Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of the Mid and South Essex Integrated Care Board

Thursday, 15 May 2025 at 2.00 pm – 4.00 pm

Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD.

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	4.1 Approval of Minutes of previous Part I meeting held 13 March 2025. 4.2 Matters arising (not on agenda) – ratification of approval of Operational Plan at extraordinary meeting held on 30 April 2025.	Approve Ratify	Attached Verbal	Prof. M Thorne Prof. M Thorne	7 -
5.	2.14 pm	Review of Action Log	Note	Attached	Prof. M Thorne	18
		Items for Decision / Non-Standing Items				
6.	2.15 pm	Community Beds Working Group Final Report	Approve	Attached	T Abell C Hankey D Doherty	19
7.	2.30 pm	Lampard Inquiry Update	Note	Attached	Dr M Sweeting	33
8.	2.35 pm	Palliative and End of Life Care Delivery Plan	Approve	Attached	Dr M Sweeting	40
9.	2.45 pm	Mid and South Essex Hospitals NHS Trust compliance with 10 Maternity Standards	Note	Attached	Dr G Thorpe	73
10.	2.55 pm	Mental Health Update 10.1 Manchester Report 10.2 Nottingham Report	Note	Attached	Dr G Thorpe	 91 129
11.	3.05 pm	Health Inequalities Annual Report 2024/25	Approve	Attached	R Jarvis	137
12.	3.15 pm	Communications Strategy Update	Approve	Attached	C Hankey	175

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Standing Items				
13.	3.25 pm	Chief Executive's Report	Note	Attached	T Abell	208
14.	3.30 pm	Quality Report	Note	Attached	Dr G Thorpe	212
15.	3.40 pm	15.1 Finance & Performance Report	Note	Attached	J Kearton	217
		15.2 Finance Plan 2025/26	Note	Attached	J Kearton	228
16.	3.50 pm	Primary Care and Alliance Report	Note	Attached	P Green D Doherty R Jarvis A Mecan	233
17.	3.55 pm	General Governance:				
		17.1 Board Assurance Framework	Note	Attached	T Abell	240
		17.2 New and Revised Policies	Note	Attached	Prof. M Thorne	244
		17.3 Approved Committee minutes	Note	Attached	Prof. M Thorne	246
		17.4 Delegation to the Audit Committee for approval of the Annual Report and Accounts 2024/25	Approve	Attached	Prof. M Thorne	308
18.	3.59 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
19.	4.00 pm	Date and time of next Part I Board meeting: Thursday, 17 July 2025 at 2.00 pm, in Marconi Room, Chelmsford Civic Centre, Duke Street, Chelmsford, CM1 1JE.	Note	Verbal	Prof. M Thorne	-

Mid and South Essex Integrated Care Board
Register of [voting] Board Members' Interests - May 2025

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer	Aidsmap, a HIV information service charity			x	Direct	Chair of Trustees	Jan 2020	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Tom	Abell	Chief Executive Officer	Community First Responder			x	Direct	Community First Responder (voluntary)	Nov 2023	Ongoing	No conflict of interest is anticipated. I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented.
Anna	Davey	ICB Partner Member (Primary Care)	Coggeshall Surgery Provider of General Medical Services	x			Direct	Partner in Practice	09/01/17	Ongoing	I will not be involved in any discussion, decision making, procurement or financial authorisation involving the Coggeshall Surgery or Edgemead Medical Services Ltd
Anna	Davey	ICB Partner Member Primary Care)	Colne Valley Primary Care Network	x			Direct	Partner at The Coggeshall Surgery who are part of the Colne Valley Primary Care Network - no formal role within PCN.	01/06/20	Ongoing	I will declare my interest if at any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented and will not participate in any discussion,
Anna	Davey	ICB Partner Member (Primary Care)	Mid and South Essex Integrated Care Board	x			Direct	Employed as a Deputy Medical Director (Engagement).	April 2024	Ongoing	I will declare my interest if at any time issues relevant are discussed so that appropriate arrangements can be implemented
Joseph	Fielder	Non-Executive ICB Board Member	Four Mountains Limited	x			Direct	Director of Company - provides individual coaching in the NHS, predominantly at NELFT and St Barts	01/05/17	Ongoing	No conflict of interest is anticipated but will ensure appropriate arrangements are implemented as necessary.
Joseph	Fielder	Non-Executive ICB Board Member	North East London Foundation Trust	x			Indirect	Partner is NELFT's Interim Executive Director of Operations for North East London (Board Member).	01/03/19	Ongoing	I will declare my interest as necessary to ensure appropriate arrangements are implemented.
Joseph	Fielder	Non-Executive ICB Board Member	NHS England	x			Indirect	Son (Alfred) employed as Head of Efficiency.	Jan 2023	Ongoing	No conflict of interest is anticipated but will declare my interest as necessary to ensure appropriate arrangements are implemented.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropraite arrangements can be made to manage any conflict of interest.
Matthew	Hopkins	ICB Board Partner Member (MSE FT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive	01/08/23	Ongoing	Interest to be declared, if and when necessary, so that appopriate arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Neha	Issar-Brown	Non-Executive ICB Board Member	Independent Consultancy	x			Direct	Independent Consultancy contracts, including with other management consultancy firms (such as Deloitte, EY, etc.) on (predominantly international) research, innovation, early careers development, and R&D strategies. No contracts undertaken with any direct or indirect overlap with NHS/MSE/constituent Trusts/providers or consultancy firms (that I am aware are engaged with the system) to avoid conflict.	June 2023	Contract based and time limited	Info only. No direct action required.
Jennifer	Kearton	Chief Finance Officer	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
Sarah	Muckle	ICB Partner Member (Essex County Council)	Essex County Council	x			Direct	Director of Wellbeing Public Health & Communities	24/04/25	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Robert	Persey	ICB Partner Member (Thurrock Council)	Thurrock Council	x			Direct	Interim Executive Director of Adults and Health		Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Essex Partnership University NHS Foundation Trust	x			Direct	Chief Executive Officer	01-Jul-23	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Integrated Leadership Coaching Limited	x			Direct	10% share holder	Aug 2024	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Paul	Scott	ICB Partner Member (Essex Partnership University Foundation (Trust)	Carradale Futures		x		Direct	Non Remunerated Non Executive Director	Jan 2024	Ongoing	I will declare this interest as necessary so that appropriate arrangements can be made if required.
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust			x	Direct	Part Time Geriatrician - hold no executive or lead responsibilities and clinical activities limited to one Outpatient clinic a week and frailty hotline on call.	01/04/15	Ongoing	Any interest will be declared if there are commissioning discussions that will directly impact my professional work. I will liaise with CEO or Chair, as appropriate, for mitigations. These could include removal from said discussions, not voting on any proposals or nominating a deputy. For sign off of commissioning budgets, if a conflict arises, I will delegate to the CFO.
Mike	Thorne	ICB Chair	Nil								N/A

Mid and South Essex Integrated Care Board
Register of [voting] Board Members' Interests - May 2025

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Giles	Thorpe	Executive Chief Nurse	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
George	Wood	Non-Executive ICB Board Member	Princess Alexandra Hospital	x			Direct	Senior Independent Director, Chair of Audit Committee, Member of Board, Remuneration Committee and Finance & Performance Committee	01/07/19	Ongoing	Clear separation of responsibilities and conflicts.

Mid and South Essex Integrated Care Board - Register of Interests
May 2025

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of Interest	From	To	Actions taken to mitigate risk
Mark	Bailham	Associate Non-Executive Member	Enterprise Investment Schemes in non-listed companies in tech world, including medical devices/initiatives	x			Direct	Shareholder - non-voting interest	01/07/20	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Mark	Bailham	Associate Non-Executive Member	Mid and South Essex Foundation Trust	x			Direct	Council of Governors - Appointed Member	01/10/23	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Joanne	Cripps	Executive Director of System Recovery	Lime Academy Trust (education)			x	Indirect		June 2023	Ongoing	No conflict is anticipated.
Daniel	Doherty	Alliance Director (Mid Essex)	North East London Foundation Trust	x			Indirect	Spouse is a Community Physiotherapist at North East London Foundation Trust		Ongoing	There is a potential that this organisation could bid for work with the CCG, at which point I would declare my interest so that appropriate arrangements can be implemented
Daniel	Doherty	Alliance Director (Mid Essex)	Active Essex		x		Direct	Board member	25/03/21	Ongoing	Agreed with Line Manager that it is unlikely that this interest is relevant to my current position, but I will declare my interest where relevant so that appropriate action can be taken.
Barry	Frostick	Chief Digital and Information Officer	Nil								
Samantha	Goldberg	Executive Director of Performance and Planning	Mid and South Essex Foundation Trust			x	Direct	Substantively employed at Mid and South Essex Foundtion Trust - seconded to ICB role	13/01/25	Ongoing	Where there is a conflict of interest on formal agenda items/discussions, will vacate the meeting to protect discussions/decisions.
Pamela	Green	Alliance Director, Basildon and Brentwood	Kirby Le Soken School, Tendring, Essex.			x	Direct	School Governor (voluntary arrangement).	September 2019	Ongoing	No action required as a conflict of interest is unlikely to occur.
Pamela	Green	Alliance Director, Basildon and Brentwood	University of Essex			x	Direct	Lecturer - Honoree agreement	July 2024	Ongoing	No action required as a conflict of interest is unlikely to occur.
Claire	Hankey	Director of Communications and Partnerships	Hethersett Parish Council			x	Direct	Parish Councillor	20/01/25	Ongoing	No conflict of interest is anticipated. Interest will be declared, if necessary, to ensure appropriate arrangements are implemented.
Emily	Hough	Executive Director of Strategy & Corporate Services	Brown University		x		Direct	Holds an affiliate position as a Senior Research Associate	01/09/23	Ongoing	No immedicate action required.
Rebecca	Jarvis	Alliance Director (South East Essex)	Nil								
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company - Mecando Limited	x			Direct	Potential Financial/Director of own Limited Company Mecando Ltd	2016	Ongoing	Company ceased activity due to Covid-19 pandemic currently dormant; if any changes occur those will be
Aleksandra	Mecan	Alliance Director (Thurrock)	Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	x			Direct	Potential Financial/Director of own Limited Company Matthew Edwards Consulting and Negotiations Ltd	2021	Ongoing	Company currently dormant; if any changes occur those will be discussed with my Line Manager
Geoffrey	Ocen	Associate Non-Executive Member	The Bridge Renewal Trust; a health and wellbeing charity in North London		x		Direct	Employment	2013	Ongoing	The charity operates outside the ICB area. Interest to be recorded on the register of interest and declared, if and when necessary.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Professor and Director of the Vision and Eye Research Institute (Research and improvements in ophthalmology pathways and reducing eye related health inequality - employed by Anglia Ruskin University	31/03/23	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Direct	Director of Centre for inclusive community eye health. Lead for Grant to Anglia Ruskin University to improve eye health, prevent eye disease and reduce eye health inequality in mid and south Essex	01/05/23	01/04/27	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various Universities	x				PhD Examiner	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various grant awarding bodies UK and overseas		x		Direct	Grant reviewer	01/03/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Visionary (Charity)		x		Direct	Trustee	20/04/22	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Cambridge Local Optical Committee	x			Indirect	Partner is a Member	2015	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Shahina	Pardhan	Associate Non Executive Member	Various optometry practices in Cambridge and Peterborough (not MSE)	x			Indirect	Partner works as anOptometrist	10/09/01	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.

Mid and South Essex Integrated Care Board - Register of Interests
May 2025

Shahina	Pardhan	Associate Non Executive Member	Anglia Ruskin University, Cambridge	x			Indirect	Partner works as a Research Optometrist	10/01/09	Ongoing	Will declare this interest as necessary so that appropriate arrangements can be made if/when required.
Lucy	Wightman	Chief Executive, Provide Health	University of Essex		x		Indirect	Honorary Professorship		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Health Council Reform (Health Think Tank)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	The International Advisory Panel for Academic Health Solutions (Health Advisory Enterprise)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Faculty of Public Health		x		Indirect	Fellow		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	UK Public Health Register (UKPHR)		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Nursing and Midwifery Council		x		Indirect	Member		Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.
Lucy	Wightman	Chief Executive, Provide Health	Provide CIC	x			Direct	CEO Provide Health and Chief Nurse	02/04/24	Ongoing	Interest will be declared if at any time issues relevant are discussed, so that appropriate arrangments can be implemented.

Minutes of the Part I ICB Board Meeting

Held on Thursday, 13 March 2025 at 2.00pm – 3.30pm

Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend on Sea, SS2 6ER

Attendance

Members

- Professor Michael Thorne (MT), Chair, Mid and South Essex Integrated Care Board (MSE ICB).
- Jennifer Kearton (JK), Executive Chief Finance Officer, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB (representing Tom Abell, Chief Executive Officer, MSE ICB for item 8).
- Dr Kathy Bonney (KB), Interim Chief People Officer, MSE ICB.
- Joe Fielder (JF), Non-Executive Member, MSE ICB.
- George Wood (GW), Non-Executive Member, MSE ICB.
- Dr Neha Issar-Brown, (NIB), Non-Executive Member, MSE ICB.
- Matthew Hopkins (MHop), Partner Member, Mid and South Essex NHS Foundation Trust (MSEFT) (from item 6).
- Dr Anna Davey (AD), Partner Member, Primary Care Services.
- Mark Harvey (MHar), Partner Member, Southend City Council.
- Robert Persey (RP), Partner Member, Thurrock Council.
- Peter Fairley (PF), Partner Member, Essex County Council.

Other attendees

- Mark Bailham (MB), Associate Non-Executive Member, MSE ICB.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.
- Professor Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Pam Green (PG), Alliance Director (Basildon & Brentwood and Primary Care), MSE ICB
- Aleksandra Mecan (AM), Alliance Director (Thurrock), MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director (South East Essex), MSE ICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Jo Cripps (JC), Executive Director of System Recovery, MSE ICB.
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB.
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB.

Apologies

- Tom Abell (TA), Chief Executive, MSE ICB.
- Paul Scott (PS), Partner Member, Essex Partnership University NHS Foundation Trust (EPUT)

- Samantha Goldberg (SG), Executive Director of Performance and Planning, MSE ICB.
- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Barry Frostick (BF), Executive Chief Digital and Information Officer, MSE ICB.
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).
- Emily Hough (EH), Executive Director of Strategy and Corporate Services, MSE ICB.

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

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

Apologies were noted as listed above.

MT noted that this would be the last meeting that Peter Fairley would attend as a Partner Member of the Board and thanked him for his support and contribution to the work of the ICB.

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

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

Declarations made by the Integrated Care Board (ICB) Board members and other attendees were in the Register of Interests within the meeting papers. No further declarations were made.

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

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

MT advised that questions had been submitted by members of the public, as set out below, which would be either be responded to in writing or answered during the meeting.

Peter Blackman had requested summaries of records of meetings held with various groups regarding the Community Services Consultation, so that those who were not members of working groups could follow the process.

GT advised that it was agreed by the working group that the detail of meetings would not be circulated broadly so as not to prejudice the discussions of the working group given that these were dynamic in nature. The focus in respect of St. Peter's Hospital had been on the future location of ambulatory care services and exploring the underpinning rationale around changes to Intermediate Care (IMC) and stroke beds, and midwifery led birthing services. A detailed update on the work of the working group was included within the January 2025 Board papers which included the 3-month report. Any wider discussions on Integrated Neighbourhood Teams (INTs) development happened with those groups and were not within the scope of the community consultation working group.

Jackie Fosten asked whether GPs refusing to issue attention deficit hyperactivity disorder (ADHD) prescriptions, which was part of the shared care agreement, was due to ongoing insufficient support/resource/funding from the ICB.

A similar related question was asked by **Paula Farrow, MyOTAS (My Own Time and Space)** who highlighted that several families had approached the charity concerned about being able to obtain medication for their privately diagnosed children with ADHD and asked for confirmation of communication processes, waiting times and how medication could be obtained.

PG advised that the ICB had made an offer to GPs to receive additional funding to continue prescribing and monitoring ADHD medications on a per patient basis. Several GPs signed up to the arrangement and the ICB held a regularly updated list of GP practices who had opted in or out of the arrangement. Where practices had opted out, children registered with those practices were being referred to their specialist provider whose care they were under for ADHD. Privately funded patients would be referred to their private provider, or into an NHS funded service, following discussion with their GP. GPs had been communicating directly with their patients advising how medication could be obtained. Detailed guidance and frequently asked questions (FAQs) regarding ADHD medication, including steps to address the concerns raised, had been posted on the ICB website. Confirmation of waiting times was unable to be provided as this would vary according to the location and the provider delivering the service.

4. Minutes of the ICB Board Meeting held 16 January 2025 and matters arising (presented by Prof. M Thorne)

MT referred to the draft minutes of the ICB Board meeting held on 16 January 2025 and asked members if they had any comments or questions.

There were no comments or amendments.

Matters Arising

JK advised that at the Board meeting on 16 January 2025, the Board agreed the award of some contracts to NHS providers for one or three years, and a request had been received to include specialist commissioning in the Mid and South Essex Foundation Trust (MSEFT) contract. JK confirmed that the change requested had been made and that the new value of the contract for MSEFT for the next three years would be £4.01billion.

Resolved: The Board approved the minutes of the ICB Board meeting held on 16 January 2025, as an accurate record.

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

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

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

6. Joint Forward Plan (presented by J Cripps)

JC advised that the Joint Forward Plan (JFP) was a statutory requirement for ICBs which was updated annually and detailed the ICB's forward plan for the next five years. This was the third year of the plan.

Part 1 (Appendix A) was a recommitment to the strategic ambitions agreed in the first iteration of the JFP with the three upper tier Health and Wellbeing Boards.

Part 2 (Appendix B) was a look back at some of the successes over 2024/25 and would form part of the ICB's annual report.

Following approval, Parts 1 and 2 would be published on the ICB's website.

Part 3 was under development and would become the ICB's forward plan incorporating the 2025/26 planning guidance, the elective care reform guidance issued by NHS England, and the actions required in the 10-year plan, when published. It would also reflect the local medium-term plan, which was being worked on with system partners.

An overview of the work would be discussed with the three Health and Wellbeing Boards in the coming weeks. Feedback was awaited from NHS England (NHSE) on Parts 1 and 2.

JF asked how specific the plan would be for recovery of services where the ICB was not comfortable with performance as a system. JC advised that the Medium-Term Plan (MTP) aimed to address those areas of clinical, financial and operational sustainability and performance. The expectation was that the MTP and Part 3 of the JFP would explain how performance would be recovered in those areas, including elective care activity

GO suggested that Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations should be included in the plan for completeness.

SP asked when the updated research strategy would be published and suggested that the ICB's involvement with the National Institute of Health and Care Research (NIHR) Applied Research Collaboration (ARC) should be included in the JFP. MS confirmed that the ICB's Research and Innovation Board wanted to bring partners together across the system to have a clear strategic direction focused on delivery and the MTP.

Resolved: The Board approved the refresh of Parts 1 and 2 of the Joint Forward Plan, subject to any comments received from NHS England, noting that:

- **An overview of the work would be shared with the three Health and Wellbeing Boards.**
- **The full refresh of the Joint Forward Plan (including Part 3, the forward plan) would take place once the NHS 10-year plan was published and the ICB's local Medium-Term Plan was finalised.**

7. Equality Delivery System 2022 (presented by Dr G Thorpe)

GT advised that the Equality Delivery System 2022 (EDS) was a requirement for all NHS commissioners and provider organisations. There were three domains with multiple sub-sections as noted in the appendices.

The first domain related to commissioned or provided services. A system response had been developed with Essex Partnership University NHS Foundation Trust (EPUT) in relation to their diabetes service, with MSEFT in relation to their paediatric transitioned service and for heart failure services led through the Community Collaborative.

Domains 2 and 3 related to the ICB's development of workforce health and wellbeing and included leadership.

The overall conclusion of the work undertaken was that the system and the ICB was rated as 'Developing' according to the EDS standards and the Board was requested to ratify this position statement agreed by the Executive Committee on 18 February 2025.

Resolved: The Board ratified the Equality Delivery System Report.

8. Chief Executive's Report (presented by Dr G Thorpe)

On behalf of TA, who had to attend a national meeting, GT gave a statement which would be shared with stakeholders following the announcements made to the ICB on the evening of 12 March 2025.

"This statement was provided to update the Board and members of the public on announcements that were published in the media today on significant changes being made to the ICB.

NHS England mandated that all ICBs reduced their running costs by 50% as part of a broader financial and organisational reset across the NHS and the Department of Health and Social Care. This directive followed previous cost cutting measures and would require significant changes across the entire NHS system, including MSE ICB. To deliver this mandate will require a fundamental shift in how the ICB operated. Whilst much detail was not known, it was anticipated that there would be rapid movement on the following areas:

- The need to comprehensively review the structure to identify where costs savings could be made, as well as considering how the ICB could work differently with others in the system or more broadly across the NHS.
- A focus on core functions to ensure the statutory responsibilities continued to be met.

To meet such a reduction, staffing levels would need to be assessed, and role reductions would be necessary. This would disrupt some of the ICB's work with partners and stakeholders.

Assurance was provided that no decisions had been made, and the implications of the mandate would be worked through, especially where this impacted upon partners and stakeholders, and the Board would do their best to keep stakeholders informed and involved whenever possible.

MT noted that this would clearly be a difficult and distressing time for the ICB team. The energy which the teams have been giving to progress how healthcare is commissioned and delivered since the ICB establishment in 2022 was hugely valued.

Further information would be available through usual channels as more details became available."

MT advised that the situation would become more complex given the announcement that NHS England would be disbanded, as they were the regulator of the ICB.

MT advised that there were no key areas of concern in the Chief Executive's report to highlight and invited comments from Board members.

GW suggested a report should be provided on cancer performance to detail how successful and sustainable the plans in place were.

Resolved: The Board noted the statement on the ICB reset and noted the Chief

Executives Report.

Action: SG to provide a report to the Finance and Performance Committee on cancer performance to provide assurance that the plans were achievable and sustainable.

9. Quality Report (presented by Dr G Thorpe)

GT presented the quality report and highlighted key points for noting.

A positive deep dive was held on the dentistry service which noted several pilots that achieved a radical improvement in access and outcomes for residents across Mid and South Essex (MSE). The Dental Access Pilot saw 21,732 additional patients seen across the system.

There had been a further focus on Babies, Children and Young People (BCYP), noting improvements on planning for initial health assessments for Looked After Children (LAC), the contract award had been finalised for counselling services for children and young people (CYP), but there remained a challenge regarding CYP with learning disabilities, autism and neuro divergence who were at risk of being admitted into inpatient mental health settings; work was ongoing to manage the risk.

MSEFT had achieved all ten safety standards of the Clinical Negligence Scheme for Trusts (CNST). A fuller report outlining the safety standards, and the associated evidence would be submitted to the May Board meeting.

Action: GT/ MSEFT to provide a report for the May ICB Board meeting outlining compliance with the CNST standards.

MT congratulated all those involved in the dentistry work and invited questions from the Board.

PF asked if there was an update to the risk regarding admissions of children with learning disabilities into inpatient mental health settings. GT advised that the risk summit in January focused on the adults' position and a separate summit on BCYP was being considered. Section 75 arrangements (contractual arrangements to deliver services jointly across health and social care) were being reviewed, and there was a focus on prevention, particularly for CYP, and a holistic support offer was being considered.

GO sought assurance that health inequalities were considered when progressing initiatives, such as the case finding hypertension pilot. RJ confirmed that within the health inequalities programme, cardiovascular disease (CVD) was one of the key priorities. As the MTP was developed, there would be a requirement for Equality and Health Inequality Impact Assessments (EHIIA) to be completed for any process to capture any impact upon health inequalities. GT advised that new guidance on EHIIAs had been issued and was currently being reviewed by the ICB to ensure that at the beginning of any process both EHIIAs and Quality Impact Assessments (QIAs) were undertaken. RJ advised that the CQC framework would also be used to develop the recommendations.

MT suggested a report to the Board on EHIIAs and QIAs should be provided at a future date.

Action: NA to include a report on EHIIAs and QIAs on the schedule of Board business for a future meeting.

NIB advised that an additional benefit of the Dentistry in Care Homes pilot was that dentistry

staff satisfaction had increased.

AM advised that the Athena platform was being utilised to support case finding for practitioners and INTs to identify CVD and other conditions.

LW commented that the high-level results for dentistry were impressive as this had been an area of concern for some time, but the challenge would be sustainability and queried future funding, acknowledging existing financial constraints. PG advised that all funding arrangements were under review and the care home pilot had been approved as 'business as usual'.

Resolved: The Board:

- **Noted the development work in place to support dental services across Mid and South Essex.**
- **Noted Mid and South Essex Trust's full compliance with Clinical Negligence Scheme for Trusts requirement for Year 6 for maternity and neonatal services.**
- **Noted the commissioning decisions made to improve services for Looked After Children through enhanced Initial Health Assessment provision, and a single commissioned provider to mental health counselling services.**
- **Noted the ongoing risks related to the number of children and young people with learning disabilities and autism requiring inpatient mental health services, and the actions being taken to address the risk.**
- **Noted the decision to defer publication of the ICB's Quality Strategy to ensure alignment with national policy and local planning developments.**

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

JK presented the finance and performance report and highlighted key points to note.

At month 10 the overall health system position is a deficit of £27.9m against the revised plan of breakeven. This is an improvement on the M8 position which was £32.1m off plan. Regional NHS England gave systems the opportunity to revise their forecast outturn positions from plan as part of M10 reporting. Through this process the MSE system agreed a revised forecast outturn position of £32.5m deficit to the breakeven plan, a total of £128m deficit excluding deficit support funding (£92million received in year).

The system entered the Investigation and Intervention (I&I) programme at month 4 and a tremendous effort had been made across all three organisations in response to the I&I programme, particularly MSEFT, which had the majority share of the deficit position. Assurance was provided of the commitment to drive that deficit position down further before year-end.

The month 11 figures were being processed but had started to show improvement. The run rate had consistently improved over the last four to five months.

The ICB was maintaining its break-even position for 2024/25, although there had been challenges regarding spend on continuing healthcare and prescribing.

The month 10 efficiency position show delivery of £100.2million of efficiencies against the planned £130million. There was a potential adverse variance of £7million against the year-end plan.

MHop suggested that the significant financial improvement made so far at MSEFT was at a cost to the waiting times reduction and the Trust's staff survey results were not positive.

JF commented that MSEFT's trend of improvement was welcomed. The ICB was in balance, but clarification was requested on the run rate for EPUT.

JK advised that EPUT's main cost pressures related to mental health inpatients, which was a national pressure, and the high level of scrutiny (and resulting cost) from the Lampard Inquiry, although it was difficult to understand how much was compounded by the Inquiry. Over the coming months, through the planning round, there would be a need to understand that more and how the system could support, given the immense amount of pressure EPUT was experiencing.

JF asked if this could impact on the Mental Health Investment Standard (MHIS). JK confirmed that was being considered as part of the planning round. The MHIS was being met and flexibilities had been used to support EPUT. Priorities would be reviewed, including how best to utilise any remaining funds.

GW requested clarification on the capital which was going to be under spent on the original plan. JK advised that part of forecasting [capital] underspend was due to the reprofiling of projects, such as the Unified Electronic Patient Record, in conjunction with the national team and the 23-hour day surgery unit. This meant that some projects would be included in next year's capital programme, so the team were reviewing what could be brought forward.

JK highlighted the following additional key points.

Performance was poor against expectations and consequently there had been a focus on next year in terms of the system delivering performance within the financial envelope. MSEFT was working closely with national colleagues and the cancer alliance on understanding where improvements to the cancer trajectories could be made using pathway analyser tools to support changes. Support was being provided from the national intensive support team for referral to treatment (RTT), with some modelling, which was a challenge considering the existing backlog.

In response to a query from SP, JK agreed that going forward the RTT position table should include percentages, so the figures were more meaningful.

MT advised that the system must work collaboratively to progress workstreams, including asking difficult questions, to improve outcomes. MHop advised that ensuring that best practice was utilised across pathways was where more progress was needed. Within MSEFT, there was no lack of commitment, however some issues were longstanding and had been supported by non-recurrent funds.

Resolved: The Board noted the Finance and Performance Report.

Action: SG to include percentages in the RTT position table in the performance report so that the figures were more meaningful.

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

PG presented the Primary Care and Alliance report and highlighted key points to note.

PG highlighted the case study within the report showing how INTs support admission avoidance.

It was noted that there had been an agreed an offer for general practice with the British Medical Association (BMA), which had paused the collective action. A significant change was noted in the GP contract for 2025/26. It was stressed that the substantial contract deal was still to be negotiated with the government and there would be changes to the Quality and Outcomes Framework (QOF).

Overperformance in dentistry was noted, recognising the ring fencing around dentistry and the challenges with head and neck cancer services to unlock blockages for residents within the dental offer.

A positive evaluation of Pharmacy First had recognised the ease of access for the public and the value of that offer.

There had been a focus on the development of INTs since planning guidance had been published, which recognised the neighbourhood level of working. The programme approach in the MTP offered a proactive model for frailty and end of life services to reduce the demand on GPs, voluntary sector and secondary care and would improve patient experience.

AD advised that the new contract settlement was welcomed but highlighted that the 7.2% included extra provision for the national insurance (NI) contributions that would make a significant difference to budgets within practices. There was no exemption for GP practices who would be paying the highest NI contributions. The change to QOF was welcomed but one area of concern was the money being put into CVD and childhood vaccination rates. Both targets were difficult to attain in practices with high deprivation levels, so there was a possibility of worsening health inequalities in MSE. The way in which practices were remunerated, would mean that those practices in more affluent areas hitting those targets would do better with this arrangement than previously. The ICB would need to support relevant practices in dealing with challenging circumstances to reach unserved populations.

MS advised that the Ageing Well Stewards had developed an award-winning electronic tool to support frailty services. This identified individuals living with frailty in the community and targeted them earlier in the pathway with evidence-based interventions. A priority in the MTP, driven by the INTs, would be to focus on recognition, diagnosis and intervention for frailty and those in their last years of life. From a health economics point of view, it had the best benefit for improving care of our population, and reduced unnecessary hospital admissions, freeing up capacity and supported primary care.

MT reflected on a case study whereby two GPs reviewed frequent visitors and the reason for their visit, utilising data. The age range of the group was 15-45 years old. A package of care was created which enabled those individuals to receive care quicker, by utilising the new additional roles in GP practices, where they may have otherwise presented at Emergency Departments (ED). PG provided further assurance regarding the work within INTs to further reduce ED attendances and NIB confirmed discussions regarding this had been held at the Quality Committee.

In response to a query from SP regarding the spike in consultations in primary care during October 2024, PG confirmed that the peak was due to the vaccination programme.

PG advised that MSE Alliances were reviewing their Section 106 (S106) funding and had released some smaller projects to reinvest in primary care estate. Basildon and Brentwood Alliance were focused on INT delivery, linking in with primary care.

RJ advised of activity in primary care across MSE regarding reconfigurations of PCNs and leveraging S106 monies to improve primary care estate. Health and inequality funding continued to be discharged, including multiple schemes through 2024/25. There was concern regarding the ongoing vulnerability of the voluntary and community sector and how support could be provided within the system. Significant work was ongoing with the Southend Enhanced Discharge service and a model had been agreed for 2025/26.

MHar commented that the work completed between the ICB, trust partners and local authorities was positive and a good example of how that integrated approach had brought efficiencies and better outcomes.

AM advised that Thurrock Alliance was focused on estate sustainability, not only with accessing S106 monies, but also looking to retrofit or upgrade any void space, working with local authority and other partners. Work was ongoing to improve dementia diagnosis rates, by identifying frail patients using the Frailty, End of Life, Dementia Review and Assessment (FrEDA). The ongoing dental programme in Thurrock regarding oral health in early years was being championed with visits to local schools and thousands of toothbrushing kits being distributed. Health watch and the voluntary sector were commissioned to provide support on the consultation for the 10-year plan and that report had recently been delivered.

SP reported that Thurrock had the highest number of people with visual impairment and asked what priorities would be given. AM advised that conversations had been held and there could be opportunities to work with Family Health and utilise digital solutions, subject to finance.

JF requested further information on the trial on the INT data dashboard. RJ advised that the dashboard would be shared with JF, and an offline discussion would be held to agree the correct forum to share the prototype, when available.

MT advised that the Board's role was to lead the organisation, whatever the circumstances, and not lose the core principles which were to encourage people to innovate, to work with partners across local authority boundaries between acute, community and mental health and to do the best for patients and the community within MSE.

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

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

12.1 Board Assurance Framework

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

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

12.2 New/Revised Policies

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

- 028 Sexual Misconduct Policy
- 044 Absence Management Policy
- 052 Fostering Policy
- 056 Dignity at Work Policy
- 057 Car Leasing Policy
- 074 Community Communcable Disease Outbreak Incdient Management Policy
- 078 Reimbursement of Staff Expenses Policy
- 090 Cycle to Work Policy
- 094 Staff Volunteering Policy

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

12.3 Approved Committee Minutes

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

- Audit Committee (AC), 15 October 2024
- Clinical and Multi-Professional Congress (CliMPC), 27 November 2024.
- Finance and Performance Committee (FPC), 7 January 2025 and 5 February 2025.
- Primary Care Commissioning Committee (PCCC), 11 December 2024 and 14 January 2025.
- Quality Committee (QC), 20 December 2024.

Resolved: The Board noted the latest approved committee minutes.

13. Any Other Business

There were no items of any other business.

MT thanked the members of the public for attending.

14. Date and Time of Next Board meeting:

Thursday, 15 May 2025 at 2.00 pm in Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD.

2025/26 Action Log

Action No.	Meeting Date	Agenda Item No.	Agenda Item Title and Action	Lead	Deadline for Completion	Update	Status
54	14/11/2024	7	**EDI High Impact Actions** TA and MT to discuss the joined up EDI approach and KB to provide a regular assurance report from People Board on the progress of the high impact actions.	T Abell M Thorne J Cripps S Morrison	30/04/2025	Report to be prepared for May 2025 Board meeting. Reporting built into 2025/26 Board workplan. Delayed to July 2025.	Outstanding
56	16/01/2025	12	**Primary Care and Alliance Report** Provide an update report on Direct Enhanced Services, including agreed actions, rationale and details of the range of services affected.	P Green W Guy	30/06/2025	A review of locally enhanced services is being undertaken, due to be finalised in June, following which a summary report will be provided at the July Board meeting.	In progress
57	13/03/2025	8	**Chief Executives Report** A report to be provided on the plans for improving cancer performance and how these would be sustainable	S Goldberg	15/05/2025	From May 2025 there will be a rotational deep dive report from MSEFT on RTT, cancer and UEC submitted to the ICB's Finance & Performance Committee.	Complete
58	13/03/2025	9	**Quality Report** A report on EHIIAs and QIAs to be included on the schedule of Board business for a future meeting.	N Adams	15/05/2025	Added to Board schedule of business (date TBC).	Complete
59	13/03/2025	9	**Quality Report** MSEFT to provide a report for the May ICB Board meeting outlining compliance with the CNST standards.	MSEFT Dr G Thorpe	08/05/2025	Report included on agenda of Part I Board meeting	Complete
60	13/03/2025	10	**Finance & Performance Report** To include percentages in the RTT position table in the performance report so that figures were more meaningful.	S Goldberg	15/05/2025	Percentages will be included in the RTT position table as from the May Board report.	Complete

Part I ICB Board meeting, 15 May 2025

Agenda Number: 6

Community Consultation Working Group – Report and Recommendations

Summary Report

1. Purpose of Report

To provide the Board with the report and recommendations arising from the Community Consultation Working Group (Appendix A).

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.
James Halden, Independent Chair, Community Consultation Working Group

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

The Board is asked to:

- Receive and note the report and recommendations of the independently chaired Community Consultation Working Group **(Appendix A).**
- Acknowledge that the findings will inform the development of the final Decision Making Business Case (DMBC), which will be brought to the Board for formal consideration and approval by July 2025.
- Note that no decisions are being sought at this stage, and that the Board will be asked to make its determinations once it has received and reviewed the full DMBC in due course.

Executive Summary

1. Introduction

An independently chaired working group was established to consider the outcome of the consultation held by the ICB into the future of community services in Mid and South Essex.

The working group was set up following completion of planned consultative activities and followed significant feedback from communities and stakeholders that was received through these activities. A key element of this feedback was that additional time and work was required to work through the proposals.

The working group was commissioned by the Board in September 2024 with a six-month mandate to work to the following terms of reference:

- To develop pathways of care, making proposals around the future shape of services in mid and south Essex which were included within the scope of the original consultation.

- Reviewing the options proposed within the consultation on the provision of maternity and community beds.

- Making proposals on a future healthcare estate model for the Maldon District given the potential impact of the proposals made in the consultation on the St Peters' Hospital site in Maldon.

The group commenced in October 2024, independently chaired by James Halden, with representation from local councils, Healthwatch, community groups, MPs and NHS providers.

The ICB supported the working group to publish and communicate the Chair's report in March 2025, ensuring wider stakeholders, patients and staff were kept informed of the focused discussions and the outcome of the work undertaken by the group.

2. Findings and recommendations from the working group

2.1 Findings

There are a number of findings within the report **(Appendix A)** and the working group recognised that, although some good work was undertaken, certain elements of the proposals could have been more fully thought through prior to the consultation commencing. For example, a particular focus being around proposals regarding the future location of services within Maldon given the commitment within the consultation document to maintain ambulatory services within the Maldon district.

There is clearly learning for the ICB in this. Where future consultations around the delivery of NHS services is required, we will endeavour to provide more developed proposals to ensure all consultees feel able to comment fully on the information provided.

2.2 Recommendations of the working group

The report from the working group sets out recommendations in five parts, as set out below, alongside progress that has been made in respect of these where this has been possible in advance of the Decision Making Business Case (DMBC).

Part A – The current estate and the arrangements to maintain service delivery in the near term in Maldon

The working group has set out a recommendation that in the near term services should be retained at the St Peter's Hospital site whilst a future location for services is identified (see Part B).

Based on our own analysis of available estate within Maldon, this is something that NHS partners also agree with. Consequently, Mid and South Essex NHS Foundation Trust (MSEFT), the owner of the site, has commenced survey work to identify areas of the site which can be improved in the short term to accommodate existing clinical services. The expectation is that any rectification activities can be completed this year to ensure services are located in better quality accommodation for the immediate future.

Part B – The future estate in Maldon

The working group set out a proposal for the creation of a new facility for ambulatory services in Maldon with the potential option of co-locating these services alongside GP services given the challenges faced regarding space availability for GP services in Maldon.

Conversations have started on the potential capital financing solution for such a facility within the NHS and with other partners, alongside the potential development options for the existing St Peter's site which could support a new facility in the longer term.

Part C – Intermediate Care and Stroke Rehabilitation Beds

Firstly, in respect of rehabilitation capacity in Maldon, there was an update of the modelling work undertaken to support the original consultation. This identified that at any given time the population of Maldon would only require up to 4 intermediate care and 2 stroke rehabilitation beds. The report sets out its finding that there would not be a way to justify the costs of such a unit, or the viability of operating a facility with this capacity.

However, the working group recommended that the existing 'home first' activities we are working on are accelerated and, alongside these steps, action is taken to move away from the spot purchasing of care home capacity to support discharge to assess pathways.

The ICB has taken steps to respond to both of these recommendations; firstly, through incorporating the acceleration of home first as part of the initial actions we will be taking when implementing the Medium Term Plan (MTP); and secondly through commencement of the procurement to establish standing care home bed capacity to support discharge to assess capacity, which the Board recently approved.

Also, in terms of the two options originally put forward within the consultation document on the location of stroke and intermediate care beds, the working group recommended 'Option B' as its preferred option. This will be incorporated within the scoring process set out in the DMBC.

Part D – Birthing unit

The working group had extensive discussion and debate on these services. This included consideration of the current and likely future birth rate within Maldon and the different choices which are being made regarding delivery, with those opting for caesarean-sections now being circa 45%.

Based on these factors the group recommended that the midwife-led birthing unit at St Peter's was closed and permanently relocated to the William Julien Courtauld Unit in Braintree. However, the group suggested that specific actions are taken by the NHS to promote, maintain, develop and monitor home birthing services to make sure people are aware of this option and can make the best choice for them.

Alongside this, the working group recommended that pre and post-natal appointments are maintained in Maldon, which is in line with the original intention of the consultation.

Part E – Making it happen and next steps.

The working group recommended that a standing public and community stakeholder committee is established to oversee, scrutinise and advise on any proposals around future estate provision within Maldon. Some work is underway to establish how this group will be setup and administered given the move away from the commissioning of service and into the practicalities and detail of estate and service delivery.

3. Recommendations

The Board is asked to:

- Receive and note the report and recommendations of the independently chaired Community Consultation Working Group **(Appendix A).**
- Acknowledge that the findings will inform the development of the final Decision Making Business Case (DMBC), which will be brought to the Board for formal consideration and approval by July 2025.
- Note that no decisions are being sought at this stage, and that the Board will be asked to make its determinations once it has received and reviewed the full DMBC in due course.

Mid and South Essex
Integrated Care Board

Report from the Commission into the St Peters Hospital and associated options with care beds and birthing unit pathways across mid and South Essex

March 2025

James Halden

Contents

Introduction and executive summary

This report is the outcome of rapid work undertaken to ensure that the people of Mid and South Essex get a better deal from the NHS than initially offered in the community consultation on the future of the St Peters Hospital and associated issues with midwifery and care beds.

The Commission into the services hosted at St Peters Hospital in Maldon, the wider pathway and wider impacted areas in Mid and South Essex was set up by the Integrated Care Board (ICB) incoming CEO Tom Abell. A lengthy consultation process had been run prior to Mr Abell's appointment which focused around 3 core elements with the following rationale:

1. Disposal of the St Peters estate given it was too large and dilapidated, and the corresponding rehousing of all ambulatory services within Maldon District.
2. Two options regarding the relocation of stroke beds where they would move away from St Peters to consolidate them in larger sites which were easier to staff with wrap around expertise, as well as the "home first" policy of care.
3. The removal of the midwife birthing unit from St Peters on the basis that the ad-hoc and stretched staffing was becoming both too complex and unsafe.

It was broadly felt, despite some good work being attempted, the consultation had left a number of issues unresolved, not fully thought-out, and needing an additional layer of critical thinking. The entire commission welcomed the pause put in place by Mr Abell.

The original consultation was far too hasty in suggesting that St Peters close with utterly inadequate plans as to how services would be managed after being separated into unspecific and likely unstable temporary arrangements. In addition, while policies such as "home first" are clinical best practice, too much was based on assumptions. While the principal was broadly supported, too much commentary was non-specific.

In short, the recommendations I present to the ICB now suggest rapid investment and support into St Peters to keep all outpatients services at the hospital over, roughly, the next 5 years. This will allow the time for the capital to be brought together to redevelop a part of the estate for a modern health hub, where primary care and possibly other services will be brought within and upgraded. It allows for a stable staffing model by no longer staffing small/unviable bed units and birthing bays but goes further to wrap additional local support and monitoring to the home first policies, protection of pre and post-natal services and new monitoring and support of other pathways such as home births. Finally, it creates a role for the community to work with the NHS in the long-term to deliver the plan and ensure such poor consultation outcomes do not take place again. I am delighted to say that these recommendations were achieved via consensus within the commission - between the community representatives, the NHS and wider leaders on behalf of the people of mid and South Essex!

Thanks

As Chairman, I have been supported outstandingly by Tegan Gardiner who is a model of administrative efficiency.

I wish to thank all those who have so ably fought on behalf of the local population and been tireless in standing up to poor historic decision making in order to achieve something better; Sir John Whittingdale MP, Dame Priti Patel MP, the leadership of "save Maldon medical services" Jo Phillips, Steve Rogers and Kerry Williams, MDC's CEO Doug Wilkinson, Cllr Richard Siddall and Town Mayor Andrew Lay. Without them, this work wouldn't have been possible.

I want to thank all those who worked on this commission, who gave up so much time and grappled with so many thorny matters; from Southend and Essex Healthwatch, Maldon District Council (MDC) and Essex County Council (ECC), and many staff from Mid & South Essex ICB and Mid and South Essex NHS Foundation Trust (MSEFT).

I want to thank Cllr Andrew Sheldon who offered an independent view of this report and pushed further on some community reassurances.

Not a single member of the Commission objected to the recommendations in this report, underscoring the collaborative and positive nature of this paper and its outcomes.

Finally, I want to thank all the staff and supporters at St Peters who were put through far too much during the original consultation.

Recommendations

Part A – The Current Estate

1. The outpatient provision (all the current services from physiotherapy to blood work) at St Peters is vital for the people of Maldon and surrounding areas. Maldon already suffers from a lack of health infrastructure. It is recommended that a new modern build and protection of current services must become a priority project for the ICB.

2. The current St Peters building has no long-term future given its age and degradation, and it's complex / logistically challenging composition. Therefore, it is agreed that the general principal of the eventual decommissioning the current building is correct in around 5 years, but only at the right moment and albeit with several firm caveats.

3. A new ambulatory hub must be constructed to house the full current suite of services, i.e. the 300 appointments which are accessed by outpatients per day. It is recommended that this requires a sufficient space to be saved on the St Peters site for this and associated parking on the basis that the current site already has all the associated transport links and is well placed in the district. An alternative site should only be considered if logistical matters make it impractical to deliver the new hub at the current St Peters site, and only if an alternative can match St Peters in terms of public transport and parking accessibility.

4. The lack of financial planning for a new hub by the ICB during the consultation was a grave error. Not only did it give the impression the offer to save all services within Maldon was an afterthought, it also opened the whole project up to risks due to not having a clear enough plan and vision. Therefore, it is recommended that there must be no closure of the current building or moving of services from the St Peters estate until the full funding stream and associated planning consents have been granted. The ICB must commit to the continuation of all outpatient services from St Peters while the new hub is built. MSEFT must make provision to keep the current St Peters site open and fit for purpose.

5. While there have been offers for temporary accommodation of some services, the reality is that “temporary plans” risk becoming de facto “regrettably permanent plans” if enacted without a fully costed and approved vision. An exception has been asked to be made of certain services such as physiotherapy on the basis that its work lends itself to be housed in a nearby leisure centre. While this seems to make much sense, it cannot be supported until there is a clear and costed plan for the rest of the site on the basis that “salami slicing” off services will likely reach a tipping point and force the premature closure of a depleted building before the replacement is approved. In addition, with local government reform, there is likely to be mass reconsideration of assets. Therefore, it is recommended that physio work remains at St Peters.

6. The site currently does not offer space for staff and patients with regards to refreshment – this closed around November 2023. It is recommended to give best endeavour to returning a café function to St Peters, both as a focal point and much needed comfort for staff and patients.

Part B – The Future Estate

1. The capital allocation for the new build is currently only the capital receipt from the disposal of the portion of the St Peters site. It requires new streams to be added. These include the continued lobbying to amend the value at which the district valuer is allowed to grant borrowing to the NHS, the attraction of capital by bringing a "Community Diagnostic Centre" to Maldon, and the potential of Maldon District Council borrowing capital via prudential borrowing to be repaid via NHS commissioned contracts. Much of this work has been held in silos. It is recommended that the ICB should immediately appoint a senior member of the board to take responsibility for the assembly/lobbying of the capital package by the end of 2025.

2. Maldon has an under provision of general practise clinical space, i.e. GP surgeries which are too small and aging. A new build is the best opportunity to address this. Therefore, it is recommended that a new St Peters Hub must also co-locate the estimated space to meet this need for new GP provision, as well as the possibility of future strands of wider primary care.

3. Maldon and surrounding areas are growing. Therefore, it is recommended that the spec of any build (and car park construction) must have capacity to grow upwards, i.e. easily add floors as demand requires.

4. The current projected space per service has been approved as acceptable by each service head. However, when fuller architect drawings are complete, it is recommended that each service lead should be reconsulted to ensure this remains fit for the future.

5. While new services didn't come forward in response to our offer to co-locate with a new hub, it is recommended that multi-functionality of clinical space must be considered in the event that other services wish to share space during periods of inactivity, i.e. mental health. This should also include any commercial/community joint use.

Part C – Intermediate Care (IMC) and Stroke Rehabilitation Beds

1. Elements of the data in the original consultation was based on national modelling. We insisted on this being rebased on local data. The outcome still provided the same basic outlook; at any one time the population of Maldon only require up to 4 IMC beds and up to 2 stroke rehabilitation beds. This is a tiny figure, even after you consider the population of Maldon has increased by over 8% between 2011 and 2021 census. There is no way to justify the capital costs of such a small unit, certainly with how pressured the capital budget is for the wider hub for outpatient services. In addition, workforce planning for such a small unit, the smallest in the ICB and one of the smallest in the nation is not viable in the long-term. Therefore, the recommendation is to cease the current bed provision within St Peters.

2. However, having local beds as close to a new hub for the small amount of appropriate provision would be ideal if possible. When you consider that the ICB does need to "spot purchase" beds on an ad hoc basis anyway, there could be a new way forward. Conversations have been had with the adjacent care home with a view to block booking a small number of beds for a long-term deal, ensuring ICB provision for Maldon (close to the wider services at St Peters) where appropriate and a funding stream for the care home. It is recommended that this arrangement attempts to be formalised by the end of 2025.

3. The "home first" model of supporting people via virtual wards is accepted as best practice, i.e. treat all those appropriate in their own homes instead of uprooting their lives to be in a hospital. There is often a better clinical pathway at home. However, this is a principle that needs to be proved on a case-by-case basis in practice. It is recommended that the ICB should commission Healthwatch or alike to conduct a major review of how they are managing this scheme in 6, 12 and 18 months, with a focus on outcomes and failed discharge/repeated admission into an acute sector.

4. With regards to the "options A or B" in the original consultation in terms of reprovision of stroke beds, it is noted that "splitting" the stroke beds means that we reflect the nature of strokes being more volatile. Therefore, it is recommended that "option B" be approved. This also ensures that the further flung area, Southend, has a healthy mix of provision and Southend City citizens will not need to travel as far. It is further recommended that the ICB provides monitoring reports on a monthly basis to Southend Healthwatch to ensure that the changes are broadly positive.

Part D – The Midwife-Led Birthing Unit

1. The services new mothers' access (pre and post-natal care) are vital appointments and must be saved in the new hub. The circa 14,000 maternity outpatient appointments a year must be protected in the current and the rebuilt St Peters.

2. The midwife-led birthing unit conversation caused the greatest consternation. Elements of the thinking and rationale seemed rushed by the ICB. Due to this, the decision was taken to having the data and conclusions undergo a lite-touch peer reviewed by an independent NHS Trust. The review helped conclude the following – the Maldon and surrounding birth rate remained low, with increases in birthing events being negligible (the rate is in fact in decline – in 2015 59.8 births per month in Maldon (Essex County Council, Birth Rates by District) whereas it had fallen by 2024 est. 53.1) .The argument that staffing an ad hoc unit for so few cases was inefficient for the taxpayer and unsafe in terms of not always being able to fully staff such a small unit was a sound argument. Therefore, it is recommended to close the midwife-led birthing unit.

3. In addition, the national and Essex figure for c-sections is ever increasing and now at 45%. To fulfil the vital obligation of supporting the choice of the mother, more staff are required at the acute hospital to undertake this work opposed to being at St Peters for birthing.

4. However, we did note with alarm the serious issues in midwifery quality at the main Foundation Trust's hospitals. The Foundation Trust was outside of the scope of this commission, but it should be considered relevant given our population is directed to the consultant-led birthing unit at Broomfield. Therefore, it is recommended, in the event serious improves are not made within 6 months, that the ICB request formal intervention via CQC.

5. It is noted that, despite the almost 50% of mothers now opting for a "c-section", that many still make other choices. The focus cannot become solely on the first cohort. Therefore, it is recommended that the ICB develop a formal plan regarding the monitoring and support of the home birth service to ensure that awareness of options and choice of the mother are maximised. As we move towards a new St Peters build, the capacity required should be kept under review to ensure services are sufficient.

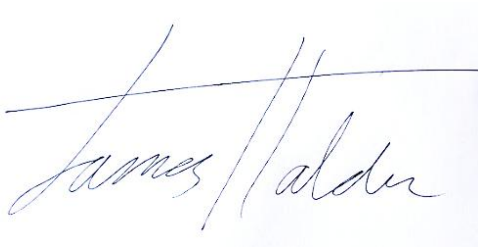
Part E – Making it happen and moving forward

1. Planning is more important than the plan itself! As this becomes a priority project for the ICB, the whole board needs to be invested in driving its success. However, there are a number of bodies the board needs to give support to in order to drive this.

2. It is recommended that the ICB establish a standing Community Committee from the Chairman of "Save Maldon Medical Services", the CEO and Leader of MDC, a representative of the health and adults team at ECC, a member of MTC, and the ICB designated leads for the estate and finance solutions to oversee, scrutinise and advise on the implementation of any recommendations that the ICB approves regarding the St Peters estate. The ICB should ensure the group has appropriate secretarial support. The first meeting should take place shortly to set the general workplan and where I transfer the Chairmanship into community hands.

3. Essex and Southend Healthwatch, and ECC (with a rep from SMMS) come together at 6, 12 and 18 month intervals to oversee, scrutinise and advise the ICB on the performance and patient experience of the rollout of the new bed pathway, and the sufficiency of the entire midwifery pathway – from births within Maldon homes all the way to Broomfield.

4. It is recommended that a member of the ICB be tasked with leading a review as to how the system handles the policy planning and resulting consultations given the problems with community communication, data issues, unclear outcomes and unsecured pledges.



James Halden LL.M, FRSPH, FRSM

Chairman of the NHS Commission into the St Peters Hospital and associated options with care beds and birthing unit pathway across mid and South Essex

Part I Board Meeting, 15 May 2025

Agenda Number: 7

Lampard Inquiry Update

Summary Report

1. Purpose of Report

To update the Board on the progress of the Lampard Inquiry and the pan-Essex ICBs' response to the Inquiry.

2. Executive Lead

Dr Matthew Sweeting, Executive Medical Director

3. Report Author

Mike Thompson, Associate Director, System Programmes

4. Responsible Committees

ICB Board
Quality Committee

5. Link to the ICB's Strategic Objectives

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

- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Impact Assessments

None applicable to this report.

7. Financial Implications

None applicable to this report.

8. Details of patient or public engagement or consultation

None directly applicable to this report. The Lampard Inquiry is being conducted publicly. The ICBs have, and will, issue communications as necessary in support or

response and the communications teams are a core part of the programme management structure.

9. Conflicts of Interest

None identified.

10. Recommendation/s

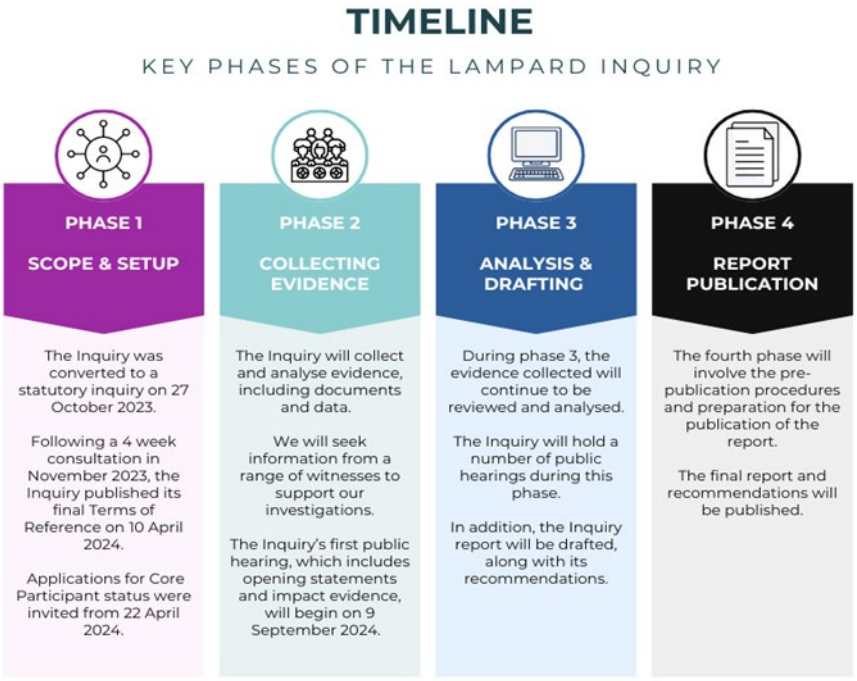
The Board is asked to note the report and take assurance on the progress in developing the pan-Essex ICBs' approach to responding to the Inquiry and to the requests of the Inquiry to-date.

Lampard Inquiry Update

1. Introduction

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

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



The three Essex Integrated Care Boards; Mid and South Essex (MSE), Hertfordshire and West Essex (HWE) and Suffolk and North East Essex (SNEE) agreed to work collaboratively to be able to respond collectively and effectively to the requirements of the Inquiry. Each of the ICBs has been designated a 'core participant' to the Inquiry. A Core Participant is an individual, organisation or institution that has a specific interest in the work of the Inquiry. Core Participants have a formal role and special rights in the Inquiry process.

A shared programme office has been established comprising:

- Programme Director (part time)
- Senior Project Manager (1 wte) – Commenced 1 Oct 2024
- Administrative Support (1wte) – Commenced 2 Dec 2024

Legal advisors have been appointed (Mills & Reeve LLP).

Programme and legal costs are being apportioned between the ICBs as follows:

- 1/7 to SNEE ICB
- 1/7 to HWE ICB
- 5/7 to MSE ICB.

The three Senior Responsible Officers (SROs) are;

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

They are supported by ICB Lampard leads;

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

This paper updates the Board following the report submitted in November 2024 and the report to the Quality Committee in February 2025. It includes;

- Inquiry Updates
- Public Hearings
- Requests to the ICBs for information
- The Joint ICBs Programme

2. Main content of Report

2.1. Inquiry Updates

Scope of the Inquiry

The Inquiry's Explanatory Note regarding Scope has been updated, to clarify the Inquiry's definition of inpatient death. This now includes Learning Disability units, and Drug and Alcohol units.

The scope on mental health assessments has been updated to clarify the Inquiry's focus on assessments in A&E, assessments by gatekeeping teams, and Mental Health Act assessments. Other cases may be included at the Chair's discretion.

Disclosure

In preparation for the hearings commencing 28 April 2025, the Inquiry has (as of 6 March) sent 293 requests for information. 130 of these requests have been sent to organisations, including 58 to Core Participants. These requests include Rule 9 requests (a formal request for submission/response) and Section 21 notices (issued by the Chair on the Inquiry to compel the submission of evidence). The ICBs have received two related Rule 9 requests (July 2024 and February 2025) noted in 2.3 below.

The Inquiry has focused its formal requests for evidence on critical issues, including: inpatient care and safety; patient monitoring and autonomy; autism and mental health

inpatients; regulatory oversight and accountability; investigations into serious incidents; and staff and staffing matters.

2.2 Public Hearings

The next public hearing will take place from Monday, 28 April 2025 to Thursday, 15 May 2025, with the Inquiry intending to hear contextual evidence relating to the provision of mental health inpatient care in Essex, and evidence relating to some systemic issues around the provision of care. This evidence will be heard from healthcare providers and other relevant organisations.

The ICBs have submitted written evidence as part of this hearing (in response to the Rule 9 requests) but have not been asked to give any evidence in person. A timetable for the hearings has been released and is available on the Inquiry's website.

The Inquiry has released further information for public hearings in 2025 and 2026. These hearings will be held in-person at Arundel House, London, but will also be streamed with a ten-minute delay, as with previous hearings.

- 7 July – 24 July 2025
- 13 October – 30 October 2025
- 2 February – 19 February 2026
- 20 April – 7 May 2026
- 6 July – 23 July 2026
- October 2026: closing statements.

2.3. Inquiry Requests to the ICBs

The ICBs received a follow up Rule 9 request on 17 February 2025 relating to the Rule 9 request received in July 2024. This request includes specific questions on the previously submitted draft response, as well as additional requests for further information. Following ongoing discussions with the Inquiry, with whom the ICBs and legal team have developed positive working relationships, the ICBs' response to priority questions was submitted in draft, in line with the Inquiry's deadlines, on 26 March 2025 and has formed part of the Inquiry's evidence for the April Hearings.

Following a request, the ICBs also submitted on 25 April 2025 a supplementary statement and have prepared a response to remaining questions for when the Inquiry requests this response.

Both submissions have been signed off by the MSE ICB SRO on behalf of the 3 ICB SROs.

The ICBs' commissioning, finance, quality and contracting teams responded positively and promptly to the request and tight timescale, especially given the challenges in navigating the complexities of the commissioning landscape from 2000, retrieving historical data or information from former commissioning organisations across this period and reliance on corporate memory of individuals for pre ICB processes. This remains the most challenging aspect of responding to the Inquiry.

Following both Rule 9 requests received, the Project Team review and iterate the processes for gathering information for responses and the submission process. As a result of learning identified, the team has made amendments to ensure that

information submitted to the Inquiry is as accurate as possible and is reviewed by the appropriate ICB teams for any clarifications. Adjustments to the process include:

- The timing of most effective discussions with our legal team.
- Enhanced identification of lead accountabilities, source, areas/organisations covered, and time periods covered.
- ICBs to re-review draft answers before submission to legal team.

3. Joint Essex ICBs Programme

The programme was formally established in autumn 2024 with the cross ICB Joint Project Working Group meeting monthly from December 2024. It is supported by several groups with targeted areas of work, which include the following:

Safeguarding

MSE ICB leads the Safeguarding process for the 3 Essex ICBs, as set out by the Safeguarding Memorandum of Understanding (MoU) with the Inquiry. The ICBs and Project Team have agreed a process for referrals, including receiving responses from EPUT, and have a weekly scheduled meeting to discuss anything outstanding. In total, 14 referrals and 1 non-referral issue not requiring response have been received and processed by the ICBs.

MSE, as the lead ICB, met with the Inquiry Team on 4 February 2025, the first of quarterly review meetings. The process and communication between the teams and EPUT has been working well and no concerns regarding the process were raised. It was agreed that the ICBs and Inquiry would review and update the MoU for 2025/26, including the addition of Bedford, Luton and Milton Keynes ICB (BLMK ICB) as commissioners of Specialist Services in Essex (from 1 April 2025), which includes the forensic inpatient units Brockfield House and Edward House, and Child and Adolescent Mental Health Services (CAMHS) inpatient units St Aubyn's Centre and Poplar Ward (Rochford Hospital), operated by EPUT and within scope of the Inquiry.

Communications

The Project Team have worked alongside the ICBs' Communications Teams to develop a dedicated Inquiry space on the respective ICBs' intranets, explaining further details about the Inquiry, where to find support, and who to contact; as well as relevant updates aligned with the Inquiry's public hearings from 2024 until 2026. There is also a space now allocated on the public internet pages for the ICBs acknowledging the Inquiry, that the ICBs are working collaboratively, and are committed to engaging and learning from the Inquiry. The Project Team meet monthly with the Communications Teams to review updates and changes with the Inquiry and where updates can be given to both staff and the public.

Human Resources (HR)

The Project Team and HR group meet monthly to review support needed for staff affected by the Inquiry, specifically focusing on legal support (provided by Mills and Reeve), practical support (provided by the Project Team), and wellbeing support. The commissioning of wellbeing support is being monitored by the Project Team and ICB Leads to ensure that a suitable wellbeing support service is in place if it is needed for ICB employees.

Subject Matter Experts

The key areas where information can be obtained in preparation for the Inquiry is commissioning, contracting, and patient safety and quality teams. The Contracting and Commissioning Group in particular has been provided with example questions that could come up as part of a Rule 9 request from the Inquiry, to enable them to start locating relevant information and report back to the group each month. As noted in 2.3 above, they have also been a key focus of the Rule 9 requests. There is also work currently undergoing to identify key sources of information, especially historically, across the ICBs and former organisations. The Quality Group also meets monthly and it is currently in the process of developing an information sheet on how the Serious Incident process and policies have changed over the years. For both groups, the current focus is on CCGs and ICBs.

Information Governance (IG) and Historic Records

The core focus of this group's activities is to identify historical records that will need to be recalled, reviewed, and either electronically scanned or catalogued so they are available for Rule 9 requests. Within this group is the Information Governance Team, with primary oversight of historic records, as well as the IT service and Cyber Security for any records from former organisations held within ICB servers and databases, and completion of the privacy impact assessment. This is a significant challenge given the range, complexities and length of period and it has highlighted potential risks relating to historical records in particular pre-CCG. The group is also looking at a cross ICB protocol for records destruction to ensure the ICBs meet the additional requirements of the Inquiry e.g further retention of documents beyond ordinary timescales.

Senior Responsible Officers (SROs)

The Senior Responsible Officers for the ICBs meet fortnightly (weekly if needed for example when a Rule 9 is in operation)) with the Project Director and legal advisors as necessary. This allows the SROs to receive assurance on progress against requests, development of the programme approach and to support mitigation to risks and issues identified. It also provides an executive director level mechanism to sign off requests within the requisite timescales.

3. Findings/Conclusion

The Essex ICBs have worked effectively together to create a joint programme approach to the Inquiry and responded positively to the Rule 9 and supplementary requests. The establishment of the project team and structure, as well as associated workstreams, has enabled more effective responses to the requests of the Inquiry, thus providing assurance to constituent Boards that the ICBs are meeting their responsibilities and duties to the Inquiry.

4. Recommendation

The Board is asked to note the report and take assurance on the progress in developing the pan Essex ICBs approach to responding to the Inquiry and to the requests of the Inquiry to date.

Part I Board Meeting, 15 May 2025

Agenda Number: 8

Mid and South Essex Palliative and End of Life All Age Strategic Delivery Plan

Summary Report

1. Purpose of Report

To seek approval for the first all age Mid and South Essex (MSE) Palliative and End of Life Strategic Delivery Plan **(Appendix A)**

This Strategic Delivery Plan outlines the work that the System will be undertaking to address the gaps that are impacting on experience and outcomes for our population when at end of life and responds to the national ambitions for effective palliative and end of life care.

2. Executive Lead

Dr Matt Sweeting, Executive Medical Director

3. Report Author

Karen Wesson, Director of Oversight and Assurance

4. Link to the ICB's Strategic Objectives

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

5. Conflicts of Interest

None identified.

6. Recommendation

The ICB Board is asked to approve the Mid and South Essex All Age Palliative and End of Life Strategic Delivery Plan

Palliative and End of Life All Age Strategic Delivery Plan

1. Introduction

Across mid and south Essex (MSE) there is variation in the offer for those who are at end of life and have palliative and end of life care (PEoLC) needs, and support for their families. In 2022 a lived experience survey led by the Hospices and Healthwatch was completed. NHS East of England Region, in partnership with Marie Curie and the Integrated Care Board (ICB), completed a review of our services against the six national ambitions for PEoLC care in 2024[1]. These identified gaps in:

- Access and provision of medication, including anticipatory (as required) medicines.
- Case management and access to care across 24 hours a day, 7 days a week
- Advance Care Planning (ACP). This is a process that recognises individual's preferences of care and ensures this is documented in their medical record.

This Strategic Delivery Plan outlines the actions being undertaken in Year One (2025/26) to address these gaps. Delivery of the actions required is overseen by the MSE Palliative and End of Life Care Board chaired by Dr Matthew Sweeting, ICB Executive Medical Director. PEoLC is a core component of the MSE Medium Term Plan with focus on:

- Early identification and advance care planning
- Reducing service disparity through agreement of the role of the specialist and generalist clinician.
- Addressing the medicines access challenge to ensure access to medication when required and proactive prescribing of said medication in anticipation of their need.

Why Change?

The 2024 review of services, mentioned above, clearly demonstrated the need to standardise services. However, the ICB received a complaint from the wife of a patient who died which outlined the impact of not getting end of life care right, who asked that her story was used to support service change. Below is a quote from her:

"A good end like that really helped me, but I remain haunted by the amount of suffering G had to go through due to vomiting, and the huge effort to get the help he needed. It certainly increased my fear of my own death. It would have been nice if anyone had contacted me after G's death to see how I was coping, but there has been no support offered …"

Strategic Delivery Plan

The Mid and South Essex All Age Palliative and End of Life Strategic Delivery Plan has identified where there are gaps that need action to improve outcomes and meet the needs of people and their families.

[1] NHS England » Ambitions for palliative and end of life care

The need for the plan:

The proportion of people requiring PEoLC will grow (by up to 47% by 2040), with the greatest rise in demand being for those over the age of 85 years. The largest area of clinical need will be for persons dying with dementia, with a far smaller rise predicted for those dying with cancer.

In MSE, almost 13,000 people die annually, however our Population Health segmentation data tool analysis has identified that the number of people being at higher risk of dying (those likely to be living with life limiting conditions) is around 34,000 people (circa 2.6% of the total Integrated Care System (ICS) population).

Across the system, we currently only identify 0.4% of the total population on our end of life system, the Electronic Palliative Care Coordination Systems (EPaCCs) register (representing around 15% of the circa 34,000 people who may be living with life limiting illness indicators). This indicates a significant amount of unmet PEoLC need and potential lack of ability to proactively support, plan and coordinate care for these individuals. In addition, a third of people currently recognised are only identified within the last 30 days of life which can be too late to make a real difference to their end-of-life journey.

There is unwarranted variation in recognition rates of people who may benefit from PEoLC, the timeliness of identification and the delivery of ACP conversations across our places, our neighbourhood localities and our providers.

