NHS
Suffolk and North East Essex
Integrated Care Board

Title	**NHS Suffolk and North-East Essex Integrated Care Board Meeting**
Date	**24 January 2023**
Place	**Edmund Room, St Edmundsbury Cathedral, Angel Hill, Bury St Edmunds, IP33 1LS**
Time	**0930-1230 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 19 January 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				
0930	**1**	**Notification of any questions from members of the public for response at the appropriate time on the agenda**.	Note	Will Pope (Chair)
0932	**2**	**Welcome and Introductions and apologies for absence**	Note	Will Pope (Chair)
0934	**3**	**Declarations of Interest** *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.*		All
0936	**4**	**Minutes of the previous ICB Board meeting held in public on 22 November 2022.** ***To approve*** *as a correct record the minutes of the ICB Board meeting held in public on 22 November 2022.*	Approve	Will Pope (Chair)
0940	**5**	**Matters arising from the ICB Board meeting of 22**	Note	Will Pope (Chair)

		November 2022 and review of outstanding actions. ***To note and endorse*** *how we have responded to the outstanding issues which arose at the last meeting.*		
0945	**6**	**General Update** ***To receive*** *an update from the ICB's Chief Executive.*	Note	Ed Garratt *(Chief Executive)*
0950	**7**	**Patient Experience**	Note	Susannah Howard *Report No: ICB 23-01*
STRATEGY				
1010	**8**	**Suffolk and North-East Essex Integrated Care Strategy** ***To receive and note*** *a report from the Integrated Care Partnership Director*	Note	Susannah Howard *Report No: ICB 23-02*
1020	**9**	**SNEE Joint Forward Plan Update** ***To receive and note*** *a report from the ICB's Director of Strategy and Transformation*	Note	Richard Watson *Report No: ICB 23-03*
1030	**10**	**Integrated Care Board (ICB) Report and System Oversight Framework (SOF) Performance Indicators and Winter Pressures** ***To receive and note*** *a report from ICB's Director of Performance Improvement.*	Note	Paul Gibara *Report No: ICB 23-04*
1040	**11**	**Support available to children and young people (CYP) presenting in crisis in Suffolk and North-East Essex (SNEE).** ***To receive and note*** *a report from the ICB's Directors of Nursing and Strategy and Transformation*	Note	Lisa Nobes/ Richard Watson *Report No: ICB 23-05*
1050	**12**	**New Special Education Needs and Disability (SEND) Inspection Framework** ***To receive and note*** *a report from the ICB's Director of Nursing*	Note	Lisa Nobes *Report No: ICB 23-06*
1100	**13**	**Embedding Allied Health Professional (AHP) Leadership across Suffolk and North-East Essex Integrated Care System.** ***To receive and note*** *a report from the ICB's Director of People and Workforce*	Note	Amanda Lyes/ Ganesh Balish *Report No: ICB 23-07*
1115	**14**	**SNEE Oral Health and Dental Services Commissioning Proposals** ***To receive and note*** *a report from the ICB's Director of Strategy and Transformation*	Note	Richard Watson *Report No: ICB 23-08*
1125	**15**	**Suffolk and North-East Essex (SNEE) Alliances – Highlight Reports** ***To receive and note*** *the following:* *a) Ipswich and East Suffolk Alliance Highlight Report* *b) North-East Essex Alliance Highlight Report*	Note	Alliance Directors *Report No: ICB 23-09*

		c) *West Suffolk Alliance Highlight Report*		
RESEARCH				
1130	**16**	**Integrated Care Academy Annual Report** **https://reports.integratedcareacademy.org.uk/home/**	Note	Amanda Lyes *Report No: ICB 23-10*
FINANCE, PERFORMANCE AND SCRUTINY				
1135	**17**	**Suffolk and North-East Essex ICB Finance Report** ***To receive and note*** *a report from the ICB's Director of Finance*	Note	Howard Martin *Report No: ICB 23-11*
1145	**18**	**Board Assurance Framework** ***To review and approve*** *the current Board Assurance Framework*	Approve	Amanda Lyes *Report No: ICB 23-12*
GOVERNANCE AND CORPORATE BUSINESS				
1150	**19**	**Review of the ICB Constitution** ***To receive and review*** *the ICB Constitution*	Review	Amanda Lyes *Report No: ICB 23-13*
1155	**20**	**Developing a Health Inequalities and Prevention Committee** ***To receive and approve*** *a report from the ICB's Chief Executive*		Ed Garratt *Report No: ICB 23-14*
1205	**21**	**Policy Endorsement** ***To endorse*** *the following policies approved by the ICB's Remuneration and HR Committee* • Change Management • Grievance • Absence • Working in partnership with trade unions	Endorse	Amanda Lyes *Report No: ICB 23-15*
1210	**22**	**Committee Minutes and Highlight Reports** ***To receive and note*** *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.* *d)* **Finance Committee** *No minutes to present this time.*	Note	Amanda Lyes *Report No: ICB 23-16*

		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* *h)* **Strategic Digital Investment and Assurance Board** *A summary of minutes of a meeting held 29 November 2022*		
1215	**23**	**Attendance Log** ***To note and review*** *attendance at ICB Board meetings.*	Note/ Review	Will Pope (Chair)
1217	**24**	**Any Other Business**		All
1219	**25**	**Date and Time of Next Meeting:** <u>Scheduled Date:</u> 21 March 2023 (0900-1200)		
1220	**26**	**Questions from the public – Maximum 10 minutes** *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.*		

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 Professional Interests	Non Financial Personal Interests		From	To			
VCSE Sector Assembley	Kirsten	Alderson	SFC is commissioned by SCC and Health in Suffolk and frequently submits bids that have been competitively tendered.	P			Direct		Ongoing	28/10/2022	To be declared when necessary	Yes
Interim Director of Finance	Chris	Arnitt	Nil							04/10/2022		Yes
Primary Care Essex Partner	Freda	Bhatti	GP partner, Gt Bentley Surgery, Colchester, cCO78PJ							04/10/2022	To be declared when necessary	Yes
			NEE LMC Member							04/10/2022	To be declared when necessary	Yes
			Spouse Consultant Gastroenterologist							04/10/2022	To be declared when necessary	Yes
Provider Partner - Community	Craig	Black	Nil							18/10/2022		Yes
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	P			Direct	Apr-22	Ongoing	06/10/2022	To be declared when necessary	Yes
			Independent Board Director, University of Suffolk		P		Direct	Aug-19	Ongoing	06/10/2022	To be declared when necessary	Yes
			Strategic Advisor, Royal College of Physicians		P		Direct	Dec-21	Ongoing	06/10/2022	To be declared when necessary	Yes
			Trustee and Hon Treasurer, Dementia UK		P		Direct	Jul-16	Ongoing	06/10/2022	To be declared when necessary	Yes
			Trustee and Hon Treasurer, Young Dementia UK		P		Direct	Nov-20	Ongoing	06/10/2022	To be declared when necessary	Yes
Suffolk County Council Partner	Sue	Cook	Nil							19/10/2022		Yes
Non Executive - People, Remuneration and Diversity	Tanya	Curry	Nil							17/10/2022		Yes
Chief Executive	Ed	Garratt	Visiting Professor of Integrated Care – University of Suffolk		P		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 Mainly teaching on the MBA programme	P			Direct	Jun-19	Ongoing	04/10/2022	To be declared when necessary	Yes
			Senior Advisor, Lexington Communications Ad hoc advice for engaged clients in relation to government affairs	P			Direct	Feb-20	Ongoing	04/10/2022	To be declared when necessary	Yes
			Ad hoc work for Innovate UK, part of UKRI, Assessing applicants for government funding	P			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	P			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	P			Direct	Apr-13	Ongoing	05/10/2022	To be declared when necessary	Yes
Medical Director	Andrew	Kelso	Member Association of British Neurologists		P		Direct	Jan-04	Ongoing	05/10/2022	To be declared when necessary	Yes
			Master, Essex Association of Change Ringers (Registered Charity No 292250)			P	Direct	Jan-18	Ongoing	05/10/2022	No further action required	Yes
			Trustee, Music in Hospitals and Care (Registered Charity No 1051659)		P		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)	P			Direct	Oct-22	Ongoing	05/10/2022	To be declared when necessary	Yes
Director of Finance	Howard	Martin	Nil							08/11/2022		Yes
Director of Nursing	Lisa	Nobes	Nil							05/10/2022		Yes
Chair	William	Pope	Professor at the University of Suffolk		P		Direct	Jul-22	2020	12/10/2022	To be declared when necessary	Yes
Primary Care Suffolk Partner	Nick	Rayner	Director of online pharmacy- L&R Pharma Ltd	P			Direct	Apr-17	Ongoing	04/10/2022	To be declared when necessary	Yes
			GP Partner at Suffolk Primary Care	P			Direct	Jan-13	Ongoing	04/10/2022	To be declared when necessary	Yes
			Non-exec Director, Suffolk GP Federation CIC ltd							04/10/2022		Yes
Provider Partner - MH	Stuart	Richardson	Nil							04/10/2022		Yes
Essex County Council Partner	Patrick	Warren-Higgs	Nil							04/10/2022		Yes
Other Regular Attendees:												
Director Ipswich and East Suffolk Alliance	Maddie	Baker-Woods	Trustee of Suffolk ArtLink		P		Direct	Mar-20	Ongoing	10/10/2022	Declaration when necessary	Yes
Director of Performance and Improvement	Paul	Gibara	Nil							12/10/2022		Yes
Integrated Care Partnership Director	Susannah	Howard	My daughter is an employee of Healthwatch Suffolk			P	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 organisations			P	Indirect	Jan-20	Ongoing	06/01/2023	To be declared when necessary	Yes
			My step-son is an employee of St Elizabeth Hospice			P	Indirect	2007	Ongoing	06/01/2023	No further action required	Yes
			My step-daughter is a community nurse employed by Virgin in NEE			P	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		P		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	P			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.	P			Direct	2022	Ongoing	06/01/2023	To be declared when necessary	Yes
Director of People and Workforce	Amanda	Lyes	Director of Workforce & People for Suffolk & North East Essex ICB	P			Direct		Ongoing	10/01/2023	No further action required	Yes
			Visiting Senior Fellow in Integrated Care, University of Suffolk		P		Direct	Jan-23	Ongoing	10/01/2023	To be declared when necessary	Yes
ICP Chair Suffolk	Andrew	Reid	Nil							04/10/2022		Yes
ICH Chair Essex	John	Spence	Chairman Spicer Haart Group Ltd (Estate Agency)	P			Direct	2021	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Business Banking Resolution Service	P			Direct	2021	Ongoing	19/10/2022	To be declared when necessary	Yes
			Chairman Cambridge Building Society.	P			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)	P			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member and Vice-Chair Mid- and South-Essex ICS	P			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Herts and West Essex ICS	P			Direct	Jul-22	Ongoing	19/10/2022	To be declared when necessary	Yes
			Board Member Chelmsford Business Improvement District Ltd	P			Direct		Ongoing	19/10/2022	To be declared when necessary	Yes
			Membership or other Roles in Charities/Political Parties/Pressure Groups/Public Bodies/Trade Unions. •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		P		Direct	Jan-13	Ongoing	19/10/2022	To be declared when necessary	Yes
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 Sufofik Alliance	Peter	Wightman	Nil							18/10/2022		Yes
Director of North East Essex Alliance	Laura	Taylor-Green	Brother-in-law works for SilverCloud UK LTD as a product manager			P	Indirect		Ongoing	09/11/2022	No further action required	Yes
			Close friend is employed by Tiptree Medical Practice (part of COLT PCN)			P	Indirect		Ongoing	09/11/2022	To be declared when necessary	Yes
			NEE Alliance director with role accountability to Tendring District Council, Colchester Borough Council and Essex County Council			P	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			P	Indirect	Nov-22	Ongoing	09/11/2022	To be declared when necessary	Yes

NHS
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Integrated Care Board

Integrated Care Board meeting held on 22 November 2022 at Endeavour House, Ipswich 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 (Part)
Steve Clarke	Non-Executive, Finance and Audit
Sue Cook	Partner Member Suffolk County Council
Tanya Curry	Non-Executive, People, Remuneration and Diversity
Steve Feast	Non-Executive, Quality and Safety (Part)
Ed Garratt	ICB Chief Executive
Howard Martin	ICB Director of Finance
Nick Hulme	Provider Partner Member – Community (Part)
Dr Andrew Kelso	ICB Medical Director
Lisa Nobes	ICB Director of Nursing
Dr Nick Rayner	Partner Member Primary Care Suffolk
Stuart Richardson	Provider Partner Member - Mental Health
Patrick Warren-Higgs	Partner Member Essex County Council

REGULAR ATTENDEES:

Maddie Baker-Woods	Director Ipswich and East Suffolk Alliance
Paul Gibara	ICB Director of Performance and Improvement
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
Andy Yacoub	Healthwatch

IN ATTENDANCE:

Angela Ashton	SNEE ICB (Part)
Dr Shane Gordon	ESNEFT (Part)
Jo Mael	Corporate Governance Manager (Minutes)
Simon Morgan	Head of Communications
Julie White	SNEE ICB Training Hub Manager (Part)
Dr David Cargill	Training Hub GP Lead (Part)
Susan Balaam	Healthwatch (Part)
Lisa Booth	Nursing and Allied Health Professional Lead (Part)

22/050 NOTIFICATION OF ANY QUESTIONS FROM MEMBERS OF THE PUBLIC FOR RESPONSE AT THE APPROPRIATE TIME ON THE AGENDA.

The Board were notified of two questions that had been received prior to the start of the meeting. It was agreed that they would be responded to at the end of the meeting.

22/051 WELCOME AND APOLOGIES FOR ABSENCE

Kirsten Alderson was welcomed to the Board as the Partner Member Voluntary, Community and Social Enterprise (VCSE) and Howard Martin was welcomed to his first meeting as ICB Director of Finance.

Apologies for absence were received from:

Craig Black Provider Partner Member – Acute

Other Regular Attendees:

Cllr Andrew Reid Integrated Care Partnership Chair, Suffolk

22/052 DECLARATIONS OF INTEREST AND HOSPITALITY AND GIFTS

As Chief Executive of ESNEFT, Nick Hulme, Partner Member – Community, declared an interest in agenda item 15 (Suffolk and North-East Essex Cancer Transformation Programme Budget Allocation Approval). At the Chair's discretion he remained in the meeting when the item was discussed.

Steve Clark, Non-Executive Member, declared an interest in agenda item 13 (Dentistry Briefing) as a member of the University of Suffolk Board and partner in creation of the joint venture. As the item was for note, at the Chair's discretion he was permitted to remain in the meeting when the item was presented.

22/053 MINUTES OF THE PREVIOUS ICB BOARD MEETING HELD IN PUBLIC ON 27 SEPTEMBER 2022.

The ICB Board approved, as a correct record, the minutes of its meeting held in public on 27 September 2022 **subject to** a change on page 8 from past to present tense to state 'would be assessing' and also to revise '6-8 metrics' to '6-8 domains'.

22/054 MATTERS ARISING FROM THE ICB BOARD MEETING OF 27 SEPTEMBER 2022 AND REVIEW OF OUTSTANDING ACTIONS.

There were no matters arising and the action log was reviewed and updated with comment as follows:

22/049 – contact with the questioner was being progressed.

22/055 GENERAL UPDATE

The ICB Chief Executive reported;

- Dr Ewen Cameron had been appointed as the new Chief Executive of West Suffolk NHS Foundation Trust, he had previously been Director of Improvement and Innovation at Cambridge University Hospitals and was a Consultant Gastroenterologist. The ICB Board thanked Craig Black for his work and contribution during the past 15 months whilst 'acting up' in that position.
- Sara Hurley, Chief Dental Officer for England had been appointed as Chair of the new dental enterprise being established with the University of Suffolk.
- As announced by the Chancellor last week, the NHS was to receive a £3.3billion increase to funding and the new hospital programme was to continue. There was increased funding for the adult discharge fund which would be taken through by local authorities, the ICS and the Better Care Fund.

- Patricia Hewitt would be leading a review of the role of Integrated Care Boards (ICBs) which would consider autonomy and accountability.
- Suffolk had been supported in its devolution bid and consultation and full council support would be required. Locally, key areas of focus were on additional investment and a net zero strategy. As part of the arrangements Suffolk County Council would have an elected leader going forward.
- Preparations for Winter continued. Additional beds had been put in place ahead of schedule and a system control centre would be in set up from December 2022. Although performance was good, the need for more initiatives remained.
- Care Quality Commission (CQC) – West Suffolk NHS Foundation Trust was congratulated on its rating of 'good' for inpatient services. Unity Healthcare in Haverhill had also received a 'good' rating and the Board noted that Dr David Brandon from that practice had accepted a leadership role with the ICB.
- The CQC had received carried out a review at Norfolk and Suffolk NHS Foundation Trust and a Section 29A had been given to Essex Partnership University Trust (EPUT) following the recent Dispatches programme regarding inpatient care. The Section 29A related to facilities in South Essex.
- The Clacton Diagnostic Centre was delivering over 2000 tests per week and work was taking place with Health Education England with regard to development of a training approach that could be rolled out across the system.

The Board was informed that Sir David Behan, Chair of Health Education England was visiting the Clacton Diagnostic Centre on 29 November 2022 and Board Members were also invited to attend.

The Board received and noted the updates.

(Dr Freda Bhatti and Steve Feast joined the meeting)

Industrial action announced by the Royal College of Nursing.

The Director of People and Workforce introduced a report that provided an update on industrial action announced by the Royal College of Nursing and the ICB's response.

Across the UK, nursing professionals at most NHS employers had voted for the first time ever to strike, in a dispute over pay. The action involved members of the Royal College of Nursing (RCN) in over 50 per cent of hospital and community teams.

The RCN was campaigning for a pay rise of 5 per cent above inflation.

Organisations that had met the legal threshold for industrial action within the East of England were set out in paragraph 1.6 of the report. The RCN's mandate to organise strikes ran until early May 2023, although action could take place before the end of 2022.

At present (15 November) no dates for strikes by NHS staff had been confirmed. While RCN had received a mandate for action at a number of NHS employers, they had not yet given formal notice of action taking place.

The position of Suffolk and North-East Essex ICB was set out in paragraph 1.8 together with operational issues to note.

Comments included;

The Board was informed that acute Trusts were carrying out detailed contingency planning. At ESNEFT 56% of eligible nurses had voted for industrial action although it was not yet clear if they would all strike. Agreement was being sought between the NHS and Unions as

to what was defined as urgent and emergency care and when that might include elective activity.

It was reported that the British Medical Association (BMA) was taking action on extra contractual work, and advice was being provided for practices with regard to safe levels of working. Discussions were continuing in order to maintain safety for patients.

The ICB Board noted the report and **was assured** of the planning work taking place.

22/056 EXPERIENCES OF WAITING FOR ELECTIVE CARE – HEALTHWATCH SUFFOLK REPORT AND SUFFOLK AND NORTH-EAST ESSEX (SNEE) WAITING WELL.

The ICB introduced the item by thanking Healthwatch for its informative report.

It was explained that the work with three acute hospitals had been unique and had brought about significant response from members of the public. The Board was being asked to note the recommendations with regard to system approach and consider a similar approach might be taken for other surveys.

The report shared the findings and recommendations of the Healthwatch Suffolk (HWS) report on 'Experiences of waiting for elective care in Suffolk and North-East Essex'.

The Healthwatch Suffolk report highlighted the breadth of impact that waiting for elective care could have on people's lives. An integrated, holistic system-wide response was required, which addressed both the immediate impact of delays as well as the longer term consequences for people. The report highlighted;

- That support whilst waiting for elective care was not felt to be adequate with key concerns being information and communication. 48% of people said they had not been given an indication of how long they would need to wait.
- There was a willingness to travel if it meant they would be seen sooner and those waiting the longest were the most willing to travel.
- Impact on life – 76% had experienced increased pain, 73% had experienced an impact on their social life, two thirds of people had experienced poorer mental health and the ability to carry out household tasks had been affected. Of the support offered whilst waiting, 39% felt it had been the right support. 53% with increased pain had been able to access help for pain, of those where it had affected their mental health only 16% felt they had been offered help.
- There was disparity of support offered and the aspects of life affected. There was a need to think about holistic care to support those impacted, together with a need for better communication and transparency. Although there was evidence of inequality it had not been possible to draw firm conclusions, and more work was required. The report provided a baseline measure from which to check if plans were making a difference. It was recommended that there be a follow up survey.
- Work already in place included the 'Together we are better' workstream which included development of the SNEE wellbeing website that provided information on mental health support, exercise, housing and finance. The website was being promoted within primary care and patient information leaflets and easy read leaflets had been produced. There was an awareness campaign associated to the website and referral and acknowledgement letters included a link to the website where patients could also view expected wait times. Integrated Neighbourhood Teams were developing a patient tracking list.

It was Healthwatch's recommendation that further work to address the findings and recommendations of the report should take place at a local alliance level to incorporate all partners in the delivery.

Comments included;

The impact of patient waits on primary care was highlighted as there were often increased requests for analgesia and support.

Having noted that 1 in 6 people were currently on a waiting list, it was questioned whether there was a need for an active strategy to seek to solve the situation.
With regard to the potential consequences of health inequality and the updating of elective care impact assessments it was queried whether anything else was required. Whilst an active strategy was welcomed, the need for it to include independent and VCSE participation was emphasized.

There was concern that only 39% of people had felt they had received the right support and it was queried whether further work with the respondents was planned. It was explained that the survey had been a 'one off' and there was no plan to continue work with responders at present.

It was highlighted that the stories within the presentation of people's experience of waiting had more impact than the numbers within the report. The stories should inform leaders to enable them to take a different approach and address challenges and should be shared amongst staff with regard to 'making every contact count' training. It was felt there was probably a need for the Alliance to provide assistance with regard to finding a solution as to which organisation was responsible for patients as they moved along pathways.

Communication was key and should be included within procedure. It was important to join forces to consider the way forward and for development of any strategy.

The impact of reading the stories within the report should not be diminished and it was felt there should be a similar survey in a years' time. The need for more work with regard to analysing inequality data was recognised and there was opportunity within development of the Joint Forward Plan to make commitments as a Board with regard to immediate need and also primary and secondary intervention. It was suggested that the Elective Care Committee should take the work forward.

Healthwatch was thanked for its work to produce the report**.**

The Board noted the report, **recognised** its importance, and **was supportive** of taking the work forward through the Alliances with further survey at a future date.

22/057 SUFFOLK AND NORTH-EAST ESSEX TRAINING HUB

The Board received an update on the work of the Suffolk and North-East Essex Training Hub. The presentation outlined work in respect of the workforce planning model; recruitment and retention and support; with current focus being on a system wide recruitment campaign for general practice and a collaborative system approach to achieve British Medical Association (BMA) safe working levels.

Comments included:

There was commonality as a system with regard to focus on workforce.

It was highlighted that a key element of how to deliver strong teams as those practices that were thriving seemed to be those with a united team across the workforce. Whilst there were a lot of initiatives it was often not possible for Primary Care Networks to step away and take time to consider those initiatives. Although there was a desire to rollout support it was also recognised that perhaps more could be done at Alliance and local level. Back office support had been provided to support training time.

The demand and pressure on general practice could not be overstated and there was a need to help general practice to help itself. The training hub was passionate about helping primary care to change the model and adapt multi-disciplinary teams.

Whilst the British Medical Association's safer working practice information was a vital document for GPs, practices could not carry out the recommendations alone as it was likely to bring push back from patients. It would be difficult to work to contract without system support.

The Board was informed that there was mental health funding available to develop the workforce which could be utilised within the wider practice community.

The Board noted the presentation **and recognised** that workforce was the largest asset. It **was reassured** by the determination to make progress and **was supportive** of the approach.

22/058 INTEGRATED CARE PARTNERSHIP UPDATE

Suffolk and North-East Essex ICP was a statutory committee jointly and equally convened under the Health and Care Act, 2022 by NHS Suffolk and North-East Essex ICB, Suffolk County Council and Essex County Council.

A key role for the 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.

The report went on to detail key issues in Section 2 and patient and engagement activity in Section 3.

The ICP had met in person on 11 November 2022 as part of a wider Community Connect Event hosted by the Ipswich and East Suffolk Alliance at The Food Museum in Stowmarket.

Work progressed to develop the ICS Integrated Care Strategy which included a comprehensive engagement programme and theme specific workshops. The steering group had proposed development of a strategic prioritisation tool to be included as part of the strategy.

Board Members were encouraged to visit the website to be informed of work that was taking and it was mentioned that what mattered was often the quality of relationships with people rather than money.

The Board noted the report.

22/059 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 - the Alliance was in the process of supporting the development of Integrated Neighbourhood Teams (INTs) and was pleased that all now had a single leader across social care and community sectors. Forward plans for INTs were being developed based on population health management data and the skills and experience of one team programme.

North-East Essex Alliance – current focus was on the 'Die Well' domain. Work included production of a spotlight report outlining progress in supporting people to die in their preferred place of care. Learning across other domains continued.

West Suffolk Alliance – the Alliance was focussing on the 'live well' domains and primary care premises issues continued to be in discussions.

The Board noted the highlight reports.

22/060 DIGITAL CARE TECHNOLOGY SERVICES

The Partner Members for Essex and Suffolk County Councils introduced the report which provided information on the development of both Councils digital care technology services.

Key points highlighted included;

There was a good business case for care technology with regard to the provision of increased efficiency and improved integration which, in turn, would provide improved experiences for members of the public. Development of Cassius within Suffolk and work carried out in West Suffolk was providing opportunity in respect of patient pathways there was a need, going forward, to think about planning development and structure.

The importance of culture to facilitate adoption and improvements was highlighted.

The Board was informed that it was nationally leading work and was a huge asset which required consideration as to how to accelerate it further. Having queried the feasibility of pursuing integration with health across the system, it was reported that the right framework was in place within Suffolk for such integration. Ensuring that correct governance was in place to facilitate replication was key.

Although there was opportunity to take the work into the elective care waiting space to improve experience, current work was focused on non-elective pathways. It was important to identify the correct technology and hardware. It was suggested that linkage into the wider system with regard to admission avoidance could prove beneficial.

Clarity with regard to funding was awaited as it was important to see more going into the care market. There was a need to think about how care technology could be used to maintain people's independence within the community.

Having queried whether an equality impact assessment had been carried out as not everyone benefitted from the use of technology, the Board was reassured that had been done as part of the service launch. It was felt there was now a growing level of maturity and proactive support and guidance was available dependent on need.

The question of clinical governance assurance with regard to ownership and sharing of the data was raised. It was explained that whilst there was a desire to prove the concept and incorporate it with other platforms, a data strategy exercise would be required. Clinical ownership and safety was a key part of the governance challenge.

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.

22/061 LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) ANNUAL REPORTS

The Board was in receipt of Learning Disabilities Mortality Review (LeDeR) annual reports in respect of Suffolk and Southend, Essex and Thurrock.

The ICB's Director of Nursing reported that the LeDeR work was carried out on national geographic areas aligned with Council footprints. The programme sought to understand why those with learning disabilities and autism died earlier and the associated themes and actions.

As set out in the reports there had been improvement with regard to the age of people when they died which, in Suffolk, had risen from 58 to 65, although that remained way off what should be expected. More people had died in their preferred place of death. There was a long way to go, and the programme was complex as it covered every service and provider. The two key elements were the facilitation of a good health check and action plan from primary care and empowering individuals to understand their rights with regard to health checks and enable them to be in control. Work was taking place in Suffolk on those elements and being extended into North-East Essex as well.

Reasonable adjustments – there was a legal requirement for those with learning disabilities to have reasonable adjustments made with regard to access and treatment and a lot of work was taking place in that area. There was a need for commitment from leaders and providers with regard to equity in user experience and it was important to ensure that everything was done to reduce variation in death for those with learning disabilities.

In response to questioning with regard to progress in respect of swallowing and airway protection, the Board was assured that work was underway to seek to address those issues.

It was highlighted that although there were approximately 14,0000 people with learning disabilities in Suffolk, only 3345 were currently registered, and a key focus should be to ensure all were registered.

Key actions from the action plan included pursuance of registration for all those with learning disabilities; support for primary care to deliver health checks and understand their importance; and ensure those with learning disabilities were aware they could have a health check.

Annual health checks actions – ensure all on register, support PC to deliver HC and understand importance. Ensure those with LD know can have HC. Action plan is key element. **Local authority Partner Members agreed** to explore options for their contribution to the work.

The Board noted the report **and supported** the work going forward.

22/062 DENTISTRY BRIEFING

There had been longstanding issues with NHS dental access including NHS routine dental care and urgent dental care. The problem had been amplified by the current Covid-19 pandemic.

In Suffolk, 224,300 dental treatments were delivered in 2020-21 which was 60% less than the pre-pandemic figure of 549,000. Suffolk was a significant pressure point for dental access with only 37.6% of the population accessing dentistry in the previous two years compared to 54.2% before the pandemic. Compared to England, Suffolk had a higher proportion of people aged 65 and over and a lower proportion of working age people. 61.1% of Suffolk households were in urban areas, compared to 82.3% for England as a whole. The centres of Suffolk's

urban areas had the highest population density: Ipswich and some surrounding areas (for example Kesgrave) and Lowestoft accounted for the ten most densely populated areas, and then major towns including Bury St Edmunds and Sudbury.

Across north-east Essex 74,821 dental treatments were delivered in 2020-21, that was 66% below the pre-pandemic figure of 223,222. In the two years to June 2021, 101,293 adults saw their local NHS dentist in north-east Essex which was 37% of the over-18 population, a drop from 50% in the two years to June 2019.

The report went on to detail key issues in Section 2 and current work underway in Section 3.

The Board noted and supported the content of the report.

22/063 SUFFOLK AND NORTH-EAST ESSEX (SNEE) INTEGRATED CARE SYSTEM RESEARCH

The ICB's Medical Director introduced the report which shared the Annual Research Report for 2021/22 (as CCGs) and sought to update the Board on the progress of the Research Strategy Action Plan.

Appended to the report for information were;

- The SNEE Annual Report which detailed the primary care research activity undertaken within the Ipswich and East Suffolk CCG, West Suffolk CCG and North-East Essex CCGs (collectively the Suffolk & North East Essex region, known as "SNEE") within 2021/22.

- The 2022-2027 SNEE Research Strategy which was adopted by the SNEE Board in July 2022. The Research Strategy Action Plan would ensure that there were clear pathways in place for the ICB to meet the Strategy aims.

- Reports of research activity at Essex Partnership University NHS Trust (EPUT), Norfolk and Suffolk NHS Foundation Trust (NSFT), West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

It was reported that outcomes improved if patients were able to contribute to research. The report had been promoted by receipt of a research report from ESNEFT and similar other provider reports. Within primary care there had been research across 64 practices and within mental health 2000 patients had had access to research, ESNEFT had carried out 260 studies across 29 depts. There was an inclusion in research focus and new researchers were being developed, providers had also engaged academic partners. The Board was reminded that the ICB Research Strategy had previously been presented and work continued on development of a detailed plan with regard to outcomes. There was intention to extend research networks into the west of Suffolk.

As there were two key pharmaceutical companies within the region and cancer research taking place, the wider commercial investment elements of the research strategy were queried. There was access to useful and representative populations and development of a commercial integration framework was being explored.

The Board noted the report and its appendices.

22/064 SUFFOLK AND NORTH-EAST ESSEX CANCER TRANSFORMATION PROGRAMME BUDGET ALLOCATION APPROVAL.

The report outlined a proposal for the current service development funding (SDF) based on the annual Cancer Programme funding schedule, which was the non-recurrent funding the

ICS Cancer Programme received each year to deliver the cancer delivery plan allocated by the national cancer programme team.

The report provided assurance that decision-making had been sought via the relevant governance to enable the distribution of the funding and sought approval to deploy the funding related to ESNEFT via a contract variation (CV). The amount to be transferred exceeded the scheme of delegation limit of the ICB Cancer Committee and was therefore submitted to the Board for approval.

In 2022/23 Suffolk and North-East Essex received £2.187m of resources for transformation projects based on weighted population (known as 'place-based funding).

ESNEFT required a contract variation (CV) to the value of £1,274,624, which was over the £1 million limit for the ICS Cancer Committee. West Suffolk NHS Foundation Trust (WSFT)'s contract variation was being progressed to the value of £638,188 following approval by the Committee. All the associated spend was monitored via monthly meetings with reporting back to the East of England Cancer Alliance (North), the ICS Cancer Operational Group and the ICS Cancer Committee.

The ICB Director of Funding reported that funding was in place and there was no objection to the recommendation.

The ICB Board unanimously approved the 2022/23 funding plan for the cancer transformation programme, as set out within the report, to enable the ICS Cancer Programme Committee to transfer funding to ESNEFT in accordance with the enclosed financial schedule.

22/065 INTEGRATED CARE BOARD (ICB) REPORT AND SYSTEM OVERSIGHT FRAMEWORK (SOF) PERFORMANCE INDICATORS

On 17 October 2022 NHS England published its Operating Framework, the publication heralded a cultural reset for the NHS which supported and reflected the change to System based approaches and the need for stronger partnership working. The framework would play a key role in guiding the creation of a new organisation bringing together NHS England, Health Education England and NHS Digital.

The document appeared to build on previously published system oversight framework and in performance terms reinforced the approach as set out in previously discussed performance paper. Importantly whilst ICBs had first line oversight of health provider performance NHS England retained its direct accountability to lead and support organisations.

It was expected that the first annual assessment of ICBs would be completed in quarter 1 of 2023/34 financial year.

On 18 of October 2022 ICBs had received several instructions under the umbrella of "Going Further on our winter resilience plans", and those were set out in paragraph 1.5 of the report.

SNEE had undertaken a gap analysis against each of the outlined requests which at the time of writing the report was demonstrating significant compliance, further discussion had taken place at the Urgent and Emergency Care Committee on the 14 November 2022.

SNEE had attended the launch of a national winter collaboration initiative on the 1 November 2022 designed to explore further opportunities to develop an improvement approach to managing urgent care activity.

The report went on to outline key issues in Section 2 and a summary of discussion at the System Oversight and Assurance Committee in Section 3.

Comments included;

Having heard the digital care technology services presentation, it was important to consider how those services might be brought into the work. The Board was reassured that the Urgent Care Committee was conscious of that work and would look to build on how it could be brought in prior to any future report.

It was questioned how we were different and what we were doing differently and queried whether there was a need to strategically act in a different way that might enable provider networks to grow. There was perhaps a need to review the governance structure and identify the information required by sub-committees in order to provide assurance to the Board. **The Board requested** that the topic be put on a future Board Development Session agenda for discussion.

It was anticipated that the forthcoming review of the role of ICB's to be carried out by Patricia Hewitt would assist the debate between ICBs and NHSE with regard to responsibility.

It was argued that the Board need to see improvement in performance and that there was no room for complacency.

The Board noted the report.

22/066 BOARD ASSURANCE FRAMEWORK

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

Amendments and additions to the BAF were detailed within Section 2 of the report.

The Board was informed conversations were taking place as to whether new risks associated to the cost of living; impact of organisational change and industrial action should be included.

The BAF was to be redesigned and updated prior to its presentation to Audit Committee on 15 December 2022 and to the Board on 24 January 2023.

Internal Audit had concluded phase 1 of its audit in respect of the ICB risk management process and their findings were awaited. Phase 2 would take place in February 2023 and would focus on how the ICB actively managed risk.

The need for the Board to consider how it might actively manage System risk was raised and **it was requested** that it would be a point for discussion at a Board Development Session from February 2023.

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.

The Board was advised that whilst it seemed to be heading in the right direction with regard to strategic risk management, it might also **benefit from development of a strategic opportunities log.**

(Nick Hulme left the meeting)

The ICB Board approved the Board Assurance Framework as presented.

22/067 PROCUREMENT IN THE INTEGRATED CARE BOARD

The report detailed the current procurement work plan in Section 2, key points highlighted from the rest of the report included;

There was now a need, for transparency, to publish any transactions above £10k.

There had been agreement to utilise Atamis 3.0 software which was a fully integrated, cloud-based modular procurement solution supporting the strategic sourcing cycle. It empowered users to analyse and understand spending behaviour, plan procurement pipelines, complete e-tenders. manage contracts and support the performance management of key suppliers.

ICB procurement was developing with current team focus on training, how to ensure the engagement of the voluntary, community and social enterprise sector, and social values.

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

Whilst the report was welcomed there were a number of procurements listed and how we linked procurements into overarching strategy would be key going forward. The capture of decision making was important and it was anticipated that the new software would assist with understanding and decision making on spend.

The ICB Board noted the information presented in the report.

22/068 CHAIR/CHIEF EXECUTIVE ACTION – 02/2022 – DELEGATION OF THE COMMISSIONING OF SPECIALISED SERVICES

The report sought endorsement of action taken by the Chair and Chief Executive as set out in Chair/Chief Executive action ICB 02-2022 with regard to the delegation of the commissioning of specialised services.

Specialised Commissioning functions and budgets for some Specialised Services would be delegated from NHS England (NHSE) to Integrated Care Boards (ICBs) from April 2023. For systems in the East of England agreement was sought that the date for delegation of specialised services be April 2024 rather than April 2023. ICBs were not ready for delegation from April 2023, and therefore 2023/24 would be an interim year, where NHSE would set up a statutory Commissioning Committee, which would require ICB representation and leadership. The six East of England ICBs were proposing to defer delegation to 2024/25.

The proposal was for the delegated specialised services to be managed initially through a multi-ICB Joint Commissioning Committee which would have representation from each of the six East of England ICBs. There were ongoing discussions with Bedfordshire, Luton and Milton Keynes (BLMK) ICB to manage the organisation of the committee and host a central specialised commissioning team, on behalf of the six ICBs.

Each ICB, working with NHSE had been required to complete a pre-delegation assessment framework (PDAF) and return it with local approval by the 25 October 2022. The proposal for ICB and regional arrangements for specialised services was tabled at a Regional Leadership Team meeting on the 3 November 2022. The NHSE Regional Director was to submit recommendations, on delegation of specialised services, to a National Moderation Panel by 23 November 2022.

The Chair and Chief Executive had subsequently taken a decision under delegated powers to approve the Pre-Delegation Assessment Framework proforma ahead of submission to NHSE.

Having queried who carried the risk of specialised commissioning spent more than intended, it was explained that accountability would remain with NHSE.

The Board endorsed action taken by the Chair and Chief Executive as set out within Chair/Chief Executive Action No 02/2022.

22/069 EXECUTIVE COMMITTEE TERMS OF REFERENCE

The Board was in receipt of terms of reference for the Executive Committee which it was being asked to approve.

It was highlighted that the Executive Committee had a role to set strategy as set by the Board to achieve best possible outcomes. It was important that the Committee used the Board to help deliver the strategic framework in order to be more effective and deliver outcomes as determined by the Board. The need to do that within available resources should be incorporate within the terms of reference.

The Board accepted the terms of reference as a working draft, **subject to** their further revision in line with comments made and return to the Board for final approval.

22/070 DECLARATION OF INTERESTS AND GIFTS AND HOSPITALITY REGISTERS

The report provided a public record of relevant and material interests declared by members of the Integrated Care Board its sub-committees, and decision making staff, together with the current Gifts and Hospitality Register. The ICB Board was asked to review the registers and consider whether any action was required prior to them being placed on the ICB's website.

The need for consistency across declarations was highlighted.

The Board;

1) **Noted and approved** the declarations of interest and gifts and hospitality registers for publication.
2) **Requested** that Decision Making Staff that had not be responded be reminded with Directors asked to follow up with relevant staff.

22/071 TECHNICAL AMENDMENTS TO THE ICB CONSTITUTION

Further to commencement of the Health and Care Act (2022) NHS England's legal team conducted a review of the model constitution that was published by them in May 2022 and identified several small technical amendments that needed to be made.

NHS England indicated that the amendments needed to be agreed by the Chair and Chief Executive by 30 September 2022 but endorsement by the Board did not need to happen by that date and could be deferred until a later meeting.

The technical amendments necessary were set out in Section 2 of the report.

NHS England was informed on 26 September 2022 that the amendments had been approved by the Chair and Chief Executive.

NHS England responded on 4 October 2022 that the amendments had been duly authorised and a copy of the revised version of the Constitution was immediately placed on the ICB's website.

The Board endorsed the decision by the Chair and Chief Executive to approve the technical amendments to the ICB Constitution as set out within the report.

22/072 COMMITTEE MINUTES AND HIGHLIGHT REPORTS

The ICB 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 26 September 2022.

b) **Quality Committee**
The minutes of a meeting held on 15 September 2022.

c) **People Committee**
The unconfirmed minutes from a meeting held on 19 October 2022.

d) **People and Communities Committee**
Highlight report October 2022

e) **Estates Committee**
Highlight report October 2022

f) **Strategic Digital Investment and Assurance Board**
A summary of minutes of a meeting held on 1 September 2022.

The Board noted that whilst the Finance Committee had not yet been established, work was underway to address that issue; and it had previously been decided that the Procurement Committee would not be established at present and could therefore be removed from the list of regular updates.

22/073 ATTENDANCE LOG

The Board received and noted the current attendance log.

22/074 ANY OTHER BUSINESS

No items of other business were received.

22/075 DATE AND TIME OF NEXT MEETING

Scheduled Dates:

24 January 2023

22/076 QUESTIONS FROM THE PUBLIC – MAXIMUM 10 MINUTES

The following questions were received;

Question 1 - I have read reports that the government is planning to offer a national contract to Palantir to handle patients' NHS data, and this will be done without any consultation with, let alone approval of, the public. Does the ICB on behalf of the residents in East and West Suffolk and North-East Essex condone this use of public money without the engagement of those of us who will be affected, particularly given the known dubious practices of that American Company, and thus will the ICB not cooperate with this and thereby put the interests of People before Profit? Patients like me have already rejected a similar proposal to access patient data without our agreement a couple of years ago. We had to 'opt out' in what should be a situation where people can make up their own minds and 'opt in' if they foolishly wish to.

Response: 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.

Question 2 - I have read that the ICS is planning to hold a People and Community public event in Ipswich in December in the Town Hall. Could you provide me with the details and point me where in the public domain where they can be found? I assume that this is going to be co-produced, is it?

Response:

A People and Communities event is being held on 14 December 2022 in Ipswich Town Hall and is open to anyone in SNEE to attend. Registration information is published on the engagement platform Letstalksnee.co.uk
https://www.letstalksnee.co.uk/people-and-communities-working-together-to-make-things-better

The event has been promoted through a number of different channels and will be co-produced with those attending. This will include an open space section of the agenda and interactive opportunities with senior members of the ICB and partners. We will be sharing more information with those signed up to attend ahead of the event. We are also very pleased to welcome representation from the national team from NHS England at the event so that we can work with them on development of the national approach.

Question 3 – is there any training around adults who are autistic? Or information for social prescribers on what is out there?

Response:

Oliver McGowan training with regard to how to better support people with autism would be rolled out next year across health partners and would be mandatory. It would be face to face training which would be delivered by experts. **The Director of Nursing agreed** to explore information for social prescribers in knowing where to signpost people to.

Question 4 – the Board was reminded that at its previous meeting a question with regard to the use of civil money from new developments to provide local services had been raised. To date no response had been received to that question. In the interim the questioner had been to see a doctor at the local practice who advised he had been informed that such monies were not necessarily used within the local area. Could assurance be provided that such monies would be utilised locally? There was great concern that monies from massive developments were not being used to contribute to local services.

Response:

The Board apologised that no response had been received and the questioner was reassured that the Ipswich and East Suffolk Alliance Director would make contact in the near future once advice from Estates colleagues had been sought.

NHS
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North East Essex
Integrated Care Board

ICB BOARD
ACTION LOG: 22 November 2022 (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 30th January to explore further.
22/066	Board Assurance Framework	1) The need for the Board to consider how it might actively manage System risk was raised and it was requested that it would be a point for discussion at a Board Development Session from February 2023. 2) 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.	Amanda Lyes Sue Cook/Patrick Warren-Higgs	Entered onto Board Development Session Forward Plan - **Complete**
22/069	Executive Committee Terms of Reference	The Board accepted the terms of reference as a working draft, subject to their further revision in line with comments made.	Amanda Lyes	13/12/22 - Further to discussion at the Board meeting in November 2022, The Executive Committee terms of reference have been updated & now read at: **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 and at: **2.3** The EC provides executive oversight and assurance to the Board in regard to the execution of agreed ICB strategy

MINUTE	AGENDA ITEM	ACTION	RESPONSIBILITY OF:	TIMESCALE/UPDATE
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	
		2) Question 3 – is there any training around adults who are autistic? Or information for social prescribers on what is out there? The Director of Nursing agreed to explore information for social prescribers in knowing where to signpost people to.	Lisa Nobes	
		3) Question 4 – the Board was reminded that at its previous meeting a question with regards to primary care estates in Felixstowe. The Board apologised that no response had been received and the questioner was reassured that the Ipswich and East Suffolk Alliance Director would make contact in the near future once advice from Estates colleagues had been sought.	Maddie Baker-Woods	The Alliance Director and Deputy Director of Primary Care met with the member of the public on 30th November in Felixstowe to discuss. - **Complete**

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ICB BOARD

Agenda Item No.	**08**
Reference No.	**ICB 23-02**
Date.	**24 January 2023**

Title	Suffolk and North East Essex Integrated Care Strategy
Lead Director	Susannah Howard, Integrated Care Partnership (ICP) Director
Author(s)	Susannah Howard, Integrated Care Partnership (ICP) Director
Purpose	Formal Receipt

Recommendation:

The agenda for the next meeting of the Suffolk and North East Essex ICP on Friday 13 January 2023 includes consideration and a recommendation to approve the Suffolk and North East Essex Integrated Care Strategy.

Subject to this approval, members of the NHS Integrated Care Board are 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. This includes 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 has informed the development of the Integrated Care Strategy.

1. Background

A key role for the ICP is to develop a single Integrated Care Strategy that sets 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, can 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 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 is readily available to people throughout the integrated care system through routes that are most meaningful to people, including those with accessibility needs and low levels of health and care literacy. It is important that the people, their communities, and organisations who have contributed to the strategy are 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. This paper provides:

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

2. Key Issues

a. Key Messages from our engagement with people living and working in Suffolk and North East Essex on our Integrated Care Strategy

To develop our Integrated Care Strategy we asked people living and working in Suffolk and North East Essex to tell us what is important to them in health and care, and how we should be thinking differently. We offered a range of ways for people to share their views:

- Completing an online survey, through our ICS, Healthwatch Suffolk and Essex websites
- Community groups holding a community conversation and telling us the key messages
- Recording their views in our pop-up video booth
- Contacting the Integrated Care Partnership secretariat team directly

From this the views and ideas of more than 600 people have directly informed our ICS strategy, which is now available at www.sneeics.org.uk. This paper describes a number of key recurring themes from this engagement, some of which focus on particular services or sectors, while others cut across all areas of health and care.

Access to health and care

Timely and convenient access to health and care was vital for many respondents:

- ***Streamlining access*** – a single point of access so that people and their carers do not have to navigate the system. Access to a consultant in a reasonable timeframe without having to go through a GP. More effective secondary care, avoiding repeated visits to have tests and obtain results over a lengthy period.
- ***More local services*** – including pop-up services such as blood tests or health screening, local hubs providing health and financial advice and access to equipment, and more services in non-health and care settings such as libraries and schools.

- ***Information on support*** –online information and support, is convenient, but those who are not comfortable with the internet or do not have access need a different approach to their support. Information on support could be made available more widely e.g. supermarkets.

Access to, and quality of GP services was the biggest single issue highlighted. People's main concerns were:

- ***Registration*** – people moving home found that GP's lists were full and so could not register with a local doctor.
- ***Access to appointments*** – difficulties getting through at 8am, the time clashing with other commitments such as travel to work, and waiting all morning/day for the GP to call. The difficulties led some to go to A&E instead. Limited availability of advance appointments, and a lack of appointments outside normal office hours.
- ***Face to face appointments*** – very difficult to secure. Most people wanted face-to-face appointments, lacking confidence that their GP can diagnose, or do an effective health review over the phone.
- ***GP reception*** – people said phones are not always answered, some people experienced receptionists as rude and that they were made to feel a burden. People were reluctant to share personal details with someone not medically trained to secure an appointment, and some believed staff were preventing them from seeing a GP.
- ***Quality of GP service*** – some positive experiences but many complained about not seeing the same person each time, varying advice from different doctors, and not being believed. People wanted prompt referrals to secondary care, and for their GP to help advocate where there were delays.
- ***Prevention role*** – GPs should provide more health prevention guidance, and to use check-ups as an opportunity to discuss and uncover any health issues. Better infection control will protect the vulnerable against Covid.

'You're always talking to someone different. It's hard to explain your issues at a distance. I think the problems build up.'

Accessible urgent and emergency care was a priority:

- ***Ambulances*** – people were very positive about paramedic services, but worried about waits.
- ***Urgent care*** – more walk-in centres should be available, open 24/7. Some people advised to go to A&E could not afford to travel there or access public transport. People worried about urgent issues worried about driving themselves to hospital. Some people are taking relatives with severe injuries to hospital in the car, others feel helpless if they have no option but to wait for the ambulance. People needing urgent NHS dentistry sometimes resorted to repairing or removing teeth themselves at home.

Waiting for care

Waiting for diagnosis, treatment and support has impacted significantly on people's physical and mental health:

- ***Stress*** – waiting for tests and treatments, including those with cancer, caused stress and mental ill-health for people and their families. Moving from screening to testing to diagnosis and treatment should be quicker.
- ***Worsening health*** – people's physical health and wellbeing deteriorated while awaiting surgery, with some avoidable deaths, Those waiting for mental health assessment and care experienced deteriorations in their condition. People wanted advice on how to cope and the support available while waiting.
- ***Lack of support*** – some people with mental health conditions had difficulties accessing a mental health professional, which was important particularly after a crisis.

'I feel waiting time for treatments is not only wasted time when there may be opportunities to do other things which might help, but also people often deteriorate more when they feel helpless.'

Joined up care delivered by a competent, caring, compassionate workforce

A trusting relationship with the health and care staff is built through providing high quality care:

- ***Listening*** – professionals should get to know the person, listen and take them seriously. Staff should ask people how they feel, and take time to understand them. Professionals should read notes to avoid people repeating their story.
- ***Responding*** – professionals should take time to explain things fully. If people have tests they want follow up, whatever the results. Staff should be competent, caring, reassuring, respectful, open and honest.

> ***'Take more time to listen to patients concerns. Think of them as individuals and not a number.'***

- ***Communicating*** – services should communicate better with each other and with the person and their carer. People moving between services need continuity of care and for services to communicate with them and their families. People want single care plans and records, shared between services.
- ***Caring*** – people need the right information on how to secure support, particularly in mental health including eating disorders and hoarding. Eligibility criteria are often high, leaving people without the right support. Older people worry about the cost of care. People need choice and control over their care, and their wishes respected. Services have been less available and accessible due to Covid, and delays continue, but early diagnosis and support is essential. Family carers need meaningful support. Shortages in social care staff resources mean people cannot return home from hospital, which is particularly hard at end of life.

> ***'Get me involved, get the next person involved. It is my health; it is my care. I should know what works best for me, so everybody should be involved.'***

Inclusive, anti-discriminatory, individualised care

- ***Recognising people's individuality*** – including their culture and spirituality, and the complexities of their lives. Disabled people and those with long term conditions can feel pushed around the system, and their health issues are simply blamed on their condition. Older people wanted to be independent for as long as possible but were often told 'what do you expect at your age?'

> ***'It's important for services to be accessible to everybody regardless of their age, ability, disabilities, financial situations and so on.'***

A 'broken' health and care system…

- ***Funding*** – many people felt the NHS and social care is underfunded, and staff are under-paid and under-valued.
- ***A two-tier system*** – people are increasingly conscious of the division between private healthcare and NHS funded care, highlighting the difficulties in accessing NHS dentistry, and seeing the increasing use of private hospitals by the NHS as evidence of NHS privatisation. People felt the high costs of care homes and their privatisation have led to profits being taken out of the health and care system. GPs were perceived by some to be operating as businesses for profit.
- ***Growing populations*** – people worried that newly built homes placed pressures on already-stretched services.

… but a system where people want the best health and care for everyone

What unites all the people who responded to our engagement is a shared commitment to securing the best health and care for them and those closest to them, to support our health and social care services, and for health and care services to continue to uphold their core principles and values of the NHS.

b. Initial Integrated Care Strategy

Our Integrated Care Strategy for Suffolk and North East Essex ICS is presented as:

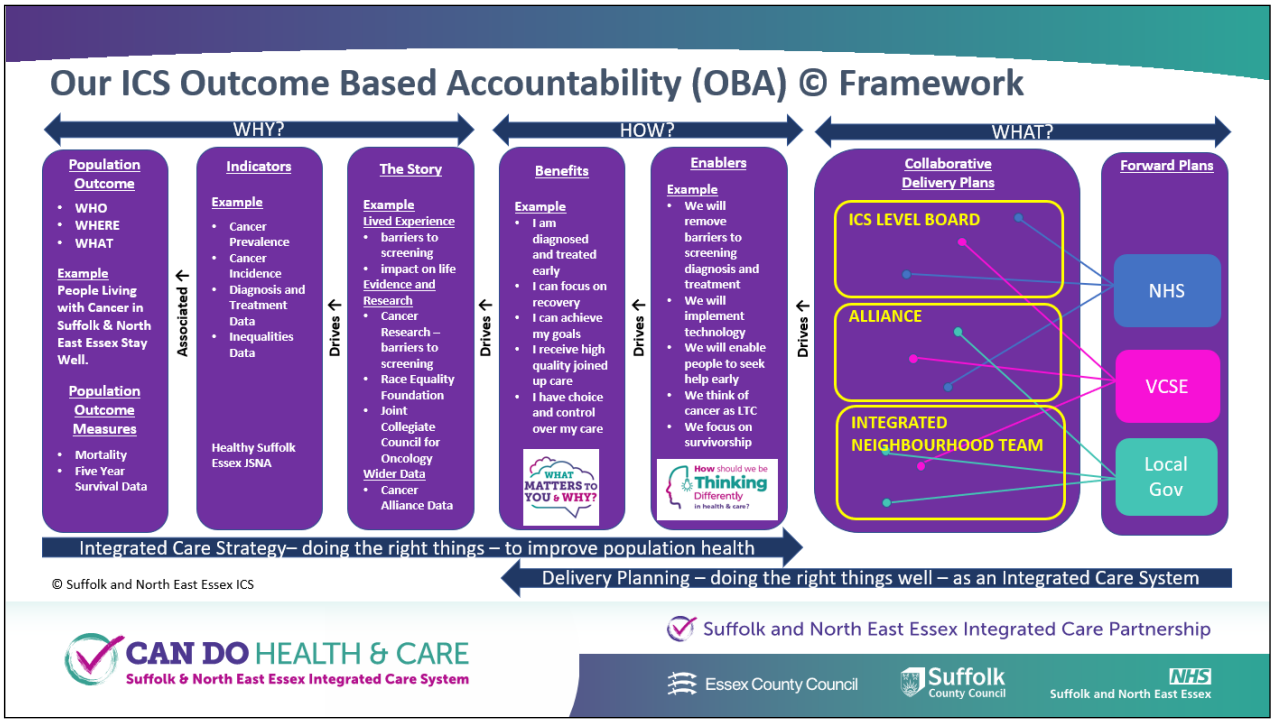
- a short high level summary document – also attached
- underpinned by a detailed new website for Suffolk and North East Essex ICS website www.sneeics.org.uk that sets out our Integrated Care Strategy in full with significantly more detail for each key area including population outcomes, data and indicators, our understanding of the story behind these outcomes based on lived experience and published evidence, information about what matters to local people, our ambition for how things will be different in Suffolk and North East Essex, case studies and links to wider resources.

As an ICP we want to encourage and enable deeper cross-sector understanding, thinking and planning in health and care. We also want this work to be informed by evidence and lived experience. Our Integrated Care Strategy provides a flexible, collective, central resource that is accessible by all, to enable everyone to be part of the work of the ICS going forward.

The strategy builds on and brings together earlier work and thinking from across partners in the Suffolk and North East Essex ICS and describes a shared vision from the perspective of ***'what matters'*** to people living in Suffolk and North East Essex and ***'our Collective Ambitions'*** as local health and care partners. It has been developed through an inclusive process involving stakeholders from across Suffolk and North East Essex including people with lived experience, clinicians and other professionals, elected leaders and others.

We have used a consistent methodology to underpin the development of our Integrated Care Strategy - Outcome Based Accountability (OBA). The approach is based on working backwards from the ends we wish to achieve – the conditions of well-being on which we are trying to make an impact – and then taking a step by step approach to understanding how we want those conditions to look and feel different; how to measure if that is happening and why; who needs to be involved in making the changes and what practical steps are going to be taken to actually achieve that change. This is often called *'turning the curve'*.

The diagram below summarises how we have applied OBA to our thinking in the ICS to show how by working together we aim to deliver collaborative programmes at system, place and neighbourhood level that will enable benefits for people that based on our understanding of the story we believe will drive measurable improvements to population outcomes.



The content and structure for the detailed sections of our Integrated Care Strategy are based on this OBA framework. As such each section is based on a common format that summarises:

- **The Population Outcome**
    - Population Outcome Measures
    - Indicators
- **The Story Behind the Outcome**
    - Lived Experience
    - Published Evidence
    - Wider Data
    - Further Reading
- **Our Ambition**
    - What we know matters to people living with cancer and why
    - How will things be different in Suffolk and North East Essex
    - Measures of Benefits
    - Case Studies
    - Relevant plans and strategies

c. Next Steps

Further to approval of the Integrated Care Strategy by the ICP further versions and creative formats for the summary document will be prepared to make the strategy accessible including to those with accessibility needs and low levels of health and care literacy.

The ICP will continue work to develop the detailed content of the strategy on an iterative basis. Key next steps in this will include the addition of:

- Population Outcome Measures for each key section
- Measures of Benefits relevant to each key section
- Further data following discussion with relevant ICS leads for business intelligence and analytics
- Further Case Studies – links to online resources describing delivery by local partners
- Links to Relevant Strategies and Plans across ICS Partners
- A Strategic Prioritisation Tool to ensure evidence based decision making based on the content of the strategy.

Going forward the strategy website provides a powerful, central cross-sector resource available to all so that as ICS partners everyone can continue to collaborate to a constantly evolving, genuinely integrated strategy based on shared evidence and thinking.

3. Patient and Public Engagement

The full range of mechanisms offered to gather feedback from patients and the public on the strategy is set out in detail on our ICS website. They included:

- **Direct feedback** via a link to an online facility to gather responses and word limited stories.
- Engagement facilitated by **Healthwatch Essex and Healthwatch Suffolk**;
- **Community Conversations** facilitated by wider ICS Partner organisations including VCFSE sector organisations, social care providers and the NHS with funding to support engagement with specific groups;
- Use of innovative **outreach engagement** including an inflatable video booth that visited 16 locations across Suffolk and North East Essex over autumn 2022;
- Outreach by clinical and professional leaders in the ICS specifically to engage with **health and care staff** to ensure that they are invited to contribute to the Integrated Care Strategy.

A short film has been prepared illustrating the key themes in our Integrated Care Strategy with quotes from local residents recorded in our pop-up video booth.

4. Recommendation

The agenda for the next meeting of the Suffolk and North East Essex ICP on Friday 13 January 2023 includes consideration and a recommendation to Approve the Suffolk and North East Essex Integrated Care Strategy.

Subject to this approval, members of the NHS Integrated Care Board are asked to:

- formally receive the Integrated Care Strategy;
- note the requirement for the NHS Integrated Care Board, Suffolk County Council and Essex County Council to have regard to the relevant integrated care strategy when exercising any of their functions, so far as relevant. This includes 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 has informed the development of the Integrated Care Strategy.

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

OUR INTEGRATED CARE STRATEGY
Summary

WHAT MATTERS TO YOU & WHY?

How should we be Thinking Differently in health & care?

December 2022

INTRODUCTION

Suffolk and North East Essex Integrated Care System (ICS) brings together the full spectrum of partners responsible for planning and delivering health and care across North East Essex, Ipswich and East Suffolk and West Suffolk to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.

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. The ICP works in the best interests of residents in Suffolk and North East Essex by bringing together the NHS, local authorities, social care providers, voluntary and community organisations, social enterprises, and other key stakeholders as equal partners to agree how to improve outcomes and experience through the integration of health and care. The Suffolk and North East Essex ICP is co-chaired by Cllr. Andrew Reid from Suffolk County Council, Cllr. John Spence from Essex County Council and Professor William Pope from NHS Suffolk and North East Essex ICB and is supported by Susannah Howard as ICP Director.

A key role for the ICP is to generate an Integrated Care Strategy that sets the direction of the system across the whole ICS footprint. The strategy sets out the ambition of all partners to improve health and care outcomes and experiences for the population of Suffolk and North East Essex. It sets out how commissioners in **both** the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life. The Integrated Care Strategy presents 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.

This document sets out a high level summary of the initial Integrated Care Strategy for the Suffolk and North East Essex ICS. This builds on and brings together earlier work and thinking from across partners in the Suffolk and North East Essex ICS and describes a shared vision from the perspective of **'what matters'** to people living in Suffolk and North East Essex and **'our Collective Ambition'** as local health and care partners. The strategy has been developed through an inclusive process involving stakeholders from across Suffolk and North East Essex including people with lived experience, clinicians and other professionals, elected leaders and others.

The Suffolk and North East Essex ICS website www.sneeics.org.uk then sets out our Integrated Care Strategy in full with significantly more detail for each key area including population outcomes, data and indicators, our understanding of the story behind these outcomes based on lived experience and published evidence, information about what matters to local people, our ambition for how things will be different in Suffolk and North East Essex, case studies and links to wider resources.

As an ICP we want to encourage and enable deeper cross-sector understanding, thinking and planning in health and care. We also want this work to be informed by evidence and lived experience. Our Integrated Care Strategy provides a flexible, collective, central resource that is accessible by all, to enable everyone to be part of the work of the ICS going forward.

www.sneeics.org.uk

OUR **INTEGRATED CARE STRATEGY** IN SIX NUMBERS

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

1

ONE MILLION PEOPLE

We are **ONE** team with a shared vision of the best possible health outcomes being a reality for every **ONE** of the **ONE** million people that we all serve.

2

TWO COUNTIES

We work flexibly with wider partners across the **TWO** counties of Suffolk and Essex

3

THREE LOCAL ALLIANCES

We co-ordinate delivery as locally as possible through our **THREE** local place-based alliances

4

FOUR COLLECTIVE AMBITIONS

We are united around our **FOUR** collective ambitions:

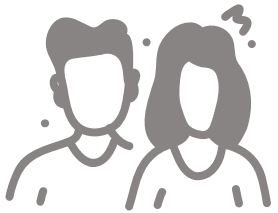
- the **best health and wellbeing** a genuine reality for all
- the opportunity of **health equality** for everyone
- everyone able to '**Live Well**' – Start Well, Be Well, Stay Well, Feel Well, Age Well, Die Well
- a genuinely **'Can Do' Health & Care System** that people can trust.

5

FIVE EQUAL SECTOR PARTNERS

We believe in parity between all **FIVE** sectors in the ICS – NHS, primary care, social care, public health and the voluntary community social enterprise and faith (VCSEF) sector.

6

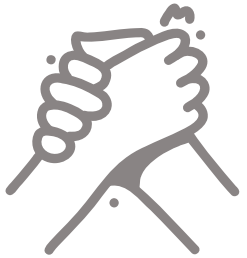


SIX 'CAN DO' VALUES

The way we work together as a 'Can Do' Health and Care System is underpinned by our **SIX** core values: Collaborative, Creative, Courageous, Compassionate, Cost Effective, Community Focused

OUR INTEGRATED CARE SYSTEM: **WORKING TOGETHER**



What matters to me is that all the different parts of my local health and care system are genuinely ***'Working Together'*** for me and my family – this means that:

There is genuine **partnership** and **parity** between the different sectors and partners involved in my health and care, including:

- **NHS Acute, Community and Mental Health Services, NHS Commissioners**
- Primary Care – **GPs, Dentists, Optometrists and Pharmacists**
- County Councils – **Social Care** and **Public Health**
- **Voluntary, Community, Faith and Social Enterprise (VCFSE) Organisations**
- **District and Borough Councils**
- Organisations representing **patients** and the **public**.

Our Collective Ambition is ***'Working Together'*** as **ONE** team with the shared vision of the best possible health outcomes being a reality for every **ONE** of the **ONE** million people living in Suffolk and North East Essex.

We will do this by:

- **Working Together Across the System** – through our **Integrated Care Partnership (ICP), NHS Integrated Care Board (ICB), ICS VCFSE Assembly, ICS Chairs Group and NED Forum and Provider Collaboratives**
- **Working Together in Place Based Alliances** – co-ordinating delivery as locally as possible through our THREE local place-based alliances in **North East Essex, West Suffolk** and **Ipswich and East Suffolk**
- **Working Together Across Counties** – working flexibly with wider partners across the **TWO** counties of **Suffolk** and **Essex** including working together through local Health and Wellbeing Boards
- **Working Together in Neighbourhoods** – through local Integrated Neighbourhood Teams and Primary Care Networks.

"I think if we treat everyone equally, we will get it right and we will improve in terms of our health outcomes… we need to respect each other, trust each other, work together and love one another."

"Thinking differently about the future of health and care is that we don't just say 'health and social care are together', but we actually mean 'they are together'."

COLLECTIVE AMBITION: **BEST HEALTH AND WELLBEING**

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

"Just to focus thinking of my physical health… Because if like myself, they've got a mental health disability and or a physical health problem like I have, sometimes you feel self conscious and some people aren't as understanding as others when you go out. And maybe… creating a safe space where people can go and speak to kind of personal trainers, people who are kind enough to volunteer their time to do that."

What matters to me is that the ***'Best Health and Wellbeing'*** is a genuine reality for me, because I am able to:

- **be resilient** through a sense of **belonging, safety and purpose**
- live a **healthy life** in a **healthy neighbourhood with** a good home, good work or education, a good environment and a good local community
- adopt and maintain **healthy behaviours** – I am able to be active, eat well, sleep well and maintain good mental wellbeing
- **avoid** needing treatment and care for physical or mental health conditions in the first place
- **prevent** any condition from getting worse, by **intervening early** and/or **slowing or reducing disease progression**
- be able to **manage the impact** of any lasting illness or condition for either ourselves or those who care for us
- avoid **harmful substances** and be protected from **avoidable diseases**.

"At this point in time I am needing support, not care. If I have the correct support now then it will mean that I won't need care for some years to come."

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

We will do this by:

- taking action across our Integrated Care System to support people and communities to **improve** their health and wellbeing and **prevent** physical and mental ill-health which could result in the need for future care and support, loss of independence and premature death
- enabling people and communities to be **resilient** by developing a sense of **belonging, safety and purpose**
- focusing on where we believe that we can **make the most difference** to individual health, **minimising the risk factors** that drive the most death and disability in our population e.g. smoking, alcohol use
- working with partners to address the **wider determinants** of health – the conditions in which people are born, grow, live work and age; and inequities in power, money and resources
- moving our focus away from just treatment towards being a **health and wellbeing service** supporting rehabilitation, recovery and promoting self-care
- considering how **all partners** can **intervene earlier** to support people to remain healthy and **independent** for as long as possible
- valuing the role of local community organisations in **strengthening communities**, delivering **social value** and helping families and carers to **support independence**, health and wellbeing for people and communities.

COLLECTIVE AMBITION: **HEALTH EQUALITY**

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Suffolk & North East Essex Integrated Care System

What matters to me is that I have ***'Health Equality'*** – this means that I have the same opportunity of good health and wellbeing, dignity and respect regardless of:

- my **ethnicity, race or religion**
- my **age, gender** or if I identify as **LGBTQ+**
- if I am living with a **physical, sensory or learning disability**
- my circumstances – if I am experiencing **deprivation**, **homelessness** or **growing up in care**
- if I live in a **coastal, rural or traveller community**.

"I really believe that if you think about others, care about others, we will make this place a better place and completely remove racism from the NHS. And care for others and treat each other equally with dignity and respect."

"I think that thinking differently in health and care is to have every part of the ethnic minorities in Ipswich and in Suffolk .... come together, and to kind of express but what is needed, and what support and more information that can be given."

Our Collective Ambition is to enable ***'Health Equality'*** to be an opportunity for everyone in Suffolk and North East Essex.

We will do this by:

- ensuring that a focus on health equality is **woven through** every aspect of our work as an Integrated Care System
- recognising and focusing on overcoming the many different **barriers** to health equality that exist through **health equity**, inclusion and social justice
- being **allies** to people experiencing marginalisation or disadvantage, speaking out against discrimination and injustice
- being **aware** of both our own individual unconscious bias and the structural and institutional discrimination that exists in our wider health and care system
- **assessing** the equality and health inequality impact of what we do both as individual organisations and collectively as a health and care system
- everyone being **accountable** for maintaining continued effort over time and monitoring the impact of our actions in the short, medium and longer term
- taking a **population health management** approach that maintains a strong focus on **prevention** and helps keep people healthier longer
- **taking action** in our ICS **at every opportunity** to reduce health inequalities in smoking cessation, early cancer diagnosis, high blood pressure, supporting those with chronic respiratory disease and severe mental illness and improving maternity care
- **taking action** in our ICS **at every opportunity** to reduce health inequalities for children and young people in asthma, diabetes, epilepsy, oral health and mental health.

COLLECTIVE AMBITION: **LIVE WELL**

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

What matters to me is that I can continue to ***'Live Well'*** – this means that I am able to:

- **START WELL** – before **conception**, during **pregnancy and birth**, through **childhood** and into **adolescence**
- **BE WELL** – maintain good **oral and dental health**, good **eye and ear health** and good health for my **gender**
- **STAY WELL** – if I am living with **cancer** or any other **long term condition**, if I am living with **obesity**, if I require **urgent or emergency care** or if I am living with a **disability**
- **FEEL WELL** – if I am living with a **mental health** problem or **addiction**, or if I am a survivor of **trauma or abuse**
- **AGE WELL** – as I grow older, particularly if I am living with **frailty** or **dementia**
- **DIE WELL** – for myself and those close to me when I reach the **end of my life**.

"Being independent, having that ability to continue to be independent in your own home and not stay in hospital for longer than you need to, so you're not vulnerable."

"How do you think we should think differently in health and care? I think this is about getting everyone involved. Getting me involved, getting the next person involved. It is my health, it is my care. I should know what works best for me, so everybody should be involved."

Our Collective Ambition is to enable everyone in Suffolk and North East Essex to ***'Live Well'***.

We will do this by:

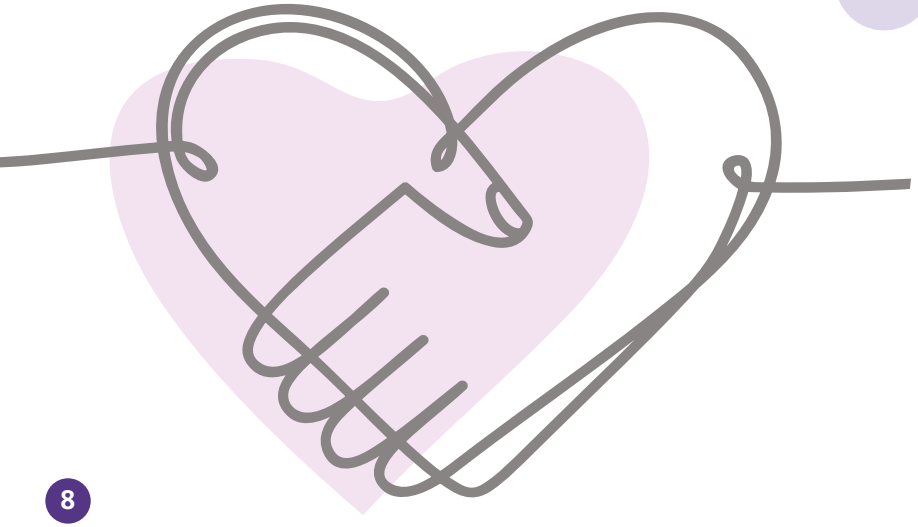
- not just **'Thinking Differently'** but **'Doing Things Differently'** together delivering **wherever the work is best done**. This could be in:
  - local **neighbourhoods**
  - place based **alliances**
  - across the **counties** of Essex or Suffolk
  - across the Suffolk and North East Essex **system**
  - across the East of England **region**
- improving **access** to high quality support, diagnosis and treatment
- supporting people to **wait well** when there are delays in accessing support, diagnosis or treatment
- working across sectors and organisations to **co-produce** with people and families, genuinely **collaborative** programmes that we know, based on evidence, will improve their health and wellbeing outcomes.

