only members of the People and Communities Committee have the right to attend People and Communities Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of People and Communities Committee

6. Secretary and Administration

- 6.1. The People and Communities Committee shall be supported with a secretariat function. Which will include ensuring that:
 1. 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

2. Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
3. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
4. The Chair is supported to prepare and deliver reports to the Board
5. The People and Communities Committee is updated on pertinent issues/ areas of interest/ policy developments
6. Action points are taken forward between meetings.

7. Meeting Quoracy and Decision

- 7.1. For a meeting to be quorate there must be a minimum of 50% membership representation.
- 7.2 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

- 7.3 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
- 7.4 Decisions will be taken in according with the Standing Orders. The People and Communities Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 7.5 Only members of the People and Communities Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter
- 7.6 The exception to this will be Healthwatch Suffolk and Healthwatch Essex. The impartiality and independence of Healthwatch organisations is critical to their role. Therefore it has been agreed mutually that they will not have voting membership on the group. They will be fully involved and collaborate within the partnership, but without voting rights.
- 7.8 Where there is a split vote, with no clear majority, the Chair of the People and Communities Committee will hold the casting vote.

8. Frequency of Meetings

- 8.1 The People and Communities Committee will meet every two months. However, it may meet more or less frequently as circumstances dictate.

9. Conduct of the People and Communities Committee

Benchmarking and Guidance

- 9.1. The People and Communities Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

- 9.2. Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
- 9.3. Members of, and those attending, the People and Communities Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

- 9.4. Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

10. Review

- 10.1 The People and Communities Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)

ICB Estates Committee Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

1 Purpose

- 1.1 The ICB (Integrated Care Board) Estates Committee is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The Committee's main purpose is to provide a safe, functionally suitable, and digitally enabled, sustainable, efficient, and integrated estate that allows for the accessible delivery of the right care, in the right place allowing better patient outcomes.

2 Authority

The ICB Estates Committee is authorised by the Board to:

- 2.1 Provide collective leadership that delivers on our vision, strategy, plans and objectives and supports our ICP (Integrated Care Partnership) to develop and deliver the strategic estates vision and priorities, that support the Suffolk and North East Essex ICP
- 2.2 Lead the development of an ICB Estate Strategy, a Capital Investment Pipeline, and align to the ICB Green Plan for all Estates related NZC (Net Zero Carbon) actions. Ensure that the ICB Estate Strategy is up to date in line with latest policy, relevant and being delivered to schedule
- 2.3 Ensure a whole system approach in the delivery of the net zero and sustainability targets as outlined in the NHS Net Zero Strategy and NHS Supply Chain Roadmap.
- 2.4 Work with the ICB Workforce, Finance, Procurement, and Digital groups to enhance and support our direction in relation to People Board directives, on sustainable investment pipelines, collaborative procurement opportunities and estate informatics and digital system development opportunities, respectively
- 2.5 Ensure a whole system approach to improving the condition, optimisation, integration, and rationalisation of the existing ICB/ICP estate where required and future models of care are supported
- 2.6 Ensure a whole system approach to strategic planning in relation to population growth forecasts, Infrastructure Delivery Plans (IDP) and Health Impact Assessments (HIA) to ensure fit for purpose Estate is identified to support the wider determinants of health and wellbeing

3 Remit and Responsibilities

The ICB Estates Committee is responsible for

- 3.1 Ensuring collaboration and true system working around the use, development, and optimisation of estate across all system partners to maximise value for money, patient/service user benefit and delivery of system objectives.
- 3.2 Prioritising and overseeing the development and implementation for the estate's elements of the ICB Clinical, Digital, Workforce and Alliance workstreams through an approved estates work Programme
- 3.3 The appraisal of regular progress performance and risk status reports from each member Organisation to ensure the correct management and delivery of the overall system wide estates strategy is successful
- 3.4 Provide leadership and oversight in ensuring alignment with the ICB Estates Strategy for all ICB Estates investment schemes (and other provider capital schemes which impact on the wider health system) following the Business case Process set out by NHS England and

provide relevant governance for business cases to be forwarded onto the relevant review groups (e.g., NHS England Business Case Review Group, JISC etc.) for approval

- 3.5 Working closely with the ICT & Digital Strategy work streams within the ICB to ensure use of technologies in increasing the optimisation of the Estate and introducing technologies into Clinical Service Delivery where appropriate
- 3.6 Providing oversight and delivery of the ICB Green Plan in support of system partners Green Plans and activities.
- 3.7 Responding to and informing Local Authority planning policy documentation to ensure that these reflect the current estates strategy and the health economy.
- 3.8 Developing and maintaining a summary of estate data for the overall ICP area, using the SHAPE tool or equivalent and agree and monitor performance against ICP wide Estates National and Local metrics, and progress against KPI's
- 3.9 Ensure that essential policies and procedures are in place, approve policies and procedures where necessary, and support and follow existing policies and procedures
- 3.10 Ensure there is a planned programme of work for the financial year that aligns to the ICB Estate Strategy
- 3.11 Maximise and take advantage of opportunities that collaborative working brings, in use or operation of the estate or in services to meet national and local targets and commercial ambitions.
- 3.12 Work with the ICB Board to agree capital investment priorities
- 3.13 Work together to achieve the ICB estates principles around access, efficiency, performance, and quality & standards
- 3.14 Ensure our group partners are following our agreed behaviours and values: trust, collaboration, willingness, resilience, consistent and transparent
- 3.15 Support appointed Capital Programme SROs to collectively consider priorities, interdependencies, risks, and opportunities arising from system working
- 3.16 Undertake specific tasks or projects where directed by the ICB with due consideration of an equal and balanced representation of all system partners.
- 3.17 To monitor and measure the success of the ICB Estates Committee against set KPI's

4 Relationship with the ICB Board, other relevant committees, and forums etc.

- 4.1 The ICB Estates Committee is accountable to the ICB Board and shall report to the Board on how it discharges its responsibilities.
- 4.2 The ICB Estates Committee has delegated powers from the ICB Board for prioritising and delivery of the ICB Estate Strategy, Estate Investment and annual operating plans and work programmes following approval of the ICB Board
- 4.3 The ICB Estates Committee is not permitted to make decisions on matters that have a financial impact on the system or individual partner organisations unless expressly delegated to the ICB Estates Committee from the ICB Board.
- 4.4 Formal minutes shall be kept of the proceedings of the ICB Estates Committee which will be submitted to the ICB Board.
- 4.5 Meetings will be held monthly, (to be reviewed after 6 months) at a time which allows for presentation and/or reporting of any information to the ICB Board.
- 4.6 ICB Estate Committee meetings will be private and not open to the public
- 4.7 ICB Estate Committee meetings will generally be undertaken to support flexible working principles and ensure as complete attendance as possible
- 4.8 ICB Estate Committee meeting dates will be set in March, for the following reporting year, wherever possible, taking account of the optimal day and time to support the greatest attendance
- 4.9 ICB Estate Committee meetings in addition to those referred to at 5.4 above can be called by the Chair at any time outside of the usual meetings in consultation with the membership
- 4.10 The Suffolk and North East Essex Local Estates Forum will report into the ICB Estates Committee. Reports from both forums will be presented by the chairs to the ICB Estates Committee
- 4.11 The ICB Estates Committee Chair, Vice Chair or nominated representative will represent the committee at the Ipswich Central and East Suffolk, West Suffolk, and Essex One Public Estate (OPE) Partnerships and Board meetings to ensure close working relationships and that OPE representation is present at the ICB Committee

5 Membership

- 5.1 The ICB Estates Committee members shall be appointed by the Board in accordance with the ICB Constitution.
- 5.2 When determining the membership of The ICB Estates Committee active consideration will be made to diversity and equality with due consideration of an equal and balanced representation of all system partners.
- 5.3 The membership comprises of:
 - **Suffolk North-East Essex ICB – Strategic Estates Advisor (Chair)**
 - East Suffolk and North Essex NHS Foundation Trust – Head of Capital Development

- Suffolk North-East Essex ICB – Director of People and Workforce
- East of England Ambulance NHS Trust – Head of Business Relationships
- Essex County Council – Lead Officer, Property & Facilities
- Essex Partnership University NHS Trust – Senior Director of Estates and Facilities
- Suffolk North-East Essex ICB Estates – Senior Estates Development Manager – Primary Care Estate Development
- NHSEI – Regional Strategic Estates Advisor
- NHS Property Services – Regional Partnership Director EAST
- Norfolk & Suffolk NHS Foundation Trust – Director of Estates and Facilities
- Suffolk North-East Essex ICB Estates – Senior Estates Development Manager – Strategic Planning
- Suffolk North-East Essex ICB Estates – Sustainability Lead
- One Public Estate, Ipswich Central and East Suffolk – Representative
- One Public Estate West Suffolk – Place Programme Delivery Lead
- One Public Estate Essex – Development Operations Manager
- Ipswich and East Suffolk Alliance Primary Care – Non-Executive Suffolk GP Fed
- West Suffolk Alliance Primary Care – to be confirmed
- VCSE Representative
- North East Essex Alliance Primary Care
- Suffolk County Council – Senior Manager Corporate Property
- West Suffolk Hospital NHS Foundation Trust – Associate Director Estates and Facilities
- Suffolk North-East Essex ICB Digital – Programme Assurance Lead
- Suffolk North-East Essex ICB – Associate Director for Public Relations

Chair and Vice Chair

- 5.4 The ICB Estates Committee will be chaired by **the Suffolk North-East Essex ICB – Strategic Estates Advisor**
- 5.5 The ICB Estates Committee members may appoint a Vice Chair from amongst the members. The Vice Chair should be a member from a different provider discipline or organisation to allow fair representation.
- 5.6 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
- 5.7 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

- 5.8 Only members of the ICB Estates Committee or their confirmed delegates have the right to attend meetings, however, the Chair may invite relevant staff to the meeting as necessary in accordance with the business of The ICB Estates Committee.

6 Secretary and Administration

- 6.1 The ICB Estates Committee shall be supported with a secretariat function. Which will include ensuring that:
1. 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

2. Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
3. Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
4. The Chair is supported to prepare and deliver reports to the Board
5. The ICB Estates Committee is updated on pertinent issues/ areas of interest/ policy developments
6. Action points are taken forward between meetings.
7. All papers are to be submitted 1 week in advance of the meeting date unless by approval of the chair
8. All papers are to be taken as-read to ensure the Committee has the opportunity to discuss highlights

7 Meeting Quoracy and Decision

7.1 For a meeting to be quorate the ICB Estates Committee should have the following members present:

- Chair or Vice Chair of the Committee
- Minimum of six attendees as a proportion of the membership organisations

- 7.2 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

- 7.3 Decisions will be guided by national NHS policy and best practice to ensure that staff are motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
- 7.4 Decisions will be taken in accordance with the Standing Orders. The ICB Estates Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 7.5 Only members of The ICB Estates Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 7.6 Where there is a split vote, with no clear majority, the Chair will hold the casting vote.

8 Conduct of The ICB Estates Committee

Benchmarking and Guidance

- 8.1 The ICB Estates Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England, and the wider NHS in reaching their determinations.

ICB Values

- 8.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
- 8.3 Members of, and those attending, The ICB Estates Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity, and Inclusion

- 8.4 Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

9 Review

- 9.1 The ICB Estates Committee will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)



**Suffolk and
North East Essex**
Integrated Care Board

**Suffolk and North-East Essex ICS
System Oversight & Assurance Committee (SOAC)**

Terms of Reference

1 Purpose

The System Oversight and Assurance Committee (SOAC) is a formal Committee of the SNEE ICB overseeing the system's accountability and performance, and enables system partners to hold each other to account for performance and delivery of agreed plans, formal reporting and escalation of key performance and delivery issues.

These Terms of Reference describe the scope, function, and ways of working for the SOAC, and should be read alongside the Memorandum of Understanding between NHSEI and SNEE ICS.

2 Context

The NHS long term plan, integrating care: next steps to building strong and effective integrated care system across England, the white paper Integration and innovation: working together to improve health and social care and the 2021/22 Operational Planning Guidance make it increasingly clear that the best way to manage health is both at system and organisational level.

The NHS System Oversight Framework¹ provides the approach to managing improvement and performance at ICS (system), placed based and organisation level and sets out how the level and nature of support for systems will be determined.

NHS England & Improvement will adopt a new relationship with regulated organisations in Suffolk and North East Essex ICS, enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on delivery of the NHS Constitution and Mandate, financial and operational control, outcomes and quality;
- NHS
E intend that they will intervene in the individual NHS provider and commissioner partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance work through the SOAG to seek a resolution prior to making an intervention with the Partner.

3 Responsibilities of the SOAC

The partnership approach to NHS system oversight will be geared towards performance improvement and development. It will be data-driven, evidence-based and rigorous. The focus will be on supporting the spread and adoption of innovation and best practice between Partners. Peer review and Partnership working will be core components of the methodology.

The SOAC will:

- Oversee the development of a dashboard of key outcome, performance, and quality and transformation metrics for the ICS, linking with the system Data and Intelligence function.
- Take an overview of performance and transformation at whole system, place and organisation levels in relation to ICS objectives and wider national requirements.

¹ [NHS England » NHS Oversight Framework 2022/23](#)

- Creates links with external organisations
 - NHS England & Improvement
 - Care Quality Commission
 - Partnership Boards
 - Voluntary care sector

- Lead the development of a framework for peer review and support for the ICS and oversee its application.

- Make recommendations to the ICS NHS Board on the deployment of improvement support across the ICS, and on the need for more formal action and interventions. Actions will include the requirement for:
 - agreement of improvement or recovery plans;
 - more detailed peer-review of specific plans;
 - commissioning expert external review;
 - co-ordination of formal intervention and improvement support;
 - restrictions on access to discretionary funding and financial incentives.

- Receive reports from ICS priority programmes and enabling workstreams on issues which require escalation.

4 Membership

The membership of the SOAC will include representation from each sector of the NHS as well as the three Alliances, who will represent primary care.

The membership will comprise:

- ICS Chief Executive (Chair)
- Regional Director Nursing, NHS England (co-chair)
- Regional Directors, NHS England (as required)
- Nominated Executive ESNEFT
- Nominated Executive WSFT
- Nominated Executive NSFT
- Nominated Executive EPUT
- Nominated Executive, EEAST
- ICS NHS Executive lead for the North East Essex Alliance
- ICS NHS Executive lead from the West Suffolk Alliance
- ICS NHS Executive lead from the Ipswich and East Suffolk Alliance
- ICS NHS Director of Performance Improvement
- ICS NHS Director of Strategy and Transformation
- ICS NHS Director of Nursing and Chair of ICS Quality Forum
- ICS NHS Medical Director
- ICS NHS Director of Finance and Chair of ICS Directors of Finance
- ICS NHS Director of Workforce and ICS People Board lead
- ICB GP Board member(s)

In order that NHSE can undertake its regulatory function, the SOAC meeting will be co-chaired by a Director from NHSE. This will be particularly relevant where NHSE has exercised its regulatory powers relating to any one of the regulated organisations within the ICS.

If a member is unable to attend a meeting of the SOAC, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered, to represent their organisation, place or Board/committee.

Additional attendees may routinely include:

- SROs for identified quality and performance areas
- SROs and programme leads for transformation.

5 Quoracy and voting

The SOAC is not a formal decision-making body. The Committee will operate on the basis of joint accountability and consensus. The Committee will not take votes and will not require a quorum of members to be present to consider any business.

Under exceptional circumstances any substantive difference of views among members will be reported to the NHS ICS Board.

6 Accountability and reporting

The SOAC does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations although this may change over time.

NHSE may, where appropriate, enact certain regulatory and system oversight functions through the group.

The SOAC will formally report, through the Chair, to the NHS SNEE Integrated Care Board.

7 Conduct and Operation

The SOAC will normally meet monthly.

Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of two working days' notice will be given when calling an extraordinary meeting.

The agenda and supporting papers will be sent to members and attendees no less than week before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.

Draft minutes and action log will be issued within 10 working days of each meeting.

8 Secretariat

The secretariat function for the SOAC will be provided by SNEE ICB CEO. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

9 Review

These terms of reference and the membership of the Committee will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board September 2022)

Strategic Digital Investment and Assurance Board (SDIAB) Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

Note from Jill Fernandez, PMO Manager, Digital Programme Team

Additional text taken from the following documents:

[Digital ToRs Summary Final v1.0](#)

[STP SDIAB ToRs \(v0.2\) updated section 4 \(05.09.19\)](#) - (Draft document presented at SDIAB 2019 09 12

Updated by Kate Walker following ICS Board 10 June and in line with the DDaT Strategic Delivery Plan 22-25.

1 Purpose

The Strategic Digital Investment and Assurance Board is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The ICS SDIAB is formed from ICS Board Members, including local government, NHS England regional leads, Strategic Investment SROs, CIOs & CCIOs and Chairs of sub-groups.

The Committee's main purpose is to:

- 1.1 Further develop the Digital, Data and Technology (DDaT) vision that enables the outcomes of the ICS
- 1.2 Further define the direction of the ICS Digital, Data & Technology Strategy and supporting programmes and provide approval for further investment opportunities.
- 1.3 Provide strategic leadership, including prioritisation for the ICS DDaT Agenda and development of the Strategic Delivery Plan and Roadmap.
- 1.4 Provide assurance and accountability for the ICS DDaT investments and delivery that enable priority outcomes.
- 1.5 Further develop the approach to leadership and governance at place, system and regional levels.
- 1.6 Empower the Programme Director to resolve strategic issues related to workstream delivery to ensure that progress remains aligned to ICS needs.

2 Authority

- 2.1 The ICB is accountable for using **joined-up data and digital capabilities** to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and **drive continuous improvement** in performance and outcomes.

It is the responsibility of the ICB to create and enable the levers that make this happen

The Strategic Digital Investment and Assurance Board is authorised by the Board to:

- 2.2 Lead **system-wide action** on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care.
- 2.3 Develop and be accountable for the ICS Digital, Data & Technology Strategy
- 2.4 Create the environment that enables us to work together to deliver our mission, goals and principles, including providing expert advice to the ICB associated with levers and policy.
- 2.5 Define priorities and authorise change in the context of our agreed strategy and landscape
- 2.6 Devolve investment and delivery decision rights to associated provider collaboratives and other delivery functions. This will be appended to this Terms of Reference and any sub groups will apply the same governance principles as set out for SDIAB.

3 Remit and Responsibilities

The Strategic Digital Investment and Assurance Board is responsible for

- 3.1 Ensure operation is in line with scheme requirements, agreed priorities and the building block maturity model: connecting neighbourhood, place, system and region.
- 3.2 Ensure partner obligations set out in funding agreements are fulfilled, which will encompass spending, reporting of progress and exceptions, record keeping, procurement, commitment to architectural and safety standards, intellectual property rights, supplier contracting, acknowledgement, publicity and knowledge sharing
- 3.3 Programmes are coordinated widely across the system, seeking to overcome barriers to information flow and digital transformation, in order to maximise benefits for the population and workforce
- 3.4 Ensure delivery of agreed enablers, to ICS priority outcomes, seeking to maximise opportunities through collaboration and alignment
- 3.5 Ensure that the assurance model evolves in line with need, complementing rather than competing with organisational governance to focus on delivering higher ambitions

4 Relationship with the ICB Board

- 4.1 The Strategic Digital Investment and Assurance Board is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 4.2 The Strategic Digital Investment and Assurance Board has delegated powers from the ICB Board for:
 - Development and ownership of the Digital, Data & Technology Strategy and Strategic Delivery Plan
 - Digital, Data and Technology investment prioritisation and the delegation of associated delivery responsibility
 - Execution and assurance of the Strategic Delivery Plan
 - Definition of standards and methodologies associated with this agenda
- 4.3 Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

5 Membership

- 5.1 The Strategic Digital Investment and Assurance Board members shall be appointed by the Board in accordance with the ICB Constitution.
- 5.2 When determining the membership of the Strategic Digital Investment and Assurance Board, active consideration will be made to diversity and equality.
- 5.3 The membership comprises of:

Member	Deputy	Role
Alison Wigg		Independent Chair, linked to ICS Chairs Group
Andrew Kelso		SNEE ICB Medical Director & CIO
Susannah Howard		SNEE ICP and Strategy
Kate Walker		SNEE ICS Digital Programme Director

Keith Wood		SNEE ICS Finance Lead
Mike Meers		CIO ESNEFT
Liam McLaughlin		CIO WSFT
Stephen Bromhall		CIO EEAST
Chris Bally		Exec Lead SCC
Peter Fairley		Exec Lead ECC
Zephan Trent		Exec Lead EPUT
Daryl Chapman		Exec Lead NSFT
Dermot 'O'Riordan		CCIO WSFT
David Grannell		CNIO ESNEFT
Dr Ed Garratt	Richard Watson	SNEE ICB AO and Exec Transformation
Regional Director DT	Sarah Stone	NHS E / I
Support		
John Lamont		SNEE DDaT Programme Assurance
Jill Fernandez		SNEE DDaT PMO
Saty Raviraj		SNEE DDaT PMO Investment
Kate Asbridge		SNEE DDaT PMO Secretariat

Chair and Vice Chair

- 5.4 The Strategic Digital Investment and Assurance Board will be chaired by Alison Wigg.
- 5.5 The Strategic Digital Investment and Assurance Board members may appoint a Vice Chair from amongst the members.
- 5.6 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
- 5.7 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

- 5.8 Only members of the Strategic Digital Investment and Assurance Board have the right to attend Strategic Digital Investment and Assurance Board meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Strategic Digital Investment and Assurance Board.
- 5.9 The Strategic Digital Investment and Assurance Board is chaired by Alison Wigg who has been formally nominated through the ICS Chairs Group and outlined in the membership table on page 4 and 5.
- 5.10 Membership of the Strategic Digital Investment and Assurance Board should incorporate members of the ICS Board and other key stakeholder groups. Other members may be included in the group from time to time as subject matter experts to assist in deliberations or provide information.
- 5.11 Members of the ICS Strategic Digital Investment and Assurance Board (SDIAB) must be able to represent and make decisions and collaborate on behalf of their organisation, alliance or systemwide project.
- 5.12 To ensure consistency, members should see attendance at meetings as a priority or send a deputy. Deputies to be nominated in advance and should have the delegated authority to make decisions.

6 Secretary and Administration

- 6.1 The Strategic Digital Investment and Assurance 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

Records of members' appointments and renewal dates 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 and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

Minutes will be circulated to all members within 10 days of the meeting taking place.

The Chair is supported to prepare and deliver reports to the Board

The Strategic Digital Investment and Assurance Board is updated on pertinent issues/ areas of interest/ policy developments

Action points are taken forward between meetings.

Action notes of meetings will be kept on [FutureNHS \[Can Do Digital\]](#) providing a full audit trail of on-going issues and comply with all applicable statutes, laws and regulations.

7 Meeting Quoracy and Decision

- 7.1 For a meeting to be quorate, the number of members required shall be five (to include deputies).
- 7.2 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

- 7.3 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
- 7.4 Decisions will be taken in according with the Standing Orders. The Strategic Digital Investment and Assurance Board will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 7.5 Only members of the Strategic Digital Investment and Assurance Board may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 7.6 Where there is a split vote, with no clear majority, the Chair of the Strategic Digital Investment and Assurance Board will hold the casting vote.

8 Frequency of Meetings

- 8.1 The Strategic Digital Investment and Assurance Board will meet every two months. However, it may meet more or less frequently as circumstances dictate.

9 Conduct of the Strategic Digital Investment and Assurance Board

Benchmarking and Guidance

- 9.1 The Strategic Digital Investment and Assurance Board will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

- 9.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
- 9.3 Members of, and those attending, the Strategic Digital Investment and Assurance Board shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

- 9.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

10 Review

- 10.1 The Strategic Digital Investment and Assurance Board will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)

Strategic Digital Investment and Assurance Board (SDIAB) Terms of Reference

NHS Suffolk and North-East Essex Integrated Care Board

Note from Jill Fernandez, PMO Manager, Digital Programme Team

Additional text taken from the following documents:

[Digital ToRs Summary Final v1.0](#)

[STP SDIAC ToRs \(v0.2\) updated section 4 \(05.09.19\)](#) - (Draft document presented at SDIAB 2019 09 12)

Updated by [Kate Walker](#) following ICS Board 10 June and in line with the DDaT Strategic Delivery Plan 22-25.

1 Purpose

1.1 The Strategic Digital Investment and Assurance Board is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution. The ICS SDIAC is formed from ICS Board Members, including local government, NHS England regional leads, Strategic Investment SROs, CIOs & CCIOs and Chairs of sub-groups.

The Committee's main purpose is to:

- Further develop the Digital, Data and Technology (DDaT) vision that enables the outcomes of the ICS
- Further define the direction of the ICS Digital, Data & Technology Strategy and supporting programmes and provide approval for further investment opportunities.
- Provide strategic leadership, including prioritisation for the ICS DDaT Agenda and development of the Strategic Delivery Plan and Roadmap.
- Provide assurance and accountability for the ICS DDaT investments and delivery that enable priority outcomes.
- Further develop the approach to leadership and governance at place, system and regional levels.
- Empower the Programme Director to resolve strategic issues related to workstream delivery to ensure that progress remains aligned to ICS needs.

2 Authority

2.1 The ICB is accountable for using **joined-up data and digital capabilities** to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and **drive continuous improvement** in performance and outcomes.

2.2 It is the responsibility of the ICB to create and enable the levers that make this happen

2.3 The Strategic Digital Investment and Assurance Board is authorised by the Board to:

- Lead system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care.
- Develop and be accountable for the ICS Digital, Data & Technology Strategy
- Create the environment that enables us to work together to deliver our mission, goals and principles, including providing expert advice to the ICB associated with levers and policy.
- Define priorities and authorise change in the context of our agreed strategy and landscape
- Devolve investment and delivery decision rights to associated provider collaboratives and other delivery functions. This will be appended to this Terms of Reference and any sub groups will apply the same governance principles as set out for SDIAB.

3 Remit and Responsibilities

The Strategic Digital Investment and Assurance Board is responsible for

- 3.1 Ensure operation is in line with scheme requirements, agreed priorities and the building block maturity model: connecting neighbourhood, place, system and region.
- 3.2 Ensure partner obligations set out in funding agreements are fulfilled, which will encompass spending, reporting of progress and exceptions, record keeping, procurement, commitment to architectural and safety standards, intellectual property rights, supplier contracting, acknowledgement, publicity and knowledge sharing
- 3.3 Programmes are coordinated widely across the system, seeking to overcome barriers to information flow and digital transformation, in order to maximise benefits for the population and workforce
- 3.4 Ensure delivery of agreed enablers, to ICS priority outcomes, seeking to maximise opportunities through collaboration and alignment
- 3.5 Ensure that the assurance model evolves in line with need, complementing rather than competing with organisational governance to focus on delivering higher ambitions

4 Relationship with the ICB Board

- 4.1 The Strategic Digital Investment and Assurance Board is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 4.2 The Strategic Digital Investment and Assurance Board has delegated powers from the ICB Board for:
 - Development and ownership of the Digital, Data & Technology Strategy and Strategic Delivery Plan
 - Digital, Data and Technology investment prioritisation and the delegation of associated delivery responsibility
 - Execution and assurance of the Strategic Delivery Plan
 - Definition of standards and methodologies associated with this agenda
- 4.3 Formal minutes shall be kept of the proceedings which will be submitted to the ICB Board.

5 Membership

- 5.1 The Strategic Digital Investment and Assurance Board members shall be appointed by the Board in accordance with the ICB Constitution.
- 5.2 When determining the membership of the Strategic Digital Investment and Assurance Board, active consideration will be made to diversity and equality.
- 5.3 The membership comprises of: [See Appendix B](#)

Member	Deputy	Role
Alison Wigg		Independent Chair, linked to ICS Chairs Group
Andrew Kelso		SNEE ICB Medical Director & CIO
Susannah Howard		SNEE ICP and Strategy

Kate Walker		SNEE ICS Digital Programme Director
Keith Wood		SNEE ICS Finance Lead
Mike Meers		CIO ESNEFT
Liam McLaughlin		CIO WSFT
Stephen Bromhall		CIO EEAST
Chris Bally		Exec Lead SCC
Peter Fairley		Exec Lead ECC
Zephan Trent		Exec Lead EPUT
Daryl Chapman		Exec Lead NSFT
Dermot 'O'Riordan		CCIO WSFT
David Grannell		CNIO ESNEFT
Dr Ed Garratt	Richard Watson	SNEE ICB AO and Exec Transformation
Regional Director DT	Sarah Stone	NHS E / I
Support		
John Lamont		SNEE DDaT Programme Assurance
Jill Fernandez		SNEE DDaT PMO
Saty Raviraj		SNEE DDaT PMO Investment
Kate Asbridge		SNEE DDaT PMO Secretariat

Chair and Vice Chair

- 5.4 The Strategic Digital Investment and Assurance Board will be chaired by Alison Wigg.
- 5.5 The Strategic Digital Investment and Assurance Board members may appoint a Vice Chair from amongst the members.
- 5.6 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number Chair the meeting.
- 5.7 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

- 5.8 Only members of the Strategic Digital Investment and Assurance Board have the right to attend Strategic Digital Investment and Assurance Board meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Strategic Digital Investment and Assurance Board.
- 5.9 The Strategic Digital Investment and Assurance Board is chaired by Alison Wigg who has been formally nominated through the ICS Chairs Group and outlined in the membership table on page 4 and 5.
- 5.10 Membership of the Strategic Digital Investment and Assurance Board should incorporate members of the ICS Board and other key stakeholder groups. Other members may be included in the group from time to time as subject matter experts to assist in deliberations or provide information.
- 5.11 Members of the ICS Strategic Digital Investment and Assurance Board (SDIAB) must be able to represent and make decisions and collaborate on behalf of their organisation, alliance or systemwide project.
- 5.12 To ensure consistency, members should see attendance at meetings as a priority or send a deputy. Deputies to be nominated in advance and should have the delegated authority to make decisions.

6 Secretary and Administration

- 6.1 The Strategic Digital Investment and Assurance 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
 - Records of members' appointments and renewal dates 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 and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
 - Minutes will be circulated to all members within 10 days of the meeting taking place.
 - The Chair is supported to prepare and deliver reports to the Board
 - The Strategic Digital Investment and Assurance Board is updated on pertinent issues/ areas of interest/ policy developments

- Action points are taken forward between meetings.
- Action notes of meetings will be kept on [FutureNHS \[Can Do Digital\]](#) providing a full audit trail of on-going issues and comply with all applicable statutes, laws and regulations.

7 Meeting Quoracy and Decision

- 7.1 For a meeting to be quorate, the number of members required shall be **six** (to include deputies).
- 7.2 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

- 7.3 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.
- 7.4 Decisions will be taken in according with the Standing Orders. The Strategic Digital Investment and Assurance Board will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.
- 7.5 Only members of the Strategic Digital Investment and Assurance Board may vote. Each member is allowed one vote and a majority will be conclusive on any matter.
- 7.6 Where there is a split vote, with no clear majority, the Chair of the Strategic Digital Investment and Assurance Board will hold the casting vote.

8 Frequency of Meetings

- 8.1 The Strategic Digital Investment and Assurance Committee will meet every two months. However, it may meet more or less frequently as circumstances dictate.

9 Conduct of the Strategic Digital Investment and Assurance Board

Benchmarking and Guidance

- 9.1 The Strategic Digital Investment and Assurance Board will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

ICB Values

- 9.2 Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
- 9.3 Members of, and those attending, the Strategic Digital Investment and Assurance Board shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality, Diversity and Inclusion

- 9.4 Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

10 Review

- 10.1 The Strategic Digital Investment and Assurance Board will review on an annual basis its own performance and effectiveness including membership and terms of reference. The ICB Board will approve any resulting changes to the terms of reference or membership.