There are approximately 1,800 babies, children, and young people (BC&YP) living with life limiting conditions (LLC) within MSE, with around 350 accessing palliative care services. According to the Make Every Child Count report (Fraser et al 2020), MSE has a high prevalence due to diverse ethnicity and areas of deprivation seen within its locality. As the population of BC&YP continues to increase, the number requiring PEoLC will continue to grow. It is currently estimated there are around 99,000 children in the UK living with LLC (TfSL 2024). It is crucial to acknowledge that most children with LLC can enjoy active and fulfilling lives for many years if they receive the necessary care to maintain their health.

Fifty-four percent of the total population deaths in MSE occur at home and in care homes. This is positive, but further work is necessary to improve the quality of care and planning to support families and professionals.

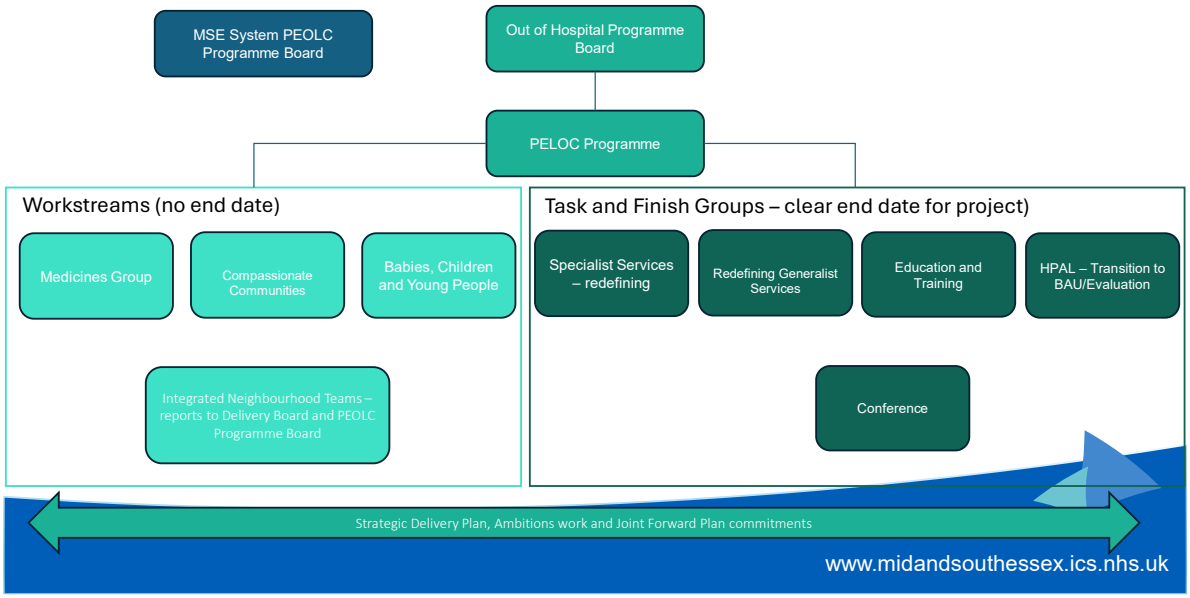
The changing role of the generalist health and social care workforce and increasing reliance on family/significant others and unpaid carers, all contribute to providing end of life care with little preparation or knowledge. BC&YP can have very complex and unpredictable needs; with families often providing highly skilled and complex care 24/7 for their child. Workforce and capacity issues are impacting the ability of organisations to be flexible and responsive in delivering high quality care.

Our Palliative and End of Life Care Strategic Delivery Plan intends to ensure that our work plan continues the momentum that we can support more people to die in their usual place of residence through early identification and advance care plans.

Year One work plan:

The priorities and work plan has the following governance in place to ensure that we deliver our commitments:

PEOLC Delivering the Strategic Delivery Plan



The work plan for year one, set out in the delivery plan (**Appendix A**) has been developed to reflect the asks from the national ambitions work but will focus on the key areas of:

- Access and provision of medication including anticipatory medicines
- Case management and access to care across 24 hours a day, 7 days a week
- Advance Care Planning (ACP).

It is acknowledged that to achieve this a competent, confident workforce is required. All partners are now part of the ICB People Board. As part of the year one plan, work is underway to ensure access to training and education is available to partners, and that we maximise opportunities between partners alongside formal e-learning which is in place. In May 2025 the MSE Integrated Care System Immersive Training will be going live. This has been developed to support staff to have complex conversations with people who are at end of life.

2. Recommendation

The ICB Board is asked to approve the Mid and South Essex All Age Palliative and End of Life Strategic Delivery Plan.

3. Appendices:

Appendix A: Strategic Delivery Plan

Appendix A

MID and SOUTH ESSEX

INTEGRATED CARE SYSTEM

ALL AGE

PALLIATIVE and END of LIFE CARE

STRATEGIC DELIVERY PLAN

2025 - 2028

"Lack of joined up care between service providers makes things difficult and far more time consuming and complicated than it should be need a single point of contact and relationship for all health and social care" (Marie Curie Experiences Of Palliative And End Of Life Care In East Of England (Lived Experience) Survey, Mid and South Essex

Vision

Mid and South Essex have an equitable Palliative and End of Life service that meets its population needs regardless of age. It provides and supports people to receive high quality care, in their preferred place, through personalised communication with the individual and their family and has robust coordinated services for safe, effective care delivery.

Executive Summary

This Palliative and End of Life Strategic Delivery Plan has been developed with partners across Mid and South Essex to ensure that have a plan to address the variation in access and service that we provide our population.

In 2022 the Integrated Care Partnership, led by the Mid and South Essex Hospices undertook a lived experience survey, in 2024 Marie Curie, as part of the East of England work completed a lived experience survey. In Quarter Four of 2024/25 a refresh of the self-assessment of the Ambitions Framework[1] was completed for mid and south Essex. Unfortunately, as a System the themes and narrative hadn't improved for our population. This Strategic Delivery plan outlines the actions we intend to take together to improve end of life care for our population.

The Health & Care Act 2022 places a statutory duty upon Integrated Care Boards (ICB) to commission Palliative and End of Life Care for *all* ages, and to involve "people and communities at every stage". Most importantly, this Strategic Delivery Plan focuses upon the **"***outcomes that matter most"*[2] to those at the end of their lives and their families, including the outcomes identified through the Mid and South Essex all age Lived Experience survey undertaken in 2022 and Marie Curie Lived Experience Survey 2024. This Strategic Delivery Plan utilises as it's framework the six National Ambitions for Palliative Care[3].

Delivery of this Strategic Plan will be led at a local level by our Integrated Care Board Alliances. Working with local service providers, the Alliances and other partners will look at how they can best deliver this Strategic Plan for their local population. The Integrated Care

[1] NHS England » Ambitions for palliative and end of life care
[2] Palliative-and-End-of-Life-Care-Statutory-Guidance-for-Integrated-Care-Boards-ICBs-September-2022.pdf
[3] NHS England » Ambitions for palliative and end of life care

Board will work with local partnerships to ensure improvements are delivered as soon as possible in line with this Strategic Delivery Plan.

Palliative and end of life care quality indicators and dashboards are in place at a System level with Electronic Palliative Care Coordination Systems (EPaCCS) helping to inform the Alliances and System on progress and provides oversight on the outcomes from care conversations. There is a gap for Babies, Children and Young People as there is no consistent or central system, reflected in this Strategic Delivery plan. Success will be measured against the following high-level outcomes:

People die with dignity and their wishes are respected – preferred place of care and death will be utilised as the measure of this.

- Care is provided in the community, wherever possible, and palliative and end of life care is available when people, families and carers need it. For adults, this will be measured using the mid and south Essex Palliative and End of Life Dashboards and patient experience surveys and feedback / complaints / incident report. For Babies, Children and Young People (BC&YP) these dashboards and ways of reporting need to be established.
- Palliative care needs across all health conditions are identified early and support is provided, this is tracked by the adult End-of-Life register size relative to the population size and demography at both ICB and Place.
- Palliative care needs across all health conditions for Babies, Children and Young People are contained within the annual data as part of the wider East of England Managed Clinical Network BC&YP Point Prevalence survey.
- Palliative and end of life care is coordinated evidenced by:
- Integrated care partnerships (e.g. effective MDT's) where there are clear pathways and patient flow between teams with identified key workers. This will be evidenced through the number of patients referred to the PEOLC register (for adults). For BC&YP this will be evidenced when the register is in place.
- patient experience surveys and feedback / complaints / incident reporting.
- Patient reported outcomes measures via provider reports for adults e.g. IPOS (Integrated palliative outcome scale) or other validated quality of life measures. For BC&YP there is to be published the CPOS (children palliative outcome scale) which will be used.

After someone has died, families and carers are supported through:

- Access to bereavement services.
- Reduction in waiting times for bereavement support.
- Access to information to support post death (e.g. *MSE public facing web resources and support for public, social media campaigns*).

Within the NHS England Standardising Community Health Services[4] the requirement for planned and reactive PEOLC for both adults and babies, children and young people is

[4] NHS England » Standardising community health services

seen as a core component of community services, it is through these services that we can ensure support to our population and enable delivery of this plan.

Without support and engagement of our Integrated Care Partners, the ability to deliver this Plan is limited. As an Integrated Care System, we champion a whole System population-based approach, which includes health and social care providers, including the voluntary sector, and of course, learning from, and empowering our local population, as we promote palliative and end of life care as “everybody’s business”. This requires our ICS to be innovative, outward thinking, agile, and collaborative to achieve the change in culture and mindset towards proactive personalised care that will meet the needs and wishes of people and those important to them, in their final but most important journey.

Thanks to all System Partners for their help in developing this Strategic Delivery Plan and for their commitment to being part of that change.

Introduction

Following the development of the Integrated Care Board (ICB) the need for Strategic Leadership for Palliative and End of Life Care was acknowledged; to enable the ICB to fulfil its statutory duty, the Medical Director was appointed Executive Lead, a clinical lead was appointed and Senior Responsible Officer for oversight of delivery of the ICB commitments and developments for Palliative and End of Life Care (PEOLC).

Prior to the COVID-19 pandemic, the numbers of deaths within the UK were steadily increasing, with forward projections suggesting that by 2040, annual deaths will rise by 25% in England and Wales.3 In part this can be explained by our ageing population: currently one in every five people is aged 65 and over, rising to one in every four by 2050. In 2021, 82% of deaths were in those aged 65 and over, with a projected rise to 91% by 2040.

Unsurprisingly, the proportion of people requiring palliative and end of life care will grow, with almost all the growth predicted to be in those older than age 75, with the greatest rises in demand being for those over age 85 years. National and regional population predicted projections for persons needing Palliative and End of life Care (PEOLC) are for up to 47% increase in demand by 2040. The largest areas of growth being for persons dying with dementia and smaller rises for those dying with cancer.

In Mid and South Essex, almost 13,000 people die annually, however our Population Health segmentation data tool analysis has identified that the number of people being at higher risk of dying (those likely to be living with life limiting conditions) is around 34,000 people (circa 2.6% of the total ICS population).

Defining when a person may be entering their last 12 months of life is difficult, given inherent unpredictability in the timing of terminal trajectories for unique people. The benefits of receiving palliative and end of life care support is not always necessarily time bound to being just within the last one year of life but dependent on the unique needs, priorities and wishes of individuals.

Across the system, we currently only identify 0.4% of the total population on EPaCCS registers (representing around 15% of the circa 34,000 people who may be living with life limiting illness indicators) indicating a potentially significant amount of unmet PEOLC need and potential lack of ability to proactively support, plan and coordinate care for these individuals. In addition, a third of people currently recognised are only identified within the last 30 days of life and this can be too late to make a real difference to their end-of-life journey.

Sadly, even where identification has occurred, only 57% of people identified on EPaCCS registers in MSE have undertaken any form of personalised care support planning for their future to help them to stay in their preferred place of care or to prepare for a good death in the place of their choice.

There is also unwarranted variation in recognition rates of people who may benefit from palliative and end of life care, the timeliness of identification and the delivery of Advance Care Planning conversations across our places, our neighbourhood localities and our providers.

There are approximately 1800 babies, children, and young people living with life limiting conditions (LLC) within Mid and South Essex, around 350 access palliative care services. According to the Make Every Child Count report (Fraser et al 2020), Mid and South Essex has a high prevalence due to a diverse ethnicity and areas of deprivation seen within its locality. As the population of BC&YP continue to increase, the number requiring palliative and end of life care will continue to grow this is currently estimated to be around 99,000 children in the UK who are living with LLC (TfSL 2024). It is crucial to acknowledge that most children with LLC can enjoy active and fulfilling lives for many years if they receive the necessary care to maintain their health".

Child death data for Southend, Essex and Thurrock 2021/22 reported that of the 55 children who died with a condition likely to fall within the scope of hospice care (expected death), 89% died in hospital and just under half of these were neonates. The national average for BC&YP deaths in hospital is 74%. This figure increased to 63 in 2023/24.

In 2021, Mid and South Essex started to experience an increase in home death (including care homes) on the background of a continuing national pandemic shift towards dying at home. With now 54% of total population deaths in Mid and South Essex occurring at home and in care homes. This is a positive and welcome trend, but further work is necessary to improve the quality of care and planning to support families and professionals.

The changing role of the generalist health and social care workforce and increasing reliance on family/significant others and unpaid carers, all contribute to providing end of life care with little preparation or knowledge.12 Babies, children, and young people, can have very complex and unpredictable needs; with families often providing highly skilled and complex care 24/7 for their child. Workforce and capacity issues are impacting the ability of organisations to be flexible and responsive in delivering high quality care.

The COVID-19 pandemic has driven positive developments through rapid innovation, adoption of technology and collaboration of services and organisations to meet the palliative and end of life care demand like never before.5 Public awareness of death, dying and bereavement has been heightened and allowed opportunities for public discussion on

difficult topics such as Advance Care Planning (ACP). Not adopting a proactive, anticipatory, and personalised approach, risks our population receiving a poorer experience of care and outcomes at their end of life. Advance Care Planning interventions have been shown in systematic reviews to improve patient experience and comfort at the end of life.16

Our Palliative and End of Life Care Strategic Delivery Plan intends to capitalise on these positive developments for the benefit of our population.

Development of the Strategic Delivery Plan

This Strategic Delivery Plan has been developed in collaboration with all System Partners across Mid and South Essex who constitute the PEOLC Programme Board and workstreams. It was approved by the Programme Board on 19 March 2025.

Engagement, context, and insight

In 2022 and 2024 Lived Experience Surveys were undertaken that identify areas of challenge to us delivering our vision for PEOLC. In the Marie Curie (2024) survey, there remain gaps in communication and involvement of individuals in their care. As a System, we must utilise the insights from the public experience surveys, this has been captured in our Strategic Delivery Plan. Insight from the Ambitions self-assessment incorporated within the plan with the summary of the refresh work shown in the section below.

National and Local Context

The Ambitions for Palliative and End of Life Care (PEOLC): A national framework for local action 2021 to 2026[8] was published by a broad partnership of national organisations and builds on a report of the same name published for 2015 to 2020, and the first national Strategic Delivery Plan for end-of-life care published in 2008. Its purpose is to provide a best practice national framework for commissioning and delivering all age PEOLC services.

After the COVID-19 pandemic the national framework highlighted the value of well-co-ordinated palliative and end of life care services and competent practitioners to deliver it across provider and organisational boundaries. This is why a single Mid and South Essex PEOLC Strategic Delivery Plan is critical, it acknowledges palliative and end of life care across the life continuum and supports valuable collaboration between partners and with affected people and families themselves.

The Six Ambitions[5]:

As an integrated care system, the use of population health management approaches to champion a whole system approach will be used to provide collaborative, proactive, focused care, and the promotion of community discussions of dying, death, and bereavement. PEOLC services should evidence local delivery against the Ambitions Framework and the NICE quality standards for end-of-life care.[19] There must be a strategic and cultural shift towards PEOLC being "everyone's business" and a reduction in variation of service delivery with due consideration given towards the wider social determinants of health. This will reduce health inequalities that are experienced by those at end of life. Alignment to relevant workstreams such as Start Well, Ageing Well, Die Well, and Digital Innovation, alongside visible clinical leadership is essential. The National PEOLC Programme of improving equity of access, improving quality and experience, and improving sustainability must be a key consideration for delivering the best care we can.

The Mid and South Essex ICS Integrated Care Strategy 2022-2033 and Joint Forward Plan (2024-2029) identifies Palliative and End of Life Care for all ages as a strategic priority for our 1.3million population. This Strategic Delivery Plan underpins delivery of the Joint Forward Plan commitments whilst recognising the importance of alignment with individual Alliance and Neighbourhood Strategies in achieving success.

[5] NHS England » Ambitions for palliative and end of life care

March 2025 Ambitions refresh:

Following the Ambitions refresh work completed in March 2025 the below table shows at ICB level how the System is achieving delivery of the Ambitions, the gaps identified through this work have been incorporated into the delivery plan.

	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5
Ambition 1: Each Person Seen as an Individual	0.0%	21.1%	21.1%	42.1%	15.8%	0.0%
Ambition 2: Each person gets fair access to care	0.0%	16.7%	33.3%	50.0%	0.0%	0.0%
Ambition 3: Maximising comfort and wellbeing	0.0%	12.5%	6.3%	68.8%	6.3%	6.3%
Ambition 4: Care is coordinated	0.0%	13.0%	0.0%	34.8%	4.3%	47.8%
Ambition 5: All staff are prepared to care	0.0%	28.6%	0.0%	42.9%	0.0%	28.6%
Ambition 6: Each community is prepared to help	0.0%	25.0%	25.0%	50.0%	0.0%	0.0%

The above shows that mid and south Essex still has a way to go to become a mature system achieving and providing equitable palliative and end of life services. The levels are defined as below:

Level	Locality Level Descriptor
Level 0	Not at all ready to achieve/ anticipate barriers to achievement
Level 1	Desire to achieve this ambition but there are currently no plans in place
Level 2	Plans are in place towards achieving this ambition
Level 3	Limited achievement across one or two organisations only
Level 4	Partially achieving e.g. across most, but not all care settings
Level 5	Fully achieving e.g. across all care settings, with supporting evidence available

Delivery Plan:

The Mid and South Essex Strategic Delivery Plan for year one is shown below with the detail for each component outlining what is in place and where there are gaps in the sections following the plan. The total plan for the three years is in Appendix Three. This plan will be used to inform the System work programme overseen by the Palliative and End of Life Programme Board and has incorporated work from the:

- Mid and South Essex Ambitions refresh March 2025
- Mid and South Essex 24/7 Service mapping work February/March 2025
- Draft Strategic Delivery Plan December 2023
- Marie Curie Survey 2024

Personalised Care Planning which is shared to support care	Plan: - Build on the EPaCCS and PEACE work with greater emphasis on roll out with Alliances leading at a local level. - Ensure EPaCCS is utilised. - Embedding CYPACP into systemwide practice, including education on the use of ReSPECT for BC&YP - EPaCCS for BC&YP development, implementation and roll out.	By: 31/03/2026 31/03/2026 31/03/2026 31/03/2026
Care Model – reducing variation	Plan: - Review services against national expectations, 2025/26 Operational Plan (standardising community services planned/reactive offer) and identify gaps/ efficiencies/opportunities. - Ensure services use consistent definitions (agreed through 2024/25 24/7 mapping) - Work with Specialist Services to review against national specifications and identify gaps opportunities	31/03/2026 31/03/2025 31/03/2026
Bereavement Care	Plan: - Ensure promotion of current services through website and social media with additional work being undertaken to ensure up to date BC&YP information is included.	31/03/2026
Care Model – reducing variation	Plan: - Review services against national expectations, 2025/26 Operational Plan (standardising community services planned/reactive offer) and identify gaps/ efficiencies/opportunities. - Sharing of Audits outcomes to show how services are achieving the five priorities of the dying person[6]	31/03/2026 31/03/2026
Service outcomes	Plan: - Implementation and adoption of validated outcome measures across services (IPOS, CPOS) and sharing the outcomes to support service improvement	31/03/2026 (CPOS subject to national roll out)
Early identification and anticipatory care	Plan: - Ensure services have the right knowledge, skills, and training to be able to plan, identify early and ensure good anticipatory care including provision and access to medicines to reduce delays and impact to the individual.	31/03/2026

[6] One Chance to get it right

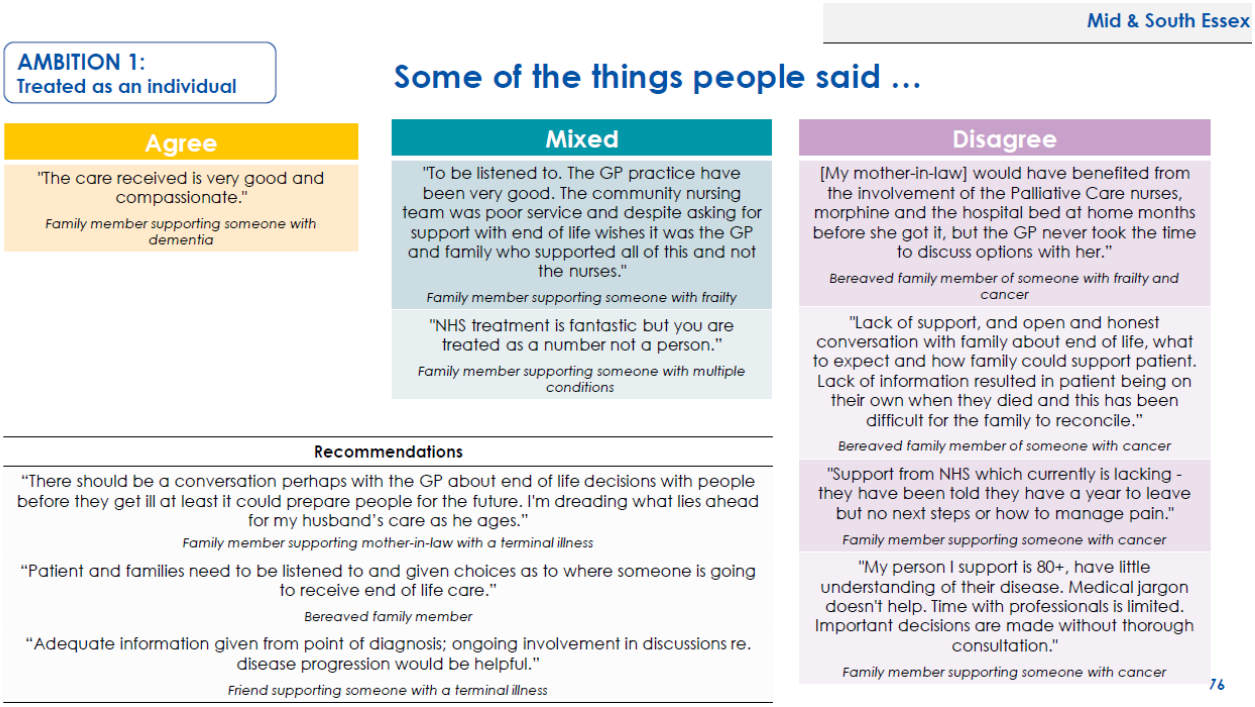
	- For Adults ensure roll out of PEACE/FrEDA to enable early identification and support is in place. (Some patients may have ReSPECT document). - For BCY&P ensure the roll out and awareness of ReSPECT	31/03/2026 31/03/2026
Skilled workforce	Plan: - Use the information from the baseline work to determine gaps that can be shared with the People Board to help support the development of the workforce. - Training Strategy and Framework for health and care staff, with framework to include competencies for generalist staff. - Training Strategy should include training for non-health and care for example domiciliary care, care homes and families and carers.	31/03/2026 31/03/2026 31/03/2026
Specialist Palliative Care	Plan: - Continue to promote the Hospice Rapid Access Service for adults with Rapidly Deteriorating Condition to ensure coordination and care is in place in a timely manner.	Ongoing
Rehabilitation	Plan: - Ensure that all rehabilitation services maximise the person's independence and social participation to the extent that they wish and enable them to achieve their personal goals.	31/03/2026
Care Coordination System – regardless of age	Plan: - Ensure promotion and increase use of EPaCCS for adults, increasing register size and care coordination. - Understand what would be required to have a system in place for BC&YP and scope requirements and resulting plan.	Ongoing 31/03/2026
Standardised approach/model	Plan: - Review services against national expectations, 2025/26 Operational Plan (standardising community services planned/reactive offer) and identify gaps/ efficiencies/opportunities.	31/03/2026
Transition	Plan: - Understand current offer, gaps, and opportunities to ensure smooth, coordinated transition pathway. - Ensure greater coordination between services to reduce delays or impacts of transition between services.	31/03/2026 31/03/2026

	- Consider the recently published Inbetweeners Report (NCEPOD) and mapping the services and transition pathways against the recommendations included in this report and the wider transition work programme	31/03/2026
Workforce report	Plan: - Ensure shared understanding of workforce plan – report pending and actions resulting from this. - Ensure report is shared with the People Board so that there is a System wide understanding.	31/03/2025 31/03/2026
Specialist roles and opportunities	Plan: - Understand the need for specialist roles and gaps. - Explore opportunities for creative workforce solutions and training opportunities.	31/03/2026 31/03/2026
Public Communications and promotion of services	Plan: - Ensure clear communication plan and approach for PEOLC across the System and at Alliances.	31/03/2026
	Plan: - Develop a model of service user engagement and feedback to ensure co-production[7] of high-quality service developments.	31/03/2026
	Plan: - Embed Compassionate Communities within local Alliance Plans to ensure local networks and sustainability of approach	31/03/2026

[7] Co-production: what it is and how to do it - SCIE

Strategic Delivery Plan:
The below section by each Ambition outlines the current position and the gaps this has.
Local Delivery Plan: Ambition One – Each person is seen as an individual.

What we already know:
Using the lived experience survey (2024) feedback and Ambitions refresh, we can see that there is work to do across the System, to ensure greater coordination and involvement of individuals in their care. Whilst this survey was adult only, the theme of engagement and personalised care equally applies to babies, children and young people and their families when planning PEOLC.



What we have in place:
Across Mid and South Essex, we have a standardised tool for advance care planning called PEACE, this supports conversation and planning for adults. This is embedded within the Frailty End of life Dementia Assessment (FrEDA) care delivery tool, available to multiple providers across the system, for adults which has additional identification and proactive care delivery functions- such as adding identified adults to Electronic Palliative Care Coordinating System (EPaCCS) end of life care registers, recording resuscitation decisions, End of life staging (using Gold standard framework needs based staging) and prompting anticipatory palliative care symptom control prescribing .

We have in place for adults the EPaCCS which is our end-of-life care register that can capture conversations and advance care plans within patient records. Plans are in place to replicate this for those under 18 years of age.

Since the recent development here in Mid and South Essex of the Population Health Management (PHM) Segmentation tool now live on Athena platform since 2024, which delineates out population groups at rising risk who have developed end of life clinical risk indicator markers, there are potential opportunities for places, providers and services to make

use of this data insight tool to improve performance around earlier identification and to reduce current inequalities for more effective population health management.

As this develops further, the PHM tool has potential to drive improvements for providers across community settings (for example as the Integrated Neighbourhood team model develops) plus for other acute and specialist providers, to move towards more predictive modelling strategies that can identify people earlier for offering both timelier Advance Care Planning and sharing of people's preferences for care via EPaCCS platforms.

We have services across mid and south Essex that can verify expected death, and these clinicians would be a first provider of support to families and carers.

Gaps across Mid and South Essex including variation:

Bereavement:
There is inequity in accessing services with the main offer that provided by the three mid and south Essex hospices and a MSEFT offer, lack of information and variation in provision for the population relating to bereavement services and the after-death care provided to families and carers after a death.

Fragmented Services and Hand-offs:
The System does not have a consistent model or service for palliative and end of life care in place for any age, there are gaps and variation in what is available, this can be seen in the Ambitions refresh summary table shared earlier.

The March 2025, 24/7, service mapping used the NHS England Phase 1 Codifying core community health services[8] work to understand the difference in generalist and specialist services across mid and south Essex including the functions that the services provided. The recommendations from this work have been reflected into this plan.

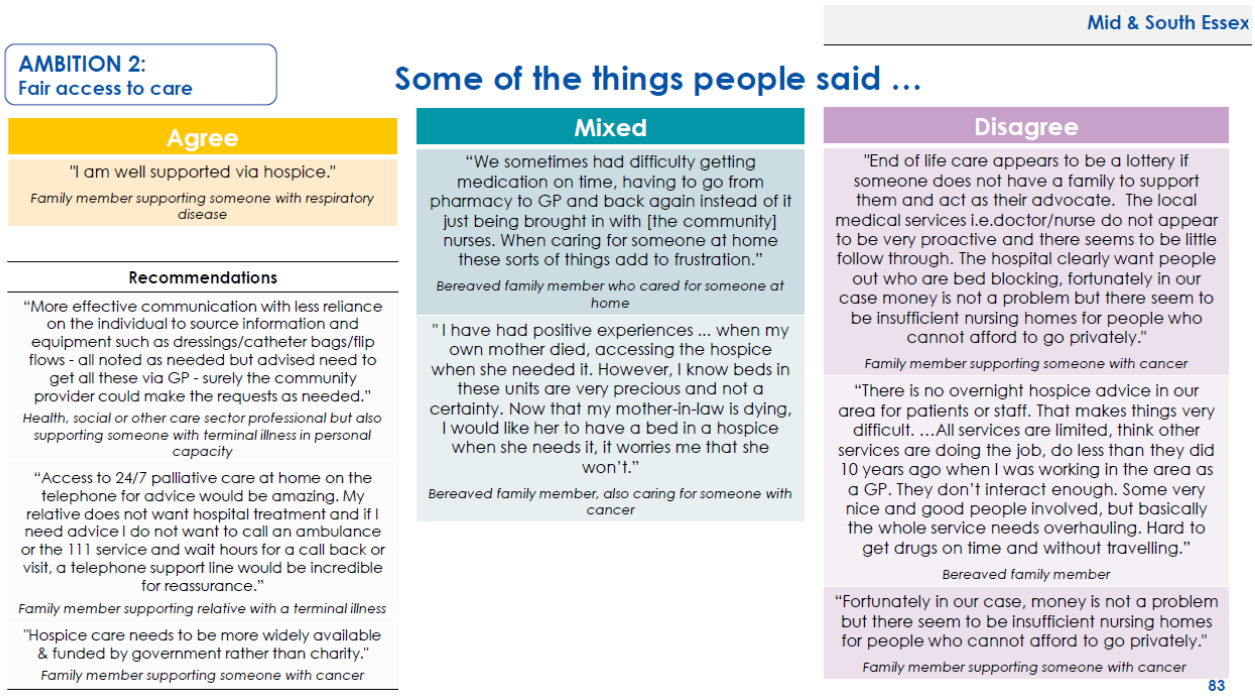
Definitions for specialist and generalist were agreed, these can be found in the definitions section of this paper.

Local Delivery Plan: Ambition Two – Each person gets fair access to care.

What we already know:
We know that we have variation in offer for palliative care across our population based on historic commissioning of services. While this survey was for adults, we know there is variation for BC&YP and disparity of offer across all ages.

There are areas of inequality and inequity (as identified on the data dashboards in place) for certain population groups especially non cancer groups, in receiving timely recognition of palliative and end of life care needs and being able to have personalised advance care planning conversations.

[8] NHS England » Standardising community health services



What we have in place:

Data and services:
We have in place data to support decisions and identify areas of focus that our Alliances can use to target improvements improvements and reduce inequalities. We have two collaboratives (Community; Hospices; Hospitals) and a single acute provider that provide most of the services for our population (all ages). We need to maximise the benefits this provides in reducing hand-offs, boundaries to integration and variation.

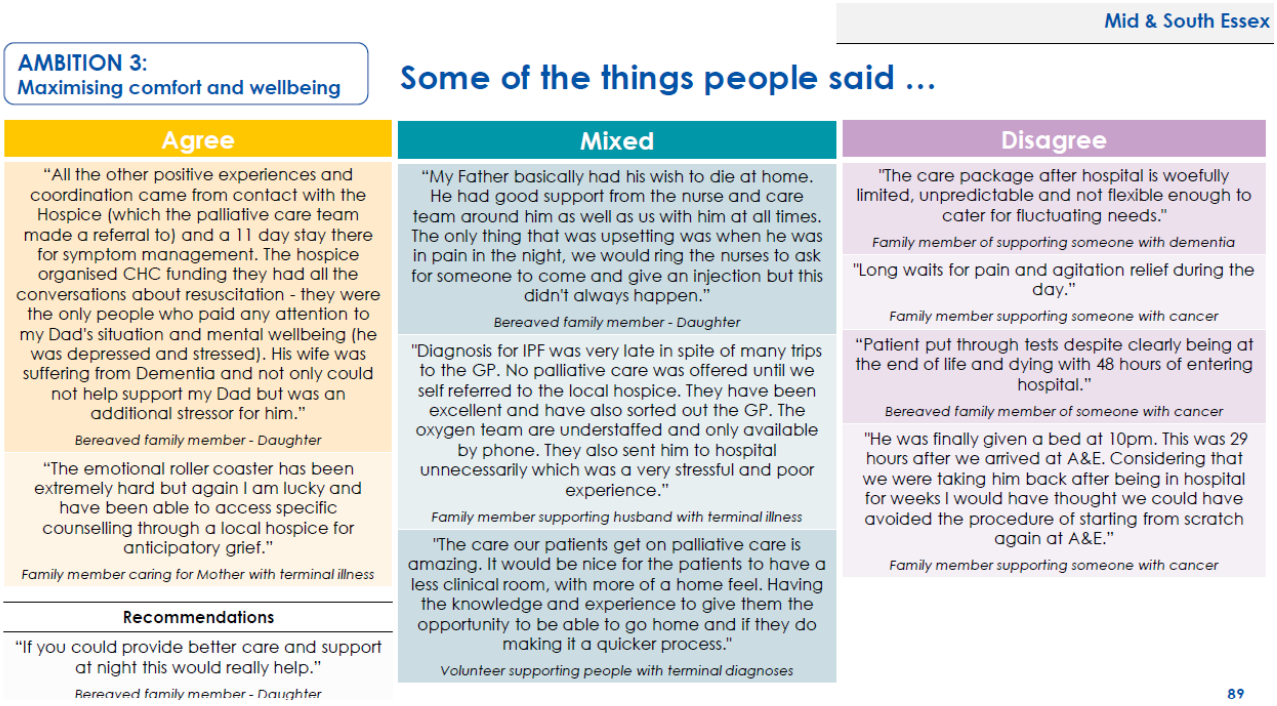
Local Delivery Plan – Achieving our Ambition – Maximising Comfort and Wellbeing

What we already know:
As a System, we have disparity of service model, provider services and offer for our population. There are gaps in provision, there is no consistent 24/7 model of care for any age which can have a significant impact on the comfort and wellbeing of the individual and the experience of both them and their family. The 2023 Health and Safety Executive[9] report outlines the need for collaboration between health and care organisations to define clear routes of support for people in and out of normal working hours to ensure they know how to access help for palliative care and end of life needs was stated as a key recommendation.

Access to anticipatory medication, rapid access to medication is limited by service provider and capacity. Medication pathways and guidance are in place, however, there remains a gap in accessing medication in a timely way across Mid and South Essex, from the 2025 mapping of services work this is only equitable where the person is an inpatient (hospital or hospice).

Feedback from those who participated in the 2024 Marie Curie Lived Experience is shown below and echoes the impact of poor coordination and continuous provision:

[9] HSIB: Variations in the delivery of palliative care services to adults (13 July 2023) - HSSIB investigations - Patient Safety Learning - the hub



What we have in place:

We have variation in provision across all ages both in and out of hours. We have a varied workforce with different levels of skills, qualifications, and experience in supporting those with life limiting conditions, we have variation in access to Specialist Palliative Care.

We have across Mid and South Essex an on-call Specialist PEOLC Consultant rota for health professionals to access support and advice if required for adults.

We have completed a workforce assessment – report to be shared, a People Board that has all provider representation to enable conversations across organisational boundaries.

We have an ICS Medicines Optimisation Committee that supports development and guidance on medicines to enable effective symptom management.

We have a website that gives information and advice for professionals and public which can provide guidance and support for adult palliative and end of life care. This is supplemented by our providers websites and information and social media campaigns that are System led.

Local Delivery Plan – Achieving our Ambition – Care is Coordinated

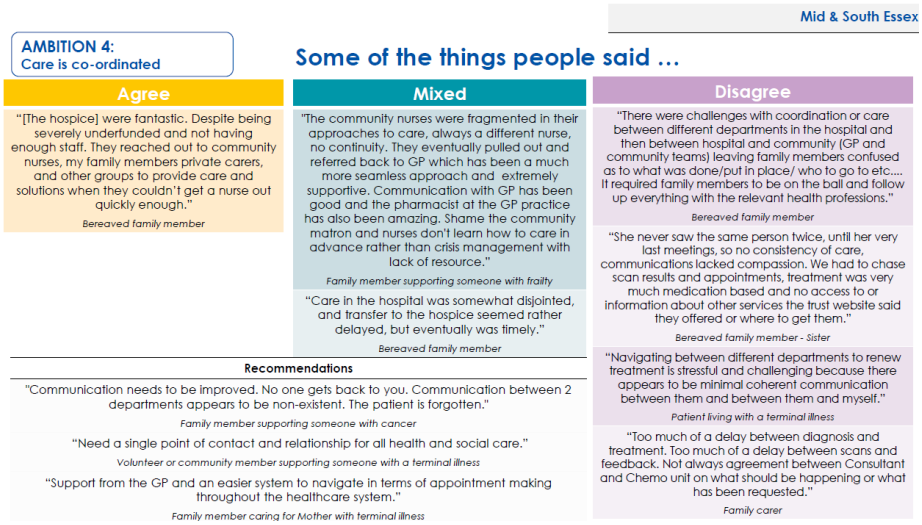
What we already know:
As stated in the Ambitions for PEOLC[10] we know that fragmented and disjointed care is a source of frustration and anxiety for the dying person and for all those important to them. Carers often testify to the difficulties of multiple professionals and organisations working with little awareness of each other. This lack of coordination causes significant distress.

No central register to easily identify BC&YP on palliative care and/or end of life care – less opportunities to support co-ordination of care across different organisations.

[10] ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf

Each organisation has different policies, different assessments, different documents – making it difficult to communicate effectively across boundaries and can be confusing for families. Variation in transition practices between children and young people's service and adult's services.

The 2024 Marie Curie Lived Experience feedback for Mid and South Essex that states:



What we have in place:

EPaCCS and Mid and South Essex End of Life Performance Dashboard (adult only data) currently receives data from three established Electronic Palliative Care Co-ordination Systems (EPaCCS) covering our four Alliances. The data currently demonstrates a culture of reactive rather than proactive, anticipatory care within our ICS including the key areas below:

- Poor identification: only 0.4% of the population are identified meaning many of our population who may die are not recognised. Late identification leading to late PEOLC input: 32% of those on EPaCCs registers are identified within 30 days of death. This can be too late to make a difference.
- Unwarranted degrees of variation in End-of-Life recognition rates across Providers, Alliances and Neighbourhoods.
- Evidence of inequity in recognition of End of Life between cancer and non-cancer groups.
- Suboptimal performance for Personalised Care Support Planning (PCSP) or ACP delivery: 55% of persons on EPaCCS do not have evidence of a PCSP or ACP in place.
- Poorer performance compared with the national average for PHE benchmarked measures with unwarranted variation across our Alliances for:
    - 7% population deaths with 3+ unplanned non-elective admissions in last 90 days of life.
    - 40% of population deaths occurring in acute hospitals, which is higher death rates in acute hospital when compared to national "best performing peers".
    - 61% of all call outs for ambulances is for people who are end of life.
- Shared Care Records, ability to put markers on a person's SystmOne record to support NHS111 directing them to a clinician.

Gaps in provision:
PEOLC does not have a single point of contact across the system. No case management approach except for the Hospice Rapid Access Service. Transition is in place for some of the specialist services but stops at organisational boundaries.

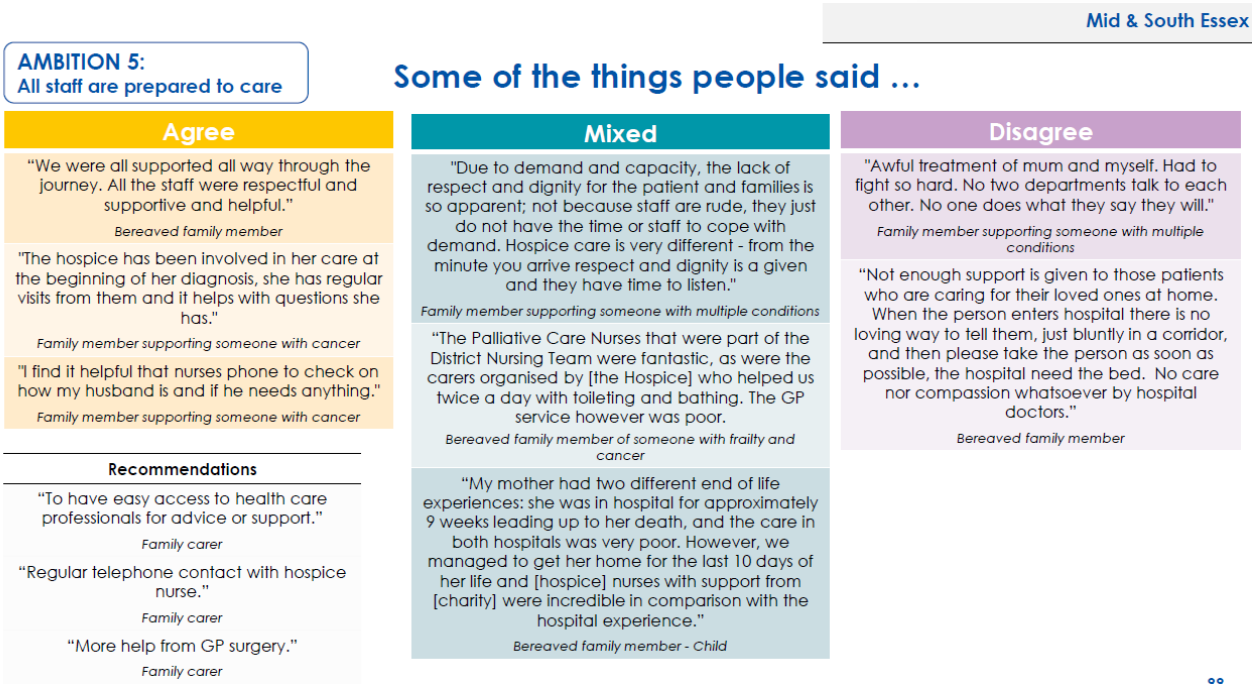
Standardised care model for each service (specialist and generalist), reducing the disparity in offer or provision.

Local Delivery Plan: Ambition Five – All Staff are Prepared to Care

What we already know:

- Recruitment and retention of workforce – currently there are insufficient workforce trained specialists in palliative and end of life care to deliver 24/7 palliative and end of life care services.
- Access to specialist symptom management expertise and advice – there is no dedicated Paediatric consultant level role or ANP/CNS role to support delivery of PEOLC both in the hospice and at home and provide first level specialist advice. In addition, access to a level four Children's Palliative Medicine Consultant is inconsistent and depends on diagnosis and which tertiary centre oversees the BC&YP care.
- That across mid and south Essex services who support with access, navigation, advice, and guidance to services for PEOLC, for example Unscheduled Care Coordination Hub (UCCH) need to be able to provide a consistent service, not be person dependent.
- Education and training for our workforce to enable a good quality of care and effective discussions taking into consideration the Training Needs Analysis 2024 outcomes.

We know that we have variation in offer and workforce for palliative care across our population based on historic commissioning of services. The 2024 Lived Experience Marie Curie feedback identifies, whilst this is adults, there is variation for BC&YP workforce as well:



What we have in place:

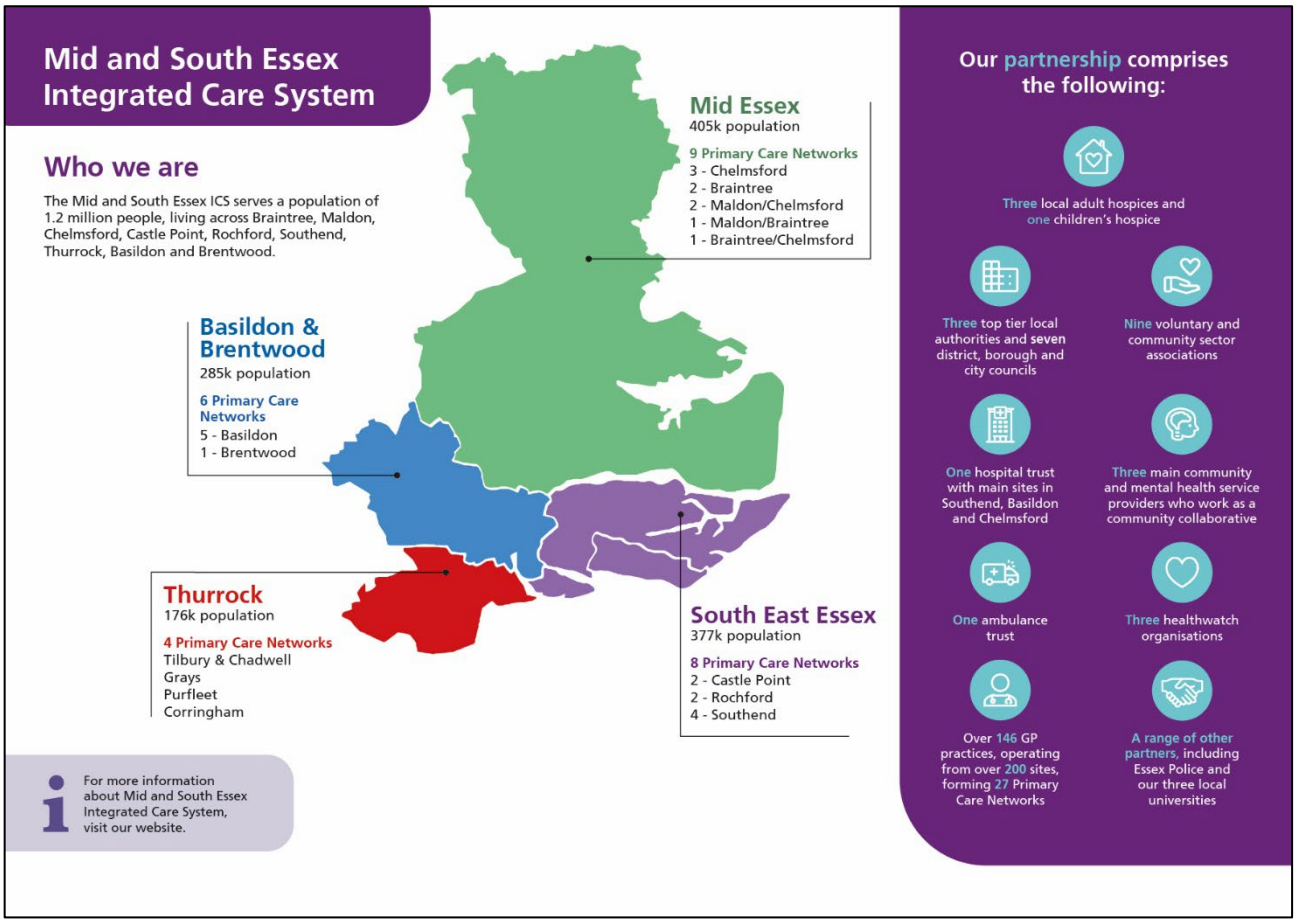
A workforce that is challenged due to capacity, lacking in experience and confidence, and further complicated by organisational specific policies and procedures in many cases.

Local Delivery Plan: Ambition Six – Each Community Is Prepared to Help

What we already know:

Mid and South Essex Integrated Care System (MSE ICS) serves a population of 1.3 million people across four place-based Alliances, which are local partnerships of many organisations across health, social care and the voluntary sector who work together to ensure the local population live well.

Alliances are further subdivided into teams and services consisting of Primary Care Networks, Integrated Neighbourhood Teams, community providers, secondary care, social, and care staff all working in an integrated multi-disciplinary, psychosocial model of care to improve the health and wellbeing of their local community whilst tackling health inequalities. All these stakeholders or providers (see diagram below) are associated with direct or indirect delivery of Palliative and End of Life Care for all ages.



What we have in place:

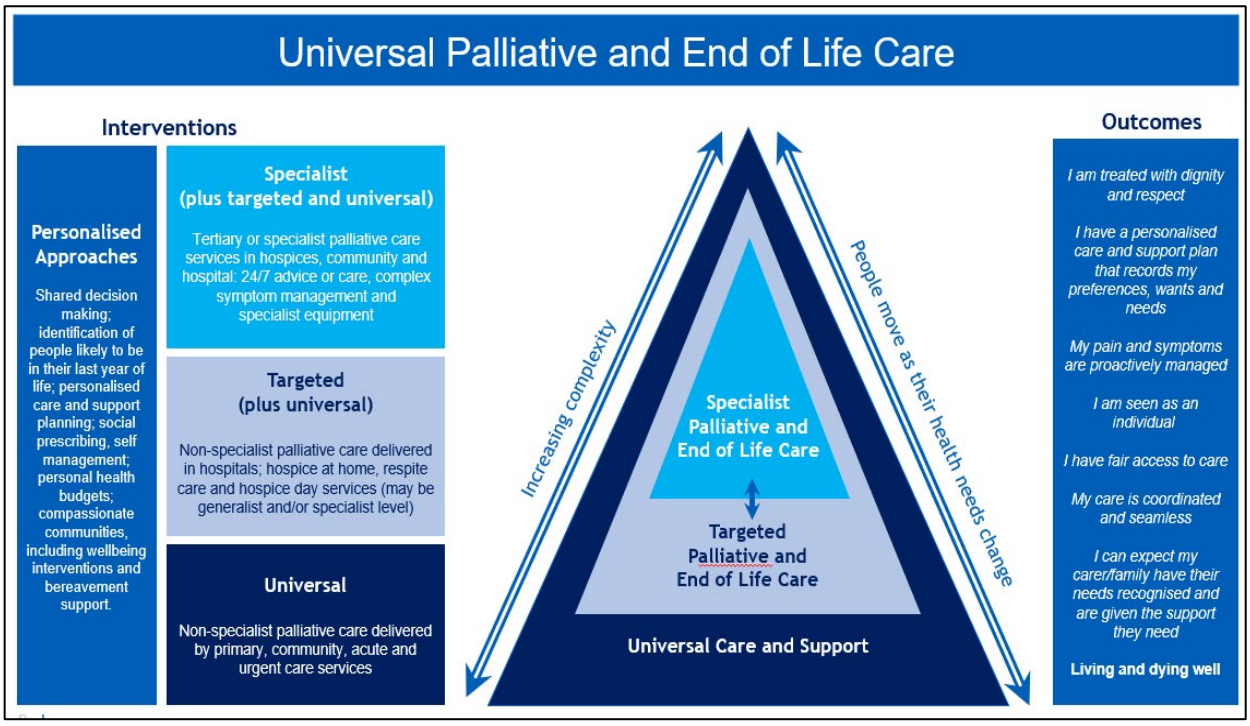
The development of Compassionate Communities, a collaborative approach of partners, whose aim is to create a social movement of compassionate communities across the Integrated Care System. Compassionate Communities enables a cultural movement that recognises and embraces dying, death and bereavement as a normal part of life, and activates our communities to care for and support one another during these times.

HPAL a public facing website that provides information and support for professionals and the public regarding PEOLC. Link: HPAL MSE

Definitions

This Strategic Delivery Plan uses the Universal model and definitions for the Palliative and End of Life Care for **all ages** as below[11]:

[11] B1674-specialist-palliative-and-end-of-life-care-services-adult-service-specification.pdf



Babies, Children and Young People (BC&YP)

Palliative Care

Babies, children, and young people's palliative care is an active and total approach to care, from the point of diagnosis or recognition to death and bereavement. It embraces physical, psychological, emotional, social, and spiritual elements and focuses on enhancement of quality of life for the baby, child or young person and support for the family. It includes the management of symptoms, anticipatory and parallel planning, complexity and crisis provision through death and bereavement. Palliative care is not dependent on diagnosis or prognosis and can be provided at any stage of the illness, not only in the last few days of life.

End of Life

The end-of-life stage begins when professionals caring for the baby, child or young person and their family recognise, that death may be imminent. This could be antenatally, following birth or during childhood. End of life care helps all those with advanced, incurable illness to live as well as possible in the final stages of their illness. This includes care during and around the time of death and immediately afterwards. It enables the supportive and palliative care needs of both the child or young person and their family to be identified and met throughout the last phase of life and into bereavement.

Adult

Palliative Care

The World Health Organisation (WHO 2021) definition: Palliative care is an approach that improves the quality of life of patients and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

End of Life Care

NHS England[12] states that the term 'end of life care' refers to the last year of life.

NICE (QS13) defines end of life as people (aged 18 and over) who are approaching the end of their life. This includes people who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life threatening acute conditions[13].

Specialist:

People approaching the end of life should have access to Specialist Palliative Care when this is needed. Specialist Palliative Care staff should be able to demonstrate how they have met the duties upon them to develop the capability of generalist staff to understand and support the physical and psycho-social needs of dying people. This should include a clear understanding of how to access medicines, equipment, and expert advice as part of the rapid response to changing needs.

The NHSE Specification for Specialist Palliative Care states[14]:

The main components are:

- specialist knowledge (specialist consultant and specialist nursing services as a minimum) to assess and manage physical, psychological, social, religious, and spiritual needs to reduce symptoms, suffering and distress.
- supporting analysis of complex clinical decision-making challenges where medical and personal interests are finely balanced by applying relevant ethical and legal reasoning alongside clinical assessment.
- providing specialist advice, support, education, and training to the wider care team who are providing direct core level palliative care to the person.

Generalist:

NHS Workforce handbook[15] defines generalist as:

- Comprising holistic approaches to both the health and wellbeing of the individual, and entire populations.
- Generalist approaches to healthcare delivery augment and potentiate specialist capability, ensuring that all healthcare professionals are confident at managing complex care across multiple, intersecting and overlapping physical and mental health services throughout their careers.
- Generalist skills improve patient experience and quality of healthcare reducing the need for patients to move between multiple specialists.

NICE CKS States[16]:

The aim of general palliative care is to provide:

- Information for the person and their careers, with 'signposting' to relevant services.

[12] NHS England » Palliative and end of life care
[13] Overview | End of life care for adults | Quality standards | NICE
[14] B1674-specialist-palliative-and-end-of-life-care-services-adult-service-specification.pdf
[15] Introduction | NHS England | Workforce, training and education
[16] Definition | Background information | Palliative care - general issues | CKS | NICE

- Accurate and holistic assessment of a person's needs.
- Co-ordination of care teams in and out of hours and across boundaries of care.
- Basic levels of symptom control.
- Psychological, social, spiritual, and practical support.
- Open and sensitive communication with the person, their careers, and professional staff.

Informing the Strategy: Mid and South Essex Population Health Needs Assessment

1. Local Assessments

Firstly, a self-assessment against the six ambitions of the Ambitions for PEOLC framework 2021 – 2026[15], this was refreshed in February/March 2025 and the NICE Quality Standards for end-of-life care for adults[17] in line with the statutory requirements for MSE ICB.

2. A Lived Experience Survey

Working together with the ICB commissioners and the MSE PEOLC Programme Board, the Mid and South Essex Hospice Collaborative Partnership (HCP) commissioned an all-age population survey to identify *"what people want and need during their palliative illness and end of life, what is their experience, what went well and what could be improved, including any barriers to accessing the right support at the right time."*

This was undertaken by Healthwatch Essex as an independent voice of patient advocacy. The survey received over 200 responses, mainly from bereaved relatives, and over 90 one-to-one interviews were undertaken, as well as focus groups. The views of under-represented groups were also specifically requested at the outset of the work.

The report findings highlighted some of the gaps and needs for care across our ICS:

- Poor communication and access to information are significant barriers to care.
- Highlighted the importance of:
  - 24/7 access to care and a single point of access
  - Good holistic symptom management
  - 24/7 robust access to end-of-life medications
  - Planning for the end of life
- Lack of suitable bereavement support, especially for children and young people.
- Need for a co-ordinated, multi-agency, system wide approach from the point of diagnosis to death in conjunction with timely information sharing between organisations and individuals involved.
- Partnership working between health and social care, and the community voluntary sectors, such as hospices, is key with assurance that views and needs of person and loved ones are sought, heard, and respected at every stage.

Whilst these findings do support the outcome of the Ambitions Benchmarking self-assessment, the MSE PEOLC Programme Board also acknowledge that there were some limitations to the survey. Therefore, findings may not be fully representative of the entire end of life experience across all care settings, and all ages, especially within the acute sector. However, as the first ever PEOLC Lived Experience survey across our ICS, the study still provides some informative data to help to shape our priorities for action. As part of an iterative Strategic Delivery Plan, the Programme Boards are committed to designing and conducting further qualitative studies

that are truly reflective of all experience in all care sectors and by all providers, providing real time feedback that will continually inform and shape our work plan.

Delivery of the Mid & South Essex PEOLC Strategic Delivery Plan

The Mid and South Essex Palliative End of Life Care Programme Board (MSE PEOLC PB) comprising of key stakeholders across the Integrated Care System (ICS). This reports through to the ICB via Finance and Performance Committee and the ICB Portfolio Group.

Authors
The Strategic Delivery Plan has been developed by representatives of the MSE Palliative and End of Life Care Programme Board, in addition to members of the MSE BC&YP Palliative and End of Life Steering Group.

Appendix One provides a list of those involved.

It has been ratified by the Mid and South Essex Palliative End of Life Care Programme Board, Growing Well Programme Board, and the Community Transformation and Improvement Board.

Appendix One: Those involved in the development of the document.

Appendix Two: References used to develop this document.

Appendix Three: Three Year Work Plan.

Appendix One

Acknowledgements

We would like to acknowledge and thank the key organisations and representatives who have been involved in reviewing and consulting on the Strategic Delivery Plan:

Mid Essex Alliance
Southeast Essex Alliance
Basildon & Brentwood Alliance
Thurrock Alliance
Mid and South Essex Hospitals NHS Foundation Trust (MSEFT)
PROVIDE CIC
Essex Partnership University Trust (EPUT)
Northeast London Foundation Trust (NELFT)
Farleigh Hospice
St Luke's Hospice
Haven's Hospices (including Little Havens)
Saint Francis Hospice
Macmillan Cancer Support
Marie Curie
Essex County Council (ECC)
Southend Borough Council (SBC)
Thurrock Council
Integrated Care 24 (IC24)
East of England Ambulance Service (EEAST)
Healthwatch Essex
Service Users via the Marie Curie Regional Report.

Appendix Two

References and Documents used for the development of this Strategic Delivery Plan.

- Palliative End of Life Care Statutory Guidance for Integrated Care Boards (September 2022)
- Palliative End of Life Care Handbook for Statutory Guidance for Integrated Care Boards (September 2022)
- NHS Long Term Plan (January 2019)
- Personalised Care Institute. Universal Personalised Care: Implementing the Comprehensive Model (2019)
- Adult Social Care Outcomes Framework 2023 - 24
- Working in partnership with people and communities: statutory guidance (October 2022)
- Next steps for integrating primary care: Fuller stocktake report (May 2022)
- Mid and South Essex ICS Integrated Care Strategic Delivery Plan (2023-2033)
- NHS Mid and South Essex Joint Forward Plan 2023 - 2028
- This Ambitions for Palliative and End of Life Care, a national framework for local action (2021-2026)
- The Future of Palliative and End of Life Care in Mid and South Essex. Report to Mid and South Essex Integrated Care Board, prepared by Hospice Collaborative Partnership (November 2022)
- The Lasting Impact of Covid-19 on Death, Dying and Bereavement, All Party Parliamentary Group Hospice and End of Life Care (March 2023)
- Specialist Palliative and end of life care services adult specification (January 2023)
- National Institute for Health and Care Excellence. End of life care for adults. Quality Standard 13 (Updated September 2021)
- Specialist Palliative and end of life care services children and young people specification (January 2023) - https://www.england.nhs.uk/publication/service-specifications-for-palliative-and-end-of-life-care-children-and-young-people-cyp/
- The All-Party Parliamentary Group (APPG) for Children who need Palliative Care enquiry report of October 2018 Pol_Res_181019_APPG_Children_Who_Need_Palliative_Care_inquiry_report.pdf (togetherforshortlives.org.uk)
- Caring for a child at end of life, Together for Short Lives, October 2019 - https://www.togetherforshortlives.org.uk/resource/guide-end-life-care/
- End of life care for infants, children and young people with life-limiting conditions: planning and management – NICE Guidelines (Published 2016 / Updated 2019)
- The Inbetweeners: A review of the barriers and facilitators in the process of the transition of children and young people with complex chronic health conditions into adult health services (2023) - NCEPOD

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- The Future of Palliative and End of Life Care in Mid and South Essex. Report to Mid and South Essex Integrated Care Board, prepared by Hospice Collaborative Partnership (November 2022)
- Marie Curie Experiences of Palliative and End of Life Care in East of England (Lived Experience) Survey
- https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/a-manifesto-for-palliative-and-end-of-life-care-october-2023.pdf A manifesto for palliative and end of life care October 2023
- Fraser et al 2021 Estimating the current and future prevalence of life-limiting conditions in children in England https://pubmed.ncbi.nlm.nih.gov/33323043/
- https://spcare.bmj.com/content/bmjspcare/early/2024/11/28/spcare-2023-004673.full.pdf Bedendo et al (September 2024) End of life care in paediatric settings: UK national survey
- Short Lives Cant Wait: the state of children's palliative care in 2024 A report by Together for Short Lives (19th June 2024)

Appendix 3 - Three Year Work Plan

Personalised Care Planning which is shared to support care	Plan: - Build on the EPaCCS and PEACE work with greater emphasis on roll out with Alliances leading at a local level. - Ensure EPaCCS is utilised. - Embedding CYPACP into systemwide practice, including education on the use of ReSPECT for BC&YP - EPaCCS for BC&YP development, implementation and roll out. - Enabler - Use of FrEDA as a common delivery tool to be adopted by all provider front line staff. - Promote the use of the GSF framework and Prognostic Indicator Guide Promote the use of the GSF framework and Prognostic Indicator Guide indicators tool, as well as using other validated markers such as Clinical Frailty Scoring which can improve both accuracy and timeliness in identifying more adults who are likely to be nearing end of life. - Enabler - Training and Education of staff providing EoL Care	By: 31/03/2026 31/03/2026 31/03/2026 31/03/2026 31/03/2027 31/03/2027
Care Model – reducing variation	Plan: - Reduce variation in service offer, through provider alignment. - Review services against national expectations, 2025/26 Operational Plan (standardising community services planned/reactive offer) and identify gaps/ efficiencies/opportunities. - Ensure services use consistent definitions (agreed through 2024/25 24/7 mapping) - Work with Specialist Services to review against national specifications and identify gaps opportunities	 31/03/2027 31/03/2026 31/03/2025 31/03/2026
Bereavement Care	Plan: - Ensure promotion of current services through HPAL website with additional work being undertaken to ensure up to date BC&YP information is included. - Ensure after death care is consistent offer as first line of support. - Widen range of services who can verify expected death	 31/03/2026 31/03/2028 31/03/2028

Appendix 3 - Three Year Work Plan

Using the data for local Alliance based delivery	Plan: - Ensure that datasets for adults and BC&YP are used to inform local workplan and conversations between partners to improve experience and outcomes for the local population. - Accessibility of data and shared care records beyond health providers (social care, domiciliary care, and care homes)	31/03/2027 31/03/2028
Care Model – reducing variation	Plan: - Reduce variation in service offer, through provider alignment. - Review services against national expectations, 2025/26 Operational Plan (standardising community services planned/reactive offer) and identify gaps/ efficiencies/opportunities. - Sharing of Audits outcomes to show how services are achieving the five priorities of the dying person[1] - Adopting and using technology to support individuals with their care (e.g. remote monitoring, virtual consultations)	31/03/2027 31/03/2026 31/03/2026 31.03.2027
Service outcomes	Plan: - Ensure services use person-centred outcome measures that can be shared to enable services to be held to account. With independent analysis of a consistent data set, improvement can be tracked, and regulatory actions taken to ensure all providers are enabling fair access to care. - Implementation and adoption of validated outcome measures across services (IPOS, CPOS) and sharing the outcomes to support service improvement	31/03/2027 31/03/2026 (CPOS subject to national roll out)

[1] One Chance to get it right

Part I Board Meeting, 15 May 2025

Agenda Number: 9

NHS Resolutions Clinical Negligence Scheme for Trusts – Maternity Incentives Scheme Year 6

Mid and South Essex LMNS Evidence Assurance Process

Summary Report

1. Purpose of Report

To provide the Board with assurance of Mid and South Essex's NHS Foundation Trust (MSEFT) evidential compliance with the ten maternity safety actions required for year five of the Clinical Negligence Scheme for Trusts, Maternity (perinatal) Incentive Scheme (MIS).

2. Executive Lead

Dr Giles Thorpe, ICB Executive Chief Nursing Officer

3. Report Author

Gemma Hickford, MSE Local Maternity and Neonatal System (LMNS) Consultant Midwife

4. Responsible Committees

MSE Local Maternity and Neonatal System Steering Board and MSEFT Perinatal Assurance Group.

5. Link to the ICB's Strategic Objectives

- To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop effective oversight and assurance of healthcare service delivery across Mid and South Essex ensuring compliance with statutory and regulatory requirements.

- To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.

- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Impact Assessments

Not applicable.

7. Financial Implications

It is important to note that Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their Clinical Negligence Scheme for Trusts (CNST) maternity premium contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

8. Details of patient or public engagement or consultation

This process of LMNS assurance has not directly involved the MSE Maternity and Neonatal Voices Partnership (MNVP), however evidence for the Maternity Incentives Scheme (MIS) Safety Action six directly reflects how as an organisation MSEFT 'Listen to women, patients and families using maternity and neonatal services and coproduce services with users.'

9. Conflicts of Interest

None identified.

10. Recommendation

The ICB Board is requested to note the content of this report for assurance and seek any further assurance required.

NHS Resolutions Clinical Negligence Scheme for Trusts Maternity Incentives Scheme Year 6

Mid and South Essex LMNS Evidence Assurance Process

1. Introduction

The Maternity Incentive Scheme (MIS) supports the delivery of safer maternity and neonatal care through an incentive element linked to trust contributions to the Clinical Negligence Scheme for Trusts (CNST). The scheme rewards trusts that meet all ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. Obstetric incidents can be catastrophic and life-changing, with related claims representing the CNST's biggest area of spend. Of the clinical negligence claims notified in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number but accounted for 62 per cent of the total value of new claims; almost £6 billion.

To be eligible for payment under the scheme, Trusts must have submitted a completed Board declaration to NHS Resolution by noon on 3 March 2025. In addition, the CEO of the Trust is required to ensure that the Accountable Officer (AO) for their Integrated Care Board (ICB) is appraised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the MIS Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

2. CNST Evidence Assurance Process

To support MSEFT's internal evidence assurance process and to ensure a robust and transparent approach to inform the ICB's Accountable Officer's declaration and sign off, the Local Maternity and Neonatal System led its own evidence assurance process, with the involvement of NHS England (NHSE).

The LMNS received evidence in January 2025 reflecting all ten safety actions following signoff from the MSEFT Evidence Assurance Group (EAG). This has a core membership that reflects both internal and external stakeholders, including representation from the ICB and NHSE regional maternity team.

The LMNS then worked closely with the two NHSE Maternity Improvement Advisors, Sandra Smith (Midwife) and Sonji Clarke (Obstetrician), to review the evidence provided by MSEFT and followed this up by meeting with the senior leadership team to clarify any areas that remained outstanding. The Director of Midwifery, Heads of Midwifery, Consultant Midwives, Maternity Compliance Administrator and associated Trust safety action leads engaged with the LMNS and NHSE colleagues until this process was completed.

Following a review of the evidence the LMNS Consultant Midwife and NHSE Maternity Improvement Advisors were assured of the Trust's full compliance with all ten safety actions.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

3. Conclusion

Following the evidence assurance process, MSE LMNS are assured that MSEFT have met the required standards and minimum evidential requirements to declare full compliance with the CNST MIS year 6 ten safety actions.

The hard work undertaken by MSEFT, and its maternity and neonatal teams is to be acknowledged and commended, recognising the extensive evidence required to demonstrate full compliance for year 6 of the scheme. The Trust has demonstrated an ongoing commitment to deliver best practice within its maternity and neonatal services and the delivery of safer care.

4. Recommendation

Mid and South Essex LMNS recommends to the ICB, that Trust evidence meets the required standard and demonstrates full compliance with the CNST MIS year 6 ten safety actions.

The ICB Board is therefore requested to note the content of this report for assurance and seek any further assurance required.