COLLECTIVE AMBITION: **'CAN DO' HEALTH AND CARE**

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

What matters to me is that I am supported by a genuinely ***'Can Do' Health and Care System*** that I can **trust** – this means that:

- I am both **listened to** and **heard**
- I am treated with **kindness, dignity, respect** and **compassion**
- I can **access** support, diagnosis and treatment when I need to
- I have care and support that enables me to **live as I want to**, seeing me as a **unique person** with **skills, strengths and personal goals**
- When I move between services, settings or areas, there is a **plan for what happens next** and **who will do what**, and all the **practical arrangements are in place**
- I have care and support that is **co-ordinated** and **everyone works well together and with me**.



"What matters to me is that I'm treated with dignity and respect and that people are kind and approachable and that I'm listened to."

"I think there should be some more joined up thinking between the two social care and health… at the moment I've got a very difficult health condition I'm trying to come to terms with and, which is bad enough, without other stressful situations which I don't think should be there."

Our Collective Ambition is to enable everyone in Suffolk and North East Essex to be supported by a ***'Can Do' Health and Care*** system that people can genuinely **trust**.

We will do this by:

Working together as an Integrated Care System that is:

- **COLLABORATIVE** – by focusing on **system leadership** and **culture**, supporting our **people and workforce** across all sectors and using **population health management** through linked data and analytics
- **COMPASSIONATE** – by focusing on **personalised care** in all sectors, supporting **family carers** and enabling genuine **co-production**
- **COURAGEOUS** – by focusing on enabling **equity, inclusion and social justice**, ensuring **clinical and care quality** across all sectors and enhancing the roles of all **clinical and care professionals**
- **COMMUNITY FOCUSED** – by focusing on enabling a **resilient VCFSE sector**, the importance of **volunteering** and the roles of **Community Connectors**, **Anchor Institutions** and **community pharmacy**
- **CREATIVE** – by focusing on the use of **digital, data and technology**, **innovation** and **research** and **environmental sustainability**
- **COST EFFECTIVE** – by focusing on **financial sustainability** and the effective use of our collective health and care **estate**.

INTEGRATED CARE PARTNERSHIP: **GET INVOLVED**

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

What matters to me is that I can ***'Get Involved'*** in shaping my local Integrated Care System – this means that:

I can **find out what is happening** in the ICS:

- I can **access information** in the right language and format for me, that explains how the Integrated Care System works and our local Integrated Care Strategy
- I can find out about the **statutory boards and committees** responsible for local health and care, read the meeting papers, attend public meetings and ask questions if I want to
- I can find out about informal meetings, **attend events** on the topics that interest me, and access any written reports.

I can **share my views and influence** the ICS:

- I can **share my views and my story** with the ICS in different ways, so that local health and care organisations can learn from my experiences
- I have **independent support** from my local **Healthwatch** organisation who can make sure my voice is heard, and influence how health and care services are provided locally
- I can see, through improved strategies, plans and services, how the views of different people with diverse perspectives have **influenced** the ICS.

"I care, we do care, I am part of the change and I'm here to listen and work with everyone and amplify those voices that have been supressed and oppressed for quite a while."

(mental health practitioner)

"It's important to me to share my lived experiences of good practice in the NHS to shine a light on when things have gone well, and to share poor practice so that other people don't have to experience the same mistakes I have."

(patient)

Our Collective Ambition is to enable everyone in Suffolk and North East Essex to be able to ***'Get Involved'*** in our work as an ICS.

We will do this by:

- providing **information** on how the different parts of Integrated Care System work, our local Integrated Care Strategy and the evidence that underpins it, **available online** and in **other formats** upon request
- for formal meetings of the **statutory boards and committees** responsible for local health and care: publishing details and papers online, livestreaming proceedings, and offering people the means to attend meetings and ask questions
- **sharing** on the ICS website and social media details of forthcoming informal ICS meetings, community ICS events and online events, ways to participate, and reports of past events
- putting **lived experience** at the heart of our **Integrated Care Strategy** embedding it in an outcome based approach
- providing both **traditional and new opportunities** for people to share their lived experiences about health and care (e.g. pop up video booths, film competitions, lived experience facilitators), in places and ways that are convenient and accessible
- supporting and upholding the **statutory role** of our local **Healthwatch** organisations to independently represent the views and experiences of local people and enable their voice to be heard
- being proactive about **enabling diversity of engagement** in the work of the Integrated Care System, including providing information in different languages or formats, including translation and easy read summaries.

Further details for the Suffolk and North East Essex Integrated Care Strategy is available at: **www.sneeics.org.uk**

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

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Essex County Council

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North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**09**
Reference No.	**ICB 23-03**
Date.	**24 January 2023**

Title	**SNEE Joint Forward Plan (JFP) 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 Ruth Kelly, Archus
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 the final version for agreement to the March 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 SNEE ICB and its partner trusts intend to arrange and provide NHS services to meet its population's physical and mental health needs. This includes consideration for the delivery of universal NHS commitments and addressing the ICSs' four core purposes.

1.2 Archus 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. 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

1.3 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, organise ourselves and define 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 comminates 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***
• Maternity & Neonatal Care • Children & Young People incl. CAMHS, Neuro Developmental, SEND, Community and LTCs	• Mental Health & Wellbeing • Suicide Prevention • Addictions • Trauma and Abuse	• Healthy Behaviours • Personalised Care • Women's Health • Dental / Oral Health • Eye Health	• Primary Care • Elective Care & Diagnostics • Urgent & Emergency Care incl. community • Cancer • Diabetes • Respiratory • Cardiovascular Disease • Stroke & Stroke Rehab • Neuro Rehab • Learning Disabilities & Autism	• Ageing Well Programme • Dementia • Carers	• 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

Alongside the six Live Well Domains, 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
    - 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 – co production
    - Workforce
    - Estates
    - Digital
    - Intelligence
    - Communication and Engagement
    - Research and Innovation

    - Sustainability
- Our partners aligned plans including primary care, community, acute, mental health, local government, voluntary care and social enterprise, care homes, Healthwatch and hospices
- 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 first draft of the JFP and are planning to engage more widely with our local population and partners.

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 started to engage a range of partners and stakeholders from across the ICS 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 has been established to plan out key activities for 2023. The ICB People and Communities Team have developed an approach that enables the ICB to share the draft JFP with the wider public as well as key partners throughout January and February 2023 via meetings, an engagement event in each Alliance and using the letstalksnee.co.uk/ platform for wider engagement and comment on the content of the JFP.

3.3 The JFP pages on the LetsTalkSNEE platform went live on 16 January 2023. On 27 January, a full, revised JFP draft will be published online on letstalksnee.co.uk/, a platform which over 1,000 local people are signed up to. The platform enables the opportunity to consider the content of the Live Well Domains and suggest any changes whilst also commenting more broadly on the one to two top priorities each person feels the ICB should commit to over the next five years.

3.4 All feedback will be analysed and a revised version of the JFP developed by 24 February 2023 for consideration and agreement which will include a suggested top set of commitments the ICB will make over the next five year as part of the document.

3.5 As JFPs do not require full formal public consultation unless a significant reconfiguration or service change is proposed, previous local patient and public engagement exercises have informed this work for SNEE ICB. An engagement tracker has been developed to minimise duplication across teams on where the JFP content has been shared for development. This tracker also supports the team in identifying key groups that are yet to be engaged and/or consulted as part of the work to ensure a thorough JFP is produced by 31 March 2023.

4. Next Steps

4.1 Key timelines for the JFP as detailed within the NHSE guidance documents are noted below:

- NHSE expects 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. This aligns to the work underway by the JFP development team since October 2022.
- Consultation on further iterations will 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 are proposed to still aim to finalise the JFP for approval at the 20 March ICB Board. Key next steps are:

Action	Date
Launch public and system partner engagement on the JFP via pages on https://www.letstalksnee.co.uk/ with a summary of the Live Well domain sections	16-17 January
Final iterations of JFP sections received from all leads	25 January
Share full draft of the JFP on the LetsTalkSNEE platform	27 January
Public and system partners engagement on the JFP	16/17 January – 17 February
North and East Essex Health and Wellbeing Alliance Committee	7 February
West Suffolk Alliance Committee	14 February
Ipswich and East Suffolk Health and Wellbeing Alliance Committee	21 February
Share JFP update at ICB Board Development Session with focus upon key commitments	21 February
Alliance based engagement events (x3) on the JFP	Early February
Weekly summary of comments received shared with section leads as appropriate for further updating of the JFP sections	23 January – 17 February
Final version of the JFP completed	24 February
SNEE ICB Executive consideration of the JFP	6 March
ICP consideration of draft JFP	10 March
ICB approval of the JFP	21 March
ICP consideration of the final JFP	April meeting (14th?)
Essex Health and Wellbeing Board consideration of the final JFP	17 May
Suffolk Health and Wellbeing Board consideration of the final JFP	18 May
Publication of JFP	*

**Clarity being sought on whether the JFP must go to the Health and Wellbeing Boards before formal publication.*

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 March meeting of the ICB.

Suffolk and North East Essex Integrated Care Board

ICB BOARD

Agenda Item No.	**10**
Reference No.	**ICB 23-04**
Date.	**24 January 2023**

Title	**Integrated Care Board (ICB) Report and System Oversight Framework (SOF) Performance Indicators and Winter Pressures**
Lead Director	Paul Gibara, ICB Director of Performance Improvement
Author(s)	Paul Gibara and ICB Directors
Purpose	The paper covers several areas: • 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 System Oversight Assurance Committee in December. • Summary of System Oversight Key performance indicators.

Recommendation:
The Board is requested to: -

1) Note the content of this report
2) Discuss the content where issues are identified by Board Members
3) Make any recommendations or identify any actions to be undertaken by relevant committees.

1.0 Introduction

The paper covers several areas:

- 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 System Oversight Assurance committee in December.
- Summary of System Oversight Key performance indicators.

2.0 Operational Guidance

The 2023/24 priorities an operational guidance was published on the 23rd of December 2022, with one immediate and two ongoing priorities:

1. Recover Core services and productivity *(immediate priority)*
2. Make progress in delivering key ambitions set out in the Long-Term Plan
3. Continue with transforming the NHS for the future.

The table below sets out the measures identified which underpin the above identified priorities

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Planning guidance and priorities are underpinned by the need to recognize that our people are fundamental to delivering our ambitions together with our ability to manage our resources effectively.

The system oversight framework remains in place to support Integrated Care Boards (ICBs) with service providers required to publish progress against key objectives set out in the NHS Long Term Plan.

For 2022-23 it is expected that NHS England will update the NHS Oversight Framework in line with recommendations following a review of ICS oversight and governance being undertaken by the Rt Hon Patricia Hewitt.

3.0 Development of Infographics

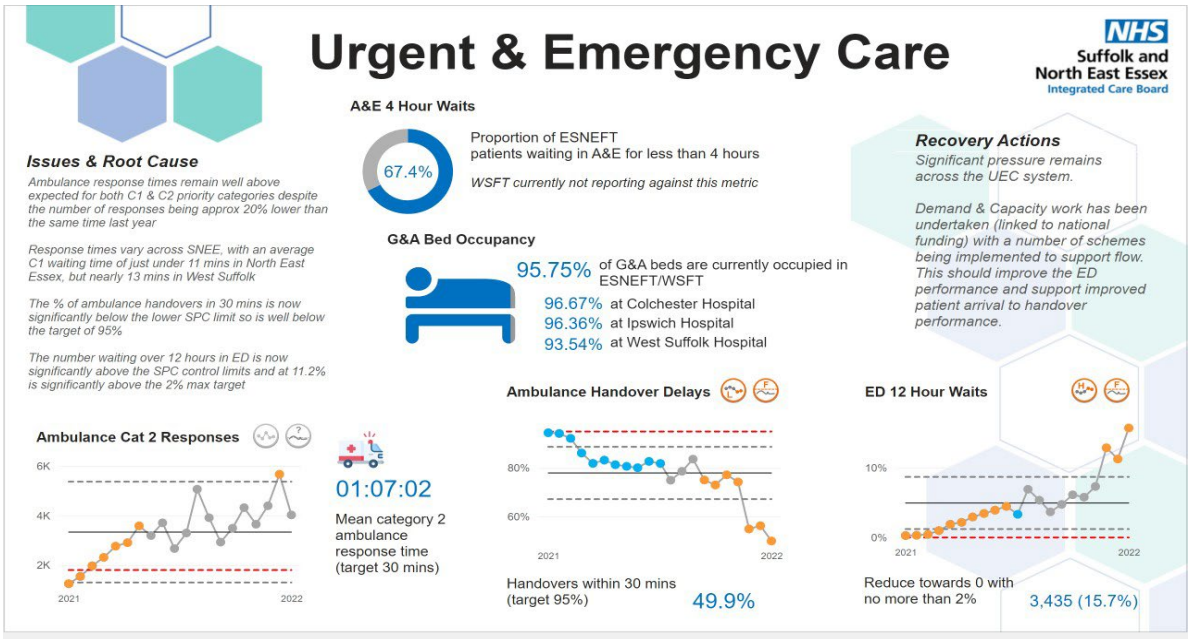
The business Intelligence team are currently developing a set of infographics which will routinely report on current performance for the ICB against the priorities signaled in the operational guidance.

An Initial three infographics have been developed for Cancer, Elective recovery and Urgent care with future reports including infographic clustering of data for the key areas identified by national objectives -See appendix 1 for Cancer and Elective Care infographics.

4.0 Focus on Urgent Care Performance.

Given the significant urgent care pressure across the NHS, it was felt important to highlight to the board the current position regarding urgent care pressures and actions being taken to address them.

Despite detailed seasonal planning the urgent care system has experienced significant pressures and challenges across all sectors and partners, sustainably declaring a level 4 escalation which is the highest level reportable short of critical incident.



Several concurrent pressures have led to the challenges experienced:

- High number of inpatients with Covid and Flu
- Increased demand due to Strep A concerns.
- Significant rise in activity across all partners:
    - 15.8 % increase in UEC attendances (*comparison December 2021 and 2022)*
    - 38 % increase in Clacton Urgent Treatment Center attendances *(comparison December 2021 and 2022)*

    - Week ending the 18th of December ICB urgent care saw in excess of 8000 attendances a 1000 more than might have been expected.
    - Week ending 18th December 111 services received a significant 11440 calls only 8% were redirected to A&E/UTC or ambulance service. Normal week would typically be 8000 calls.
- Admissions routinely exceeding discharges *(December compared to 2021 was 4% increase in discharges but 6% increase in admissions)*
- Patient acuity reported as high
- Workforce challenges
- Strike Actions
- Continued focus on elective recovery

In response to this pressure several additional measures have and continue to be undertaken:

4.1 Governance

A tactical response structure has been stood up:

- A System Control Centre has been established providing 7 day a week system support.
- Daily system calls have been established
- Weekly senior operational system meeting is in place
- Alliance tactical cells have been established to support local delivery
- Daily senior clinical system huddles have been established.
- Clear ambulance delay escalation protocols are in place
- Daily Regional meetings
- Links to Local Resilience Forums have been maintained.
- Urgent Care Committee programme of work is being maintained

4.2 Additional actions

Over and above already established seasonal plans **see appendix 2** several additional key initiatives have been undertaken:

- Reset programme has been ongoing in both our acute trusts with senior executive oversight to support patient discharge and improve pathways.
- Progress against Urgent Care Assurance Framework continues to be made and reported monthly to NHS England.
- Additional physical bed capacity *(daily reports show that on average the system is running with 216 acute additional beds)*
- Virtual Ward capacity has and continues to be developed with 66 beds available with plans to further expand.
- Ambulance conveyancing avoidance has been developed with UCR team with average of 50 patients a week taken off the ambulance queue and managed through an alternative pathway.
- Call before conveying remains in place with an average of 140 patients offered alternative pathway per week representing 90% of all calls.
- Alternative model to support an integrated response to urgent care is being developed to provide alternatives to A&E and support primary care.
- Full hospital protocol has been established to help reduce front door pressures.
- Rapid release protocol to ensure services to our most unwell patients are safeguarded.
- Plans for co-horting patients which enables early release of ambulances are in place across all hospitals.

- Business continuity plans are in place across all partners with non-critical activities reduced or suspended.
- Plans to invest a share of national £500 million discharge funds have been agreed in partnership with local authority through the Better Care Fund
- Plans for additional non-recurrent national £200 million care home are being worked through at time of this report.
- Additional capacity has been made available through primary care respiratory hub funding.
- Extensive communication plans have been put in place.

Whilst we have remained in a difficult position this is not unique to Suffolk and North East Essex system and during December SNEE benchmarked as:

- 2nd best performer in the region for A&E performance and
- 3rd within the region for 12hr waits
- ESNEFT remained 12th best performer nationally with only 7 % of patients awaiting complex discharges.

4.3 Industrial Action

At the time of writing this report the system is preparing to manage the industrial action declared by the Royal College of Nursing on the 18th and 19th of January 2023.

Whilst the East of England Ambulance Service did not elect to take industrial action the system has planned to support the ambulance service in the event of any unforeseen consequences at the time of writing this report future dates included the 11th and 23rd of January 2023.

4.4 Next Steps

The Urgent and Emergency Care Committee met on the 11th of January 2023 to review progress against key work streams and our urgent care assurance framework.
In anticipation of the awaited national strategy for urgent care the committee invited Chris Morrow – Frost National Clinical Advisor for NHS England to present the findings of a national review of high performing organisations and systems.

The presentation was well received, and the findings will form part of developing our future approach to urgent care. Chris Morrow–Frost has been invited to come and work with our system and will in the first instance link up with our Medical Director, Andrew Kelso.

5.0 System Oversight Assurance Committee (SOAC) activities.

5.1 Key issues discussed at December 2022 meeting:

Focus on Urgent Care

<u>EEAST</u>:

- Best practice guidelines had been implemented for patient handover, however average handover time was 60 minutes, compared to 31 minutes in October.
- Flexibility to offload was challenging, particularly at the Ipswich Hospital site.
- The access to stack, cleric project, commenced in November
- EEAST were looking at upskilling paramedics to be able to triage patients and were also looking at ‘no send’ and demand management.

System Control Centre (Operational Control Hub):

The Hub was in place and would run 7 days a week 0800-1800. The weekend rota went live on 1 December with access to clinical expertise. There was a clear escalation process in place to report to regional and national level.

Assurance Framework:

Good progress had been made with actions, with just 16 areas remaining outstanding or partially complete.

Bed capacity:

The virtual ward programme had been implemented and there would now be a 2-weekly report on utilisation to national team.

System Oversight Performance indicators

Cancer:

- There were concerns that 62 days and 28-day faster diagnosis would meet the performance target for 2023/24 Each Trust has an action plan for recovery which is overseen through ICS wide Cancer Operational Group and the ICS Cancer Committee. Challenges are being experienced within colorectal at ESNEFT and Skin at WSFT

Maternity:

- A lack of accurate maternity data was flagged as a risk for ESNEFT. This had resulted in the inability to create reliable SPCs or create analysis to identify trends and impact of QI measures
- A system QI approach was being taken regarding post-partum haemorrhage to understand why rates were not decreasing

Mental Health:

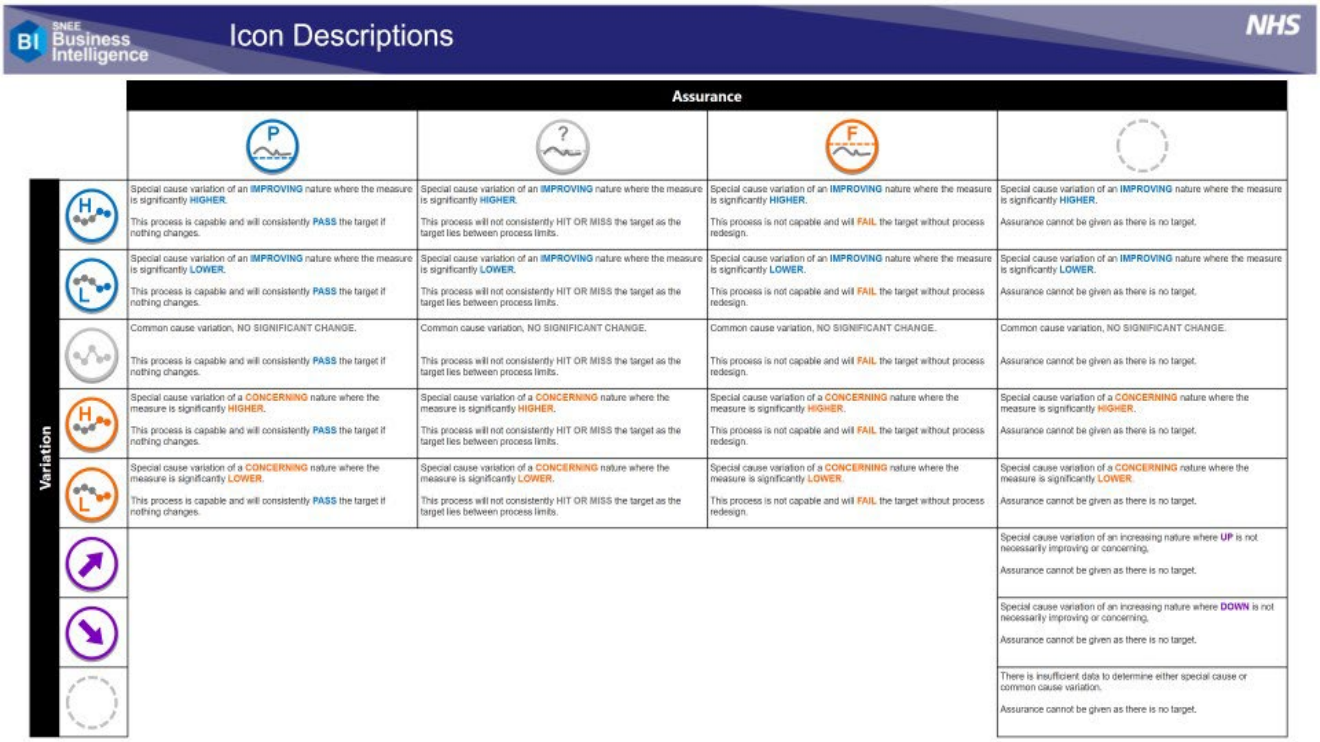
- Performance against many of the national mental health KPIs are being met including for Early Intervention in Psychosis, IAPT access and recovery rates and perinatal access
- Demand for services has continued to increase and waiting times for assessment and treatment has grown with actions plans in development
- Out of area bed days had increased to levels last seen in July 2021
- CQC assessments had been undertaken at NSFT & EPUT. A Quality Review meeting was scheduled for 14 December with regard to EPUT and following a CQC S31 enforcement letter.

Workforce

- HCSW recruitment and retention: presentation given detailing actions being taken across the system around recruitment and retention of HCSW staff – aim to achieve a 20% vacancy reduction by March 2023. A proactive approach to recruitment had been devised, taking recruitment to the local population via a bus tour, recruiting to entry level HCSW across all disciplines. The programme would also address developing and upskilling candidates by providing an education and training pathways guide for all applicants and assisting employing organisations to review onboarding processes to incorporate wellbeing support and flexible working into their policies.
- A reservist programme had been initiated; since inception & as of December 2022, 719 expressions of interest had been received.

The second quarterly review of ICB performance with NHS England is scheduled for the 27th January 2023

6.0 System oversight Key Performance indicators



SNEE Business Intelligence

NHS

Cancer & Rapid Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	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	Nov-22				879		
62+ day waiting list - over 104 days		Trust Local PTL	Nov-22				232		
Increased first cancer treatments	Reduce shortfall	National CWT	Oct-22			566	620		
28 day faster diagnosis	75% by Mar 23	National CWT	Oct-22		75.0%	75.1%	66.2%		
31 day wait diagnosis to treatment	Improve performance	National CWT	Oct-22		96.0%		93.7%		
Patients treated within 62 days	Improve performance	National CWT	Oct-22		85.0%		69.3%		
Screening uptake - Cervical (25-49)	Maintain and restore cancer screening programmes	NHS Digital	Jun-22				73.8%		
Screening uptake - Cervical (50-64)	Maintain and restore cancer screening programmes	NHS Digital	Jun-22				77.5%		
Screening uptake - Breast (50-70)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-21				69.8%		
Screening uptake - Bowel (60-74)	Maintain and restore cancer screening programmes	PHE - Fingertips	Mar-21				73.4%		

Key performance issues & root cause summary

ESNEFT - 62 day backlog 11.5% which is 2% over their recovery trajectory, with with colorectal 54% of the backlog
WSFT - 62 day backlog 10.7% which is 19% over their recovery trajectory, with skin 57% of the backlog.

Key performance recovery actions

ESNEFT - FiT uptake on the colorectal pathway has seen a significant improvement over this quarter. Next step is to embed the new FiT pathway into their colorectal Multi Disciplinary team.
A new skin pathway has gone live as the first contact on the faster diagnosis pathway, this has had a positive impact on waiting times.
WSFT - Two Dermatology locums have recently started, assurance has been that this will improve the 62 day pathway and WSFT will recover their 62 backlog by March 2023.
A new colorectal pathway has gone live at WSFT, and is currently being evaluated, the colorectal backlog is 9%.

Cancer & Rapid Diagnostics Committee

Narrative submitted: 21/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

1. Agreed and approved new Faster Diagnosis pathway for a two week wait referral for the Upper Gastroenterology pathway for WSFT through local and regional governance.
2. Best practice timed pathway audits for faster diagnosis are being completed for prostate, skin and lung pathways, learning shared with specialties multi disciplinary teams and via the Faster Diagnosis Steering Group.
3. A new 2WW skin platform now live at ESNEFT Colchester site, the platform utilises AI to support rapid triage of patients and is supporting the recovery of the skin 2WW's.
4. First of a series of five patient engagement sessions held with the initial sessions focusing on early diagnosis, including screening. x
5. Continued focus on 62 backlog reduction and planning for rest of 22/23.

Key actvities planned for the next 2 months

1. Non Site Specific (NSS) Clinical Multi Disciplinary Team lead to be agreed for ESNEFT 2. Recruit clinical and admin roles for NSS pathway for ESNEFT
3. Recruitment commences for Upper Gastroenterology Faster diagnosis nurse for WSFT 4. Implement the new Faster Diagnosis 2ww form for primary care to refer on the Upper Gastroenterology pathway at WSFT
5. Second patient engagement session in Feb 2023 focussing on faster diagnosis element of the cancer pathway
6. Complete JFP for cancer and Cancer 5 year Strategic Plan

We have learned this and need to share...

1. Following our first patient session in 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 Lets Talk SNEE platform.

We need help with..

1. NSS Clinical MDT leadership within ESNEFT
2. Workforce remains a key issue within the cancer programme, due to the non recurrent nature of the funding many posts are fixed term. A paper has been developed to support a sustained approach to cancer workforce recruitment utilising SDF.

Key Issues

1. Within the system we have a shortage of specialist roles, including consultant radiologists and speciality consultants, this results in vacancies and high locum workforce.
2. Transformation capacity within the providers to support the cancer programme outcomes.
3. Cancer demand and ability to meet the 62 day standard and backlog metric.

Key Risks

1. Clinical MDT leadership for NSS pathway without it unable to progress pathway. 2. Due to high vacancy rate of general managers across ESNEFT, sustaining transformation is now a risk.

SNEE Business Intelligence

NHS

Strategic Programmes, Elective Care and Diagnostics

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
RTT Admitted Pathways	110% of 19/20 baseline	National RTT	Oct-22	○		4,010	3,282		
RTT Non-Admitted Pathways	110% of 19/20 baseline	National RTT	Oct-22	○		19,004	17,289		
104 weeks wait	0 by 31 Jul 2022	National RTT	Oct-22	●	0		19		
78 weeks wait	0 by 31 Mar 2023	National RTT	Oct-22	●	0		596		
52 weeks wait	Reduction on Apr 22 baseline	National RTT	Oct-22	●	0		5,342		
Diagnostic Tests	Increase diagnostic capacity to 120% of pre-pandemic activity	DM01	Oct-22	●		29,483	27,840		
Elective Day Case		Faster SUS	Nov-22	○		11,983	11,849		
Elective Ordinary		Faster SUS	Nov-22	○		1,735	1,728		
First outpatients - F2F		Faster SUS	Nov-22	○		40,952	34,669		
Follow up outpatients - F2F	25% reduction in outpatient follow-ups by 2023	Faster SUS	Nov-22	●		94,145	54,956		
First outpatients - Virtual		Faster SUS	Nov-22	○		13,103	4,671		
Follow up outpatients - Virtual	25% reduction in outpatient follow-ups by 2023	Faster SUS	Nov-22	●		32,366	17,051		

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. 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 (particularly at WSFT); use of advice and guidance; use of virtual clinics (particularly at ESNEFT) and reducing the demand for face to face follow up attendances. 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: 22/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Our focus remains on reducing our long waits - we are beginning to increase the emphasis on how we can slow down waiting list and one year waiter growth.

Efficiency programmes in operating theatres, outpatients and diagnostics continue to increase our ability to use the resources we have but there remain significant risks in terms of workforce availability. Our Getting It Right First Time recovery plan has been reviewed and will be followed up in February. We are progressing 5 priority actions for diagnostics. We are focussed on increasing our usage of the independent sector to supplement NHS capacity.

Patient safety and experience for long waiters remains a priority and 'waiting well' programmes continue.

Key actvities planned for the next 2 months

Productivity work will continue in both trusts with a specific emphasis on outpatients and theatres. Significant additional insourced capacity for General Surgery at ESNEFT begins in February and WSFT are also providing mutual aid to ESNEFT. We will continue to explore opportunities to insource or outsource Urogynaecology work for WSFT.

We are exploring further outsourcing opportunities for West Suffolk endoscopy.

There will be a regional deep dive into General Surgery in February.

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 Oral Maxillo Facial Services for ESNEFT.

Key Issues

Our key issues are: long term sustainability - our outpatient waiting list continues to grow; diagnostics where our recovery plans include significant risks that impede on our ability to recover waiting times and cancer services.

Key Risks

We have identified a number of risks relating to workforce availability, the risks of rate card demands being unaffordable and the threat of industrial action. Uncertainty about long term funding availability is a risk to our longer term planning. Other risks include non elective growth beyond the planned levels which lead to elective cancellations.

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

Narrative submitted: 22/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

1. Lets Talk SNEE respiratory public engagement platform launched
2. Comms awareness raising of pulmonary rehabilitation self referral service continues and engagement with PCNs. We have shared our learning with neighbouring ICB's of the launch of the pulmonary rehabilitation self referral service
3. A "Type 2 diabetes prevention" page has been added to the SNEE wellbeing site
4. West Suffolk have now completed their updates on the Diabetes care process data and now proceeding to find routes to increase numbers
5. Healthy Hearts Together bid successful (£178K) and will support health inequality work on lipid management for LD / SMI patients
6. Catalyst funding to initiate the plan for 6 month reviews for ICSS successful.
7. Inhip AF project started, logic model and pathways updated

Key actvities planned for the next 2 months

1. Recruitment of community engagement officers to increase smoking cessation support across SNEE, particularly to address health inequalities
2. Maternity IES and WS to launch inhouse tobacco dependency treatment service
3. Business case to be developed for the ME&CFS service and community spirometry service
4. Undertake work on the IES Diabetes LES for 23/24
5. Launch new year diabetes prevention campaign
6. Launch of Liberate Pro for cardiac rehab
7. Start procuremnt of Level 2b Neuro Rehab service once service spec is signed off and QIA completed
8. Catalyst project planning will start, aiming for delivery from April 23 onwards.
9. Continue plans for other SQuIRe projects
10. Complete strategic programmes content for the 5 year Joint Forward Plan

We have learned this and need to share...

We need help with..

1. Any support / campaigning with practices / PCNs to promote more NDPP referrals would be of help.

Key Issues

1. Practices remain very busy and managing multiple challenges at this time given all the current pressures

Key Risks

1. Recurrent funding allocation 23/24 for NHS tobacco treatment programme, SNELCAS and pulmonary rehabilitation unknown
2. Community spirometry service is 12 month contract due to end July/August 23
3. Unlikely to return to pre-Covid levels for diabetes care processes
4. Catalyst funding is non recurrent, funding to be used in 2023-24 for 6 month review project but no onwards funding identified

SNEE Business Intelligence

NHS

Urgent & Emergency Care

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Ambulance response times - C1 Mean	7 mins	EEAST	Nov-22		00:07:00		00:10:49		
Ambulance response times - C1 90th percentile	15 mins	EEAST	Nov-22		00:15:00		00:20:21		
Ambulance response times - C2 Mean	18 mins	EEAST	Nov-22		00:18:00		01:07:02		
Ambulance response times - C2 90th percentile	40 mins	EEAST	Nov-22		00:40:00		02:25:32		
Ambulance handover delays	95% within 30 mins	EEAST	Nov-22		95.0%		56.1%		
A&E Attendances - Type 1&2		Faster SUS	Nov-22			20,759	20,563		
12 hour waits in ED	Reduce towards 0 and no more than 2%	Local Trust Report	Nov-22		0	2.0%	2,404 (11.2%)		
NEL Spells		Faster SUS	Nov-22			9,608	8,636		

Key performance issues & root cause summary

Ambulance response times remain well above expected for both C1 & C2 priority categories despite the number of responses being approx 20% lower than the same time last year

Response times vary across SNEE, with an average C1 waiting time of just under 11 mins in North East Essex, but nearly 13 mins in West Suffolk

The % of ambulance handovers in 30 mins is now significantly below the lower SPC limit so is well below the target of 95%

The number waiting over 12 hours in ED is now significantly above the SPC control limits and at 11.2% is 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

Narrative submitted: 25/11/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Virtual ward continues to move into the implementation stage, after some delays due to IT issues.
UECC met on 9th Nov with a focus on virtual ward, Access to the stack implementation of the Cleric portal, and 'Going further for winter resilience letters' audit and their subsequent future actions. The meeting also discussed current clinical risks and serious incidents.
Patient hand over hand plans submitted to NHSE/I and now the localities are producing their delivery plans.
The Access to the Stack Clerical portal went live on 8/9 November and early indication are very positive with 65 referrals accepted in the first week.
Participated in various assurance meetings with NHSE/I

Key actvities planned for the next 2 months

Work continues on producing the 'SNEE UEC one plan' which will be a working document that captures all of the UEC actions/owners/milestones.

Alliance implementation of their seasonal plans continues at pace, integrating with the new winter discharge funding through BCF.

Test and learning continuing on A2S so that we learn where to push the envelope further to get the biggest return.

Engagement with workforce and alliance teams re the implications of the planned industrial action.

The system control room as per the GFFW letter commences on 1 Dec 2022 and Changing to the new Operational Pressures Escalation Levels (OPEL) once release from NHSE/I

We have learned this and need to share...

The system is under extreme pressure early into the winter months.

The prior preparation and planning for A2S led to a seamless commencement of the Cleric portal, which is making a significant different and has led to the building on excellent relationships between, ICB, UCRS providers and EEAST

We need help with..

Supporting resources to met current demands

Key Issues

UEC performance
Covid (and seasonal illness) demand and impact on UEC services expected surge post Christmas
High bed occupancies in acute, community and mental health.
Part of the care market are unable to met the current demand leading to social care being in business continuity, leading to added pressure to D2A and POLR.

Key Risks

Workforce fatigue and possible industrial action as well as high vacancies and reducing in agency availability.
Cost of living impacts on health and care services and health inequalities
UEC demand has the potential to impact on elective recovery
Potential for power outages impacting services

SNEE Business Intelligence

NHS

Maternity & Neonatal

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
Number of live births		Trust Local Data	Oct-22	○			776		
Preterm Births (<37 weeks)	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Oct-22	○			57		
3rd/4th Degree Tears	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Oct-22	○			8		
Postpartum haemorrhage (PPH) >=1500mls	Clinical Quality Improvement Metrics (CQIM)	Trust Local Data	Oct-22	○			29		
Smoking at time of delivery		Trust Local Data	Oct-22	○			8.5%		
Stillbirth Rate (per 1,000)		Civil Registration of Births	Jul-22	●			6.14		
Neonatal Mortality Rate (per 1,000)		Civil Registration of Deaths	Jul-22	●			4.61		

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

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.

Maternity Committee

Narrative submitted: 28/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Post Partum Haemorrhage workshop completed with representation from across SNEE. Themes identified for further exploration, including data quality
Independent Senior Advocate role scoped with EoE LMNS colleagues, collective approach agreed
Negotiations with NHSE National Retention Team - funded allocated to SNEE to pilot wellbeing schemes for MW retention
Joint work with Public Health teams in Suffolk and Essex for programme of healthy pregnancy campaigns
Presented VCSE parternship work at SNEE ICP Board, with support received
Confirming pathway for smokefree pregnancy within Suffolk, including NRT provision via SCC
Support to reviewing term admissions to neonatal care, tool piloted across LMNS
Support to Trusts with CNST evidence submission

Key actvities planned for the next 2 months

Confirm Independent Senior Advocate role and procure with EoE LMNS's
Launch joint campaigns with public health re Feotal Alcohol and Healthy eating campaign
Agree and implement midwifery welfare schemes on behalf of national reterntion team
Finalise antenatal education specification and commence procurement
Data quality task and finsnh group to commence
Maternal Mental Health Service business case approval at LMNSB
LMNS and ICB Workforce team workshop to be held 1st Feb

We have learned this and need to share...

Nil return

We need help with..

See issues below

Key Issues

1. Ipswich hospital national outlier for term admissions to neonatal unit
2. 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.
3. Colchester elective list admissions not staggered
4. ESNEFT not yet submitted BR+ data so workforce planning impacted, and 6 monthly workforce Board reports not yet delivered (national deliverable)
5. Both Trusts having difficulty with full MDT ward rounds, 12 hours apart
6. MDT training compliance a challenge for both Trusts.

Key Risks

1. Poor data quality within ESNEFT resulting in limited understanding of clinical outcomes and whether services safe
2. Ipswich Hospital national outlier for term admissions to neonatal unit
3. LMNS regional outliers for preterm birth, PPH, smoking at time of delivery
4. Stillbirth and neonatal mortality rates not reducing as per national ambition

SNEE Business Intelligence

NHS

Mental Health & CYP

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
CYP accessing MH services		MH Core Data Pack	Jun-22		12,039		13,060		
SMI full annual physical health checks		MH Core Data Pack	Sep-22		5,209		4,233		
IAPT Access		MH Core Data Pack	Sep-22		2,304		2,005		
Community MH services access (older adults/SMI)		MH Core Data Pack	Jun-22				5,875		
Inappropriate OOA placement bed days		MH Core Data Pack	Sep-22				820		
Dementia diagnosis rate		NHS Digital	Sep-22		66.7%	61.7%	60.3%		

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 continuely since Dec-21

Access to community MH services has been decreasing steadily since Dec-21, with the last 3 months actvity 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 consistant, 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

TBC

Mental Health Committees (Suffolk & North East Essex)

Narrative submitted: 28/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

SNEE
-Mental Health Investment Standard 22/23 (MHIS). Proposals worked up to deliver.
-Suffolk Steam Crisis Cafes (Ipswich and Bury) due to be formally launched in January 23.
-MH Winter Plans agreed and feeding into the NHSE MH 100 day discharge until 31.03.23.
-Suffolk and NEE: EEAST Ambulance Car(s) proposals agreed and in process of implementation.
-Suffolk ADHD and ASD working group launched to scope a new service model. Immediate response considering long waiters at NSFT.
-Feel Well Domain- 24 bids (almost £1M) covering Tendring and Colchester localities supporting a range of initiatives targetting groups identified as part of the community asset mapping work.
-Eating Disorder- FREED model implementation underway following successful recruitment to key posts.

Key actvities planned for the next 2 months

SNEE
-Planning- Finalise Mental Health and Dementia NHSE Joint Forward Plan (JFP).
-Collaborative Development
Suffolk Mental Health Collaborative development continues with system workshop planned for 09.01.23.
North East Essex working as part of a pan Essex approach to review progress against the MH Taskforce which focussed on Personality Disorder, Eating Disorders, Specialist Perinatal, Crisis and Supoported Accomodation. Southend, Essex and Thurrock Mental Health Strategy due for completion by 31.03.23.
-Multi-Agency Discharge Event (MADE) planned for January 23 in Essex system.
-Dementia deep dive- February 23. Strategic system post recruited to.
-SCC Public Health Mental Health Prevention Strategy- March 23.
-Specialist Maternity Mental Health Service proposal- March 23.

We have learned this and need to share...

SNEE
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 fully value co-production in underpinning our programme of work and will continue to strive to ensure it flows through all of our projects.

We need help with..

SNEE
Request Alliance suport 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.
Recruitment and retention of workforce.
Agreeing proiritisation of cost pressures and use of 22/23 financial slippage.
Focus on linking increased investmet to recovery of access imes at NSFT and EPUT.

Key Risks

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

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

Narrative submitted: 22/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

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 in NEE and supporting provider to address the backlog challenges re. assessments
3. NEE Community Paediatric Services - working with the provider to establish recovery plans that will support the reduction in backlog
4. VCSE mental health support in Suffolk, bids assessed, award and mobilisation imminent
5. Funding for additional Parent Carer support in Suffolk has been agreed via PACT
6. Funding for 1000 students to be trained in MH First Aid and suicide prevention in Suffolk schools has been agreed
7. Crisis workshops taken place and Peripatetic Team now live

Key actvities planned for the next 2 months

1. NEE NDD pathway - addressing ADHD/ASD effectiveness measures and backlog
2. Continued development of avoidant/restrictive food intake disorder (ARFID) pathway - working with system leads and families to co-produce a new pathway and support
3. CYP Mental Health Crisis offer in Suffolk mapped and communication plan for CYP and Families co-produced
4. NEE Community therapies - decision on transfer of contract
5. Suffolk NDD Pathway - Commence pathway review and complete with focus on managing demand
6. Confirm scope and commence steering group for acute and community paediatric services review
7. Confirm JFP CYP content setting our 5 year priorities
8. Workshop between SCC and NSFT to work through model for provision of CAMHS in Suffolk
9. Preparation for Suffolk SEND inspection

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 replicated within CYP to ensure better join up and sharing of resources
2. Ongoing communication and relationship building vital across all programmes
3. Importance of co-production in service transformation highlighted across SNEE

We need help with..

1.Ensuring both NDD pathways continue to be highlighted across the system and demand challenges being experienced
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.
3. Ensuring we can share key information and resources across all system areas to support CYP more consistently

Key Issues

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

Key Risks

1. Lack of ring fenced financial support for non-mental health investment for CYP
2. 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
5. Delay in short breaks review

SNEE Business Intelligence

NHS

Learning Disabilities & Autism

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
LD health checks		NHS Digital	Oct-22		75.0%	43.8%	38.3%		
Adult Inpatients - Suffolk TCP (Rate per million)		NHS England	Oct-22				23.35		
Adult Inpatients - Essex TCP (Rate per million)		NHS England	Oct-22				21.01		
Flu Vaccination Uptake		CQRS	Oct-22				45.9%		
COVID-19 Vaccination Uptake - 1st & 2nd Vaccines		SystmOne	Dec-22				89.6%		
COVID-19 Vaccination Uptake - 1st Booster		SystmOne	Dec-22				80.1%		
COVID-19 Vaccination Uptake - 2nd Booster		SystmOne	Dec-22				49.4%		
COVID-19 Vaccination Uptake - 3rd Booster		SystmOne	Dec-22				6.6%		

Key performance issues & root cause summary

Healthchecks - October data shows that IES have completed 44.2% of annual healthchecks an 2.3% increase from October 21. West Suffolk have completed 36.1% an 4% increase from October 21.
Adults Inpatients – Suffolk trajectory is set at 7 with current inpatients at 3. 1 Ministry of Justice permanently on home leave, 1 in active treatment and 1 on discharge pathway

Key performance recovery actions (Suffolk)

Healthchecks - There are a few practices in Suffolk who have completed a small amount of healthchecks. This is being escalated through primary care and discussions with the specific practices.

Key performance recovery actions (NEE)

Re LDHCs in NEE. Regularly sharing activity data at practice level, guidance and resources with all NEE practices, to achieve peer pressure. Targeting the least well performing practices - holding meetings; requesting action plans; addressing coding issues; sharing best practice; encouraging PCN working/resource sharing; promoting the funding available; ensuring practices know their aligned specialist LD nurse. Jackie Bland is attending the NEE PCN Clinical Directors meeting on 5th Jan to highlight activities levels need improving.

Learning Disabilities & Autism Committee (Suffolk)

Narrative submitted: 28/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

1. My Health Focus Group met and discussed the Oliver McGowan Mandatory Training, West Suffolk Hospital presented an easy read survey they are rolling out to gather patient feedback, and a discussion took place on what quality means to a person with a learning disability as part of the ICB quality strategy
2. Inaugural meeting of the joint LD&A Integrated Board held.
3. Market engagement event to engage interested providers in the future procurement of a proactive support service
4. Procurement exercise completed and contract awarded to an organisation who will develop an All Age Autism network and partnership to develop the All Age Autism strategy
5. ASD/ADHD oversight group has been established to provide system assurance for the performance, delivery and transformation of the ASD and ADHD adult pathways

Key actvities planned for the next 2 months

1. Tom Cahill, national LDA director, to visit the Suffolk LD Partnership in early February.
2. LD&A Integrated Board to meet in January 2023
3. Steering Group established to work on the rollout of the Oliver McGowan Mandatory Training in SNEE. Trios and lead trainer have been identified and will attend training in January 2023
6. BI Dashboard for LDA will continue to be developed to work towards including not only quantatitive but qualitative data
7. The new C(E)TRs (care education and treatment review) policy due to be released in the new year.
8. Final arrangements are being put into place for Essex County Council LeDeR workforce to support the Suffolk LeDeR process from the 1st January 2023.

We have learned this and need to share...

The Oliver McGowan Mandatory Training on Learning Disability and Autism is for all health and care staff and will be delivered in two Tiers. Tier 1 for people who require general awareness of the support autistic people or people with a LD may need.
Tier 2 for people who may need to provide care and support for autistic people or people with a LD.
A SNEE rollout plan is in development

We need help with..

Current annual healthcheck performance shows that IES have completed 44.2% in October 22 an increase of 2.3% from October 2021 and WS 36.1% in October 22 an increase of 4% from October 2021. 3421 patients still require a check between Nov 22- March 23.
1 practice in West Suffolk have still to complete any checks

Key Issues

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

Key Risks

1. Healthchecks - Young people not having a learning disability code are not being identified to be added to the LD register and are therefore not receiving an annual healthcheck.
2. Funding to rollout the training of the Oliver McGowan Mandatory Training is non recurrent.
3. ASD waiting lists are long and demand is not being met.

Learning Disabilities & Autism Committee (North East Essex)

Narrative submitted: 28/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

- Practice level activity data, guidance and resources is being regularly shared with all NEE GP practices to achieve peer pressure.
- Targeting the least well performing practices: holding meetings; requesting action plans, addressing coding issues; sharing best practice models; promoting available funding; ensuring practices know their specialist LD nurses; encouraging PCN working and sharing of resources/ supporting struggling member practices.
- Liaising with the commissioned Herts Parts specialist LD nursing team, sharing performance data, so the Team can target support to the least well performing practices.
- Analysis of action plan audit commissioned from EQUIP

Key actvities planned for the next 2 months

- CDs meeting - Jackie Bland is attending the NEE PCN Clinical Directors meeting on 5th January to raise awareness of the issues around practices leaving most of their LD health checks until the end of the financial year.
- LeDeR report evidence. Advise practices that most 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.
- Continuing with the above activities, chasing practices for updates on their progress with their action plans. Continued working with Bluebell surgery, who are doing checks but cannot get their activity to pull through into the reporting.

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.

SNEE Business Intelligence

NHS

Quality

Metric	Planning Requirement	Data Source	Latest Date	SOF	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	Jul-22				1.0756 (2)		
Summary Hospital Mortality Index rate - WSFT	SHMI banding = 2, 'as expected' (1, 'higher than expected')	NHS Digital	Jul-22				0.8862 (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	Oct-22		0		1		
C Diff rate (current year - cummulative)		GOV.UK	Oct-22		157		105		
E-coli rate (current year - cummulative)		GOV.UK	Oct-22		155		116		

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 Jul-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 Oct-22
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

Narrative submitted: 20/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

On the 13 Oct 2022 the Quality Committee held its second development session. There was good representation from all partner organisations. The meeting concentrated on the development of the Collective Assurance Framework with a view to capturing assurance and improvement across the ICS.

On the 10 Nov 2022 the Quality Committee held its third meeting where the Joint Forward Plan for 2023-28 was presented. The plan would be elaborated on at the next Development session on the 08 Dec 2022. Quality and Safety of Mental Health was discussed by our Mental Health Providers. Reports were presented on Suffolk LeDeR, Safeguarding, SNEE Integrated Medicines Optimisation Committee and our Patient and Public Involvement team.

Key actvities planned for the next 2 months

The next Quality Committee will be held on the 12 Jan 2023.

Following the inaugural meeting of the Dashboard Task and Finish group on the 15 Dec 2022, Attain will be presenting an updated version of the Quality Data Metrics going forward.

We have learned this and need to share...

There is a requirement to devise metrics associated to the quality of care.
Attempts would be made to use patient stories as part of the dashboard.
There was also a requirement for ICB organisations to develop a five year Joint Forward Plan by the end of March 2023

We need help with..

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

Collective Assurance Framework.
Provide assurance and improvement acros the ICB.

ICB Quality Dashboard.
Consider all aspects of Data across the ICS.

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.

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.

SNEE Business Intelligence

NHS

Alliance - Ipswich & East Suffolk

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	Oct-22		70.0%		81.1%		
Hospital discharge to usual place of residence		SUS	Nov-22				96.6%		
GP appointments per 10k weighted pop		NHS Digital	Oct-22				5,591		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				67.6%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Sep-22		0.871		0.910		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Sep-22		10.0%		7.92%		
All 8 diabetes care processes		Eclipse	Dec-22				48.13%		
Supported through NHS diabetes prevention programme		Eclipse	Nov-22			4,228	1,612		
Referrals to NHS weight mgmt services per 100k pop		SystmOne	Dec-22				1,152		
Seasonal flu vaccination (over 65s)		CQRS	Oct-22				74.2%		
MMR 2 doses (5 year olds)		GOV.UK	Jun-22				89.97%		

***Activity from S1 practices and for all weight management services (not just digital)*

Key performance issues & root cause summary

The reported UCR % is well above the target of 70% in September. DQ work remains on-going to ascertain whether the currenlty 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. Live data shows our overall SNEE Care Processes (rolling 12 month) performance is at 56% with IES at 50%. For the current QoF year (YTD) IES is low at 38% though Q4 is typically when a lot of QoF updates are made.
NDDP – Existing Engagement Lead continues to work across all SNEE practices. Recruitment for the second engagement lead has stalled. This is a significant concern, Xyla are working on a solution. October data shows IES is only delivering 33% of NDPP referrals though it has 40% of the population.

Ipswich & East Suffolk Alliance Committee

Narrative submitted: 28/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Be Well: Primary Care Personalised Care Programme received 59 referrals; Connect for Health Contract extension agreed; Scoping document in development to support hypertension case finding/management/prevention for BAME community in Ipswich; Feasibility study of green space at Unity Centre underway; Discussions/planning underway to integrate Social Prescribing within A&E at ESNEFT supporting REACT & Welcome Home team; Unmet Needs Navigator Team to receive referrals from EEAST; Oral Health Campaign approved
Age Well: Winter support schemes in place - In-hours home visiting service, additional care home ward rounds, COPD support.
Stay Well: Primary Care Suffolk Fuller stocktake meeting held; Inaugural Primary Care Commissioning Group; ICB project on reducing carbon impact of inhalers won a national PrescQIPP award for sustainability; Exploring prescribing efficiencies with relevant practices; Public campaign in Ipswich town centre/social media promoting reduction of carbon impact of prescribed inhalers coinciding with World COPD Day; First face to face pharmacy forum event held
Die Well: RESPECT Steering Group set up; Overarching palliative care and end of life outcomes agreed

Key actvities planned for the next 2 months

Be Well: SystmOne – risk assess & develop consultation and implementation plan for SPLWs to access SystmOne; Continue development of an ICS formulary;
Feel Well: Complete rollout of community MH programme to all PCNs
Age Well: Prepare for mobilisation of strength and balance service and anticipatory care.
Stay Well: Local Enhanced Services 23/24 development; Development of primary care strategy alongside refreshed delivery plan including safe working levels and Fuller requirements; Commission Winter Phlebotomy scheme for primary care; Review cardiology advice and refer pilot
Die Well: End of Life Workforce Workshop

We have learned this and need to share...

- CQC inspections undertaken for many practices, results yet to be ratified
- See below re contingency/business continuity plans re shortages

We need help with..

- Cohesive joint estates plan
- Further discussions to reduce demand and duplication across the system
- Funding for Population Health Management interventions/alternative offers for care outside of traditional statutory services (e.g. VCSE).

Key Issues

- Increased additional needs across all services
- Estate issues unresolved impacting primary care and INT staff
- Increased demand for Social Prescribing
- Transport costs
- Medicines shortages
- IT issues in INTs unresolved

Key Risks

- Workforce capacity to meet urgent and emergency need and continue long term condition management and elective care
- Organisational resilience, particularly amongst smaller partners
- Forward funding of key voluntary sector led services from end March 2023
- Delayed mobilisation of strength and balance service (for falls prevention)

SNEE Business Intelligence

NHS

Alliance - North East Essex

Metric	Planning Requirement	Data Source	Latest Date	SOF	National Target	Local Plan (for this time period)	Actual	Variation	Assurance
UCR Referrals in 2 hours	70%	CSDS	Oct-22		70.0%		57.4%		
Hospital discharge to usual place of residence		SUS	Nov-22				95.6%		
GP appointments per 10k weighted pop		NHS Digital	Oct-22				5,339		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				57.0%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Sep-22		0.871		1.011		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Sep-22		10.0%		8.44%		
All 8 diabetes care processes		Eclipse	Dec-22				68.87%		
Supported through NHS diabetes prevention programme		Eclipse	Nov-22			3,699	1,861		
Referrals to NHS weight mgmt services per 100k pop		SystmOne	Dec-22				324		
Seasonal flu vaccination (over 65s)		CQRS	Oct-22				67.0%		
MMR 2 doses (5 year olds)		GOV.UK	Jun-22				86.98%		

***Activity from S1 practices and for all weight management services (not just digital)*

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: 20/12/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

The Committee received the Start Well domain spotlight report which highlighted the ongoing focus on emotional health and wellbeing. It was confirmed the Children's and Partnership post at ECC had been recruited to which will act as a joint domain lead.
The Committee received an overview of the medicines optimisation update which will continue to be reported on a quarterly basis.
The Alliance Exec highlight report was presented, focusing on the two system workshops held during November - Harwich place planning and Thinking Differently about Intermediate Care.
The finance report was received highlighting that whilst we are currently on track, there are increasing pressures regarding prescribing pricing concessions.
A contracts checklist was presented to support the transformation of the Alliance to ensure all key information is picked up at the beginning of each project.
The Committee were informed the primary care commissioning group is now in place which will also see responsibilities for dentistry and eye care from Jan 2023.

Key actvities planned for the next 2 months

Distribution of approved funds from the Feel Well domain programme.
Evaluation of bids received for the Start Well fund to commence.
To launch Age Well and Be Well application process - focusing on cost of living and physical activity as priority areas.
Wider mental health transformation update to be received by the Committee.
Joint forward plan update to be received, to inform contents of the updated Alliance local delivery plan.
End of Year review to be shared with Alliance partners for comment.
WELL group report to be shared with Alliance partners for comment.
A review of the Alliance Operational group working against its TOR is also planned for the new year by the chair.

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 and a scheduled Alliance development session due to be held in the new year.

We need help with..

No new requests of SOAC.

Key Issues

The impacts of the cost of living impacts is elected to have operational difficulties for some services, discussions across partners continue in order to understand the learnings and inform mitigation plans. Remains as a standing agenda item on the Alliance Executive Group.
Sustained operational pressures place competing demands on some of the domain leads - focused operational support being provided to system for the period 12/12/22 - 23/12/23

Key Risks

No current risks to escalate to SOAC.

SNEE Business Intelligence

NHS

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	Oct-22		70.0%		93.1%		
Hospital discharge to usual place of residence		SUS	Nov-22				94.4%		
GP appointments per 10k weighted pop		NHS Digital	Oct-22				5,099		
Experience of making a GP appointment - Good		GP Patient Survey	Apr-22				59.7%		
Antibiotic Items/STAR-PU	0.871 or below	PrescQIPP	Sep-22		0.871		1.006		
Co-amoxiclav, Cephalosporins & Quinolones	Broad spectrum antibiotics - 10% or below	PrescQIPP	Sep-22		10.0%		9.47%		
All 8 diabetes care processes		Eclipse	Dec-22				42.97%		
Supported through NHS diabetes prevention programme		Eclipse	Nov-22			2,641	1,295		
Referrals to NHS weight mgmt services per 100k pop		SystmOne	Dec-22				689		
Seasonal flu vaccination (over 65s)		CQRS	Oct-22				69.1%		
MMR 2 doses (5 year olds)		GOV.UK	Jun-22				89.81%		

Key performance issues & root cause summary

The reported UCR % is significantly above the target of 70% in October. 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. 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.
Diabetes programme looking at practice level data and targeting support.

***Activity from S1 practices and for all weight management services (not just digital)*

West Suffolk Alliance Committee

Narrative submitted: 29/11/2022

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

Explored how to better understand and respond to pressures in primary care. A "perfect week" concept is being developed to take this further.
Reviewed the YTD forecast which suggested an underspend of £268K
Approved a paper outlining the approach to implementing the Live Well Domains
Approved a business case for Virtual Ward transferring the funding from the ICB to WSFT.
Approved a Diabetes recovery paper against the 8 primary care processes
Received a report on the implementation of the Dementia Strategy
Agreed in principle to submit a consortium bid in response to the Healthy Behaviours procurement led by Public Health
Approved the seasonal winter plan and associated funding streams and noted the risks to delivery and their mitigations

Key actvities planned for the next 2 months

Continue to grow a partnership leadership model of the Live Well Framework in preparation for finalising the Alliance Delivery Plan once the JFP has been drafted. Work across all three Alliances to agree a framework for the Delivery Plans
Finalise clinical safety documentation for Cassius+ and incorporate learning and recommendations into a business case to scale
Continue to work with primary care and clinical system team in ICB to ensure the reporting against diabetes care processes is accurately captured
Develop and implement plans for the Winter Discharge Fund
Socialise the Community Discovery outputs and continue to build the VCSE network for Winter and in response to the Cost-of-Living Crisis
Finalise Social Prescribing draft model and prepare to take through governance
Work with District and Boroughs to explore capacity and capabilities to deliver Healthy Behaviours and agreed scope

We have learned this and need to share...

Work with partners to explore opportunities for co-commissioning in advance of contract end dates. There are opportunities to align how we approach digital transformation as a system by approaching a set of core themes
Recruitment to fixed term roles is not enabling transformation over the medium-longer term.

We need help with..

Reviewing non-recurrent funding and fixed term positions

Key Issues

Fixed-terms roles without security of future employment
Diabetes data quality - this continues to be in progress to be resolved. data extraction attempts so far have failed.

Key Risks

Workforce gaps - increased demand on system and capacity gaps due to unfilled vacancies and sickness

SNEE Business Intelligence

NHS

Workforce

Metric	Planning Requirement	Data Source	Latest Date	SOF	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	Oct-22				5.3		
Direct pt care staff per 10k weighted pts		NHS Digital	Oct-22				5.6		

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

Workforce

NHS
Suffolk and North East Essex
Integrated Care Board

Key activities completed in the previous 2 months

- Reservists: The reservist recruitment programme has begun, we expected 150 applicants in the first three weeks we have had over 500 applicants.
-Deep dive into Support Workers completed and presented to SOAC
-Ipswich and East Alliance and North East Essex Workforce sub-group reset
-West Suffolk Workforce sub-group first meeting held
-Pharmacy Workforce Strategy approved at People committee
-Industrial Action groups convened

Key actvities planned for the next 2 months

-Healthcare Science workforce Strategy in final draft, launched by January 2023
-Pharmacy Strategy implementation workshops set for Jan-March
-System wide care support worker recruitment days set for Jan (this includes social care, NHS, voluntary sector and primary care). the plan is to recruitment on the days via recruitment bus.
-System Retention workshop planned for end of January
-SNEE ICB are one of seven ICB's nationally who have been selected to take part in a pilot looking at how we can integrate planning data across finance, activity and workforce.

We have learned this and need to share...

Importance of stakeholder involvement
Data quality for workforce

We need help with..

Data quality for workforce

Key Issues

Industrial Action- awaiting outcomes of trade unions ballots from current date onwards (RCN confirmed)
Winter pressures
Workforce Retention
Workforce work life balance
Workforce - professional development
Workforce- health and wellbeing

Key Risks

Industrial Action- RCN Industrial action confirmed for 15th and 20th of December
Winer Pressures- effected by a number factors (see key issues)

SNEE Business Intelligence

NHS

Finance

Financial Position: Performance against Key Targets

- Revenue (YTD and Forecast Outturn) Break-even

Month 8	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	250	250	0	0	0
WSFT	672	502	-170	1,008	1,008	0
Sub-total	672	752	80	1,008	1,008	0
EEAST	-1,512	-1,906	-394	-1,000	-1,000	0
NHS Sub-total	**-840**	**-1,154**	**-314**	**8**	**8**	**0**

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

Year to Date Month 8	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	17,714	7,846	-9,868	17,937	17,495	-442	7,080	1,988	-5,092	42,731	27,329	-15,402
CDEL	58,425	18,764	-39,661	20,536	18,948	-1,588	15,936	2,538	-13,398	94,897	40,250	-54,647

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	10,233	-385	64,179	65,294	1,115
CDEL	99,267	79,260	-20,007	33,201	39,182	5,981	29,645	29,260	-385	162,113	147,702	-14,411

- Mental Health Investment Standard

The ICB forecast MH spend of £149.067m against a target of £148.310m; exceeding the MHIS target by 0.51% (0.63% last month).

NHS Organisations within the system are reporting positions YTD and Forecast at or close to plan and little changed from last month. EEAST continues to brief Regulators on their challenging financial position, but are not expected to trigger the protocol to change the forecast outturn position.

No solutions have yet been identified to address the significant slippage in National Programme projects (ESNEFT acute reconfiguration). The issues, caused by global supply issues, are common to other systems, although others have been slower to reflect this in reporting. The expected scale of the problem nationally will mean that this will need to be addressed at National/Treasury level.

The forecast slippage identified in the tables reflects about half of the estimated £30m forecast slippage. The remainder is masked by diagnostic capital allocations that have yet to be announced and reflected in plans.

Routine capital allocations (system capital)are also affected, although system organisations are working to avoid underspend. The apparent system, capital forecast overspend (£1.115m) in the tables is a result of RAAC expenditure committed by WSFT, endorsed by NHSE but not reflected yet in additional allocations (£1.500m).

SNEE Business Intelligence

NHS

Finance

Financial Position: Other Issues

Risks and Mitigations

- The unmitigated financial risks position is unchanged from month 7: £5.700m. Reduced from £37.777m included in the 2022/23 plan submission, the remaining unmitigated risk rests wholly with EEAST, and relates to unfunded inflation and higher than planned prevalence of Covid19.

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	16,454	12,695	-3,759	27,567	21,480	-6,087	16,006	5,474	21,480
WSFT	4,802	4,802	0	7,500	7,500	0	6,500	1,000	7,500
EEAST	6,224	1,378	-4,846	13,200	13,200	0	10,800	2,400	13,200
ICB	11,528	10,339	-1,189	17,293	15,131	-2,162	8,344	6,786	15,130
Total	**39,008**	**29,214**	**-9,794**	**65,560**	**57,311**	**-8,249**	**41,650**	**15,660**	**57,310**

- There have been increases in the level of forecast slippage on efficiency schemes in two system organisations in month 8. Forecast slippage is £8.249m, compared with £5.706m reported at the end of month 7. It is noted that the delivery of planned financial performance is not expected to be affected by this with all system organisations continue to forecast an 'on-plan' position at the year-end.
- There has been a small increase to £15.660m in the contribution made by non-recurrent schemes. Whilst non-recurrent schemes will help to ensure the delivery of 2022/23 financial plans, dependence on such scheme highlights the scale of the financial challenge in 2023/24, when they will no longer contribute.
- Planning assumptions for 2023/24 have yet to be published at the time that this dashboard is completed, but may have been released by the time that this report is socialised. The current version of the long-term financial plan based on assumptions discussed by ICS finance colleagues suggest a significantly higher efficiency savings requirement than those in the table above in each of the next 5 financial years.

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. Action taken to achieve the target risks impacting on elective recovery and other operational targets and deliverability is likely to be adversely affected by proposed strike action by key staff groups. Reporting of performance against this target for the purposes of this dashboard have therefore been suspended

7.0 Recommendations

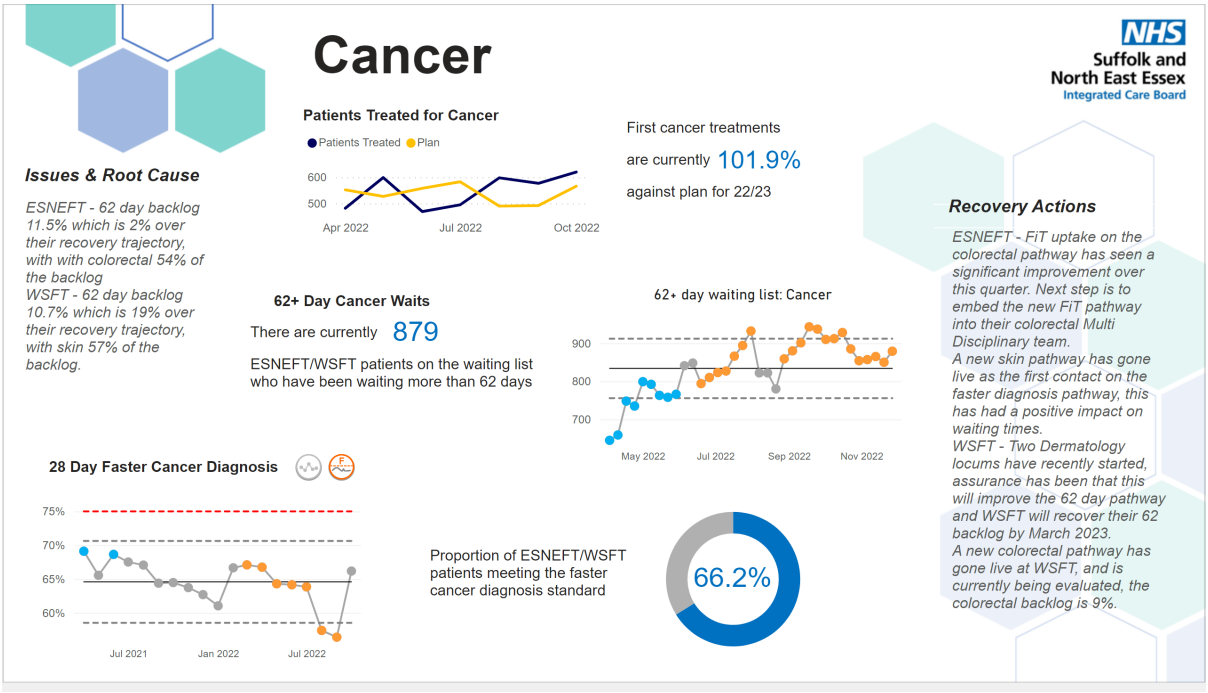
The Board is requested to:

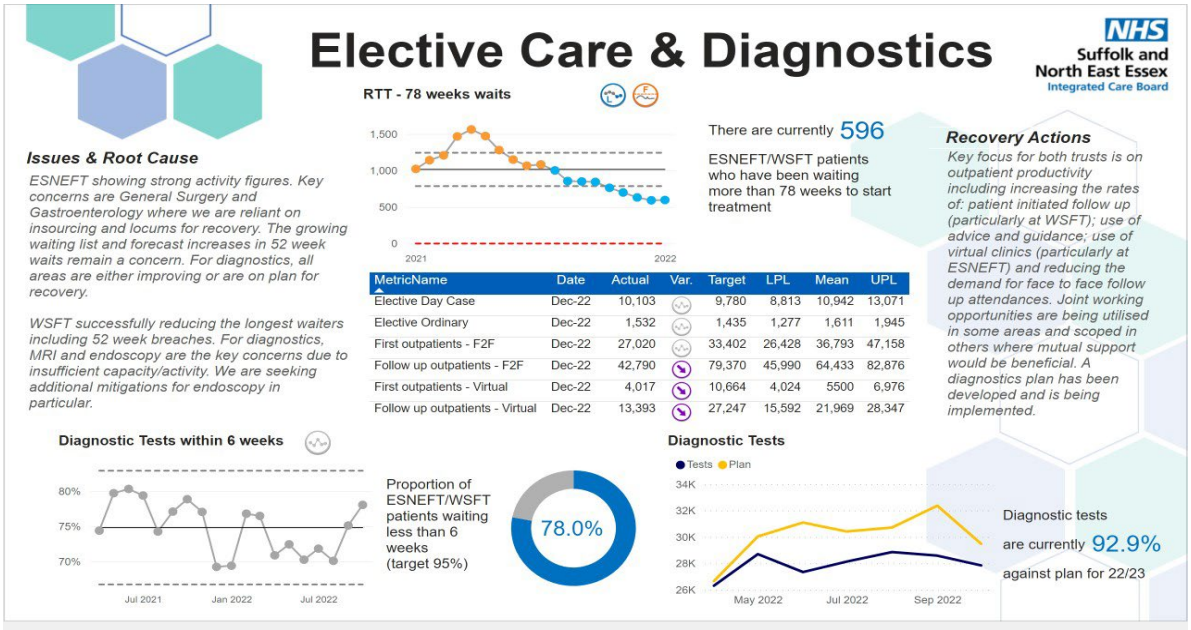
7.1 Note the content of this report

7.2 Discuss the content where issues are identified by Board Members

7.3 Make any recommendations or identify any actions to be undertaken by relevant committees.

Appendix 1


Cancer
NHS
Suffolk and
North East Essex
Integrated Care Board
Issues & Root Cause
ESNEFT - 62 day backlog 11.5% which is 2% over their recovery trajectory, with with colorectal 54% of the backlog
WSFT - 62 day backlog 10.7% which is 19% over their recovery trajectory, with skin 57% of the backlog.
Patients Treated for Cancer
Patients Treated
Plan
600
500
Apr 2022
Jul 2022
Oct 2022
First cancer treatments are currently 101.9% against plan for 22/23
62+ Day Cancer Waits
There are currently 879
ESNEFT/WSFT patients on the waiting list who have been waiting more than 62 days
62+ day waiting list: Cancer
900
800
700
May 2022
Jul 2022
Sep 2022
Nov 2022
Recovery Actions
ESNEFT - FiT uptake on the colorectal pathway has seen a significant improvement over this quarter. Next step is to embed the new FiT pathway into their colorectal Multi Disciplinary team.
A new skin pathway has gone live as the first contact on the faster diagnosis pathway, this has had a positive impact on waiting times.
WSFT - Two Dermatology locums have recently started, assurance has been that this will improve the 62 day pathway and WSFT will recover their 62 backlog by March 2023.
A new colorectal pathway has gone live at WSFT, and is currently being evaluated, the colorectal backlog is 9%.
28 Day Faster Cancer Diagnosis
75%
70%
65%
60%
Jul 2021
Jan 2022
Jul 2022
Proportion of ESNEFT/WSFT patients meeting the faster cancer diagnosis standard
66.2%


Elective Care & Diagnostics
NHS
Suffolk and
North East Essex
Integrated Care Board
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. For diagnostics, MRI and endoscopy are the key concerns due to insufficient capacity/activity. We are seeking additional mitigations for endoscopy in particular.
RTT - 78 weeks waits
1,500
1,000
500
0
2021
2022
There are currently 596 ESNEFT/WSFT patients who have been waiting more than 78 weeks to start treatment
MetricName | Date | Actual | Var. | Target | LPL | Mean | UPL
Elective Day Case | Dec-22 | 10,103 | | 9,780 | 8,813 | 10,942 | 13,071
Elective Ordinary | Dec-22 | 1,532 | | 1,435 | 1,277 | 1,611 | 1,945
First outpatients - F2F | Dec-22 | 27,020 | | 33,402 | 26,428 | 36,793 | 47,158
Follow up outpatients - F2F | Dec-22 | 42,790 | | 79,370 | 45,990 | 64,433 | 82,876
First outpatients - Virtual | Dec-22 | 4,017 | | 10,664 | 4,024 | 5500 | 6,976
Follow up outpatients - Virtual | Dec-22 | 13,393 | | 27,247 | 15,592 | 21,969 | 28,347
Recovery Actions
Key focus for both trusts is on outpatient productivity including increasing the rates of: patient initiated follow up (particularly at WSFT); use of advice and guidance; use of virtual clinics (particularly at ESNEFT) and reducing the demand for face to face follow up attendances. 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.
Diagnostic Tests within 6 weeks
80%
75%
70%
Jul 2021
Jan 2022
Jul 2022
Proportion of ESNEFT/WSFT patients waiting less than 6 weeks (target 95%)
78.0%
Diagnostic Tests
Tests
Plan
34K
32K
30K
28K
26K
May 2022
Jul 2022
Sep 2022
Diagnostic tests are currently 92.9% against plan for 22/23

NHS
Suffolk and North East Essex
Integrated Care Board

CAN DO
HEALTH & CARE

Seasonal Plan
Winter 2022/23 Focus

Context

Purpose

The purpose of the seasonal plan is to bring together all relevant activities across Suffolk and North East Essex (SNEE) health and social care which relates to planning for the coming winter 2022/23 ensuring that all possible plans are being progressed.