Date Approved:	27 September 2022
Next Review:	March 2023 (as agreed ICB Board 27 September 2022)

Appendix B			
Member	Deputy	Role (Member / Deputy)	Organisation
Alison Wigg		Independent Chair, linked to ICS Chairs Group	Independent
Andrew Kelso	Richard Watson	SNEE ICB Medical Director & CIO	SNEE ICB
Susannah Howard	TBC	SNEE ICP and Strategy	ICB
Jo Lennox	Andrew Kelso	SNEE ICS Digital Programme Director	SNEE ICS
Keith Wood	Andrew Kelso	SNEE ICS Finance Lead	SNEE ICS
Mike Meers	David Grannell	CIO ESNEFT / CNIO ESNEFT	ESNEFT
Liam McLaughlin	Dermot O'Riordan	CIO WSFT / CCIO WSFT	WSFT
Stephen Bromhall	Kevin Smith	CIO EEAST	EEAST
Krishna Yergol	TBC	Exec Lead SCC	SCC
Tracy Lindeman	Jamie-Lee Fox	Lead ECC	ECC
Zephan Trent	TBC	Exec Lead EPUT	EPUT
Dave Huggins	TBC	Lead NSFT	NSFT
Dr Ed Garratt	Richard Watson	SNEE ICB AO and Exec Transformation	SNEE ICB
Sarah Stone	Kate Snaith	NHS E / I	NHS E/I
Mark Gladwell	TBC	Associate Director	Primary Care

SDIAB Support			
John Lamont		SNEE DDaT Programme Assurance	SNEE ICS
Jill Fernandez		SNEE DDaT PMO Manager	SNEE ICS
Saty Raviraj		SNEE DDaT PMO Investment	SNEE ICS
Kate Asbridge		SNEE DDaT PMO Secretariat	SNEE ICS

Membership – Change Control

Details of Change	Raised by	Approved at (meeting)	Date approved
Rifat Qureshi was added as the Deputy for NHS E/I to the draft membership list, but Sarah Stone has confirmed a deputy for NHS E/I is to be confirmed.	Sarah Stone	<i>To be presented to SDIAB on 29/11/22</i>	
Daryl Chapman removed as member for NSFT, Dave Huggins added as replacement.	Daryl Chapman	<i>To be presented to SDIAB on 29/11/22</i>	
Kate Walker removed as member for SNEE ICS, replaced by Jo Lennox.		<i>To be presented to SDIAB on 29/11/22</i>	
Kevin Smith added as deputy for EASTAMB.	Stephen Bromhall	<i>To be presented to SDIAB on 29/11/22</i>	
Kate Snaith added as deputy for NHS E/I.	Sarah Stone	<i>To be presented to SDIAB on 29/11/22</i>	
Chris Bally removed as member for SCC, replaced by Krishna Yergol	Chris Bally	<i>To be presented to SDIAB on 29/11/22</i>	
Peter Fairley removed as member for ECC, replaced by Tracy Lindeman and Jamie-Lee Fox added as deputy.	Peter Fairley	<i>To be presented to SDIAB on 29/11/22</i>	
Mark Gladwell added as member for Primary Care.	Kate Walker	<i>To be presented to SDIAB on 29/11/22</i>	



**Suffolk and
North East Essex**
Integrated Care Board

NHS Suffolk and North-East Essex Integrated Care Board

Executive Committee

Terms of Reference

1. Overview

- 1.1 The Integrated Care Board (the ICB) must ensure it can effectively discharge its full range of statutory functions and duties. This includes establishing Committees, Groups and Teams to support the Board and exercise any delegated functions, to help effective discharging of their range of functions and responsibilities.

2. Purpose

- 2.1 The Executive Committee (EC) is established by the ICB as a formal Committee of the Board as part of its overall governance processes.
- 2.2 The EC is established as a collegiate, co-ordinating forum that is responsible for executing ICB strategy as set by the Board and NHS England within the resources available, achieving the greatest possible outcomes at best value for the taxpayer.
- 2.3 The EC provides Executive oversight and assurance to the Board in regard to the execution of agreed ICB strategy.
- 2.4 The EC acts as the Executive body for day-to-day operations management for delivery (finances, performance, transformation, workforce), jointly exploring the implications of holding the system collectively to account for delivery of the shared agenda.
- 2.5 The EC is therefore a formal Committee of the Board, acting as its key operational management forum. Its members are thus bound by the ICB's Constitution, Standing Orders and other key policies.
- 2.6 The EC exists to:
- a) Provide oversight and management of the day-to-day management functions of the ICB and supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care
 - b) Review, support and agree key reports and business critical documents, suggesting amendments, prior to submission to relevant Committees and Groups and the Integrated Care Board for agreement and ratification
 - c) Provide a medium for sharing expertise and good practice
 - d) Support collaborative working to ensure efficient and effective health care provision across Suffolk and North East Essex
 - e) Provide a medium in which Directors can discuss shared positions regarding individual commissioning decisions and other key management issues.

3. Authority

- 3.1 The EC is a formal committee of the ICB.
- 3.2 The EC holds only those powers as delegated in these Terms of Reference and as determined and agreed by the ICB Board.

4. Remit and Responsibilities

- 4.1 The EC will:

- a) Be assured that there are robust processes in place for the effective management of the day-to-day functions of the ICB.
- b) Agree and put forward policies for ratification by the ICB
- c) Oversee and monitor delivery of the ICB key statutory requirements.
- d) Review risks on the BAF to ensure risks are adequately and accurately portrayed.
- e) Oversee the ICB's response to relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, NHSEI to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained.
- f) Hold delegated responsibility for approval of expenditure up to a limit of £3m.

5. Relationship with the ICB Board

- 5.1 The EC is accountable to the Board and shall report to the Board on how it discharges its responsibilities.
- 5.2 The EC has delegated powers from the ICB Board as delegated in these Terms of Reference and as determined by the ICB Board.
- 5.3 Formal minutes, together with an action and decision log, shall be kept of the proceedings.

6. Membership

- 6.1. Membership of the EC comprises:
 - a) ICB Chief Executive (Chair)
 - b) ICB Director of Nursing
 - c) ICB Medical Director
 - d) ICB Director of People & Workforce
 - e) ICB Director of Strategy & Transformation/Deputy Chief Executive
 - f) ICB Director of Performance Improvement
 - g) ICB Director of Finance
 - h) Alliance Directors

7. Chair and Vice Chair

- 7.1 The EC will be chaired by the ICB Chief Executive with the Deputy Chief Executive as Vice Chair
- 7.2 In the absence of the Chair, or Vice Chair, the remaining members present shall elect one of their number to Chair the meeting.
- 7.3 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

8. Attendees

- 8.1 Only ICB Directors have the right to attend meetings of the EC but relevant staff will be invited to attend to present papers for discussion and be in attendance for that agenda item only.

- 8.2 In the absence of a Director, a Deputy Director should be nominated to represent them at the meeting.
- 8.3 The Integrated Care Partnership Director will be invited to attend one meeting per month

8. Administration

- 8.1 The EC shall be supported by the Executive Assistant to the Chief Executive, to ensure that:
- a) Meetings are timetabled and agreed in advance
 - b) The agenda and papers are prepared and distributed, 3 days in advance of each meeting; having been agreed by the Chair with the support of the relevant executive lead
 - c) Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept
 - d) A record of attendance is kept
 - e) The Executive Team are updated on pertinent issues/ areas of interest/ policy developments
 - f) Action points are taken forward between meetings
 - g) A forward plan of agenda items is in place

9. Quorum

- 9.1. For a meeting to be quorate there will be a minimum of 3 Executive Directors.
- 9.2 If a quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

10. Decision Making and Meeting Frequency

- 10.1 Decisions will be guided by national NHS policy and best practice, whilst ensuring proper regard to wider influences such as national consistency.
- 10.2 The EC will ordinarily reach conclusions by consensus. Where there is no clear majority, the Chair will hold the casting vote.
- 10.3 The EC will convene weekly on a Monday, except on the third Monday of the month. Meetings will be held virtually, with one in person (or hybrid) meeting per month

11. Conduct of the Committee

11.1 ICB Values

- a) Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.
- b) Members, and those attending, shall behave in accordance with the ICB's Standards of Business Conduct Policy.

11.2 Equality, Diversity and Inclusion

- a) Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

12. Declarations of Interest

12.1 All members, and those in attendance, must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

13. Review

13.1. These Terms of Reference will be reviewed on an annual basis.

Date Approved:	22 November 2022
Next Review:	March 2023



**Suffolk and
North East Essex**
Integrated Care Board

NHS Suffolk and North-East Essex Integrated Care Board

Commissioning Governance Process Group

Terms Of Reference

1. OVERVIEW

- 1.1 Managing potential conflicts of interest appropriately is needed to protect the integrity of the NHS commissioning system, Integrated Care Boards (ICBs) and its provider partners from any perceptions of wrongdoing.
- 1.2 With the advent of ICBs together with local Alliances where potential providers of services are also Partner Members of the Board &/or Alliance Committees, there is an increased risk for conflicts of interest to occur across both primary, secondary and social care commissioning.
- 1.3 The Commissioning Governance Process Group (the CGPG) therefore focuses on ICB investments and contract arrangements, providing an additional safeguard for the ICB when commissioning services for which a Partner Member organisation is the recommended provider.
- 1.4 Where the ICB Board, Alliance Committees or Executive Committee would not be quorate for approving or recommending commissioning intentions, due to the withdrawal of Partner Members or Directors because of conflict of interest, the CGPG assumes delegated responsibility, reporting its decisions to the ICB in public.

2. PURPOSE OF THE GROUP

- 2.1 As a formal sub-group of the ICB Board, the purpose of the CGPG is to:
 - Provide a process for delegated decision-making powers, for approval of commissioning intentions where the recommended providers are Members of the ICB Board or Alliance Committee(s) and a conflict of interest exists.
 - Provide assurance to the Board, Audit Committee, NHS England and general public that the ICB has the necessary governance arrangements in place to manage conflict of interest in regard to the procurement of services from provider member organisations.
 - Facilitate a culture of openness and probity around the commissioning of services.
 - Demonstrate that the ICB, its Directors and its Partner Members are acting fairly and transparently and that final commissioning decisions are made in ways that preserve the integrity of the decision-making process.

3. ROLE OF THE GROUP

- 3.1 On behalf of the Board, the role of the CGPG is to scrutinise and approve proposals ensuring that where the recommended providers are Members of the ICB Board or Alliance Committee(s), there is evidence that they:
 - Clearly meet local health needs and have been planned appropriately
 - For primary care services, that they go beyond the scope of the GP contract
 - Have been procured using the appropriate methodology
 - Promote improvements in the quality of care
 - Demonstrate the achievement of improved outcomes and value for money

- Cannot be delivered by another provider to the same level of quality, specification and/or price
- Include details for monitoring the quality-of-service provision
- Include the details of any actual or potential conflict of interest having been appropriately declared and entered in the register which is publicly available
- Maintain confidence and trust between patients and the ICB
- Have been clearly detailed within the agreed proforma

4. AUTHORITY

4.1 The CGPG is accountable to the ICB Board and operates within agreed delegated powers.

5. MEETINGS

5.1 The CGPG does not meet in person other than in exceptional circumstances and the work of the group is conducted on a 'virtual' basis through the use of e-mail communication or teleconferencing if necessary.

5.2 Notes of the group's decisions will be presented to the next available meeting of the ICB Board in public.

5.3 Papers for consideration will be circulated to members with a requirement to respond within a minimum of five working days.

6. MEMBERSHIP OF THE GROUP

6.1 Membership of the CGPG comprises the ICB Chief Executive, Director of Strategy and Transformation, Director of Finance, Director of Performance Improvement, the Medical Director and ICB Non-Executive Members.

6.2 The group is normally convened to make decisions by e-mail

6.3 As such, a physical quorum is not necessary but responses must be received from at least one Non-Executive Member and at least three other members for a decision to be carried.

6.4 In exceptional circumstances when an in-person meeting is required, this will be conducted by video or teleconferencing

6.5 In such circumstances, a Non-Executive Member will chair the meeting.

6.6 For a meeting in person, a quorum shall comprise at least four members, one of whom shall be a Non-Executive Member and three other members.

6.7 In both circumstances, where a vote is required and in the event of an equality of votes, the Chief Executive shall have a casting vote.

7. REVIEW

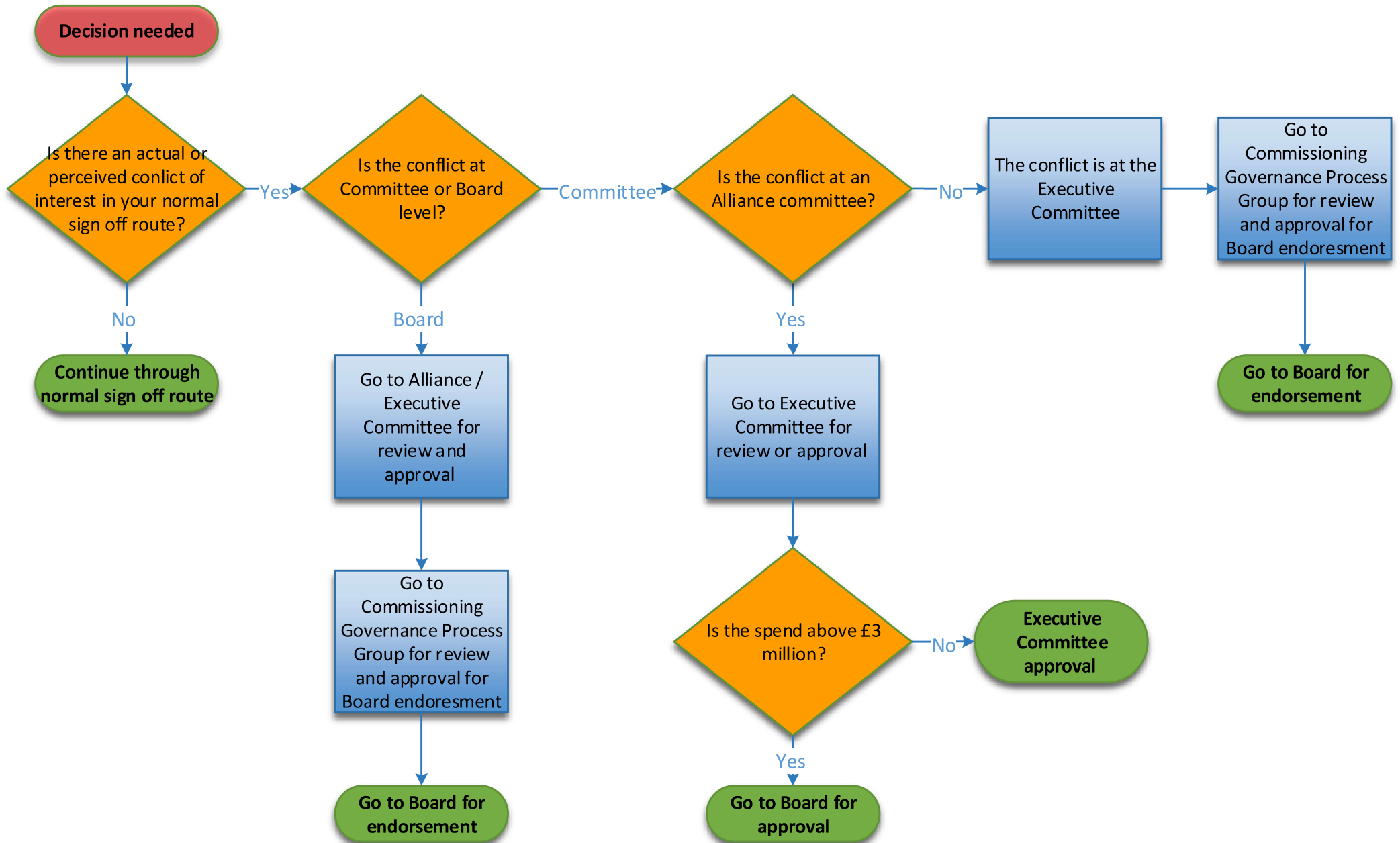
7.1 The CGPG shall review its own performance and terms of reference on an annual basis.

8. AUTHOR

Colin Boakes – Independent Governance Advisor

Date Approved:	
Next Review:	

Decision making process and conflicts of interest



ICB BOARD

Agenda Item No.	18
Reference No.	ICB 23-18
Date.	21 March 2023

Title	Delegation of Direct Commissioning for Specialised Services
Lead Director	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)	Nerinda Evans and NHSE Specialised Commissioning Working Group
Purpose	To provide an update on the development of the direct commissioning arrangements for the shadow year for delegated commissioning through the Joint Commissioning Committee and approve the proposed joint working agreement for 2023 – 2024 for this Committee, leading to full direct commissioning responsibility form 1 April 2024.

Recommendation:

To endorse the draft working agreement which has been developed collaboratively with partners from each of the six other Regional ICBs.

This agreement will provide the framework for the development of shared commissioning arrangements and from April 2024 commissioning and financial responsibility for specialised services for the population of SNEE will be delegated to the ICB who will need to determine how best to discharge this responsibility, enable the opportunity this presents, and manage risk. The SSJCC will provide strategic decision-making, leadership, and oversight for the Joint Specialised Services, and any associated activities. ICBs and NHSE-EoE will have equal representation in the SSJCC and the responsibilities and the working of the SSJCC will be to agree work programmes, joint commissioning of services within the portfolio and through a financial risk sharing agreement where integration of pathways may be required. The SSJCC will represent systems on the development of national service specifications and clinical policy, partnership boards or commissioning committees that have oversight of patients flows to providers outside the East of England region. The SSJCC will have oversight of commissioned providers and specialised clinical networks with respect to quality of service, performance, work programmes and service transformation. The SSJCC will also have oversight of the East of England Provider Collaborative (Mental Health).

Executive Summary

The Board is asked to endorse the working agreement, recognising it may change in year as it will be work in progress and may be altered after extensive engagement on specialised commissioning debate over the next year with and input from across a diverse range of stakeholders and partners.

The Board are asked to agree and support the establishment of the Joint Commissioning Committee and the proposed working agreement.

The Board are asked to note it will receive regular updates on progress with implementation of the agreement, decisions required in year and development of collaborative working arrangements.

The Health and Care Act 2022 determined that Specialised Services could be delegated to Integrated Care Boards from April 2023. An assessment of ICBs' readiness through a Pre-Delegation Assessment Framework (PDAF) was completed in partnership with NHS England and all the six ICBs in the East of England (EoE). A paper was presented to the ICB Board in a PDAF form which set out a number of criteria on how the transfer would work. This has been worked on by NHSE with and system representatives to produce a joint document covering all six ICBs.

The PDAF was submitted formally to NHSE on 25/10 signed off by the ICB Board through Chair and Chief Executive action recommending that the delegation be deferred until April 2024 and for a joint commissioning committee be constituted for 2023/24.

This recommendation was presented to the Delegation of Specialised Commissioning National Moderation Panel in December 2022, which agreed with the EoE proposal. It is expected that this proposal will be formally signed off by the NHS Board in early February 2023.

The Specialised Services Joint Commissioning Committee (SSJCC) will be a statutory committee for one year from 01 April 2023, governed through a nationally prescribed legal Joint Working Agreement (JWA).

The SSJCC requires ICB leadership, engagement and representation and will be formally responsible for the joint commissioning of Specialised Services that are assessed to be '*Ready for Delegation*' to ICBs. ICBs will have voting rights on the Committee in respect of decisions about the listed Specialised Services, but responsibility and funding for the services will remain with NHS England during 2023/24.

The Committee will also be a forum where NHS England and ICBs can jointly review and discuss the commissioning work programmes for other services that are either not ready to be delegated to ICBs or will not be delegated to ICBs. The latter includes Highly Specialised Services and Health and Justice Services.

The NHS England Regional Director and the ICB Accountable Officers will need to formally sign off the JWA. Most of the Terms of the JWA are nationally determined and cannot be amended. Two schedules to the JWA (Schedule 2 Terms of Reference and Schedule 9 Local Terms) can be amended to take account of any regional or ICB local requirements and locally agreed approaches to joint commissioning. These two schedules have been developed in collaboration with the ICBs. This paper:

- summarises the contents of the JWA, including the local schedules for the East of England,
- highlights the potential risks and implications for SNEE ICB,
- seeks approval for the JWA and the local schedules and

- sets in context the work needed to enable most specialised services to be fully delegated to ICBs from April 2024/25.

The final JWA and the proposed schedules are appended to this paper.

Recommendations and next steps

The ICB Board is asked to:

- Agree the JWA, including the draft regional ToR, and the setting up of a Joint Commissioning Committee in 2023/24.
- Agree that the JWA can be signed by the ICB's Accountable Officer on behalf of the ICB
- Note the further work required for transition to full delegation to ICBs from April 2024.

1. Introduction

- 1.1 The Health and Care Act 2022 determined that Specialised Services could be delegated to Integrated Care Boards from April 2023. An assessment of ICBs' readiness through a Pre-Delegation Assessment Framework was completed in partnership with NHS England and all the six ICBs in the East of England (EoE).
- 1.2 A paper was circulated to the SNEE ICB for internal review on the 7th October 2022. The ICB Board were asked to: note the contents of this paper; provide comment on the proposed arrangements; and approve the PDAF proforma ahead of submission to NHSE-EoE and ultimately, the NHSE Board. The process recommended that the delegation be deferred until April 2024 and for a Joint Commissioning Committee be constituted for 2023/24.
- 1.3 Chairman's and CEO Action was taken for the Approval of the Pre-Delegation Assessment Framework proforma ahead of submission to NHSE. A completed Assessment Proforma was sent to NHSE England - East of England (NHSE-EoE) on the 10th October 2022.
- 1.4 To establish the Committee, and in partnership with the other five East of England ICBs and NHS England - East of England (NHSE-EoE), SNEE ICB has been reviewing a Joint Working Agreement (JWA) and developing the schedules, including draft Terms of Reference. The JWA sets how the Specialised Services Joint Commissioning Committee (SSJCC) will function and deliver its formal responsibilities.
- 1.5 From April 2024 commissioning and financial responsibility for their respective populations will be delegated individually to each ICB who will need to determine how best to discharge this responsibility, exploit the opportunity this presents, and manage risk. A draft timetable is at Appendix One.

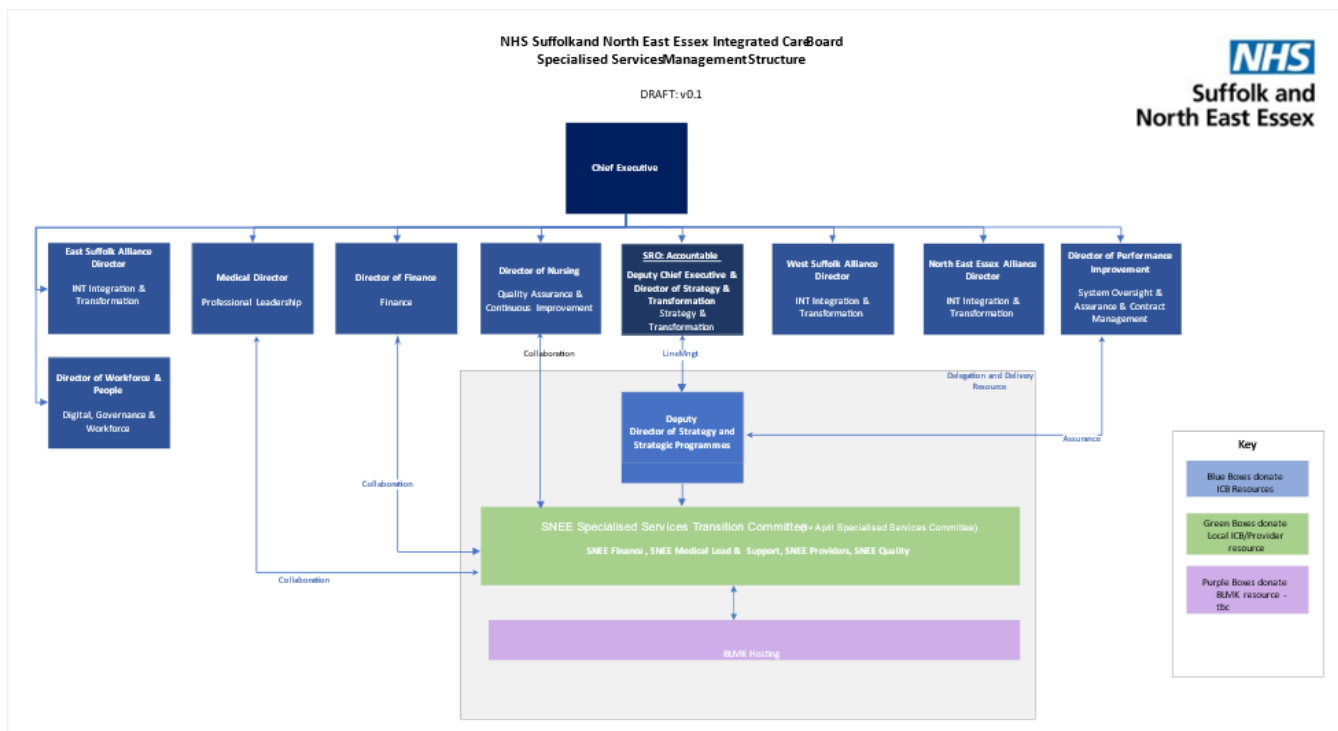
2. Proposed Governance model for 2023/24

- 2.1 The East of England Specialised Services Joint Commissioning Committee (SSJCC) will operate for 2023/24 and be a regional joint committee of all six ICBs and NHSE-EoE.
- 2.2 The ICBs and NHSE-EoE will have equal representation in the SSJCC and the responsibilities and working of the SSJCC are set out in the Terms of Reference.
- 2.3 The SSJCC will have responsibility for:
 - making decisions about the commissioning of services within the portfolio.
 - agreeing the work programmes.
 - financial risk sharing on specialised services with ICB services where integration of pathways may be required.
 - representation on Partnership Boards or Commissioning Committees that have oversight of patients flows to Providers outside the East of England region.

- representation at the national Delegated Commissioning Group, which is the national group that has oversight of national service specifications and clinical policy.
- oversight of commissioned providers with respect to quality of service, performance, and service transformation.
- oversight of commissioned specialised operational delivery and specialised clinical networks, with respect to agreeing their work programmes, reporting of progress and signing off annual reports and as a point of escalation; and
- oversight of the East of England Provider Collaborative (Mental Health).

2.4 The SSJCC will need to have clear and agreed lines of governance into and out of each ICB, with appropriate reporting. It is for each ICB to ensure that SSJCC representatives have appropriate authority as set out by the Joint Working Agreement and Terms of Reference and that any issues that require ICB approval are taken through the relevant ICB governance structures.

2.5 SNEE ICB Governance for Specialised Commissioning



**NHS Suffolk and North East Essex Integrated Care Board
Functions and Decisions Map**

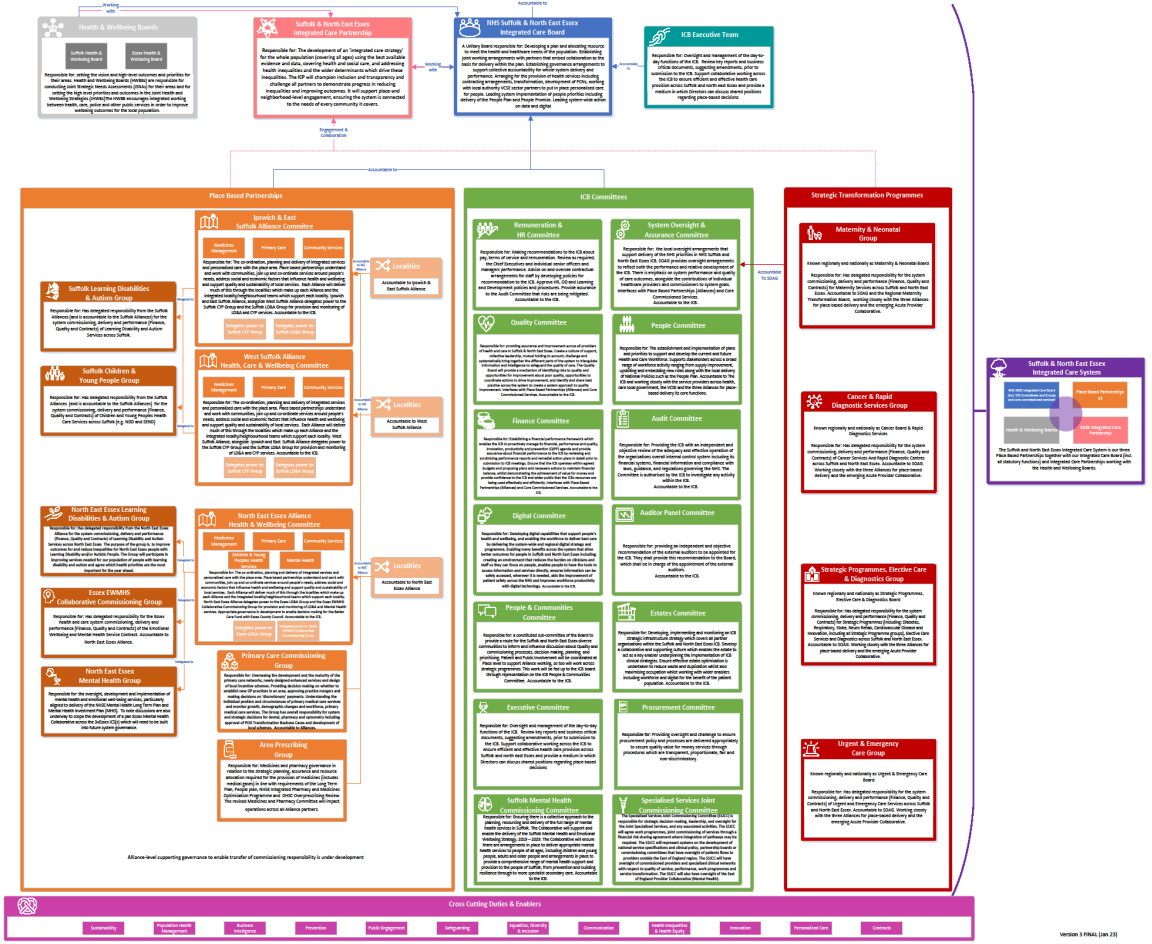
The Suffolk and North East Essex Functions and Decisions Map sets out the governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance.

The purpose of this Functions and Decisions Map is to facilitate transparent decision-making and foster the culture and behaviours that enable system working. This document details the health commissioning duties of NHS Suffolk and North East Essex Integrated Care Board, it does not detail the wider system duties of the Integrated Care Partnership or the Integrated Care System.

This document should be read in conjunction with the ICB Constitution, ICB Statutory Functions document and the Scheme of Reservations and Delegations document.

NHS England & Improvement, Department of Health & Social Care & Department for Levelling Up, Housing and Communities

Responsible for setting the direction and supporting the commissioning of high-quality services to deliver the NHS Long Term Plan including national direction with local autonomy to ensure the best outcomes for patients. Making decisions about how best to support and secure performance, as well as supporting system transformation and the development of Integrated Care Systems. Acting as guarantor of the health and care framework to ensure the legislative, financial, administrative and policy framework are fit for purpose and work together.



Note: National organisational internal governance to run alongside and interrelate to the ICB functions and decisions map

SNEE will establish a Specialised Commissioning Sub Committee responsible for strategic decision-making, leadership, and oversight for the specialised services, and any associated activities. This committee will be multi-disciplinary and will provide recommendations through to the JCC. This new approach presents the opportunity for specialised services and patients to fully benefit from the focus of ICBs on their local population's health and ensure that the specialised elements of pathways are part of the integrated design and delivery of care to patients.

The portfolio of specialised services is varied in nature, with services that incorporate a range of complexities, types of condition, modes of treatment, and size of patient groups. In order to maximise the benefits from integration, it is important that there is a clear understanding of where services, pathways and patients will benefit from integrated commissioning arrangements, and therefore it is more beneficial for services to continue to be commissioned by NHS England and NHS Improvement. ICBs will be responsible for approximately 59 services (out of c.154 services) to be delegated as agreed by the National Specialised Commissioning Board in February 2023.

Role of the Committee

3.1 The role of the SSJCC is set out in the Terms of Reference (Schedule 2 to the JWA) as *'to provide strategic decision-making, leadership, and oversight for the Joint Specialised Services, and any associated activities. The SSJCC will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services'*. The SSJCC will do this by:

- Identifying and setting strategic priorities.
- Making joint decisions in relation to the planning and commissioning of Specialised Services.
- Making recommendations on the population-based financial allocation and financial plans.
- Oversight of the contractual process for Specialised Services, in relation to quality, operational and financial performance; and
- Working with partners, stakeholders, including patients and the public, clinicians and leaders.

3. Terms of Reference for the Committee

4.1 The draft Terms of Reference are set out in Schedule 2 of the JWA. The first version will need to be ratified at the first formal meeting of the Committee.

4.2 The Terms of Reference sets out the role of the SSJCC as well as describing membership, meetings, voting arrangements and accountability. This would include the reporting lines to both individual committees of each ICB and to the NHS England Board via regional NHS England governance arrangements.

5. Delivering the work of the Committee

5.1 A Standard Operating Procedure (SOP) is being developed in partnership with NHSE-EoE and the five other ICBs and sets out how the responsibilities of the SSJCC will be discharged. The SOP supports the JWA including the Terms of Reference and will be regularly updated and reviewed throughout 2023/24, with the SSJCC as the owner.