5. Appendices

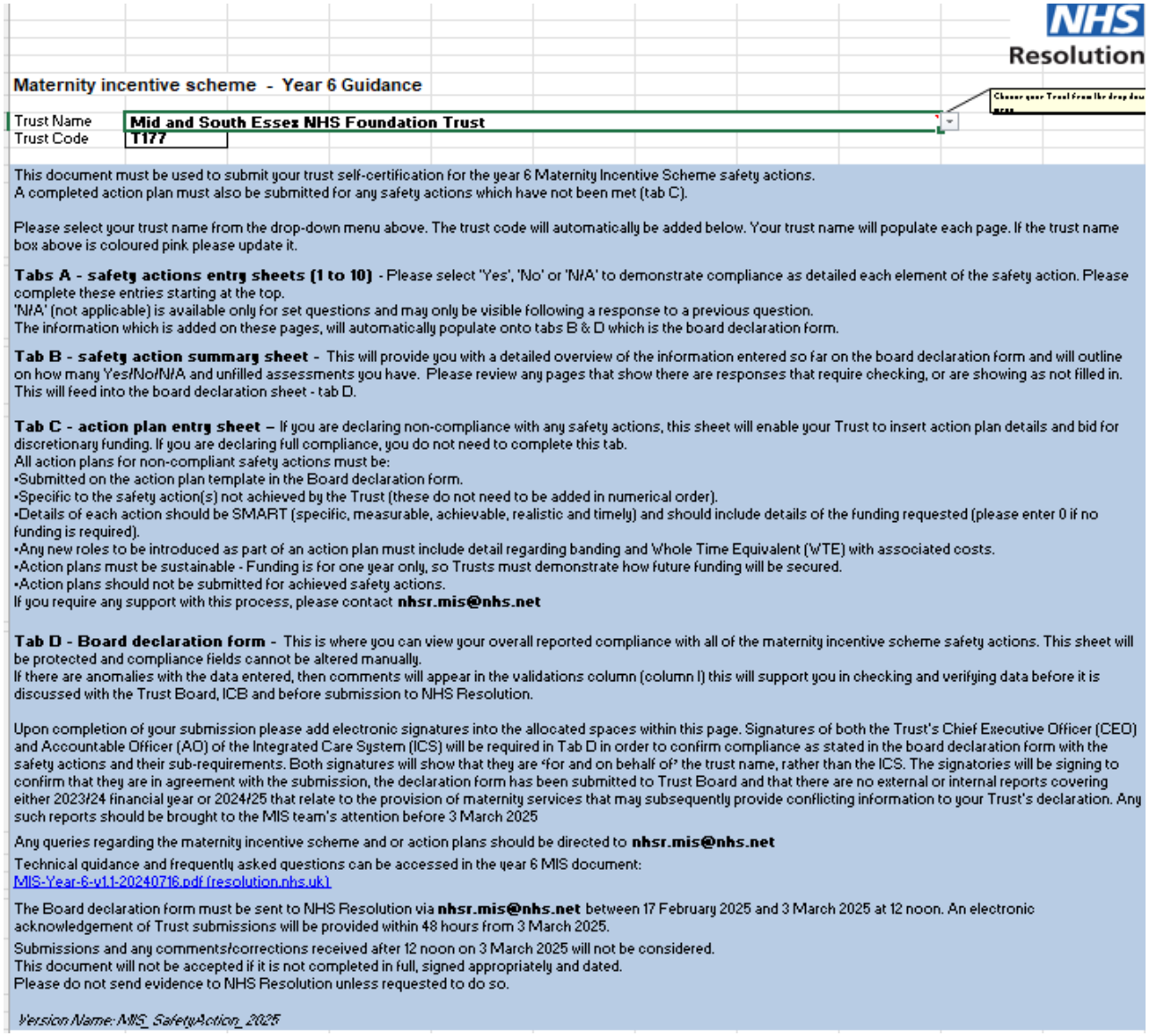
Appendix A – CNST MIS Year 6 Declaration form for MSEFT.

Part I Board Meeting, 15 May 2025

Agenda Number: 9

NHS Resolutions Clinical Negligence Scheme for Trusts – Maternity Incentives Scheme Year 6

Appendix A – CNST MIS Year 6 Declaration form for MSEFT



NHS Resolution

Maternity incentive scheme - Year 6 Guidance

Trust Name	**Mid and South Essex NHS Foundation Trust**
Trust Code	**T177**

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust Board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2		
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3		
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4		
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

Safety action No. 5		
Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: • Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. • The midwife to birth ratio • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety action No. 6		
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7		
Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8		
Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10		
Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Section A : Maternity safety actions - Mid and South Essex NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	12	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

NHS Resolution

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**Mid and South Essex NHS Foundation Trust**
Trust code	**T177**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Part I Board Meeting, 15 May 2025

Agenda Number: 10.1

Greater Manchester Mental Health Report

Summary Report

1. Purpose of Report

This report provides an overview of key quality and safety issues and progress pertaining to the Greater Manchester Mental Health Report.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Shelley Wallace, Quality Lead Nurse – Mental Health

4. Responsible Committees

Quality Committee. The committee reviewed this report on 25 April 2025. A further update has been requested for the June committee meeting.

5. Link to the ICB's Strategic Objectives

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop effective oversight and assurance of healthcare service delivery across Mid and South Essex ensuring compliance with statutory and regulatory requirements.

- To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.

- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Conflicts of Interest

None identified

7. Recommendation/s

The Board is requested to review the content of this report for informational and assurance purposes, and to identify any further information or clarifications needed.

Independent Review – Greater Manchester Mental Health NHS Foundation Trust Report

1. Introduction

The Greater Manchester Mental Health Report (GMMHR) is an independent investigation commissioned by NHS England, spearheaded by Oliver Shanley, a senior NHS leader with over 30 years of experience in mental health services. This review was initiated following the airing of the Panorama current affairs programme in September 2022, which raised concerns regarding the care provided at the Edenfield Centre in Prestwich, Greater Manchester, run by Greater Manchester Mental Health NHS Foundation Trust.

The primary focus of the review was to investigate the reported incidents of abuse and substandard care that patients experienced at the centre. However, the findings also shed light on broader governance issues within the wider Trust. The report uncovered a series of systemic failures, including inadequate care, ineffective and 'disconnected' leadership, a lack of psychological safety for staff, low staff morale, unsafe staffing levels, a culture of nontransparency, and subpar physical facilities that further compromised the quality of patient care.

The final GMMHR, published in January 2024, detailed these findings and offered a comprehensive set of recommendations aimed at addressing the identified deficiencies. In total, the review outlined eleven key recommendations designed to improve governance, patient safety, leadership effectiveness, and overall care standards within the Trust.

2. Main content of Report

In response to the GMMHR, the Mid and South Essex Integrated Care Board (MSEICB) formally requested that the mental health service providers, Essex Partnership University NHS Foundation Trust (EPUT) and North East London NHS Foundation Trust (NELFT), present a detailed overview outlining their actions and responses to the eleven recommendations outlined in the report.

The responses provided by EPUT (Appendix 1) and NELFT (Appendix 2) offer clear and comprehensive insights into how each Trust is addressing the specific recommendations. Both organisations have presented their positions in relation to the recommendations, highlighting the measures being implemented to rectify the issues identified and improve patient care, governance, leadership, and operational effectiveness.

This report provides a summary of the responses submitted by both EPUT and NELFT, offering a high-level overview of their plans and progress. The full, detailed submissions from both trusts are included as appendices for further reference and transparency. These submissions provide in-depth information on the strategies, timelines, and actions being taken to ensure compliance with the recommendations and to foster continuous improvement in service delivery.

Recommendation 1 - Patients, Families and Carers.

EPUT have a dedicated lived experience team within the organisation. Recognising the importance of this team, EPUT acknowledges the need to further develop a peer-

led Meeting Pack Page 33 workforce across its six care units. This development will include enhanced engagement with a more diverse range of communities to ensure broader representation.

However, several challenges have been identified in this process, particularly around access to training and development opportunities. For the lived experience team to fully integrate, they need to be registered on the Electronic Staff Records (ESR) system and provided with NHS email accounts, both of which are essential for seamless participation in training and organisational processes.

Meanwhile, NELFT has implemented the Patient and Carer Race Equality Framework (PCREF), ensuring that racial equality is embedded within its services. Additionally, NELFT has prioritised the inclusion of patients, families, and carers through the Patient Safety Incident Response Framework (PSIRF), ensuring that their voices are consistently heard and considered.

Furthermore, both EPUT and NELFT actively engage individuals with lived experience in various aspects of service development, delivery, and monitoring. These efforts ensure that lived experience is not only acknowledged but is integral to shaping services that are responsive to the needs of the community.

Recommendation 2 – Strengthen Clinical Leadership.

Through its gap analysis, EPUT identified the need to establish greater clarity around roles and responsibilities within care unit leadership teams. As part of this work, the roles of Deputy Director of Quality and Safety (DDQS) and Deputy Medical Director are currently under review to ensure consistency and equity in role scope and function across the organisation.

Additionally, EPUT has recognised the need for the Patient Safety Team to refine its approach, particularly in terms of communication methods and tone, to align more closely with the Trust's target operating model. Furthermore, the Trust acknowledges the importance of enhancing its ability to proactively identify emerging safety risks. To support this, efforts are being made to develop systems capable of horizon scanning and the triangulation of data across services, strengthening early identification and mitigation of patient safety concerns.

In parallel, NELFT has undertaken significant organisational restructuring, resulting in enhanced clinical leadership across all directorates. Each directorate now benefits from a strengthened senior leadership team comprising professionals from medicine, nursing, psychology, operations, and allied health disciplines. This multidisciplinary leadership approach ensures a more cohesive and responsive management structure, with a focus on integrated, high-quality care delivery.

Recommendation 3 – Organisational Culture.

EPUT are actively engaged in ongoing, organisation-wide cultural reviews to support the development of a safe, transparent, and inclusive working environment. These reviews are complemented by regular, in-person executive engagement across both community settings and inpatient wards. EPUT continues to strengthen and embed proactive mechanisms such as the Freedom to Speak Up (FTSU) initiative, promoting openness and psychological safety among staff.

A central element of EPUT's cultural development strategy is the promotion of accountability, ensuring that staff are supported to consistently meet professional standards. Mechanisms are in place to provide regular feedback, including the formal recognition of staff achievements, which contribute to appraisal outcomes and career progression.

NELFT demonstrates a strong commitment to Equality, Diversity and Inclusion (EDI). Cultural intelligence training is regularly incorporated into trust-wide learning events, enhancing staff awareness and sensitivity to diverse patient and workforce needs. NELFT's FTSU process is well-established, with strong levels of engagement across the organisation.

In relation to governance and organisational learning, NELFT has made significant improvements since the implementation of the PSIRF. The Trust has established ten distinct learning workstreams, each led by a dedicated senior lead. These workstreams facilitate the systematic identification, analysis, and dissemination of learning across the organisation, strengthening its ability to drive continuous improvement and ensure consistent, high-quality care.

Recommendation 4 – Workforce Planning & Managing Risk.

Staff survey results from EPUT have highlighted the need to strengthen the connection between the Board, senior leadership, and frontline staff. A key priority for the organisation is developing leadership capability to ensure a consistent and robust approach to addressing incidents of staff abuse and promoting a positive workplace culture.

EPUT continues to make progress in reducing workforce vacancies across all service areas, thereby decreasing reliance on temporary staffing. Strategic initiatives include the conversion of student placements into substantive roles and the integration of lived experience advisors and peer support workers. These measures are intended to enhance both workforce stability and the overall staff experience.

NELFT is addressing workforce challenges through several targeted capacity and improvement workstreams. These include the recruitment and ongoing support of international nurses, initiatives to encourage the return of retired professionals, and programmes to facilitate return-to-practice pathways.

NELFT also plays a key role in the expansion and delivery of Mental Health Support Teams across the organisation. This includes the development of a new workforce through the implementation of national Recruit to Train programmes, further supporting the sustainability of mental health services.

Recommendation 5 – The Quality of Estate.

EPUT has established systems to ensure that the internal care environment remains clean, safe, and fit for purpose. The Trust is also adopting innovative technologies to enhance operational efficiency and support the adaptability of its estate, recognising the need for flexible use of buildings and clinical spaces.

NELFT have strengthened its estates leadership capacity through the appointment of a Director of Estates, reflecting its commitment to improving and maintaining high-quality care environments across its services.

Recommendation 6 – Governance Framework.

EPUT has identified the need to enhance the resourcing of its governance functions to effectively support the operational and strategic requirements of the organisation. This includes the rationalisation of internal meetings and the refinement of its governance framework to ensure effective information flow and actionable insight is accessible across all staff levels. In addition, the Trust has recognised the importance of designing and implementing a comprehensive Quality Management System (QMS), alongside the development of staff competence and training programmes aimed at supporting a cultural reset around the delivery of high-quality care.

NELFT has undertaken a refresh of its governance framework, ensuring clear escalation and assurance pathways from frontline services through to board level. Distinct corporate functions, including safeguarding, complaints, and FTSU are structured to ensure clarity of roles and accountability. NELFT also leverages digital tools such as Power BI to identify emerging trends and areas of concern, including data derived from Patient Safety Incidents. These insights inform monthly assurance meetings led by Associate Directors of Nursing and Quality, who also contribute to learning and oversight through regular participation in Incident Review Groups.

Recommendation 7 – The clinical care model at Edenfield, including staff capacity and skills.

EPUT recognises that enhancing transparency and clarity in its reporting mechanisms, governance processes, and the scrutiny of information is essential to driving timely and effective action. Strengthened governance will support the organisation in maintaining momentum for change and ensuring that issues are addressed in a system-wide context rather than in isolation.

NELFT has transitioned to a clinically led model of service delivery, supported by targeted investment in clinical leadership and the development of evidence-based care models. This approach is further reinforced by a dedicated National Institute for Health and Care Excellence (NICE) and Clinical Audit team, which provides strategic oversight and operational support to ensure services are aligned with best practice standards.

Recommendation 8 – The Content and Implementation of the Improvement Plan.

EPUT acknowledges the importance of clearly articulating areas requiring improvement and is committed to developing a structured and prioritised work plan. This plan will be sequenced appropriately to ensure deliverability and will be co-produced with input from both service users and clinicians. A key focus will be the definition and application of clear impact measures to monitor progress and effectiveness.

NELFT is actively addressing the issues highlighted within the GMMHR, with an emphasis on embedding learning and tackling any systemic or organisational challenges. These efforts are subject to oversight through established governance mechanisms, including the Care Quality Commission (CQC) Assurance Group and ongoing learning and improvement events.

Recommendation 9 – Assurance around other services, including ligature risks and learning from deaths.

EPUT has outlined that robust systems are in place to ensure the lived experience and expertise of patients and families are central to its quality and improvement processes. These perspectives are triangulated with data, intelligence, and staff-reported quality concerns and improvement suggestions to provide comprehensive and meaningful oversight across the organisation.

NELFT reports significant advancements in governance related to organisational learning. Frontline staff are actively engaged from the point of incident identification through to the development and implementation of action plans. The implementation of the PSIRF has further strengthened learning and governance processes, ensuring that lessons learned are systematically disseminated and embedded across all services and teams.

Recommendation 10 – A review of the Provider Collaborative.

EPUT's system partners continue to play a key role in supporting the Trust to maintain a focused and outcomes-driven approach. This includes facilitating the identification of priority areas, driving measurable improvements, and modelling compassionate leadership at a system level—recognised as essential for delivering sustainable cultural and service transformation.

The MSE ICB, through their mental health leadership and expertise, maintain appropriate oversight, ensuring that staff involved have the necessary experience and seniority to identify and respond to quality concerns. EPUT remains committed to collaborative working with system partners, promoting effective information sharing, joint understanding, and timely responses to emerging issues.

NELFT reports that its inpatient services maintain consistent and proactive engagement with colleagues from the Provider Collaborative, ensuring that clinical care, service planning, and strategic objectives are aligned across organisational boundaries. This collaboration supports a more integrated approach to care delivery, facilitating the sharing of best practices, joint decision-making, and collective ownership of patient outcomes.

Through this engagement, NELFT contributes to a system-wide governance framework that enhances transparency, accountability, and the ability to respond to emerging quality and safety concerns. Regular interaction with the Provider Collaborative enables real-time feedback, shared learning, and coordinated interventions, which are essential in maintaining high standards of care and supporting the delivery of improved mental health outcomes across the region.

Recommendation 11 – A need for system-wide learning from Edenfield, including how partners work together to identify and respond to services in distress.

EPUT has requested that NHS England review and provide clarification regarding the role of the Greater Manchester Adult Secure (Northwest) Provider Collaborative, including an assessment of the governance structures and any potential implications for other provider collaboratives.

NELFT reports that it recently held a learning event where the author of the Greater Manchester Mental Health Report (GMMHR) presented the findings. During this event, NELFT also outlined the ongoing work within the organisation and shared key initiatives being undertaken. Additionally, NELFT has organised similar learning events in collaboration with system partners to ensure shared understanding and coordinated efforts.

3. Findings/Conclusion

Following the publication of the GMMHR, a set of key recommendations was identified to address areas of concern and drive improvements across the mental health care system. In response to these recommendations, both EPUT and NELFT have conducted detailed reviews and provided comprehensive updates on their actions and progress.

These updates indicate that significant strides have been made in several critical areas, with both Trusts demonstrating good practice and positive developments that align with the recommendations. Notable improvements include the enhancement of leadership structures, increased engagement with patients and families, and better governance mechanisms aimed at ensuring safer, more effective care. These actions highlight a commitment to addressing the issues raised in the report and improving care for individuals with learning disabilities and autism.

However, while progress is evident, there remain areas that require further work to ensure full and consistent compliance with the GMMHR recommendations. Some of the initiatives are still in the process of being fully embedded across services, and additional steps need to be taken to ensure that the systems in place are sustainable, adequately resourced, and capable of delivering long-term change.

To provide full assurance to the MSE ICB and NHS England, further evidence of the impact and outcomes of these efforts will be necessary. This includes ensuring that all actions outlined in the response to the GMMHR are fully implemented, rigorously monitored, and that their effectiveness is demonstrated. A continued focus on addressing any gaps in the implementation process, including further engagement with staff, service users, and system partners, is critical to ensuring that the recommendations lead to tangible improvements in care quality and safety.

As part of this ongoing process, it is essential that both EPUT and NELFT continue to work collaboratively with their system partners, engaging in regular reviews and updates to track progress and adapt strategies as needed. The ultimate goal is to ensure that all aspects of the GMMHR recommendations are not only met but are also sustained and integrated into the fabric of service delivery moving forward.

4. Recommendation(s)

The Board is requested to review and acknowledge the contents of this report for informational and assurance purposes. Additionally, the Committee may request any further information as needed. The report authors recommend that EPUT and NELFT provide a progress update in June 2025 regarding the implementation of the recommendations.

5. Appendices

Appendix 1 - EPUT Response

Appendix 2 - NELFT Response

NHS
Essex Partnership University
NHS Foundation Trust

Trust Response To the Greater Manchester Mental Health Report

September 2024

EPUT

Background

This report provides the framework for the programme of work to review the Independent Review of Greater Manchester Mental Health NHS Foundation Trust (published January 2024) following the BBC broadcast Panorama (September 2022). Whilst the review focused on the abuse and poor care of patients at the Edenfield Centre in Prestwich, Greater Manchester it also offered insights to the governance of the wider organisation.

An independent review commissioned by NHS England and led by Oliver Shanley, a senior NHS leader with 30 years' experience in mental health settings, investigated what took place at Edenfield. The team spoke to over 400 people about the "horror" of what was shown in the BBC film and found a "striking" level of distress among patients, families, and staff. The report highlighted a catalogue of failures at the trust, including poor care, poor and "disconnected" leadership, lack of psychological safety and low staff morale, unsafe nursing levels, a lack of openness, and poor physical environment.

Introduction

For EPUT there are some parallels to be drawn with our own experience of the Channel 4 Dispatches Programme (October 2022). Following the report, EPUT using feedback gathered during engagement events including a presentation by Oliver Shanley to the senior leadership team, alongside feedback gathered from frontline staff and patients reflects the Trust position against each recommendation.

The following slides shows the Trust position against each recommendation with the additional opportunities identified to learn and improve our care delivery. The approach taken involves reviewing and appraising each strategy that aligns with each recommendation and adapting the implantation plan to include these areas of improvement that will report into the relevant sub committee of the Board and to the Trust Board.

One of the key learning points from the Independent Review was the importance of listening to service users and their carers. We have been working hard to improve our listening skills and creating more opportunities for service users and carers to have a voice and to be directly involved in the work that we do and the decisions we make.

Area for Improvement Patients, families and Carers:

GMMH had not kept patients, families and carers at the centre of their service delivery.

It missed opportunities to hear the voices of patients, families and carers when services failed to meet expectations and, in the case of Edenfield, care has sometimes been abusive, unkind and unsafe.

The previous strategies in relation to engagement with patients, families and carers have not been fully effective.

EPUT has appraised its enabling strategy working in partnership with people and communities. This new Trust Strategic Plan launched in January 2023, with lived experience, service user involvement, co-production, patient partnership, and peer support highlighted throughout was co produced with patients, families, carers and key stakeholders. It details the 3 year plan where the trust will continue to strength partnerships with patients and families as partners in care.

The EPUT Lived Experience team was formed due to the work underpinned in the previous Involvement Strategy 2021 – 2023. This is now 190 strong, and growing at rapid rate. It is formed of people with lived or living experience of community and mental health services, be it as a patient, service user, or a supporter, parent or carer. Their input is invaluable to everything we do together.

Since April 2021 EPUT has had a Director of Patient Experience, and professional lead for developing the Trust's capability for public participation and lived experience. Further to this the patient experience directorate is now well established, and continuously improving.

The Reward and Recognition Policy is now well established and being utilised to remunerate our Lived Experience team. Along with this there are supporting systems and processes that have made getting involved less complicated.

I Want Great Care launched at EPUT in January 2022 and whilst uptake started slowly, we have seen a progressive increase in response rates from those on the receiving end of our services. In addition to this, we are nurturing a network of peer networks to support and enhance our ability to listen to, and collaborate with, people using our services.

Area for Improvement Patients, families and Carers :

Recommendation 1 :

The Trust must ensure that patient, family and carer voices are heard at every level of the organisation.

The Trust must respond quickly when people experience difficulties with the services they receive and make lived experience voices central to the design, delivery and governance of its services..

Gap Analysis Findings:

- Despite the development the Trust has experienced in lived practitioners since 2021, there is a need to develop a peer led workforce at a care unit level.
- All involvement activity that qualifies for reward and recognition is funded centrally and this will be impacted by financial pressures in the system.
- We need more involvement from people who understand our services from a diverse range of communities is vital for us to partner in a meaningful way. Equality, diversion and inclusion must underpin our development.
- Training generally for our Lived Experience team is challenging. Access, and a clear programme of training development is key.
- Giving our Lived Experience team access to our training environment is difficult, and requires them being set up on ESR and having an NHS mail account.
- Having a clear carers strategy that listens and supports carers and families

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board.

Trust Lead – Zephan Trent, Executive Director of Strategy, Digital and Transformation

Timescale – 2024-2027

Area for Improvement Clinical Leadership:

The voice of clinicians was undervalued and weak in the GMMH . The investigation heard this from all professional groups, and especially from direct care nursing staff. It has been further muffled by a more dominant operational voice.

The organisation needs to develop and nurture a strong clinical voice that is present at every level and in every forum across the organisation, so that clinical quality is at the centre of every decision made.

The Trust's Operating Model is based around six clinical operational delivery units which are led by multi-disciplinary and multi-professional leadership teams. They are supported and corporately enabled from corporate business units. This model supports a leadership model that includes clinical and quality leadership roles

The EPUT Trust Executive commissioned an external review to consider progress in delivering the new target operating model and the Accountability Framework. A key focus of the review was to seek feedback from the Care Units on progress, the effectiveness of the enabling corporate functions and business partnering approach.

The review was also asked to consider what organisational development is required to develop the sharing of accountabilities across Care Unit leadership teams and to achieve a broad ownership of the agenda; the thread from services to Board committees through the Accountability Framework and Executive Team (Ward/Service to Board); a review of the KPIs to be used in 2024/25; progress against the internal audit report on the Accountability Framework; and to make recommendations about the future structure of the Care Units.

The Trust will shortly agree the recommendations with an implementation plan to be developed that will develop and nurture clinical voice and presence across the organisation.

Area for Improvement Clinical Leadership:

Recommendation 2 :

A strong clinical voice must be developed and then heard and championed from Board to floor, and in wider system meetings.

Gap Analysis Findings:

- Develop clear roles and responsibilities for the Care Unit Leadership Team with a developmental plan.
- The Patient Safety team need to change their approach, tone and method of communication in line with the Target Operating Model.
- The breadth of the DDQS and Deputy Medical Director roles in MSE should be reviewed. The remit is wider and more complex than in many other Care Units, yet the resource is the same.
- The Medical management model needs to change in line with the Target Operating Model.
- The new Quality and Safety KPIs should replace the existing KPIs in the Accountability Framework once they are approved by the Trust Executive
- Ensure that governance functions are adequately resourced to meet the needs of the size of the Trust.
- Developing systems that proactively scan for safety concerns across all services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board

Trust Lead – Alex Green, Chief Operating Officer

Timescale – 2024-2027

Area for Improvement Culture:

The culture of an NHS organisation is determined by the Trust Board. The GMMH Board allowed a dysfunctional executive team with a culture that valued operational performance above clinical quality. The Board did not balance its responsibilities to its external environment with its responsibilities to its internal quality of services. It had a poor patient safety culture, and the investigation heard consistent reports of management behaviours at every level across a number of services that discouraged and suppressed staff speaking up about quality concerns. This had a major impact on the Trust's ability to deliver safe care..

We want a consistent culture across EPUT where staff are willing to solve problems creatively with their teams and other directorates and where permission and guidelines are not used as absolute rules. We want our culture to move towards greater empowerment across the organisation so we can all find patient centric solutions.

Since the North Essex Partnership and South Essex Partnership NHS Trusts merged over six years ago, we have continued to develop our culture across EPUT with a single set of values and behaviours. Where there are differences, and we can learn from each other, we will share best practice to enable us all to be the best that we can be.

Similarly across the different systems and three Integrated Care Boards we work within, we have opportunities for further learning, partnership approaches and sharing across the different geographical areas of our organisation.

Our staff survey results show that our colleagues' experiences at work are significantly improving in many areas. Where people do not behave in line with our values and behaviours we will challenge this and will ensure that where performance and behaviour are not consistent with our vision for a high performing organisation, this is addressed.

Our Speak Up, Listen Up, Follow Up campaign has been very well received and people are feeling more confident about speaking up.

We have signed up to the NHS Sexual Safety Charter which will help us to ensure the sexual safety of our staff and patients across all our sites.

Well-being is at the centre of our culture and our staff are our number one asset – we need to build on our current offer with staff and build psychological safety as our priority.

Area for Improvement Culture:

Recommendation 3:

The Board must develop and lead a culture that places quality of care as its utmost priority, which is underpinned by compassionate leadership from Board to floor.

This culture must ensure that no staff experience discrimination.

Gap Analysis Findings:

- Holding regular organisation-wide cultural reviews and ensure actions are met
- Having regular in-person Executive engagement in the community and on wards, and include in objectives
- Continue to embed the Freedom to Speak Up approach, including proactive interventions that allow staff to come forward sooner.
- Remodel staff recognition to ensure there is consistent, in-person, and senior acknowledgement of achievements, and recognition that counts towards appraisal and progression
- Establish regular drumbeat of staff feedback via procurement of staff engagement platform, that also supports the annual staff survey
- Focus on creating a culture of accountability across the organisations, supporting staff to meet standards, and communicating the consequences of not doing so
- Focus on creating a culture of accountability across the organisations, supporting staff to meet standards, and communicating the consequences of not doing so.

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board

Trust Lead –Andrew Andrew McMenemy -Executive Chief People Officer

Timescale – 2024-2027

Area for Improvement

Workforce:

GMMH Trust failed to provide an environment that supported staff to provide high-quality care and maintain their health and wellbeing.

The national staffing crisis is likely to remain an ongoing issue for some years, and this reality must be factored into the improvements that the Trust can make in its workforce planning.

Adaptations will need to be made to account for this, such as consideration of the training and supervision of temporary staff, as well as permanent staff

The Trust is committed to helping our people be the best they can be, ensuring they have the tools in place to thrive. The five-year People and Education Strategy provides the foundations from which we will deliver on that commitment which has been reviewed and appraised. Engagement has taken place at Board level internally and externally, including the views of our main higher education partners.

We have already achieved a lot in key areas of the People and Culture directorate – vacancy rates for registered nursing is now at an all-time low at 15% from 26% in July 2022. Our workforce plan is above plan for 2023/24 and we have successfully recruited over 260 international nurses and Allied Health Professionals in the last two years.

Retention across the Trust has improved with turnover at less than 10% at the end of 2023. Our focus is on listening to and responding to staff feedback, such as from staff surveys, and to support enhanced career development and high performing team cultures.

Temporary staffing has reduced across inpatient settings by over 60% in 23/24 including agency but bank staffing remains higher than we would want it to be in some areas.

We actively seek out black and ethnic minority talent through our RISE development programme to help us address that black and ethnic minority staff make up over a quarter of the workforce but are mainly represented in the lower pay bands.

NHS England rated EPUT's Workforce Race Equality Standard action plan as outstanding, which shows the Trust is on the right path. We now need to ensure that the actions taken positively shift the experience of black and ethnic minority staff.

Our staff survey results show that people are experiencing their immediate managers as being more supportive and there has been a strong focus on Board and Executive development in the last year.

Area for Improvement Workforce:

Recommendation 4 :

The Trust must work with its current and future workforce levels to recognise, adapt to and manage the safety challenges that a staffing shortfall may pose, ensuring the stability of nursing staff.

The Trust must develop a representative, competent and culturally sensitive workforce which is supported to provide services that meet the needs of its communities.

Gap Analysis Findings:

- We need to continue developing our leaders to ensure that they are equipped to take an appropriate and consistent approach to tackling abuse of staff, such as racism leading to staff feeling supported and engaged.
- Our staff survey results show that we must ensure that the Board and our senior management teams and the frontline workforce are well connected.
- Embedding more lived experience within the mental health workforce (e.g. peer support workers and lived experience advisors).
- While medical vacancies are safely covered with locum doctors, we need to continue to recruit more substantive medical consultants
- Continue efforts to reduce vacancies, and reduce the use of temporary staff, through improved, targeted domestic recruitment and student conversion
- We must ensure that we engage more proactively with our higher education institution partners to provide the best environment for students.
- Ensure the learning environment for students, including routes to raising concerns, is improved in partnership with higher education institutions.

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board

Trust Lead –Andrew McMenemy – Chief People officer

Timescale – 2024-2027

Area for Improvement Workforce:

We know that the quality of the environment impacts on patients, their families and the workforce; a number of the buildings within the GMMH Trust estate were no longer fit for the purpose of providing modern mental health care. The Trust is undertaking some rebuilding to improve their estate.
However, buildings are not always maintained to a standard that allows services to be delivered safely, and issues with the fabric of buildings are not always reported and if reported not always maintained in a timely way. Where safety critical maintenance is not being undertaken, mitigation should always be considered to manage risks that this creates. Ward environments are not always clean and uncluttered.

The Trust has a hugely complicated estate which ranges for whole hospitals to sessional room use in shared premises. It covers a mixed portfolio of Freehold, PFI, Leasehold with NHSPS, Private Leasehold and licenced premises. Whilst most of the Freehold premises are utilised for trust business there is a sizable investment portfolio which generates a revenue stream to support our clinical activities. The strategy is currently under review and will consider this recommendation. The Trust has delivered several key programmes over the last number of years which has enhanced patient and staff experiences.

1. Inpatient modernisation - the is the removal of Dormitory Accommodation with the replacement with Single Room Accommodation providing high quality care facilities
2. Backlog Maintenance – The Trust has maintained its used estate to a level that provides high quality facilities for patients and staff.
3. Improved the efficiency of its estate – the Trust occupies approx.150,000 sq m of accommodation and premises cost accounts for 10% of total expenditure.
4. Working with Services - Clinical engagement needs to start with a dialogue about the service and its vision for future development.
5. Compliance and Safety -The Trust currently places considerable importance on compliance and risk reduction.

Area for Improvement Workforce:

Recommendation 5 :

The Trust needs to have a good understanding of the quality of its estate and the impact of this on the delivery of high-quality care, including providing a safe environment.

It must ensure that essential maintenance is identified and carried out in a timely manner and that the cleanliness of units is maintained.

Areas for consideration

Systems in place that ensure that the internal environment is clean, safe and fit for purpose.

requires the repurposing of estates to ensure staff have collaboration spaces

Bringing new technology to an existing estate to transform its efficiency

Buildings and space should be flexible to support different levels of acuity, function and/or technology.

It's important to focus on what matters to both and what they see making a difference in the future and adapting estates to suit.

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board.

Trust Lead – Trevor Smith- Chief Finance Officer

Timescale – 2024-2027

Area of Concern Governance:

The current (and historical) governance structure had not been effective in escalating information in ways that are sufficiently timely, clear or useful. The reasons for this are twofold. Firstly, the structures and processes in place were unclear, including a poor use of data and intelligence to understand the current quality of services. Secondly, the organisational culture had inhibited the raising of concerns at every level. This has had a significant detrimental impact on the Trust's ability to learn and improve in its services.

EPUT's core business is to provide care services. The Quality of Care Strategy drives care quality principles as a foundation for other enabling Trust strategies. The interdependencies of these strategies will together deliver our Trust strategic vision and support our clinical governance structure.

This strategy has been shaped by listening to a range of important voices. Representatives bringing their experiences of physical and mental health services begun the strategy development and their views and wishes then guided the approach taken thereafter. The strategy was launched in April 2024 and we are in the process of its six month review and appraisal.

Our vision is to continuously improve patient safety, built on two foundations set out in the NHS National Patient Safety Strategy: A patient safety culture and a patient safety system.

We also will ensure that everyone receives the care they need which is beneficial, evidence based and effective. Provided by teams who are confident, competent and knowledgeable within a culture of quality care. Our aim : To build consistency, reliability, equity and driving improved outcomes for all. This will also include the Quality Senate providing the Trust with a new process to enable, support and endorse effectiveness through collaborative partnerships.

The key to our success is to fully understand people's experience of care in order to improve. Working in partnership with the people we care for, their loved ones and their supporters. To do this, we are committed to adopting the 10 principles as set out in the national statutory guidance from NHS England and the Department for Health and Social Care.

Area of Concern Governance:

Recommendation 6:

The Trust must ensure that its governance structure (and the culture that this is applied within) supports timely escalation and that the right information can be used at the right level, by the right staff. There must be much greater focus on the validation and triangulation of information to ensure that quality issues can be resolved quickly and learning can take place.

Gap Analysis Findings:

- Ensure quality governance structures are robustly in place, rationalising meetings and providing assurance and delivery to Quality Committee and Executive team
- Ensure that governance functions are adequately resourced to meet the needs of the size of the Trust.
- Develop staff competence training and develop the reset of a quality of care culture though confidence, competence and leadership.
- Ensure that the governance framework supports the necessary information flows and insights for staff at all levels to manage and improve quality (from Board to floor).
- Developing systems that proactively scan for safety concerns across all services, using and triangulating a range of information and intelligence sources: including, but not limited to, safeguarding referrals, complaints, staff and patient surveys, staffing levels, FTSU cases, and incidents.
- Design a quality management system to enable the systematic planning for, maintaining and improving quality.
- Ensure financial impact assurance through business planning and budget setting.

Improvement Plan:

The governance arrangement will include reporting into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board

Trust Leads –Dr Milind Karale, Executive Medical Director

Zephan Trent, Executive Director of Strategy, Digital and Transformation

Ann Sheridan, Executive Chief Nurse

Timescale – 2024-2027

Area for improvement Edenfield:

Edenfield had not been able to consistently provide the forensic services that its patients need and deserve. At times, services there have been unsafe, unkind and abusive to those using them.

Management behaviours have actively discouraged and suppressed concerns being raised and there has been long standing dysfunction in the consultant group, which has impacted adversely on relationships and consultants' leadership.

Adaptations in response to the national staffing shortages, such as consideration of the training and supervision of temporary staff alongside permanent staff will need to be made with outside support.

The care unit leadership team at Brockfield work closely with the collaborative to deliver best clinical forensic model and practice. They are working on systems that deliver and measure key aspects of culture with particular emphasis on compassionate, high-quality care and a positive patient safety culture.

There are systems in place to ensure that the lived experience and expertise of patients and families are central to the work of the service.The use of data and intelligence is supporting the leadership team have meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.

Staff are encouraged to report quality concerns and improvement ideas.

The safeguarding team is reviewing the use of advocacy services to ensure that they are delivering the intended benefits for patients there which includes how leaders value advocacy.

The care unit with HR and corporate nursing is working with the care unit to support all staff, including those who are temporary, to work effectively in multi-professional teams. This includes consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing.

Area for improvement Edenfield:

Recommendation 7:

The Trust must ensure that its equivalent services to Edenfield provides compassionate, high-quality care and that all staff, permanent or temporary, have the skills, knowledge, and support to achieve
this.

Gap analysis findings:

- Ensure pace of change on improvements identified with actions being completed in a timely manner.
- Ensure transparency and /or clarity of reporting
- governance processes, including consideration of the need for impartiality
- Ensure scrutiny of key information
- Issues not treated in isolation
- Rigour in the monitoring of change / impact of actions.
- Critical that the trust is able to evidence learning and improvements when things go wrong.

The governance arrangement will include reporting through the Accountability Framework into the Strategic Implementation Steering Group with the plan including these areas of improvement that will then report into the relevant sub committee of the Board and to the Trust Board

Area for Improvement Plan:

The GMMH improvement plan was large and ambitious but problems it was trying to solve were not clearly defined, and actions often lack appropriate consideration of how their impact will be evaluated.

The Trust's prioritisation will be focused on what makes the most difference to the quality of care for people using services, or the experience of people working in these services. The safe and sustainable delivery of the plan is fundamental to confidence of stakeholders including patients and staff in the organisation.

The governance arrangement will include reporting into the Improvement Plan Steering Group that has system partner oversight, in addition to a number of sub committees of the Board and to the Trust Board. This will ensure that there is the right level of oversight and scrutiny that will support sustainable progress.

Area for Improvement Plan:

Recommendation 8:
The improvement plan against the gap analysis findings must be developed with clarity about the problems that need to be taken to achieve better outcomes.
It needs to be clear on how all actions will be evaluated so that it can be assured about whether changes being made are having the desired impact. The plan will be prioritised to ensure that actions are sequenced, build on each other, and prioritise the quality of care people receive from EPUT.
This will ensure a balanced approach between the number of improvements required and setting out a realistic timescale for implementing identified actions with the support of our system partners.

Areas to work for the plan :

- Articulate clearly the areas the Trust is trying to resolve. This process needs to involve clinicians and service users.
- Ensure that impact measures are clearly defined and that the Trust knows how it will measure them.
- Ensure the plan is prioritised, sequenced, and the initial months of work are described clearly.
- Make use of data and intelligence that to give meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.

The governance arrangement will include reporting into the Executive Team to understand and monitor progress.

Area for Improvement Elsewhere in the Organisation:

In each area the investigators were struck again by the commitment of staff and their desire to improve their services.

They found evidence of concerns in all of the services we visited. Some of these reminded them of the culture and working practices at Edenfield, which precipitated the abuse and poor treatment of patients which Panorama uncovered (such as low levels of staffing and psychological safety).

The Trust Quality Committee gets monthly data on safety metrics with each care unit referenced through the Quality Assurance Report. This will include the controls in place to address any immediate risks.

The Trust has systems in place that identifies safety concerns and initiates sustainable learning when people die unexpectedly while using their inpatient services. This includes a weekly update to Executive Directors.

The Trust works closely with ICB and local authority partners who carry out regular visits and monthly deep dives on services which offers further independent assurance.

Area for Improvement Elsewhere in the Organisation:

Recommendation 9:

The investigation identified some common concerns across services visited at the GMMH Trust, which were also prevalent within Edenfield.

EPUT and the wider system must consider how they understand issues identified in these services (and others) in more detail, including through the actions described below.

Gap Analysis Findings:

- The systems to ensure that the lived experience and expertise of patients and families are central to the work of the service.
- The use of data and intelligence that gives leaders meaningful oversight of restrictive practices, complaints, concerns, safeguarding and incidents.
- The systems that encourage staff to report quality concerns and improvement ideas.
- A review of advocacy services to ensure that they are delivering the intended benefits for patients there which includes how leaders value advocacy.
- The systems that support all staff, including those who are temporary, to work effectively in multi-professional teams. This should include consideration of training, supervision, mentoring, coaching, reflective practice and wellbeing

Improvement Plan

The governance arrangement will include reporting into the Strategic Implementation Steering Groups for the Quality of Care with the plan including these areas of improvement that will then report into the Quality Committee and to the Trust Board

Trust Leads –Dr Milind Karale, Executive Medical Director

Zephan Trent, Executive Director of Strategy, Digital and Transformation

Ann Sheridan, Executive Chief Nurse

Timescale – 2024-2027

Area for Improvement System Oversight:

The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting providers did not identify and respond to the failings happening within GMMH prior to BBC Panorama airing. We consistently heard that the Trust had a reputation for strong performance and its ability to deliver, despite there being signals of significant quality concerns across several of the Trust's services. The regulator did not identify some of the key safety issues in relation to closed cultures and poor patient care.

The organisations external to the Trust that have responsibilities for regulating, overseeing quality, and supporting the Trust most be able to identify and respond to the concerns.

This is happening within the Trust with regular scrutiny by ICB Quality Forums and Adult and Children Safeguarding Boards who monitor the Trust performance and its ability to deliver safe services by looking for signals of quality concerns across Trust's services.

Area for Improvement System Oversight:

Recommendation 10:

The organisations with responsibility for regulation, oversight and support to GMMH must review their current systems of quality assurance. They must also review how they work together collectively to identify concerns in a provider at an early stage to prevent tragedies like those seen at Edenfield from reoccurring. Where learning is identified that applies nationally, this must be cascaded by the relevant organisation.

There are a number of areas to be considered by system partners:

- For each organisation to review the assurance architecture for the oversight of EPUT and have the ability to identify workforce, culture, and quality concerns at an earlier stage.
- The ICBs have developed a level of mental health expertise it has in its oversight of mental health organisations, ensuring that its staff have the relevant experience and seniority to be able to identify leading quality concerns in providers.
- EPUT will continue working with system partners to support partnership-working between external agencies, so that information is shared and understood in a timely way to identify potential services in distress.
- The system partners continue to support the Trust to ensure that their approach is focused on enabling the Trust to identify priorities, make the improvements needed, and model, at a system level, the compassionate leadership that is required to achieve sustainable change.

Area for Improvement System Oversight:

The Greater Manchester Adult Secure (Northwest) provider collaborative was not effectively fulfilling its quality oversight responsibilities, and lacks the necessary clinical input to support this role.

There appeared to be an overall lack of clarity about the purpose of the collaborative and the subsequent governance structures required to support the delivery of this role. GMMH acted as the lead provider within this collaborative.

NHS England has responsibility to clarify the role of the Adult Secure provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise. In light of the concerns identified in this report in relation to GMMH Adult Forensic Services (and wider issues in the Trust's Specialist Services), the role of a provider as lead providers needs to be reviewed by NHS England.

The Trust has a good relationship with regional NHSE colleagues and their Director for Quality meets regularly with the leadership team, as well as visiting the wards and speaking with patients and frontline staff.

Area for Improvement System Oversight:

Recommendation 11:

NHS England must review and clarify the role of the Adult Secure provider collaborative and the governance structures needed to oversee this role. The responsibilities of the collaborative need to be discharged by staff with the right experience and expertise.

NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

There are a number of areas that must be considered:

- NHS England must review and clarify the role of the Greater Manchester Adult Secure (Northwest) provider collaborative and the governance structures needed to oversee this role and therefore the implications for other provider collaborative.

- NHS England should develop a Standard Operating Procedure within six months to provide clarity around the thresholds for information sharing and escalation of concerns (e.g., relating to IC(E)TRs, and include Contract Performance Notices and other sources) when issued in relation to patient care.

Recommendation	Organisational narrative on actions taken and progress	Progress RAG rating
1 Patients, families and Carer's voice	• PCREF is established in NELFT. • Additionally workstreams have developed under PSIRF include collaboration with users of service, carers and parents to enable their voices to be heard in service changes and delivery. • Work in both Risk Formulation and Care Planning workstream are ensuring the voice of the user of service is heard, recorded, and working alongside them. • People with lived experience are engaged in many aspects of service development, delivery and monitoring (e.g. NELFT have participation leads who partake in co-production/service development initiatives/Trust wide meetings, the Quality Support Visits we conduct have Users of Services and carers/parents involvement)	
2 Strengthen Clinical Leadership	• There have been a significant changes in NELFT structures allowing the organisation to be clinically led and operationally enabled with substantial investment in senior clinical leads across the directorates. • Each directorate now has a senior leadership team consisting of Operational, AHP, Psychology, medical and nursing representatives.	
3 OrganisatiWithi NELFTonal culture	• Freedom to speak up (FTSU) is well established across the organisation and good engagement with this aspect of our service. The FTSU guardian is independent and impartial. We have speak up champions across the organisation. • Since the implementation of PSIRF in June 2023, the governance around learning lesson across teams has vastly improved, with front line staff being engaged from the outset (PSIG) through to action plan implementation. • Through implementation of PSIRF NELFT has developed 10 learning workstreams which now have dedicated leads attached and these workstreams engaged in improvement. • NELFT is widely recognised as having a strong EDI agenda. • Specific Cultural intelligence training offered to colleagues at a trust wide learning event.	
4 Workforce planning and managing risk	• There are relevant workforce and capacity improvement workstreams across NELFT and in place to tackle and address increased vacancies. However, there are vacancies across the organisation.	

	• Recruitment and support for international nurses is developing the current nursing workforce. • NELFT is currently supporting Return to Practice and retired and returning nurses. • Accepting management placement students and support them into NELFT for newly qualified nurses. • Development of Mental Health Support Teams across the directorate with a new workforce (Recruit to Train Programmes).	
5 The quality of estate	• Recent recruitment of a Director of Estates within NELFT	
6 Governance framework (including how information is used and governance resource)	• NELFT have recently developed a new and refreshed governance framework is established with floor to board routes clearly identified. • New PSIRF process in place picking up themes from PSI's and development of workstreams from this. • NELFT currently have separate Corporate functions such as Safeguarding, complaints, FTSU to support operational and clinical leads. • Use of PowerBI to alert to developing themes and potential concerns. • Associate Director's of Nursing and Quality conduct monthly LT and assurance meetings, and also attend Incident Review Groups to monitor and support all operational and clinical leads in order to establish good reporting links, ensure PSI are reported accordingly and followed up in a timely fashion with outcomes and learning.	
7 The clinical care model at Edenfield, including staff capacity and skills	• NELFT have moved to being a clinically led and operationally enabled organisation with significant investment in the clinical leadership and models of care. • Have an established NICE and clinical audit team which supplement the operational services and guide and support with guidance and audit.	
8 The content and implementation of the Improvement Plan	• NELFT is working to address some of the issues raised at the Greater Manchester Review to ensure lessons are learnt from this and address any organisational issues picked up through this. • This is being monitored through NELFT's governance structure e.g. CQC Assurance group, learning events and Safe Group.	
9 Assurance around other services, including ligature risks and learning from deaths	• Since the implementation of PSIRF in June 2023, the governance around learning lesson across teams has vastly improved, with front line staff being engaged from the outset (PSIG) through to action plan implementation.	

	• NELFT learning and governance process has been strengthened with PSIRF and Trust wide learning forums, with learning being shared across the organisation. • Sharing of lessons learnt occurs across the organisation with local information cascaded to all teams and services.	
10 A review of the Provider Collaborative	• Inpatient services are engaged with Provider Collaborative Colleagues across the organisation	
11 A need for system-wide learning from Edenfield, including how partners work together to identify and respond to services in distress	• NELFT has held its own learning event and had Professor Oliver Shanley present the findings from the Greater Manchester Review and NELFT also outlined the work being undertaken from colleagues across the organisation focussing on this. • Health and care integration delivery programmes progressing at pace across each alliance, Thurrock and Basildon & Brentwood. • NELFT also has joint learning events with system partners.	

Part I Board Meeting, 15 May 2025

Agenda Number: 10.2

Nottingham Report

Summary Report

1. Purpose of Report

This report provides an overview of key quality and safety issues and progress pertaining to the Independent Investigation into the Care & Treatment provided to VC (Nottingham Report).

2. Executive Lead

Dr Giles Thorpe – Executive Chief Nurse

3. Report Author

Shelley Wallace, Quality Lead Nurse – Mental Health

4. Responsible Committees

Quality Committee, reviewed the report on 25 of April 2025. A further update has been requested for the June committee meeting.

5. Link to the ICB's Strategic Objectives

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop effective oversight and assurance of healthcare service delivery across Mid and South Essex ensuring compliance with statutory and regulatory requirements.
- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Conflicts of Interest

None identified

7. Recommendations

The Board is asked to:

- review and acknowledge the contents of this report for informational and assurance purposes and seek any further information required.
- Note that a Statutory Inquiry into the Nottingham attacks is being established.

Independent Investigation into the Care & Treatment Provided to VC (Nottingham Report)

1. Introduction

NHS England commissioned an independent investigation to conduct a comprehensive review of the care and treatment provided to VC by NHS services prior to the tragic events that unfolded on 13 June 2023. This investigation aimed to thoroughly explore the events leading up to that day, with a focus on understanding the circumstances surrounding VC's care, the decision-making processes involved, and the interventions provided by NHS professionals. The objective was to assess the quality of care, the adherence to clinical guidelines, and whether any systemic issues, gaps, or lapses in communication or service delivery played a role in the tragic outcome.

The investigation delved into the clinical decisions made at various stages of VC's treatment, identifying any potential failures or missed opportunities in care that could have altered the course of events. In addition, it reviewed whether the treatment and interventions were in line with established best practices and whether the care provided was patient-centred, timely, and adequately coordinated between relevant healthcare teams.

Furthermore, the review considered the broader context of NHS services involved in VC's care, including any issues related to staffing, resources, and organisational processes that may have impacted the level of care provided. It also investigated whether any previous concerns or warning signs were appropriately addressed, and whether there were any lessons to be learned from this case to prevent similar incidents in the future.

The final report provided a detailed analysis of the findings, highlighting both the strengths and weaknesses identified throughout the investigation. The outcomes of this review will play a crucial role in shaping future healthcare policies, practices, and training, with the aim of improving patient safety, enhancing the quality of care, and ensuring that lessons are learned from this tragic event.

The investigation's findings have been shared with relevant stakeholders, including NHS service providers, regulators, and governing bodies, and will contribute to ongoing efforts to strengthen the NHS's approach to patient care, risk management, and quality assurance.

2. Main content of Report

The investigation conducted by NHS England examined the period beginning in May 2020, when VC first engaged with mental health services, through to the tragic events of 13 June 2023, when VC took the lives of three individuals and seriously injured three others. This investigation aimed to comprehensively review the care VC received during this period to identify key insights and lessons that could drive improvements in NHS care and prevent similar incidents in the future.

The focus of the investigation was to critically assess the mental health care provided to VC at local, regional, and national levels. By doing so, the investigation sought to uncover systemic weaknesses, missed opportunities, and areas for improvement in

the mental health system. Ultimately, the goal was to reduce the risk of similar tragedies occurring in the future by implementing actionable recommendations for better care, early intervention, and risk management.

On 5 February 2025, NHS England issued a formal communication to all NHS mental health trusts and Integrated Care Boards (ICBs), requesting that they review their local action plans and ensure that they specifically address the concerns and findings outlined in the independent investigation. The letter highlighted key areas for improvement, urging NHS providers to prioritise the following:

• **Personalised Risk Assessments:** Ensuring that risk assessments are tailored to the individual, considering their unique needs and circumstances across both community and inpatient teams. This approach should be holistic and dynamic, adjusting to changes in the individual's mental health and life situation.

• **Collaborative Discharge Planning:** Promoting a coordinated approach to discharge planning, which includes input from the individual receiving care, their family, inpatient and community teams, and any other relevant agencies. This collaborative model ensures that all perspectives are considered, and that the discharge process is safe, effective, and sustainable.

• **Effective Multi-Agency Collaboration and Information Sharing:** Strengthening the collaboration and information-sharing protocols between agencies involved in a patient's care. Clear communication and shared understanding between healthcare professionals, social services, law enforcement, and other relevant bodies are crucial to providing integrated and continuous care.

• **Engagement with Families:** Ensuring that families and caregivers are closely involved in the care process, with an emphasis on their role in supporting the individual's recovery journey. This includes clear communication, regular updates, and involvement in decision-making at every stage of care.

• **Elimination of Out of Area Placements:** Aligning with ICBs' 3-year plans to eliminate out-of-area placements, where patients are placed in facilities far from home. This is aimed at ensuring more personalised, community-based care and reducing the potential for isolation and disconnection from local support networks.

NHS England's directive underscores the importance of making tangible improvements in these critical areas to prevent future tragedies and enhance the quality of care within the mental health system. The review process will help ensure that these issues are addressed comprehensively at all levels, leading to safer, more effective care and better outcomes for individuals in need of mental health support.

3. Findings/Conclusion

NHS mental health trusts and ICBs are required to revise and update their local ICB action plans to incorporate the findings and outcomes of all relevant reviews, as well as any associated actions aimed at driving local improvements in care. These updated action plans must ensure that identified issues and areas for improvement are adequately addressed at the local level, in line with the recommendations from the independent investigation.

The updated action plans should be thoroughly discussed and presented in public board meetings of both NHS trusts and ICBs by 30 June 2025, in conjunction with the scheduled review of the current action plans. This will allow for transparency and accountability, ensuring that stakeholders, including the public, have visibility into the progress being made and the steps being taken to enhance patient safety and care quality.

In addition, NHS England's regional colleagues will offer ongoing support throughout this process, assisting NHS Trusts and ICBs in implementing the necessary changes and ensuring that the updates to the action plans are both effective and aligned with national priorities. Regular progress reports on the implementation of these updated action plans should be submitted to the Boards of both NHS trusts and ICBs, ensuring continued oversight and allowing for any necessary adjustments to be made in a timely manner.

This process is vital in ensuring that the necessary improvements are made in the mental health system, with a focus on safeguarding patient care, addressing systemic weaknesses, and fostering a culture of continuous improvement. By ensuring that progress is regularly reported and openly discussed, NHS England aims to promote accountability and drive meaningful, sustained change across mental health services.

4. Recommendation(s)

The Board is asked to:

- review and acknowledge the contents of this report for informational and assurance purposes and seek any further information required.
- Note that a Statutory Inquiry into the Nottingham attacks is being established.

5. Appendices

Appendix 1 - Action Log (see below)

2	**Risk** - We found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience suggests that this issue is not isolated to this case. NHS England should, in the next six months consider:					On Time
2.1	How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures.	Jan-25	Jun-25	NHSE		On Time
2.2	What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.	Jan-25	Jun-25	NHSE		On Time
2.3	How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need	Jan-25	Jun-25	NHSE		On Time
2.4	Given that The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes.	Jan-25	Jun-25	NHSE		On Time
3	**Reccomendation Implementation** - We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.					On Time
3.1	The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process	Jan-25	Sep-25	EPUT		On Time
4	**Serious Incident Policy** - We found that the Trust's serious incident policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.					On Time
4.1	The Trust needs to ensure that its Patient Safety Incident Response is in line with NHS England's new patient safety framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.	Jan-25	Jun-25	EPUT		On Time
5	**Family Engagement** - We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.					On Time

Slippage/At Risk
Overdue
On Time
Complete

Action ID	Action/ Description	Start Date	Due Date	Lead	Current Status	RAG
1	**Care Delivery** - NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community. National leaders should, in the next six months, include, as part of this debate, the following key areas:					On Time
1.1	The demands on mental health services have increased over recent years. Services are often delivered across complex multi-agency systems. People who use mental health services frequently have multiple needs that require significant support to enable them to live well. National leaders must be confident that the financial resources currently available are sufficient to meet the needs of those experiencing severe and enduring mental illness.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.2	What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of relevant parts of the Mental Health Act.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.3	The debate should ensure that the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds in the context of increasing demand and acuity. This must be supported by sufficiently trained and developed workforce, including people with lived experience.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.4	The dissonance between what people think should be happening, for example care described in national policies and guidance compared to what is actually being delivered in some services.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.5	The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.6	That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice and co-produced with people with lived experience. Commissioners should assure themselves that services they are commissioning are being delivered as intended.	Jan-25	Jun-25	NHSE / DHSC		On Time
1.7	Whether the recurring, common themes that are identified in similar reviews are an accepted risk in the system or whether there are fundamental changes that can be made to mitigate these risks further.	Jan-25	Jun-25	NHSE / DHSC		On Time

5.1	The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care3 and the Patient and carer race equality framework4), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.	Jan-25	Jun-25	EPUT		On Time
6	**Clinical Information Sharing** - We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.					On Time
6.1	The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.	Jan-25	Sep-25	EPUT		On Time
7	**Across Organisational Working** - We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.					On Time
7.1	The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.	Jan-25	Jun-25	EPUT / MSE ICB / System Partners		On Time
8	**Governance Arrangements** - In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.					On Time
8.1	The Trust and the Integrated Care Board should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.	Jan-25	Jun-25	EPUT / MSE ICB		On Time
9	**Policy Development & Review** - We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day to day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.					On Time

9.1	The Trust should ensure that all Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. Where appropriate, policies should be coproduced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.	Jan-25	Jun-25	EPUT		On Time
10	**Peer Support** - In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.					On Time
10.1	As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.	Jan-25	Jun-25	EPUT		On Time
11	**Care Planning** - We found limited evidence that care planning arrangements were co-produced with VC and his family. Building on area for improvement 5, once the Trust has developed its family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family					On Time
11.1	The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.	Jan-25	Jun-25	EPUT		On Time
12	**Joint Clinical Decision Making** - We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.					On Time
12.1	The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.	Jan-25	Jun-25	EPUT		On Time

ICB Part I Board Meeting, 15 May 2025

Agenda Number: 11

Summary Report

1. Purpose of Report

To seek Board approval of the Annual Health Inequalities Statement for 2024/25.

2. Executive Lead

Rebecca Jarvis, Alliance Director, SEE Alliance

3. Report Author

Emma Timpson, Associate Director Health Inequalities and Prevention

4. Responsible Committees

Audit Committee reviewed and supported the Annual Health Inequalities Statement submission to the Board.

5. Link to the ICB's Strategic Objectives

- To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
- To develop effective oversight and assurance of healthcare service delivery across Mid and South Essex ensuring compliance with statutory and regulatory requirements.
- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Impact Assessments

Not applicable to this report.

7. Financial Implications

Not applicable to this report.

8. Patient or public engagement or consultation

The individual programmes of work that are covered by the Health inequalities Information Statement undertake patient or public engagement.

9. Conflicts of Interest

None identified.

10. Recommendation

The Board is asked to approve the Annual Health Inequalities Statement for 2024/25 that will be published alongside the ICB's Annual Report and Accounts 2024/25.

Health Inequalities Information Statement - Annual report 2024/25

Document Control:

Date: 06/05/25
Version: v1.6

Contents

Introduction

Health inequalities are preventable, unfair and unjust differences in health across the population and between groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact health and wellbeing. These are sometimes referred to as the wider determinants of health. For example, people living in areas of high deprivation, with low educational attainment and in poor quality work would be at even greater risk of experiencing health inequalities. Healthcare inequalities are part of wider inequalities and relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare.

NHS organisations have a legal duty to collect, analyse and publish information on health inequalities every year. NHS England's Statement on Information on Health Inequalities sets out how organisations should exercise this duty and what information should be published[1]. This includes a list of indicators which organisations should report against. The indicators are aligned to key health inequalities priorities for the NHS, which includes the five priority areas for addressing healthcare inequalities and the Core20PLUS5 approach to reducing inequalities for adults and children and young people[2].

This is the second year NHS bodies have been required to publish this information. In line with the guidance in the statement, NHS Mid and South Essex will continue to take a proportionate and phased approach to gathering and making use of available information on health inequalities. This report presents a summary of new and existing analyses of the health and care areas within the statement. The report will evolve and change over time as we improve data collection and reporting locally and as indicators within the statement are updated nationally.

The report has a section focused on each health condition or group of conditions covered within the statement. Each section opens with a brief description of the condition and key health inequalities issues and provides a summary of the information and data relating to that indicator. We highlight where inequalities may exist in relation to deprivation, gender, age and ethnicity where the data is available.

This report should be read in conjunction with our annual report that sets out how the ICB meets its legal duty regarding the need to reduce health inequalities that includes:

- Taking a population health improvement approach to understanding health needs and designing interventions that reduce health inequalities.
- Implementation of the Equality Delivery System within MSE.
- Ensuring that that health inequalities are properly considered when we make commissioning decisions for our population.

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

2 NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities, NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

Executive Summary

There are 1.3 million people living in mid and south Essex (MSE). Around 10.5% of population live in areas of higher deprivation where we tend to see greater health inequalities and poorer health outcomes.

Focused initiatives and targeted interventions have led to tangible improvements in reducing health inequalities in access, outcomes, and equity for several key health indicators.

- **Preventative Health checks:** Health check uptake among people with learning disabilities and severe mental illness exceeded national targets (75% and 60% respectively).
- **Access Equality:** Waiting time disparities across ethnic and socio-economic groups for outpatients (non-admitted) acute care have significantly reduced.
- **Oral Health:** A marked decrease in childhood tooth extractions among deprived populations has narrowed the inequality gap.
- **Mental Health Recovery:** Outcomes from Talking Therapies for people from global majority background now meet or exceed those of White British individuals.
- **Inpatient Mental Health:** Significant reduction in the number of people with learning disabilities or autism receiving inpatient mental health care between 2023/24 and 2024/25.
- **Vaccinations:** Improved flu vaccination rates in high-risk, deprived groups with respiratory conditions.
- **Cardiovascular Health:** Fewer admissions for heart attacks among the most deprived groups and statin prescribing in the most ethnic diverse and deprived populations is higher than the national average.
- **Maternal Health:** A drop in Smoking status at time of delivery (child birth) rate, now below 6% meeting the national target.
- **Weight management:** Increased referrals to the NHS Digital Weigh Management Programme from deprived and global majority background, with rising male engagement.

Despite progress, there remains several challenging areas where health inequalities continue to persist which are subject to ongoing actions to address:

- **Maternity:** Higher preterm birth rates among Asian and Black women.
- **Mental health inpatients:** Disproportionate use of the Mental Health Act and rates of restrictive interventions among deprived and ethnically diverse populations.

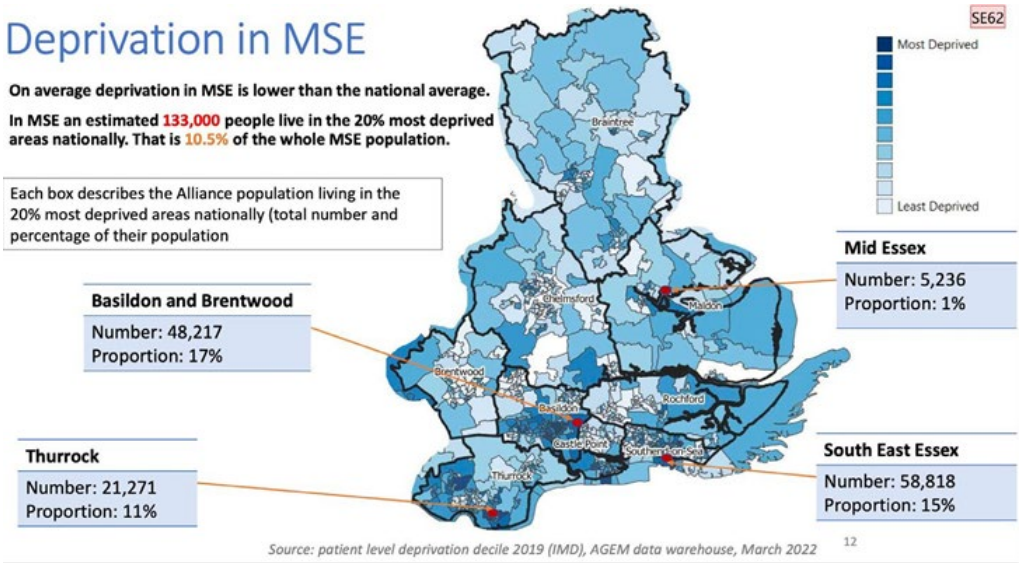
- **Vaccinations:** Low Covid and Flu vaccine uptake which remain in deprived groups and non-white British groups.
- **Cancer screening:** Reduced Breast and Bowel cancer screening rates in deprived areas.
- **Hypertension:** Inadequate hypertension management among non-white British and young individuals.
- **Diabetes:** Widening gaps in diabetes care processes for under-40s and those in deprived communities.

These ongoing disparities highlight the need for sustained, tailored efforts to ensure equitable health outcomes for all segments of the MSE population.

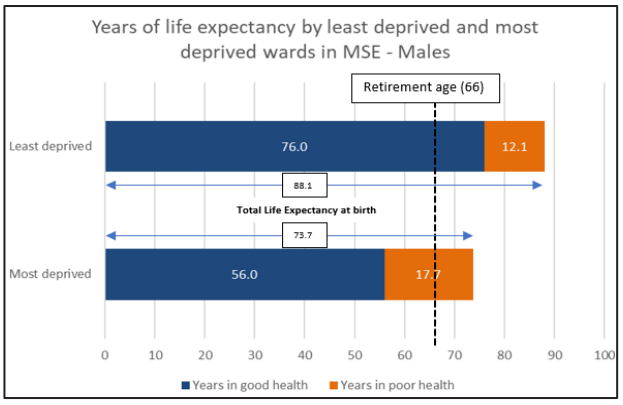
Health inequalities Tackling Health Inequalities in Mid and South Essex

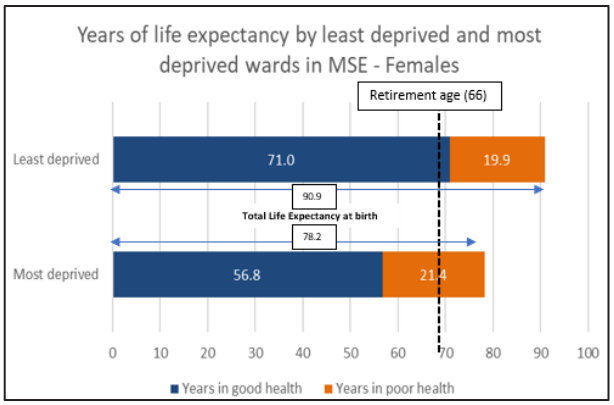
Tackling inequalities in outcomes, experience and access is one of the four key purposes of ICSs and is at the heart of the Mid and South Essex (MSE) 10 year strategy.

There are 1.3 million people living in MSE. Across this area, there are localities of both relative affluence and high deprivation. Around 10.5% of population live in areas of higher deprivation where we tend to see greater health inequalities and poorer health outcomes.



There is a 14.4 year difference in life expectancy for males living in our most and least deprived wards, and 12.7 for females. Those living in our most deprived wards will also live in ill-health for longer.





Source: Fingertips 2021-23

Within MSE there are over 140,000 registered patients who are from an ethnic minority background, which represents 10.8% of the population. Thurrock has a higher proportion (21.2%) of its population from an ethnic minority background. Those from an ethnic minority

background can experience greater health inequalities and for example we see poorer uptake of vaccinations and breast cancer screening uptake in this group.

Within MSE the top three contributors to premature mortality attributable to socioeconomic inequalities are cancer, cardiovascular disease, and respiratory disease. In MSE about 73 in 100,000 people die prematurely from CVD, which is the highest under 75 mortality rate in EoE. Furthermore, within MSE, 124 in 100,000 people die prematurely from **cancer** which is similar to the national average of 122 in 100,000.

The average age of death for people with a **learning disability** in MSE is 57, which is up to 20 years before the rest of the population. Respiratory conditions are by far the leading primary cause of death for people with a Learning Disability.

The Premature mortality in Adults with **Severe Mental Illness (SMI)** per 100,000 is significantly high in Thurrock (130.4 per 100,000). This is more than the national and regional values (110.8 and 95.3 respectively).