Development of the Plan

- This plan must be seen in the context of the Newly formed ICB Urgent Care Committee who's new responsibility is to oversee the development of this plan.
- The plan needs to be seen in context of building onto existing service which are continually evolving and being delivered as business as usual.
- The plan will continue to evolve throughout the winter period and be continually evaluated and updated to meet emerging challenges.

Challenges

SNEE system has continued to be under significant pressure with all involved in the delivery of care experiencing significant pressure whilst continually recovering services, meeting the urgent care needs of our population and facing the challenges associated with Covid-19.

Key areas of pressure:

- Ambulance performance for C1 & C2 patients
- Patient handover delays
- ED performance and specifically 12 hour waits
- Acute occupancy
- Challenged flow out of acute settings
- Mental health demand & capacity
- Workforce

In addition, we are striving to recovery elective care and planning for the potential impacts of:

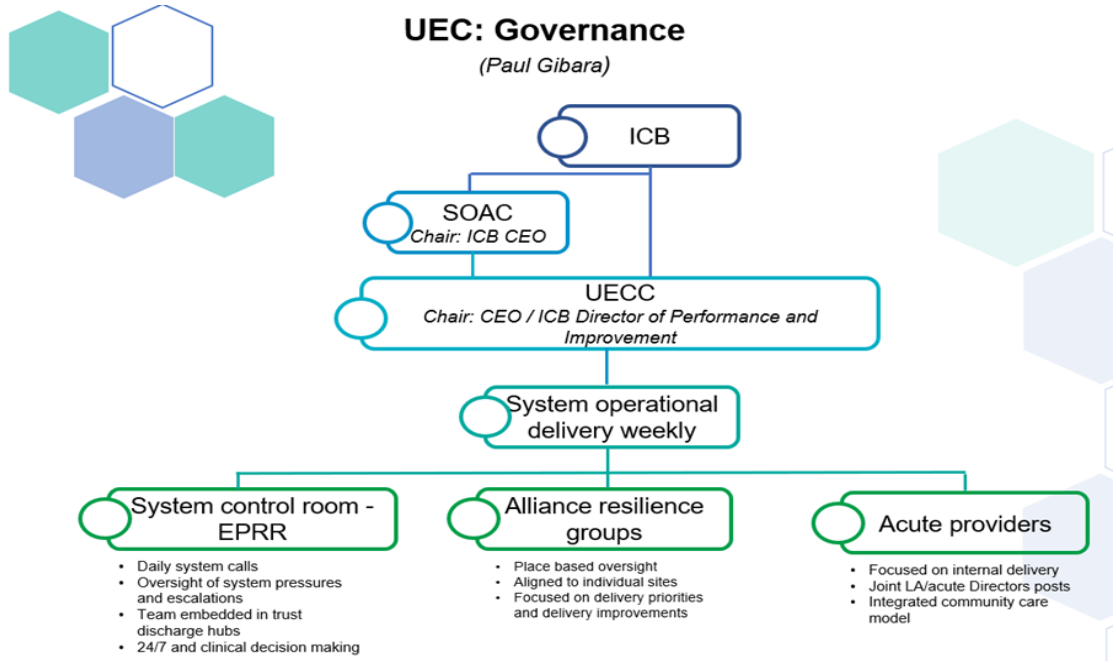
- Winter weather
- Further spikes in Covid 19/ Seasonal Flu
- Industrial action across multiple sectors
- National power outages
- Cost of living impacts on our workforce & wider population

Governance

System Governance

SNEE system has established an Urgent and Emergency Care committee to oversee the development and performance of the system in respect of urgent care provision.

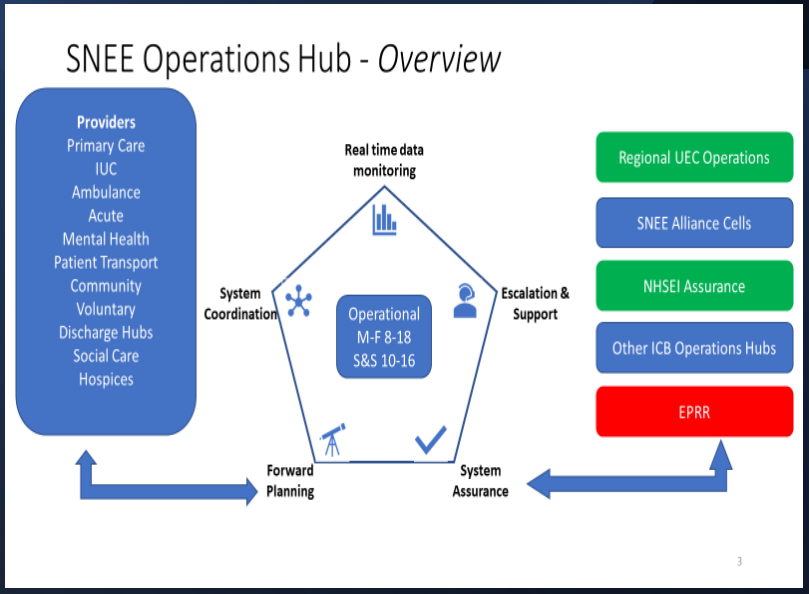
The committee is inclusive of all system partners and whilst each organisation has individual responsibility for provision of services the main delivery and improvement of services will happen through the established Alliance structures. These groups meet weekly to drive the delivery of schemes, chaired by directors.



UEC Strategic Leadership

Guidance / Programme	Place vs System	SRO
Internal hospital site actions: • ED performance • No 12 hr ED waits • Increased use of SDEC and hot clinics to include frailty services • Improved internal flow i.e. Red to Green	Place	ES – Sarah Noonan WS – Nicola Cottington NEE – Alison Stace
Focus on Ambulance performance: *(work with other workstreams)* • Reduction in ambulance handover delays • Improved response times C1 & C2 • C3-5 Stack management	System & Place	EEAST –Jemma Varela ES – Sarah Noonan WS – Nicola Cottington NEE – Alison Stace
Focus on external factors affecting discharge: • Reduction and maintenance of long stay patients 7, 14 and 21 days • Development of Virtual Ward 40 to 50 per 100,000 population for admission avoidance and early supported discharge. • Maintain D2A gains achieved through pandemic in partnership with local authority working through better care funds and development of virtual wards. • Weekend discharge • 2 hrs crisis community and ill health response 8-8pm 7 days a week	Place	IES – Paul Little WS – Clement Mawoyo NEE – Ali Armstrong
Focus on prevention: • Expansion of primary care and improved access in line with Oct 21 plans • Develop plans for personalised and integrated care in the community and care closer to home	Place	IES – Maddie Baker-Woods WS – Peter Wightman NEE – Laura Taylor-Green
Focus on supporting right pathways: (working with other workstreams) • 111 – 70 % of patients referred to A&E in booked slots • Conveyancing rates	System & Place	PPG – Belinda White ES – Sarah Noonan WS – Nicola Cottington NEE – Alison Stace
Focus on Mental health: • Mental Health Crisis Team • Tier 4 access and care	System & Place	ICB – Richard Watson/Lisa Nobes

System Operational Hub

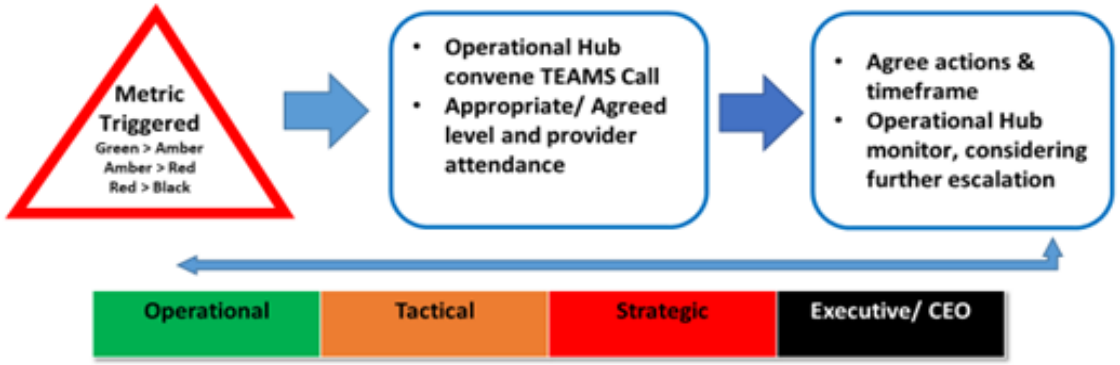


System Oversight

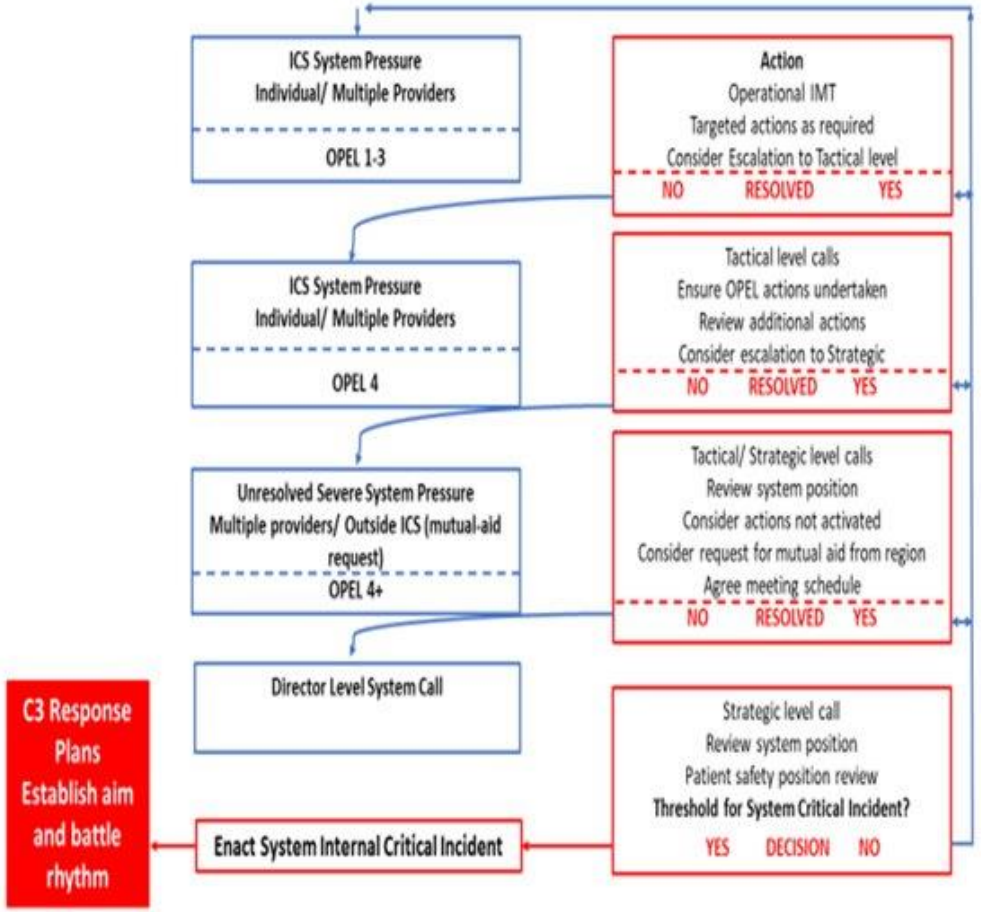
Our Operational hub operates 7/7 to support the delivery of urgent & emergency care, patient flow and discharge across our system. The dedicated team supported by the on call teams ensure we are available to support our system 24/7.

- Attendance at all regional Tactical and Strategic Command meeting by senior manager and system executive.
- SNEE have maintained a 'Tactical' system wide meeting throughout the incident response
- On site liaison several times a week to support acutes
- Embedded EEAST local ToC
- Clinical risk oversight
- Identified SRO Cells to balance planned care and emergency care with system workforce enabler response
- Weekly / daily Silver tactical Alliance based response
- Daily system patient flow capacity meetings to coordinate system response
- Emergency funding arrangements governance maintained
- Increased the frequency for these oversight groups to respond to system pressures

System Triggers for Escalation

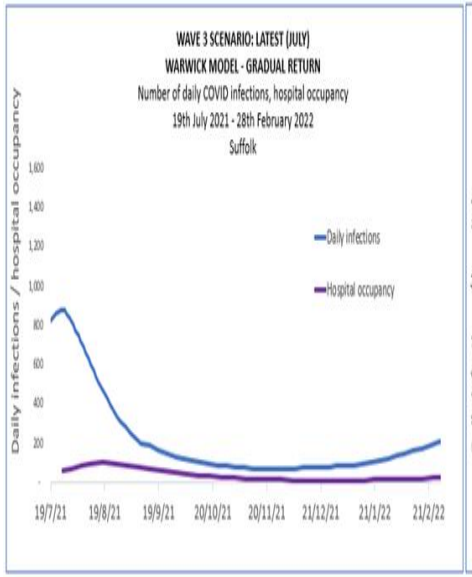


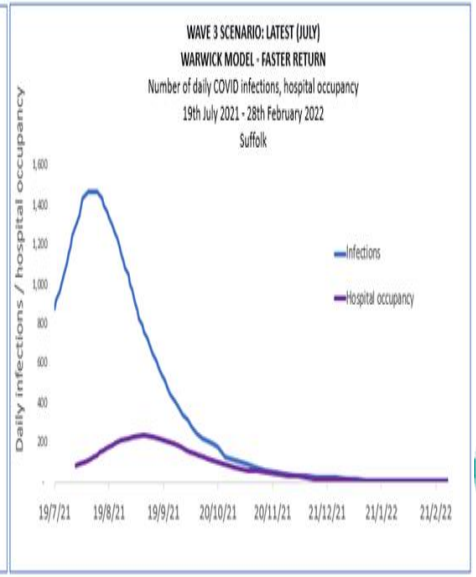
- Place-based and ICS level tactical groups in place to oversee activity and ensure system escalation as required. SNEE recognises the need for timely dynamic management of escalation and balanced risk assessments, which is supported by place-based System Escalation managers and the system Operational hub and clinical teams.
- Metrics are measured by site and by the Operational hub on a daily basis. Real time capacity oversight in place through utilisation of SHREWD and SNEE BI based activity dashboards.
- Escalation flow charts agreed (see above)
- Established process to link to C3 arrangements (see right)



Infection, Prevention & Control

Covid hospitalisation modelling has been completed for the ICS based upon SAGE predications which have been incorporated into the demand & capacity work for our three acute sites. We continue to work closely with our PH colleagues to ensure we remain responsive to seasonal infections and the pandemic impact on health & care.





CAN DO HEALTH & CARE

Infection, Prevention & Control

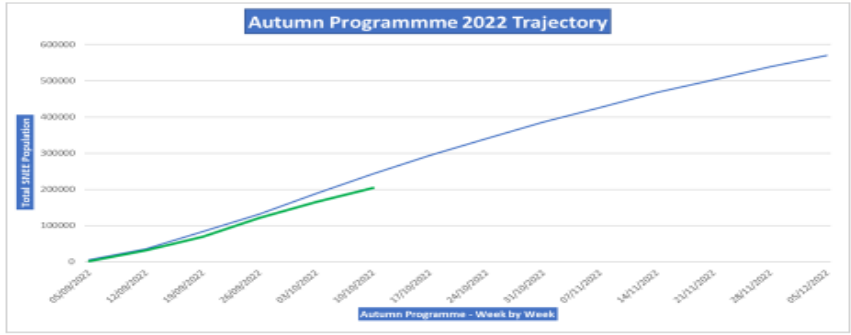
Suffolk and North East Essex ICS — Flu Vaccine Uptake

Key Take-homes

- Since the beginning of the 2022 Autumn Campaign, we have administered 167,842 flu vaccinations. Out of our eligible population, 23.5% have received their jab.
- 18% of these vaccinations have been co-administered with COVID-19.
- 75% of flu vaccinations have been administered by a GP Practice. The remaining 25% have been administered by a Pharmacy.
- Within Suffolk and North East Essex, there are 170 sites actively administering flu vaccines.

#CanDoHealthandCare — CAN DO HEALTH & CARE

Suffolk and North East Essex ICS — Autumn Programme 2022 Trajectory



01 SNEE remains the highest performing ICS nationally in relation to population uptake of the vaccine. The green line outlines our progress so far against our planned supply. As of Monday 17th October, we have vaccinated 39% of our eligible population.

02 Graph showing planned vaccine supply in the Autumn Booster Programme based on planned weekly vaccination capacity as agreed with providers. SNEE has a total eligible population of 526,500. Based on our planned capacity, we aspire to achieve 85% uptake however, citizen insight clearly evidences C19 vaccination is no longer a key priority when compared to the broader social, economic and political landscape. This further strengthens the importance of our focused communications campaign.

#CanDoHealthandCare — CAN DO HEALTH & CARE

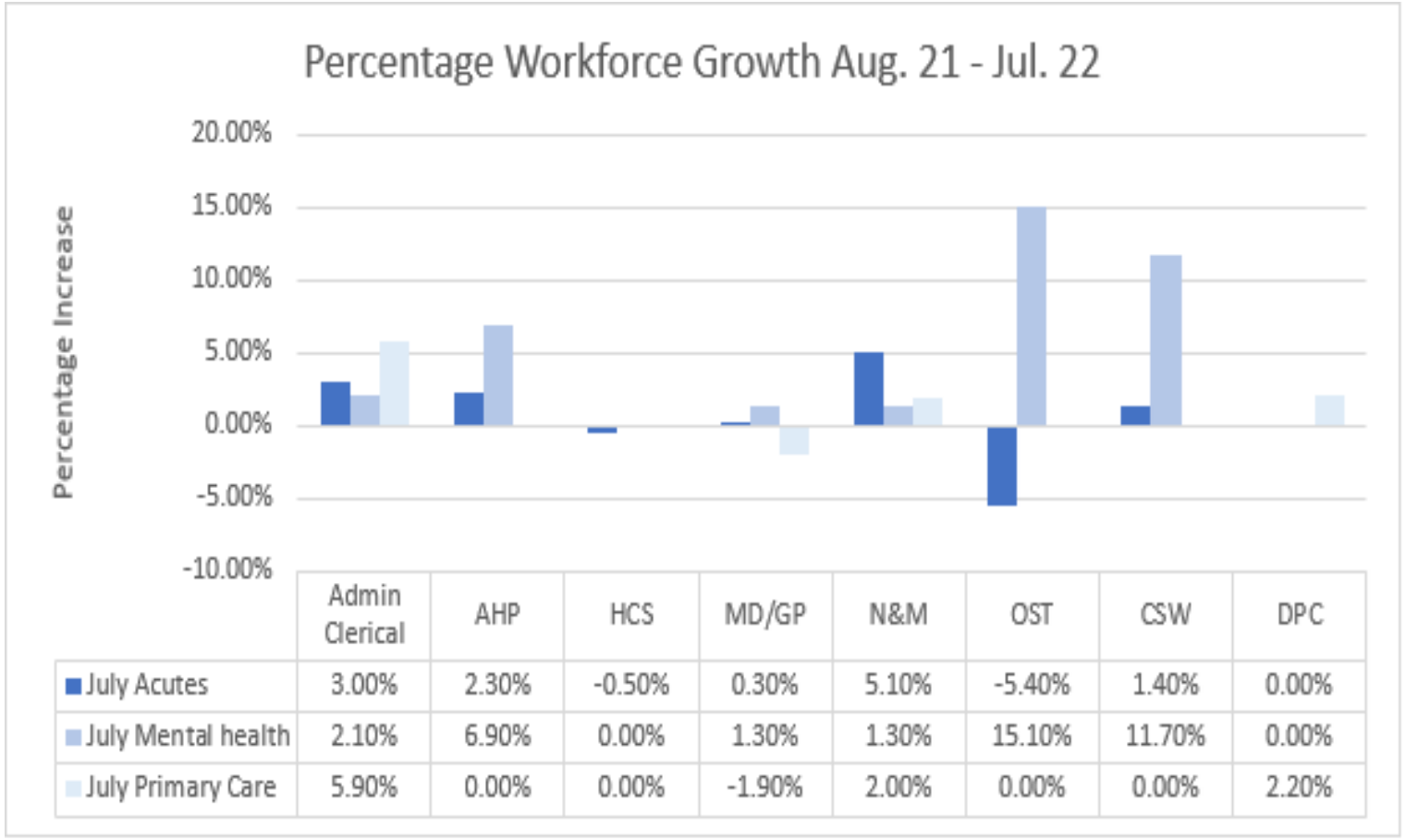
Workforce

Workforce Challenges

- Potential for Industrial action across all Health and Social Care
- Ongoing retention issues excecated by the cost of living crisis (in particular health care assistants/ care support workers) and continued demand/ workload leading to burnout.
- Sickness absence likely to remain high due to Covid related absences, on top of general sickness absence.

- **Workforce Interventions**
- Recruitment continues to be steady, with the exception of healthcare assistants care support workers.
- Reservist Model options currently being developed and revised recruitment campaign is being designed .
- Standard Operating Procedure is the escalation of normal risk management processes within individual providers where the risk is such that Mutual Aid arrangements are required. **(Please note that this is only effective when one organisation has issues and for use in emergencies only)**
- Health and Wellbeing interventions continued to be designed and promoted at a system and local level (including menopause support) .
- Bespoke workforce transformation workshops using HEE star.
- Cost of living support at both system and local levels including system wide financial planning workshops for staff.
- Retention officers in place to help with retention within organisations.

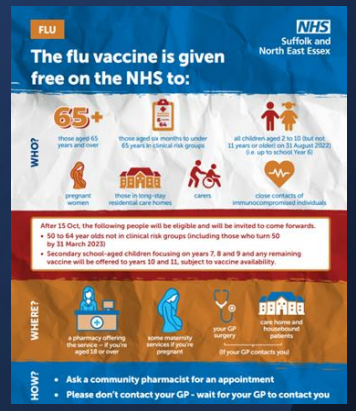
Workforce



	Admin Clerical	AHP	HCS	MD/GP	N&M	OST	CSW	DPC
July Acutes	3.00%	2.30%	-0.50%	0.30%	5.10%	-5.40%	1.40%	0.00%
July Mental health	2.10%	6.90%	0.00%	1.30%	1.30%	15.10%	11.70%	0.00%
July Primary Care	5.90%	0.00%	0.00%	-1.90%	2.00%	0.00%	0.00%	2.20%

SNEE has seen success in growing the workforce in key areas.

Communication



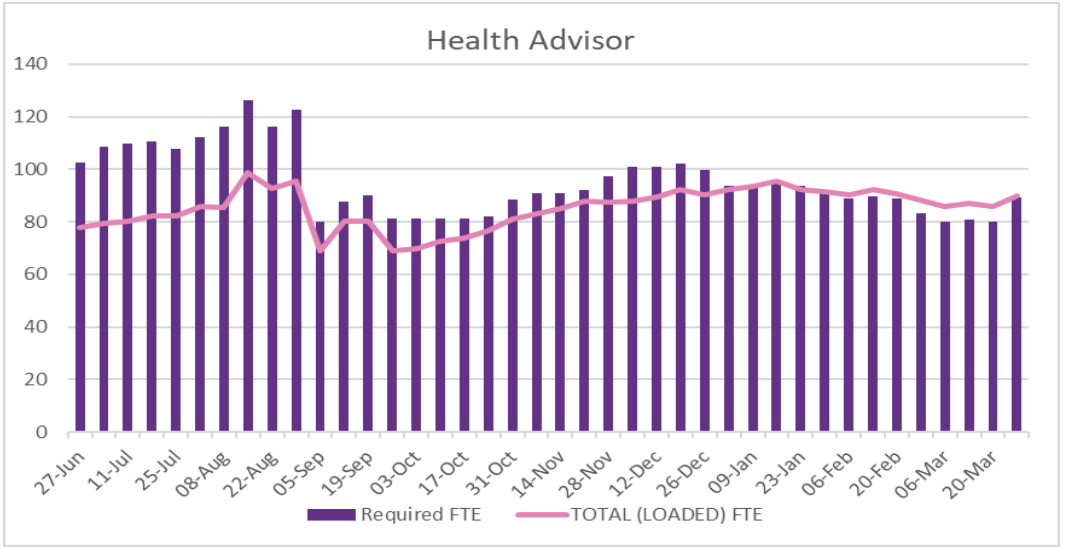
- The key messages our system will seek to communicate are:
  - We anticipate another challenging winter but the NHS is well-versed in planning for winter pressures;
  - Planning for this year started at the end of last winter, with the preparation of joint winter resilience plans between hospitals, community health services and social care services setting out where extra resources would be needed over winter.
  - The public can help the local health and care system to cope with winter pressures by taking steps to keep themselves well. This includes getting their flu jab and COVID-19 booster vaccination; seeking advice at the first sign of illness by making use of NHS 111; seeking advice at their local pharmacy for minor ailments and ensuring that they order repeat prescriptions in good time.
  - Prompt discharge from hospital is especially high priority for the health and care system across Suffolk and North East Essex during the winter period. Families and friends of loved ones in hospital can support this by making sure they are helped to return home as soon as they are fit and able to do so.
- The system (through the ICB Communications team) has also repurposed its wellbeing website to include self care messaging, a booklet which promotes locally available services and details of local support groups across SNEE – www.sneewellbeing.org.uk

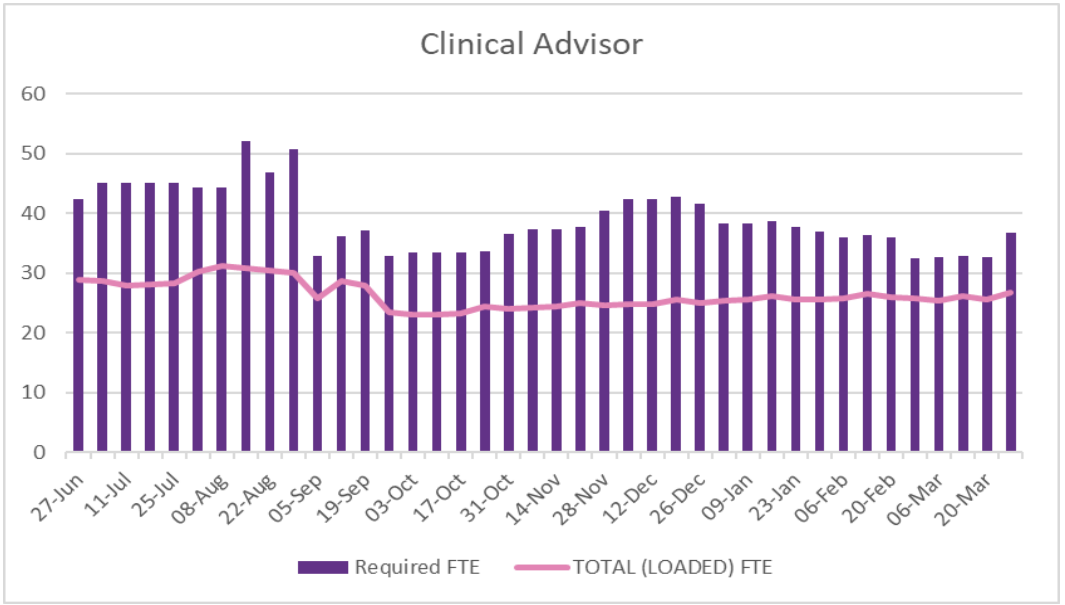
- A key element of our system plan this year is the promotion of COVID-19 autumn booster and flu vaccinations. As such infographics have been produced which have been uploaded on sneevaccine website (www.sneevaccine.org.uk) and used on local social media platforms (please see opposite).
  - The system's sneevaccine website – which has been developed and updated daily by the ICB Communications team – has the latest information and assets relating to the roll out of the COVID-19 Autumn Booster and Flu vaccinations. Walk in clinics are posted on a daily basis – www.sneevaccine.org.uk
- We have a very proactive approach to social media messages. The ICB creates new content, supports national messages and reshares partners messages relating to staying well on a daily basis.

PPG IUC Delivery

Practice Plus Group

- PPG's 'flightpath' processes ensure capacity to manage predicated demand across the winter period (see graphs right)
- Other focus areas to support the system include:
  - •Conveyance Avoidance Helpline
  - •Transfer of low acuity cases from EEAST stack to CAS
  - •Support for Virtual Wards in the OOH period (*process to be agreed but in transit)*
  - •In-hours Home Visiting Service for Primary Care (NEE)
  - •Move of Colchester OOH base to co-locate with UTC
  - •Enhancement of clinical capacity
    - •Home Working Clinician recruitment increased to build 111 Clinical Adviser capacity
    - •Agency Pathways trained Clinicians added to 111 workforce capacity
- Potential risks include:
  - •Single Virtual Contact Centre (SVCC) impact
  - •Higher than modelled; staff absence, demand, poor response to recruitment activity for Ops and Clinical roles





EEAST Ambulance

East of England Ambulance Service NHS Trust

Regional intent:

- Provide a safe service to patients
- Ensure the efficient use of resources
- Achieve the relevant standards associated with service delivery
- Maintain public confidence in the Trust
- Provide compassionate leadership to ensure health, safety, support, & wellbeing of staff
- .Ensure the resilience of the Trust to respond to any critical or major incidents
- Ensure ongoing risk assessments COVID-19 and identification of actions across the organisational functions to maintain business continuity

Regional Actions:

- Increase Hear & Treat capacity
- Increase PAS provision
- Command & Control structures
- Mobilise local Operational cells
- Revise Patient Handover protocol/ escalation

Local SNEE Focus:

- Workforce
  - Recruitment – Year end total increase will be 136, with 42 started and booked for training with Q3 and 4. Further offers made
  - Implementing Non Clinical Drivers
  - Reduction in sickness absence – active management in sector
- Oversight Cell – local cell linked with Operational hub to manage service delivery pressures
- Implement Cleric stack management solution across SNEE in conjunction with UCRS (Nov 22)
- Continued collaboration to focus on safe admission avoidance - GP Advice/ Support line
- Maintain safe PFSH hours, mobilisation of leadership team in to regular PFSH shifts

EPUT Mental Health

Essex Partnership University
NHS Foundation Trust

Demand Vs Capacity

- Inpatient MH capacity continues to be a challenge.
- - Occupancy in core bed base has remained above 95% for 11 out of the last 12 months, and has seen some of it's highest levels in the last 6 months
- - The number of inappropriate OOA placements in the June-August period this year is nearly triple what it was in the same time period last year (16 in 2021/22 up to 44 this year)
- - Average length of stay is up about 20% from last year, with an average of 55 days in Adult Acute beds in Q1 22/23
- MH Community caseloads have dropped by around 3.5% since August last year, although this is largely down to post-COVID caseload cleansing/data quality work, and the increase in the number of primary care mental health pathways available
- CRHT teams are seeing significantly more referrals coming compared to this time last year - up nearly 40% from August 2021
- The number of 111 calls into EPUT have also increased, with six hundred more calls in the last 3 months than the same period last year.
- Crisis cafes in Essex are seeing slightly lower numbers now than this time last year, but did see a busy winter with 600 referrals between December and February
- ED referrals into EPUT MH teams have been high since April, but remain in line with levels seen last year

Workforce

There are mechanisms in place to help mitigate against the anticipated increase in demand by addressing workforce requirements and recruitment. These include:

• An established command and control structure, which can be stepped up when required;
• Business Continuity Plans are in place in all areas;
• Staffing Surge Plans are in place; these include overtime payments for bands 3-7 and a stepped approach to ensure critical services are maintained and gaps are mitigated;
• Twice daily safer staffing sit-reps;
• Recruitment and retention team is in place, with a focus on urgent and inpatient care;
• International recruitment programme in place, with dedicated HR processes and personnel to support this;
• Regular bank staff and agency workers for inpatient and urgent care;
• Recruitment drive to recruit agency workers onto bank;
• Community caseloads have reduced due to cleansing and the implementation of primary care models/workers;
• Time to care programme is being rolled out across inpatient areas.

Risks and Actions

A multi-faceted approach has been taken, encompassing development of infrastructure, working with VCSE and transforming community care and core teams for 18+ services. Some existing actions in place across EPUT are outlined below:

- MH workers are connected into PCNs to support patients in primary care;
- MH Liaison Teams are based within/next to all acute Trusts in Essex;
- Community teams and pathways are established across all areas to support patients outside of an inpatient setting;
- Crisis services are in place with 24/7 cover to support patients and help prevent admission;
- Working closely with system partners and third sector to develop pathways and to deliver Crisis cafes in both North and West Essex

(further examples include partnership between EPUT and WECAN);

- Dementia Intensive Support Teams, Adult and Older Adults Home Treatment Teams are place across the Trust;
- Currently revisiting OPEL 4 escalation actions which will be co-ordinated by clinical patient flow team;
- Development of a MH Urgent Care Department is underway;
- Work is underway around virtual wards and the home treatment model.

The Trust has started to develop a Flow and Capacity team to focus on purposeful admission and safe and timely discharge. There is an aim to reinforce this over the winter period to make it more robust, integrated and consistent across the Trust. Developing this targeted resource could help deal with Winter pressures by improving patient flow; in particular to address any prolonged length of stay and out of area placements that have notably increased.

Community provision was previously reinforced by increasing resource into the Home First Team and lowering the threshold for acceptance into this team, particularly over the weekend and bank holidays. This proved to be an effective action to that could be replicated into the forthcoming winter. Furthermore, it would be implemented within established infra structure and safety mechanisms in place.

Building on partnership work with social care and VCSE would enable people to access a range of support in the community and also practical help that addresses their wider needs. This close partnership working would provide a more effective use of funding; it would not only support discharge from inpatient care, but it could also be developed to support crisis prevention within community teams and therefore help ensure more appropriate and purposeful admissions. There are existing examples of successful partnership working with VSCE across systems (e.g. WECAN and Mind). With additional funding over the winter period, these could be further developed to help address the needs of the population and pressures across the system.

Some winter money was previously used to set up a small discharge fund, with a purpose of accelerating discharge of those identified as clinically appropriate. The fund could be utilised for small, short-term costs and overcome barriers to discharge such as practical provisions or short term accommodation.

NSFT Mental Health

- MH Demand and Capacity (NSFT) Acute MH Inpatient Capacity – September 2022
- In response to Q1, item iv. Acute MH Inpatient Capacity - based on a demand and capacity model that has been developed by NSFT as part of the Urgent and Emergency Care Programme the following chart is included.
- This forecast is based on historic data from May 2021 and CCG allocations data published by NHS England - NHS England - CCG allocations 2019/20 to 2023/24 (NHS England » Allocations).
- The forecasting model will continue to be developed over the next 12 months and this will mean that additional services coming online can be factored into the capacity and demand planning.
- This is based on the current situation. Due to immaturity of new services the impact of new service offers has not been overlaid on the model.
- The numbers are based 90% occupancy as requested.

Out of Area Placements model

O_Suffolk

	Forecast Oct-2022	*Forecast* Nov-2022	*Forecast* Dec-2022	*Forecast* Jan-2023	*Forecast* Feb-2023	*Forecast* Mar-2023
	Ok	Ok	Ok	Ok	Ok	Ok
All Trust bed days						
Adult Acute	2,022	2,022	2,022	2,022	2,022	2,022
Adult rehab	30	30	30	30	30	30
PICU	-	-	-	-	-	-
Older People Acute	672	656	656	657	657	657
Older people rehab	-	-	-	-	-	-
TOTAL	**2,724**	**2,709**	**2,709**	**2,709**	**2,709**	**2,709**
All OAP bed days						
Adult Acute	784	786	788	789	791	793
Adult rehab	-	-	-	-	-	-
PICU	56	56	56	56	56	56
Older People Acute	304	287	288	288	289	289
Older people rehab	-	-	-	-	-	-
TOTAL	**1,145**	**1,129**	**1,132**	**1,134**	**1,136**	**1,139**
Total bed days						
Adult Acute	2,806	2,808	2,810	2,811	2,813	2,815
Adult rehab	30	30	30	30	30	30
PICU	56	56	56	56	56	56
Older People Acute	977	944	944	945	945	946
Older people rehab	-	-	-	-	-	-
TOTAL	**3,869**	**3,838**	**3,840**	**3,843**	**3,845**	**3,848**

NSFT Mental Health

Norfolk and Suffolk NHS Foundation Trust

Anticipated Demand

- We have obtained modelling that suggests that our demand of OAP's will be in excess of 1100 bed days without the introduction of new schemes or understanding the impact of projects such as community transformation, equating to 36 beds in the month. Bed occupancy is consistently aroun 106% in West Suffolk and 100% in East Suffolk. See supporting information attached.
- Community mental health teams are also under immense pressure, with consistently high caseloads across the county and continued staff vacancies.
- We have evidenced an increase in A&E referrals, both within East and West Suffolk, however breaches are minimal for patients being assessed within one hour of referral.

Workforce

- It is recognised that this is a difficult period for staffing, whilst there is a higher turnover than we would like, most also remain within the Trust and move on to opportunities elsewhere. We have overseas nurses that are being supported with opportunities to work on our wards, we are also engaging with recruitment agencies to ensure that we have staff available to support.

Key Risks and Actions

An increase in bed demands, bed demands for OAP's is likely to increase to 1100 bed days per month during the winter. West Suffolk continually have bed occupancy at a level of around 106% for adult beds, due to utilising leave beds to support urgent admissions. In the East, bed occupancy is consistently at 100%.

A dedicated bed management team in West and East Suffolk, who will actively seek to support the avoidance of admissions, working alongside the Crisis Pathway. Our community colleagues are supporting with robust crisis and safety plans, with the additional support that the county offers a First Response Service for periods of crisis, this is managed via the 111-2 service.

Reducing the average length of stay will support the more-timely availability of beds, we also have discharge co-ordinators who can support the discharge of patients and work to prevent re-admission and the provision will be further enhanced. Reinforcing the red to green processes and ensuring CRHT are supporting those who are identified as suitable for continued recovery in the community will be key to reducing length of stay.

WEST SUFFOLK ALLIANCE

about people & places

Introduction

Seasonal planning will now become an all round activity for the West Suffolk Alliance with a focus on a more proactive approach to planning as an integrated system. Evidence tells us that our resilience comes from a sustainable model of delivery that can adapt and be flexibly to the variation in demand rather than a suite of short term schemes or interventions that take time to implement and are difficult to evaluate.

This years plan therefore builds on what we have in place already and is informed by local modelling where we have it and known pinch points in the system resilience. The summary of this is outlined below

Primary Care

- Managing variation in urgent care demand
- Increasing access to out of hours appointments
- Improving access to diagnostics such as phlebotomy
- Delivery of combined flu and covid campaign

Improving delivery of Discharge to Assess

- Improving the resilience of our local home care provision and therefore creating capacity in our reablement service to support same delay discharges
- Improving our reablement wrap around offer to support discharge to assess into our community assessment beds
- Commissioning additional community assessment beds to support the deficit in acute bed modelling created by RAAC programme and potential surge
- Improve the resilience of our delirium support offer to people discharged from acute care
- Increase the number of weekend discharges by investing in reablement capacity and 7 day working

System issues

- Developing a plan that provides flexible support as a system to workforce challenges
- Building our insight into the data analytics of the demand in a live and proactive way that supports decision making

Assumptions for the bed model

WEST SUFFOLK ALLIANCE
about people & places

Adult Non-elective Activity:

2021/22 activity was compared to historical activity from 2019/20 and an activity level and calculated for the current year, using the comparative rate as at the end of February 2022 (the data for March being skewed by the beginning of the pandemic).

Non-elective occupancy rate set at 92%

100% demand for non-elective activity

Elective Activity:

Baseline set at 110% of 2019/20 activity across 12 months of the year.

Elective occupancy rate set at 100%

Elective average length of stay based on 2019/20 actuals for patients in overnight beds (excluding LoS)

Non-elective occupancy rate set at 92%

104% demand for non-elective activity

Bed Base:

Includes only G&A bed base and established contingency. All additional beds used in the 2021/22 Seasonal Variation Plan have been stripped out.

2 wards closed for RAAC programme

Baseline excludes Maternity, Neonates and Critical Care.

Seasonal System Initiatives

Scheme	Description	Potential beds	Start date	Risk
Hybrid CAB model	Operate a hybrid of Community Assessment Beds and spot purchased with significant 'wrap round' reablement support to manage length of stay. Convert 15 block purchased bed to the CAB model and spot purchase up to 10 beds as necessary	25	Oct-22	Dependent on care home capacity, which currently is challenged and workforce availability for the wrap round support
Additional beds at SNHC	SNHC will increase their bed capacity from 8 to 12 until 31-3-23 including staffing, pharmacy, catering and domestic cost	4	Oct-22	Workforce dependent and service variation agreements
Increase interim care home beds	Block purchase and/or spot purchase care home beds	25	Nov-22	Dependent on care home capacity, which currently is challenged
Covid designated setting	To enable discharge of Covid Positive or contact patients requiring care			
Spot purchase delirium beds				
Reduce P1 discharge delays	Focus on the causes of delays (average 2.7 days) with task and finish group. Continue to use agency where needed	10	Nov-22	Reliant on multiple internal and external factors. Use of agency staff causes quality and safety concerns
Virtual Ward	A safe and efficient alternative to NHS bedded care, enabled by technology. Supporting patients who would otherwise be in an acute hospital bed by receiving the acute care, monitoring and treatment needed in their own home. Virtual Ward supports early discharge and preventing avoidable admissions.	47	Soft launch from Nov 23	Workforce dependent and service variation agreements
UCR - All	Additional ACP's as well as extended weekend and core hours	4.5	Dec-22	Dependent recruitment of the necessary staff

Seasonal System Initiatives

Scheme	Scheme Description	potential beds	Start date	Risk i.e. workforce
Improve discharges - CLD	CLD is a process that empowers a competent member of the multidisciplinary team to discharge a patient when they meet pre-agreed clinical criteria for discharge	2.8	Oct-22	Dependent on medical staffing cooperation, however is ready to implement
SDEC	Optimisation of the SDEC by recruiting a Clinical Navigator to answer the GP phone for both surgical and medical patient referrals and provide a timely response, including advice, navigation thus creating a reliable robust service which does not rely on people with other clinical responsibilities	2	Dec-22	Dependent on recruitment of the necessary staff
Delirium Specialist Nurse	The specialist nurse supports patients with a delirium who have transferred from an acute hospital bed to an interim Care Home bed– monitoring their recovery and liaising with family, social care, and other stakeholders	3	Jan-23	Dependent on recruitment of the necessary staff
WSFT Surgical bed flow	Additional bed improvement projects to improve flow through surgical beds, including appointment of surgical clinical flow manager and delivery of 7 day trauma to reduce bed demand	4	Dec-22	Recruitment
Live in care	Additional Enhanced live-in provision	5	Oct-22	Dependent on live-in provider capacity. Risk of how to remove live in provider once discharged
WSFT DWA	Increase operating hours of discharge waiting area to 24/7	6	Oct-22	Recruitment of staff to cover 24/7
INT Phlebotomy	Phlebotomy provision is a system pressure due to increasing levels of demand in an attempt to manage the backlog of LTC checks following the pandemic and the rise in requests for urgent diagnostics. Primary care is seeking additional resource is considered for each PCN area to mitigate the demand on practices and acute hospital. This is currently in the scoping stage and is being worked up in preparation for any winter contingency funding. Approximate costs would be £120k for 1 year	N/A	Jan-23	
Falls support in care homes	Band 6 therapist to supplement Care homes support team, to help educate Care homes in falls prevention and how to manage someone who has fallen, therefore reduce ambulance call outs.	1	Jan-23	

Evaluation & Monitoring

A small group of West Suffolk Alliance members has been formed for an integrated approach to the translation of the schemes into reality, prioritisation of schemes and to establish a robust evaluation and monitoring process.

The working group will identify owners for each scheme who will hold responsibility for the scheme, monitor and adjust accordingly and report within set timeframes to the group.

The evaluation and monitoring of schemes will report into the West Suffolk Alliance Operational Resilience Group.

Appendix 2 - Escalation Metrics/Triggers/Actions

Metric	WSFT			
	RAG Status			
	Green	Amber	Red	Black
Ambulance				
% See, Treat & Convey	0 - 62	63 - 64	65 - 67	> 68
Number of Arrival to Handover >30mins	0 - 2	3 - 7	8 - 14	> 20
ED				
Attends previous day (including streaming)	240	260	280	300
Average Journey Time	0 - 199 minutes	200 - 299 minutes	300 - 399 minutes	> 400 minutes
Number of 12 waits	0	1	2	3
Emergency Admissions	0 - 50	51 - 60	61 - 79	> 80
Discharges	> 105	90 - 104	70 - 89	< 70
Flow				
LoS > 7 days	0 - 139	140 - 149	150 -169	> 170
LoS > 14 days	0 - 70	71 - 80	81 - 99	> 100
LoS > 21 days	0 - 30	31 - 40	41 - 59	> 60
Number of patients with no criteria to reside	0 - 30	31 - 40	41 - 59	> 60
Number of unplanned pathway 1 - 3 discharges	0 - 4	5 - 9	10 - 14	> 15
Number of Patients Wawaiting Homecare with POLR	0 - 5	0 - 10	11 - 29	> 30

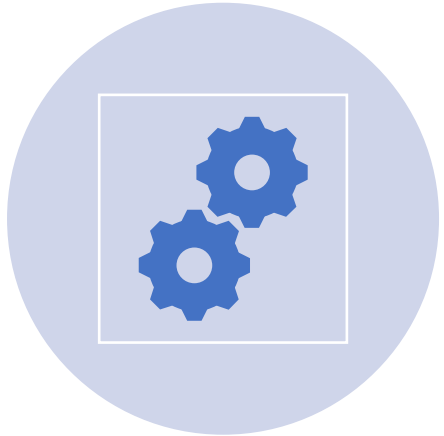
IES
ALLIANCE SLIDES

Alliance Overview - *IES*

Principles

OUR PLAN DRAWS UPON THE BEST POSSIBLE FORECASTING OF DEMAND AND CAPACITY ACROSS OUR ALLIANCE AS WELL AS LEARNING FROM PREVIOUS YEARS

OUR PLAN INCLUDES A NUMBER OF SPECIFIC ACTIONS BUT IS ALSO BASED ON THREE CORE PRINCIPLES AND OUR VALUES, WHICH ALL ALLIANCE PARTNERS WILL ADOPT



THE PRINCIPLES ARE: TIME MATTERS; OPTIMISATION; DEVOLUTION OF DECISION MAKING

Performance RAG
Amber

IPSWICH AND EAST SUFFOLK TACTIAL GROUP AND OPERATIONAL RESILIENCE GROUP

1. To understand the common operating position for IES, its demands and points of escalation and de-escalation
2. To support alignment of all partners in the operational delivery of services in times of service pressure, escalation and incident
3. To jointly plan and problem solve across all providers including through mutual aid and staffing support
4. To ensure the system can react to system escalations and incidents as they occur, specifically including seasonal surges (winter)
5. To ensure robust evaluation, learning and dissemination
6. To ensure an all age approach

Performance Updates (August to 9th September)

ED – continues to be challenged wrt 4 hour target – See action on next slide

EEAST – continued reduction in conveyancing

Urgent Community Services – 2 hour target met

Hospital Discharges (12/9/22)– 76 patients with No Criteria to Reside in acute (Pathways 1-3): total number of patients without CTR 93. 13 patients in Community settings with no criteria to reside (pathways 1-3): 18 patients overall. Majority P1 and P2

Virtual Ward: First patients have been admitted to virtual ward (frailty pathway)

End of Life - Hospice – community and bed provision currently stably staffed

CHC – Challenged position with small number of highly complex care packages – 15 pts at 09.09.22

GP+ and Out of Hours - Steady state

111 – Minimal impact of advanced ransom attack on IES limited to manual data transfer requirements and so some delays in front end call answering. Position at 08.09.22 was of restored service levels

Social Care (Home Care) - Some small reduction in home care waits in IES, down to 154 (from around 180). The IES part of Suffolk continues to be under the most strain.

Social care – Detailed analysis of current demand and capacity in, specifically focused on homecare developed and a set of responsive initiatives including geo-mapping to enable efficient operations, medical help lines to reduce delay, international recruitment and additional complex care bed purchasing. Impact analysis required. Further options- risks and benefit assessments being explored.

IHT ED and Transformation Team working with wider departments and partners is now in phase 5 of the **UEC Recalibration and Sustainability plan for Emergency Care Flow** to deliver safe patient care. Following the Time and Motion Study and constraints analysis together with prioritisation in July, the two Kaizen weeks took place with IHT and wider system partners for two weeks from 8th August. Monitoring is now underway prior to a final Kaizen week in September.

Core Primary Care – Focus currently is on resilience and delivery of good access and care quality standards and transition of extended hours arrangements to PCN commissioning

Seasonal plan – Dedicated IES plan developed using established acute modelling and assumed primary/community modelling based on previous years and this year's monthly demand profile and learning from previous years' investments. The totality of impact on system demand requires further review. IES contribution to regional additional bed requirements.

EEAST – Conveyance Avoidance Helpline – continues to perform well in partnership with Suffolk GP Fed and PPG under one number

Mental Health – Focus on community based prevention, creating primary care capacity through ARRS roles and assessment of further bed based options. Consideration of how system supported approach to delayed discharge could be applied.

Finance report – IES Executive Delivery Group to receive report of spend against plan, remaining resources and investment strategy options (to include winter plans) on 13.09.22

Overview

We have learnt this and need to share it…

Collective focused action, following a robust Kaizen methodology

We need help with…..

Interim demand analysis prior to completion of full demand and capacity modelling work being complete and analysis of collective impact of winter schemes (and assessment of inadvertent risk

We have the following risk and issue

Staff resilience and capacity
LoS and Discharge

Any resource issues to flag

As for NEE, cost of living issues remain critical to physical and mental health and well-being. Suffolk Resilience Forum is now leading co-ordination of response. Staff and provider issues are also key.
Inadvertent system workflow movements also requiring on-going analysis and action

Key Activities for September October

IHT – ESNEFT – 2nd ED Kaizen Week
EEAST – 2nd Perfect Day on 30th September; Access to the Stack – 4th November
Primary Care – INTs – Next Steps with Fuller Implementation
Social Care – Further options appraisals for Home Care

Ipswich and East Suffolk Alliance

Seasonal Surge Planning 22/23
(specifically including Winter)

Prevention – Staying well at home

	Action	Period		Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
01	Vaccination – Flu and Covid (Making Every Contact Count)	Sept-Dec		N/A	Liz Moloney (ICB)	Eligible flu population = 279k people Eligible Autumn C19 booster population = 214,650		This will engage will engage all health and social care partners across the Alliance
02	Vaccination - staff resource in the community to support flu vaccination of housebound patients (who are not on current case-load of community nursing team)	Oct - March		N/A NHS EOE	Liz Moloney	6500 housebound patients in IES		PCNs to vaccinate their housebound patients for a std fee of £10.06 plus £10 supplement pp. Where PCN isn't participating in the programme or has asked for support, referral mechanism to EPUT or WSFT who will support at the same cost.
03	Cost of Living – support to most vulnerable	In place		SCC – collaborative communities board	Richard Cracknell (SCC)– ICB liaison Louise Hardwick)	1500 (estimated)		LH/JC contacted Richard Cracknell PH for info 14.9.22 (from Shelley) £650K invested via support line into District and Borough councils
04	Loneliness and emotional well-being	In place		N/A	Louise Hardwick (ICB)	20,000		Funding – warm homes initiative. Connect for health support offer (750), Chinwag (1400), Barber training (1600), ICOPE (100), Cuppa & Chat, Financial roadshow, Silver Sunday, HEARS alarms (100). Districts and Boroughs have supplementary supporting programmes
05	Physical activity, strength and balance	In progre ss		N/A	Hannah Lord Vince	273 places available each week (classes don't run over Christmas)		Extended grant agreement with ActivLives to continue the current strength and balance classes from Oct 22 – March 23

Prevention – Staying well at home

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
06	Stepping Home	Nov 22 – Oct 23	Health and care fund Approved by EDG 4.10.22 Will need evaluation	Louise Hardwick/ Nicole Rickard	1000 referrals made annually		21/22 – 987 referrals, 1246 interventions, estimated system savings £773,000. Recurrently funded in West. No agreed funding after Nov in East. Service will cease in Dec 22 if no funding is secured, at a time of significant pressure for lower income/ vulnerable households.
07	WaitingWell@Home. This will reduce admissions amongst frail elderly population waiting for surgery, with specific targeted support. New scheme for winter.	Sept onwards	N/A	Angela Ashton	500		Proactive contact for the population waiting for surgery. Appropriate targeted support will be offered depending on need, which will mean that patients will be fit and well for surgery and avoid unplanned admissions
08	Embed new social prescribing partners into each INT-Connect	N/A – in progress	N/A	Louise Hardwick (ICB)			Connect for Health social prescribing contract. Represented in all INTs, recruitment ongoing before fully embedded in all. Inc Welcome Home in Ipswich Hospital (will cease at end of Feb – wont cover Easter)
8a	Winter night shelter - support homelessness in Ipswich in a purpose built venue. Own en suite bedroom, evening meal and breakfast and lunch. Unlimited hot drinks and welcome pack with toiletries. Support with financial advice and health issues	Oct - March	Health and care fund	Louise Hardwick	Approx 10 people supported each day		Donation to strengthen and sustain the current provision of the service run by the Selig Suffolk Trust
8b	Extension to Welcome Home programme at IH	March and April 2023	Health and care fund	Louise Hardwick	15 – 20 per month		

Primary Care

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
09	In-hours home visiting Mobilised for the last 2 winters– relieves pressure on practices. Proposal being worked up by GP Fed **Noted by GP Fed** – Better utilisation of service in the morning. Smaller geography represents better value for money (wider geography = less utilisation per surgery)	Dec - Mar	Health and Care funding EDG approved. MBW confirmed 14.10.22 GP Fed to confirm demand before progressing. Julie to work with Caroline Proctor to move forward 17.10.22	Caroline Procter (ICB) *Julie Smith (GP Fed)*	1 car = 50 visits per week, 2 cars = 100 visits per week and so on…..		This scheme has run in previous years. It can be quickly operationalised but takes time for practices to re-engage with. Noted by EDG – can this be staffed effectively. Notice needs to be given if required.
10	Additional patient communications and staff training for remote consultation	Dec - Mar	Ops budget	Caroline Procter (ICB)	All		**Approved**
11	High Intensity Users – MDT and Personalised care Primary Care Personalised Care Programme to support patients with complex needs	Sept 2022 – March 2023	MOU NHSE	Louise Hardwick (ICB)	270 patients across IES		31 practices signed up to referral incentive scheme to offer non-medical interventions from 4 provider organisations – Green Light Trust, SPOT wellbeing, Cohere Arts and Suffolk ArtLink. Providing long-term, personalised support for patients.

Primary Care

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
12	Additional primary care phlebotomy Staff	Oct - Mar	Health and care fund Approved in principle – EDG 4.10.22. More detailed paper needed with options to create capacity in primary care.	Claire Pemberton	In development		This is critical – extra capacity required
13	GP Community Pharmacist Consultation Service (CPCS)	In place	N/A	LPC, Pharmacies engaging with practices – Tania Farrow/Claire Pemberton	In development		Action needed – work up protocol from care navigator to pharmacy. David Egan supported by Clare Pemberton
14	Conveyance Avoidance Helpline (CAH) - going live 22nd August - ICS wide being delivered in partnership with PPG Already funded until 31st March 2023	Sept - March		GP Fed – Julie Smith with EEAST	EEAST – conveyance avoidance – capacity for 207 calls per week across ICS		
15	Virtual Ward OOH Support – GP Advice Line that could be incorporated with the above – Proposal being worked up.			GP Fed, PPG, Paul Little			

Urgent Care and ED

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
16	Primary care communication around ED referrals to be recirculated to include updated one page crib sheet containing all the relevant contact numbers for referrals to alternative settings.	Oct - March	N/A	Alex Osman (ESNEFT)	Aim to reduce ED attendance by 1%		
17	Message to GPs that when sending GP expected patients to assessment units at the acute they should tell the patient to go direct to the unit rather than via ED entrance		N/A	Alex Osman (ESNEFT)	Aim to reduce ED attendance by 1%		
18	EEAST engagement day planned with EEAST/ED/Primary care to build relations and discuss alternatives to ED and the issues that crews have in accessing them.		N/A	Alex Osman (ESNEFT)	Aim to reduce conveyance to ED by 1%		
18	System wide relationship building event to drive improvement in joint up working around MH pathways and patients		N/A	Alex Osman (ESNEFT)	TBC		

Urgent Care and ED – GP/ Practice Nurse streaming

	Action	**Period**	Proposed funding source, approval status and any conditions	**Lead**	**# Pop Reach Sept March**	**Evaluation status**	**Notes**
19	Extend UTC streaming service from 19.30 to 21.00 to assist with evening capacity. This timeslot coincides with influx of patients who have been unable to see their own GP. (Joint Priority 1 with alongside Minor Illness Nurse outlined below in Action 3)	Oct to March	Health and Care Fund	GP Fed – Julie Smith	Up to an extra 34 contacts per week		

Urgent Care and ED – GP/ Practice Nurse streaming

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
20	Minor Illness Nursing (practice nurses in ED Streaming, taking observations and supporting doctors) Current funding runs out 30th November. This has been very successful and the Fed have funded minor illness courses for 2 of our regular Practice Nurses….they are now seeing and treating patients in ED Funding for minor illness & prescribing courses for 2 further PNs. (Joint Priority 1 with Action 1 on this slide)	Dec to March	Health & Care Fund Approved EDG 4.10.22	GP Fed/ Primary Care	Up to 45 contacts per week (not all see & treat, some obs & supporting)		Keen to see continue. Currently funded non recurrently.
21	Transitioning Streaming to UTC model –delay to UTC (earliest Sept 2024) so we have 2 and probably 3 winters before it will be open. Proposal to move towards model with GP/NP in second room and move CAH clinician to Riverside OR create space for another clinical room in current space so that we have 3 GP/NPs working	Oct to March	Health & Care Fund Approved EDG 4.10.22	GP Fed – Julie Smith	Up to an extra 257 contacts per week		Clinician will cover the helpline that supports ambulance crews by phone. Preference for clinician to be sited at IH with team but depending on space available, may have to work from Riverside. Patients will not be required to move/ be treated elsewhere..

System wide: Clinical Assessment Service

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
22	The Minor Injuries Clinical Assessment Service, is manned by Senior ED staff, who have the opportunity to review 111 ED outcomes from general nurses/paramedics/unassessed and provide a virtual assessment of the patient before they attend an Emergency Department. This then reduces the amount of people in a waiting room at ED and diverts inappropriate patients to alternative services within SNEE.	6 months		Greg Brown Darren Maguire	200 per month		No funding required from alliances. SNEE wide plan
23	ED & 999 Validation in the CAS reduces the amount of ED/999 outcomes by using a senior GPs to review Emergency Outcomes and provide a virtual assessment of a patient. This reduces pressure on the ambulance service and emergency departments by redirecting patients elsewhere	6 months		Greg Brown Darren Maguire	350 per month		No funding required from alliances. SNEE wide plan

Non-emergency Patient Transport

	Action	Period	Proposed funding source, approval status and any conditions	ICB Lead and Partners	# Pop Reach	Evaluation status	Notes
24	Community Non-emergency Patient Transport (NEPT) support for hospitals potentially using community provider to be available to hospital to utilise as required and ensure swift movement of patients, this is outside of NEPTS contract and there is no eligibility criteria. 2 vehicles both with double crew and able to transport wheelchairs. IES only – similar proposal with WS and NEE	Oct 22 – Mar 22	IES Integrated Health and Care Fund Approved EDG 4.10.22 Could primary care requirement be included in this requirement? Hours of cover to be set to meet the times of highest demand. Noted that claim for this service was significantly lower last year than budgeted amount.	James Waites	Direct reach 1100-1300 patient journeys, indirect impact also on others for example freeing acute bed available earlier.		Noted from JW that on plan due to historical increased demand over winter. Greater bed pressure and capacity needed for quick discharge. As 21/22, gives the hospitals additional on hand wheelchair capacity to move patients out of the hospital quickly. These patients would normally not be eligible for transport and would await pick up when relative could get them etc. It frees up the bed quicker. WSFT used it this winter and were very complimentary about the service and its use.
25	**Note:** need to ensure transport is considered when adding any further community bed capacity in to support winter – approximate cost for 50 additional beds (7 day LoS) would be 18k per month IES only – similar proposal with WS and NEE	Oct - Mar	Approved EDG 4.10.22	James Waites	Direct reach 1300 patient journeys, indirect impact also in addition to others for example freeing acute bed available earlier.		Noted from JW that on plan due to historical increased demand over winter. Greater bed pressure and capacity needed for quick discharge. Extra journey - patient is discharged from acute to community hospital, then to home address. Normally transport would take them acute to home but now likely journey is acute to community and then community to home so an additional journey. Current commissioned community beds are in contract, but if

Social Care

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach	Evaluation status	Notes
26	Directly delivered reablement focused care capacity option. ESNEFT to directly run a care environment of at least 30 bed capacity. The facility and all "hotel" services being provided by an existing provider (identified as Chiltern Meadows) and commissioned by SCC. Operational and clinical services would be run directly by ESNEFT, enabling complete control over admission criteria and the interaction between the transfer of care HUB and the new facility	Nov - March	IES Health and care fund Approved EDG 4.10.22 Detailed paper presented to EDG 11.10.22 – approved.	Paul Little (SCC)	This will be targeted to where there are difficulties in providing care across the Ipswich and east area. 30 beds per week.		

Social Care

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach	Evaluation status	Notes
27	We have two home care providers who had success in attracting international employees. Both companies are estimating that their additional workforce will be ready to deploy by mid to end of September, this will be initially 50 extra people. We are adopting a partnership approach with them to particularly look at the harder to reach areas where this has an effect on system flow. Both providers work under our locality framework and will pick packages of care from that. There is also one of the providers to potentially deploy some of these staff into PW1, however this will require further scoping to legal and employment issues it may pose.	Sept -	N/A	Paul Little & Sally Darlow (SCC)	50 people		
28	Also exploring new provider entrants into the market and working with them to address the waiting lists to move long term packages from Home First to free up some more PW1 capacity. Commencing on 22/8/2022.	Nov -	Health and care fund Local primary care needs to be part of proposal. Un-intended system consequences & what happens after non recurrent funding has come to an end needs to be considered/ planned	Paul Little & Sally Darlow (SCC)	This will be based on a pilot scheme of 14 hours a day per carer on a block basis. Initial pick up is 16 packages of care in Eye NW. Second Stage commencing on 29/8/2022 will pick up all other packages awaiting care in Eye NW.		£1.2m has been set against the block contract to free up P/W 1 capacity. Funding to be considered from health and care fund.

Care Homes and End of Life

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
			Primary Care Resilience Fund				**Approved by MBW 13/9/22 £36615 for 3 schemes**
29	Primary care 22/23 LES & plan for 23/24 LES • To deliver 1 or 2 additional ward rounds into care homes over Christmas & New Year period (contribution to avoidable admissions, re-admissions, reduced ad-hoc care home visits for GP and EEAST – call outs & conveyances). Note – payment per patient – recommended increase from £6.30 to £6.62 (5% uplift)	12/12 – 6/1	Primary Care resilience fund	Shona Evans/ Caroline Procter/ Julia Smith	In 21/22 – 747 care home residents		Mobilisation in progress 12.10.22
30	• Phone calls to moderate/ severe COPD pts by practice COPD nurses + mild COPD pts with exacerbation – to check on emergency meds & vaccine status	1/11 – 28/2 TBC	Primary Care resilience fund	Caroline Procter/ Julia Smith Shona Evans/ Care Homes team	In 21/22 – 1800 pts called TBC		
31	• Extend pilot of Whzan in Care homes (Pilot being considered - Two Rivers covering 6 care homes) – possible tool for 23/24 LES. Note Whzan supports 'Restore 2' (training package for long term proactive monitoring). Current ICS bid in place for 1 WTE to support roll out across SNEE)	Oct – March	Primary Care resilience Fund	Shona Evans/ Julia Smith	239 beds (in the 6 care homes)		Mobilisation in progress 12.10.22
32	• Kit from Whzan is £600 + VAT each +£400 + VAT licence fee						

Care Homes and End of Life

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
33	My Resident App – Currently commissioned on a limited time basis. Additional funding required for app update and management of updates + training via Care Homes team and CHESS team	From Sept 2022	Suffolk Health and Care Fund Approved EDG 4.10.22	Shona Evans/ Lisa Elmy	3500 - TBC		26.9.22: could commissioned permanently with the cost being absorbed recurrently through care homes budget or via CHC? Ben Harvey – no care homes budget. With no continued funding (for next 2 -3 years) it will not be kept up to date. Funding source needed. Vicky Briggs (Newbery)/ Lucy Game - CHC can only cover costs for specific pts supported by care plan, not universally, so could not fund this.
34	Re-promotion of continued use of MANGAR camel in care homes to support falls/ ISTUMBLE for training and support	Dec – March		Shona Evans/ Lisa Elmy	Benefit all care homes. Difficult to estimate number.		
35	Extension of Verification of Expected Death/ uncomfortable conversations training – 1 additional place per nursing home.	Dec - March	Suffolk Health and Care Fund Approved EDG 4.10.22 but needs to be commissioned year round.	Gillian Mountague/ St Elizabeth Hospice	300 (estimate – 12 month period) –difficult conversation for residents/ families and VOED		Commission year round? No funding identified/ available via Lisa Nobes, Sarra Bargent (for care homes) or Julie White (Primary Care Training Hub).
35a	Added line– 4.11.22 Hospice virtual ward	Oct -	ESNEFT/ St E hospice – doubling of virtual ward capacity	Judi Newman	8 patients at any one time – with HCA recruitment, capacity will be doubled.		it is not specific to winter but will help with this winter's surge plan. Our virtual ward/OHH work is in addition to our BAU community nursing team activities: it is estimated last six weeks of life with 2-4 daily visits from one of our HCAs and sometimes a CNS if needed,. Numbers depend on geography – if the workforce is greater, we have a better chance of being able to cluster more patients geographically.

Integrated working – REACT and Urgent Community Response

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
36	Better understand MDTs across services in community - create small working group to map out what MDTs are in existence and how this can be coordinated to avoid duplication and join things up better to manage demand differently. Draft plan in place and meeting planned.	Dec - March		Emma Doughty/ Julia Smith	Emergency and urgent care services - 111, EEAST, Primary care		
37	Promote the services provided by REACT – showcase promotional video at all training and education events and promote regularly with our providers in their newsletters and comms.			Hannah Lord Vince	The system to help manage demand.		
38	Continue recruitment to all the new UCR schemes funded last year (£1.6m in total) to support winter capacity. Outstanding schemes are: Social prescribing in REACT Additional ACS workforce REACT (currently there are 16 vacancies: 6 therapy and 10 generic workers)	Dec - March		Hannah Lord Vince	System Capacity		

Integrated working – REACT and Urgent Community Response

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
39	Increasing UCR referrals from ambulance control pre-dispatch through planned automated system (Autumn 22) Nationally mandated from NHSE and EEAST have committed to this. £40k allocated to program support for embedding of Cleric portal at place level, development of any changes to triage, allocation of patient visits and service delivery models to support the take from the 999 stack. Ideally this would be a band 8A post with a candidate who has a clinical background and a sound working knowledge of the UCR teams and work across SNEE to optimise the roll out of Cleric automated referrals from ambulance to UCR. Likely to be a six month secondment opportunity for a current post holder within SNEE ICS.	Oct - March	N/A	Hannah Pont (Hannah LV link for IES)	EEAST and secondary care services		Approved via NHSE (MOU signed by Paul Gibara)
40	Additional capacity for community nursing to support growth in demand, particularly administration of Insulin and Catheter care. This would be part of the community services review (early 2023) however, as a temporary measure plan for **THE WEST** Peripatetic flexible community workforce responsive to Community & URC pressures, including from insulin and catheter care and increase in workload. Agency or bank workforce but managed by a substantive workforce/ops lead. The cost is approx. £450k for the following For 7 day week cover (bank or agency) including 16 WTE x B5 nurses, B3 x 8 generic workers to expand into both Therapy, nursing and care capacity and 1 band 7 - Operational and workforce lead/ For 6 months.	Oct to March	The west submitted this plan as part of the 1000 bed extra submission to NHSE and we are waiting to hear where funding would be provided, along with all the other schemes	Hannah P in west. Lead would be needed for East			Part of the west seasonal plan The risk is high as that it is very dependent on workforce, which we know is in very short supply

Community integrated working

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
41	COPD extended service pilot to support early discharge from hospital, for patients with other respiratory conditions. Support/ input from community COPD team. 1 additional B6 WTE nurse required. This nurse will also support COPD virtual ward. As background information, £90k was approved last year from winter funding for 1.4 WTE. 1.0 WTE B6 nurse was recruited, 0.4 could not be recruited £66,133 was used (out of the £90k for the B6 + unsocial hours and equipment) so there should be £23,867 left from the £90k pot, held by the alliance The request is that the £23, 867 is drawn down + with an additional £42,500 for a second WTE B6 nurse to fully mobilise the service. Recruitment success more likely for 1 x WTE (0.4 recruitment previously unsuccessful). This is needed to fully launch the COPD extended service.	Sept - August	Health and Care Fund	Alexis Johnys	Additional 780 pts (over 12 months)		**£66,133 Approved 13.9.22 at EDG** **Additional funding still required to fully launch the service**

Mental Health

	Action	Period	Proposed funding source, approval status and any conditions	Lead	# Pop Reach Sept March	Evaluation status	Notes
42	Steam Café – high street alternative to crisis admission to support people from 10am-10pm. Will enable police, ambulance & mental health teams to keep people in their local community, supporting A&E admissions avoidance & providing alternative to S136 suite placement.	From 1 Oct for 3 years		Jason Joseph Access Community Trust	25 – 30 people per day		
43	MH Discharge to Assess - 2 x discharge beds supporting quicker discharge from mental health acute bed and transition into the community (commissioned). The ICS has also invested in a discharge coordination team with NSFT to support the discharge process.	In place		Jason Joseph NSFT SCC Julian Support	TBC		
44	Greenlight Trust - High Intensity User project- pilot supporting people who have a higher than average use of our NHS111 option 2 service, helping to gain support away from MH services. Focus on wellbeing and engagement in more positive activity.	In place, ending in Sept 22 – plan to extend over winter	Non recurrent MH moneys (ICB funding – slippage in MH funding) Approved EDG 4.10.22	Jason Joseph (across ICS) NSFT – crisis response team	Currently supporting 24 people across Suffolk (until Sept 22)		GLT not funded for 23/24 delivery – c£400k (likely to go out to market)

Mental Health

	Action	**Period**	Proposed funding source, approval status and any conditions	**Lead**	**# Pop Reach Sept March**	**Notes**
45	Anglia Care Trust Community Connectors - supports step up from primary care & discharge from secondary care. Telephone, webchat and volunteer support to people no longer needing statutory input. Will support re-admission to MH services and the next step in their recovery.	April 22 -		Jason Joseph Anglia Care Trust	TBC	
46	Suffolk Night Owls - evening telephone support service providing registered support to people who need a connection between the hours of 6pm-1am. Initially focused on this with a personality disorder but widened to provide support for anyone who is experiencing the need for regular support in the evening.	Ongoing		Jason Joseph Suffolk Night Owls	TBC	

TIME MATTERS

East Suffolk and North Essex NHS Foundation Trust

Seasonal Variation Plan 2022/23

July 27th 2022

Authors:- Carolyn Tester / Robyn Andrews
SRO's:- Alison Stace / Sarah Noonan

Approach

- The baseline starting point of the seasonal variation plan has been developed, based on a set of assumptions,historical data and overlaid with forecasted emergency and elective care admissions

- The baseline model has then been overlaid with a set of ‘bed mitigating’ schemes, some of which are already underway and don’t require additional funding and others which require funding support. These have been carefully worked up by divisional teams, with transformation/BI and Operations Director(s) support and include a combination of projects that reduce ‘length of stay’ or prevent admission into an acute ward as well as alternatives to hospital admissions i.e. conveyancing opportunities.