5.2 NHSE-EoE will continue to be the contract lead for specialised services for 23/24. Activity, finance and relevant key performance indicators will be reported at an ICB level. Planning for 24/25 will need to proceed on the basis of delegated and retained specialised activity, finance and service documentation migrating to ICB managed contracts encompassing both specialised and non-specialised activity. The process for delivering this outcome will need to be agreed by the JCC.

5.3 ICBs will need to:

- a. Have a designated member of the ICB Executive attend regular meetings and take part as an active member in decisions of the SSJCC;
- b. Ensure there are effective communications and information exchanges between the SSJCC and the relevant ICB governance committees and work programmes; and
- c. Determine the reporting requirements for 24/25 that can be tested out in 23/24.

6 Services Covered in 2023/24

- 6.1 The specialised services to be jointly commissioned are set out in Schedule 3 of the JWA.
- 6.2 In addition, the proposal is that Committee will also be a forum between NHSE-EoE and ICBs to discuss services that remain the responsibility of NHS England. ICBs can advise but will not have decision making rights. This includes:
 - specialised service that are not yet ready for delegation, but expected to be so from 2024/25;
 - highly specialised services which will be deemed not to be delegated in the future; and
 - Health and Justice services – which are deemed not to be delegated at this stage, with no set timescale for delegation.
- 6.3 It is expected that by April 2024 most services that are currently labelled as not ready for delegation will be ready. Any services ready for delegation will be set out in the 2024/25 Delegation Agreement between NHSE and the ICB. In 2024/25 the intention will be to have a regional forum where services that continue to be commissioned by NHSE can be discussed with ICB partners.

7 Developing Governance arrangements and a new operating model for 2024/25

- 7.1 The 2023/24 interim year will enable ICBs and NHSE-EoE to set up and test out governance arrangements and new operating model which will be required when full delegation is implemented in April 2024.
- 7.2 A workplan will be overseen by the Committee which will support development of the following areas and allow some features to be tested ahead of full delegation April 2024:
 - Agreement on whether each Specialised Service will be managed at an individual ICB level or via multi-ICB joint committee arrangements.
 - An operating model which ensures specialised services are commissioned in line with agreed ICB principles and national service specifications and policies;
 - Financial framework and how financial decisions will be made;
 - Hosting arrangements for the regional Specialised Commissioning team. Subject to due diligence, the intention is for the team to be hosted by Bedfordshire, Luton and Milton Keynes ICB. become the host of the regional Specialised Commissioning team. This will include the proposed hosting arrangements for the Specialised Commissioning team by Bedfordshire, Luton and Milton Keynes (BLMK) Integrated

Care Board. Their board has agreed to BLMK being the host ICB, subject to due diligence, for the employment of the Specialised Commissioning team.

- Agreed commissioning functions delivered by the hosted central team and within ICBs;
- Ongoing communication and engagement with staff and other stakeholders; The NHSE assurance function for oversight of ICBs.

7.3 2023/24 will also allow individual ICBs the opportunity to work through their internal governance arrangements ahead of delegation in April 2024.

7.4 To support the work of the Committee and enable ICBs to understand the range of Specialised Services, during the interim year, there will be a series of regional coproduction workshops to work through each key service area and prepare for 2024/25.

8 Finance

8.1 Responsibility for Specialised Services and financial allocations will remain with NHS England in 23/24. The budgets for those services formally covered by the Committee will be reported at regional level and at ICB level.

8.2 During 2023/24 the financial framework will in line with national guidance.

9 Risks to consider for SNEE ICB

The principal risks that will need to be managed with appropriate mitigations include:

9.1 Financial risks: the move to population and then need based budgets from the existing provider budget approach. ICBs will need to be assured funds match the services commissioned and for systems, with challenged finances, they will need to be confident that specialised services will not worsen their position.

9.2 Capacity to commission and administer the services. ICBs will work closely together with the existing team to develop new working arrangements, support the staff and preserve the expertise in the team. There is no spare capacity in ICBs to deliver the commissioning functions.

9.3 Compliance with the terms of the Joint Working Agreement (& Delegation Agreement in 2024/25). ICBs would want to see an assessment completed of the current compliance against all requirements of the proposed schedules within the Agreements to identify any areas for further actions.

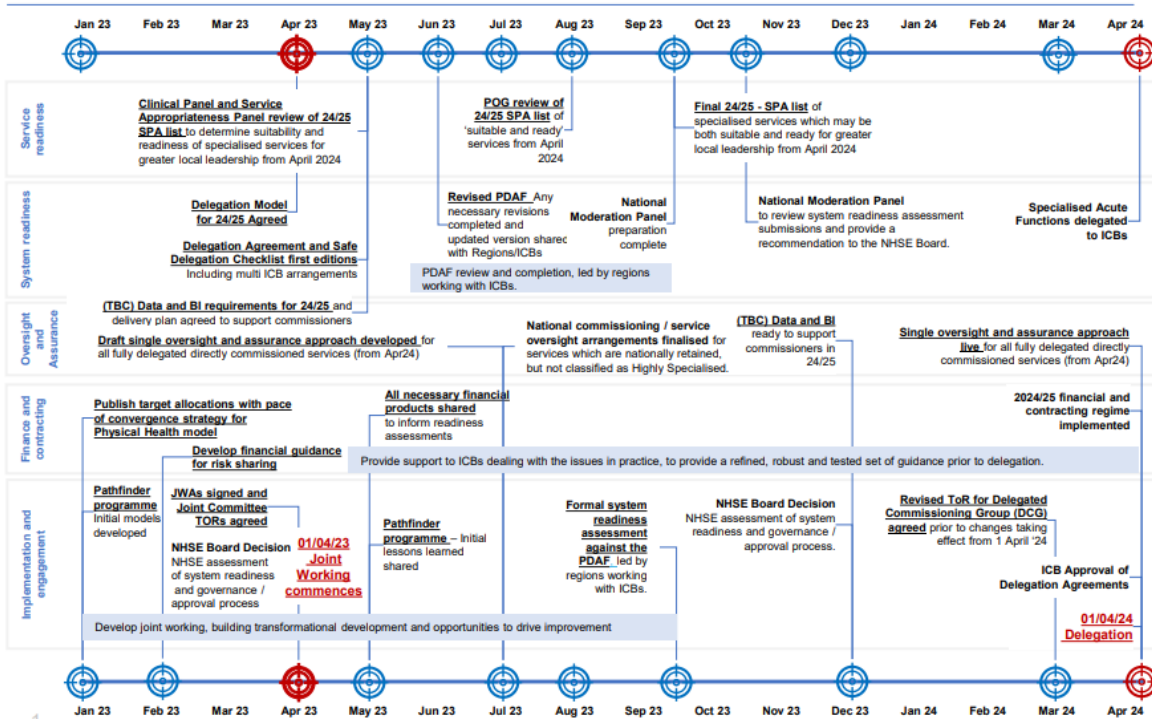
9.4 Timescales. ICBs will need to balance managing the challenge of this substantial change and the uncertainty at this point on precise deadlines, alongside other strategic work in the organisation.

9.5 Commitment of resource and time to the Committee will be more than the ICB has available. The main mitigation will be to ensure that the Specialised Commissioning team is identifying the key issues for each ICB to consider. There will also need to be appropriate resources in place.

Appendix One: Draft National Timetable for Future Commissioning Model Plan (FCMP) to 2024/25

DRAFT 2023/24 FCMP Delivery Plan

DN: To be discussed and agreed with workstream leads



Dated _____ 2023

- (1) **NHS ENGLAND**
- and -
- (2) **NHS BEDFORDSHIRE, LUTON AND MILTON
KEYNES INTEGRATED CARE BOARD**
- and -
- (3) **NHS CAMBRIDGESHIRE AND PETERBOROUGH
INTEGRATED CARE BOARD**
- and -
- (4) **NHS HERTFORDSHIRE AND WEST ESSEX
INTEGRATED CARE BOARD**
- and -
- (5) **NHS MID AND SOUTH ESSEX
INTEGRATED CARE BOARD**
- and -
- (6) **NHS NORFOLK AND WAVENEY
INTEGRATED CARE BOARD**
- and -
- (7) **NHS SUFFOLK AND NORTH EAST ESSEX
INTEGRATED CARE BOARD**

Agreement in relation to the establishment and operation
of joint working arrangements

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THIS AGREEMENT is made on the _____ day of _____ 2023

BETWEEN¹:

- (1) **NHS England** of Quarry House, Quarry Hill, Leeds LS2 7UE (acting under the name NHS England) ("**NHS England**"); and
- (2) **NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board** of [insert address] ("**Bedfordshire, Luton and Milton Keynes ICB**");
- (3) **NHS Cambridgeshire and Peterborough Integrated Care Board** of [insert address] ("**Cambridgeshire and Peterborough ICB**");
- (4) **NHS Hertfordshire and West Essex Integrated Care Board** of [insert address] ("**Hertfordshire and West Essex ICB**");
- (5) **NHS Mid and South Essex Integrated Care Board** of [insert address] ("**Mid and South Essex ICB**");
- (6) **NHS Norfolk and Waveney Integrated Care Board** of [insert address] ("**Norfolk and Waveney ICB**"); and
- (7) **NHS Suffolk and North East Essex Integrated Care Board** of [Aspen House, Stephenson Road, Stephenson Road, Severalls Business Park, Colchester CO4 9QR ("**Suffolk and North East Essex ICB**").

each a "Partner" and together the "Partners".

Bedfordshire, Luton and Milton Keynes ICB, Cambridgeshire and Peterborough ICB, Hertfordshire and West Essex ICB, Mid and South Essex ICB, Norfolk and Waveney ICB and Suffolk and North East Essex ICB are together referred to in this Agreement as the "**ICBs**", and "**ICB**" shall mean any of them.

BACKGROUND

- (A) NHS England has statutory functions to make arrangements for the provision of prescribed services for the purposes of the NHS.
- (B) The ICBs have statutory functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned by NHS England.
- (C) Pursuant to section 65Z5 of the NHS Act, NHS England and the ICBs are able to establish and maintain joint arrangements in respect of the discharge of their commissioning functions.
- (D) NHS England and the ICBs agree to jointly exercise the Joint Functions through the decisions of the Joint Committee under section 65Z5 of the NHS Act and as set out in this Agreement and the Terms of Reference.
- (E) NHS England and the ICBs acknowledge and agree that making arrangements to involve the ICBs in the exercise of NHS England's Commissioning Functions is likely to lead to an improvement in the way the Commissioning Functions of all Partners are exercised.
- (F) This Agreement sets out the arrangements that will apply between NHS England and the ICBs in relation to the joint commissioning of Specialised Services for the ICBs' Populations. These arrangements are intended to give the ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations.

¹ Complete Partners' names as appropriate.

- (G) NHS England and the ICBs have entered into this Agreement to define their arrangements for joint working. To avoid doubt, none of the Partners are delegating the exercise of any of their Commissioning Functions or any other functions to any other Partner under this Agreement.
- (H) This Agreement is intended for use in the 2023/24 financial year, to govern what are envisaged to be transitional joint working arrangements prior to the delegation of specialised commissioning functions from NHS England to ICBs, effective from 2024.

NOW IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

- 1.1 This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 20 (Leaving the Joint Committee) below.
- 1.2 The Partners may extend this Agreement beyond the Initial Term for a further period, by written agreement prior to the expiry of the Initial Term.

2. PRINCIPLES AND AIMS

- 2.1 The Partners acknowledge that, in exercising their obligations under this Agreement, each Partner must comply with the statutory duties set out in the NHS Act and must:
 - 2.1.1 consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010;
 - 2.1.2 consider how, in performing its obligations, it can address health inequalities;
 - 2.1.3 at all times exercise functions effectively, efficiently and economically; and
 - 2.1.4 act at all times in good faith towards each other.
- 2.2 The Partners agree:
 - 2.2.1 that successfully implementing this Agreement will require strong relationships and an environment based on trust and collaboration;
 - 2.2.2 to seek to continually improve whole pathways of care including Specialised Services and to design and implement effective and efficient integration;
 - 2.2.3 to act in a timely manner;
 - 2.2.4 to share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risks and reduce cost;
 - 2.2.5 to act at all times in accordance with the scope of their statutory powers; and
 - 2.2.6 to have regard to each other's needs and views, irrespective of the relative contributions of the Partners to the commissioning of any Specialised Services and, as far as is reasonably practicable, take such needs and views into account.
- 2.3 The Partners' primary aim is to maximise the benefits to patients of integrating the Joint Functions with the ICBs' Commissioning Functions through designing and commissioning the Joint Specialised Services as part of the wider pathways of care of which they are a part and, in doing so, promote the Triple Aim.

3. SCOPE OF JOINT WORKING ARRANGEMENTS

- 3.1 This Agreement sets out the arrangements through which the Partners will work together to exercise the Joint Functions as set out in Schedule 4, including:
- 3.1.1 the establishment of a Joint Committee;
 - 3.1.2 the participation by all Partners in the work of the Joint Committee;
 - 3.1.3 the development of leadership and expertise in respect of the Joint Specialised Services;
- collectively referred to as the “Joint Working Arrangements”.

4. JOINT COMMITTEE

- 4.1 NHS England shall together with the ICBs establish a Joint Committee which will operate in accordance with the Terms of Reference set out in Schedule 2 (Joint Committee – Terms of Reference). The Joint Committee (and each member of the Joint Committee) will act at all times in accordance with the Terms of Reference.
- 4.2 The Partners shall nominate Authorised Officers to the Joint Committee in accordance with Schedule 2.
- 4.3 Subject to Clauses 4.4 and 8.1 and the terms of the Schedules, NHS England shall exercise the Joint Functions collaboratively with the ICBs in accordance with this Agreement and must reach decisions in relation to the Joint Functions through discussion and agreement. Where in exceptional cases consensus cannot be reached between the members of the Joint Committee in respect of matters under consideration, the voting arrangements set out in the Terms of Reference will apply.
- 4.4 NHS England may at any time exercise the Joint Functions outside of the Joint Working Arrangements where, in its view, that is necessary for reasons of urgency, and in such circumstances it shall inform the Partners of such action at the earliest reasonable opportunity.
- 4.5 The Partners may establish sub-groups or sub-committees of the Joint Committee with such terms of reference as may be agreed between them from time to time. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).
- 4.6 The ICBs shall ensure that their Authorised Officers have appropriate delegated authority, in accordance with each ICB's internal governance arrangements, to represent the interests of each ICB in the Joint Committee and any other sub-groups or sub-committees established by the Joint Committee.
- 4.7 The Partners recognise the need to ensure that any potential conflicts of interest on the part of any Partner, including its representatives, in respect of this Agreement and the establishment or operation of the Joint Committee and any sub-group or sub-committee of the Joint Committee must be appropriately identified, recorded and managed.

5. JOINT FUNCTIONS

- 5.1 This Agreement shall include such Joint Functions as identified in Schedule 4 in respect of the Joint Specialised Services.

- 5.2 The Joint Committee must establish effective, safe, efficient and economic arrangements for the discharge of the Joint Functions.
- 5.3 The Joint Committee must exercise the Joint Functions in accordance with:
- 5.3.1 the terms of this Agreement;
 - 5.3.2 all applicable Law;
 - 5.3.3 Guidance;
 - 5.3.4 the Terms of Reference; and
 - 5.3.5 Good Practice.
- 5.4 In exercising the Joint Functions, the Joint Committee must comply with the Mandated Guidance set out in Schedule 8, or otherwise referred to in this Agreement, and such further Mandated Guidance as may be issued by NHS England from time to time, including on the NHS England or FutureNHS websites.
- 5.5 The Joint Committee must perform the Joint Functions:
- 5.5.1 in such a manner as to ensure NHS England's compliance with NHS England's statutory duties in respect of the Joint Functions and to enable NHS England to fulfil its Reserved Functions; and
 - 5.5.2 having regard to NHS England's accountability to the Secretary of State and Parliament in respect of both the Joint Functions and Reserved Functions.

6. THE RESERVED FUNCTIONS

- 6.1 NHS England will exercise the Reserved Functions, including but not limited to those set out in Schedules 5 (Reserved Services) and 6 (Reserved Functions).
- 6.2 The Reserved Functions include all of NHS England's Specialised Commissioning Functions other than the Joint Functions.
- 6.3 The Partners acknowledge that NHS England may ask the ICBs to provide certain administrative and management services to NHS England in relation to Reserved Functions.

7. FURTHER COLLABORATIVE WORKING

- 7.1 An ICB may, at its discretion, table for discussion at any Joint Committee meeting an item relating to any ICB Function, where such ICB Function relates to Specialised Commissioning Functions, in order to facilitate engagement and promote integration and collaborative working. Decision-making in respect of such discussions will remain with the relevant ICB. For the avoidance of doubt, the Joint Committee will not have any authority to take decisions in respect of ICB Functions.
- 7.2 NHS England may, at its discretion, table for discussion at any Joint Committee meeting an item relating to a Reserved Function (including but not limited to the Part A Reserved Services) or any such other of NHS England's Functions that it considers appropriate in order to facilitate engagement and promote integration and collaborative working. For the avoidance of doubt, the Joint Committee will only have authority to take decisions in respect of the Joint Functions. The decision-making will remain with NHS England for all other NHS England Functions.

8. FINANCE

- 8.1 For the Initial Term, NHS England shall hold the Specialised Commissioning Budget and shall be responsible for paying for the Joint Specialised Services from the Specialised Commissioning Budget pursuant to the Specialised Services Contracts. NHS England will establish and maintain the financial and administrative support necessary to meet any auditing regulations applicable to NHS England. The Joint Committee shall ensure full compliance with the Finance Guidance and any other relevant Mandated Guidance.
- 8.2 For the avoidance of doubt, in the Initial Term, the ICBs are not required to financially contribute to the Specialised Commissioning Budget and the Partners do not intend to create a pooled fund or joint budget for the purpose of this Agreement. The NHS England Standing Financial Instructions shall apply in respect to the commissioning of all Joint Specialised Services.
- 8.3 Each Partner shall bear its own costs as they are incurred, unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the Partners. Such costs may include, but will not be limited to, costs of attendance at Joint Committee meetings and costs in complying with each Partner's relevant obligations in this Agreement.
- 8.4 Prior to the end of the first year of the Term, the Partners will review the financial arrangements described in this Clause 8 (Finance) and consider whether alternative arrangements should be put in place for any extended Term. Any changes to this Agreement to effect such new arrangements will be made in accordance with Clause 10 (Variations).

9. STAFFING

- 9.1 During the Initial Term the Specialised Services Staff shall be employed by NHS England.
- 9.2 The Partners must comply with any Mandated Guidance issued by NHS England from time to time in relation to any NHS England Staff.

10. VARIATIONS

- 10.1 The Partners acknowledge that the scope of the Joint Working Arrangements, including the scope of the Joint Functions, may be reviewed and amended from time to time.
- 10.2 This Agreement may be varied by the agreement of the Partners at any time in writing in accordance with the Partners' internal decision-making processes.

11. DATA PROTECTION

- 11.1 The Partners must ensure that all Personal Data processed by or on behalf of them in the course of carrying out the Joint Working Arrangements is processed in accordance with the relevant Partner's obligations under Data Protection Legislation and Data Guidance, and the Partners must assist each other as necessary to enable each other to comply with these obligations.
- 11.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If any Partner:

- 11.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or
- 11.2.2 becomes aware of any security breach,
- in respect of the Relevant Information it shall promptly notify the Joint Committee and NHS England. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.
- 11.3 In processing any Relevant Information further to this Agreement, each Partner shall at all times comply with all NHS England policies and guidance on the handling of data.
- 11.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant Partner must fully inform NHS England and the Joint Committee of the information governance breach. This clause does not require the relevant Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.
- 11.5 Whether or not a Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The Partners acknowledge that a Partner may act as both a Data Controller and a Data Processor.
- 11.6 The Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.
- 11.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other Partners save as agreed by the Partners in writing.
- 11.8 Schedule 7 makes further provision about information sharing and information governance.

12. **IT INTER-OPERABILITY**

- 12.1 The Partners will work together to ensure that all relevant IT systems operated by the Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.
- 12.2 The Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

13. **FURTHER ARRANGEMENTS**

- 13.1 The Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The Partners must comply with any Guidance around the commissioning of Joint Specialised Services by means of arrangements under section 65Z5 or 75 of the NHS Act.

14. **FREEDOM OF INFORMATION**

- 14.1 Each Partner acknowledges that the others are a public authority for the purposes of the Freedom of Information Act 2000 (“**FOIA**”) and the Environmental Information Regulations 2004 (“**EIR**”).
- 14.2 Each Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:
- 14.2.1 each Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;
- 14.2.2 each Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and
- 14.2.3 each Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the Partner to whom the request is addressed.
- 14.3 NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Joint Working Arrangements. The Joint Committee and each Partner shall comply with such FOIA or EIR protocols.

15. **CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY**

- 15.1 The Partners must and must ensure that, in delivering the Joint Functions, all Staff comply with Law, with Managing Conflicts of Interest in the NHS and other Guidance, and with Good Practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.
- 15.2 Without prejudice to the general obligations set out in Clause 5 (Joint Functions), each ICB must maintain a register of interests in respect of all persons involved in decisions concerning the Joint Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.
- 15.3 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

16. **CONFIDENTIALITY**

- 16.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing Partner and the receiving Partner has no right to use it.
- 16.2 Subject to Clause 16.3, the receiving Partner agrees:
- 16.2.1 to use the disclosing Partner’s Confidential Information only in connection with the receiving Partner’s performance under this Agreement;
- 16.2.2 not to disclose the disclosing Partner’s Confidential Information to any third party or to use it to the detriment of the disclosing Partner; and

- 16.2.3 to maintain the confidentiality of the disclosing Partner's Confidential Information.
- 16.3 The receiving Partner may disclose the disclosing Partner's Confidential Information:
 - 16.3.1 in connection with any Dispute Resolution Procedure;
 - 16.3.2 to comply with the Law;
 - 16.3.3 to any appropriate Regulatory or Supervisory Body;
 - 16.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving Partner's duty under Clause 16.2;
 - 16.3.5 to NHS Bodies for the purposes of carrying out their functions;
 - 16.3.6 as permitted under any other express arrangement or other provision of this Agreement.
- 16.4 The obligations in Clause 16 will not apply to any Confidential Information which:
 - 16.4.1 is in or comes into the public domain other than by breach of this Agreement;
 - 16.4.2 the receiving Partner can show by its records was in its possession before it received it from the disclosing Party; or
 - 16.4.3 the receiving Partner can prove it obtained or was able to obtain from a source other than the disclosing Partner without breaching any obligation of confidence.
- 16.5 This Clause 16 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.
- 16.6 This Clause 16 will survive the termination of this Agreement for any reason for a period of 5 years.
- 16.7 This Clause 16 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17. **LIABILITIES**

- 17.1 Nothing in this Agreement shall affect:
 - 17.1.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or
 - 17.1.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.
- 17.2 NHS England shall be responsible for and shall retain the conduct of any Claim in relation to the Joint Functions and Reserved Functions.
- 17.3 Each ICB must:

- 17.3.1 comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims or the pro-active management of Claims;
- 17.3.2 if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;
- 17.3.3 co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;
- 17.3.4 provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or
- 17.3.5 at the request of NHS England, take such action or step or provide such assistance as may in NHS England's discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the requirements of the provider of an Indemnity Arrangement in relation to such Claim.

18. DISPUTE RESOLUTION

- 18.1 Where any dispute arises within the Joint Committee in connection with this Agreement, the Partners must use their best endeavours to resolve that dispute within the Joint Committee in accordance with the Terms of Reference.
- 18.2 Where any dispute is not resolved under Clause 18.1 on an informal basis, any Authorised Officer may convene a special meeting of the Joint Committee to attempt to resolve the dispute.

19. BREACHES BY ICBS

- 19.1 If any Partner does not comply with the terms of this Agreement, then NHS England may:
 - 19.1.1 exercise its rights under this Agreement; and
 - 19.1.2 take such steps as it considers appropriate in the exercise of its other functions concerning the Partner.
- 19.2 Without prejudice to Clause 19.1, if any Partner does not comply with the terms of this Agreement (including if the Joint Committee or any Partner exceeds its authority under this Agreement), NHS England may (at its sole discretion):
 - 19.2.1 waive its rights in relation to such non-compliance in accordance with Clause 19.3;
 - 19.2.2 ratify any decision;
 - 19.2.3 terminate this Agreement in accordance with Clause 20 (Leaving the Joint Committee) below;
 - 19.2.4 exercise the dispute resolution procedure in accordance with Clause 18 (*Dispute Resolution Procedure*); and/or
 - 19.2.5 exercise its rights under common law.

19.3 NHS England may waive any non-compliance by a Partner with the terms of this Agreement provided that the Partner provides a written report to the Joint Committee as required by Clause 19.4 and, after considering the Partner's written report, NHS England is satisfied that the waiver is justified.

19.4 If:

19.4.1 a Partner does not comply with this Agreement; or

19.4.2 NHS England notifies a Partner that it considers the Partner has not complied, or may not be able to comply with, this Agreement;

then that Partner must provide a written report to the NHS England within ten (10) Operational Days of the non-compliance (or the date on which the relevant Partner considers that it may not be able to comply with this Agreement) or such notification pursuant to Clause 25 setting out:

19.4.3 details of and reasons for the non-compliance (or likely non-compliance) with the Agreement; and

19.4.4 if the non-compliance is capable of remedy, a plan for how the Partner proposes to remedy the non-compliance.

20. LEAVING THE JOINT COMMITTEE

20.1 If an ICB wishes to exit the Joint Committee and end its participation in this Agreement, the relevant ICB must provide at least six (6) months notification NHS England of its intention to exit the Joint Committee and end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

20.2 NHS England and the ICBs will work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

20.3 The ICB(s) acknowledge that the exercise of the Joint Functions remains the responsibility of NHS England.

20.4 NHS England may terminate this Agreement forthwith where it considers it necessary or expedient to terminate the Joint Working Arrangements, but in reserving this power NHS England anticipates that this will only be used in exceptional circumstances and that in all instances it will use its reasonable endeavours to seek an orderly termination of the Joint Working Arrangements.

21. CONSEQUENCES OF TERMINATION

21.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

21.1.1 the Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.1.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination takes effect.

21.2 The provisions of Clauses 11 (Data Protection), 14 (Freedom of Information), 16 (Confidentiality), 17 (Liabilities) and 21 (Consequences of Termination) shall survive termination or expiry of this Agreement.

22. PUBLICITY

22.1 The Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

23. EXCLUSION OF PARTNERSHIP OR AGENCY

23.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners, or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

23.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

24. THIRD PARTY RIGHTS

24.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Partners to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

25. NOTICES

25.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

25.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

26. ASSIGNMENT AND SUBCONTRACTING

26.1 This Agreement, and any right and conditions contained in it, may not be assigned or transferred by a Partner, without the prior written consent of the other Partners, except to any statutory successor to the relevant function.

27. SEVERABILITY

27.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

28. WAIVER

28.1 No failure or delay by a Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

29. STATUS

29.1 The Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

30. **ENTIRE AGREEMENT**

30.1 This Agreement constitutes the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

31. **GOVERNING LAW AND JURISDICTION**

31.1 Subject to the provisions of Clause 18 (Dispute Resolution) and Clause 29 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

32. **FAIR DEALINGS**

32.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

33. **COMPLAINTS**

33.1 Any complaints received by the Partners shall be dealt with in accordance with the statutory complaints procedure of the Partner to whose Commissioning Function(s) the complaint relates. For the avoidance of doubt, NHS England shall manage all complaints in respect of the Joint Specialised Services and Reserved Services.

34. **COUNTERPARTS**

34.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by
for and on behalf of NHS England (Signature)

.....
(Date)

SIGNED by
for and on behalf of NHS Bedfordshire, Luton and
Milton Keynes Integrated Care Board (Signature)

.....
(Date)

SIGNED by
for and on behalf of NHS Cambridgeshire and
Peterborough Integrated Care Board (Signature)

.....
(Date)

SIGNED by
for and on behalf of NHS Hertfordshire and West
Essex Integrated Care Board (Signature)

.....
(Date)

SIGNED by
for and on behalf of NHS Mid and South Essex
Integrated Care Board (Signature)

.....

(Date)

SIGNED by

.....

for and on behalf of NHS Norfolk and Waveney
Integrated Care Board

(Signature)

.....

(Date)

SIGNED by ...Richard Watson.....

.....

for and on behalf of NHS Suffolk and North East Essex
Integrated Care Board

(Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

1. In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

“Agreement”	this agreement between the Partners comprising these terms and conditions together with all schedules attached to it;
“Area”	means the geographical area covered by the ICBs;
“Assurance Processes”	has the meaning in Paragraph 8 of Schedule 4 (Oversight and Assurance);
“Authorised Officer”	the individual(s) appointed as Authorised Officer in accordance with Schedule 2 (Terms of Reference);
“Change in Law”	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
“Claim”	means for or in relation to the Joint Functions and Reserved Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
“Clinical Commissioning Policies”	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
“Clinical Reference Groups”	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
“Collaborative Commissioning Agreement”	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
“Commencement Date”	means 1 April 2023;
“Commissioning Functions”	the respective statutory functions of the Partners in arranging for the provision of services as part of the health service;
“Confidential Information”	means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history;

	(b) the release of which is likely to prejudice the commercial interests of a Partner; or
	(c) which is a trade secret;
“Contracting Standard Operating Procedure”	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
“Core Membership”	means the voting membership of the Joint Committee as set out in the Terms of Reference;
“Data Controller”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Processor”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
“Data Protection Legislation”	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
“Data Protection Officer”	shall have the same meaning as set out in the Data Protection Legislation;
“Data Security and Protection Incident Reporting tool”	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/ ;
“Delegated Commissioning Group” “DCG”	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
“Dispute Resolution Procedure”	the procedure set out in Clause 18 (Dispute Resolution);
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: <ul style="list-style-type: none"> - Commissioning Change Management Business Rules;

- Contracting Standard Operating Procedure;
- Cashflow Standard Operating Procedure;
- Finance and Accounting Standard Operating Procedure;
- Service Level Framework Guidance;

"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
"High Cost Drugs"	Means medicines not reimbursed though national prices and identified on the NHS England high cost drugs list;
"ICB Functions"	the Commissioning Functions of the ICB;
"Information"	has the meaning given under section 84 of FOIA;
"Indemnity Arrangement"	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 7 (Further Information Governance and Sharing Provisions);
"Indemnity Arrangement"	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Initial Term"	the period of one year from 1 April 2023;
"Joint Committee"	means the joint committee of NHS England and the ICBs, established under this Agreement on the terms set out in the Terms of Reference;
"Joint Working Arrangements"	means the arrangements for joint working as set out in Clause 3 (Scope of Joint Working Arrangements);
"Joint Functions"	those aspects of the NHS England Specialised Commissioning Functions, as set out in Schedule 4, that shall be jointly exercised by NHS England and the ICBs through the decisions of the Joint Committee in accordance with the Terms of Reference;
"Joint Specialised Services"	means those Specialised Services listed in Schedule 3 (Joint Specialised Services);
"Law"	means: <ul style="list-style-type: none"> (a) any statute or proclamation or any delegated or subordinate legislation; (b) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been

notified to the Partner(s) or relevant third party (as applicable);
and

(c) any judgment of a relevant court of law which is a binding precedent in England;

“Mandated Guidance”	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of the Joint Functions and issued by NHS England from time to time as mandatory in respect of the Joint Working Arrangements. At the Commencement Date the Mandated Guidance in respect of the Joint Functions shall be as set out in Schedule 8;
“National Standards”	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
“National Specifications”	the service specifications published by NHS England in respect of Specialised Services;
“Need to Know”	has the meaning set out in Schedule 7;
“NHS Act”	the National Health Service Act 2006;
“NHS England Functions”	NHS England’s statutory functions exercisable under or by virtue of the NHS Act;
“Non-Personal Data”	means data which is not Personal Data;
“Oversight Framework”	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
“Part A Reserved Services”	means those services listed in Table 1 of Schedule 5;
“Partners”	the parties to this Agreement;
“Personal Data”	has the meaning set out in the Data Protection Legislation;
“Population”	means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
“Provider Collaborative”	a group of Specialised Service Providers who have agreed to work together to improve the care pathway for one or more Specialised Services;
“Provider Collaborative Arrangements”	Means the contracting arrangements entered into in respect of a Provider Collaborative;
“Provider Collaborative Guidance”	Means the guidance published by NHS England in respect of Provider Collaboratives;
“Regional Quality Group”	A group set up to act as a strategic forum at which regional partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;

“Regulatory or Supervisory Body”	<p>means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including:</p> <ul style="list-style-type: none"> (i) CQC; (ii) NHS England; (iii) the Department of Health and Social Care; (iv) NICE; (v) Healthwatch England and Local Healthwatch; (vi) the General Medical Council; (vii) the General Dental Council; (viii) the General Optical Council; (ix) the General Pharmaceutical Council; (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
“Relevant Information”	<p>means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “<i>To Share or Not to Share?</i>”;</p>
“Request for Information”	<p>has the meaning set out in the FOIA;</p>
“Reserved Functions”	<p>those aspects of the Specialised Commissioning Functions that are not Joint Functions, including but not limited to those set out in Schedule 6;</p>
“Relevant Clinical Networks”	<p>means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;</p>
“Retained Services”	<p>means those Specialised Services for which NHS England shall retain commissioning responsibility;</p>
“Shared Care Arrangements”	<p>these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;</p>
“Single Point of Contact”	<p>the member of Staff appointed by each relevant Partner in accordance with Paragraph 14 of Schedule 7;</p>
“Special Category Personal Data”	<p>has the meaning set out in the Data Protection Legislation;</p>

“Specialised Commissioning Budget”	means the budget identified by NHS England for the purpose of exercising the Joint Functions;
“Specialised Commissioning Functions”	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
“Specified Purpose”	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions as specified in Schedule 7 (<i>Further Information Governance and Sharing Provisions</i>) to this Agreement;
“Specialised Services”	means the services commissioned in exercise of the Specialised Commissioning Functions;
“Specialised Services Contract”	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
“Specialised Services Provider”	a provider party to a Specialised Services Contract;
“Specialised Services Staff”	means the Staff carrying out the Joint Specialised Services Functions immediately prior to the date of this Agreement;
“Staff”	means the Partners’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;
“System quality group”	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
“Term”	the Initial Term, as may be varied by: <ul style="list-style-type: none"> (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;
“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between NHS England and the ICBs at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee – Terms of Reference);
“Triple Aim”	the duty on each of the Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the

decision in relation to:

(a) the health and well-being of the people of England;

(b) the quality of services provided to individuals by the NHS;

(c) efficiency and sustainability in relation to the use of resources by the NHS;

“UK GDPR”

means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;

"Working Day"

any day other than Saturday, Sunday, a public or bank holiday in England.

2. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
3. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are Clauses in this Agreement.
4. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
5. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.
6. Words importing the singular number only shall include the plural.
7. Use of the masculine includes the feminine and all other genders.
8. Where anything in this Agreement requires the mutual agreement of the Partners, then unless the context otherwise provides, such agreement must be in writing.
9. Any reference to the Partners shall include their respective statutory successors, employees and agents.
10. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
11. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: JOINT COMMITTEE – TERMS OF REFERENCE
SPECIALISED SERVICES JOINT COMMISSIONING COMMITTEE

TERMS OF REFERENCE

Document name:	Draft Terms of Reference for Specialised Services Joint Commissioning Committee		
Senior Responsible Owner (SRO):	Alex Ridgeon, Director of Specialised Commissioning and Health and Justice		
Lead:	Jude Bowler, Head of Transformation		
Version	0.1	Date:	[Publish Date]

[Document management](#)

Revision history

Version	Date	Summary of changes
0.1	25/01/2023	Development of first draft following discussions and agreement at NHSE-ICB Working Group.

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Alex Ridgeon		Director of Specialised Commissioning and Health and Justice, NHSE		
Jan Thomas		Chief Executive, Cambridgeshire and Peterborough ICB		
Tracey Bleakley		Chief Executive, Norfolk and Waveney ICB		
		Mid and South Essex ICB		
Ricard Watson		Deputy Chief Executive, Director of Transformation and Strategy,		

		Suffolk and North East Essex ICB		
Beverley Flowers		Director of Strategy & Transformation, Hertfordshire and West Essex ICB		
Anne Brierley		Chief Transformation Officer, Bedfordshire, Luton and Milton Keynes ICB		

Related documents

Title	Owner	Location
Joint Working Agreement for Specialised Services in The East of England	Alex Ridgeon, Director of Specialised Commissioning and Health and Justice	Xxxxx

Document control

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Introduction and purpose	<p>From April 2023, Integrated Care Boards (ICBs) entering joint working agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services set out in Schedule 3 of the Agreement, and for any associated Joint Functions set out in Schedule 4.</p> <p>NHS England and ICBs will form a statutory joint committee to collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transitional mechanism prior to ICB taking on full delegated commissioning responsibility.</p> <p>Subject to Clauses 7.1 and 7.2 of this Agreement (Further Collaborative Working), the Partners may, to such extent that they consider it desirable, table an item at the Joint Committee relating to any other of their functions that is not a Joint Specialised Service or a Joint Function to facilitate engagement, promote integration and collaborative working.</p> <p>The Partners may, from time to time, establish sub-groups or sub-committees of the Joint Committee, with such terms of reference as may be agreed between them. Any such sub-groups or sub-committees that are in place at the commencement of this Agreement may be documented in the Local Terms (Schedule 9).</p>
The Terms of Reference	<p>These Terms of Reference provide a template to support effective collaboration between NHS England and ICBs acting through Joint Committees in 2023/24.</p>

	<p>The Terms of Reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the Joint Working Agreement between the ICB and NHS England.</p> <p>It is acknowledged that Joint Working Arrangements aim to give ICBs greater involvement in the commissioning of Specialised Services to better align and transform pathways of care around the needs of local populations.</p> <p>The Joint Committee will operate as the decision-making forum for exercising the agreed Joint Functions in accordance with the Agreement.</p> <p>By agreement, the Partners may use an alternative title for the Joint Committee that reflects local arrangements, for example, 'Commissioning Committee.'</p> <p>In the East of England, the Committee is called the Specialised Services Joint Commissioning Committee (SSJCC).</p>
<p>Statutory Framework</p>	<p>The Partners have arranged to exercise the Functions jointly pursuant to section 65Z5 of the NHS Act 2006.</p> <p>The SSJCC is established pursuant to section 65Z6 of the NHS Act 2006.</p> <p>Apart from as set out in the Agreement, the SSJCC does not affect the statutory responsibilities and accountabilities of the Partners.</p>
<p>Role of the Joint Committee</p>	<p>The role of the SSJCC is to provide strategic decision-making, leadership and oversight for the Joint Specialised Services and any associated activities. The SSJCC will safely, effectively, efficiently and economically discharge the Joint Functions and deliver these Joint Specialised Services through the following key responsibilities:</p> <ul style="list-style-type: none"> ▪ Determining the appropriate structure of the SSJCC; ▪ Making joint decisions, in line with the NHSE Operating Framework and the National Planning Guidance, in relation to the planning and commissioning of Specialised Services, and any associated commissioning or statutory functions, for the population, for example, through undertaking population needs assessments; ▪ Making recommendations on the population-based Specialised Services financial allocation and financial plans; ▪ Oversight of the contractual process for specialised commissioning (including CQUINS, Service Specifications, contract variations, SDIPs and agreement of IAPs); ▪ Oversight and assurance of the Joint Specialised Services in relation to quality, operational and financial performance, including co-ordinating risk and issue management and escalation, and developing the approach to intervention with Specialised Services Providers where there are quality or contractual issues;

- Identifying and setting strategic priorities and undertaking ongoing assessment and review of Joint Specialised Services within the remit of the SSJCC, including tackling unequal outcomes and access;
- Supporting the development of partnership and integration arrangements with other health and care bodies that facilitate population health management and providing a forum that enables collaboration to integrate service pathways, improve population health and services and reduce health inequalities. This includes establishing links and working effectively with Provider Collaboratives and cancer alliances, and working closely with other ICBs, Joint Committees and NHS England where there are cross-border patient flows to providers;
- Ensuring the SSJCC has effective engagement with stakeholders, including patients and the public, and involving them in decision-making;
- Ensuring the SSJCC has appropriate clinical advice and leadership, including through Clinical Reference Groups and Relevant Clinical Networks;
- Commencing longer-term planning, particularly in view of the ICB(s) receiving full delegated commissioning responsibility in future;
- Discussing any matter which any member of the SSJCC believes to be of such importance that it should be brought to the attention of the SSJCC;
- Where agreed by the Partners, overseeing the Collaborative Commissioning Agreements set out in the Joint Working Arrangement;
- Otherwise ensuring that the roles and responsibilities set out in the Agreement between the Partners are discharged.

The Partners must implement such arrangements as are necessary to demonstrate good decision-making and compliance with all statutory duties, guidance and good practice, including ensuring that the SSJCC has sufficient independent scrutiny of its decision-making and processes.

Further information on independent membership of the SSJCC is contained in the Membership Section.

The SSJCC will also be used as a forum for NHS England and ICBs to discuss the development of services for:

- Retained Specialised Services
- Health and Justice Services

The governance for these services will be with NHS England-East of England (NHSE-EoE) and consequently the SSJCC will make recommendations to NHSE-EoE for NHSE-EoE to review and make a final decision.

The SSJCC will agree a Standard Operating Procedure (SOP) setting out how these responsibilities will be discharged. The SSJCC SOP exists alongside these Terms of Reference. The SSJCC will own and agree the

	<p>SOP and will develop it to underpin the delegation of specialised services to ICBs.</p> <p>Additionally, the SSJCC will agree the development plan through 23/24 that will support the delivery of delegation of Specialised Services from 1 April 2024.</p> <p>In relation to the Mental Health Provider Collaborative, there will be regular updates and reporting to the SSJCC for information.</p> <p>In relation to the Specialised Clinical and Operational Delivery Networks, there is a clear governance structure in place, as set out in the SOP, which ensures there is regular reporting as well as joint commissioning arrangements as needed.</p> <p>The SSJCC must adhere to these Terms of Reference but may otherwise regulate its own procedure.</p>
<p>Accountability and reporting</p>	<p>The SSJCC will be formally accountable to the Board of NHS England through the relevant NHS England regional governance structure for specialised services.</p> <p>In the East of England, the SSJCC will report to the NHS England Board from the East of England Regional Executive Team (RET), via the East of England Regional Commissioning Committee. Reporting will also be to the East of England Regional Leadership Team (RLT), which includes ICB Chief Executives.</p> <p>In addition, the SSJCC will report to each of the six ICBs via the following Committees:</p> <p>NHS Bedfordshire, Luton and Milton Keynes ICB – Finance & Investment Committee NHS Cambridgeshire and Peterborough ICB – Commissioning and Investment Committee NHS Norfolk and Waveney ICB – Transformation Committee NHS Suffolk and North East Essex – Specialised Commissioning Committee NHS Mid and South Essex – xxx Committee NHS Hertfordshire and West Essex – Commissioning Committee</p> <p>The Joint Committee may report to the Delegated Commissioning Group (DCG) for Specialised Services on its proceedings and decisions. In the East of England this will be by exception, either with issues that need to be considered at a national level or with issues that have been raised through national specialised commissioners.</p> <p>The SSJCC’s Chair(s), or at the Chair’s discretion, another member of the SSJCC, may attend DCG and report to the DCG on its proceedings.</p> <p>Where the DCG requests that the SSJCC provides information or reports on its proceedings or decisions, the Parties must comply with that request within a reasonable timescale.</p>
<p>Membership</p>	<p><u>Core Membership</u></p> <p>Each of the Partners must nominate one Authorised Officer to be their representative at meetings of the SSJCC. The Authorised Officers</p>

nominated by the Partners and present at a meeting of the SSJCC comprise the voting membership of the SSJCC.

Each of the Partners may nominate a named substitute to attend meetings of the SSJCC if its Authorised Officer is unavailable or unable to attend or because they are conflicted.

Each of the Partners must ensure that its Authorised Officer (and any named substitute) is of a suitable level of seniority and duly authorised to act on its behalf and agree to be bound by the final position or decision taken at any meeting of the SSJCC.

The Authorised Officers (or any substitute(s) appointed) form the Core Membership of the SSJCC.

Discretionary Membership

Each of the Partners may be represented at meetings of the SSJCC by representatives (who may be officers or, in the case of an ICB, non-executive members of the ICB) who may observe proceedings and contribute to the SSJCC's deliberations as required, but these representatives will not have the right to vote.

The Partners may identify individuals or representatives of other organisations that may be invited to observe proceedings and contribute to the SSJCC's deliberations as required. These representatives will not have the right to vote.

Independent Membership and Independent Scrutiny

The Partners will appoint at least one Independent Member of the SSJCC.

The Independent Member will not have voting rights on the SSJCC. The role of the Independent Member(s) is:

- To provide constructive impartial challenge in the decision-making process;
- To support the Partners to reach a consensus position wherever possible;
- To support the SSJCC to exercise the Functions with reference to the statutory framework, good practice and the Triple Aim; and
- To encourage the Partners to undertake effective stakeholder engagement and to have regard to the outcome of engagement exercises.

Term of membership

Each member of the Core Membership (and any substitute appointed) will hold their appointment for a term of one year. The term of appointment of each member expires on the first anniversary of the first SSJCC meeting at which the member is in attendance. Members will be eligible to be reappointed for further terms at the discretion of the Partners.

Membership lists

	<p>The Chair (or in the absence of a Chair, the Partners themselves) shall ensure that there is prepared (and updated from time to time) a list of the members and that this list is made available to the Partners.</p>
Chair	<p>At the first meeting of the SSJCC, the Core Membership shall select a Chair, or joint Chairs, from among the membership.</p> <p>The Chair(s) shall hold office for a period of one year and be eligible for re-appointment for 2 further terms. At the first scheduled SSJCC meeting after the expiry of the Chairs' term of office, the Core Membership will select a Chair, or joint Chairs, who will assume office at that meeting and for the ensuing term.</p> <p>If the Chair(s) is/are not in attendance at a meeting, the Core Membership will select one of the members to take the chair for that meeting.</p>
Remuneration	<p>The Partners shall prepare a scheme for the remuneration of any external members and for meeting the reasonable expenses incurred by other classes of membership of the SSJCC.</p> <p>The scheme shall be reviewed on an annual basis.</p>
Meetings	<p>The SSJCC shall meet 6 times per year, as a minimum.</p> <p>At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the SSJCC shall prepare a schedule of meetings for the forthcoming year ("the Schedule").</p> <p>The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that the Schedule is notified to the members.</p> <p>Either:</p> <ul style="list-style-type: none"> ▪ NHS England, or ▪ The ICBs acting collectively, <p>may call for a special meeting of the SSJCC outside of the Schedule as they see fit, by giving notice of their request to the Chair. The Chair(s) may, following consultation with the Partners, confirm the date on which the special meeting is to be held and then issue a notice giving not less than 1 weeks' notice of the special meeting.</p>
Quorum	<p>A SSJCC meeting is quorate if the following are in attendance:</p> <ul style="list-style-type: none"> ▪ the Authorised Officer (or substitute) nominated by NHS England; ▪ each of the Authorised Officers (or substitutes) appointed by the ICBs.
Decisions and voting arrangements	<p>The SSJCC must seek to make decisions relating to the exercise of the Joint Functions and Joint Specialised Services on a consensus basis.</p> <p>The Partners must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to SSJCC meetings for discussions and negotiations between Partners to take place.</p>

In preparation for future delegation of Specialised Services and collaboration between them for this purpose, the ICBs should seek to adopt a common position on any matter to be decided.

Decisions must be ratified by the Core Membership of the SSJCC.

Where it has not been possible, despite the best efforts of the Core Membership, to come to a consensus decision on any matter before the SSJCC, the Chair(s) may require the decision to be put to a vote in accordance with the following provision.

There will be ICB collective voting with an NHS England casting vote: the ICBs have a single collective vote and NHS England has a vote. Where there is deadlock, NHS England will have the casting vote at the meeting of the joint committee. ICB voting will be weighted based on individual populations identified in Mid-2020 Population Estimates for 2021 Clinical Commissioning Groups.

ICB	ONS 2021	Vote Share
Cambridgeshire and Peterborough	896,725	13.66%
Norfolk and Waveney Health and Care Partnership	1,032,661	15.73%
Suffolk and North East Essex	987,177	15.04%
Bedfordshire, Luton and Milton Keynes	959,098	14.61%
Hertfordshire and West Essex	1,488,061	22.67%
Mid and South Essex	1,199,296	18.27%
Total	6,563,018	

De minimis level value

Where an individual ICBs financial exposure to a collective JCC decision is predicted to be less than £100,000 in any 12 month period that ICB agrees to waive its voting rights.

Conduct and conflicts of interest

Members of the SSJCC will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and relevant organisational policies.

The NHS Standards of Business Conduct policy is available from: <https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/>

Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life). See: <https://www.gov.uk/government/publications/the-7-principles-of-public-life>.

Members should refer to and act consistently with the NHS England guidance: *Managing Conflicts of Interest in the NHS: Guidance for staff and organisations*. See: <https://www.england.nhs.uk/ourwork/coi/>.

Where any member of the SSJCC has an actual or potential conflict of interest in relation to any matter under consideration by the SSJCC, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by

	<p>voting. A Partner whose Authorised Officer is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.</p>
<p>Confidentiality of proceedings</p>	<p>The SSJCC is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the SSJCC is at the discretion of the Partners.</p> <p>All members in attendance at a SSJCC are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.</p>
<p>Publication of notices, minutes and papers</p>	<p>The Partners shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the SSJCC.</p> <p>The Chair(s) (or in the absence of a Chair, the Partners themselves) shall see that notices of meetings of the SSJCC together with an agenda listing the business to be conducted and supporting documentation is issued to the Partners 1 week (or, in the case of a special meeting, 2 days) prior to the date of the meeting.</p> <p>The proceedings and decisions taken by the SSJCC shall be recorded in minutes, and those minutes circulated in draft form within 2 weeks of the date of the meeting. The SSJCC shall confirm those minutes at its next meeting.</p>
<p>Review of the Terms of Reference</p>	<p>These Terms of Reference will be reviewed annually.</p>

SCHEDULE 3: JOINT SPECIALISED SERVICES

Part 1 – List of Specialised Services for the purposes of this Joint Working Agreement

[DN: this will set out the services that have been identified by the Service Portfolio Analysis as being ready for greater ICB involvement]

This list will be confirmed by the NHS England Board

SCHEDULE 4: JOINT FUNCTIONS

1. Introduction

- 1.1 This Schedule sets out in further detail the functions which are to be exercised jointly by the Partners, being, in summary:
 - 1.1.1 decisions in relation to the commissioning and management of Joint Specialised Services;
 - 1.1.2 planning Joint Specialised Services for the Population, including carrying out needs assessments;
 - 1.1.3 undertaking reviews of Joint Specialised Services in respect of the Population;
 - 1.1.4 supporting the management of the Specialised Commissioning Budget;
 - 1.1.5 co-ordinating a common approach to the commissioning and delivery of Joint Specialised Services with other health and social care bodies in respect of the Population where appropriate; and
 - 1.1.6 such other ancillary activities that are necessary in order to exercise the Specialised Commissioning Functions.

2. General Obligations

- 2.1 The Partners are jointly responsible for planning the commissioning of the Joint Specialised Services in accordance with this Agreement, the Finance Guidance and the Mandated Guidance.
- 2.2 The role of the Joint Committee shall include:
 - 2.2.1 planning the commissioning of the Joint Specialised Services;
 - 2.2.2 assurance and oversight of the Joint Specialised Services, including compliance with the National Specifications and relevant Clinical Commissioning Policies;
 - 2.2.3 identifying and setting strategic priorities for the Joint Specialised Services;
 - 2.2.4 development of local commissioning expertise and advice structures.
- 2.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Services Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification where one exists in relation to the relevant Specialised Service.

Specific Obligations

3. Procurement and Contract Management

- 3.1 The Joint Committee will make procurement decisions and support NHS England to carry out any procurement processes in accordance with the Contracting Standard Operating Procedure.

- 3.2 In discharging these responsibilities, the Joint Committee must comply at all times with Law and any relevant Guidance including but not limited to Mandated Guidance; any applicable procurement law and/or guidance on the selection of, and award of contracts to, providers of healthcare services.
- 3.3 When the Joint Committee makes decisions in connection with the awarding of Specialised Services Contracts, it should ensure that it is able to demonstrate compliance with requirements for the award of such Contracts, including that the decision was:
 - 3.3.1 made in the best interest of patients, taxpayers and the population;
 - 3.3.2 robust and defensible, with conflicts of interests appropriately managed;
 - 3.3.3 made transparently; and
 - 3.3.4 compliant with relevant Guidance and Legislation.
- 3.4 The Joint Committee shall be consulted on contracting decisions relevant to the exercise of the Joint Commissioning Functions and shall ensure the performance of the following general obligations:
 - 3.4.1 oversee the management of the Specialised Services Contracts and, except in relation to payment, performance of the obligations of the commissioner in accordance with the relevant terms;
 - 3.4.2 support the active management of the performance of the Specialised Services Providers in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services, including, as appropriate, by ensuring that timely action is taken to enforce contractual breaches, serve notices or work with Specialised Services Providers to address any issues;
 - 3.4.3 review expenditure and collectively discuss how to obtain value for money in order to obtain value for money on behalf of NHS England;
 - 3.4.4 where required, support NHS England to undertake any investigations relating (among other things) to whistleblowing claims, infection control and patient complaints;
 - 3.4.5 collectively assess quality and outcomes including but not limited to clinical effectiveness, clinical governance, patient safety and the patient safety incident response framework, risk management, patient experience, and addressing health inequalities;
 - 3.4.6 consider any necessary variations (to be managed by NHS England) to the relevant Specialised Services Contract or services in accordance with Clinical Commissioning Policies, National Specifications, service user needs and clinical developments, including, where necessary, developing and implementing a service development improvement plan with Specialised Service Providers where they are not in position to meet any new National Standard or amendment to a National Specification or Clinical Commissioning Policy that is published in the future;
 - 3.4.7 agree information and reporting requirements to support NHS England to manage information breaches (which will include use of the NHS Digital Data Security and Protection Toolkit);

3.4.8 conduct review meetings and support NHS England to undertake contract management, including the issuing of contract queries and agreeing any remedial action plan or related contract management processes.

3.5 Where NHS England considers that it is necessary for the effective commissioning of the Joint Specialised Services, it may take any such decision that it considers necessary and appropriate and shall report such decision to the next Joint Committee.

4. Finance

4.1 Without prejudice to Clause 8 (Finance) of this Agreement, the Joint Committee must support NHS England to manage each of the relevant Specialised Services Contracts, including by:

4.1.1 ensuring proper financial management and governance for Joint Specialised Services in accordance with the Finance Guidance;

4.1.2 supporting the move towards management of population-based budgets for Joint Specialised Services; and

4.1.3 considering and inputting into local price agreements, managing agreements or proposals for local variations and local modifications to be implemented by NHS England.

5. Service Planning and Strategic Priorities

5.1 The Joint Committee is responsible for setting local commissioning strategy, policy and priorities and planning for and carrying out needs assessments for the Joint Specialised Services.

5.2 In planning, commissioning and managing the Joint Specialised Services, the Partners must have processes in place to assess and monitor equitable patient access, in accordance with the access criteria set out in Clinical Commissioning Policies and National Specifications, taking action to address any apparent anomalies.

5.3 The Joint Committee must ensure that the Partners work with Specialised Service Providers and Provider Collaboratives to translate local strategic priorities into operational outputs for Joint Specialised Services.

5.4 The Joint Committee shall provide input into any consideration by NHS England as to whether the commissioning responsibility in respect of any of the Part A Reserved Services should be delegated the Joint Committee or ICB.

6. Commissioning of High Cost Drugs

6.1 The Joint Committee must support the effective and efficient commissioning of High Cost Drugs for Joint Specialised Services.

6.2 The Joint Committee must develop and implement Shared Care Arrangements across the Area of the Joint Committee.

6.3 The Joint Committee must provide clinical and commissioning leadership in the commissioning and management of High Cost Drugs. This includes supporting the Specialised Service Provider pharmacy services and each Partner in the development access to medicine strategies, and minimising barriers that may exacerbate health inequalities.

6.4 The Joint Committee must ensure:

- 6.4.1 safe and effective use of High Cost Drugs in line with national Clinical Commissioning Policies;
 - 6.4.2 effective introduction of new medicines;
 - 6.4.3 appropriate use of Shared Care Arrangements, ensuring that they are safe and well monitored; and
 - 6.4.4 consistency of prescribing and unwarranted prescribing variation are addressed.
- 6.5 The Joint Committee must have in place appropriate monitoring mechanisms, including prescribing analysis, to support the financial management of High Cost Drugs.
 - 6.6 The Joint Committee must engage in the development, implementation and monitoring of initiatives that enable use of better value medicines. Such schemes include those at a local, regional or national level.
 - 6.7 The Joint Committee must provide support to prescribing networks and forums, including but not limited to: immunoglobulin assessment panels, HIV prescribing networks and high cost drugs pharmacy networks.

7. Innovation and New Treatment

- 7.1 The Joint Committee shall support local implementation of innovative treatments for Joint Specialised Services.

8. Oversight and Assurance

- 8.1 The Joint Committee must at all times operate in accordance with:
 - 8.1.1 the Oversight Framework published by NHS England;
 - 8.1.2 any national oversight and assurance guidance in respect of Specialised Services and/or joint working arrangements; and
 - 8.1.3 any other relevant NHS oversight and assurance guidance;
 collectively known as the "Assurance Processes".
- 8.2 The Joint Committee must develop and operate in accordance with mutually agreed ways of working in line with the Assurance Processes.
- 8.3 The Partners must provide any information and comply with specific actions in relation to the Joint Specialised Services, as required by NHS England, including metrics and detailed reporting in accordance with the Terms of Reference.

9. Mental Health, Learning Disabilities and Autism NHS-led Provider Collaboratives

- 9.1 The Joint Committee shall co-operate fully with NHS England in the development, management and operation of mental health, learning disability and autism NHS-led Provider Collaboratives including, where requested by NHS England, to consider the Provider Collaborative Arrangements where tabled by NHS England as an item for discussion under Clause 7.2.

10. Service Standards, National Specifications and Clinical Commissioning Policies

- 10.1 The Joint Committee shall support the development of clinical leadership and expertise at a local level in respect of Specialised Services.
- 10.2 The Joint Committee shall support local and national groups including Relevant Clinical Networks and Clinical Reference Groups that are involved in developing Clinical Commissioning Policies, National Specifications, National Standards and knowledge around Specialised Services.
- 10.3 The Joint Committee must comply with the National Specifications and relevant Clinical Commissioning Policies and ensure that all clinical Specialised Commissioning Contracts accurately reflect Clinical Commissioning Policies and include the relevant National Specification, where one exists in relation to the relevant Joint Specialised Service.
- 10.4 The Joint Committee must co-operate with any NHS England activities relating to the assessment of compliance against National Standards, including through the Assurance Processes.
- 10.5 The Joint Committee must have appropriate mechanisms in place to ensure National Standards and National Specifications are being adhered to.
- 10.6 Where any Partner has identified that a Specialised Services Provider may not be complying with the National Standards set out in the relevant National Specification, the Joint Committee shall consider the action to take to address this in line with the Assurance Processes.

11. Networks

- 11.1 The Joint Committee shall participate in the planning, governance and oversight of the Relevant Clinical Networks, including involvement in agreeing the annual plan for each Relevant Clinical Network. The Partners shall seek to align the network priorities with system priorities and to ensure that the annual plan for the Relevant Clinical Network reflects local needs and priorities.
- 11.2 The Joint Committee shall actively support and participate in dialogue with Relevant Clinical Networks and shall ensure that there is a clear and effective mechanism in place for giving and receiving information with the Relevant Clinical Networks including network reports.
- 11.3 The Joint Committee shall support NHS England in the management of Relevant Clinical Networks.
- 11.4 The Partners shall actively engage and promote Specialised Service Provider engagement in appropriate Relevant Clinical Networks.
- 11.5 Where a Relevant Clinical Network identifies any concern, the Joint Committee shall seek to consider and review that concern as soon as is reasonably practicable and take such action, if any, as it deems appropriate.
- 11.6 The Joint Committee shall ensure that network reports are considered where relevant as part of exercising the Joint Functions.

12. Transformation

- 12.1 The Joint Committee must provide such support as may be requested by NHS England with transformational programmes which encompass the Joint Specialised Services.

- 12.2 The Joint Committee shall identify the pathways and services that are priorities for transformation according to the needs of their Population.
- 12.3 The Joint Committee shall oversee local implementation of transformation programmes in respect of the Joint Specialised Services for the Population.

13. Quality

- 13.1 The Joint Committee must ensure that appropriate arrangements for quality oversight are in place. This must include the implementation of the Patient Safety Incident Response Framework for the management of incidents and serious events, appropriate reporting of any incidents, undertaking any appropriate patient safety incident investigation and obtaining support as required.
- 13.2 The Joint Committee must establish a plan to ensure that quality of the Specialised Services is measured consistently, using nationally and locally agreed metrics triangulated with professional insight and soft intelligence.
- 13.3 The Joint Committee must ensure that the oversight of the quality of the Specialised Services is integrated with wider quality governance in the local system and aligns with NHS England quality escalation processes.
- 13.4 The Joint Committee must ensure that there is a System Quality Group to identify and manage concerns across the local system.
- 13.5 The Joint Committee must ensure that there is appropriate representation at any Regional Quality Groups or their equivalent.
- 13.6 The Joint Committee must have in place all appropriate arrangements in respect of child and adult safeguarding and comply with all relevant Guidance.

14. Individual Funding Requests

- 14.1 The Partners shall provide any support required by NHS England in respect of determining an Individual Funding Request and implementing the decision of the Individual Funding Request panel.

15. Data Management and Analytics

- 15.1 The Joint Committee shall:
 - 15.1.1 lead on standardised collection, processing, and sharing of data for Joint Specialised Services, in line with broader NHS England, Department of Health and Social Care and government data strategies;
 - 15.1.2 lead on the provision of data and analytical service to support commissioning of Joint Specialised Services;
 - 15.1.3 ensure collaborative working across the Partners on agreed programmes of work focusing on provision of pathway analytics.
- 15.2 The Partners shall:
 - 15.2.1 share expertise, and, existing reporting tools, and shall ensure interpretation of data is made available to Joint Committees and other Partners to support the commissioning of the Joint Specialised Services;

15.2.2 work collaboratively with subject matter experts to ensure Partners are able to access data sources available to support the commissioning of the Joint Specialised Services.

15.3 The Joint Committee must ensure that the data reporting and analytical frameworks, as set out in Mandated Guidance or otherwise required by NHS England, are in place to support the commissioning of the Joint Specialised Services.

16. Incident Response

16.1 The Joint Committee shall:

16.1.1 support local incident management for Joint Specialised Services as appropriate to stated incident level; and

16.1.2 support national and regional incident management relating to Joint Specialised Services.

16.2 In the event that an incident is identified that has an impact on the Joint Specialised Services (such as potential failure of a Specialised Services Provider), the Joint Committee shall fully support the implementation of any requirements set by NHS England around the management of such incident and shall provide full co-operation to NHS England to enable a co-ordinated national approach to incident management. NHS England retains the right to take decisions at a national level where it determines this is necessary for the proper management and resolution of any such incident and the Joint Committee shall be bound by any such decision.

17. Freedom of Information and Parliamentary Correspondence

17.1 The Partners shall provide timely support in relation to the handling, management and response to all freedom of information and parliamentary correspondence relating to Joint Specialised Services.

SCHEDULE 5: RETAINED SERVICES

Part 1 – List of Specialised Services reserved to NHS England

[DN: this will set out the services that have been identified by the Service Portfolio Analysis as either not yet being ready for greater ICB involvement or should continue to be commissioned by NHS England.]

This list will be confirmed by the NHS England Board

Table 1 – Part A Retained Services

Table 2 – Part B Retained Services

SCHEDULE 6: RESERVED FUNCTIONS

1. Introduction

- 1.1 In accordance with Clause 6.2 of this Agreement, all functions of NHS England other than those defined as Joint Functions, are Reserved Functions.
- 1.2 This Schedule sets out further provision regarding the carrying out of the Reserved Functions as they relate to the Joint Functions.
- 1.3 The ICB Partners will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.
- 1.4 The following functions and related activities shall continue to be exercised by NHS England.

2. Retained Services

- 2.1 NHS England shall commission the Retained Services set out in Schedule 5.

3. Reserved Specialised Service Functions

- 3.1 In addition to the commissioning of Retained Services set out in Schedule 5, NHS England shall also carry out the functions set out in this Schedule 6 in respect of the Joint Specialised Services.

4. Oversight and Assurance

- 4.1 NHS England shall be responsible for developing national oversight and assurance guidance on joint working arrangements for Specialised Services.
- 4.2 NHS England shall be responsible for assuring the Joint Working Arrangements. Such assurance shall be undertaken in accordance with the Assurance Processes.
- 4.3 NHS England shall host a Delegated Commissioning Group that will undertake an assurance role in compliance with the Assurance Processes. This assurance role shall include monitoring and suggesting solutions to mitigate systemic risk to Joint Specialised Service provision.