Data intelligence and governance

MSE ICB works in collaboration with the public health teams across the three Local Authorities, Population Health Management leadership and with Arden & GEM CSU (BI intelligence provider) to strengthen its use of data and insights to understand and respond to population needs through use of:

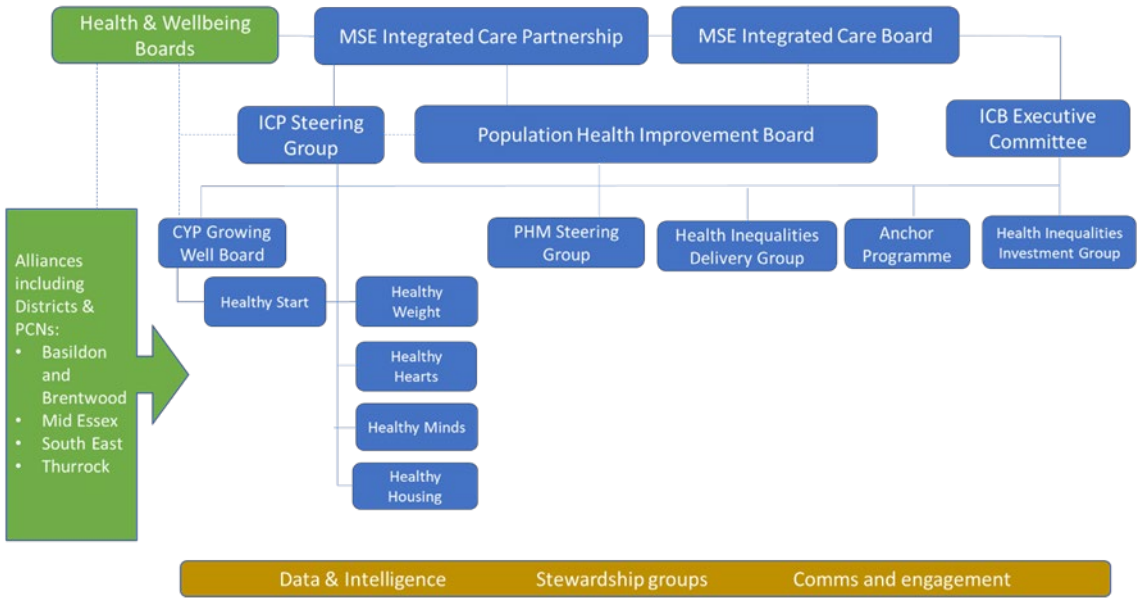
- Local Authority Joint Strategic Needs Assessments to inform decision making[3]
- Integrated health and social care data and its expansion to include other socioeconomic factors such as housing data, to enable wholistic approaches to care delivery.
- Population segmentation tool that provides insights at Alliance, PCN and Practice level to enable greater understanding of population need.
- Core20plus5 Alliance and PCN packs to inform priority setting and opportunities for addressing local health inequalities.
- Health Inequalities dashboard to track high level impact and inform this annual report
- MSE developed metrics, dashboards and reports now incorporate standard Health Inequalities functionality enabling review by deprivation, ethnicity, sex, and age.

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

This Board brings together programme of work across:

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

[3] Essex's Joint Strategic Needs Assessment | Essex Open Data, Joint Strategic Needs Assessment (JSNA) – Southend-on-Sea City Council, Joint Strategic Needs Assessment | Public Health | Thurrock Council



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

Addressing health inequalities in everything we do

In 2024/25 the MSE health inequalities programme continues to focus on embedding a culture of addressing health inequalities across all our business areas. In support of that ambition, we have:

- Applied the national **Core20PLUS frameworks for Adults and Children and Young People** to prioritise activities both across the system and through the local work delivered by alliance partnerships.
- Ensured **Equality and Health Inequalities Impact Assessments** are undertaken for service change proposals to clearly demonstrate the impact on reducing health inequalities and actions identified to mitigate wherever possible.
- Published the **'Narrowing the gap'** report that outlines how partners are working collectively across MSE to tackle health inequalities Narrowing the gap - Mid and South Essex Integrated Care System[4]
- Developed Health inequalities champions across the system as part of the NHSE **Health Inequalities Ambassador programme**.
- Invested in PCN clinical leadership development to utilise a health creation approach to addressing health inequalities.

Working with our most deprived communities – CORE20

Narrowing the gap in health inequalities in our most deprived communities is a priority for all our four Alliance partnerships. Each Alliance has tailored their approach and focused on

[4] Narrowing the gap - Mid and South Essex Integrated Care System

specific areas, groups or conditions based on the needs of their local populations and the engagement work undertaken with their communities. Some highlights include:

Basildon Alliance

- Working in partnership with Sport for Confidence to support people with Learning disabilities to access services and make informed decisions about cancer screenings and vaccinations. Resulting in an increase in cervical screening uptake from 53% to 63% over the two year programme.
- Focus on improving physical activity in partnership with Active Essex, in the latest 'Big Team Challenge', tracks steps along virtual walking route, 22 teams participated logging 32million steps.
- Learning Disability health checks increasing year on year, with 80.6% achieved in 2023/24 and this year on track to exceed by end of March 2025, which is above national target of 75%.
- Health inequalities funding has supported a range of community based developments to tackle health inequalities including; Hope Community Supermarket that provides community area that can link families into partner agencies across local government, housing, employment and health, family support group for disadvantaged families with complex needs to break down barriers that prevent them from accessing health services.

Mid Alliance

- Utilising the Thriving Places index (TPI) and framework to direct investments and grant funding towards priority areas that have included Health housing and economic wellbeing.
- Clinical outreach scheme led by Chelmer PCN in partnership with, amongst others, Sanctus, Chess and Provide to support over 165 individuals experiencing homelessness to develop confidence to engage with statutory services. Of which 43 went on to accept vaccinations and 57 engaged with interventions to improve their physical and mental health including dressings, pain management and medications.

South East Alliance

- Active outreach programmes delivered at a neighbourhood level, with partners including public health and community wellbeing services, to provide holistic health and wellbeing services that delivers education, intervention and health promotion to our most vulnerable communities. These events have reached over 2000 patients and residents throughout the area. One event had 464 attendees who received 1229 interventions allowing patients to receive care in one place and negated the need for repeat visits, ensuring that patients who cannot or do not always attend primary care, had access to long term condition education and clinical interventions.
- Focus on increasing identification and effective management of patients with hypertension to reduce the risk of strokes and heart attacks including providing access to lifestyle interventions. Two events identified patients with dangerously high blood pressure who were then transferred to Southend hospital where they were diagnosed and treated with Atrial Fibrillation and therefore avoiding an acute cardiac event.

- Learning Disability health checks increasing year on year, with 81.1% achieved in 2023/24 and this year on track to exceed by end of March 2025, which is above national target of 75%.
- Health inequalities funding has supported a range of community based developments to tackle health inequalities including; provision of family counselling service that provides preventive care approach to health and wellbeing with focus on support for children with ADHD, improving early childhood outcomes through early intervention and prevention sessions that increase health literacy around themes of nutrition, movement, oral health, winter illnesses; we are awaiting evaluation of this project and the other 6 funded projects from 2023/24

Thurrock Alliance

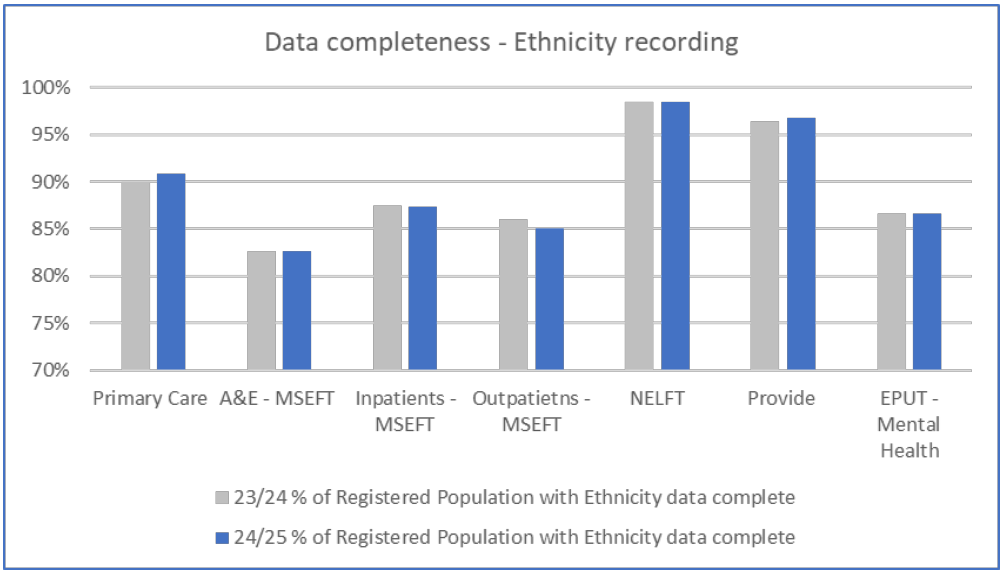
- Working in partnership with Sport England to increase physical activity and active travel in most disadvantaged areas of Thurrock and the local CVS to promote free and low cost physical activity.
- Food growing project that incorporates partnership working across 17 primary schools in the most deprived parts of Thurrock to improve childhood obesity.
- Learning Disability health checks increasing year on year, with 79.1% achieved in 2023/24 and this year on track to exceed by end of March 2025, which is above national target of 75%.

PLUS groups

The ICB PHM team have developed local data and insight for the 'PLUS' groups within MSE to identify areas of greatest need and best practice interventions. Together with national insights we continue to undertake programmes of work to address underlying health inequalities in our 'PLUS' and inclusion groups including:

Ethnic Minority Groups

- Working with Community and voluntary sector partners such as Hope for African communities UK to promote healthy eating and lifestyles
- Changing the way GP practices communicate with patients in BAME community by encouraging face to face meetings to help break down cultural barriers and allay concerns to improve uptake in cancer screening
- Continued focus on improving the data completeness of recording of ethnicity, with 91% completeness in the Primary Care record in 2024/25.



Source: SystmOne (Primary Care) and local provider SUS submissions (MSEFT, NEFLT, EPUT and Provide) Dec 2024.

Veterans

- Improving the identification and recording of Veterans in primary care and our three hospitals and using Veterans voices to inform how services are delivered utilising research conducted by Healthwatch.
- Every PCN has at least one GP practice that is veteran friendly accredited and MSEFT awarded veteran aware accreditation in 2024.
- Local hubs and community oriented drop in opportunities to raise awareness and support through the Armed Forces Covenant Fund.

Homeless

- Homeless Health Needs Assessment commenced, led by the charity Pathway Inclusion Health, to determine health service needs for those experiencing homeless.

Gypsy, Roma, Traveller Communities

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

Inclusion health groups

- MSE first ICS in EoE to commission Pride in Practice offering free training and support with 26 accredited practices.

Research and Engagement network

The ICB has established a Research and Engagement network to foster sustainable community engagement, enhance research participation, and address health inequalities in

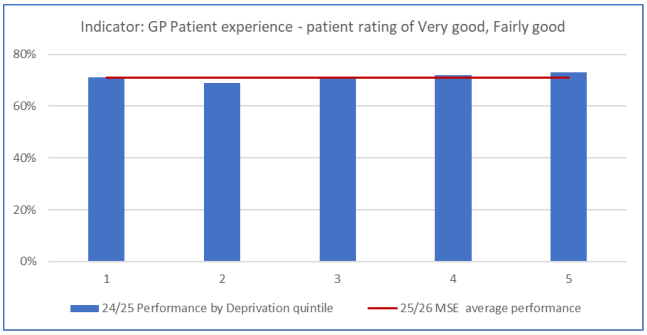
underserved populations. There are currently 24 community champions in post across a variety of partner organisations:

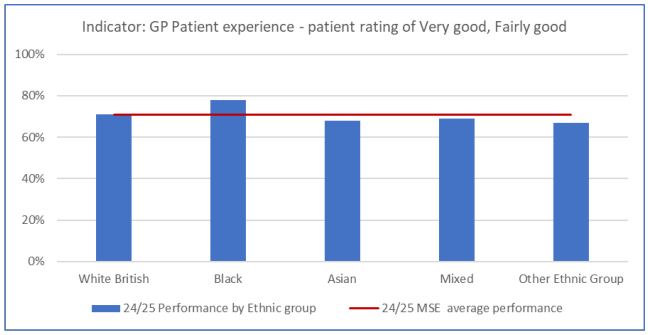
Organisation	Working with	Organisation	Working with
Thurrock Lifestyle Solutions CIC & SHIELDS	People with learning disabilities, people with Autism. Group of self-advocates to challenge and Co-produce with the Statutory.	Signpost	Muslim community, young people under 25, refugees, migrants, ethnic minorities.
Thurrock and Brentwood Mind x2 & MyOTAS	17-25's, BAME, LGBTQIA+, Young adult carers. Neurodivergent young people and their families. (Many of whom have co morbid mental health difficulties).	Essex Recovery Foundation	People in recovery from addiction - Substance misuse.
B3 - Bumps, Birth and Belonging CIC & Black working Mothers	Afro-Caribbean women of childbearing age and who have young children.	Familes InFocus	SEND, age extreme (under 25's or 65 and over), Women of childbearing age, HI, and neuro divergent.
Thinklusive	People with a learning disability & autistic people.	Essex Partnership University NHS Foundation Trust	People with SMI, and people with physical disability.
Motivated-Minds	Age extreme (under 25's or 65 and over), Women of childbearing age, LGBTQ+, HI, and neuro divergent.	Hamelin Trust	People with LD and autism.
Southend Carers	Unpaid careers, ethnically diverse groups including, faith groups, gypsy, Roma travellers.	Seventh-Day Adventist Community Services	Black, mixed especially from an African background
Southend YMCAA	Age extreme (under 25's or 65 and over), LGBTQ+, HI, and neuro divergent, community youth organisations young people under the age of 25.	Multicultural Southend	Muslim women's group, people under 25, mother and babies' group.
Essex council for voluntary youth services	Age extreme (under 25's or 65 and over), Women of childbearing age, LGBTQ+, HI, and neuro divergent.	SAFE (Supporting Asperger Families in Essex)	Any group of neurodivergent people but with a specialist in those who are autistic without a learning disability.
Over 50s Black Men Forum CIC	The over 50s' Black Male community, age extremes (under 25's or 65 and over), HI	Southend Association of Voluntary Services (SAVS)	Group of individuals with respiratory illnesses (COPD)
Blade Education	Groups of adults with LD	Mid and North Essex Minds	Mental health research in coastal and rural areas covering Maldon, Burnham on Crouch, Dengie area
South East and Central Essex Mind	Mental health research in coastal and rural areas covering Southend Shoeburyness and Canvey Island	SUMMARY	**Total of 24 partner organisations and 24 community champions.**

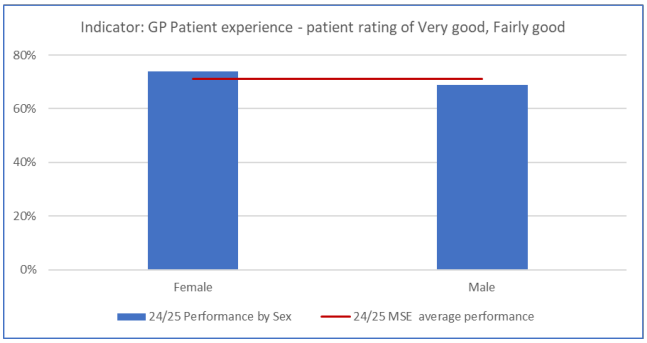
Inclusive Elective Recovery

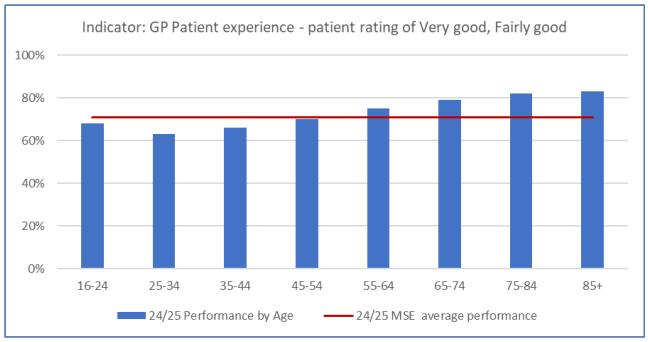
Primary care

Implementation of the ICB's Primary Care Access Recovery Programme in 2024/25 has demonstrated improved access, measured via the GP survey. Overall reported experience remains relatively consistent between a large number of demographic indicators including ethnicity, deprivation, gender. There is variation in experience across the age cohorts with a trend that young adults tend to have lower levels of satisfaction compared to older generations. The highest levels of satisfaction are experienced through the oldest part of our population, who equally tend to be the heaviest users of services.









Source: GP patient survey 2024.

As part of the local delivery of the Primary Care Access Recovery Plan, there have been multiple changes to primary care service delivery over the past 12 months. Overall capacity has significantly increased, modern general practice has been implemented across a large number of practices in MSE, with patients starting to access a range of services directly rather than via their GP. Get The Care You Need Quicker - Mid and South Essex Integrated Care System

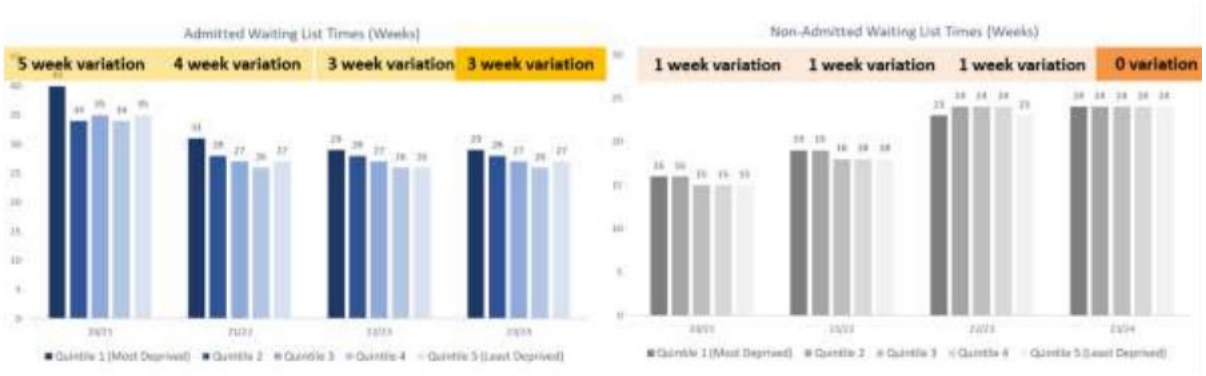
Community Collaborative

The Community Collaborative have focused on inclusive elective recovery through:

- Introduction of four Transfer of Care hubs ensure out of hospital services deliver personalised care and address wider determinants of health through relationships with housing, foodbanks etc.
- Cardiovascular Disease Prevention Programme of work – Blood pressure guidance produced and staff training completed and addressing the co-morbidity of frailty and hypertension
- Co-designed the refreshed patient engagement strategy with communities and Healthwatch
- Health Inequalities Van outreaching to seldom heard groups and improving access to services including Long Covid, Wellbeing and Sexual health services.
- Review of Heart Failure and Diabetes community services as part of the EDS2 2024/25 report incorporating patient engagement to identify actions for improvement. MSEICB-EDS-2024_25-reporting-v1.0-Feb-2025.docx

Acute services delivered by MSEFT

MSEFT completed an annual impact report and evaluation of access on the waiting list and patient experience that was presented to their public Board in June 2024. This highlighted a closing of the gap in waiting times between ethnic groups and deprivation variation gap has been closed on the non-admitted waiting list. The gap remains stable on the admitted waiting list at 3 weeks variation.



Source: MSEFT Board report June 2024.

Mid and South Essex Foundation NHS Trust continues to report bi-monthly to their Board on health inequalities within elective waiting lists as part of the integrated performance report. The waiting list analysis for MSEFT as at December 2024, shows an under-representation in all ethnicities except "other ethnic group" and over-representation of those living in the second most deprived quintile.

			Waiting Lists		
		MSE Population	Diagnostic	RTT	Cancer
Ethnicity	White	92.3%	76%	74%	75%
	Black	2.6%	2%	2%	1%
	Asian	2.7%	2%	2%	1%
	Mixed	2.0%	1%	1%	1%
	Other Ethnic Group	0.4%	1%	2%	1%
	Not Stated	0.0%	18%	20%	21%
Gender	Male	51.0%	44.4%	42.9%	41.3%
	Female	49.0%	55.1%	56.7%	58.6%
	Not Stated	0.0%	0.5%	0.3%	0.1%
Age	Under 18	21.9%	3.6%	10.2%	0.6%
	18-64	58.7%	57.8%	53.7%	48.2%
	65+	19.5%	38.6%	36.1%	51.2%
Deprivation	1st Quartile (most deprived)	14.3%	0.0%	0.0%	0.0%
	2nd Quartile	27.4%	70.0%	65.4%	68.5%
	3rd Quartile	28.2%	29.6%	31.6%	30.3%
	4th Quartile (least deprived)	30.1%	0.1%	0.1%	0.1%
	Not Recorded	0.0%	0.3%	2.9%	1.0%

Source: MSEFT Board report February 2025.

MSEFT notes the gap in recording of ethnicity data impacts their ability to understand if patients are under-represented. Whilst females are over-represented, meaning they are

more likely to appear on MSEFT waiting lists than males. This could be attributed to females living longer than males in mid and south Essex.

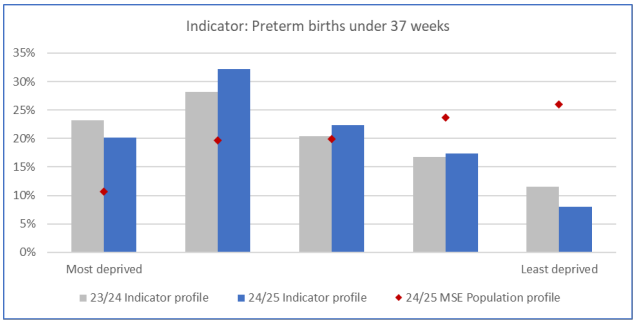
There are number health inequalities projects underway within MSEFT:

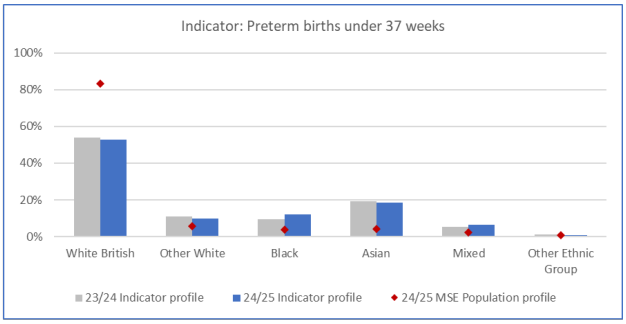
- Rapid Diagnostic Centre and Endoscopy short films and Easy Read Leaflets supporting patients with LD and/or anxiety etc.
- OVRcome project provides a virtual reality experience to support individuals with learning disabilities or autism to become more comfortable with the hospital environment and procedures. 92% of participants who used oVRcome found the app to be useful, participants saw improvements in how they felt about injections, bright lights and large building sizes.
- Improving Health Literacy working with those with diabetes to improve basic maths skills utilising the Multiply funded government scheme.
- Review of Paediatric services as part of the EDS2 2024/25 report incorporating patient engagement to identify actions for improvement. MSEICB-EDS-2024_25-reporting-v1.0-Feb-2025.docx

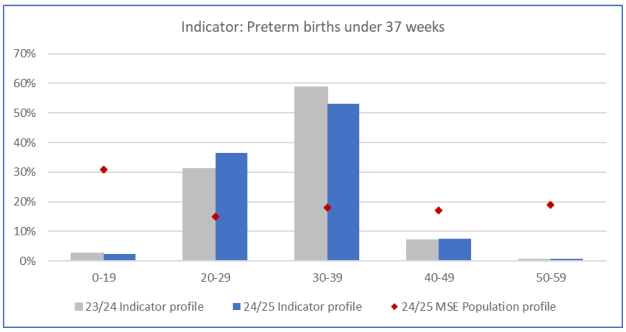
Maternity

MSEFT continue with the implementation of the Maternity Equity and Equality action plan to reduce the risk of preterm births with focus on those from a black ethnic background.

There is an over-representation of preterm births under 37 weeks from non white British women but particularly from women of an Asian or Black ethnic background. The over-representation of women from the most deprived areas (first quintile) has reduced in 2024/25 from the previous year. However, the proportion from the second quintile has increased in 2024/25. The MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confident Enquiries across the UK) reported stabilised and adjusted perinatal mortality rates at MSEFT were within an acceptable 5% compared with the group average (2023 data reported in 2025).







Source: MSE local dataset Athena taken from SUS extracts

There are a number of actions being undertaken to address health inequalities in Maternity services including:

- Maternity and Neonatal Voice Partnerships (MNVPs) continue to put service user voices at the heart of service improvement, and they are representative of our communities, with Ethnic Community Leads facilitating feedback from those that may be seldom heard.
- A Maternity and Neonatal Health Inequalities dashboard, aids the identification of themes and trends to inform areas needing further evaluation. This recently included a focus on the timing of access to antenatal care which has identified variation attributed to ethnicity.
- Perineal trauma and ethnicity has been evaluated at Basildon Hospital site and found local variation which is being addressed through staff MSEFT engagement and training.
- Southend maternity booking data specific to the Jewish population has been reviewed and identified cultural norms that may be influencing the timing of engagement with maternity services.
- Implementation of the Smoke Free Pregnancy pathway in MSEFT have seen a reduction in rates of smoking at time of delivery to around 6% which is in line with the national ambition.

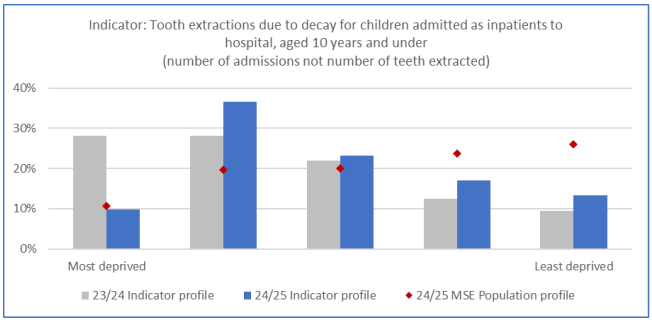
Children and Young People

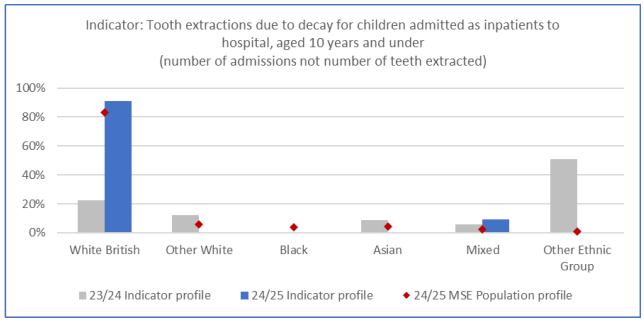
Childhood and adolescence are key life stages where people face inequalities in health outcomes (such as infant mortality rate and obesity rates) alongside inequalities in accessing services. In MSE, one in eight children live in our most deprived areas and are at risk of experiencing poorer health outcomes. The ICB has adopted the national Core20PLUS5 framework for Babies, Children and Young People. There are a number of transformation programmes that are underway that align with this framework including

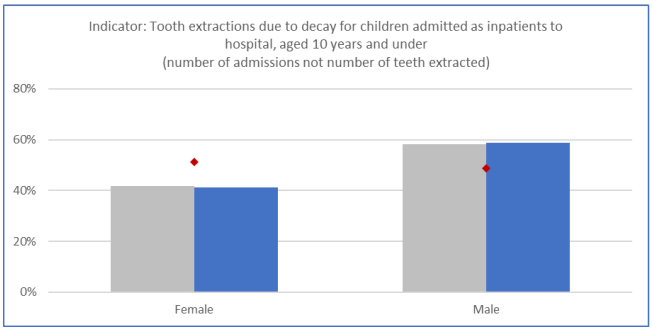
Asthma, Diabetes and Neurodiversity. The ICB is developing the information analysis to support these programmes and review the health inequalities that exist for children and young people. In 2024/25, this report focuses specifically upon Oral Health and Mental Health.

Oral Health

Nationally, children in deprived communities experience poorer oral health with significant inequalities in tooth decay that can impact their overall wellbeing and development. Poor oral health is almost entirely preventable. In MSE there has been a significant reduction in inequalities related to tooth extractions due to decay in children aged 10 years and under. There has been a narrowing of the gap with fewer tooth extractions from those children in our most deprived areas in 2024/25. Although it should be noted that the 2024/25 data represents 9 months up to December 2024 and the small numbers by ethnicity grouping does therefore not allow for a conclusion reached on whether health inequalities have been reduced for non-white British groups. There continues to be an over-representation of boys having tooth extractions.







Source: Local MSE data - Athena from SUS (Note: 23/24 12 months, 24/25 9 months data)

There are a number of actions being undertaken to prevent the risk of tooth decay that could lead to tooth extractions including:

- MSE Bright Smiles Child Oral health communications campaign rolled out which resulted in positive engagement and feedback.
- Supervised toothbrushing program continued roll out, commissioned by ICB and Local Authorities, with 37 early years and primary schools onboarded.
- Thurrock Early years pilot making good progress with integrated oral health prevention activity within family hub structure and wider community settings. 90 Thurrock based events incorporating Oral Health Promotion: 2062 people directly engaged.

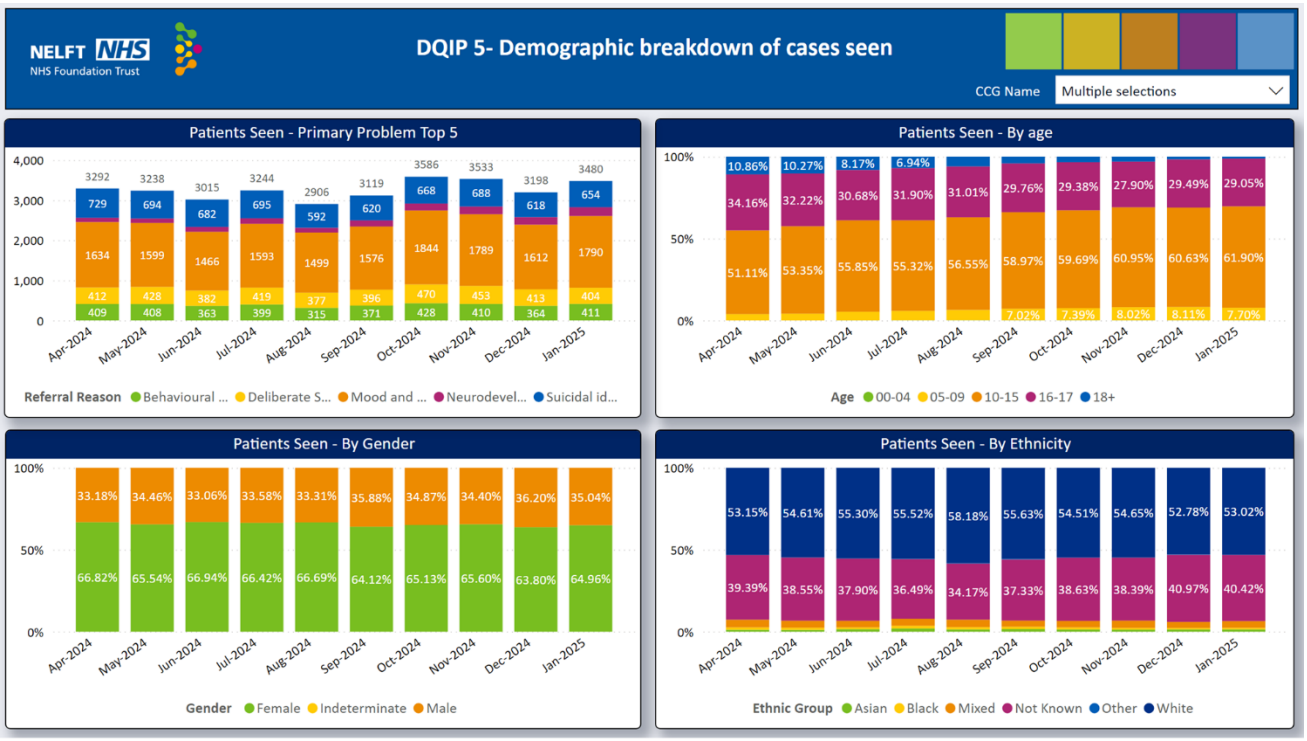
- Improved NHS dental access with dental access pilot allowing over 2700 patients under 16 yrs. to be seen by a dentist since September 2022 and partnering of all 325 MSE primary schools with a dental practice.
- ICB Early Years Oral Health Team have delivered 107 engagement events across MSE, including direct engagement with residents, co-production activities, and Oral Health Training for the Early Years Workforce (attendance by 2178 Children, 1035 Parents/Carers, 764 Members of the Early Years workforce).
- Distribution of over 17,000 toothbrush packages either directly to residents or to partner organisations working with families.
- Development of Oral Health Champion Packages – these are digital and physical packages of resources for Early Years Workforce/ Volunteers with updated oral health information

Mental Health

Up to one in five children and young people in England experience a mental health difficulty, and those from socioeconomic deprived areas can be disproportionately affected. Demand for children and young people's mental health services (CAMHS) significantly increases as a result of the Covid pandemic.

The proportion of patients seen where the ethnic background is not known is significant and therefore doesn't allow meaningful interpretation of whether inequalities by ethnic groups exist. This is being addressed with the provider of CAMHS.

The trend continues with an increasing number of children being seen in the younger age groups those 10-15 years, with proportionately fewer in those 16 years and above. A significantly higher proportion of individual accessing the service are female, although this is very gradually reducing over time.



Source: NELFT data dashboard

There are a number of actions being undertaken to support children and young people's mental health and reduce health inequalities including:

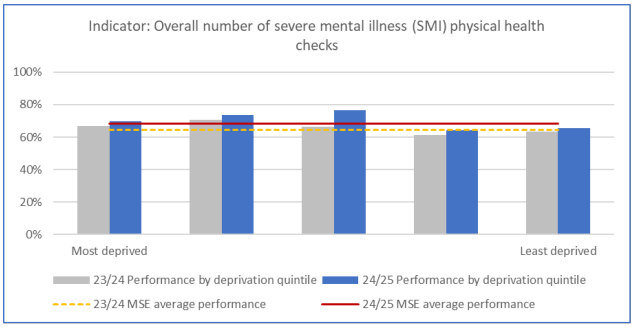
- During 2024/25 the ICB has undertaken a procurement for counselling services with a new service specification that will deliver an equitable service across MSE where inequalities are addressed by reducing variation.
- CAMHS nurses are now working a greater proportion of their time in general practice which enables early support children and young people with mental wellbeing concerns.
- Increasing access and choice of support and treatment options for Young people.
- Delivering evidence based interventions for mild to moderate mental health issues across 126 educational settings.

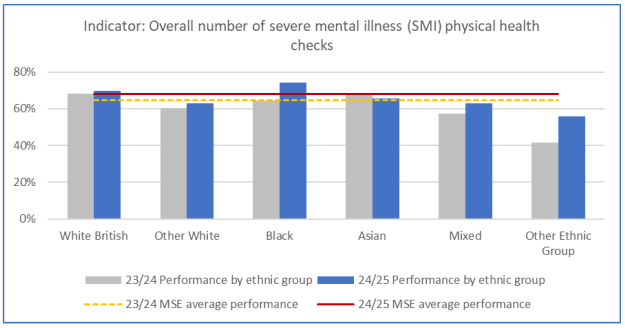
Adult Mental Health

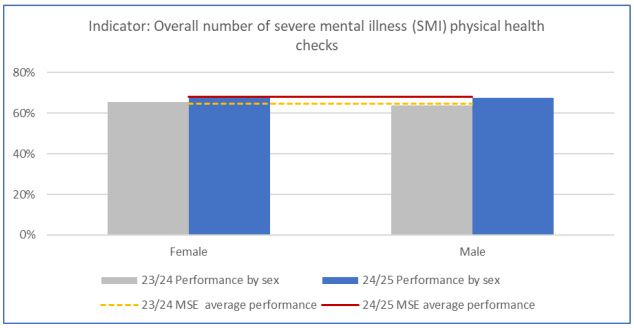
People with a mental illness such as schizophrenia or bipolar disorder die on average 15-30 years sooner than the general population.

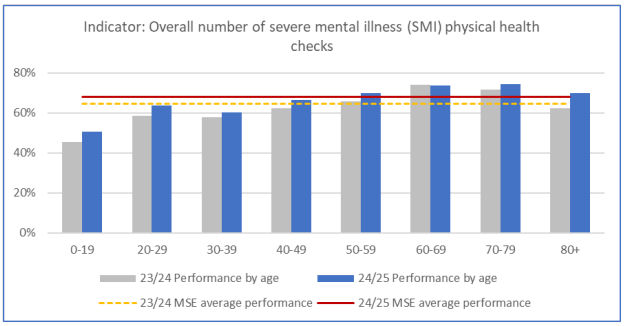
SMI Health checks

The ICB continues to focus on reducing premature mortality for those with SMI by ensuring that an annual physical health check is undertaken. The proportion of SMI health checks continues to increase year on year, currently 68% in 2024/25 against the national target of 60%. There has been a notable increase uptake in the last 12 months from those living in our most deprived communities, those from a Black ethnic background and those from aged between 20 and 29 years old.









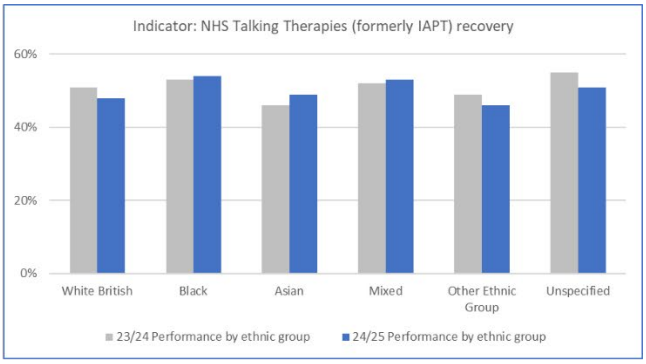
Source: MSE local dataset February 2025.

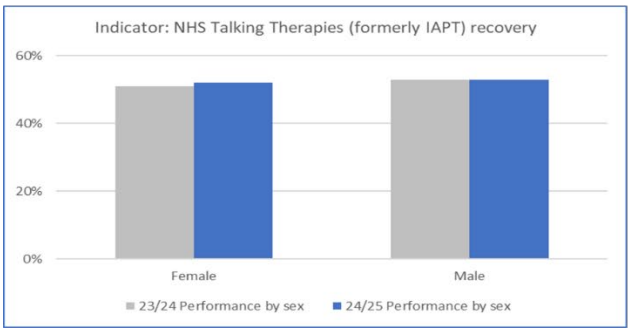
There are a number of actions being undertaken to improve uptake of SMI health checks including:

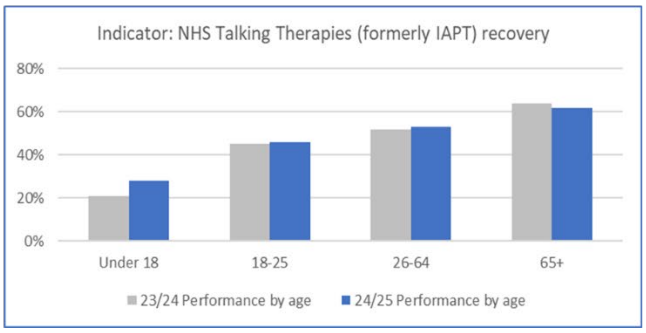
- Adoption of Standard Operating model including a step-by-step guide implemented across the three providers and General Practice has helped to improve consistency in delivery of health checks. This has reinforced a standardised approach across the ICB, leading to improvement performance and target achievement.
- Co-production of patient leaflets and posters with service users to ensure 'lived experience' reflected.
- Focus on principle 'Don't just screen, intervene' and ensuring follow up interventions supporting healthy behaviours and lifestyle changes are accessed.
- Working with VSCEs and other partners on outreach activities to target marginalised communities.

Talking Therapies

Nationally evidence has found that those from Black and minoritised ethnic backgrounds have poorer outcomes from NHS talking therapies. In 2024/25, within MSE those from a global majority background have seen improved recovery outcomes that are either in line or exceed those individuals that are White British.





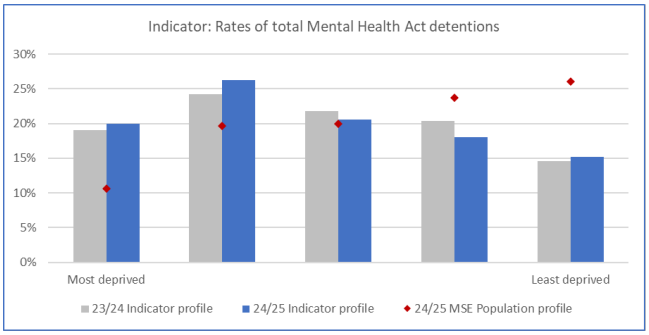


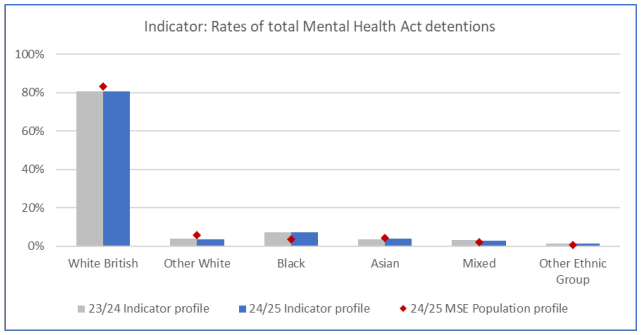
Source: IAPT dataset, NHS England.

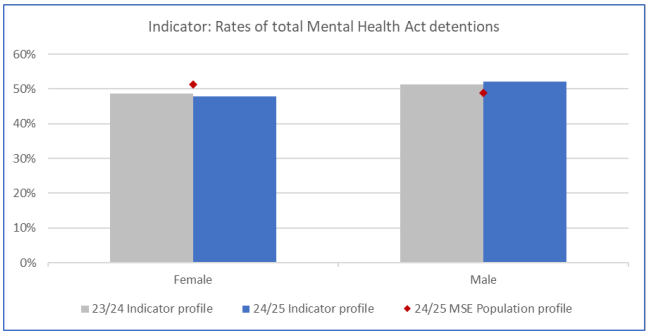
In 2024/25 the ICB has been focused on the development of a new service specification that underpins the procurement process that is underway. The outcome will be an equitable service across MSE where inequalities are addressed by reducing variation.

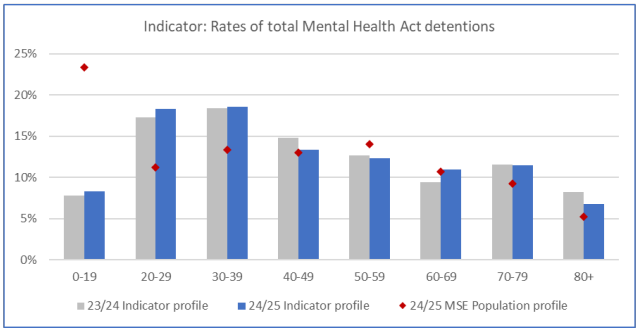
Mental Health Act detentions

Rates of Mental Health Act detentions and rates of restrictive interventions are shown nationally to be higher for those patients from deprived areas or from global majority background. In MSE the over-representation from the most deprived areas (quintiles one) and the younger age group (those under 40 years) for Mental Health Act detentions increased in 2024/25 from the previous year. There also remains an over-representation from those with a Black ethnicity.









Source: EPUT local dataset February 2025.

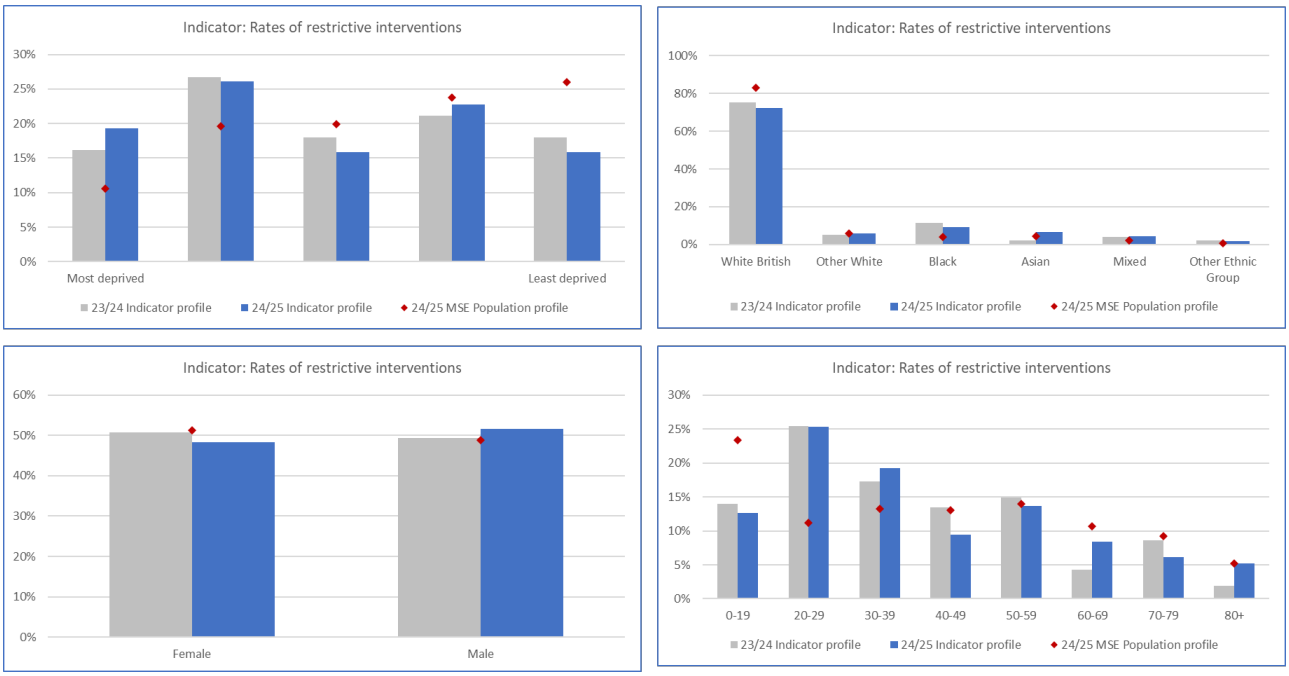
There are a number of actions being undertaken to reduce health inequalities in Mental Health detentions including:

- MSE has adopted the ***Culture of Care Programme*** that aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable place to be cared for, and fulfilling places to work.
- Cultural change programme includes wards utilising a Quality Improvement methodology to implement changes, training for newly qualified practitioners and development sessions for wards.
- Adoption of patient led care plans by continuing to focus on individuals' wishes and preferences and giving people as much choice as possible about their care and treatment.

Restrictive interventions

In MSE rates of restrictive interventions, the over-representation from the most deprived areas (quintiles one) and the younger age group (those under 40 years) for Mental Health Act detentions increased in 2024/25 from the previous year. The over-representation from

those with a Black ethnicity reduced in 2024/25 but there was an increase in the proportion from an Asian background and from the most deprived areas.



Source: EPUT local dataset February 2025.

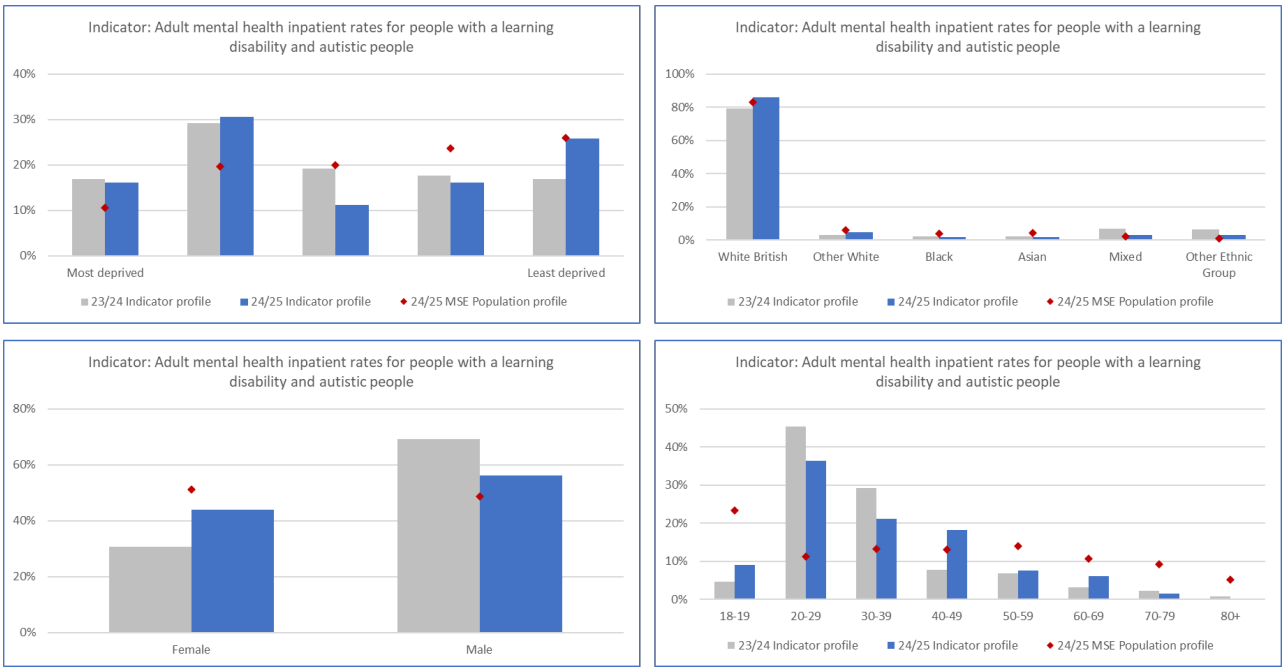
A new Therapeutic acute inpatient operating model for adults with mental health was launched in 2024/25. This has embedded the principle of personalised care and shared decision making to enable the least restrictive setting and interventions possible. The adoption of a Trauma informed outlook then enables staff to find a way to hear someone's story and their distress and put in place Positive Behaviour plans. EPUT are supporting staff with training and have invested in new posts including family ambassadors, activity coordinators, Practice Nurse Educators and peer support to deliver the system and cultural change required.

Learning Disabilities

People with a learning disability and autistic people face significant health inequalities leading to lower life expectancy and more avoidable deaths than the general population.

Adult mental health for people with a learning disability and autistic people

The NHS long term plan set out an aim to reduce the number of people with learning disabilities and autism in inpatient mental health care. The NHS long term plan set out an aim to reduce the number of people with learning disabilities and autism in inpatient mental health care. In MSE there has been some significant work towards a reduction in the number of people with learning disabilities that are in mental health inpatients with some improvements noted between 2023/24 and 2024/25 position. There has been a reduction in the proportion that are from a non-white British ethnic background and Males over the past 12 months.



Source: MSE local dataset February 2025.

MSE has improved the oversight through the use of the Dynamic Support Register; a list of people with learning disability and autistic people who need support because they are at risk of going into hospital if they do not get the right care and treatment in the community. By regularly reviewing individuals that are at high and medium risk of admission and ensuring that personalised care and treatment plans are implemented. For those that are admitted, the ICB has put in place assurance mechanisms to ensure that regular and robust Care (Education) and Treatment Reviews are in place that set out actions to support discharge to a less restrictive setting.

Annual health check for people with Learning Disabilities

Annual health checks for people with learning disabilities are crucial for addressing health inequalities by identifying and managing previously unrecognised health needs. In MSE, there has been a year-on-year increase in percentage of individuals having a health check There has been improved uptake across all demographics in the last year, but it notable to see an increased proportion of people with learning disabilities from a black ethnic background and in the younger cohort those aged 20-29 years.

Source: MSE local dataset Athena extracted from SystmOne January 2025.

The Southend Essex and Thurrock Learning from Lives and Deaths – People with a learning disability and autistic people (LeDeR) Deliverable Plan 2024-2027 has a priority to 'Promote Preventative Health': An improvement plan has been implemented that has improved the uptake and effectiveness of learning disability annual health checks and health action plans. This has been delivered through greater partnership working between the learning disability specialist health team and primary care colleagues.

Our providers within MSE continue to focus on improving the voice and experience of individuals with learning disabilities and/or autism. The I Have Voice - Learning Disabilities website sets out the improvement plans with Provide Community.

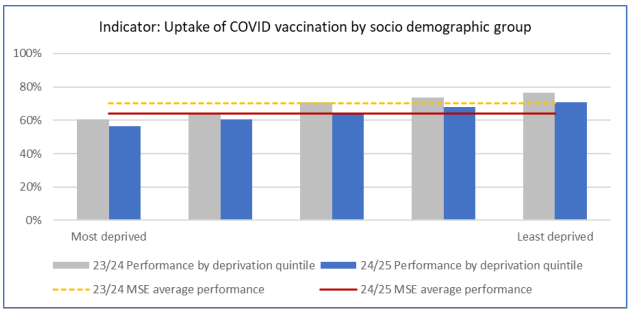
Work continues to improve the uptake of screening and vaccination programmes by those with learning difficulties. Through the partnership working across Southend Alliance with Lady McAdden Breast Cancer Trust, support has been provided to enable outreach workers support individuals with learning difficulties and autism to access their routine breast screening.

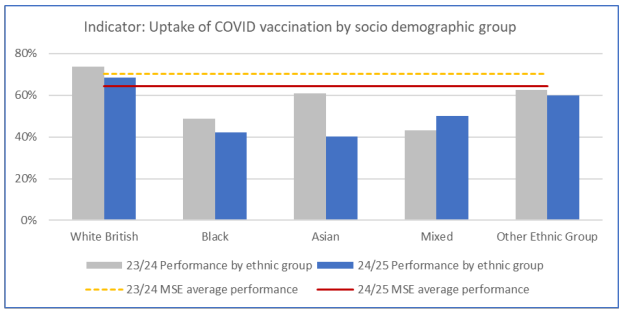
Respiratory

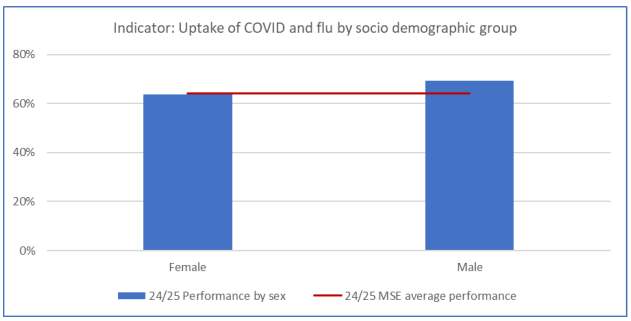
There has been a focus within MSE to drive up uptake of Covid, Flu and Pneumonia vaccines to reduce Respiratory emergency hospital admissions due to exacerbations.

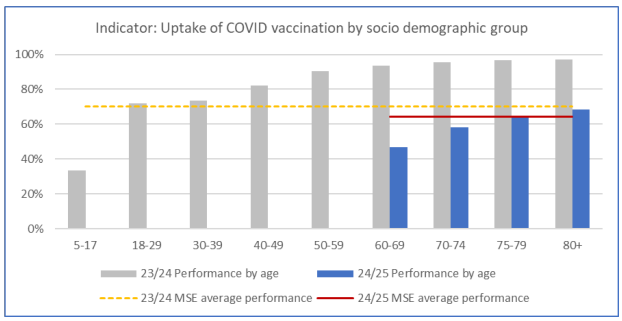
Covid vaccinations

In line with the national picture, MSE has seen a decline in the overall uptake of Covid vaccinations. Higher levels of vaccination are observed in less deprived and older age groups. In addition, ethnicity has an impact on relative rates of vaccination with White British having the higher levels of vaccination and mixed, black and unknown ethnicities having lower levels of vaccination.







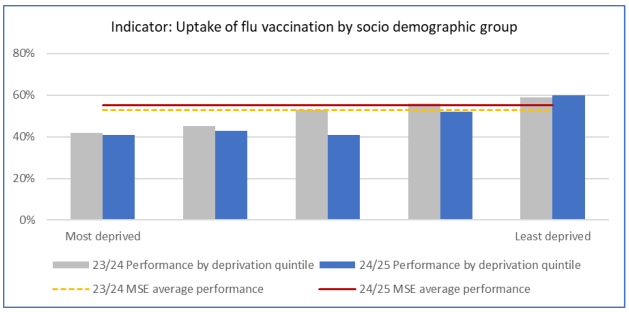


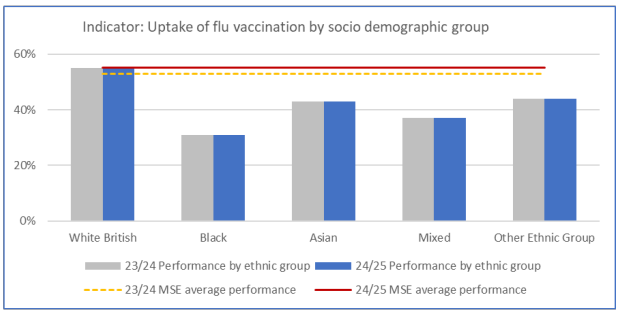
Source: Foundry February 2025.

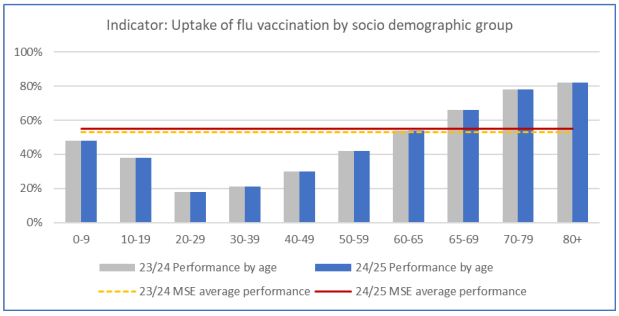
Various programmes were undertaken to target key demographics in particular, targeted promotions in deprived communities. A winter roadshow toured various deprived communities particularly in south Essex. Pop up vaccination clinics in areas such as Thurrock, Basildon and Southend also helped to promote the message, but these events often generated small numbers of vaccinations.

Flu vaccinations

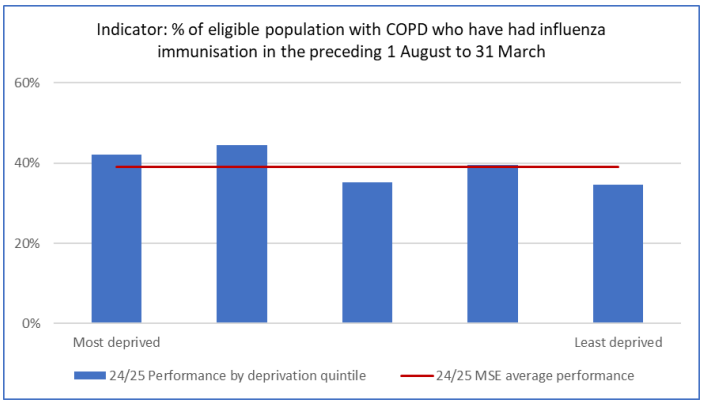
The uptake of Flu vaccinations increased in 2024/25 in MSE. However, across the full programme there remains a lower uptake across our most deprived groups, non-white British groups and younger age cohort.







The ICB has undertaken some targeted work to improve the uptake of Flu vaccinations for those most at clinical risk with known respiratory disease, this has resulted in higher vaccination rates in our most deprived groups.

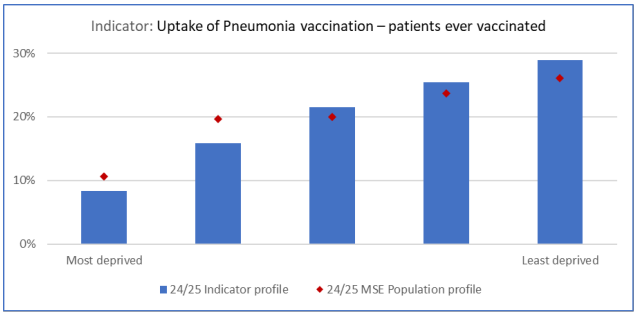


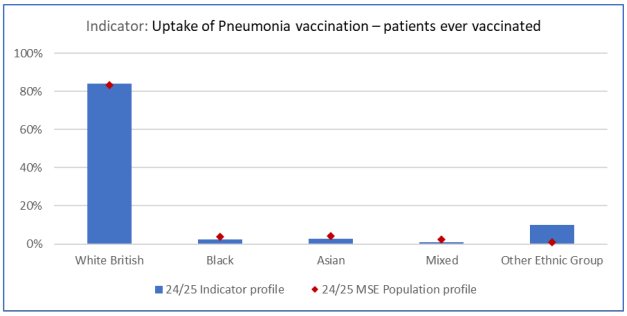
Source: MSE local dataset Athena February 2025.

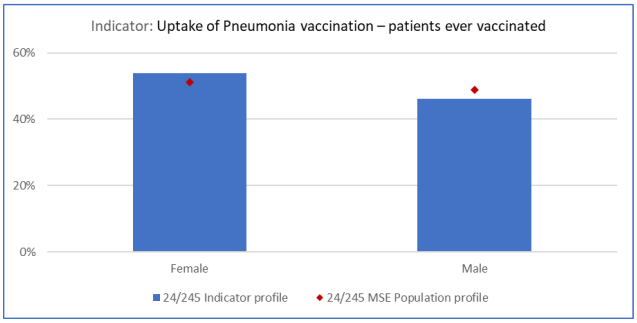
The Flu vaccination continues to be promoted across GP practices, community pharmacy and as part of the targeted winter roadshow in areas of greatest deprivation or poor engagement with primary care.

Pneumonia vaccinations

For most adults will need only one dose of the pneumonia vaccine for long term protection. In MSE there remains an under-representation of those from our deprived communities (quintile one and two) and from males.







Source: MSE local dataset Athena February 2025.

In 2024/25 the ICB launched a communications campaign to raise awareness and encourage eligible individuals to receive the free pneumococcal vaccination. Together with an education campaign, with easy-to read document developed in partnership with voluntary sector groups to increase awareness and uptake among those with learning

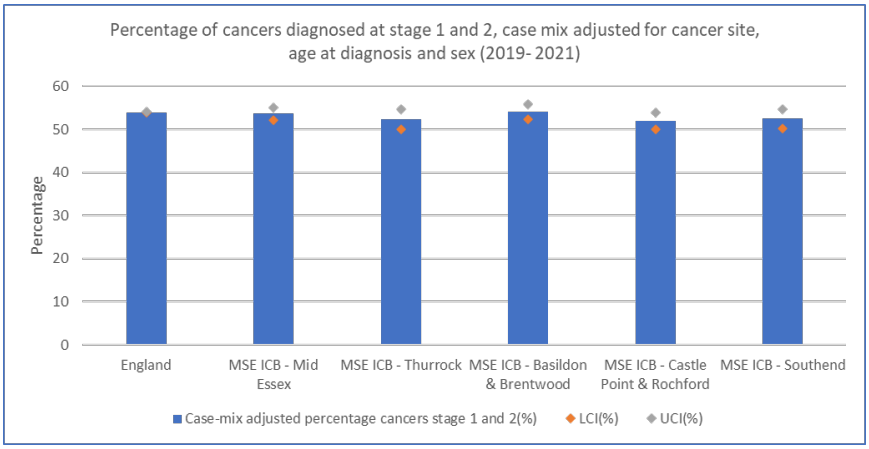
disabilities. The targeted work through communities and voluntary sector in our most deprived areas has shown good uptake.

Cancer

Early cancer diagnosis is a specific priority for MSE ICB as part of its adoption of the Core20PLUS5 framework. A collaborative approach has been taken across the ICB, Cancer Alliance, NHSE East of England region, MSEFT, PCNs and GP Practices in reducing health inequalities in Cancer.

Early Cancer Diagnosis

A national ambition has been set that 75% of all stageable cancers will be diagnosed as stage 1 and 2 by 2028. The National Disease Registration Service collects and complies the cancer staging data. The latest data available is for 2019-2021. MSE ICB has a lower proportion of cancers diagnosed at stage 1 and 2 in comparison to the England average. There is variation between the localities in MSE with the highest proportion of cancers diagnosed at an early stage in Basildon and Brentwood. The lowest early cancer detection rates are in Castle Point and Rochford

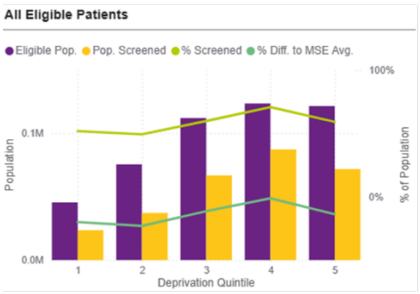


Source: Cancer Registry staging data from NDRS

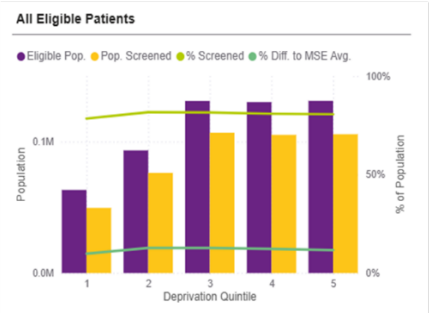
Cancer Screening

Nationally 90% of cancers found via screening were diagnosed at an early stage. However, there is lower uptake of cancer screening programmes in adults living in more deprived areas. In MSE there is marginal variation in cervical screening rates by level of deprivation. However, for Breast and Bowel screening the uptake is lower in areas of deprivation (quintile one and two).

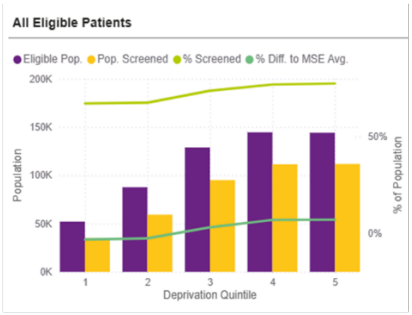
Screening uptake for Breast Cancer



Screening uptake for Cervical Cancer



Screening uptake for Bowel Cancer



Source: Local MSE data extracted from SystmOne

There are a number of actions being undertaken to improve uptake of cancer screening including:

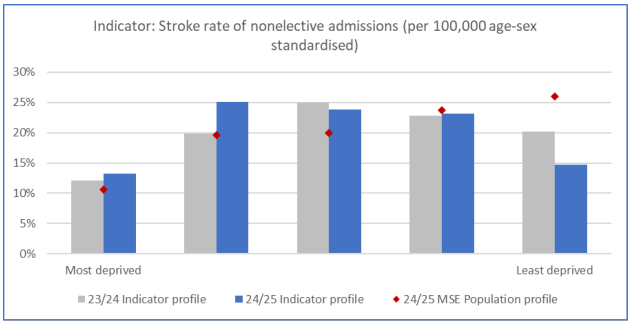
- Monthly PCN data continues to be shared on uptake of cancer screening with follow up by designated Primary care cancer leads to identify and share good practice across MSE.
- Conducting a survey to understand public attitudes, knowledge and experiences relating to breast cancer screening.
- Expansion of culturally competent communication with videos from local doctors about how to recognise signs and symptoms of some of most common cancers.
- Promotion of Essex Frontline as a one-stop shop for cancer care in the community. Offering patients hyper-local support groups that provide advocation for screening programmes.
- Expansion of national Lung Cancer Screening Programme to Castle Point and Rochford with continuation in Thurrock and Southend.

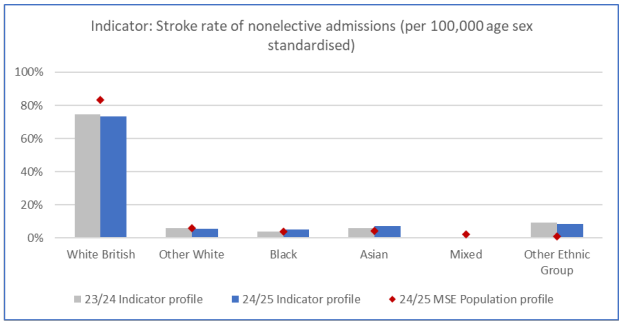
Cardiovascular

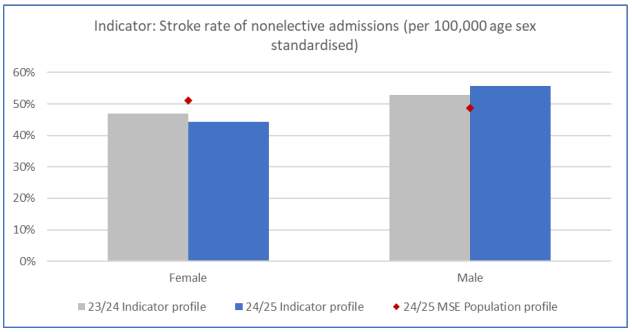
Cardiovascular disease (CVD) causes 1 in 4 deaths in England and is one of the leading causes of morbidity in MSE. CVD and Stroke is largely preventable and therefore has been a priority for the ICB over the last year.

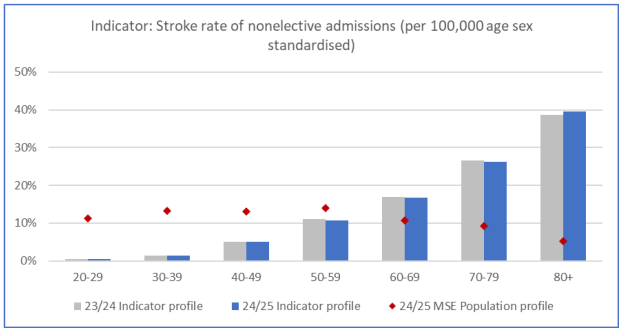
Stroke and Heart Attack Admissions

Nationally, there has been an increasing number of people admitted to hospital following a stroke. With people from lower socioeconomic groups experiencing strokes earlier and facing poorer care outcomes. This is borne out in MSE with an over-representation of stroke admissions from more deprived groups, which increased in 2024/25. There is also over-representation from Black and Asian groups and Males, all of which have widened health inequalities in 2024/25.