Governance:-

- Weekly **‘bed optimisation’** meetings are in place, represented by all clinical divisions, estates, transformation, BI and pharmacy, to jointly work through progress against the model and associated ward reconfiguration requirements.

- Regular progress updates are fed through to the Urgent and Emergency Care Programme Board and ultimately to Time Matters Board

Assumptions which have been built into the baseline model

Adult Non-elective Activity:

- 2021/22 activity was compared to historical activity from 2019/20 and an activity level for each site calculated for the current year, using the comparative rate as at the end of February 2022 (the data for March being skewed by the beginning of the pandemic).
- Non-elective occupancy rate set at 92%
- Non-elective average length of stay for patients in overnight beds (ie excluding 0 LoS) based on current average for each site as of 18th April – ie **8.2 days** for Ipswich and **8.1** for Colchester

Elective Activity:

- Baseline set at 110% of 2019/20 activity across 12 months of the year.
- Elective occupancy rate set at 85%
- Elective average length of stay based on 2019/20 actuals for patients in overnight beds (excluding 0 LoS)

Bed Base:

- Includes only G&A bed base and established contingency. All additional beds used in the 2021/22 Seasonal Variation Plan have been stripped out.

Baseline excludes Maternity, Neonates and Critical Care.

NEE ALLIANCE SLIDES

North East Essex
Health & Wellbeing Alliance

Alliance Overview - *NEE*

NEE shares in common many of the issues that are common across ICS.

Our Seasonal plan is built on all year round surge plans and aims to continue to build strong relationships as an Alliance and support system pressures, through;

1. Seasonal Variation Plan – continuation and funding of key community schemes delivered by a range of Alliance partners that support the bed capacity of the system and ensure adequate flow to manage periods of pressure as detailed in the ESNEFT capacity plan.
2. Essex County Council Schemes via the BCF that support system flow and capacity.
3. Primary care plans - outlining support/funding put in place above business as usual to contribute to system capacity.
4. System Operational support and co-ordination for seasonal pressures remains in place including

    Our Tactical cell which steps up and down as required,

    A monthly Alliance Operational Group

    And the daily SNEE System operational hub.

NEE has a dedicated Escalation manager within the Operational hub team who supports our High Intensity User group and has daily contact with providers before during and after the daily operational call to support System working.

Assumptions which have been built into the baseline model

Adult Non-elective Activity:

- 2021/22 activity was compared to historical activity from 2019/20 and an activity level for each site calculated for the current year, using the comparative rate as at the end of February 2022 (the data for March being skewed by the beginning of the pandemic).
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- Elective average length of stay based on 2019/20 actuals for patients in overnight beds (excluding 0 LoS)

Bed Base:

- Includes only G&A bed base and established contingency. All additional beds used in the 2021/22 Seasonal Variation Plan have been stripped out.

Baseline excludes Maternity, Neonates and Critical Care.

Colchester Hospital – overlaid schemes

2. Overlay initial set of schemes

Colchester Site - 2022/23 Adult Bed Demand Summary													
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Owner
NEECS	Remove Community Escalation						(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	(12.0)	
NEECS	NEECS Inpatient LoS reduction*	0.0	4.7	8.6	12.1	16.5								Simba Chandiwana
Community	Virtual Wards						14.0	28.0	28.0	28.0	28.0	28.0	28.0	Paul Little
Med	Medicine Inpatient LoS reduction	0.0	4.5	8.5	14.5	17.5								Shona Rafique
C&D	Electronic safety questionnaire - for MRI inpatient bookings				6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	Bee Anthony
C&D	Acute Oncology - includes changes to pull patients earlier, linked with infection control and AOS						1.0	1.0	1.0	1.0	1.0	1.0	1.0	Darin Geary
MSK	Patients admitted from ED with a primary diagnosis of back/radicular pain that do not go to theatre							2.3	2.3	2.3	2.3	2.3	2.3	Cheryl Marchant
MSK	MSK - TKR & THR Enhanced Recovery			1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	Cheryl Marchant
MSK	Discharge to Assess for #NOF, wider roll out					2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	Cheryl Marchant
S&A	SAU benefits realisation	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	Becky May
S&A	Third surgical robot							5.2	5.2	5.2	5.2	5.2	5.2	Valerie Pentney
	Risk assessment	(0.6)	(3.4)	(6.2)	(10.9)	(13.7)	(8.0)	(14.5)	(14.5)	(14.5)	(14.5)	(14.5)	(14.5)	
Demand surplus/deficit General Schemes Applied		(56.0)	(33.4)	(12.9)	(28.3)	(7.3)	(26.3)	(47.1)	(43.5)	(42.7)	(58.7)	(48.9)	(21.3)	

Reduces largest deficit to -58.7 in Jan 23

Colchester Hospital – overlaid schemes :-

3. Final overlay of schemes final position expected

		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Owner	RAG	Support Recommendation
	Additional Contingency Unfunded	0.0	0.0	0.0	0.0	0.0	0.0	8.0	8.0	8.0	8.0	8.0	8.0			Birch
NEECS	Unfunded - Community Escalation						12.0	12.0	12.0	12.0	12.0	12.0	12.0			
NEECS	Discharge to Assess (inc Care)						4.0	4.0	4.0	4.0	4.0	4.0	4.0	Simba Chandiwana		
NEECS	Voluntary Sector Discharge Support						2.0	2.0	2.0	2.0	2.0	2.0	2.0	Simba Chandiwana		
NEECS	Additional prescribers 7 days (UCRS)						3.0	3.0	3.0	3.0	3.0	3.0	3.0	Simba Chandiwana		
NEECS	Additional Care Managers/Assessors (TOCH)						4.0	4.0	4.0	4.0	4.0	4.0	4.0	Simba Chandiwana		
NEECS	IRAS support at the front door						2.0	2.0	2.0	2.0	2.0	2.0	2.0	Simba Chandiwana		
Med	Additional Nursing WTE to support "Flo for Flow"						25.0	25.0	25.0	25.0	25.0	25.0	25.0	Shona Rafique		
S&A	Care of the Elderly physician reviews for elderly emergency general surgical (EGS) patients						2.8	2.8	2.8	2.8	2.8	2.8	2.8	Valerie Pentney		
S&A	Increased SAU footprint and opening hours						3.0	3.0	3.0	3.0	3.0	3.0	3.0	Valerie Pentney		
W&C	Young Person's Unit							6.6	6.6	6.6	6.6	6.6	6.6	Amy Bruce		
	Risk assessment	0.0	0.0	0.0	0.0	0.0	(13.7)	(15.7)	(15.7)	(15.7)	(15.7)	(15.7)	(15.7)			
	Demand Surplus/Deficit, All schemes applied	(56.0)	(33.4)	(12.9)	(28.3)	(7.3)	17.8	9.6	13.2	14.0	(2.0)	7.8	35.4			

Additional enabling Schemes	WTE	Staffing	Category	No. beds mitigate	Recommend	Funding pot	Comments
ED patient Safety Registrar (24/7)	4.20	Registrar - agency & bank	Safety in ED		H	SV	Additional ED Patient Safety Registrar, covered by Bank
FDAT (Medical & Nursing)	10.68	4.29wte B2 HCA 4.29wte B5 RN 2.1wte Registrar			H	SV	ED nursing requirements at the front door (UTC). This is so that patients can be safely cohorted in the UTC when there is not capacity in ED as they all require to be triaged and clinically prioritised. 10:00-22:00 Medical support (Reg).
EAU Patient Safety Consultant & Junior Medical	3.00	1.0 wte Consultant 2.0WTE FY2	Supports additional escalation		H	SV	Additional 1.0wte consultant, covered by Agency, additional 2.0wte FY2 covered by Bank
Copford	1.47	band 5			H	SV	m-s 24/7 Copford
Copford	0.37	band 2			H	SV	m-s 24/7 Copford

Delivers 57 beds mitigated, bringing final result forecast of positive bed position from Sep 22 (except for -3.4 in Jan)

North East Essex– Primary Care

- General population combined Covid 19 and flu vaccinations via Primary care planning
- Primary care to follow Admission avoidance schemes
- Increased resilience of additional laptops available to support remote working

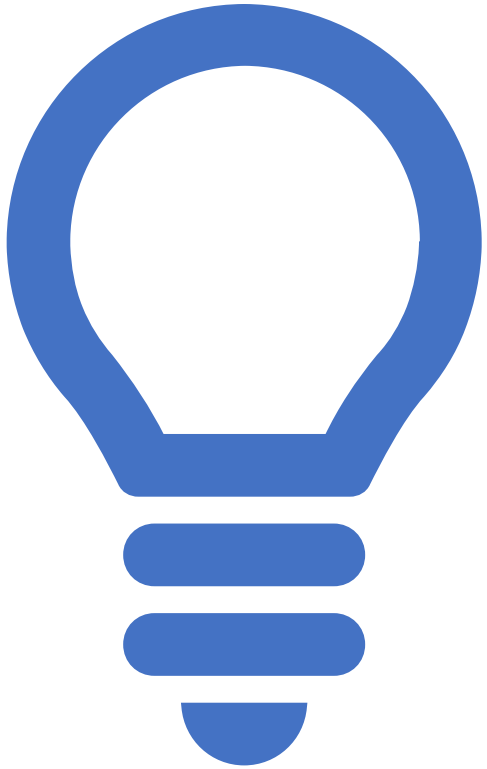
- Primary care funding targeted towards proactive care strategies, such as using search tools better to stratify patients into risk cohorts, integration of pathways for which prioritise high risk patients, and offering training to staff by autumn 2022 for personalisation and shared decision making
- Implementation of Enhance Access plans from October 2022
- Further roll out and awareness of Additional Roles leading to extra primary care workforce

- Support and resilience activities to reduce impacts on primary care. For example, use of primary care measures to identify team in need to an offer of support through the local Wrap Around Support forum and team

- Increased access via GP Community Pharmacist Consultation Service (CPCS) avoiding demand in primary care and other providers (i.e. 111)

Essex County Council's Winter Planning Summary for 2022 – 23
Work in progress

- System learning events and coordinated planning via OTCG. Further session due August 2022 to achieve system assurance
- Tender out for Dom Care and POLR Block contracts
  - These are for 2 years
  - Will cover hard to source areas
- Decision pending on continued provider incentive payments (domiciliary and residential care)
- Development of an Essex campaign to promote care jobs in the county (to include video commission and social media)
- Development of a Centre of Excellence to provide opportunities and support to the market to raise the profile of care
- Potential longer term funding for the Nightingale programme which includes an Ambassador programme to promote care to younger people.
- Market support decisions on CPI, fuel price increases and 'workforce recruitment and testing claims fund' communicated to care market
- IRN block beds in place to support discharge
- Cedars block in Mid Essex convertible to a designated setting site
- LAPEL escalation plan including Lifeboat and LAPEL support team if required
- New ARC and bridging contracts, supported in implementation by Connect team



Partner spotlight

Specific Provider Actions

Mental Health Response

EPUT

Pathway Improvements

- Work is ongoing with system partners to maximise flow pre and during the Easter period. Up to 3 x daily SITREPS in place to focus on patients who require admission, transfer and discharge.
- Utilising the voluntary sector to support pathway light and patient discharges.
- Making every contact count with vulnerable patients remains a focus, ensuring face to face contacts for SMI and High Intensity Users Group supported by the police.
- Volunteers being coordinated via CVST, C360, MIND, Haven, who are very supportive of the system needs and very responsive.
- Focus on discharge/EDD's to provide required capacity re Easter Holidays.
- Discussion with ECC leads re DTOC's
- Urgent Care Pathway capacity to be maximised over the next four weeks. 111 press 2 embedded.
- Confirmation of AMHP services across the BH period.
- Increase inpatient and urgent care staffing above establishments to support activity and unplanned sickness
- Additional beds with Colchester Cygnet contracted.
- Sec 135/136 MHA Essex wide workshop held to review system policies and response - aiming for Sec 136 only to be taken to ED's in exceptional circumstance.
- EPUT continued discussions with ESNEFT & CCG refunding regarding assessment space (mental health suite) /place of safety/UEC as this is the limiting factor for completing multiple assessment that are required at the same time

NSFT

Pathway Improvements

- Continued funding for Discharge to Assess/Step Down beds for 12 months across East and West Suffolk.
- VCSE provider (Green Light Trust) supporting identified high frequency callers to FRS, often high users of other UEC pathways too, to access the right support for their needs. Reduces frequency, frees up capacity and supports improved service user experience
- NSFT moving to NHS 111 option 2 (national platform) beginning April 2022
- Full time bed manager in situ for West Suffolk to support timely flow through pathway
- Staff moved/flexed between different teams in UEC pathway in West Suffolk to support demands, 10am daily huddle supports decision making and forward planning around this
- Active management plans to support Service Users in the department if they need to wait (East and West)
- Letter sent to service users who decline or leave before assessment to support them to access services; preventing re-presentations (East Suffolk)
- Additional bed management resource being sought to support flow in East Suffolk
- Non Medical Prescriber introduced to East Suffolk Thurs, Fri and Sat (identified peak time)
- Trialling MH being available at point of triage within ED department- QI project outcome not yet known
- East Suffolk continued discussions with ESNEFT regarding assessment space as this is the limiting factor for completing multiple assessment that are required at the same time
- Development of NSFT Central Ops team to support care groups and provide oversight across NSFT

Specific Provider Actions

Acute and Community Trust - ESNEFT

Enhance ED Processes

- Implementation of ED escalation and cohorting SOP, along with ED triggers SOP now complete
- 'Clinically ready to proceed' embedded in ED at both sites with ongoing work to embed in specialties
- Review of Straight to service pathways to reduce time spent in the ED to include Internal and external pathways are being reviewed such as pregnancy, GP direct, Surgery and MSK
- Continue to undertake a quarterly Criteria to Admit audit ensuring admission numbers remain low . Admissions rates to be monitored each week at ODG and remain lower than pre pandemic levels On the Ipswich site we have looked at the respiratory admission rate and the lower due to a high number of respiratory conditions meeting the criteria for suspected covid and being managed through a respiratory assessment pathway under the acute physicians.
- Work collaboratively with mental health services to reduce waits. Introduction of a band 3 extended role to support mental health.
- Senior overview of patients that have breeched 12 hours and is now report as part of bed meetings with site oversight.
- Updated ambulance escalation and Cohorting SOP implemented. Continued work around Paediatric decant SOP
- New ED trigger tool to have soft launch 15th August in Ipswich with a view to rolling out in Colchester once process proven
- ED huddles to continue with HALO, Floor Coordinator and Site Team embedded as BAU to identify key actions required
- Continue Fit to Sit review of all patients arriving by ambulance. - New chairs and screens placed in the Ipswich ED waiting room from mid April increasing capacity to allow more fit to sit and additional resource has funded to support cohorting of bed waits to enable handovers.
- Spot Check Audit to highlight barriers impeding flow in and out of ED incorporating actions from Dr Ian Sturgess visit
- Move confirmed discharge awaiting transport patients & ward allocated patients to be moved within 30mins – enhanced ED projects with both site team to help expedite flow out of ED both sites have a well established boarding policy and boarding is encated on a regular basis to support flow form ED. All wards are asked to review the sick and discharges first on the board rounds to help speed up earlier discharge of patients before midday.
- Speciality assessment area to move referred patient to correct team quickly .Being driven by focus on new CRtP metric
- Utilise agreed referral pathway in hours as per ECDS / An agreed pathway for speciality review OOH – working with NHSE on a missed opportunities audit

Utilisation of alternative pathways

- New AMSDEC and Frailty at Colchester now open with new pathways in place
- Frailty model being developed to support direct ambulance conveyance to AMSDEC / FAB the Ian Strugess visit also listed a number of actions to help support an increase in ambulatory care patients through SDECs
- GP Fed and Practice Plus group to provide an enhanced admission avoidance line to cover both Ipswich and Colchester. Service go live form 27 August
- Frailty Silver phone giving crews direct access to speciality frailty advice to be available from September
- Working with GP Fed to increase the pathways to the GP releasing medical and Nursing resource to see and treat the sick in ED. Missed opportunities audit being carried out with NHSE in August
- Second GP is to be funded for 22/23 allowing more patients to be streamed away from ED creating capacity and resource to see the emergency patients.
- Work collaboratively to support development of EEAST's junior workforce to ensure awareness of alternative options for safe patient management
- UCRS to take direct referrals from EEAST with additional REACT resource being funded as part of SVP plan. Automated CLERIC system to go live in November to increase referrals from EEAST to REACT/UCRS
- Promotion of Clacton UTC/AMSDEC/Frailty services for Tendring residents as the most appropriate services, and as a navigation away from Colchester acute services, where possible.
- SAU to open at 8am in line with other assessment areas on the CH site

In-hospital discharge processes

- Review of in-patients three times a week to maintain traction on discharge and reduce LOS with senior teams have been attending board rounds, Matrons are undertaking a daily review and all patients over 21 days every week. Flow also work stream for the ED enhanced recovery programs.
- Continue to improve on initiatives implemented in line with the national discharge policy, i.e., Reason to Reside, Discharge to Assess and system led stranded patient review structure.
- Regular review and audit of all patients waiting social care with the aim of reducing referral numbers back to pre-pandemic levels . To include Discharge Hub reviews for all patients referred to ensure appropriate referrals
- Implement a push / pull model for the discharge lounge and review the current weekend provision. Discussions around developing discharge lounge model for Colchester ongoing
- BC for New medical model now submitted for Exec review with greater focus on getting the right patent into the right speciality bed reducing length of stay
- All weekend discharges are flagged on the Red Day Tracker throughout the week ensuring weekend discharge consultant can prioritise time
- Diagnostics Imaging 7 day service model now which will allow greater access to weekend diagnostics CT now available 7 days a week with MRI to be available from new year

Specific Provider Actions

Acute and Community Trust - WSFT

Enhance ED Processes

- Revised and updated UEC escalation plans. Includes provision of extended RAT service (staffing dependent) and additional use of MAA and general waiting areas.
- Agreed process for handover from EEAST utilising HALO input with ED team and crews. This is designed to minimise handover delays once patients have been offloaded.
- Review HALO operating hours
- Continue to embed clinically ready to proceed
- Increase GP streaming slots to match current demand profiles
- Clear focus on ED exit block which includes improvement of internal processes and pathways
- Focus on P1&P2 delays.
- Daily reviews of patients in the hospital who don't meet criteria to reside. Clear threshold for escalation.
- Escalation of out of area delays, particularly to Norfolk.

Utilisation of alternative pathways

- Focus on SDEC services for both medical and surgical admissions.
- Enhanced frailty hub model
- Surge capacity plans for Community Health Teams initiated
- Daily MDTs
- Expansion of Enhanced offer: current capacity for 20 people, increase to 25 by end of April and 30 by end of May
- Joined up approach with partner agencies including Hospice, Social Care, Reablement services
- Heightened focus on Community Beds to maximise flow
- Continued staffing 0800 hours to 2000 hours (Nursing and Therapies

Specific Provider Actions – Essex Local Authority Actions

Action Essex County Council	Narrative
Support Hospital Flow	• Extended block contract with some residential providers post March 2022. • 6-7% uplifts on home care, care homes and supported accommodation contracts to reflect higher costs and increase payments to staff to improve recruitment and retention. • Continued to incentivise for care starts via the £1000 payment. • "Provider of last resort" has continued and is supporting some unmet need in the community, both domiciliary and residential. • We have met with ECL to look at their challenges and develop plans for maximising capacity for reablement. • Work via Connect is ongoing with ECL and ILOR to streamline processes and maximise capacity. • We have consulted our D2A staff to all work across 7 days p/w in line with our hospital teams, thereby ensuring capacity across all days
Designated Settings	• Reviewing Cedars (Designated setting) contract with options to continue post April 2022. • Reviewing Red and Amber pathways into Cedars • Support for care setting impacted by outbreaks
Support for System	• Non recurrent support for workforce supplementing the national scheme with a focus on retention of staff over winter has been undertaken. • 'Test and learn' approach to improve use of existing capacity including work on 'package exchanges' between providers to support harder to source care packages, manual handling with dignity focused on redesign double handed packages of care and moving our Connect programme methodology to wider reablement provision. • Essex wide prioritisation matrix agreed for home care. • Socialising the Newton Europe discharge to assess review to support better processes and flow into next winter • Work is underway with the virtual ward to support across health and care to support admission avoidance and maximise discharge • Supporting reablement to continue to reduce failed starts alongside system colleagues • Supporting provider queries and ensuring they have links with our teams if they have concerns so we can collaborate on them together to avoid unnecessary admissions

Specific Provider Actions – Suffolk Local Authority

Action Suffolk County Council	Narrative
1. Kickstart a career in care Scheme	The recruitment scheme is aimed at encouraging new recruits into the care sector by offering a £750 bonus if they stay in their position for 12 weeks.
2. Rural Rate	Offering providers up to £27 an hour for packages picked up in the hard to reach areas
3. Locality home care framework	To return to a single contract which improves councils levers and ability to influence the market and develop new initiatives. Reduces providers on SPOT rates.
4. Home care digital pilot	Providing digital care to those eligible to reduce travel times for carers and increase productivity time.
5. Targeted intervention in a specific area	This has been carried out successfully in Bury Rural area (prior to intervention the waiting lists sat at 34-50 customers and now sits between 5-8 customers). To replicate in other particularly challenged INT areas.
6. Brokerage Team & Geo-mapping	(previously Placement Team) DMTs approved increased staffing within the Brokerage Team, dedicated area support with a greater focus on building relationships with the local system.
7. Volunteers	Working with volunteering schemes to alleviate pressures on the market by carrying out non-personal care tasks.
8. **Community Catalysts**	Developing micro-enterprises and personal assistants as alternative delivery of Home Care in hard to reach areas.
9. Overseas Recruitment	Working with SAICP to support providers in navigating Home Office Process
10. Medical/advice line	To be able to provide carers with clinical advice to make best use of their time.

Specific Provider Actions – Home First Actions

Action Suffolk County Council	Narrative
1. Increased Recruitment initiatives into Home First	A recruitment plan is in place and is being further developed to increase net the number of Reablement Support Workers in the service. Increasing spending on recruitment initiatives.
2. Increasing Home First “contact time” with customers	Optimising rostering and shifts of HF teams to boost the % of contact time (time spent face to face with customers)
3. Increase integration with Health colleagues at place level	Build on the work already carried out around stronger integration with health colleagues to maximise customers independence and experience of our services.
4. Decrease of agency usage	Represents very poor value for money and is unaffordable in the medium to long term. Difficulty in ensuring quality of care, lack of reablement training. A scaled down approach has been agreed by ACS DMT and shared with local health colleagues.

Specific Provider Actions

EEAST

Operational Improvements

- Process to maximise C3-5 stack support with Community providers embedded locally to reduce the long waits and allow ambulance resources to be directed to higher priority calls.
- 'Access to the stack' regional workstream delayed – expected go live date for SNEE 4th November for push model.
- GP Advice line for, on scene crews to support use of admission avoidance and reduce conveyance to ED, moving to a single number on 22nd August
- Additional clinical support at Colchester to support AtoH delays (cohorting)
- Reviewing further support to Care homes to reduce ambulance calls – part of a wider care home review and support from EEAST
- Fire Response Service supporting on scene crews with lifts to reduce the number of ambulances required at scene
- Use of Advanced Paramedics to rotate in AOC and vehicle based to target C2 demand – Initial staff to be in place in October
- Implementation of a Mental Health joint provision with the MH providers – still under discussion with no confirmed start date yet
- Reviewing Early Intervention resource – potential for repurposing resource.
- Improving Ambulance efficiencies to increase availability of resources.
- Complete HALO permanent recruitment – currently 50% complete.

111 / Clinical Assessment Service

- Revised process to maximise C3-5 stack support with Community providers to reduce the long waits and allow ambulance resources to be directed to higher priority calls
- Additional high acuity triage questions training (ensuring probing questions are asked and accurately reflected.
- Ambulance Validation queueing extended to 1 hour from 30 minutes (hold time for C3-C5 clinical assessment before sending to 999) KPI is 80% validation .
- Programme to electronically send 999 Cat 3-5 to the CAS for review and assessment.

Specific Provider Actions

Alliance Response (including Primary Care) – West Suffolk, Ipswich & East Suffolk and North-East Essex

Pathway Improvements

- Daily system tactical meetings in place via the operations hub
- Post HDP funding remain in place to sustain level of reablement support for P1 and P2 whilst long term plans are being agreed ahead of winter.
- Primary care operates a BAU with focus clearing backlog of LTC checks supporting early intervention. Enhanced access plans submitted and on track for operational delivery from 1 October
- Mutual aid in place supporting elective care backlog
- Virtual ward system plans accelerating at pace, building on the foundations of the Enhanced INT model for operational delivery by 1 October
- Work continues to support and energise the care market.
- Focus on Care home support and DES development, medicines reviews and anticipatory care
- Urgent Community Response operational 24/7 and now fully responding to non injurious fallers
- PPG Ambulance support line – direct access to the CAS for Ambulance staff to support transfer to UCRS and community services as an alternative to conveyance to hospital
- PPG *Line supporting Care home admission avoidance
- Hospice at home and single point of access support for Palliative care service support to patients in the community
- Support from District and Bourgh council teams with housing issues delaying discharge from hospital
- Voluntary Services partnership with discharge support in NEE with pathway light and across all three Alliances with Social Prescribing into the discharge hub, PHB in place for discharge cases to support low level needs.
- UCRS - use of Cleric system to enable electronic pulling of lower category patients from the ambulance stack to support Ambulance response and demand and ensure people are treated in the most appropriate service for need (aiming by Sept 2022)
- UCRS (NEE)- Integration with the Integrated Rapid Assessment Service (IRAS) to provide joined up Hospital front door and community admission avoidance support
- UCRS (NEE)– exploring opportunity to integrated service with Mental Health crisis teams
- UCRS and EIV –(NEE) Exploring commissioning options of EIV service with EEAST with options including integrating EIV car with mental health professionals

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ICB BOARD

Agenda Item No.	**11**
Reference No.	**ICB 23-05**
Date.	**24 January 2023**

Title	**Support available to children and young people (CYP) presenting in crisis in Suffolk and North East Essex (SNEE).**
Lead Directors	Lisa Nobes, Director of Nursing and Richard Watson, Director of Strategy and Transformation.
Author(s)	Lianne Joyce- Associate Director of Nursing CYP, SNEE ICB and Suffolk County Council (SCC) Sarah Hannington- Assistant Director Southend, Essex & Thurrock Children & Young Peoples Emotional Wellbeing & Mental Health Collaborative
Purpose	Update

Recommendation:

To be updated 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.

1. Background

1.1 In line with the national picture, Suffolk and northeast Essex has seen an increase in demand and complexity of children and young people requiring mental health crisis support. This increase in need has been further exacerbated by the COVID-19 pandemic.

1.2 As a system, we have faced challenges in meeting the need: increasing levels of complexity and acuity, variable waits for assessment and treatment, workforce challenges, the impact of regional Tier 4 bed closures and variable implementation of CYP home treatment and crisis outreach.

1.3 These challenges result in negative impact and outcomes for CYP, who are already in very challenging situations. The impacts include long waits in inappropriate environments in acute hospitals, emotional impact on families, loss of trust in getting help and the right help. And the outcomes can include not just a lack of improvement in mental health but mental health deterioration whilst waiting for therapy and other specialist mental health care support.

1.4 For our staff caring for these CYP, they can feel unable to deliver the right care in the acute setting which impacts on staff wellbeing and there have been unrealistic expectations within core MH and CYP services to continue to meet needs with increasing demands.

1.5 It has felt untenable for individual organisations to continue to hold the risk of these situations therefore we have developed a SNEE CYP crisis protocol which has enabled us to develop a shared, system ownership of clinical risk in these circumstances.

1.6 There have been identified pressures within acute services which has been important for us to address as a system.

1.7 This paper will discuss the steps we have taken as a system to support each other across organisations and co-produce a system CYP crisis protocol which we believe has impacted positively on the numbers of CYP presenting in crisis and the length of stay that those CYP experience in acute hospitals if they do present to the emergency department.

1.8 The paper also presents the recent commissioning arrangements that are in place to support CYP and their families and the work that our acute hospitals have led on to ensure that they have staff available who are skilled and confident in providing crisis mental health care and support to children, young people and their families.

1.9 These new protocol and commissioning arrangements we believe have contributed to the reduction of CYP presenting with acute mental health need and reduction in requirement of tier 4 bed admission. This reduction has been from 13 CYP requiring tier 4 admission in Jan 2022 to 3 CYP requiring tier 4 admission in December 2022.

2. National context

- 1 in 4 young people aged 17-19 have a mental health difficulty in 2022, this was 1 in 6 in 2021
- 1 in 4 (29%) of 7-16 year olds experiencing a mental health difficulty live in a household with reduced income.
- There have been reversed patterns of mental health difficulty in boys/young men and girls/young women in 7-10 year olds: twice as many boys than girls have a mental health difficulty.
- This changes in the 17-24yr age range – 31% young women and 13% young men have a mental health difficulty.
- Education – 13% of CYP missed more than 15 days of schools, it is estimated that 9% are likely to have a mental health disorder.

- In 11-16 year olds with a mental health difficulty, 61% do not feel safe at school. 89% of 11- 16 year olds with a mental health difficulty are less likely to enjoy learning or have a friend they can talk to.

(www.centreformentalhealth.org.uk December 2022)

3. Suffolk and north east Essex context

3.1 Locally there have been identified gaps of capacity and flexibility within services to support children and young people in a tier 3 to 3.5 setting which represents the mental health support options prior to needing a mental health hospital bed, and when accessing services within community mental health settings, within Suffolk and northeast Essex.

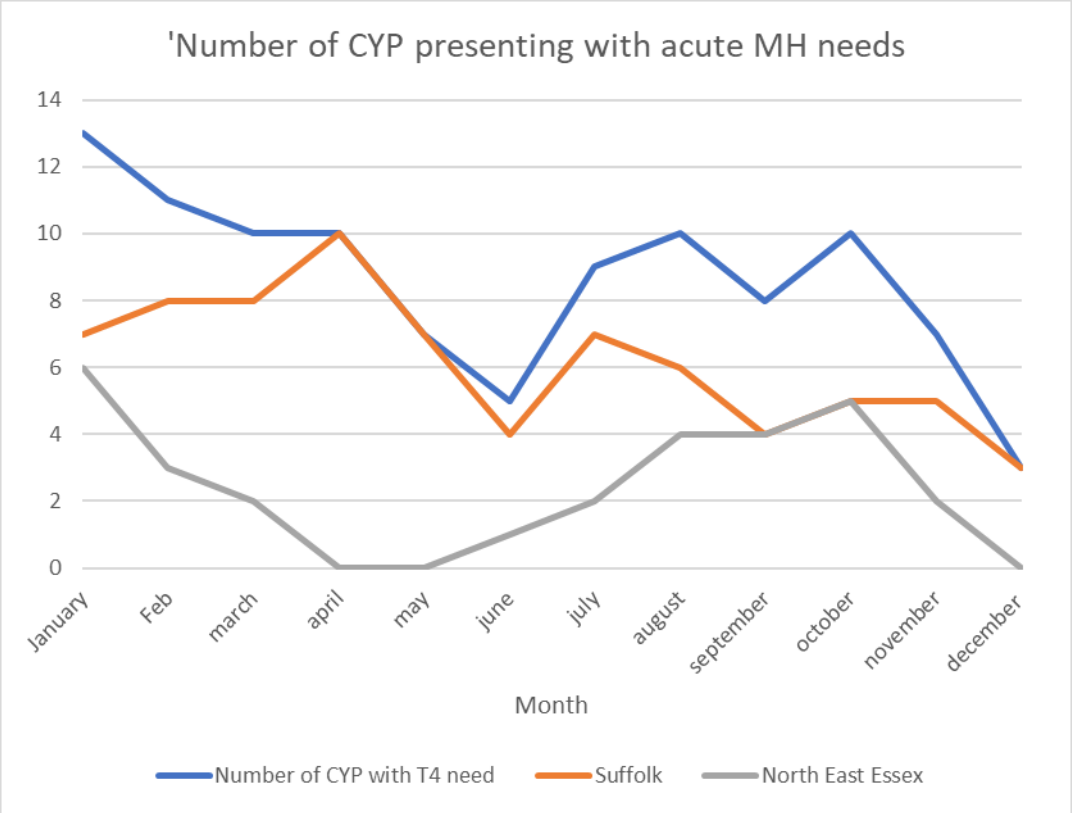
3.2 The demand for this support has overwhelmed community teams impacting on their ability to respond to that CYP and family in crisis, leading to a deterioration in their mental health and resulting in crisis and tier 4 support. We have no tier 4 inpatient services in SNEE; therefore they are always out of area and away from a child or young person's support network. 71% of SNEE CYP admitted to tier 4 units were outside East of England. The impact of a tier 4 admission on a child, young person and their family is felt through isolation from social and family settings, educational outcome impact and the potential of pathologizing their condition and affecting their long-term recovery ability, which ultimately impacts on their life chances and success of achieving their potential.

3.3 Across SNEE we have been monitoring needs and numbers of presentations of CYP presenting in mental health crisis:

- Twelve months ago, we had 13 CYP across SNEE awaiting a tier 4 bed or a social care placement.

- During the last three months of 2022 we have had extended periods of time without any young person waiting for a tier 4 bed or a social care placement in an acute hospital or in the community and 3 CYP in December in total that required a tier 4 bed.

3.4 The following chart details the numbers of young people presenting with acute mental health need. We have seen an initial decrease in numbers, but we have also seen the length of stay decrease within an acute hospital setting due to positive system working and the newly introduced protocol and developed options available.



4. CYP crisis protocol

4.1 In Spring 2022, colleagues from organisations across SNEE came together to form a CYP crisis working group. We wanted to work together to improve the support we give to these CYP as a system recognising that no one area across health/education or care could solve this alone.

4.2 The CYP crisis working group worked at pace to build and agree a protocol for the whole system to support young people in mental health crisis.

4.3 Before we developed the protocol, we agreed the following principles:

- Caring for the child/young person where possible at home or in a care environment which is suitable to meet their needs
- Upholding the human rights of the child/young person and ensuring they are safe
- Holding collective accountability, understanding what this means in reality for organisations and most importantly for the well-being of the child/young person across the mental health, physical health, and care systems. We also need to acknowledge this will include joint positive risk taking when making decisions.
- Working as a mental health, physical health and care system in partnership
- Joint commissioning and joint provision of services across health and social care- and education where appropriate.
- Commissioning with compassion and kindness as a system

4.4 The protocol established the systems, process and accountability across the health, social care and VCSE sector for the support of CYP and their families and carers in crisis. It sets out the support for staff in the risk management and care of CYP in crisis; the escalation points and processes within the locality; the principles and processes for discharge if the CYP is admitted into an acute hospital inpatient bed; and the principles and processes for discharge if the CYP is admitted into a mental health inpatient bed.

4.5 We are now expanding this to include crisis presentations within the community settings.

The purpose of the protocol is:

- To develop a clear plan of care and support with the child/young person in crisis and their family/ carers which promotes/maintains safe working within a therapeutic framework to achieve agreed outcomes.
- To have a clear process for discharge if a child or young person is admitted to an acute hospital bed while:
  - awaiting further mental health assessment
  - awaiting transfer to a mental health bed
  - awaiting determination of a discharge destination in the community that could include a care setting determined from the local authority or home setting with parents and or carers.
- To provide clarity on the expectations, roles and responsibilities of the various professionals and organisations supporting a child or young person at the point of crisis.
- To provide a framework and process for escalation in the instance where all appropriate steps and care have been followed but there is either a lack of agreement in decision making or there are other issues preventing the onward, appropriate discharge of a child or young person.
- To have absolute clarity if further escalation is needed and what the expectations are from the next stage of escalation.

The second phase of the working group was to identify ways to further support CYP, parents and carers in a needs led and flexible way. This led to the development of the peripatetic offer.

Peripatetic offer- What is it?

SNEE ICB have reached out to VCSE partners to build a peripatetic team to provide wrap around support dedicated to meet the needs of the young person in crisis. It starts with developing a “pen portrait” of the CYP to identify their specific needs and we then commission an organisation to provide support personalised to that CYP.

This team can work flexibly, can move with the CYP depending on setting i.e hospital to home. The offer is comprised of a variety of support options including direct care support, parent peer support, community-based support and more. We want to grow this further to ensure this flexible, needs led approach is available and has the widest range of support possible.

The peripatetic offer has also brought together several organisations and allowed them to discuss children, young people and their families on the fringes of crisis and in need, we hope to progress this system approach to support joint working and escalation of need.

It offers:

- Delivery of support at the location of the young person; this could be within an acute hospital setting or another community setting. (to be defined in each case)
- There will be a requirement to deliver support/intervention within 24 hours’ notice.
- The ability to cover 24/7 support if needed, this will not be for all cases as the package of care will be different for each young person.
- To work alongside new MH specialist posts within the hospitals to agree appropriate support needed for CYP and family or placement provider and other key leads in the support of the CYP in crisis.
- To support cross organisation working in order to support CYP and their needs.

To access peripatetic team the following steps process will be followed: -

- Discussion at Multi Agency Liaison Meeting (MALM)
- Pen portrait of child or young person to be completed by group/those that know young person the best. This will include the CYP and the family's voice.
- The above documents to be shared to the peripatetic email address (TBC), and a full standard operating process to be shared.
- This will then be sent out to the approved providers and feedback to MALM group as soon as possible.

This process went live on 1st December 2022, and we have supported two young people and their families so far. Below is an anonymised case study that helps detail the approach and the outcomes seen.

Case study from December 2022:

Young person A is a 13-year-old male with an autism diagnosis who has previous reported trauma that has had a significant impact on his emotional wellbeing. He attends a specialist educational placement and has an education health and care plan (EHCP). He has a social worker and receives support from a mental health community team

He presented in A&E with his parents who were desperate for support, feeling overwhelmed and unable to care for their son any longer. They requested that their son goes into care or a tier 4 hospital bed.

Actions:

- Multi agency liaison meeting called
- Pen portrait completed including young person and family wishes
- Joint meetings and communication with young person from social care and mental health services
- Peripatetic support access providing peer support to family members, direct care provided within the hospital setting that also support with family home (transitioned with family) and future support options available within the community.

This young person and his family were supported home without the need for care or ongoing hospital support

Learning:

- How can we intervene sooner to prevent people feeling their only option is to present to A&E?
- Steps agreed on how we can we create this positive approach within the community setting more proactively, involving mental health services and social care working together to discuss escalating needs of young people on both caseloads.

Acute hospital mental health professionals:

Over the last year, SNEE have funded Band 7 CYP mental health professional posts across all three acute hospital sites, these roles provide an additional level of support and focus on the needs of young people in crisis.

There are two dedicated roles in Ipswich and Colchester Hospitals and one post, which is to be recruited to at West Suffolk.

Initial feedback has been positive and discussions between the ICB and both acute trusts is to continue to support and agree outcomes and the direction of the roles.

Our local mental health trusts have led on the CYP mental health training and education for staff and have supported SNEE to develop an agreed approach to risk management training. This is being rolled out across our acute hospital paediatric wards, mental health services, social care and early help and education to ensure we all have agreed levels of confidence and training.

5. Other CYP crisis support offers available- Suffolk:

5.1 February 2022 saw the introduction of the Crisis help risk intervention service (CHRIS) in Suffolk. CHRIS is a psycho-social risk support service, which offers a range of short-term direct and indirect interventions for CYP and their families.

5.2 The development of CHRIS is a crucial part of the overall mental health transformation plan for CYP and families across East & West Suffolk. Crisis support for children and young people (0-18yrs) and their families has been identified in coproduction as a key priority and fits with local and national drivers and objectives.

5.3 Some extracts from CHRIS feedback forms since it started:

- 'You have really changed my attitude toward mental health services, as you know i had a awful experience with them before but you have really changed my view. I see you as a massive reason why I'm still alive' (young person feedback from CHRIS)
- 'Fantastic job working with the school in terms of safety planning.' (parent feedback for CHRIS)
- 'Clinical psychologist presented with a good understanding of the situation' (parent feedback for CHRIS)
- 'Flexibility in visits was positive' (parent feedback for CHRIS)
- 'I felt completely involved in everything, always asked my input, and kept me informed of what was happening. Safety plan was useable' (parent feedback for CHRIS)
- 'Always checked in with me, listened to me, made sure I was understood, really good, they were understanding, flexible and worked around me, never rushed me. I always felt heard and that I was important to them.' (Young person feedback from CHRIS)
- 'Always explained things to you and what would happen next. Always updated me after meetings and kept promises. Always got back to me when I contacted them.' (Parent feedback for CHRIS)
- The parent that I spoke to described the service support as 'amazing' 'really supportive'

5.4 She described the two members of the team who had supported her and her daughter as wonderful and they had made really good progress with engaging her daughter. She described her and her daughter fleeing domestic violence and that her daughter finds it hard to open up and engage. She said the team has been very skilled at doing this.

5.5 When asked about what difference the team had made, she said without the team she really doesn't think her daughter would be here right now and that she would have taken her own life. She feels so grateful for this service and hopes that it is appreciated and it is continued.

5.6 She felt the team had supported her to have more confidence as a parent and to make decisions and as a result she now felt more equipped to advocate for her daughter. She talked about long waits in CAMHS and how the team had managed to navigate and support access to the right treatment whilst they had been waiting. Areas of improvement: she felt the team covered a large area and maybe having a base in west of county might help reduce travelling as they were based in Haverhill.

5.7 She asked that a massive thank you is given to practitioners in the team.

Case study from CHRIS (young person name is anonymised)

Adam is a 16-year-old male who was referred to CHRIS service following several visits to A&E. Adam was seen in hospital five times during the same week prior to the CHRIS referral being received. He had tried to end his life by taking tablets, tying a ligature around his neck, and was found by Police at the top of a railway bridge where he said he had intent to jump. The formulation indicated that Adam's crisis could be attributed to him being 'stuck' in the belief that he would only be safe in hospital, and the only action available to him was to be admitted. CHRIS work was mainly focused in helping Adam to shift from that belief and start to 'see' and accept that he can be better supported in the community.
CHRIS practitioners held consistent professionals' meetings to ensure that the same messages were being conveyed to Adam - that he would no longer be admitted to hospital and that, as an alternative, his needs would be met by the community. CHRIS offered individual work with Adam (based on acceptance, value-based goals, belonging) and systemic work with the parents and the wider system.
When closing the case, a structured and planned ending was provided to support the change being sustained. Adam spoke of the ending being "sad but good sad" which was massive step forward in his ability to tolerate emotions, something he could not do before.
At the time of discharge, Adam had no incidents requiring him to attend A and E for over a month. He has acquired a gardening job and starting to spend more time with his friends and was starting college in September 2022.

The Green Light Trust (GLT)is now working alongside CAMHS and CHRIS to support CYP within Suffolk. They will work with professionals to support CYP who are referred into either CAMHS or CHRIS. The GLT team will create joint plans with the MH teams and CYP to ensure needs can be met. This may be through GLTs own offer or via other VCSE organisations (Noise solutions, computing club etc).This offer will be monitored, and outcomes captured for us to understand impact for CYP and wider system but so far, we have seen some amazing outcomes, specifically for CYP who have been excluded from school and where alternative types of support are needed.

The pilot of CAMHS alternative to admissions team (CATAT) for Suffolk, this has been funded by the Provider collaborative. This provision already exists within Essex provided by Northeast London foundation trust (NELFT)

This is a pilot project, initially for one year.

The teams aim to:

- establish a team that will provide enhanced assessment, clinical outreach, and support to CYP and system partners when a Tier 4 level of need is identified.
- hospital admission will be based on clinical need
- ensure that children & young people in Norfolk & Suffolk access care in the least restrictive environment possible.
- if a lesser restrictive option exists, the team will work with partners to establish a safe plan in the community.

6. Other CYP crisis support offers available: Essex

6.1 In order to support young people in crisis the following has been put in place in Essex, these are pan Essex Approaches available to NEE.

Tier 2 support

The CAMHS provision has increased in tier 2 and there is a partnership in place with HCRG in conjunction with NELFT.

In addition to CAMHS in Essex;

Schools Provision

- Self-Harm Management Toolkit (SHMT)
- Wellbeing Workshops in Primary Schools
- Mental Health Support Teams

Parental and family support

- ASD Family support (health based coaching)
- CYP MH Family Support (health based coaching)
- Barnardos crisis support
- Triple P online provision

Other Young People Support

- Progressions Core Assets
- KOOTH
- Transforming Care 'Spot Purchase'
- CYP MH Ambassadors – Healthwatch

Eating Disorder team

The eating disorder team are also now attending wards to provide oversight and assurance to ward staff whilst awaiting beds or physically able to return home under the community eating disorder team. This has been alongside further expansion of the team that comprises of a home treatment team and community refeeding team. For those on the cusp of an eating disorder an ARFID (avoidant and restrictive food intake disorder) and FREED (first episode eating disorder) model put in place.

Vanguard from Health and Justice

Essex has also been awarded the national vanguard site with West Essex CCG hosting and including the three LA via education to develop a service structure to further enhance the 'offer' to CYPs who are identified as potentially benefitting from health input to support them to engage in meaningful patterns of behaviour, rather than moving towards anti-social behaviour and criminogenic tendencies with a lower age limit of 5 years old and encompassing a family therapy approach, mentorship and further support. This contract has been awarded to Virgin and will be called Affinity. It will further links for education partners and a presentation has been given at a national meeting outlining our plans. This will link closely with POWER to support CYP identified at need and potentially resulting in referrals to the YOT teams.

Expansion of the crisis team and 72 hour bed

There has been increased expansion of the crisis team this financial year alongside a brand new project for a 72 hour bed model. This model comprises of 2 beds on EPUT wards that are used for a short and brief interventions before the young person returns back home.

7 Recommendation

7.1 For the ICB Board to note the contents of this report.

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ICB BOARD

Agenda Item No.	**12**
Reference No.	**ICB 23-06**
Date.	**24 January 2023**

Title	**New Special Education Needs and Disability (SEND) Inspection Framework**
Lead Director	Lisa Nobes, Executive Nurse SNEE ICB
Author(s)	Dr Jack Walker, Designated Clinical Officer SEND
Purpose	Provide update re SEND Inspection Framework

Recommendation:

To note updated SEND Inspection Framework.

1. Background

1.1 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. This includes integrated practices in identification and assessment of needs, and integrated planning to meet needs. It also includes 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 are met.

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

1.3 Ofsted and CQC have in November 2022 published details on how they will inspect services for children and young people with SEND in a local area. This new inspection framework came into force in January 2023.

2. Key Issues

2.1 The previous SEND inspection framework focused on how local authorities met their responsibilities within the SEND Code of Practice. The new framework has a greater focus on hearing directly from children and young people with SEND, and their families. This will allow inspectors to get a better understanding of what it's like to be a child or young person with SEND in that local area.

2.2 Key changes when compared to the previous inspection framework:

- Greater focus on hearing directly from CYP with SEND and their families to better capture their experiences
    - Moving away from staff focus groups which featured heavily in previous framework
- Stronger accountability through ongoing contact with local areas – including inspections and monitoring inspections where required
- New thematic visits each year
- Multi-disciplinary approach to gathering evidence, deploying an inspection team that includes education, health and social care inspectors

Three distinct inspection outcomes which determine future inspection activity:

- The local area partnership's SEND arrangements **typically lead to positive experiences and outcomes for CYP with SEND**. The local area partnership is taking action where improvements are needed
    - Full inspection within 5 years
    - Engagement meetings with local area partnerships
- The local area partnership's arrangements lead to **inconsistent experiences and outcomes for CYP with SEND**. The local are partners must work jointly to make improvements
    - Full inspection within 3 years
    - Engagement meetings with local area partnerships
- There are **widespread and/or systemic failing leading to significant concerns about the experiences and outcomes of CYP with SEND**, which the local area partnership must address urgently
    - Submission of priority action plan
    - Monitoring inspection usually within 18 months
    - Full reinspection usually within 3 years
    - Engagement meetings with local area partnerships

2.3 The inspection will take place over three weeks. Week one will consist of notification, setup meetings, and requests for information to support the inspection. Six CYP will be selected by the inspection team for in-depth tracking meetings. Surveys will be disseminated to parents and carers, practitioners, and CYP.

2.4 Inspectors will request information from the local partnership about strategy and commissioning arrangements for CYP with SEND; person-level data, which inspectors will use to select the CYP whose experiences they will evaluate; and providers and services (but not an inspection of the providers).

2.5 Week two will include case tracking meetings with the selected CYP, finalising an onsite inspection timetable and analysis of information received.

2.6 Week three will consist of onsite visits, carrying out sampling visits to evaluate CYP experiences and outcomes by reviewing documents and discussing with practitioners. Health services visited could include specialist health, universal services, therapies, and mental health teams. Focussed sampling of partnership's decision-making processes and policies will also take place.

Post inspection

- Draft report shared within 14 working days
- Local area has 10 working days to comment on the draft report
- The report intended for publication is shared with the local area within 30 working days
- Local area has 5 working days to submit a complaint
- Publication is 3 working days later

2.7 The local area partnership has to publish an updated strategic plan 30 working days following publication of the inspection report, which should include the actions the partnership is taking, or will take, in response to the recommendations made in the inspection report.

2.8 If required to produce a priority action plan (following receipt of third outcome), Ofsted and CQC will ask the local area to submit this within 30 working days following the publication of the inspection report. Ofsted and CQC will then decide whether to approve the action plan. The local area must publish the final priority action plan within 70 working days of the publication of the inspection report. The local area must set out actions to address the areas for priority action in the inspection report, the responsibly organisation for each proposed action, and the period within which the action is to be taken.

3. Patient and Public Engagement

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

4. Recommendation

4.1 Note the contents of this paper.

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New SEND Inspection Framework

Integrated Care Board

January 2023

Dr Jack Walker (DClinPsy)

Children and Families Act (2014)
SEND Code of Practice (2014)

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- The Children and Families Act (2014) introduced requirement for education, health and social care agencies to work together more closely, including integrated practices in identification and assessment of needs, and 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

- The SEND Code of Practice (2014; produced by the Department for Education and the Department for Health and Social Care) is statutory guidance which sets out the duties, policies and procedures following on from legislation set out in the Children and Families Act (2014)

SEND Inspection Framework

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- Ofsted and CQC have published the new SEND inspection framework in November 2022, which came into force in January 2023

- The previous framework focused on how local authorities met their responsibilities within the SEND Code of Practice

- The new framework has a greater focus on hearing directly from children and young people with SEND, and their families. This will allow inspectors to get a better understanding of what it's like to be a child or young person with SEND in that local area.

Key Changes

Suffolk and North East Essex Integrated Care Board

- Greater focus on hearing directly from CYP with SEND and their families to better capture their experiences. Moving away from staff focus groups which featured heavily in previous framework
- Stronger accountability through ongoing contact with local areas – including inspections and monitoring inspections where required
- New thematic visits each year
- Multi-disciplinary approach to gathering evidence, deploying an inspection team that includes education, health and social care inspectors

Three Distinct Inspection Outcomes

- The local area partnership's SEND arrangements **typically lead to positive experiences and outcomes for CYP with SEND**. The local area partnership is taking action where improvements are needed
  - Full inspection within 5 years
  - Engagement meetings with local area partnerships
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  - Submission of priority action plan
  - Monitoring inspection usually within 18 months
  - Full reinspection usually within 3 years
  - Engagement meetings with local area partnerships

Inspection Timetable

- The inspection will take place over three weeks
- **Week one** will consist of notification, setup meetings, and requests for information. Six CYP will be selected by the inspection team for in-depth tracking meetings. Surveys will be disseminated to parents and carers, practitioners, and CYP. Inspectors will request information from the local partnership about strategy and commissioning arrangements for CYP with SEND; person-level data, which inspectors will use to select the CYP whose experiences they will evaluate; and providers and services (but not an inspection of the providers).

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Integrated Care Board

Post Inspection

- Draft report shared within 14 working days
- Local area has 10 working days to comment on the draft report
- The report intended for publication is shared with the local area within 30 working days
- Local area has 5 working days to submit a complaint
- Publication is 3 working days later

- The local area partnership has to publish an updated strategic plan 30 working days following publication of the inspection report, which should include the actions the partnership is taking, or will take, in response to the recommendations made in the inspection report

NHS
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Post Inspection

- If required to produce a **priority action plan** (following receipt of third outcome)
- Ofsted and CQC will ask the local area to submit within 30 working days following the publication of the inspection report
- Ofsted and CQC will then decide whether to approve the action plan
- The local area must publish the final priority action plan within 70 working days of the publication of the inspection report
- The local area must set out actions to address the areas for priority action in the inspection report, the responsibly organisation for each proposed action, and the period within which the action is to be taken

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ICB BOARD

Agenda Item No.	**13**
Reference No.	**ICB 23-07**
Date.	**24 January 2023**

Title	**Embedding Allied Health Professional (AHP) Leadership across Suffolk and North-East Essex Integrated Care System.**
Lead Director	Amanda Lyes, ICB Director of People and Workforce
Author(s)	Ganesh Baliah, Chief AHP and System AHP Programme Director
Purpose	To provide the Board with an update on Allied Health Professional (AHP) Leadership.

Recommendation:

To note the report.

NHS Suffolk & North East Essex Integrated Care Board Meeting

Embedding AHP Leadership Across SNEE ICS

Ganesh Baliah

Chief AHP & System AHP Programme Director – SNEE ICS

24 January 2023

CAN DO HEALTH & CARE

Chief Allied Health Professional

These roles are central to improving:

- quality of care
- patient safety
- AHP workforce and clinical experience of NHS trusts

The Role of the Chief AHP

Professional & Clinical Leadership	**Governance & Assurance**	**Quality**	**Workforce & Service Transformation**
Patient Safety & Experience	**Workforce Planning, Development, Utilisation & Deployment**	**Operational Delivery Issues**	

Chief AHP Variation across organisations

Despite a growing body of evidence, there is still a wide variation in

the approach trusts are taking when developing these roles, including:

- Job titles
- Roles and responsibilities
- Positioning in organisational structures

There is an increasing expectation for chief AHPs to act as system leaders through the ICS AHP architecture

- including AHP councils & AHP faculties
- supporting ICS workstreams relevant to AHPs

Benchmarking against other systems and providers

Chief AHP roles across regions (within the ICS and neighbouring ICSs)

New or transformational models of care in the trust ICS and/or region.

Current AHP leadership structure in trust(s)

Ratio of AHP strategic leads to number of AHPs (when compared to the ratio of Nursing and Medical strategic leads)

Workforce Data

- number of AHPs
- ratio of registered AHPs versus unregistered AHP staff
- number of AHPs working in advanced and/or non-traditional AHP roles

Quality & Workforce Metrics

- **length of stay**
- **long length of stay**
- **delayed transfers of care**
- **admissions**
- **place of discharge**
- **waiting lists**
- **re-admissions within 28 days of discharge**
- **failed discharges**

- **sickness absence**
- **recruitment/retention**
- **vacancies**
- **agency spend**
- **the NHS staff survey – engagement score**
- **student placements**
- **apprenticeships**

Diversity of AHP Leadership

- One of the strengths of AHP leaders is the breadth and depth of their experience across:
  - health, social care, and wider system.

- Skills acquired as clinicians, leaders, and managers - ideally places them to work alongside the senior leadership team to deliver key trust/system priorities and objectives.

#AHPsDeliver

Figure 1: The AHP Strategy for England: AHPs Deliver (2022-2027)

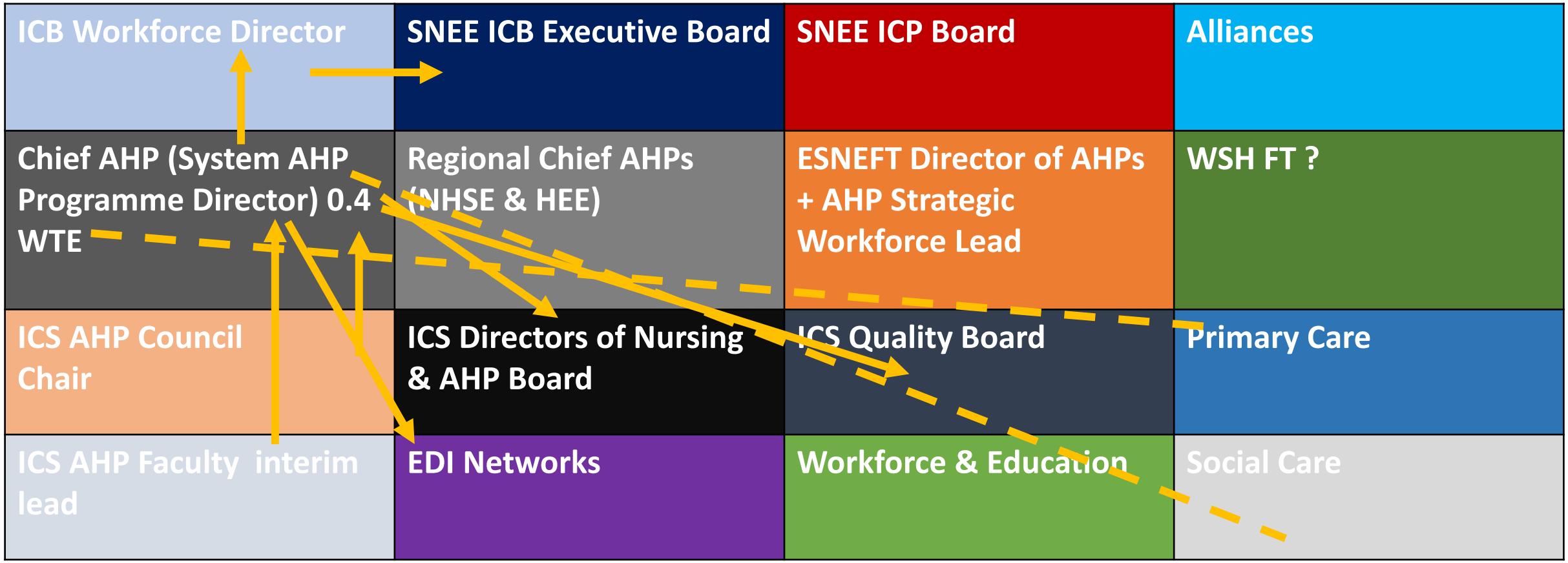
Four ‘Enhanced Foundations’

1. AHPs champion diverse and inclusive leadership
2. AHPs in the right place, at the right time with the right skills
3. AHPs commit to research, innovation, and evaluation
4. AHPs can further harness digital and innovation through data

Five ‘Areas of focus’

	People first	Optimising care	Social justice: Addressing health and care inequalities	Environmental sustainability: Greener AHPs	Strengthening and promoting the AHP community
AHPs champion and promote diverse and inclusive leadership	How can I ask and listen to “what matters to you?” for AHPs in my system?	How could I appreciate and celebrate the impact of AHPs in my system?	How well is AHP system leadership representative of the communities and professions the leaders are serving?	How could I hold the net zero agenda central to my system level decision making, and is my AHP community contributing to the delivery of my Green Plan (or equivalent)?	How can AHP leadership within the system effectively engage and advocate for the entire AHP community?
AHPs in the right place, at the right time, with the right skills	How can AHPs and the support workforce be supported to promote an increased focus on preventative care alongside social prescribing and community-based support?	How could diverse AHP roles and career development be supported within my system to optimise care provision?	How could I use the My role in tackling health inequalities framework to support career and skills development for AHPs from all personal and professional backgrounds?	What structures are in place to support AHPs across the system to work in greener ways, including promotion of public health and preventative healthcare approaches and access to current sustainable healthcare training?	How can I better support the physical and mental wellbeing of the AHP community to care for those who care?
AHPs commit to research, innovation, and evaluation	How could the ICS nurture a culture of ground-up research and innovation of care amongst the AHP workforce at all career stages?	How could the impact of AHP’s cross-clinical pathway working being measured and best practice shared to maximise high quality care provision?	How could I better understand and advocate for the roles AHPs could play to address health and care inequalities within the health system?	How could I support, collate and share examples of Greener AHP practice across my system, and learn from other systems to achieve a more sustainable delivery of care?	What support is in place for AHPs at all career stages to pursue research and innovation activities in support of the ICS as outlined in Allied Health Professions’ Research and Innovation Strategy for England?
AHPs can further harness digital technology and innovation through data	Are the digital needs and capabilities of the AHP workforce in my system and the people they support central in decision making?	How can the Digital Framework for Allied Health Professionals support my system to be digitally ready to provide optimised care?	How could digital tools be used to minimise the experience of health inequalities and achieve the ambitions outlined in AHPs Deliver?	What mechanisms could I have in place that enable AHPs to adopt technologies for greener healthcare with system wide benefits?	How can I better use data to understand the experiences of AHPs within the system to provide support to care for their health and wellbeing needs?

AHP Leadership influence & positioning



AHP Councils - Purpose

- Provide collective strategic leadership and advice to the ICS.
- Support & inform system transformation with the prime aim to secure ongoing improvement in value based clinical outcomes, facilitate transformation and integration and enhance the experience of care in the ICS
- Provide strategic advice, leadership and assurance related to the optimal use of AHP contributions to value, quality and transformation initiatives.

Areas to explore for AHP Faculties

- **Focus & added value** – what does this look like? Narrow or broad focus on W/force & Training ? Sustainable funding models.
- **Informing strategies** – Do the local priorities & the delivery approach maximise the contribution of **all** AHP professions?
- **System workforce plans** – Are these deliverable ? Sustainable? Well informed by underpinning w/f & training plans and projections?
- **Clinical Leadership** – amplifying the AHP voice across relevant forums and wider, maximising clinical strategies and optimising delivery
- **Training programmes** – ensuring content of training programmes develop to reflect the new & emerging collaborative arrangements of the ICS

AHP Faculty funding

Financial breakdown of allocated budget:	Ref. No.	Resource Description	Cost £
		AHP support worker programme: - 1 x 0.6 WTE - Support Worker Lead - Band 5 with Project Manager Role (entry point with on costs)	£19'479.60
		AHP Leadership Programme development - 1 x Research Lead + existing infrastructure to support this programme - Commission research team to lead this work	£19'500.00
		Develop a system-wide approach to the retention of newly qualified AHP staff-groups: - 1 x 0.5 WTE AHP Preceptorship programme lead - Band 7 with Project lead role (mid-point with on costs)	£21'027.00
		OT Workforce Project	£15'000 *

AHP Faculty deliverables

AHP 2 - Placement Recovery and Expansion

AHP 3 - Workforce, Data and intelligence ★

AHP 4 - Retention and Support for Students, Newly Qualified Workforce & Early Careers ★

AHP 5 - AHP Workforce Equity, Diversity, and Inclusivity (EDI)

AHP 6 - Quality

AHP 7 - Supporting AHP to Return to Practice (RtP)

AHP 8 - AHP International Recruitment

AHP 9 - AHP & Support Workforce Apprenticeships

AHP 10 - Leadership, System and Process Infrastructure ★

AHP 11 - Profession Specific Growth

AHP 12 - AHP Support Workforce ★

AHP 10 Leadership, System and Process Infrastructure

Gaps in formal AHP Leadership

- Integrated Care System
- AHP Faculty
- West Suffolk Hospital
- Social Care
- Primary Care
- Alliances

Developing a new to NHS leadership development programme

Inclusive Leadership Programmes (Common Purpose)

Innovations + Leadership + AHP Community

= IMPACT

Thank you!

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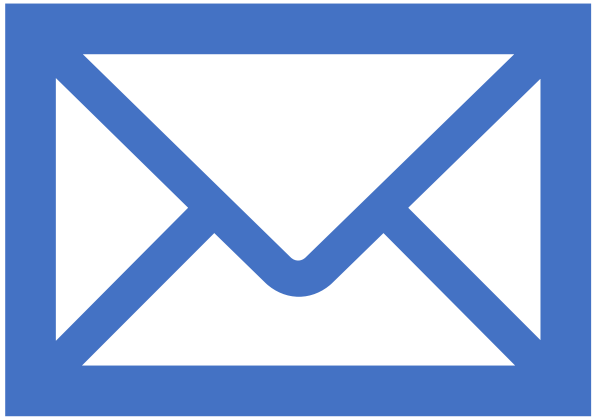
Twitter: @GBaliah

CAN DO
HEALTH & CARE



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ICB BOARD

Agenda Item No.	**14**
Reference No.	**ICB 23-08**
Date.	**24 January 2023**

Title	**SNEE Oral Health and Dental Services Commissioning Proposals**
Lead Director	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)	Greg Brown & Lizzie Mapplebeck
Purpose	For discussion and note

Recommendation:

The Board is asked to note the agreement of the ICB Executive to the additional funding set out for oral health and dental services and to commence the commissioning of services within SNEE.

1. Background

1.1 SNEE ICB has 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 regions MPs over the past 12 months to develop solutions to the present oral health crisis in the short, medium and longer term.

1.2 As the current responsible commissioner, NHS England is 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 has delegated the funding to NHS Suffolk and North East Essex ICB for distribution.

1.3 NHS Suffolk and North East Essex ICB is 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.

2. Grants

2.1 Grants of £2.78m proposed below meet the criteria for the funding received from NHS England and will support the ongoing work of local system partners.

Provider	**Cost**
1. Suffolk Public Health grant to support improvements in the oral health of the population. (as set out in Appendix 1)	£966,514
2. Essex Public Health grant to support improvements in the oral health of the population. (as set out in Appendix 1)	£320,929
3. Domiciliary and Specialist Dental Services Grants	£300,000
4. Suffolk Public Health grant for support for the Dental Taskforce for future use related to Oral Health priorities to increase access	Up to £1,200,000 Subject to approval by SCC
Total of all schemes	**£2,787,443**

3. Recommendation

3.1 The Board is asked to note the agreement of the ICB Executive to the additional funding set out for oral health and dental services and to commence the commissioning of services within SNEE.

Appendix One

1.1 Proposal Set One: Public Health Suffolk Proposals

Funds to be held by Suffolk County Council.

Initiative / Description	Cost
Keep Suffolk Smiling Packs • Build on current 'Keep Suffolk Smiling' project at 12-month child development check for additional packs to be offered at child's 2 Year check through Suffolk Health Visiting service. • Target vulnerable and isolated communities through venues such as food banks, family hubs and toddler groups for supplementary packs. • Translation of materials e.g. leaflets, digital content for greater understanding within vulnerable communities.	**£90,000** Cost includes all materials to cover next 5 years based on current birth rate.
Supervised Toothbrushing schemes in schools and early years settings. • Build on current early years and school settings engaged in programme to expand provision to cover age range of children 2-8 years old and look into healthy meals and cookery classes. • Develop programme for older age groups and promote reduction of sugar with programmes to offer initiatives such as healthy vending machines and reducing energy drinks. • Link with work already undertaken through OneLife Suffolk for engaging schools and build on their healthy school programmes.	**£207,370** Cost includes materials to cover next 2 Years of schools.
Community Varnishing programme in community • Dental Varnish is one method of fluoride treatment, which involves applying a varnish rich in fluoride to the enamel, to help strengthen it and protect against caries. • Recruit 2 x Community Staff Nurse on fixed term contract for 2 years to offer teeth varnishing with outreach scheme to target vulnerable communities (similar to previous COVID-19 vaccination scheme). • Use of potential public health containers for mobile clinics to act as venue for scheme or rent local premises in community for easy access. • Project could provide two Fluoride Varnish applications per year to children aged 3-10 years, in children's centres, the most deprived schools (up to year 5) and other selected early year's settings. • The programme would need sign off from NHS England Oral Health Consultant.	**£205,341** Cost includes staff for 2 Year delivery.
Training for key partners in Early Year setting, Schools and Health Care Professionals • Training programme targeted at early years and school staff to champion healthy food and drink advice which will tie into supervised brushing schemes. • Training programme for health care professionals run across East and West Suffolk.	**£87,670** Cost includes 2 x 0.5 WTE staff to deliver training over 2 years.

Community clinics for vulnerable families • Offer community clinics for dental assessments and care including extractions for families who are not registered with NHS Dentistry services and who currently receive universal credit. • Reduce waiting lists for vulnerable groups such as Looked After Children (LAC) by offering easy access into community clinics. • Additional staff will be needed to run clinics on fixed term contracts. • Potential use of current provider clinics or work in partnership with Primary Care to find alternative venues within community.	**£195,341** Cost includes 4 x 1.0 WTE's over 2 years
Coordination and promotion of oral health projects • Band 5 Coordinator to implement project for Public Health on behalf of SNEE ICB with provider. • Management costs for procurement of oral health projects. • Use of digital platforms to promote oral health projects across Suffolk.	**£180,792** Cost includes 1x1.0 WTE over 2 years. (potential joint post)
Total	**£966,514**

1.2 Proposal Set Two: CDS Proposals (North East Essex)

Funds to be held by Essex County Council.