5. Clinical Leadership and Clinical Reference Groups

- 5.1 NHS England shall be responsible for the following:
 - 5.1.1 providing clinical leadership, advice and guidance to the Joint Committee in relation to the Joint Specialised Services;
 - 5.1.2 supporting ICB Partners to develop clinical leadership for Joint Specialised Services; and
 - 5.1.3 providing clinical and public health leadership for Specialised Services.
- 5.2 NHS England will host Clinical Reference Groups, which will lead on the development and publication of the following for Specialised Services:
 - 5.2.1 Clinical Commissioning Policies;

- 5.2.2 National Specifications, including National Standards for each of the Specialised Services.

6. Clinical Networks

- 6.1 Unless otherwise agreed between the Partners, NHS England shall put in place contractual arrangements and funding mechanisms for the commissioning of the Relevant Clinical Networks.
- 6.2 NHS England shall be responsible for the following in respect of the Relevant Clinical Networks:
 - 6.2.1 developing national policy for the Relevant Clinical Networks;
 - 6.2.2 developing and approving the national specifications for the Relevant Clinical Networks;
 - 6.2.3 maintaining links with other NHS England national leads for clinical networks not focused on Specialised Services;
 - 6.2.4 convening or supporting national networks of the Relevant Clinical Networks;
 - 6.2.5 agreeing the annual plan for each Relevant Clinical Network with the involvement of the Joint Committee and Relevant Clinical Network, ensuring these reflect national and regional priorities;
 - 6.2.6 managing Relevant Clinical Networks jointly with the Joint Committee; and
 - 6.2.7 agreeing and commissioning the hosting arrangements of the Relevant Clinical Networks.

7. Complaints

- 7.1 NHS England shall manage all complaints in respect of the Joint Specialised Services and Reserved Services.

8. Procurement

- 8.1 In relation to procurement, NHS England shall be responsible for:
 - 8.1.1 setting standards and agreeing frameworks and processes for provider selections and procurements for Specialised Services;
 - 8.1.2 monitoring and providing advice, guidance and expertise on the overall provider market in relation to Specialised Services;
 - 8.1.3 running provider selection and procurement processes for Specialised Services.

9. Contracting

- 9.1 NHS England shall retain the following obligations in relation to contracting:
 - 9.1.1 except where 9.1.2 applies, entering into Specialised Commissioning Contracts with Specialised Service Providers as Co-ordinating Commissioner including negotiation of the Specialised Services Contracts and creating all contract documents (including indicative activity plans) and

schedules for inclusion in the Specialised Services Contracts, including the process of negotiation;

- 9.1.2 where NHS England in its absolute discretion agrees to enter into Specialised Commissioning Contracts with Specialised Service Providers as Associate Commissioner and perform all contracting duties required of an associate as well as ensure oversight of the relevant Specialised Commissioning Contracts through the Joint Committee;
- 9.1.3 setting, publishing or making otherwise available the Contracting Standard Operating Procedure and other Mandated Guidance detailing contracting strategy and policy for Specialised Services; and
- 9.1.4 providing and distributing contracting support tools and templates to the Partners.

9.2 NHS England shall keep a record of all of the Specialised Services Contracts setting out the following details in relation to each Specialised Services Contract

- 9.2.1 name of the Specialised Services Provider;
- 9.2.2 the name by which the Specialised Services Provider is known;
- 9.2.3 commissioner name;
- 9.2.4 Specialised Services Contract start date and end date;
- 9.2.5 description of Specialised Services;
- 9.2.6 location of provision of services; and
- 9.2.7 amounts payable under the Specialised Services Contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

10. Mental Health, Learning Disability and Autism NHS-led Provider Collaboratives

10.1 NHS England shall commission and design Provider Collaborative Arrangements for mental health, learning disabilities and autism services. Where it considers appropriate, NHS England shall seek the input of the Joint Committee in relation to relevant Provider Collaborative Arrangements.

11. Finance

- 11.1 NHS England shall be responsible for:
 - 11.1.1 Performing all necessary financial transactions associated with Specialised Services unless expressly agreed and set out in Local Terms;
 - 11.1.2 Setting financial policy and frameworks and developing the support tools necessary to enable commissioners to plan and deliver against a population-based allocation;
 - 11.1.3 Setting financial allocations for Specialised Services, including the move from historic actual to population-based allocations and including growth, inflation and efficiency targets;

- 11.1.4 Consolidating and reporting plans and in-year financial delivery against the Specialised Services Budget;
- 11.1.5 Developing financial impact assessments for National Specifications;
- 11.1.6 Overseeing dispute escalation and resolution where there are material changes to out-of-area cross-border flows;
- 11.1.7 Supporting the Joint Committee to ensure the financial delivery of the Joint Specialised Services according to financial business rules and financial frameworks including but not limited to:
 - 11.1.7.1 financial planning;
 - 11.1.7.2 investment and commissioning decision-making;
 - 11.1.7.3 budgetary control and delivery of efficiency targets;
 - 11.1.7.4 financial reporting and accounting;
 - 11.1.7.5 system financial oversight.

12. Individual Funding Requests (IFRs)

- 12.1 NHS England shall be responsible for the following:
 - 12.1.1 Leading on IFR policy, supporting IFR governance and managing the IFR process; and
 - 12.1.2 Providing pharmacy activity input and public health medicines expertise into IFR decisions.

13. Data Management and Analytics

- 13.1 NHS England shall:
 - 13.1.1 Lead on data collection, data acquisition and reporting;
 - 13.1.2 Provide leadership of data management and analytics to support the Partners, including professional network development, workforce development and information dissemination;
 - 13.1.3 Set Specialised Services data strategy and ensure alignment with broader NHS England, Department of Health and Social Care and government data strategies;
 - 13.1.4 Secure appropriate resource to support a national service for data processing and analytics for Specialised Services;
 - 13.1.5 Oversee standardised collection, processing and sharing of data used to support Specialised Services commissioning across the Partners, in line with national data strategy;
 - 13.1.6 Work collaboratively with all Partners to drive continual improvement of the quality and coverage of data used to support commissioning of Specialised Services; and

- 13.1.7 Support ICB data and analytic functions and wider data and analytic networks to develop, deploy locally and utilise business intelligence tools.

14. Pharmacy and Optimisation of High Cost Drugs

- 14.1 In respect of pharmacy and optimisation of High Cost Drugs, NHS England shall:
 - 14.1.1 support the Joint Committee on strategy for access to medicines, minimising barriers to health inequalities;
 - 14.1.2 provide financial management of High Cost Drugs spend, including prescribing analysis, to identify, scope, engage, deliver and record better value medicines strategy and initiatives;
 - 14.1.3 commission High Cost Drugs for Retained Services and of High Cost Drugs for Joint Specialised Services working jointly with Joint Committee;
 - 14.1.4 ensure consistency of prescribing in line with Clinical Commissioning Policies, introduction of new medicines, and addressing unwarranted prescribing variation;
 - 14.1.5 set medicines commissioning policy and criteria for access to certain medicines commissioned by Specialised Services including developing any necessary support tools;
 - 14.1.6 provide expert medicines advice and input into all Specialised Services activities; and
 - 14.1.7 provide direction and support to medicines leads at ICB level to support discharge of duties and delivery of strategic objectives and National Standards.

15. Quality

- 15.1 In respect of quality, NHS England shall:
 - 15.1.1 work with the Joint Committee to ensure oversight of Specialised Services through quality oversight and risk management;
 - 15.1.2 ensure that quality and safety issues and risks are managed effectively and escalated to the National Specialised Commissioning Quality and Governance Group, or other appropriate forums, as necessary;
 - 15.1.3 ensure that the Joint Specialised Services are aligned and integrated with broader clinical quality governance and processes;
 - 15.1.4 when quality issues relating to Specialised Services are identified, facilitate improvement through programme support, and mobilise intensive support when required on specific quality issues;
 - 15.1.5 facilitate review of Specialised Services where concerns arise, utilising peer reviews or clinical assessment, as appropriate;
 - 15.1.6 ensure all relevant intelligence is shared appropriately for quality and safety monitoring, including between organisations and at system quality groups or appropriate alternative forums;

- 15.1.7 identify and act upon issues and concerns that cross multiple ICBs, coordinating response and management as necessary;
- 15.1.8 provide guidance on quality and clinical governance matters and benchmark available data;
- 15.1.9 support Joint Committees to identify key themes and trends across their Area and utilise data and intelligence to respond and monitor as necessary; and
- 15.1.10 facilitate and support the national quality governance infrastructure (Specialised Commissioning Quality and Governance Group).

16. Service standards

- 16.1 NHS England shall carry out the following:
 - 16.1.1 development, engagement and approval of National Standards for Specialised Services (including National Specifications, Clinical Commissioning Policies, quality and data standards);
 - 16.1.2 production of national commissioning products and tools to support commissioning of Specialised Services; and
 - 16.1.3 maintenance and publication of the 'Manual' of prescribed Specialised Services and engagement with the Department of Health and Social Care on policy matters.

17. Transformation

- 17.1 NHS England shall be responsible for:
 - 17.1.1 providing leadership for transformation programmes and projects that have been identified as priorities for national coordination and support, and / or are national priorities for the NHS, including supporting delivery of commitments in the NHS Long Term Plan;
 - 17.1.2 co-production and co-design of transformation programmes with the Joint Committee and wider stakeholders; and
 - 17.1.3 supporting Joint Committees in co-ordinating and enabling Specialised Services transformation programmes for Joint Specialised Services where necessary.

18. Incident Response

- 18.1 NHS England shall, lead on incident management for Specialised Services.
- 18.2 NHS England shall lead on monitoring, planning and support for service and operational resilience and provide support to the Joint Committee to develop its oversight of these arrangements.
- 18.3 NHS England shall respond to specific service interruptions; for example. supplier, workforce challenges and provide support to the Joint Committee in any response to interruptions.

19. Innovation and New Treatment

- 19.1 NHS England shall ensure the implementation of innovative treatments for Joint Specialised Services and Retained Services such as Advanced Medicinal Therapy Products (ATMPs), recommended by NICE technology appraisals within statutory requirements.
- 19.2 NHS England shall provide national leadership for innovative treatments with significant service impacts including liaison with NICE.

SCHEDULE 7: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

- 1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the Partners on a Need To Know basis, in order to enable the Partners to exercise their functions in pursuance of this Agreement.
- 1.2. References in this Schedule (*Further Information Governance and Sharing Provisions*) to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.
- 1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:
 - 1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the Partners;
 - 1.3.2. describe the purposes for which the Partners have agreed to share Relevant Information;
 - 1.3.3. set out the lawful basis for the sharing of information between the Partners, and the principles that underpin the exchange of Relevant Information;
 - 1.3.4. describe roles and structures to support the exchange of Relevant Information between the Partners;
 - 1.3.5. apply to the sharing of Relevant Information relating to Specialised Services Providers and their Staff;
 - 1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
 - 1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
 - 1.3.8. apply to the activities of the Partners' Staff; and
 - 1.3.9. describe how complaints relating to Personal Data sharing between the Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

- 2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions and NHS England's Reserved Functions.
- 2.2. Each Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third party organisations from which the Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

- 3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Joint Specialised Services.

4. Lawful basis for sharing

- 4.1. The Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.
- 4.2. The Partners shall ensure that there is a Data Protection Impact Assessment (“DPIA”) that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.
- 4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

- 5.1. Each Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.
- 5.2. Access to, and processing of, the Relevant Information provided by a Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the Partners’ Staff should only have access to Personal Data on a justifiable Need to Know basis.
- 5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the Partners.
- 5.4. Neither Partner shall subcontract any processing of the Relevant Information without the prior consent of the other Partner. Where a Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.
- 5.5. The Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.
- 5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

- 6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the Partners will take the following measures as reasonably required:
 - 6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;
 - 6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering

the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

- 6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and
- 6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.
- 6.2. Each Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.
- 6.3. The Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.
- 6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the Partners.

7. Governance: Staff

- 7.1. The Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.
- 7.2. The Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.
- 7.3. The Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data) are informed of the confidential nature of the Personal Data. The Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information.

Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

- 7.4. The Partners shall ensure that:
 - 7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and
 - 7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

- 7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

- 8.1. At all times, the Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.
- 8.2. Wherever possible (in descending order of preference), only anonymised information, or, strongly or weakly pseudonymised information will be shared and processed by the Partners. The Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.
- 8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis.
- 8.4. If any Partner
 - 8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or
 - 8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information,it shall promptly, within 48 hours, notify the other Partners. The Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.
- 8.5. In processing any Relevant Information further to this Agreement, the Partners shall process the Personal Data and Special Category Personal Data only:
 - 8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;
 - 8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;
 - 8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.
- 8.6. The Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

- 8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and
- 8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data, and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. In particular, each Partner shall:

- 8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;
- 8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;
- 8.7.3. obtain prior written consent from the originating Partner in order to transfer the Relevant Information to any third party;
- 8.7.4. permit any other Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and
- 8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

- 8.8. The Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.
- 8.9. The Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third party security measures.

9. Governance: Transmission of Information between the Partners

- 9.1. This paragraph supplements paragraph 8 of this Schedule.
- 9.2. Transfer of Personal Data between the Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.
- 9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

- 9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.
- 9.5. Each Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.
- 9.6. The Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the Partners.

10. Governance: Quality of Information

- 10.1. The Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

- 11.1. A non-originating Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Partner they came from.
- 11.2. Each Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.
- 11.3. If a Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other Partners in writing of that retention, giving details of the documents or materials that it must retain.
- 11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.
- 11.5. The Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.
- 11.6. The Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

- 11.7. Each Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.
- 11.8. Electronic records will be considered for deletion once the relevant retention period has ended.
- 11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

- 12.1. The Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.
- 12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.
- 12.3. The Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.
- 12.4. Basic details of the Agreement shall be included in the appropriate log under each Partner's Publication Scheme.

13. Governance: Single Points of Contact

- 13.1. The Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

- 14.1. The Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

SCHEDULE 8: MANDATED GUIDANCE

Generally applicable Mandated Guidance

- [National Guidance on System Quality Groups.](#)
- [Managing Conflicts of Interest in the NHS.](#)
- Arrangements for Delegation and Joint Exercise of Statutory Functions.
- Guidance relating to procurement and provider selection.
- IG Guidance relating to serious incidents.
- All other applicable IG and Data Protection Guidance.
- Any applicable Freedom of Information protocols.
- Any applicable guidance on Counter Fraud, including from The NHS Counter Fraud Authority.
- Any applicable guidance relating to the use of data and data sets for reporting.

Workforce

- [Guidance on the Employment Commitment.](#)

Finance

- [Guidance on NHS System Capital Envelopes.](#)
- [Managing Public Money \(HM Treasury\).](#)

Specialised Services Mandated Guidance

- Commissioning Change Management Business Rules.
- Cashflow Standard Operating Procedure.
- Finance and Accounting Standard Operating Procedure.
- Provider Collaborative Guidance.
- Clinical Commissioning Policies.
- National Specifications.
- National Standards.
- The 'Manual' for Specialised Commissioning.

SCHEDULE 9: LOCAL TERMS

General

Where there is a dispute as to the content of this Schedule, the Partners should follow the Disputes Resolution procedure set out at Clause 18.

Following signature of the Agreement, this Schedule can be amended by the Partners using the Variations procedure at Clause 10.

Part 1 – Further Governance Arrangements

All local arrangements will be included in the Standard Operating Framework which will be approved by the Joint Committee

The Partners can use this Part for any governance arrangements not covered by the main agreement or the existing Schedules.

It is advised that sub-committees (those forums with decision-making power) and sub-groups (those forums without decision-making power, but are advisory in nature) are set out in this part. It is advised that the role, purpose and membership of the sub-committees or sub-groups are set out in this part.

Part 2 – Workforce Arrangements

All local arrangements will be included in the Standard Operating Framework which will be approved by the Joint Committee

It is recognised that, in 2023/24, NHS England will retain the relevant specialised commissioning workforce which will support the arrangements described in this Agreement. The Partners can use this Part to detail any arrangements relating to the supporting workforce for the Joint Functions. As examples, this may include setting out the list of activities that NHS England teams will carry out, the support that will be provided to ICBs and any other relevant arrangements. The Partners may also wish to detail how any additional requests will be managed and agreed to, including any role of the Joint Committee.

ICB BOARD

Agenda Item No.	19
Reference No.	ICB 23-29
Date.	21 March 2023

Title	Committee Minutes and Highlight Reports
Lead Director	Amanda Lyes, Director of Corporate Services and System Infrastructure
Author(s)	Jo Mael, Corporate Governance Manager
Purpose	<p>Minutes and Highlight Reports:</p> <p><i>To receive minutes and highlight reports from the following ICB Sub Committees.</i></p> <ul style="list-style-type: none"> a) Audit Committee <i>The unconfirmed minutes of a meeting held on 16 February 2023</i> b) Remuneration and HR Committee <i>The unconfirmed minutes of a meeting held on 7 March 2023</i> c) Quality Committee <i>The minutes of a meeting held on 12 January 2023 and unconfirmed minutes of a meeting held on 9 March 2023.</i> d) Finance Committee <i>The minutes of meetings held on 17 January and 14 February 2023</i> e) People Committee <i>The minutes of a meeting held on 15 February 2023</i> f) People and Communities Committee <i>No report received</i> g) Estates Committee <i>Highlight report from January and February 2023 meetings</i> h) Strategic Digital Investment and Assurance Committee <i>A summary of minutes of a meeting held on 3 February 2023</i>

Recommendation:

To receive the minutes and highlight reports as attached to the report whilst noting that 'unconfirmed' minutes remain subject to change by the relevant Committee/Group.

**Meeting of the SNEE ICB Audit Committee held on
16 February 2023**

PRESENT:

Steve Clarke (Chair)	SC	Non-Executive Member, Finance and Audit
Tanya Curry	TC	Non-Executive Member, People, Remuneration and Diversity
Phanuel Mutumburi	PM	External Independent Member

IN ATTENDANCE:

Chris Armitt	CA	ICB Deputy Director of Finance
Lisa Blake	LB	External Audit, BDO
Colin Boakes	CB	ICB Governance Advisor
Janine Combrinck	JC	External Audit, BDO
Nick Fanning	NF	RSM, Internal Audit
Tshiamo Hlatshwayo	TH	External Audit, BDO
Mark Kidd	MK	Local Counter Fraud Specialist (LCFS)
Amanda Lyes	AL	ICB Director of People and Workforce
Howard Martin	HM	ICB Director of Finance
Sophie Martin	SM	ICB Patient and Public Involvement Team
Jo Mael (Minutes)	JM	ICB Corporate Governance Manager

23/001 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed all to the meeting. Apologies for absence were received from:

James Thompson, ICB Finance Team

23/002 DECLARATIONS OF INTEREST

The Committee noted the register of interests. There were no declarations in relation to the agenda items and the meeting was confirmed as quorate.

23/003 MINUTES OF THE PREVIOUS MEETING

The minutes of the SNEE ICB Audit Committee meeting held on 15 December 2022 **were approved** as correct record **subject to** correction of External Audit members job titles.

23/004 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising from the previous meeting and the action log was reviewed and updated.

23/005 AUDIT COMMITTEE BRIEFING ON MATTERS OF INTEREST OR STRATEGY

The ICB's Director of Finance reported;

At present the Finance Team was focused on financial planning for 2023/24 and also

working through the implications of allocations and planning guidance. SNEE as an ICS would deliver its obligation to break-even in 2022/23 through a greater than expected application of non-recurrent measures. There would be less flexibility going into 2023/24 as there would be a reduction of £50m through allocations to correct Covid-19 funding which meant that the allocation growth of £89m would be subsumed by inflation with little growth funding.

Messages from NHSE were that there was a need to return to pre-Covid productivity. Plans were due for submission on 23 February 2023 and were likely to report a circa £50m deficit. There had been a £30m improvement since the last submission which was due to EEAST changing its position to break-even having received additional funding and there was hope that the position could be improved further. It was critical that focus moved to delivery of efficiency, recurrent efficiency and productivity in order to improve the underlying position.

A lot of work had taken place in development of the ICP Strategy and Joint Forward Plan which was due to be published in June 2023. Support was also being provided with regard to the transfer of responsibility for dental provision. The operational system had settled since the Christmas period although there remained ongoing issues with work to ensure minimal disruption from industrial action. A meeting had taken place with Patricia Hewitt to feed into the Hewitt review and at the ICB's quarterly review with NHSE on 27 January 2023 there had been positive feedback.

The Committee noted the update.

23/006 BOARD ASSURANCE FRAMEWORK (BAF)

Content of the BAF document was reviewed by the Executive Committee (EC) every month and by the Board, Quality and Audit Committees at each of its meetings. All BAF updates had been received and were up to date.

A brief overview of the amendments was set out within a table appended to the report.

Discussions and questions regarding the BAF at the January 2023 ICB Board meeting had not resulted in any actions.

A process change had already been initiated with the risks for Referral to Treatment, Cancer Targets and A&E waiting times being addressed as system risks rather than separate provider risks in the current iteration of the BAF.

At the ICB Board meeting in November 2022, Partner Members had been asked to ensure that, where appropriate, their own strategic risks were aligned with those of the ICB.

Internal Audit had recommended a greater focus on Risk Appetite which would necessitate a small amendment to the BAF layout prior to presentation to the April Audit Committee.

The Committee was informed that the ICB Board Development Session on 18 April 2023 would have one hour dedicated to risk management with content including the risk management process, questions to obtain further assurance, and conclude by looking at an enhancement to the framework to attempt to ensure there were fewer, but more meaningful, risk on the BAF.

At present there were 19 strategic risks on the BAF, and it was noted that Risk 26 with regard to the refugee community whilst dropping of the BAF would continue to be monitored via the departmental risk register.

Assurance was provided that the Executive Committee was continually reviewing and

updating risks.

It was highlighted that at the previous meeting Internal Audit had recommended that key risks be confined to between 5-10 and be refocused to look at assurance rather than on how to obtain assurance and queried whether that had been followed up on. In response, the Committee was advised that was the intention of the forthcoming Board Development Session in April 2023.

In light of recent discussion at the People Committee, it was queried whether there might be a need to review the workforce risk with regard to whether it was a provider or system workforce issue and also whether the risk rating was accurate.

As the People Committee meeting had only been held the previous day, the ICB's Director of People of Workforce gave reassurance of the intention to review the risk within the Executive Committee as part of the normal process **and agreed** to report back to a future meeting.

The Committee reviewed the BAF document **and approved** the amendments as set out within the report.

23/007 INTERNAL AUDIT

The Committee was in receipt of the Indicative Internal Audit Plan for 2023/24 and the Internal Audit Progress Report. Points highlighted from each included;

a) Internal Audit Progress Report

Three draft reports were currently being finalised with management and the remainder of the plan was scheduled. There was good engagement and the process worked well. Status with regard to management actions was that there were currently eight open and overdue actions and work continued with management to effect sign off.

b) Indicative Internal Audit Plan 2023/24

In line with the three-year strategy the plan had been circulated to the Executive for comment having had business continuity and dental accountability elements added. Comments were invited after which the plan would be costed for final comment by the Executive and presentation to the Audit Committee.

The Chair advised that the willingness to be flexible was helpful.

The Committee noted the Plan and Progress Report.

23/008 LOCAL COUNTER FRAUD SPECIALIST (LCFS) PROGRESS REPORT + FRAUD AND BRIBERY RISK ASSESSMENT

The Committee was in receipt of the current progress report and a fraud and bribery risk assessment from the Local Counter Fraud Specialist with key points highlighted being:

Comments included;

- Sessions with GP practices were being organised and two of the three intended sessions had now been booked. Sessions for all staff and for the SNEE senior leadership team had also been arranged.
- A three-hour interactive recruitment training session had been held and well received by the six attendees.
- Seven intelligence alerts had been issued regarding concerns in the wider NHS and the ICN internal team were thanked for actioning them.
- Field work had been completed with regard to a joint review of conflicts of interest

which was being finalised and also for a pre-employment check review which had just commenced.

- The Fraud and Bribery Risk Assessment had been included within the papers. It had previously been approved and recently updated in respect of the ICB.

Having noted the success of the three-hour recruitment session, it was queried whether a shorter version was available for other staff. The Committee was informed that indeed two versions were available, one for specialist staff and another for other staff.

The Committee noted the reports.

23/009 EXTERNAL AUDIT

The ICB's External Auditors advised that the update would cover the following three areas:

1. The current position on sign-off of the CCGs 2021/22 audits.
2. A Mental Health Investment Standard update.
3. Update on progress of the 2022/23, part year audits for both the CCGs and ICB.

2021/22 sign-off of CCGs audits

Members and staff were thanked for their patience whilst the External Auditor had been away from business. Delay had occurred as some work was required to be completed by the person that signed off the audit which included the modified opinion. 2021/22 sign-off was now progressing and papers had been updated and a review completed. Review by a quality reviewer was expected on 17 February 2023 after which the opinion would be sent over to the ICB's Finance team. Unfortunately, the External Auditor was due to be away until 13 March 2023 which would delay the updated completion report and sign-off. Apologies were given that the work could not be completed earlier.

The ICB's Director of Finance asked for confirmation that 17 March 2023 was the anticipated date for completion of the audit. In response it was reported that the 17 March had been sighted as the date for an 'Extraordinary' Audit Committee to receive the final documentation with the audit opinion probably being provided the following working day. It was intended that the draft opinion would be received prior to the External Auditor going on leave.

The Chair advised that concerns with regard to the delay had already been raised.

It was agreed that an 'Extraordinary' Audit Committee be convened on 17 March 2023.

Mental Health Investment Standard (MHIS)

All three CCGs had declared compliance with target in 2021/22. The last review had been in 2019/20 as there had been no review in 2020/21. Following the review in 2019/20 the reasonable assurance conclusion had included qualification on continuing healthcare as the CCGs could not separate learning disability and dementia elements. For 2021/22 the CCGs had done an estimate and split out and excluded learning disability and dementia. As it was an estimate further work was being carried out via a sample from the Broadcare system to seek to ensure that the qualification could fall away for 2021/22.

There remained some loose ends to clear up and some unadjusted errors to report on relevant to prescribing, however there was nothing that gave cause for concern or was likely to result in non-compliance. More information would be provided to the Committee with regard to the exclusion of prescribing multi-use drugs. There were five multi-use drugs as referred to in NHS guidance and the CCGs had excluded all. It was

not thought that the total value of the multi-use drugs was material, and it was not a qualification issue as the CCGs approach had been consistent with previous years. At the request of NHSE statements of compliance were due to be published when all reviews were complete on a designated day in April 2023.

2022/23 progress.

The planning work had started whilst the External Auditor was away with teams now working on risk assessment and implementation of ISA 315 which was a new standard for auditors. Discussions were ongoing with regard to the detail associated to ISA 315 and its impact of the level of work. On return, the External Auditor had progressed team discussions in order to get planning finalised and risk assessments notified. It was intended that audit plans for all entities would be presented to the April Audit Committee along with risk assessments and audit strategy. There was continued pressure on resources, and it was disappointing to have to report that there had been challenges associated to recruitment and resourcing. Although resources were continually being replanned there remained a risk of non-delivery of the audits to the four entities by 30 June 2023 deadline. The Committee was assured that everything was being done to meet the deadline. Current focus was on getting the CCG opinions completed as ICB accounts relied on their brought-forward balances.

The ICB's Director of Finance sought expansion on the potential risk on the first three months of 2021/22 relevant to the CCGs and nine months associated to the ICB. The External Auditor clarified that whilst there was confidence that the CCG opinion could be delivered prior to the 30 June 2023 deadline the ICB element was a greater risk. Reassurance was provided that SNEE was not being treated differently to other contracts and it was explained that planning included the allocation of resources via agreement with the auditor's public sector leadership team in order that there was equitable discussion. There was recognition that the delay was a reputational risk for BDO as an NHS audit supplier.

The Committee noted the update and expressed its disappointment that the deadline was not likely to be met.

23/010 FREEDOM OF INFORMATION

The report sought to inform the Committee on the statutory function to respond to Freedom of Information requests in line with the Freedom of Information Act 2000.

The report covered the period from July 2022 to December 2022. During that period there had been 128 requests averaging 21 per month. Sources of the requests were varied as was the information requested. All the requests had been answered within the 20 working days as defined in the Freedom of Information Act 2000.

Tables within the report gave a breakdown of each months' requests and the type of information requested.

The Committee was informed that Freedom of Information activity was regularly reported to the Information Governance Steering Group and had previously been reported to the ICB Board. It was now felt more appropriate for it to be reported to the Audit Committee hence today's report.

As the intention was now for Freedom of Information activity to be presented to the Audit Committee for oversight, the ICB's Governance Advisor reported the need to add the responsibility to the Committee terms of reference which were due to be presented, along with other sub-committee terms of reference, to the ICB Board in March 2023 for review.

The Committee noted the content of the report **and agreed** that Freedom of Information be included within its terms of reference prior to them being presented to the ICB Board in March for approval.

23/011 POLICIES/DOCUMENTS FOR APPROVAL

The Committee was in receipt of the Patient Safety Partner Involvement Policy for approval.

Comments included:

It was suggested that Section 3.3.1 with regard to equality and diversity be revised to state 'not unlawfully discriminate' rather than 'do not discriminate'.

Having queried whether the Quality Committee had been involved in the policy, the Committee was informed that it had been discussed at System Quality Group and presented to Audit Committee as it being, along with Remuneration and HR Committees the only committees able to approve policies.

The Committee approved the Patient Safety Partner Involvement Policy as appended to the report, **subject to** the change to Section 3.3.1 as mentioned above.

23/012 GOVERNANCE LOGS

Waivers

The Committee received the following waivers of competitive tendering.

ICB 012	Green Light Trust – High Intensity User Support Project
ICB 013	Tobacco Dependency Prevention Programme – Suffolk County Council
ICB 014	Suffolk GP Federation – SNEE ICS Pulmonary Rehabilitation service delivery support

Hospitality and Gifts Register

The Committee received the current hospitality and gifts register for review and was informed that staff had recently been reminded via the staff newsletter of the need to declare.

The Committee noted the waivers of competitive tendering and hospitality and gifts register as presented.

23/013 ANY OTHER BUSINESS

No items of other business were received.

23/014 DATE AND TIME OF NEXT MEETING

As discussed, attempt would be made to convene an 'Extraordinary' meeting on 17 March 2023.

The next scheduled meeting was due to take place on 13 April 2023.

**Minutes of a meeting of the
SNEE Integrated Care Board Remuneration and HR Committee
held at 0900 hrs on 7 March 2023**

PRESENT:

Tanya Curry Non-Executive Member, People, Remuneration and Diversity (Chair)
Prof. Will Pope ICB Chair

IN ATTENDANCE:

Ben Askew ICB Head of People and Culture (Part)
Amanda Lyes ICB Director of People and Workforce
Lizzie Mapplebeck Associate Director of Strategic Change (Part)
Howard Martin ICB Director of Finance
Nick Oldfield ICB HR Manager (Part)

23/001 APOLOGIES FOR ABSENCE

No apologies for absence were received.

23/002 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and introductions were made.

23/003 DECLARATIONS OF INTEREST

Amanda Lyes, ICB Director of People and Workforce and Howard Martin, ICB Director of Finance both declared an interest in agenda item 6 (Pension Recycling), as attendees of the Committee the Chair advised they could remain in the meeting when the item was discussed.

(The Chair advised that the 'Policies for Approval' item would be taken first to allow those presenting to leave the meeting).

23/004 POLICIES FOR APPROVAL

The Committee was in receipt of the following policies for approval;

- a) Dealing with concerns around conduct
- b) Domestic Abuse Policy
- c) Agile Worker Policy
- d) Social Media Policy

The Committee was informed that, prior to their presentation today, the policies had been agreed by the Joint Staff Partnership, with the Domestic Abuse Policy also have been through the Organisational Development Group.

Having queried whether the policies were in alignment with other ICBs, it was explained that the Conduct Policy had been a merger of previous CCG policies as a result of work associated to a directive from NHS England that had looked at conduct policies and which

had included a review of examples from other NHS organisations. The Domestic Abuse Policy had been written in consultation with a local charity that had also advised other organisations within the system on similar policies.

The Committee approved the policies as presented **and thanked** those that had been involved in their development.

(Nick Oldfield left the meeting)

23/005 SAFE DELEGATION OF PHARMACY, OPTOMETRY AND DENTAL

In May 2022, NHS England set out its intention to delegate responsibility to all ICBs for all pharmaceutical services, general ophthalmic services and dental services (primary, secondary and community) (known collectively as 'POD services') in April 2023.