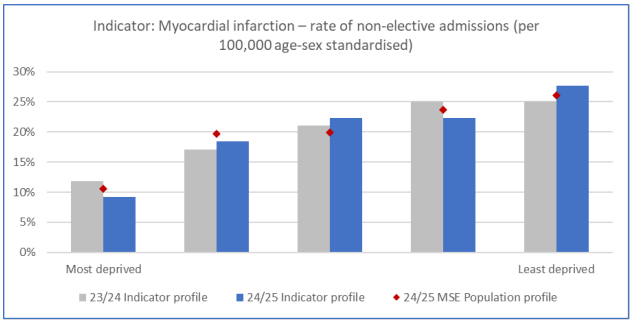


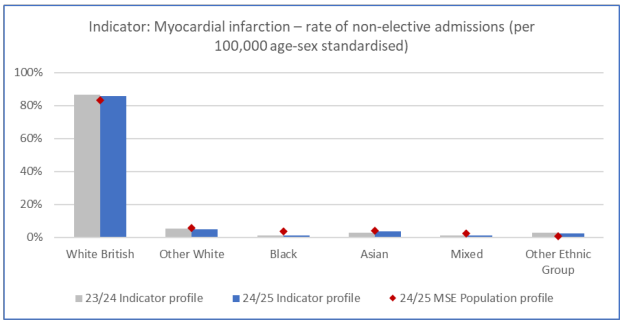


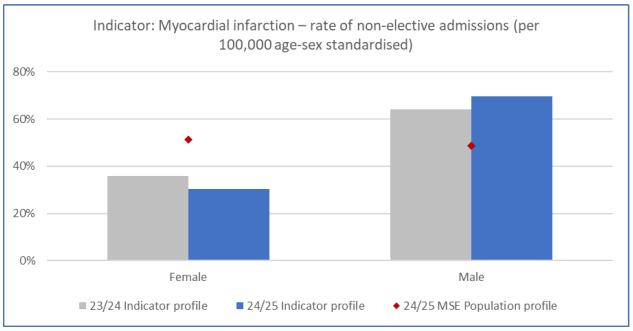
Source: Local MSE data - Athena from SUS (Note: 23/24 12 months, 24/25 9 months data)

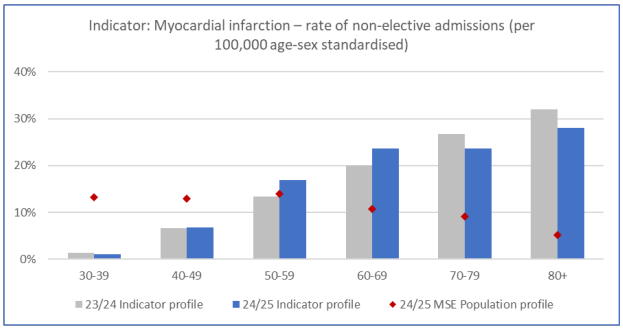
Heart attacks (Myocardial infarction) is a leading cause of hospital admissions and mortality in the UK. Nationally, the emergency admission rate for heart attacks is higher from lower socio-economic groups and women often face disparities in care and outcomes. In MSE, there is a significant over-representation of Males which has increased in 2024/25. This may indicate potential underdiagnosis in women, due to differences in clinical presentation compared to that of men.

In MSE the inequalities gap due to socioeconomic deprivation closed slightly in 2024/25, with a reduced proportion of admissions for heart attacks from our most deprived groups.







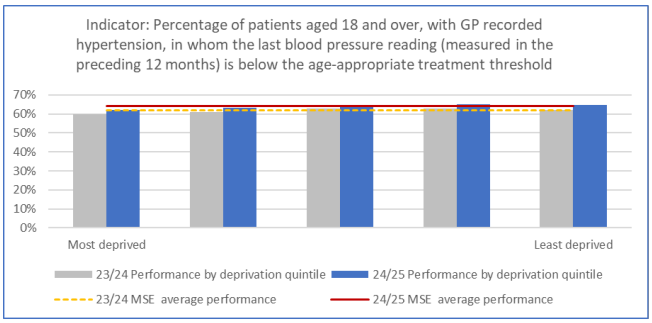


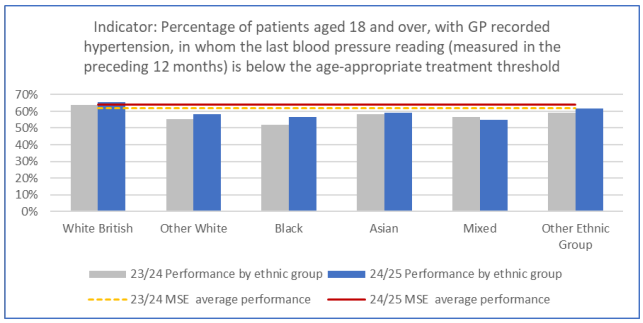
Source: Local MSE data - Athena from SUS (Note: 23/24 12 months, 24/25 9 months data)

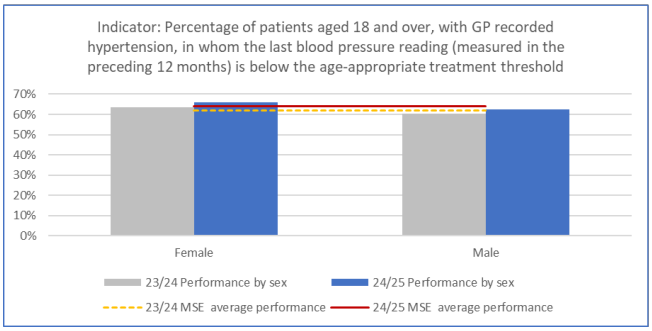
The ICB has focused on interventions for the prevention and treatment of cardiovascular disease across three main areas (1) Hypertension – diagnosis and treatment of high blood pressure (2) Cholesterol – reduction through prescribing of statins (3) Atrial fibrillation or abnormal heart rate – regulate through prescribing of anticoagulants.

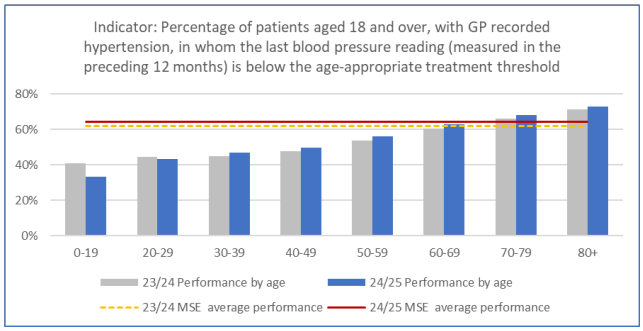
Hypertension

Hypertension (high blood pressure) is a key priority within the NHS Long Term Plan and was a National NHS objective for 2024/25. A key measure is the proportion of patients with hypertension that are treated according to NICE guidance. There has been an overall increase in the proportion of patients that are treated to threshold. However, a lower percentage of those from a non-white British background and those in the younger age cohorts (under 60 years) are likely to be treated in accordance with NICE guidance. Although the gap is closing from the previous year for those for Other White and Black ethnic background.









Source: Local MSE data- Athena extracted from SystmOne

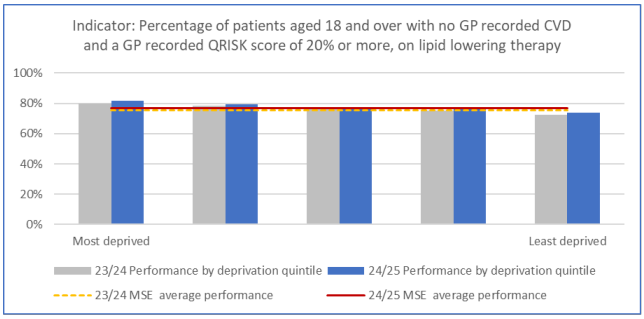
There are a number of actions being undertaken to improve management of Hypertension including:

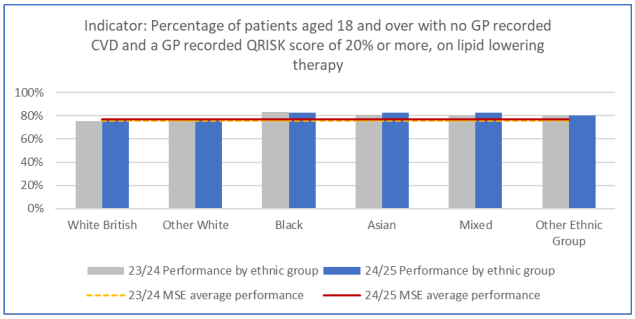
- Local Enhanced scheme working with 14 PCNs focused on areas of greater deprivation and the non-white British population providing holistic clinics to optimise management of Hypertension, Atrial Fibrillation and Cholesterol along with providing support for risk factors like smoking and weight management.
- Hypertension Quality Outcomes Framework (QOF) extension scheme, that provides incentives for primary care to effectively management a greater proportion of their patients.
- Outreach clinics undertaken in deprived areas of Southend to improve identification and management of hypertension.

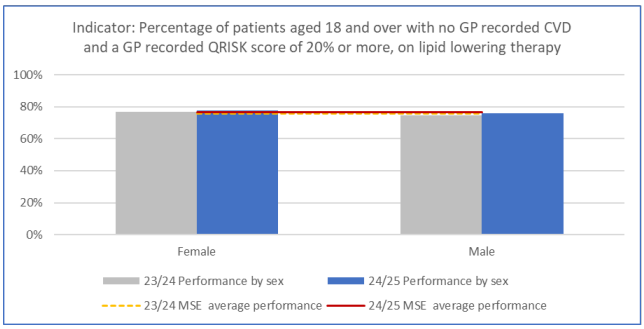
- Working collaboratively with Essex County Council on the pilot of SISU mobile health check machine pilots in MSE to support hypertension case identification targeted at those least engaged with primary care in work place locations.
- Regular public campaigns 'Know Your Numbers to reduce your risk of heart attacks and strokes' and 'Invincible Feeling, Invisible Danger' encouraging taking regular blood pressure checks.

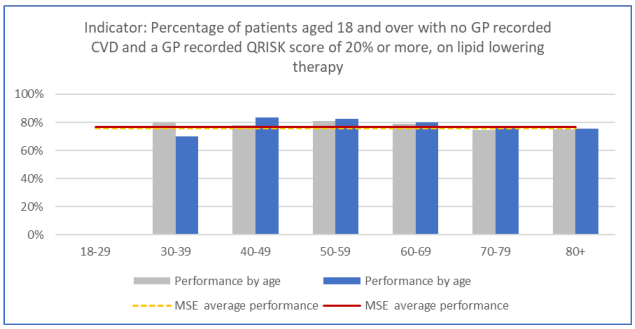
Cholesterol

Raised cholesterol is one of the top three modifiable contributors to risk of cardiovascular death. Stains, a lipid lowering therapies, are the most effective medicines for reducing cholesterol levels for most people. A National NHS objective for 2024/25 was to increase the percentage of patients at the highest risk of CVD on lipid lowering therapy to 65%. In MSE has consistently performed above this level, 77% for 2024/25. There is a greater uptake of lipid lowering therapies in our most deprived areas and from those with global majority background.







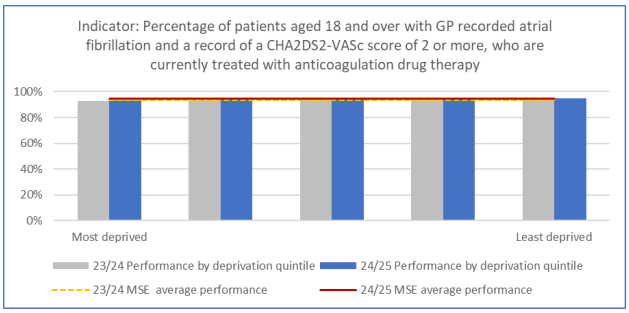


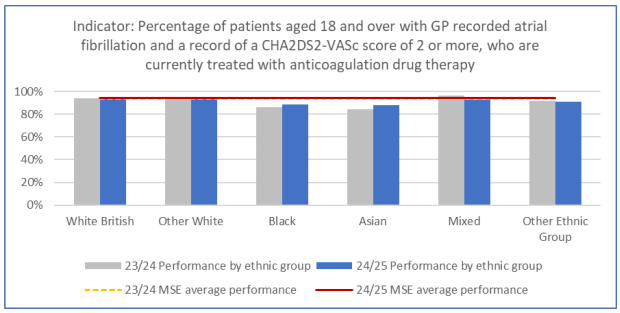
Source: Local MSE data- Athena extracted from SystmOne

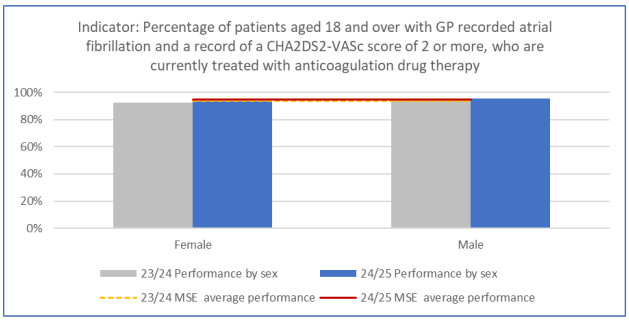
The ICB has been focused on ensuring that lipid lowering therapies are optimised and the use of high intensity statins are considered along with other medication options. A free e-learning course has been made available to over 550 GP and pharmacy participants.

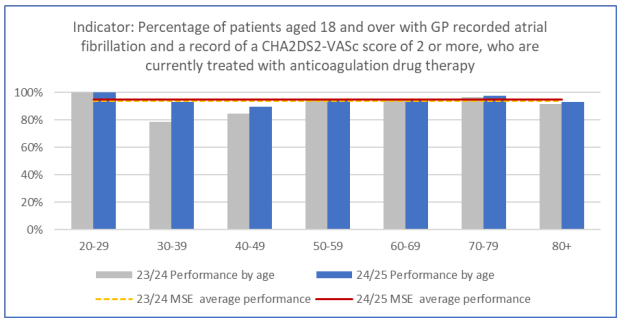
Atrial Fibrillation

Atrial Fibrillation (AF) is the most common form of heart arrhythmia and doubles a person's risk of stroke. Prescribing anticoagulants for patients with AF are an effective and low risk method of reducing the likelihood of stroke. In MSE, the percentage of patients with AF that currently are on anticoagulants increased from 93.8% in 2023/24 to 94.7% in 2024/25. There remains a lower uptake with those from a Black or Asian ethnic background or aged 40 to 49 years, although the gap is beginning to close.









Source: Local MSE data- Athena extracted from SystmOne

The Local enhanced CVD scheme, detailed above, not only covers Hypertension but also AF. The outcomes from this scheme will be known in Q1 of 2025/26. In addition the CVD Community Outreach activities being undertaken across 18 PCNs, many are carrying out pulse checks to identify new cases of AF and exploring opportunities of treatment optimisation for existing patients.

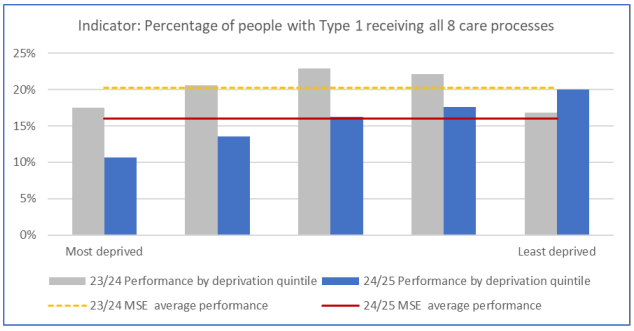
Diabetes

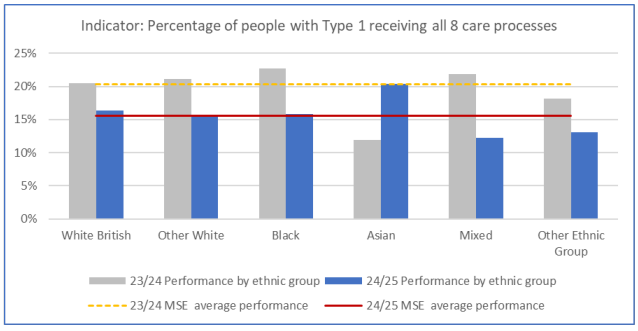
Diabetes does not affect everyone equally, with inequalities in access to service and outcomes along with the risk of developing type 2 diabetes being driven particularly by ethnicity and socioeconomic deprivation.

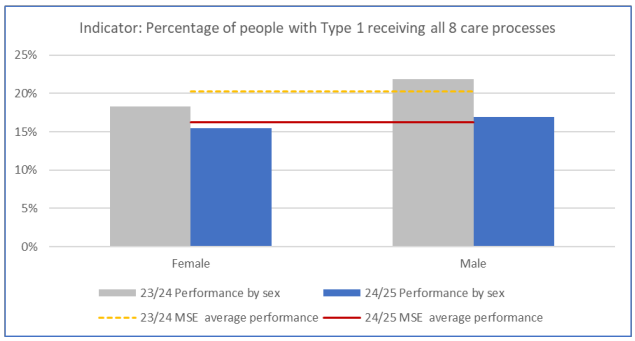
Type 1 Diabetes

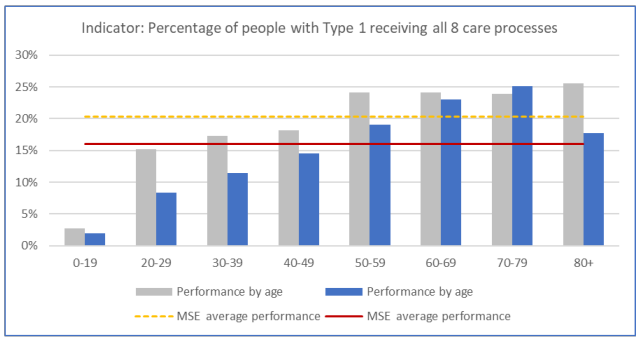
For those with Type 1 Diabetes there are eight key care processes that are recommended by NICE that support the prevention of complications associated with diabetes. In MSE it appears there has been a deterioration in the overall percentage of people with Type 1 Diabetes receiving the eight care process. However, it should be noted that the data is recorded up to end of February so doesn't represent a full year. Many GP practices undertake these checks in the final quarter of year, and therefore the data could be under reporting activity and performance.

Based on the available data, there appears to be a widening of health inequalities based on deprivation, with those from our most deprived areas less likely to have all eight care processes completed. There has also been a widening based on age, with a lesser proportion of patients aged under 40 years having all eight care processes completed. There has however, been a narrowing of the gap with a significantly greater proportion of people from an Asian background receiving the eight care processes.









Source: Local MSE data- Athena extracted from SystmOne

There are a number of actions being undertaken to improve the effective management of Type 1 diabetes including:

- Implementation of hybrid closed loop system, that automatically adjusts the amount of insulin given through a pump, to reduce variation in care and inequalities for patients. The focus has been initially on areas of greatest deprivation, those who are pregnant and children and young people.
- Patient survey via our engagement platform 'virtual views' on their experiences of diabetic care to inform the development of a new service model.
- Training on foot screening delivered to GP practices to increase competency of foot checks to prevent serious foot problems and even amputations.
- Promotional videos developed in multiple languages to highlight the importance of eye screening and used as part of engagement with local ethnic minority communities.

Type 2 Diabetes

The eight care processes are also recommended by NICE for those with Type 2 Diabetes. There has been an overall increase in the proportion of people with Type 2 Diabetes receiving all eight care processes. However, it should be noted that the same data limitations apply for Type 2 and described above for Type 1 Diabetes.

It appears that the gap in inequalities due to socioeconomic deprivation has increased, with the greatest increase in people receiving all eight care processes seen in the least deprived group. With under representation from those from a black ethnic background and those aged under 50 years.

Source: Local MSE data- Athena extracted from SystmOne

There are a number of actions being undertaken to improve the effective management of Type 2 diabetes including:

- Targeted PCN Innovation and Recovery Funding to improve uptake of the Care Processes in two PCNs serving our most deprived population. Evening and weekend clinics delivered by Community collaborative and PCN staff have enabled 1200 patients to receive all care process, who had not previous received in the last 2 years.
- Providing support to Primary care though clear Type 2 Diabetes Management Guidelines and promoting awareness through training sessions.
- Working with Diabetes UK and our Research and Engagement champions to promote awareness amongst communities in our most deprived areas or from an ethnic or inclusion background.
- Working with Eye screening provide to locate care closer to local communities to reduce inequalities relating to travel.

Risk factors; Smoking and Obesity

Smoking and Obesity are the main risk factors that drive premature mortality from cardiovascular disease, lung cancer and chronic lower respiratory diseases. Smoking is the single largest driver of health inequalities in England.

Smoking

The MSE Maternity stop smoking pathway launched in February 2024 across the three hospital sites: Basildon, Broomfield, and Southend. Providing women divulge their smoking status, electronic reports are set up to capture the personal details of all birthing people who 'currently smoke' and those who have 'quit since conception.' All women and birthing people within this category receive a telephone call during the next working day irrespective

of their postcode and or deprivation level. The outcome has been a reduction in the Smoking at time of delivery rate from 9% in 2023 to below 6% in December, in line with the national target.

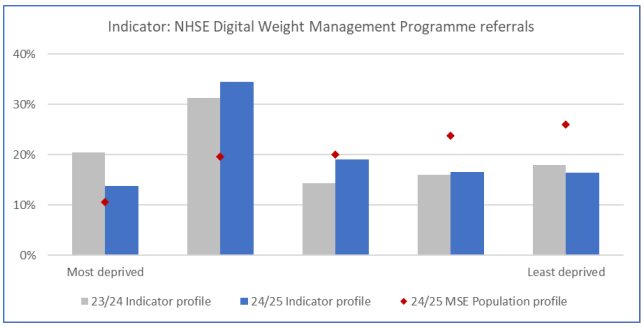
A smoking cessation in-house service is currently available for those patients admitted into wards in Basildon, Broomfield and Southend Hospitals. With a mental health inpatient service launched in December 2024 by EPUT. Whilst some smoking data is currently collected it is incomplete so once there is a comprehensive dataset available in 2025/26 an assessment will be undertaken to identify if there are any inequalities to accessing the service and address as required.

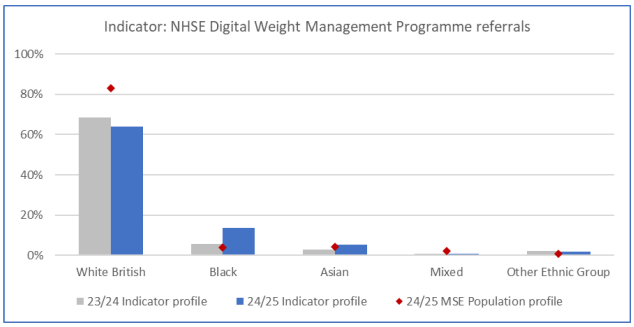
Patients continue to be able to access the Local Authority public health commissioned community smoking cessations services in addition to those above.

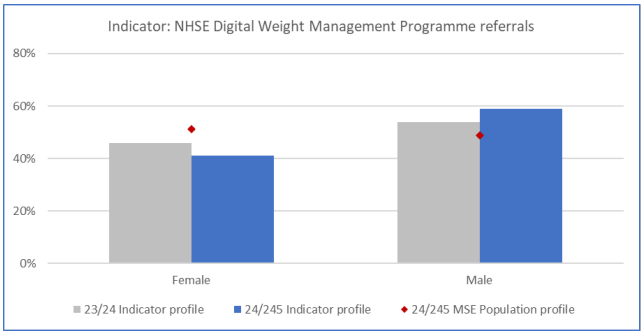
Weight Management

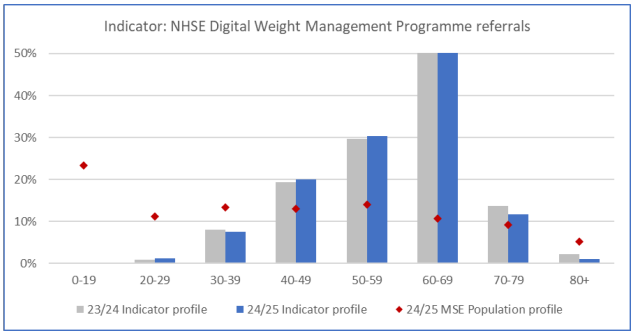
The ICB supports GP Practices in referring patients to the nationally commissioned NHS Digital Weight Management Programme. The programme supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

There is a greater proportion of referrals into the Digital Weight Management Programme from the more deprived areas of MSE, and an over-representation from non-white British ethnic groups, and an increasing proportion from men. These are positive trends that will support the reductions in health inequalities in obesity.









Conclusion

This is the second health inequalities annual report that NHS Mid and South Essex has published. We have seen an expansion in the number of metrics and quality of data and insights, to facilitate action in reducing health inequalities. Now for the first time we have trend data that enables us to assess whether we are narrowing the gap in health inequalities and areas we need to put more effort and focus.

This report shows our health inequalities gaps are concentrated around our population that live in the most deprived communities and those from diverse ethnic backgrounds. The ICB continues to be committed to embedding prevention, early intervention and tackling health inequalities across all our work and with our partners within the Integrated Care System.

Part I Board Meeting, 15 May 2025

Agenda Number: 12

ICB QUARTERLY COMMUNICATION & ENGAGEMENT IMPACT REPORT

Quarter 4, 2024/25

Summary Report

1. Purpose of Report

To provide the Board with an overview of performance against the ICB Communications and Engagement Strategy 2025-2027 during Quarter 4 (Q4) of 2024/25.

2. Executive Lead

Tom Abell, Chief Executive Officer

3. Report Author

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

4. Responsible Committees

Not applicable to this report.

5. Link to the ICB's Strategic Objectives

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
- To be an exemplary partner and leader across Mid and South Essex Integrated Care System, working with our public, patients and partners in the Integrated Care Partnership to jointly meet the health and care needs of our people.

6. Impact Assessments

Delivered within the context of work programmes across the reporting period as outlined

7. Financial Implications

Delivery is within the confirmed corporate and associated programme budgets

8. Details of patient or public engagement or consultation

Delivered within the context of work programmes across the reporting period as outlined

9. Conflicts of Interest

None identified

10. Recommendations

- **Note** the delivery and impact of strategic and operational communications and engagement activities in Q4 2024/25, including alignment to the Communications and Engagement Strategy 2025–2027 approved at the Board meeting on 14 November 2024
- **Endorse** the proposed improvement actions and acknowledge the capacity risks posed by running cost reductions, including the need to re-prioritise planned activity in 2025/26.
- **Provide feedback** to inform the refinement of future reporting.

EXECUTIVE SUMMARY

This report provides a comprehensive overview of communications and engagement activity delivered by the ICB during Quarter 4 (Q4) of 2024/25, aligned to the Communications and Engagement Strategy 2025–2027 approved by the Board in November 2024. It outlines how strategic communications supported the system's Joint Forward Plan, development of the Medium-Term Plan (MTP), and ICB transformation priorities.

The report is structured around three strategic pillars:

1. **Supporting system strategic priorities** through proactive campaigns and stakeholder engagement.
2. **Delivering business-as-usual (BAU) communications** to maintain effective operational communications and engagement.
3. **Strengthening internal communications** to improve staff engagement and resilience during organisational change.

Headline Achievements This Quarter

- **Winter communications** supported a 149% increase in Winter Hub visits YoY and a 22% reduction in falls admissions among 85+.
- **Primary care campaign** delivered a 22.5% increase in NHS App downloads and a 166% increase in Frontline Essex referrals.
- **Email marketing reach** grew by 7.6%, with average open rates of 43.3% and a campaign-high click rate of 76.9%.
- **Media relations** delivered over 90 pieces of coverage with 60% positive sentiment, supported by a new editorial partnership with the *Echo*.
- **Internal engagement** saw an increase in the NHS Staff Survey engagement score from 5.87 to 6.60, aligning with national ICB averages.
- **Insight-led engagement** reached over 6,000 people via Virtual Views and gathered over 1,300 contributions to inform system planning.

These activities have contributed directly to strategic priorities including urgent and emergency care pressures, improved access to services, and stronger staff morale during cost reduction planning.

The final section of the report summarises lessons learned, areas for improvement, and key opportunities to enhance the impact of communications and engagement in 2025/26.

We are pleased to share this inaugural report and would welcome your feedback to help strengthen and refine future reporting as we move forward.

Appendix A – NHS Change 10-Year Plan Insight Report – output of our engagement activity

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1. STRATEGIC PRIORITIES

Progress on supporting system strategic priorities through proactive communications campaigns and engagement activity in Q4 2024/25.

Key Campaign Performance

Figure 1, proactive communications campaigns and engagement activity in Q4 2024/25

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
Local insight to inform 10 Year Plan / ICB Medium Term Plan	To capture local insight to inform the national 10-Year Plan and local medium-term plan and specifically around the three 'shifts'.	Underserved community groups. Staff and stakeholders.	Nine community focus group.s Four online workshops plus staff and stakeholder workshop. Stakeholder bulletin/social media.	Feedback has been shared with national colleagues to help inform the 10-year plan. A local insight report has also been developed – see Appendix A.	Insight is already being used to inform local planning and strategies as part of the ICB Medium Term Plan and MSEFT 10 Year Strategy. It has also been shared with partners to support wider planning.
Urgent & Emergency Care (UEC) & System	Achieving 55-60% vaccine uptake by Mar '25	People aged 65 and over People 18-64 with	12 press releases, Digital: 129 social posts with 441,767	Generated 44 media placements reaching over 736,000 people	Partial achievement of vax uptake (53.3% overall) Winter Hub visits up 149% from

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
Flow **Supporting System resilience in winter in Q4**	Increasing online winter hub traffic by 5% Delivering communication sprints, increasing email subscriptions by 5%, securing media partnerships Reducing falls-related admissions by 10%	clinical long-term conditions Pregnant women and birthing people Residents of Basildon, Brentwood, Thurrock, Southend, and Canvey Parents of children aged 0-11	average reach, 21,576+ emails sent to subscribers, Digital advertising campaign with 220,056 impressions Vaccination bus roadshow to four target areas	1,000+ older people provided with new slippers to prevent falls 46,767 views of Winter Hub Falls prevention ranked as most clicked content area in winter emails 206 vaccinations administered at roadshows	previous year Email subscriptions increased by 7.6% (exceeding 5% target) Falls-related emergency admissions reduced by 22% in January 2025 compared to January 2024 23% reduction in falls for high-risk 85+ age group
Strengthening primary care	Raise awareness of the modern general practice model and free up access to GP services via new ways to access care in mid and south Essex i.e. self-referral, pharmacy consultations, and NHS App tools.	Local residents aged 25–65, targeting specific areas that see frequent access to GP services for minor or non-urgent issues. Carers, parents, and digitally-engaged patients likely to benefit from self-service and app-based options.	6 press releases 16 patient and staff case studies Editorial media partnership delivering six GP-led columns and an exclusive video cascade. Integrated advertising campaign, across traditional print (newspapers), digital outlets.	2,471,540 media reach, editorially across 42 media outlets via 59 news items. Further 1,044,560 reach via print advertising. 5 broadcast interviews secured with 187,500 impressions delivered via radio advertising 46,776 impressions	**NHS App downloads, logins and prescriptions ordered for mid and south Essex:** • **22.46% increase** in downloads from Q4 2024 to Q4 2025 • **61.91% increase** in logins from Q4 2024 to Q4 2025 • **38.54% increase** in prescriptions ordered via NHS App from Q4 2024 to Q4 2025 **Pharmacy First consultations:** **47.67% increase i**n Pharmacy

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
			Insight driven campaign creative System campaign toolkit with assets for GP surgeries: posters, digital screen graphics, pop-up banners, short film.	delivered via digital advertising (display and Facebook) 6,713 total views on the main campaign landing pages on the ICS website. 3,358 total views of self-referral information on ICB website an increase of 32.5% vs Q3. 3,400 views on the campaign launch video via the Echo Essex Facebook page Campaign resources showed the highest engagement for Q4 on the MSE Primary Care Hub.	First consultations from Q4 2024 to Q4 2025. **Frontline Essex referrals and signposts:** Referrals: • Q4 2024: 459 • Q4 2025: 1,222 166.23% increase Signposts: • Q4 2024: 2,760 • Q4 2025: 10,062 264.57% increase Incr. awareness and knowledge of local service provision / NHS app capability.
	Promote improvements in dental service provision.	Local residents. Parents and carers of primary school children. Care home residents/families	2 press release plus pitch to national media 1 blog 4 internal updates ICS Website content	11 news items across 11 media outlets (online and print) including The Express online. Blog: 71 views Website page: 241	Increased public awareness of strengthened dental access. Positive engagement from staff on internal updates. Bolstered reputation of schemes helping engage further schools/care homes who have

Campaign area	Objectives	Audience	Outputs	Outtakes/Outcomes	Impact
		of residents. Users of NHS dental services.	further developed 1 marketing email sent to 9k+ subscribers	views	been reluctant to engage.
Shared Care Record	Support onboarding of new partners and data sources through timely, targeted communications. Improve awareness of new data availability among current and potential users. Encourage meaningful use of the Shared Care Record to support safer, more joined-up care.	Wider MSE ICS partners already live with the ShCR Teams in local hospices Southend City Council Adult Social Care Programme Board and digital transformation leads Comms engagement teams across partner orgs	4 launch comms toolkits created to support onboarding of new partners 65 tailored comms assets developed and shared to support integration of new data Case study framework introduced to support safe, ethical, and effective storytelling Two case studies approved and promoted across internal and external channels	2,408 new users registered during Q4, bringing total to 8,534 Average logins per user per week increased to 7.86 from 7.26 (an 8.3% increase) 2,384 views of ShCR information and guidance via internal channels	Increased user engagement and utilisation of the Shared Care Record Improved awareness and confidence in data availability, supporting more proactive and informed care decisions Four new partners successfully onboarded during Q4 New data from Southend City Council adult social care, NHS111, and MSEFT safely communicate

2. BUSINESS AS USUAL ACTIVITIES

The section contains a brief description of significant business as usual (BAU) communications delivered and their outcomes.

2.1 Internal communications highlights

Staff intranet and bulletin

2024 staff survey results show an upward trend in ICB staff engagement with ICB staff feeling more motivated and involved to deliver against the organisational strategic objectives. The ICB intranet serves as the main internal communications hub, with the homepage attracting **90,000 views** during Q4. User engagement remains strong, with visitors spending an average of 8 minutes per session.

Content related to professional development drove the longest engagement metrics in Q4, with Learning and Development Week content holding user attention for 28 minutes on average. Allied Health Professionals content followed with 18-minute average sessions, while the Safeguarding Survey showed strong engagement.

A **dedicated space for the ICB Running Cost Reduction programme** has also generated significant interest, with 1,744 views in Q4. Maintaining a regular drumbeat of information and support with frequently updated FAQs helps allay confusion and anxiety and support staff in maintaining performance during a period of uncertainty. HR policies, forms, and guidance continue to be a valuable resource, with 1,313 views.

Q4, saw intranet development with several new and refreshed sections to serve staff needs better:

- Launch of a ICB Running Cost Reduction section
- Refresh of the Digital and Technology self-serve resources
- Update of the ICB Staff Networks section
- Development around our guide to ICB communications and engagement for staff
- "Understanding Devolution in Greater Essex," a comprehensive guide for staff.

The Connect Digest newsletter with key organisational updates has also maintained strong engagement metrics across 12 editions in this quarter, with open rates routinely outperforming industry averages.

Staff engagement and briefings

The Viva Engage platform (as part of Microsoft 365 package) continues to drive internal social engagement, with 38 posts from a mix of staff during Q4 averaging 393 views per post. This quarter's six all-staff briefing sessions drew consistently strong participation, with an average of 289 attendees per session with regular updates on financial efficiency measures, medium-term plan/priorities and ICB cost reductions.

2.2 Primary care communications highlights

Primary Care intranet and bulletin

The Primary Care Hub has emerged as our highest-performing resource platform with **82,000 page views in Q4** and over **4,000 active users**, demonstrating strong engagement from healthcare professionals regularly accessing the hub to support in delivering services to patients. A key milestone achieved in this quarter is **surpassing 1 million site visits since the Primary Care Hub launched in June 2023.**

The Medicines Optimisation section was 'most visited,' with nearly 11,000 views in Q4, highlighting the critical importance of centralised medication management resources for local primary care professionals. The Hub homepage follows closely with 10,433 views in Q4, serving as an effective gateway for system updates, key announcements, operational updates and resources, and support.

The section with the highest engagement in Q4 (i.e. most time spent) featured communications resources to help GP practice staff promote ways patients can help free up access to GP appointments through a 'Get the Care you Need Quicker' campaign page hosted on the intranet.

High use of the search function (9,373 views in Q4) indicates that users are actively navigating the platform to locate specific information rather than passively browsing—a strong indicator of the Hub's value as a practical, on-demand resource. Ongoing engagement across our alliances and directly via practices ensures a regular stream of access requests to the hub continues, demonstrating that practices across mid and south Essex value the use of the resource.

Analysis of our most-accessed clinical topics provides valuable insight into frontline priorities and challenges:

- Weight Management Services dominated, with multiple related pages appearing in our top 30 most visited resources, together with information around ADHD prescribing also attracting 541 views during this period. Timely information and resources such as patient letter templates have also helped save time for GP staff and ensured consistency of communications to avoid confusion.
- Similarly, a dedicated webpage to convey regular HbA1c testing information to GP practices in mid Essex has ensured business continuity.
- Cancer updates across various pages have drawn significant traffic, reflecting the ongoing priority to improve performance in this area.

The MSE Primary Care Bulletin continues to be a well-utilised resource by practices across mid and south Essex achieving high, above standard engagement rates.

The bulletin was also redesigned in this quarter to ensure easier navigation (including a new overview links section and 'practice action' highlights). Anecdotal feedback so far from practices and colleagues across the ICB has been positive.

2.3 Media relations highlights

26 press releases issued by the ICB team in Q4 generated **over 90** proactive pieces of media coverage across national, regional and local print, online and broadcast channels. This includes; a national feature on the care home dental service in The Express, coverage of the winter vaccination programme and oral health school initiative on BBC Look East, national trade coverage (Digital Health) for UKs first 111

dental booking technology and HSJ Executive Interview with Tom Abell highlighting system challenges and opportunities, all of which have strengthened relations with key media outlets.

Timely responses for **45 media enquiries** on a range of topics linked to system performance, quality, estates and financial challenges also ensured fair, accurate representation of complex issues affecting the ICB.

Following proactive and reactive media relations efforts, 60% of ICB media coverage carried positive sentiment compared to around 30% negative sentiment with the majority of coverage now via online media. System media coverage has seen a more split sentiment with reporting around patient concerns linked to a recent GMC hearing, the conditions at the Wethersfield asylum site and the Lampard Inquiry negatively impacting sentiment.

Strategic Media Partnerships: Success in negotiating an editorial partnership with the biggest daily newspaper (Echo), to help deliver targeted reach to digitally excluded target audiences and support delivery of key messages around primary care access recovery – see Figure 1. This resulted in significant free publicity to promote benefits of downloading the NHS App, promotion of local self-referral services, and the new roles available at local GP practices. This approach helped the ICB to tap into established audiences and deliver organic reach leading to higher engagement rates than paid-for communications activity, building trust and authentic engagement.

2.4 Digital communications highlights

ICS Website

Total visits to the ICS website in **Q4**: 108,586, with 57.5% engagement (62,436 engaged sessions i.e. people stayed longer than 10 seconds and/or clicked on multiple pages).

Website acquisition data shows us that most people visited our site following use of search engines. This was dominated by Google (63.3% of traffic), with higher engagement on Bing (68.5% vs. Google's 60.1%). This indicates the website is likely addressing specific search queries that users are looking for. Proactive media coverage will support this as people seek out more information on priority health topics they hear or read about. Search engine optimisation (SEO) is working effectively with content being indexed and ranked well by search engines.

Top performing Content

Health Advice Pages: Strong performance, especially Winter Health content (above average engagement at 52.3%) and information about how people can self-refer into services with over 3,300 views in Q4, helping support primary care access recovery.

An ADHD prescribing FAQ has also delivered over 3,200 total views helping to ensure people have access to the latest accurate information to help counter misinformation circulating on social media.

Publications (commissioning policies and corporate documents) and job vacancy sections are also generating high engagement (57.8 seconds for publications).

Email marketing

Regular and automated email series have generated 3% of all traffic to the ICB website (0.5% more than social media), with high engagement (62.7%) and 31% more time spent on-site. This indicated that the content via email is resulting in people actively searching on our website for more information linked to priority health campaigns.

Automated email campaigns, developed by the ICB comms team in partnership with clinical leads, offer an efficient way of getting pre-written key information about service provision in the community to local residents, helping people get the right care at the right time from the right service. To date we have just under 30,000 subscribers, who receive ICB communications across the below topics.

Current Subscription Distribution (as of March 1, 2025)

Topic	Subscriptions
General news	6,963
Health and wellbeing matters	6,776
Mental health	5,552
Children's health matters	4,863
Winter communications	3,228
Engagement (get involved)	1,732
Pain management	514
Women's health and wellbeing	209
Men's health and wellbeing	82
Total subscriptions	29,889

Note: Total subscriptions represent the cumulative number of topic subscriptions, not unique subscribers. Many subscribers choose multiple topics of interest, so the number of unique individuals is lower than the total subscription count.

An automated email campaign sent in Q4 around 'Children's Health Matters' saw the biggest reach, with key health information linked to nine topics. Topics included top tips from local clinical leads about physical and mental wellbeing, oral health, sepsis warning signs and key vaccination information including measles. This campaign reached over 4,700 people.

Overall open rates of ICB e-marketing bulletins is **43.26%** with click rate of **5.61%** among those who opened. E-marketing bulletins have also supported the ICB to directly engage with the community it serves with the highest click rate across all external bulletins linked to a 10-year plan engagement session at 76.92%. Multiple case studies and user-generated content have also been sources via our e-marketing subscriber lists.

Social media

Our social media activity generated a total organic reach of 67,667 across all platforms in Q4. This figure represents the number of times ICB-generated content appeared on users' screens without paid promotion. Increased link clicks indicate

improved traffic to services and key health and wellbeing information on the website. Content focused on health prevention, such as managing blood pressure or recognising early signs and symptoms of conditions like cancer and stroke, has been especially well received with video content performing particularly well.

Summary of platform-specific achievements

LinkedIn: Highest engagement rate across all platforms at 3.3% - significantly outperforming industry benchmarks with 36 posts successfully resonating with professional audiences (3,451 followers) to showcase work in mid and south Essex.

Nextdoor: building on learning from local authority partners, a new strategy focused our efforts on sharing targeted content. This platform is mainly used by over 55s, who tend to be key service users. This has seen exceptional reach efficiency with 419,873 impressions **(**number of times ICB content is shown on someone's screen) - nearly six times higher than Facebook with 88 link clicks from just 74 posts. As a public sector organisation, content is automatically sent to **all** Nextdoor members in mid and south Essex. The ICB shares an account with our hospital Trust (same geography) to drive efficiencies. Every click drives target audiences to specific information to support local health communications and engagement goals from vaccination clinics to information about local pharmacies offering blood pressure checks.

Facebook and Instagram: Maintained a consistent community presence with 2,601 followers and 2,499 page fans. Generated steady engagement across 204 published posts.

Instagram stories showed promising engagement metrics with 1,562 views.

Audience sentiment analysis shows positive sentiment (42.17%) outweighing negative sentiment (31.30%)

Key Q4 Insights

Health condition management (e.g., self-harm, ADHD, fertility) and winter health information accounts for nearly half of all page views with e-marketing and search engine optimisation approaches being the most successful in driving website traffic. The data demonstrates the role of communications in supporting system pressures, ensuring residents can find information about which services or action they need to take to stay well.

2.5 Engagement highlights

Q4 has seen significant work to gather local insight to help inform the national 10 Year Plan / ICB Medium Term Plan, please see Figure 1 for more information and Appendix A for the full report.

Virtual Views

Virtual Views, the digital engagement platform in mid and south Essex, continues to deliver high levels of engagement to support and inform a range of strategic commissioning decisions. Q4 saw 6,170 people visit Virtual Views with 1,334 contributions and an engagement rate of 26%.

This quarter's top survey was the public's experience of blood testing services with over 1,000 people informed about the work and over 650 people taking part in the survey. A recent Talking Therapies survey delivered 110 survey responses in just a week.

The team has also helped facilitate local engagement, supporting Colne Valley PCN to create a specific local page, looking at experiences of breast screening in the area to help improve future uptake. From The Pump House Surgery, we had 399 survey responses. This comprehensive tool has really supported the ICB to meet our statutory requirement of involving the public, especially when promoted via trusted voices within our underserved communities, and is demonstrated by the levels of engagement we now achieve.

Research Engagement Network (REN)

The REN project has continued to deliver improved research opportunities for underserved communities across mid and south Essex. The ICB has secured £63,500 funding from the NIHR and NHSE Research in Q4. This funding supports REN community groups and our community champions to deliver research in their community. Including the Genes & Health research study that targeted Bangladeshi and Pakistani communities.

Via a Be Part of Research QR code we have increased the numbers involved by more than 12,000. Covering a wide age range and matching our local demographics.

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3. ORGANISATIONAL DEVELOPMENT SUPPORT

Effective internal communications is a key tool in supporting organisational development. Q4 data shows the valuable role internal communications is playing in supporting staff engagement and the People Promise to staff around their learning and development. Clear, accessible and timely information around ICB cost reductions is helping maintain staff performance during a period of uncertainty. While easy access to organisational forms, guidance and policies is ensuring the ICB's workforce can comply with organisational expectations and procedures. This protects and supports both employees and the organisation from legal issues, regulatory penalties, and reputational damage. Developments in corporate internal channels in Q4 have ensured the ICB can listen and engage with staff instead of just telling. See section 2.1 for more information.

The 2024 NHS Staff Survey results in Q4 show a marked improvement in staff engagement across the Integrated Care Board (ICB), with the overall engagement score rising from 5.87 in 2023 to 6.60 in 2024 on a 0–10 scale. This brings the ICB in line with the national average of 6.63 for other ICBs. The engagement theme comprises three sub-scores, all of which have shown meaningful progress: motivation increased to 6.61 (from 5.97), involvement to 7.11 (from 6.47), and advocacy to 6.05 (from 5.19).

4. Q4 SUMMARY: what worked well, what didn't and opportunities to improve

Strengths:

- Effective stakeholder workshops and focus groups with underserved communities to inform national/local plans and priorities.
- Strong case studies ensured human interest/storytelling which boosted media coverage and generated highest engagement.
- Negotiated editorial columns effectively reached harder-to-reach groups.
- Effective co-production and early engagement with key partners has supported system working while ensuring consistent messaging and assets to support key campaigns.
- Strong use of data/local insight has effectively informed communications planning and resulted in positive impact (see Figure 1).
- Early stakeholder involvement and public engagement has helped ICB successfully manage difficult issues.
- Strong email marketing (7.6% subscription growth) and social media (441,767+ reach)
- Successful proactive PR (Over 90 pieces of generated media coverage) ensuring key message delivery in line with organisational priorities.
- Timely media statements has ensured balanced reporting, supporting effective reputation management with 60% positive sentiment.
- Strong engagement and positive feedback on ICB internal communications channels supporting effective primary care communications and ensuring staff are supported with clear, timely information during a period of uncertainty.
- The Research Engagement Network project provided valuable insights and actionable recommendations for enhancing community engagement and research participation to help improve future services.

Improvement Areas:

- Opportunity to localise national campaigns, with local people and services seeing stronger engagement than nationally developed materials.
- eMarketing - whilst open rates were strong, for some campaigns, click-through rates are lower than expected as content is contained within the email body rather than encouraging website visits. Therefore we need to shift from putting full content in emails to using them as teasers that drive traffic to website for more detailed information to improve overall digital performance.
- Access recovery campaign - while the editorial aspect of the campaign has been successful with PR agency support via external funding, investing more time in short-form video, and real patient and staff case studies to help humanise and boost interaction across our social channels could have generated further engagement. However, more investment would be needed.
- Clarification on campaign budgets early in campaign planning.
- Improved stakeholder engagement framework to reduce fragmentation and duplication across ICB and the system.
- Some staff reported that they struggled to easily find important information on the Intranet in a recent Pulse survey.

Opportunities:

- Expand case study development and digital channel reach.
- Build on winter communications framework.
- Further integrate community insight into planning and strategies.
- Enhance ICS partnerships and leverage relationships with underserved trusted voices who can help amplify campaign messages.
- Further develop geographically-targeted communications and media, using local insight and data to help address local challenges and improve outcomes.
- Increase myth-busting content and how-to guides.
- Build feedback from stakeholder interests identified through pulse survey into content plans for stakeholder bulletins.
- Review findings of recent Pulse survey with staff to understand how we can make important information easier to locate.
- Broaden the local role of the MSE Research Engagement Network to ensure its sustainability and support the delivery of engagement within our underserved communities.

4.1 Looking ahead

Next Quarter Strategic Communications Priorities

As we enter the next quarter, our key focus will be taking learning forward while supporting the priority areas outlined in the Medium Term Plan (MTP) and leading internal communications around ICB cost reductions. We will develop a comprehensive communications approach to support implementation, ensuring staff and stakeholders understand the direction of travel.

Risks for Q1 include existing capacity concerns. ICB running cost reductions and consequential reorganisations will also naturally present a risk to delivering plans meaning re-prioritisation will be required, as necessary.

APPENDICES:

Appendix A – NHS Change 10-Year Plan Insight Report

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

NHS Change:
10-year Plan Insight Report

Author: Tina Starling
Senior Insight and Involvement Manager

Date: 3 March 2025

Executive Overview

Introduction

In October 2024, a joint **DHSC and NHS England** team was established to deliver a 10-Year Health Plan entitled the **'NHS Change 10-Year Plan.'** The plan aims to set out how we will deliver an NHS that is fit for the future, creating a truly modern health service designed to meet the changing needs of our population.

The plan aims to set out how we will deliver an NHS that is fit for the future, creating a truly modern health service designed to meet the changing needs of our population."

An interim report from the entire feedback received nationally has now been published and all who participated in the workshops are being asked to give their feedback to the priorities identified so far. A final plan is due to be published later in the Spring of 2025.

This executive summary for mid and south Essex combines the findings from staff and stakeholder focus groups within the area and covers the three shifts required by the NHS 10 Year change plan. The analysis reveals strong interconnections between these areas, with stakeholders consistently emphasising the need for integrated, accessible, and patient-centred healthcare delivery while using technology and community-based services for prevention and treatment.

The local story Mid & South Essex

It was really important that the feedback we collected came from a diverse range of community groups. The engagement team were successful in bidding for some engagement funding which they allocated to underserved community groups to encourage them to take part. We offered small grants of £200 to those who wanted to lead a focus group within their community. The incentive could be used to give honorariums to participants or pay for rooms and refreshments, whatever was appropriate for their community.

A wide range of groups came forward, many from our Research Engagement Network community.

- Seventh Day Adventist Church – Black Community
- Southend Community Assembly – Healthwatch Southend
- Westcliff Gifted Kids – Jewish Community
- Save Maldon Medical Services – Maldon Campaign Group
- Multicultural Essex Women's Assn – South Asian ladies
- Mzansi UK Forum Group – South African group
- Brentwood and Thurrock MIND – Mental health group
- Gypsy Roma focus group – GRT community
- B3 Bumps, Birth Belonging – Black women's maternity group

Many more groups wanted to get involved but time restraints and local resource prohibited their participation. To facilitate the focus groups, especially those from our underserved communities, the engagement team provided training and support using the national 'Workshop In a box' slides and tools. This offered us the opportunity to maximise the amount of insight gained.

We also ran a successful session during a regular staff briefing, to capture the views of the staff as well as a session with our MSE Integrated Care Partnership members.

To capture the broadest range of views we also ran four online sessions, initially we organised two focus groups with 20 places each, as both sessions filled within 24 hours, we had to add another two session and upped the numbers to 40.

ICB’s Medium Term Plan & MSEFT’s 10-year strategy

Insight from the focus groups

1. Analogue to Digital Improvement

Patients generally support the integration of digital tools within mid and south Essex to enhance both accessibility and convenience. The NHS App has seen increased usage, allowing patients to manage appointments, access medical records, and receive health information digitally and this is welcomed in general by the participants.

However, concerns persist regarding AI, data security and digital literacy. Many attendees taking part in the focus groups feared that their personal health information may not be adequately protected in digital formats, leading to potential breaches of privacy. Additionally, individuals with limited digital skills or access may feel excluded from these advancements in technology thus increasing overall health inequalities.

Priorities for MSE should include:

- Implementation of an MSE Electronic Patient Records (EPR) system with standardised access
- AI integration for diagnostic support and data analysis
- A multi-channel communication system that supports diverse access needs
- Robust security and privacy protection measures

2. Hospital to community services

Participants of the focus groups were generally supportive for community-based care. Many people appreciate the idea of receiving care closer to home, avoiding long travel times, expensive parking, and the stress of hospitals making it generally more convenient and accessible. They felt patients feel more comfortable in familiar environments and prefer local, more personalised care which would be offered in their own home.
This would lead to;

- Freeing up hospital beds so our acute hospitals can focus on the most critically ill and sickest patients while others recover in the community.
- Potentially quicker access to care in local settings.
- Being treated at home reduces exposure to hospital-acquired infections.
- Improved well-being, some groups, like dementia and Parkinson’s patients, may benefit from staying in familiar surroundings.
- Virtual wards and home-based care, provide additional support whilst allowing medical teams to monitor patients remotely.

Concerns

There are concerns about whether local services can match hospital expertise, especially given community staff shortages. Many feel that community care is underfunded and poorly co-ordinated, leading to inconsistent services. A lack of social care support puts vulnerable individuals at risk, while rural transport issues make access difficult. Shifting care to home-based may burden unpaid carers who may have their own health issues to contend with. The reliance on digital platforms raises accessibility concerns, particularly for older adults or those with poor internet connections, especially in rural areas. Unequal service access, funding disparities, and gaps in support for specific populations worsen health inequalities. Past failures, like 'Care in the Community' for mental health, serve as cautionary examples.

Conclusion from the focus groups:

> **"The idea of moving more care into the community is widely supported if done correctly. However, there's a lack of trust that the necessary funding, staff, and co-ordination will be in place to make it successful."**

People want **real investment in community care, not just hospital closures without proper replacements.**

A phased approach, including rehab care hospitals, could ease transitions from hospital to home. Success does depend on properly funding social care, improving co-ordination between hospitals, community, and primary care, and providing better training for community staff. Investing in local health hubs, community diagnostic centres, well-maintained community facilities, and transport solutions are essential for both accessibility and effective service delivery.

3. Prevention-focused healthcare

Insight from the focus groups showed that the public strongly supports prevention but highlights several concerns. They see it as a way to reduce reliance on medication, improve long-term health, and ease pressure on the NHS. However, they emphasise that prevention must be well-designed, properly funded, and accessible to all.

Key themes include:

- **Early detection and screening:** Calls for earlier and more accessible cancer screenings, blood tests, and genetic risk assessments. Many feel cut-off age limits should be reconsidered.
- **Mental health and social support:** Prevention must go beyond physical health, addressing mental health through early intervention, education, and social care. Loneliness and isolation are also seen as major risk to health.
- **Health inequalities and accessibility:** Poverty, poor transport, and digital barriers make prevention inaccessible for some, highlighting more local, in-person services are needed.
- **Education and behaviour change:** Prevention starts in schools, with better education on nutrition, exercise, and lifestyle choices. Nudges and practical support are preferred over top-down messaging.
- **Vaccinations and misinformation:** While many value vaccines, misinformation remains a barrier, which seems to be growing. Stronger public health campaigns and direct access to vaccines are needed.
- **Holistic and personalised care:** The insight shows that one-size-fits-all strategies don't work. People need tailored support, especially for weight loss, diabetes, and long-term conditions.
- **Better system integration:** Prevention efforts must be joined-up across the whole system NHS, system partners including various private providers, the social care system, and the community organisations and charities, with long-term funding plans and less bureaucracy.

> **"Ultimately, prevention is seen as essential by the participants but must be practical, inclusive, and genuinely improve lives."**

Conclusion

“The successful transformation of healthcare services within MSE requires a carefully balanced approach that integrates digital technology, community-based services, and prevention initiatives.“

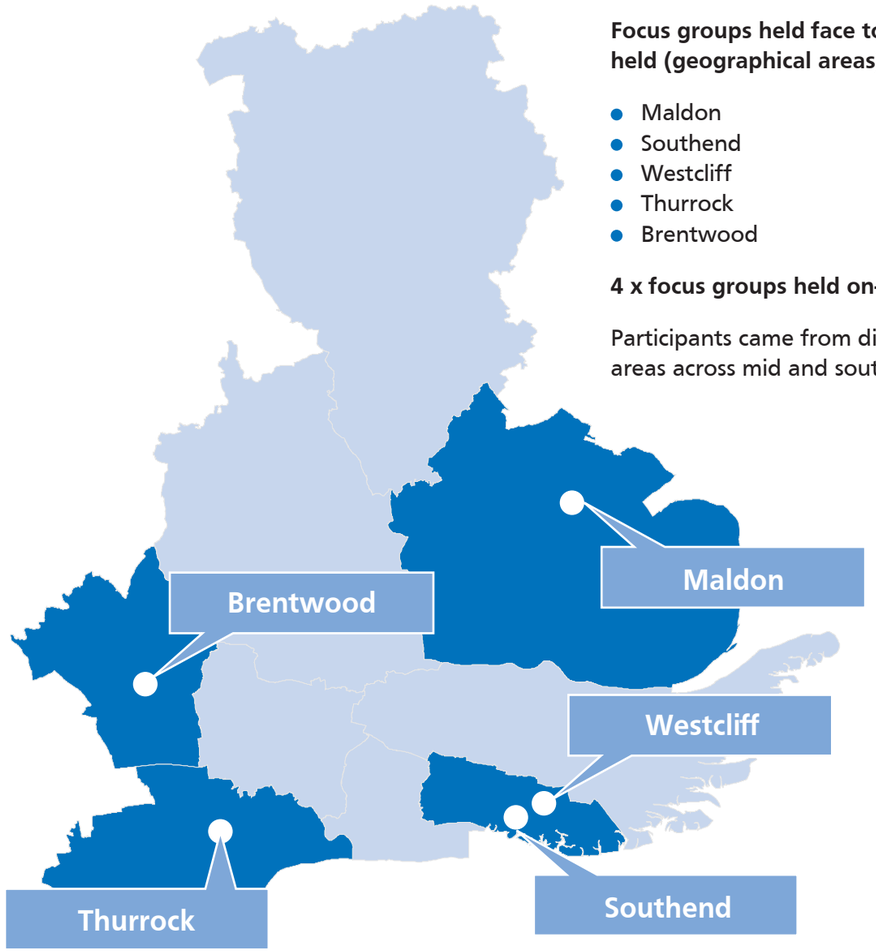
Key to success will be maintaining accessibility for all populations, ensuring robust support systems, and carefully managing the transition to prevent exclusion of vulnerable groups. The focus should remain on creating an integrated, accessible service that maintains high standards of care while improving patient experience and outcomes.

The ICB should prioritise:

1. Sustainable, long-term funding commitments
2. Breaking down silos between services and organisations
3. Maintaining the ‘patient-centred’ element in healthcare delivery
4. Addressing social determinants of health
5. Regular evaluation and adaptation of services

The insight we have gained as part of this process represents a significant opportunity to improve healthcare delivery and outcomes in mid and south Essex. As part of this process, we collected feedback from a wide range of people and many different communities, but success will require careful attention to concerns our people and communities have raised and a commitment to inclusive, services that are accessible to everyone.

Community Engagement map



Focus groups held face to face held (geographical areas):

- Maldon
- Southend
- Westcliff
- Thurrock
- Brentwood

4 x focus groups held on-line:

Participants came from different areas across mid and south Essex.

Participation statistics

For demographic/community groups taking part in face to face focus groups

Gypsy Roma Traveller
(Included Polish community)

Jewish Community
(Westcliff Gifted Kids cultural/faith group)

Afro Caribbean
(pregnancy, birth and parenting)

South African group
(Mzansi UK Forum Group)

Asian
(Multicultural/Ethnic Womens Association)

Mental Health communities

Seventh Day Adventists
(Global majority faith group)

Community Voice Panels

AI has the potential to address and lift some racial bias in treatment as well as people being held accountable for their actions. AI simply uses numbers, ethnicity doesn't and shouldn't come into it as a result.

Quote from
Bumps, Births and Belonging CIC

Virtual GP appointments we felt could be a disservice to the public as the GP's will possibly miss signs and symptoms by doing virtual appointments.

Quote from **Jewish community**

New houses need more GP's – link housing and infrastructure.

Quote from **Healthwatch Southend**

Community Diagnostic Centres to me are a no brainer! I think they are an excellent idea.

Quote from
focus group run on line 16 Jan 2025

Hospital to community care - I live in Shalford and we no longer have a bus service, so local services would be brilliant!

Quote from
focus group run on line 16 Jan 2025

Ambulance triage – No visit to A&E is always good!

Quote from
focus group run on line 22 Jan 2025

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Communications and Engagement Impact Report: Q4 2024/25

Q4 key campaigns and coverage


Youngsters at Southend High School for Boys learn about health service

Pupils create games to help NHS 'manage budget'

Echo

BBC ESSEX

Norovirus – What you need to know and how to look after yourself

By John Swanson, Lead Nurse for Infection Prevention and Control

Essex NHS campaign to tackle 'silent killer' launched

21ST FEBRUARY HEALTH

Campaign - Baba Akomolafe at the pharmacy counter (Image: Mid and ... Integrated Care Board)

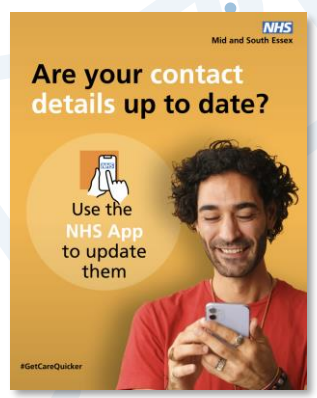
EXPRESS

'Amazing' 105-year-old woman eats her favourite breakfast again thanks to NHS scheme

Ivy Ritter benefitted from a new NHS scheme launched in Essex

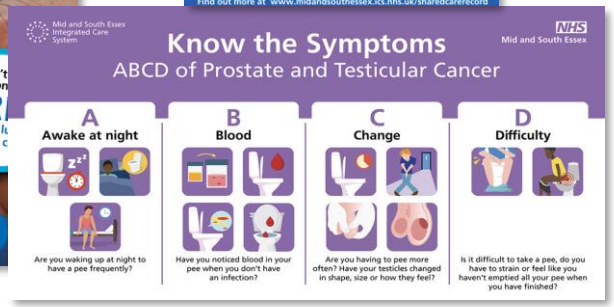
By HANNA GEISSLER, Health Editor

Share Article Bookmark 0 Comments



Appointments with GP teams increase while services demand rises

Slipper swap project is helping to cut down on people having bad falls



7 Million Appointments delivered by GP Practices in Mid and South Essex in 2024

By Essex Mag February 18, 2025

Share on Facebook Tweet on Twitter

Latest figures reveal that GP teams across mid and ... delivered almost seven million appointments in 2024*, a 5% increase in appointment activity compared to 2023.