Initiative / Description	**Cost (excluding VAT)**
Oral Health Training and Supervised Toothbrushing Programme (STB) • To deliver a STB programme in 25 early years settings across targeted areas in North East Essex (using the Index of Multiple Deprivation (IMD)) to encourage settings to adopt tooth-friendly practises and reduce tooth decay.	Year 1 - 15 settings - £15,450.00 Year 2 – 20 Settings - £22,660 Year 3 – 25 Settings - £31,157.50 Total: £69,267.50 For 3 years
Oral Health Training and Implementation of Lifelong Smiles Programme • To deliver evidence-based Oral Health training (across 30 settings) via the Lifelong Smiles training programme to ensure care homes are achieving best practice, CQC compliance and implementing the Quality Standards to improve the oral health of residents. • The implementation of this programme will include providing settings with a resource pack, a set of standards, advice, guidance and support on how to achieve standards, and	Year 1 - 10 settings - £6500.00 Year 2 – 20 Settings - £14,300.00 Year 3 – 30Settings -

monitoring and evaluation to provide assurances and compliance of the programme.	£23,595.00 Total: £44,395.00 For 3 years
Young People Oral Health Champions Programme (Peer-Led) • To deliver a bespoke Young People Oral Health Champion training programme in 45 primary schools across targeted areas in North East Essex (using the Index of Multiple Deprivation (IMD)) to encourage schools via a peer-led approach to adopt tooth-friendly practises and reduce tooth decay. • The implementation of this programme will include Young People Oral Health Champions playing a significant role in increasing awareness about the importance of oral health	Year 1 - 25 settings - £23,762.50 Year 2 – 35 Settings - £36,594.25 Year 3 – 45 Settings - £51,754.50 Total: £112,111.25 For 3 years
Keep Essex Smiling • Target vulnerable and isolated communities through venues such as food banks, family hubs, community supermarkets, and toddler groups for supplementary packs. • Materials eg leaflets, digital content for greater understanding • within vulnerable communities.	**£50,000** for 2 Years **(Incl. VAT)**
Total (Incl. VAT)	**£320,928.50**

1.3 Proposal Set Three: Domiciliary and Specialist Dental Services

Funds to be held as agreed with an MOU and directly awarded to the providers as below.

Initiative / Description (for 1 year initially)	Cost
Domiciliary and Specialist Care Suffolk • Provided by Cambridge Community Services (CCS) • Aim to reduce the expected waiting list for Domiciliary and Specialist Care Dentistry in Suffolk, and support wider dental initiatives from 1st April 2023	**£200,000**
Domiciliary and Specialist Care North East Essex • Aim to reduce the expected waiting list for Domiciliary and Specialist Care Dentistry in north east Essex and support wider dental initiatives from 1st April 2023.	**£100,000**
Total	**£300,000**

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ICB BOARD

Agenda Item No.	**15**
Reference No.	**ICB 23-09**
Date.	**24 January 2023**

Title	**Suffolk and North-East Essex (SNEE) Alliances – Highlight Reports**
Lead Director	Alliance Directors
Author(s)	Alliance Directors
Purpose	To receive highlight reports from the following Alliances: a) *Ipswich and East Suffolk Alliance* b) *North-East Essex Alliance* c) *West Suffolk Alliance*
Recommendation: To note the reports	

Ipswich Suffolk Alliance Committee January 2023

Our vision is that 'Ipswich and East Suffolk is a place of strong communities in which everyone is able to stay well, take control over their mental and physical well being and when support is needed, receive joined up care'

'Working seamlessly together with you'

Being

Collaborative – Co-ordinating – Creative – Courageous- Compassionate - Community -focused; Creating One Team; Cost-effective

This report includes:

- A summary of the key items discussed and approved by the Ipswich and East Suffolk Committee in December and items for consideration at its meeting in January (being held subsequent to publication of these papers)
- A summary of items and decisions of the Executive Delivery Group in January 2023
- Summary progress from other workstreams including Integrated Neighbourhood Teams and the One Team programme

Other positive matters for reporting include:

- A new Steam Café has opened in the centre of Ipswich; a supportive community mental health and emotional well-being venue
- Suffolk Primary Care, which includes six practice teams in Ipswich and East Suffolk has been rated 'good' with 'outstanding' leadership by the Care Quality Commission
- Suffolk Multi-Cultural Services, one of our social prescribing partners, was this week presented with one of Her Majesty's final awards for Voluntary Service excellence in acknowledgement of their outstanding work.
- Over 90% of all participants in the mental health and well-being focused One Team programme have sustained their participation including in a Joint Enquiry with senior leaders and progressed to develop collective service development projects in their INTs

Alliance Committee Reports (December 2022)

The Committee received a Director's Overview Report in respect of ICB delegated functions including integrated commissioning processes, performance, transformation, patient safety and governance. The Director focused particularly on operational resilience including the urgent response to Strep A and other respiratory conditions.

The Committee received a focused report on the **Start Well** domain including partnerships; social care and youth justice services; community health services; education, learning and skills; children's physical - and mental health; governance and critical alignment; strategic oversight; priorities; Suffolk mental health and Suffolk therapeutic services.

The Committee also considered the Alliance's financial report which indicated a current underspend in mental health and community services (due primarily to recruitment challenges) but which remained committed and an overspend against the prescribing budget, arising from supply issues but which could, at this point, be offset by non recurrent reserves.

Alliance Committee (January 2023)

The January Committee will be held on the date of publication of the ICB Papers. Understanding and respecting immense current operational pressures, the meeting will be of just one hour and focused on decisions. The agenda will include: (1) the Director's Report focused on: performance; priorities for the final quarter of 2022/23; and development of the forward plan; as well as (2) integrated 'end to end' quality reviews; and (3) mental health.

Highlights of Groups reporting into Alliance Committee (January 2023) - Executive Delivery Group

This month the EDG met virtually to consider and approve:
•Operational pressures and priorities for Alliance action
•Strategic priorities for Quarter 4 of 2022/23
•Performance against ICB delegated metrics
•Financial performance (core budget and Alliance Health and Care Fund commitments).
•ICS strategy
•ICB Joint Forward Plan
•Suffolk All Age Carers Strategy
•CORE 20PLUS 5 for children and young people

The Executive Delivery Group is recommending to the Committee that by the end of Quarter, the Alliance would have:
1.Stabilised and improved operational resilience
2.Completed forward INT plans based on population health management insights
3.Initiated development of dedicated plans for Ipswich and Felixstowe
4.Begun co-production of 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 pharmacy, dental and optometry commissioning and developed outline plans for integration at Alliance level
7.Concluded the agreed community MH model specifically related to the role of Mental Health Practitioners,
8.Established the refreshed Alliance Workforce Operational Group and forward estates plan (within respective ICB contexts), specifically including next steps in our partnership with the University of Suffolk
9.Agreed a forward financial strategy within the ICB framework
10.Further evolved the Alliance's governance and management including completion of the Alliance's refreshed forward delivery plan

Highlights of Groups reporting into Alliance Committee

The Primary Care Commissioning Group will meet for the second time on Tuesday 24th January. The Group will be asked to consider and approve as appropriate to item: practice resilience; practice leases; a Quality Support and Stability Payment; childhood immunisations in Ipswich; clinical waste; performance; Care Quality Commission inspection outcomes; and financial performance. The Group will report to the December meeting of the Alliance Committee.

All Integrated Neighbourhood Teams met on 13th December with sponsors and aligned Public Health colleagues to consider progress and newly published Population Health Management data and insights. Each INT is now developing its local plan. People at risk of falling and housebound people were priorities for almost all INTs.

The **Suffolk-wide transformation and performance of Mental Health and Emotional Well-being Services as well as Children's Services** are reported separately to the Board

NEE ALLIANCE COMMITEE

High Level Domain Objectives

	**Start Well:** Improving emotional wellbeing and mental health of children and young people.
	**Feel Well:** Reducing suicide rates, with an ambition of zero suicide
	**Be Well:** Increasing the proportion of physically active people across North East Essex
	**Age Well:** Improving the support of people living with frailty and their carers.
	**Stay Well:** Supporting people to live independent lives through integrated intermediate care.
	**Die well:** Support an increased number of people to die in their preferred place of death.

Elizabeth Amodio – Head of Alliance Development
Laura Taylor-Green - Alliance Director
14th Oct 2022

Key activities completed this month (December 22) (Part 1)

Start Well Spotlight Report
The committee received a detailed overview of the Start Well spotlight report, with continued focus on the emotional health and wellbeing for children and young people.
The Childrens and Young Peoples partnership role had recently been appointed to at ECC, who will join the ICB lead as the joint Start Well domain lead. Focusing on educational needs and access to skills and development was agreed as a priority, with the agreement that an updated dashboard will be shared with the next update due in March 23.

Medicines Optimisation Update
The Committee received the update, highlighting financial pressures in relation to the prescribing forecasts and agreed this would continue to report on a quarterly basis.

Alliance Executive Group Highlight Report
It was outlined that no AEG meetings took place during November in their usual format, with two system workshops taking their place focusing on (1) Harwich Place Planning and (2) Thinking Differently about Intermediate Care. Both workshops were received well with confirmation that dates are being put in the diary for Jan 2023.

Alliance Finance Highlight Report
It was confirmed that as of M7, the NEE Alliance is currently on track, however the committee acknowledged the prescribing forecasts as per the medicines optimisation up-date. It was announced in the Autumn statement that additional funds will be made available with further information due to follow in Jan 23. There was no further action for the Committee to take at present, with slippage plans ready to be circulated to the group.

Contract Checklist
To support the transformation of the Alliance and decision making process for contacting, a contracts checklist had been created and shared to ensure project managers are supported and all key information is picked up at the beginning of each project.

Primary Care Commissioning Group Report
The Committee were informed that this group has now started, meaning there will be less discussion around some of the primary care elements moving forward, with a highlight report being shared with the Committee instead. It was confirmed that the group will also see responsibilities around dentistry and eye care when delegated to the ICB.

Groups reporting into Alliance Committee – December Updates

Alliance Executive Group - The Alliance Executive Group did not meet in its usual format for the month of November, but had two focused system workshops as outlined below;

Harwich Place Planning Workshop

- The purpose of this workshop was to provide dedicated time to Alliance partners to have a specific health outcomes placed discussion focused on the Harwich and Dovercourt locality. The emphasis being placed on how we build on the positives that are already in place which will help address some of the identified challenges moving forward.
- It was recognised that the Freeport East presented a real opportunity for Tendring and its communities and this needs to feature as a key part of the plan.
- Travel and access to services was raised as an area of focus with many residents finding it easier to travel to Colchester than other sites within the same district e.g. Clacton hospital and how we need to consider location of services.
- An engagement piece of work was agreed as a key next step to understand from the residents of Harwich what it is like to live in Harwich and what is important to them, aligning to the live well neighbourhood team model.

Thinking Differently about Intermediate Care (IC)

- This session was supported by Newton Europe who are working with Essex County Council to review intermediate care services. This included an overview of what good intermediate care looks like, reviewing examples of best practice across the country.
- Recognised system challenges facing intermediate care including ability to recruit, workforce retention, the need for a clear and collective system vision, available information that is readily understood by all system partners.
- Three themes were identified for further system discussion to inform next steps of programme; (1) Maximising independence, (2) Making the most of our own staff capacity (3) Positive resident and staff experience. These themes were considered within discussion groups covering the IC pathway including Bedded care, prevention and admission and home based care.
- A number of key recommendations made including setting up working groups to support continuing progression, with further updates to be shared with the Alliance Exec Group.

Alliance Operational Group

- The primary care operational report was received with highlights including (1) progress on the PCN maturity matrix, (2) increased access via GP community pharmacists consultation service to avoid demand in primary care and other providers, (3) further roll out and awareness of additional roles leading to extra primary care workforce.
- EEAST noted that whilst demand was decreasing, acuity was increasing, handover to clear times were reported as good and improving within NEE.
- Performance in ED was reported – weekly executive led performance meetings continue, with an audit of plans at 2 hours undertaken the week commencing 14th November.
- Continued focus on ensuring all beds are declared in a timely way, all pathways are used consistently and the ‘flo for flow’ programme is fully implemented to ensure any exit blocks are removed consistently.

Alliance Quality Committee

- It was reported that the Alliance Quality Group did not meet this month however arrangements for an Alliance Quality Group development session is underway. The purpose of the session will be for all relevant stakeholders to agree how we get assurance in relation to our delegated functions (primary care, medicines management and community services). In addition, the group will be encouraged to consider how we can respond as an alliance to quality and patient safety concerns as they emerge.
- STOMP - Nursing and Medicines Management colleagues have agreed to set up a task and finish group which deals with the performance in NEE in respect of the overmedication of people with learning disability (NEE are an outlier in Essex).
- Primary Care and Deputy Directors of Nursing and quality colleagues have almost completed the first draft of the SNEE Primary Care Assurance Framework. This is due for socialisation with key groups and stakeholder is in the coming weeks. BI are assisting with primary quality dashboard development.
- The Primary Care Team, Quality Team and contract colleagues in NHSE continue support primary care providers in either responding to CQC concerns and in improving their processes (with a view to supporting readiness for inspection by the regulator).

NEE ALLIANCE COMMITEE

High Level Domain Objectives

	**Start Well:** Improving emotional wellbeing and mental health of children and young people.
	**Feel Well:** Reducing suicide rates, with an ambition of zero suicide
	**Be Well:** Increasing the proportion of physically active people across North East Essex
	**Age Well:** Improving the support of people living with frailty and their carers.
	**Stay Well:** Supporting people to live independent lives through integrated intermediate care.
	**Die well:** Support an increased number of people to die in their preferred place of death.

Elizabeth Amodio – Head of Alliance Development
Laura Taylor-Green - Alliance Director
01st Nov 2022

Key activities completed this month (Jan 23) Part 1

SNEE ICB Joint Forward Plan Update
A high level outline of the SNEE ICB 5 year joint forward plan was shared with the Committee. It was confirmed Alliance partners have contributed to the contents of the plan, with intention of utilising primary care networks to engage primary care. A more detailed draft will be shared with the Committee in Feb 2023.

Alliance Review
Three workshops dates have been circulated to Alliance partners happening through February and March. An outline of the intention of the workshops was shared with Committee which includes (1) Reviewing and setting Alliance aims/ambitions (2) Shape specific shared Alliance projects (across 3-5 years), (3) How we engage and work collectively moving forward. A core group will develop the content for each workshop, with the actual workshops to be externally facilitated.

Procurement Update
The Committee received an overview of the current procurement updates for the ICB, which supports and aligns to the contracts checklist received by the Committee previously.

Stay Well Domain Spotlight Report
The domain lead presented an overview of progress within the Stay Well domain. This is included the early findings that are coming through the community asset deep dive in to Stay Well and the development of 'I statements' and patient activation measures for specific long-term conditions.

Alliance Finance Highlight Report
The report detailed the forecast for year-end finances. Including detail of further reimbursement from NHSE for the Additional Roles Reimbursement Scheme. Underspends in Community remain at the same level as month 6, the remaining variances are driven by mental health and primary care.

Discussions on finance will continue within both the Alliance and through the ICB with up-dates agreed to be brought back to Alliance Committee.

Groups reporting into Alliance Committee

Alliance Executive Group

- The group received an update on the early intervention vehicle, with aim to reach approval by April 23.
- An update to the WELL group was received, including a change of chair.
- An overview of the Children's and Young Peoples transformation was provided to the group.
- Lessons learnt and recommendations provided on the GP Training on green prescribing was provided, with actions agreed to address the challenges highlighted.
- An overview of the Housing Funds Initiative for Jaywick Sands lead by TDC from the Alliance funding allocated. Opportunities were identified to work closer with councils to support how we can link and work with multi-use spaces.
- The group received the Stay Well domain spotlight report with progress noted, especially in relation to the ward enablement project. actions agreed to make further link in with public health.
- The trusted assessor model for Colchester General Hospital was presented. AEG agreed to support this proposal in principle but requested clarification around funding and procurement processes needed due to mitigate and conflicts of interest.
- The Alliance highlight report was shared in an updated format. Highlights included the neighbourhoods away day, the outputs of which will be presented to AEG at the end of Jan.
- Cost of living remained as a standing item, TDC highlighted they have delivered the first of their cost of living drop in sessions, an additional £100k has been allocated to their community fund to support these pressures and confirmed their dedicated webpage is now live. Colchester updates included publication of a promotional cost of living support video.

Alliance Operational Group

- Group received an update on the work provided by voluntary sector partners supporting people to live well including, support manage the cost of living pressures.
- Update received that ECL now achieving 100% of block hours compared to 80% in August – using MDT approach to establish learning from failed starts. NEE is currently highest performing for the number of people that go on to be self-caring (64%).
- An update of the Ward Enablement Pilot was provided, this launched on 3rd October with successful outcomes to date, supported by positive feedback from all staff involved.
- IUC performance overview was provided, Further information to be provided at a future group on other developments including care home advice line and integration with the urgent treatment centre at Colchester.
- The group noted the funding update report with the recommendation to Alliance committee to agree the additional funding via adult social care winter discharge fund to continue service with discussions within ICB to look at potential for recurrent funding in the next planning round.

Alliance Quality Group

- It was reported that the Alliance Quality group is undergoing some development to reflect the delegated duties in relation to quality assurance for Primary Care, Community and Medicines Management, whilst also reflecting the needs of Alliance partners for the quality group.
- Assurance was provided that an Alliance Quality Committee report will be shared moving forward, following some review on format and timing.
- The Committee were made aware that NEE resilience calls to support all system partners operational responses have increased from bi-weekly to weekly from January until March 23, when the frequency will continue to be reviewed in order to support the management of system pressures.

Overview

We have learnt this and need to share it…

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.
Three Alliance development sessions have also been scheduled for February and March as an opportunity to review Alliance priorities and ways of working.

We need help with…..

No new requests of the ICB.

We have the following risk and issues

No current risks to escalate

Any resource issues to flag…

- The impacts of the cost of living impacts is elected to have operational difficulties for some services, discussions across partners continue in order to understand the learnings and inform mitigation plans.
- Sustained operational pressures place competing demands on some of the domain leads/ Alliance partners.

Key Activities for January/ February

- Alliance development workshops
- Distribution of funds form Feel Well domain programme.
- Evaluation of Start Well bids received.
- To launch Age Well and Be Well application process
- Wider mental health transformation update to be received.
- Further joint forward plan updates to inform Alliance Local Delivery Plan.
- Circulation of the End of Year review.
- WELL group report to be shared with partners for comment.
- Review of Alliance Operational Group TOR.

WEST SUFFOLK ALLIANCE
about people & places

Overall RAG

Alliance Committee December 2023

Our goals

- Empower people to live healthy and connected lives
- Create environments that enable people to thrive
- Develop services that are joined up, accessible, responsive and wrapped around people and families in the communities in which they live

Part 1

Health Inequalities and Cost of living

The Committee received three reports

- Public Health Report on Core Plus 5 approach. Committee agreed a local group was established to progress the recommendations and embed into each of the Live Well Domains, linked to ICS-wide Health inequalities group.
- Healthwatch Report on Poverty. Suffolk-wide work has commenced and Alliance partners will contribute and review findings in due course
- Community Action Suffolk: Cost of Living impact on VCSE. Noted the major pressures being felt. Reporting back to a future Committee on next steps.

Update on Discharge Funding

- The Committee heard how the national funding to social care was allocated locally to support the discharge of people from the acute hospital. The impact of the spend will be managed through the Better Care Fund led by Suffolk County Council.
- The committee approved the spending plan in west Suffolk and agreed to offer executive support to staff operationalising the plan locally.

Die Well Domain

- The Committee received and approved a paper highlighting the priorities for the Die Well Domain

Start Well Domain

- The Committee received a briefing from the children and young people service on the current challenges.

Part 2

Director Report

The Committee received and noted a report from the Alliance Director. Members were pleased to note the Good CQC rating for the provider "Suffolk Primary Care Services".

Alliance Finance Report

The Committee received and noted a report from the Finance Officer which outlined an overspend on the primary care prescribing budget. The Alliance Director said a process was in place to review the spending position and report back to the Committee

Primary Care Estates

The Committee considered a paper on the current and forecast deficit in space for primary care medical services in west Suffolk with a particular challenge in Bury St Edmunds. The Committee notes that the ICB and Alliance partners are working closely together to develop an Alliance based estates strategy. The PCN estate element of this will be considered at the March Committee with a business case for the Bury Town challenges in June 2023

Diabetes performance

The Committee received an update on the Diabetes performance and noted that whilst some of the low achievement relates to data quality issues, an underlying performance challenge across many practices was evident. It was agreed to bring an update to Feb Committee

Highlights this month (December) Groups reporting into Alliance Committee

Operational Resilience Group - Sponsor: Nicola Cottington, Stay Well Domain

The Committee was informed of the following updates:

- Seasonal Plan signed off and funding streams aligned. First report on progress around delivery due to next Operational meeting 17 January. Due to on-going internal pressures at WSFT, acute scheme reporting has been temporarily paused whilst the Trust looks at the new 'Right care, Right place, Right time' programme. This is to enable work on internal pressures in a targeted approach.

  First oversight meeting taken place to report on national ACS Discharge funding. Bi-weekly reporting template under construction and being led by ACS. Data being collected from ACS and WSFT discharge data for schemes funded by ACS Discharge funding. Planning has commenced for schemes able to be rolled over into 2024 with recurrent funding.

- Increased pressure and scrutiny on arrival to handover delays especially with impending industrial action from both RCN and ambulance service (EEAST not a part of industrial action, however during last strike day East of England was one of the worst performing for AtoH delays). C2 performance also a challenge for EEAST. Mental health have coped over the holiday period but remain with high demand.

- A challenging period over the Christmas/new year period across the system. Acuity of demand remains high across all urgent and emergency care services with particularly high level of respiratory needs. Workforce challenged by high levels of sickness and competing demand.

- Over 50 additional community step down beds have been created to maintain flow whilst the acute trust manages higher than usual admission rates. Further community beds are being considered.

- Planning commenced to develop system lessons learned and refreshed plan for 2023. Review of scheme challenges, blockages and also positive outcomes to be undertaken.

- Virtual Ward continues to struggle to achieve level of occupancy and currently under review.

Quality Group

The Committee received a report from the Quality Group that outlined the following updates:

- Quality assurance/patient safety visit to WSFT and Newmarket Hospital with a focus on falls and frailty was undertaken in October
- Infection Prevention and Control surveillance continues and new governance framework for the ICB awaiting sign off
- Two primary care CQC inspection reports received with Good ratings

VCSE network and engagement – Sponsor: Ian Gallin/Kathy Nixon, Be Well Domain

- Community Discovery report completed and shared with Alliance Delivery Groups. Next steps are to develop a communication and engagement plan to consider how to use the findings inform our longer-term approach to how we work with communities
- Volunteer MDT that was stood up to bring the voluntary sector together at place is now renamed as a VCSE network meetings , this continues to have good engagement from contacts across the VCSE. Additional funding to develop this further as part of the system approach to supporting flow and discharge.

Integrated health and activity - Be Well Domain

- Three new managers have started in post in Haverhill, Sudbury and M&B appointed to rollout physical activity model in 3 localities in West Suffolk. Leadership group agreed to consider approach to work with wider system to agree priorities for increasing activity across population.

Social Prescribing core design team – Be Well Domain

- Recruitment complete for additional Life-Link Co-ordinators within Integrated Neighbourhood Teams
- Service spec written and signed off for green social prescribing with Green Light Trust as part of redesign test and learn and supporting flow and discharge. Plan to take to PCN and high intensity user MDT next month
- inequalities data has been framed into a database for LifeLink social prescribers to take a needs based approach to developing a case load

Population Health Management – Sponsor Nicola Cottington, Stay Well Domain

- Task and finish groups progressing through the implementation of the waiting well T&O project. Go live is predicted to be early 2023. The trust has created a draft website for First Outpatient appointment average waits per speciality. Plan is to build upon to include estimated waits for surgery.
- Cerner have started the mapping exercise of primary care data for inclusion into the PHM dataset. Starting with Glemsford, Breckland and Forest Heath practices. This exercise is lively to take approx. 3 months.
- Atrial Fibrillation – DSA complete and dataset shared with University of Essex for evaluation. EAHSN bidding for funds to extend the work – decision due in early November.
- Frailty risk stratification – Follow-up care complete and letters in progress (n=30) to be sent. Data collation and evaluation underway. Respiratory risk stratification – Agreed to focus on Breckland PCN service gaps initially.

Future System community group – Stay Well Domain

- The Denosumab surveys for the baseline evaluation show 72 responses of which 64 were fully complete. The evaluation paper is currently in production to fully analyse the results.
- A presentation has been produced for the two localities that were part of the FSP workshops carried out earlier in the year, to establish what is working well in the area as well as identifying gaps and needs (M&B and Haverhill). These have been supplied to the respective locality lead. The presentations can be supplied upon request.
- The December meeting where the Demand and capacity modelling for the community services (including adult social care) is an agenda item looked at the progress made with the aim to agree the assumptions and continue with the modelling for the first few weeks of January. The output is then planned to be shared a the 19th January meeting.
- The Haverhill FSP Locality mapping work has now completed and a number of areas of secondary care provision have been prioritised to explore transfer to community.

Diabetes Recovery Group – Sponsor Nicola Cottington, Stay Well Domain

- The Group is specifically focussing on recovery of delivery of the 8 primary care processes. 24/25 practices (Ixworth in progress but not part of the Enhanced Service) are now extracting to Eclipse, but we are aware of 2 practices with ongoing data discrepancies.
- Latest data is showing little improvement and West Suffolk are now below national average (QOF year to date). Analysis of lower performing practices shows care processes are being completed, but many patients are outstanding 1 or 2 of the checks. Completion of these outstanding checks would bring these practices up to around 50% completion of all 8 care processes.
- Dr Jon Ferdinand is to meet with these practices to discuss performance and what else could be done to support them to improve. Data on WSFT performance has been requested to ensure performance across the entire pathway is being reviewed.
- Programme Group in development to review the end to end Diabetes pathway in West Suffolk under the Stay Well Domain.

Age Well Domain – Sponsor: Clement Mawoyo

The initial mapping for the Domain is complete and the priority detailed mapping is currently being developed though an Age Well Steering Group. Domain to include the following areas:

- Dementia, Frailty, Carers, Loneliness and isolation. Adult Social Care Reform and Care Market Resilience will also sit within this domain. The Initial mapping for this Domain is to be received by the January Committee

Die Well Domain - Sponsor: Sue Wilkinson, WSFT

- The Alliance Committee signed off the Die Well Domain priorities at the December meeting
- Recommended Summary for Emergency Care and Treatment (ReSPECT) steering groups have been set up and inaugural meeting held and the project is on track to launch in March on schedule
- RoSI –project on pause currently with Bury Town PCN - System wide conversations underway to support and a number of technical challenges being worked through to ensure stability of system.
- Access to specialist palliative care is now law and a new commissioning model for hospice services shows that this should be ICB funded however this does not come with additional funding.
- Patient and public engagement project (ICS wide) underway with online End of Life programme, people and community engagement tool established and a series of online discussion topics to host conversations throughout November and December with end of life patient engagement survey launched via the 'Lets talk SNEE' platform
- SNHC Care home project – One year project with St Nicholas's Hospice to support adjustment to loss and improve wellbeing following bereavement. The project has started in 3 care homes and will roll out to 3 more every quarter over one year. Volunteers have been trained to provide reflective practice, bereavement cafes, St Nick's chat and memorialisation. The support is given to residents, recently bereaved families of residents and care home staff. The volunteers will work with the care homes for 8 weeks which is followed by a period of evaluation.
- HEST - Six month evaluation of St Nicholas Hospice Extra Support Team (HEST) underway looking at outcomes and patient/system benefits. Task and finish group continue to explore further enhancement of service to include overnight specialist support

Localities Enabler – Sponsor: Molly Thomas-Meyer, Consultant in Public Health and Christine Abraham, CEO, Community Action Suffolk

The initial mapping is complete and a working group to progress the detailed asset mapping has been developed. Initial priorities include:

- Asset and service mapping
- Coterminous boundaries between INTs and PCNs
- Establish locality groups

The initial mapping and next steps are being presented to the January Alliance Committee

Digital Change – Current Sponsor Clement Mawoyo, Digital Domain

- The CASSIUS + project achieved clinical safety for sign off and is live.
- The Cassius + DPIA was approved by WSFT IG and I.T department. This meant clinicians could access the data on the secure portal.
- The first two patients were referred to CASSIUS + monitoring these were from the heart failure cohort.
- We hosted the first CASSIUS + meet the team session.
- We stood up regular "data review workshops to support the clinicians. We attended change co-ordinator meetings for the living well domains and produced our first draft of the "digital enablement" domain to be presented to WSA committee in January
- We presented our "case for change" to key stakeholders and have been asked to deliver a business case to support this by the end of January 2023.
- The digital change working group will be increased to monthly sessions to increase momentum of the digital change agenda.
- We completed mapped the roles of each member of the group in achieving our aims.
- We met with maternity to begin conversations about how digital can assist "starting well". These conversations will be expanded.
- The clinical practice reference group started to identify clinicians who would be willing to lead their specialities in the digital change agenda offer their support.

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Integrated Care Board

ICB BOARD

Agenda Item No.	**17**
Reference No.	**ICB 23-11**
Date.	**24 January 2023**

Title	**NHS Suffolk and North-East Essex ICB Finance Report**
Lead Director	Howard Martin, Director of Finance
Author(s)	Howard Martin, Director of Finance
Purpose	To provide the Board with the current financial report.
Recommendation: To note the report.	

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NHS Suffolk and North East Essex ICB Finance Report

Month 8 2022/23

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ICB Report

Month 8 2022/23

ICB Key Financial Metrics Month 8 2022/23

Suffolk and North East Essex

	Month 8	Forecast	
Surplus / Deficit	G	G	The year to date and forecast position remains on plan for break even.
Efficiency Delivery	A	A	Efficiency forecast is at £15.1m of the £17.3m target (87%). The under delivery is still manageable within the financial position.
Running Costs Limit	G	G	The forecast is an underspend against of £1.1m against the annual limit.
Mental Health Investment Standard	G	G	The forecast is for an overachievement; £149.1m vs a target of £148.3m (0.5%).
Net Risk	G	G	It is anticipated remaining reserves for inflationary pressures are still sufficient to offset risks for the remainder of the financial year.

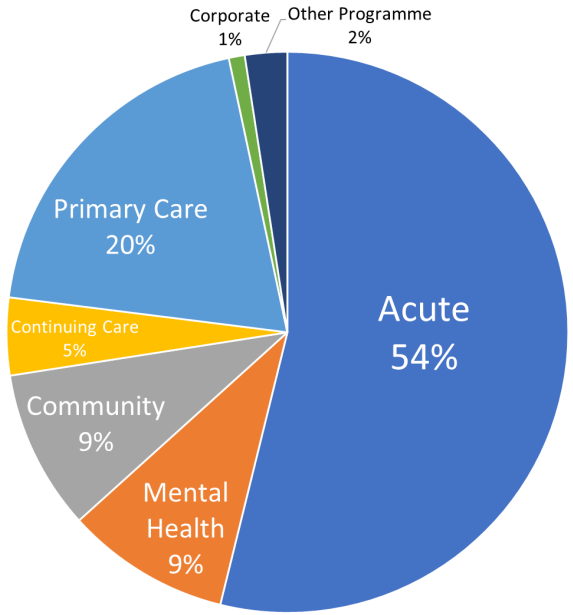
G On plan

A Adverse variance to plan within manageable tolerance

R Adverse variance to plan above manageable tolerance/risk to financial duties

Annual Funding & Expenditure by Category

Funding Type	2022/23 (CCG + ICB) £m
Core Programme	1,777.7
Delegated Commissioning	176.3
Running Costs	19.4
Total	**1,973.3**
Control Total Surplus/(Deficit)	Break Even
Forecast Surplus/(Deficit)	Break Even



ICB Summary Position at Month 8 2022/23

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The ICB has reported a balanced position for Month 8 and a balanced forecast post reimbursement of Additional Role Reimbursement Scheme (ARRS) costs of £3.3m.

The largest areas of cost pressure continue to be:

- Primary Care Prescribing due to increases in national pricing concessions by £4.8m above the previous year
- Continuing Care due to increasing demand, complexity and the knock on impact of the Local Authority Fair Cost of Care exercise.
- Independent Sector acute activity continues at significantly higher than historic levels to support waiting list improvements and funded through the Elective Recovery Fund.

Remaining reserve balances for inflation (£5m) and Covid (£2.5m) should be sufficient to mitigate against further increases in costs for the final quarter of the year.

Category	1 Jul 22 to 30 Nov 22 YTD			Forecast to 31 Mar 23		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Revenue Resource Limit (in year)	838.8	838.8	0.0	1,494.8	1,494.8	0.0
CCG 22/23 Surplus b/f	11.7	11.7	0.0	11.7	11.7	0.0
Anticipated Reimbursements	0.0	0.0	0.0	0.0	3.3	(3.3)
TOTAL REVENUE RESOURCE LIMIT	**850.4**	**850.4**	**0.0**	**1,506.4**	**1,509.7**	**(3.3)**
Acute	458.0	456.6	1.5	813.1	812.9	0.2
Mental Health	81.9	79.8	2.1	145.1	142.8	2.3
Community Health Services	78.7	77.7	1.0	140.6	139.3	1.3
Continuing Care	37.1	36.3	0.8	66.2	67.4	(1.2)
Primary Care	90.1	88.8	1.3	158.6	159.0	(0.5)
Delegated GP	76.5	74.3	2.1	137.7	137.6	0.0
Corporate	8.5	7.4	1.1	15.0	13.9	1.1
Other Programme	19.6	29.6	(9.9)	30.2	36.7	(6.5)
TOTAL EXPENDITURE	**850.4**	**850.4**	**0.0**	**1,506.4**	**1,509.7**	**(3.3)**
IN YEAR SURPLUS/ (DEFICIT)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

ICB Headline Commentary Month 8 2022/23

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Acute - The underspend to date is mainly due to timing of plans for SDF (£0.2m), Maternity (£0.3m), System Resilience (£0.6m). Forecast Independent sector over performance is circa £2.5m which is funded through Elective Recovery Funding (ERF).

Mental Health – The Year to date and forecast underspend is being driven by reduced individual packages of care compared to budget in both mental health and LD placements in addition to investment slippage in the main Mental Health contract (EPUT and NSFT). However, the ICB is still forecasting to exceed the Mental Health investment standard.

Community - Year to date and forecast underspend being driven by Ageing Well investment slippage due to recruitment delays and some funding (£0.2m) yet to be committed and non NHS contract underperformance (£0.2m).

Continuing Healthcare - The forecast position deteriorated by £1m in month to a deficit position, as the upward pressure on packages of care and the increased costs due to the knock on impact of the Local Authority Fair Cost of Care exercise. Analysis by place shows the overspend this year is being driven in West Suffolk with costs forecast in excess of £1.5m more than the plan. Staff vacancies are currently being mitigated by outsourcing to ensure reviews continue to be completed on time.

Primary care - Prescribing – there have been substantial increases in national pricing concessions which has impacted the forecast position by £4.8m At this stage the pressure is still within the overall inflationary estimates made during planning and has been mitigated using £4m of inflation reserves and £0.8m of prior year prescribing benefits. There is still a risk of further pricing concessions which is being monitored. Home Oxygen costs also continue to increase due to a stepped change in the reimbursable energy costs in line with national increases.

Primary Care Delegated - Post reimbursement of ARRS funding the forecast is an overall underspend of £3.2m against budget but still in excess of the delegated allocation of which £2m is due to prior period benefits. The overall spend is still in excess of the delegated allocation from NHS England. Due to pressures additional funding for Respiratory Hubs (£0.8m) and to support quality were approved post closure of the financial position. The impact of this will be reflected in month 9.

Other Programme shows a forecast over spend of £6.5m to offset underspends in other areas and to ensure the ICB achieves a balanced position.

Running Costs Year to date and forecast underspend due to vacancies so far this year and budget contributions to the efficiency target.

Alliance Delegated Budgets Month 8 2022/23

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Overall each Alliance should remain within it's delegated budgets post reimbursement of funding for ARRS.

System Resilience – The budget is planned to be fully utilised in each Alliance by the end of the financial year as part of Seasonal Resilience plans.

Community –The overall underspend is being driven in Ipswich & East due to the slippage on Ageing Well investments

Mental Health – The forecast underspend is relatively consistent across all Alliances with reduced individual placement costs and investment slippage being the key drivers. The investment standard is forecast to be met in each of the 3 Alliances.

Primary Care - West Suffolk prescribing costs are growing at a higher rate than the rest of SNEE and England creating a further pressure on the West Alliance budgets and likely to leave the West Primary Care budget overspent. Both Ipswich & East and North East Essex are on track for underspends.

Category	1 Jul 22 to 30 Nov 22 YTD			Forecast to 31 Mar 23		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
System Resilience	0.2	0.0	**0.2**	0.3	0.3	**0.0**
Community Health Services	30.8	30.3	**0.5**	55.6	54.8	**0.8**
Mental Health	33.2	33.0	**0.3**	58.8	58.2	**0.7**
Primary Care	59.7	59.5	**0.2**	106.8	107.7	**(1.0)**
IES Alliance - Delegated budgets	**123.9**	**122.8**	**1.1**	**221.4**	**221.0**	**0.4**
System Resilience	0.2	0.1	**0.1**	1.0	1.0	**0.0**
Community Health Services	28.8	28.5	**0.3**	50.2	50.0	**0.2**
Mental Health	30.0	28.6	**1.4**	53.3	52.3	**1.0**
Primary Care	58.0	55.7	**2.3**	102.8	102.0	**0.8**
NEE Alliance - Delegated budgets	**117.0**	**113.0**	**4.1**	**207.3**	**205.3**	**2.0**
System Resilience	0.4	0.0	**0.4**	0.5	0.5	**0.0**
Community Health Services	18.1	18.0	**0.1**	32.9	32.7	**0.1**
Mental Health	18.3	17.8	**0.5**	32.3	31.7	**0.6**
Primary Care	41.9	41.7	**0.3**	74.5	75.5	**(1.1)**
WS Alliance - Delegated budgets	**78.7**	**77.4**	**1.2**	**140.1**	**140.5**	**(0.4)**
Total Delegated	**319.6**	**313.2**	**6.4**	**568.9**	**566.8**	**2.1**

Efficiency Summary Month 8

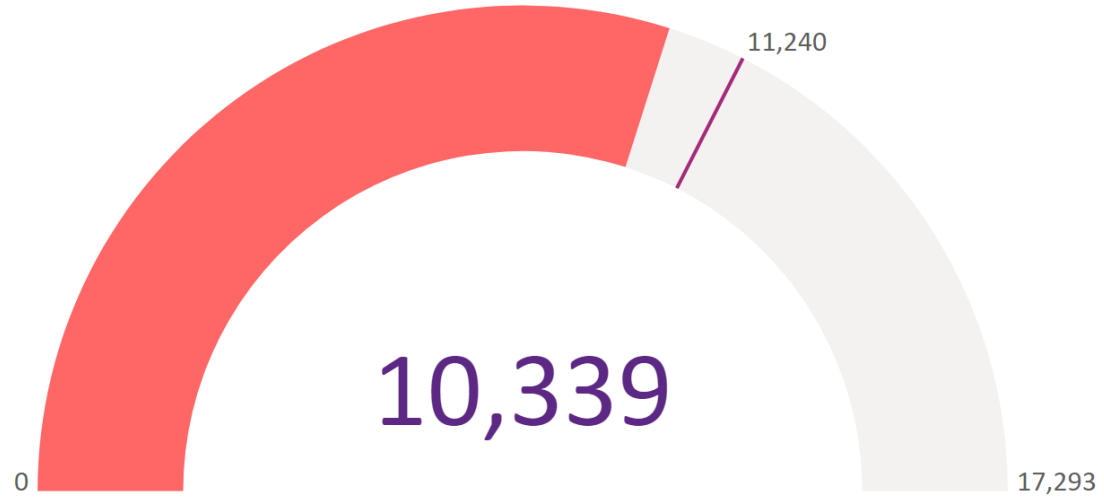
Suffolk and North East Essex

	£,000
Annual Plan	17,293
YTD Plan	11,240
YTD Actual	10,339
YTD Variance	(901)
Forecast value	15,131
Forecast Variance	(2,162)

Recurrent/ Non Recurrent	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Non-Recurrent	3,904	4,837	933	5,678	6,786	1,109
Recurrent	7,336	5,502	(1,834)	11,615	8,344	(3,271)
Total	**11,240**	**10,339**	**(901)**	**17,293**	**15,131**	**(2,162)**

Directorate	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	Annual Plan £,000	Forecast value £,000	Forecast Variance £,000
Delivery Contingency	(424)	0	424	(637)	0	637
Finance	1,697	1,715	17	2,546	2,550	4
IES Alliance	2,170	1,873	(297)	3,323	2,667	(656)
NEE Alliance	2,340	1,917	(422)	3,720	2,876	(845)
Nursing & Clinical	2,225	2,225	(0)	3,338	3,338	(0)
Performance Improvement	1,245	772	(473)	1,867	1,148	(720)
Strategy & Transformation	400	401	1	600	614	14
Workforce & People	86	310	224	340	532	193
WS Alliance	1,501	1,126	(375)	2,195	1,406	(789)
Total	**11,240**	**10,339**	**(901)**	**17,293**	**15,131**	**(2,162)**

YTD Actual £,000, Annual Plan £,000 and YTD Plan £,000



At month 8 we are under-plan by £901k year to date and forecasting under delivery of £2,162k which is a slight improvement on the month 7 position. The key drivers of the are:

- Prescribing is £1,140k under plan year to date based on M06 PPA data. At this stage with the increasing pricing concessions and capacity constraints in primary care due to system pressures we are no longer forecasting prescribing will recover and therefore the updated forecast is now under delivery of £2,321k.
- Non NHS contract clawback £666k year to date - Contract performance improved early in the financial year reducing potential clawback. This is being offset through other non recurrent opportunities.

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System Report

Month 8 2022/23

System Summary

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- At month 8 SNEE hosted NHS organisations reported an adverse aggregate variance of £314k (£311k at month 7). The forecast position for the year-end is on plan.
- In month 8 the level of unmitigated risk reported by SNEE hosted NHS organisations was unchanged at £5.7m. This is significantly below the level identified at the point of plan submission in June 2022 (£37.8m). The remaining unmitigated risk sits with EEAST.
- The EEAST Board continues to brief Regulators regarding its forecast outturn position. Month 9 represents the final opportunity for organisations to declare an off-plan forecast financial position. There is no indication that EEAST need to trigger that protocol. All NHS organisations are reporting a deterioration to the underlying financial position, as operational challenges and inflation add to the recurrent cost base.
- 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.
- Significant issues continue in the capital programme. ESNEFT is reporting issues of availability of raw materials, and supply chain interruption causing slippage affecting the wider 'CDEL' capital target to the value of £30m. NHSE have yet to confirm flexibility in the management of these national programme resources pending the completion of a business case to HM Treasury to enable this. Business as usual, or 'system' capital expenditure is broadly on line with plan.
- Both County Councils are currently reporting deficits both YTD and forecast. The deficit is being driven in both cases by children's social care costs. The combined deficit of £5.4m is expected to rise to £7.1m by the end of the financial year.

System Financial Performance

NHS
Suffolk and
North East Essex

Month 8	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	250	250	0	0	0
WSFT	672	502	-170	1,008	1,008	0
Sub-total	672	752	80	1,008	1,008	0
EEAST	-1,512	-1,906	-394	-1,000	-1,000	0
NHS Sub-total	**-840**	**-1,154**	**-314**	**8**	**8**	**0**
SCC	210,369	213,249	-2,880	360,633	365,570	-4,937
ECC	116,331	118,471	-2,140	175,487	177,625	-2,138
Total	**325,860**	**330,566**	**-5,334**	**536,128**	**543,203**	**-7,075**

- 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.
- There is a small overspend in NHS organisations year to date of £1.154m (£1.269m at month 7) against a planned overspend of £0.840m most of which can be attributed to EEAST. Recovery of the current system deficit is expected by the year-end, although all organisations are reporting deteriorating underlying positions offset by use of non-recurrent reserves as inflation impacts.
- EEAST continues to brief Regulators on its financial position, but has not stated an intention to trigger the recently agreed protocol for formal change to the forecast outturn financial position.
- Suffolk and Essex County Councils are currently reporting overspend positions (£2.880m and £2.140m) respectively, with children's social services accounting for the majority of the overspend. Neither is forecasting recovery before the year-end, which would require a transfer of resource from reserves to offset.

System Financial Risks

NHS
Suffolk and
North East Essex

Organisation	RAG Status	Key Financial Risks
Suffolk and North East Essex ICB		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 dus to social care capacity is an emerging 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. The Trust is currently undertaking a significant capital programme including two surgical elective hubs. Supply chain challenges, and price inflation in the construction industry, mean that delivery of CDEL is challenging. The Trust is exploring brokerage options with EoE NHSE/I sur to slippage on the surgical hub projects.
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 althouth these have started to subside. Covid impact on both oprations and staffing levels. Handover delays impact on flexible staffing requirements; whilst the recruiting market remains challenging. Under-delivery of efficiency plans.
Suffolk County Council		Domicilary care market capacity, infaltionary pressures (impacting cost base and workforce recruitment and retention), uncertain demand for adult social care
Essex County Council		Domicilary care market capacity, infaltionary 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	
	Financial plan targets unlikely to be delivered without external support
	Risk of financial plan targets not being delivered
	Financial plans targets expected to be delievered

- 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 that increase in cost is filtering through. This risk 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.
- On-going prevalence of Covid above planning levels contributes (with inflation) to an unmitigated risk of £5.7m across the health system, although this is significantly reduced from plan (£37.8m), and below figures reported last month (£12.1m)
- Supply chain interruption and global commodity shortages are also impacting delivery of capital and revenue plans.

NHS
Suffolk and North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**18**
Reference No.	**ICB 23-12**
Date.	**24 January 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 January 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. Please see the updates below regarding the risks which it considered could potentially be added to the BAF:

- Organisational Change – this was not considered to be a significant risk warranting inclusion in the BAF.
- Refugees – this risk has been included in the BAF (risk 26) for all 3 Alliances
- Cost of Living Crisis – this risk is included in the Workforce risk (risk 12)
- Availability of GP Appointments – included
- Industrial Action has been included as part of the Workforce risk (risk 12)

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 on 22 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 The format of the BAF document has been revised and is based on an Excel spreadsheet. This sets out where ownership and responsibility rests and the design will also ensure that entries are more succinct, focused and aligned.

2.7 The redesigned BAF document remains reliant upon Directors populating the document with relevant risks with these being regularly addressed at the Executive Committee.

2.8 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
System A&E Risk 1 Paul Gibara	*The ICB continues to be under significant pressure and whilst benchmarks well against other regional systems it continues to fail several established standards.* **Current risk rating 16.** **January 2023 update.** Seasonal plans in place detailing measures to be taken in the coming months to improve performance. Monitored and acted on by the Urgent and Emergency Care Committee. Demand in December exceeded planning assumptions and has resulted in the need to open additional clinical areas.
System RTT Risk 3 Paul Gibara	*System is not meeting Constitutional Referral to treatment Target of 18 weeks.* **Current risk rating 16.** **January 2023 update.** System is on track to reduce 78 week waits to 100 by April 2023. Risk of not delivering this are growing as a result of increased urgent care demand, strike action and BMA rate card rates being unaffordable. Long term sustainability risk as waiting lists and numbers of patients waiting over 52 weeks are growing.
NSFT CQC Risk 8 Lisa Nobes	*Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout it services present significant patient safety risks to the population of Suffolk.* **Current risk rating 20** **January 2023 update.** CQC have completed another unannounced follow up visit for Well-Led and section 29 areas. No further information to-date.
NSFT Performance Risk 9 Richard Watson	*Unsatisfactory performance of mental health services.* **Current risk rating 20** **January 2023 update.** Mental Health Committees overseeing recovery plans on a county basis. Suffolk system taking forward the development of a Mental Health Collaborative to go live from 01.04.23. Significant reform programme in place across four priority areas; Crisis, Community, Children and Young People and Learning Disability & Autism. CQC outcomes of inspection expected Spring 2023. **Four actions in place.**
Access to Primary Care Risk 10 Maddie Baker-Woods Peter Wightman Laura Taylor-Green	*Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates).* **RAG rating increased to 16.** **January 2023 update.** Deliver primary care training hub work programme (2022/23). Develop Fuller implementation strategy at ICB, Alliance and PCN level (Dec-Mar23). Specific targeted actions to support practices with specific immediate challenges including: adverse CQC, patient satisfaction reports, or workforce challenges. Delivery of specific actions to support practice resilience and workload pressures.
Cyber Security Risk 11 Andrew Kelso	*Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc.* **Current risk rating 20** **No further update** No applicants for Programme Director Security and Standards position. Exploring alternative options with system partners.
Provider Workforce Risk 12 Amanda Lyes	*Workforce challenges across the system.* **Current risk rating 16** **January 2023 update.** Over 700 applicants have been received for the Reservist Programme, screening of applicants underway. System and ICB IMTs established to support Industrial Action. SNEE Industrial Action Meeting to take stock of current IA position across SNEE ICB and establish actions as required. **Additional action.** 6.BMA rate card - a system wide meeting held end Oct. Communication between ICB and NHSE expressing systems concerning. Went to SOAC 5/12 for discussion. CMO's and HRD's to meet in Jan '23 to discuss impact and next steps. **Target date:** 31/03/2023.
Covid-19 Outbreak Risk 13 Lisa Nobes	*The Incident Level is currently at Level 3.* **January 2023 update.** Remaining at level 3 incident. System Control Centres (SCCs) have now go live across England. This has increased our operating hours to 08.00 - 18.00 7 days per week in line with guidance.
WSFT Infrastructure	*WSFT have identified and alerted the CCGs to risks associated with the Trusts Reinforced*

Risk 14 Paul Gibara	*Autoclaved Aerated Concrete (RAAC) infrastructure.* **Current risk rating 12** **January 2023 no further update.**
EEAST Quality/Performance Risk 16 Ed Garratt	*EEAST is not meeting performance targets against ambulance response categories.* **Current risk rating 20** **January 2023 no further update.** a. EEAST Winter Plan is estimating 82k PFSH – requirement average 90k – 95k through winter based on demand trends – NHSE/I and Lead commissioner working with EEAST to see how capacity can be increased, primarily through reducing abstraction rates, and how new models of care can reduce inappropriate 999 pathway responses with C3 – C5 call categories. b. Refreshed handover delay plan in place, critical that Norfolk delivers reduction in delays to reduce SNEE based crews diverting c. Sickness rate target of 9% under review, noting longer term sickness remains over 4% which is high as a trend d. Overtime/Private Ambulance capacity targeted to peak demand shifts, assurances from EEAST that overtime is maximised. e. Local demand management schemes in place f Handover delays managed /monitored weekly.
CYP Access to MH Therapy & Treatment Risk 17 Lisa Nobes	*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.* **Current risk rating 16** **January 2023 update.** Local protocol for managing need in acutes in place. Review taking place based on practice-based evidence across CYP system agencies and led by ICB. Potential funding being accessed to improve/provide better environments for CYP with acute needs. Peripatetic offer is now in place. Applied for medium term funding to extend pilot offer and CATAT hosted by NSFT.
Clacton Hospital Redevelopment Risk 18 Amanda Lyes	*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.* **Current risk rating 20** **January 2023 no further update.** The OBC development has been taken over by ESNEFT.
System Cancer Standards Risk 19 Richard Watson	*System not meeting the outcomes within the NHS constitution in regard to cancer standards* **Current risk rating 16** **January 2023 update** New recovery trajectories developed by the providers with both reporting 62 back log recovery by March 2023. ESNEFT current 62 backlog position (w/e 4/12) is 12.8% of their PTL and WSFT is 10.7% of their PTL. WSFT skin pathway remains 56% of their PTL, they have locums in place and expect to see week on week recovery. ESNEFT LGI PTL is currently 55% and growing week on week. NHSE have released updated information on managing FiT results within the pathway, this has been shared with key partners. 2WW referrals remains high, although improvement has been noted on the LGI Pathway with FiT results available. 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.
EPUT Fixed Ligature Points Risk 20 Lisa Nobes	*Patient safety risk in relation to Fixed Ligature Points and clinical governance of EPUT Ligature process.* **Current risk rating 15** **No further update** NEE has not experienced further incidents however non-fixed ligature deaths have sadly happened elsewhere in EPUT. Ongoing monitoring though PSIRF reference group by the Essex Mental Health collaborative continues.
NEE Special Schools Risk 21 Lisa Nobes	*The 5 Special schools across NEE do not have access to the Universal School Nursing commissioned offer and as such, the healthy Child Programme.* **Current risk rating 16** **January 2023 update** 1.That there is a Specialist Community Paediatric/Nursing offer from ESNEFT to all NEE special schools. The need for this offer is largely within two of these schools where pupils have complex physical health needs. The further three schools are SEMH schools. 2.All schools have been contacted to support with training requirements for health needs however uptake of this offer is limited. ECC are fully aware and have been provided with a chronology of engagement where there may be high needs but schools have not engaged. We are continuing to progress these discussions and work with ECC. 3.There is a universal School Nursing offer commissioned for Essex provided by HCRG

	but not for special schools across Essex, including NEE. There is a variable offer across other ICB's with additional commissioning by West Essex to enhance the offer. 4.A full update on current situation will be presented at next SEND Partnership Board and joint commissioning group from an NEE perspective 5.We will be working with Public Health who commission the universal School Nursing offer to work towards a solution.
Covid Patient Public Access Risk 22 Lisa Nobes	*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.* **Current risk rating 15** **January 2023 no further update.**
Dementia Environment Risk 24 Lisa Nobes	*Dementia is excluded from MH D2A pathways.* **Current risk rating 16** **January 2023 update.** A business proposal has been shared with the MH Transformation team for Step Up and Step Down.
Financial targets Risk 25 Howard Martin	*Failure to meet statutory ICB financial targets.* **Current risk rating 15.** **January 2023 no further update.**
Primary care access to Afghan nationals, asylum seekers, and refugees in NEE Alliance Risk 26 Andrew Kelso	*Reduction in access to, experience of and outcomes in primary care due to capacity.* **Revised RAG risk rating 16.** **January 2023 update.** Nearly all residents have been registered with GP Practice, confirmation of exact numbers awaited. Public Health have met with provider to provide reassurance that infection control measures are robust within hotel. Risk continues to be high due to workforce issues and the arrival of more refugees in the future.

Suffolk and North East Essex ICB Board Assurance Framework: Overview

NHS
Suffolk and
North East Essex
Integrated Care Board

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.

Risk no	Risk title	Risk owner
1	System A&E	Paul Gibara
3	System RTT	Paul Gibara
8	NSFT CQC	Lisa Nobes
9	NSFT Performance	Richard Watson
10	Access to Primary Care	Alliance Directors
11	Cyber Security	Andrew Kelso
12	Provider Workforce	Amanda Lyes
13	Covid outbreak	Lisa Nobes
14	WSFT Infrastructure	Paul Gibara
16	EEAST	Ed Garratt / John Harris
17	CYP access to mental health	Lisa Nobes
18	Clacton Hospital	Amanda Lyes
19	System Cancer Standards	Richard Watson
20	EPUT ligature	Lisa Nobes
21	NEE Special Schools	Lisa Nobes
22	Covid patient public access	Lisa Nobes
24	Dementia Environment	Lisa Nobes
25	Fainance statutory targets	Howard Martin
26	Refugees etc	Alliance Directors

Suffolk and North East Essex ICB Board Assurance Framework

NHS Suffolk and North East Essex Integrated Care Board

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 Competition
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 fail several well established standards namely 4hr wait 12 hour delay (new standard) Ambulance off load delays Ambulance response times **Cause** - demand to the department Insufficient flow through the department Delays to discharge medically fit patient.s **Effect** - poor patient experience and heightened safety risk.	Compounding these difficulties remains the prevelance 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 meetings to support effective use of available capacity. Routine weekend planning and on call arrangements. Admission avoidance schemes aimed at reducing ambulance conveyancing.	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 SOAC oversight of performance and risks Regional oversight of performance and risks	Treat	4	4	16	Same 16	Amber	**January 2023 update:** Seasonal plans in place detailing measures to be taken in the coming months to improve performance. Monitored and acted on by the Urgent and Emergency Care Committee. Demand in December exceeded planning assumptions and has resulted in the need to open additional clinical areas.		

Suffolk and North East Essex ICB Board Assurance Framework

NHS Suffolk and North East Essex Integrated Care Board

Risk 3 SYSTEM RTT

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 Competition
Strategic Programmes and Elective & Diagnostics Committee	Paul Gibara	System is not meeting Constitutional Referral to treatment Target of 18 weeks. Patients are not receiving care within expected standards. This is a national issue underpinned by Covid-19 pandemic. **Cause** Backlog built up during the pandemic when treatment slowed. Insufficient capacity to treat the incoming demand and backlog. **Effect** Poor patient experience and heightened safety risk	Covid 19 has led to a backlog and continues to provide challenges, namely ; Reduced outpatient capacity. Theatre throughput for routine electives activity. Diagnostic capacity back up and running but is restricted in certain areas due to Covid restrictions.	4	4	16	Recovery is overseen by the Strategic Programme and Elective recovery committee.	ICB attend/active part of Elective Care Programme Board.	Treat	4	4	16	Same 16	Amber	**January 2023 update:** System is on track to reduce 78 week waits to 100 by April 2023. Risk of not delivering this are growing as a result of increased urgent care demand, strike action and BMA rate card rates being unaffordable. Long term sustainability risk as waiting lists and numbers of patients waiting over 52 weeks are growing.	Seek to utilise the digital mutual aid system to identify any opportunities to improve position	31/03/2023
							Committee supported by a joint operational delivery group between WSFT and ESNEFT.	Long waits and overall length of wait are both on downward trend although mutual aid support to WSFT (system long waiters) has affected over last few months.									
							The system has established plans aimed at reducing patients waiting for a long time over 78 weeks and patients requiring urgent treatment.	ICB monitoring new targets in 22/23 operational targets to: a. eliminate waits of over 104 weeks as priority and maintain this position through 22/23 (except if patients choose to wait longer). b. reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort, extend three-monthly reviews to patients waiting over 52 weeks from 1 July 2022. c. develop plans that support overall reduction in 52-week waits.									
							Mutual aid across organisations is in place with conversation extending into regional support.										
			Covid 19 has led to a backlog and continues to provide challenges, namely ; Reduced outpatient capacity. Theatre throughput for routine electives activity. Diagnostic capacity back up and running but is restricted in certain areas due to Covid restrictions. Whilst number of long waiting patients are reducing as planned, we are seeing an increased level of patients waiting over 52 weeks. Much effort has been diverted to reviewing and ensuring patients waiting long period of time are monitored so as to mitigate risk associated with long waits. Focus continues to be on patient waiting over 78 weeks and patients requiring urgent care.				Weekly review of performance against plan. Focus on productivity and efficiency across waiting list management, theatre utilisation and outpatient.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 8 NSFT CQC inspection

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 Competition
ICB Quality Committee	Lisa Nobes	Statutory Duty to ensure patient safety within commissioned services: The Trust inability to demonstrate appropriate safety standards throughout it services present significant patient safety risks to the population of Suffolk. **Cause** The Trust inability to demonstrate appropriate safety standards throughout it services. **Effect** Significant patient safety risks to the population of Suffolk.	Inability to meet performance/clinical quality targets in access to service/care in service/discharge arrangements.	4	4	16	Quality assurance process initiated jointly with NSFT to review every service line in NSFT.	Improvements to patient safety and experience noted through QA process.	Treat	4	5	20	Same	Green	**January 2023 update** CQC have completed another unannounced follow up visit for Well-Led and section 29 areas. No further information to-date.		30/03/2023
			Inability to maintain safer staffing levels in accordance with NICE/ NQB guidance				Monthly meetings to review / challenge quality performance.	Demonstrated improvement against identified contractual key performance indicators evidenced through quality dashboard escalation of issues via Contract Quality Performance Review (CQPR) meetings.									
			Lack of confidence in performance data				Quality dashboard. Attendance at monthly stakeholder assurance meetings led by NHS Improvement / CQC.	Confidence that NSFT have capability and capacity to deliver the required quality improvements.									
			Lack of patient safety culture impacting clinical risk assessment, care planning.				Oversight of quality improvement plans (trust / local) and monthly monitoring of progress.	Assurance that actions detailed in the quality improvement plan have been implemented.									
			Lack of clinical leadership structure.				Monitor primary care contract issues and Trust response.										
			NSFT have lack of willingness to work as part of the system.				New Chair appointed and partnership arrangement agreed with East London Foundation Trust (ELFT).										
			5 high risk areas are: All age eating disorders Emotional wellbeing hub ADHD all ages Youth secondary care teams. First Response Service				Quality Improvement methodology introduced by Trust and training rolled out. Weekly ICB/ NSFT Director meeting to check progress against actions and escalate concerns.										
							Escalation through joint NHSI: ICB oversight meeting. Service user tracker list commenced, and patient harm review process commenced.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 9 NSFT Performance

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 Competition
	Richard Watson	The worsened performance of mental health services provided by NSFT causes poor patient outcomes and reduced quality of services provided. Cause Capacity insufficient to meet the rising demand for services and resolve the backlogs created. Effect Poor patient experience and heightened safety risks.	Poor performance against a number of performance indicatorsy, driven by: •Demand over plan for many services •Workforce gaps across services and challenge to fill key posts •System gaps particulary within primary care MH support	4	4	16	National standards scrutinised by NHS E/I. ICB teams working closely with NSFT counterparts to identify root causes of problems through: -SNEE ICB MH monthly MDT meetings providing overview of MH performance. -Monthly joint quality/ performance meetings (QCPM) between NSFT and ICB. - Monthly NSFT/ICB Director to Director meetings for escalation -NSFT Improvement Board	Reporting through the Suffolk MH Committee and SNEE ICB Board Director attendance at Trust Finance/Business Investment Committee.	Treat	4	5	20	Same	Amber	January 2023 update: -Mental Health Committees overseeing recovery plans on a county basis. -Suffolk system taking forward the development of a Mental Health Collaborative to go live from 01.04.23. - Significant reform programme in place across four priority areas: Crisis, Community, Children and Young People and Learning Disabilities & Autism. - CQC outcomes of inspection expected Spring 2023	1. MH Collaborative Launch 2. Service Review for CYP MH Services completed 3. Service review for Adults Community MH model and business case finalised 4. Additional services commissioned through MH Commissioning Framework completed	1. April 2023 2. February 2023 3. February 2023 4. March 2023
			National standards: 1. Early intervention in psychosis (14 days referral to treatment) 2. Eating disorder (1-week urgent referral to treatment) 3. Eating disorder (4-week routine referral to treatment)				Additonal capacity sought from other providers, including the VCSE	Mental Heath Commissioning Framework Contracts put into place with other organisations and monitored									
			Local standards: 4. Emergency referrals (4 hours referral to assessment) 5. Routine referrals (28 days referral to assessment) 6. Referral to treatment (15 weeks) 7. Children's emotional wellbeing hub (10 days referral to discharge) 8. Increasing waiting times for ADHD assessment and treatment				Additional investment into NSFT to support increasing workforce numbers	NSFT QCPM and Suffolk MH Committee									
			CQC rating as 'Inadequate' and Trust in special measures- April 2022				Development of Suffolk MH Collaborative and service review	Programme Plan and oversight through the Suffolk MH Committee									
							Development of demand and capacity plans for MH services with linked investment plans	NSFT Improvement Board and Suffolk MH Committee									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 10 Access to Primary Care

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
	Alliance Directors	Reduction in access to, experience of and outcomes in primary care due to capacity, demand, constraints (workload; workforce; digital and estates). **Causes** Workforce – recruitment Inability to recruit or retain GPs Reduction in partners to take on liability Stress leading to high turnover Reduction in clinical sessions to protect from burnout Reduction in trainees IT pressures Availability of hardware and changing systems Lack of system alignment Financial Partner liabilities (estates, employment and single partners) Wage growth and inflation including energy prices System pressure Movement of unfunded workload Reduction in carers Lack of dental capacity Increased waiting times for elective care **Effect** Potential quality of outcomes for patients. Increased workforce issues remain challenging and exacerbated by estate issues and workload pressures	Waiting resulting in deterioration (delay in accessing appointments (first and follow up). Further reduction in GP numbers. Increased referral to acute diagnostic and/or planned care services. Increased attendance at Adverse impact on continuity of care and daily acute demand	4	4	16	Development of Primary Medical Care Task Force -forward strategy and plan towards new models of care including safe working levels	Primary Care Commissioning Groups Training Hub Operational Support (PM meetings / PCN CD and PCN Business Manage Meetings)	Treat	4	4	16	Risk Increased	Green	**January 2023 update:** Deliver primary care training hub work programme (2022/23). Primary Medical Care Task Force to develop refreshed strategy and plan with focus on new models of care, workforce, estates, digital with implementation strategy at ICB, Alliance and PCN level (Jan-Mar23) -Specific targeted actions to support practices with specific immediate challenges including: adverse CQC, patient satisfaction reports or workforce challenges -Delivery of winter support actions -Input to national policy and contractual change fora - Delivery of specific actions to support practice resilience and workload pressures		
							Recruitment and retention programmes (clinical and non clinical) including ARRS roles	Alliance clinical leads meetings (weekly).									
							Workload management models. Development of PCN estates plan and delivery of new digital support.										
							Patient comms										
			Increased pressure on 111 and Pharmacy services														
																	31/03/2023
																	31/03/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 11 Cyber Security

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 Competition
	Andrew Kelso	Potential impact of cyber security incident could lead to wide scale IT system outages, meaning no access to patient records, e-dispensing services etc. **Cause** Cyber security attack. **Effect** Wide scale IT system outages, meaning no access to patient records, e-dispensing services etc	National requirements have increased, in respect of the need to achieve cyber essentials + accreditation.	4	5	20	Service provider (NEL) have achieved cyber essentials accreditation and cyber essentials + accreditation. ICB has own domain and has achieved cyber essentials. RSM reviewed cyber controls. Assurance received.	External Audit. Internal audit complete Monthly SLA provider meetings. Monthly service review provider meetings.	Treat	4	5	20	Same	Amber	January 2023 reviewed, no update: No applicants for Programme Director Security and Standards position. Exploring alternative options with system partners.		
			No national funding has been identified specifically for cyber security work to mitigate against the increased risk, and the increased requirements.				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.	Monthly Joint Digital and IT Services Board. Audit Committee review.									
			No access to systems – would require frontline services to fully enact Business Continuity and Disaster Recovery procedures.				Improved access controls and enabling multi-factor authentication with OKTA. Implementation of effective incident response plan via ICC. Regular patch of systems and planned forced machine restarts.										
			Potential for lack of access to relevant IT skills and insight to develop a recovery plan (dependent on type of attack).				Ensure that backups, restore mechanisms and online defences are working as BAU, monthly reporting and live dashboards.										
			Restoration of services complex, would involve multiple vendors and take a significant period of time				NEL have team to keep up to date with latest threat and mitigation information.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 12 Provider Workforce

				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 Competition
ICB People Committee	Amanda Lyes	Workforce challenges across the system. **Cause** Staff burnout. Acuity of patients. Increased demand. Seasonal pressures. Industrial Action. Cost of living. **Effect** Leading to risks to patient safety, care and services.	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. Local Workforce Transformation Groups established in each Alliance. PC WIG and GPCC that report into People Board for Primary Care.	SNEE People Committee, IES, NEE and WS Local Workforce Transformation groups, PC WIG and GPCC reporting to SNEE People Committee. Working groups to address topic specific challenges e.g. retention, 50K nursing, H&WB.	Treat	4	4	16	Same	Green	January 2023 update: Over 700 applicants have been received for the Reservist Programme, screening of applicants underway. System and ICB IMTs established to support Industrial Action. SNEE Industrial Action Meeting to take stock of current IA position across SNEE ICB and establish actions as required.	1.Cost of Living Workshops are currently running. Work continues H&WB interventions. 2.Activities to support career aspiration/development are being planned for Jan-March '23	Actions, target date Mar 23
			Staff absence due to Mental Health and MSK.				Plans for Retention in place incl. workshop in March '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. 4.Retention Summit arranged	
			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.								5. Workforce Workshops arranged for: Maternity/EoL/Frailty and Community Services	
			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.								6. BMA rate card - a system wide meeting held end Oct. Communication between ICB and NHSE expressing systems concerning. Went to SOAC 5/12 for discussion. CMO's and HRD's to meet in Jan '23 to discuss impact and next steps.	
			Risk of breaching constitutional obligations.				Reservist Programme now launched. Workshop held for Pharmacy Workforce Strategy. Education Transformation Workshop held.	SNEE Industrial Action SOP.									
			Primary care risk of some practices not being able to function and list closures.				System Cost of Living Working Group established.										
			Industrial action and the impact on operations activity and elective care.				System IA meetings now established weekly and now have internal daily calls.										
			BMA rate card, this is non contractual rate of pay for consultants.														

Suffolk and North East Essex ICB Board Assurance Framework

Risk 13 Covid Outbreak

				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 Competition
ICB Quality Committee	Lisa Nobes	The Incident Level is currently at Level 3. **Cause** The impact of a widespread Epidemic on the ICB will see an increase in demand on all commissioned services. **Effect** The ICB could see significant changes to establish ways of working. The ICB may have absenteeism as staff self-isolate / ill over the period of the outbreak.	Increased risk of fraud from Covid-19 related claims.	4	5	20	Business continuity plan in use. SNEE incident room 0800-1800 Mon-Fr, 1000-1600 Sat/ Sun/ Holidays, on-call cover outside these hours. Daily SNEE operational meetings, with Place based Tactical escalation calls as required.	SNEE Covid-19 Incident room staffed on rota basis. Virtual support from Primary Care / Care homes / Communications and IPC teams.	Treat	4	5	20	Same	Green	**January 2023 update.** Remaining at level 3 incident. System Control Centres (SCCs) have now go live across England. This has increased our operating hours to 08.00 - 18.00 7 days per week in line with guidance.		
			The impact of a widespread Epidemic on the ICB will see an increase in demand on all commissioned services.				Tactical resource supporting the Suffolk Outbreak Management Centre. Local Outbreak Management Plan in place.	Business continuity plans in full operational use.									
			The ICB could see significant changes to establish ways of working.				Daily tracking of case numbers in place. On-going liaison with Local Resilience Forums (currently stood down). ICB staff working virtually where possible and controls in place at office locations.										
			The ICB may have absenteeism as staff self-isolate / ill over the period of the outbreak				LCFS distributed warnings re Covid related fraud and passed to relevant finance staff. Invoice checking in place, where there are changes to these they do not relate to new suppliers and all items will be reconciled as required.										