Hertfordshire & West Essex ICB (HWE) would be hosting Pharmacy and Optom (P&O) for the East of England. That meant they would host the team that managed P&O market entry and contract management (including complaints and communications) and P&O finances on behalf of all six East of England ICBs.

Suffolk and North-East Essex ICB would lead (in house) management of Suffolk and North East Essex dental contracts (and wider functions), dental transformation, pharmacy transformation and optom transformation.

Currently within SNEE there were:

- 174 Pharmacy contractors
- 160 Optometry services
- 144 primary dental providers

The report went on to provide more detail in each area together with outlining progress to date, governance and management structures, information regarding the national customer contact centre, transfer of the workforce and concerns to note.

The Committee was informed that the delegation agreement had not yet been received from NHS England for signature and that a letter of comfort was expected in the near future.

Comments included;

Having noted the areas of concern set out within Section 5 of the report it was suggested that it might be beneficial to receive a further report once there was more clarity with regard to finance, workforce and risk. The role of the Remuneration and HR Committee was questioned.

The ICB Director of Finance reported that there was a potential significant financial risk which would be reported and monitored via the ICB's Finance Committee going forward.

Having noted concerns with regard to quality as set out within the report, it was queried where monitoring would take place. In response, the Committee was informed that quality oversight would be carried out via the three Alliances and the Quality Committee. The issue was already highlighted within the Board Assurance Framework.

The Alliances would have delegated responsibility to facilitate specific population issues, with further delegation to the Primary Care Commissioning Group (PCCG) which was held in common for discussion of system level issues. The PCCG would also have linkage with Herts and West Essex Pharmacy and Optom Team and the Pharmacy Services Regulation Committee. The ICB had written to all service providers as a way of introduction and it was felt that the change of responsibility should provide opportunity to integrate services with other primary care services going forward.

Due to the forthcoming period of challenging finances, the need for appropriate communication was highlighted.

The ICB Board was to receive a report to its meeting on 21 March 2023 prior to delegation from April 2023.

The Chair welcomed the assurance with regard to governance and review of quality and financial risk.

The Remuneration and HR Committee noted the report and requested that it receive a further update to its next meeting.

(Lizzie Mapplebeck left the meeting)

23/006 GENDER PAY GAP REPORT

Organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The requirements of the mandate within the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, are to publish information relating to pay for six specific measures:

1. Mean gender pay gap – ordinary pay
2. Median gender pay gap – ordinary pay
3. Mean gender pay gap – bonus pay in the 12 months ending 31st March 2022
4. Median gender pay gap – bonus pay in the 12 months ending 31st March 2022
5. The proportion of male and female employees paid a bonus in the 12 months ending 31st March 2022
6. The proportion of male and female employees in each pay quartile.

The report was based on the Government's methodology for calculating difference in pay between female and male employees, considering full pay relevant employees of **NHS West Suffolk Clinical Commissioning Group only**.

The data published was based on a 'snapshot' of average hourly pay data taken as at 31 March 2022 and bonus data based on the period 1 April 2021 to 31 March 2022.

We are mandated to publish a 'written statement'. The statement needed to be signed and confirm that the published information was accurate.

Our gender pay gap report and written statement must be published in a prominent place on our public-facing website.

A combined account including NHS North-East Essex Clinical Commissioning setting out the gender pay gap was also provided within the report (although not for publication on our website) as at 31 March 2022 – that was prior to the formation of the ICB in July 2022.

Key points included:

Although the female workforce was significantly higher than the male workforce there was an issue associated to the redistribution of pay as a lot of female workers were in the lower pay quartile. The situation needed to be addressed hence the intention to establish a Women's Network Group and carry out more work with regard to promotion and careers.

The report being published reflected the position in March 2022 with regard to Suffolk CCGs as, at that time, North-East Essex CCG was not subject to publication due to its size. That

situation would change going forward.

It was noted that, whilst there had been improvement, a gender pay gap issue remained and there was desire to remove the gap entirely. It was suggested that benchmarking information be included in future reports, together with consideration of pursuing reverse mentoring opportunities. It was suggested the whole system be considered when attempting to facilitate reverse mentoring.

Having sought clarification of 'other' on page 7 of the report, it was explained that had been used to indicate those not on the Agenda for Change pay scales. Generally equal pay was seen with the Agenda for Change pay scales. Having queried whether there were many grievances received in respect of equal pay, it was reported that approximately 50 pay re-evaluation requests had been received over the last 12 months mainly from female employees.

Having noted the recommendations it was suggested that consideration also be given to dovetailing the work with the Equality, Diversity and Inclusion Group.

The Committee noted the content of the report and steps planned/ongoing to reduce the pay gap, those being;

- To remind managers of the governance requirements that help minimise gender pay gaps and test those out, for example, through internal audit.
- To continue to promote awareness of unconscious bias in selection processes, supported through training.
- To establish a womans network group as an opportunity to support talented female staff in their career progression
- To also consider mentoring and coaching to support and develop our plans around succession planning and talent management, particularly as part of our new appraisal and review processes.
- As part of our planned womans network to develop an effective communications strategy that highlighted female role models at all levels of the organisation and celebrated success
- To work with universities, through apprenticeships and through our recruitment marketing, to challenge traditional gender role stereotypes.
- To expand our pay gap reporting to include ethnicity (as part of our Anti-racism charter pledge made in partnership with UNISON)

23/007 PENSION RECYCLING

The report sought approval from the Committee to the launch of Pension recycling. The report set out principles for pension recycling as an optional alternative reward for those employees who could demonstrate that they were impacted by the pension tax thresholds and had decided to opt out of the NHS pension scheme.

The report went on to provide background information and set out the process and principles of the scheme, together with outlining national pension reforms and risks.

Next steps included:

That the scheme would become effective from 1 June 2023 and run until 31 December

2023 or until a national scheme had been introduced.

To work with key stakeholders, including staff side representatives and the ICB payroll team, to finalise the Pension Recycling policy for discussion and agreement in principle.

A copy of the paper would be submitted to Joint Staff Partnership and presented at the Executive Committee alongside an associated formal policy.

The scheme was scheduled to launch on 1 June 2023 to maximise the benefits of the new scheme and to ensure that we had complete buy-in and understanding of the scheme. We would be required to roll out a comprehensive communication plan and offer Q&A sessions with the ICBs Pension Team.

Comments included;

The purpose of pension recycling was to ensure that senior paid staff did not miss out on total reward packing as they had exceeded the annual lifetime allowance for pension. The aim was to seek to retain senior staff and pension reform was currently going through consultation which looked to realign the pension service to support retention and support fewer people from exceeding annual allowance for pensions.

Having questioned whether it was necessary, the best timing for doing it and whether any decision not to do it might result in disadvantage to the organisation, it was explained that NHS organisations had been asked to review pension recycling in October 2022 to ensure the retention of senior staff. There was however recognition that pension reforms were on the way and it might not be the best time to consider the issue in light of current industrial action and forthcoming financial pressures.

There was concern that the timing did not feel quite right and also with regard to the impact on the retention of talent should it not be pursued at present.

The Director of People and Workforce reported that conversations with regard to pension recycling were taking place elsewhere and other organisations being in a similar position. A meeting of HR Directors was scheduled to take place later in the week at which the subject was likely to be discussed. In terms of the ICB it potentially impacted 9/10 individuals and had been designed to retain senior clinical staff within NHS Trusts.

Having noted the report and whilst being sympathetic to the advantages of pension recycling, in the current circumstances, it was not felt to be the correct time to pursue it and **the Committee requested** that it receive a further update in approximately two months' time once the Director of People and Workforce had been able to discuss the issue with colleagues and there was more information with regard to the financial position.

Should the ICB find itself at a competitive disadvantage from deferring any decision with regard to the pursuance of pension recycling there was opportunity to revisit.

(Ben Askew left the meeting)

23/008 ANY OTHER BUSINESS AND REFLECTION

Running Cost Reduction

The Director of People and Workforce reported that the Chief Executive had recently written to staff attaching a letter from NHSE informing of the need for running cost reduction going forward. A staff briefing had been scheduled to take place today which was likely to be the first of many briefings going forward. The briefing was an opportunity to share information with staff and provide opportunity for staff to raise questions.

The Committee was given oversight and reassurance relating to the key messages of the

staff engagement and communication plans.

The Committee members offered their support as required to the Executive team and recognised the leadership commitment that would be required over the coming months.

The Committee noted the update.

23/009 DATES OF FUTURE MEETINGS

The Committee requested that more frequent meetings be set up which could be removed from diaries should they not be required.

**Minutes of a meeting of the ICB Quality Committee held on
12 January 2023**

PRESENT:

Steve Feast	ICB Board Non-Executive, Quality and Safety (Chair)
Jackie Bland	North East Essex Alliance Representative
Sue Cook	Suffolk County Council (SCC) Representative
Richard Cracknell	Suffolk County Council, Asst Director of Public Health and Communities
Samantha Glover	Healthwatch, Essex
Diane Hull	Norfolk and Suffolk NHS Foundation Trust (NSFT) Representative
Dr Andrew Kelso	ICB Medical Director
Paul Molyneux	West Suffolk NHS Foundation Trust (WSFT) Representative
Lisa Nobes	ICB Director of Nursing
Rebecca Pulford	Essex Partnership University NHS Foundation Trust (EPUT)
Daniel Showell	Essex County Council, Public Health Representative
Giles Thorpe	East Suffolk and North Essex NHS Foundation Trust (ESNEFT) (Part)
Damon Wheddon	East of England Ambulance Service NHS Trust (EEAST)
Andy Yacoub	Healthwatch, Suffolk

IN ATTENDANCE:

Victoria Baster	ICB Associate Director of Nursing, Urgent and Elective Care
Olubusola Daramola	ICB Head of Medicines Optimisation, North-East Essex
Karen Egan	ICB Infection, Prevention and Control Lead
Lucy Game	ICB Continuing Healthcare Manager
Amanda Lyes	ICB Director of People and Workforce
Jo Mael	Corporate Governance Manager (Minutes)
Sophie Martin	ICB Patient and Public Involvement and Experience Team
Michael Wigg	ICB Clinical Quality Lead
Tracey Sharpe	ICB Infection Prevention and Control Nurse Advisor
Stephen Woods	Patient Safety Manager

23/001 INTRODUCTION, APOLOGIES AND QUORACY

The Chair welcomed everyone to the meeting and apologies for absence were noted from;

Sarra Bargent	Ipswich and East Suffolk Alliance Representative
Nicole Day	
Simon Froud	Essex County Council (ECC) Representative
Natalie Hammond	Essex Partnership University NHS Foundation Trust (EPUT)
Rebecca Thompson	Practice Plus Group Representative

The meeting was noted as quorate.

23/002 DECLARATIONS OF INTEREST

No declarations of interest were received and those that had not yet submitted declarations were encouraged to do so.

23/003 MINUTES OF THE PREVIOUS MEETING

The minutes of meetings of the ICB Quality Committee meeting held on 15 September and 10 November 2022 **were approved** as correct records.

23/004 MATTERS ARISING AND REVIEW OF ACTION LOG.

There were no matters arising and the action log was reviewed and updated.

23/005 REVISED TERMS OF REFERENCE

The Committee was in receipt of its terms of reference which, it was reported, had been revised in relation to membership and quoracy requirements.

The Chair advised that appointment to the role of Vice Chair remained outstanding and members of the Committee, if interested, were invited to contact him outside of the meeting.

The Committee agreed its terms of reference as presented **and recommended** that they be presented to the ICB Board for approval in March 2023.

The Chair advised that Agenda item 06 (STOMP) would be taken later.

23/006 SNEE NHS CONTINUING HEALTHCARE (CHC) TEAM UPDATE

The Committee was informed that the report presented a snapshot of SNEE NHS CHC performance, and went on to set out current pressures and risks for information.

Key issues included;

- Band 6 Nurse Coordinator vacancy rates threatened performance of the NHSE mandated metric for assessments of eligibility within 28 days. Although recruitment had recently improved.
- Extension of Broadcare (patient information system already in place in Suffolk) into NEE had provided improved clinical and management oversight to service delivery in NEE (the previous patient information system was not fit for purpose). That, along with senior managers having areas of responsibility pan SNEE, had identified areas for improvement.
- Priority for improvement was given to the NEE Case Management and Commissioning function. As the function responsible for case management of the most complex NHS CHC funded individuals, and for supporting system flow by commissioning care packages and placements for Fast Track, NHS CHC and D2A funded individuals it was important to provide additional staff resource to bolster the NEE element of the team. In addition, the Case Management and Commissioning function now sat under a single senior manager with responsibility across SNEE to ensure equity and consistency of service delivery, as well as providing more resilience across the team.
- A workplan was in place for further alignment and improvements which would be implemented during 2023.

Comments included;

Having been informed that there was to be a 'deep dive' to investigate the reason for seemingly low referral numbers within North-East Essex, it was queried whether the area was more deprived relative to the rest of SNEE, and it might be beneficial to compare

numbers with a similar area such as Waveney. The reason for the lower referral rate was concerning and there was a need to monitor the situation closely especially as there had been previous work carried out to encourage fast track referrals which although had increased numbers remained less than Suffolk.

The Committee was informed that monthly meetings were held with regional colleagues who were supportive of how the CHC service was operating.

It was suggested that it might be of benefit to identify what proportion of the caseload were adults versus elderly and also to explore differences in adult services across the locations.

With regard to appeals and reviews, it was explained that referrals necessitated a decision within 28 days unless they were fast track when a decision was made the same day. A review was carried out within three months. If a full assessment was carried out and the individual found to be not eligible they could appeal. If they did not appeal but their needs changed it was dependent on how recent their previous assessment was as to whether a new referral was instigated.

It was queried how additional funding from government to support discharge might be utilised. It was explained that with regard to the issue of 'lost in care' the pathway was tight, and people were acting in the interest of need. The new funding was restricted to the use of beds until the end of March 2023 and it was not so much beds as workforce and complexity of care that were the key issues.

The Committee noted the update and thanked the Continuing Healthcare Team for their hard work.

23/007 COLLECTIVE ASSURANCE FRAMEWORK DEVELOPMENT

The ICB Medical Director reminded the Committee that development of the Collective Assurance Framework had formed part of the last Board Development Session and continued to be a work in progress to attempt to describe a trajectory of accountability and how the Committee's aims might be achieved.

To date, phases had been identified together with self-assessment against maturity and it was intended that further information would be circulated prior to the next Committee meeting and the item be put on the agenda for discussion.

There was a need to agree internal ICS governance with regard to how the Alliances worked and their governance fitted in with quality, together with how the System Quality Group might operate more effectively and provide meaningful reports to the Quality Committee.

The Committee noted the update.

23/008 INFECTION PREVENTION AND CONTROL INCLUDING INFECTION PREVENTION SYSTEM COLLABORATIVE (IPSC) TERMS OF REFERENCE AND WORKPLAN.

The Committee was in receipt of the December 2022 Infection, Prevention and Control (IPC) report together with Infection Prevention System Collaborative terms of reference and workplan.

The Committee received a presentation which provided information on infection, prevention and control activity and headlines.

Key points included;

C.difficile rates had increased by 25% which was the highest rate in seven years. Reduction strategies were being investigated. There was a national drive to reduce rates.

Recent issues discussed by the Infection Prevention System Collaborative included ventilation, winter pressures, and training. Attendance was good and the Collaborative was evolving.

80 infection, prevention and control audits had been carried out in primary care and improvements were being seen. There were no outliers and issues were the same across practices. Infection, prevention and control champions were being encouraged in all practices together with ways in which SystemOne might be able to assist in respect of data.

As yet there was no comparative primary care data within the East of England.

Over the next three months work would continue to support acutes and carry out visits to assist with outbreaks. National flu rates had been challenging and it was felt that pro-active work in preparation for next winter should commence soon.

A seven week IPC training programme was now available.

Having queried how well the team was linked in with the plans of Public Health, the importance of pursuing such links was emphasized.

There was concern at the situation within care homes and the availability of funding to carry out IPC work in that environment. Previously Covid-19 funding had been utilised which had not been recurrent and there was now no additional funding available to the care home sector. **It was agreed** that an update be provided to the next meeting in an attempt to provide assurance.

The training programme was welcomed and it was felt that a modified version could be utilised more widely. Having queried whether work took place with the ambulance and patient transport service, the Committee was informed that whilst work did take place with EEAST it was more aligned to contract monitoring and review of policies with regard to patient transport. There was a desire to provide future training for voluntary organisations.

The relationship between infection and bed moves within acute settings was questioned and whether there had been any investigative work carried out. It was reported that whilst bed moves were relevant there was also a need to consider respiratory needs and other aspects.

The Committee noted the report **and agreed** that the IPSC terms of reference be further reviewed and amended in respect of the IPSC being a sub-committee of the Quality Committee and not the ICB Board as written, prior to their return for final approval.

23/009 STOMP

The Committee was informed that work was taking place across Essex to identify patients with learning disability and autism that were on anti-psychotics.

North-East Essex was currently an outlier in terms of numbers and a forum had been established which would look to put together an Advanced Clinical Pharmacist led service supported by a multi-disciplinary team with the aim to visit Primary Care Networks and practices to review patients.

The plan was to initially review patients at the top prescribing practices with Pharmacists carrying out face to face reviews with patients and carers.

The forum included representatives from secondary learning disability providers who had expertise in quality care planning for people with behaviour that was difficult to manage. Social Care colleagues were also invited to be part of the forum.

Having noted that the work was likely to be interesting, the importance of sharing

information with the Alliances was emphasized.

The Committee noted the update.

23/010 QUALITY DASHBOARD

The Committee was informed that a task and finish group had been established to develop the quality dashboard. There had been good levels of attendance at the group across partners which had facilitated beneficial discussion.

The Group had recognised the need to include marginalised communities within the dashboard and information from other ICBs had also been explored by Attain to identify potential improvements.

The Group was due to meet again at the end of month and Attain would be providing an updated dashboard to that meeting.

The Committee welcomed the conversations taking place in respect of the social economic situation, and experience and outcomes of patients and recognised that the dashboard was developing.

The Committee was reassured of the aim not to ask for data that was not already being collected and the attempt to seek consistency across ICSs. It was felt that Attain were doing a good job and there was excitement as to what the dashboard might achieve.

Being aware of the work taking place for development of the Joint Forward Plan in respect of people reported experience measures the need to seek alignment was highlighted.

The Committee noted the dashboard as presented **and looked forward** to its future development.

23/011 SYSTEM QUALITY GROUP (SQG) HIGHLIGHT REPORT

The Committee received an update on the work of the System Quality Group (SQG). Key issues for the Group were detailed in Section 2 of the report.

Comments included;

How the work of the System Quality Group might be used to set the agenda for Quality Committee.

The Committee was informed that the remit for the System Quality Group was a surveillance meeting where all partners came together to look at surveillance. The Group discussed the challenges being experienced and it was envisaged that some of its work would drive implementation of the Quality Improvement Strategy.

At present, Members of the group had not reached the stage where they were comfortable raising issues about other organisations.

The Care Quality Committee was active and had visited ESNEFT, EPUT and the care home and primary care sectors. Updates were provided to Alliance Quality Committees.

Going forward the Group would start to seek to escalate key issues to the Quality Committee.

The Group had held discussions around workforce, and it was recognised that bigger conversations were required around emotional resilience, compassion fatigue and their effect on quality and safety. It was felt there could be greater alignment to the ICB People Committee – might consider top issues what need to escalate for wider conversation to the

PC. Giles Turner now attends the SQG and takes points of escalation back. Standard item on PC for escalation items from SQC.

The Committee noted the report.

23/012 ICB QUALITY RISK REGISTER

The ICB Quality Risk Register was presented for the Committee to note risks contained within the ICB's Board Assurance Framework (BAF) and to approve those on the Quality risk register.

The Committee was informed that;

- All risks had been reviewed and updated in December 2022.
- *Risk CNO-039 - GNP Cytology Takers Training* - six nurses had been identified as not having completed the correct interim assessment documentation. The risk had been fully mitigated and the Risk Lead recommended closure.
- *Risk CNO-040* - the ICB currently funded the Nippy Cough Assistor and ongoing consumables and servicing/repair of the device. However no formal contract was in place to enable a loan device whilst the machine was in for repair. Waiting time could be 6-8 weeks for clients that did not have a contract, to the detriment of the patient. The risk had been fully mitigated and the Risk Lead recommended closure.

Comments included;

The Chair advised that there should be wider discussion with regard to how dynamic the risks were and how they reflected the different way of working. As the Committee's role was to review system wide risks thought would be required as to where more local risks should be reported.

The risk associated to Looked After Children (LAC) health assessments was highlighted as a long standing risk and the importance of resolving it highlighted. **It was agreed** that an update on Looked After Children would be presented to the next meeting. A new LAC nurse was in post and there had been improvements in data. Dementia was also a concern, and it was noted that an associated business case was being developed. Concern with regard to dementia was recognised as discharge to assess pathways saw people being retained within the acute sector due to behaviour change whilst in hospital that had resulted in them being unable to return to their care home.

Having queried whether LAC could be looked at in a holistic way to take account of education, dental and wellbeing as well as health care, it was explained that the local authority already had a virtual school team in place that looked at the attainment of LAC which included data associated to education, dental checks and other indicators. There was also a corporate parenting group that reviewed the data.

The Quality Committee noted the BAF for Quality Risks **and approved** the ICB Quality Risk Register as presented.

23/013 SUFFOLK AND NORTH-EAST ESSEX PATIENT AND PUBLIC INVOLVEMENT AND EXPERIENCE TEAM REPORT

The Committee was in receipt of the current SNEE Patient and Public Involvement and Experience ICB Team quarterly report.

Key points highlighted included;

The People and Communities Committee continued and would welcome opportunity to hold a joint meeting with the Quality Committee to look at people experience. All partner organisations were represented on the People and Communities Committee which currently reported into the Alliance Quality Groups.

A new assessment framework was due to be launched in the near future with an interim assessment planned for the first year and then a more formal assessment from 2024/25 onwards. In light of new guidance assurance with regard to people and community activity was being sought which could be presented to the Committee if felt appropriate. The work would be peer led and rely on peer assessments.

The ICB was due to receive delegated responsibility for primary care, pharmacies, dental and optometry from 1 April 202 which would include all complaint functions.

The Chair advised that joint meetings would be welcomed although they should identify a theme and think about how to best use experience to make change.

The Committee noted the report.

(Andy Yacoub left the meeting)

23/014 ALLIANCE UPDATES

The Committee received updates from the following Alliances:

- Ipswich and East Suffolk Alliance
- North-East Essex Alliance
- West Suffolk Alliance

Key reported issues within each report were medicines management, community services and primary care.

Work had commenced in North East Essex Alliance to align dashboards with emerging risks in Integrated Neighbourhood Teams.

Whilst acute provider reports were received monthly the Alliances were currently not in position to do that. There were similar themes across the Alliances and it was hoped that discussion across the Alliances could identify key issues for report to the Quality Committee in future.

The Committee was informed that Ipswich and East Alliance was currently reviewing its terms of reference.

The Committee noted the updates.

23/015 PARTNERSHIP UPDATES

The Committee received updates from the following partners:

- a) Suffolk County Council.
- b) Suffolk Public Health.
- c) West Suffolk NHS Foundation Trust (WSFT)
- d) East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
- e) Essex Partnership University NHS Foundation Trust (EPUT)

Comments included;

It was suggested that thought be given to whether it might be beneficial for the System

Quality Group to review the partnership updates in detail going forward.

There was concern as to whether representation on the Committee required review in light of its length and content, particularly in light of current operational pressures. The Chair explained that the intention was that a core group sit through the meeting with others able to join at appropriate times. The need for continuity of membership was emphasized and **it was agreed** that further discussion by the Chair and ICB's Medical Director and Director of Nursing would take place outside of the meeting.

It was felt that any review of membership should wait until the collective assurance framework was received. The Quality Committee was an assurance committee which needed people amongst its membership that could scrutinise. There was however recognition of the need to ensure that agendas were focussed and not lengthy.

The Committee was reminded that it was not an ICB Committee but a system Committee which was owned equally across the system with its members working collectively to improve quality across the system.

(Giles Thorpe joined the meeting)

The Committee noted the partnership updates received.

23/016 ITEMS FOR ESCALATION

Having sought items for escalation to the ICB from today's meeting, it was suggested that the quality impact of operational delivery, changes to mortality figures, and self-preservation in secondary care, together with quality outcome changes in 111 and EEAST should be escalated to the ICB Board. At present the system was not delivering the desired standard of care.

There was recognition of the pressures and it was clear that something different needed to happen.

Within mental health there were a lot of people waiting for beds, recruitment and retention issues and concern with regard to the moral injury to staff.

The EEAST representative reported that the ambulance service was not currently able to meet the needs of patients that were critically unwell and was unable to deliver appropriate care.

It was questioned what the ICB could do and the need to work more cohesively as to how the situation could be managed was highlighted. ICB plans for the increased funding to facilitate improved patient flow were queried. Where was the money going to be spent? It was explained that the work in respect of the funding had been carried out within the Alliances.

The Chair agreed to further discuss escalation to the ICB Board with the ICB's Medical Director and Director of Nursing with a view to raising concern with regard to resilience, and the fatigue and stress on staff of current working conditions. It would also be questioned as to whether there were timescales for delivery of Alliance plans and how outcomes would be monitored.

23/017 ANY OTHER BUSINESS

The Committee was informed that the Care Quality Commission's draft report in respect of Norfolk and Suffolk NHS Foundation Trust should be available in the near future prior to publication in March 2023.

23/018 DATE OF NEXT MEETING

09 March 2023 – 1400-1700

**Unconfirmed Minutes of a meeting of the ICB Quality Committee held on
9 March 2023**

PRESENT:

Lisa Nobes	ICB Director of Nursing (Chair)
Sarra Bargent	Ipswich and East Suffolk Alliance Representative
Nettie Burns	Suffolk County Council, Public Health
Sue Cook	Suffolk County Council (SCC) Representative
Simon Froud	Essex County Council (ECC) Representative (Part)
Diane Hull	Norfolk and Suffolk NHS Foundation Trust (NSFT) Representative
Dr Andrew Kelso	ICB Medical Director
Phanuel Mutumburi	Acting ICB Board Non-Executive Member (Part)
Rebecca Pulford	Essex Partnership University NHS Foundation Trust (EPUT)
Damon Wheddon	East of England Ambulance Service NHS Trust (EEAST)

IN ATTENDANCE:

Joe Allen	ICB Head of Patient Safety
Ganesh Baliah	ICS Strategic AHP Workforce Lead, Suffolk and North East Essex ICS
Victoria Baster	ICB Associate Director of Nursing, Urgent and Elective Care
Cindie Dunkling	ICB Designated Nurse for Safeguarding Children
Georgina Edwards	ICB Designated Nurse for Children in Care
Catherine Ritson	ICB Continuing Healthcare Lead
Jo Mael	Corporate Governance Manager (Minutes)
Michaela Sen	St Helena Hospice
Stephen Woods	Patient Safety Manager

23/019 INTRODUCTION, APOLOGIES AND QUORACY

In the absence of the Chair, it was agreed that Lisa Nobes would take the Chair for today's meeting.

Phanuel Mutumburi, Acting Non-Executive Member to the ICB Board was welcomed to the meeting and introductions were made. Apologies for absence were noted from;

Jackie Bland	North-East Essex Alliance Representative
Richard Cracknell	Suffolk County Council, Asst Director of Public Health & Communities
Steve Feast	ICB Board Non-Executive, Quality and Safety
Samantha Glover	Healthwatch, Essex
Paul Molyneux	West Suffolk NHS Foundation Trust (WSFT) Representative
Daniel Showell	Essex County Council, Public Health Representative
Natalie Hammond	Essex Partnership University NHS Foundation Trust (EPUT)
Rebecca Thompson	Practice Plus Group Representative
Giles Thorpe	East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
Andy Yacoub	Healthwatch, Suffolk

The meeting was noted as quorate.

23/020 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/021 ANY SERIOUS SAFETY CONCERNS NOT ON THE AGENDA?

No items were notified. The Chair advised that, earlier in the day, the System Quality Group had been advised of the current pressure on urgent and emergency care pathways together with the impact of industrial action on providers.

23/022 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Quality Committee held on 12 January 2023 **were approved** as a correct record.

What is the data telling us?

23/023 QUALITY DASHBOARD

The Quality Committee was in receipt of a report regarding the quality dashboard. The Committee had established a working group to populate the dashboard and finalise the template. It was important to be able to provide assurance to the ICB of early warning signs. Whilst the importance of data was recognised there was also a need to take account of patient feedback and soft intelligence. Healthwatch received a lot of information and provided guidance via in-depth stories across a range of subjects.

The task and finish group was due to hold its final meeting tomorrow after which it was anticipated the final dashboard would be available. A letter had been sent to providers seeking the provision of data in a timely fashion going forward. It should be noted that the dashboard was a working model and likely to change over time.

Key points highlighted included;

Having queried whether members were happy with decision that had been made in the dashboard workshops, the Committee was informed that some people had been unable to access the link within the report. It was important that the dashboard had balance between being useful and inclusive.

The Patient Safety Manager agreed to ask Business Intelligence how the dashboard might be accessed more widely and report back.

The Committee noted the report **and welcomed** seeing the revised version at a later date.

23/024 SNEE QUALITY GROUP

No report for the March 2023 meeting.

23/025 QUALITY RISK REGISTER

The ICB Quality Risk Register was presented for the Committee to note risks contained within the ICB's Board Assurance Framework (BAF) and to approve those on the Quality risk register.

The Committee was informed that all risks had been reviewed and updated and approval was being sought to close the following risks on the Quality Risk Register;

- *CNO-028 - Home Care and Care Home providers in Suffolk were reporting significant workforce pressures causing them to close to new admissions, to close home care lists to new customers/patients, and in some cases to hand back cases.*
The situation with Care Availability had improved over recent months and it was deemed that the risk had been fully mitigated and the Risk Lead recommended closure.
- *CNO-031 - The Chimney's Elysium Hospital in Rougham Suffolk was not sustainable*

and did not have the confidence of its host commissioner.

Following a period of enhanced surveillance, the ICB felt assured that there had been an improvement plan and delivery of quality improvement. The risk had been fully mitigated and the Risk Lead recommended closure.

- *CNO-042 - Clinical Priorities Team Staffing Levels.*

Recruitment had now taken place and the Risk Lead recommended closure.

The Committee;

- 1) **Approved** the ICB High Risks Quality Risk Register that were not on the BAF
- 2) **Approved** the closure of those risks set out above as included within the report.
- 3) **Noted** the Board Assurance Framework (BAF)

National Child Mortality Database (NCMD) Sudden, unexpected deaths in Infancy and Childhood Thematic Report – Recommendations

The report looked at all children that had died suddenly and unexpectedly between April 2019 and March 2021. National figures for unexpected deaths had not previously been reported anywhere, for any country. The figures published previously had been only for the final identified “cause” of death not for the presentation as unexpected.

Key issues were set out in Section 1 of the report and recommendations in Section 2.

There had been 49 incidences within Suffolk of children having died suddenly and unexpectedly during the time referred to in the report, with the majority being in the under one age group. In 75% of cases the child had died in sleep with causes including being face down or on side; hazardous co sleeping; inappropriate sleeping surfaces and inappropriate items in the bed.

Of the 1-17 age group key factors were deprived neighbourhoods and link to a previous history of convulsions.

The Committee was asked to take note of the recommendations set out in the report and how it was intended they be addressed. Of the 10 recommendations listed, two were national and sat with Government departments, and for the remaining eight there were proposed actions to address which had also been discussed at a meeting earlier in the day.

The Committee noted the report.

23/026 ALLIANCE UPDATES

The Committee was informed that historically the three CCGs had had different approaches primary care quality assurance and work was being carried out to facilitate a more consistent approach going forward and also to move into a pro-active rather than reactive space.

Working groups had been established to seek to design a Primary Care Assurance Framework. Good progress had been made and it was up and running and underpinned by a large database that had soft intelligence built in. The Framework was almost complete with the next step being to share it with the Local Medical Committee for comment prior to bringing it to the Committee.

The Chair advised that as the delegated assurance function for primary care sat within the Alliances, the Quality Committee’s role was to be assured that the Alliances had oversight and were responding to quality risks.

It was hoped that similar work could be carried out regarding community and medicines

management services in future.

The Committee noted the updates **and welcomed** a further update in May 2023.

23/027 PARTNERSHIP UPDATES

The Committee received updates from the following partners:

- f) West Suffolk NHS Foundation Trust (WSFT)
- g) East Suffolk and North Essex NHS Foundation Trust (ESNEFT)
- h) Essex Partnership University NHS Foundation Trust (EPUT)
- i) East of England Ambulance Services NHS Trust (EEAST) – challenges continued with regard to hospital delays which although had improved in November and December 2022 and resulted in the loss of 164 shifts in January 2023 at a cost of £192k to the Trust. Jan/Feb 2023 performance was consistent across the three acute Trusts and it was likely that forthcoming industrial action by doctors and ambulance staff would have an impact.