NHS scheme praised for helping patients to receive urgent treatment

Initiative delivers 23,500 extra dental appointments

Staff comms

Connect intranet

90,000 total visits

500 unique visitors

8 mins per visit (avg)

Highest engagement

1. **28 minutes**
   Learning and development week
2. **18.5 minutes**
   MSE Allied Health Professionals
3. **14.4 minutes**
   Important safeguarding survey

Connect Digest

31.4% average open rate

26% average click rate

Top topics

1. Annual Leave Carry Over: Important Deadlines Approaching
2. ICB Running Cost Reduction
3. NHS Staff Survey

Primary care comms

Primary Care Hub

82,000 Page views

4,160 Active Users

Highest engagement

1. **8 minutes**
   Get the Care You Need Quicker campaign resources
2. **7+ minutes**
   Designing Accessible Content for Patients
3. **6+ minutes**
   Meds Optimisation (MSEMOC)

Primary care bulletin

36.63% average open rate

20.81% average click rate

Top topics

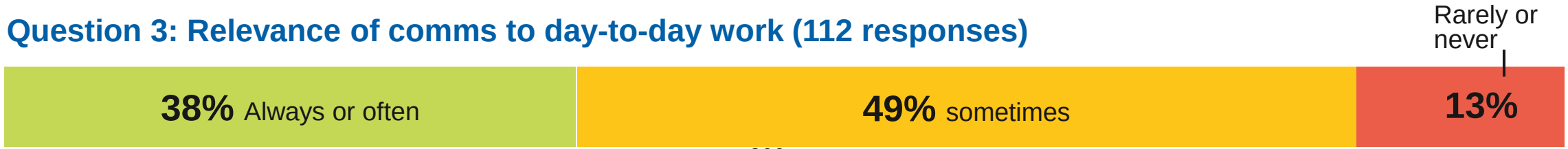
1. HbA1c updates
2. Tier 3 Weight Management
3. ADHD

Internal comms quarterly pulse poll

Question 1: Understanding organisational priorities (91 responses)

Question 2: Ease of finding important information (109 responses)

Question 3: Relevance of comms to day-to-day work (112 responses)



External Communications

Social media

nextdoor

74 Posts	0.12% Engagement
419,873 Impressions	88 Link clicks

219,252 Members

No benchmark sources for Nextdoor

Facebook

204 Posts	1.2% Engagement
71,500 Impressions	61 Link clicks

2,601 Followers

Engagement benchmark: 1.4%
(Source: Orlo)

Instagram

117 Posts	0.61% Engagement
4,732 Impressions	69% Story interaction

691 Followers

Engagement benchmark: 2.7%
(Source: Orlo)

LinkedIn

36 Posts	3.3% Engagement
12,246 Impressions	34 Link clicks

3,451 Followers

Engagement benchmark: 2.9%
(Source: Orlo)

Sentiment (of messages and comments)

42.6%	25.6%	31.7%
Positive or semi-positive	Neutral	Negative or semi negative

Trust indicator

External Communications

Public emails

Number of campaigns 35	**Number of emails delivered** 192,095
Total opens 84,710	**Avg open rate** 44.10%
Total clicks 5,310	**Avg click rate** 6.27%
Subscribers engaged 56%	**Unsubscribe rate** 0.06%

Public subscription topics

General news	Health prevention	BCYP Health	Engagement
63% Engaged	68% Engaged	60% Engaged	59% Engaged

Topic	Total subscribers	Q4 new subscribers	% increase
General news	6,969	38	0.6%
Health prevention	6,779	45	0.7%
BCYP health	4,862	22	0.5%
Mental health	5,525	24	0.4%
Winter communications	3,226	14	0.4%
Engagement	1,743	31	1.8%
Women’s health and wellbeing	235	68	28.9%
Men’s health and wellbeing	102	37	36.3%
Pain management	529	37	7%

External Communications

ICS/B website

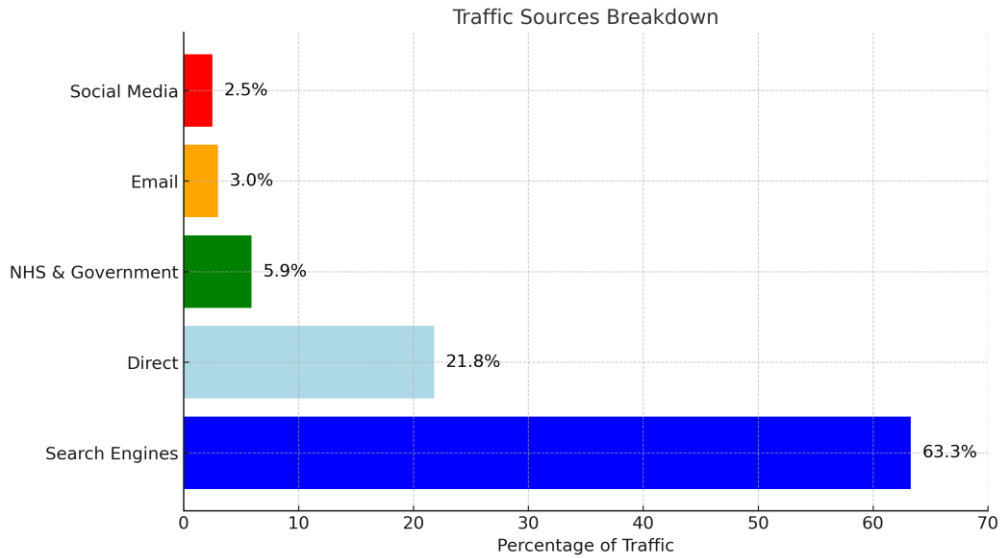
Audience

Total sessions
106,586

Total page views
186,049

Engaged sessions
62,436

Source of our audience



1. Search engine:	**63.3%**
2. Direct traffic:	**21.8%**
3. NHS and government:	**5.9%**
4. Email:	**3%**
5. Social media:	**2.5%**

Email traffic

3,201
Sessions via email

62.7%
Engaged sessions

73.9 seconds
Average engagement time

31%
More time engaging that website average

External Communications

ICB news coverage

171
Total coverage for ICB

58
Covering outlets

ICB coverage by media type

71.4% Online **20.5%** Print **8.2%** Online

ICB sentiment

60% Positive **9.4%** Neutral **30.6%** Negative

System news coverage

1,507
Total coverage for system

441
Covering outlets

System coverage by media type

70.5% Online **21.7%** Print **7.8%** Online

System sentiment

43.9% Positive **12.6%** Neutral **43.5%** Negative

Proactive media

26 Press releases issued

92 Pieces of media coverage generated

Stories with the most coverage

1. Rise in norovirus cases, NHS urges people to treat at home
2. 7 Million Appointments delivered by GP Practices in MSE in 2024
3. Working group for community hospital services submits recommendations
4. Simple health checks can protect thousands from silent killer

Stakeholder comms quarterly pulse poll

How informed do you feel about local healthcare topics that impact you/your residents and constituents? (1= not well informed, 5 = extremely well informed) (18 respondents)

Please rate communications updates from the ICB on the following attributes (18 respondents)

How well do you think communications from the ICB support your awareness and understanding of key issues impacting the local healthcare system? (1 = not very well, 5 = extremely well) (18 respondents)

Stakeholder contact lists

Stakeholder	MPs & Cllrs
56% Engaged	**53%** Engaged

Stakeholder emails

30.8% average open rate

4.6% average click rate

Stakeholder briefing

30.4% Jan issue open rate – **up 10%** from Nov issue

7.5% click rate

Parliamentary Hub Enquiries

10 Parly Hubs received between January and March

Engagement

Virtual views

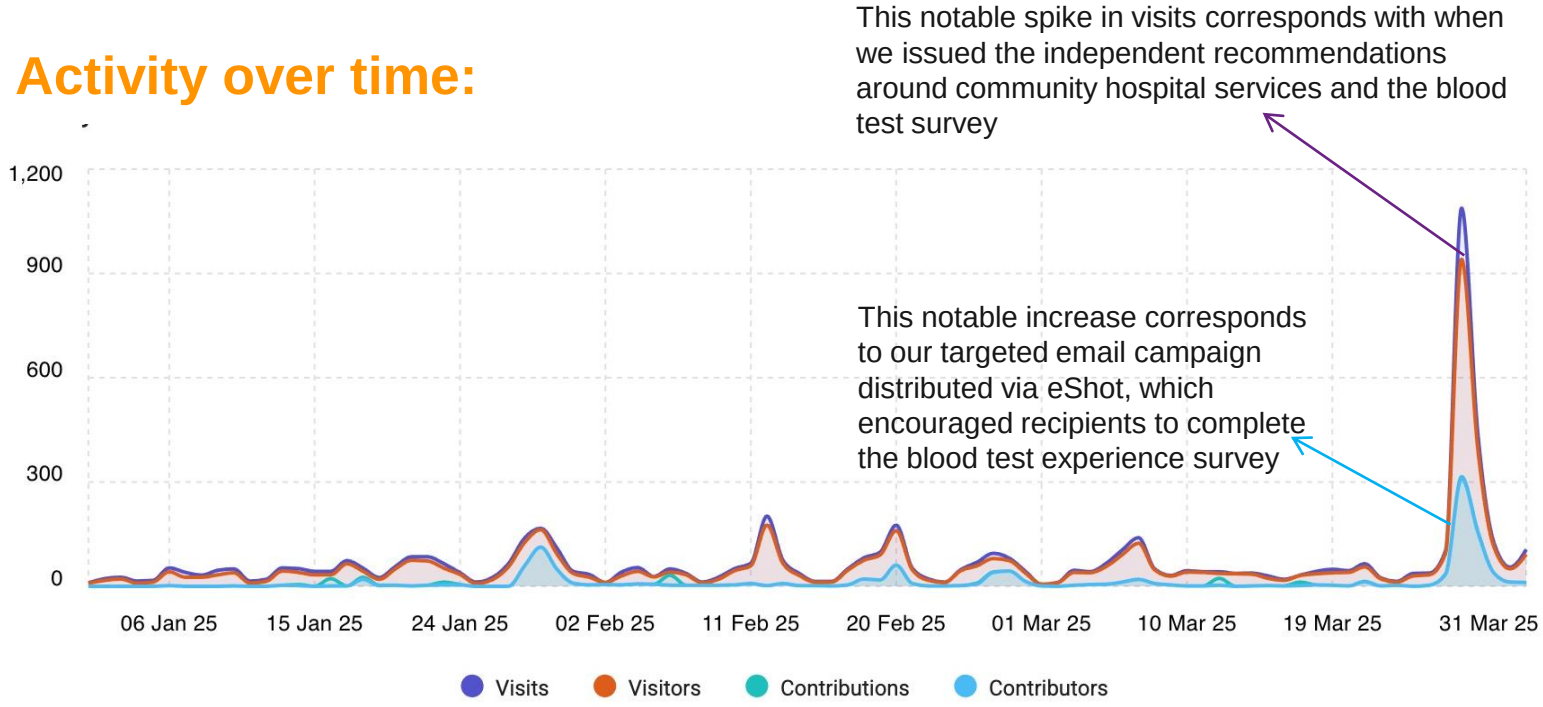
Number of visits
6,170

Contributions
1,334

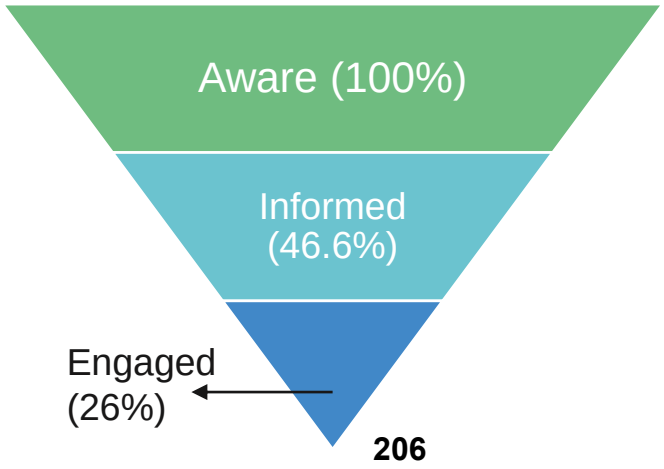
Engagement rate
26%

New registrations
81

Activity over time:



Visitor engagement:



What people have been sharing their experiences of:

1. Experiences of the blood testing services across mid and south Essex
2. Experiences of breast screening (Colne Valley PCN)
3. Experiences of using talking therapies to support mental health (IAPT)

Engagement

REN

REN Funding won

Mental Health PARITY- 30K
REN Continuation - 30K
Digital Inclusion- 3.5K

Total REN engagement via Be Part of Research

12,342

New Groups

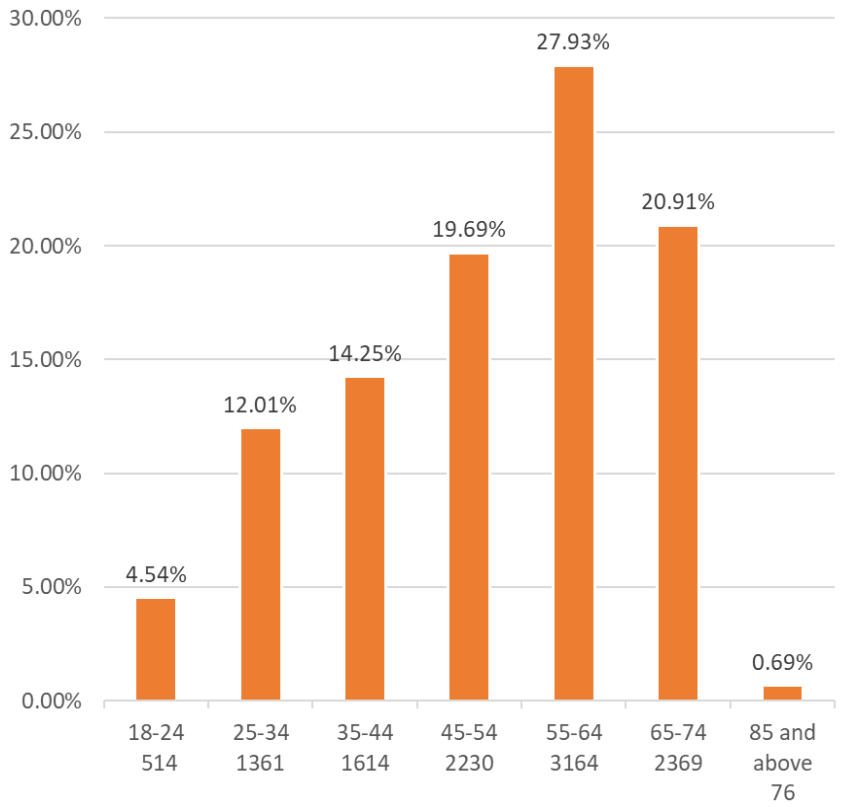
Blade Education
Southend Association of Voluntary Services (SAVS)
Mid and North Essex Minds
South East and Central Essex Mind

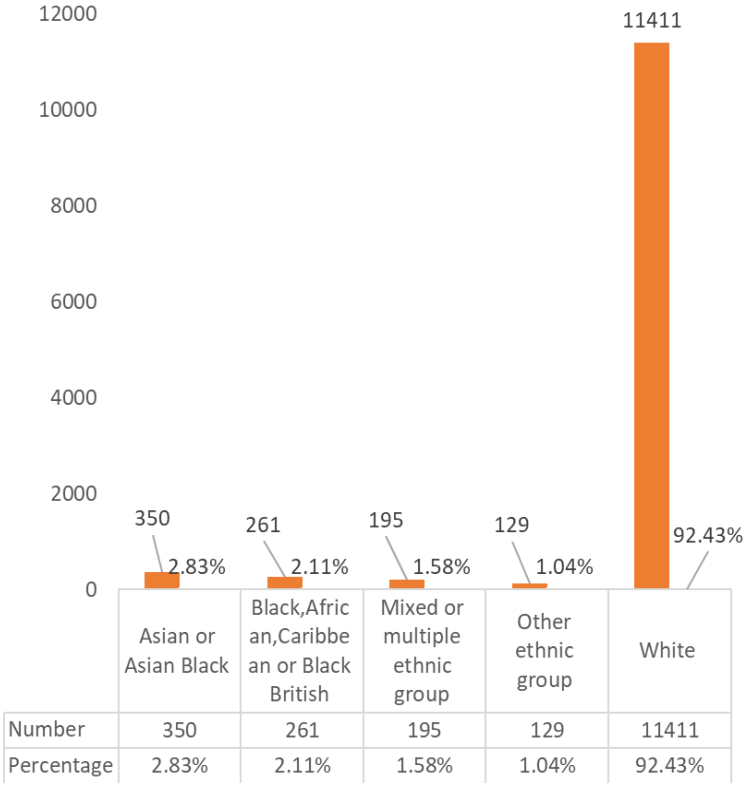
Engagement

Engagement opportunities

500+ people involved in the NHS 10-year change

Be part of Research





	Asian or Asian Black	Black,African,Caribbean or Black British	Mixed or multiple ethnic group	Other ethnic group	White
Number	350	261	195	129	11411
Percentage	2.83%	2.11%	1.58%	1.04%	92.43%

Engagement supporting NHS 10-year change plan

Over 500 people got involved to give their feedback for the NHS 10-year change plan, including:

- 4 online sessions with 155 participants (this was originally 2, however due to high demand an extra 2 dates were added)
- 9 diverse community groups from 5 different geographical areas, which were funded through an NHSE bid that we won.

Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Part I ICB Board meeting, 15 May 2025

Agenda Number: 13

Chief Executive's Report

Summary Report

1. Purpose of Report

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

2. Executive Lead

Tom Abell, Chief Executive Officer.

3. Report Author

Tom Abell, Chief Executive Officer.

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

Not applicable

5. Conflicts of Interest

None identified.

6. Recommendation(s)

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

Chief Executive's Report

1. Introduction

This report provides the Board with an update from the Chief Executive covering key issues, progress and priorities since the last update. The report also provides information regarding decisions taken at the weekly Executive Committee meetings.

2. Main content of Report

2.0 ICB running cost reductions and changes.

Since the last Board meeting, there has been the announcement of the requirement for ICBs across England to reduce their running costs by 50% alongside the intention to reset roles and responsibilities between different parts of the NHS which will result in a change to functions of ICBs.

We are working with NHS England and ICBs regionally to fully understand the implications of these changes and our response to these, however there will need to be significant change in the way that we organise ourselves and work to respond to this.

As such, there are two principle workstreams that are currently being worked on:

1. The future geographical footprint of ICBs in the East of England, recognising that the existing population sizes of ICBs regionally are insufficient to be able to deliver the running cost reduction ambition.

2. The future role and functions of ICBs, with expectation that NHS England will publish future guidance on this imminently.

ICBs are expected to submit their transition plans for how the running cost reduction will be delivered by the end of May, with implementation underway during quarter 3 of 2025/26.

We are working to keep our people and stakeholders as involved as we can as we work through this process including establishing weekly staff briefings and regular engagement sessions with stakeholders.

2.1 Planning

Since our last meeting we have submitted our system finance and operating plans for 2025/26. This has represented significant work to balance the need to deliver improved access for patients within the financial allocation we received locally. This has required a number of iterations but believe we have now secured a plan which delivers improvements in both areas. Our focus now moves onto ensuring that these plans are delivered, and steps are taken to mitigate the risks identified which will form part of our ongoing reporting to the Board.

Alongside the 2025/26 plan we have continued to mobilise our Medium Term Plan with the programme structures and delivery teams having now been put in place and starting work. We held a system wide initiation meeting earlier in April and again the focus being both getting high quality transformation plans in place and ensuring rapid delivery of these to underpin the quality and effectiveness of NHS services in mid and south Essex.

2.4 Community Services Consultation

The report from the Community Services Working Group is included elsewhere on the agenda today for consideration by the Board.

2.5 Other Updates

Since the last report, there has been a number of other activities and initiatives undertaken locally which I wanted to celebrate including:

- The ICB working with Southend United Football Club and Southend Council to tackle the silent killer of high blood pressure to promote free NHS blood pressure checks to help reduce the risk of heart attacks, strokes and vascular dementia.

- Dental teams across mid and south Essex have started to carry out in-school dental checks to help tackle tooth decay, and to provide educational sessions around oral health. This initiative also includes familiarisation sessions in dental practices to reduce anxiety and improve confidence of people to go to the dentist.

- We were awarded Early Adopter Status for the General Practice Patient Safety Incident Response Framework (PSIRF) by the South East London Health Innovation Network for our work in learning, sharing best practice and shaping the future of patient safety in General Practice.

- Our partnership with local hospices won the 'Best Not-for-Profit Working in Partnership with the NHS' award at the HSJ Partnerships Awards.

- The lung cancer screening programme was extended to residents in Brentwood.

- Our Women's Health Programme Team, in collaboration with the MSE Training hub hosted a full-day educational event focused on improving Women's Health.

- The ICB became a Fostering Friendly Employer, a scheme designed by The Fostering Network.

3. Executive Committee

Since the last report, there have been nine weekly meetings (from 4 March to 29 April 2025)

Aside from noting the recommendations from the internal recruitment panel and investment decisions through the triple lock arrangements, the following decisions were approved by the Executive Committee:

- Contract Award for Online Consultation/Video Consultation tools for Primary Care.
- Established a Research and Innovation Programme Board, reporting to the ICB's Quality Committee.
- Reviewed options for the future of Community MSK & Pain Services provision across MSE.
- Undertook a review of Clinical Leads across the system, ensuring alignment to Medium Term Plan delivery.
- Undertook a review of Stewards across the system, ensuring alignment to Medium Term Plan delivery.

- Commissioning of Long Covid Service across MSE, with a further review for service provision into 2026/27.
- Approval of ADHD Shared Care Arrangement with Primary Care to cover all ages (Adults & Chilldren).
- Review of commissioning and procurement arrangement for Mental Health Services across MSE.
- Approval to develop a business case for review of Paediatric ENT services across MSE.
- Approval of ICB's Health Inequalities Investment Plan across 2025-26.
- Approval of Internal Audit Plan for MSE ICB across 2025-26.
- Contract Award for Call EEAST to provide support to Complaints & PALS function of the ICB.
- Approval of ICB's Patient Choice Policy and Operational Guidance.
- Approval of ICB's Dental Provision Plan across 2025-26.
- Approval to enact break clause for the ICBs Corporate HQ, in line with overall efficiency requirements for ICBs.

The Committee continued to provide executive oversight and scrutiny of operational business, performance and financial sustainability. Furthermore, the Committee worked together in preparation for the NHS England quarterly review meeting that took place on 2 May 2025.

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

4. Recommendation(s)

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

Part I ICB Board meeting, 15 May 2025

Agenda Number: 14

Quality Report

Summary Report

1. Purpose of Report

The purpose of this report is to provide assurance to the ICB Board through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response.

This Quality Report provides a focus the current position in relation to regulatory oversight by the Care Quality Commission and an update in relation to the regional and national offer related to quality oversight and assurance.

To note, the members of the Quality Committee did not request anything to be escalated to the Board following the most recent meeting in April 2025.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer.

3. Report Author

Dr Giles Thorpe, Executive Chief Nursing Officer.

4. Responsible Committees

Quality Committee.

5. Link to the ICB's Strategic Objectives

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

To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

None required for this report.

7. Financial Implications

Not relevant to this report.

8. Details of patient or public engagement or consultation

Not applicable to this report.

9. Conflicts of Interest

None identified.

10. Recommendations

The Board is recommended to:

- Note the ongoing regulatory oversight in relation to provider services in Mid and South Essex NHS Foundation Trust
- Note the oversight and assurance support offer provided by NHS England regional team during ICB transitional phase.

Mid and South Essex Quality Report

1. Introduction

1.1 The purpose of the report is to provide assurance to the Board of the Integrated Care Board (ICB) through presentation of a summary of the key quality and patient safety issues, risks, escalations, and actions being taken in response.

2. CQC Regulatory Update

Mid and South Essex NHS Foundation Trust

2.1 The Care Quality Commission (CQC) are preparing to conduct a Well Led Review of the Mid and South Essex NHS Foundation Trust (MSEFT). The inspection process will last three days, with an expectation of interviews being conducted across leadership teams and key individuals responsible for the delivery of safe, effective, caring, responsive and well-led services. The Integrated Care Board (ICB) has been contacted as part of the wider stakeholder feedback process and has engaged accordingly in line with expected standards of engagement with regulatory processes.

2.2 In addition, MSEFT is expecting the draft reports in relation to paediatric services across its three acute sites. The Trust will engage in factual accuracy processes with final reports expected to be published in 6 weeks' time. A Quality Improvement Group, convened by the ICB continues to provide wider stakeholder support in relation to key workstreams that support ongoing improvement activities.

2.3 The current Section 31 Notice relating to Broomfield's maternity services remains in place at the current time, with evidence being supplied to the CQC as part of its ongoing assurance process to meet the necessary standards. The national Maternity Services Support Programme continues, with Maternity Improvement Advisors covering both midwifery and obstetric professions liaising closely with the ICB in its ongoing support activities to help gain assurance against key exit criteria relating to sustainability of services, and robust governance processes.

Essex Partnership University NHS Foundation Trust

2.4 The CQC have published their report into secure services at Brockfield House, which has been rated 'Good' in all areas following the inspection in 2024. The final report was published on 15 April 2025.

3. NHS England Core Quality Offer during transitional period

Announcements of the abolishment of NHS England, changes to the infrastructure of ICBs announced in Q4 2025, and changes in the NHS England (NHSE) team, signals the requirement to update the quality offer on an interim basis. This offer will continue to be refreshed in line with changes throughout 2025/26.

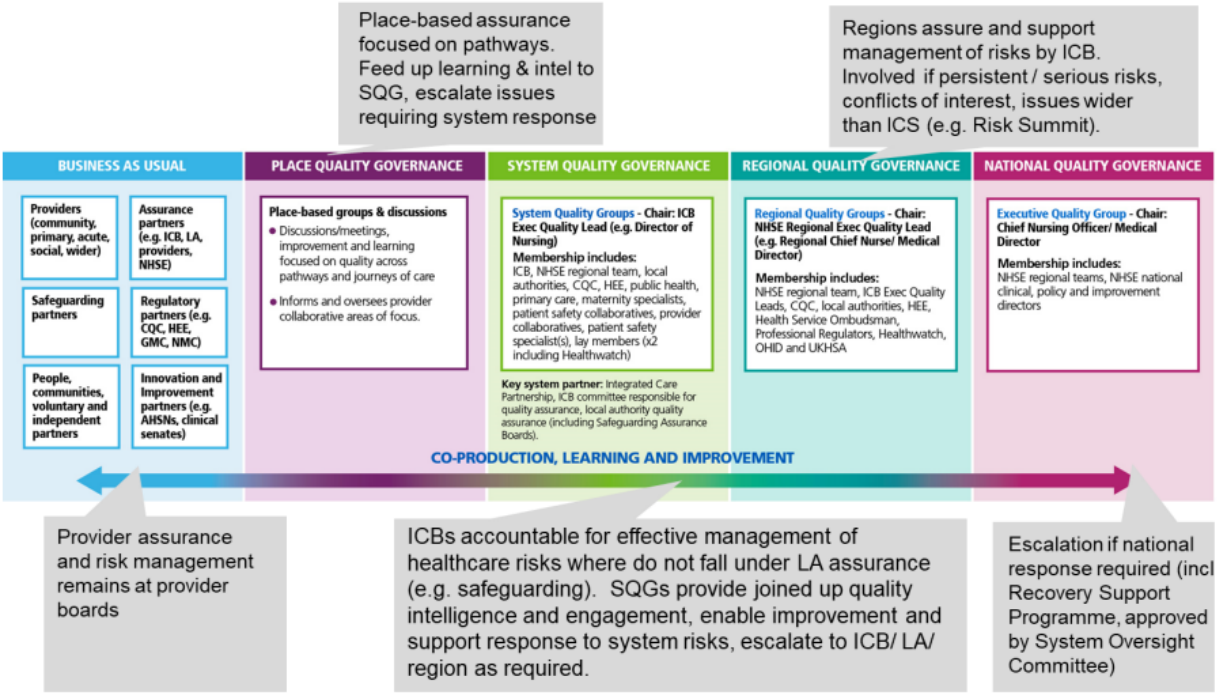
This following sets out how the Regional Nursing Directorate work with the 6 Integrated Care Systems (ICSs) and aligns with the new NHS Improvement & Assessment Framework (IAF) and National Quality Board guidance on System Quality Groups.

Quality care according to the National Quality Boards (NQB) Shared Commitment's definition is care that is safe, effective, provides a personalised experience, is well-

led and sustainably resourced. In the Guidance on System Quality Groups, the NQB emphasised the importance of all ICSs having effective structures and infrastructure in place to support quality management, combining quality planning, quality assurance/ control and quality improvement functions.

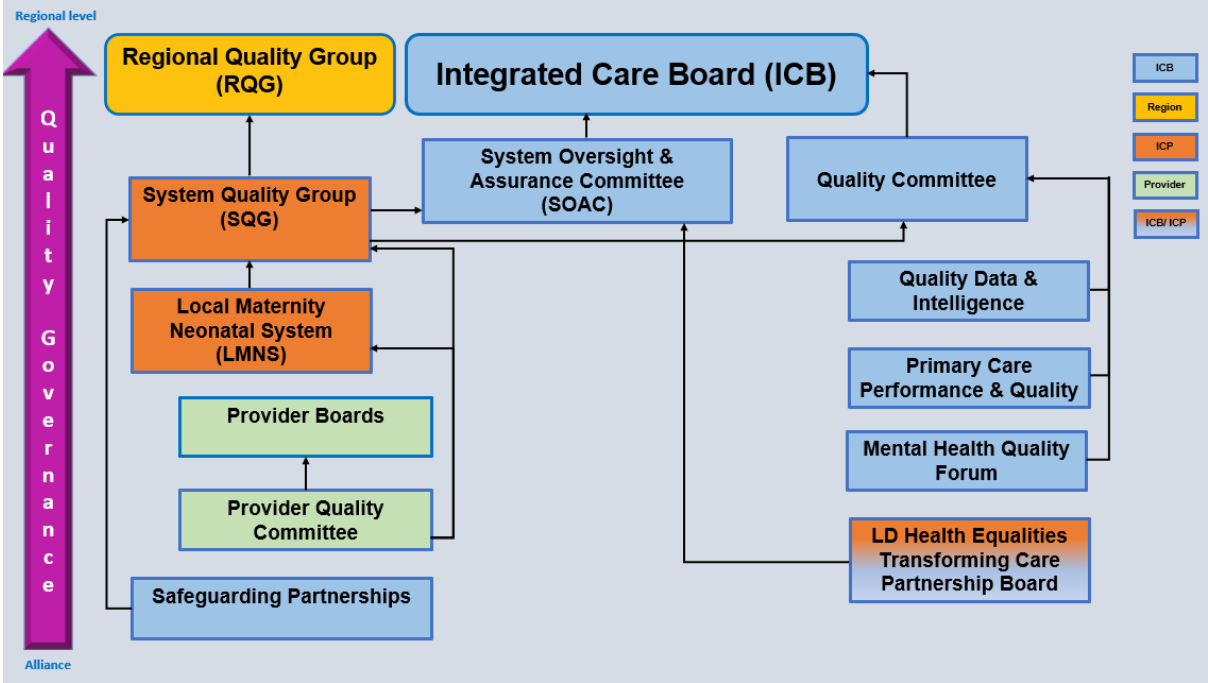
The NQB set out the roles that System Quality Groups and wider quality forums such as the ICB Quality Committee would play in quality management providing clarity on the expected relationships between ICBs and NHSE.

An overview of present quality governance from provider level to the national executive group is captured on page 2. NHSE's Operating Model for Quality provides a further framework for current responsibilities at National/Regional/System/Provider levels moving forward.



Integrated Care Board (ICB) Governance

In line with present quality requirements for an ICS, each ICB has governance in place for quality. The simplified diagram below is illustrative of ICB quality governance flow only and it is acknowledged each system has its own organic quality governance, with generic core elements.



The Nursing Directorate team will work with the ICBs to discharge our current respective roles and responsibilities to improve the quality of care and reduce inequalities, taking into consideration system maturity, risks and support needs.

To ensure this is proportionate and effective it is proposed that as a core offer for all systems, the regional team join the existing cross-system quality governance already established. It is of note that systems in segments 3 & 4 there will be additional jointly agreed mandated support offers, as assessed, and this will be drawn up in an additional agreement.

Core offer – External Meetings

Core System Meetings (ICB led) for regional quality attendance, as follows.

- System Quality Group
- Quality Committee
- System oversight and Assurance Group
- Local Maternity and Neonatal System

It is of note that individual systems will have their own governance for quality and may invite regional colleagues to additional meetings. This will be on a holistic and ad hoc basis as agreed between the regional and system teams.

In addition, it is recommended the Chief Nurse for the ICB (and other quality team members as required) meet on an individually agreed basis with the regional quality lead to discuss intelligence, talk through horizon scanning and make any escalations. It is of note that systems in segments 3 & 4 may require greater support. This will also be enhanced on a group basis into the ICB Chief Nurse meetings.

4. Recommendations

The Board is asked to:

- Note the ongoing regulatory oversight in relation to provider services in Mid and South Essex NHS Foundation Trust
- Note the oversight and assurance support offer provided by NHS England regional team during ICB transitional phase.

Part I Board Meeting,15 May 2025

Agenda Number: 15.1

Month 12 Finance and Performance Report

Summary Report

1. Purpose of Report

To present an overview of the final financial performance of the ICB and broader partners in the Mid & South Essex system (period ending 31 March 2025).

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

2. Executive Lead

Jennifer Kearton – Chief Finance Officer.

Report Author

Jennifer Kearton – Chief Finance Officer
Keith Ellis - Deputy Director of Financial Performance, Analysis and Reporting
Ashley King – Director of Finance & Estates
James Buschor - Head of Assurance and Analytics.

3. Committee involvement

The most recent finance and performance position was reviewed by the Finance & Performance Committee on 6 May 2025.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to receive this report for information.

Finance & Performance Report

1. Introduction

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

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

NHS England provided Deficit Support Funding which adjusted the £96m deficit to breakeven. The system is now measured against a breakeven plan. The System were given the opportunity to revise its forecast outturn position at M10 and agreed a £32.5m deficit to plan. The deficit support funding plus agreed change in forecast outturn is repayable in future years.

2. Key Points

2.1 Month 12 ICB Financial Performance

The overall System Allocation (revenue resource limit) held by the ICB saw a reduction of £8.91m between M11 and M12.

Table 1 – Allocation movements between month 11 and month 12

Allocations	Funding Stream	Current Month £m	Previous Month £m	Monthly Change £m
Recurrent	Programme	2,267.57	2,267.57	0.00
	Delegated - Specialised	286.56	286.56	0.00
	Co-Comm	227.10	227.10	0.00
	Delegated - DOP	106.92	106.92	0.00
	Running Costs	20.55	20.55	0.00
	Total	**2,908.69**	**2,908.69**	**0.00**
Non-Recurrent	Programme	278.98	288.01	-9.03
	Co-Comm	11.46	11.34	0.12
	Delegated - DOP	7.16	7.16	0.00
	Running Costs	1.82	1.82	0.00
	Delegated - Specialised	(37.54)	-37.54	0.00
	Total	**261.89**	**270.80**	**-8.91**
Total		**3,170.58**	**3,179.49**	**-8.91**

The ICB recovered its forecast position to break even at month 10 and maintained this for the remainder of the year, balancing off adverse variances with mitigations across spend categories. Additional growth above plan in All Age Continuing Care is offset by in year benefits in Acute, Mental Health Services and applied mitigations.

Table 2 – summary of the position against the revenue resource limit for month 12.

Summary of ICB Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	YTD Variance Mth on Mth Change £m
Acute	1,559.63	1,552.27	7.35	4.85
Community Health Services	241.90	240.83	1.06	0.21
Continuing Care	159.18	186.38	(27.20)	(4.85)
Mental Health	295.14	293.12	2.02	(0.51)
Other Commissioned Services	6.07	0.50	5.58	(4.52)
Other Programme Services	20.16	15.80	4.36	2.51
Primary Care	614.19	614.05	0.15	0.30
Programme Reserve & Contingency	0.00	0.00	(0.00)	(0.00)
Specialised Commissioning	249.02	242.80	6.22	3.44
Corporate	18.05	17.53	0.52	(1.35)
Hosted Services Admin	3.36	3.38	(0.02)	0.00
Hosted Services Programme	3.88	3.84	0.04	(0.00)
Total	**3,170.58**	**3,170.51**	**0.07**	**0.07**

2.2 ICB Finance Report Conclusion

The ICB is delivered to plan at yearend. Whilst there were challenged areas during the year deliberate steps were taken to mitigate these pressures. The Finance and Performance committee have been in receipt of deep dive work throughout the year with respect to overspending areas.

2.3 Month 12 System Financial Performance

At month 12 the overall health system position was a deficit of £16.3m against the revised plan of breakeven.

Table 3 – summary of the System position against the revenue resource limit for month 12.

System I&E Analysis	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
System Revenue Resource Limit	(3,170.58)	(3,170.58)	0.00	(3,170.58)	(3,170.58)	0.00
Total ICB Net Expenditure	3,170.58	3,170.51	(0.07)	3,170.58	3,170.51	(0.07)
TOTAL ICB Surplus/(Deficit)	0.00	0.07	0.07	0.00	0.07	0.07
Income	(2,193.78)	(2,304.71)	(110.93)	(2,193.78)	(2,304.71)	(110.93)
Pay	1,452.16	1,507.08	54.92	1,452.16	1,507.08	54.92
Non-Pay	693.57	768.32	74.74	693.57	768.32	74.74
Non Operating Items	48.05	45.73	(2.31)	48.05	45.73	(2.31)
TOTAL Provider Surplus/(Deficit)	(0.00)	(16.42)	(16.42)	(0.00)	(16.42)	(16.42)
TOTAL ICS Revenue Resource Limit	(3,170.58)	(3,170.58)	0.00	(3,170.58)	(3,170.58)	0.00
TOTAL ICS Net Expenditure	3,170.58	3,186.93	16.35	3,170.58	3,186.93	16.35
TOTAL ICS Surplus/(Deficit)	(0.00)	(16.35)	(16.35)	(0.00)	(16.35)	(16.35)

The outturn position against plan is reflective of ongoing cost pressures and a shortfall in system efficiency programme delivery.

Both our system providers implemented grip and control actions during 2023/24 and continue to work collectively with the ICB to reduce the run rate during 2024/25. The whole system continues to operate in Triple Lock with regional oversight of expenditure items greater than £25k.

2.4 System Efficiency Position

At month 12 the system has delivered £143.93m of efficiencies against a plan of £167.77m reflecting the revised planning submission made to NHS England in June 2024.

Our overall financial position was dependent on the delivery of efficiencies and the final outturn position reflects the impact of non-delivery of efficiencies along with

Table 4 – System Efficiency summary

System Efficiencies

Organisation	Plan £m	Actual £m	Variance £m	Full Year Plan £m	Forecast £m	Full Year Variance £m
ICB	47.62	47.62	0.00	47.6	47.62	0.00
EPUT	28.65	23.26	(5.39)	28.7	23.26	(5.39)
MSEFT	91.50	73.05	(18.45)	91.5	73.05	(18.45)
SYSTEM	**167.77**	**143.93**	**(23.84)**	**167.8**	**143.93**	**(23.84)**

2.5 System Capital Position

Total system capital expenditure for 2024/25 across the two provider Trusts and the ICB was £128.1m, £9.8m below the £137.9m plan submitted to NHSE in June 2024. The variance reflects the re-profiling of Electronic Patient Record (EPR) programme funding, MSEFT's re-profiling of 23hr Surgical Unit funding to 2025/26, and EPUT's International Financial Reporting Standard 16 (IFRS 16) lease adjustments. The year end position was slightly above the overall system forecast of £127.9m

Table 5 – Capital Spend Summary

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
Externally Financed						
MSEFT	72.85	59.02	13.83	72.85	61.99	10.86
EPUT	14.46	6.15	8.31	14.46	7.21	7.25
ICB	0.00	2.30	(2.30)	0.00	2.30	(2.30)
Total	**87.30**	**67.46**	**19.84**	**87.30**	**71.50**	**15.80**
Internally Financed/System CDEL						
MSEFT	38.73	47.48	(8.74)	38.73	44.23	(5.50)
EPUT	9.92	10.94	(1.02)	9.92	9.92	0.00
ICB	1.99	2.24	(0.25)	1.99	2.24	(0.25)
Total	**50.64**	**60.66**	**(10.02)**	**50.64**	**56.39**	**(5.75)**
Total	**137.94**	**128.12**	**9.82**	**137.94**	**127.89**	**10.05**

Capital Summary	YTD Plan £m	YTD Actual £m	YTD Variance £m	Full Year Plan £m	Full Year Forecast £m	Full Year Variance £m
ICB - Potential new IFRS 16 leases						
ICB	20.00	2.30	17.70	20.00	2.30	17.70
Total	**20.00**	**2.30**	**17.70**	**20.00**	**2.30**	**17.70**

2.6 System Finance Report Conclusion

At month 12 the System has delivered an outturn position of £16.3m deficit to plan. The total deficit for 2024/25 excluding deficit support funding totals £111.8m deficit.

The system remained focused on delivering its Operating Plan for 2024/25 during the last quarter with the final position being agreed with NHS England in M11. Financial efficiencies were largely delivered whilst mitigating risks to the plan during the year. The System was under regular review with both regional and national NHS England colleagues and continues to operate under strengthened internal governance and financial control.

2.7 Urgent and Emergency Care (UEC) Performance

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

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

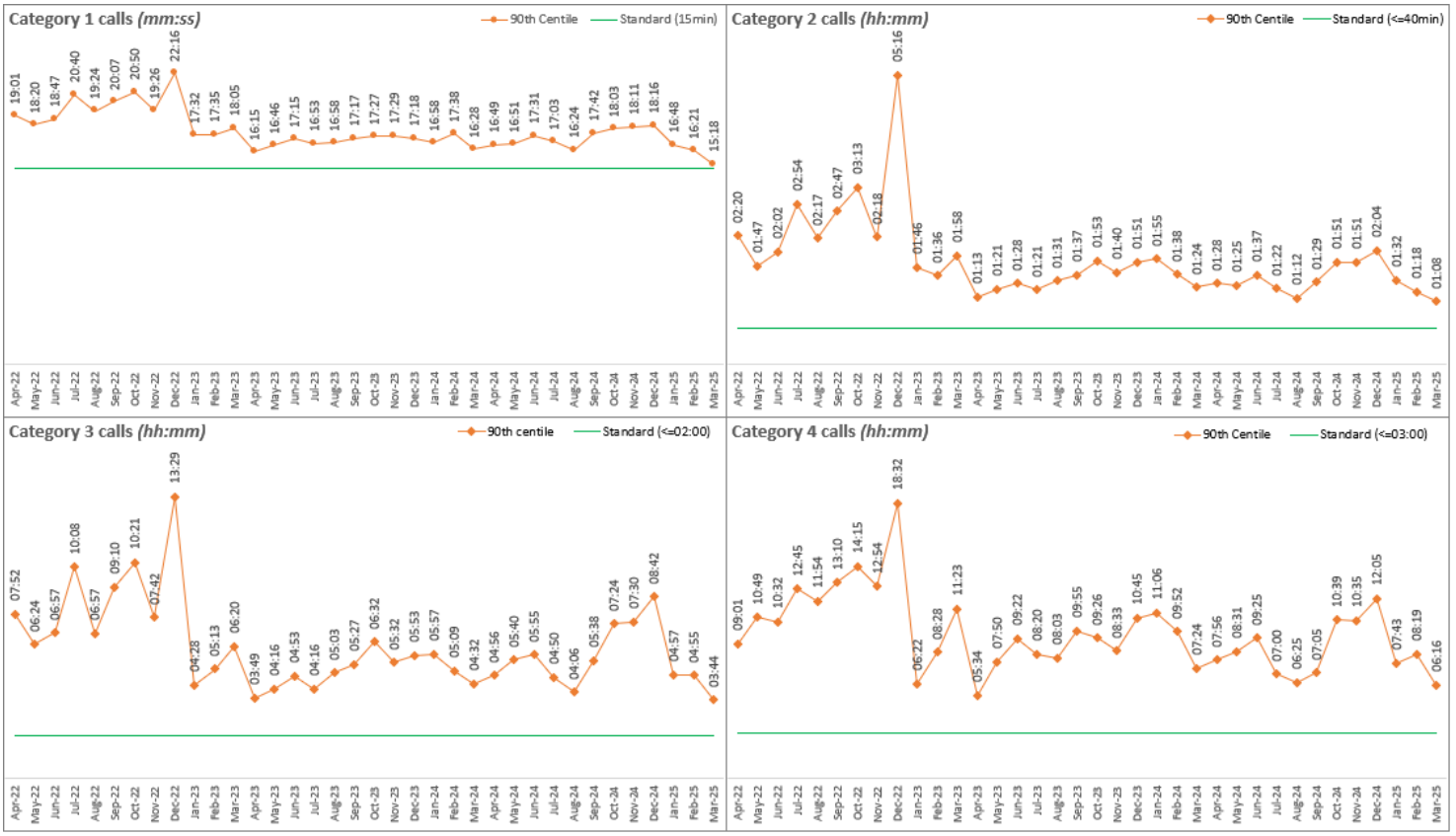
Our current performance is below the standard required as outlined below:

Ambulance Response Times

Standards:

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

The 90th centile response times for East of England Ambulance Service for all four categories of calls do not meet their respective standards as shown in the following graphs.

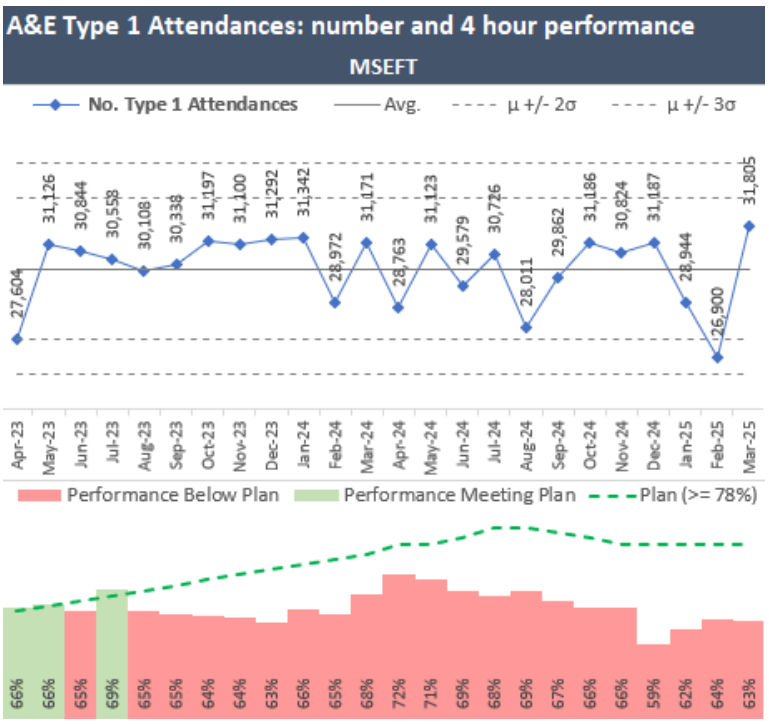


Emergency Department – waiting times

2024/25 priorities and operational planning guidance ask:

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

The four-hour performance has not met operational plan to achieve the 2024/25 priorities and operational planning guidance across all three MSEFT sites as per following graph. February 2025 achievement of 67% remains below the Operational Plan of 78%. The MSE system performance is identical to the MSEFT reported position.



2.8 Elective Care

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

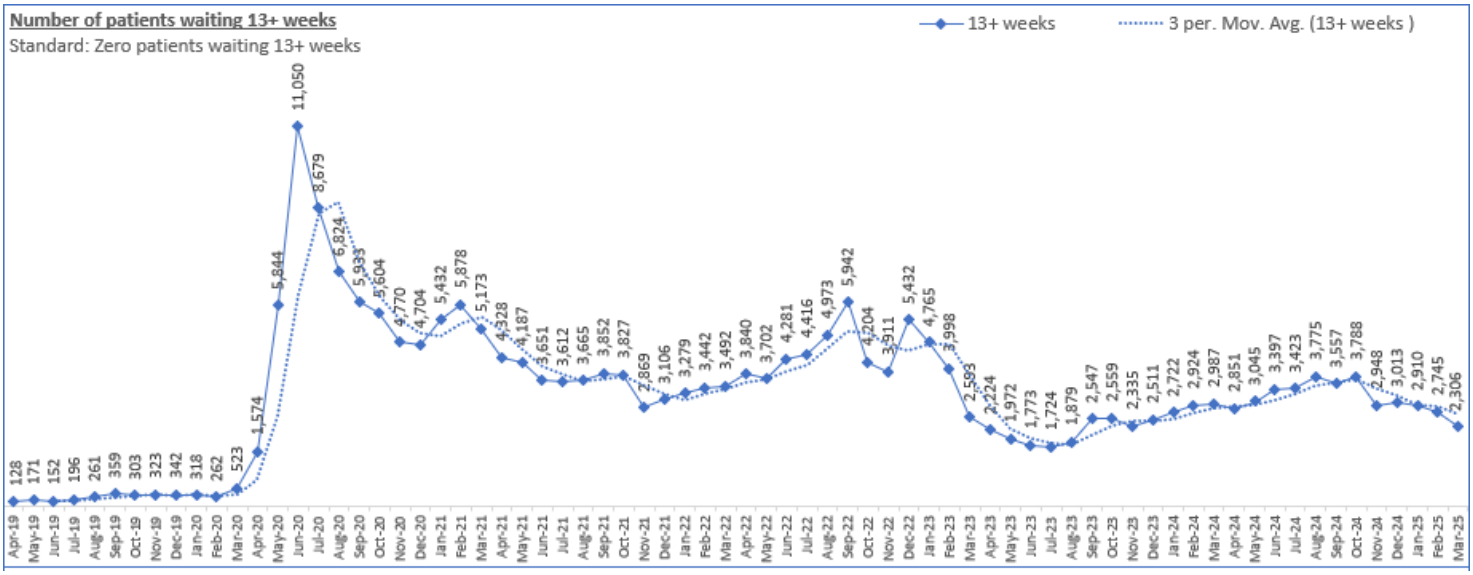
The performance does not meet the targeted national standard as set out below.

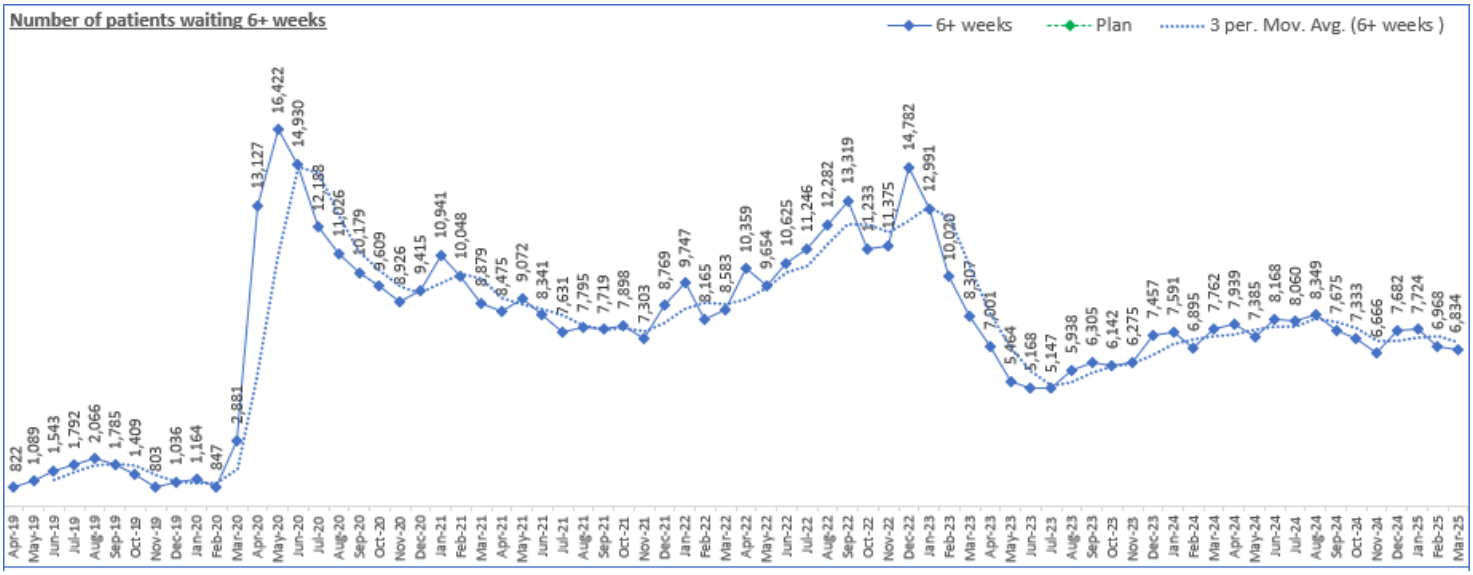
Diagnostics Waiting Times

Standard:

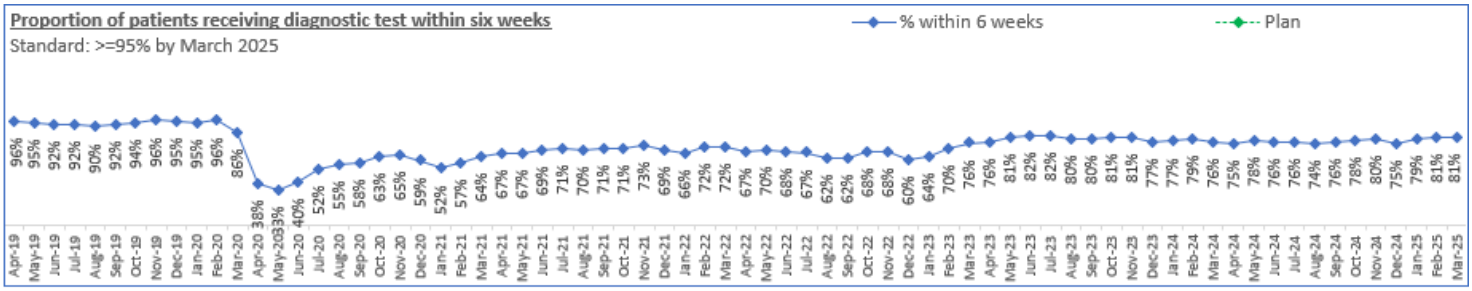
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

The following graphs show the total number of Mid and South Essex (MSE) registered population waiting 13+ and 6+ weeks across all providers to March 2025.





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



In March 2025, 2,306 people were waiting over 13 weeks (standard: zero) and 81% of all people waiting for their diagnostic test were seen within six weeks (standard: >=95%).

The following table shows the number people waiting over 13 and 6 weeks for their diagnostic test by test type. The areas of risk are as follows:

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

Mar-25	Mid and South Essex: Diagnostic DM01 waiting list summary					
Diagnostics		Number of patients waiting 13+ weeks Standard: 0	Six week wait performance and number of patients waiting 6+ weeks Standard: >=95%	Plan Mar-25	Breaches above plan	Plan March 2025
MSE patients at all providers						
Imaging	Barium Enema	1	81.8% (2)			
	CT	8	94.6% (206)	94%	40	94%
	DEXA Scan	24	85.9% (156)	89%	71	89%
	MRI	94	83.6% (1405)	93%	1,080	93%
	Non-Obstetric Ultrasound	639	88% (1480)	97%	1,166	97%
Physiological Measurement	Audiology Assessments	26	92.6% (89)	93%	18	93%
	Cardiology Echocardiography	209	66% (1262)	82%	661	82%
	Peripheral Neurophysiology	121	57.5% (235)			
	Respiratory Physiology Sleep Studies	129	52.9% (248)			
	Urodynamics - Pressures & Flows	12	63.6% (20)			
Endoscopy	Colonoscopy	514	63.5% (816)	86%	625	86%
	Cystoscopy	92	58.2% (146)			
	Flexi sigmoidoscopy	118	60.6% (215)	84%	155	84%
	Gastroscopy	318	69.9% (553)	86%	361	86%

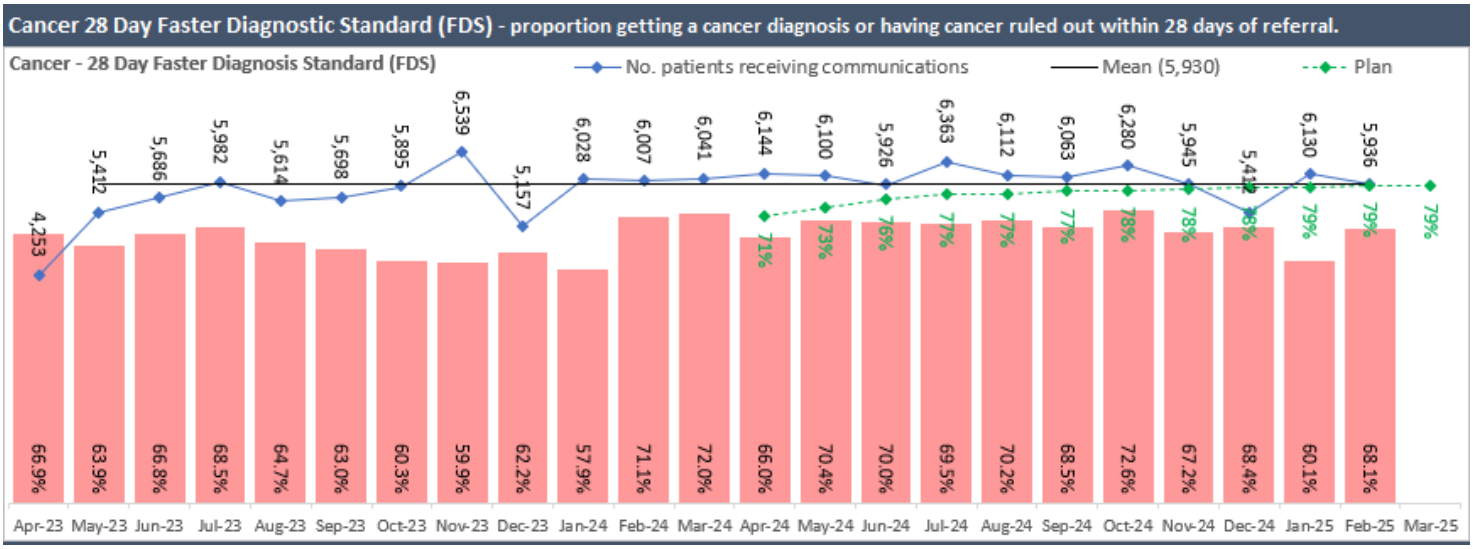
Cancer Waiting Times

Standards: For people with suspected cancer:

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

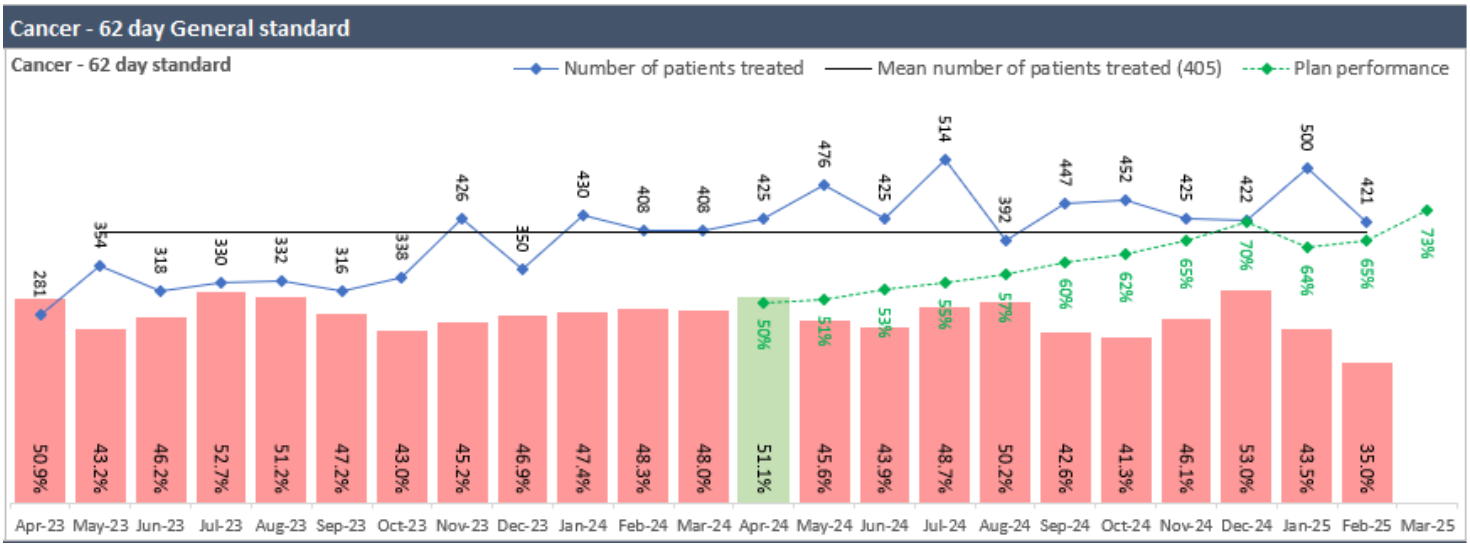
The waiting times for patients on a cancer pathway are not meeting the NHS constitutional standards.

The following graph shows the MSEFT monthly performance for the 28-day Faster Diagnosis Standard. The February 2025 performance at 68.1% did not meet the operational plan to achieve the 2024/25 priorities and operational planning guidance requirement of >= 77% by March 2025 from September 2024.



The following graph shows the 62-day general standard performance. The February 2025 performance at 35% did not meet plan of >=65%. The constitutional requirement is 85%.

The Trust is in national oversight Tier 1 for cancer performance.



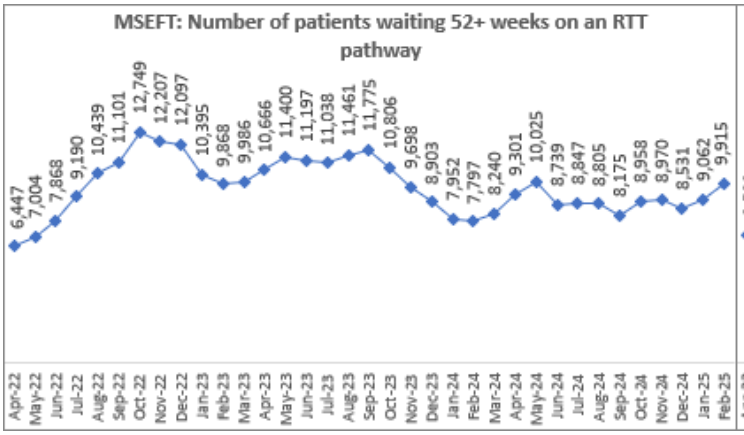
Referral to Treatment (RTT) Waiting Times

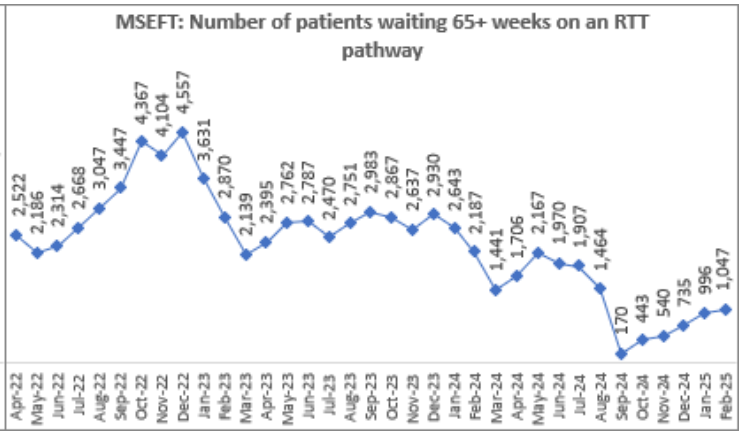
Standards:

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

As at February 2025, the following number of patients were on a RTT pathway:

- 1,047 patients waiting 65+ weeks.
- 9,915 patients waiting 52+ weeks.





The operational plan to have zero people waiting over 65 weeks by September 2024 has not been achieved.

The following table summarises the latest MSEFT RTT position (February 2025) by specialty.

Specialty	Total waiting list size	Average (median) waiting time in weeks	92nd percentile waiting time in weeks	% of patients waiting within 18 weeks	Total number of patients waiting 52 plus weeks	% 52 plus weeks	Total number of patients waiting 65 plus weeks	% 65 plus weeks
Total	**170,098**	**18**	**49**	**51%**	**9,915**	**6%**	**1,047**	**0.6%**
General Surgery Service	8,653	20	53	47%	731	8%	64	0.7%
Urology Service	10,341	17	50	52%	666	6%	72	0.7%
Trauma and Orthopaedic Ser	18,317	24	53	39%	1,580	9%	291	1.6%
Ear Nose and Throat Service	17,083	27	54	34%	2,013	12%	176	1.0%
Ophthalmology Service	13,177	15	45	56%	447	3%	9	0.1%
Oral Surgery Service	5,028	22	58	43%	660	13%	210	4.2%
Neurosurgical Service	88	29	50	33%	6	7%	1	1.1%
Plastic Surgery Service	5,419	17	46	52%	262	5%	29	0.5%
Cardiothoracic Surgery Service	1	-	-	0%	0	0%	0	0.0%
General Internal Medicine Se	2,560	12	35	68%	10	0%	0	0.0%
Gastroenterology Service	10,380	18	48	51%	582	6%	11	0.1%
Cardiology Service	10,388	12	34	65%	41	0%	0	0.0%
Dermatology Service	13,629	20	52	47%	1,025	8%	20	0.1%
Respiratory Medicine Service	4,730	16	39	56%	46	1%	0	0.0%
Neurology Service	5,979	18	49	49%	352	6%	12	0.2%
Rheumatology Service	2,649	12	44	62%	54	2%	0	0.0%
Elderly Medicine Service	766	7	23	86%	0	0%	0	0.0%
Gynaecology Service	13,627	18	43	50%	417	3%	29	0.2%
Other - Medical Services	13,536	12	42	65%	389	3%	28	0.2%
Other - Mental Health Service	0	-	-	0%	0		0	
Other - Paediatric Services	3,785	20	52	46%	321	8%	43	1.1%
Other - Surgical Services	6,869	11	41	67%	219	3%	44	0.6%
Other - Other Services	3,093	12	45	61%	94	3%	8	0.3%

The Trust is in national oversight Tier 1 for RTT performance.

2.9 Mental Health

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

Improving access to psychology therapies (IAPT)

Standards include:

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

95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.

This standard is being sustainably achieved across MSE (latest position: February 2025).

Early Intervention in Psychosis (EIP) access

Standard:

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

The EIP access standard is being sustainably met across MSE (latest position: February 2025).

3.0 System Performance Report Conclusion

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

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

4.0 Recommendation

The Board is asked to receive this report for information.

Part I Board Meeting,15 May 2025

Agenda Number: 15.2

2025/26 Finance Plan Report

Summary Report

1. Purpose of Report

To present an overview of the financial plan of the ICB and broader partners in the Mid & South Essex system (period ending 31 March 2026).

2. Executive Lead

Jennifer Kearton – Chief Finance Officer.

Report Author

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

3. Committee involvement

The ICB Finance Plan was reviewed at the Finance and Performance meeting on 6 May 2025.

4. Conflicts of Interest

None identified.

5. Recommendation

The Board is asked to receive this report for information.

2025/26 Finance Plan Report

1. Introduction

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

In a change in approach to previous years, NHS England (NHSE) calculated the maximum deficit support funding that was available to systems. For the MSE System this was a total allocation of £106m for the year. The requirement for the system was to set a breakeven plan, net of the deficit support funding.

2. Key Points

2.1 2025/26 ICB Financial Performance

The overall System Allocation for 2025/26 is £3,256m, this includes £106m deficit support funding £11.7m of deficit repayment and has been adjusted by £11.8m for convergence. £3,003m of the funding is recurrent and includes £263m funding for specialised activity and £19.2m running costs allowance.

Table 1 – Allocation 25/26

Recurrent/Non-Recurrent	Revenue Stream	24/25 Allocation £k	Change in Allocation £k	Adjusted Baseline £k	25/26 Increase £k	New Allocation 25/26	25/26 Allocation £k
⊟ Recurrent	Core Allocation Recurrent	2,268,608	(3,820)	2,264,788	87,153		2,351,941
	Corneal Tissue (£k)					(243)	(243)
	Delegated Specialised Commissioning					788	788
	ICB Programme Allocation					606	606
	Pharmacy, Optometary and Dental	104,825	2,220	107,045	3,714		110,760
	Primary Care	227,097	(0)	227,097	6,688		233,785
	Primary Medical Care Services					22,172	22,172
	Roll out of OCT (£k)					(146)	(146)
	Running Costs	20,550	(2,119)	18,431	773		19,204
	Specialised - Physical Health	286,559	(33,365)	253,194	10,606		263,800
	Total	**2,907,639**	**(37,084)**	**2,870,555**	**108,934**	**23,177**	**3,002,667**
⊟ Non-Recurrent	CDC Funding	17,059	(2,345)	14,714		33	14,747
	Central technology licence arrangement adjustment (£k)					(1,312)	(1,312)
	Charge exempt overseas visitor adjustment	(1,350)	(94)	(1,444)			(1,444)
	Community LFD Testing					70	70
	Covid-19 testing (£k)	2,114	(349)	1,765			1,765
	Deficit repayment	(10,861)	(899)	(11,760)			(11,760)
	Deficit Support Funding	95,698	10,396	106,094			106,094
	Discharge (£k)					9,972	9,972
	Elective Recovery Funding (additional)					12,314	12,314
	Elective Recovery Funding (core)					5,677	5,677
	Elective Recovery Funding: Additional (£k)	30,200	(5,467)	24,733			24,733
	Elective Recovery Funding: Core	55,388	1,571	56,959			56,959
	Other In Year Allocations	(43,042)	43,042	0			0
	Other POD allocations					281	281
	Pay: Other income support (£k)					1,646	1,646
	SDF	49,568	(19,114)	30,454			30,454
	Service Development Fund (SDF)					2,698	2,698
	Total	**194,774**	**26,741**	**221,515**		**31,380**	**252,895**
Total		**3,102,413**	**(10,342)**	**3,092,071**	**108,934**	**54,557**	**3,255,562**

The ICB financial plan was built from a M9 forecast outturn position adjusted for non-recurrent allocations and related spend, full year impact of 24/25 cost pressures and other baseline adjustments. The revised 25/26 baseline is then adjusted for national inflation net of expenditure (4.15% inflation less -2% efficiency). Further adjustments are made to include costs relating to Service Development Funding (SDF), Recurrent and Non-recurrent investments including Elective Recovery Funding

and the allocation of deficit report funding across the two System providers (MSEFT £85.5m and EPUT £20.5m). Finally, efficiencies are applied to the plan totalling £28.5m for the ICB. This equates to the overall target required to bring the ICB plan back to breakeven.

Table 2 – summary 25/26 plan by ICB Directorate

Directorate	2425 FOT (SBS) £,000	FOT Adjustments £,000	25/26 Baseline £,000	Net Tariff Inflation / Deflation (+/-) £,000	Growth £,000	Other Expenditure £,000	Draft Plan £,000	Local Efficiencies £,000	Draft plan 25-26 net of Efficiencies £,000
Allocation	3,102,413	(231,858)	2,870,555	108,934	(0)	276,073	3,255,563	(0)	3,255,563
Acute	(1,528,643)	167,131	(1,361,512)	(29,273)	(0)	(170,530)	(1,561,315)	421	(1,560,894)
Community Health Services	(239,952)	1,352	(238,600)	(3,065)	(508)	(9,519)	(251,692)	4,075	(247,617)
Continuing Care	(180,858)	585	(180,273)	(14,422)	(0)	(178)	(194,873)	4,676	(190,196)
Mental Health	(288,875)	26,680	(262,195)	(4,371)	(7,132)	(46,511)	(320,209)	2,066	(318,143)
Other Commissioned Services	9,815	(17,886)	(8,072)	(161)	(0)	(493)	(8,726)	7,510	(1,216)
Other Programme Services	(18,219)	241	(17,978)	(355)	(0)	7	(18,326)	(0)	(18,326)
Primary Care	(599,427)	11,122	(588,306)	(15,363)	(0)	(28,949)	(632,618)	9,769	(622,849)
Programme Reserve & Contingency	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Specialised Commissioning	(236,659)	(9,450)	(246,109)	(5,291)	(0)	(25,719)	(277,119)	(0)	(277,119)
Corporate	(19,167)	1,623	(17,543)	(368)	(0)	(811)	(18,723)	(0)	(18,723)
Hosted Services Admin	(427)	(44)	(471)	(10)	(0)	(0)	(481)	(0)	(481)
TOTAL	(0)	(50,504)	(50,504)	36,255	(7,639)	(6,629)	(28,517)	28,517	0

The ICB has identified areas for delivering efficiencies in year totalling £24.2m with £4.3m unidentified at present. All identified efficiencies are recurrent within the plan.

Table 3 – ICB Local Efficiency schemes

Efficiency Scheme	Sum of £,000
All Age Continuing Care	5,048
Contractual Changes	5,136
Discharge to Assess	3,195
Future Pathway Reviews	1,000
Grip & Control	789
Prescribing	9,000
Unidentified	4,349
Total	**28,517**

2.2 ICB Finance Plan Conclusion

The ICB has developed a breakeven plan for 2025/26 as required by NHSE. Work continues to identify opportunities to deliver the unidentified £4.3m efficiencies on a recurrent basis and controls such as triple lock may remain in place during 25/26 to continue to manage costs across the system.

2.3 2025/26 System Financial Plan

The overall 2025/26 plan for the health system position shows breakeven, net of the £106m deficit support funding. The position excluding deficit support funding is ICB breakeven, MSEFT £85.5m deficit and EPUT £20.5m deficit.

Table 4 – summary of the System plan

ICB/Provider	System Plan	Plan £,000
⊟ ICB	ICB Allocation	3,266,524
	Acute Service Expenditure	(1,570,838)
	Mental Health Service Expenditure	(301,103)
	Community Health Service Expenditure	(247,617)
	All-age Continuing Care Service Expenditure	(190,197)
	Primary Care Service Expenditure	(253,979)
	Other Programme Services	(18,326)
	Other Commissioned Services	(19,267)
	Primary Medical Services Expenditure	(257,756)
	Delegated Primary Care Expenditure	(111,112)
	Reserves / Contingencies	0
	Delegated Specialised Commissioning	(277,125)
	Running Costs	(19,204)
	Surplus/(Deficit)	**0**
⊟ Provider	Income	2,262,612
	Pay	(1,367,968)
	Non-Pay	(837,159)
	Non operating income and expenditure	(51,965)
	Other adjustments to get to adjusted financial performance	(5,520)
	Surplus/(Deficit)	**0**
Surplus/(Deficit)		**0**

Delivery of the system plan is dependent on maintaining high levels of scrutiny on expenditure and management of risks and cost pressures during the year.