Suffolk and North East Essex ICB Board Assurance Framewor

Risk

Suffolk and North East Essex Integrated Care Board

				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 Competition
	Paul Gibara	WSFT have identified and alerted the ICB to risks associated with the Trusts Reinforced Autoclaved Aerated Concrete (RAAC) infrastructure. **Cause** Hospital built from RAAC planks. **Effect** Risk of shear failure in buildings made from RAAC planks.	May 2019 Standing Committee on Structural Safety (SCOSS) alert identified a risk of shear failure in buildings made from RAAC planks.	3	5	20	WSFT have established a significant surveyance program/remedial plan to ensure safety of patients, visitors and staff are met. ICB is required to ensure WSFT who are legal owners of estate and provider of services give assurance as to the safety of services.	The ICB has established a RAAC Risk Committee independently chaired to ensure that the ICB undertakes all necessary actions required to provide assurance to mitigate risks. These include:	Tolerate	3	4	12	Same	Green	**January 2023 no further update.** 1. Meetings ongoing between structural expert and trust engineers on end bearing work. 2. ICB has requested Trust decision process document from Trust. 3. DAB Beachcroft asked WSFT to provide document scoping SWECO work.		
			Dust released from a plank failure is likely which will require decontamination of those affected. What is currently not known is the quantity of dust that may be released.				The ICB developed a governance structure to monitor the level of assurance together with a set of measures to assess and give the ability to respond to any adverse changes and consequence of the risks identified.	• Emergency preparedness • Alternative service provision • Internal WSFT governance and remedial works • New hospital build • Quality and physical environment. • Exercise programme at Trust, System and Regional Levels. • Attendance of WSFT to ICB Risk committee for regular updates and assurance.									
							WSFT internal expert leadership team in place. System has developed initial plans which will be reviewed. The ICB has worked with Region to ensure regional/local plans are aligned.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 16 EEAST Performance and Quality

				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 Competition
	Ed Garratt	EEAST is not meeting performance targets against ambulance response categories. A particular concern is delays in the higher acuity Category 1 and 2 calls. Particular concern to patient safety are delays & that patient waits are longer than previous winters. **Cause** Capacity constraints, productivity issues around abstraction rates and to some degree handover at hospital delays **Effect** There has been a trend increase in SIs arising from delays in response. Continued high pressure on staff in patient facing positions resulting in relatively high sickness rates and high vacancy rates	Leadership New CEO recently appointed, there are many substantive vacancies in the current exec team.	5	5	25	Bi-Monthly Oversight & Assurance meeting. (Regulator and Lead Commissioner). Review of serious incidents caused by delays. Bi-Monthly Oversight and Support meetings (Regulator and Lead Commissioner).	Escalation of EEAST capacity issues to NHSE/I Regional Team. AACE Peer Review of Winter Plan. Joint Review of Winter Plan by NHSE/I and Lead Commissioner. New CEO assembling substantive executive team.	Treat	5	4	20	Same	Red	**January 2023 no update** a.EEAST Winter Plan is estimating 82k PFSH – requirement average 90k – 95k through winter based on demand trends – NHSE/I and Lead commissioner working with EEAST to see how capacity can be increased, primarily through reducing abstraction rates, and how new models of care can reduce inappropriate 999 pathway responses with C3 – C5 call categories. b.Refreshed handover delay plan in place, critical that Norfolk delivers reduction in delays to reduce SNEE based crews diverting c.Sickness rate target of 9% under review, noting longer term sickness remains over 4% which is high as a trend d.Overtime/Private Ambulance capacity targeted to peak demand shifts, assurances from EEAST that overtime is maximised. e.Local demand management schemes in place f.Handover delays managed /monitored weekly.		
			Workforce EEAST had previously recruited to 2019/20 ISR plan levels, the level of PFSH available to deploy on the road is less than last winter. Sickness levels and abstraction rates are high in the sector as main causes of this.				Fortnightly Working Group meetings (Regulator and Lead Commissioner) Monthly regional quality and performance meetings. Monthly quality and performance meetings held locally at ICS level.	Regular reviews of handover performance and action plans in place based upon Best Practice. Monthly review of NHS 111/IUC clinical validation performance. Clinical review of serious incidents through SI panel.									
			Handover delays Arrival of ambulance to handover at ED delays now worse than previous winters running at circa 3,000 hours lost a week, more than double in previous years.				Commissioner attendance at EEAST internal Strategic Efficiency and Capacity review meetings. ICS/Alliance UEC System meetings. Reporting of Serious Incidents to Commissioner and Lead Commissioner oversight.	Escalation to Exec Quality & Safeguarding, QSAF, Quality and Scrutiny Committees. Previous Winter Plans estimated 85k to 90k capacity on front line with lower abstraction rates than current position.									
			COVID 19 Continuing threat of rising infection rates means that this could increase already high sickness levels.				ICB to 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.										
			Response times Unprecedented system pressure in Eastern Region is causing ambulance response delays; risk an ambulance resource cannot be immediately deployed to Cat 2 calls, which require an average response time of 18 minutes.														

Suffolk and North East Essex ICB Board Assurance Framework

Risk 17 CYP Access to mental health

				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 Competition
ICB Quality Committee	Lisa Nobes	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. **Cause** CYP are unable to access MH therapy and treatment due to capacity issues. **Effect** 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.	1.Availability of Tier 4 Beds 2.Blocking of Paediatric Beds 3.Safety of CYP 4.Safety of other Patients 5.Safety of Staff 6.Safety of Families / Visitors / Carers 7.PWB of Staff 8.Increased Complaints 9.Adverse Publicity	4	5	20	1.local CYP MH providers regular calls with provider collaborative to review capacity for admissions 2. Introduction of risk matrix (et to be seen and confirmed) by CYP NHSE provider collaborative to review requests for admission 3. ICB Escalation and flow management in acute hospitals 4. ICB financial support to provide care input for YP in acute settings where and seeking regular oversight to all admissions 5. Regular reporting and escalation through QSAF/ NEE QC/ ICB CYP MDT 6. Regular system calls for CYP with involvement of all partners and ICB to manage clinical risk, share information and plan delivery of care	Involvement of the CCGs Governing Bodies. Regular reports to Clinical Executive & other statutory committees. JLT Assurance Board for CCG Closure. Chaired by EG.	Treat	4	4	16	Same	Green	**January 2023 update.** Local protocol for managing need in acutes in place. Review taking place pased on practice based evidence across CYP system agencies and led by ICB. Potential funding being accessed to improve/provide better environments for CYP with acute needs. Peripatetic offer is now in place. Applied for medium term funding to extend pilot offer and CATAT hosted by NSFT.		03/04/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 18 Clacton Hospital Redevelopment

				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 Competition
	Amanda Lyes	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. **Cause** Insufficient finance for hospital redevelopment. **Effect** Building will not be fit for purpose for future model of primary care.	If significant monies are not obtained through the bidding process for the STP Capital, the primary care estate in Clacton will not be fit for purpose for the future model of primary care. The initial financial risk gives rise to a variety of other risks, so grip on the project and its finances acts to control the other risks.	4	4	16	Controls over quality, performance, reputational and financial risk: Programme governance established with project board, which includes representation from NHSE via SEA. NHSE Regional team engaged in early page turns of business case to ensure correct content and context provided. Wider master planning taking place to look at options beyond phase one project and ensure maximum efficiencies are implemented. NHSE to explore potential of site ownership from NHS PS to a NHS Provider organisation which may reduce costs of the scheme. Full business case being developed at risk to reduce overall programme.		Treat	5	4	20	Same	Amber	**January 2023 no further update.** An update from NHSE Regional finance team indicates that the national financial position for the STP Wave 3 funding is still in abeyance and therefore business cases cannot be put forward. Further work to be undertaken to review and streamline business case to put in best possible position. The OBC development has been taken over by ESNEFT.		01/12/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 19 System Cancer Standards

				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 Competition
	Richard Watson	System not meeting the cancer related standards within the NHS constitution leading to worsening patient outcomes and quality of services. **Cause** Capacity insufficient to meet the rising demand for services and resolve the backlogs created. **Effect** Poor patient experience and heightened safety risks.	• Clinical risk of patients not being seen in appropriate timescales • Risk of deteriorating patient outcomes and experience due to long waits.	4	4	16	National standards scrutinised by ICB and NHS Cancer Alliance. ICB teams working closely with provider counterparts to identify root causes of problems through: -SNEE Cancer Ops Group monthly meetings providing overview of Cancer performance. -Monthly joint quality/ performance meetings (QCPM) between ESNEFT and ICB and WSFT and ICB. -SNEE ICS Cancer Committee (bi-monthly) In addition, both WSFT and ESNEFT have their own Cancer Boards in place which oversee cancer delivery including MDT tracking and breach reporting.	Local cancer programmes and performance reports up into: 1. SOAC and through to the ICB Board 2. Regional Cancer Alliance Board	Treat	4	4	16	Same	Green	**January 2023 update** New recovery trajectories developed by the providers with both reporting 62 back log recovery by March 2023. ESNEFT current 62 backlog position (w/e 4/12) is 12.8% of their PTL and WSFT is 10.7% of their PTL. WSFT skin pathway remains 56% of their PTL, they have locums in place and expect to see week on week recovery. ESNEFT LGI PTL is currently 55% and growing week on week. NHSE have released updated information on managing FiT results within the pathway, this has been shared with key partners. 2WW referrals remains high, although improvement has been noted on the LGI Pathway with FiT results available. 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.	Recovery Plans in place for 62 backlog and 62 day performance	01/04/2023
			• Risk of breaching constitutional obligations. • Risk of increasing patient harm both physically and mentally due to being on Cancer pathway for extended period of time.				Weekly specialty reporting and cancer focused ESNEFT and WSFT PTLs in place.	At ESNEFT, to the Time Matters Board and WSFT to the Trust's Executive									
			In addition to the above there is a new risk emerging relating to patients not attending cancer appointments.				SI reporting procedures	As above									
							Additonal investment into cancer services through SDF funding	ICS Cancer Committee									
							Recovery Plans development and in place down to specialty level within ESNEFT and WSFT	ICS Cancer Ops Group and through the ICS Cancer Committee									
							Best Practice Timed Pathway Audits and Action Plans	ICS Cancer Ops Group and through the ICS Cancer Committee									
							Additonal diagnostic capacity through other providers and Community Diagnostic Centres development	ICS Cancer Ops Group and through the ICS Cancer Committee									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 20 EPUT ligature points

				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 Competition
ICB Quality Committee	Lisa Nobes	Patient safety risk in relation to Fixed Ligature Points and clinical governance of EPUT Ligature process. **Cause** Inappropriate management and or inappropriate mitigation of risk of fixed ligature points. **Effect** Patient serious harm or death.	Patient serious harm of death as a result of inappropriate management and or inappropriate mitigation of risk of fixed ligature points.	3	5	15	Robust ligature assessment process that aligns with Trust policy. No reported Serious Incidents in relation to Patient Harm due to fixed ligature points.	Quality Assurance Visits NHSE/I Mental Health Task Force	Treat	3	5	15	Same	Green	**January 2023**, no further update on below following review. NEE has not experienced further incidents however non-fixed ligature deaths have sadly happened elsewhere in EPUT. Ongoing monitoring though PSIRF reference group by the Essex Mental Health collaborative continues.		31/03/2023

Suffolk and North East Essex ICB Board Assurance Framework

Risk 21 NEE Special Schools

				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 Competition
ICB Quality Committee	Lisa Nobes	The 5 Special schools across NEE do not have access to the Universal School Nursing commissioned offer and as such, the healthy Child Programme. **Cause** There is variable or no commissioned special school nursing support within these schools. **Effect** Young people do not receive the Universal Offer which impacts on their health and wellbeing.	All pupils attending these schools have an Education Health and Care Plan. There is variable or no commissioned special school nursing service supporting these schools.	4	4	16	Raised as a risk at SEND Health Subgroup. Raised at Essex SEND Health Improvement board. DCO team to meet with headteacher to offer ongoing support. Audit of 20% of Langham Oaks EHCP's to identify Health needs and provision.	Minutes of meetings. Action Plan for Langham Oaks. Audit results 08/21 NEE Health Sub- group Minutes.	Treat	4	4	16	Same	Green	**January 2023 update:** 1.1 That there is a Specialist Community Paediatric/Nursing offer from ESNEFT to all NEE special schools. The need for this offer is largely within two of these schools where pupils have complex physical health needs. The further three schools are SEMH schools. 2.1 All schools have been contacted to support with training requirements for health needs however uptake of this offer is limited. ECC are fully aware and have been provided with a chronology of engagement where there may be high needs but schools have not engaged. We are continuing to progress these discussions and work with ECC. 3.1 There is a universal School Nursing offer commissioned for Essex provided by HCRG but not for special schools across Essex, including NEE. There is a variable offer across other ICB's with additional commissioning by West Essex to enhance the offer. 4.1 A full update on current situation will be presented at next SEND Partnership Board and joint commissioning group from an NEE perspective 5.1 We will be working with Public Health who commission the universal School Nursing offer to work towards a solution.		03/04/2023
			There may not currently be health representation at safeguarding meetings for these students. Young people currently not offered health consultation in 'drop-in sessions' or sexual health and relationship advice.				Working with LA colleagues to scope the extent of health provision detailed in EHCP plans. Liaising with key health providers to Map provision historically and to re-establish links.									
			Consequences are that young people do not receive the Universal School Nursing Service which impacts on their health and wellbeing.				NELFT to offer regular consultation with Langham Oaks and offer support as required. DCO team to meet with headteacher to offer ongoing support.									

Suffolk and North East Essex ICB Board Assurance Framework

Risk 22 Covid Public Patient Access

				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 Competition
ICB Quality Committee	Lisa Nobes	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. **Cause** NHS service disruption due to pandemic. **Effect** Patients will present with late symptoms or not at all with worsening outcomes for both acute and longer-term conditions.	Risk that patients will present with late symptoms or not at all with worsening outcomes for both acute and longer-term conditions.	3	5	15	Clear local/national communications that NHS services are open. Online options for consultations rolled out across primary and secondary care.	Activity Reporting via Contract meetings, F/P Tactical Cell information and Feedback. BI team data reporting regarding referrals.	Treat	5	3	15	Same	Amber	**January 2023:** No further update on below. Messaging to patients, public and professionals around service changes and NHS is open for urgent care other than Covid19 at national and local level. Cancer promotions underway re early checks with primary care teams. Support to services caring for vulnerable groups enhanced, staff redeployed to alternative care settings and support with a focus on supporting UCRS for admission avoidance. Increased demand across CYP ad Adult MH services, with focus on supporting delivery of services including suicide prevention across Alliance Partners including Police and Fire Services, and other services. Focus on Ambulance handover delays and ED performance at Alliance and SNEE Tactical Meetings. Support to hospital discharge flow with ECC and partners working together. National Cancer campaign amplified on previous CCG comms. Primary care focused on recovery and returning to BAU referrals to return to normal level.		
			Risk to increased mortality due to both Covid and Non Covid presentations. Increased risk of fraud from Covid related claims.				Virtual content and support networks set up by providers for all ages with support of voluntary services.	Monitoring of virtual appointments for the Acute via the elective care programme board. PH reporting on excess death reporting. Virtual support from Primary Care / Care homes / Communications and IPC teams.									
							Response to Covid managed at ICS, Alliance and LRF levels and will step up and down linked to covid waves for recovery actions to be managed.	Board Oversight. Alliance Operational Group overseeing local recovery planning related to community and urgent care services.									
							Business continuity plan in use. SNEE incident room established. SNEE operational and tactical meetings stood up and down dependant on waves.										
							Local Outbreak Management Plan. Tracking of case numbers in place. LRF stood down both TCG & SCG meetings but will stand up again as needed.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 24 Dementia Environment

				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 Competition
ICB Quality Committee	Lisa Nobes	Dementia is excluded from MH D2A pathways. **Cause** Dementia is excluded from MH D2A pathways. **Effect** There is a risk of Serious Physical and/or Psychological Harm to Patients with Dementia whilst remaining in the wrong environment.	The D2A assessment process is undertaken when individuals are in heightened states of distress due to the environmental triggers.	5	4	20	There are regular patient flow meetings involving both NSFT & ACS to discuss barriers to discharge. There are individually funded packages of D2A for this cohort, which alleviates some pressure but is done on a SPOT purchase approach.	ICB Quality Committee. ICB MH Transformation team aware.	Treat	4	4	16	Same	Green	**January 2023 update:** A business proposal has been shared with the MH Transformation team for Step Up and Step Down.		30/09/2023
			There is a risk of Serious Physical and/or Psychological Harm to Patients with Dementia whilst remaining in the wrong environment.				Consideration for extending the use of Wickham House with additional resources is currently being explored. Transformation MH team within ICB are sighted upon this issue.										

Suffolk and North East Essex ICB Board Assurance Framework

Risk 25 Failure to meet financial targets

NHS Suffolk and North East Essex Integrated Care Board

				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 Competition
ICB Finance Committee	Howard Martin	Failure to meet statutory ICB financial targets to: - At least break even. - Ensure both capital and revenue resources do not exceed the limit set by NHS England. - Ensure expenditure on running costs does not exceed the limit set by NHS England. **Cause** Insufficient monies to meet statutory targets. **Effect**	Prescribing price inflation. Non NHS contract inflation. Delivery of efficiency target. Cost of waiting list recovery.	3	5	15	Guaranteed Income Contracts resumed with key providers in 22/23. ICB Financial Recovery Group in place to ensure delivery of efficiency programme.	Internal audit of key financial controls. Internal audit against HfMA Financial Sustainability Checklist.	Treat	3	5	15	Same	Amber	**January 2023** no further update.	Implementation of ICB Finance Committee.	Target date: January 2023
			Additional cost of Urgent and Emergency Care pressures. Cost of supporting organisations in financial distress.				Clear internal expenditure controls in place to ensure spend is only authorised within limits and funding available. Inflationary pressures reserves established.	Financial Recovery and Sustainability Group scrutiny of financial position and efficiency delivery.							Delivery against internal audit actions and recommendations.	Target date: TBC
			Increased workload and staffing requirements due to additional organisation responsibilities. Lack of clarity on financial allocations and operational deliverables for 23/24.					Monthly director budget scrutiny meetings. Alliance Committees scrutiny of financial position for delegated budgets.							Development of 23/24 efficiency programme	Target date: January 2023

Suffolk and North East Essex ICB Board Assurance Framework

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

NHS Suffolk and North East Essex Integrated Care Board

				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 Competition
Aliance Committees	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	4	4	16	Same	Green	**January 2023 update.** Nearly all residents have been registered with GP Practice, confirmation of exact numbers awaited Public Health have met with provider to provide reassurance that infection control measures are robust within hotel Risk continues to be high due to workforce issues and the arrival of more refugess in the future	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								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.										
			Where patients not registered risk of duplicate records by supporting providers														
			Lack of workforce to be deployed to preferred model.														

Directorate Risk Register summary of top risks

Date: December 2022

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	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 2023	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 Proctor
	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. There is currently limited assurance that WSFT has implemented the service restoration plan.	**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 completion of the NDD procurement.	No end date	Nicola Brunning

				Service has contacted all families to support signposting.		
2. Performance Improvement	Pandemic Disease Hazard: 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. 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. Any prophylaxis or vaccination program will also add a huge demand on NHS services.	UKHSA monitoring for potential outbreaks. Resilience Forum Pandemic Plans. Resilience Forum Mass Fatality and excess death plans. ICB Business Continuity Plan, ICB Emergency Response Plan, Provider business continuity plans. NHS EPRR Core Standards process.	**15**	Annual ICB Business Continuity exercise. Annual flu vaccination campaign.	01/04/2023	Chris Chapman
3. Performance Improvement	Practice Plus Group are unable to deliver the 20 second response target for 111 The risk is that patients with urgent needs are delayed or missed due to the longer than standard waits.	Regular monitoring and action meetings are in place, Director Level conversations occurring.	**16**	Additional funding for Think 111 First given to PPG. Regular System Escalation conversations occurring	March 2023	Greg Brown

	Risk Description / consequences	Current controls / assurance	RAG	Actions with status	Completion date	Responsible person
1. Finance	Failure to achieve in year financial balance, secure financial sustainability and deliver optimum service from financial resources available.	Guaranteed Income Contracts in place with key providers. Clinical Executive and Governing Body review expenditure and significant investments. Project management approach to delivery of QIPP through PMO	**10**	Regular executive level dialogue between CCG and providers. Regular FPC reporting. Risk rating may need to increase further for FY 22/23 – discussion recommended. Uncertainty over non-recurrent funding brings a risk to overall financial stability. Financial sustainability work underway with planned investments committee to review unfunded proposals for expenditure. Planning work continues to minimise any gap.	November 2022 **Risk transferred to BAF**	Howard Martin
	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	**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

		NSFT with progress for operational delivery to enable MCP process in 2022.				
	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 scanning across the locality being a key issue for delays.	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 56.9% at April 22	**9**	Transformation programme active with additional NHSE/I funding received as part of Covid recovery which includes supporting primary care, memory services and support services in addressing capacity, pathway flow and navigation of the system.	March 2023	Rob Chandler
	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.	**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
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

NHS
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ICB BOARD

Agenda Item No.	**19**
Reference No.	**ICB 23-13**
Date.	**24 January 2023**

Title	**Review of the ICB Constitution**
Lead Director	Amanda Lyes (Director of Workforce and People)
Author(s)	Colin Boakes – Independent Governance Advisor
Purpose	To review the ICB Constitution
Recommendation: The ICB Board is asked to 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 Prior to its approval, the Constitution, in line with NHS England guidance, was developed in consultation with system partners and key stakeholders.

2.2 Consultation on the Constitution content was achieved through a series of ICS Partnership Board workshops, ICS Partnership Board meetings and discussions with individual partners and stakeholders.

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

2.4 Now, some six months after establishment of the ICB, this is 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.

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

3. Recommendation

3.1 The Board is requested to review the ICB Constitution and in order to assist discussion at the meeting, to send any thoughts or suggestions in advance to Amanda Lyes – Director of Workforce and People.

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Suffolk and North East Essex Integrated Care Board

CONSTITUTION

VERSION CONTROL

Version	Date Approved by the ICB	Effective Date
V1.0	1 July 2022	1 July 2022

CONTENTS

1. Introduction

1.1 Background/ Foreword

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

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

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

a) improving the health of children and young people
b) supporting people to stay well and independent
c) acting sooner to help those with preventable conditions
d) supporting those with long-term conditions or mental health issues
e) caring for those with multiple needs as populations age
f) getting the best from collective resources so people get care as quickly as possible.

1.1.3 Suffolk and North East Essex Integrated Care Board (the ICB) brings together partners responsible for planning and delivering health and care across Suffolk and North East Essex to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.

1.1.4 ICBs are central to the NHS Long Term Plan and have a key role in ensuring joint working across the NHS and Local Authorities to make shared commissioning decisions together with providers on how to use resources, design services and improve population health.

1.1.5 The ICB will enable communities to continue to shape priorities and release the assets which contribute to their wellbeing, care and health, within a common set of standards which reduce unnecessary variations in performance and outcomes. By working with people in our communities the ICB will develop trust and understanding with stakeholders about what matters.

1.1.6 Integrated care systems are partnerships of health and care organisations, local government and the voluntary sector. They exist to improve population health, tackle health inequalities, enhance productivity and help the NHS support broader social and economic development. Each ICS is comprised of an Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

1.1.7 The ICP is required to produce an integrated care strategy and the ICB and local authorities are required by law to have regard to the ICPs strategy when making decisions, commissioning and delivering services.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Suffolk and North East Essex Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is coterminous with and includes the District of Babergh, Borough of Colchester, Borough of Ipswich, District of Mid Suffolk, District of Tendring and the District of West Suffolk. The area also includes part of the District of East Suffolk as per the following LSOAs: (E01030201, E01030219, E01030222, E01030154, E01030172, E01030173, E01030174, E01030176, E01030186, E01030208, E01030209, E01030210, E01030212, E01030152, E01030153, E01030187, E01030188, E01030189, E01030193, E01030194, E01030195, E01030220, E01030175, E01030200, E01030221, E01030199, E01033443, E01033445, E01033446, E01033448, E01033449, E01030155, E01030185, E01030203, E01030211, E01030179, E01030180, E01030183, E01030184, E01030207, E01030181, E01030190, E01030191, E01030192, E01030198, E01033442, E01033444, E01033447, E01030196, E01030197, E01030204, E01030205, E01030206, E01030171, E01030214, E01030215, E01030216, E01030217, E01030218, E01030158, E01030159, E01030164, E01030166, E01033450, E01030160, E01030161, E01030168, E01030169, E01030170, E01030162, E01030163, E01030165, E01030167)

1.4 Statutory Framework

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

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

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

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its constitution (section 14Z29). This Constitution is published at www.suffolkandnortheastessex.icb.nhs.uk

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

duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

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

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

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation)
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

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

1.5 Status of this Constitution

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

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

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

1.6 Variation of this Constitution

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

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

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

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

1.6.3 Before any amendments can be approved under Clause 1.6.2, above, the proposed amendments must be provided to all relevant respondents with a period of twenty-one days from the date the amendments are sent in which they can respond with any comments on the amendments. Any comments provided must be submitted to the Board in writing before the meeting at which the amendments proposed are to be considered.

1.7 Related Documents

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

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

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

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

a) The Scheme of Reservation and Delegation (SoRD) - sets out those decisions that are reserved to the board of the ICB and those decisions that

have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to to whom functions and decisions have been delegated to.

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

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

d) **The ICB Governance Handbook** – this brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) to c)
- Terms of reference for all committees and sub-committees of the Board that exercise ICB functions
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act
- The up to date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents** – which should be included in the Governance Handbook or linked to it - including:

- Standards of Business Conduct Policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

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

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

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

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

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

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

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members

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

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

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has seven Partner Members, as follows**:**

a) Two members who bring the perspective of the acute and community sector
b) One member who brings the perspective of the mental health sector
c) Two members who bring the perspective of the primary care sector
d) Two members from the upper tier local authorities whose area coincides with, or includes the whole or any part of, the ICB's area

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

a) Non-Executive Member
b) Member representing the VCSE sector

2.2.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) Three Partner Members NHS and Foundation Trusts
d) Two Partner Members Primary Medical Services
e) Two Partner Members Local Authorities
f) Three Non-Executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) One Member for the VCSE sector

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

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

2.3 Regular participants and observers at board meetings

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

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

2.3.3 The board will regularly invite the following individuals to attend any or all of its meetings as regular participants:

a) Director: North East Essex Alliance
b) Director: Ipswich and East Suffolk Alliance
c) Director: West Suffolk Alliance
d) Director of People and Workforce
e) Director of Strategy and Transformation
f) Director of Performance and Improvement
g) Integrated Care Partnership Co-Chair – Suffolk County Council
h) Integrated Care Partnership Co-Chair – Essex County Council

i) Integrated Care Partnership Director

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

2.3.5 The board will regularly invite a number of observers to attend any or all of its meetings, to include Healthwatch Suffolk and Healthwatch Essex together with Lay Member representatives from the North East Essex, Ipswich and East Suffolk and West Suffolk Alliances.

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

3 Appointments process for the board

3.1 Eligibility criteria for board membership

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification
d) Familiarise themselves with the eligibility and ineligibility requirements, confirming their eligibility prior to appointment and immediately notifying the Chair of the ICB of a change of circumstances that may render them no longer eligible

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

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

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

a) in the United Kingdom of any offence, or

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

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

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

3.2.6 A person whose term of appointment as the Chair, a Member, a Director or a Governor of a Health Service Body, has been terminated on the grounds:

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

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

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

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

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

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

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria:
c) The Chair will be independent.

3.3.3 Individuals will not be eligible if:

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

3.3.4 The term of office for the Chair will be 3 years and the total number of terms a Chair may serve is 3 terms. The maximum term of 9 years is in place to ensure ongoing independence.

3.4 Chief Executive

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

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

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Meets the ICB leadership competency domains
c) Meets the requirements of the role function and specification that the Board shall approve and including:
    (i) Executive health care experience
    (ii) Substantial experience of operating at board level and as a CEO leading across complex, regulated environment. A track record of navigating the media and political stakeholders
    (iii) Extensive knowledge of the health, care and local government landscape and an understanding of the social determinants of public health
    (iv) Sound understanding of strategic financial planning, oversight and control of significant public funds
    (v) Communication skills which engender community confidence, strong collaborations and partnerships
    (vi) Strong critical thinking and strategic problem-solving skills

3.4.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Members – NHS trusts and foundation trusts

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

a) East Suffolk and North Essex NHS Foundation Trust
b) West Suffolk NHS Foundation Trust
c) Norfolk and Suffolk NHS Foundation Trust
d) Essex Partnership University NHS Foundation Trust
e) East of England Ambulance Service NHS Trust

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

a) Be the Chief Executive Officer or another Executive Director of one of the NHS trusts or foundation trusts within the ICB's area
b) Meet any other criteria set out in NHS England guidance or supporting legislation
c) Meet the requirements of the role specification for the post
d) One member shall have specific knowledge, skills and experience of the provision of acute services

e) One member shall have specific knowledge, skills and experience of the provision of community services
f) One member shall have specific knowledge, skills and experience of the provision of mental health services.

3.5.3 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.5.4 These members will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.5.5 below.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.5.1 a) to e) will be invited to make up to two nominations each per role (one Partner Member role for acute, one Partner Member role for community, and one Partner Member role for mental health)
- The nomination of an individual must be seconded by one other eligible organisation outside the nominated individual's own eligible organisation
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

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

3.5.6 The term of office for these Partner Members will be 3 years and the total number of terms they may serve is 3 terms.

3.6 Partner Members - Providers of Primary Medical Services.

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

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

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

a) Is a partner or salaried GP working in a GP practice within the ICB geographical area and included on the Medical Performer List
b) Is a Practice Manager or Healthcare Professional working within the ICB geographical area
c) Is actively engaged in the work of the ICS at place
d) As a commitment to the ICB, this member shall work for a minimum one session per week
e) Meets the requirements of the role specification for the post
f) Collectively provide different perspectives of the Suffolk and North East Essex populations.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They are a GP working predominantly in the out-of-hours service
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointments panel, which results in the individual being unable to fulfil the role.

3.6.5 These member(s) will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.6.6 below.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:

- When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make up to two nominations each per role
- The nomination of an individual must be seconded by one other eligible organisation outside the nominated individual's own eligible organisation
- Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment subject to approval of the Chair under c):
   - The full list of nominees will be considered by a panel convened by the Chief Executive
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

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

3.6.7 The term of office for this Partner Member(s) will be 3 years and the total number of terms they may serve is 3 terms.

3.7 Partner Members - local authorities

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

a) Suffolk County Council
b) Essex County Council

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

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1
b) Meets the requirements of the role specification for the post
c) Collectively provide different perspectives of the Suffolk and Essex populations.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Any other disqualification criteria prescribed through NHS England guidance or supporting legislation apply
c) A conflict of interest is evident, as determined by the Chair or the ICB Board appointment panel, which results in the individual being unable to fulfil the role.

3.7.4 These members will be appointed by the Chief Executive subject to the approval of the Chair in accordance with the process set out at 3.7.5 below.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
- When a vacancy arises, each eligible organisation listed at 3.7.1 will be invited to make up to one nomination each per role
- Eligible organisations may nominate individuals from their own organisation or another organisation
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals with a failure to confirm within five working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they do not agree the list, the nomination process will be re-run until a majority acceptance is reached on the nominations put forward.

b) Assessment, selection and appointment Subject to approval of the Chair under c):
- The full list of nominees will be considered by a panel convened by the Chief Executive
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

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

3.7.6 The term of office for this Partner Member will be 3 years and the total number of terms they may serve is 3 terms.

3.8 Medical Director

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.8.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair

3.9 Director of Nursing

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

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 18(4)(b) of Schedule 1B to the 2006 Act
b) Be a Registered Nurse
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.9.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply
b) They do not maintain a current Nursing and Midwifery Council (NMC) registration.

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

3.10 Director of Finance

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Is a qualified accountant with full membership of a recognised accountancy qualification awarding body
c) Meets the ICB leadership competency domains
d) Meets the requirements of the role specification for the post.

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply
b) They do not maintain the necessary professional qualification requirements.

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

3.11 Three Non-executive Members

3.11.1 The ICB will appoint three Non-executive Members

3.11.2 The appointment process for these members will include local advertising via established channels. Interviews will be conducted by a panel comprising

members of the Board. These members will be appointed by the board subject to the approval of the Chair.

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

a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) One should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration and Human Resources Committee
e) One should have general knowledge, skills and experience in quality and safety that makes them suitable for the role
f) Must live or work within the area of the ICB.

3.11.4 Individuals will not be eligible if

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

3.11.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms after which they will no longer be eligible for re-appointment.

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

3.11.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

3.12 Other Board Members – Member for Voluntary, Community and Social Enterprise (VCSE)

3.12.1 This member represents the VCSE Assembly.

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

a) Be the Chief Executive Officer or another Executive Director/Officer of one of the VCSE organisations within the ICB's area.

3.12.3 Individuals will not be eligible if:

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

3.12.4 The appointment process will be as follows:

a) The nomination will be received from the VCSE Assembly.

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

3.12.6 The term of office for this Member will be 3 years and the total number of terms they may serve is 3 terms.

3.13 Board Members: Removal from Office

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) If they fail to attend a minimum of 75% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.3 apply.

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

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

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

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

3.14 Terms of Appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive Members, arrangements for remuneration and any allowances will be agreed by the Remuneration and Human Resources Committee in line with the ICB remuneration policy and any other relevant policies published at www.suffolkandnortheastessex.icb.nhs.uk or any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by a Non-executive Member Remuneration Panel.

3.14.2 Other terms of appointment will be determined by the Remuneration and Human Resources Committee.

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

3.15 Specific Arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as “designate Ordinary Members” prior to the ICB being established.

3.15.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate Ordinary Members should follow, as far as possible, the processes set out in section 3.5-3.12 of this constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and an HR representative will appoint the Ordinary Members who are expected to all be individuals who have been identified as designate appointees prior to ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial Ordinary Members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

4 Arrangements for the exercise of our functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England. These include but are not limited to:

a) The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business
b) The Good Governance Standard for Public Services
c) The seven key principles of the NHS Constitution
d) The Equality Act 2010
e) The Standards for Members of NHS Boards and Governing Bodies in England

4.1.2 The ICB has agreed a code of conduct and behaviours which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB code of conduct and behaviours is published in the governance handbook.

4.2 General

4.2.1 The ICB will:

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

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

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:
a) any of its members or employees
b) a committee or sub-committee of the ICB

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

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

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published at www.suffolkandnortheastessex.icb.nhs.uk

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.

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

4.6 Committees and sub-committees

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

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

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

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:
a) Submit regular decision and assurance reports to the board
b) Submit minutes of committee meetings to the board
c) Ensure that the committee Chair or designated deputy attends meetings of the board as necessary
d) Comply with internal audit findings and committee effectiveness reviews.

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

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

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

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

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

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

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

5 Procedures for making decisions

5.1 Standing Orders

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

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

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

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

5.2 Standing Financial Instructions (SFIs)

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

5.2.2 A copy of the SFIs are published in the ICB Governance Handbook.

6 Arrangements for conflicts of interest management and standards of business conduct

6.1 Conflicts of Interest

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

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

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

6.1.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of

interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

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

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

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

6.2 Principles

6.2.1 In discharging its functions, the ICB will abide by the following principles:

a) acting in good faith and in the interests of the ICB
b) following the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) compliance with the standards set out in the Professional Standards Authority guidance - Standards for Members of NHS Boards and Governing Bodies in England; and
d) comply with the ICB's Standards of Business Conduct and Conflicts of Interest Policy, including the requirements set out in the policy for managing conflicts of interest, which is available on the ICB's website and will be made available on request.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

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

6.3.2 In accordance with section 14Z30(2) of the 2006 Act, registers of interest are published on the ICB website www.suffolkandnortheastessex.icb.nhs.uk

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

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

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

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

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

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

6.4 Standards of business conduct

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

a) act in good faith and in the interests of the ICB
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)
c) comply with the ICB's Standards of Business Conduct and Conflicts of Interest Policy, and any requirements set out in the policy for managing conflicts of interest.

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

7 Arrangements for ensuring Accountability and Transparency

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

7.2 Principles

7.2.1 The ICB will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by being open and transparent.

7.2.2 In addition to statutory requirements, the CCG will demonstrate its accountability by publishing a range of documents and information on its website at www.suffolkandnortheastessex.icb.nhs.uk

7.3 Meetings and publications

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

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

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

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

7.3.6 Information will be provided to NHS England as required.

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

a) Standards of Business Conduct and Conflicts of Interest Policy and procedures
b) Registers of interests
c) Key policies

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

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

And

a) proposed steps to implement the Suffolk and North East Essex joint local health and wellbeing strategy.

7.4 Scrutiny and Decision Making

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

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

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

a) Complying with existing procurement rules until the provider selection regime comes into effect
b) Ensuring appropriate governance structures and arrangements are in place to deal with any provider selection challenges which may arise.
c) Retaining evidence to underpin the proper exercise of the ICB's responsibilities for arranging healthcare
d) Publishing intentions for arranging relevant healthcare services in advance
e) Publishing contracts awarded and retaining records of decision making
f) Ensuring audit arrangements are capable of examining the decisions made

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

7.5 Annual Report

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

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under

section 13SA(1) (views about how functions relating to inequalities information should be exercised) and

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007

8 Arrangements for Determining the Terms and Conditions of Employees

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

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

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

a) A senior representative for HR, and the Chief Executive, attending in an advisory capacity. It is acknowledged that HR advice should be sought to assist the Committee in reaching decisions and it would be expected for the HR representative to be present throughout the meeting unless the majority of the Committee and the Chair considered otherwise

b) Other Directors or Senior Managers invited to attend as appropriate.

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

8.1.5 The main purpose of the Remuneration and Human Resources Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act.

8.1.6 The duties of the Remuneration and Human Resources Committee are set out in detail in its terms of reference, which in summary are 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. The full terms of reference are included in the ICB Governance Handbook.

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

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services that are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and

their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

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

9.1.2 In line with section 14Z54 of the 2006 Act, the ICB has made arrangements to consult the local population on its system plan, following best practice for the conduct of public consultations published by HM Government.

9.1.3 The ICB has adopted the 10 principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS
b) Start engagement early when developing plans, and feed back to people and communities how it has influenced activities and decisions
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
d) Build relationships with excluded groups – especially those affected by inequalities
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust
g) Use community development approaches that empower people and communities, making connections to social action
h) Use co-production, insight and engagement to achieve accountable health and care services
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities
j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

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

Appendix 1: Definitions of terms used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Integrated Care Board (ICB)	A body corporate with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act
ICB board	Members of the ICB
Chair of the ICB Board	The individual appointed to act as chair of the ICB board
Chief Executive	An individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act, appointed by NHS England, with responsibility for ensuring the ICB complies with its obligations under: sections 14Q and 14R of the 2006 Act, sections 223H to 223J of the 2006 Act, paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006, and any other provision of the 2006 Act specified in a document published by the Board for that purpose; exercises their functions in a way which provides good value for money.
Director of Finance	A qualified accountant employed by the ICB with responsibility for financial strategy, financial management and financial governance and who is a member of the ICB Board.
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution.
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership (ICP)	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area

	coincides with or falls wholly or partly within the ICB's area.
Place-based partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.
Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following: • NHS trusts and foundation trusts that provide services within the ICB's area and are of a prescribed description • The primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • The local authorities that are responsible for providing social care and whose areas coincide with or include the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.
Professional Standards Authority	An independent body accountable to the UK Parliament which help Parliament monitor and improve the protection of the public. Published *Standards for Members of NHS Boards and Governing Bodies in England* in 2013
NHS England	The body which leads the NHS in England
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in Section 25(3) of the National Health Service Reform and Health Care Professions Act 2002

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022.

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

2.3. Amendments to these Standing Orders will be made as per clause number 1.6 in the constitution which sets out the procedure for making amendments to the Constitution and its constituent parts.

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

3. Interpretation, application and compliance

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

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

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

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

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

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

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

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

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

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2 Chair of a meeting

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

4.2.2 If the Chair is absent, or is disqualified from participating by a conflict of interest, the Deputy Chair, if present, shall preside.

4.2.3 If both the Chair and Deputy Chair are absent, or are disqualified from participating, then a member of the Board shall be chosen by the members present, or by a majority of them, and shall preside.

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

4.3 Agenda, supporting papers and business to be transacted

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

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

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

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the board may nominate a deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf if authorised to do so in advance.

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

4.5.3 If a member of the ICB is unable to attend two consecutive meetings, other than as the result of illness or other exceptional circumstance, the member will be asked to meet with the Chair

4.6 Virtual attendance at meetings

4.6.1 The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7 Quorum

4.7.1 The quorum for meetings of the board will be 50% of its members, including:

a) The Chair or nominated deputy
b) Either the Chief Executive or the Director of Finance
c) Either the Medical Director or the Director of Nursing
d) At least one further Non-executive Member
e) At least two Partner Members

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.

b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

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

4.8 Vacancies and Defects in Appointment

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

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

a) Vacant roles will not be included in the total number.

4.9 Decision making

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

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

a) All members of the board who are present at the meeting will be eligible to cast one vote each.

b) Under no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

c) For the sake of clarity, any additional participants and observers (as detailed within Section 2.1 of the Constitution) will not have voting rights.

d) A resolution will be passed if more votes are cast for the resolution than against it.

e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.

f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

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

Urgent decisions

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

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

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit Committee for oversight.

4.10 Minutes

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

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

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

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

4.11 Admission of public and the press

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

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

4.11.3 The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board business shall be conducted without interruption and disruption.

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

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

5 Suspension of Standing Orders

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

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

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

NHS
Suffolk and
North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**20**
Reference No.	**ICB 23-14**
Date.	**24 January 2023**

Title	**Developing a Health Inequalities and Prevention Committee**
Lead Director	Dr Ed Garratt, NHS Suffolk and North East Essex ICB
Author(s)	Dr Jeptepkeny Ronoh, Public Health – Suffolk County Council Stuart Keeble, Public Health – Suffolk County Council Richard Watson, NHS Suffolk and North East Essex ICB Sharon Rodie, Suffolk and North East Essex IPC Secretariat
Purpose	This report sets 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 recommends the establishment of a Health Inequalities and Prevention Committee (HIPC) reporting into the Integrated Care Board (ICB) and sets out the suggested remit, membership, and terms of reference of the committee for endorsement by the Board. It also recommends the establishment of an Operational Delivery Group, which will report to the HIPC and drive the agenda and programmes of work. The report additionally seeks 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).

Recommendations:

The Board is asked to:

- support the establishment of a Health Inequalities and Prevention Committee (HIPC) which will report into the SNEE Integrated Care Board (ICB) and endorse its proposed function and governance.
- support the establishment of an Operational Delivery Group, which will report to HIPC and drive the agenda and programmes of work.
- note the establishment of a system-wide Integrated Care Partnership (ICP) Equality and Prevention Sub-Committee (EPSC) which will report into the ICP Committee and act as an advisory group to the ICB HIPC.

1. Background

1.1 Health inequalities are unfair and avoidable differences in health and wellbeing across the population, and between different groups within society. These inequalities are evident for some people living in Suffolk and North East Essex (SNEE). Addressing health inequalities therefore is a key priority for the SNEE Integrated Care System (ICS).

1.2 A population health approach aims to improve physical and mental health outcomes across the population, while reducing health inequalities. It takes into consideration the wider factors that influence these outcomes and recognises the need to work with communities and across partner agencies. An understanding of the complex interplay between these factors and joined-up action by partner agencies across the whole system is therefore required to effectively address inequalities.

2. Key Issues

Across SNEE, different causes of death contribute to the difference in life expectancy between our most deprived and least deprived communities. Leading causes of death include circulatory conditions, cancer and respiratory conditions. Several underlying risk factors are implicated in their causation, e.g., tobacco, high body mass index (BMI), diabetes, dietary risks, high blood pressure, alcohol and high LDL (low-density lipoproteins or "bad" cholesterol). Focused action to tackle these risk factors will not only prevent people from developing these conditions but will also reduce health inequalities. A system-wide focus on prevention, targeting areas where we have the strongest evidence for inequalities, is therefore important.

Core20PLUS5, a national NHS England and NHS Improvement (NHSEI) approach to reducing health inequalities, highlights areas for targeted prevention work. It asks for a focus on the target population of the 20% most deprived population as defined by the Index of Multiple Deprivation (the "Core 20" of the national population), ICS-determined groups experiencing poorer than average access, experience, or outcomes from healthcare (the "PLUS") and "5" clinical focus areas with the greatest opportunities to narrow the current gap in life expectancy due to health inequalities. These areas include the same conditions and underlying risk factors outlined above. Core20PLUS5 therefore offers a way of reducing inequalities by targeting prevention work using population health management data and approaches in ways which are responsive to the needs of our ICS population.

Population health management (PHM) data will help the system to identify areas of focus and individuals or communities for targeted interventions. Linked datasets will provide insight into current and future population needs, allow targeted action to prevent ill health and reduce health inequalities, and enable the delivery of better coordinated care and better use of scarce resources. It will enable us to move from data to action and have much greater impact than could be achieved previously.

Effective action to address health inequalities in SNEE will require a coordinated and whole-system approach, with targeted prevention work focusing on Core20PLUS5, and using PHM as an enabler. To facilitate this, we propose the establishment of:

- a Health Inequalities and Prevention Committee (HIPC) reporting into the Integrated Care Board (ICB)
- an Operational Delivery Group, which will report to the HIPC and drive its agenda and programmes of work, and
- a system-wide Integrated Care Partnership Equality and Prevention Sub-Committee (EPSC) reporting into the Integrated Care Partnership (ICP).

Work is ongoing to define the membership and remit of the Operational Delivery Group, and how this might work. The suggested remit, membership, and terms of reference of the HIPC and EPSC is outlined next.

2.1 Health Inequalities and Prevention Committee (HIPC)

2.1.1 Purpose

The HIPC will:

- Provide a focal point and strategic leadership on reducing health inequalities and embedding prevention across the ICB.
- Take a lead responsibility for the development and oversight of delivery of the Core20PLUS5 for adults and children and young people.
- Influence ICB resources and priorities to ensure a focus on reducing health inequalities and prevention including responsibility for the distribution of and oversight of the use of the health inequalities funding from NHS England to support the inequalities agenda.
- Use data-led approaches driven by Population Health Management (PHM) to inform and drive collective action on health inequalities and to evaluate the impact on outcomes through its subgroup structure.
- Support more systematic approaches to health inequalities and prevention across the ICB. This could include embedding a 'Health Inequalities in all Policies' approach e.g., ensuring health inequalities consideration in all ICB papers, developing additional metrics for board reports to measure performance for different groups, etc.
- Support the ICB in understanding the broad dimensions of health inequalities between population groups i.e., socio-economic groups and deprivation, protected characteristics in the Equality Duty, geography, and vulnerable groups across the ICB.
- Provide steer into ICB long-term condition committees work programmes and projects to ensure actions are data driven, improve population health and reduce inequalities. This will include for example the CVD, Respiratory, Diabetes, Stroke and Cancer Committees/Networks.

2.1.2 Membership

- The HIPC will be chaired by the Director of Public Health for Suffolk.
- The suggested membership of the HIPC and the Operational Delivery Group will include representatives from the following organisations:

    - ICB
        - Chief Executive
        - Deputy Chief Executive
        - Medical Director
        - Non-Executive Member
    - ICP Director
    - North East Essex Alliance Director
    - Ipswich & East Suffolk Alliance Director
    - West Suffolk Alliance Director
    - Suffolk County Council
        - Healthcare Public Health Lead – Suffolk
        - Adult and Children's Services representative(s)
    - Essex County Council
        - Director of Public Health
        - Adult and Children's Services representative(s)
    - Healthwatch Suffolk
    - Healthwatch Essex

- ICS VCFSE Assembly representative
- Acute sector representative
- Community sector representative
- Acute Mental Health Trust representative
- Primary care representatives (x 2)
- PHM lead
- OHID representative

2.1.3 Governance

The HIPC will be accountable to the ICB Board and will make recommendations to inform health inequalities strategy development, priority setting and resource allocation. The committee will also work with the EPSC and report into the ICP.

The PHM Strategic Group and the Operational Delivery Group will report into the HIPC.

As part of the Operational Delivery Group, sub-groups may be established to deliver on specific programmes of work as required. Work is ongoing to determine how this will work in practice.

The terms of reference will be reviewed annually to ensure these reflect current priorities.

2.1.4 Meeting frequency

The HIPC will meet once every two months.

2.1.5 Resourcing

Consideration needs to be given on how we resource programme support to drive agenda.

2.2 ICP Equality and Prevention Sub-Committee (EPSC)

2.2.1 Purpose

The ICP EPSC will

- Bring the wider system together to address health inequalities across SNEE.
- Promote joined-up action on health inequalities partner organisations across SNEE.
- Act as an advisory group to the ICB HIPC.
- Provide a forum for discussion, sharing good practice, learning, and networking.
- Champion a greater understanding of and commitment to addressing health inequalities across the ICS.
- Promote system learning on health inequalities across SNEE.

2.2.2 Membership

To be agreed to include a broad range of stakeholders with frontline roles from across Alliances, health and care providers, community organisations, etc.

2.2.3 Governance

The ICP EPSC will report into to the ICP Committee.

In its role as a system-wide resource, the ICP EPSC will provide advice on health inequalities to the ICB and other statutory organisations.

The ICP EPSC will be supported by the ICP Secretariat Team.

The terms of reference will be reviewed annually to ensure these reflect current priorities.

2.2.4 Meeting frequency

The ICP EPSC will meet once every two months.

3. Patient and Public Engagement

Patient and public engagement will be facilitated through established forums and mechanisms.

Both committees will work with local communities to coproduce plans, projects and approaches whenever possible.

4. Recommendations

The Board is asked to:

- support the establishment of a Health Inequalities and Prevention Committee (HIPC) which will report into the SNEE Integrated Care Board (ICB) and endorse its proposed function and governance.
- support the establishment of an Operational Delivery Group, which will report to HIPC and drive its agenda and programmes of work.
- note the establishment of a system-wide Integrated Care Partnership (ICP) Equality and Prevention Sub-Committee (EPSC) which will report into the ICP Committee and act as an advisory group to the ICB HIPC.

NHS
Suffolk and North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**21**
Reference No.	**ICB 23-15**
Date.	**24 January 2023**

Title	**Policies for Approval**
Lead Director	Amanda Lyes, Director of Workforce and People
Author(s)	Ben Askew, Head of People and Culture
Purpose	For Approval

Recommendation:

To note the changes from legacy policies and endorse a recommendation from the ICB's Remuneration and HR Committee:

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

1. Background

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

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

2. Key Issues

2.1 The four policies have been developed jointly by a combined Management and Staff side policy working group. The following table sets out any major changes between the current and legacy policies:

Policy	Change from legacy policy
Change Management	Follows similar outline process from legacy policies. Threshold for job matching increased from 51% to ensure closer match. Clearer guidance on information that is required at the start, during and end of consultation period.
Grievance	Main theme and process behind policy, along with stages for raising concerns/grievances, remain. Improved language and emphasis on informal resolution in the first instance. Sets out requirement for recording/logging details of grievance. Provides common form for raising grievance.
Absence	No major changes in respect of thresholds or classification of absence types. Improved understanding of recording different types/subsets of absences (i.e. half-day, disability leave etc). Better instruction and guidance for managers on handing sickness absence issues.
Working partnership with trade unions	Adapted from national template circulated as part of the formation of ICBs. Minor adjustments in respect of terminology (union learning reps) and time off template.

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

3. Recommendation

3.1 As recommended by the ICB's Remuneration and HR Committee to endorse the Committee's approval of the above policies.

NHS
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Integrated Care Board

Management of Change Policy

Suffolk and North East Essex Integrated Care Board

1 Version Control

Version	Date	Author and Role	Detail of Change
1.0	8th June 2022	Ben Askew, Head of People and Culture	First Version

2 Approval History

Version	Date	Approver
<version>	<dd/mm/yyyy>	<name of person and role / board / committee>

3 Next Review Date

The date this policy is due for review is: <Day, Month, Year> (three years)

4 Contents

5 Statement of Overarching Principles

All Policies, Procedures, Guidelines and Protocols of the Suffolk and North East Essex Integrated Care Board (ICB) are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

6 Introduction

NHS Suffolk and North East Essex ICB aims to provide all employees with the highest possible level of employment security. However, service development and the need to continually improve organisational effectiveness will sometimes necessitate changes to staffing levels, structures, roles and ways of working. In these circumstances the organisation committed to ensuring that organisational change is managed in a way that is in line with statutory requirements and best practice as well as being non-discriminatory, sensitive, consistent and fair.

It is recognised that any change within the organisation can cause concern for staff and in these situations; it is the organisations intention to consider staff members' individual and collective interests with care. Consultation with staff side representatives and recognised Trade Unions/Professional Associations will therefore take place at the earliest opportunity so that Staff Side can participate in the development of any decisions taken.

"Major organisational changes" will include the reorganisation, relocation, merger, TUPE transfer, significant expansion or reduction of a function/service area, competitive tendering or outsourcing, or a major change in working practice. All such changes will be conducted in accordance with this document which incorporates best practice and legal requirements and aims to provide a framework for common understanding for managers, staff and trade unions.

Ongoing minor changes are typically; periodic changes to roles, responsibilities and working practices. Staff will be expected to accept reasonable changes where appropriate to the level of their post only.

Where required, more substantial change to roles, responsibilities will require job roles to be re-evaluated. Such matters will be monitored during annual appraisal meetings.

For further information and support as to the practical application of this policy please contact the relevant Human Resources Adviser / Human Resources Business Partner, the relevant Trade Union and/or members of Staff Side. At all times Human Resources will provide an advisory service and will be in place to ensure that processes are followed and adhered to. In all cases it is recommended to liaise with Human Resources before embarking on a change programme to ensure that the process can be followed (in terms of recommended timescales) and applied transparently, consistently and fairly.

This policy has been written in line with Employment Rights Act 1996 and other relevant current legislation/best practice from the Department of Health and NHS Employers. Nothing in this policy overrides legislation.

7 Purpose

The purpose of this policy is to set out the organisations' approach to the management of organisational change and the procedures that should be followed by managers wishing to implement major change.

The principles and procedures support the aim of managing strategic and operational change in a way that is both supportive to staff and enhances the effectiveness and efficiency of commissioning.

8 Equality Statement

This Policy will operate alongside the ICBs Equal Opportunities, Diversity at Work Policy, and Equality Delivery System. The ICB's vision is to have in place a sustainable people driven service system of care which is best of class, and values based on hope inspiring environments and embracing diversity. The ICB will ensure that all staff, volunteers, service users and visitors are treated with dignity and respect, and no individual is treated differently on the grounds of their marital status, maternity, race, gender, gender reassignment, disability, age, religious belief or their sexual orientation.

The ICB assures staff, volunteers and people entitled to our services are treated fairly, equally and with respect and dignity. The ICB will challenge discriminatory attitudes and provide rules and standards of behaviour.

The ICB will monitor the use of this Policy, and will ensure that the policy is implemented fairly, and will take action if it appears that it is has a disproportionate effect.

9 Scope

This policy applies to all employees of the ICB, including fixed term employees when working within the ICB and whilst on ICB business, it includes those who are seconded out to another organisation, and will be applied consistently and equitably to all staff.

It does not apply to staff employed by other organisations and seconded into the ICB (those staff are the responsibility of their substantive employer), agency staff or contractors (e.g. those engaged on a contract for service).

10 Cross Reference to Other Policies

Grievance Policy

Travel and Expenses Policy

Pay Protection Policy

NHS Agenda for Change Terms and Conditions Handbook

11 Definitions

For the purpose of applying the provisions contained in this document, the following definitions shall have the following meanings:

Continuous Service means full or part time employment with the ICB, or any previous NHS employer, provided there has not been a break of more than one week (Sunday to Saturday) between employments. This reflects the provisions of the Employment Rights Act 1996 and Agenda for Change handbook (where applicable) on continuous employment. An individual is only eligible for a redundancy payment if they have Continuous Service of a minimum of 2 years' recognised NHS service at the date of termination through redundancy.

Reckonable Service If the individual meets the Continuous Service criteria and is made redundant the payment will be calculated based on Reckonable Service. This is defined as any recognised NHS service where there has been no more than a break of 12 months, calculated back from the intended redundancy date. Employment outside the NHS which is relevant to NHS employment may be counted as Reckonable Service if it has been previously agreed and formally documented/evidenced by the ICB or a predecessor NHS organisation. Redeployment means the transferring or recruitment of Staff at Risk into a suitable alternative post.

Ring-fencing means posts within a new staffing or management structure will have a restricted pool of people who are able to apply for these posts. Staff 'At Risk' will be considered for a post in a new staffing or management structure as a first priority which is similar to their current substantive post and where there is more than one contender for that post (i.e. establishing a pool of workers for interview without advertising). Ring fencing arrangements apply where the management of change has identified one or more of the following situations:

- The establishment of new posts arising from a changed or new service where staff are identified as being at risk;
- The establishment of fewer posts arising from the changed or new service;
- The integration of existing departments or structures including situations where a new organisational structure has resulted in changes to existing roles;
- A combination of any of the above.

Matching means the process by which the ICB will review and assess individuals suitability for roles in the new structure utilising existing role profiles/job descriptions which 'match' to the proposed new role(s), based on the NHS jobs that have been matched to nationally evaluated profiles, based on information from job descriptions, person specifications and additional information.

Slotting In means the process by which staff 'At Risk' are confirmed into a post in a new staffing or management structure which is similar to their current substantive post and where that individual is the only contender for that post. Slotting in may occur where a post is in the same band as the individual's current post or where it remains substantially the same (usually defined as 60%+ the same) with regard to job content, responsibility/status, grade, and requirements for skills, knowledge and experience/professional registration.The key criterion for slotting is an employee's substantive band being the same as the post they are being slotted into.

Staff at Risk means staff whose posts may potentially be redundant as a result of organisational change if suitable alternative employment cannot be found.

Staff Affected by Change means staff that may be affected by the change e.g. change of line manager, changes to responsibilities, but may not be at risk of redundancy

Protection Arrangements covers how staff's pay may be protected if, as a result of the organisational change the banding for their role, or the pay for their new role would be less than they received prior to the change. Protection arrangements are covered in the ICB's Pay Protection policy.

At Risk Register is a list of staff who, at the end of the consultation period, are 'At Risk' of Redundancy. This will be used to try and ensure that any member of staff who is 'At Risk' of redundancy will be given priority for any suitable jobs that become available.

The Change refers to any change that may be being undertaken by the ICB and each change will be covered by a 'consultation document' that details the specific details of what the change is and who is affected.

TUPE means the Transfer of Undertaking (Protection of Employment) Regulations 2006, when whole services or parts of services are transferred from one employer to another

COSOP means Cabinet Office Statement of Practice. National NHS guidance should be referred to if COSOP applies.

12 Statement and principles

Organisational change is driven by the business needs of the ICB. Change can be triggered either by the external environment or by an internal review of organisational requirements. Examples of significant organisational change include the reorganisation, relocation, merger, expansion or closure of a service, competitive tendering or outsourcing, or a major change in working practice.

In order to meet changing business needs more effectively, there may be occasions when managers need to implement relatively minor changes. Reasonable minor changes and adjustments to duties and working practices may be implemented without recourse to the formal procedures in this document but will require reasonable consultation with staff affected and their representative if requested. Any situation which may lead to redundancy will not be deemed to be a minor change.

The ICB is responsible for deciding the size and most efficient use of the workforce but in doing so are committed to the following principles for managing organisational change:

- The ICB will provide such information about the proposed organisational change as would be in accordance with good employee relations practice to disclose to staff and the trade unions;

- The ICB will work in partnership with relevant trade union/staff representatives from the earliest stage possible;

- Staff will receive notice of any organisational change which may affect their futures at the earliest opportunity;

- Staff will be treated as individuals with due regard to their personal and employment circumstances and their career aspirations at all stages of the change management procedure. This will take into consideration any reasonable adjustments required in line with the Equality Act 2010;

- Staff will have the right to be accompanied by an accredited trade union representative or workplace colleague at meetings to discuss the organisational change;

- Requests by the employee for additional support at any individual meetings should be considered e.g. where disability is involved and familiarity with the impairment or the individual or specialist input would be beneficial;

- The ICB will consider all reasonably practicable steps to avoid compulsory redundancies;

- Staff will receive training and development as appropriate, to meet new skill requirements and where appropriate to identify new career opportunities, with funding and time to attend training and development activities provided;

- Staff will have access to the ICB counselling services, Employee Assistance Programmes and career support where available;

- Staff will be considered against their substantive post and contractual arrangements.

13 Measures to limit the impact of the change

Every effort will be made to avoid compulsory redundancies as the ICB will endeavour to retain the skills and experience of staff.

In seeking to avoid compulsory redundancies the ICB will consider the following steps:

- Use of vacancy control

- Not replacing staff that leave

- Reduction in overtime

- Reducing the use of agency / bank / temporary staff

- Review of the use of fixed term contracts (in line with the requirements of the Fixed Term (prevention of less favourable treatment) (Amendment) Regulations 2008

- Giving at risk staff priority over vacancies in the organisation

- Working with other NHS employers in the area to identify vacancies wherever possible

- Voluntary reductions in hours of work / job sharing

- Redeployment / re-training
- Voluntary early retirement
- Voluntary redundancy*, subject to the overall operational requirements of the service and within the level affordable by the ICB and agreed by the ICB.
- Ensuring staff have access to regular support and advice from their managers/relevant trade unions/professional association/Staff Side representatives
- Any other measure agreed with the unions and Staff Side at the time of the change.

* The ICB will consider an expression of interest in voluntary redundancy or voluntary early retirement from any employee whose own job is not proposed for redundancy, but whose termination will lead to replacement by another employee whose job is to be made redundant.

14 Roles and responsibilities

14.1 Line Manager Responsibilities

- To recognise that staff are central to the achievement and success of organisational change, and to acknowledge that change can cause concern and uncertainty and should therefore be managed fairly and consistently in accordance with established good practice.
- To consult with staff and engage with staff representatives in any change management procedure
- To ensure they maintain full awareness of all aspects of the changes planned, and how plans and their implementation may be affected as the change management process progresses, in order to be able to respond to the concerns of staff in their teams at all times
- To provide information to staff and trade unions so that they are able to make meaningful contributions to the consultation process
- To ensure that no member of staff is discriminated against on the grounds of contractual status, caring responsibilities, or any protected characteristic as defined by the Equality Act 2010 e.g. ethnic origin, nationality, race, disability, gender, marital or partnership status, age, religion or belief, sexual orientation or transgender status, when applying this policy
- To attend any training provided by the ICB in Equality and Diversity, e.g. statutory and mandatory training. All managers involved in managing a change process should have had coaching/development on the operation of this procedure delivered by a member of the human resources team and the associated equality and diversity issues will be covered.
- To liaise with HR to ensure the ICB is not open to claims of discrimination as a result of a change management process, and be mindful of the need to consider making any necessary reasonable adjustments at the job design stage, when considering the suitability of alternative employment for an individual and the arrangements for filling posts

- To enable union or other staff representatives to fully participate in the process, (which may require frequent meetings with managers and in particular affected staff), by agreeing paid time off for them to undertake this work as appropriate.

14.2 Employee Responsibilities

- To engage with pre-consultation and consultation stages, in the further processes of implementation, and in identifying new career opportunities.

- To make themselves aware of the content of this policy, and where necessary seek advice on any policy or procedural aspects from their line manager, HR or their trade union representative.

- Being open to retraining opportunities in order to maximise options for suitable alternative employment

14.3 Human Resources Responsibilities

- To assist managers in the fair and consistent application of the policy, ensuring that the ICB meets it legal obligations relating to any organisational change.

- To provide advice and support to managers at all stages of the change management process.

- To provide advice to employees on the content of the policy and the change management process, including directing staff to other agencies for assistance such as Occupational Health or the Employee Assistance Programme.

14.4 Trade Union Involvement

• To represent employees, who are trade union members, when requested to do so.

• Where organisational changes are intended, to advise and represent staff undergoing organisational change,

• To participate in the consultation process in line with legal requirements following receipt of formal notification of any proposed major organisational changes by the ICB

15 Consultation

15.1 Purpose of consultation

In accordance with legislation and the partnership working principles of the NHS, the ICB is committed to meaningful and appropriate consultation with trade unions and staff affected by organisational change, with a view to reaching agreement on the way forward whilst recognising there may be times when organisational change will need to proceed without a consensus being reached on all issues. The timing and extent of consultation will be proportionate to the degree of proposed change, the number of staff affected and the impact on individuals.

The purpose of the consultation meetings with staff and their representatives will be:

- to receive and where possible address any questions on the consultation document;

- to consider any comments or views on the consultation document including any alternative proposals and costings (which the ICB will as far as practicable make available) before determining any final decision to proceed;

- to clarify any change processes and timeframes specific to the proposed organisational change exercise under discussion.

15.2 Consultation Procedure

Managers shall prepare a consultation document on the proposed organisational change having gathered information to support the need for change and consulted with HR as appropriate.

The consultation document will include details of the following:

- Current situation analysis including staffing structure

- Impact on service/business

- Impact on other areas / services

- Consideration of any relevant health and safety assessment

- The need for change and the rationale behind the change

- The options that have been considered

- The proposals for change including the proposed staffing structure(s) and any location change

- Proposed job description

- The financial, staffing and workload implications of the proposals

- The number and grades/bands/descriptions of staff who may be at risk of redundancy as a result of the proposal

- Proposed timescale for consultation and implementation of the proposed change

- The way in which staff will be selected for posts within the new structure or transferred

- If necessary, the method and selection criteria for redundancy, including how redundancy payments will be calculated

- The measures to be taken to avoid compulsory redundancies which may include natural wastage, redeployment with retraining, or voluntary early retirement or voluntary redundancy

- Details of any suitable alternative employment which may exist

- Details of how this information will be disseminated to staff

- Description of the consultation process, including planned meetings, timetable, how staff and representatives can respond and the deadline.

The consultation document will provide the basis of initial discussions with Trade Unions and staff but it is recognised that the plans may subsequently need to be amended to take account of the outcome of the consultation.

The consultation document will include an equality impact assessment.

15.3 Time periods for consultation

In all cases the ICB will allow sufficient time for reasonable and meaningful consultation with staff and their representatives. All documentation that is required for a meaningful consultation will be available; which will include items listed in 15.2 above. Changes not involving redundancies can involve consultation of less than 30 days by agreement with the staff affected and their representatives. The length of consultation period will also apply where TUPE transfers are planned (there is no statutory consultation period under the TUPE Regulations), and in situations where there are less than 20 redundancies proposed (which also does not require a statutory minimum consultation period). In exceptional circumstances where changes need to be made very quickly, the trade unions will be briefed immediately and the verbal briefing will be followed by a written brief.

In a collective redundancy scenario, consultation will commence for a period of no less than the statutory time scales:

- Where 20 - 99 redundancies are proposed then consultation should commence at least 30* days before the first redundancy takes place;

- Where 100 or more redundancies are proposed then consultation should commence at least 45* days before the first redundancy takes place.

* These timeframes are subject to change in the event of statutory changes.

The employer and the staff representatives can decide that they have informed and consulted on the issues and do not need 45 days. If that is the case, then dismissal notices can be sent out earlier (Note: that this can only happen if the staff representatives agree that they have been fully informed and consulted within the 45 day period and do not need the full 45 days).

Trade unions and staff may request additional information or an extension of time if this is necessary to enable them to understand and contribute to an informed discussion on the merits of the proposal. Such requests will not unreasonably be refused, and where they cannot be accommodated a reason will be given.

15.4 Consultation with the trade unions

Early informal consultation with the trade unions is encouraged and should occur where possible. This is also known as pre-consultation. Meaningful pre-consultation often leads to an agreed shorter formal consultation time and greater staff satisfaction with the process.

Formal consultation with the trade unions via an agreed Joint Consultative Committee or a staff side equivalent body will commence within the minimum timescales above

once any informal comments have been considered and the consultation document has been finalised. This will take the form of:

- On-going discussions with the local accredited representatives
- Trade unions representing staff affected by the change being invited to the first meeting with all affected staff and being given reasonable notice to attend.

In a redundancy scenario, the information provided in writing to the relevant trade unions shall include the following:

- The numbers and descriptions of employees whom it is proposed to dismiss as redundant
- The total number of employees of any such description, employed by the organisation, at the establishment in question
- The proposed method of selecting employees who may be dismissed
- The proposed method of carrying out the dismissals, with due regard to any agreed procedure, including the period over which the dismissals are to take effect (reference NHS Terms and Conditions Handbook: para 16)
- The proposed method of calculating the amount of any redundancy payments to be made (over and above the statutory redundancy payment) to employees who may be dismissed.

During a period of major change, management will ensure that the relevant trade unions are kept informed of developments and will meet with trade union representatives as appropriate.

15.5 Consultation with individual staff

A meeting will be held with all staff affected by the organisational change to announce the proposed change and explain the consultation process which will follow.

Each member of staff affected by the organisational change will be provided with a copy of the consultation document. Staff who are absent from work for any reason including maternity leave, sickness absence, secondment to another organisation, career breaks etc. will be sent a copy of the consultation document at their home address/other suitable address so that they can participate in the consultation process.

Each member of staff will be offered the opportunity of at least one individual meeting with their manager at which they have the right to be accompanied by an accredited trade union representative or workplace colleague. HR advisory support will also be offered to support the process including engaging with managers, staff members and staff representatives. In a redundancy scenario, the meeting will be to discuss the issues set out in section 18 below.

At the meeting, each member of staff will be invited to comment and respond to the proposals, including how they may impact on their personal circumstances. It is recognised that staff may require time to respond and may not be able to do so at that particular meeting.

A written record of the individual meetings will be kept and provided to the employee and their trade union representative where applicable. The record will be a note of the main points discussed at the meeting, not verbatim notes.

Regular updates and frequently asked questions may be circulated to staff throughout the formal consultation period. Throughout this period staff should be encouraged to discuss their concerns and queries with their line manager and trade union.

In addition to the individual consultation meetings, staff can be kept informed as appropriate by management, team meetings and briefings, newsletters, trade union meetings, email and other written communication and information supplied by the trade unions.

15.6 End of consultation

At the end of the consultation period the manager will consider all comments received from staff and the trade unions and will decide on the way forward. A written report will be provided to the staff and recognised trade unions covering the change process to be followed and the timeframe. The report should (where appropriate) include:

- The reasons for the decision
- Any relevant health and safety assessments
- An explanation where the management decision is in conflict with the views of the trade unions representatives and staff or where the proposal has changed as a result of consultation
- Identification of posts which are the same or substantially the same in the old and new structures
- Arrangements for filling posts via Slotting In or Ring-fencing
- Details of staff members that have been pooled for competitive interviews
- Selection arrangements for posts within the new structure
- Measures that will be taken to avoid compulsory redundancies
- Arrangements for seeking suitable alternative employment
- Reference to the ICBs protection arrangements and how these will apply
- Support for staff who are affected by the change, including any career counselling and reasonable time off to seek other employment or undertake training
- Proposed timescales for each stage of the change process
- Equality impact assessment.

Where redundancies are inevitable the ICB will set selection criteria for inclusion in the conclusions to consultation document. These criteria should be objective, clearly defined, measurable and non-discriminatory. Managers should seek advice from HR on the selection criteria to be used to ensure the ICB is not open to legal challenge. Selection criteria will be discussed, and agreed, with trade unions/staff representatives.

Under normal circumstances, staff will be selected on the basis of their relevant skills, experience and qualifications to undertake the remaining jobs, as assessed through formal interviews held in accordance with ICB selection procedures. However, there may be occasions where the use of additional selection criteria is agreed with the Trade Unions during the consultation process, that may act as a final arbiter where two or more employees are equally scored in a competitive interview situation such as for example:

- Conduct and performance (as evidenced through the disciplinary and performance review records);

- Attendance records (due regard will be given to the causes of absence and the equality impact of use of this criterion).

These may only be considered if there has been a issue which has reached formal stage of the Organisation's disciplinary/performance/absence procedures i.e. formal warning/performance improvement framework in place and will still be live at the proposed time of assessment.

In considering any measures to avoid compulsory redundancies, including requests for voluntary redundancy or early retirement, operational efficiency and service needs must be taken into consideration. If a member of staff volunteers for redundancy/early retirement, approval of the request will be subject to the needs of the service and the cost implications. Care must be taken to ensure that decisions are based on sound organisational reasons and do not breach equality legislation. All efforts will be made to mitigate redundancies (see section 18 onwards).

15.7 Support for staff

All staff affected by the organisational change will be encouraged to seek the advice and support of their trade union. Relevant support will be provided by the ICB and may include:

- Help with the production of CVs/application forms (including assistance with NHS Jobs)

- Help with preparation for interviews

- Careers advice

- Support in developing coping strategies and stress management, with support of the counselling service

- Time to meet with recognised trade union representatives to discuss the change

- Further assistance to staff who are at risk of redundancy will include reasonable time off to seek other employment or undertake training

- Placement on the ICB at risk register.

Even after the change has taken place, it is acknowledged that staff may take some time to adjust to the change itself. Managers should remain available to staff to manage any issues that arise and support staff through the transition.

16 The Process for Filling Posts in the New Structure

The Management of Change process will usually start with the very senior management levels first and then cascade down through the organisation on a level by level (or 'tiered') basis. There will be three stages for every level of the Management of Change process in the process for filling posts in a new structure. The levels may be run in parallel, but will be run independently of each other:

The following process will apply to all posts.**Stage One** takes place amongst the staff affected by the change. Posts in the new structure are filled either by Matching and Slotting In or by a Ring-fencing process. Stage one will apply only to staff holding permanent contracts of employment or for those who have more than one-year's service on a temporary or fixed term contract: Applications will be restricted to members of staff who have been identified as "At Risk of redundancy".

Staff will be slotted or ring fenced according to their substantive band (See Appendix B for additional information around 'Matching, Pooling and Slotting Guidance'). Where staff are ring-fenced, competitive interviews will be used to identify which staff will then be appointed to the available posts.