Comments included;

Concern was raised that the West Suffolk NHS Foundation Trust (WSFT) report referenced workforce shortages for Speech and Language Therapists (SaLTs) and that students were currently unable to find placements. The Committee was informed that work was underway to address the situation with ESNEFT having created a few placement opportunities and primary care exploring ways it might be able to assist. There might be a need to stagger placement dates.

There was discussion as to how the County Council's might be able to assist as they did not have facility to directly place SaLT students and the **ICS Strategic AHP Workforce Lead, Suffolk and North East Essex ICS agreed** to discuss the matter further with the Suffolk County Council representative outside of the meeting.

The Committee noted the partnership updates received.

How we work together.

23/028 CONTINUING HEALTHCARE (CHC) ONE TO ONE POLICY

The purpose of the document was to advise and provide guidance on the assessment, implementation and use of additional and one-to-one monitoring for individuals whose care was commissioned via NHS Continuing Healthcare within care home settings. The policy aimed for all additional monitoring arrangements to be ethical, equitable, necessary and proportionate, person centred, safe and reasonable.

The policy was intended for use by SNEE ICB CHC teams and care home staff and supported the existing ICB Equity and Choice Policy which was available to patients and their representatives.

Key issues were outlined in Section 2 of the report and engagement within Section 3.

Comments included;

The importance of working together with County Councils was emphasized as the One to One assessment of need would probably include a Deprivation of Liberty assessment and there was need to check that was in place as Councils had that duty of care. There was a need to ensure connections were in place and policy suggestions linked in. The Committee was informed that there was already linkage in place of staff across health and local authorities.

The Committee was reminded that when previously presented the Committee had requested there be further involvement of care homes which was now happening. ICB staff had attended the Suffolk Care Home Forum and had also created a leaflet which summarised key points of the policy. The Committee was informed that from conversations had with care homes the work had been received well and it was felt the policy was clear and consistent.

The Quality Committee recommended the policy for final approval by the Audit Committee.

How are we progressing on priorities?

23/029 CARE QUALITY COMMISSION (CQC) REPORT – ESNEFT ACTION PLAN

The Committee was in receipt of a report presented to the ESNEFT Board on 2 March 2023. The Chair explained that ESNEFT representatives were not in attendance at today's meeting to present the report as the Trust was currently subject to a maternity inspection.

The Care Quality Commission (CQC) conducted an unannounced statutory inspection of services at Colchester General Hospital on 3 November 2022, focused on medical care and older people's services; and published the formal report of that inspection on 2 February 2023. The ratings awarded at that inspection for the service were:

Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

As was usual following a CQC inspection, an action plan in response to the matters identified for improvement in the inspection had been prepared and was attached to the report presented to ESNEFT's Board on 2 March 2023. The action plan was to be submitted to the CQC and progress would be regularly reviewed through the Trust's Quality and Patient Safety Committee, supported by the Patient Safety Group and Clinical Reference Group. That would be in association with the wider action plan from the previous full inspection report for the Trust, which was published in 2020.

The Committee noted the report **and requested** that it receive further update to a future meeting.

23/030 SAFEGUARDING

The Committee was in receipt of the Safeguarding Quality Overview and Statutory Initial Health Assessments for Children in Care report with comments in respect of each as follows:

a) Safeguarding Quarterly Overview

Key issues were addressing recommendations from the national child mortality database and strategy with regard to health assessments for Looked After Children (LAC). Key issues for SNEE were escalation of the issue whereby EEAST staff, when in homes, were not able to access the child protection system which had potential to cause delay, and access to clinical photography at WSFT which underpinned safeguarding medical assessments. Mitigations for both issues were being pursued. It was noted that although EEAST staff when in homes did not have access to the information, the EEAST control room was able to access it.

Having questioned whether it was possible to identify if there had been missed opportunity from EEAST staff not being able to access information when in homes, and also to obtain a

timeframe for access to information, the **ICB's Designated Nurse for Children in Care agreed** to investigate.

At the time of writing there had been identification of safeguarding concerns in ESNEFT maternity as there was no compliance with regard to safeguarding supervision. Mitigation included a current external review of safeguarding in maternity and midwives were reviewing complex safeguarding cases. It was noted that the concerns were with regard to Colchester hospital and not Ipswich and Colchester was about to commence a review of safeguarding arrangements.

The risk register reflected the use of unregulated placements for Looked After Children (LAC) as being an issue. There were currently a small number of children in unregulated accommodation and they were subject to a high level of scrutiny and good system working in order to reduce any risk. Safeguarding in respect of liberty protection was on the risk register and guidance from Government was awaited with regard to implementation.

The Committee noted the update.

b) Statutory Initial Health Assessments for Children in Care (SNEE)

The report gave the current position on compliance with Statutory Initial Health Assessments (IHA's) for Looked After Children placed within SNEE and for SNEE Children placed in other Local Authorities. It highlighted challenges to achieving the timeframes within the Suffolk and Essex system and outlined current actions in place and further initiatives to improve timescales for children receiving their IHA.

Risks associated to delayed health assessments included not being aware of health needs and potential harm. SNEE offered health assessments to all children placed in its area regardless of where the child had originated from. Despite a range of improvement measures compliance remained inconsistent and was variable across SNEE.

Deep dives had been carried out into local clinics and pathways. Actions to improve service delivery were outlined in the report and included the establishment of regular health assessment and monitoring groups, the development of health assessment media clips to support children to understand the benefit, and pursuance of a data collection pilot as part of the ongoing audit.

It was felt the issue should remain on the risk register as despite best efforts improvement had not been achieved to date. There was support for the use of a digital solution to obtain data and it was queried whether working groups were able to break down data so that it was more localised in order to seek solutions to address the problems. Media clips were welcomed but there was caution that they might make assumptions on the cause of missed appointments, some of which, were due to the ability of the service to be flexible.

Due to the complexity of cohorts and the organisations collecting information, it was felt that sometimes although there was best endeavour the data was not broken down enough in order to achieve a resolution.

It was explained that, when offering appointments, clinical coordinators attempted to provide flexibility when liaising with children and foster parents.

The ICB's Director of Nursing and County Council Representatives agreed to explore the supply of more granular information outside of the meeting and report back.

Having queried whether there was co-production with young people and carers when seeking a solution, the Committee was informed that had happened more so in Suffolk and Essex. The feasibility of introducing podcasts for foster carers was currently being explored.

It was felt that with the actions planned and good working relationships in place that the situation would improve.

The Committee noted the update **and requested** that Health Assessments for LAC remain on the risk register and that the Committee have an update to its next meeting on the break down of information.

c) SEND Quarterly Report - (not received)

The Committee noted the report.

(Simon Froud left the meeting)

(Phanuel Mutumburi left the meeting due to technical issues leaving it inquorate going forward)

23/031 ICB PATIENT SAFETY UPDATE REPORT

The NHS safety agenda had a primary focus to reduce harm and improve on safety for patients. In January 2023, NHSE had released new priorities for Patient Safety Specialists.

Developments made during the reporting period and reflected in the substantive update report were:

That system partners across the ICB continued to work on implementing the new Learning from Patient Safety Events system, ahead of the target date of September 2023. The ICB had been promoting the implementation of the LFPSE system within primary care, as uptake was currently very low with only eight GP practices signed up to the new system.

The ICB had appointed three Patient Safety Partners. Their role was to work within the Patient Safety Agenda, bringing the patient voice into discussions to ensure improvements to safety were implemented that were effective and made sense to patients.

A patient Safety Collaborative meeting had been developed by the ICB. The Collaborative would be a sub-Committee of the Quality Committee reporting on the safety agenda and helping deliver the ICB oversight role across Suffolk and North-East Essex.

The ICB would continue to support the implementation of the patient safety incident response Framework (PSIRF), focusing on implementation across independent providers of NHS funded care and supporting partners in the Eastern region following our work as early adopters.

A presentation had been provided to the ICB Board on the Patient Safety Strategy.

There was a system issue relating to Never Events reported at Trusts and a workshop event had been convened in May to discuss the issue in more detail across organisations. The workshop should provide opportunity to have a focussed discussion on safety and support the reduction of Never Events.

Work had been carried out in primary care to promote patient safety with the aim to enable primary care to report issues which could assist with the publication of national alerts.

EEAST had relaunched its urgent and emergency care quality systems with aim to bring all partners together to review system delays and treatment delays through urgent and emergency care and the emergency care pathway.

Those present noted the report.

23/032 COLLECTIVE ASSURANCE FRAMEWORK DEVELOPMENT

The ICB's Medical Director apologised for not presenting the framework to today's meeting and advised that it would be deferred to the May 2023 meeting.

Celebrating Excellence

23/033 HOSPICE PEER REVIEWS

Michaela Sen from St Helena Hospice was welcomed to the meeting and proceeded to give a presentation that provided information on the Hospice Peer Review. Key points highlighted included;

- The Peer Review had taken place between St Helena, St Elizabeth and St Nicholas hospices.
- The presentation provided information on the background to the visits, and the intention for the peer review approach to share excellence across organisations.
- The review had been coordinated by the ICB and the Care Quality Commission was to use the 15-step challenge approach to support its inspections.
- Teams of peer inspectors were identified and arranged for each day. Each hospice was allocated a person to facilitate inspection and provide feedback.
- The 15 steps were associated to immediate experience of arrival on an in-patient unit but the whole organisation had also been looked at.
- Areas from each hospice that others could learn from were highlighted within the presentation.
- The conclusion incorporated an aim to review and develop a report template and meetings to update actions and share good practice. It was intended that the peer review would be an annual event and ways of benchmarking activities are to be explored.

There had been much positive feedback and it was felt the work should be rolled out across other providers.

Having questioned whether there had been any anxiety, it was explained that it had all been pre-arranged with the same people on the inspection team which had helped. All had been honest and the report template had been shared between organisations initially to ensure agreement of what was written and provide opportunity to challenge if necessary. The reports had been presented to the ICB.

Those present noted the report.

23/034 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated.

23/035 ITEMS FOR ESCALATION

That staff continued to work in a period of exceptional pressure with high risk of harm as a result of that.

23/036 ANY OTHER BUSINESS

No items of other business were received.

23/036 DATE OF NEXT MEETING

11 May 2023 – 1400-1700

**Meeting of the SNEE ICB Finance Committee held on
 17 January 2023**

PRESENT:

Edward Creasy	EC	Interim Chair
Paul Gibara	PG	ICB Director of Performance Improvement
Howard Martin	HM	ICB Director of Finance
Adrian Marr	AM	ESNEFT Representative
Nick MacDonald	NM	WSFT Representative
Kevin Smith	KS	EEAST Representative
Louise Aynsley	LA	Suffolk County Council
Lauren Gable	LG	EPUT Representative
Jason Hollidge	JH	NSFT Representative

IN ATTENDANCE:

Chris Armitt	CA	ICB Deputy Director of Finance
Keith Wood	KW	ICB/ESNEFT
Jo Mael	JM	Corporate Governance Manager (Minutes)

23/001 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting introductions were made and apologies for absence were noted from;

Daryl Chapman	NSFT Representative
Steve Clarke	ICB Board Non-Executive Member
Dr Nick Rayner	ICB Board Primary Care Representative
Trevor Smith	EPUT Representative

23/002 DECLARATIONS OF INTEREST

No declarations of interest were received.

The Corporate Governance Manager agreed to request declaration of interest forms from those representatives of partner organisations for which one was not already held by the ICB.

23/003 TERMS OF REFERENCE

The Committee was in receipt of revised terms of reference for agreement prior to them being presented to the ICB Board for final approval. The terms of reference had previously been agreed by the ICB Board on 1 July 2022 but recently revised in respect of membership of the Committee going forward.

Comments included;

Having queried whether the membership should include non-executive representation from

partner organisations, it was explained that whilst they had included such membership when first drafted that had fell off in later drafts which might have been due to a desire not to have a large membership.

Having noted that the terms of reference referred to activity and workforce it was queried whether that work was the responsibility of other ICB Committees, and also where performance was reported within the ICB Committee governance structure. It was also felt that the terms of reference should include reference to the operating framework.

In response it was explained that the ICB System Oversight and Assurance Committee (SOAC) had oversight of performance and that there needed to be connection between finance and performance. Performance issues sat across Committees.

The Chair advised that there was no reason not to invite non-executives from provider organisations as long as relevant management teams approved. There was however a desire for the Committee not to have a large membership. Whilst performance was not in the remit of a finance committee it was important to consider and review money spent on performance in order to ensure the efficient use of funds.

Having queried responsibility for the financial position it was felt that the TOR should hold the Committee accountable collectively. The Committee was an ICB Committee in the context that the ICB was the whole system.

Whilst there was recognition that each organisation had its own Finance Committee and own assurance arrangements. The ICB Committee was holding all partners to account for system control targets.

Subject to minor amendment of the Terms of Reference by the ICB's Director of Finance, as discussed in relation to provider non-executive representation; responsibility re activity and workforce and the inclusion of reference to the operating framework, the Committee;

agreed the terms of reference as presented **and recommended** them to the ICB Board for final approval.

The schedule of current finance meetings was noted.

Part 1a – System Financial Issues

23/004 ICS FINANCE REPORT

The Committee was in receipt of the system finance report which incorporated information on the following:

- 1) A finance summary
- 2) Financial risks
- 3) Efficiency programme
- 4) Capital expenditure

Appendix 1 of the report contained individual Trust reports.

Key points highlighted included;

The forecast was to deliver a break-even position at year end with much of that being delivered through application of non-recurrent measures which would create risks and challenges in the next financial year.

There was a bonus attached to delivering financial balance which included a capital bonus of £5m. Conversations with the Regional Director of Finance had resulted in confirmation of

the need to achieve targets in order to acquire the bonus. There was also likely to be an additional bonus associated to delivery of the 104% elective target and linked to delivery of the financial target.

Whilst the incentives were welcomed, in light of the need for all ICBs to hit targets in order for them to obtain the bonus it was queried how feasible that was and whether the share had potential to be higher. There was also previous surplus of £7m that had been lodged and it had been queried whether that might return. NHSE had advised that from a System point of view it was waiting to see how financial positions materialised prior to making decisions with regard to individual System benefit.

At Month 8 SNEE hosted NHS organisations had reported an adverse aggregate variance of £314k (£311k at Month 7). The forecast position for the year-end was on plan. The Month 9 position had narrowed. The forecast position for both months was achievement of plan.

The Committee was informed that the presented dashboard had grown over the years and was based on information already available. It was intended to be a headline report. Committee members were invited to feedback comments and any potential improvements to the dashboard to KW outside of the meeting.

The Chair then invited reports from providers as follows;

ESNEFT – for 2022/23 at Month 8 there was a £276k surplus. A break-even position was being forecast for year end. Key issues were that, although an ambitious plan, the cost improvement programme was £5m behind plan. The cash position was currently stable at £66m with a forecast of £85m at year end. Capital year to date had an underspend of £37m and the Trust was in negotiation with NHSE regional and national teams and the Department of Health with regard to brokering £30m into 2023/24 in respect of the Dame Clare Marx Orthopaedic Centre. Representatives of the Trust had been asked to attend a meeting at the Department of Health to discuss the reasons for the brokerage request. Nationally NHSE had ability to vire £170m across the country although there were larger issues nationally. Key risks included the need for increased capacity in order to reduce ambulance delays. Delayed transfers of care and freeing up bed capacity to get through winter as safely as possible. Non pay inflation was of concern, together with the BMA rate for consultant additional sessions. Whilst the System had made a reasonable transition downwards from Covid-19 monies there would be a significant challenge in 2023/24 and culture change would be difficult with limited guidance. Bed capacity and utilisation of social care monies would be important. Capital would be tight in 2023/24 and the Orthopaedic Centre was dominating the capital programme. If the capital brokerage was addressed the Trust would forecast a break-even position – 2023/24 transition would be key.

As ESNEFT was one of the 12 best performing Trusts in the country it was queried where conversations were taking place to mitigate the position into 2023/24 and explore options. As a result of ESNEFT bed modelling the requirement for 2023/24 had been identified. There was a need for increased resource for bed capacity and virtual wards. It was noted that virtual wards were not prescriptive and there was flexibility.

It was queried where within the governance structure work was to take place for a wider system solution. It was highlighted that it would be useful to know when known benefits from social care investment would materialise. **The ICB's Director of Performance Improvement and ESNEFT's Director of Finance agreed** to discuss the issue offline and bring back their thoughts.

WSFT – the situation mirrored ESNEFT's in respect of operational pressures. The Trust was slightly off plan at Month 7 with an £120k overspend but was forecasting a year end break- even position. There was likely to be a significant problem in 2023/24 built up from the use of non-recurrent Covid-19 funding and non-delivery of cost improvement programmes. Capital was expected to be overspent in 2022/23 due to diagnostic funding and would be addressed via brokering with ESNEFT with intention to pass back next year.

WSFT had agreed an internal rate for four of its consultants in respect of additional hours which were not as high as the BMA rate.

EEAST – there were similar themes across organisations. The Trust was marginally off plan with a current deficit of £1m. There were a number of risks which amalgamated resulted in a potential £5/6m risk. The Trust was comfortable it could manage the risk in year but that would remove any comfort from the future balance sheet. Key issues were associated to operational availability in 999 and patient transport services which had been impacted by the approach to Covid-19 funding. The situation was offset within support services where there was some difficulty in recruitment. Going forward the Trust was likely to see an underlying deficit of approximately £17m although detail from the centre was required. There was a need to refocus on the cost improvement challenge and cultural challenge to approach that as it was difficult to communicate to staff. It was likely that the Trust would underspend on capital due to the supply of hazardous team vehicles that were nationally specified being delayed in production. There was confidence that the underspend of approximately £2m could be utilised. Cash was stable at approximately £32m and no problems were foreseen at present.

SCC – the Council was working on its quarter three position. There was a small overspend on adult social care and demand was increasing. The situation was being worked through at present and being offset by underspend on the area social work team which had retention issues. The largest issue for 2022/23 was costs associated to children in care where there was a small cohort with complex needs. The quarter two position was an overall overspend of £6m although that was not just attributed to SNEE ICB. The 2023/24 budget would be presented to Cabinet next week and contained significant challenges for adult care services and transformation savings in respect of the use of technology and improvements at the front door. The Council was pushing forward on recruitment. 2022/23 overspends were funded by reserves.

It was felt that overarching principles in respect of the receipt of discharge monies should include for the money to be for additional capacity within the system and, being aware of the short deadlines for utilisation, to look for solutions to ensure spend by year end. The County Council was appreciative of the need to utilise the money to assist the System as a whole.

It was reported that the message from the NHS National Chief Finance Officer was to ensure to consider how best to get value for money and achieve a long-standing benefit.

ICB – the Chair agreed that agenda item 6 (ICB Finances) be brought forward. Overall the 2022/23 position was acceptable and there were sufficient reserves to cover off non pay inflation regarding prescribing and the further £2.5/3m identified since the report. There were mental health underspends in relation to individual placements at Month 8 that had been eroded in the Month 9 figures due to mental health balance growth and increased mental health prescribing. Alliance positions were all on track to remain within delegated budgets with the latest increase being in relation to West Suffolk prescribing which was being investigated. There was currently no concern at the ICB's ability to hit its financial position at year end although 2023/24 would be challenging.

NSFT – forecasting a break-even position and associated similar risks into 2023/24. There was an underlying operational deficit due to the use of non-recurrent funding in 2022/23.

EPUT – forecasting a break-even position. The Trust would be challenged going into 2023/24 and was currently working through any implications for the System.

The Chair thanked everyone for their detailed reports and updates and expressed appreciation for the preparation work.

The Committee noted the report.

23/005 FINANCIAL PLANNING 2023/24

Although planning information was published on 23 December 2023 further detail was yet to be published which was required in order to develop both the operational and financial plans.

Headline funding changes for SNEE in 2023/24 were:

- Core base growth of £89m (5.45%) less convergence reduction £11.8m (0.68%)

- Primary Medical growth of £10.2m (5.78%) less convergence reduction of £0.7m (0.4%)
- ICB Running Costs Allowance flat with reduction tbc for 24/25
- £32m reduction in Covid funding (82%)
- £10m increase in Elective Recovery Funding
- £10.6m of physical/virtual bed funding with further allocation to be agreed.
- Capacity funding for Ambulance held by central team for a separate process.

The detail underlying the base growth had not yet been published, current information showed:

- Net inflation assumed at 1.8% (2.9% inflation less 1.1% efficiency)
- A number of separate funding streams have ceased so this needs to be covered by base growth
- In addition support for underlying capacity recovery and additional funding for community and mental health services is also in base growth.
- No information to date on assumed activity/capacity growth levels, inflation for prescribing, continuing care etc.

The report went on to look in detail at financial allocations; specialised services; NHS payment scheme; elective activity and capital, and next steps.

The teams continued to work with the information received to develop plans. The first formal system plan was due to be submitted to NHSE on 20 February 2023 with regional checkpoints beforehand. A draft timetable was included in the report.

There was concern at the timescales associated with getting a plan together by 20 February 2023 as it was now 17 January 2023 and a lot of key data was not currently available. There was concern such timescales might result in more prudent discussions. The message to non-executive members of the ICB was that it was worse than previous years and contained a lot of large numbers. Going into business planning sessions there was concern that unrealistic bids might be put forward with colleagues being unable to rebut them due to not knowing the terms of agreements. The Chair gave reassurance that the situation would be reported back to the ICB Board next week.

There was a need to be clear on assumptions and seek to align them going forward.

The Committee noted the report.

Part 1b – Internal ICB Finances

23/006 ICB MONTH 8 FINANCES

The item had been discussed previously as part of on agenda item 04 (ICS Finance Report).

23/007 CHAIR SUMMARY

The Chair advised that his summary and report to the ICB Board on 24 January 2023 would reference;

That the System had worked well in 2022/23 and was on track to deliver its forecast position. The Committee had been notified of two potential bonuses and the over-utilisation of application of non-recurrent funding to support in year financial balance. There was a risk of a significant reduction in non-recurrent flexibility as we move into 2023/24.

2023/24 was also likely to be more challenging in light of the risk of inflation associated to both pay and non-pay, together with prescribing costs. There was concern at the delay in

receipt of national guidance and the short timetables which meant that realism would be difficult. The situation was worse than previous years and compounded risk when settlements were made on an uninformed basis.

There was a need to be consistent in assumptions behind plans in order to ensure there were no outliers when discussing at an ICB level.

23/008 ANY OTHER BUSINESS

No items of other business were received.

23/009 DATE OF NEXT MEETING

14 February 2023

**Meeting of the SNEE ICB Finance Committee held on
14 February 2023**

PRESENT:

Howard Martin	HM	ICB Director of Finance (Chair)
Steve Clarke	SC	ICB Board Non-Executive Member
Adrian Marr	AM	ESNEFT Representative
Ross Beard	RB	WSFT Representative

Chris Armit	CA	ICB Deputy Director of Finance
Louise Aynsley	LA	Suffolk County Council
Jason Hollidge	JH	NSFT Representative
Trevor Smith	TS	EPUT Representative

IN ATTENDANCE:

Keith Wood	KW	ICB/ESNEFT
Jo Mael	JM	Corporate Governance Manager (Minutes)

23/010 WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

In absence of the Chair, it was agreed that the ICB's Director of Finance, Howard Martin would take the Chair for today's meeting.

Apologies for absence were noted from;

Edward Creasy	EC	Interim Chair
Paul Gibara	PG	ICB Director of Performance Improvement
Nick MacDonald	NM	WSFT Representative
Dr Nick Rayner	NR	ICB Board Primary Care Representative
Kevin Smith	KS	EEAST Representative

23/011 DECLARATIONS OF INTEREST

No declarations of interest were received.

23/012 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the ICB Finance Committee held on 17 January 2023 **were approved** as a correct record **subject to** the following amendments being made;

That the Chair's summary be revised to reference 'non-recurrent flexibilities'

That within the report from SCC the word 'NHS' be included prior to reference to the 'National Chief Finance Officer'.

23/013 MATTERS ARISING AND REVIEW OF ACTION LOG

There were no matters arising and the action log was reviewed and updated with comment as follows:

23/003 -Terms of Reference – the Chair reminded Members that he had recently circulated some slides setting out a proposal to formally separate Part 1a and Part 1b of the meeting and for the Part 1a membership to include an additional Non-Executive Member as nominated by provider organisations.

As such, **and following approval** of the proposal, the following actions were agreed;

- 1) That the Chair would be asked to write formally to partner organisation members seeking nominations for the additional Non-Executive Member position.
- 2) Separate invitations would be issued for Part 1a and Part 1b of future meetings.
- 3) The terms of reference would be revised accordingly for presentation to the SNEE ICB Board in March 2023 for approval and would be reviewed by the Committee by June 2023.

Part 1a – System Financial Issues

23/014 ICS FINANCE REPORT

The Committee was in receipt of the system finance report which incorporated information on the following:

- 5) A finance summary
- 6) Financial risks
- 7) Efficiency programme
- 8) Capital expenditure

Key points highlighted included;

There was currently a £735k system overspend with the plan being £677k resulting in a variance down to £58k. The forecast across the system was to achieve £8k surplus in line with the 2022/23 plan.

There was no net unmitigated risk resulting in assurance in the position to deliver on plan for the current financial year, a situation which was also being reflected in month 10 data. Challenges were associated to capital where there was ongoing discussion. There was a business as usual, system capital plan of an £1.5m overspend associated to WSFT's acceleration of its RAAC project which was a known and expected overspend.

There were issues associated to ESNEFT with regard to the national capital programme and specifically with regard to acute reconfiguration resource. A £30m shortfall had been reported since the end of August 2022. The Trust had met with NHSE regionally and nationally and the DoH which had resulted in agreement to look forward for a solution. Recent communications had been positive, and it was hoped that acceptance of brokerage of £30m from 2022/23 to 2023/24 would be confirmed.

The WSFT element of the capital overspend was thought to be manageable within that organisation.

With regard to the ICB, it was felt that discussion was required on the anticipated £11m bonus funding from NHSE for pressures in order to seek to gain maximum benefit going into 2023/24. The overall position was on track and manageable.

Having noted from the report that efficiency performance required improvement within transformation and reform, it was queried what was required in order to avoid being in a similar position in 2023/24 at that year end. It was also queried why WSFT efficiency

numbers appeared to be round. It was noted that there was inconsistency in reporting between organisations. The position had largely been achieved through delivery of non-recurrent means and the underlying challenge going forward was recognised. With regard as to whether we would do anything different in 2023/24 to ensure an improved position with regard to efficiency plan delivery, the Committee was informed that the ICB was looking to obtain external support to bolster programmes such as medicines management and continuing healthcare.

The ESNEFT representative reported that delivering a Cost Improvement Programme (CIP) throughout the pandemic had helped the underlying position. Challenging areas for the Trust in respect of cost improvement had been estates and transformation and there was a need to be better at tracking productivity. The CIP would be carried forward and an additional 1.5% would be applied together with a further 1.5% for productivity.

Action collectively with regard to CIPs could include exploring opportunity to reduce duplication, ensure EPR synergy and, in terms of clinical strategy determine the way forward for the next 5-10 years and work towards its delivery.

It was agreed that time would be devoted in the March 2023 meeting to look at CIPs in more detail and consider opportunities.

The Chair then invited reports from other providers as follows;

SCC – at present the key issue was a worsening situation with regard to children in care overspend as waiting lists were reducing, there was increased spend on recruitment resulting in more overspend in care purchase than anticipated. Overspends were being funded via the use of reserves. The SCC budget for 2023/24 had been set last week and it looked like there would be deficit before the start of the year. It was hoped that anticipated new pathways for children in care would have an impact.

EPUT – double and triple lock mechanisms were in place. The Trust would not deliver a balanced position and continued to forecast breakeven. Support was being provided and information channelled through ICB colleagues to protect from the triple lock via delivering on numbers. The Regional Finance Director had oversight of the triple lock system and discussion with national colleagues continued. Work had taken place with independent accountants in order to confirm the drivers of the deficit and agree a way forward with onus on all organisations across the system. Going into 2023/24 it was planned to have Chief Executive oversight of key areas of work such as workforce numbers, system flow and length of stays, together with productivity. The Chief Executive Forum was the key vehicle for oversight, and it would be challenging to bring numbers back to a balanced position.

NSFT – £20m-£25m deficit anticipated for 2023/24 and work was underway to understand the triple lock process.

The EPUT representative agreed to provide more detail on the implications of the triple lock process to the March 2023 meeting.

In light of the revised system control total, it was queried whether there might be opportunity to de-risk the overspend to gain benefit in 2023/24. Could we improve the position in 2022/23 to benefit next year?

There was concern at the anticipated widespread overspends within the East of England.

The Committee noted the report.

23/015 FINANCIAL PLANNING UPDATE

The Committee was in receipt of a report which included information on the planning timetable, governance, work that was outstanding, allocations, national notifications re inflation and growth, risks, draft ICB position, cost improvements and next steps which included;

- Elective Service Recovery Funding - resolution of detail, inclusion in plan or risks

schedule

- Validation of cost pressures/impact of cessation of prior year non-recurrent funding underpinning ICB plan position.
- Development of financial 'bridge' analysis at organisational level.
- Allocation of EEAST capacity funding (and interpretation of associated requirements and regulations)
- Based on feedback from NHSE, ESNEFT and WSFT there might be some pressure to increase CIP percentages and develop detailed plans.
- The deadline for submission of the draft plan to NHSE was noon on 23 February 2023.

Comments included;

The £82m deficit mentioned in the report did not include risk associated to the Elective Recovery Fund and further information from the national team was awaited. It was anticipated that in order to deliver the 114% elective recovery target, the system was underfunded by approximately £35m which was predominantly down to differences in money from fair shares v payment on tariff.

Feedback from the regional team in respect of CIP levels was questioned, and it was reported that whilst, at present, there was little pressure as it was hoped the situation would improve, that could change going forward.

The need to do further work with regard to CIP was emphasized, together with having further discussion with regard to the Elective Recovery Fund (ERF) and how it should be represented. There was a need to ensure the Regional Finance Director was kept up to date on any submission with regard to the ERF risk.

The ICB felt there might be opportunity to improve the situation by circa £9m from pushing down on cost pressures and realigning expectations with regard to funding going forward. £15m of issues were due to be reviewed by Panel on 24 February 2023.

The Chair queried whether organisations had had discussion with regard to any clinical risk associated to the withdrawal of non-current Covid-19 funding. ESNEFT reported that discussions were taking place internally to rate the spending and also to reduce and limit scope with regard to testing. EPUT was reviewing the situation to ensure the costs were taken out but recognised that a gap would remain as it had become reliant on non-recurrent funds.

The Committee noted the update and agreed that financial planning and a focus on CIP would be items for the March 2023 agendas.

Part 1b – Internal ICB Finances

No items received.

23/016 CHAIR SUMMARY

The Chair advised that his summary and report to the ICB Board would include report of a system deficit of £82m as at 14 February 2023 with risks being the Elective Recovery Fund, allocations only covering inflation and the requirement for system focus regarding the underlying position re CIP and productivity which would be followed up in organisations finance committees.

In respect of the year to date position there were risks associated to pressures with regard to children in care, the use of non-recurrent flexibility to get across year end, and capital.

23/017 ANY OTHER BUSINESS

No items of other business were received.