2.4 System Efficiency Position

The system plan includes £219m of required efficiency to deliver a breakeven plan, this equates to 7% of the total System Allocation for the year.

Table 4 – System Efficiency summary

Organisation	Recurrent £,000	Non-recurrent £,000	Total
EPUT	27,058	4,277	**31,335**
ICB	66,035	4,349	**70,384**
MSEFT	109,233	8,254	**117,487**
Total	**202,326**	**16,880**	**219,206**

2.5 System Capital Position

The capital plan for the system in 2025/26 totals £164.4m (ICB £2.4m, EPUT £36.1m and MSEFT £125.9m).

Table 5 – Capital Plan Summary

Capital	EPUT	ICB	MSEFT	System
Operational Capital	17,193	2,412	48,032	**67,637**
PDC Capital Funding	18,941		77,829	**96,770**
Total System CDEL	**36,134**	**2,412**	**125,861**	**164,407**

2.6 System Finance Plan Report Conclusion

The System has submitted a breakeven plan for 2025/26, this is net of £106m of deficit supporting funding and requires £219.2m of efficiency savings to be delivered.

The system remains challenged in 25/26 given the significant efficiency requirements, but significant work has been undertaken to de-risk the plans.

Monitoring of the system financial performance will continue through the Finance & Performance committee with regular deep dives into areas of concern during the year.

3. Recommendation

The Board is asked to receive this report for information.

Part I ICB Board Meeting, 15 May 2025

Agenda Number: 16

Primary Care and Alliance Report

Summary Report

1. Purpose of Report

To update Board members of the development of services by the Alliance teams including the Primary Care Team.

2. Executive Lead

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

3. Report Author

Kate Butcher, Deputy Alliance Director – Mid Essex
Margaret Allen, Deputy Alliance Director – Thurrock
Caroline McCarron, Deputy Alliance Director – South East Essex
Simon Williams, Deputy Alliance Director – Basildon and Brentwood
Vicki Decroo, Deputy Director of Integrated commissioning
Paula Wilkinson, Director of Pharmacy and Medicines Optimisation
William Guy, Director of Primary Care

4. Responsible Committees

Primary Care Commissioning Committee (Primary Care elements only)
Alliance Committees

5. Impact Assessments

Not applicable

6. Financial Implications

Not applicable to this report.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation

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

Primary Care and Alliance Report

1. Main content of Report

Primary Care – General Practice

The ICB has overseen several changes to GP providers locally as of the end of March 2025 including:

- A practice merger
- Three branch surgery closures
- Several changes to Primary Care Network (PCN) configurations

The Primary Care Commissioning Committee (PCCC) received a summary of national changes to the GP contract. This includes additional investment in the core contract as well as several targeted functions. Practices will need to deliver several requirements as a result of this settlement. This includes online consultation access during core hours from October 2025.

The PCCC has been sighted on the primary care programme within the Medium-Term Plan (MTP). The Committee will oversee delivery of the schemes which include developments across primary, medical, pharmacy and dental services. This covers the interface with other services, development of estates, our strategic approach to left shift and the continued implementation of Connected Pathways.

The Connected Pathways Team have continued to implement the local Primary Care Access Recovery Programme. Achievements within the programme include:

- Widespread use of online consultation software across practices
- Increased usage of NHSApp
- Significant growth in the use of 'Frontline' to support MSE residents to be directed to alternative services to support their wellbeing
- Continued growth in Pharmacy First
- Good engagement in the usage of self-referral pathways
- Improving delivery of patients seen within 14 days of contacting general practice (nearly 86% in Thurrock).

Primary Care – Pharmacy

The PCCC received an overview of the community pharmacy national settlement for both 24/25 and 25/26. The key settlements include investment in Pharmacy First which is core to our local Primary Care Access Recovery Programme.

The PCCC welcomed a report from Healthwatch Southend on Pharmacy First. This report provides valuable insight into people's experience of using Pharmacy First pathways and opportunities to improve utilisation and experience. This will be considered by our newly established Community Pharmacy Commissioning and Transformation Group.

Primary Care – Dentistry

The ICB is set to achieve the highest level of actual delivery against contracted Units of Dental Activity since pre-COVID. This achievement has been delivered through early agreement to allow dental practices to deliver up to 110% of contracted activity (a national initiative) and the early implementation of contract rebasing work. This allowed a better understanding of expected levels of delivery and the measures dental practices are taking to deliver contracted activity.

Preparations have been put in place to support the ICB to deliver our allocation of the national urgent access to dental services target. The ICB is required to deliver approximately 6k additional Units of Dental Activity in 2025/26. This will be achieved through the extension of the existing access pilot.

The roll out of the Children and Young Peoples pilot continues to make good progress. Significant progress has been made on the coverage of schools across the ICB. The pilot is being steered through a working group involving dentists delivering services. Approaches are being refined on a test and learn basis. The development has attracted media attention.

Estates

Alliance Teams have been beginning to prioritise strategic and tactical premises locations aligned to local priorities. This has been supported by the production of local data packs for each Alliance that provides contextual information and data in respect of demography, local primary care estates and current and future housing developments including potential S106 availability.

Alliances are due to produce initial local estates plans, with indications for potential S106 priorities during Q1 2025/26.

In addition, Alliance Teams have been progressing several Section 106 estates developments working with a range of practices across MSE. In Rochford for example, alongside the development of a draft ‘Rochford Estates Plan’, the Alliance has undertaken a prioritisation process, using a locally developed tool, to assess Expressions of Interest from local practices in relation to S106 pots of funding potentially available across the PCN. The outcome of this is due in the coming month.

In Thurrock a business case is being prepared in April for potential S106 funding in relation to increasing capacity at Purfleet Care Centre.

Over the last few months Mid Essex Alliance has worked with four practices where there are smaller S106 pots available for practices to use to improve estates, through reconfiguring and adapting existing space to create more clinical space.

Basildon and Brentwood Alliance are applying a similar prioritisation process to South East Essex and considering amalgamating smaller S106 pots across PCNs.

Focus of Alliance Teams

Alliance partnership working

Alliance teams continue to meet regularly with their Alliance Committees and wider Partnerships arrangements to mobilise action to integrate care and improve health and wellbeing outcomes at place. In the short-medium term Alliance delivery will be targeted to deliver integrated neighbourhood working and support delivery of the MTP.

One of the opportunities of working collaboratively through place-based partnerships is being able to connect with people away from health and care settings to stimulate a change in how they manage their health and wellbeing. An example of this is set out below:

On Good Friday, the SEE Alliance and ICB teamed up with Southend United Football Club to raise awareness of high blood pressure when Southend United played against Braintree Town. Home supporters and away fans scanned a QR code attached to food and drink packaging at the football match. The code linked to our Invincible Feeling, Invisible Danger campaign webpage, offering information about the dangers of high blood pressure and how to get blood pressure checks Blood Pressure Check: Why Regular Monitoring Matters - Mid and South Essex Integrated Care System Health inequalities funding continues to be distributed through trusted partners.

Integrated Neighbourhood teams

As mentioned above, Alliances will be prioritising at-scale delivery of frailty and improved end of life identification via Integrated Neighbourhood Teams (INTs), to support the MTP.

Progress so far as follows:

- Programme structure has been established and clear delivery goals and data sources defined for the scaling of the approach
- 11 out of our 24 INTs already have a focus on frailty and end of life (EOL) care within their model
- 4 have a partial focus on Frailty and EOL and 9 currently have a focus on other areas such as Mental health, Children and Young people or a disease specific focus.

Our work over the next three months will be to support all our 24 INTs to both support their existing good work and to ensure the focus on frailty and EOL is MSE wide. A support tool is being produced to facilitate this with INT leadership teams.

Engagement work with partners in adult social care, primary care, community teams and wider community leads has been undertaken over April; to share the refreshed vision for INTs over the next year, this will continue in May and beyond.

Progress has been made in trialling a case finding and risk stratification tool developed by AGEM (the ICB's IT provider), with a PCN in Southeast Alliance, to ensure interventions within neighbourhoods are tailored to the needs of the resident linked to frailty and EOL.

Thurrock continues to build on its ways of working, re-setting its arrangements through the development of the Place Based Partnership under Thurrock Integrated Care Alliance (TICA). A workshop in April focused on the role of INTs, the overview of the vision for INTs and focus on frailty.

Work with the Ageing Well Stewards on the development of a Frailty, EOL and Dementia Programme to underpin the INT focus on Frailty and EOL care has progressed at pace and has informed the further development of the INT vision. Effective utilisation of digital tools including FrEDA, electronic Frailty registers and electronic End of Life registers is a focal point of the programme alongside championing the Frail+ training available to all partners via the Our People, Your Future website Frail+ Excellence in Personalised Care (Including How to Use FrEDA Training) - Our People Your Future

Embedding FrEDA and other digital tools within the system will support comprehensive, personalised approaches to assessment, interventions and wellbeing outcomes.

We have also been sharing good practice and learning at a wider Essex and regional basis to support the work.

This work has a close alignment with the Urgent and Emergency Care (UEC) and Flow workstream within the MTP and leaders will be ensuring close alignment as needed.

Better Care Fund

The updated Better Care Fund (BCF) policy framework sets out the objectives, funding and conditions for BCF for 2025 to 2026 and has been used to support and inform planning for the BCF.

The framework is framed around a commitment to reforming and strengthening neighbourhood services across health and social care, with the goal of:

- providing more care closer to home
- increasing the focus on prevention so that people are living healthier and more independent lives
- harnessing digital technology to transform care.

For people with more complex health and care needs, this relies on having joined-up health and social care services that work to provide co-ordinated, person-centred care and support, drawing upon effective use of data and technology.

The better care teams have completed the 25/26 Q1 submission to the national team including refreshing the intermediate care capacity and demand plan for MSE, updating and confirming the financial allocations and, where possible, planning for service continuity for the next year.

There is recognition that local authority (LA) devolution and changes to ICB boundaries and responsibilities may affect funding flow and the work undertaken in the BCF space and some pre-planning around this is starting with LA colleagues within the realms of the information available currently.

The routine timetable of meetings in all localities has been maintained with reporting into the Alliance committees/ meetings.

For 2025 to 2026 there are three headline metrics within the BCF:

- Emergency admissions to hospital for people aged over 65 per 100,000 population
- Average length of discharge delay for all acute adult patients, derived from a combination of:

    - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
    - for those adult patients not discharged on their DRD, average number of days from the DRD to discharge
- Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population.

Within the Essex County Council (ECC) facing part of the system, the focus of the recent meeting was on the evaluation of the Home to Assess Service, which has not shown the outcomes expected and consequently, will not move out of the pilot stage within MSE in its current format. Work to support the transition of our existing bridging capacity into a Home to Assess (H2A) model continues, Mid Essex are testing the model which has successfully been piloted in South West and North Essex. The proposed procurement of this new H2A model will be undertaken by ECC with the ICB's support and will be in place as a mobilised service by November 2025.

The planning for 2025/26 has been informed by a review of existing projects being supported by the BCF, the data supporting these and evaluations completed over the year.

In Essex we will be maintaining our 'home first' focus and will be supporting the development of INTs and promoting independence and care closer to home including support to unpaid carers.

In Thurrock, the line-by-line review of expenditure within BCF is now complete and has informed the contents of the 2025/26 BCF submission. Improved alignment of expenditure with the Thurrock Health & Wellbeing Strategy, the ICB Joint Forward Plan, the NHS Planning Guidance and the council's new Operating Plan, is intended to deliver a more coherent approach to managing resources.

A focus on moving from acute to community will take the form of (amongst other things) deploying the By Your Side service into the Emergency Department (ED) at Basildon Hospital, working with the unit Matrons to identify people who can be supported in the community without needing to go through the acute service.

Additionally, work with the VCFSE sector in providing additional support to adults and children with a learning disability is expected to start in the summer of 2025. This work will focus on supporting the 10% of people on the learning disability (LD) register in Thurrock who find it challenging to engage with services, to have their annual health check.

Unpaid carers will also benefit from BCF funding via a pilot service which is intended to support carers who are about to go into crisis. This initiative will aim to prevent hospital admissions for carers and hospital/care home admissions for the cared for person.

The Southend-on-Sea (Southend) BCF Plan for 2025/26 is part of a wider programme of work to integrate health and care across the City of Southend for the benefit of local residents and the community. The alignment of organisational priorities serves to advance local service development and shared outcomes. The focus for 2025/26 will be ensuring current resource is maximised with high quality data to evidence impact.

There is a commitment to maintain areas of investment from the 2023-25 plan, including the previously ringfenced discharge funding.

We will concentrate on aligning our resources to improve support across three focus areas:

- Neighbourhood Development
- System Flow
- Health & Social Care Inequalities.

The Renewed Southend City Council Housing Assistance and adaptions policy was adopted on 16 October 2024. This policy ensures the council meets its statutory duty to provide mandatory Disabled Facilities Grants (DFGs) for residential adaptations. This policy also recognises the wider strategic planning and implementation of the BCF plan and intends to explore opportunities for the DFG service to support wider services within health and urgent and emergency flow, social care and housing.

Refreshed mechanisms for reporting at scheme and system level are being established for better insight and evidence of the impact of the BCF programme on wider system priorities. Working across the council and ICB with wider Essex partners, we are developing a cohesive reporting mechanism to enable sharing of insight across Health and Well Being Boards (HWBs) through the Mid and South Essex BCF Board. This will enable us to better identify and embed best practice to better support outcomes of our integrated health and care offer.

Transfer of Care Hubs (TOCH)

Our focus on TOCHs has been to maintain ‘business as usual’ while further developing links to INTs to facilitate improved discharges and more streamlined care including admission avoidance. Each hub is sharing learning to improve effectiveness and outcomes.

The first year of the TOCH development evaluation is being undertaken by our health economist to support next steps in the way in which the teams can further support the INTs. The discharge cell has been transitioned to the Integrated Care Transfer Hub (ICTH) and has taken over oversight and reporting on discharge pathways for the system.

2. Recommendation

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

Part I ICB Board meeting, 15 May 2025

Agenda Number: 17.1

Board Assurance Framework

Summary Report

1. Purpose of Report

To provide assurance to the Board regarding the management of strategic risks via the ICB's Corporate Risk Register and Board Assurance Framework (BAF).

2. Executive Lead

Tom Abell, Chief Executive Officer and named Executive Directors for each risk.

3. Report Author

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

Each sub-committee of the Board is responsible for their own areas of risk and receive risk reports to review on a bi-monthly basis.

5. Link to Strategic Objectives

Each BAF risk (and associated risks on the ICB's corporate risk register recorded on Datix) is linked to one or more of the ICB's 7 strategic objectives, these being:

1. To ensure that the MSE ICB and ICS deliver good quality health care and services within financial resource limits.
2. To reduce health inequalities across mid and south Essex including access to, experience of, and outcomes of the services we provide.
3. To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
4. To develop and support our workforce through compassionate leadership and inclusion, achieving significant improvement by March 2026.
5. To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.
6. To embrace service improvement by adopting innovation, applying research and using data to drive delivery, transformation and strategic change.
7. To be an exemplary partner and leader across mid and south Essex ICS, working with our public, patients and partners in the ICP to jointly meet the health and care needs of our people.

6. Conflicts of Interest

None identified.

7. Recommendation/s

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

Board Assurance Framework

1. Introduction

The ICB Board is responsible for ensuring that adequate measures are in place to manage its strategic risks. This is discharged through oversight of the Board Assurance Framework (BAF) by the Board itself, supported by the Audit Committee which reviews the BAF and corporate risk register at each committee meeting. The ICB's main committees also receive excerpts from the BAF in relation to risks within their remit, alongside the full risk registers that relate to their committee.

2. Review of Risks currently on the Board Assurance Framework

As reported to the March Board meeting, the ICB's BAF included eight strategic risks, as detailed below:

- Workforce
- Primary Care
- Capital
- Urgent Emergency Care (UEC) and System Co-ordination)
- Diagnostics, Elective Care and Cancer Performance
- System Financial Performance
- Inequalities
- Mental Health Services

As of March 2025, all BAF risks were 'RAG' rated red, except Health Inequalities (rated Amber).

The Executive Team revisited the risks on the BAF on 7 March and the ICB Board was due to consider proposals regarding the future content and format of its BAF to reflect changes to the ICB's risk profile at a Board Seminar on 13 March. However, due to the announcements made regarding the reduction in ICBs' running costs and the abolition of NHS England, this did not occur.

The Board's review of the BAF, including a review of the ICB's risk appetite, will now take place at a Board Seminar on 15 May 2025 prior to the Part I Board meeting being held that afternoon.

The BAF has therefore not been included within this report. A revised version will be submitted to the July Board meeting.

In the meantime, the Board is asked to take assurance that the ICB continues to manage and monitor risks within its remit via:

- reports to the board on existing risks
- regular review of risks by risk leads and teams with regular updates recorded on Datix (the ICB's risk management system)
- presentation of bi-monthly risk reports to each main committee
- presentation of the full corporate register and BAF to the Audit Committee
- annual audit of its governance and risk management processes, which identified 'substantial' assurance during 2024/25.

3. Assessment and Management of Risks across Integrated Care Systems

As highlighted in the March BAF Board report, the ICB is participating in a pilot with NHS England for the assessment and management of risks across integrated care systems in line with new National Quality Board guidance.

Two risks were chosen to pilot the NHS England tools for assessing system risk: firstly, relating to mental health patients who require urgent emergency care; and secondly, the risk associated with inconsistencies in the service offer for palliative and end-of-life care. The ICB's Associate Director of Corporate Services led two workshops to discuss the risks with appropriate representatives from relevant partner organisations on 4 and 9 April 2025 respectively.

Feedback from the two workshops is being analysed to identify action required. An update on the result of the pilot will be provided to the Quality Committee and Board in due course.

This pilot will run alongside the further development of the ICB's own risk framework including how the ICB collaborates with partners to manage risks.

4. Recommendation

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

Part I ICB Board Meeting, 15 May 2025

Agenda Number: 17.2

Revised Policies

Summary Report

1. Purpose of Report

To update the Board on policies that have been revised and approved by sub-committees of the Board.

2. Executive Leads

- Jennifer Kearton, Executive Chief Finance Officer
- Barry Frostick, Executive Chief Digital and Information Officer
- Dr Giles Thorpe, Executive Chief Nursing Officer
- Jo Cripps, Director of System Recovery

3. Report Author

Sara O'Connor, Senior Manager Corporate Services.

4. Responsible Committees

Audit Committee and Quality Committee

5. Link to the ICB's Strategic Objectives:

- To ensure that the Mid and South Essex Integrated Care Board and Integrated Care System deliver good quality healthcare and services within financial resource limits.
- To improve standards of operational delivery, supported by collaborative system working, to deliver patient centred care in the right place at the right time and at the right cost to the NHS.
- To develop effective oversight and assurance of healthcare service delivery across mid and south Essex ensuring compliance with statutory and regulatory requirements.

6. Impact Assessments

Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.

7. Conflicts of Interest

None identified.

8. Recommendation

The Board is asked to note the revised policies set out in this report.

Revised ICB Policies

1. Introduction

The purpose of this report is to update the Board on new and revised policies which have been approved by the relevant committees since the January Board meeting.

2. Revised Policies

The following policies were approved by the relevant committees, as per the authority set out in the relevant committee terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit Committee 15 April 2025	The committee approved revised versions of the following: • 010 Information Governance Framework and Policy • 011 Information Sharing Policy • 012 Records Management and Information Lifecycle Policy • 013 Access to Information Policy • 018 Management of Conflicts of Interest Policy (Including Gifts and Hospitality, Outside Employment, Commercial Sponsorship and other situations where conflicts might arise). • 019 Standards of Business Conduct Policy. • 076 Individual Funding Request Policy The committee also extended the review dates of the following: • 014 Information and Cyber Security Policy (extended to September 2025) • 021 Health & Safety Policy (extended to July 2025) • 024 Incident Reporting Policy (extended to July 2025) • 027 Forensic Readiness Policy (extended to July 2025)
Finance & Performance Committee 6 May 2025	The committee approved a revised version of the following: • 009 Financial Allocations and System Reporting Policy
Quality Committee 28 February 2025	The committee extended the review date of the All Age Continuing Care Policy (Ref 068) until June 2025.
Remuneration Committee	The committee virtually approved amendments to the Pay Protection Policy (087) on 8 May 2025.

3. Findings/Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The approved policies will be published on the ICB's website.

4. Recommendation

The Board is asked to note the new and revised policies set out in this report.

Part I ICB Board meeting, 13 March 2024

Agenda Number: 17.3

Approved Committee Minutes

Summary Report

1. Purpose of Report

To provide the Board with a copy of the approved minutes of the following committees:

- Audit Committee (AC), 21 January 2025.
- Clinical and Multi-Professional Congress (CliMPC) – 29 January 2025
- Finance & Performance Committee (FPC) – 4 March 2025
- Primary Care Commissioning Committee (PCCC): 12 February 2025 and 12 March 2025
- Quality Committee (QC): 28 February 2025.
- Digital and Data Technology Board (DDaT): 13 February 2025
- People Board (PB): 6 March 2025

2. Chair of each Committee

- George Wood, Chair of AC
- Dr M Sweeting, Chair of CliMPC.
- Joe Fielder, Chair of FPC and PB.
- Prof. Sanjiv Ahluwalia, Chair of PCCC.
- Dr Neha Issar-Brown, Chair of QC.
- Barry Frostick, Chair of DDaT.

3. Report Authors

Sara O'Connor, Senior Corporate Services Manager

4. Responsible Committees

As per 1 above. The minutes have been formally approved by the relevant committees.

5. Conflicts of Interest

Any conflicts of interests declared during committee meetings are noted in the minutes.

6. Recommendation/s

The Board is asked to note the approved minutes of the above committee meetings.

Committee Minutes

1. Introduction

Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of the meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on the functions and decisions delivered on its behalf.

2. Main content of Report

The following summarises the key items that were discussed / decisions made by committees as recorded in the minutes that have been approved since the last Board meeting.

Audit Committee, 21 January 2025

The following items of business were considered:

- The committee received a copy of the Board Assurance Framework submitted to the January Board meeting and the full corporate risk register. The committee noted that the annual internal audit of the ICB's governance and risk management arrangements had concluded a 'substantial' assurance opinion on the ICB's processes.
- A deep dive relating to diagnostics, elective care and cancer performance risks.
- An update on changes to the ICB's governance arrangements.
- Progress with the Annual Report and Accounts, including the Month 9 Governance Statement.
- Update on the status of ICB policies.
- Mandatory Training compliance.
- Overview of work being undertaken for the Data Security Protection Toolkit (DSTP) submission and the associated audit, plus other information governance related work across the ICB and Integrated Care System.
- Emergency Planning, Resilience and Response update.
- Health & Safety update.
- Review of the Audit Committee draft workplan for 2025/26.
- Contract governance, procurement register, waiver report and losses and special payments.
- Internal Audit, Local Counter Fraud Specialist and Local Security Management Specialist updates.
- External Audit update.
- Gifts and Hospitality Register.
- Minutes of other main ICB committees.

Finance and Performance Committee, 4 March 2025

The following items of business were considered:

- System Finance and performance report for month 10.
- Planning 2025/26 – Headline submission.
- Deep Dive on Financial Risk – All Age Continuing Care.
- MSE ICB Care Transfer Hub and supporting care framework
- Integrated Urgent Care - NHS 111 Contract 2025-2027

- HSCN Network Connectivity
- Review of committee effectiveness 2024/25
- Board Assurance Framework and Finance Risk Register
- Minutes of the System Investment Group (SIG) meeting held on 27 January 2025.
- Single Contract Award for MSEFT for NHS General & Acute Services and NHSE Specialised Services 2025/26

Primary Care Commissioning Committee, 12 February 2025

The following items of business were considered:

- Primary medical services contracts update.
- Women's Health Hub Local Enhanced Service update.
- Medicines Optimisation Local Enhanced Scheme 2025-26 and Prescribing Efficiencies Plan.
- Finance update.
- Training Hub/workforce update.
- Primary care risk management update.
- Community Pharmacy update.
- Dental update and minutes of the Dental Commissioning and Transformation Group, 4 December 2025.

Primary Care Commissioning Committee, 12 March 2025

The following items of business were considered:

- Dental Finance
- Primary Medical Services – Branch closures.
- Primary Care Strategy / Integrated Neighbourhood Team update.
- Internal audit of delegated commissioning.
- Pharmacy First report.
- Review of committee effectiveness 2024/25.

Quality Committee, 28 February 2025

The following items of business were considered:

- A deep dive on dental services, including a lived experience story relating to the dental care home pilot.
- The ICB's Executive Chief Nurse reported escalations from Safety Quality Group and provided an update on emerging safety concerns.
- MSEFT acute care update.
- Community Collaborative update report.
- Primary Care update
- Sodium valproate alert update.
- Special Educational Needs and Disabilities update.
- Babies, children and young people update, including neurodiversity.
- Infection Prevention and Control update.
- Lampard Inquiry update.
- Patient Safety and Quality Risks update.
- The committee agreed the refreshed ICB Quality Strategy would be considered again following finalisation of the Medium Term Plan.

- The committee approved Terms of Reference for the newly established Infection Prevention and Control Oversight Group.
- The committee approved the revised Communicable Disease Outbreak and Incident Management Policy (Ref 074).
- The committee approved its workplan for 2025/26 and noted the arrangements in place to review the committee effectiveness for 2024/25.
- The committee agreed that a deep dive relating to maternity services would be held at its April meeting.

Digital, Data and Technology Board, 13 February 2025

The following items of business were considered:

- A discussion was held to develop ideas for the refresh of the ICS Digital Strategy.
- New Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) update.
- Telephony changes update.
- ICS digital dashboard.
- Minutes of recently held ICS Information Governance and Cyber Steering Group meetings were noted.

People Board, 6 March 2025

The following items of business were considered:

- Highlight reports were received from the following workstreams:
  - Clinical Capacity Expansion / Education Innovation
  - Colleague Engagement, Wellbeing & Retention
  - Culture
- The ICB as an Anchor Organisation.
- Workforce data and the challenges it presents at System level.
- People Promise and Retention.
- People Board risks.
- Committee effectiveness desktop review.

3. Recommendation

The Board is asked to note the approved minutes of the above committee meetings.

Minutes of the Audit Committee Meeting

Held on 21 January 2025 at 1.00pm

via MS Teams and Face to Face at Phoenix Court

Attendees

Members

- George Wood (GW), Non-Executive Member, MSE ICB – Audit Committee Chair.
- Dr Geoffrey Ocen (GO), Associate Non-Executive Member, MSE ICB.

Other attendees

- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSE ICB.
- Nicola Adams (NAd), Associate Director of Corporate Services, MSE ICB.
- Natalie Brodie (NB), Deputy Director of Finance Primary Care & Financial Services, MSE ICB.
- Darren Mellis (DM), Head of Financial Services, MSE ICB.
- Jane King (JKi), Corporate Services and Governance Support Manager (minute taker), MSE ICB.
- Iain Gear (IGe), Information Governance Manager, MSE ICB.
- Jim Cook (JC), Deputy Director of EPRR and Operational Resilience, MSE ICB.
- Mike Thompson (MT), Associate Director of System Programme, MSE ICB (Item 5 only).
- James Buschor (JB), Head of Assurance & Performance Analytics, MSE ICB (Item 5 only).
- Emily Hughes (EH), Deputy Director Delivery and Specialised Commissioning, MSE ICB (Item 5 only).
- Janette Joshi (JJ), Deputy Director System Purchase of Healthcare, MSE ICB (Items 14 & 15 only).
- Barry Frostick (BF), Chief Digital & Information Officer, MSE ICB (Item 12 only).
- Nathan Ackroyd (NAc), Manger, KPMG.
- Karen Swainson (KS), Head of Internal Audit, TIAA.
- Jai Gundigara (JG), Director of Audit, TIAA.
- Hannah Wenlock (HW), Anti-Crime Specialist, TIAA.
- Inge Damiaens (ID), Anti-Crime Manager, TIAA.

Apologies

- Mark Harvey (MH), Partner Board Member, Southend City Council, Local Authority Representative.
- Sara O'Connor, (SOC), Senior Manager, Corporate Services, MSE ICB.
- Emma Larcombe (EL), Director, KPMG.

1. Welcome and Apologies

GW welcomed everyone to the meeting. Apologies were noted, as listed above.

2. Declarations of Interest

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

There were no further declarations raised.

3. Minutes and Action Log

The minutes of the ICB Audit Committee on 15 October 2024 were received.

The action log was discussed and noted that all actions were complete.

Under Matters Arising, NAd advised that following the recent health inequalities audit, a recommendation was made for the Equality and Health Inequalities Impact Assessment Panel to report into the Audit Committee.

ACTION: The Audit Committee Terms of Reference should be updated to reflect the Equality and Health Inequalities Impact Assessment Panel as a responsibility of the Audit Committee.

Outcome: The minutes of the meeting held on 15 October 2024 were approved as an accurate record.

4. Board Assurance Framework & Corporate Risk Register

NAd presented the latest iteration of the Board Assurance Framework (BAF) which was submitted to the Part I ICB Board meeting on 16 January 2025. An updated BAF would be submitted to the next Part I ICB Board meeting on 13 March 2025.

There were 8 ICB red rated risks outlined in the BAF. A summary of Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust's (EPUT) red rated risks were also included.

A copy of the Corporate Risk Register was also presented to the committee, which detailed 57 active directorate level risks.

Since the last committee meeting 1 risk had been closed and no new directorate/corporate level risks had been opened. The Digital and Business Intelligence team were now using Datix to record team/project level risks and there had been meetings with other directorates to discuss them using Datix for team-level risks.

Arrangements to inform the ICB's Operational Group (IOG) and Executive Team on progress with the updating of risks each month had been implemented which had significantly improved the timeliness of receipt of updates and, at the time of writing, there were no outstanding risk updates.

There would now be a focus on ensuring that risk leads provided accurate information on existing controls/assurances, improved information within updates and identification of actions to further mitigate the risk. A 'lunch and learn' session was being planned to support this.

The annual internal audit of the ICB's governance and risk management arrangements by TIAA concluded a 'substantial' assurance opinion on the processes in place.

In response to GO, NAd confirmed the Primary Care Commissioning Committee was responsible for the oversight of primary care risks.

GW was surprised that MSEFT had not explicitly identified Maternity Services and Urgent and Emergency Care (UEC) as red rated risks.

JKe explained that the ICB was working through the connectivity between the performance report and risk register e.g., if performance dropped below a specified level, it would automatically link into the risk register.

ACTION: Review MSEFT related risks for Maternity Services and UEC issues.

GW commented that the BAF should provide assurance that any barriers or gaps were being addressed, be clear on who or what groups were receiving assurances at the ICB and provide details on actions being taken where improvements were not seen e.g., the Cancer 62-day target performance was at 41.3% against the plan of 62%, but queried what was being done to meet the target. GW also highlighted that the mental health Out of Area placements were significantly above the target but it was not clear what actions were being taken to reach the target and what groups were receiving assurance.

JKe advised that this was also discussed at the Executive Committee and providers would be asked to provide greater assurance and detail on the actions taken to mitigate risks.

The committee noted that the ICB was working with NHS England on a pilot for a new risk management process for assessing system risks within an Integrated Care System, which followed guidance from the National Quality Board on dynamic and complex system risk assessments.

The pilot would focus on 2 specific risk areas and due for completion in May 2025. Concurrently, the ICB was developing its own risk framework and culture so it could roll out the principles and learning identified from the pilot, across the risk management process.

GO enquired to what extent would the new risk management process drive and prioritise decisions relating to system risks. NAd explained the vision was for risks to drive discussion at forums across the system. JKe added that risk references were now included on the Finance and Performance Committee agenda, which supported committee decision making from a risk perspective. NAd explained that the use of risk references would be rolled out to all Board and committees once updated templates were finalised.

Following a recent article reporting that 1 in 7 hospital beds were taken up by patients awaiting social care, GW queried who was horizon-scanning for this and who would pick the risk up. NAd commented that the pilot would bring partners together to understand the impact of risks such as this.

Outcome: The Committee NOTED the Board Assurance Framework, Corporate Risk Register and NHS England risk management pilot update.

5. Risk Deep Dive - Diagnostics, Elective Care and Cancer Performance Risk

GW welcomed JB, EH and MT to the meeting to present a deep dive into the BAF Diagnostics, Elective Care and Cancer Performance risk. The purpose was to provide assurance to the Audit Committee that there was a clear plan to manage the risk, with metrics and milestones in place, provide understanding of the resources required and expected timing/resolution to mitigate the risk.

JB presented the actions being taken to address the risks in relation to Cancer Performance. It was noted that the 62-day cancer performance targets were low compared to the standard target, therefore performance for this standard was monitored via fortnightly Tier 1 meetings between MSEFT, national and regional teams. Some improvement had been seen month-on-month, however MSEFT remained a national outlier for the target of 62%.

JB provided further assurances regarding actions being taken to improve the position, particularly around skin cancer.

In response to GW's query on when the target would be met for the 62-day standard, JB advised that a number of Cancer Alliance pathway analyser tools were to be completed to provide revised trajectories indicating when each cancer speciality should expect to recover. JKe added that the revised trajectories would be known by the next Tier 1 meeting.

ACTION: Update the BAF before the next Board meeting to reflect the improvements in the 62-day standard.

In response to GO, JKe explained that the specific actions needed to meet the standard targets would become known following the outcome of the pathway analysis. EH added that there were a number of operational actions undertaken by MSEFT to improve pathway efficiency and utilisation of resources that were reported at Tier 1 meetings. The ICB were also taking actions to support the system recovery, in particular around pathway redesign, e.g., the tele-dermatology service had reduced the demand for face-to-face appointments.

Members of the Audit Committee would be included in Finance and Performance Committee (FPC) paper distribution to ensure they were sighted on any financial risk items presented to FPC.

ACTION: Add Audit Committee members to Finance and Performance Committee paper distribution.

MT spoke about the national programme to create new Community Diagnostic Centres (CDCs) to address the demand on diagnostic services by increasing capacity for diagnostic tests. Four permanent CDC sites were being established in Thurrock, Braintree, Southend and Pitsea. Additional capacity had been provided, until they were built.

A paper setting out information on CDC capital, revenue and risks e.g., delay to Braintree CDC opening would be presented to the System Oversight and Assurance Committee (SOAC) in February 2025. Any key risks identified would be added to the Risk Register.

GW stressed the importance of ensuring CDCs were fully utilised and enquired who had responsibility for managing CDC utilisation across the system. JKe commented that MSEFT had overall productivity measures, but it was not clear if CDCs were included. MT and JKe agreed to discuss CDC productivity measures with MSEFT colleagues to ensure assurance could be provided that CDC utilisation was managed.

ACTION: MT and JKe discuss CDC productivity measures with MSEFT colleagues to provide assurance that the utilisation of CDCs was appropriately managed and monitored.

Outcome: The Committee NOTED the presentation on the BAF Diagnostics, Elective Care and Cancer Performance risk deep dive.

6. ICB Governance Update

NAd advised that, due to updated model constitution guidance issued by NHS England (NHSE) in July 2024, changes were required to the ICB Constitution to incorporate the role of the Senior Independent Director (SID) Non-Executive Member which were approved at the November 2024 Board meeting.

The Digital, Data and Technology Board was established as a sub-committee of the ICB Board and, as a consequence, the ICB Scheme of Reservation and Delegation (SoRD) was updated to reflect this.

As part of the delegated Specialised Commissioning, a further 11 services would transfer to the ICB from 1 April 2025. The ICB Board had delegated to the Chief Executive Officer (CEO) to sign off the necessary governance documents. NAd gave assurance that there were no significant changes to the governance and there would be an update at the next meeting.

A Board Development Session had taken place in January to look at ICB Board effectiveness and how the Board could strengthen the way it works in the future.

There were no comments or questions.

Outcome: The Committee noted the update on ICB Governance

7. Annual Report and Accounts Timetable and Month 9 Governance Statement

NAd presented the paper which provided an update on the draft timetable for preparation and governance approval of the 2024/25 ICB Annual Report and Accounts and Month 9 Governance Statement. The ICB was required to submit a Month 9 Governance Statement outlining any key risks likely to be included in the Annual Report.

There were no comments or questions.

Outcome: The Committee NOTED the update on the timetable and governance for the 2024/25 ICB Annual Report and Accounts.

8. Policy Update

NAd provided a progress update on the review of ICB Policies, including those within the remit of the Audit Committee, and requested the committee to extend the review date of the Risk Management Policy (Ref: 017), Freedom to Speak Up Policy (Ref: 023), Incident Reporting Policy (Ref: 024) and Forensic Readiness Policy (Ref: 027).

NAd advised that the Standards of Business Conduct Policy (Ref: 019) had received minor changes and, following issue of new guidance, the Management of Conflicts of Interest Policy (Ref: 018) had been updated. Due to the timing of the next committee, the committee agreed the policies could be circulated for virtual approval.

ACTION: Revised Management of Conflicts of Interest, Gifts and Hospitality and Commercial Sponsor Policy (Ref 018) and Standards of Business Conduct Policy (019) to be circulated to the Audit Committee for virtual approval.

It was noted, under the Information Governance (IG) update (item 10), a request to extend the review dates of all IG policies.

There were no comments or questions.

Outcome: The Committee NOTED the update on progress with the review of existing ICB policies, including those within the remit of Audit Committee.

Outcome: The Committee APPROVED the extension of the review date of the following policies:

- 017 Risk Management Policy (to April 2025)
- 023 Freedom to Speak Up (to July 2025)
- 024 Incident Reporting Policy (to April 2025)
- 027 Forensic Readiness Policy (to April 2025)
- All information governance policies as detailed within the IG update report (April 2025).

9. Training Compliance

RS presented a summary of the mandatory training compliance figures as of 31 December 2024. Overall compliance for the organisation was 79% and for the majority of courses there had been an increase in completion rates since the last report in July 2024. The only exceptions were Data Security and Deprivation of Liberty Safeguards / Mental Health Act. The most improved was Resuscitation due to additional face-to-face training taking place. Understanding Sexual Misconduct training was a new requirement added in November 2024 and had reached 43% by December 2024. A new section was included on the monthly 1:1 meeting template to ensure managers review mandatory training compliance.

Outcome: The Committee NOTED the update on Training Compliance.

10. Information Governance Update

IGe provided the committee with an overview of the work undertaken towards the Data Security Protection Toolkit (DSPT) submission, the associated DSPT audit, and wider Information Governance (IG) related work across the ICB and ICS.

The ICB was working towards DSPT completion and submission at the end of June 2025. The DSPT baseline was submitted, as required, by the December 2024 deadline.

The Cyber Audit was due to commence in February 2025 and the annual DSPT audit at the beginning of April 2025.

There had been an increase in Freedom of Information (FOI) breaches, partly due to capacity issues within the IG team which had now been resolved. The ICB's FOI breach rate of 2.5% was below the Information Commissioners Office maximum breach rate of 5% which would prompt a review. JKe added there had been a huge increase in the volume and complexity of FOI's received.

Minutes of the IG Steering Group held on 26 September 2024 were presented to the committee for information.

It was not fully understood how the requirements of the Cyber Assurance Framework DSPT should be reflected within the ICB's IG related policies, therefore an additional extension to the review date was requested from the committee. The extension would allow time to review and update the policies for presentation to the next IG Steering Group, ahead of submission to the Audit Committee in April 2025.

Outcome: The Committee NOTED the quarterly report on Information Governance.

Outcome: The Committee APPROVED the extension of the IG policies until 30 April 2025.

11. Emergency Planning, Resilience and Response Update

JC presented the Emergency Planning, Resilience & Response (EPRR) and the System Co-ordination Centre (SCC) report.

Following submission of its annual NHSE EPRR Core Standards self-assessment, the ICB received a confirmed rating for 2024/25 of 'substantial compliance'. The ICB was working with providers who achieved 'partial assurance' to improve their position during 2025/26.

JC highlighted the withdrawal of pagers for on-call purposes at the ICB and the associated savings.

The EPRR and SCC continued to work across the ICB and with system partners to manage operational pressures and to prepare for, respond to and recover from incidents and emergencies. The ICB were leading the multi-agency Mass Casualty Framework review for Essex. The EPRR team was now focussed on the national pandemic planning exercise.

Changes within the team included the Executive Director Performance and Planning undertaking the role of Accountable Emergency Officer.

GW commented that the slide outlining the long-term risks projected an increase in population by 2030 in mid and south Essex of 200,000, which seemed exceptionally high. JC agreed to check the source of the information for accuracy. JKe advised that updated population data was included in the draft Medium Term Plan that she would share with JC.

Outcome: The Committee NOTED the quarterly EPRR Update and NHSE EPRR Core Standards submission.

12. Health & Safety Update

BF presented the Health and Safety (H&S) report to the Audit Committee.

The report highlighted the internal H&S inspection undertaken on 18 December 2024, which included a review of ICB offices, common areas and car parking area allocated to the ICB. The majority of issues identified related to general housekeeping which were being addressed and progress monitored by the Health & Safety Working Group (H&SWG).

The final report relating to the security review undertaken by TIAA was included on the agenda under item 18. Although several recommendations would not be taken forward at this time (for the reasons provided in the report) security continued to be monitored on an ongoing basis, including via the H&SWG workplan. A Lockdown Exercise was planned later in the year.

As of 15 January 2025, 95% of ICB staff had undertaken and submitted a Working From Home (WFH)/Display Screen Equipment (DSE) assessment.

The membership outlined in the H&SWG Terms of Reference had been revised to reflect that the responsibility for H&S had transferred from the EPRR to the Corporate team. SOC would be the lead and would deputise for BF where necessary at meetings. H&SWG meetings were aligned with the Audit Committee to ensure latest information was available.

Minutes of the Health & Safety Working Group for 23 September and 22 November 2024 and 2024-25 Annual Workplan were presented to the Audit Committee for information.

GO enquired whether influenza was a workplace health and safety risk for the ICB. NAd explained that ICB staff predominately worked from home so the risk was very low. BF added that results from the staff survey found that staff did not feel pressurised to come into work if they were unwell.

Outcome: The Committee NOTED the Health & Safety update and approved the updated H&SWG Terms of Reference.

13. Audit Committee Draft Workplan 2025/26

NAd presented the first draft of the committee's workplan for 2025/26, highlighting the workplan could be flexed as necessary, and gave a verbal update on arrangements for the review of committee effectiveness. Given the timing of the Audit Committees, the self-assessment process would be undertaken virtually in between meetings with the aim of bringing the outcome report to the next meeting.

KS requested that the workplan be updated to present the Internal Audit Plan (including the Terms of Reference and Internal Charter) and Counter Fraud Plan to the Committee in April 2025. The Final Head of Internal Audit Opinion/annual report would be presented in June 2025.

Outcome: The Committee APPROVED the Draft Audit Committee Workplan subject to amendments discussed.

14. Contract Governance & Procurement Register

JJ presented the Register of Procurement Decisions detailing the 3 decisions (which had a published Contract Award Notice (CAN) on the 'Find a Tender' service, for Mid and South

Essex Integrated Care Board) for contracts awarded between 2 October 2024 and 19 December 2024.

The latest Procurement Register would be published on the ICB website following review by the Audit Committee.

There were no questions raised.

Outcome: The Committee NOTED the Contract Governance update and the latest iteration of the Procurement Register.

15. Waiver Report

JJ presented the Waiver Report. There were 6 procurement waivers signed since the last Committee totalling £460,421.

There were no questions raised.

Outcome: The Committee NOTED the Waiver Report.

16. Losses & Special Payments

The ICB Board approved the payment of a financial settlement that pre-dated the ICB, of £120k in relation to judicial review costs, that were mandated by the court in relation to a GMS Contractor which would be accounted for as a loss.

There were no questions raised.

Outcome: The Committee NOTED the special payment.

17. Internal Audit

KS advised that she was leaving her role at TIAA in February 2025 and introduced JG as the new Head of Internal Audit. GW thanked KS for her support and welcomed JG.

KS presented the Internal Audit Progress Report, detailing the progress of work undertaken against the 2024/25 Internal Audit Plan, highlighting that the final audit report for the Governance, Risk Management and Board Assurance Framework audit concluded 'Substantial' assurance.

KS commented that there was capacity to undertake audits in different areas as there had been changes to the 2024/25 audit plan, and invited suggestions from the committee. NAd advised that there was a potential conflict of interest issue that the ICB would like support with and to provide independent scrutiny. The detail would be discussed outside of the meeting.

GW suggested it would be helpful for TIAA to provide guidance on 2 or 3 concerns identified from audits undertaken for other ICBs to ensure the ICB was focusing on the right areas. KS confirmed that ICB's audit plans were consistent with other ICBs but would discuss with NAd.

The first draft of the Head of Internal Audit Opinion was on track to be issued at the beginning of March 2025.

In response to GO, KS advised that the DSPT audit had been deferred to Q1 2025/26 to better align with the 2024/25 submission deadline of 30 June 2025.

Outcome: The Committee NOTED the Internal Audit update.

18. LCFS/LSMS

HW presented the Anti-Crime progress report which summarised the proactive work completed against the 2024/25 work plan.

A proactive review of contract management and due diligence had been completed. The action plan contained four amber-rated and one green-rated management actions, that had been completed. A review of declarations of interest was due to commence and would be undertaken jointly with internal audit. The ICB was participating in the National Fraud Initiative 2024/25.

The Anti-Crime Service had produced an introductory news article for dissemination to GP practices via the primary care hub and weekly GP bulletin. The aim of the article was to raise the profile of the Counter Fraud function at the ICB as there had been a drop in the number of referrals into the service.

The report also included a summary of the status of investigations and referrals since the last paper presented to the committee, noting that two referrals had been received however both referrals were closed without investigation. One case was referred on to NHS England Counter Fraud team for further investigation.

ID provided an update on the Security Management work plan for Q3 which took into consideration the Violence and Aggression Prevention Standard, updated in December 2024. An update report on the ICB Head Quarters Security Audit undertaken by TIAA on 9 April 2024 was shared and the updates on the recommendations were noted.

Outcome: The Committee NOTED the update from the Local Counter Fraud and Security Management Services.

19. External Audit

NAc advised that KPMG were on track with the annual audit planning work which consisted of the financial statement audit and Value for Money (VFM) audit. Once the work on the financial statement was complete, the VFM audit would commence. The final plan would be presented to the next Audit Committee.

Work on the Mental Health Investment Standard (MHIS) was also progressing well and on track for completion.

There were no questions raised.

Outcome: The Committee NOTED the update from External Audit.

20. Gifts and Hospitality Register

The MSE ICB Gifts and Hospitality Register was presented to the committee for information. The Register detailed a record of any declarations made by staff in relation to gifts and/or hospitality, whether accepted or declined. Reminders were published in the

Connect Newsletter on the requirement for staff to re-familiarise themselves with the ICB's Conflicts of Interest Policy, which included guidance on when gifts and hospitality may be accepted or must be refused. Staff were also asked to declare any offers or gifts or hospitality made to them for inclusion in the ICB Gifts and Hospitality Register. The latest register was available on the ICB website. The Committee noted an audit of conflicts of interest was due to commence later in the month.

There were no questions raised.

Outcome: The Committee NOTED the Gifts & Hospitality Register.

21. Minutes of other ICB Committees

The following minutes were presented to the committee:

- Finance & Investment Committee – 3 September, 1 October, 5 November, 3 December 2024.
- Quality Committee – 30 August, 25 October 2024.
- Primary Care Commissioning Committee – 14 August, 9 October 2024.
- Clinical & Multi Professional Congress – 28 August 2024.

Outcome: The Committee NOTED the minutes of the sub-committees.

22. Any other Business

There was no other business to discuss.

23. Items to escalate

There were no items to escalate to the BAF, Board or other committees.

24. Effectiveness of Meeting

The Committee agreed the meeting had been well run and effective.

25. Date of Next Meeting

1.30pm–3.30pm, Tuesday 15 April 2025.

Minutes of the ICB Finance and Performance Committee

Held on 4 March 2025 at 1.30pm

ICB Headquarters and Microsoft Teams meeting

Attendees

Members

- Joe Fielder (JF) Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB), **Chair**
- Tom Abell (TA) Chief Executive Officer, MSE ICB
- Mark Bailham (MB) Associate Non-Executive Member and Vice Chair, MSE ICB
- Jo Cripps (JC) Executive Director of System Recovery, MSE ICB
- Laura Davis-Hughes (LDH) Local Authority representative, Essex County Council (ECC)
- Jennifer Kearton (JK) Executive Chief Finance Officer, MSE ICB
- Diane Leacock, Non-Executive Director, EPUT (Microsoft Teams)
- Julie Parker (JP) Non-Executive Director, Mid and South Essex NHS Foundation Trust (MSEFT)

Other attendees

- Ashley King (AK) Director of Finance and Estates, MSE ICB
- Keith Ellis (KE) Deputy Director of Financial Performance, Analysis and Reporting, MSE ICB
- James Buschor (JB) Head of Assurance and Analytics, MSE ICB
- Les Sweetman (LS) Deputy Director - Programme Delivery, MSE ICB (agenda item 11 via (Microsoft Teams)
- John Walter (JW) Director of Operations - All Age Continuing Care
- Alan Whitehead (AW) Associate Director UEC & SCC (Microsoft Teams)
- Nicola Adams (NA) Associate Director of Corporate Services, MSE ICB (Microsoft Teams)
- Emma Seabrook (ES) Business Manager, MSE ICB (minutes)

1. Welcome and apologies

JF welcomed everyone to the meeting and confirmed the meeting quorate.

Apologies were received from Matt Sweeting, Executive Medical Director and Sam Goldberg, Urgent Emergency Care System Director.

NA reminded the Committee of the confidential nature of some papers and asked papers were not shared outside of the Committee.

2. Declarations of interest

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

There were no declarations of interest in relation to the agenda items.

Outcome: The Register of Interests was noted.

3. Minutes of previous meetings

The minutes of 5 February 2025 were agreed as an accurate record.

Outcome: The minutes of 5 February 2025 were approved.

4. Action Log / Matters arising

Following a query from JF on the progress of the acute services reconfiguration business cases (3 storey Southend development and acute kidney unit), the Committee were advised a letter of support had been provided by the ICB. At the time of the meeting, the ICB had not been notified whether cases had received approval by NHS England.

JP referred to the supplementary update on action 52 (TPP SystmOne GP Enhanced contract extension). Following the action taken at the February meeting to query who was accountable by approving a non-compliant extension, NHS England confirmed the ICB would be the contracted body held accountable should any legal challenge arise. The Committee noted the risk associated to the reliance placed upon such frameworks in future and requested the risk be raised with NHS England through the appropriate forum.

Outcome: The action log was noted.

Action: The broader risk on reliance upon frameworks outside of the ICBs control be raised at the appropriate forum with NHS England.

5. System Finance and Performance Report – Month 10

Prior to the change of forecast outturn in Month 10, the System were reporting against an agreed planned deficit of £96m for 2024/25.

JK presented the Month 10 report and confirmed a revised forecast outturn position had been agreed with NHS England of an additional £33m for 2024/25 (taking into account the deficit cash support from NHS England). This consisted of £19m deficit for MSEFT and a deficit of £13.5m for EPUT. The total agreed forecast deficit for 2024/25 was therefore £128m (£104m deficit MSEFT, £28m EPUT and a balanced position for the ICB).

Of the £13.5m further deficit for EPUT, £1.5m was to support the provision for the Mental Health Inquiry. The remainder £12m was due to continued pressures in Mental Health inpatients.

MSEFT delivered a break-even variance to plan for Month 10 despite pressures over the winter period and pay costs.

JK confirmed despite challenges during the year, the ICB were on plan to deliver the trajectory for all age continuing care for 2024/25.

The Committee noted the improvement in the delivery of efficiencies for the later part of the financial year.

JP queried how the implementation of controls had been progressed within EPUT. It was clarified work had commenced to adopt a similar model as enacted within MSEFT to address bank and agency costs. DL reported an improvement had been seen in agency costs.

MB asked if posts had been completely removed from the MSEFT workforce structure, which was confirmed by JK.

LDH referred to the projected WTE position for MSEFT for Month 11 and Month 12 and asked for clarification on deliverability. JK said there was a reliance on MSEFT to stabilise the financial position and flagged the difficulty to reduce workforce spend in Month 9 and Month 10 due to the impact from winter and increased pressures on the ability to deliver.

There was a discussion on the difference of reporting workforce data within the ICB and MSEFT Finance and Performance Committees.

Following a review on workforce, MSEFT had ringfenced additional capacity to recover breast cancer performance, work was taking place to identify patients who required an urgent pathway of care.

JP highlighted that performance data on general practice did not correlate to data within the National Oversight Framework. JB explained that the data within the National Oversight Framework was captured at a point in time and so the difference could result from a time lag, and expected MSEs ranking would improve in the framework's next iteration. JB took an action to check with NHS England when the next data refresh would be and establish what period the current framework covered.

JF noted a decline in performance for referral to treatment (RTT) (incomplete Pathways; number of patients waiting 65+ week waits). TA advised theatre capacity within MSEFT had significantly reduced following the failure of several air handling units. Orthopaedics was one of the areas most affected.

Outcome: The Finance and Performance Committee noted the Month 10 System Finance and Performance report.

Action: JB to establish what time period the National Oversight Framework covered (when it is next released), compared to the latest period of data held by the ICB for primary care, to determine the period of time lag.

6. Planning 2025/26 - Headline submission

JK provided a verbal update on planning following the headline submission made to NHS England on 27 February 2025.

Following receipt of £106m deficit support funding, the System agreed an approach to distribute funding based on the proportion of outturn this financial year. As a result, £85m was allocated to support the MSEFT deficit and £20m allocated to support the EPUT deficit. Discussions were taking place with EPUT on potential opportunities to close the £5m shortfall.

The planning submission highlighted unidentified efficiencies of £6.5m for the ICB. The ICB would undertake an expenditure review later this week as part of next steps to mitigate the gap and present the breakeven route at the regional planning meeting on 10 March 2025.

The headline submission showed a reduction in workforce for both MSEFT and EPUT.

It was agreed JF, JK and MB would meet ahead of the presentation of the ICB plan to the ICB Board meeting on 13 March. A Board meeting with MSEFT and EPUT was taking place on 18 March 2025 to triangulate plans and discussions.

Feedback from the planning headline submission was due in the coming days. This would form the key lines of enquiry for the MSE regional planning review meeting on 10 March 2025.

The submission was based on the ask from NHS England to present what a balanced plan looked like and any impact operationally.

Outcome: The Finance and Performance Committee noted the update on Planning 2025/26.

ACTION: Meeting to be arranged between JF, JK and MB prior to the ICB Board on 13 March 2025 for the Chair and Vice Chair to be fully briefed on planning.

7. Medium Term Planning update

JC advised the Medium-Term Plan (MTP) was being taken through governance in each of the organisations within the system. The underpinning MTP model was handed from PA Consulting to ICB Finance colleagues. There were 7 strategic change programmes that had been established, Executive Leads and Senior Responsible Officer (SROs) were being finalised and discussions were taking place on potential joint Committee arrangements.

The Committee highlighted the need for good engagement, JC confirmed a communications plan was in place.

JF welcomed a separate session with Non-Executive Members to provide feedback on the plan.

Outcome: The Finance and Performance Committee noted the verbal update on Medium Term Planning.

8. Deep Dive on Financial Risk – All Age Continuing Care

The purpose of the report was to provide the Committee with an overview of the All Age Continuing Care (AACC) Programme, summary of 2024/25 outturn and opportunities within 2025/26.

JW highlighted the work that had taken place within the team which had seen an improvement from April 2024 to February 2025 in all Key Performance Indicators (KPIs) with the exception of retrospective cases.

The target of £8.7m efficiencies had been achieved in 2024/25, the majority had been attained through the recovery of the discharge to access backlog. JW flagged the consequent limited efficiency opportunities for future years

Despite achievements, JW flagged a significant level of growth within AACC during 2024/25 particularly within the discharge to access pathway.

The team had been focused on identifying key opportunities for 2025/26 including discharge to assess transformation and AACC/discharge to assess care framework. JW highlighted the team would be in recovery mode during 2025/26 as it recovered its position on the backlog for AACC appeals, the retrospective position and Court of Protection/Deprivation of Liberty (CoPDoLS).

JP suggested the team link in with the local authority with regards to personalised budgets to share any learning and shared activity.

JP suggested the team link in with the innovation team following work carried out within MSEFT to embed technology into the way of working. JW confirmed he had reached out to the team.

JF queried the consequential impact to repurpose 22 immediate care beds to discharge to assess beds as highlighted within the paper. JW highlighted the repurposing of beds was made possible due to the reduction in length of stay from 30 days to 20 days led by the Community Collaborative.

Outcome: The Finance and Performance Committee noted the contents of this report and endorsed the direction of travel for AACC for 2025/26.

Business Cases

9. MSE ICB Care Transfer Hub and supporting care framework

Following the success of the Discharge Cell established over the winter period, the business case sought agreement to support the strategic intent to establish a substantive Care Transfer Hub through alignment of existing system resource and funding arrangements.

The case requested support to commence a discharge to assess transformation programme including a procurement to facilitate best value in care home requirements and repurpose 22 NHS commissioned beds to support discharge to assess. This would reduce spot purchasing by approx. 25%.

The System discharge cell was established in November 2024 had seen a 30% reduction in delayed discharge in December 2024/January 2025 compared to previous years**.** The recommendation was to formalise the arrangement as the Care Transfer Hub.

JW advised a spot purchase arrangement was in place for health discharges, this provided no wrap around support. The service was housed within the AACC team and formed approximately 50% of the team's workload. The proposal was to formally commission discharge to assess capacity within a small number of care homes for the utilisation of short-term intermediate care beds to enable patients being discharged appropriately.

Following a query from MB on the tracking of readmission rates, JW reported the pilot showed readmission rates reduced to 8% (previously between 15%-18%) and saw a 17% reduction for patients who died whilst on the pathway.

JF queried the summary of concerns regarding discharge systems and comments concerning premature and unsafe discharges. It was noted comments were provided prior to the establishment of the discharge cell. JW confirmed a survey would be undertaken in time to show the improvement.

LDH advised the ICB were able to access the Integrated Residential and Nursing Care (IRN) Framework and Domiciliary Framework in place within Local Authority and welcomed a discussion outside of the meeting to ensure alignment.

Outcome: The Finance and Performance Committee approved the proposal for the ICB to establish a dynamic framework agreement for AACC (care home beds and domiciliary care provision) and D2A (non-NHS commissioned beds), procured via the Competitive Procedure under PSR 23 Reg 6 (7 and 11), meaning a framework agreement that was re-opened annually to allow additional providers to apply to be appointed to the 'Approved Provider List'.

JB left the meeting.

10. This item has been minuted confidentially

11. HSCN Network Connectivity

It was noted that the recommendation within the paper was not approved by the Executive Committee, a request was made for an options appraisal to be undertaken. Members were asked to feedback any comments/questions to be fed into the options appraisal.

MB noted the ICB position and welcomed sight of the wider impact including the overall cost the System would incur by reprocuring the service.

Following a query from JP, LS confirmed the risk was captured on the directorate risk register and had been escalated due to the inability to mitigate the risk.

Outcome: The Committee noted the paper.

Financial Governance

12. Committee Effectiveness

The desktop review of the ICB Committee Effectiveness for the Finance and Performance Committee was being undertaken and would be shared with the Committee along with a questionnaire to capture feedback.

JF queried the establishment of Programme Boards following work on the MTP Non-Executive members had been asked to support. JF asked governance was streamlined within the work of the MTP to avoid duplication and additional asks.

Outcome: The Finance and Performance Committee noted the update on Committee effectiveness.

DL left the meeting

13. Board Assurance Framework and Finance Risk Register

The Committee were presented with the finance risk register and the finance and performance related risks on the Board Assurance Framework.

NA advised of the need to undertake further work to ensure a clear process for the handover of risks between Committees and recognise where risks may overlap into Committees.

Work continued to look at how risk was assessed within the ICS following the establishment of the pilot established by NHS England.

The Committee noted the inclusion of the following risks that fell outside the remit of the Finance and Performance Committee due to the high-level clinical input that was required.

- ID6: Quality Assurance of Autism Spectrum Disorder (ASD) assessments (also reported to Quality Committee)
- ID63: Court of Protection - Deprivation of Liberty Safeguards (CoPDoLS)
- ID93: Mental Health Patient Flow / Out of Area Bed Utilisation

The Committee asked the risks were referred back to the Quality Committee.

MB welcomed sight of how risks had changed over time to understand if actions implemented were addressing mitigation of the risk. Following a discussion on the need to review risk appetite it was clarified discussions are taking place in the appropriate forums to enhance how we assess risk appetite within the ICB.

Outcome: The Committee noted

- **the most recent updates on risks within the remit of the Committee as set out on Appendix 1.**
- **one new risk, ID93 (Mental Health Patient Flow / Out of Area Bed Utilisation)**
- **risk ID60 (Palliative and End of Life Care - MSEFT staffing levels) was closed**
- **the 4 finance/performance related risks on the ICB's Board Assurance Framework (BAF) at Appendix 2**

Action: The Committee noted the inclusion of risks ID06, ID63 and ID93 that fell outside the remit of the Finance and Performance Committee due to the high-level clinical input that was required. The Committee asked the risks were referred back to the Quality Committee.

14. Financial Governance

No items presented for this meeting.

15. Triple lock ratification

No items presented for this meeting.

16. Feedback from System groups

The minutes of the System Investment Group (SIG) held on 27 January 2025 were presented for information.

Outcome: The minutes of the System Investment Group was noted

17. Any other Business

- **Single Contract Award for MSEFT for NHS General & Acute Services and NHSE Specialised Services 2025/26**

The ICB was notified by NHS England of the requirement for Specialised Services to be commissioned by a single ICB-led contract. The combined indicative contract value for NHS General and Acute and Specialised Services was £4.01bn over the 3-year period.

Outcome: The Finance and Performance Committee agreed to award a single 3-year contract to MSEFT for General & Acute Services and Specialised Services from 1 April 2025 under Provider Selection Regime Direct Award Process A.

The Committee noted that final contract values for 2025/26 would be calculated in line with national guidance and using the ICBs planning principles.

- **Provider Selection Regime Panel**

Following challenge from a current procurement, the Provider Selection Review Group would be enacted and chaired by MB.

18. Items for Escalation

To the ICB Board:

- Integrated Urgent Care - NHS 111 Contract 2025-2027
- Single Contract Award for MSEFT for NHS General & Acute Services and NHSE Specialised Services 2025/26

19. Date of Next Meeting

Tuesday 1 April 2025, 2.00pm - 4.30pm
Microsoft Teams Meeting.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 12 February 2025, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Dr Anna Davey (AD), ICB Primary Care Partner Member, Chair
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead, MSEICB
- William Guy (WG), Director of Primary Care, MSEICB
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSEICB
- Dr James Hickling (JH), Deputy Medical Director, MSEICB (nominated deputy for Dr Matt Sweeting)
- Margaret Allen (MA), Deputy Alliance Director for Thurrock, MSEICB (nominated deputy for Aleksandra Mecan)
- Dan Doherty (DD), Alliance Director for Mid Essex, MSEICB
- Ashley King (AK), Director of Finance and Estates, MSEICB (nominated deputy for Jennifer Kearton)
- Victoria Kramer (VK), Head of Nursing, Primary Care Quality, MSEICB (nominated deputy for Viv Barker)

Other attendees

- Nicola Adams (NA), Associate Director of Corporate Services (minutes), MSEICB
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood, MSEICB
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex, MSEICB
- Michelle Cleary (MC), SEE Alliance Delivery and Engagement Lead, MSE ICB
- Maggie Glover (MG), Local Optical Committee (nominated deputy for Emma Spofforth and Sheils Purser)
- Jennifer Speller (JS), Deputy Director for Primary Care Development, MSEICB
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee
- Rebecca Jarvis (RJ), Alliance Director for South East Essex, MSEICB
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee
- Sarah Crane (SC), Training Hub SRO Clinical Lead, MSEICB (attending on behalf of Kathryn Perry)
- Siobhan Redwood (SR), BB Alliance Delivery and Engagement Manager, MSEICB (observing)
- Tony Clough (TC), Local Dental Committee (LDC) (from 10am)

Apologies

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair, MSEICB
- David Barter (DBa), Head of Commissioning, MSEICB

- Emma Spofforth (ES), Clinical Lead, Local Optical Committee
- Sheila Purser (SP), Chair, Local Optical Committee
- Karen Samuel-Smith (KSS), Community Pharmacy Essex
- Jane King (JKi), Corporate Services and Governance Support Manager, MSEICB
- Jennifer Kearton (JKe), Executive Chief Finance Officer, MSEICB
- Viv Barker (VB), Director of Nursing, MSEICB
- Dr Matt Sweeting (MS), Executive Medical Director, MSEICB
- Aleksandra Mecan (AM), Alliance Director for Thurrock, MSEICB
- Kathryn Perry (KP), Head of Primary Care Workforce, MSEICB

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that the meeting was quorate.

2. Declarations of Interest

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

It was noted that for item 6; Medicines Optimisation Local Enhanced Services, that any committee members who were GP Partners at a Mid and South Essex practice were considered providers subject to the proposed services. The item was however, not for decision and would be considered for approval by the Executive Committee. The item was not commercially sensitive and therefore the paper was not treated confidentially.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 14 January 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 14 January 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (157, 165) were within timescales for completion and JS requested that the update for 165 was moved to April.

Outcome: The updates on actions were noted.

5. Primary Medical Services

JS provided an update on primary medical service contract activity for assurance and information. JS stated that the team continue to receive high volumes of requests from practices relating to challenges with premises/landlords. JS highlighted the partnership disputes that were being addressed with the support of legal services, and the quality and performance issues with two practices where specific concerns were raised; some discussion was held with members regarding the practices with quality concerns. JS also

highlighted the potential changes to GP Practices and an anticipated application for a site closure in Thurrock, for which a decision was expected within a month.

Finally, JS noted the key issues stated in section 13 of the report relating to the timetable for finalising the Primary Care Strategy and the impact of the Medium-Term Plan in that regard, in addition to continued uncertainty around contracts.

AD invited questions from Members.

In response to JH, JS stated that there were six financial recovery programmes for 2024/25 and that work was underway on efficiency programs within Primary Care for 2025/26.

JH sought clarification on the NHS debt programme. NHS Property Services (NHSPS) had a debt recovery programme with practice and occupiers, for mid and south Essex (MSE) there was a programme whereby the finance and primary care teams work with NHSPS locally to resolve disputes. The dispute was caused by NHSPS not having billed practices properly or a lease was not in place. It was noted that some practices paid all the bills, and some did not, but there were also occasions where bills were not correct, hence the teams are working to resolve the issues. JS clarified that there was a small risk of contract hand-back in these cases, however, that would not affect the legal requirement to settle disputes; the usual notice period would be six months if this were to happen. PG stated that this had been raised with the regional team at NHS England who were trying to understand the scale of the issue across the region.

The Committee also noted the Connected Pathways update, that the programme was on track.

Outcome: The Committee NOTED the Primary Medical Services Contract Report.

Women's Health Hub LES update

AW presented the evaluation and sustainability review of mid and south Essex local enhanced service (LES) for Gynaecology to support future commissioning of the service. The women's health budget was funding the activity undertaken through the LES. The funding would cease on 31 March 2025 and beyond this date there was no identified funding to support the LES.

NHS guidance on reforming elective care, published in January 2025, was clear that ICBs should be delivering innovative models offering patients care closer to home for post-menopausal bleeding. The Gynaecology LES supported the shift of activity out of acute to a setting closer to home. Feedback from patients who have used the local service was positive and supported ongoing commissioning.

Funding for 2025/26 was required to allow the service to continue and reach its full potential. The Commissioning team were reviewing potential funding options as part of wider elective recovery options.

Members discussed the LES and that whilst there had been potential benefits, these were not yet being fully realised and therefore a longer period of implementation was necessary to realise the benefits.

AD raised and discussed with Members that GPs were already providing services in this area and consequently it was complex patients who were seen in the acute setting and

therefore it was unlikely that these patients could be seen within primary care as they required the support available within the hospital. WG noted that GPs were enthusiastic about having more activity in this area and that therefore a break in funding and therefore a pause in the LES could impact on the future success of the service. AD noted the potential benefit of having community ultrasound alongside the service.

AK noted that there was a more holistic review of LES programmes, and that this LES should be considered in the wider context of that review.

ACTION: The future of the Gynaecology LES be considered as part of the wider review of the LES offer from the ICB.

JH felt that the purpose of the hubs was to increase access and activity and that this had been achieved demonstrating the success of the hubs.

Outcome: The Committee NOTED the success of the pilot and that there was no identified funding for the service in 2025/26.

6. Medicines Optimisation Local Enhanced Scheme 2025-26 and Prescribing Efficiencies Plan

PW presented the 2025/26 Medicines Optimisation Local Enhanced Service Scheme (MOLES) to support the delivery of the Medicines Optimisation and Prescribing Efficiencies.

As MOLES was a commissioning intention, and not part of the core allocation, the scheme would need to be approved by the Executive Committee; the recommendation of the PCCC was therefore sought to inform that decision. Through the scheme, PCNs (and their member practices) would be funded to deliver the work required to address medicines optimisation priorities locally (quality, safety, and efficiency) and were incentivised to reduce their target spend through the opportunity to earn a year-end financial award at practice level for achieving the individualised target.