Where slotting-in has not been agreed those staff who are unsuccessful in obtaining a post in step one will be placed 'At Risk' of redundancy and will be eligible to be considered for any posts not filled, at their level or once the Matching, Slotting-in and ring-fencing and competitive interviews have been completed at the next or subsequent levels;

In situations where an individual employee, or group of employees, believe they have been wrongly excluded (or included) from the 'ring fence', the position will be re-examined by the management team. This process will require meeting with the nominated employee representative(s) to fully discuss the issue. Such a meeting must, unless mutually agreed to the contrary, take place within one working week of the issue being raised;

- All posts within the 'ring fenced' area will be subject of limited competition in that they will at the first round be available only to staff employed within the 'ring fenced' area, in accordance with agreed selection procedures, unless otherwise agreed in consultation with staff side representatives

- Applications from employees within a 'ring fenced' area will not normally require the completion of a standard application form. Instead, employees will either be asked to complete an internal application form or expression of interest form identifying the role(s) for which they wish to be considered

- In circumstances when considered appropriate by management in consultation with employees and their representatives, employees may be slotted into posts within a re-organised area. This may be appropriate where the number of current staff within the 'ring fenced' area is equal to or less than the number of posts available. In these situations an interview may not be necessary

- Staff seeking to apply for existing or new posts within their 'ring fenced' area which are at a lower band than their present posts may make application for the post, but only after 'at risk' applicants already at that level have been interviewed or otherwise selected unless the post at the lower band could be matched (apart from band) to their current substantive role in which case they may be included in the ring fence if not already included in a ring fence at their substantive band

- Staff seeking to apply for existing or new posts within their 'ring fenced' area which are at a higher level than their present substantive post may make application for the post, but only after 'at risk' applicants already at that level have been interviewed or otherwise selected.

Stage Two (prior consideration/restricted internal competition) is where any posts that remain vacant following Stage One for that specific level of the new structure and will be opened up to access by any staff on the ICB's at risk register for whom the post is considered suitable alternative employment or holding a fixed-term contract of employment (with less than 1 year service with the ICB or previous organisations)

For staff, this may include posts at a lower pay band, in which case the ICBs pay protection policy might apply. At Risk staff will only be considered for posts once the Matching, Slotting-in and Ring-Fencing and interview process has been completed at the appropriate level;

- Any post in the new structure which remains vacant following the appropriate level's Stage One process will then be eligible for consideration under Stage Two of the previous level. If the post still remains vacant it will then be considered under Stage Three and will be open to all staff and/or advertised externally. Priority will be given to employees who are in a redundancy notice period over employees who are on the at-risk register for other reasons. For staff who apply for and are successful at obtaining a post in the new structure, which is at a lower band than their substantive post, and which qualifies as suitable alternative employment, the ICB's Pay Protection Policy will apply. Where staff apply for a post at a lower level, which does not qualify as suitable alternative employment i.e., more than one band below their substantive role, to avoid redundancy, the ICBs Pay Protection policy provision will also apply.

Stage Three is where vacancies are advertised internally in the first instance;

- The three stages may not run in parallel and will be dependent on the previous steps being completed. All reasonably practicable steps will be taken to avoid compulsory redundancies. Priority will be given to employees that are affected by the change

- Job descriptions and person specifications will be produced for new posts. Jobs will be matched or evaluated in partnership in accordance with the national NHS

Agenda for Change job evaluation scheme. In cases of workforce re-profiling the principles of Annex 24 of the NHS Agenda for Change terms and conditions will be applied.

Selection criteria for all posts in the new structure (whether or not there is competition) must be non-discriminatory, fair, objective, clearly defined and based on the skills and competency requirements of the post. The selection criteria must be made available with the consultation document.

Staff who are offered posts during Stage One will be deemed to have been offered suitable alternative employment by the ICB. This will be confirmed in writing by the manager. This is on the basis that if staff are Slotted In or offered Ring-fenced posts it will be assumed that the posts offered are suitable alternative employment and hence the consequences of refusing to accept these posts will be as per refusing suitable alternative employment. (See paragraph 18.2 for more information on suitable alternative employment).

Employees shall have the right to appeal during Stage One against the decision to be chosen to slot/not to slot into a post or for selection or non-selection to a ring-fenced pool. Employees shall have 5 working days from the date of the letter advising them of the decision, to submit their appeal in writing to the manager, in accordance with the Appeal process under Section 20 of this policy.

Employees should only be turned down for posts where they fail to meet the essential criteria, unsuccessful at interview or where others in the at risk pool are considered to meet the requirements better after assessment/interview (the fact that there may be better candidates in the external labour market is not a reason for non-selection) by the appointing panel (including Human Resources). Any member of staff who is not appointed to a post in the new structure will be offered post-interview feedback, coaching or training where appropriate, and has the right to appeal in accordance with the Appeal process in Section 20.

Stage Four – Open Competition - this stage opens up the recruitment process to external applicants.

17 Staff at Risk

When changes in staffing levels or skill mix are proposed which will lead to a reduction in the numbers of staff employed in particular grades, occupational groups or specialties, management will identify the positions, individual staff or pool of staff who are at risk of redundancy as a result of the changes in line with the agreed criteria stated within the consultation pack.

Staff acting up (which should be for no more than 6 months) at the time of the change will be placed in the pool relating to their substantive post.

Staff seconded into a different role will be placed in the pool relating to their substantive post.

The identification of being at risk of redundancy is not a notice of redundancy.

Staff at Risk will be invited to a meeting(s) with their manager and trade union representative or work colleague to:

- discuss how the proposed changes affect the individual
- explain why the individual is at risk of redundancy
- discuss ideas for avoiding redundancy dismissals, reducing the number of Staff At Risk who are made redundant and mitigating the consequences of any redundancy dismissals
- explore the possibility of Redeployment
- explain the process for Redeployment
- explain the arrangements for protection of pay and terms and conditions where applicable

- offer support and assistance

- discuss any other relevant issues and processes which may include providing a redundancy payment estimate if requested.

Following the meeting, Staff At Risk will be given a letter within five working days to confirm their at risk status and the key points discussed at the meeting including answers, wherever possible, to questions raised at the meeting for which there were no immediate answers available at the time.

Staff at Risk will be given prior consideration for posts within the new structure where they meet the selection criteria, under Stage Two of the process and those posts are vacant after the appropriate Matching, Slotting-in, Ring-fencing and competitive interview processes for that level have been completed. Where they are selected for a new post they will normally be given the offer in writing within seven working days of the interview. Any training required will be discussed with the member of staff as part of the offer process. The appointment will be subject to a trial period.

In the case of significant change which spans a number of NHS organisations, the ICB will endeavour to reach an agreement with those organisations regarding the establishment of job redeployment opportunities. The agreement will contain a commitment to equality of opportunity for all staff who will then have the same access to opportunities and vacant posts with any of the organisations.

Staff who are not selected for a post in the new structure will be formally declared at risk of redundancy in accordance with their contract of employment. They will continue to be listed on the ICB's at risk register whilst alternative employment may be identified. There may be situations where it is necessary to give notice of redundancy in accordance with the contract of employment at the end of the consultation process.

Staff at Risk will be required to register with NHS Jobs and apply for suitable posts within the NHS. The ICB will use the full functionality of NHS Jobs (including "internal only" and "restricted vacancy" functionality) to support redeployment of staff at risk.

Staff At Risk will be given prior consideration for other posts that are or become vacant in the ICB during a specific organisational change and, subject to the arrangements regarding suitable alternative employment and trial periods, they will remain on the register until their last day of service.

Special provision is made in law where an employee's job becomes redundant while he or she is absent on maternity or adoption leave; the employee is entitled to be offered any suitable alternative vacancy before the existing contract ends, in preference to employees who are not absent on such leave.

18 Redundancy

18.1 Definitions

A member of staff may become redundant if they are dismissed and the reason for the dismissal is wholly or mainly due to:

- the fact that the ICB has ceased, or intends to cease, to carry on the activity for the purposes of which the individual was employed, or has ceased, or intends to cease, to carry out the activity in the place where the individual was employed;

or

- the fact that the requirements of the ICB for staff to carry out work of a particular kind in the place where they were so employed, have ceased or diminished or are expected to cease or diminish.

The HR Department is responsible for notifying the relevant Department (currently the Department for Business, Energy and Industrial Strategy (BEIS)) in writing if the ICB proposes to make 20 or more staff redundant, within the terms of the legislation in force at the time. A copy of the notification form will be sent to the relevant trade union concerned. Advance notification to the relevant Department does not bind the ICB to make the employees redundant.

18.2 Suitable Alternative Employment

Suitable alternative employment will be an equivalent post defined in terms of pay, working hours, status, grade, duties and responsibilities, location. It must be suitable to the individual's personal circumstances, skills and experience. It may be on any site operated by the ICB subject to individual travel considerations. This may be within a job at the same band as the employee's current job, or within a job at one band below (attracting pay protection in redundancy situations), Staff at Risk will be given prior consideration for suitable posts in line with their skills, experience and capabilities and where appropriate will receive protection of pay.

Where there are insufficient numbers of vacant posts within the ICB, the Human Resources Team will endeavour to identify suitable redeployment opportunities within the wider NHS and draw these to the attention of the staff.

Staff are reminded that under Agenda for Change terms and conditions an unreasonable refusal to accept suitable alternative employment offered by the ICB or another NHS employer, will mean that they are not entitled to a redundancy payment. (See section 18.5 of this policy and the NHS Terms and Conditions Handbook Section 16).

In considering suitable alternative employment priority will be given to staff with a Contract of Employment with the ICB.

Following identification of potentially suitable posts at either Stage One or Stage Two, individual staff 'At Risk' will be offered the position in writing and be given a copy of the job description/person specification and a deadline of at least five working days within which to apply. In some circumstances e.g. annual leave and other types of leave, this period may be appropriately extended. During this period the individual may meet with the appropriate manager informally to discuss their interest.

If the individual is offered the post, this will be treated as an offer of suitable alternative employment and a trial period will apply, where staff will be assessed against the role's job description.

Staff members will be expected to actively seek alternative employment opportunities alongside the support given from the ICB. Where a staff member fails to make an application for a suitable post or fails to reasonably engage with the selection process for that post, they may be deemed to have unreasonably refused suitable alternative employment.

18.3 Trial Periods and Training

A trial period will only apply to Staff at Risk where a formal offer of suitable alternative employment has been made.

The purpose of a trial period is for both the manager and the individual to assess the suitability of the post as alternative employment.

Where staff have the potential ability but not the immediate experience to undertake full duties of the role, they will be provided with appropriate skills development/training. This will be provided when it is reasonable, practical and cost effective and where the member of staff demonstrates a willingness to learn and can apply the new skills within an agreed timeframe.

Where suitable alternative employment is offered, an individual under notice of redundancy has a statutory right to a trial period of 4 weeks from that date subject to the terms as agreed in Section 138 (c) of the Employment Rights Act 1996 and in conjunction with Section 16 of the Agenda for Change (AFC) terms and conditions handbook.

The trial period will normally last for four weeks but may be extended by mutual agreement where a member of staff requires additional training and development or where reasonable adjustments are required, in line with the Equality Act 2010. In exceptional circumstances and subject to a written agreement between the staff member and the line manager and written sign off from the Director responsible for Human Resources the trial period can be extended up to a maximum period of 12 weeks. The extension will be subject to regular review.

If the trial period is unsuccessful, as determined by the individual and/or the manager concerned, redundancy arrangements will apply as from the end date of the trial period when the original contract of employment will terminate. Until the end of their notice period Staff at Risk will be considered for other suitable alternative employment if available.

18.4 Change of location

If, as a result of organisational change, there is a requirement to move staff from their normal place of work to another location within the ICB on a temporary or permanent basis, and this results in increased travel costs to and from work, staff may be reimbursed their extra daily travelling expenses for a period of 4 years from the date of transfer in accordance with paragraph 17.17 & 17.25 of the NHS Terms and Conditions handbook.

18.5 Redundancy arrangements

A member of staff will have their contract of employment terminated on the grounds of redundancy if no suitable alternative employment can be found or if a trial period is unsuccessful.

The terms under which a redundancy payment and/or early retirement benefit are payable are summarised below:

- To qualify for a redundancy payment/early retirement benefit the individual must have:

- a contract of employment with the ICB; and
- at least 2 years' (104 weeks) Continuous Service within the NHS.

- A redundancy payment takes the form of a lump sum, dependent on the employee's Reckonable Service at the date of termination of employment
- The lump sum is calculated on the basis of one month's pay for each complete year of Reckonable Service, subject to a minimum of 2 years' Continuous Service and a maximum of 24 years Reckonable Service (i.e. the maximum payable is 24 months)
- For those earning below the minimum level or for high earners as outlined by Agenda for Change, redundancy payments will be calculated in line with the most recent Agenda for Change Terms and Conditions and legislative requirements. (Please note there is both a minimum level for redundancy and a maximum cap).
- Early retirement on the grounds of redundancy is available, subject to the employee:
  - being a member of the NHS Pension Scheme;
  - having at least 2 years' Continuous Service and 2 years' pensionable membership; and
  - having reached the minimum pension age in accordance with the relevant NHS Pension Scheme arrangements.
- Some staff may be subject to locally-agreed contractual arrangements in respect of redundancy which must be honoured
- In some circumstances tax benefit may be applied to the payments. Individuals should source independent financial advice
- In order to comply with eligibility for redundancy payments and avoid overpayments, the employee must declare any other NHS employment current or planned prior to the redundancy payment being requested by the ICB.

Staff will not be entitled to redundancy payments/early retirement on the grounds of redundancy if they:

- Are dismissed for reasons of misconduct
- At the date of the termination of the contract have obtained without a break, or with a break not exceeding four weeks, suitable alternative employment with the ICB or other NHS employer
- Unreasonably refuse to accept suitable alternative employment with the ICB or another NHS employer
- Leave their employment before expiry of notice, except if they are being released early
- Are offered a renewal of contract with the substitution of a new employer for the ICB

Staff whose employment is subject to TUPE transfer will not be redundant and therefore will not be entitled to redundancy payments/early retirement on the grounds of redundancy.

The manager will liaise with HR in order to obtain details of redundancy entitlements and other aspects of the redundancy process. The manager will provide the individual and their trade union representative, in writing, with the following details:

- The number of weeks' notice, in accordance with the contractual notice period
- The effective date of the redundancy, which will also be the last day of service
- The number of days' outstanding annual leave, where applicable, to be paid in lieu
- The amount of redundancy payment/enhanced pension benefits that will be paid, where applicable
- What efforts will be made to assist the individual in seeking suitable alternative employment during the notice period
- What support is offered during the notice period e.g., help with job search, CV and interview preparation
- What work the individual will be expected to undertake during their notice period
- That reasonable time off with pay will be given to seek and prepare for alternative work (staff should request this time off at the earliest opportunity through the normal leave procedures and they should not have these requests unreasonably refused)
- That early release will normally be given, unless there are compelling service reasons to the contrary, if the individual is successful in obtaining other employment (with evidence provided of such employment) outside the NHS and wishes to take this up during the notice period; the date of early release will then become the revised date of redundancy for the purpose of calculating any entitlement to a redundancy payment
- The right of appeal against selection for redundancy or the terms of the redundancy
- The date on which redundancy payment will be made should be no less than 4 weeks' after the last day of employment (termination date) and on receipt of a signed declaration from the staff member that no work has been entered into with an alternative NHS employer within this timeframe.

18.6 Protection arrangements

Protection of pay provisions will be put in place in order to support staff that, as a result of organisational change, are required to move to a new post which would entail a reduction of earnings and certain terms and conditions of employment.

Pay protection will apply for the agreed periods set out in the ICB's Pay Protection Policy or until the member of staff moves voluntarily to a new post within the ICB, or leaves their employment with the ICB.

19 TUPE Transfers of services and staff

Where there is a proposal to transfer services and staff to a different employer, the ICB will ensure there is sufficient time for a meaningful consultation process to occur in line with relevant statutory requirements and with engagement with the trade unions at the earliest opportunity. There will usually be a minimum of 30 days (unless otherwise agreed) consultation with staff

When services are transferred from one organisation to another in line with TUPE or by virtue of a Transfer Order under the National Health Service Act 1977, which mirrors TUPE, the employment of staff who are assigned to the services which are being transferred will transfer to the new organisation. TUPE applies in contracting out scenarios, retendering and where the services are brought back into the NHS.

All the terms and conditions within the transferring employee's contract of employment (including relevant policies and procedures) will transfer with them and should not be changed as a consequence of the transfer.

Where staff have responsibilities spanning more than one NHS organisation or more than one service, discussions will take place with the individual, their trade union representative and the organisations concerned to determine if their employment should transfer. The options in this situation might be that the individual will transfer to one organisation with an agreement to provide services to the other(s), or have more than one contract of employment, or, in exceptional circumstances, to be declared at risk.

In all of these circumstances, for the purposes of the consultation that will be carried out, the manager will identify the functions, posts and individual staff that will transfer or be affected in accordance with the obligations of TUPE and shall write to the staff affected and the trade unions informing them of the intention that staff will transfer, the implications of the transfer and any measures which will be taken in connection with the transfer.

All staff have the right to request one to one meetings during the consultation period with a right to representation.

The manager will then upon request hold one-to-one meetings with individual staff (and their representative) within the consultation period to discuss the implications of the transfer, measures to be taken in connection with the transfer, answer any concerns or queries, discuss possible options if appropriate and consider personal circumstances. These discussions will be documented and confirmed in writing. Every possible support will be given to staff to understand the reasons for and implications of the transfer and to ensure they have the necessary information with which to prepare themselves.

Formal notice of a transfer will be issued as long before the date of the transfer as possible in order to comply with the obligations of TUPE and this policy.

The ICB will make every effort to give up to 3 months' notice of a transfer, where possible. Where 3 months' notice is not possible, for example due to the timing of external announcements or approval, a shorter notice period will be provided following consultation with the trade unions and staff representatives.

20 Appeals

Employees have the right to appeal against the following decisions or actions:

- To slot, or not slot the employee into a post as a result of organisational change
- The selection or non-selection of an employee within ring fenced pooling
- The selection criteria for redundancy
- The decision to dismiss an employee by reason of redundancy
- An offer of a suitable alternative post
- Where an individual believes there has been misapplication of the Change Management Policy in the way that the consultation or redeployment processes have been handled.

Appeals, outlining the grounds on which the appeal is being made, must be lodged in writing to the employee's Head of service within 5 working days receipt of the decision against which the employee is appealing. In exceptional circumstances this period may be extended.

Appeals will normally be heard by a Director (or equivalent) within a different ICB service to that affected directly by the organisational change, and a senior Human Resources Representative.

The employee must provide to the Appeal Hearing Panel, a written statement of case including the grounds upon which the appeal is presented, with copies of any documents the employee concerned intends to use in evidence, and the identities of any witnesses the employee intends to call, at least 3 working days prior to the Appeal Hearing.

Appeals will be heard within 15 working days of receipt of the letter requesting the appeal but either party may, with the consent of the other and in exceptional circumstances, be entitled to extend this period.

The employee must be given at least 5 working days' notice of the date of the appeal hearing.

The ICBs Appeals Hearing Procedure will be followed – see Appendix C.

The employee will have the right to be accompanied by either an Accredited Trade Union representative, or workplace colleague.

The manager of the employee must provide to the Appeal Hearing Panel, a written statement of case responding to the grounds upon which the appeal is presented, with copies of any documents they intend to use in evidence, and the identities of any witnesses they intend to call, at least 1 working day prior to the Appeal Hearing. In redundancy dismissal appeals, there will be a requirement for both parties to exchange Statement of cases at least 5 working days before the hearing unless agreed otherwise by both sides.

The decision of the panel will be communicated to both parties verbally at the end of the hearing or if this is not possible, and in any case, will be confirmed in writing to both parties, no later than 5 working days after the Appeal Hearing.

The decision of the appeal panel is final and there will be no further opportunity for recourse to the Grievance Procedure.

21 Appendix A: Abbreviations and Definitions

Abbreviation / Item	Definition
CE	Chief Executive
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
NHS	National Health Service
SC	Social Care
We	The ICB
TUPE	Transfer of Undertaking (Protection of Employment)
COSOP	Cabinet Office Statement of Practice

22 Appendix B: Matching, Pooling and Slotting Guidance

Each relevant Assessment Panel will comprise of a Senior Manager as functional expert, Trade Union representative (this could be a ICB employee Trade Union lay representative or Regional/local official) and a member of the Human Resources Team who is formally trained in NHS Agenda for Change job matching methodology, where it is deemed appropriate an additional manager/subject matter expert may be included on the panel.

Essentially, the panel will review the documentation listed below for the purpose of carrying out the assessment.

1) Candidate's current Job Description/Person Specification
2) New potential role Job Description/Person Specification

NB – the below will be required for a successful job match:

- 60% or more role match
- New potential role should be a match at the same as current banding
- Matching one band up or one band down should only be considered in exceptional circumstances and where clear evidence to support such a decision has been reviewed by the panel.

In the event an employee believes they should be matched to a role one band higher than their current substantive role, they will be required to provide clear evidence to support their case once they have been provided with a copy of the proposed organisational structure and role descriptions within it that relate to their situation.

As a minimum, the employee will be required to evidence that their current job description matches to the higher banded role. Job evaluation factors relating to'Knowledge, Skills and Experience' and 'Freedom to Act' will be key when deciding whether a post is considered a match or not. Only the main functions, duties and responsibilities of the job should be considered as part of this process. Elements which are generic to all roles such as organisational responsibilities should not be included during this assessment. If the Panel were to determine that an employee could be matched to a role one band higher than their current substantive post, the employee would be required to undertake an interview for the role before a potential appointment was made, they would not be automatically 'slotted' into it.

The Panel are reminded that a successful job match leading to a proposed 'slotting in' can only be done where a post is in the same band as the individual's current substantive post or where it remains substantially the same (usually defined as 60% the same) with regard to job content, responsibility, grade, status and requirements for skills, knowledge, experience and location, and where that individual is the only contender for that post.

The matching will be based upon an objective comparison of the new role/job content compared with the existing role, based on the overall job purpose, key principle responsibilities and essential criteria, not on an assessment of an individual's ability or performance in their existing role or elements which are generic to all roles such as organisational responsibilities which are consistent across bandings.

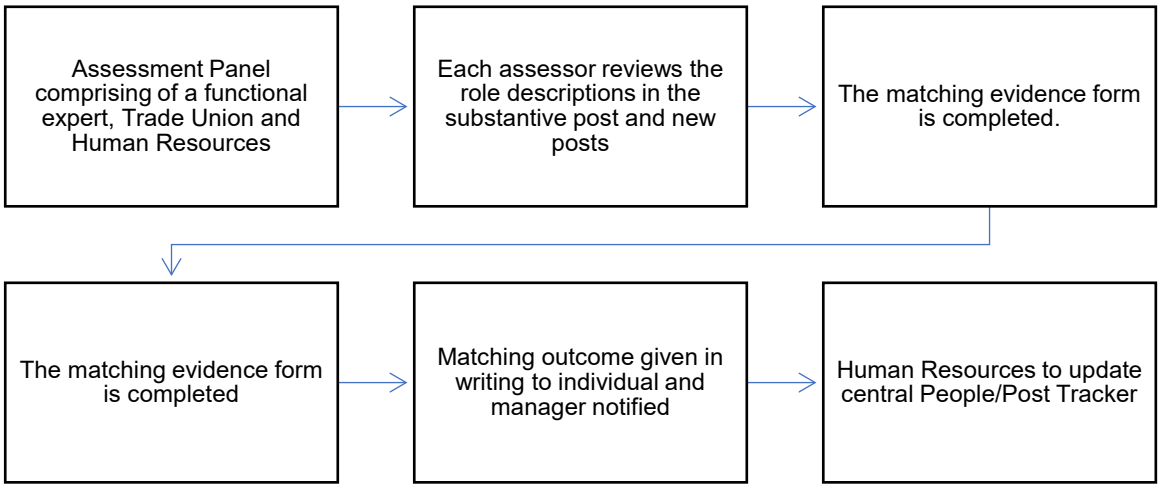
Panel members are asked to compare the role descriptions and person specifications and using the new job description, they will be required to confirm where this is a match and 'cross' where there is not. Functional expert opinion will be sought and discussion will be had where required.

The matching process should not be used as an opportunity to ‘promote’ staff into higher banded roles.

Managers may need to be aware of roles that could potentially match across more than one type of role (at the same band), if this is the case, then Managers may need to consider matching an employee against more than one role.

23 Appendix C: Matching, Pooling and Slotting Guidance – Flow Chart

Staff are not required to submit anything to assist at this stage of the process. Employees will be assessed based on their substantive job banding and job description/person specification against the new job description.



Human Resources Department will support the process to ensure overall fairness and will consistency check the matching outcomes to ensure equal and fair application of the criteria across all employees in the pools across the ICB

24 Appendix D: Redundancy Dismissal Appeal Hearing

24.1 Appeal Panel

On receipt of the appeal the organisation will set up an appeal panel where possible within 15 working days of receipt of the grounds of appeal in accordance with the table below.

Human Resources will provide advice to the panel.

If possible at least one member of the panel will have a specialist knowledge of the field of work of the employee.

Where appropriate, the Head of HR may appoint a technical or professional assessor/advisor to advise the panel in consultation with all parties.

The members of the appeal panel shall not include anyone who has been directly involved in the circumstances leading to redundancy decision. No manager of the organisation who has been directly involved in the circumstances leading to the redundancy dismissal shall act as Chair of the appeal panel or in any other capacity except as a witness or as the representative of the organisation.

24.2 Statement of Cases

Statement of cases will be exchanged at least 5 working days before the hearing unless agreed otherwise by both sides.

The employee must submit their case and arrange any witnesses and or representation.

24.3 Conduct of the Appeal

Nothing in the following will prevent members of the panel seeking clarification of any issue or of amending the process.

The employee will have the right of appearing personally before the appeal panel (subject to circumstances allowing for such presentation) either alone or accompanied by a staff representative or colleague. There is no right to legal representation.

24.4 Appeal Procedure

The procedure to be followed at the Appeal Hearing will be as follows:

1. Chairperson to introduce those present, explain the purpose of the meeting, and format of hearing
2. Chairperson will invite Employee (or representative) to present their appeal case.
3. Allow Manager to question Employee
4. Panel to question Employee.
5. Employee calls witnesses who may be questioned by Management/Panel.
6. Management to present case in response.
7. Staff Side/employee to question Management
8. Panel to question Management
9. Management call witnesses who may be questioned by employee/staff side/panel

10. Chairperson will invite Employee to summarise case. No new evidence can be presented at this stage of the hearing.
11. Chairperson will invite Management to summarise case. Please note no new evidence can be discussed at this stage of the hearing
12. Adjourn for a decision (Presenting Manager and Staff Side /Employee asked to leave the room)
13. Reconvene (Panel, Staff Side/Employee and Presenting Manager) and announce
14. Decision or confirm decision will follow in writing if further deliberations are required by the Appeal Panel.

N.B: Adjournments may occur throughout the hearing as and when necessary and as requested by either party or the panel.

The Appeal Panel shall have the power to rescind the redundancy decision though this will not necessarily mean reinstatement to the original role. If this is not possible suitable alternative employment will be identified.

The decision of the appeal panel will be communicated to the appellant verbally at the end of the hearing or if this is not possible it will be confirmed no later than 5 working days after the Appeal Hearing.

The decision of the committee will be reported to the organisations remuneration committee.

NHS
Suffolk and
North East Essex
Integrated Care Board

Grievance Policy

Suffolk and North East Essex Integrated Care Board

1 Version Control

Version	Date	Author and Role	Detail of Change
1.0	09/09/2022	Saima Ali - Senior HR Business Partner	First verison

2 Approval History

Version	Date	Approver

3 Next Review Date

The date this policy is due for review is December 2025

4 Contents

5 Statement of Overarching Principles

All Policies, Procedures, Guidelines and Protocols of the Suffolk and North East Essex Integrated Care Board (ICB) are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

6 Introduction

The Organisation encourages open communication between employees and their managers to ensure that questions and problems arising during the course of employment can be aired and, where possible, resolved quickly and to the satisfaction of all concerned.

The aim of this policy is to encourage early informal resolution to settle issues and concerns. It is also preferable that both employees and managers should try to resolve issues informally first, and to use the formal route where the informal route has been explored but has been unsuccessful.

The definition of a 'Grievance' can be given as: 'complaint, criticism, or objection'. Grievances can be collective or individual.

Grievances apply to complaints connected with employment where the concerns raised are not covered by any other organisational policy and the problem cannot be resolved through alternative means (i.e. informal discussion, mediation).

7 Purpose

This procedure is designed to help and encourage all employees to achieve and maintain standards of conduct, attendance, and job performance.

All grievances arising from employment matters will be dealt with fairly, consistently, and promptly.

The policy has been prepared in line with legislative requirements and appropriate guidance. This policy applies to all members of staff with a contract of employment with the ICB.

8 Equality Statement

This Policy will operate alongside the ICBs Equal Opportunities, Diversity at Work Policy, and Equality Delivery System. The ICB's vision is to have in place a sustainable people driven service system of care which is best of class, and values based on hope inspiring environments and embracing diversity. The ICB will ensure that all staff, volunteers, service users and visitors are treated with dignity and respect, and no individual is treated differently on the grounds of their marital status, maternity, race, gender, gender reassignment, disability, age, religious belief or their sexual orientation.

The ICB assures staff, volunteers and people entitled to our services are treated fairly, equally and with respect and dignity. The ICB will challenge discriminatory attitudes and provide rules and standards of behaviour.

The ICB will monitor the use of this Policy, and will ensure that the policy is implemented fairly, and will take action if it appears that it is has a disproportionate effect.

9 Scope

This policy applies to all employees of the ICB, including fixed term employees when working within the ICB and whilst on ICB business

10 Cross Reference to Other Policies

- Disciplinary
- Capability
- Managing sickness absence
- Equal opportunities
- Managing stress in the workplace
- Harassment and bullying
- Fraud response
- Disclosure of information in the public interest
- Special leave

11 Policy Statements

In April 2009, the Employment Act 2008 repealed the Statutory Dismissal, Disciplinary, and Grievance procedures (the Procedures). The Procedures were replaced by a new ACAS Code of Practice on Discipline and Grievances (the Code) in March 2015.

The Code covers the actions of a third party that the employer could be vicariously liable for and any grievance about action by the employer that could form the basis of an Employment Tribunal claim. Accordingly, this procedure applies to all employees of the Trust who have a grievance about their personal terms and conditions of service.

Employees should aim to settle most grievances informally with their line manager. Many problems can be raised and settled during the course of everyday working relationships.

This also allows problems to be settled quickly.

In some cases, outside help such as an independent mediator can help resolve problems especially those involving working relationships.

Anyone employed by the ICB may, at some time, have problems or concerns about their work, working conditions or relationships with colleagues that they wish to talk about with management. They want the grievance to be addressed, and if possible, resolved. It is also clearly in manager's interests to resolve problems before they can develop into major difficulties for all concerned. Issues that may cause grievances include:

- terms and conditions of employment
- health and safety
- work relations
- bullying and harassment
- new working practices
- working environment
- organisational change
- discrimination.

Employees should raise their grievance as soon after the event(s) as possible. Employees will be expected to raise a grievance within three months. It is recognised however that it may be appropriate to investigate incidents that have taken place over a period or are ongoing.

Where the grievance is against the line manager the employee may approach another manager or raise the issue with their HR department. It is helpful if the grievance procedure sets out whom the individual should approach in these circumstances.

The Human Resources Department must be involved at all formal stages of the procedure.
The status quo i.e. the working arrangements and patterns that operated prior to the commencement of the grievance, will remain in force until the grievance is resolved wherever possible.

The timescales set out below may be amended by mutual agreement.

A formal grievance must be made in writing and grievance forms to be used by an individual to initiate their grievance, and by management to record their response. (Appendix B).

Grievance raised on an exit questionnaire or at an exit interview may be dealt with under this policy.

A written record of all meetings and agreements, whether formal or informal, should be kept with a copy being given to the employee.

Should the member of staff require assistance at meetings, i.e. language or disability, this should be highlighted to the HR department who will arrange the necessary support.

12 Inclusions

Grievances may be raised about:

- The nature of duties
- Conditions of service
- Working relationships
- Bias or unfair discrimination on employment decisions

13 Exclusions

This policy should not be used for the following:

- Appeals against disciplinary decisions which should be dealt with within the context of the disciplinary procedure
- Grievances about a matter over which the employer has no control e.g. income tax and NI issues, NHS Pension Scheme etc.
- Appeals against pay banding decisions for which the Review procedure should be used
- Appeals against non-renewal of fixed term contracts
- Appeals against redundancy dismissals
- Problems relating to ethical conduct or to the treatment of patients for which the policy on Whistle blowing / Public Interest Disclosure should be used.

14 Monitoring Compliance and Effectiveness

The organisation is responsible for recording and monitoring information relating to grievances.

The organisation reserves the right to modify, amend or alter the policy and its appendices as appropriate, in partnership with the recognised trade unions and only within the recognised national forum. The organisation will review the policy periodically to ensure it is relevant, up-to-date, and compliant with current legislation and best practice.

15 Time Limits

The ICB recognises that excessive delays can be detrimental to all parties and therefore all reasonable steps will be taken to hold meetings within a timely manner. However, where there are extenuating circumstances (e.g., lack of availability, or number of people involved) time limits outlined in this policy may need to be extended. Every effort must be made in such cases to ensure that extensions are kept to a minimum and that all parties involved are kept informed

16 Support

The ICB recognises that the grievance process can be stressful for members of staff. It is therefore important that all grievances are treated sensitively and confidentially, and appropriate support is provided where required.

Various forms of support are available through HR; Occupational Health; the Employee Assistance Programme; Trade Unions

When considering grievances, all individuals are expected to have regard to the values of the NHS Constitution

17 Written Records

The foreword to the Code of Practice advises employers to keep a written record is to include:

- the nature of the grievance
- what was decided and actions taken
- the reason for the actions
- whether an appeal was lodged
- the outcome of the appeal
- review and follow up for any subsequent developments.

Records should be treated as confidential and be kept no longer than necessary in accordance with the Data Protection Act 1998. This Act gives individuals the right to request and have access to certain personal data. The Information Commissioner has produced Codes of Practice covering recruitment and selection, employment records, monitoring at work and information about an employee's health.

Copies of meeting records should be given to the employee including copies of any formal minutes that may have been taken.

The ICB may in certain circumstances (for example to protect a witness) withhold some information.

18 Right to be Accompanied

The employee may be accompanied at any stage of the procedure by a trade union representative or by a work colleague not acting in a legal capacity.

The Code states, "The companion should be allowed to address the hearing to put and sum up the employee's case, respond on behalf of the employee to views expressed at the meeting and confer with the employee during the hearing. The companion does not however, have the right to answer questions on the employee's behalf, address the hearing if the worker does not wish it or prevent the employer form explaining their case."

Should the employee be accompanied by anybody other than a work colleague or staff side representative then the ICB reserves the right to defer any meetings until the member of staff, in line with the details above, finds a suitable alternative.

19 Mediation

With the agreement of all parties, stages of the grievance procedure may be suspended if it is deemed that mediation is an appropriate method of resolving the issue. Mediation is a voluntary process where the mediator helps two or more people

in dispute to attempt to reach an agreement. Any agreement comes for those in dispute, not the mediator who is only there to facilitate the process not to make decisions.

20 Collective Grievances

Where the grievance involves more than one employee, representatives of the group will present their case.

21 Informal Stage

Employees should aim to settle most issues and concerns informally with their line manager. This means that it is not appropriate to give definitive timescales for an informal stage but to emphasise that managers and staff must work together to resolve issues promptly, fairly and consistently.

Managers should note that the involvement of an accredited Trade Union representative could often facilitate the resolution of a grievance at this stage.

At the informal stage further meetings between the manager, other relevant parties, trade unions and Human Resources can take place if this is considered to be helpful. Further meetings at the informal stage would be used to facilitate a resolution, without resulting in a formal process being invoked.

Employees and managers should be able to clearly demonstrate that every effort has been made to resolve their issue(s) informally before the formal process is commenced. This may include sourcing additional assistance such as mediation. HR can provide managers and employees with help or guidance in informal resolution and mediation.

As a result of informal discussions, it may be appropriate for the line manager in conjunction with the employee to draw up an action plan, outline objectives, timescales for completion and any follow-up action and a copy kept on the personal files of those parties involved.

Whilst it is preferred that employees use the organisation grievance form to lodge a grievance, managers should be aware that grievances can be lodged in any other written format and should still be treated as per this policy. Where any written complaint is unclear in any part, the individual may be asked to complete the organisation's grievance form in order to ensure that all issues are understood, and the redress sought is clear.

If the complaint is concerning the line manager, the form should be sent to the next line of management (the line manager's manager).

If it is not possible to resolve the issues informally, or if it is agreed that the issues are of significant seriousness and it is not felt that the informal route is appropriate, the matter should proceed to the formal stage of the policy.

22 Formal Stage

Should the matter not be resolved informally, or where the issue is felt to be more serious, then the employee has the right to raise the matter formally. To do this, the employee should set out the details of the grievance and desired outcome in writing (using the grievance form within this policy or any other appropriate written format) and

send the written complaint to their line manager. Should they feel unable to do this, the grievance should be submitted to the next line of management.

Any manager receiving a formal grievance must act upon the matter promptly and must also notify Human Resources.

The Manager must make arrangements for a meeting with the employee as soon as is reasonably practicable and inform the employee of the date within 5 working days of receipt of the written grievance unless there is a good reason for doing so (e.g. periods of annual leave). Should there be a delay in arranging the date the employee must be kept informed.

This meeting should be held as soon as possible, and no later than 5 working days after receipt of the grievance. All parties must take all reasonable steps to attend this meeting.

The employee has the right to be accompanied to this meeting by a work colleague or union representative. If this cannot be achieved, the reasons for delay are to be recorded. The timing and location of the meetings must be reasonable to all parties.

Wherever possible it is expected that resolutions will be presented at the meeting by the manager hearing the grievance. However, it may be necessary to adjourn the meeting to further investigate the issues.

If having received the grievance the manager believes formal investigation is required prior to the meeting to resolve the dispute, they will inform the employee.

In cases where two or more employees raise a grievance on the same issue, this could be classed as a “Collective Grievance”. In such cases, an appropriate representative may set out details of the grievance in writing on behalf of the employees. Representative shall be defined as Trade Union Representatives or nominated employee representatives.

23 Investigation Process

In some cases where a decision has been made to carry out a formal investigation, the line manager will appoint an Investigating Officer

Investigating Officers will be appointed to gather all the facts of the case promptly and must be given a clear understanding of the allegations to be investigated.

Investigating officers will be individuals independent to the person being investigated.

Investigating officers will receive training in respect to undertaking an investigation.

At the point of the investigation being instigated a colleague has a valid objection to the person appointed to undertake the investigation or to hear the case, they must raise this objection in writing, clearly stating their reasons, to the HR Team.

Only appoint individuals as case managers, case investigators and panel members who, are able to demonstrate the aptitude and competencies (in areas such as objective critical thinking and assessment of information) required to undertake these roles. It is imperative that they are also part of a different team from the individual under investigation.

The colleague will be informed in writing that the matter is to be investigated and the name of the Investigating Officer. The letter should confirm the likely timescale for the investigation (which should take no longer than 4 weeks, where possible) and of the right for representation.

Regular communication should take place with the colleague to ensure they are kept up to date.

The investigation may include:

- Giving the colleague an opportunity to provide evidence to the Investigating Officer by interviewing all parties involved
- The colleague may be accompanied by a work colleague or trade union representative not acting in a legal capacity if desired.
- Interviewing any witnesses and taking written statements, making it clear that the statements may be used as evidence and they are obliged to attend a hearing should this be required.
- Gathering documentary evidence, including medical advice, records, electronic files, diaries, worksheets etc.

Notes of any meeting should be confirmed in writing, in summary, via a letter to the colleague and file notes given to any witnesses to confirm accuracy and content.

Once the investigation is concluded, the investigating officer will produce a written report which gives their findings against the allegations. This report should be submitted to the commissioning manager.

The commissioning manager will need to decide what action to take.

The commissioning manager will need to hold an outcome meeting with the complainant to give an outcome of the grievance investigation.

The employee must be given at least 5 working days' notice of the date of the outcome meeting.

The outcome of any grievance meeting should l be confirmed in writing within 5 working days and will include a right of appeal.

Should any colleague be found to be deliberately attempting to interfere with an investigation, either through intimidation, harassment or bullying of another colleague, they may be subjected to separate investigation including formal action being taken against them.

24 Disciplinary and Grievance Procedure

In the event when an employee raises a grievance during a disciplinary process, the disciplinary process may be temporarily suspended in order to deal with the grievance.

In cases where the grievance and disciplinary cases are related, it may be appropriate to deal with both issues concurrently.

25 Counter Grievance

In the event of a counter grievance being submitted the grievance should be presented to the employee's line manager, or appropriate recipient and the usual process followed i.e. from informal to formal.

If, having considered the allegations, it is the manager's decision to commission an investigation, serious consideration should be given to the most appropriate investigator to complete this.

If it is decided that the investigating officer commissioned to complete the original investigation is also instructed to investigate the counter claim, the rationale and decision for this should be shared with both complainants i.e. extend the scope of the investigation.

26 Appeal Process

If an employee is dissatisfied or remains aggrieved after the grievance meeting has taken place, they have the right to make a formal appeal.

The appeal should:

- Be in writing (Appendix B to be completed)
- Enclose a copy of the original Grievance
- Specify which aspects they remain aggrieved about, and the redress being sought
- Be submitted within 10 working days of the receipt of the outcome from the Grievance Meeting.

The appeal should be acknowledged within 5 working days of receipt.

The appeal should be made by a letter to the Director for Corporate Services. An appeal meeting should be arranged within 10 working days of receipt of the appeal.

The employee must be given at least 5 working days' notice of the date of the appeal hearing.

The employee will have the right to be accompanied at the Appeal Hearing by either a staff side representative or workplace colleague.

The next line manager, Chief Officer or another senior nominated manager will review the findings of the original hearing (including any formal investigation that may have taken place) and consider whether the conclusion reached in the grievance hearing was appropriate. The appeal panel will be required to consider whether due process was correctly followed.

The appeal hearing panel will include a senior member of the HR team.

The appeal hearing is not a rehearing of the original grievance but an opportunity for consideration of specific areas where the employee remains aggrieved or is dissatisfied with from the original hearing.

Where the appeal panel feels that any elements of the original grievance have been missed/omitted, and the employee submits clear evidence which proves this, the areas of concern will be addressed at this meeting (with any necessary information submitted by the employee ratified, as required).

The outcome of the appeal hearing will be confirmed in writing within 5 working days of the Appeal Hearing.

The decision of the Appeal panel is final. There is no further internal redress following the appeal outcome.

27 Confidentiality

Grievance matters are considered confidential. Only those persons who need should be given access to relevant information and in turn should treat that information as confidential.

All those involved, including the employee, should be informed that any breach of confidentiality (including informal discussions with colleagues) may prejudice an investigation and may in itself constitute a disciplinary offence.

28 Process for Monitoring Compliance and Effectiveness

A summary of the actions being taken will be reported to HR RemCom in the HR quarterly report.

29 Process for Waivers

Any waivers would need the agreement of both parties

30 Policy Circulation

Managers and staff will be able to access this policy via the intranet.

31 Appendix A: Abbreviations and Definitions

Abbreviation / Item	Definition
CE	Chief Executive
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
NHS	National Health Service
SC	Social Care
We	The ICB

32 Appendix B: Grievance Notification Form

Grievance Notification Form – Strictly Private and Confidential

Name:	Line Manager:
Job Title:	Representative (if applicable and known):
Directorate:	Union (if relevant):
Email:	Representative Email:
Tel:	Representative Tel:
Stage: Please indicate which stage of the Grievance Policy you are invoking. Formal Stage ☐ Appeal Stage ☐	
Details of the Grievance Please state the grounds for your grievance, giving details of the circumstances or events that have occurred (you may continue on further pages or attach additional papers in support):	
Remedy If appropriate, please indicate what you could consider to be a satisfactory remedy to your grievance or appeal.	
Statement of Truth I believe that, to the best of my knowledge, the facts stated in this document are true. Signed: ……..Date: …….. Name (block capitals): ……	

Guidance on the use of the form

This form should be used to submit a formal complaint under the Grievance Policy.

Therefore, the Policy should be read before completing the form.

The use of the policy and the outcomes reached will be monitored in accordance with section 15 Monitoring Compliance and Effectiveness of the Policy. All personal details will remain highly confidential.

If you believe your complaint concerns harassment, victimisation or bullying, then the Dignity at Work Policy should be referred to. The Policy can be accessed on the intranet.

Please note that grievances are to be registered within 3 months of the circumstances or event occurring unless otherwise agreed following discussions with HR.

If you require help or support in filling out this form, you can get in touch with your line manager, HR team or Trade Union representative

NHS
Suffolk and
North East Essex
Integrated Care Board

ABSENCE MANAGEMENT POLICY

Suffolk and North East Essex Integrated Care Board

1 Version Control

Version	Date	Author and Role	Detail of Change
1.0	02/02/22	Saima Ali, Senior HR Business Partner	First Version

2 Approval History

Version	Date	Approver

3 Next Review Date

The date this policy is due for review is: December 2025

4 Contents

5 Statement of Overarching Principles

All Policies, Procedures, Guidelines and Protocols of the Suffolk and North East Essex Integrated Care Board (ICB) are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

6 Introduction

This policy covers short-term sickness absences from work, which are defined as frequent and persistent days off lasting less than 27 calendar days.

This policy also covers long-term sickness absence, defined as 28 calendar days or more.

The organisation aims to encourage all its employees to maximise their attendance at work whilst recognising that employees will, from time to time, be unable to come to work for short periods due to sickness.

The organisation recognises that most employees will occasionally have genuine and acceptable reasons to be absent from work through either ill health or an injury. Equally however, due regard must be given to the business needs.

Sickness absence does have a major impact on the quality of the service we provide and places colleagues and managers under additional pressure. Ultimately, if there is no resolution to the sickness problem, formal disciplinary processes may be instigated and any resulting dismissal is likely to be based on the grounds of capability or some other substantial reasons.

Employees unreasonably failing to discharge their responsibilities under this policy may lose their entitlement to occupational sick pay and/or be subject to disciplinary action in accordance with the provisions of the Organisation's Disciplinary Procedure.

7 Purpose

The purpose of this policy is to ensure that managers manage sickness absence effectively to reduce its impact upon service delivery, whilst providing employees with appropriate support to improve attendance where necessary.

8 Equality Statement

This Policy will operate alongside the ICBs Equal Opportunities, Diversity at Work Policy, and Equality Delivery System. The ICB's vision is to have in place a sustainable people driven service system of care which is best of class, and values based on hope inspiring environments and embracing diversity. The ICB will ensure that all staff, volunteers, service users and visitors are treated with dignity and respect, and no individual is treated differently on the grounds of their marital status, maternity, race, gender, gender reassignment, disability, age, religious belief or their sexual orientation.

The ICB assures staff, volunteers and people entitled to our services are treated fairly, equally and with respect and dignity. The ICB will challenge discriminatory attitudes and provide rules and standards of behaviour.

The ICB will monitor the use of this Policy, and will ensure that the policy is implemented fairly, and will take action if it appears that it is has a disproportionate effect.

9 Scope

This policy applies to all employees of the ICB, including fixed term employees when working within the ICB and whilst on ICB business.

10 Cross Reference to Other Policies

- Leave Policy
- Redeployment Policy
- Flexible Working Policy
- Stress Management Policy
- Disciplinary Policy
- Grievance Policy
- Capability Policy

11 The role of the ICB

Under this policy, the ICB commits to ensuring that:

- It fulfils its duty of care towards its employees
- It promotes a culture that encourages attendance at work
- All policies, rules and procedures concerning absence are communicated clearly to all employees and reviewed in a timely manner in line with both changing needs of the organisation and any changes to legislation
- Managers apply the procedures fairly and consistently
- Cases falling within the remit of the Equality Act (2010) are readily identified and supported
- Records of absence are held for all employees and levels of absence are monitored to indicate where further action may be needed
- Where appropriate advice and guidance may be sought, regarding employee's medical issues from the government's Fit for Work Plan, Occupational Health Department or another appropriate external Medical Adviser
- It complies with health and safety requirements, including the reporting of injuries and dangerous occurrences (RIDDOR), the Equality Act (2010), Access to Medical Reports Act 1988, when requesting medical information from Medical practices, and other relevant legislation.

12 Responsibilities

12.1 Line Manager

The control and management of absenteeism is a management function. Each manager is responsible for managing absenteeism for the staff that are accountable to them and for treating employees who are ill in a sensitive, fair and consistent manner. Managers have a responsibility to:

- Ensure that they are familiar with the Absence Management Policy and their obligations in relation of the management of the policy
- Apply the principles of the Absence Management Policy fairly and sensitively
- To ensure that employees' absences are certificated appropriately
- To notify and seek support from the Human Resources Department when an employee hits the relevant trigger points
- Communicate appropriately with absent staff

- For long term sickness, line manager to mutually agree a regular contact with absent staff
- Dealing with any actions in a timely manner when dealing with absence at work,
- Maintain accurate records of all absences and reasons for absence using the appropriate method or system
- Hold “return to work meeting” after each individual episode of sickness as soon as practically possible
- To initiate, monitor and pursue action in relation to the management of short- and long-term absences
- To refer employees to Occupational Health as appropriate with employee’s knowledge
- To ensure that the outcome of any sickness review meeting is communicated to the employee in writing within 5 working days
- To treat all employees fairly, sensitively and ensure that any personal information, including medical diagnosis, is kept in complete confidence
- To support staff who are covering for a colleague’s absence due to sickness
- To encourage a culture of attendance and help employees to minimise absence.
- Attend any Organisation training provided on policy updates
- Identify a ‘nominated deputy’ for staff to report sickness absence to during periods of annual leave/out of the office/non-working time and communicate this to staff
- Identify early warning signs at work that might prevent sickness (i.e. stress, incidents at work)

12.2 Employee Responsibilities

All employees are expected to demonstrate a commitment to the Organisation and discharge the obligations of their contract by regular attendance at work. Therefore all employees have a duty to:

- To make every effort to attend work regularly and carry out their duties to an acceptable standard
- To report absence to their line manager on the first day as early as possible and give a reason for the absence
- To send in fit notes in a timely manner
- Engage and communicate with their line manager regularly during sick leave
- To ensure that they do not work excessive bank/agency/locum shifts and jeopardise their ability to undertake their permanent post
- To comply with the Absence Management Policy
- To obtain appropriate medical treatment and/or other support or assistance if ill or suffering from a condition that may affect their work performance or make them unable to work
- Attend Occupational Health appointments as previously agreed and confirmed
- To take note of any advice given by Occupational Health or their own Medical Practitioner to protect their own health and that of their colleagues.
- Ensure that they have read and fully understood the provisions of this policy
- Take reasonable steps to keep themselves in a good standard of general health in order that they can effectively carry out their role
- Co-operate fully in the use of this policy and the procedure
- Communicate appropriately with their manager when absent from work
- Attend a Fit for Work Assessment if referred by GP or the organisation
- Attend an appointment with an organisation nominated medical practitioner where appropriate
- Attend sickness review meetings as per advised in this policy with Management when discussing periods of absence or planning return to work, reasonable adjustments or alternative employment.

12.3 Occupational Health Responsibilities

To provide impartial advice to managers and employees about an individual's fitness to attend work and perform their duties. This will include:

- Prospects of returning to work, adjustments to work, redeployment, assessment for ill health retirement and likely future sickness absence
- To discuss with/give employees details of any letters/reports being sent to their manager
- To provide confidential advice to employees who have concerns about the impact of their work or working environment on their health
- To maintain confidentiality of medical matters unless it is essential to release information in connection with the employee's work or in connection with patient safety and in these circumstances, consent from the employee to release information will be sought
- To liaise with GPs, medical practitioners as required subject to gaining the relevant authorisation from the employee
- Provide advice on temporary exclusion from work on medical grounds in cases of contact with notifiable or contagious disease.
- To encourage a culture of attendance and help employees to minimise absence

12.4 Human Resources Responsibilities

- To assist managers with the fair and consistent application of the policy
- To provide advice to employees and managers concerning individual sickness issues
- To provide managers with sickness absence data and assist with the analysis and recommend appropriate management action
- To provide training for managers on the application of the policy
- To encourage a culture of attendance and help employees to minimise absence.

12.5 The role of Trade Unions

This policy has been drawn up in consultation with the Trade Unions and as such the Trade Union representatives will:

- Support the fair and equitable application of this policy
- Represent their members at any stage as appropriate if requested to do so
- Support appropriate efforts for a successful return to work of those employees who have been absent due to sickness
- In the spirit of joint working, participate in training programmes associated with this policy.

13 Thresholds

The following are used by the ICB as 'automatic' threshold points for further action within this Procedure:

Short–term Absence: An employee whose cumulative absence reaches 16 calendar days and / or in any case where the employee has 4 episodes of absence within a rolling 12 month period.

Long-term Absence: This is the point where an employee is absent from work due to illness or injury for a continuous period of 28 calendar days within a rolling 12-month period.

Action may be taken at earlier points if there appears to be some specific medical or other problem that can be addressed to improve attendance.

Should the line manager have reasonable concerns about the health of, or pattern of absence of, an employee where the employee does not meet the “threshold point”, the line manager may still meet with the employee as per this policy to have a supportive discussion.

The above thresholds should take into account all sickness absence including those that are work related or that are as a result of any underlying health issue covered under the Equality Act 2010, to ensure that the employee is appropriately supported in attending work.

All reasonable adjustments must be considered before a manager implements a formal sickness absence improvement plan for an employee covered under the Equality Act 2010.

Managers however should discount any work-related absence or absence that is pregnancy related for the purposes of determining the successful achievement of any improvement plan identified as part of the short-term sickness process.
Managers should still manage the sickness and provide the necessary support.

14 Short-term sickness absence

Frequent absence refers to instances where an employee is frequently absent from work for relatively short periods of time due to sickness.

When an employee reaches the threshold point, the line manager will meet with the employee. The employee will be advised in writing (giving a minimum of 5 working days’ notice) of the details of the meeting and will include the actual dates of absence to be discussed.

Review periods for the monitoring of improvement between each of the formal stages of the process should be for not less than six weeks and for not more than three months.

If no improvement has been achieved or maintained, the process may proceed to the next stage or an extension of the current stage depending on individual circumstances. This will continue until the point where a Sickness Absence Hearing is necessary.

To manage sickness absence consistently across the ICB, the following 3 stage approach will be undertaken by each manager:

	Return to Work (RTW) meetings.	Managers will conduct the RTW meetings after every occasions of sickness absence and record this on the form and on ESR.
Informal Stage		In cases where the short-term threshold has been met. **Action:** Complete ‘Informal’ Improvement Plan – Available on the Intranet Other actions that line managers may take are: Identify any health/non-health related contributory factors Referral to Occupational Health Services provider as appropriate with employee’s knowledge Self/Fit Note certification required for every absence Referral to Physiotherapist or Manual Handling Advisor if appropriate

		Reasonable adjustments to the workplace Reasonable adjustments to shift patterns Flexible working to be considered
Stage 1	'First Formal Stage' Minimum 6 week review period and Maximum of three months review period	Where the 'Informal' Stage has not achieved the required improvement or where the employee has re-met the threshold following a recent informal improvement plan, a first Formal Improvement Plan will be put in place. Any objectives set within the improvement plan will have agreed timeframes and specified outcomes. **Action:** Issue a 'First Stage Formal Notice' of unsatisfactory attendance levels and complete 'Formal' Improvement Plan – available on the intranet. Consider extending this stage depending on individual circumstances The employee has a right of Appeal
Stage 2	'Second Formal Stage' Minimum 6 week review period and Maximum of three months review period	Where the First Stage Formal Plan has not achieved the required improvement or where the employee has re-met the threshold following a recent First stage improvement plan, a second stage Formal Improvement Plan will be put in place. **Action:** Issue a Second Stage Formal Review Notice of unsatisfactory attendance levels and complete 'Formal' Improvement Plan – available on the intranet. Consider extending this stage depending on individual circumstances The employee has a right of Appeal
Final Stage	Sickness Absence Hearing	Where the Second Stage Formal Notice has not achieved the required improvement or where the employee has re-met the threshold following a recent Second Stage Improvement Plan, a Sickness Absence Hearing will be arranged. The Hearing will consider dismissal on the grounds of capability or 'some other substantial reason', or, an appropriate alternative course of action.
	Sickness Absence Hearing	The Sickness Absence Hearing will be convened. The employee should be given 7 working days' notice of this hearing. Those in attendance at the meeting will be: The employee The employee's representative (if requested) The line manager – to present the case An HR representative who has been supporting the line manager in the case to date. The panel will consist of: A senior manager – with authority to dismiss (at level 8b or above) and senior to the line manager, to hear the case and make a decision on an outcome with the support of HR. The senior manager must be impartial and from a different team/directorate. An HR representative to support the senior manager. In some cases a third panel member may be invited to act as an expert and advisor to the senior manager

At each stage of the short-term improvement plan, managers should consider setting an improvement objective in terms of defining the improved attendance required between review meetings.

In setting this objective, managers should consider an appropriate level of improvement that is defined once any reasonable adjustments to the role have been considered that would assist mitigating any underlying health issues.

The attendance objective should therefore typically be set as a full attendance for the employee between review meetings.

If the employee has been unable to achieve the objective, the manager may consider that the objective has been partially achieved if the employee has made significant progress towards achieving a level of attendance that falls below the ICB sickness absence threshold within a reasonable time frame not exceeding 6 months from the commencement of the informal process.

Employees who achieve their agreed success criteria at the review meeting of the improvement plan but whose overall sickness absence in the rolling 12 months still exceeds the ICB threshold will have their plan extended at the same stage until their attendance falls below the ICB threshold of either less than 16 calendar days or 4 absences.

15 Long-term Sickness Absence:

Employees with long-term absence of 28 consecutive calendar days and/or more may have an underlying medical reason for their absence, should be referred to occupational health for further support.

The manager should therefore seek advice and guidance from the Occupational Health Services provider as to the nature, prognosis and duration of the absence, the likely impact on their work and likely period of recovery; as well as their fitness to return to work in the same post or an alternative post.

This information will be obtained prior to any decision made in respect of continuing employment.

In cases where an employee's absence is long term, line managers will contact the employee at set intervals agreed between the employer and employee and at times and in the manner (email or telephone for example) agreed between both parties including conducting periodic home or off-site visits as appropriate and by arrangement, with the purpose of facilitating the employee's return to work at the earliest opportunity where a return is possible.

16 Sickness Review Meeting - Long–term Sickness Absence

The stages in the short-term sickness absence process will not normally apply to long-term absence cases where the only relevant absence being managed is the long-term absence.

Rather, a series of sickness review meetings involving the Manager, HR Business Partner (and sometimes a Specialist Medical Adviser) will take place where the employee and their representative will discuss progress with a view to the employee's likely date of return to work.

The first sickness review meeting will normally take place within 10 working days after the threshold is reached.

The number of sickness review meetings will depend upon each individual case and circumstances.

Employees attending a sickness review meeting may be accompanied by a recognised trade union representative or work colleague.

Normally the sickness review meeting would take place every 4-6 weeks during the long term absence.

Outcomes may include:

- Establishing contact arrangements during absence
- Referral to Occupational Health Services Provider
- Referral to Physiotherapy Service
- Temporary adjustments to the workplace/role
- Temporary or longer-term redeployment and other reasonable adjustments
- Back to work rehabilitation
- Application for Ill-health retirement
- Progress to the final stage hearing, where it may result in termination on the grounds of incapability due to Ill-health

On return to work, following a long-term absence, any employee who is then absent for a subsequent short-term absence within a rolling 12-month period will be reviewed under the short-term sickness absence process if the overall sickness exceeds the ICB's threshold as defined in section 17 of this policy.

The review will consider all absence within the rolling 12-month period including any long-term absences except those that are work related or for pregnancy related reasons.

If the sickness review meetings have exhausted all reasonable options that would lead to a successful return to work and sickness absence is continuing and there is clear evidence of impact on service delivery in the work area.

In these circumstances, the manager will refer the case to a Sickness Absence Hearing.

Once the case has been referred to a Sickness Absence Hearing, same rules would apply as stated in section 18 of this policy (short-term sickness absence)

Possible outcomes from the Sickness Absence Hearing could include a notice of termination of their employment on grounds of capability or some other substantial reasons and/or supported to seek retirement on the grounds of ill health, if appropriate.

It must be made clear to the employee, prior to the Hearing that the termination of their contract of employment with the ICB is a likely outcome in some cases.

The line manager will confirm the outcome of the meeting in writing within 5 working days, and a copy will be placed on the employee's personal file.

The employee must be advised of their right to appeal against their dismissal. Please refer to section 24 of this policy.

17 Return to Work Meeting (RTW)

After all periods of absence irrespective of the duration, the line manager will meet with the employee in private, on their return to work.

This meeting will be confidential and the purpose of it is to ensure the welfare and wellbeing of the employee and to explore any patterns of absence and any further action to be taken to support the employee and to comply with the relevant Policy.

18 Phased Return to Work

Not everyone will need a phased return to work but in some situations such as long-term absence or absence due to some conditions such as serious mental health problems or severe musculoskeletal problems this can benefit both the organisation and the individual.

A phased return will normally be for a maximum of 4 weeks based upon medical practitioner's guidance, with the employee building up to normal hours by week 5. In exceptional circumstances an extended phased return to work may be agreed.

19 Dismissal

It is possible for the dismissal of an employee who has been, or will be, absent for a long period of time due to ill health. Such a dismissal would be on the grounds of capability or some other substantial reasons.

The Hearing Officer (decision-maker) must be satisfied the ICB can demonstrate that it acted reasonably both in treating the long-term ill health as a sufficient reason for dismissing the employee and in the procedure adopted to affect that dismissal.
If the employee is disabled, the Hearing Officer will also need to ensure that they have not been treated unfavourably because of something arising in consequence of their disability.

An employee who is dismissed because of disability-related absence will be able to argue that, as the absence arises from their disability, this constitutes discrimination. The ICB must be able to show that dismissal is justified, i.e. that it is a proportionate means of achieving a legitimate aim.

In reaching a decision as to whether or not to terminate the employee's employment, the Hearing Officer should carefully consider:

- the length of the employee's employment
- the employee's past sickness record
- the nature, effect and anticipated length of the employee's illness
- whether or not it is envisaged that the employee may return to work and, if it is, when
- the nature of the employee's job
- the reasonable adjustments that could be made to accommodate the employee
- whether or not the employee could undertake alternative work
- whether or not the employee's work could continue to be done by a replacement in the meantime; and
- the effect of the employee's absence on other employees and on the business

If, considering all the circumstances of the case, termination of employment appears to be a fair and reasonable option, a capability dismissal should be affected with notice or pay in lieu of notice and should be confirmed in writing. The employee should receive the greater of their contractual or statutory minimum notice period and any pay in lieu of accrued but untaken annual leave.

Any payments made will be subject to UK taxation rules current at the time.

An employee's contract may be terminated prior to the exhaustion of contractual sick pay entitlement if all potential options have been fully explored.

Where dismissal is the outcome the Hearing Officer, on completion of the Hearing, will tell the employee immediately (or if this is not possible within 24 hours) that the ICB is terminating the employee's contract of employment on the grounds of 'capability' for unsatisfactory attendance.

The decision must be confirmed in writing to the employee within 5 working days of the meeting and must include the following:

- The reason for dismissal
- The process undergone including opportunities to improve
- The date of Termination
- Notice period, and whether this is required to be worked or paid in lieu
- Any outstanding payments
- Confirmation of the right of Appeal

20 Right of appeal

Where an employee considers that they have been treated unfairly in respect of the management of their sickness absence, they are entitled to raise the matter under the ICB's Grievance Procedure.

An appeal against any sanction issued in accordance with this policy will be heard as below:

Employees should indicate their wish to appeal against a sanction issued in accordance with this policy within 10 working days of receipt of the outcome of the meeting.

Appeal hearings will normally take place within 2 working weeks of the appeal being received. Although there would be scope for some degree of mutually agreed flexibility.

Those in attendance at the meeting will be:

- The employee
- The employee's representative (if requested)
- The senior manager of the original sickness absence hearing panel
- An HR representative who supported the senior manager at the sickness absence hearing panel

The panel will consist of:

- A senior manager at director or deputy director level
- An HR representative to support the senior manager.
- In some cases a third panel member may be invited to act as an expert and advisor

The outcome of the appeal will be confirmed in writing to the employee within 7 working days of the hearing-taking place.

There is no further right of appeal against the decision of the appeal hearing.

21 Rights of Representation

At all formal stages of the procedure the employee has the right to be accompanied by a trade union representative or another person not acting in professional capacity.

It would not normally be reasonable for an employee to ask to be represented at 'informal' meetings or where informal coaching/counselling is being undertaken by the Manager.

Where possible, managers will identify if the employee intends to be represented and should work with the employee and the representative to identify a suitable date for a meeting, providing the employee has given an appropriate permission it would be recommended to share documentation and invite letters with both the employee and trade union representative to facilitate a smooth and transparent process to avoid any additional undue delay and minimise the impact on the employee and the ICB.

Only one postponement to a formal meeting date will usually be allowed unless in exceptional circumstances and in the event a chosen representative is unavailable.

22 Notification & Reporting Procedures

22.1 First day of absence

On the first day of absence (or the nearest working day if ill health or injury commences on a non-working day) employees must contact their line manager (or designated person in charge if the line manager is not available) within15 minutes prior to their usual start time and sooner if possible.

The following details must be provided:

- The date sickness commenced whether or not a working day
- The date and time of the first shift that will be missed
- Whether the employee considers the absence to be work related
- Whether the employee has already worked on the day of reporting
- The reason for the absence and the likely date of return

22.2 Absence of less than one working day

Part days worked are not recorded as Sickness Absence. If an employee reports part way through a shift that they are sick and can no longer continue, this sickness absence is not recorded if an employee has completed at least half of their working day.

A file note of the absence should be made by the line manager detailing the absence and the reason for it. Line managers will monitor all such occurrences and hold a back to work meeting and may seek Occupational Health advice if appropriate. Where there is a pattern of absence of this nature this will be explored and, where necessary, appropriate action taken, this may include formal disciplinary or capability procedures. Work related absence

The line manager must ensure that HR is informed of all cases of work-related absence. If the absence is due to a musculoskeletal injury the line manager must also inform the Information Governance & Risk Manager, who would then follow the correct protocols.

22.3 Stress related absence

Where the sickness is stress related, the line manager should refer to the Stress Management Policy for further guidance.

22.4 Injury Allowance (formerly known as TIA)

Where sickness absence is related wholly or mainly attributable to their work, the employee may be entitled to Injury allowance (IA) if they reach a period of reduced pay or no pay.

Managers will arrange for the completion of IA forms in relevant circumstances. Completed IA forms should be returned to the line manager.

The decision for the approval of IA rests with the ICB and will be considered by the line manager in partnership with Human Resources and in consultation with Occupational Health if required.

22.5 Eighth day of absence

The employee must contact their line manager and submit a Statement of Fitness to Work (Fit Note). The employee must obtain a Fit Note from their General Practice or a hospital doctor and ensure that their line manager receives it within 3 working days.

The employee must continue to send in consecutively dated Fit Notes as necessary and keep their line manager informed on a weekly basis on their progress.

Please note that a Fit Note issued by a general practice may be taken as evidence of the ability to return to work either on full-time hours or on a phased return in lieu of a report from occupational health.

22.6 Medical Suspension

In exceptional circumstances, it may be necessary to medically suspend an employee, as they are unfit, on health grounds, to undertake the duties of their post.
Advice must be sought from Occupational Health and Human Resources prior to medical suspension taking place. An employee who is medically suspended will continue to receive full pay.

In circumstances where a quick decision needs to be made in the benefit of the individual and others, managers have the discretion to medically suspend staff where health and safety at work is compromised. In such cases, relevant advice must be sought from Occupational Health and Human Resources as soon as practically possible.

All medical suspensions should be regularly reviewed.

22.7 Unauthorised absence

Failure to follow notification procedures is likely to result in absence being recorded as unauthorised. Employees will not be paid for any period of unauthorised absence and disciplinary action may be considered in such circumstances.

23 Disability

Disability is a "protected characteristic" under the Equality Act 2010. An employee has a disability if they "have a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on [their] ability to carry out normal day-to-day activities.

The effect of an impairment is long-term if it has lasted at least 12 months, is likely to last at least that long, or is likely to recur if in remission.

If an employee has a disability that prevents them from carrying out their contracted duties, the manager will seek advice from HR and Occupational Health, and this may subsequently be extended to getting further relevant advice.

The ICB will be discriminating against a disabled employee if, because of something arising from their disability, it treats them less favourably, and cannot show that the treatment is justified in the circumstances. This includes less favourable treatment because of a person's association with someone who has or is believed to have a protected characteristic 'discrimination by association', or because the person is wrongly thought to have a protected characteristic 'discrimination by perception'.
In addition, if we fail to comply with our duty to make reasonable adjustments in relation to the disabled employee.

Reasonable adjustments to be considered therefore may include:

- adjusting premises
- adjustment of sickness absence threshold
- reallocating duties
- transferring the employee to fill an existing vacancy
- altering work or training hours
- assigning a different place of work or training
- allowing absence for treatment/rehabilitation or assessment
- arranging training or mentoring (whether for the disabled person or any other person)
- acquiring/modifying equipment
- modifying procedures for testing or assessments
- providing a reader or interpreter
- providing information in an accessible format; or
- providing supervision or any other relevant support that would enable the employee to continue within their role

24 Employees with more than one job

Employees may have more than one job, either with the same employer or with a different employer.

It would be unusual for the employee to report sick for one job and be fit to attend work for the other. To do so and/or claim sick pay may be considered an act of fraud.

Fraud is classed as gross misconduct and may result in dismissal from employment and criminal charges.

25 Sickness and Bank Working

Employees who are off sick or on a phased return to work must not undertake any type of work during their allocated working hours, including working for the Bank, Agencies, or any other private organisations.

This restriction is lifted when the employee returns to working their contractual hours.

26 Conduct during Sickness

Whilst on sick leave employees will be expected to behave in a manner that will assist their recovery and return to work.

Employees should not engage in any activity, which is inconsistent with the nature of their illness/injury, however if there is a recommendation which could potentially be beneficial for employee and their recovery, they must seek line manager's permission prior to engaging with the activity.

The ICB considers it a disciplinary offence to claim occupational sick pay or Statutory Sick Pay (SSP) from the ICB whilst undertaking paid or unpaid employment elsewhere without the prior express agreement of the ICB.
It can also be a criminal offence to claim Statutory Sick Pay (SSP) from an employer whilst undertaking paid or unpaid employment elsewhere without the agreement of the ICB.

Where the ICB has reason to believe an employee is working elsewhere whilst off sick without prior agreement, an investigation under the ICB's Disciplinary Policy and Procedure will be implemented, which could lead to dismissal, as well as a criminal investigation in accordance with the ICB's Counter Fraud and Corruption Policy.

Where the ICB has reason to believe that an employee's conduct during sick leave has been prejudicial to their recovery, sick pay may be withheld, following an investigation into the circumstances.

If the ICB has reason to believe that an employee has received any salary fraudulently, including sick pay, this will result in action being taken in accordance with the ICB's Disciplinary Policy and Procedure and in accordance with the ICB's Counter Fraud and Corruption Policy.

Where fraudulent claims of sickness absence are suspected, these will be investigated by the Local Counter Fraud Specialist (LCFS).

Employees are expected to cooperate in the management of their sickness absence. This expectation extends to making all reasonable efforts to attend sickness review and occupational health meetings.

Where an appointment has been made which is inconvenient for the employee, it is their responsibility to contact the manager / occupational health advisor and rearrange the appointment for a more suitable time and date.

Persistent failure to attend sickness review and occupational health meetings without good reason (whether notice of the intention not to attend has been given or not) will be viewed as the refusal to follow a reasonable management instruction and may lead to disciplinary action being taken against the employee, and the formal meeting may take place in their absence and a normal process to be followed thereafter

27 Misuse of sick leave arrangements

Employees must not take sickness absence instead of, or to supplement their annual leave.