23/018 DATE OF NEXT MEETING

14 March 2023

**Meeting of the Integrated Care Board People Committee
held on 15 February 2023
(via MS Teams)**

PRESENT:

Tanya Curry	TC	Non-Executive Member, People, Remuneration and Diversity, Chair
Alison Andreas	AA	Principal and Chief Executive, Colchester Institute
Ganesh Baliah	GB	ICS Strategic AHP Workforce Lead, Suffolk and North-East Essex ICS
Peter Bumphrey	PB	EEAST Representative
Penny Cason	PC	IES Alliance Representative
Paul Driscoll-Evans	PDE	HEI Representative
Rachel Laverty	RL	EPUT Representative
Jo Lennox	JL	Digital and Workforce – ICS Programme Lead
Amanda Lyes	AL	Director of People and Workforce
Carol Magnus	CM	Tendring District Council
Jeremy Over	JO	West Suffolk NHS Foundation Trust
Deborah O'Hara	DO	ESNEFT
Saffron Rolph-Wills	SRW	HEE Representative
Graham Seward	GS	ICB Head of Workforce Transformation
Dr Mark Shenton	MS	ICS Clinical Lead & ICS Integrated Care Academy Representative
Giles Thorpe	GT	ESNEFT Representative

IN ATTENDANCE:

Jo Mael	JM	ICB Corporate Governance Manager (Minutes)
Giles Turner	GT	ICB Head of Workforce
Liesel Kennedy	LK	ICP Research, Information and Analysis Lead
Stephen Welfare	SW	University of Suffolk
Adelaide Appiah	AA	ICB Clinical Workforce Programme Manager
Amina Chitembo	AC	Health Education England
Kelly Worger	KW	ICB EA to Director of People and Workforce
Mark Smith	MS	Allied Health Professional

ACTION

23/001 WELCOME, INTRODUCTION AND APOLOGIES

The Chair welcomed everyone to the meeting and apologies for absence were noted from:

Dr Penny Ashbee, Primary Care Representative
Steve Colmer, EEAST Representative
Jessica Douglas, Essex County Council
Ed Garratt, ICB Chief Executive
Susannah Howard, ICP Director

Lisa Nobes, ICB Director of Nursing
Peter Smye, Suffolk GP Federation
Emma Sweeney, ESNEFT
Paul Taylor, EPUT Representative

23/002 MINUTES OF PREVIOUS MEETING, MATTERS ARISING AND REVIEW OF ACTION LOG

The minutes of the previous ICB People Committee meeting held on 19 October 2022 **were approved** as a correct record.

The action log was reviewed and updated.

23/003 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

No declarations of interest were received.

23/004 SNEE ICB PEOPLE COMMITTEE TERMS OF REFERENCE

The Committee was in receipt of revised terms of reference for review and recommendation to the ICB Board for approval. Changes to the terms of reference were with regard to membership.

The Committee approved its terms of reference for presentation to the ICB Board in March 2023 for final approval **subject to** the inclusion of EPUT and University of Essex representatives within the membership.

STRATEGY

23/005 SNEE INTEGRATED CARE STRATEGY

The Health and Care Act 2022 created a statutory basis for Integrated Care Systems by creating a statutory Integrated Care Partnership (ICP) and an NHS Integrated Care Board (ICB) for each ICS. A key role for the ICP was to generate an Integrated Care Strategy that set the direction of the system across the whole ICS footprint. The strategy set out the ambition of all partners to improve health and care outcomes and experiences for the population of Suffolk and North-East Essex.

It set out how commissioners in both the NHS and local authorities, working with providers and other partners, could deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. The Integrated Care Strategy presented an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services.

Key issues were set out in Section 2 of the report and public engagement in Section 3.

The Committee were shown a film which presented feedback from the local population.

Comments:

It was felt the film reiterated the importance of co-production and the need to listen to those receiving care as priorities were not always aligned.

Having noted the themes of communication and listening the need to think about that within the workforce strategy was emphasized.

The Committee noted the Suffolk and North-East Essex Integrated Care Strategy **and thanked** the team for their work.

23/006 SNEE JOINT FORWARD PLAN (JFP) - WORKFORCE

In line with the Health and Care Act 2022, Integrated Care Boards (ICBs) and their partner NHS Trusts and NHS Foundation Trusts must develop an annual Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP described how Suffolk and North-East Essex (SNEE) ICB and its partner trusts intended to arrange and provide NHS services to meet its population's physical and mental health needs. In addition, the plan took account of and aligned to the:

- 2022 SNEE Integrated Care System (ICS) Strategy
- Essex Joint Health and Wellbeing Strategy (2022 to 2026)
- Transitional Joint Suffolk Health and Wellbeing Strategy 2022 to 2023

A range of partners and groups from across the system had supported the development of the document and a core component of the work had been the agreement of a number of goals the ICB must achieve by 2028. Furthermore, the JFP considered:

- the health and well-being of its population
- the quality of services provided to local people
- best use of resources

The JFP would be delivered through the three place-based alliances that existed within the ICB's area. Each was developing its own localised delivery plan. The draft would be revised to co-ordinate with the data received from the 2023/23 operation plan.

The Committee was informed that this item and the next with regard to operational planning would be taken together.

The Committee noted the content of the report and draft Joint Forward Plan.

23/007 2023/24 PRIORITIES AND OPERATIONAL PLANNING

Every system would need to develop whole system workforce plans, building on the 2023/24 priorities and operational planning guidance, published in December 2022, and the three tasks: recover our core services and productivity; make progress in delivering the key ambitions of the NHS Long Term Plan; and continue transforming the NHS for the future.

The 2023/24 workforce planning collection included greater granularity for roles in acute, ambulance, community, mental and specialist health providers, alongside primary care. A supply bridge was included for year one at an aggregate level to describe and explain the anticipated workforce change.

The mental health collection was also incorporated in the planning round. Plans must demonstrate an integrated approach to activity, finance and workforce planning for year one, and provide realistic workforce plans for years two to five. The latter were vital for education commissioning and ensuring we are able to scope supply against demand into the mid-term.

The Health Education England (HEE) portal included information governance requirements relating to the workforce planning data collection, intended data use and data sharing.

Comments regarding both the Joint Forward Plan and Operational Planning included;

The plans were living documents that would inform system strategy going forward. They needed to link with social care, voluntary and community sector and education plans. They would provide a plan placed into a system which was integrated and that

which had been triaged with finance and activity. The submission date to NHSE was 31 March 2023 and once complete it was intended that the Plan would be shared with the People Committee in order to consider a way forward.

Key work was the gathering of information to bring back to the planning programme to ensure that patient care was at the forefront.

The Committee was being asked to support the direction of travel and organisations were encouraged to share data and participate in the overall plan; and also, to champion workforce when attending other meetings.

Along with productivity, quality and safety, outcome and patient and family experience were other key aspects.

Mental Health was the highest cause for the absence of staff and staff health and wellbeing was key going forward.

It was important to give staff a rest which could be facilitated by using their experience in a different way to help with the development of teams and the system itself. Talent management was key as there were many talented individuals and it was important to develop a systematic approach to talent management to enable greater development across the system. It was also important to consider how to bring the non-health care workforce and volunteers and non-paid care workforce into development and the leadership space, in order that the paid workforce gained experience of working in a broader way. There should be more opportunity to develop the integrated team approach.

Work had begun with regard to talent management and further information would be presented to the Committee at a later date as conversations were taking place with the Integrated Care Academy. There was opportunity to scale up the systematic approach across the system. With regard to the non-health care workforce that was a challenge going forward as to how to embed current work into emerging strategies.

Whilst we know where we are and where need to be at the end of March 2023 for submission, as a Committee there was a need to track progress and delivery and it was suggested that a 'plan on a page' be developed to facilitate that work.

The ICB's Head of Workforce agreed to seek to develop a 'plan on a page' and also to gather information across providers in order to provide an update for presentation to the Committee at the next meeting.

The need for all organisations to be involved in workforce planning was emphasized.

The Committee was informed that the acute Trusts already held a lot of evidence and had teams carrying out work. Members were encouraged to be clear about what organisations were doing and the ICB could be most helpful in looking beyond boundaries of organisations and strategically.

It was highlighted that funding streams were constrained and there was a need to be creative with regard to managing within available resources. It was important to have realistic conversations.

The Committee noted the report and appended workforce operational plan 2023/24.

23/008 ESTABLISHING A NETWORK OF EXCELLENCE IN HEALTH APPRENTICESHIPS

The University of Suffolk had received funding from Health Education England to strengthen its partnership working between FE colleges in the region and the SNEE ICS, with a view of maximising apprenticeship-affiliated workforce pipelines. The report

provided an overview of an innovative approach to partnership working, which sought to create a cohesive educational eco-system prompting a seamless transition between level 2-7 apprenticeships for relevant learners.

The proposal was to introduce a network of centres of excellence in health apprenticeships across SNEE. £1.9m of funding had been secured from Health Education England (HEE) and engagement would take place with all partners in health and social care and further education to drive the work forward and promote apprenticeships. It was noted that Allied Health Professionals were also in integrated care.

The initiative was welcomed as a great step forward.

The Committee approved the direction of travel as set out within the report **and empowered** the author and SNEE ICS' Director of Workforce and People to further develop the proposal via the Integrated Care Academy.

23/009 SNEE HEALTHCARE SCIENCE WORKFORCE STRATEGY

There was currently an exponential pace of change in scientific and technological advances, coupled with an ability to compare and interrogate large datasets. Those developments had the potential to revolutionise many areas of healthcare delivery and benefit patients through more personalised and evidenced based interventions.

The healthcare science workforce was a unique, diverse and specialised community within the NHS who used their knowledge and expertise to develop, design and deliver transformative patient care. There were over 56,000 people that made up the healthcare science workforce, working in the NHS in over 150 service areas across pathology and laboratory science, physiological sciences, data science and bioinformatics, and in medical physics and clinical engineering.

The strategy set the context for workforce transformation within the Healthcare Science workforce to attract, recruit, retain and develop. In addition, there would be a Healthcare Science Workforce Group which would provide oversight and peer support.

The Strategy was welcomed as excellent and much needed.

The Committee approved the Strategy as presented **and requested** an update to a future meeting.

UPDATES AND ITEMS FOR INFORMATION

23/010 HEALTHCARE SUPPORT WORKER (HCSW) RECRUITMENT CAMPAIGN – JANUARY 2023

The SNEE ICB workforce team had led on a collaborative recruitment event in January 2023 filling HCSW vacancies across health and social care sectors. "The Bus" aimed to take recruitment activity into the community and city centres, promoting career opportunities in health and social care. The event highlighted the benefits of synchronising our recruitment processes and the importance of collaborative work between system partners. The objective was to reduce HCSW vacancies by 20% vacancy reduction by the end of March 2023 to support winter pressures.

The report provided more detail on the work that had taken place which included;

There had been 2000 vacancies in social care together with Trust vacancies. The caveat had been that funding was available to support winter pressures.

There had been a lot of interest and 231 interviews had been facilitated with 173

successful candidates across the three locations of Bury St Edmunds, Colchester and Ipswich.

Lessons learnt included the need to facilitate flexible working as 40 applicants had been turned down due to the non-availability of flexible working. The next event was to be held in Tendring which would be challenging. Offer of support from Tendring District Council colleagues was offered.

Comments included;

It was questioned whether there was any understanding of where success lay in different places with regard to engagement in order to identify areas for high responses. Was there a way we could advertise common factors for success or common themes for rejection so that candidates could get an idea of where to put their pitch. In response it was reported that there had been a high number of attendees in Colchester due to the University, whilst conversion rates had been highest within West Suffolk where the team had been well prepared. Colchester and Ipswich had the highest number of opportunities. The event had been successful everywhere, there was a need for future events to ensure that candidates were prepared in respect of health and social care values and the various settings and sectors.

It was felt that there needed to be more realism with regards to the role of a Health Care Support Worker (HCSW) within the acute sector as that had not truly been understood by candidates. Since the event a 'day in the life of a HCSW within the acute and community setting' had been put together which had helped in getting the right candidates. ESNEFT had also facilitated a number of summits and were to explore opportunities for shadowing and taster days.

The Committee noted the report and supported the programme of work.

23/011 LEADING SYSTEM CHANGE PROGRAMME UPDATE

Leading for System Change was a set of flexible components, tailored to the needs of a particular system and delivered within that locality, which aimed to develop and extend the capacity for systemwide thinking and action within a system:

The report also highlighted links between the offer and the wider Leadership programmes and next steps on scoping and plans to formulate a Leadership & Talent Management Collaborative Group as part of the People Committee.

We are requesting help from our stakeholders to identify 40 people from across our ICS. They could be frontline service professionals and/or managers working in social care, public health, the VCFSE sector or in the NHS with a passion to deliver something completely new and achieve better outcomes for people by working across boundaries to genuinely 'Break the Mould'.

The course was free of charge and began in April 2023. An online information event was scheduled to take place on Wednesday 22 February 2023 at 1:00pm.

To date, 35 expressions of interest had been received across health, social care and the voluntary sector, the closing date was late February 2023.

The WSFT Representative expressed concern at the nomination process and reported that the opportunity had been offered to everyone at WSFT with people given until Friday this week to express an interest.

The importance of candidates having the support of the organisation and line manager sponsorship was highlighted in order to be able to spread benefit within the organisation when they returned.

It was highlighted that programmes in Mid and South Essex and Gt Yarmouth and Waveney would soon be coming to an end and there might be lessons that could be utilised from any feedback.

The Committee noted the report.

23/012 EQUALITY, DIVERSITY AND INCLUSION (EDI) PROGRAMME UPDATE

It was widely recognised that the work delivered by the NHS would not be possible without the critical contribution of its diverse workforce. When referring to diversity, we included gender, ethnicity, disability, religion, national origin, sexual orientation and age (i.e. protected characteristics). It was however recognised that there was further scope for the NHS to become a more inclusive, diverse and equitable employer at every level.

As a health and care partnership we believe that all lives in Suffolk and North-East Essex have equal value and recognise that not all of our population have access to the same opportunities. Research had demonstrated that the level of inequality could have a dramatic impact on health outcomes – and on the demand of the system.

A set of commitments had been agreed to ensure equality, diversity and inclusion was enshrined within ways of working. That agreement was received and approved in December 2022 with those commitments and actions outlined in the 'how do we plan to make a difference' section of the Joint Forward Plan and ICP briefings.

SNEE ICS (ICB & ICP) would ensure that equality, diversity and inclusion was embedded in every strand of our organisations in order to support better outcomes for the people we serve. The ICB Executive was currently working on delivery and to understand how best to support established staff networks (as outlined in the SNEE ICB Delivery Plan). A system EDI Summit would be hosted in March 2023 and from that system priorities would be built with established and emerging workstreams.

In the coming months plans would be shared on further developing EDI support and resource and linkage would take place with system partners to establish an EDI community of practice. All programmes of work would be in keeping with the principles and methodology of co-production.

The Committee was informed that NHSE had supported the recruitment of EDI leads and one would be aligned to SNEE.

The Chair queried how the work fed up to the ICB Board and it was explained that was via the People Committee and the ICB Director of People and Workforce. The EDI summit was intended for Board members and EDI practitioners and leads who could take the work forward.

The Committee was informed that WSFT was reviewing its governance around staff networks in order to underpin and reinvigorate a more robust model.

The Committee noted the report.

23/013 WORKFORCE TRANSFORMATION PROGRAMMES

The Committee received and noted the Workforce Transformation updates.

23/014 ANY OTHER BUSINESS

Policy Development

The ICB's Director of People and Workforce reported that at the last SNEE ICB Board

meeting the People Committee had been challenged to consider the feasibility of aligning policies across organisations and thoughts were welcomed from Committee Members.

There was some concern that this might be a distraction from other work and would be a large task. From a digital perspective some work had begun to consider the streamlining of policies in order to address the current recruitment challenge.

The ICB's Director of People and Workforce agreed to facilitate a conversation offline that would enable report back to the ICB Board.

Digital Update

The Committee was informed that a Digital Workforce Away Day had been held in December 2022 with key themes being knowledge and competencies being in the right place and the impact of digital programmes and funding schemes. Also discussed was the need to be smarter with regard to recruitment and development of a sustainable workforce strategy. Another workshop was scheduled to take place on 20 April 2023 and all Members were encouraged to attend or send a representative. There had been contribution to the national workforce strategy led by NHSE and development of digital maturity assessments. The work would shape and frame the conversation regarding digital and technology and how to manage and overcome barriers across the ICB.

Mike Bone Potential Programme – cohort 1 of the programme launched in September 2022 had now ended and a baseline exercise across the ICB to identify skills gaps was underway and due to be completed in May 2023. Information from that work could be presented to the Committee if felt appropriate. The work was linked to the regional skills development network to make best use of resources.

Industrial Action

The ESNEFT representative highlighted the challenging position with regard to forthcoming nursing industrial action dates, a 72-hour period of industrial action was planned with no derogation likely. There was concern as to how divisive it was becoming. EEAST were due to carry out industrial action on 6 and 9 March 2023. There was concern at the significant risk to both the workforce and patients should the situation not be resolved and the role of the ICS was questioned with regard to the welfare of the workforce and of those people it served.

The ICB's Director of People and Workforce reported that further information was awaited from the Royal College of Nursing with regard to clarity re derogation and teams across the ICB and providers were working through information available and feedback from previous strikes.

The role of the People Committee was to understand information with regard to derogation and to follow it through with organisations strike committees. There was a duty to understand the impact and consider report to the ICB Board. Unfortunately the Committee was unable to make a difference to what happened on the ground.

It was suggested that it would be helpful to understand as statutory bodies for health and social care what ICB Chief Executives were doing to influence conversations at central government as the Royal College of Nursing was not able to have such a conversation.

The Chair agreed to talk with the ICB Director of People and Workforce offline in order to reflect on what should be fed back to the ICB Board.

23/015 DATE AND TIME OF NEXT MEETING

19 April 2023 – 1500-1700 hrs

Title	Estates Committee Highlight Report
Lead Director	Paul Fenton, Director of Estates and Facilities - ESNEFT and Chair of the SNEE ICB Estates Committee
Author(s)	Corporate Governance Manager

1. Summary

- 1.1 The ICB Board is asked to note the highlight report from ICB Estates Committee meetings held in January and February 2023.

2. Key points to note

- 2.1 At its meeting held on 31 January 2023 the Estates Committee received the following reports/updates:

1) **Strategic Planning Report**, key points:

- Work was taking place with West Suffolk Council on development of the local plan as West Suffolk was likely to experience significant housing development over the next 15-18 years. A workshop was scheduled for the following week to enable Health partners to provide input into the potential impact and consider mitigation. The importance of considering linkage of the Estates Infrastructure Plan (EIP) with local authority development plans was emphasized.

2) **NHSEI Regional Strategic Estates Advisor Update**, key points:

- The Committee was informed that current focus was with regard to Targeted Investment Fund (TIF) funding and work associated to the new hospital programme. The next iteration was due to be presented to the Major Project Review Group and Treasury in early February 2023.
- The ability to facilitate introduction of discharge lounges across hospital sites to enable flow had been highlighted as a key initiative. December had not been a good month for activity in the system and in respect of ESNEFT space had been created by use of the physiotherapy gym, heart centre and Musculo-skeletal admission unit at Ipswich and in Colchester by use of the emergency department and outpatients waiting room.
- Having noted that there was mention of digital benefit in respect of transformation within ICS strategy documentation, the need to ensure that digital intervention was considered in respect of the running of services as well as for patient interaction within primary care was highlighted.

- The Chair agreed to circulate the draft Joint Forward Plan to members.

3) Estates Infrastructure Strategy (EIS) Update

- The Chair informed the Committee that there had been good progress on the EIS, and Members were thanked for their contribution to date. Work had taken place to ascertain progress of organisations in respect of carbon zero targets and progression of the Green Plan.
- Baseline information for the EIS had been completed and current focus was on ensuring that Shape was populated with the estate information acquired to ensure it was up to date as it was likely it would be used as the central database system for the management of estate moving forward.
- It was anticipated that the first draft would be complete by the end of February 2023 when it would be shared with the Committee with the final draft at the end of March 2023. Work on delivery of a number of its outputs was anticipated commencing from late 2023 and into 2024 and it was expected that Members would play an active part in that work.

4) Sustainability Update

- There was currently a lot of work taking place within the NHS that was looking across the System and there was more representation across local authorities with the ICB Sustainability Lead now participating in the Suffolk Climate Emergency Board and similar Group at Essex County Council Essex.
- The Carbon Net Zero Strategy had been circulated and incorporated 11 strategic themes both for primary care and acutes. The Strategy had been presented to the Estates Infrastructure review team which had resulted in the addition of 5/6 key areas which would benefit from a system wide approach, those being; renewable energy sourcing; the role of purchasing and procurement of power; retrofit and retrofit economy opportunity; climate adaption and resilience; roll-out of the capital decision making process and carbon budgeting.
- Elective vehicle infrastructure – work was currently taking place on a non-emergency patient transport tender. There would be a larger requirement for ambulances when switching to electric.
- The Committee was informed that EEAST were obtaining 20 mobile chargers for staff to utilise although Trust policies would need amendment for that to happen. The ability for staff across the System to charge vehicles at the same rate as organisations was welcomed if feasible. It was noted that the carbon net zero requirement had been removed as part of the cost of living challenge.
- At a recent meeting with Transport East, electric vehicle and infrastructure across the region had been discussed and the position within SNEE aired. Whilst there were some quick wins, the importance of engagement and need for support to primary care in order to send the message of commitment was emphasized.
- Due to the need to facilitate a governance and reporting mechanism for Sustainability issues, discussions had taken place with regard to it being built into the ICB Estates Committee terms of reference as an area of responsibility. The Committee supported a change to its terms of reference for review at the next meeting.

- 5) At each meeting, the Committee also receives One Public Estate updates along with highlight reports from providers and the three Alliances.

2.2 At its meeting held on 28 February 2023 the Estates Committee received the following reports/updates:

1) **Strategic Planning Report**, key points:

The volume of housing development applications this month indicates that an additional 4,000 patients will populate the area, which over the course of a month is quite substantial. Not all are new applications, but it does show the volume of housing that is coming through at the moment; this is likely to get worse over the next few years as the local authorities need to ramp up housing development to meet the government targets.

2) **Estates Infrastructure Strategy (EIS) Update**, key points;

The Chair informed the Committee that the EIS was progressing well but still awaiting some information from members regards Capital programs over the next 2-3 years along with some detail from a high-level angle to capture what major investment is required into the SNEE ICS Estate. The document itself is taking shape and is becoming densely populated with the relevant sections in regards to giving the national context, the ICS priorities, (taken from the joint forward plan), the Digital Data & Technologies Strategy, the Workforce Strategy, the Green Plan and gives the baseline of our current Estate and the developments required over the next few years. Whilst the document will be completed as far as possible, and articulate the future requirements of the estate in SNEE, much work will be required through 2023/2024 to completely finish the estate development delivery plan section as this is reliant upon other strategies being completed over coming months.

The Chair will release the latest iteration of the draft document to members by the 10th March for comment and will be presented to the March meeting for debate, and then for approval at the April ICB Estates Committee. It will then be presented to the Integrated Care Board for approval in May 2023.

3) **Sustainability Update**

The ICB's Sustainability Lead reported on:

The Net Zero Building Standard that he shared on screen giving a whistle top summary. It is a very high-level overview with an ask at the end. There are six documents and the guidance document being shared in itself is 146 pages, it has the introduction, whole life carbon, the approaches to it, embodied carbon, operational carbon and some delivery stages and reporting. The Chair asked for a small working group to be formed to undertake the challenges set out within the document and report back to the Committee.

4) **Revised Terms of Reference**

The Chair informed the Committee that the Terms of Reference of the Committee required review as it had been agreed that Sustainability, and the oversight and management of the ICS Green Plan would be managed by the ICB Estates Committee. The Chair also informed the Committee that there will be change to his title to reflect that upon his retirement from ESNEFT he is being seconded to the ICB on a part time basis to complete the work around the EIS and will also continue to Chair the Committee.

The amendments to the terms of reference had been made to reflect these changes. The Committee noted and approved the changes.

3) **Recommendation**

3.1 The ICB Board is asked to note the report.

Suffolk & North East Essex ICS
Strategic Digital Investment and Assurance Board

Meeting held on Friday 3rd February 2023 from 15.00 – 17.00
Virtual Microsoft Teams Meeting

Notes and Actions

Note for ICB: These are draft minutes and have not yet been approved by SDIAC

Ref:	Item
1	<p>Welcome & Introductions Apologies from members were given. Slides for the meeting were available in FutureNHS.</p>
2	<p>Minutes, Actions & Matters Arising</p> <p><u>Minutes:</u> (221129) approved. Matters arising: None declared.</p> <p><u>Outstanding Actions:</u> SDIAC221129-06. Post Project Reviews. An update to be provided about the closed ESNEFT projects at the next meeting. Update 3.2.23. Update postponed to meeting in May. SDIAC221129-07. Update to be provided at next meeting regarding the integration of the new social care system. Update 26.1.23. Due to time constraints this has been deferred to the next meeting in May.</p> <p>Updates on all other closed actions given. There were no declarations of interest given.</p> <p><u>SDIAC Terms of Reference (ToR) – for approval.</u> Due to the increase of organisations invited to the meeting the quorum in the ToR was increased to six to represent 50%, in line with the ICB ToR. Members asked to give approval. Approval given by members.</p> <p>It was noted that the name of the meeting needed to be changed to Strategic Digital Investment and Assurance Committee (SDIAC) and this change will be updated on the ToR. Approval given by members.</p> <p>Appendix B. Changes reviewed by members. Noted that this would be living document that will be updated with membership changes when required. Missing deputy membership names will be added to the document. Approval given by members.</p> <p>SDIAC 230203-01. Appendix B. Deputies to be added where missing to Appendix B, ready for the next SCIAC meeting.</p>
3	<p>Our meeting in context Aware of the pressures in the system, particularly around urgent and emergency care. It is necessary to take the pressures that the system is under into account. It was agreed to focus on the key issues which the team could help address, and the priorities for moving out of winter pressures.</p>
4	<p>22/23 Investment Plans An update on investments was provided.</p> <p>SDIAC 230203-02. Funding links. Members of SDIAC are to have access to all documentation.</p> <p>SCIAC 230203-03. Cost Pressures for Virtual Wards. Discussion to take place offline.</p>

5	<p>Post Project Reviews and Findings</p> <p>The 10 projects were reviewed. It was noted that 4 out of 5 of the thematic findings are the same as previous year. Funding from the national teams was outlined and discussed in detail.</p> <p>SDIAC 230203-04 – Meeting slides. In future, slides will be provided prior to the meeting to allow members time to read the information and have questions ready to be raised.</p> <p>Post project reviews were outlined, focusing on recruitment, engagement, assurance reporting and provider organisation collaboration.</p> <p>Benefits Realisation</p> <p>The benefits of two programmes were outlined, and it was noted that lessons learned information would be analysed and tracked against actions.</p>
5	<p>SDIAC Items for ratification / information</p> <p><u>DDaT PMO Team Operating Framework</u></p> <p>Key risks were discussed, relating to recruitment, long term funding, business continuity, the potential to streamline centralised activities and ensuring resources are deployed effectively.</p> <p>It was proposed to commission an independent contractor to undertake a baselining exercise about what, how and who is doing what to include an analysis of the provider DDaT strategies and delivery plans, priorities and resourcing. The proposal was discussed was agreed that it should be pursued but would need further work.</p> <p>SDIAC 230203-05. DDaT PMO Team Operating Framework. Feedback and contributions to be sought from members to scope the baselining exercise and further commission work to produce a report with recommendations that can be agreed at the next SDIAC meeting.</p> <p>SDIAC 230203-06. CE+ Accreditation. Deadline to achieve standards met CE+ accreditation is 30.6.23. A follow up meeting will be scheduled.</p>
6	<p>Strategic Delivery Programme Update</p> <p>48 active projects underway at present. 37 are at various stages of implementation and all bar 2 are on track – issues on these 2 are being addressed.</p> <p>SDIAC 230203-07. ROSI project. Discussion to be held regarding the ROSI end of life and diabetes projects.</p> <p><u>Developing our Digital Workforce (Well Led)</u></p> <p>The vision was outlined, including the wish for input across the ICS, linking in with other workforce leads including local authorities and ICB. The Mike Bone People Potential Programme (MBPPP) has been very successful, and the next cohort will be launched in September 2023, for which the PMO team will seek investment. A desktop data review has taken place looking at what is happening across the workforce. A workforce model has been developed for automation and DDaT leadership training will be created with NHS providers. Approval for baselining work will be sought at the next meeting in May.</p> <p>SDIAC 230203-08. FNHS links. Links to be attached to all agenda items if there are relevant documents on the platform that will give additional information for the discussion.</p>

	<p><u>Success Measures Progress Updates</u> – Key messages</p> <p>Progress updates were given for Safe Practice, Digital Care, Enabling Insights, sustainable change and digitising social care records.</p> <p><u>ShCR and HIE update</u> - An update was provided.</p> <p><u>Enabling Unified Digital Care Committee Update</u> - An update was provided.</p> <p>A paper on Cassius+ 23/24 will be taken to the ICB in February.</p>
7	<p>Most Pressing Concerns for the System</p> <p>Members were asked their views on the questions raised and several points were raised.</p> <p>It was agreed to change the MS form to an EasyRetro board so further comments could be added.</p> <p>SDIAC 230203-09 Most Pressing Concerns for the System.</p> <p>Top three points will be transferred to the board and enable members to build on these points, link will be shared. Requested members use next 3 weeks to add comments.</p>
8	<p>Cyber – An update was provided.</p> <p>Deadline to achieve standards met CE+ accreditation is 30.6.23. It was agreed that action may need to be taken before the next SDIAC meeting and another meeting may need to take place before May.</p> <p>SDIAC 230203-10 Cyber security. Information to be shared about recent cyber contract.</p>
9	<p>Agreed Actions and Next Steps</p> <p>Summary and close</p> <p>The Chair summed up the discussions held in the meeting. In particular she noted positive discussion on the post project reviews and systems working. She thanked the team for their support.</p> <p>SDIAC 230203-11 FNHS. A meeting will take place to signpost information to a member.</p> <p>SDIAC 230203-12 FNHS. Any other members requiring help with the information system to make themselves known.</p>
	<p>Meeting closed at 17:10 Next meeting 5.5.23.</p>
<p>Minutes approved on</p>	

Suffolk and North East Essex Integrated Care Board Attendance Log

Role	Name	01-Jul-22	Part 1 and 2 26-Jul-22	Via Email' 01-Aug-22	Part 1 and 2 27-Sep-22	Part 1 and 2 22-Nov-22	Part 1 and 2 24-Jan-23	Part 2 21-Feb-23
Acting Director of Finance	Armitt Chris	Yes	Yes	Yes	Yes			
Member VCSE Sector	Alderson Kirsten					Yes	Yes	Yes
Partner Member Primary Care Essex	Bhatti Freda	Yes	No	Yes	Yes	Yes only part of P1	Yes	Yes
Provider Partner Member - Acute	Black Craig	Yes	Yes	Yes	No	No	Yes	
Provider Partner Member - Acute	Cameron Ewen							Yes
Non Executive, Finance and Audit	Clarke Steve	No	Yes	Yes	Yes	Yes	No	Yes
Partner Member Suffolk County Council	Cook Sue	No	Yes	Yes	No	Yes	Yes only Part of P2	Yes
Non Executive, People, Remuneration and Diversity	Curry Tanya	Yes	No	Yes	Yes	Yes	Yes only Part of P2	Yes
Non Executive, Quality and Safety	Feast Steve	Yes	Yes	Yes	Yes	Yes only part of P1	Yes	
Chief Executive	Garratt Ed	Yes	Yes	No	Yes	Yes	Yes	Yes
Partner Member Essex County Council	Higgs Patrick	No	P1 only (part)	Yes	No	Yes	Yes	No
Provider Partner Member - Community	Hulme Nick	Yes	No	Yes	Yes	Yes P1 only (Part)	Yes	Yes
Medical Director	Kelso Andrew	Yes	No	Yes	Yes	Yes	Yes only Part of P1	Yes
Director of Finance	Martin Howard					Yes	Yes	Yes
Director of Nursing	Nobes Lisa	Yes	Yes	Yes	Yes	Yes	Yes	No
Chair	Pope Will	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Partner Member Primary Care Suffolk	Rayner Nick	Yes	Yes	No	Yes	Yes	Yes	Yes (Part)
Provider Partner Member - Mental Health	Richardson Stuart	No	Yes	Yes	No	Yes	No	Yes
Deputies:								
Partner Member Essex County Council	Fairley Peter				Yes			
Partner Member Suffolk County Council	Keeble Stuart				Yes			
Provider Partner Member - Community (Deputy)	Moloney Neill		Yes					
Other Regular Attendees								
Director of Ipswich and East Suffolk Alliance	Baker-Woods Maddie	Yes	Yes		No	Yes	Yes only Part of P1	Yes
Director of Performance and Improvement	Gibara Paul	Yes	No		Yes	Yes	No	Yes
Integrated Care Partnership Director	Howard Susannah	No	Yes		Yes	Yes	Yes	Yes
Director of People and Workforce	Lyes Amanda	Yes	No		Yes	Yes	Yes	Yes
ICP Chair Suffolk	Reid Andrew Cllr	No	No		No	No	No	No
ICP Chair Essex	Spence John Cllr	Yes	No		No	No	No	No
Director of North East Essex Alliance	Taylor-Green Laura	Yes	No		Yes	Yes	Yes	Yes
Director of Strategy and Transformation	Watson Richard	Yes	Yes		Yes	Yes	Yes	Yes
Director of West Suffolk Alliance	Wightman Peter	Yes	Yes		Yes	Yes	Yes	Yes