The MOLES scheme across Mid and South Essex required a total budget of £2,283K (uplifted for inflation each year), however it was likely that there would be an annual underspend with an anticipated total pay-out of not more than £1,867K. The agreed efficiency saving would be removed from the prescribing budget before being allocated to practices. The funding for the scheme was within budgeted resources and agreed in principle with the finance team. A triple lock application for approval of spend had been submitted.

PW noted the focus on holistic patient care through structured medication reviews. Members discussed the proposal noting that there was a tool to support the medication reviews, a process by which audits could be undertaken and that there had been good engagement in previous years resulting in there being efficient processes operated with practices and pharmacists supporting the programme in previous years.

Following a query from MC, PW confirmed that the method of administering the scheme had not changed from the previous year whereby PCNs received some payment ‘upfront’, followed by a reward payment at the end of the year based on how close to target they were.

Outcome: The Committee SUPPORTED the implementation of the Medicines Optimisation Local Enhanced Service (MOLES) scheme for 2025/26, recommending approval by the Executive Committee.

Primary Care Prescribing Efficiency Delivery Plan 2025-26

PW presented the paper setting out an overview of the primary care prescribing efficiency plans for 2025/26 which were expected to deliver savings of £6.5m. The main focus was targeted Structured Medication Reviews (SMRs) with consideration of cost-effective prescribing. SMRs were an evidence-based and comprehensive review of a patient's medication, taking into consideration all aspects of their health. As part of the SMR, clinicians were asked to consider cost effective prescribing supported by the MOLES. Where a patient was receiving a medicine or devices on prescription that fell within the efficiency target areas, local recommendations should be considered. These areas have been identified from the 'PrescQIPP' budget setting support tools where efficiencies were most likely to be deliverable based on local data.

Following discussion relating to the MOLES there were no further questions raised.

Outcome: The Committee NOTED the Primary Care Prescribing Efficiency Delivery Plan 2025/26.

7. Finance Update

AK presented the month 9 finance update noting that whilst the ICB were forecasting breakeven, in line with plan, it was reporting a year-to-date adverse variance of £0.87m, which was an improvement on the month 5 position. For the efficiency programmes directly related to the committee it was noted that the medicines optimisation was forecast in line with plan, but would continue to be closely monitored, but that the primary care efficiencies continued to forecast under-delivery.

AK reported that specific risk areas relating to prescribing, premises costs and collective action may impact in-year financial performance and the future ability to make new investments into primary care. The ICB had circa £597m (£581m at month 5) of funding identified for the Primary Care portfolio, but that forecasts were projecting over utilisation, so the team were working to bring the position back in line with forecasts.

It was noted that planning guidance had now been received and the team were working through the 2025/26 plan over the next few weeks, in particular the impact of changes to Service Development Funding (SDF).

JS sought clarification regarding the use of the Additional Roles Reimbursement Scheme (ARRS), AK noted that the ICB was not necessarily spending the full allocation of the ARRS, and a report would be brought back to the PCCC to provide assurance around the ARRS process.

ACTION: AK provide a report on the utilisation of the ARRS funding as part of a future Finance Update.

Outcome: The Committee NOTED the finance update report.

8. Training Hub/workforce update

SC presented the workforce training hub update noting that the original contract end date of 2025 has been extended to 31 March 2026 with the possibility of using the option to extend by two years to 2027.

SC outlined initiatives and programmes of work delivered by the training hub from GP and Practice Nurse fellowships, GP networks, conferences, and induction training to retention initiatives such as the 'Thrive' fellowship, the 'first 5 portfolio scheme' and the 'portfolio development scheme'.

The work of the hub to support the ARRS programme was also recognised, noting 9 ARRS GPs claimed in January.

Challenges and risk for the year ahead were summarised because of clinical leads contract for service ending at the end of March. There was some question regarding the availability of funding to extend and consequently a short extension to July was requested while waiting for notification of funding. WG acknowledged how the delay in SDF guidance affected workforce and transformation, making planning challenging and potentially risking the implementation of some programmes.

The committee recognised the strength of having the hub in MSE.

PW highlighted how medicines optimisation linked with pharmacy and pharmacy training and noted a gap whereby the ICB needed to bring on pharmacists and pharmacy technicians. SC noted that this was developing.

AD recognised that the pharmacy is the largest component of the ARRS workforce, which is extremely valued.

JH referenced GP figures being aggregated in terms of fully trained and training and asked if the groups could be split to understand the component parts of the data including by age.

Outcome: The Committee NOTED the workforce training hub update.

9. Primary Care Risk Management update

The Committee noted that there were 11 risks on the risk register relating to Primary Care that included 1 red rated risk, 6 rated amber.

In addition, WG stated that one risk was new and related to estates challenges, discussed earlier on the agenda.

WG also noted the potential difficulties of managing ADHD prescribing in primary care and that would be considered as a risk to be included in the future.

NA commented on some of the actions being taken to embed risk management such as referencing risks on agenda items and ensuring that report authors reference risk within their reports ensuring that risks are raised on Datix where appropriate.

Outcome: The Committee NOTED the primary care risk management update.

10. Community Pharmacy update

PW presented the community pharmacy update report noting that appendix A of the report included the decisions taken by the Pharmaceutical Services Regulations Committee,

hosted by Hertfordshire and West Essex ICB on behalf of the east of England ICBs. It was also noted that the three yearly Health and Wellbeing Boards Pharmaceutical Needs Assessment was due to be published in October 2025 and steering groups had been set up to support the process. PW stated that it was important that our population understood the ICB does not influence the needs assessment and consequently could not make decisions on when new pharmacies were needed. Appeals to the needs assessment could be heard nationally.

PW further updated on the productivity of 'pharmacy first', noting that monitoring data was more readily available where GPs make a referral rather than signpost to the service.

AD noted that there had been no referrals from hospital accident and emergency (A&E) departments and wondered if there was an opportunity to develop. PW had referred that to the stewardship group to see if it could be addressed.

Following a request from SW, PW confirmed that discussions were being held with business intelligence colleagues regarding how data could bd presented e.g. by Alliance.

PW raised a potential future risk in relation to increased access to covid treatments and whether the related commissioning would be transferred to ICBs, but remain centrally funded, particularly given the decommissioning of the lateral flow device supply service.

Finally, PW mentioned the national community pharmacist independent prescribing pathfinder service, which has been particularly successful in the Benfleet area; noting that there had been some interoperability problems elsewhere because there is no direct booking.

PW noted that the NHS England commissioned 'CLEO' platform for electronic prescribing within pharmacy first had gone live in one site. AD raised antibiotic stewardship, and asked if the ICB had a way of monitoring it and sought clarity over what early data showed. PW responded that prescribing was in line with expectations and not excessive.

Outcome: The Committee NOTED the community pharmacy update.

11. Dental update

WG presented the dental update providing an overview and update on primary care dental services. WG noted that the dental access pilot had been extended for a further two years and was progressing well and that the national team and the BBC had recognised the good work happening across mid and south Essex.

WG noted the government pledge regarding dental appointments and that national guidance on what that meant for ICBs was awaited; this would be a 'must do' target. WG was confident that the schemes in place were delivering on the potential ask.

TC clarified that the pledge was 700k appointments nationally, the mid and south Essex share would be in the tens of thousands of new appointments.

Outcome: The Committee NOTED the dental update.

12. Minutes of the Dental Commissioning and Transformation Group

The minutes of the Dental Commissioning and Transformation Group were received, no questions were raised.

Outcome: The Committee NOTED the minutes of the Dental Commissioning and Transformation Group on 4 December 2024.

13. Items to Escalate

There were no items to escalate.

14. Any Other Business

There was no other business items to discuss.

15. Date of Next Meeting

9.30am-11.30am, Wednesday, 12 March 2025
Via Microsoft Teams.

Minutes of ICB Primary Care Commissioning Committee Meeting

Wednesday, 12 March 2025, 9.30am–11.30am

Via Microsoft Teams

Attendees

Members

- Prof. Sanjiv Ahluwalia (SA), Primary Care Commissioning Committee Chair.
- Pam Green (PG), Alliance Director for Basildon and Brentwood and ICB Primary Care Lead.
- William Guy (WG), Director of Primary Care.
- Dr Anna Davey (AD), ICB Primary Care Partner Member
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation.
- Margaret Allen (MA), Deputy Alliance Director for Thurrock (nominated deputy for Aleksandra Mecan).
- Kate Butcher (KB), Deputy Alliance Director for Mid Essex (nominated deputy for Dan Doherty).
- Rebecca Jarvis (RJ), Alliance Director for South East Essex.
- Ashley King (AK), Director of Finance and Estates (nominated deputy for Jennifer Kearton).
- Eleanor Sherwen (ES), Deputy Director of Nursing (nominated deputy for Viv Barker).

Other attendees

- David Barter (DBa), Head of Commissioning.
- Jane King (JKi), Corporate Services and Governance Support Manager.
- Simon Williams (SW), Deputy Alliance Director for Basildon and Brentwood.
- Karen Samuel-Smith (KSS), Community Pharmacy Essex.
- Dr Brian Balmer (BB), Chief Executive, Essex Local Medical Committee.
- Sheila Purser (SP), Chair, Local Optical Committee.
- Bryan Harvey (BH), Chairman, Essex Local Dental Committee (Item 5 only).
- Sarah Cansell (SC), Contracts Manager (Primary Care).
- Michelle Cleary (MC), Alliance Delivery & Engagement Lead.
- Jackie Graham (JG), Dental Manager.

Apologies

- Viv Barker (VB), Director of Nursing.
- Dr James Hickling (JH), Deputy Medical Director.
- Dan Doherty (DD), Alliance Director for Mid Essex.
- Aleksandra Mecan (AM), Alliance Director for Thurrock.
- Nicola Adams (NA), Associate Director of Corporate Services.
- Jennifer Speller (JS), Deputy Director for Primary Care Development.

- Victoria Kramer (VK), Head of Nursing, Primary Care Quality.
- Emma Spofforth (ES), Clinical Lead, Local Optical Committee.
- Jennifer Kearton (JKe), Executive Chief Finance Officer.
- Dr Matt Sweeting (MS), Executive Medical Director.

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. It was noted that the meeting was quorate.

2. Declarations of Interest

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

Members noted the register of interests. No issues were raised.

3. Minutes

The minutes of the ICB Primary Care Commissioning Committee (PCCC) meeting on 12 February 2025 were received.

Outcome: The minutes of the ICB PCCC meeting on 12 February 2025 were approved.

4. Action Log and Matters Arising

The action log was reviewed and updated accordingly. It was noted that outstanding actions (165, 171 and 172) were all within timescales for completion.

Outcome: The updates on actions were noted.

5. Dental Finance

DB explained that, at the request of the Executive Committee, a review of dental finance had been undertaken to ensure effective usage of dental allocations up to 2027/28. It was expected that the dental budget for 2025/26 would remain ringfenced.

JG outlined the breakdown of the dental allocation, made up of committed contractual costs and funding, future planned costs and a small underspend. DB explained the dental allocation underspend provided flexibility to commission additional services to benefit the local population and core dental services.

JG advised that orthodontic activity was a priority for the ICB, particularly with a growing, young population and increased waiting lists for orthodontic treatment. Orthodontic treatment usually spans 2 years, therefore long term planning was required.

It was proposed to allow dental contracts to deliver up to 110% of contracted Units of Dental Activity (UDAs) in 2025/26. It was evident that same arrangement for 2024/25 had greatly improved access to dental treatment. The ICB were in a position to deliver a greater

number of dental appointments above the national 2025/26 target of 700,000, and appropriate to the needs of the mid and south Essex population.

BH commented that Orthodontics was an important dental service and the investment would enable Orthodontists to plan ahead.

Given the financial position of the ICB and wider system, PG suggested it would be prudent to understand the construct for a sustainable Dental service. JG confirmed that this had been an ask of the dental providers.

SA commented that it was helpful to align financial information with outcomes beyond activity, e.g. user experience and oral health outcomes. The relationship between resourcing, clinical outcomes and workforce sustainability should also be taken into consideration.

DB highlighted that the recent care home dental pilot review had demonstrated a significant impact on the length of waitlists and numbers waiting to be seen by the Community Dental Service. The Local Dental Committee had recently joint funded the upskilling of dental nurses which had a high uptake and a positive impact on the workforce.

Outcome: The Committee NOTED the Dental Finance update.

6. Primary Medical Services – Branch Closures

WG presented the following branch surgery closures for consideration:

Branch closure (Thurrock Alliance)

A site closure request was received from a surgery in Thurrock, effective from 28 March 2025, due to the premises no longer being available for the delivery of primary medical services as notice to vacate was served by the landlord.

The practice had undertaken the necessary patient engagement in relation to the site closure and provided assurance around their ability to provide services for the benefit of all their registered patients from the redesignated main site and new branch site, as well as setting out plans to mitigate potential issues arising from their change of operating model. The benefits of a main location shift and new branch would enhance patient experience and deliver longer-term sustainability.

PG stressed the importance of Alliance teams undertaking stakeholder engagement and understanding local views on any branch closure. MA confirmed that the Thurrock Cabinet member for Health & Wellbeing was briefed on the proposal ahead of wider stakeholder engagement and supported the branch closure.

Outcome: The Committee APPROVED the closure of the main site, effective 28 March 2025, the transfer of the main site and establishment of a new branch site following the submission of an application to close the site, completion of a patient engagement and submission of Quality Impact Assessments (QIA) and Equality and Health Inequality Impact Assessments (EHIIA).

Branch closure (South East Essex Alliance)

A site closure request was received from a surgery within South East Essex Alliance, effective 31 March 2025. The practice was seeking to move services delivered through the

older site, which would require estates improvement, out to their other two larger purpose-built sites and consolidate staff, enabling them to provide improved day-to-day direct supervision of trainees in turn enabling additional appointments to be offered.

The practice had undertaken the necessary patient engagement in relation to the branch closure and provided assurance on their ability to provide services for the benefit of all their registered patients from the remaining two sites and plans to mitigate potential issues arising from their change of operating model. There was a mixed response to the extensive and wider engagement.

WG advised that feedback from the QIA and EHIIAs had highlighted some issues for people with limited access to transport. The ICB awaited response from the practice to questions around physical disability access that needed to be explicitly set out in the impact assessments.

A great deal of stakeholder engagement had been undertaken on the branch closure which included local councillors and Member of Parliament. RJ acknowledged that the proposed branch closure was a contentious issue.

RJ supported the rationale for closure, which would improve clinical capacity and aid the practice business model to deliver more accessible care to patients, however raised concerns around continuity of care for the elderly percentage of population who would be affected. RJ stressed the need for clear communications on the mitigations that the practice and ICB would put in place to support this cohort of patients.

In future, the ICB should be clear on the level of support they can provide to practices during the pre-engagement period, this case had shown that early support can help support decisions in the longer term.

MC advised the practice had estimated there would be minimal impact to patients as around 85% of patients already attended their other sites. WG added that approximately 2,200 patients would be affected by the closure, across all age groups.

BB commented that the practice had undertaken thorough stakeholder engagement and the branch closure was a logical move by the practice, who had taken all possible steps to improve access for their patients.

SA was in support of the proposal however shared RJ's concerns around the risk to access for elderly patients. SA requested RJ's comments on appropriate mitigations were considered and supported to ensure that no residents struggled to access primary care.

Outcome: The Committee APPROVED the closure of the branch site, effective 31st March 2025 following the submission of an application to close the site, completion of a patient engagement and QIA and EHIIA templates and subject to putting the appropriate mitigations in place to ensure continuity of care patients affected by access.

7. Primary Care Strategy / Integrated Neighbourhood Team update

PG and WG gave a presentation to the committee on the Mid and South Essex ICB Medium Term Plan (MTP) which set out the overarching approach the system would take to address capacity and financial challenges it faced over the next 3-5 years. Within the

overarching programme of work there was a specific Primary Care programme. It was highlighted that there was no new investment for the programme.

The emerging areas of focus for the primary care elements of the MTP included a review of Local Enhanced Services (LES); a primary care commissioning approach (strategic and left shift specific); the development of the GP Provider Collaborative (GPPC); and Primary Care transformation. WG set out the objectives for each of the areas. Feedback would be sought from the wider system and a cross correlation exercise undertaken with other programmes of MTP work to ensure all areas were following the same path.

The areas of primary care focus linked back to the committee's previous discussions on the emerging Primary Care Strategy and planning guidance, contract changes, elective recovery and financial recovery plan. All MTP working groups have been asked to form a business case to identify the changes that would need to be put in place over the next 3 years.

PG and AD agreed that a change of mind-set was required around what general practice was capable of. The challenge was to encourage innovation and use the GPPC to help strengthen the voice of general practice and create opportunities for GP practices to work together to deliver left shift opportunity.

BB suggested ICB Board did not yet fully understand the role of primary care and felt strongly that all system plans should first undergo a primary care impact assessment. The GPPC would require funding, particularly as the system became more ambitious with primary care. PG confirmed that Primary Care Impact Assessments were now in place. PG confirmed that Primary Care Impact Assessments were now part of central business processes and should also be part of discussion when committee members were operating in other programmes/spaces.

RJ suggested that the primary care programme plan should be more explicit on the work that needed to be undertaken on relationships, communications and raising awareness of plans, particularly in the secondary/primary care space. The plan should also highlight what was needed to allow a left shift from acute into primary care and suggested the GPPC could support this.

SA requested that the development and sustainability of workforce was included in the plan and exemplars of how reinvestment out of secondary care into primary care was taking place. A mechanism was required to extract resource from secondary care into primary care. Consideration needed to be given to publishing the Primary Care Strategy and how to make a clear public statement about the ICBs ambition for primary care being at the centre of its focus. The relationship between primary and community care needed to be included in proposals and consideration would need to be given to including the voice of community care to the committee.

PG welcomed the comments made by the committee and acknowledged that detailed business cases looking at the impact on workforce, IT systems and infrastructure would be required. The Primary Care Strategy was a statutory requirement and would be reframed based on the MTP and left shift work, the MTP would be wrapped into the NHS 10 year plan. PG agreed that community services were key to left shift in to Primary Care.

KSS highlighted that Pharmacy First had funding only for 1 more year and there were other sources of funding not included in the MTP e.g. contraception, hypertension finding and monitoring.

It was agreed that the MTP would be a standing item on the committee's agenda to keep the committee informed of developments.

ACTION: WG and JK to decide on timing / frequency of MTP updates to the committee.

SW presented the Integrated Neighbourhood Team (INT) update, setting out a revitalised approach to INTs, aligned to the 2025/26 Neighbourhood Health Guidelines.

The presentation highlighted a growing population in mid and south Essex over the next 10 years, with the largest increase in those aged 65+. The ageing population would have a significant impact on the health and social care system, therefore a focus on frailty and end of life services was required. It was important that a delivery model was established to ensure consistency in the 'INT' offer for residents.

SW outlined the key frailty and end of life components and service interventions that INTs needed to work towards and the specific measures to monitor their progress. There were 24 INTs across mid and south Essex and a huge task ahead to embed a consistent approach, whilst sill allowing for local nuances within individual INTs.

SA remarked that it made sense for INTs to all focus on the same area of activity which would generate evidence of impact at scale. Consideration should be given to differentiate between the work INTs were expected to undertake and how they choose to deliver, which would allow INTs local control and ownership. SA highlighted there was an important role for the ICB and Alliance teams to facilitate engagement with partners on INT developments. SW added that partner engagement would provide opportunity to highlight how partners would benefit from INTs. KB added that local voluntary sectors and councils were part of INT engagement.

PG stressed that a balance was needed between INT autonomy and outcomes.

Outcome: The Committee NOTED the Primary Care Strategy and Integrated Neighbourhood Team update.

8. Internal Audit of Delegated Commissioning

WG advised that as part of the delegation of services from NHS England to ICB's, the ICB was required to undertake an annual self-declaration review of compliance with a range of assurance requirements covering General, Pharmaceutical, Primary Ophthalmic, Dental and Primary Medical services.

The ICB's first self-assessment in 2023/24 declared an overall 'amber' compliance rating. During 2024/25 work had been undertaken to strengthen a number of areas of compliance. Additionally, the ICB had engaged with NHS England on progress made on issues and ensured the ICB was consistent in the grading of compliance compared to peer organisations. The general feedback was that the ICB had made good progress and were "fully compliant" on significantly more areas than 2023/24.

The 2024/25 self-assessment was currently being reviewed by the internal auditors and the findings would be presented to the Audit Committee and NHS England.

SA acknowledged the work undertaken on the delegation self-assessment and the improvements made.

KSS commented that there were aspects of pharmacy delegation to Herts & West Essex regarding local resolution measures that she would discuss with WG outside of the meeting.

Outcome: The Committee SUPPORTED the outcome of the self-declaration of delegated functions and subject to the completion of the Internal Audit, support the declaration of the self-assessment to NHS England. In addition, the Committee will provide oversight of the developmental actions stemming from the audit.

9. Pharmacy First Report

PG presented a report produced by Healthwatch Southend setting out the findings of a local resident survey on the Pharmacy First service.

The committee welcomed the positive response to the survey and views on the effectiveness of the service. Some respondents had raised concerns that pharmacists could may miss serious conditions or that it may still be necessary to make an appointment with a GP after seeing a pharmacist. The report concluded that there was much opportunity to deliver care closer to the patient by using community pharmacists, alongside other clinicians in primary care.

The ICB had acknowledged receipt of the report and would take actions on the recommendations made by Healthwatch around raising awareness of the service and patient safety. Healthwatch Southend planned to revisit the recommendations set out in the report during 2026/27 to understand what actions had taken place.

PG extended thanks to Community Pharmacy and Pharmacy First colleagues for their work and acknowledged the vital role of the service in response to communities' ill health, as well as wellness and prevention.

PW welcomed the report from the independent organisation highlighting the benefits of the Pharmacy First service.

Outcome: The Committee NOTED the Pharmacy First report.

10. Committee Effectiveness Review

In accordance with good practice guidance, each formal sub-committee of the ICB Board was required to undertake an annual review of its effectiveness. JKi explained that a desktop review of PCCC effectiveness for 2024/25 had been undertaken and shared with the Chair of the Committee and Executive Lead for their comment. The updated desktop review and an online survey would be distributed to members and regular attendees of the committee for completion after the meeting, to gather their views on how they felt the committee had performed over the last year. The combined results would be collated and a final report and action plan developed to summarise the outcome of the review and presented at the next meeting.

SA took the opportunity to request that consideration be given to GPPC representation at committee meetings.

AD agreed it was important to have a GPPC voice at PCCC meetings and reported that a GPPC Terms of Reference (ToR) was being finalised. AD, as the ICB Primary Care Board Member, and BB, as the Local Medical Council representative, regularly attended PCCC meetings, however consideration would need to be given to how the GPPC can attend in its own right.

There were no objections raised to a member of the GPPC attending PCCC meetings.

ACTION: Anna Davey to identify a nominated GPPC individual, when appropriate.

ACTION: Committee ToR to be updated to reflect GPPC as attendee.

SA added that consideration should be given in the future to whether a representative from community services should be invited to attend PCCC. PG suggested that once a primary care strategic commissioning approach was agreed it would become clear whether community services would be involved in PCCC.

ACTION: Once a primary care strategic commissioning approach is agreed, consider whether a representative from community services should be involved in PCCC.

11. Items to Escalate

No Items to escalate.

12. Any Other Business

JKi highlighted that from August 2025, PCCC meetings would move to the second Thursday of each month (pm) to accommodate the Chair's academic and clinical commitments. SA was grateful the committee could accommodate the change.

ES highlighted a national GP Screening alert had been received. The committee were aware via general practice and internal communications.

13. Effectiveness of meeting

SA commented that the papers and slide decks were particularly informative, facilitating exceptional discussion.

14. Date of Next Meeting

1.00pm, Wednesday 9 April 2025
Via Microsoft Teams

Minutes of MSE ICB Quality Committee Meeting

Held on 28 February 2025 at 10.00 am – 1.00 pm

Via MS Teams

Members

- Dr Neha Issar-Brown (NIB), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) and Chair of Quality Committee.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB (present up to item 16).
- Prof. Shahina Pardhan (SP), Associate Non-Executive Member, MSE ICB.
- Dr Matt Sweeting (MS), Executive Medical Director, MSE ICB.
- Rebecca Jarvis (RJ), Alliance Director, South East Essex, MSE ICB (present up to item 16).
- Joanne Foley (JF), Patient Safety Partner, MSE ICB.
- Diane Sarkar (DSa), Chief Nursing and Quality Officer, Mid and South Essex Foundation Trust (MSEFT) (present up to item 16).
- Ann Sheridan (AS), Executive Nurse, Essex Partnership University NHS Foundation Trust (EPUT).
- Diane Searle (DSe), Deputy Chief Nurse, Director of Nursing, North East London Foundation Trust (NELFT).
- Wendy Dodds (WD), Healthwatch Southend.

Attendees

- Viv Barker (VB), Director of Nursing for Patient Safety, MSE ICB.
- Paula Wilkinson (PW), Director of Pharmacy and Medicines Optimisation, MSE ICB.
- John Swanson (JS), Lead Nurse for Infection Prevention and Control, MSE ICB.
- Victoria Kramer (VK), Senior Nurse for Primary Care Quality, MSE ICB.
- Sara O'Connor (SOC), Senior Manager Corporate Services, MSE ICB (present up to item 16).
- Clare Angell (CA), Deputy Director for Babies, Children and Young People, MSE ICB.
- Gemma Stacey (GS), Designated Clinical Officer for Special Educational Needs and Disabilities (SEND), MSE ICB (present up to item 16).
- Vicky Cline (VC), Senior Nurse for Acute/Community, MSE ICB (present from item 7).
- Mike Thompson (MT), Associate Director System Programmes, MSE ICB (present for item 15).
- Olivia Burrows, (OB), Senior PMO Manager for the Inquiry, MSE ICB (present for item 15).
- Helen Chasney (HC), Corporate Services and Governance Support Officer, MSE ICB (minutes).

Apologies

- Dan Doherty (DD), Alliance Director (Mid Essex), MSE ICB.
- Christine Blanshard (CB), Chief Medical Officer, MSEFT.
- Alison Clark (AC), Head of Safeguarding Adults and Mental Capacity, Essex County Council.
- Lucy Wightman (LW), Chief Executive Officer, Provide Community Interest Company.
- Stephen Mayo (SM), Director of Nursing for Patient Experience, MSE ICB.
- Karen Flitton (KF), Patient Safety Specialist, MSE ICB.
- Eleanor Sherwen (ES), Deputy Director of Nursing, MSE ICB.

1. Welcome and Apologies

NIB welcomed everyone to the meeting. Apologies were noted as listed above. The meeting was confirmed as quorate. NIB advised that risk numbers had been added against each item on the agenda, if relevant.

2. Declarations of Interest

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

It was noted that AS and DSe had an interest in item 15 Lampard Inquiry Update due to them being core participants in the Lampard Inquiry.

3. Minutes & Matters Arising

The minutes of the last Quality Committee meeting held on 20 December 2024 were reviewed and approved.

Resolved: The minutes of the Quality Committee meeting held on 20 December 2024 were approved without amendment.

4. Review of Action log

The action log was reviewed, and updates were noted.

Action 66 – GT and DSe to discuss datasets required: A quality triangulation meeting set up by the Community Collaborative would develop the datasets at a collaborative level and would be reviewed at the Quality Contract Performance meeting (QCPM). The information required for future Community Collaborative reports would be considered to provide the committee with adequate oversight and assurance and would avoid duplication.

NIB requested that details of the membership and datasets be provided at the next committee meeting.

Action 75 – SM and VK had been contacted to advise when the first Independent Provider report would be ready for Quality Committee review and would be scheduled on the workplan for 2025/26.

Resolved: The Committee noted the Action Log.

Action: GT to provide details of the quality triangulation meeting membership and datasets developed by it at the next committee meeting.

5. Lived Experience Story – Dental Services

VK presented a lived experience story relating to the dental care home pilot.

The initial concerns included the lack of general knowledge and care for oral hygiene for those residing in care homes. Poor dental care could be linked to many other conditions such as cardiovascular disease and dementia. The findings were advanced gum disease, decay and mobility of teeth, and no staff training or knowledge in recognising early dental decay.

Concerns and findings regarding dentures included instances where carers were unaware that residents had dentures.

A video and three different patient stories were shared with the committee highlighting the positive impact that the pilot made to residents, the care home staff and also the dental care providers' staff.

WD asked if there was a limit to the type of treatment that could be provided in care homes. VK confirmed that if a patient required a more complex intervention, community dental services would be contacted to provide the treatment.

NIB commented that responsibility and ownership should be taken by care home staff to maintain the positive impact that the pilot achieved. Elements that could be measured were the awareness and training of care home staff and the resources that this pilot had saved. JS commented that the care home training team at EPUT provided training on oral/health care but not all care homes took up the offer.

Action: GT to circulate the impactful case study and slides to the ICB Board for wider outreach and awareness.

6. Deep Dive – Dental Services

VK advised that dental commissioning was delegated from NHS England to the Integrated Care Boards (ICBs) on 1 April 2023. The number of dental contracts within Mid and South Essex (MSE) was 117, with a total value of just under £60,000,000 per annum. Separate contracts were held for minor oral surgery, sedation, domiciliary and special care community services.

VK provided detail on the three national dental incentives; new patient premium which would cease on 31 March 2025; national dentist incentivisation scheme, by which MSE had funded for three places which were filled; and dental cardio-vascular disease prevention – hypertension case finding pilot for dental practices to carry out blood pressure readings, in which there were 12 providers in MSE.

The Dental Access pilot was based on providers opening at evenings, weekends and bank holidays and an additional 29,000 patients had been seen. A new direct booking system was being trialled by 111 which would prevent patients with dental issues presenting at

Emergency Departments (ED).

The Care Home Pilot had seen a reduction in the Community Dental Service waiting list from over 12 months to 12 weeks over one year and had been approved to become a fully commissioned service from 1 April 2025.

The Children and Young People Pilot was specifically for first year infants up to first year juniors. Dental providers visited schools to initiate a first check of children's mouths and provide early dental education. Out of 325 schools in MSE, 202 schools were participating with a further 65 due to start. The safeguarding team had provided support to raise awareness of consent and signs of neglect when visiting schools.

Details provided on meetings, processes and work streams put in place for the Primary Care Quality Team (PCQT), including regular meetings with Care Quality Commission (CQC), Local Dental Committee and the dental contracting team. The development of a Quality Assurance Visit (QAV) tool was in progress.

SP asked if community pharmacies could prescribe medication for the hypertension pilot. PW advised that community pharmacies would carry out the routine blood pressure check service and determine next steps. There was also an opportunity for 24-hour blood pressure monitoring before referral to GPs for treatment. Prescribing was not part of the community pharmacy blood pressure check commissioned service, however there were four community pharmacy independent prescribing pathfinder (pilot) sites in MSE with two specifically aligned to hypertension.

SP also asked if the dental access pilot would be sustainable following the cessation of funding. VK advised that the pilot was not currently a permanently commissioned service, but had been extended and she hoped that this would continue. A Task and Finish Group would be working with the ED to ensure patients were getting the right contact and treatment first time.

AS advised that EPUT's quality priorities and health checks were under review, which should include dentistry. There had been a challenge to engage dentistry at Brockfield House and AS would contact VK outside of the meeting to discuss further. JS commented that dental care at Brockfield House had been raised previously with the EPUT Infection Prevention and Control (IPC) team due to links between poor oral hygiene and physical health deterioration.

RJ offered support with engaging dental contractors in other areas as there were more from mid Essex who were taking part in the hypertension case finding.

NIB asked how the areas where there were cases of undiagnosed high hypertension could be focused on. VK explained that those conversations would be held with providers during relationship building and navigating the quality assurance tool. The number of providers taking part could increase as the pilot progressed. VK confirmed that dental providers could refuse to see patients.

7. Executive Chief Nurse Update

7.1 Safety Quality Group - Escalations

GT advised that Safety Quality Group (SQG) was undergoing redesign, and an evaluation

was being undertaken nationally with regards to system quality groups. The focus would be for SQG to be the central hub around collaboration and learning together at a system level. SQG would also be reviewing the development of system level risks.

7.2 Emerging Safety Concerns/National Update

GT advised that ongoing winter surveillance and norovirus continued to be a challenge nationally. There was a good correlation between the flu vaccine and the strains being identified this year.

Amanda Pritchard, Chief Executive Officer for NHS England was stepping down and Sir Jim Mackey would transfer into the interim role for one to two years in relation to national strategy on the quality agenda. Aidan Fowler had transferred to the CQC to be the interim Chief Inspector of Health Care for 6 months.

Both quality and nursing strategies would not be published until the 10-year plan was completed to ensure alignment. East of England engagement events for the 10-year plan were currently underway.

The Clinical Negligence Scheme for Trusts 6 (CNST 6) was in the process of being signed off following partnership working with maternity and neonatal services to evidence the improvements in safety standards. NHS Resolution were taking a further review of CNST standards and Maternity Outcomes Signal System (MOSS) was being developed which would provide be real-time data collection and was currently being piloted by another system.

In response to a query from NIB, GT confirmed that the pilot sites would be the influencers and provide feedback. The expectation would be that the system would be rolled out during 2025/26.

Outcome: The committee noted the verbal update on Emerging Concerns and National update.

7.3 ICB Board/SOAC concerns and actions

There were no escalations reported.

8. MSEFT / Acute Care Update

DS took the report as read and highlighted the following key points.

There had been a high incidence of respiratory patients over the Christmas period and the last few weeks, and a high number of patients with norovirus, although these had both decreased recently.

Following the unannounced CQC inspection of the ED at Basildon in December 2024 which resulted in a letter of intent for Section 31, a reinspection was carried out in January 2025. The three key areas of concern from the December inspection were timely streaming and triage of patients; delay of timely medical review and subsequent interventions for ambulance patients; and IPC issues, such as dirty cups, spilt liquids and damaged chairs in the department. Following the reinspection there was an improved performance of ‘handover 45’ and infection control. The key concern was the lack of clinical oversight and

leadership within the waiting area. The waiting room on both inspection days was extremely busy, with several specific concerns observed. Inspectors also spoke to staff who raised concerns primarily around communication of the implementation of new policies, and not being involved in the handover 45 process, which was a regional process. Not all staff spoken to were aware of the changes that had been implemented.

A Section 31 Notice was issued following the reinspection, with several conditions imposed. The three actions were: ensuring improved clinical leadership and oversight in the waiting area which was a challenge due to the number of patients being seen; a robust system and process to record patients when they cross the threshold, which would be implemented; and effective governance systems which would be put in place to manage, share and communicate information to staff.

A rapid review meeting was held with external partners and regional colleagues which had instigated support.

A monthly report was now provided, and the focus would be on the actions and sustainability of changes already made. A significant amount of data requests had been received and significant evidence had been submitted for the Section 31. Meetings were held with staff to ensure engagement and involvement.

Work was ongoing to address the frequent incidence of violence and aggression to staff members from patients in ED. An increased level of security had been required at the front door.

An impact assessment on the Section 31 had been completed for staff and patients. The number of patients with mental health needs had increased and a mental health review had been completed so that appropriate care could be provided for these patients in the right place at the right time, which had impacted on staff within ED. A governance structure had been set up to monitor work completed. A meeting was held with the CQC Emergency Leads who offered support and advice and the regional emergency care lead would visit in March to review and assess the department.

A review had been completed of the ED at Southend and Broomfield hospitals which highlighted no major issues. This was mainly due to the footprint and layout of the departments which led to better clinical oversight in waiting areas.

WD asked if there was a sufficient staff within the department to meet the conditions with the right staff mix. DS confirmed that the establishment was correct with regards to skill mix and numbers, however there were some vacancies which were challenging to fill.

SP asked what steps were being taken to deal with the volume of patients. DS advised that a new clinical model had been introduced in the waiting area in terms of additional staff and the triage streaming process had been reviewed so patients went to the right area. A pilot was being run whereby a nurse was situated at the ED front door at different times during the day to review patients. There had been no reported patient safety incidents with harm.

NIB commented that consideration was required to prevent patients attending ED by redirecting and advertising the benefits of Pharmacy First, especially when norovirus and other diseases were known to be prevalent.

MS commented that the Medium-Term Plan (MTP) was key and a review of the whole

emergency care process across the system was required to ensure the correct cohort were going to ED and consider other alternatives. This would be a big focus in the next five years including how the system responded to the challenges of ever-increasing emergency admissions. SP commented that data could be reviewed on the repeat admissions and regular attendees to ED.

Resolved: The Committee noted the MSEFT Acute Care update report.

9. Community Collaborative Update Report

DSe advised that quality governance was being strengthened with the quality triangulation assurance meeting and three strategic risks had been identified with mitigations and workstreams in place as detailed in the report.

One key risk was the significant demand for community nursing with increased numbers of patients with more complex conditions. Work was ongoing within MSE to improve arrangements, and the system workforce plan should be thinking more about the community nursing element.

A recent CQC inspection had been completed on the Adult and Community Health Service and the response was awaited, however no immediate concerns had been raised. The CQC well led inspection was underway and further details would be provided when received.

SP asked what plans were in place to mitigate risks. DSe advised that data was captured differently in the three organisations and a review to strengthen data was underway. Each organisation had their own datasets that were reviewed and escalated. A governance manual was being developed for operations to strengthen governance. Each organisation had their own governance processes and monitoring and linking into the quality governance meeting. With regards to capacity and demand, different models of delivery were being reviewed to be more effective and efficient. GT explained that QCPM would be discussing capacity and demand linked to the Medium-Term Plan. The function of Quality Committee would be reviewing the data to seek assurance that conversations were happening on those emerging quality risks in the community space within the collaborative.

Resolved: The Committee noted the Community Collaborative Update report.

10. Primary Care Update

VK took report as read and highlighted the following key points.

The total number of practices in MSE had reduced to 143 due to the merger of two practices. The CQC were currently inspecting primary care. A practice currently rated ‘inadequate’ in Thurrock had received positive feedback. Two further CQC inspections were planned in the next two weeks.

Details of Primary Care Network (PCN) changes had been added to the report which had previously been approved at Primary Care Commissioning Committee (PCCC).

WD referred to the increase of housing development, particularly in the Castle Point area, and asked what futureproofing was in place to meet demand on primary care services. VK advised that the Primary Care Contracting team and Estates team provided support in this

regard GT advised that the ICB worked closely with local authorities, noting that the reorganisation and devolution in Essex could change the responsibility and accountability for the provision of service under the new combined authority with mayoral oversight. PW commented that the Health and Wellbeing Boards were reviewing pharmaceutical needs assessments and would consider housing developments.

SP asked for clarity on the alliance information where the ICB ratings were always higher than the CQC ratings. VK advised that the ICB worked to a quality assurance process. Bi-monthly risk meetings were held to discuss all practices who needed to meet certain criteria for the rating and was an internal escalation process. GT confirmed that the CQC rating formed part of the overall risk assessment and a different methodology was used so there was no direct correlation.

Resolved: The Committee noted the primary care update report.

Action: VK to amend future primary care update reports to include an explanation of the difference between ICB ratings and CQC ratings.

11. Sodium Valproate Update

PW took the report as read and highlighted the key points.

The sodium valproate (valproate) alert was originally issued in 2023. Work had been ongoing with providers to implement the associated action plan to ensure that the drug was prescribed safely and annual risk assessments were completed on time for patients, including males, particularly within age groups 13-54.

Over 400 female patients, between the ages 13 to 54, were currently prescribed valproate. The dashboard also provided data on new patients starting valproate and for patients resuming their valproate prescription.

Everyone was clear on the process to initiate the medication and the checks and balances required, however it was the annual checks that needed to be completed. The use of the drug in EDs was highlighted and that consideration should be given for the use of alternatives for patients presenting in that urgent situation. However, if valproate was prescribed then the requirements must be complied with.

Assurance was provided that processes were in place at NELFT and EPUT to address this. EPUT had a referral process in place, however this was a challenge for the acute trust as the three hospitals worked differently. Further work was to be done to provide assurance that a robust pathway was in place and there was sufficient capacity to ensure patients received an annual check.

General practitioners (GPs) coded patients so reports would be pulled from the GP system to validate data. Due to General Data Processing Regulations, this was a challenge for the ICB and the requirement for full engagement from the Trust. A document was in place, particularly for primary care, to ensure that annual reviews were being undertaken.

SP asked how the ICB compared with regional or national levels. PW confirmed that the processes, in terms of annual reviews varied across the East of England.

MS asked who would be responsible for the annual review. PW advised the consultant

remained responsible for prescribing the choice of prescription, and the annual check/review should be completed by a Neurologist.

Resolved: The Committee noted the Sodium Valproate Update report.

12. Special Educational Needs and Disabilities Update

CA advised that the report covered activities such as quality assurance on Education and Health Care Plans, and forward planning in terms of the joint commissioning agenda with local authorities.

SP asked how training and support for practitioners would be delivered and what were the challenges. CA confirmed that the biggest challenge for the Designated Clinical Officer post was capacity. A new appointment would start in March, focusing on quality assurance plans, which would allow GS to design a training programme that would be coordinated and implemented across the MSE system. There was a better grip of the current and future position for SEND and two inspections were anticipated in the summer when progress made could be evidenced.

Resolved: The Committee noted the Special Educational Needs and Disabilities Update report.

13. Babies, Children and Young People Update, including Neurodiversity

CA advised that at the last committee meeting, some of the factors influencing inconsistent experiences for autistic young people with or without a learning disability was discussed. This included a diagnosis led system, and over the last 10 years there had been cuts to local authority services which had created an over medicalised model in how these young people were treated. This had led to an holistic approach to meeting their wider care needs being lost. The pandemic had raised more questions and prompted more GP consultations and referral for diagnostic pathways.

Work had been ongoing locally and nationally regarding how inclusivity could be improved for neurodivergent young people in schools. Key worker teams were in place to support those young people at risk of admission to a psychiatric bed and the right to choose provider frameworks had created different risks but also opportunities to think flexibly about commissioning models.

One of the pillars in the MTP was Learning Disabilities and Autism. The challenges included that there was no alternative means for screening or profiling the needs of children without a clinical assessment. Until an alternative route was found, professionals across education, health and care, would not have the confidence to deliver interventions in a meaningful way. An improved grip was required on the 16 young people in psychiatric beds and the ICB needed to take more leadership in terms of multi-disciplinary team discharge meetings.

The ambition would be an improved experience for young people who were likely or confirmed to be autistic. Some children should be seen sooner and most children's needs could be met without a diagnosis. For some children, regardless of diagnosis, their experience and disruption to care, which would either be as a result of lack of community provision which meant they required more targeted specialist intervention, or access to

medication, was not consistent.

NIB asked what could be done to provide an alternative route for some children to get support quicker as there seemed to be an overreliance on clinical diagnosis. CA advised that other areas had implemented a needs profiling tool which crossed domains from cognitive development through to social and emotional wellbeing and comparing that with views and experience from parents and carers, had realised a change in referral activity. This required a national policy level change. Some adults and children experienced genuine exclusion from services because they either have or do not have a diagnosis, so the offer of support was inconsistent.

AS commented that young people with neurodivergent needs tended to experience exclusion and long-term segregation and how that could that be addressed and reduced must be considered. EPUT had been working with families with regards to managing distressing behaviours. AS offered the provision of support.

MS commented that a need-based approach would be a huge cultural shift and would require support and communications with a national approach. CA explained that a mechanism was required for demonstrating prevalence. Trained therapeutic teams focused solely on assessment and diagnosis, rather than delivering the therapy they were trained to do. Multiple factors affected this and in the education space needs were often met regardless of diagnosis. However, with autism cases there was an over reliance on diagnosis.

In response to a query from WD, CA explained that SEND guidance for schools was clear that it was a needs led process and as long as the need was demonstrated there was no reason why that child should not have that funding. However, school leaders were required to spread that funding further and there had been cuts in other areas.

Resolved: The Committee noted the Babies, Children and Young People Update, including Neurodiversity report.

14. Infection Prevention and Control (IPC) Update

JS highlighted the following key points.

Norovirus had been a challenge for the system through quarter 3 and into quarter 4. There had been 22 outbreaks between September and December 2024 of varying organisms including norovirus, respiratory infections, including flu and RSV outbreaks. There had also been an ongoing Group A Streptococcus outbreak.

Norovirus had been particularly virulent this year, with MSE one of the highest reporters of norovirus outbreaks in the region, with the exception of Thurrock and Southend. MSEFT had managed their outbreaks really well and were working with other providers to provide education to their IPC teams in how best to manage outbreaks going forward to ensure that patient safety and flow was maintained in an efficacious manner.

SP asked why some MSE areas had been more affected than others. JS explained that there could be variants in the reporting. There was a timescale of 12 weeks to report norovirus, so next month other areas could provide a similar picture. Also, the acute trust in MSE was quite large and there were a high number of care homes in the area.

NIB asked if community messaging was increased in times of prevalence. JS confirmed that the ICB communicated through social media, and a statement went out from Dr Giles Thorpe, ICB Executive Chief Nursing Officer. All providers were responsible for their own internal and external messaging regarding norovirus, posters had been displayed in primary care services and messages were sent to local schools.

Resolved: The Committee noted the Infection Prevention and Control Update report.

15. Lampard Inquiry Update

MS advised that work to support the Lampard Inquiry was actively ongoing within the ICB and a new Rule 9 request had recently been received. Appropriate governance structures were in place with executive oversight.

The report detailed the scope and purpose of the Lampard inquiry, along with details of the public hearings held and the future public hearings during 2025/26 with an indication of the key lines of enquiry themes. The future public hearings were scheduled for April 2025. The report also included details of the Rule 9 request received last summer regarding out of area placements.

A further Rule 9 request had been received and followed up on the information regarding out of area placements. Since the Inquiry had started there had been an increased interest in the whole commissioning landscape over the last 20 plus years and therefore information on how mental health services were commissioned through Primary Care Trusts (PCTs), Clinical Commissioning Groups (CCGs) and ICBs was being reviewed. Good engagement had been received from commissioners and staff within the three ICBs who were reviewing historical records. Mills and Reeve were providing legal advice, and a good working relationship had been established.

Fortnightly meetings were held with the Senior Responsible Officers which changed to weekly when a Rule 9 request was received.

The MSEICB lead operated the 'Safeguarding process' for the 3 ICBs, through which the inquiry sends 'referrals' to the MSE Safeguarding Team, which could be from members of the public or people affected by the Inquiry. A memorandum of understanding had been developed across the three ICBs and selected partners, such as EPUT.

In response to a query from SP, MS confirmed that the Inquiry timeline was two years but could be longer.

NIB asked if an issue was identified, particularly internally, how it would be addressed. MT advised that a learning log was being developed, where specific learning could be actioned immediately, rather than waiting for the recommendations from the Inquiry. The learning to-date was generally regarding how the ICB was organised to respond to Rule 9 requests.

SP requested clarification on the possible outcomes of this Inquiry and would evidence of sustainability be expected. MT advised that it would be hard to advise on the outcomes as the Inquiry was in its early stages. The recommendations could relate to the commissioning arrangements, processes and contractual arrangements for mental health services and could also be national based as NHS England and CQC were also core participants. In the opening statements, the ICBs clearly stated they wanted the Inquiry to be a learning experience for the commissioning organisations, so that better processes and procedures

could be put in place.

VB confirmed that there would be several learning points and actions for each element of service provision and was fairly standard with this type of inquiry.

SP asked if there would be a follow up assessment. MT advised that the Inquiry would close in 2026, however there could be recommendations with regards to future oversight and assurance. The recommendations would need to be adopted by NHS England and would be filtered down to commissioners, providers and other organisations for implementation.

AS commented that this would be the first investigation into mental health and acute services and the learning from the Manchester report would also drive those wider national agenda issues and would be welcomed.

In response to a request from NIB for an update, MS confirmed that an update report would be presented at ICB Board, however any quality issues identified could be reported to Quality Committee, recognising that there were multiple stakeholders in attendance. NIB requested that the learning log was shared with the committee when available and appropriate. VB advised that it may not be appropriate for the learning log to be shared with Quality Committee and would discuss with GT the governance and where the information needed to be disseminated. MT advised that there may be some learning as commissioners which could be brought in the future but would need to go through due diligence for the conflicts to be managed.

Resolved: The Committee noted the Lampard Inquiry Update report.

16. Patient Safety & Quality Risks

This item was presented after item 11.

SOC took the report as read and highlighted they key points.

Four new risks had been opened and allocated to the Quality Committee. Some risks had transferred to different directorates due to changes to directors' portfolios which had resulted in some outstanding updates and was being addressed.

No risks were recommended for closure.

The six high level quality related risks currently included within the Board Assurance Framework (BAF) were highlighted. The BAF would be updated prior to the next Part I Board meeting on 13 March 2025.

Datix continued to be rolled out and had started to be used for directorate team risks and risk registers could now be created for discussion at QCPM. The incident reporting module would be rolled out on Monday 3 March 2025 within the ICB, and initial discussions had been held with the quality team to consider using the module to support work undertaken by the quality team.

The system risk assessment pilot would focus on two risks; mental health patients requiring urgent emergency care; and palliative and end of life care. Provider colleagues would be asked to provide support with the workshop. GT advised these risks were chosen as they

multi agency and multi factorial complex risks where the national team maintained oversight. However, that did not negate the need for organisational level risk management practice.

SOC explained that work was ongoing to review the ICB's risk management arrangements, and an update would be provided as it progressed.

NIB asked if future reports should include ongoing assurances on what was being done or needed to be done to further mitigate risks and improve the risk rating. GT confirmed that effectiveness of risk control would be reviewed, which should be considered to provide assurance.

Resolved: The Committee noted the Patient Safety and Quality Risk report.

17. ICB Quality Strategy

VB advised that the ICB Quality Strategy had been refreshed. Publication of the strategy would be suspended until the medium-term plan (MTP) plan had been finalised to ensure any additional amendments could be made.

NIB asked how much of the strategy was aligned to the MTP. VB advised that 'left shift' would be a focus in the MTP which could require quality to be more focused in that area and demonstrate delivery on some of those priorities in the MTP.

NIB asked if the strategy which included the achievements and challenges over the last year, could inform the MTP, rather than including the next steps as it felt inappropriate to approve this before the MTP had been finalised. SP agreed that the MTP should inform the strategy.

MS welcomed the clear outcomes and demonstration of how the actions would be delivered and measured and queried the quality ambitions and whether points 2 and 4 could be made into one recommendation as there were similar.

MS advised that the MTP would focus on data driven quality outputs and transformational processes in five or six key areas, so should consider delaying the Quality Strategy until the MTP had been finalised to ensure alignment.

Resolved: The Committee agreed that the 'we said, we did' and impact assessments should remain and for the Strategy to be refreshed following the finalisation of the MTP and would be brought back to a future Quality Committee meeting for approval.

18. Terms of Reference

18.1 Infection Prevention and Control Oversight Group

JS advised that the Infection Prevention and Control Oversight Group would be established from April 2025 and met the quality functions document and would involve all main providers.

Resolved: The Committee approved the Terms of Reference for the Infection Prevention and Control Oversight Group.

19. Nursing and Quality Policies and Procedures:

19.1 Review of Nursing and Quality Policies:

The committee were asked for comments on the revised Communicable Disease Outbreak and Incident Management Policy (Ref 074). JS advised that the policy worked alongside a MOU established with local authorities, Health and Safety Authority and the ICB. No comments were received.

Resolved: The committee approved the Communicable Disease Outbreak and Incident Management Policy.

20. Draft Quality Committee workplan 2025/26

HC advised that the draft committee workplan had been included for committee review. A deep dive planner had been included as a separate table on the work plan. Committee members were invited to provide feedback.

HC explained that the governance team would complete a desktop review on the committee's effectiveness which would be shared, along with revised terms of reference and workplan, with the Chair and Executive Lead for their review and comment. Following review, a short online survey would be sent to all committee members to complete. The final assessment report would be presented to a future Quality Committee meeting.

There were no further comments.

Resolved: The committee approved the committee workplan for 2025/26 and noted the arrangements in place to review the committee effectiveness for 2024/25.

21. Discussion, Escalations to ICB Board and agreement on next deep dive.

21.1 Escalations to:

- **Other ICB main committees (including SOAC)**

There were no escalations to other ICB main committees.

- **ICB Board**

There were no escalations to ICB Board.

- **Safety Quality Group**

There were no escalations from Safety Quality Group.

21.2 Agreement on next deep dive

The next deep dives were confirmed as follows:

April – Maternity Services

VB requested to add Community Pharmacy deep dive/lived experience to work plan for

next available meeting.

Action: HC to add Community Pharmacy to deep dive planner.

22. Any Other Business, including discussion on effectiveness of meeting

NIB noted that the meeting had held a balanced discussion with good participation.

There were no items of any other business raised.

23. Date of Next Meeting

Friday, 25 April 2025 at 10.00 am to 1.00 pm via MS Teams.

Minutes of the Digital Data and Technology Board (DDaT)

Held on Thursday 13th February 2025

Via MS Teams

Attendees

Members

- Barry Frostick (BF), Chief Digital & Information Officer (CDIO), Mid and South Essex Integrated Care Board (MSE ICB) – *Vice Chair*
- Claire Hankey (CH), Director of Communications and Partnerships, MSE ICB
- Peter King (PK), Director of Digital Services/Deputy Chief Information Officer (CIO), Mid and South Essex Foundation Trust (MSEFT) *(for MC)*
- Jane Marley (JM), Head of Information Governance (IG), MSE ICB
- Mandy Moore (MM), Head of Business Intelligence (BI), Thurrock Council
- David Pike (DP), Assistant Director of Healthcare Informatics, North East London Foundation Trust (NELFT)
- Paul Scott (PS), Chief Executive, Essex Partnership University Trust (EPUT) – *Chair*
- Sarah Stone (SS), Acting Assistant Director of Digital Transformation, NHS England (NHSE)
- Les Sweetman (LS), Deputy Director of Digital Technology, MSE ICB
- Adam Whiting (AW), Deputy Director of Digital & Business Partner, EPUT (*for ZT*)
- Chris Wright (CW), Director of Programmes & Digital Development, Provide

Other attendees

- John Adegoke (JA), Head of IG, Provide
- Matthew Barker (MB), IG Lead, MSEFT
- Josh Brewster (JB), Digital Business Partner, MSE ICB
- Stephen Gallagher (SG), Director of Data & BI, MSE ICB
- Iain Gear (IG), IG and FOI Manager, MSE ICB
- Hana Gunfield (HG), Assistant Director, PR, Marketing and Sales, Provide
- Gurminder Khamba (GK), Consultant Physician, MSEFT
- Ciara Moore (CM), Programme Director, MSEFT
- Joe Nellist (JN), Communications Manager (Digital), MSE ICB
- Robert Paley (RP), IG Lead, NELFT
- Sadie Plunkett (SP), Head of Assurance & Oversight, MSE ICB
- Claire Sladden (CS), Associate Director of Electronic Systems and Information Governance, EPUT
- Clare Steward (CS), Programme Director – Digital Transformation, MSE ICB
- Charlotte Tannett (CT), Digital Business Manager, MSE ICB – *Minute Taker*
- Punya Vaswani, (PW), Programme Assurance Manager, MSE ICB
- Andy Webb (AW), Senior Business Partner, Essex County Council (ECC)

Apologies

- Martin Callingham (MC), Chief Information Officer, MSEFT
- Peter Fairley (PF), Director for Strategy, Planning and Innovation, ECC
- Emily Hough (EM), Executive Director, Strategy & Corporate Services, MSE ICB
- Janette Leonard (JL), Director of ITT, Business Analysis & Reporting (EPUT)
- Ian McLernon (IM), IT Business Portfolio Manager, Southend Council
- Phillip Richards (PR), Chief Finance Officer, Provide
- Zephan Trent (ZT), Director for Strategy, Transformation & Digital, EPUT

1. Welcome and Apologies

The Chair welcomed everyone to the meeting and apologies were noted as listed above.

2. Register of Interests

The Register of Interests was reviewed and no new declarations were made.

PS confirmed he had a new declaration to add to the register but it did not impact the agenda.

Action: CT to source updated Declaration of Interest form for PS.

3. Minutes

The minutes of the last meeting on 14 November 2024 were reviewed and approved.

Outcome: The minutes of the meeting held on 14 November 2024 were approved.

4. Action log

The action log was reviewed.

BF confirmed all actions except action #99 would close as they now formed part of Business As Usual (BAU) activities.

Outcome: The DDaT Board agreed to close actions: #92, #101, #103, #104, #105, #107, #108 and #109.

5. ICS Digital Strategy Refresh - Workshop

The group were split into three breakout sessions as detailed below where they held focussed discussions and updated a Miro whiteboard with ideas and suggestions for development of the strategy:

- Principles and Leadership
- Engagement and our Residents
- Innovation, Research and known Gaps

The three groups came back to the main meeting and leads for each of the sessions summarised their discussions.

BF confirmed the revised strategy would be brought to the meeting on 8 May 2025 before being submitted for final approval at the MSE ICB Board.

Outcome: Noted.

6. New Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) update

JM confirmed that five focussed sessions had been held with the MSE ICS IG and Cyber Steering Groups to enable guidance and support to be shared between organisations on completion of the CAF DSPT.

Baseline submissions in December 2024 had received regional feedback that the East of England were not outside of the national standard. Following an initial assessment, MSE organisations were not expected to meet the requirements largely due to lack of resources. Action plans would be put in place to address the gaps but a timeline on when these would need to be achieved was not yet clear.

The groups had brought in Emergency Preparedness Resilience and Response (EPRR) colleagues to discuss cyber tabletop exercises and it was agreed that for 2025/26, each organisation would undertake these individually with a DSPT focus. They would then look to complete a joint exercise in 2026/27.

AW noted that CAF DSPT was how EPUT would measure its cyber assurance and the position would be reported through their Finance and Performance Committee (F&P) up to their Board Assurance Framework (BAF).

PS queried if local authority and Community Interest Companies (CICs) would be following the same approach. JM confirmed that they along with our IT providers would be expected to complete the CAF DSPT in the future but the timeline of this was changeable.

Outcome: Noted.

7. Telephony changes update

AW confirmed the team who had upgraded telephony services at MSEFT had completed some analysis work on potential opportunities to do the same within EPUT. Following this, the decision had been taken that work would not proceed imminently due to the occupation of a large amount of physical infrastructure that still had a 2/3-year shelf life. The opportunity would be explored further in the future.

BF noted a potential challenge to the system to review the use of landlines for access and where we could modernise operationally to make ourselves more accessible to patients. AW confirmed they had reduced landlines within EPUT from 3000 to 1250 where they were not being used and would continue to look for opportunities for efficiencies in this area.

Outcome: Noted.

8. ICS Digital Dashboard

SP noted there were escalations within the dashboard that were being managed as part of individual projects.

The Information Standard Notice (ISN) slide had been updated using a system recommended by Provide to assist in the management of ISN's.

There had been no input from partners on upcoming opportunities in relation to contract expiries and SP asked for feedback on how best to document these across system partners moving forwards.

There had not been a Community of Interest Network (COIN) submission this month, but an update was expected the following week.

Outcome: Noted.

9. Minutes of ICS IG and Cyber Steering Groups

The following minutes of the ICS IG and Cyber Steering Groups were noted:

- ICS IG Steering Group Minutes 26th September 2024
- ICS Cyber Security Steering Group Minutes 20th November 2024
- ICS Cyber Security Steering Group Minutes 18th December 2024
- ICS Cyber Security Steering Group Minutes 15th January 2025

Outcome: Noted.

10. Any Other Business

There was no other business.

11. Date of Next Meeting

Thursday 13th March 2025, 09:00-10:30, via MS Teams

Minutes of People Board Committee Meeting

Held on 6th March 2025 at 11:00am

Boardroom, MSEICB Headquarters and via MS Teams

Attendees

Members

- Joe Fielder (JF), Non-Executive Member, Mid and South Essex Integrated Care Board (MSE ICB) – Chair
- Kathy Bonney (KB), Interim Chief People Officer, MSE ICB
- Andrew McMenemy (AMc), Chief People Officer, Essex Partnership University Trust (EPUT)
- Lorraine Hammond Di-Rosa (LHD), Director of Culture & OD, Mid and South Essex Foundation Trust (MSEFT) – Deputy for SD
- Anna Davey (AD), ICB Partner Member (Primary Care), MSE ICB
- Giles Thorpe (GT), Executive Chief Nursing Officer, MSE ICB
- Siobhan Morrison (SM), Group Chief People Officer, Provide CIC
- Eileen Marshall (EM), Chief Executive, St Luke's Hospice, Hospice Representative
- Emma Sweeney (ES), MSEFT – Deputy for DS

Other attendees

- Sarah Crane (SC), Associate Medical Director for Development, MSE ICB
- Rachel Sestak (RS), Head of Systems Workforce, MSE ICB
- Sharon McDonald (SMc), Head of Systems Workforce, MSE ICB
- Amy Evans (AE), Business Manager, MSE ICB – Secretariat
- Nicola Adams (NA), Associate Director of Corporate Services, MSE ICB
- Paul Taylor (PT), Director of OD and Culture, EPUT
- Stuart Hastings (SH), People Promise Manager, EPUT
- Sarah Davies (SD), Finance Improvement Lead, MSE ICB
- Kate Merritt (KM), Health & Care Academy Manager, MSE ICB

Apologies

- Selina Dundas (SD), Chief People & Organisational Development Officer, MSEFT
- Kathryn Perry (KP), Head of Primary Care Workforce, MSE ICB
- Fiona Wilson (FW), People Business Partner, Essex County Council
- Di Sarkar (DS), Chief Nursing & Quality Officer, MSEFT

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Introductions were made for new attendees. JF expressed disappointment at lack of attendance from MSEFT. ES agreed to relay the message.

2. Declarations of Interest

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

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

There were no other declarations raised.

3. Minutes & Action Log

The minutes of the meeting on 9th January 2025 were received and the group approved as an accurate record.

Outcome: The minutes of the meeting held on 9th January 2025 were approved as an accurate record.

The action log was reviewed and updated.

4. Highlight Reports from Workstream Chairs

Clinical Capacity Expansion / Education Innovation Workstream (CCEI)

SC shared with the group the volume of work the Health and Care Academy (HCA) continues to do as well as the work being completed by the Workforce Training Hub in Primary Care. AMc asked how effectiveness was being measured in regards to engagement with schools, RS suggested the college enrichment programme was the most measurable, however reports go to NHS England each quarter to capture long-term effectiveness.

Outcome: Members noted the CCEI highlight report.

Colleague Engagement, Wellbeing & Retention (CEWR) Group

SM shared the progress being made by the group, and spoke positively about the HCA Application that was demonstrated in the last meeting. SM spoke of Provide's learning and development week, which was being advertised within the system. There would be a focus on the Staff Survey when results were released, and the CEWR was keen to have further discussions around the HCA Application due to a potential bid for monies to create a Health and Wellbeing Application. RS confirmed the ICB had a license with the company used for

the HCA Application and could have as many applications as required. The Board discussed action plans and some revisions that were required.

Outcome: Members noted the CEWR highlight report.

- **Action:** SM to revise the action plans presented by CEWR workstream i.e. wrong date shown for deadline and 'TBCs'.
- **Action:** Regarding action on CEWR action plan - 'to ensure all line managers have attended health and wellbeing conversation training across the system' - SM to have conversation with Aleks Mecan about how Alliances to feed into this work.

Culture Workstream

LHD praised the activity that has taken place within the Culture workstream. The Reciprocal Mentoring Programme ended and was well received, Board Members were enthusied by the programme and made a commitment to drive the agenda forward. Discussion around the the Staff Networks and ensuring alignment to objectives, increased amount of work and training with the Chairs had taken place. Work continued on the Equality, Diversity and Inclusion (EDI) dashboard and LHD was keen to see the Staff Survey results upon release. KB confirmed that a strengths, weaknesses, opportunities and threats (SWOT) analysis was taking place in relation to mid and south Essex and this would be shared with the Board. LDH stated that representation in leadership roles and making a commitment to drive change was key. SC asked to ensure Primary Care was linked in with such initiatives to ensure system-wide working.

Outcome: Members noted the ED&I highlight report.

5. ICB as an Anchor Organisation

RS provided an overview of the HCA, which had been under scrutiny because of high vacancies. The HCA launched 1 July 2024 and had seen 188 new starters since its introduction with a 98% retention rate. EPUT decreased their vacancy rate from 21% to 10% since starting. The HCA Application was launched and had been successful thus far, helping with training and communications. Primary Care Health Care Assistants had also used the HCA Academy for inductions, and other organsations, such as hospices were keen to join.

KM presented to the group on the HCA, with its aim to engage young people with various careers in the NHS, looking at future talent pipeline development, attracting and inspiring young people with access to educational events and interactive activities. The school engagement strand of the Academy had 97% engagement from 79 schools and the college enrichment programme had 3 Full-time Education colleges over 5 different sites which covered a large area in MSE. The HCA were holding 2 events this year. Last year, 29 Year 2 students attended a recruitment event and 25 of those had a positive employment outcome. The group discussed how, as a system, it needed to identify vacancies and link in with the Academy to ensure those students were not lost to other organisations i.e. Social Care. AMc and SM agreed the onus should be on our organisations to provide vacancies for the students to move into, which would also decrease bank and agency usage. KM

stated the students were keen to gain practical experience and need placement hours to complete training. KM also shared that the HCA would like to extend into Primary Care and had offered to attend recruitment events. The group discussed how the organisations could assist with getting students into placements and / or vacancies after completion.

Outcome: Members noted the presentations.

- **Action:** Kate Merritt (KM) and RS to link in with all Leads regarding Health & Care Academy.

6. Workforce Data and the Challenges it presents at System Level

RS approached the group with a paper written regarding the workforce data and the challenges it presented in regards to creating a working dashboard. A workforce intelligence subgroup had been set up and met to start the piece of work. Recommendations from the group was that the dashboard required one version of the truth from the data which would require a project of data cleansing, which EPUT and MSEFT would need to agree in order to complete. SD had previously been employed by other organisations to conduct projects such as this, and was hopeful MSE could gain the same benefits. Group collectively supported confirming that data reconciliation was integral to ensure a system-wide dashboard runs effectively.

Outcome: Members noted the paper.

- **Action:** RS to ensure Provide attend the Workforce Intelligence Subgroup - SM to raise at CPO meeting.

7. People Promise & Retention

PT presented to the group the status of the People Promise Exemplar Programme which was focussed on onboarding and an Allied Health Professional (AHP) Pilot. SH provided some detail into the pilot, including AHPs and support to AHPs having the highest 12 month rolling turnover and reasons for leaving; worklife balance rating highest within control. SH shared with the group three initiatives that were in progress to reduce AHP turnover and improve experience, for example one member of staff was retained following a ‘rescue call’. From August 2024 to January 2025, turnover had reduced from 9.5% to 8.8%. It was suggested that this work should be sustained as business as usual (BAU) and learning should be shared. RS was keen to ensure work was not duplicated and to work alongside the HCA Academy where possible. JF sought clarification on how much the 1% reduction in turnover saved the public pound.

Outcome: Members noted the presentation.

8. People Board Risk Report

KB shared the current risks and noted there was a decision to make in regards to closing one. GT and JF agreed that they were uncomfortable closing the risk currently. KB also stated there are some new risks to be added, and AMc also suggested another potential

risk to add. JF asked the group if this current risk set was right, and suggested that the risk report was taken away as a whole and re-looked at.

Outcome: Members noted the People Board risk report.

- **Action:** KB to take current risks and work with Execs to create new set of risks / actions;
  - Entry Band 5 increase to 6 to be added.
  - Capacity to set up CDCs to be added.

9. Committee Effectiveness Desktop Review

NA gave a brief overview of the Committee Effectivess Desktop Review to the group which should also consider its achievements as a new committee. Reiteration was made to the group that the member survey needed to be completed, AE to resend. JF agreed all feedback was welcome and asked the group to consider if the Terms of Reference (ToR) was meeting the committees objectives.

Outcome: Members noted the update.

10. Items for Information

No items presented.

11. Any Other Business

None discussed.

12. Items to Escalate

No items to escalate.

13. Date of Next Meeting

1 May 2025, 11:00 – 13:00 – Virtual

Part I ICB Board meeting, 15 May 2024

Agenda Number: 17.4

ICB Annual Report and Accounts

Summary Report

1. Purpose of Report

The ICB has a statutory duty to prepare and publish its Annual Report and Accounts in accordance with guidance issued by NHS England. The draft report was submitted to NHS England and the ICB External Auditors on 25 April 2025, with the final version to be submitted by 23 June 2025.

The purpose of this report is to seek delegation from the Board to the Audit Committee to approve the Annual Report and Accounts on behalf of the Board prior to submission to NHS England and the External Auditors.

Once submitted the final accounts will be published in accordance with NHSE guidance.

2. Executive Lead

Dr Giles Thorpe, Executive Chief Nursing Officer

3. Report Author

Nicola Adams, Associate Director of Corporate Services

4. Responsible Committees

The Board is responsible for approval of the Annual Report and Accounts.

The Audit Committee has responsibility for overarching governance and that described in the Annual Report.

The Finance & Performance Committee has responsibility for review of the ICB Annual Accounts.

5. Impact Assessments / Financial Implications / Engagement / Conflicts of Interest

Not applicable to this report.

6. Recommendation(s)

The Board is asked to formally delegate responsibility for approval of the ICB Annual Report and Accounts 2024/25 to the Audit Committee, having had assurance regarding the accounts from the Finance and Performance Committee.