If an employee has been refused annual leave, flexi time, time off in lieu or special leave, but then subsequently reports sick, the line manager will investigate the circumstances.

If after a thorough investigation there appears to be a misuse of the Managing Absence Policy, then the matter becomes one of conduct and will be managed in accordance with the ICB's Disciplinary Policy.

False use of sick leave arrangements amounts to fraud. Fraud is classed as gross misconduct and may result in dismissal from employment and criminal charges.

28 Sickness absence and annual leave

Employees who are unfit for work may take periods of planned annual leave, or request annual leave, as an alternative to sick leave.

They would be paid in accordance with their terms and conditions of service for any period of annual leave.

29 Accrual of Benefits during Sick Leave

Annual leave is accrued during all sickness absence. The leave is accrued as per the employee's contractual entitlement during periods of paid sick leave and based on statutory entitlement, as per the Working Time Directive, during episodes of unpaid sick leave.

In the cases of long-term sickness absence where an employee is prevented from taking annual leave during the leave year in which it has been accrued as their absence goes from one leave year into the next, they may carry over a maximum of 20 days annual leave (statutory entitlement) into the new leave year (pro rata for part time staff).

This carried over leave must be used in the subsequent leave year.

The annual leave accrued is advised to taken as soon as practicably possible upon return with line manager's agreement.

If a worker wishes to take annual leave whilst on sick leave or as part of a phased return, the ICB will allow them to do so.

Annual leave cannot be replaced by a payment in lieu, except in some circumstances where the employee's contract is terminated.

30 Sick Pay

The payment of salary during absence through sickness, injury, or accident will be in accordance with national terms and conditions.

The payment of sick pay is dependent upon the correct reporting and certification of sickness as detailed above. Failure to comply with the conditions of this policy may lead to payments being withheld.

31 Salary Increments

Entitlements to receive salary increments are not affected by sickness absence.

32 Terminal Illness

Where the employee is suffering from a terminal illness there are a variety of options open to the employee/ manager.

These options must be explored sensitively in conjunction with HR and OH.

33 Process for Analysing Sickness Absence Data

The ICB will monitor employee absence through the data collated by Payroll detailing when employees are absent from work due to sickness.

This data will be used to promotes a culture that encourages attendance at work.

34 Third Party claims

If an employee makes a successful claim that includes a claim for loss of earnings against a third party, any sick pay received during the period they were absent from work will have to be reimbursed to the ICB.

35 Pension Entitlements

An employee who is a member of the NHS Pension Scheme (1995, 2008 or 2015 sections) may make an application for ill health retirement direct to the NHS Pension Agency.

However, the applications are made with the support of a medical report written by an Occupational Health Doctor, a General Practitioner or a Consultant, if the doctor considers the employee may meet the criteria for an early retirement on ill health grounds.

Advice on the application process can be sought from Human Resources.

36 Miscellaneous

36.1 Medical Appointments

When an employee requires time off work for medical or dental appointments, they must give their line manager the maximum notice of the appointment and may be asked to present evidence of that appointment.
When arranging time off to attend a medical, dental or counselling appointment, wherever possible the employee should make appointments outside of their working hours. If this is not possible then the appointment must be made at either end of their working hours to minimise disruption to service. If this is not possible the proposed time off must be discussed and agreed with the line manager.
In exceptional circumstances line managers may ask the employee to re-arrange an appointment in the interests of operational requirements.
The ICB will reimburse employees who are charged for cancelling appointments at short notice if asked to do so by their line manager for operational requirements, on the production of a receipt.

36.2 Elective medical treatment

The ICB wants to support employees who need planned treatment for a medical condition and who wish to remain at work and return to work during and/or after treatment.
The ICB will support the employee in phasing a return to work, reasonable adjustments to the usual work, temporary change to the usual work location and redeployment on medical grounds if appropriate.

36.3 Cosmetic surgery

Attendance at appointments, and time off, for elective cosmetic medical or dental procedures including recovery, must be taken as annual leave or an employment break.
Where sickness is caused by non-routine complications related to the surgery, subject to relevant notification and Fit Note requirements, sick leave would apply at that stage. Additionally, time off for cosmetic surgery which is indicated to improve the health and welfare of the employee (as indicated by some form of health assessment) may be taken as sick leave.

36.4 Gender re-assignment

Sick leave will apply, and relevant support as necessary would be provided upon return to work.

36.5 Referral to Occupational Health Services Provider

The Occupational Health Service provider provides an independent assessment to the ICB of the medical condition of an employee. They do not act as an advocate for the employee or the ICB.

The Occupational Health Service provider advises on:

- The cause and prognosis of the illness
- The anticipated period of absence
- If the employee is considered 'disabled' under the relevant Act
- What type of work the employee will be capable of on their return
- Any reasonable adjustments to be made
- Whether a "phased return" to work is advisable for employees who have had a period of absence exceeding 28 days
- Suitable alternative jobs (re-deployment)
- If someone is eligible for ill health retirement

A referral to Occupational Health Services can occur in two ways:

- Referral by the line manager
- Self-referral by the employee

Consultation with GPs or Hospital Consultants should be made by the Occupational Health Service and should not be undertaken by line managers.

In exceptional circumstances a line manager, in liaison with the appropriate HR representative, may consult with the employee's GP or Hospital Consultant only after obtaining the written consent of the employee.

When an employee disagrees with the opinion expressed by the Occupational Health Service provider the employee will be given the opportunity, at their own expense, to obtain additional medical opinion. On receipt of additional medical opinion, the line manager will refer the case back to the Occupational Health Service provider who will be asked to review their original advice in light of any new information that has been provided. If a difference of opinion continues, the line manager, in liaison with Human Resources will consider all the information available and base decisions on a reasonable assessment of the information.

In addition, or alternatively, the employee is able to comment on the occupational health advice and this will be taken into account by the line manager.

37 PROCESS FOR WAIVERS

Any waivers would need the agreement of both parties.

38 POLICY CIRCULATION

Managers and staff will be alerted of the existence of this policy via the in-house newsletter, Staff Partnership Forum meeting minutes and Chief Officers.

39 Appendix A: Abbreviations and Definitions

Abbreviation / Item	Definition
CE	Chief Executive
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
NHS	National Health Service
SC	Social Care
We	The ICB
RTW	Return to work
OH	Occupational Health
ESR	The Electronic Staff Record
IA	Injury Allowance

40 Appendix B: Return to Work Meeting Form

The primary purpose of a return-to-work meeting is to welcome the employee back, discuss the reasons for their absence (if unknown) and confirm that they are fit to attend work.

You may also use this opportunity to provide work update and discuss any support that may be needed to facilitate a comfortable return

Employee Name:					
Job title:				**Band:**	
Meeting conducted by:					
Date of meeting:					
Dates of absence:	**From:**		**To:**		
Reason for absence:					
Total no. of days absent:					
Total days/occurrences absence in rolling year (last 12 months):	**Total Days in past 12 months**:		**Total occurrences in the past 12 mths:**		
Did the employee follow the ICB's guidelines regarding notification? (If no, give details)					
If the absence was over 7 days was a 'fitness to work' certificate provided?					
DETAIL OF DISCUSSION					
How are you feeling? Discuss reasons for absence					
Was the illness work related? Did work impact on the illness?					

Do you feel that there is anything the ICB can do to assist your return/help you in future?	
Is a referral to Occupational Health required?	**Yes / No** *(please circle)*
If yes, what date was the referral sent to Occupational Health:	
If appropriate, discuss the individual's pattern of sick leave. Are there any reasons for the pattern?	
Is there a requirement to move to formal absence monitoring under policy?	
Update on work developments and work during absence:	
Any other concerns/issues discussed:	

Reviewing Manager signature:		**Date:**	
Employee signature:		**Date:**	

Please send a copy of this form to the HR Department via HRForms@Suffolk.nhs.uk

Working in Partnership with trade unions.

Framework and Agreement for Suffolk and North East Essex Integrated Care Board

Contents

1 Introduction

1.1 Suffolk and North East Essex ICB recognises the benefit of effective communication, joint consultation and, where appropriate, negotiation between management and employees.

1.2 Suffolk and North East Essex ICB as an NHS body endorses and implements part one of the NHS terms and conditions of service handbook, Principles and Partnership, as agreed by the NHS staff council.

1.3 Suffolk and North East Essex ICB fully recognises and supports a positive culture of openness and participation where every member of staff is valued. This agreement sets out the ways in which Suffolk and North East Essex ICB and trade unions will continue to work together in partnership. We are jointly committed to working together to create a fair and consistent working environment across the whole of Suffolk and North East Essex ICB.

1.4 Effective partnership arrangements will make a critical contribution to representing the interests of staff and Suffolk and North East Essex ICB.

2 Suffolk and North East Essex ICB Constitution: General Principles

2.1 Suffolk and North East Essex ICB commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership arrangements. The following working principles are agreed and adhered to by both Suffolk and North East Essex ICB and staff side:-

- We commit to working jointly to solve problems and identify solutions
- We are committed to a relationship of trust between Suffolk and North East Essex ICB, its employees and trade union representatives
- We agree that decisions made by Suffolk and North East Essex ICB and Staff Partnership Forums including sub-groups and task and finish groups of that forum will be in consensus
- We will ensure fair treatment of employees and a mutual respect between all working within the partnership approach including employees, managers and trade union colleagues
- We will engage in open, honest and meaningful dialogue
- We will ensure the recommended and appropriate agreed time is allocated to partnership working and is appropriately managed
- We will actively seek, listen to, value and respond to the views of colleagues

- Suffolk and North East Essex ICB will communicate and consult (whether locally, regionally or nationally) about any significant decision that is likely to affect employees. As a matter of good practice, the organisation will communicate to employees and their representatives about:-
  - The organisation structure and purpose, arrangements for supervision and management, operating and technical processes, training opportunities etc.
  - Strategic planning decisions that affect the workforce
  - How the organisation is performing including its financial performance, service developments and operational performance.

3 Recognition and Facilities Arrangements

3.1 Suffolk and North East Essex ICB Through the People Impact Assessment, ICBs will have determined existing recognition with certain trade unions. All of the NHS Staff Council Trade Unions should be recognised by an ICB, but if any others have been granted recognition locally the continuation of this should be discussed and agreed in partnership with those trade unions already represented through the transfer.

3.2 This agreement applies to the trade unions as defined above. Suffolk and North East Essex ICB will not consult with unions not recognised within this agreement.

3.3 Further requests for recognition will be considered with reference to the numbers of members employed by Suffolk and North East Essex ICB and in accordance with the Employment Relations Act 1999.

4 Suffolk and North East Essex ICB Partnership Forum

4.1 The Suffolk and North East Essex ICB Partnership Forum has been established to provide a regular and formal means of information, consultation and negotiation between managers of Suffolk and North East Essex ICB and elected trade union representatives.

4.2 The Partnership Forum will be the main forum for formal consultation between management and staff side on strategic issues of concern and interest to either party.

4.3 The Partnership Forum will act as the final stage of consultation for organisation wide strategic human resources issues, People and Organisational Development policies and procedures and any other organisation wide best practice or improvement programmes not covered by the other function based committees.

4.4 The chair for the Partnership Forum will alternate between the management side chair and the staff side chair. In addition to current issues, the agenda will

comprise a number of standing items which will include updates from each of the Partnership Forum Subgroups and a Diversity and Inclusion update.

4.5 Consultation for the purposes of the forums set out within this agreement is described in the definition below:-

"Consultation is the dynamic process of dialogue between individuals or groups based on a genuine exchange of views and normally within the objective of influencing decisions, policies or programmes of action" (Consultation Institute 2009)

4.6 Consultation involves an opportunity to influence decisions and their application. The aim of consultation is to take account of, as well as listen to, the views of staff and their representatives.

4.7 Suffolk and North East Essex ICB will consult through the Partnership Forum on matters relating to any national and local agreements pertaining to National NHS terms and conditions of service and/or Medical and Dental Terms and Conditions of Employment, where appropriate.

5 Membership of Partnership Forum

5.1 Membership of Suffolk and North East Essex ICB Partnership Forum should include at least two representatives each of management and staff side, and at least one rep from each recognised TU, balanced by an equal number from management. Full time officers can be part of local partnership forums as ex-officio members. The composition of the group may change over time to reflect emerging organisational arrangements but the overall numbers described below will remain the same:-

Management	Staff Side
• Director of People and Workforce for Suffolk and North East Essex ICB • (Chair) • Representative from Suffolk and North East Essex ICB • Senior HR Representative for Suffolk and North East Essex ICB • Secretary/Minute taker • Co-opted members as appropriate – by mutual agreement	• Staff side representative for each recognised trade union i.e., MiP, RCN and Unison, UNITE, BMA • Full-time Officials from all recognised Trade Union/Professional Bodies will have an open invitation to attend meetings organised by the Joint Staff Partnership Committee. • Co-opted members as appropriate – by mutual agreement

5.2 Nominated deputies, who shall have full rights of representation, may attend the Partnership Forum when management or staff side representatives are absent.

5.3 At the request of Partnership Forum members, the joint chairs may agree for guests to attend meetings and participate as appropriate. Subject to this approval, management and trade union representatives may therefore invite guests to attend the meeting of the Partnership Forum in an advisory capacity or as an observer. Advance notice of the proposed attendance of all guests, shall be given to the joint chairs in advance of the meeting.

5.4 Where it is deemed to be appropriate and helpful other employees may be co-opted onto the forum for particular agenda items with advance agreement received from the joint chairs.

6 Functional Suffolk and North East Essex ICB Sub-groups and Task and Finish Groups

6.1 There are a number of standing sub-groups and task and finish groups that feed in to the Suffolk and North East Essex ICB Partnership Forum.

6.2 Sub-groups and task and finish groups are the recognised forum where all appropriate, policies and procedures and operational issues for each area will be discussed and consulted.

6.3 Sub-groups and task and finish groups will have the authority to make decisions relating to changes to work practices/processes that affect the staff it covers. These groups do not have the authority to agree changes or alterations to policies and procedures or local arrangements accompanying NHS terms and conditions of service or any issue that will impact on another staff group. Any issues of this nature must be referred to Suffolk and North East Essex ICB Partnership Forum for consideration and final consultation and adoption.

7 Meeting Operating Arrangements

7.1 For all forums sufficient time will be made available to enable pre meets for both management and staff side. It is accepted that any pre meets on the day should not normally last for more than two hours on the day of the meeting. Any additional preparation will be organised by management and staff side at their discretion on alternative days.

8 Meeting Chair

8.1 The Chairing of the Partnership Forum will alternate between the management side chair, the Chief People Officer for Suffolk and North East Essex ICB and the staff side chair.

9 Meeting Purpose and Duration

9.1 Suffolk and North East Essex ICB Partnership Forums and sub-groups will not be normally expected to last for more than three hours in duration. Any matters requiring more detailed discussions will either be worked on by a small time limited working party with recommendations being brought back to the main committee, or a separate meeting will be set up to discuss specific matters if and when necessary.

10 Agenda and Minutes – for partnerships forums, subgroups and task and finish groups

10.1 Meetings for all partnership forums and sub-groups will be arranged at the start of the calendar year where possible. If during the year these dates are not convenient or attendance is low, owing to a range of circumstances, then the meeting may be postponed or cancelled by the agreement of both the management and staff side chairs.

10.2 There are some key principles with which both management and staff side will adhere to in order to ensure the appropriate information and records of any such meetings are efficient and timely as follows:-

- Agendas will be sent out, a minimum of five working days before any forum following input from both staff side and management. All agenda items will be tabled through the staff side or management side secretaries of each committee.

- Individuals submitting agenda items will be asked for their proposed time allocation which should not normally be more than thirty minutes.

- Individuals submitting agenda items will also be expected to complete a summary page to their item, which specifically states the outcome/decision expected so that all attending the meeting are clear of the outcomes required.

- Minutes/action logs will be drafted and distributed for agreement within five working days of the date of the forum/sub group.

- All agendas and minutes will be agreed by the members of the Partnership Forum and joint communications after each meeting will be agreed and

communicated throughout the organisation by e-mail to staff side members and posted on the staff intranet site and made available to all staff via circulation in The Buzz weekly staff newsletter.

- All agendas and minutes will be made available on the Suffolk and North East Essex ICB intranet once agreed.

11 Partnership Forum Quorum

11.1 To be considered quorate management side will have at least two 2 representatives present, and staff side will have two 2 union representatives. Where a quorum is not available, the meeting will take place on the agreement of both sides.

12 The Function of Representatives and Officials

12.1 Suffolk and North East Essex ICB and the Unions recognise that the industrial relations functions of representatives and officials are important responsibilities in addition to their duties as employees of Suffolk and North East Essex ICB. Their functions and responsibilities are as follows:

- to be responsible to and for a group of members
- to undertake industrial relation duties operating within the policies of Suffolk and North East Essex ICB
- to seek full Trade Union membership amongst all employees of the Organisation
- to represent the Union in the joint negotiating and joint consultative machinery at system levels
- to attend meetings of the Trade Union of which the person is a representative or of which he/she is an official, (such as Branch or Branch Committee Meetings)
- to seek to ensure that agreements are adhered to
- to organise meetings of members during working hours in accordance with the ACAS Code of Practice and any prevailing local agreements.

13 Time Off for Trade Union Duties

13.1 Suffolk and North East Essex ICB is subject to the provisions laid out in statute through Sections 168 of the Trade Union and Labour Relations (Consolidation) Act 1992, Suffolk and North East Essex ICB will permit an employee who is an official (as defined in Section 119 of the Trade Union and Labour Relations (Consolidation) Act 1992) of an independent trade union recognised by the organisation, to take reasonable time off during their working hours for the purposes of carrying out the duties described in section 12.1.

13.2 As an NHS organisation Suffolk and North East Essex ICB intends to comply with section 25 of the NHS terms and conditions of service handbook "Time off and facilities for trades union representatives". Section 25 should be referred to for further information in relation to both time off and facilities for accredited trade unions, who have been duly elected or appointed, and who represent their members on matters that are of concern to Suffolk and North East Essex ICB and/or its employees.

13.3 As described in section 25.7 of the NHS Terms and Conditions of Service handbook, '*subject to the needs of the service and adequate notification, accredited representatives should be permitted paid time off, including time to prepare for meetings and disseminate information and outcomes to members during working hours, to carry out duties that are concerned with any aspect of:*

- *negotiation and/or consultation on matters relating to terms and conditions of employment or agreed partnership processes – examples include:*
  - *terms and conditions of employment;*
  - *engagement or termination of employment;*
  - *allocation of work;*
  - *matters of discipline;*
  - *grievances and disputes;*
  - *union membership or non-membership;*
  - *facilities for trades union representatives;*
  - *machinery for negotiation or consultation or other procedures;*
  - *meetings with members;*
  - *meetings with other lay officials or full time officers;*
  - *appearing on behalf of members before internal or external bodies;*
  - *all joint policy implementation and partnership working;*
  - *other matters relating to employee relations and partnership working*.'

13.4 Suffolk and North East Essex ICB recognises as per section 25.8 of the NHS Terms and Conditions of service that as a matter of good practice that '*staff representatives should indicate the general nature of the business for which time off is required and where they can be contacted if required. Requests should be made as far in advance as possible, as is reasonable in the circumstances. Wherever possible the representatives should indicate the anticipated period of absence. The expectation is that requests for paid time off for trades union representatives will not be unreasonably refused.*'

13.5 Working hours of trade union officials will be considered in line with the definition outlined in Section 173 (1) of the Trade Union and Labour Relations (Consolidation) Act 1992.

13.6 This agreement seeks to establish a formal procedure on trade union duties and activities in accordance with the legislative framework. It is recognised that it is

not possible to be prescriptive about all duties, activities and the time required carrying them out. Suffolk and North East Essex ICB agrees that requests for time off will not be unreasonably refused.

14 Time Off for Union Learning and Health and Safety Representatives

14.1 Accredited Health and Safety Representatives are entitled to take reasonable paid time off to undertake for their duties and relevant training. Accredited Trade Union learning representatives are also entitled to reasonable paid time off for the following specific purposes. Requests can be logged using the form in Appendix 3:

- analysing learning or training needs;
- providing information and advice about learning or training matters;
- arranging learning or training;
- promoting the value of learning or training;
- consulting the employer in relation to such duties;
- preparation in relation to such duties;
- Undergoing relevant training.

15 Special Arrangements for Time Off

15.1 In the case of employees who work shifts or unsocial hours, Suffolk and North East Essex ICB will allow reasonable time off for trade union duties.

15.2 Where time with pay has been approved, the payment due will equate to the earnings the employee would otherwise have received had he/she been at work.

15.3 Where representatives attend meetings called by management which occur outside of their normal working hours, payment will be made for the hours spent at the meetings. Alternatively, by agreement, an equivalent amount of time off in lieu will be given at a time agreeable to both parties, subject to the contingencies of the service.

15.4 In the case of representatives who consider themselves to have a disability, or long term condition, Suffolk and North East Essex ICB will allow additional time and facilities, if necessary, and make suitable arrangements to allow them to carry out their responsibilities.

15.5 Travelling and subsistence costs will be reimbursed to accredited representatives for periods of work approved in accordance with this agreement. Requests can be logged using the form at Appendix 3.

16 Time off to cover related workplaces

16.1 Any extension of representational rights to cover employees outside of Suffolk and North East Essex ICB will be subject to agreement on a case by case basis.

17 Training

17.1 Reasonable time off with pay will be granted to enable accredited trade union representatives, learning representatives and health and safety representatives to attend training courses approved by their trade union. Suffolk and North East Essex ICB supports the need for newly appointed trade union officials to be granted reasonable time off for initial training in basic representational skills as soon as possible after his or her appointment. Following this further reasonable time should be considered:

- For further training, particularly where the official has special responsibilities
- To deal with changes in the structure or topics of negotiation, or where significant changes in the organisation of work are contemplated;
- Where legislative changes affect the conduct of employee relations.

17.2 The trade unions must give adequate advance notice of course dates in writing to relevant line-mangers and co-operate in making arrangements to cover jobs during the absence of Representatives on courses. Details of the course should be provided (see Appendix 3)

17.3 Part-time employees who are required to attend recognised training courses as detailed above will be paid for the whole of their attendance time, even if it exceeds their normal working hours.

18 Procedures

18.1 Before taking time off, the accredited representatives must obtain the permission of their manager, informing the manager of the general purpose of the time off, the intended location, the expected timing and duration of time off required. The Form at Appendix 3 may be useful for recording such applications and the outcome.

18.2 The employer will ensure that management at all levels are familiar with agreements and arrangements relating to this agreement.

18.3 Suffolk and North East Essex ICB recognises that the duties carried out by Staff side representatives are as important to the needs of the service as any other part of ICB business. When considering the balance in relation to service needs and the request for facility time, managers need to weigh up the importance of the duty being required of the representative against the needs of the service.

The manager should seek advice from HR before declining any request where practical.

18.4 Requests for time off for union duties should be made in advance of the activity wherever possible (see Appendix 3). It is acknowledged that Trade Union representatives may be required to provide urgent support/advice to staff members at short notice and may be the first point of contact for staff in distress, requiring emotional/mental health support and sign posting to other ICB support mechanisms.

18.5 In extenuating circumstances such as these, retrospective agreement for time off in lieu can be sought from the line manager. An initial discussion should have been undertaken with the line manager and agreement gained for these working arrangements prior to any retrospective request. In these circumstances the line manager must be informed at the earliest opportunity. Staff side members with facilitated time would endeavour to claim back the hours worked within their backfilled facilitated hours.

19 No Detriment

19.1 Individuals will not be discriminated against during the course of their employment for membership of a trade union or activities as a union representative.

19.2 There will be no disciplinary action taken against accredited representatives of any union until the matter has been discussed with the full time officer of the union concerned.

20 Collective Disputes

20.1 It is recognised that there may be occasions where Suffolk and North East Essex ICB and recognised trade unions despite consultation cannot reach formal agreement in relation to some matters. If this occurs then the matter would enter a stage of formal dispute.

20.2 Under the circumstances described above every effort should be made to escalate and resolve the issue through the established forums i.e. Partnership Forum.

20.3 Should the issue be escalated to the Partnership Forum and an appropriate resolution is still unable to be agreed then the trade union(s) concerned should formally write to the Chief People Officer [or equivalent] outlining the issues concerned and what would be a satisfactory resolution from their perspective. The Chief People Officer will then consider appropriate action to undertake relating to the specific nature of the concern. At this point the organisation and union(s) concerned will be deemed to be ‘in dispute’ on the matter in question.

20.4 Where mutually agreed, support may be requested from independent parties in an effort to resolve the matter in question i.e. ACAS.

20.5 Once the matter reaches a satisfactory resolution for both parties the trade union(s) concerned should formally write to the Chief People Officer to confirm that the issue has been satisfactorily resolved and that there is no longer a dispute.

21 Individual Disputes

21.1 Where individual disputes arise from the application of this framework, or access to the facilities in support of carrying out duties and activities for example, issues relating to time off for representation to undertake trade union duties, every effort should be made to informally resolve these in the first instance. If it is not possible to reach an informal resolution then the process outlined below should be followed.

21.2 Under the circumstances described above every effort should be made to escalate and resolve the issue through the established Partnership Forum.

21.3 Should the issue be escalated to the Partnership Forum and an appropriate resolution is still unable to be agreed then the individual concerned should formally write to the Chief People Officer outlining the issues concerned and what would be a satisfactory resolution from their perspective. The Chief People Officer will then consider appropriate action to undertake relating to the specific nature of the concern. At this point the individual concerned will be deemed to be 'in dispute' on the matter in question.

21.4 Where appropriate, support may be requested from independent parties in an effort to resolve the matter in question i.e. ACAS. If both parties agree to this.

21.5 Once the matter reaches a satisfactory resolution for both parties the individual concerned should formally write to the Chief People Officer to confirm that the issue has been satisfactorily resolved and that there is no longer a dispute.

22 Amendment or Termination of Agreement

22.1 Either side may submit proposals in order to amend this agreement. Such proposals will be in writing to all parties concerned and will be the subject of joint discussions.

22.2 Both sides commit to agree to review this Agreement in twelve months and annually thereafter.

Signatories

Management:- ……. Date:-……

Staffside (UNITE):- …….. Date:-……

Staffside (Unison):- …….. Date:-……

Staffside (MIP):- …….. Date:-……

Staffside (RCN):- …….. Date:-……

Staffside (BMA):- …….. Date:-……

Appendix 1 – Template consultative framework

Sub-groups that feed in to the Suffolk and North East Essex ICB Partnership Forum will be listed here:

- No Current Groups.

Appendix 2 – Time off and Facilities for the Trade Union representatives involved in supporting the Partnership roles – a joint statement of understanding and principles

1. Day to day facilities for local Trade Union (TU) representatives

Within this Partnership Working Framework Agreement there is a clear recognition and endorsement that accredited TU representatives of the TUs recognised by Suffolk and North East Essex ICB are given reasonable time off to carry out their industrial relation duties and activities and also reasonable time off for training.

Within Suffolk and North East Essex ICB Teams there are a range of day to day activities: formal/informal consultations, issues at work, some informal and others formal in nature, such as grievance or disciplinary processes. Our Partnership Agreement correctly specifies that managers are encouraged to take a sensible and reasonable approach to these day to day requests for time off for TU duties.

The number and demands placed upon TU representatives will very much be a function of what is happening at any given time. If there are several consultations involving possible job losses and subsequent 1-1 meetings or collective workplace meetings, then requests for time off for our local TU representatives will increase. However, this is a two way process, given that there will equally be managers in these areas also devoting increased time to such discussions and meetings.

This can all be described as the day to day process of fostering and encouraging good industrial relations. Reasonable time off for accredited TU representatives is therefore to be encouraged in our partnership relationship and is also to be expected.

2. Facilities for Suffolk and North East Essex ICB TU representatives involved in the Partnership Forum and subgroups

The funding that has been identified and set aside by the Chief People Officer for Suffolk and North East Essex ICB is separate to the need for the day to day local or regional TU activities that need to occur. This funding is to support and strengthen the partnership relationships working on behalf of the whole of Suffolk and North East Essex ICB.

This funding identified is in recognition of the need to help develop local TU representatives who are playing a significant role in the Suffolk and North East Essex ICB partnership arrangements. The funding concerned is to protect and advance that relationship, enabling some monies to be made available to back fill an individual whilst performing their system wide TU role.

The mechanism and agreement for distribution of the money and time off will be agreed between the individual, their TU officer, the Chief People Officer or Regional

Director of People and OD on his behalf and the relevant line manager / budget holder for the Suffolk and North East Essex ICB member of staff concerned. However, it is clear that this time off is for activities over and above those normally identified in the first section of this statement. There will be a separate individual agreement made and reviewed each year for those in receipt of such supported and additional facilities time.

It is agreed between Suffolk and North East Essex ICB and all the recognised TUs that no individual member of staff will exceed time off greater than 50% of their normal working time in any financial year for TU duties and activities, whether system or place. The only exception to this principle would be where there is a formal secondment agreement in operation where the trade union concerned becomes wholly responsible for the salary costs and expenses of the individual to whom it applies. It is also agreed that day to day TU activities will be undertaken in the spirit of partnership, where there is goodwill from all parties concerned and there will be give and take in terms of day to day operational needs of roles people are employed in, balanced by the needs for the partnership work that needs to occur.

3. Reviews and problems

This agreement will be regularly reviewed at the Suffolk and North East Essex ICB Partnership Forum and by the joint officers. Any difficulties in fulfilling these facilities will in, the first instance, be raised by the appropriate Officer of the recognised trade union with Suffolk and North East Essex ICB and if there is no resolution or mutually agreeable solution, then this will result in reference being made to the Suffolk and North East Essex ICB Partnership Forum for joint resolution.

Appendix 3 – Request for Time Off for Union Duties Form

To:	
From:	
Name of Trade Union and position held	

Request for time off work (with/without pay or TOIL) to undertake trade union duties/activities or duties/training associated with being a recognised union representative on:

Date ……

Time……

Place ……

Approx. duration ……

Outline nature of business (e.g. internal/external):

Signed (union rep) …… date ……

This request is made in advance /retrospectively* (delete as appropriate)

This request is approved/not approved* (delete as appropriate)

Reason if not approved:

Signed (approver) …… date ……

NHS
Suffolk and North East Essex
Integrated Care Board

ICB BOARD

Agenda Item No.	**22**
Reference No.	**ICB 23-16**
Date.	**24 January 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	**Minutes and Highlight Reports:** ***To receive*** *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.* *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* *h)* **Strategic Digital Investment and Assurance Board** *A summary of minutes of a meeting held 29 November 2022*

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.

NHS
Suffolk and
North East Essex
Integrated Care Board

Meeting of the SNEE ICB Audit Committee held on 15 December 2022

PRESENT:

Steve Clarke **(Chair)**	SC	Non-Executive, Finance and Audit
Steve Feast	SF	Non - Executive, Quality and Safety
Phanuel Mutumburi	PM	External Independent Member

IN ATTENDANCE:

Chris Armitt	CA	ICB Deputy Director of Finance
Steve Bladen	SB	External Audit Partner, BDO
Colin Boakes	CB	ICB Governance Advisor
Tony Buckle	TB	ICB Risk Manager
Paul Cook	PC	ICB Information Governance Manager
Mark Game	MG	ICB Deputy Director of Finance (Financial Reporting and Governance)
Ed Garratt	EG	ICB Chief Executive
Tshiamo Hlatshwayo	TH	External Audit Partner, 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
James Thompson	JT	ICB Finance Team
Liz Wright	LW	Head of Internal Audit, RSM
Jo Mael (Minutes)	JM	ICB Corporate Governance Manager

22/027 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed all to the meeting. Apologies for absence were received from Tanya Curry, Non-Executive, People, Remuneration and Diversity

22/028 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.

22/029 MINUTES OF THE PREVIOUS MEETING

The minutes of the SNEE ICB Audit Committee meeting held on 26 September 2022 **were approved** as correct record.

22/030 MATTERS ARISING AND REVIEW OF ACTION LOG

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

22/031 INTERNAL AUDIT

Along with the Internal Audit Progress report, the following internal audit reports were

received:

a) Governance Phase 1

b) Risk Management

c) Financial Sustainability

The Committee was advised that both Governance and Risk Management were Phase 1 reviews with phase 2 of each to be completed later next year. Governance Phase 1 had achieved a 'substantial' rating and Risk Management Phase 1 a 'reasonable' rating.

The 'substantial' rating in respect of Governance was welcomed.

The Financial Sustainability internal audit had been a mandatory audit associated to 72 areas of self-assessment. The audit's aim was to check responses completed by the ICB in its self-assessment. The methodology had been that ICB scores between 1-3 were accepted with evidence required, and further testing required for scores of 4-5. The audit was unusual in that it was not tracked back to source data as with other audits. Although it had resulted in a clean opinion it was to be noted that it was not the same as a usual financial controls audit as it was focussed on answers to the checklist. Three management actions had arisen which was relatively low when compared to other clients.

It was mentioned that the ICB might have slightly under-rated itself, and questioned whether that reflected the change of financial leadership and maturity of the organisation. It was felt that the forthcoming discussion on the Board Assurance Framework should reflect how to identify strategic, rather than, operational risk.

In respect of the internal audit progress report, despite the complexity of carrying out two sets of reporting for the legacy of the CCGs and also the ICB, the Internal Auditors were making good progress against the timetable.

There were currently four actions that remained open although none were of a serious level or complexity.

The Committee noted the reports from Internal Audit and **the Directors of Finance and People and Workforce agreed** to chase staff in respect of closure of outstanding actions.

22/032 LOCAL COUNTER FRAUD SPECIALIST (LCFS) PROGRESS REPORT

The Committee was in receipt of the current progress report from the Local Counter Fraud Specialist with key points highlighted including;

- Staff training continued to be delivered with more scheduled for the New Year.
- Awareness materials had been circulated in relation to Internal Fraud Awareness Week and there had been agreement to commence a proactive exercise with regard to the recruitment process.
- Investigations – there had been two new referrals. One had been closed following investigation as the potential loss to the ICB was low.
- Alerts continued to be issued and actioned by the ICB team.

In response to questioning the Committee was informed that discussions were ongoing in respect of the provision of training to wider primary care services although it was important there was no duplication with any training to be provided by NHSE.

The Committee noted the report **and requested** that it receive an update to the next meeting on the outcome of discussions relating to training provision for primary care

services.

22/033 EXTERNAL AUDIT

The ICB's External Auditors provided the following update:

SNEE CCG Accounts 2021-22 - Audit position update

The Committee was informed that work associated to the audit of the CCGs 2021-22 accounts was complete. The External Audit opinion had not been issued as it had been pending resolution of issues in respect of exit packages. It was now understood that those issues were resolved and NHSE had decided not to give retrospective approval for the package in question. As a result, the Auditors were likely to have to qualify the irregularity opinion on the three CCGs. Due to absence of the Head of External Audit, BDO was not currently able to conclude the audits and issue opinions. It had spoken with the National Audit Office to provide an update on the position and had also made contact with NHSE to establish what could be done in respect of their opinion and its effect on overall NHS accounts.

Comments included:

Having queried whether the qualification would apply to all three CCGs, it was explained that as the exit package had been split across the three CCGs it would apply to all three.

It was mentioned that when the matter had previously been discussed, it had been indicated that there were similar cases across the country and queried whether that was still the case. The Committee was informed that there were other organisations that had similar issues although the impact on their audit opinions was not known.

Whilst noting that qualification was not desirable, it was queried if there was opportunity within the qualification to state that decisions had been made on information available at the time. It was explained that the qualification would be factual and there were rules in place for such approvals that had not been sought. There would be more detail in the audit completion report. There would be a full discussion with the ICB's Executive and a draft report would be issued to Directors that provided opportunity to comment prior to finalisation.

It seemed that the External Auditors were likely to find meeting the timetable challenging and there was disappointment that there was no mitigation plan in place. The Committee was informed that although the exit package issue had been known about in June, there had been a delay in obtaining a response from NHSE. Should the Head of External Audit not return to work and be able to complete the audit, anyone taking over would need to carry out a full file review prior to issuing an opinion which would be time consuming. Should a critical point be met then an alternative plan would be instigated.

SNEE CCG Accounts for the three months ending 30 June 2022 and ICB Accounts for remainder of 2022/23 – Audit progress update

Work had commenced on the audit of CCG and ICB accounts for 2022/23. A lot of planning and walking through key financial system work had been carried out. In the absence of the Head of External Audit, BDO was unable to issue an audit plan at present. The audit plan would commence in the New Year should that member of staff return and, if not, alternative arrangements would be put in place.

The Committee noted the update.

22/034 AUDIT COMMITTEE BRIEFING ON MATTERS OF INTEREST OR STRATEGY

The ICB's Director of Finance reported;

- Having been in post for approximately six weeks, Howard Martin thanked everyone for being welcoming and supportive.
- From an early observation the system had significant challenges ahead but had excellent relationships across all partners.
- Current focus was on development of financial plans for 2023/24 which was challenging as the ICB was working with incomplete information with regard to allocations and guidance. All indications were that it would be a challenging planning round.
- A ICB cost pressures identification exercise was being progressed to better understand risk. It was hoped the exercise would be concluded at the end of January 2024.
- Work to facilitate an infrastructure for the development of longer term financial sustainable plans was underway and there was resetting of the existing ICS Financial Recovery Group to invest more of the allocation to prevention over time. That work would underpin development of the ICP strategy and ICB Joint Forward Plan.
- There continued to be significant operational discharge pressures. Nationally £0.5billion had been provided to ICBs to address the issue which was recurrent funding. The share for SNEE was £7.7m split between health and social care. Plans were well advanced and there was a clear commitment to review plans by March 2024 to ensure there was an optimal mix of plans to be taken forward recurrently.
- Strep A – £14m had been secured with £700k available to support additional capacity in Primary Care. Letters had been issued to GPs and plans were awaited.
- Plans for the delegation of dental and pharmacy services by April 2023 were well advanced. There was an allocation of £11m to improve dental support for the local population.

Comments included:

In response to questioning it was explained that there were two financial groups, one that was ICB focussed on cost improvement that was within the ICB gift; the other group was more in relation to the whole system and was likely to seek agreements about how to start to move funding around to match services that were in the best interest of patients.

The funding for dental services was welcomed.

Having described major difficult decisions to be made, the importance of there being an assurance framework at ICP level that was aligned with the ICB framework was emphasized. The Committee was informed that the ICB's Executive Committee now had dedicated time to review risks and it was appropriate those discussions were extended to reflect the ICP.

The ICP strategy was high level. The local authorities had expressed the same concern that it was important not to raise expectations that could not be delivered and the ICP Director and ICB Director of Strategy and Transformation were working to ensure continuity between the two. The Hewitt Review was highlighted as there was intention to streamline directives that NHSE wanted us to deliver which would need to be fed into planning work.

The Committee noted the update.

22/035 BOARD ASSURANCE FRAMEWORK

The Committee was in receipt of the current and proposed new template for the Board Assurance Framework.

The Committee was informed that there was now dedicated discussion at the Executive Committee every month to ensure all risks were being addressed sufficiently.

The Committee was reminded that, at its previous meeting, it had asked if other risks needed to be added as set out in paragraph 2.2 of the report, the result being;

- Organisational change – it was felt not to be a significant risk at present that warranted inclusion on the BAF.
- Refugee risk – the risk had been included
- Cost of living – the risk had been included
- Lack of GP appointments – the risk had been incorporated within the primary care risk.
- Industrial action – the risk had been incorporated within the workforce risk.

Given the main priorities and structural change from CCGs to Alliances etc and ICP versus ICB it was queried whether that might cause a strategic risk. It was also queried whether there was an electronic platform rather than word document option for review and report. It was felt that a lot of the risks had no close date with many being operational rather than strategic.

The Head of Internal Audit reported that the BAF was very detailed compared to other organisations and should perhaps only include 5-10 key risks. It was felt that the assurance column did not contain actual assurance but how assurance would be gained. The Committee was informed that Internal Audit would be happy to carry out some training should that be felt appropriate.

Training support was welcomed. The current BAF was completed by officers within the ICB and it was recognised that if produced across partners it would have a different narrative.

The Director of People and Workforce agreed to discuss future risk reporting training possibilities with the Head of Internal Audit outside of the meeting, **and also committed** to take forward work on the strategic level of the risk management process to support the BAF.

It was suggested that executive summary reports could be provided at Board level. The Audit Committee was reminded that its role was to ensure there was an effective risk management process in place and not to review the content of the BAF.

The Committee was informed that the ICB did have the DATIX system which could currently only be used in relation to Suffolk although North-East Essex was expected to be able to access it next year. In the meantime a new proposed template for reporting was presented for consideration.

The Committee noted the report and approved the new template as an interim solution.

22/036 REGISTER OF INTERESTS & MANAGEMENT OF CONFLICTS OF INTEREST – REQUEST FOR URGENT SELF-ASSESSMENT FROM CHIEF FINANCIAL OFFICER AT NHS ENGLAND.

The Committee was asked to note the response to an urgent self-assessment questionnaire received from NHS England's Chief Financial Officer on 5 December

2022 in relation to the management of conflicts of interest.

Having queried whether Non-Executives were considered as employees and therefore had been included, the **Director of Finance agreed** to investigate.

The Committee noted the response and that there had been no subsequent feedback from NHSE.

22/037 POLICIES/DOCUMENTS FOR APPROVAL

No policies or documents had been received for approval.

22/038 GOVERNANCE LOGS

Waivers

The Committee received the following waivers of competitive tendering.

ICB 006	GPIT Framework
ICB 007	Green Social Prescribing
ICB 008	North East Essex Special Allocation Scheme (SAS)
ICB 009	GMS/PMS Scheme (PRIME) – direct award
ICB 010	Evolution Recruitment Solutions Ltd
ICB 011	Patient and Carers Together

It was queried how the number of waivers presented compared to previously and whether there was a way of establishing if the waivers had been successful or outcomes monitored.

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.

22/039 INFORMATION GOVERNANCE UPDATE

The purpose of the report was to provide an update on;

- organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (2018), UK GDPR and the Freedom of Information Act (2000),

- compliance with the Data Security and Protection Toolkit (DSPT) and to provide assurance of ongoing improvement in relation to managing risks to information, and an update on any development plans, current projects or forthcoming projects the Information Governance Team were involved in or planning for during 2022/23.

Key issues were detailed in Section 2 of the report, and the report went on to seek approval of terms of reference for the ICB Information Governance Steering Group as appended to the report.

The Committee noted the report, **congratulated** the Team on its nomination, **and**

approved the terms of reference for the ICB Information Governance Steering Group as appended to the report.

22/040 ANY OTHER BUSINESS

No items of other business were received.

22/041 DATE AND TIME OF NEXT MEETING

16 February 2023 – 10.00-12.00 hrs

Suffolk and North East Essex Integrated Care Board

Decisions from an electronic meeting (by email) of the ICB Remuneration and HR Committee
Opened: 13 December 2022
Closed: 20 December 2022

DECISION RECORD – Electronic Meeting

Participating ICB Board Members:

Non Executive, People, Remuneration and Diversity (Chair)	Tanya Curry
ICB Chair	Will Pope
Non Executive, Quality and Safety	Steven Feast

Declarations of Interest

No declarations of interest were received.

Agenda items:

2 Policies for Approval — Amanda Lyes

To receive and approve *the following attached policies prior to their endorsement by the ICB Board.* — *Report No: ICB RC 22-07*

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

Decision/s

The Committee;

Noted the changes to the above policies **and approved and recommended** them to the ICB Board for endorsement.

NHS
Suffolk and North East Essex
Integrated Care Board

Minutes of a meeting of the ICB Quality Committee held on 10 November 2022

Meeting was inquorate

PRESENT:

Sarra Bargent	Ipswich and East Suffolk Alliance Representative
Jackie Bland	North East Essex Alliance Representative
Nettie Burns	Public Health, Suffolk County Council
Sue Cook	Suffolk County Council (SCC) Representative
Nichole Day	West Suffolk Alliance Representative (Part)
Simon Froud	Essex County Council (ECC) Representative
Samantha Glover	Healthwatch, Essex
Natalie Hammond (Part)	Essex Partnership University NHS Foundation Trust (EPUT) Representative
Diane Hull	Norfolk and Suffolk NHS Foundation Trust (NSFT) Representative (Part)
Dr Andrew Kelso	Medical Director (Chair)
Lisa Nobes	Director of Nursing
Carl Smith	Deputy Clinical Director (EEAST)
Daniel Spooner	West Suffolk NHS Foundation Trust (WSFT) Representative

IN ATTENDANCE:

Laura Bowen	ICB Senior Information Analyst
Georgina Edwards	Designated Nurse, Safeguarding Children
Caroline Holt	Designated Nurse, Safeguarding Children
Jo Mael	Corporate Governance Manager (Minutes)
Jarrad Murray	ICB Information and Modelling Manager
Richard Watson	ICB Director of Strategy and Transformation
Tracey Welham	ICB Designated Nurse, Looked After Children
Stephen Woods	Patient Safety Manager

22/026 INTRODUCTION, APOLOGIES AND QUORACY

The Chair welcomed everyone to the meeting introductions were made and apologies for absence were noted from;

Richard Cracknell	Asst Director of Public Health and Communities
Steve Feast	Non-Executive, Quality and Safety
Paul Molyneux	West Suffolk NHS Foundation Trust (WSFT) Representative
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 in quorate.

22/027 DECLARATIONS OF INTEREST

No declarations of interest were received.

22/028 MINUTES OF THE PREVIOUS MEETING

As the meeting was inquorate those present agreed the minutes of the ICB Quality Committee meeting held on 15 September 2022 subject to final approval by the Committee at its meeting in January 2023.

22/029 MATTERS ARISING AND REVIEW OF ACTION LOG.

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

22/030 DEVELOPMENT OF JOINT FORWARD PLAN 2023-28

The ICB Director of Strategy and Transformation was welcomed to the meeting to provide an update on the process for development of a joint forward plan for 2023-28. The following key points were highlighted:

- Development of an integrated care system strategy was the first element. That strategy should set out a five year vision and outcomes. There was an aim to achieve development of the strategy by December 2022 in order to meeting NHSE timescales for approval.

- There was also a requirement for ICB organisations to develop a five year Joint Forward Plan by the end of March 2023 and for it to be signed and published. Work was currently underway to draft the plan and workshops and engagement exercises were planned for staff, service users, carers etc.

- The current 2019-2024 version of the plan was being used to assist development of the Joint Forward Plan and named leads had been identified for each element of work.

- With regard to the quality and safety section the 2019-2024 plan had been high level. There was opportunity for the Quality Committee to take lead of that section with a high level summary position of priorities. The Quality Strategy would be appended to the plan. The aim was to have a draft in place by the end of November 2022.

Comments included;

It was suggested that the December 2022 development session might provide an opportunity to discuss the issue in more detail via facilitation of a workshop.

It was mentioned that EPUT might be able to provide support with regard to quality and safety and mental health sections.

Having highlighted that it provided opportunity to set out five key ambitions, it was mentioned that it would be good to have a conversation about how ambitious we wanted to be in the space.

Having queried what would be of interest with regard to social care, it was reported that social care had been very much involved in the previous plan on which the new one would be built. There was a need to link into high level strategies, assurance and ensure plans were consistent with other ICSs'. It would be important to take account of electoral cycles and budget positions. The current demand with regard to safeguarding was considerable.

The importance of working through the principles of developing desired priorities was emphasized.

Those present noted the update.

22/031 QUALITY AND SAFETY OF MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

INPATIENT SERVICES.

Those present were in receipt of a letter from the National Mental Health Director to mental health providers with regard to the quality and safety of mental health, learning disability and autism inpatient services. Responses from Essex Partnership University NHS Trust (EPUT) and Norfolk and Suffolk NHS Foundation Trust (NSFT) were attached for information with key points highlighted being;

EPUT

Care and safety were the number one priority. The programme had resulted in trauma within the organisation for leaders and staff and initiated conversations such as 'is this really us?' The Care Quality Commission (CQC) had carried out an unannounced inspection after the programme and the findings and response to that inspection were being worked on.

Reviews of staffing resilience and compassion were taking place and there was increased management oversight and onsite presence. Safeguarding concerns raised had resulted in an investigation prior to filming. Assurance with regard to recruitment practice was sought.

Confidence within the community for patients in treatment had been affected and wrap around support had been provided together with the patient experience team facilitating community meetings. A standalone process and confidential helpline and been established which had received one call. Safety strategy and workforce were key determinates to the safety of care delivered. Work was taking place to recruit bank and agency staff into the substantive workforce. With regards to safety, there had been extensive work to reduce fixed ligature points and absconds had reduced by 60% over three years.

In respect of response to the letter, a Board seminar was planned around workstreams and ongoing programmes of work. Patient voice – there were patient safety partners within the organisation, five new deputy directors of quality and safety had been appointed. The Freedom to Speak up Guardian was new to the organisation. A new complaints process had been developed and new liaison roles established. The organisation had asked for an increase of independent mental health advocates as a form of feedback. The culture of care assessment was an early warning scoring mechanism and it **was agreed** that it be circulated to members outside of the meeting.

NSFT

A report had been provided to NSFT's quality assurance committee and then to its Board. Immediate actions taken after the programme had included a meeting with managers to reflect and seek learning. Actions included increased clinical visibility at night. People participation leads were in place and conversations had taken place with teams and film footage used as learning. Whilst there was CCTV in place its use was difficult. Audits were taking place and a deep dive into forensic services had been carried out. A key question was how intelligence was collated, how do we hear from people such as housekeepers, students etc. There was awareness of compassion fatigue and tiredness of the workforce. Safeguarding complaints and freedom to speak up information had been reviewed with analysis showing no specific themes or trends. It was important that people were being open with regard to how it felt working on the wards and how to remain compassionate when feeling weary.

Comments included:

It was queried what the key thing to be aware of was and in response it was reported that there needed to be awareness of staff competencies and why people worked in agency roles rather than within substantive teams. It was felt that substantive teams could be managed better with strengths and weaknesses recognised.

There was a need for the system to think differently with regard to recruitment and retention,

and to think about new working roles. Often junior staff with less experience were caring for the most unwell patients.

There was a need to look more widely and there were significant comparisons with East Kent's report into maternity services. The CQC had published a report on closed cultures last year and tried to identify triggers for organisations to be aware of. It was questioned whether it was useful to bottom out key things that all systems should be aware of that posed a risk.

Healthwatch advised of its feedback centre which was a good way of getting a temperature check of how the public were seeing the service.

It was highlighted that thought would be required as to how assurance would be provided to the Board as the issue was system wide.

Those present noted the report.

22/032 SUFFOLK AND NORTH EAST ESSEX INTEGRATED MEDICINES OPTIMISATION COMMITTEE

In accordance with the Committee Terms of Reference, the report sought to provide assurance to the SNEE ICB Quality Committee on medicines optimisation related to patient safety. The report was submitted for information to provide assurance of the medicines safety activities undertaken by the Integrated Medicines Optimisation Committee (IMOC).

The role of the Suffolk and North East Essex (SNEE) Integrated Medicines Optimisation Committee (IMOC) was to promote cooperation and consistency of approach in the commissioning and use of medicines within and across different care pathways, and to ensure that robust standards and governance for medicines optimisation underpinned and provided accountability for community wide decision making.

Various stakeholders provided advice and professional support to ensure safe, quality and cost effective prescribing in SNEE.

The report went on to highlight activity from the August and September 2022 meetings of the IMOC.

The Chair reported that an integration pharmacist had been appointed to work between ESNEFT and the ICB and it was queried whether there was scope for a similar role within mental health organisations. It was reported that any pharmacy support would be welcomed as mental health trained pharmacists were becoming a rarity and it was important not to lose that skill set.

Having queried where incidents relating to medicines where reported, it was explained that there was further work to do in that area as currently they were mainly reported via secondary care where medicines safety officers were in place.

It was reported that STOMP (stopping over medication of people) with a learning disability, autism or both with psychotropic medicines, was making progress locally. **It was agreed** that attempt be made for the Committee to receive a presentation on STOMP to a future meeting.

Those present noted the report.

22/033 SAFEGUARDING – CHILDREN AND ADULTS

Those present were in receipt of safeguarding reports from Suffolk and North East Essex with comments in respect of each as follows:

Suffolk Safeguarding Annual Report

The report was developed during the pandemic when restrictions remained in place for families, vulnerable people and healthcare providers. One success had been supporting providers. There had been an increase in domestic abuse nationally and locally, families were in crisis and there was an increase in non accidental injuries with children. Success had been the support of named professionals within providers.

Key issues included beginning to understand the ICS. The SNEE safeguarding team had come together to work well and although they worked within the three Alliances they did look collectively at what was happening across SNEE to identify where an impact could be made. Timely review work was progressing with regard to Looked After Children although dental provision was a key challenge.

Work with regard to adults included a move into liberty protection training. NHS funding was being used for training sessions, which had been well received and took place in collaboration with police and social care staff.

North East Essex Locality Safeguarding Annual Report 2021-22

Whilst there had been work to produce a SNEE approach, the report reflected North East Essex's place based team which operated across Essex counterparts. A lot of policy work associated to domestic abuse was taking place and North East Essex were entering into a multi agency sharing agreement with primary care.

Work was taking place to ensure that Looked After Children had the right support across the system despite placements being limited.

It was recognised that there would be a joint policy next year.

Comments included;

With regard to actions arising from case reviews as set out within the Suffolk report, the lack of specificity in relation to the adult actions was questioned**. The Suffolk Safeguarding Lead agreed** to seek a response to the question and report back to the Suffolk County Council representative outside of the meeting.

When looking at how actions were progressing it was important to evidence where changes had been made. A collaborative approach was being taken with providers. Within Essex childrens safeguarding board there was a tool and template that providers were asked to complete to evidence work which could be utilised elsewhere.

The follow up of risks was queried and the importance of reviewing them in a multi-agency way emphasized. Current key issues included unaccompanied asylum seeker children and unregulated placements.

The Chair advised that it was a good principle in future papers to provide assurance on actions.

Having suggested that the Committee might like to see provider safeguarding annual reports, it was recognised that such information was currently presented to safeguarding boards and it was important to avoid duplication.

Having recognised there was a Suffolk Health forum and Essex Health Executive Forum, it was suggested that thought be given to perhaps receiving a report from those groups into here that brought everything together. More thinking was required.

Those present noted the reports as presented.

22/034 LEARNING FROM LIVES AND DEATHS – LeDeR ANNUAL REPORT 2021/22

Suffolk LeDeR Annual Report 2021/22

Transforming care partnerships (TCP) were required to publish an annual Learning from Lives and deaths – LeDeR report. LeDeR was a process of reviewing deaths of people with a learning disability and autistic people to see where we could find areas of learning, opportunities to improve, and examples of excellent practice. The information was then used to improve services for those people.

The Suffolk TCP annual report looked at the deaths of 32 people with a learning disability who had died between 1st April 2021 – 31st March 2022, with key points outlined in Section 2 of the report.

Essex LeDeR Annual Report 2021/22

Transforming care was a hosted service on behalf of five Alliances. Although the average age of death had come down some had been quite old which impacted on the figures. Causes were similar, those being respiratory disease and Covid-19.

The Essex team were thanked for their work.

Those present noted the report.

22/035 QUALITY DASHBOARD / TOOLKIT

The Medical Director reported that business intelligence was currently working on a Dashboard for the Quality Committee in liaison with Attain and Partners within the ICS.

Those present were shown a dashboard which included data currently being reviewed.

There was also a quality toolkit template with useful metrics.

The Quality 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.

Those present were informed of another quality dashboard that had been created which included a breakdown of QOF details and Friends and Family test information. A meeting had been held to explore whether serious incident and complaint information could be fed into the dashboard.

(Nichole Day joined the meeting and Diane Hull and Natalie Hammond left the meeting)

Those present noted the dashboards as presented.

22/036 SYSTEM QUALITY GROUP (SQG) HIGHLIGHT REPORT

Those present received an update on the work of the System Quality Group. Key issues for the Group were detailed in Section 2 of the report.

Those present noted the report.

22/037 ICB RISK REGISTER

The Board Assurance Framework (BAF) was presented to the Board by the Director of Workforce & People. The ICB Risk Management Strategy was currently under review.

Key issues outlined within the report were;

CNO-034 - *There was a backlog of PIRs (post infection reviews) from providers that related to HCAI reportable infections. Reduced assurance of review and subsequent learning identified.*
The risk had been fully mitigated and the IPC Lead recommended closure.

CNO-004 - *Safety concerns regarding maternity services across the ICS. Specific concerns related to staffing*
The current Risk Rating had been reduced to 12 (moderate), removing it from the BAF.

CNO-041 – New Risk - Dementia was excluded from MH D2A pathways

Clarification of the risk was sought. It was explained that the issue was that when individuals with dementia were admitted for another cause, at the point they were ready to go home, if they subsequently had more challenging behaviour care homes were unwilling to take them back causing them to be in hospital for long periods of time as there was no pathway in place. There was a need to explore the commissioning of a new pathway.

Those present noted the BAF Quality Risks **and agreed** the ICB Quality Risk Register **subject to** its approval at the next meeting.

22/038 ONE-TO-ONE MONITORING WITHIN CARE HOME SETTINGS POLICY & PROCEDURE

Those present were in receipt of the One to One Monitoring within Care Home Settings Policy and Procedure for review prior to its presentation to the ICB's Audit Committee for final approval.

The purpose of the policy 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.

This 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.

It was noted that the policy within the agenda pack was not the correct version. The correct version had been circulated to members just prior to the meeting.

There was concern that the policy had not been co-produced with the care sector and it was felt that it would be useful to present it to the continuing healthcare forum in Essex for discussion and to ensure consistency.

It was recognised that more work was required on the policy **and agreed** that it would be presented to a future meeting once that work had been carried out.

22/039 SUFFOLK AND NORTH EAST ESSEX PATIENT AND PUBLIC INVOLVEMENT AND EXPERIENCE TEAM REPORT - QUARTER 2 2022/2023 – JULY TO SEPTEMBER 2022

Those present were in receipt of the SNEE Patient and Public Involvement and Experience Team report for July to September 2022.

Those present noted the report.

22/040 ALLIANCE UPDATES

Those present received updates from the following Alliances:

- Ipswich and East Suffolk Alliance
- North East Essex Alliance

Key reported issues within North East Essex included:

GP access for migrants. The Executive team had agreed to put together a multi-disciplinary team to address the issue with wide representation and intensive primary care support.

Those present noted the updates.

22/041 PARTNERSHIP UPDATES

Those present were in receipt of updates from the following partners:

a) Suffolk Public Health - key issues reported were refugee demand and mental health.

b) West Suffolk NHS Foundation Trust (WSFT)

c) Essex Partnership University NHS Trust (EPUT)

Those present noted the partnership updates received.

d) Never Event Status – ESNEFT

Those present were in receipt of a report from ESNEFT in respect of its never event status.

Those present noted the report.

22/042 ITEMS FOR ESCALATION

The Chair advised that items for escalation to the ICB from today's meeting included:

1) The need to devise metrics associated to the quality of care.
2) That a number of provider reports had not been provided, along with an update from West Suffolk Alliance.
3) No ESNEFT representative had been in attendance.
4) Attempt would be made to use patient stories as part of the dashboard
5) There was a need to escalate the matter of refugee health in Essex and Suffolk.

22/043 ANY OTHER BUSINESS

None declared.

22/044 DATE OF NEXT MEETING

Thursday 12 January 2023 – 1400-1700

NHS
Suffolk and North East Essex
Integrated Care Board

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 decisions made by the ICB Estates Committee since its last report to the Board in November 2022.

2. Key points to note

2.1 At its meeting held on 21 November 2022 the Estates Committee received the following reports/updates:

1) An update on affordable housing, key highlights being:

- Formation of a Working Group with representatives from across the ICS
- Work to explore ways to address affordable housing, specifically for the nursing workforce, transport, unused housing and effective use of existing accommodation
- Identification of the greatest impact relating to international recruitment, identification documents, lack of guarantor etc
- Working with Homestay.com for affordable rooms to let.
- Holding an open forum with landlords to help to streamline the process of renting rooms to the nursing workforce
- Data Collection project to inform future strategic planning - running for 12 weeks
- Working with Local Authorities regarding unused care homes
- Working with voluntary organisation who can supply minibuses

2) **Hardwicke House** - since the original Full Business Case submission for the Hardwicke House Group Practice's proposed new healthcare facility, the practice had expressed a desire for greater flexibility in relation to the lease. A potential solution had been identified for the council to enter in to a 25-year headlease and then sub-let the entire building to the Hardwicke House Group practice.

As a result of the delays to the project, the costs for delivering the project had increased which presented a cost pressure to the ICB. A request was to be taken via internal governance to uplift the level of investment.

3) **Strategic Planning Report,** key points:

- The Committee was informed there was a significant amount of National Strategic Infrastructure Projects (NSIPs) locally, the time taking to complete requests was flagged as a key risk. It was suggested, where possible work took place across boundaries to support requests with potential provision sought externally. SNEE ICB and EEAST had been working with Mid and South Essex ICB to provide a response for the East Anglia Green Non-Statutory Consultation.

- The response for the Sea Link proposal (Suffolk-Kent) had been drafted and was due for submission tomorrow.

- The Committee was referred to a list of Local Plans requiring input from an infrastructure delivery plan perspective. An overarching horizon scan was suggested for all organisations within the ICB to support discussions with Local Authority

- The Committee was informed of an expectation for health to produce a document around the strategy to support the additional population for the Tendring Colchester Borders of Garden Community. There was a requirement for that to be taken to the joint cabinet in January outlining the infrastructure need for the next 20 years.

4) **Strategic Estates Advisor Update** - the Committee was advised of an enormous effort locally and nationally regarding the strategic 'Estates Infrastructure' planning process and upcoming pending review. It was vital there was a compelling health sector estates infrastructure strategy in readiness of the end of the financial year. The Chair and the Strategic Estates Advisor updated the committee as to progress made against developing the plan and welcomed feedback was as to how to streamline the process to enable full acceleration of the delivery programme.

5) The Estates Committee received highlight reports from providers and the three Alliances.

2.2 At its meeting held on 19 December 2022 the Estates Committee received the following reports/updates:

1) An overview of the current position with regard to RAAC identification, mitigation and monitoring.

2) Strategic Planning report which included information in respect of planning applications and the National Strategic Infrastructure Project (NSIP). It was noted that the financial decision on Sizewell C had been delayed until 2023 and therefore work was unlikely to commence until early 2024.

3) The report from the Chair and the Strategic Estates Advisor included a progress update on the SNEE Estates Infrastructure Plan. The Chair stated that it was hoped that by the end of March 2023 there would be an emergent strategy to help inform the Estates requirements of the overall SNEE ICS Strategy and wider national programme and assist other ICSs to develop their strategies. The overall goal was for all 42 ICSs to have a strategy in place by the end of 2023 in order that they might inform the health presentation to Treasury and 2024 spending review.

4) The Committee also received One Public Estate updates along with highlight reports from providers and the three Alliances.

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 Tuesday 29th November 2022 from 09.00 – 10.30

Virtual Microsoft Teams Meeting

Summary of minutes taken

Ref:	Item
1	**Welcome & Introductions** Apologies from members were given. Slides for the meeting were available in FNHS.
2	**Minutes, Actions & Matters Arising** Minutes: (220902) approved. Matters arising: None declared. Actions: SDIAB 220902-02: Noted nominations for deputies still required for EPUT, ICP, NSFT and SCC. SDIAB 220902-03: Declaration of interest required from EPUT. SDIAB 220902-10: Digital Collaboratives – Action to forward information when available. SDIAB 220902-13: Strategic plan - ICB board development meeting. Will have a session on digital where the agreement and discussion on the SDIAB principles will take place. No firm date set yet. **SDIAB 221129-01: Declaration of Interest**. New members to be sent the Declaration of Interest form to complete and return SDIAB Terms of Reference – for approval. Approved at September meeting. Update – separated the membership list and put into a new document (Appendix B). Included a change control table and added new members. Reviewed Appendix B. It was noted that the deputy for WSFT has accepted a joint role as a CIO as ESNEFT helping the collaborative work on EPR. There was a suggestion to refine the section in the ToR about quoracy, currently 5 members, in order to be more specific about the representation being from a number of different organisations in the quoracy. **SDIAB 221129-02**. **Terms of Reference**. The section about quoracy is to be reviewed and updated if required. It was confirmed a nomination has been received to be the deputy for EPUT. **SDIAB 221129-03**. **Appendix B**. New deputy for EPUT to be added to Appendix B. **Agreed decision**. Appendix B approved, living document that will be updated with membership changes when required.

3	**22/23 Investments –** reviewed slides Finance Representative outlined the updates since the last SDIAB meeting in September 2022. It was noted that the funding this year has been lower this year than the last two years; this is because most of the funding falls in Q3/Q4 and this is expected to be the same for next financial year. Further, the falling funds are expected to continue, especially through the normal operating planning guidance and funding streams. There is a need to be mindful of this as there will be significantly less opportunity to bid for central capital funds. Reviewed the Thematic Post Project Review Findings slide.
4	**Post Project Reviews and Findings:** Reviewed the presented slide. It was confirmed that lessons learned exercises for the closed projects would take place during the next financial year. Further information about the ESNEFT projects will be provided at the next meeting. **Agreed decision**: Update about the closed ESNEFT projects to be provided at the next meeting.
5	**SDIAB Programme Dashboard** (PDF available in FNHS) Reviewed live dashboard. Drew attention to ROSI end of life project which currently has a RAG status of red. Programme has been on track to go live at the beginning of November but the project has experienced a number of technical issues as well as concerns from the Bury PCN which prevented the "go live" - these are being investigated with a view to resolution. The Supporting Social Care Tech has also deteriorated over the last month, showing as amber. Actions to turn this around are now in place. It was explained how to get further information from the links in the dashboard. Thanks was given to several team members who are now engaging with Smartsheet and helping with the tracking. This will improve the benefits and valuation and will be much more accurate.
6	**SDIAB Items for ratification / information** **Enabling Unified Digital Care Committee ToRs** (Document in FNHS). Reviewed new ToR as the previously submitted document was considered to have a too large scope. Amended wording so now it shows the programme enabling the ability to have unified digital care. Noted that a chair was not confirmed for the committee. An interim has stepped up and it was mentioned that across the system there are a number of CCIOs, CCMOs etc. that have ringfenced time in their calendars who could be approached. **Agreed decision**: ToR approved by members. **SDIAB 221129-04. Enabling Unified Digital Care Committee ToRs.** CCIOs, CCMOs etc. across the system to be approached to see if someone would be willing to sit on the committee as chair.

	EPR OBC – ESNEFT (Document in FNHS). Strategic outline case shared with the members earlier, now proceeded to OBC which has been submitted to Region to go through the review groups. Been approved by the executive management group and trust board. Currently at OBC, seeking to go out to tender with the preferred option being to explore a convergence EPR approach alongside West Suffolk Hospital. Funding profile discussed in recognition of this being a major clinical transformation programme for the next three years. ESNEFT looking to do some additional collaborative work with West Suffolk around the integration agenda as it is recognized the workforce is going to be a challenge with the inclusion of a Digital Training Centre still being factored into plans to provide the wider system with an asset to provide continued digital training facilities as well as a wider clinical education and training benefit. Need to be realistic that the benefits perceived can be achieved. **Agreed decision**: EPR OBC – ESNEFT. Letters of support noted. OBC approved. **East Accord 2022-23 Contribution MoU** Reviewed slide. Approval given at last DoFs meeting. It is a continuation of previous years charges, of 35k per ICS plus a voluntary 20k from EEAST. **Agreed decision:** East Accord 2022-23 Contribution MoU. Approved by members. **SNEE Core Digital Team (23-24) Funding Agreements** DoFs agreed in principle the underwriting of the core digital team 23/24 subject to endorsement by ESNEFT CIO as ESNEFT is the main financial host. Discussions on going. There is full support for the core digital team and central PMO function but main providers need to discuss aspects of transformation work and assure contributions for core delivery to establish a recurrent and stable workforce. Should refine things to get a proposal that can be supported recurrently by the DoFs in recognition of what is required going forwards. The decision was supported. The Board need to work towards a recurrent and properly employed workforce. Local authorities should also be included in the discussions as things are often health focused and we are keen to work across systems. Members agreed this approach is the way forward. **SDIAB 221129-05. SNEE Core Digital Team (23-24) Funding Agreements.** Further discussions with organisations to be organized, to create a proposal to establish a recurrent and stable workforce.
7	**Strategic Delivery Programme Update** Programme Leads gave updates and the following comments were made by members: ROSI: Important to focus on the outcomes for patients and people. Whilst this is a powerful tool, matters raised by GP's around clinical safety need to be resolved for it to be ready to go live and implemented. Enabling Insights: Using data effectively is the best way to achieve a return on tax payers money (investment) and is one of the great advantages of having the digital team and network we currently have as well as being transparent to the public

	Enabling Unified Digital Care: it was observed that the focus for this should be the return on investment as the funding is reducing. ESNEFT are having discussions about business cases for future years investments. This is a multiple organisational investment opportunity.
8	**Prioritising Areas of Focus –** Slides available in FNHS Reviewed slides, the following comments were made by members. Having a stable workforce is fundamental to achieving the focus areas. Requested approval from members to continue working towards a stable workforce with assistant partners aiming to give a further 12 months of contracts to the PMO team where affordable. Members agreed this is a key action and approval given for work to continue.
9	**AOB** The East of England team has been selected as an area for a pilot of secure data environment. Will report further as information is available. ECC are out to procurement for a new social care system. Feel it would be useful to give an update when integration with the multiple systems in Essex takes place to outline the opportunities for shared pathways. Suggest an item for the next meeting.
10	**Summary and close** Very good meeting with a lot of good updates, slides and input from everyone across the team. Any further comments on how things can be improved please inform the team. **Meeting closed at 10.33**

Minutes approved on

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
Acting Director of Finance	**Armitt Chris**	Yes	Yes	Yes	Yes	
Member VCSE Sector	**Alderson Kirsten**					Yes
Partner Member Primary Care Essex	**Bhatti Freda**	Yes	No	Yes	Yes	Yes only part of P1
Provider Partner Member - Acute	**Black Craig**	Yes	Yes	Yes	No	No
Non Executive, Finance and Audit	**Clarke Steve**	No	Yes	Yes	Yes	Yes
Partner Member Suffolk County Council	**Cook Sue**	No	Yes	Yes	No	Yes
Non Executive, People, Remuneration and Diversity	**Curry Tanya**	Yes	No	Yes	Yes	Yes
Non Executive, Quality and Safety	**Feast Steve**	Yes	Yes	Yes	Yes	Yes only part of P1
Chief Executive	**Garratt Ed**	Yes	Yes	No	Yes	Yes
Partner Member Essex County Council	**Higgs Patrick**	No	P1 only (part)	Yes	No	Yes
Provider Partner Member - Community	**Hulme Nick**	Yes	No	Yes	Yes	Yes P1 only (Part)
Medical Director	**Kelso Andrew**	Yes	No	Yes	Yes	Yes
Director of Finance	**Martin Howard**					Yes
Director of Nursing	**Nobes Lisa**	Yes	Yes	Yes	Yes	Yes
Chair	**Pope Will**	Yes	Yes	Yes	Yes	Yes
Partner Member Primary Care Suffolk	**Rayner Nick**	Yes	Yes	No	Yes	Yes
Provider Partner Member - Mental Health	**Richardson Stuart**	No	Yes	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
Director of Performance and Improvement	**Gibara Paul**	Yes	No		Yes	Yes
Integrated Care Partnership Director	**Howard Susannah**	No	Yes		Yes	Yes
Director of People and Workforce	**Lyes Amanda**	Yes	No		Yes	Yes
ICP Chair Suffolk	**Reid Andrew Cllr**	No	No		No	No
ICP Chair Essex	**Spence John Cllr**	Yes	No		No	No
Director of North East Essex Alliance	**Taylor-Green Laura**	Yes	No		Yes	Yes
Director of Strategy and Transformation	**Watson Richard**	Yes	Yes		Yes	Yes
Director of West Suffolk Alliance	**Wightman Peter**	Yes	Yes		Yes	Yes